

# APPLICATION for INDIVIDUAL DENTAL INSURANCE WITH OPTIONAL VISION RIDER

### **ILLINOIS**



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

ILLINOIS				
ZIP Codes	Mutual Dental Preferred Mutual De		Vision Rider 0PD1M	
613-615, 623-625,				
628, 629	\$44.65	\$22.98	\$8.28	
609-612, 616-622,				
626, 627	\$48.08	\$24.75	\$8.28	
600-608	\$55.44	\$28.53	\$8.28	

Rates Subjeut to Change.

As of 10/01/2020

The applicant will eueive the following benefits unde the Optional Vision Ride . The applicant must be en olled in the Mutual of Omaha dental plan to apply.

u p to \$50 eve y ualenda yea fo one eye exam (no waiting pe iod) u p to \$150 eve y two ualenda yea s fo eyeglasses o uontaut lenses (afte a six-month waiting pe iod)

Internal Tracking Code
Group # (if applicable)



Mutual of Omaha Insurance Company

3300 Mutual of Omaha Plaza Omaha, Nebraska 68175

### **AMMication for Individual Dental Insurance with OMional Vision Rider A.** AMMicant Information

Name (First, Middle Initial, Last)		Phone Number Home Cell				
Residence Address (Street, City, Stat	e, ZIP)	E-mail				
Mailing Address (Street, City, State, 7	ZIP) (if different from residenc	ce address)		Deliver Policy to		lucer
Gender  Male Female	Date of Birth		Social Sec	curity Number		
B. Plan Information						
	ınual Maximum \$M,5 ınual Maximum \$M,			tive Date		
Optional Vision Rider (only avail	able with Dental)	Mo	onthly Prem	ium Rate for Vis	sion \$	
C. Frietine Correspond	. C		Tota	l Monthly Prem	ium \$	
C. Existing Coverage In	nformation					
If Yes, answer the following about the Name of dental carrier(s)	eplacing existing dental insumentating existing vision insumentations and complete to the best dany issued policy. I underst	rance? rance? of my know and that no	vledge and	belief. Any inco	rrect or mis	sleading
Applicant Signature		Da	te	 Signed	d at City	State
I/We acknowledge that if the applicar  Signature of Licensed Insurance		have provi		of the replacem	ent notice	, if applicable
Printed Name		Age	ent Writing	Number	Comm. %	% Share
Signature of Licensed Insurance	Producer	Da				
Printed Name	<del></del>	Age	ent Writing	Number	Comm. %	Share





### **METHOD OF PAYMENT FORM**

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

Parol . SelecoPremiom PaymenoOpdon

Inidal Premiom Paymeno(Selecoopdon #1 <u>or</u> #2)			
Inicial premiom amoono (based on age at application date)	\$		
1 Paper Check (submit signed check with application)			
2 Automatic Bank Account Withdrawal			
Ongoing Premiom Paymenos (Selecoopoion #1a, #1b, or #2)	st		
1 I want my payments automatically withdrawn from my bank a Choose the day payments will be deducted every month from your bank account	1 <sup>st</sup> through the 28 <sup>th</sup> or the last day of every month		
OR	Week (1 <sup>so</sup> , 2 <sup>nd</sup> , 3 <sup>rd</sup> , 4 <sup>ch</sup> , laso)		
<ul> <li>b. Choose the week and weekday that payments will be deducted every month from your bank account (For Example: 3rd Wednesday of every month)</li> </ul>	Weekday (Mon, Toe, Wed, Tho, Fri)		
2 I will mail my premium to the company every 3, 6, or 12 months (Monthly billing is not allowed <b>Seleco</b> frequency of billing)	everymondhs 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 withdrawa 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 <b>CANNOT</b> establish electronic payments from foreign banks			
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 Ongoing dedoccions will begin once the policy is issued. If the schedoled dedoccion date begins on a wee will process on the following bosiness day.	n be found within the policy)		
Paroll. Payor Informacion			
<ul> <li>Accoono Owner Name, if different than applicant's</li> <li>If premium is NOT paid by Proposed Insured/Insured (inclodes spoose or joinomarried accoond), indicate the bank account owner's relationship to Proposed Insured/Insured by selecting one of the following</li> </ul>			
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			
ParoIII. Mod-Policy Discoono			
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 □ Y □ N		



Part IV. Account information			
Complete the Following ONLY if Automated Bank Account Wi This section is intended a uthhriz thin the debit your bank account with the control of the control	thdrawal is Chosen: hunt. vhhded check (Dh NOT use dephsht slhp)		
Applicant A  Acchunt Type (check hne):  Checking  S vings  N me hf Fm nch   Institution  Rhuting Number (9 digits hn lhwer left side hf check)  Acchunt Number (Dh NOT use Deblit/Credit C rd numbers)  N me s Shhwn hn Acchunt			
• P yments c nnht be phstphned unth 1 terd te.	Account Holder Name    Do NOT include the check # in the Routing or Account Number.		
I uthhrize Mutu I hf Om h Insur nce Chmp ny ("Mutu I hf Om h ") th withdr w funds frhm my cchunt fir the initial nd/hr minthly renew I premiums and underst nd that the minutes my differ. Premium shirt ges may result frhm and variety his cases, including underwriting djustments. I uthhrize my fin noch I institution that pay frhm my cohunt the Mutu I hf Om hand prediction in noch I institution that I is right to not esphasibilities regarding the payment shall be the same of the payment were signed personally by me. I gree than this the business in writing hand on the same of the payment were signed personally by me. I gree than this the business in writing hand on the same of the payment with the signed personally by me. I gree than this payment with the business of the payment with the payment with the same of the payment with the payment with the payment with the same of the payment with the pa			
Applicant A  Authhrized Sign ture s Shhwn hn Acchunt  D te			



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### Mutu LMMOM h Insur nce CMMp ny – NMtice MMnMrM tiMn Pr ctices

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** 



### 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!

<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/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	50%		
WAITING PERIOD	TIME FRAME		
Class I- Diagnostic & Preventive Services	None		
Class II- Basic Services	None		
Class III- Major Services	1 Year		
MAXIMUM BENEFIT	AMOUNT		
Annual Maximum Benefit per Calendar Year	\$1,500.00		
Implant Lifetime Maximum Benefit	\$3,000.00		

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>D aiting Period</u> – Class III 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 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 illness;
- (o) services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
- (p) office infection control charges;
- (q) charges for copies of your records, charts or x-rays, or any costs associated with forwarding/mailing copies of your records, charts or x-rays;
- (r) state, federal, or territorial taxes on dental services performed;
- (s) those charges submitted by a dentist, which are for the same services performed on the same date by another dentist;
- (t) those dental services provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
- (u) those dental services for which you would have no obligation to pay in the absence of this or any similar insurance;
- (v) those dental services which are for specialized procedures and techniques;
- (w) those dental services performed by a dentist who is compensated by a facility for similar covered services performed for you on the same date;
- (x) duplicate, provisional and temporary devices, appliances, and services;
- (y) plaque control programs, oral hygiene instruction, and dietary instructions;
- (z) services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to:
  - 1. equilibration;
  - 2. periodontal splinting;
  - 3. full mouth rehabilitation and;
  - 4. restoration for misalignment of teeth;
- (aa) gold foil restorations;
- (bb) services or treatment for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization;
- (cc) hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient);
- (dd) charges by the provider for completing dental forms;
- (ee) adjustment of a denture or bridgework which is made within 6 months after installation by the same dentist who installed it;
- (ff) use of material or home health aids to prevent decay, such as:
  - 1. toothpaste;
  - 2. fluoride gels;
  - 3. dental floss and;
  - 4. teeth whiteners;
- (gg) sealants;
- (hh) precision attachments, personalization, precious metal bases and other specialized techniques;

- (ii) replacement of dentures that have been:
  - 1. lost:
  - 2. stolen or;
  - 3. misplaced;
- (jj) repair of damaged orthodontic appliances;
- (kk) replacement of lost or missing appliances;
- (ll) fabrication of athletic mouth guard;
- (mm) internal bleaching;
- (nn) nitrous oxide;
- (oo) oral sedation;
- (pp) topical medicament carrier;
- (gg) 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.

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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.

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<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/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	50%		
WAITING PERIOD	TIME FRAME		
Class I- Diagnostic & Preventive Services	None		
Class II – Basic Services	None		
Class III- Major Services	1 Year		
MAXIMUM BENEFIT	AMOUNT		
Annual Maximum Benefit per Calendar Year	\$1,000.00		
Implant Lifetime Maximum Benefit	\$2,000.00		

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.

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<u>Waiting Period</u> – Class III 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 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 illness;
- (o) services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
- (p) office infection control charges;
- (q) charges for copies of your records, charts or x-rays, or any costs associated with forwarding/mailing copies of your records, charts or x-rays;
- (r) state, federal, or territorial taxes on dental services performed;
- (s) those charges submitted by a dentist, which are for the same services performed on the same date by another dentist;
- (t) those dental services provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
- (u) those dental services for which you would have no obligation to pay in the absence of this or any similar insurance;
- (v) those dental services which are for specialized procedures and techniques;
- (w) those dental services performed by a dentist who is compensated by a facility for similar covered services performed for you on the same date;
- (x) duplicate, provisional and temporary devices, appliances, and services;
- (y) plaque control programs, oral hygiene instruction, and dietary instructions;
- (z) services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to:
  - 1. equilibration;
  - 2. periodontal splinting;
  - 3. full mouth rehabilitation and;
  - 4. restoration for misalignment of teeth;
- (aa) gold foil restorations;
- (bb) services or treatment for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization;
- (cc) hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient);
- (dd) charges by the provider for completing dental forms;
- (ee) adjustment of a denture or bridgework which is made within 6 months after installation by the same dentist who installed it;
- (ff) use of material or home health aids to prevent decay, such as:
  - 1. toothpaste;
  - 2. fluoride gels;
  - 3. dental floss and;
  - 4. teeth whiteners;
- (gg) sealants;
- (hh) precision attachments, personalization, precious metal bases and other specialized techniques;

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- (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;
- (gg) 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.

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