Mutual of Omaha

Underwritten by
Mutual of Omaha Insurance Company

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

APPLICATION for

INDIVIDUAL DENTAL INSURANCE WITH OPTIONAL VISION RIDER

MONTANA

MAP642_MT
10/04/2023

Mutual of Omaha

Underwritten by
Mutual of Omaha Insurance Company

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

Monthly Rates (Issue Age 19-99)

MONTANA							
ZIP Codes	**Mutual Dental Preferred DNT2**			**Mutual Dental Protection DNT5**			**Vision Rider 0PD1M**
	$1,500	$3,000	$5,000	$1,500	$3,000	$5,000	
591, 592, 595-598	$55.10	$63.10	$65.85	$30.20	$31.05	$31.63	$8.28
590, 593, 594, 599	$57.22	$65.52	$68.39	$31.36	$32.25	$32.84	$8.28

Rates Subject to Change.

As of 10/05/2023

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)

Internal Tracking Code _____
Group # (if applicable) _____

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Omaha, Nebraska 68175

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 ☐ Applicant ☐ Producer

Gender ☐ Male ☐ Female	Date of Birth	Social Security Number

B. Plan Information

Select Dental Benefit Plan	**Select Annual Maximum**	
☐ Mutual Dental Preferred ☐ Mutual Dental Protection	☐ $1,500 ☐ $3,000 ☐ $5,000	**Requested Effective Date** _____ **Monthly Premium Rate for Dental $** _____
☐ Optional Vision Rider (only available with Dental)		**Monthly Premium Rate for Vision $** _____
		Total Monthly Premium $ _____

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. 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.

✍ _____ _____
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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METHOD OF PAYMENT FORM

REQUIRED FORM – PLEASE RETURN 1 & 2

Part I . Select Premium Payment Option

Initial Premium Payment (Select option #1 or #2)

✍ **Initial premium amount** (based on age at application date)..... $ _____.__

1. Paper Check (submit signed check with application)..... ☐
2. Automatic Bank Account Withdrawal..... ☐

Ongoing Premium Payments (Select option #1a, #1b, or #2)

1. I want my payments automatically withdrawn from my bank
   a. Choose the day payments will be deducted every month from your bank account..... 1st through the 28th or the last day of every month

   OR

   b. Choose the week and weekday that payments will be deducted every month from your bank account..... **Week (1st, 2nd, 3rd, 4th, last)** _____ **Weekday (Mon, Tue, Wed, Thu, Fri)** _____
   (For Example: 3rd Wednesday of every month)

2. I will mail my premium to the company every 3, 6, or 12 months. (Monthly billing is not allowed. **Select** frequency of billing)..... **every_____months** Insert 3, 6, or 12

When choosing automatic bank account withdrawal, MONEY WILL BE WITHDRAWN FROM YOUR ACCOUNT IMMEDIATELY UPON POLICY APPROVAL AND ISSUE. The first withdrawal date may be different from the monthly date selected for ongoing premiums. Depending on the amount of time elapsed between the policy date and the date the policy is placed inforce, the amount of the first ongoing withdrawal may exceed one modal premium and may occur on a date other than the policy date. The Proposed Insured(s) will not receive premium billing notices while on this premium payment option. We **CANNOT** establish electronic payments from foreign banks.

Each month, payments will be automatically deducted from the account below on the day selected above. If no date is selected, premiums will be deducted on the policy date (which is determined at the time the policy is issued and can be found within the policy). **Ongoing deductions will begin once the policy is issued. If the scheduled deduction date begins on a weekend or holiday, the payment will process on the following business day.**

Part II. Payor Information

1. **Account Owner Name,** if different than applicant's..... _____
2. If premium is **NOT** 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. Muti-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

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Part IV. Account Information

Complete the Following ONLY if Automated Bank Account Withdrawal is Chosen:
This section is intended as authorization to debit your bank account.
Complete bank account information below **OR** attach a copy of a voided check (Do NOT use a deposit slip)

Can attach voided check here

Applicant A

Account Type (check one): ☐ Checking ☐ Savings

Name of Financial Institution

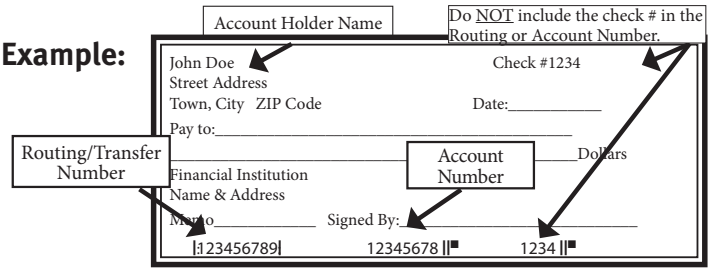
Routing Number (9 digits on lower left side of check)

Account Number (Do NOT use Debit/Credit Card numbers)

Name as Shown on Account

- Payments cannot be postponed until a later date.
- Payment from a third party, including any foundation, will not be accepted, except in certain pre-approved situations.
- All refunds will be made to the applicant in the event of rejection, incomplete submission, overpayment, cancellation, etc.

Example:



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

M469133

MUTUAL OF OMAHA
MONTANA PRIVACY NOTICE - PERSONAL INFORMATION

This Privacy Notice applies to the Personal Information of customers of the Mutual of Omaha companies. The companies include:

- Mutual of Omaha Insurance Company
- Mutual of Omaha Investor Services, Inc.
- Mutual of Omaha Marketing Corporation
- Mutual of Omaha Structured Settlement Company
- Omaha Insurance Company
- United of Omaha Life Insurance Company
- United World Life Insurance Company
- Companion Life Insurance Company

This Notice applies to our current as well as former customers.

Why You Are Receiving This Notice

The federal Financial Services Modernization Act and state privacy laws require us to send you an annual Notice. This Notice describes how we collect, use, and protect the Personal Information you entrust to us.

If you have a policy that is covered by the HIPAA Privacy regulations, you received a privacy notice that relates to the privacy of your medical information. To obtain an additional copy of the privacy notice related to your medical information you can log onto our company's website:

www.mutualofomaha.com/hipaa.html

or you can contact us at:

Mutual of Omaha
Attn: Privacy Office
Mutual of Omaha Plaza
Omaha, NE 68175-1029

Personal Information

Personal Information means information that we collect about you, such as name, address, Social Security number, income, marital status, employment and similar Personal Information.

Information We Collect

In the normal course of business we may collect Personal Information about you from:

- Applications or other forms we receive from you
- Your transactions with us, such as your payment history
- Your transactions with other companies
- Other sources (such as motor vehicle reports, government agencies and medical information bureaus)
- Consumer-reporting agencies

Insurance-Support Organizations

The Mutual of Omaha companies may exchange Personal Information about you with organizations that are referred to as "insurance-support organizations".

These organizations furnish Personal Information about applicants and policyholders for use in a number of insurance transactions, such as for underwriting and claims. These organizations may retain Personal Information we provide them and disclose it to other companies.

How We Protect Your Information

We restrict access to your Personal Information. It is given only to:

- The employees of Mutual of Omaha companies
- Others who need to know the information to provide our insurance or financial services to you

We have physical, electronic and procedural safeguards in place to make sure your Personal Information is protected. These safeguards follow legal standards and established security standards and procedures.

Sharing Within Mutual of Omaha

Your Personal Information

In the normal course of business we may share your Personal Information among the Mutual of Omaha companies listed above and with our banking affiliates. The type of information we share could include your name, Social Security number and other identifying information you provide to us. We may also share information about your transactions with us, such as your payment history.

We do not share your medical information, except to the extent we are required or permitted to under federal or state law.

Your Creditworthiness Information

We may also share certain information about your creditworthiness among the Mutual of Omaha companies listed above and with our banking affiliates. We do so to make it easier to do business with us. It also lets us better match our products and services with your needs. Creditworthiness includes:

(Continued on reverse side)

- Your marital status
- Your income
- Your employment history
- Your credit history

If we did not share this information among our companies, you might be required to provide the same information each time you apply for one of our products or services.

If you prefer us to not share information about your creditworthiness among the Mutual of Omaha companies, you may tell us by calling toll free at:

1-800-522-6912

When you call us, please be prepared to give us your policy or account number

Sharing With Third Parties

Montana law prohibits us from sharing Personal Information about you with certain third parties outside the Mutual of Omaha companies without your authorization. Since the Mutual of Omaha companies do not share Personal Information with such third parties, we are not requesting your authorization.

We may still share your Personal Information with third parties in those circumstances where sharing is permitted or required by law. For example:

- With our agents and brokers
- To respond to a judicial process or government regulatory authority
- To process an insurance transaction that you request
- To service your account, such as paying a claim
- To allow third parties to perform insurance functions on our behalf
- To other financial institutions with whom we have joint marketing agreements

We do not sell names or other information about our Montana customers to third parties for marketing purposes.

We do not share your medical information, except to the extent we are required or permitted to under federal or state law.

Your Rights Under Montana Law

Under Montana law, you have the following rights regarding your Personal Information:

Your Rights to Access Your Personal Information
You have the right to request a copy of the Personal Information that we have about you.

If we receive such a request, we will provide you a copy of your Personal Information within 30 days, as long as the information is reasonably locatable and retrievable.

We may charge you a nominal fee to provide you with copies of requested Personal Information.

Your Rights to Correct Your Personal Information
You have the right to correct, amend or delete Personal Information we may have recorded about you.

We will respond to your written request to correct, amend or delete Personal Information about you, within our possession, within 30 business days from the date your request is received.

Disclosures of Your Medical Information
You are entitled to request a list of disclosures we have made of your medical records. If we receive such a request from you, we will give you:

- The name, address and institutional affiliation, if any, of each person receiving your medical information during the prior 3 years
- The date the person examined or received your medical information
- A description of the information disclosed, unless it would not be practical to provide such a description

How to Exercise Your Rights
If you wish to exercise any of your rights under Montana law as provided for in this Notice, please write to us at:

Mutual of Omaha
Attn. Privacy Office
Mutual of Omaha Plaza
Omaha, NE 68175-1029

When you write to us, please provide us with your full name, complete address and your policy and/or account numbers.

Mutual of Omaha Insurance Company – Notice of Information Practices

In the course of properly underwriting and administering your insurance coverage, we will rely heavily on information provided by you. We may also collect information from others, such as medical professionals who have treated you, hospitals, other insurance companies, and consumer reporting agencies.

In certain circumstances, and in compliance with applicable law, we or our reinsurers may also release your personal or privileged information in our/their files, to third parties without your authorization. Upon request, you have the right to be told about and to see a copy of items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of personal information you believe to be inaccurate.

In compliance with applicable law, we or our reinsurers may also release information in our/their files, including information in an application, to other insurance companies to which you apply for life or health insurance or to which a claim is submitted.

So that there will be no question that the insurance benefits will be payable at the time a claim is made, we urge you to review your application carefully to be sure the answers are correct and complete.

THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THESE PRACTICES, PLEASE SEND YOUR REQUEST TO: MUTUAL OF OMAHA INSURANCE COMPANY, DIRECTOR OF INDIVIDUAL UNDERWRITING, MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175.

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GIVE THIS 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

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.

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.

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 injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
(o) office infection control charges;
(p) 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;
(q) state, federal, or territorial taxes on dental services performed;
(r) those charges submitted by a dentist, which are for the same services performed on the same date by another dentist;
(s) those dental services provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
(t) those dental services for which you would have no obligation to pay in the absence of this or any similar insurance;
(u) those dental services which are for specialized procedures and techniques;
(v) those dental services performed by a dentist who is compensated by a facility for similar covered services performed for you on the same date;
(w) duplicate, provisional and temporary devices, appliances, and services;
(x) plaque control programs, oral hygiene instruction, and dietary instructions;
(y) 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;
(z) gold foil restorations;
(aa) 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;
(bb) hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient);
(cc) charges by the provider for completing dental forms;
(dd) adjustment of a denture or bridgework which is made within 6 months after installation by the same dentist who installed it;
(ee) use of material or home health aids to prevent decay, such as:
    1. toothpaste;
    2. fluoride gels;
    3. dental floss and;
    4. teeth whiteners;
(ff) sealants;

(gg) precision attachments, personalization, precious metal bases and other specialized techniques;
(hh) replacement of dentures that have been:
    1. lost;
    2. stolen or;
    3. misplaced;
(ii) repair of damaged orthodontic appliances;
(jj) replacement of lost or missing appliances;
(kk) fabrication of athletic mouth guard;
(ll) internal bleaching;
(mm) nitrous oxide;
(nn) oral sedation;
(oo) topical medicament carrier;
(pp) orthodontic services, treatment or supplies, including braces and retainers;
(qq) bone grafts when done in connection with:
    1. extractions;
    2. apicoectomies or;
    3. non-covered/non-eligible implants;
(rr) tooth whitening;
(ss) occlusal guards;
(tt) space maintainers;
(uu) services or treatment received outside of the United States, its possessions or territories, Canada, or Mexico; or
(vv) 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 –The premiums for the policy are shown in the Policy Schedule. 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. In no event will the premium rate increase more often than once during any 12 month period. We will give you at least 45 days advance notice prior to any such premium change.

Premiums are based on the following: (1) Zip code; (2) State of purchase; (3) Dental benefit plan selected. Your selections are shown in the Policy Schedule.

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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

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.

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.

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.

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 injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
(o) office infection control charges;
(p) 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;
(q) state, federal, or territorial taxes on dental services performed;
(r) those charges submitted by a dentist, which are for the same services performed on the same date by another dentist;
(s) those dental services provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
(t) those dental services for which you would have no obligation to pay in the absence of this or any similar insurance;
(u) those dental services which are for specialized procedures and techniques;
(v) those dental services performed by a dentist who is compensated by a facility for similar covered services performed for you on the same date;
(w) duplicate, provisional and temporary devices, appliances, and services;
(x) plaque control programs, oral hygiene instruction, and dietary instructions;
(y) 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;
(z) gold foil restorations;
(aa) 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;
(bb) hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient);
(cc) charges by the provider for completing dental forms;
(dd) adjustment of a denture or bridgework which is made within 6 months after installation by the same dentist who installed it;
(ee) use of material or home health aids to prevent decay, such as:
    1. toothpaste;
    2. fluoride gels;
    3. dental floss and;
    4. teeth whiteners;
(ff) sealants;

(gg) precision attachments, personalization, precious metal bases and other specialized techniques;
(hh) replacement of dentures that have been:
    1. lost;
    2. stolen or;
    3. misplaced;
(ii) repair of damaged orthodontic appliances;
(jj) replacement of lost or missing appliances;
(kk) fabrication of athletic mouth guard;
(ll) internal bleaching;
(mm) nitrous oxide;
(nn) oral sedation;
(oo) topical medicament carrier;
(pp) orthodontic services, treatment or supplies, including braces and retainers;
(qq) bone grafts when done in connection with:
    1. extractions;
    2. apicoectomies or;
    3. non-covered/non-eligible implants;
(rr) tooth whitening;
(ss) occlusal guards;
(tt) space maintainers;
(uu) services or treatment received outside of the United States, its possessions or territories, Canada, or Mexico; or
(vv) 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 The premiums for the policy are shown in the Policy Schedule. 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. In no event will the premium rate increase more often than once during any 12 month period. We will give you at least 45 days advance notice prior to any such premium change.

Premiums are based on the following: (1) Zip code; (2) State of purchase; (3) Dental benefit plan selected. Your selections are shown in the Policy Schedule.