



Underwritten by
Mutual of Omaha Insurance Company

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

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

VIRGINIA



Underwritten by
Mutual of Omaha Insurance Company

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

Monthly Rates (Issue Age 19-99)

VIRGINIA							
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	
242, 243, 246	\$48.21	\$55.20	\$57.61	\$26.43	\$27.16	\$27.66	\$8.28
239-241, 244, 245	\$54.57	\$62.48	\$65.21	\$29.91	\$30.75	\$31.31	\$8.28
226-238	\$58.28	\$66.73	\$69.64	\$31.94	\$32.84	\$33.44	\$8.28
220-225	\$61.46	\$70.37	\$73.44	\$33.69	\$34.63	\$35.26	\$8.28
201	\$61.99	\$70.97	\$74.07	\$33.98	\$34.92	\$35.57	\$8.28

Rates Subject to Change.

As of 03/15/2024

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 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

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

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.

ANY PERSON WHO, WITH THE INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY HAVE VIOLATED STATE LAW.

I, and the undersigned agent, certify that I have read the completed application or had it read to me and I realize that any false statement or misrepresentation may result in loss of coverage under the policy.

If I am applying for the vision rider, I understand there is a 6-month waiting period for eye equipment.

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 _____%

This Page Left Blank Intentionally.

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.....
(For Example: 3rd Wednesday of every month)

Week (1st, 2nd, 3rd, 4th, last)

Weekday (Mon, Tue, Wed, Thu, Fri) _____

- 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 in force, 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?
- 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
- Y N



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:

Account Holder Name	Do NOT include the check # in the Routing or Account Number.	
John Doe	Check #1234	Date: _____
Street Address	Town, City ZIP Code	
Pay to: _____	Account Number	Dollars
Routing/Transfer Number	Financial Institution Name & Address	Signed By: _____
[123456789]	12345678 [1]	1234 [1]

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





Underwritten by
Mutual of Omaha Insurance Company

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

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. For your own information and protection, you should be aware of and seriously consider certain factors that 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 present under the new policy, whereas a similar claim might have been payable under your present policy.
2. 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.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to Mutual of Omaha Insurance Company within ten (10) days if any information is not correct and complete, or if any past medical history has been left out of the application.

The above Notice to Applicant was delivered to me on _____
Date

Applicant's Signature



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.

M26977

GIVE THIS NOTICE TO THE APPLICANT

This Page Left Blank Intentionally.

**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. 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/dental-insurance.

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
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.

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

- (a) services or treatment not prescribed by or under the direct supervision of a dentist;
- (b) services or treatment which is experimental or investigational;
- (c) 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 and paid, in whole or in part, under the provision of any law or regulation or any government unit;
- (d) 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;
- (e) services or treatment performed prior to the policy effective date;
- (f) services or treatment incurred after the termination date of your coverage unless otherwise indicated;
- (g) services or treatment which is not dentally necessary or which does not meet generally accepted standards of dental practice;
- (h) services or treatment resulting from your failure to comply with professionally prescribed treatment, unless you were unable to do so;
- (i) telephone consultations;
- (j) any charges for failure to keep a scheduled appointment;
- (k) any services that are considered strictly cosmetic in nature, except when services are incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part;
- (l) fluoride treatments;
- (m) services or treatment provided as a result of intentionally self-inflicted injury or illness;
- (n) services or treatment provided as a result of injuries suffered while participating in a riot;
- (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) duplicate, provisional and temporary devices, appliances, and services;
- (v) plaque control programs, oral hygiene instruction, and dietary instructions;
- (w) 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;
- (x) gold foil restorations;
- (y) services or treatment for injuries resulting from war or act of war, whether declared or undeclared;
- (z) hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient);
- (aa) charges by the provider for completing dental forms;
- (bb) adjustment of a denture or bridgework which is made within 6 months after installation by the same dentist who installed it;
- (cc) use of material or home health aids to prevent decay, such as:
 - 1. toothpaste;
 - 2. fluoride gels;
 - 3. dental floss and;
 - 4. teeth whiteners;
- (dd) sealants;
- (ee) precision attachments, personalization, precious metal bases and other specialized techniques;
- (ff) replacement of dentures that have been:
 - 1. lost;
 - 2. stolen or;
 - 3. misplaced;
- (gg) repair of damaged orthodontic appliances;
- (hh) replacement of lost or missing appliances;
- (ii) fabrication of athletic mouth guard;
- (jj) internal bleaching;
- (kk) nitrous oxide;

- (ll) oral sedation;
- (mm) topical medicament carrier;
- (nn) orthodontic services, treatment or supplies, including braces and retainers;
- (oo) bone grafts when done in connection with:
 - 1. extractions;
 - 2. apicoectomies or;
 - 3. non-covered/non-eligible implants;
- (pp) tooth whitening;
- (qq) occlusal guards;
- (rr) space maintainers;
- (ss) services or treatment provided by a member of your immediate family;
- (tt) services or treatment received outside of the United States, its possessions or territories, Canada, or Mexico; or
- (uu) 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). 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.

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.

This Page Left Blank Intentionally.

**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. 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/dental-insurance.

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
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.

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

- (a) services or treatment not prescribed by or under the direct supervision of a dentist;
- (b) services or treatment which is experimental or investigational;
- (c) 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 and paid, in whole or in part, under the provision of any law or regulation or any government unit;
- (d) 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;
- (e) services or treatment performed prior to the policy effective date;
- (f) services or treatment incurred after the termination date of your coverage unless otherwise indicated;
- (g) services or treatment which is not dentally necessary or which does not meet generally accepted standards of dental practice;
- (h) services or treatment resulting from your failure to comply with professionally prescribed treatment, unless you were not able to do so;
- (i) telephone consultations;
- (j) any charges for failure to keep a scheduled appointment;
- (k) any services that are considered strictly cosmetic in nature, except when services are incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part;
- (l) fluoride treatments;
- (m) services or treatment provided as a result of intentionally self-inflicted injury or illness;
- (n) services or treatment provided as a result of injuries suffered while participating in a riot;
- (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 Medicaid or 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) duplicate, provisional and temporary devices, appliances, and services;
- (v) plaque control programs, oral hygiene instruction, and dietary instructions;
- (w) 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;
- (x) gold foil restorations;
- (y) services or treatment for injuries resulting from war or act of war, whether declared or undeclared;
- (z) hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient);
- (aa) charges by the provider for completing dental forms;
- (bb) adjustment of a denture or bridgework which is made within 6 months after installation by the same dentist who installed it;
- (cc) use of material or home health aids to prevent decay, such as:
 - 1. toothpaste;
 - 2. fluoride gels;
 - 3. dental floss and;
 - 4. teeth whiteners;
- (dd) sealants;
- (ee) precision attachments, personalization, precious metal bases and other specialized techniques;
- (ff) replacement of dentures that have been:
 - 1. lost;
 - 2. stolen or;
 - 3. misplaced;
- (gg) repair of damaged orthodontic appliances;
- (hh) replacement of lost or missing appliances;
- (ii) fabrication of athletic mouth guard;
- (jj) internal bleaching;
- (kk) nitrous oxide;

- (ll) oral sedation;
- (mm) topical medicament carrier;
- (nn) orthodontic services, treatment or supplies, including braces and retainers;
- (oo) bone grafts when done in connection with:
 1. extractions;
 2. apicoectomies or;
 3. non-covered/non-eligible implants;
- (pp) tooth whitening;
- (qq) occlusal guards;
- (rr) space maintainers;
- (ss) services or treatment provided by a member of your immediate family;
- (tt) services or treatment received outside of the United States, its possessions or territories, Canada, or Mexico; or
- (uu) 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). 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.

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.

