



1515 South 75th Street
Omaha, Nebraska 68124

Outline of Coverage for
Dental, Vision and Hearing Policy DVA48

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Toll-Free 1-800-228-6080

DENTAL, VISION AND HEARING COVERAGE
LIMITED BENEFIT POLICY

RETAIN THIS OUTLINE FOR YOUR RECORDS
THE POLICY IS NOT A MEDICARE SUPPLEMENT POLICY

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. Only the actual policy provisions will control. The policy 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 Coverage: Policies of this type are designed to provide, to persons insured, limited or supplemental coverage. This policy does not provide any benefits other than the coverage described below.

BENEFITS PROVIDED BY THE POLICY

Policy Year Maximum Benefit: The maximum benefit we will pay during any one Policy Year. You may choose from:

- \$1,000 \$1,500

Policy Year Deductible: You are responsible for the first \$100 of Covered Expenses during each Policy Year.

After satisfaction of the \$100 Policy Year Deductible, the policy will pay the following percentages of actual charges, not to exceed Reasonable and Customary Charges for Covered Expenses up to the Policy Year Maximum Benefit based on the Policy Year:

- 60% – First Policy Year
- 70% – Second Policy Year
- 80% – Third Policy Year and thereafter

Covered Expenses, subject to the limitations described in the Exceptions and Limitations Section, are:

- (1) Dental services, performed by a licensed Dentist, including semi-annual examinations and cleanings (prophylaxis), semi-annual periodontal maintenance, biennial periodontal surgery (once every two years), x-rays, the cost of fillings, bridges, crowns, dentures and outpatient dental surgery prescribed as Medically Necessary.
- (2) Visits to a Physician for a basic eye examination or eye refraction, including the cost of eyeglasses or contact lenses prescribed by the Physician, up to a maximum benefit of \$200 in any one Policy Year.
- (3) Hearing examinations performed by a Physician or Audiologist, the purchase of hearing aids prescribed as Medically Necessary by a Physician or Audiologist, including the cost of the hearing aid and any necessary repairs or supplies.

Reasonable and Customary Charges are the normal and prevailing charges, fees or expenses for the service rendered or for the material furnished in the geographic area where rendered or furnished.

EXCEPTIONS AND LIMITATIONS

Benefits will not be payable for the following items and/or services **during the first six months following the Policy Date:**

- (1) Eyeglasses or contact lenses.

Benefits will not be payable for the following items and/or services **during the first Policy Year:**

- (1) Endodontics (including root canals), periodontal surgery, bridges, crowns, full dentures or partials, any work relating to replacement of natural teeth which were missing at the time coverage becomes effective, “full mouth” extractions, fluoride treatments or outpatient dental surgery; or
- (2) Hearing aids.

Benefits will not be paid under this policy for: (1) any loss resulting from war, declared or undeclared; (2) any intentionally self-inflicted Injury; (3) any loss to which a contributing cause was your commission of or attempt to commit a felony or your being engaged in an illegal occupation; (4) any services that are not recommended by a Physician; (5) any Experimental or Investigational procedure or treatment; (6) orthodontic treatment or dental implants; (7) any expenses incurred for the diagnosis or treatment of temporomandibular joint disorder (TMJ), unless benefits are otherwise required by your state; (8) expenses incurred for surgical procedures (other than Medically Necessary outpatient dental surgery following the first Policy Year) performed on an inpatient or outpatient basis (including any surgical procedure performed in the treatment of cataracts); (9) charges for radial keratotomy (RK), automated lamellar keratoplasty (ALK), conductive keratoplasty (CK) or other cosmetic procedures; (10) impacted wisdom teeth; (11) occlusal guards; (12) prescription drugs; (13) charges in excess of Reasonable and Customary Charges; (14) treatment or diagnosis received while outside the territorial limits of the United States; (15) services for which you are not liable or for which no charge normally is made in the absence of insurance; and (16) loss that occurs while the policy is not in force.

THE POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR DENTAL, VISION AND HEARING NEEDS.

RENEWABILITY, PREMIUM CHANGES AND CANCELABILITY

Renewability – Guaranteed Renewable – This means you have the right, subject to the terms of your policy, to continue the policy as long as you pay your premiums before the end of the grace period.

Terms Under Which We May Change Premiums – We can change premiums only if we do the same to all policies of this form issued to persons of your class in your state, and we notify you in advance of the due date. “Class” means the factors of age, gender, underwriting class and geographic area of your state of residence that determined your premium rate when coverage was issued. If we make a change, it will not be based on any physical impairment you might have or any claims you have incurred under the policy. If it is necessary to change the premium for your policy, we will notify you in advance of the change in premium.

Cancellation By Insured: You may cancel this policy at any time by written notice delivered or mailed to us, effective upon receipt of such notice or on such later date as may be specified in such notice. In the event of cancellation or your death, we will promptly return the unearned portion of any premium paid. The earned premium shall be computed by the use of the pro rata method. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

PREMIUMS

| PAYMENT METHOD | MONTHLY | QUARTERLY | SEMI-ANNUALLY | ANNUALLY |
|-----------------------|----------------|------------------|----------------------|-----------------|
| BANK DRAFT | | | N/A | N/A |
| DIRECT BILL | N/A | | | |

Premiums are subject to change on a limited basis, as stated above. You have a 31-day grace period in which to pay your premium. Your policy stays in force during your grace period.

PRODUCER, YOU MUST SIGN THIS FORM!

If assisting an applicant online, please verify that the typed name (which constitutes an electronic signature), is correct.

Producer’s Name/Signature: _____ Date: _____