



DentalWise

DentalWise® plans are dental plans for individuals and families

Golden Rule Insurance Company is the underwriter of these policies. Benefits are administered by Dental Benefit Providers, Inc.

Policy Forms: DEN-CH-GRI-36

UnitedHealthcare
Golden Rule Insurance Co.

Table of Contents

Why choose dental coverage?	3
Dental plan options	4
Dental plan benefits	5
Dental plan network	6
Exclusions and Limitations	7
Policy Provisions	10
Privacy and other notices	11



Why choose dental coverage?



Dental highlights

Coverage for your oral health in a convenient plan designed with budget-friendly premiums in mind



Why dental insurance?

Taking care of your health goes beyond regular medical checkups. Dental health is just as important to your overall well-being. Having a supplemental plan like DentalWise can provide additional coverage to help protect your overall health and budget.



Use dental benefits right away, no wait for most services

Our DentalWise plans offer you coverage without waiting periods for preventive, basic and most major services so you can start using them right away! This means you have immediate coverage for routine services like exams and cleanings, plus major repairs like crowns and root canals.



Helping to enhance your quality of life

Your overall health and well-being rely greatly on your dental care. When you smile more, life is naturally more enjoyable. Choosing a DentalWise plan can help enhance your quality of life and help you feel good about yourself.

This is an outline only and is not intended to serve as a legal interpretation of benefits. Reasonable effort has been made to have this outline represent the intent of contract language. However, the contract language stands alone, and the complete terms of the coverage will be determined by the policy.

Dental plan options

Our plan options allow you to select a plan that best balances your premium and out-of-pocket expenses, with your anticipated benefit use, giving you the freedom to choose what works best for you.

DentalWise plan availability All benefits are per insured person, per Policy Year ¹ unless otherwise noted		Basic Plan²	Plan 1000²	Plan 2000²
Dental waiting period		None	None	None, except for Implants benefit only
Dental benefit deductible (per insured person, per Policy Year)	You pay:	\$100	\$100	\$100
Dental benefit maximum (per insured person, per Policy Year)	We pay up to:	\$1,000	\$1,000	\$2,000
Preventive services³ (includes exams and x-rays)				
Includes 2 routine exams and cleanings per Policy Year	We pay:	100% (no deductible)	100% (no deductible)	100% (no deductible)
Basic services³ (includes simple fillings)				
First Policy Year	We pay:	60% after deductible	60% after deductible	60% after deductible
Second Policy Year and after	We pay:	80% after deductible	80% after deductible	80% after deductible
Major services³ (includes bridges, crowns, dentures, extractions, partials, root canals)				
First Policy Year	We pay:	Not covered	15% after deductible	15% after deductible
Second Policy Year and after	We pay:	Not covered	50% after deductible	50% after deductible
Implants (12 month waiting period) \$1,500 Implant Maximum Lifetime Benefit ⁴	We pay:	Not covered	Not covered	50% after deductible

¹ Policy Year means each consecutive 12 month period beginning with the effective date. ² For covered dental expenses, non-network provider benefits are determined by ZIP Code. They are either based on the network negotiated rate or are based on the reasonable and customary charge (reasonable and customary benefits are identifiable by the word "Plus" added to the plan name). Non-network dentists can bill a patient for any remaining amount up to the billed charge. ³ Limitations and exclusions may apply based on type of service. ⁴ The Implant Maximum Lifetime Benefit is separate from, and not subject to, the Dental Benefit Maximum.

Dental benefit details

The following dental benefits are subject to plan provisions, Exclusions and Limitations, the deductible, and any applicable coinsurance and all Policy Provisions. This is only a general outline of the dental benefits. It is not an insurance contract, nor part of the insurance policy. You will find complete coverage details in the policy.

Preventive services (all plans)

- Oral evaluations - 2 per Policy Year
- Routine cleanings - 2 per Policy Year
- Complete series of radiographic images - 1 per 36 months
- Bitewings, single film - 4 per Policy Year
- Vertical bitewings, 7 to 8 radiographic images - 1 per 36 months
- Panoramic radiographic images - 1 per 36 months
- For insured persons under the age of 16 years:
 - Fluoride treatments - 2 per Policy Year
 - Sealant - once per first and second permanent molar every 36 months

Basic services (all plans)

- Fillings - amalgam and resin-based composite (resin-based composite limited to anterior tooth)
 - multiple restorations on the same tooth will be treated as one filling
- Simple (non-surgical) extractions
- General anesthesia in conjunction with oral surgery or the removal of 7 or more teeth
- Local anesthesia
- Therapeutic drug injection, limited to 1 per visit

Major services (all plans except Basic)

- Bridges - 1 per tooth per 60 months
- Crowns - 1 per tooth per 60 months
- Full or partial dentures - 1 per 60 months
- Periodontal maintenance - 2 per Policy Year
- Root canals - 1 per tooth per lifetime
- Surgical extractions and oral surgery on erupted permanent teeth - 1 per tooth per lifetime

Implants (Plan 2000 only)

12 month waiting period applies. Implant related procedures are subject to Implant Lifetime Maximum Benefit of \$1,500.

- Implant placement - 1 per tooth per 60 months
- Implant supported prosthetics - 1 per tooth per 60 months
- Implant maintenance procedures - 1 per tooth per 60 months

Dental benefit network



Dental benefits and how they work

Dental benefits are administered by Dental Benefit Providers, Inc. We will cover dental services subject to the terms, conditions, exclusions and limitations of the policy. All services are subject to Dental Benefit Maximum and applicable coinsurance. All services, except Preventive, are subject to deductible.

Network provider services

You can see any dentist you want, anywhere across the country. When you choose a dentist who is part of the large national network, National Options PPO 30, you can receive network discounts without the hassle of negotiations. Visit yourdentalplan.com/dentistsearch to find a provider and present the provider with your dental ID card. We will pay the provider the covered benefit, and the provider will bill you for the remainder.



There are no claim forms to fill out when obtaining services from a network provider.

Non-network provider services

The non-network provider may submit the claim to us directly. The provider can then bill you for any remaining amount due up to the billed charge. If a provider does not wish to submit the claim to us, you will need to pay in full at the time of service. You can then submit the claim for reimbursement by going to myuhc.com and completing the dental claim form.

Exclusions and Limitations

(insurance plans)

This is only a general outline of the exclusions. It is not an insurance contract, nor part of the insurance policy. You will find complete coverage details in the policy. Some state exceptions may apply.

General exclusions and limitations

No benefits will be paid for any service or treatment for which charges incurred are not identified and included as covered expenses under the policy. You will be fully responsible for payment for any services for which charges incurred are not covered expenses under the policy.

For ALL plans, the policy does not pay benefits for any service or treatment caused by, resulting from, for, which are, or relating to any of the following:

- Fees/surcharges imposed on the insured person by a provider but that are actually the responsibility of the provider to pay
- Provided prior to the effective date or after the termination date of the policy
- In excess of the frequency limitations or maximum benefits as shown in the policy
- Covered expenses which exceed the non-network provider reimbursement, as shown in the policy
- A service that is not rendered or that is not rendered within the scope of the provider's license
- Telephone consultations or for failure to keep a scheduled appointment
- Experimental or investigational treatment or for complications there from
- Which arise out of, or in the course of, employment for wage or profit, if the insured person is insured, or is required to be insured, by workers' compensation insurance pursuant to the applicable state or federal law
- Intentionally self-inflicted bodily harm
- Any act of declared or undeclared war
- The insured person taking part in a riot
- The insured person's commission or attempt to commit a felony
- Provided by a government plan, program, hospital or other facility, unless by law an insured person must pay and it is otherwise a covered expense or which by law must be provided by an educational institution
- Provided without cost to an insured person in the absence of insurance covering the charge
- Provided by an immediate family member or someone who ordinarily resides with an insured person
- Received outside of the United States, except for a dental emergency
- Related to the temporomandibular joint (TMJ), upper and lower jaw bone surgery or orthognathic surgery
- Teeth that can be restored by other means; for purposes of periodontal splinting; to correct abrasion, erosion, attrition, bruxism, abfraction, or for desensitization; or teeth that are not periodontally sound or have a questionable prognosis
- Performed for cosmetic/aesthetic reasons
- Mouthguards; precision or semi-precision attachments; duplicate dentures; harmful habit appliances; occlusal guard; replacement of lost or stolen appliances; treatment splints; bruxism appliance; sleep disorder appliance
- Oral hygiene instructions; plaque control; charges for completing dental claim forms; photographs; any dental supplies including but not limited to take-home fluoride; sterilization fees; diagnostic casts; treatment of halitosis and any related procedures; lab procedures
- Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the covered person's dental visit
- Maxillofacial prosthetics and related services
- Hospital or other facility charges and related anesthesia charges

Exclusions and Limitations continued

(insurance plans)

This is only a general outline of the exclusions. It is not an insurance contract, nor part of the insurance policy. You will find complete coverage details in the policy.

- Charges for dental services that are not documented in the dentist records, that are not directly associated with dental disease, or that are not performed in a dental setting
- Two or more dental services are submitted and the dental services are considered part of the same dental service to one another, we will pay the most comprehensive dental service
- Two or more dental services are submitted on the same day and the dental services are considered mutually exclusive (when one dental service contradicts the need for the other dental service), we will pay for the dental service that represents the final treatment
- Replacement of full or partial removable dentures, bridges, crowns, inlays, onlays or veneers which can be repaired or restored to natural function
- Billed for incision and drainage if the involved abscessed tooth is removed on the same date of service
- Reconstructive surgery when the primary purpose is to improve physiological functioning of the involved part of the body
- Changing vertical dimension; restoring occlusion; bite analysis, congenital malformation
- Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue
- Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal
- Treatment of malignant neoplasms or congenital anomalies of hard or soft tissue, including excision
- Removal of sound functional restorations; temporary crowns and temporary prosthetics; provisional crowns and provisional prosthesis
- Altering vertical dimension and/or restoring or maintaining occlusion
- Non-intravenous conscious sedation, analgesia, anxiolysis, inhalation of nitrous oxide and conscious sedation
- Acupuncture; acupressure and other forms of alternative treatment
- Bone grafts, guided tissue regeneration, biologic materials to aid in soft and osseous tissue

regeneration when performed in edentulous (toothless areas, ridge augmentation or preservations)

- Surgical extractions of wisdom teeth

For Basic and Basic Plus plans, the policy does not pay benefits for any service or treatment relating to major services, which includes all procedures or services related to endodontics, periodontics, major restorative services (crowns, inlays, onlays and veneers), dental implants, prosthetics (bridges and dentures, fixed or removable), and oral surgery

For Plan 1000 and 1000 Plus, the policy does not pay benefits for dental implants and any related procedures

For plans covering major services, the policy does not pay benefits for any service or treatment caused by, resulting from, for, which are, or relating to any of the following:

- Replacement within 60 consecutive months of the last placement for full and partial dentures, crowns, bridges, inlays, onlays and veneers. This exclusion does not apply if the replacement is necessary because of extraction of a functioning natural tooth; or a present crown, bridge, or dentures is temporary and a permanent crown, bridge or denture is installed within 12 months from the date the temporary service was installed.
- Replacement of complete dentures, fixed and removable partial dentures, or crowns, implants, implant crowns, implant prosthesis and implant supporting structures, if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the dentist. If replacement is necessary because of the insured person's non-compliance, the insured person is liable for the cost of the replacement.
- Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction
- Placement of fixed partial dentures solely for the purpose of achieving periodontal stability

Exclusions and Limitations continued

(insurance plans)

This is only a general outline of the exclusions. It is not an insurance contract, nor part of the insurance policy. You will find complete coverage details in the policy.

For plans covering major services (continued)

- Initial placement of full or partial dentures or bridges and related services, to replace functional natural teeth that are: (a) congenitally missing; or (b) lost before insurance under the policy is in effect. However, benefits are available for covered expenses for initial placement of full or partial dentures or bridges to replace loss of functional natural teeth, including necessary adjustments during the first 6 months following the date of placement, only if: (a) the teeth were lost while the insured person was under the policy and the placement is within 12 months of the date of the loss of the teeth; or (b) the extraction took place while the insured person was both under age 16 and insured under the policy.
- Replacement of crowns, bridges, dentures and fixed or removable prosthetic appliances, implants, implant crowns, implant prosthesis and implant supporting structures, inserted prior to plan coverage unless the insured person has been insured under the plan for 12 continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12-month period, dental services associated with the addition will be covered when the service is a covered expense.

For plans covering implants, the policy does not pay benefits for any service or treatment caused by, resulting from, for, which are, or relating to any of the following:

- Covered expenses incurred during the waiting period

Policy Provisions

This is only a general outline of the provisions. It is not an insurance contract, nor part of the insurance policy. You will find complete coverage details in the policy.

Definitions:

- **Dental Benefit Maximum** means the maximum amount payable under the policy for each insured person, per Policy Year, for all dental covered expenses, after the application of any dental benefit deductible and coinsurance.
- **Policy Year** means each consecutive 12 month period beginning with the effective date.

Eligibility

Plans can be issued to a primary insured ages 18 - 99 and spouse/domestic partner ages 16 - 99. Eligible dependent children include your natural and adopted children and step-children, children placed with you for the purpose of the child's adoption, and children for whom you are required to provide coverage by a court or administrative order, who are under 26 years of age.

Age Misstatement

If the age of any insured person has been misstated, our records will be changed to show the correct age. Premium adjustments will be made so that we receive the premiums due at the correct age payable on the premium due date following our notification of an age correction. If the insured person's age has been misstated and we would not have issued coverage for the insured person, we will refund the premium paid minus any benefit amounts paid by us, and coverage will be void from the effective date.

Alternate Procedure

If two or more services are considered acceptable to correct the same dental condition, the amount payable will be based on the covered expenses for the least expensive service that will produce a professionally satisfactory result.

Change of Residence

If you change your residence, we request you notify us.

Non-network vs. network

You may pay more using non-network providers. Non-network providers may bill you for any amount up to the billed charge after the portion covered by the policy has been paid. Network providers have agreed to discounted

pricing for covered expenses with no additional billing to you other than the coinsurance and deductible amounts.

Premium Changes

Subject to the prior approval by the Division of Financial Regulation, we reserve the right to change the table of premiums on a class basis, as defined in the policy. We will give you written notice of at least 31 days prior to the effective date of the new rates. Each premium will be based on the rate table in effect on the premium due date. Any change in rates will be effective on the next premium due date.

Reimbursement

If dental services are caused by the acts or omissions of a third party, we have the right to be reimbursed to the extent of benefits we paid for dental services, as outlined in the policy.

Renewability and Termination of Coverage

The policy is renewable until the earliest of the following:

- Nonpayment of premiums when due, subject to the provisions in the policy
- The end of the premium period following a request by you to terminate the policy
- On the date you: perform an act or practice that constitutes fraud; or make an intentional misrepresentation of material fact, relating in any way to the coverage provided under the policy, including claims for benefits under the policy
- On the date we elect to discontinue this plan, type of coverage, or all coverage in your state
- The date of your death, if it is a primary insured only policy. (If there are other members on the policy, Continuation provisions apply.)

Right to Examine

It is important to us that you are satisfied with the coverage being provided. This product has a Right to Examine period, also commonly referred to as "free look." After applying and after your policy is issued, if you are not satisfied the coverage will meet your insurance needs, you may return the policy to us within 10 days and have the paid premium refunded. Refer to policy for details.

Note to our customers about supplemental insurance

- The supplemental plan discussed in this document is separate from any health insurance or Medicare Advantage coverage you may have purchased with another insurance company
- This plan provides optional coverage for an additional premium. It is intended to supplement your health insurance and provide additional benefits for covered expenses.
- This plan is not required in order to purchase health insurance with another insurance company
- This plan should not be used as a substitute for comprehensive health insurance coverage. It is not considered Minimum Essential Coverage under the Affordable Care Act.

Health plan notices of privacy practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

VIEW NOTICE HERE. Please review it carefully.

(<https://www.uhc.com/content/dam/uhcdotcom/en/npp/NPP-UHC-EI-UHOne-EN.pdf>)

Conditions prior to coverage (applicable with or without the conditional receipt)

Subject to the limitations shown below, insurance will become effective if the following conditions are met:

1. The application is completed in full and is unconditionally accepted and approved by Golden Rule Insurance Company
2. The first full premium, according to the mode of premium payment chosen, has been paid on or prior to the effective date and any check is honored on first presentation for payment
3. The policy is: (a) issued by Golden Rule Insurance Company exactly as applied for within 45 days from date of application; (b) delivered to the proposed insured; and (c) accepted by the proposed insured

After you have completed the application and before you sign it, reread it carefully. Be certain that all information has been properly recorded. Keep an electronic copy of this document. It has important information.