

# APPLICATION for INDIVIDUAL DENTAL INSURANCE WITH OPTIONAL VISION RIDER

## **PENNSYLVANIA**



### Monthly Rates (Issue Age 19-99)

PENNSYLVANIA							
ZIP Codes	Mutua	al Dental Pre DNT2	ferred	Mutua	l Dental Pro	tection	Vision Rider 0PD1M
	\$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)



Underwritten by

Mutual of Omaha Insurance Company

3300 Mutual of Omaha Plaza Omaha, Nebraska 68175

Internal Tracking Code Group # (if applicable)

## **Application for Individual Dental Insurance with Optional Vision Rider A. Applicant Information**



						·		
Name (First, Middle Initial, Last)			Phone Nu Home	ımber	(	Cell		
Residence Address (Street, City, State, ZIP)			E-mail			2011		
Mailing Address (Street, City, Sta	ate, ZIP)	(if different from residence	e address)		Deliver Polic	_	roducer	
Gender Date of Birth  Male Female				Social Sec	urity Number	,		
B. Plan Information								
Select Dental Benefit Plan	Select	Annual Maximum						
☐ Mutual Dental Preferred	\$1	,500						
☐ Mutual Dental Protection	\$3	3,000	Reque	ested Effec	tive Date			
	□ \$5	5,000	Мо	nthly Prem	ium Rate for	Dental \$_		
Optional Vision Rider (only a	available	e with Dental)	Monthly Premium Rate for Vision \$					
			Total Monthly Premium \$					
C. Existing Coverage Inf	format	tion						
Are you covered by any other de  If Yes, answer the following about Name of dental carrier(s) Name of vision carrier(s) Is the coverage you are applying Is the coverage you are applying  D. Multi-policy Discoun  You may be eligible for a lower pare you applying for or have you Company or its affiliates within the land to you have a Medicare supplementation above  I represent the information above	for repla for repla for repla remium applied the last 3 ment poli ast 30 da	icing existing dental insural acing existing vision insural rate based on your answer for a Medicare supplements of days?	er to the st	atement in th Mutual o	this section of Omaha Inst	urance ffiliates	- - - Y	
answers may void this application the first premium is received by N Any person who knowingly and w statement of claim containing any fact material thereto commits a frace Applicant Signature    We acknowledge that if the app	n and any Autual of vith inten material udulent in	r issued policy. I understand Omaha during my lifetime to defraud any insurance ly false information or concusurance act, which is a crimer replacing coverage, I/We	nd that no ince. company ceals for the ne and subj	or other pe e purpose o ects such p	nall take effect rson files an a f misleading, i erson to crimi Sigr	et until a po application information nal and civil	for insurn concern penaltie	rance or ning any es.
Signature of Licensed Insurar	nce Prod	ucer	Da	te				
Printed Name			Ag	ent Writing	Number	Comm	n. % Shar	_ % e
Signature of Licensed Insurar	nce Prod	ucer	Da	te				
				ont \\/::ti:	Numbar	<u></u>	0/ Cha::	_ %
Printed Name			Ag	ent Writing	rivurnber	Comm	n. % Shar	е

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## **METHOD OF PAYMENT FORM**

## **REQUIRED FORM – PLEASE RETURN PAGES 1 & 2**

Part I . Select Premium Payment Option

Initial Premium Payment (Select option #1 <u>or</u> #2)		
Initial premium amount (based on age at application date)	\$	
Paper Check (submit signed check with application)		
2. Automatic Bank Account Withdrawal		
Ongoing Premium Payments (Select option #1a, #1b, <u>or</u> #2)	1 <sup>St</sup> through the 28 <sup>th</sup> or	
1. I want my payments automatically withdrawn from my bank	the last day of every month	
a. Choose the day payments will be deducted every month from your bank account		
OR	Week (1 <sup>st</sup> , 2 <sup>nd</sup> , 3 <sup>rd</sup> , 4 <sup>th</sup> , last)	
b. Choose the week and weekday that payments will be	Weekday (Mon, Tue, Wed,	
deducted every month from your bank account	Thu, Fri)	
(For Example: 3rd Wednesday of every month)	, ,	
2. I will mail my premium to the company every 3, 6, or 12 months.	everymonths	
(Monthly billing is not allowed. <b>Select</b> frequency of billing)	Insert 3, 6, or 12	
the amount of time elapsed between the policy date and the date the policy is placed inforce, the amount may exceed one modal premium and may occur on a date other than the policy date. The Proposed Insure billing notices while on this premium payment option. We <b>CANNOT</b> establish electronic payments from for Each month, payments will be automatically deducted from the account below on the day selected above. premiums will be deducted on the policy date (which is determined at the time the policy is issued and car <b>Ongoing deductions will begin once the policy is issued.</b> If the scheduled deduction date begins on a wee will process on the following business day. <b>Part II. Payor Information</b>	ed(s) will not receive premium eign banks.  If no date is selected, no be found within the policy).	
1. Account Owner Name, if different than applicant's		
2. If premium is <b>NOT</b> paid by Proposed Insured/Insured (includes spouse or joint-married account), indicate the bank account owner's relationship to Proposed Insured/Insured by selecting one of the		
following.  Employer (3 app minimum/applicant must be retired. Refer to List-Bill guidelines. N/A for Direct-to-Consumer business)  Living Trust  Power of Attorney or legal guardian (documentation required)		
Business owned by applicant or applicant's spouse		



## Part III. Account Information

attin. Account information				
Complete the Following ONLY if <u>Automated Bank Account Withdrawal</u> is Chosen: This section is intended as authorization to debit your bank account. Complete bank account information below <b>OR</b> attach a copy of a voided check (Do NOT use a deposit slip)				
Applicant A Account Type (check one): Checking Savings  Name of Financial Institution  Routing Number (9 digits on lower left side of check)  Account Number (Do NOT use Debit/Credit Card numbers)  Name as Shown on Account				
<ul> <li>Payments cannot be postponed until a later date.</li> <li>Payment from a third party, including any foundation, will not be accepted, except in certain pre-approved situations.</li> <li>All refunds will be made to the applicant in the event of rejection, incomplete submission, overpayment, cancellation, etc.</li> </ul> Example: <ul> <li>Account Holder Name</li> <li>Bo NOT include the check # in the Routing or Account Number.</li> </ul> Example: <ul> <li>John Doe</li> <li>Street Address</li> <li>Town, City ZIP Code</li> <li>Pay to:</li> <li>Routing/Transfer Number</li> <li>Financial Institution</li> <li>Name &amp; Address</li> </ul>				
I authorize Mutual of Omaha Insurance Company ("Mutual of Omaha") to withdraw funds from my account for the initial and/or monthly renewal premiums and understand that the amounts may differ. Premium shortages may result from a variety of causes, including underwriting adjustments. I authorize my financial institution to pay from my account to Mutual of Omaha any preauthorized bank account withdrawals. I agree that my financial institution shall be fully protected in honoring any such payment and that its rights and responsibilities regarding the payment shall be the same as if the payment were signed personally by me. I agree to notify the business in writing of any changes in my account information. This authorization will be effective until I give you at least three business days' notice to cancel. If notice is given verbally, Mutual of Omaha may require written confirmation from me within 14 days after my verbal notice.				
Applicant A				
Authorized Signature as Shown on Account				
Date				





# 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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	Date	
	Applicant's Signature	





## 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** 



## 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!

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

<u>Benefits</u> – 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.

#### **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.

<u>Waiting Period</u> – 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;
  - 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;
  - 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.

<u>Multiple Procedure Limitations</u> — 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.

<u>Guaranteed Renewable For Life</u> – 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.

<u>Premiums Can Change</u> — 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.



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

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

## 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!

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

<u>Benefits</u> – 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.

#### **DENTAL BENEFITS SUMMARY**

DEDUCTIBLE	AMOUNT
Class I Diagnostic & Preventive Services, Class II - Basic Services and Class III - Major Services Combined	\$100.00
COINSURANCE	PERCENTAGE PAYABLE
Class I – Diagnostic & Preventive Services	100%
Class II – Basic Services	50%
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	\$2,000

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 an amount equal to the lowest prevailing scheduled fee used for in-network dentists in the geographic area.

<u>Waiting Period</u> – 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;
  - 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.

<u>Multiple Procedure Limitations</u> — 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.

<u>Guaranteed Renewable For Life</u> – 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.

<u>Premiums Can Change</u> — 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.