



Underwritten by  
Mutual of Omaha Insurance Company

3300 Mutual of Omaha Plaza  
Omaha, Nebraska 68175

**APPLICATION for  
INDIVIDUAL DENTAL INSURANCE  
WITH OPTIONAL VISION RIDER**

**PENNSYLVANIA**



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3300 Mutual of Omaha Plaza  
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Monthly Rates (Issue Age 19-99)

PENNSYLVANIA							
ZIP Codes	Mutual Dental Preferred DNT2			Mutual Dental Protection DNT5			Vision Rider OPD1M
	\$1,500	\$3,000	\$5,000	\$1,500	\$3,000	\$5,000	
155,157-159,179	\$46.09	\$52.78	\$55.08	\$25.27	\$25.98	\$26.46	\$8.28
153,154,161-169, 173-178,184-188	\$48.75	\$55.82	\$58.26	\$26.72	\$27.47	\$27.97	\$8.28
150-152,156,160, 170-172,195,196	\$51.40	\$58.85	\$61.42	\$28.17	\$28.96	\$29.49	\$8.28
180-183,190,191	\$56.69	\$64.91	\$67.74	\$31.08	\$31.95	\$32.54	\$8.28
189, 192-194	\$57.23	\$65.53	\$68.39	\$31.37	\$32.25	\$32.84	\$8.28

Rates Subject to Change.

As of 07/14/2023

The applicant will receive the following benefits under the Optional Vision Rider. The applicant must be enrolled in the Mutual of Omaha dental plan to apply.

Up to \$50 every calendar year for one eye exam (no waiting period)

Up to \$150 every two calendar years for eyeglasses or contact lenses (after a six-month waiting period)



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Internal Tracking Code \_\_\_\_\_  
Group # (if applicable) \_\_\_\_\_

# Application for Individual Dental Insurance with Optional Vision Rider



## A. Applicant Information

Name (First, Middle Initial, Last)		Phone Number Home _____ Cell _____	
Residence Address (Street, City, State, ZIP)		E-mail _____	
Mailing Address (Street, City, State, ZIP) (if different from residence address)		Deliver Policy to <input type="checkbox"/> Applicant <input type="checkbox"/> Producer	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth _____	Social Security Number _____	

## B. Plan Information

<b>Select Dental Benefit Plan</b> <input type="checkbox"/> Mutual Dental Preferred <input type="checkbox"/> Mutual Dental Protection	<b>Select Annual Maximum</b> <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$5,000	<b>Requested Effective Date</b> _____ <b>Monthly Premium Rate for Dental \$</b> _____
<input type="checkbox"/> Optional Vision Rider (only available with Dental)		<b>Monthly Premium Rate for Vision \$</b> _____ <b>Total Monthly Premium \$</b> _____

## C. Existing Coverage Information

Are you covered by any other dental or vision insurance? .....  Y  N

**If Yes, answer the following about this existing coverage:**

Name of dental carrier(s) \_\_\_\_\_

Name of vision carrier(s) \_\_\_\_\_

Is the coverage you are applying for replacing existing dental insurance? .....  Y  N

Is the coverage you are applying for replacing existing vision insurance? .....  Y  N

## D. Multi-policy Discount

**You may be eligible for a lower premium rate based on your answer to the statement in this section**

Are you applying for or have you applied for a Medicare supplement policy with Mutual of Omaha Insurance Company or its affiliates within the last 30 days? .....  Y  N

Do you have a Medicare supplement policy with Mutual of Omaha Insurance Company or one of its affiliates that has been issued within the last 30 days? .....  Y  N

## E. Agreements

I represent the information above is true and complete to the best of my knowledge and belief. Any incorrect or misleading answers may void this application and any issued policy. I understand that no insurance shall take effect until a policy is issued and the first premium is received by Mutual of Omaha during my lifetime.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

\_\_\_\_\_  
Applicant Signature Date Signed at City State

I/We acknowledge that if the applicant is replacing coverage, I/We have provided a copy of the replacement notice, if applicable.

\_\_\_\_\_  
Signature of Licensed Insurance Producer Date

\_\_\_\_\_  
Printed Name Agent Writing Number Comm. % Share %

\_\_\_\_\_  
Signature of Licensed Insurance Producer Date

\_\_\_\_\_  
Printed Name Agent Writing Number Comm. % Share %

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## Notice To Applicant Regarding Replacement of Accident and Sickness Insurance

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Mutual of Omaha Insurance Company. Your new policy provides 10 days after receipt of the policy within which you may decide whether you desire to keep the policy. For your own information and protection you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have, (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. Even though some of your present health conditions may be covered under the new policy, these conditions may be subject to certain waiting periods under the new policy before coverage is effective.
3. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force.

After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above Notice to Applicant was delivered to me on \_\_\_\_\_ Date

\_\_\_\_\_  
Applicant's Signature



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\_\_\_\_\_  
Applicant's Signature



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## **Non-Discrimination Notice**

Mutual of Omaha complies with applicable laws and does not unlawfully discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity.

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**GIVE NOTICE TO THE APPLICANT**

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**MUTUAL OF OMAHA INSURANCE COMPANY  
3300 MUTUAL OF OMAHA PLAZA  
OMAHA, NEBRASKA 68175  
(402) 342-7600**

**OUTLINE OF COVERAGE FOR POLICY SERIES DNT2-25394**

**INDIVIDUAL DENTAL PREFERRED PROVIDER  
ORGANIZATION (PPO) INSURANCE**

**THE POLICY PROVIDES LIMITED BENEFIT DENTAL COVERAGE ONLY.  
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.**

**THIS POLICY IS NONPARTICIPATING. NO DIVIDENDS WILL BE PAID.**

**Read Your Policy Carefully** – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

**Limited Benefit Dental-Only Insurance Coverage** – This policy is designed to provide you **ONLY** with limited benefit dental insurance coverage. Coverage is **NOT** provided for any other diseases or accidents.

**Benefits** – This is a Preferred Provider Organization (PPO) dental insurance policy that pays benefits for covered dental services provided by in-network and out-of-network dentists. It pays benefits for Diagnostic and Preventive Services, Basic Services, and Major Services. If you incur expense for a covered dental service, we will pay the coinsurance percentage of the allowed amount after you have satisfied the deductible and any applicable waiting period. Benefits payable are limited to any annual maximum benefit and lifetime maximum benefit.

Shown below is a brief summary of the dental benefits we will pay under this policy. For a full list of covered dental services and procedures, please visit our website at [www.mutualofomaha.com/individual-dental](http://www.mutualofomaha.com/individual-dental).

**DENTAL BENEFITS SUMMARY**

DEDUCTIBLE	AMOUNT
Class I -- Diagnostic & Preventive Services	None
Class II – Basic Services and Class III - Major Services Combined	\$50.00
COINSURANCE	PERCENTAGE PAYABLE
Class I – Diagnostic & Preventive Services	100%
Class II – Basic Services	80%
Class III – Major Services	20% Day One, 50% After Year One
WAITING PERIOD	TIME FRAME
Class I– Diagnostic & Preventive Services	None
Class II– Basic Services	None
Class III– Major Services	None
MAXIMUM BENEFIT	AMOUNT
Annual Maximum Benefit per Calendar Year	\$1,500, \$3,000 or \$5,000
Implant Lifetime Maximum Benefit	\$3,000

You may obtain dental care for covered dental services from any licensed dentist. No matter which dentist you choose, you will be eligible for some level of benefits for covered dental services. However, when you use an in-network dentist who participates in the PPO network, that dentist has agreed to provide dental care at negotiated fees. For in-network dentists, you will not be responsible for the difference between your dentist’s submitted amount and the scheduled fee amount that the dentist has contractually agreed to accept as payment in full. The PPO network used by this policy is DenteMax Plus.

If you select a dentist who does not participate in the PPO network, your out-of-pocket expenses may be greater. For out-of-network dentists, you will be responsible for the difference between your dentist’s submitted amount and our payment. The amount we use to

calculate our payment will be the lesser of the dentist's submitted amount or the 80th percentile amount for covered dental services as identified by the Dental Charges Database.

**Waiting Period** – Covered dental services are subject to the waiting period shown in the above Dental Benefits Summary chart. You must satisfy the waiting period before benefits are paid for these services. The waiting period begins on the policy effective date and is applied once during the lifetime of your policy.

**Exclusions** -- Your policy pays benefits only for covered dental services. We will not pay benefits for:

- (a) first installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth all of which were lost while the person was not covered;
- (b) services or treatment not prescribed by or under the direct supervision of a dentist;
- (c) services or treatment which is experimental or investigational;
- (d) services or treatment which is for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the provision of any law or regulation or any government unit. This exclusion applies whether or not you claim the benefits or compensation;
- (e) services or treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, Veterans Administration hospital or similar person or group;
- (f) services or treatment performed prior to the policy effective date;
- (g) services or treatment incurred after the termination date of your coverage unless otherwise indicated;
- (h) services or treatment which is not dentally necessary or which does not meet generally accepted standards of dental practice;
- (i) services or treatment resulting from your failure to comply with professionally prescribed treatment;
- (j) telephone consultations;
- (k) any charges for failure to keep a scheduled appointment;
- (l) any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- (m) fluoride treatments;
- (n) services or treatment provided as a result of intentionally self-inflicted injury or illness;
- (o) services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
- (p) office infection control charges;
- (q) charges for copies of your records, charts or x-rays, or any costs associated with forwarding/mailing copies of your records, charts or x-rays;
- (r) state, federal, or territorial taxes on dental services performed;
- (s) those charges submitted by a dentist, which are for the same services performed on the same date by another dentist;
- (t) those dental services provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
- (u) those dental services for which you would have no obligation to pay in the absence of this or any similar insurance;
- (v) those dental services which are for specialized procedures and techniques;
- (w) those dental services performed by a dentist who is compensated by a facility for similar covered services performed for you on the same date;
- (x) duplicate, provisional and temporary devices, appliances, and services;
- (y) plaque control programs, oral hygiene instruction, and dietary instructions;
- (z) services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to:
  - 1. equilibration;
  - 2. periodontal splinting;
  - 3. full mouth rehabilitation and;
  - 4. restoration for misalignment of teeth;
- (aa) gold foil restorations;
- (bb) services or treatment for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization;
- (cc) hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient);
- (dd) charges by the provider for completing dental forms;
- (ee) adjustment of a denture or bridgework which is made within 6 months after installation by the same dentist who installed it;
- (ff) use of material or home health aids to prevent decay, such as:
  - 1. toothpaste;
  - 2. fluoride gels;
  - 3. dental floss and;
  - 4. teeth whiteners;

- (gg) sealants;
- (hh) precision attachments, personalization, precious metal bases and other specialized techniques;
- (ii) replacement of dentures that have been:
  1. lost;
  2. stolen or;
  3. misplaced;
- (jj) repair of damaged orthodontic appliances;
- (kk) replacement of lost or missing appliances;
- (ll) fabrication of athletic mouth guard;
- (mm) internal bleaching;
- (nn) nitrous oxide;
- (oo) oral sedation;
- (pp) topical medicament carrier;
- (qq) orthodontic services, treatment or supplies, including braces and retainers;
- (rr) bone grafts when done in connection with:
  1. extractions;
  2. apicoectomies or;
  3. non-covered/non-eligible implants;
- (ss) tooth whitening;
- (tt) occlusal guards;
- (uu) space maintainers;
- (vv) services or treatment provided by a member of your immediate family;
- (ww) services or treatment received outside of the United States, its possessions or territories, Canada, or Mexico; or
- (xx) services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD, TMJD) and related disorders.

**Multiple Procedure Limitations** – When two or more dental services are submitted and the dental services are considered part of the same service to one another, this policy will pay the most comprehensive service (the service that includes the other non-benefited service) as determined by us. When two or more dental services are submitted on the same day and the dental services are considered mutually exclusive (when one service contradicts the need for the other service), this policy will pay for the service that represents the final treatment as determined by us.

**Guaranteed Renewable For Life** – The policy is guaranteed renewable for life. We cannot cancel your policy as long as you pay the required premium before the end of each grace period.

**Premiums Can Change** – We will not increase your policy’s premium due to any change in your health. However, we can change premiums if we make the same change to all policies of this form issued to persons of the same class. We will give you the advance notice required by your state prior to any such premium change.

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**MUTUAL OF OMAHA INSURANCE COMPANY  
3300 MUTUAL OF OMAHA PLAZA  
OMAHA, NEBRASKA 68175  
(402) 342-7600**

**OUTLINE OF COVERAGE FOR POLICY SERIES DNT5-25397**

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**Benefits** – This is a Preferred Provider Organization (PPO) dental insurance policy that pays benefits for covered dental services provided by in-network and out-of-network dentists. It pays benefits for Diagnostic and Preventive Services, Basic Services, and Major Services. If you incur expense for a covered dental service, we will pay the coinsurance percentage of the allowed amount after you have satisfied the deductible and any applicable waiting period. Benefits payable are limited to any annual maximum benefit and lifetime maximum benefit.

Shown below is a brief summary of the dental benefits we will pay under this policy. For a full list of covered dental services and procedures, please visit our website at [www.mutualofomaha.com/individual-dental](http://www.mutualofomaha.com/individual-dental).

**DENTAL BENEFITS SUMMARY**

DEDUCTIBLE	AMOUNT
<b>Class I -- Diagnostic &amp; Preventive Services, Class II – Basic Services and Class III – Major Services Combined</b>	<b>\$100.00</b>
COINSURANCE	PERCENTAGE PAYABLE
<b>Class I – Diagnostic &amp; Preventive Services</b>	<b>100%</b>
<b>Class II – Basic Services</b>	<b>50%</b>
<b>Class III – Major Services</b>	<b>20% Day One, 50% After Year One</b>
WAITING PERIOD	TIME FRAME
<b>Class I– Diagnostic &amp; Preventive Services</b>	<b>None</b>
<b>Class II– Basic Services</b>	<b>None</b>
<b>Class III– Major Services</b>	<b>None</b>
MAXIMUM BENEFIT	AMOUNT
<b>Annual Maximum Benefit per Calendar Year</b>	<b>\$1,500, \$3,000 or \$5,000</b>
<b>Implant Lifetime Maximum Benefit</b>	<b>\$2,000</b>

You may obtain dental care for covered dental services from any licensed dentist. No matter which dentist you choose, you will be eligible for some level of benefits for covered dental services. However, when you use an in-network dentist who participates in the PPO network, that dentist has agreed to provide dental care at negotiated fees. For in-network dentists, you will not be responsible for the difference between your dentist’s submitted amount and the scheduled fee amount that the dentist has contractually agreed to accept as payment in full. The PPO network used by this policy is DenteMax Plus.

If you select a dentist who does not participate in the PPO network, your out-of-pocket expenses may be greater. For out-of-network dentists, you will be responsible for the difference between your dentist’s submitted amount and our payment. The amount we use to

calculate our payment will be the lesser of the dentist's submitted amount or an amount equal to the lowest prevailing scheduled fee used for in-network dentists in the geographic area.

**Waiting Period** – Covered dental services are subject to the waiting period shown in the above Dental Benefits Summary chart. You must satisfy the waiting period before benefits are paid for these services. The waiting period begins on the policy effective date and is applied once during the lifetime of your policy.

**Exclusions** -- Your policy pays benefits only for covered dental services. We will not pay benefits for:

- (a) first installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth all of which were lost while the person was not covered;
- (b) services or treatment not prescribed by or under the direct supervision of a dentist;
- (c) services or treatment which is experimental or investigational;
- (d) services or treatment which is for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the provision of any law or regulation or any government unit. This exclusion applies whether or not you claim the benefits or compensation;
- (e) services or treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, Veterans Administration hospital or similar person or group;
- (f) services or treatment performed prior to the policy effective date;
- (g) services or treatment incurred after the termination date of your coverage unless otherwise indicated;
- (h) services or treatment which is not dentally necessary or which does not meet generally accepted standards of dental practice;
- (i) services or treatment resulting from your failure to comply with professionally prescribed treatment;
- (j) telephone consultations;
- (k) any charges for failure to keep a scheduled appointment;
- (l) any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- (m) fluoride treatments;
- (n) services or treatment provided as a result of intentionally self-inflicted injury or illness;
- (o) services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
- (p) office infection control charges;
- (q) charges for copies of your records, charts or x-rays, or any costs associated with forwarding/mailing copies of your records, charts or x-rays;
- (r) state, federal, or territorial taxes on dental services performed;
- (s) those charges submitted by a dentist, which are for the same services performed on the same date by another dentist;
- (t) those dental services provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
- (u) those dental services for which you would have no obligation to pay in the absence of this or any similar insurance;
- (v) those dental services which are for specialized procedures and techniques;
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- (y) plaque control programs, oral hygiene instruction, and dietary instructions;
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- (cc) hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient);
- (dd) charges by the provider for completing dental forms;
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  - 1. toothpaste;
  - 2. fluoride gels;
  - 3. dental floss and;
  - 4. teeth whiteners;

- (gg) sealants;
- (hh) precision attachments, personalization, precious metal bases and other specialized techniques;
- (ii) replacement of dentures that have been:
  1. lost;
  2. stolen or;
  3. misplaced;
- (jj) repair of damaged orthodontic appliances;
- (kk) replacement of lost or missing appliances;
- (ll) fabrication of athletic mouth guard;
- (mm) internal bleaching;
- (nn) nitrous oxide;
- (oo) oral sedation;
- (pp) topical medicament carrier;
- (qq) orthodontic services, treatment or supplies, including braces and retainers;
- (rr) bone grafts when done in connection with:
  1. extractions;
  2. apicoectomies or;
  3. non-covered/non-eligible implants;
- (ss) tooth whitening;
- (tt) occlusal guards;
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