MUTUAL OF OMAHA INSURANCE COMPANY
3300 Mutual of Omaha Plaza, Omaha, NE 68175

INDIVIDUAL DENTAL PREFERRED PROVIDER ORGANIZATION (PPO) INSURANCE POLICY

REVIEW YOUR APPLICATION

Please review the attached copy of your application. Your application becomes a part of your policy. If anything in your application is incorrect, you must tell us right away. We issued your policy on the basis that all information shown in the application is correct and complete. If it is not, your policy may not be valid.

30-DAY RIGHT TO RETURN POLICY

You have 30 days from the date of its delivery to review your policy. If during that time you are not satisfied with it, you can return your policy to us or your agent. We will promptly refund all premiums you paid. Your policy will then be considered never to have been issued.

GUARANTEED RENEWABLE FOR LIFE

Your 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 at least 30 days advance notice as required by your state prior to any such premium change.

This Is a Legal Contract Between You and Us.
NOTICE TO BUYER: THIS POLICY PROVIDES LIMITED BENEFIT DENTAL COVERAGE. THIS POLICY HAS A ONE-YEAR WAITING PERIOD FOR [1][CLASS III] SERVICES. BENEFITS PROVIDED ARE SUPPLEMENTAL AND NOT INTENDED TO COVER ALL MEDICAL EXPENSES. READ YOUR POLICY CAREFULLY WITH THE OUTLINE OF COVERAGE.
THIS IS NOT A MEDICARE SUPPLEMENT POLICY.
THIS POLICY INCLUDES AN IN-NETWORK PPO DENTIST OPTION. YOUR OUT-OF-POCKET EXPENSES MAY BE GREATER WHEN USING AN OUT-OF-NETWORK DENTIST.

James T. Blackledge
[Chief Executive Officer]

Richard C. Anderson
[Corporate Secretary]

DNT5-25447

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DEFINITIONS

The defined terms used in your policy are shown below. We have *italicized* these terms wherever they appear to make them easier for you to find (except for *we*, *us*, *our*, *you*, and *your*).

Allowed amount means the amount used to calculate the portion of the dental payment for which you are responsible.

(a) For an in-*network dentist*, the allowed amount is the lesser of the *submitted amount* or the *scheduled fee*. If the *submitted amount* is higher than the *scheduled fee*, you will not be responsible for paying the difference;
(b) For an *out-of-network dentist*, the allowed amount is the lesser of the *submitted amount* or an amount equal to the lowest prevailing *scheduled fee* used for *in-network dentists* in the geographic area. If the *submitted amount* is higher than such fee, you will be responsible for paying the difference.

Annual maximum benefit means the total maximum benefit payable for *covered dental services* each *calendar year*. The annual maximum benefit only applies to the *benefit classes* specified in the Policy Schedule. When the annual maximum benefit has been reached during the *calendar year*, no further benefits will be payable for those *covered dental services* provided under the specified *benefit classes* for the remainder of that *calendar year*.

Approved amount means the amount that the *dentist* has agreed to accept as full payment for treatment.

(a) For an *in-network dentist*, the approved amount is the *scheduled fee*;
(b) For an *out-of-network dentist*, the approved amount is the *submitted amount*.

Benefit class means the classification of *covered dental services* provided under this policy as follows:

(a) Class I: Diagnostic and Preventive Services;
(b) Class II: Basic Services; and
(c) Class III: Major Services.

Calendar year means the 12-month period of January 1 through December 31 of each year.

If your policy was issued on a date other than January 1, the first *calendar year* begins on your *policy effective date* and ends on December 31 of that issue year. Thereafter, a *calendar year* will always begin on January 1.

Class means persons who have the same application date, policy form, issue age, issue year, rate classification, coverage, and state listed on the Policy Schedule as you do.

Coinsurance means the percentage we pay for *covered dental services* as shown on the Policy Schedule.

Covered dental service means the dental procedures and services covered under this policy as listed in the Benefits Schedule. A procedure or service must be provided by a *dentist* for the prevention, diagnosis, care, or treatment of a covered condition in order to qualify as a covered dental service. When more than one method of treatment can be used to treat a condition, benefits will be based on that of the least expensive method of treatment that is a *covered dental service*.

Deductible means the *allowed amount* of expense you must incur and pay in *covered dental services* each *calendar year* before we will pay benefits for certain *benefit classes.* The deductible amount is shown on the Policy Schedule.

Dentally necessary means that a dental service or treatment is performed in accordance with generally accepted dental standards. Such dental standards are determined from multiple sources. These sources include, but are not limited to, relevant clinical dental research from various research organizations including:

(a) dental schools;
(b) current recognized dental school standard of care curriculums; and
(c) organized dental groups including the American Dental Association.

The dental service or treatment must also be necessary to treat decay, to treat disease or injury of teeth, or essential for the care of teeth and supporting tissues of the teeth.

Not all dental needs are covered under this policy.

Dentist means an individual licensed to practice dentistry at the time and in the place where services are provided. He or she must be operating within the scope of his or her license.

Emergency means oral or dental care needed immediately because of a medical condition of sudden and unexpected onset.

Immediate family means your spouse, registered domestic partner or civil union partner or anyone who is related to this person or you as a parent, grandparent, child, grandchild, brother, sister, aunt, uncle, first cousin, nephew or niece.

In-network means services provided by *dentists* who are contracted with our *preferred provider organization (PPO)* network under this policy. The *PPO* network is named on the Policy Schedule.

Lifetime maximum benefit means the total maximum amount we will pay for certain benefits shown on the Policy Schedule during the lifetime of the policy.

Out-of-network means services provided by *dentists* who are not contracted with our *PPO* network to provide services to you under this policy.

Policy effective date means the date on which this policy becomes effective. The policy effective date is shown in the Policy Schedule.

Preferred Provider Organization and ***PPO*** mean a managed care organization of *in-network dentists* who have agreed to provide dental care at negotiated fees. You are not obligated to use an *in-network dentist,* but if you use an *out-of-network dentist,* your out-of-pocket expenses may be greater than they would be for an *in-network dentist.*

Premium due date means the date your policy's premium is due.

Pre-treatment estimate means an estimate for the coverage provided under this policy prior to such services being rendered.

Scheduled fee means the amount an *in-network dentist* has contractually agreed to accept as payment in full for *covered dental services.*

Submitted amount means the amount billed or charged by a *dentist* on a submitted claim.

We, us, and ***our*** mean Mutual of Omaha Insurance Company.

You and ***your*** mean the person named as the Insured on the Policy Schedule.

DENTAL BENEFITS

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.*

Your policy pays benefits for three different dental *benefit classes* – Diagnostic and Preventive Services (Class I); Basic Services (Class II); and Major Services (Class III). The Benefits Schedule shows the most common *covered dental services* for each *benefit class*. For a full list of *covered dental services,* please refer to our website listed on the Benefits Schedule.

NETWORK AND DENTIST SELECTION

You may choose to go to any *dentist* at any time. However, there are differences in the level of benefits payable depending on whether you receive *covered dental services* from an *in-network* or *out-of-network dentist*. If you select a *dentist* who does not participate in the *PPO* network, your out-of-pocket expenses may be greater since *out-of-network dentists* do not provide dental care at negotiated fees.

If you would like to nominate an *out-of-network dentist* to become an *in-network dentist*, you may submit a request by phoning the toll-free telephone number shown on the Policy Schedule or your policy's identification card.

Dentists are periodically added to and removed from the *PPO* network. It is your responsibility to ask your *dentist* if he or she is still participating in the *PPO* network prior to receiving treatment.

For a current list of *in-network dentists*, please visit our website or call our toll-free telephone number shown on the Policy Schedule.

WAITING PERIOD

[2][Class III] *covered dental services* are subject to the waiting period shown on the Policy Schedule. You must satisfy the waiting period before we will pay benefits for these services. The waiting period begins on the *policy effective date* and is applied once during the lifetime of your policy.

Expense you incur for *covered dental services* during the waiting period will apply to the *deductible*.

REPLACEMENT COVERAGE

If this policy replaces another Mutual of Omaha Individual Dental Insurance DNT Policy Form, we will:

(a) reduce this policy's waiting period by the amount of time your replaced coverage was in force; and
(b) apply any benefits that were paid under the replaced coverage towards the *annual maximum benefit* and *lifetime maximum benefit* of this policy.

EXCLUSIONS AND LIMITATIONS

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 for which benefits are paid, in whole or in part, under the provision of any law or regulation or any government unit;
(e) services or treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, Veterans Administration hospital or similar person or group;
(f) services or treatment performed prior to the *policy effective date*;
(g) services or treatment incurred after the termination date of your coverage unless otherwise indicated;
(h) services or treatment which is not *dentally necessary* or which does not meet generally accepted standards of dental practice;
(i) services or treatment resulting from your failure to comply with professionally prescribed treatment;
(j) telephone consultations;
(k) any charges for failure to keep a scheduled appointment;
(l) any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
(m) fluoride treatments;
(n) services or treatment provided as a result of intentionally self-inflicted injury or illness;
(o) services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
(p) office infection control charges;
(q) charges for copies of your records, charts or x-rays, or any costs associated with forwarding/mailing copies of your records, charts or x-rays;
(r) state, federal, or territorial taxes on dental services performed;
(s) those charges submitted by a *dentist*, which are for the same services performed on the same date by another *dentist*;
(t) those dental services provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
(u) those dental services for which you would have no obligation to pay in the absence of this or any similar insurance;
(v) those dental services which are for specialized procedures and techniques;
(w) those dental services performed by a *dentist* who is compensated by a facility for similar covered services performed for you on the same date;
(x) duplicate, provisional and temporary devices, appliances, and services;
(y) plaque control programs, oral hygiene instruction, and dietary instructions;
(z) services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to:
    1. equilibration;
    2. periodontal splinting;
    3. full mouth rehabilitation and;
    4. restoration for misalignment of teeth;
(aa) gold foil restorations;

(bb) services or treatment for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization;
(cc) hospital costs or any additional fees that the *dentist* or hospital charges for treatment at the hospital (inpatient or outpatient);
(dd) charges by the provider for completing dental forms;
(ee) adjustment of a denture or bridgework which is made within 6 months after installation by the same *dentist* who installed it;
(ff) use of material or home health aids to prevent decay, such as:
    1. toothpaste;
    2. fluoride gels;
    3. dental floss and;
    4. teeth whiteners;
(gg) sealants;
(hh) precision attachments, personalization, precious metal bases and other specialized techniques;
(ii) replacement of dentures that have been:
    1. lost;
    2. stolen or;
    3. misplaced;
(jj) repair of damaged orthodontic appliances;
(kk) replacement of lost or missing appliances;
(ll) fabrication of athletic mouth guard;
(mm) internal bleaching;
(nn) nitrous oxide;
(oo) oral sedation;
(pp) topical medicament carrier;
(qq) orthodontic services, treatment or supplies, including braces and retainers;
(rr) bone grafts when done in connection with:
    1. extractions;
    2. apicoectomies or;
    3. non-covered/non-eligible implants;
(ss) tooth whitening;
(tt) occlusal guards;
(uu) space maintainers;
(vv) services or treatment provided by a member of your *immediate family*, unless they are the only provider available within the area and they are acting within the scope of his or her license;
(ww) services or treatment received outside of the United States, its possessions or territories, Canada, or Mexico; or
(xx) services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD, TMJD) and related disorders.

MULTIPLE PROCEDURE LIMITATIONS

When two or more dental services are submitted and the dental services are considered part of the same service to one another, this policy will pay the most comprehensive service (the service that includes the other non-benefited service).

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.

[3][COORDINATION OF BENEFITS (COB)

If you are covered by another *plan* or *plans*, the benefits under this policy and the other *plans* will be coordinated. This means one *plan* pays its full benefits first, and then the other *plans* pay.

The primary *plan* determines payment for its benefits first without considering any other *plan's* benefits. The primary *plan* pays before the secondary *plan.*

The secondary *plan* will limit the benefits it pays so that the sum of its benefits and all other benefits paid by the primary plan will not exceed the greater of:

(a) 100% of total covered expenses; or
(b) the amount of benefits it would have paid had it been the primary *plan.*

This COB provision will not apply to a claim when the covered expense incurred during a *calendar year* is $50 or less.

This COB provision will apply to the total amount of the claim if additional covered expense is incurred during such *calendar year* and the total covered expense exceeds $50.

The ORDER OF BENEFIT DETERMINATION provision below explains the order in which *plans* must pay benefits.

ORDER OF BENEFIT DETERMINATION

When another *plan* does not have rules coordinating its benefits with those of this policy, or if it has coordination of benefits rules which differ from the rules described in this COORDINATION OF BENEFITS (COB) provision, that other *plan* must determine benefits first.

When another *plan* does have rules coordinating its benefits with those of this policy, and those rules are similar to the rules described in this COORDINATION OF BENEFITS provision, the first of the following rules which applies will govern:

(a) If a *plan* covers you as an employee, retiree, member, subscriber, or nondependent, then that *plan* will pay its benefits first; except when:

1. one *plan* covers you as a laid-off or retired employee (or a dependent of such person); and
2. the other *plan* includes this Coordination of Benefits rule for laid-off or retired employees (or is issued in a state which requires this Coordination of Benefits rule by law);

then the *plan* which covers you as other than a laid-off or retired employee (or a dependent of such person) will pay first. If the other *plan* does not have this Coordination of Benefits rule regarding laid off or retired employee rule, and if, as a result the *plans* do not agree on the order of benefits, this rule will not apply.

(b) If none of the above rules applies, the *plan* which has covered you for the longer period of time will pay its benefits first.

Where part of a *plan* coordinates benefits and a part does not, each part will be treated like a separate *plan*.

REQUEST TO COLLECT AND RELEASE NEEDED INFORMATION

In order to receive benefits, you may be asked to provide additional information needed to coordinate benefits. With your consent, we may release to or collect from any person or organization any applicable coordination of benefits related information about you.

PLAN REIMBURSEMENT FOR THIRD PARTY PAYMENT

If benefits, which this policy should have paid, are instead paid by another *plan*, we will reimburse you. Amounts reimbursed will be considered to be benefits paid under the policy and will be treated in the same manner as other benefits under the policy in accordance with the terms of the policy.

RIGHT OF RECOVERY

If the policy pays more for a covered expense than is required by this COB provision, the excess payment may be recovered from you or any person to whom the payment was made.

DEFINITION

Plan means the policy and any of the following coverages, including coverage which is declared to be excess to all other coverages, which provide benefit payments or services to you for hospital, medical, surgical, dental, vision, prescription or drug coverage:

(a) individual, group, blanket or franchise insurance (except student accident insurance);
(b) coverage under a labor-management trustee plan, a union welfare plan, an employer organization plan or an employee benefits plan;
(c) coverage under government programs, other than Medicare or Medicaid, and any other coverage required or provided by law;
(d) group or individual automobile "no fault" coverage or traditional automobile "fault" coverage; and
(e) other arrangements of insured or self-insured group coverage.]

GOVERNMENT ENTITLEMENTS NOTICE

Your receipt of *covered dental services* may affect your eligibility for Medicaid and other governmental benefits and entitlements.

TIME OF COVERAGE

Your coverage starts on the *policy effective date* at 12:01 a.m. where you reside. It ends at 12:01 a.m. where you reside on the first *premium due date* (shown as the first renewal date on your Policy Schedule). Each time you renew your policy by paying the premium within the 31-day grace period, a new period begins when the old period ends.

TERMINATION

Your policy will end on the earliest of:

(a) the date we receive your written or verbal request to cancel your policy, or any future date you specify in your request (in either case, the grace period will not apply);
(b) the *premium due date*, if the premium was not paid before the end of the grace period; or
(c) the date of your death.

In the event of cancellation or death, we will promptly refund the unearned portion of any premium paid.

Claims for *covered dental services* received while this policy was in force will be paid in accordance with the terms of this policy.

CLAIMS PROVISIONS

WHEN TO FILE A CLAIM

In-network dentists will automatically file a claim directly to us on your behalf.

If you use the services of an *out-of-network dentist*, you must submit to us a completed claim form, unless the provider completes and submits the claim to us on your behalf.

If you must file a claim with us, the claim should not be submitted until the *covered dental service* is completed.

PRE-TREATMENT ESTIMATES

Pre-treatment estimates are strongly recommended for treatments costing $200 or more. The *pre-treatment estimate* informs you in advance whether the requested services are *covered dental services*. The *pre-treatment estimate* request must describe the procedures and services that the treating *dentist* plans to perform, including the actual fees to be charged for each procedure or service. For information on how to submit a *pre-treatment estimate* request, please call our toll-free telephone number shown on the Policy Schedule. After the *pre-treatment estimate* request is submitted, along with any required documentation, we will then issue a *pre-treatment estimate* outlining the estimated benefit payment.

NOTICE OF CLAIM

Written notice of a claim must be given to us within 20 days after a covered loss starts, or as soon as reasonably possible. You may give the required notice or someone else may do it for you. The notice should include your name and policy number. Notice should be mailed to us at our Claims Address shown on the Benefits Schedule or your policy's identification card.

CLAIM FORMS

When we receive your notice of a claim, we will send you forms for filing proof of loss. If we do not send you these forms within 15 days of such notice, you may give us a written statement of the nature and extent of your loss. We must receive this statement within the time frame shown in the PROOF OF LOSS section. Claim forms are also available from our website shown on the Policy Schedule.

PROOF OF LOSS

Written proof of loss must be given to us within 90 days after the date of the loss. If it is not reasonably possible to give us written proof within the required time, we will not reduce or deny your claim for this reason if the proof is supplied as soon as reasonably possible. In any case, proof must be given no more than 12 months from the time specified, unless you were legally incapacitated.

TIME OF PAYMENT OF CLAIMS

We will pay benefits for a covered loss as soon as we receive adequate written proof of loss.

PAYMENT OF CLAIMS

We will pay benefits to you, if you are living and have not assigned those benefits. If you are deceased, we will pay benefits to your beneficiary or to your estate if no beneficiary is named or living.

If any benefits are payable to an estate or to a beneficiary or minor not legally able to give a valid release, we may pay up to $1,000 to someone related to you or the beneficiary by blood or marriage whom we find entitled to the benefits. If we make payment in good faith, we will be fully discharged to the extent of that payment.

CLAIM REVIEW AND APPEAL PROCESS

Claim Review

If we deny your claim in whole or in part, we will explain the reasons for our denial in our notice. If you disagree with the reasons given, you or your authorized representative may ask that we reconsider your claim through the appeal process.

Appeal Process

To appeal a denied claim, you or your authorized representative must notify us within 180 days after receiving notice of our denial and ask that we reconsider our original benefit decision. Your appeal request must be submitted to us in writing or electronically and should state the reasons why you believe the claim denial was incorrect. You should also include any additional information, documents or other materials that might allow us to change our original decision. Send your appeal request to us at the Appeals Address shown in the Benefits Schedule.

The request for an appeal should include:

(a) your name and policy number;
(b) date of birth;
(c) the date of service to be reviewed;
(d) the name and address of the treating *dentist*; and
(e) the reason for the appeal.

By requesting an appeal, you have authorized us, or anyone designated by us, to review any and all records (including medical/dental records) which may be relevant to your appeal.

Within 30 days after receiving your complete appeal request, we will notify you or your authorized representative in writing of our final claim decision. If we need more time due to circumstances beyond our control, we will inform you of our need for an extension prior to the end of this time frame.

POLICY PROVISIONS

CONSIDERATION

In consideration of the first premium you paid, the application you completed, and our reliance on your answers to the application questions, we have put this policy in force as of the *policy effective date*. That date is shown on the Policy Schedule.

ENTIRE CONTRACT AND CHANGES

This policy is a contract between you and us. The entire contract consists of:

(a) the policy;
(b) the attached signed application;
(c) any supplemental applications made part of the policy;
(d) any riders; and
(e) any endorsements or amendments.

No change in this policy will be effective until approved by a company officer. This approval must be noted on or attached to the policy. No agent can change this policy or waive any of its provisions. Any rider, endorsement, or application added after the *policy effective date* which reduces or eliminates coverage under this policy will require your signed acceptance to be valid.

TIME LIMIT ON CERTAIN DEFENSES

After two years from the date a person becomes insured under this policy, only fraudulent misstatements in the application can be used to void the policy or deny any claim for loss incurred after the two-year period.

GRACE PERIOD

Your policy has a 31-day grace period. This means that if you do not pay a premium on or before the date it is due, you can pay it during the following 31 days. Unless we receive a request from you to cancel your policy, your policy will stay in force during the grace period as long as you pay the required premium before the end of the grace period.

REINSTATEMENT

Your policy will lapse on the *premium due date* if you do not pay your premium before the end of the grace period. If we accept a late premium, your policy will be reinstated. Such premium must be paid within 90 days following the date of lapse in order to qualify for reinstatement. We will not require you to complete an application for reinstatement.

Your reinstated policy will only provide benefits for *covered dental services* received after the date of reinstatement. The balance of any waiting period that was not satisfied at the time of lapse must be satisfied following reinstatement. In all other respects your rights and our rights will remain the same as before the policy lapsed, subject to any provisions noted on or attached to the reinstated policy.

PHYSICAL EXAMINATIONS

We have the right to have you examined, at our expense, as often as reasonably necessary while a claim is pending.

LEGAL ACTIONS

You cannot bring a legal action to recover under this policy until at least 60 days after you have given us written proof of loss. You cannot bring a legal action more than three years from the date written proof of loss is required.

OTHER INSURANCE WITH US

You can be insured under only one of our dental policies at any one time. If you are insured under more than one of our dental policies, you must select the one that is to remain in effect.

UNPAID PREMIUM

When we pay benefits for a claim under this policy, we may reduce those benefits by the amount of any premium then due and unpaid. If we deduct the unpaid premium from a claim, it will not reinstate your coverage or start a new grace period. You must pay the renewal premium for your policy before the grace period ends. Otherwise, your policy will terminate in accordance with the TERMINATION section.

CONFORMITY WITH STATE LAWS

Any provision of this policy which, on its effective date, is in conflict with the laws of the state in which you reside on that date is amended to conform to the minimum requirements of those laws.