Underwritten by
United of Omaha Life Insurance Company
A Mutual of Omaha Company

› Dental Insurance

More Than a Pretty Smile

Taking good care of your teeth and mouth is an important part of a healthy lifestyle. Practicing proper dental hygiene, like brushing, flossing, and avoiding sugary foods and drinks, is only part of the oral health equation. Visiting a dentist on a regular basis is also very important.

As an active employee of Motive Power, you have access to a dental insurance policy from United of Omaha Life Insurance Company.

You have so many reasons to keep your teeth and gums healthy. Ongoing dental care will help you maintain the best possible oral – and overall – health and well-being.

Coverage guidelines and benefits are outlined in the chart below.

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES	
Eligibility Requirement	You must be actively working a minimum of 30 hours per week to be eligible for coverage.
Dependent Eligibility Requirement	A child must meet the eligibility requirements of the Policy and be under age 26 if eligible as defined by Policy. In order for your spouse and/or children to be eligible for coverage, you must elect coverage for yourself.
Premium Payment	The premiums for this insurance are shared by you and the policyholder. The premium amounts below reflect your contribution to the cost of this insurance.

PLAN YEAR DEDUCTIBLES AND MAXIMUMS	IN-NETWORK	OUT-NETWORK
Type A	Waived	Waived
Type B & C Deductible		
Individual	$0	$0
Family	3 times Individual	3 times Individual
Annual Maximum	$1,500	$1,500
Orthodontia Lifetime Maximum	$1,000	$1,000
The same expenses may be used to satisfy both the In-Network and Out-Network deductible.		

COVERED SERVICES	IN-NETWORK	OUT-NETWORK
Type A Services • Examinations/Evaluations • Bitewing X-rays • All Other X-Rays • Fluoride Treatments • Cleaning/Prophylaxis • Sealants • Space Maintainers • Brush Biopsy/Cancer Screening • Full Mouth X-rays, Panoramic Film	100%	100%
Type B Services • Palliative Treatment • Periodontal Maintenance • Fillings • Stainless Steel Crowns • Simple Extractions • Oral Surgery • Endodontics • Surgical Extractions • General Anesthesia or I.V. Sedation • Surgical Periodontics • Non-Surgical Periodontics	80%	80%
Type C Services • Full or Partial Removable Dentures • Repair of Full or Partial Removable Dentures • Adjustments, Tissue Conditioning, Rebasing or Relining of Full or Partial Removable Dentures • Bridges • Repair/Recementation of Bridges • Cast Crowns, Inlays, Onlays, Labial Veneers • Repair/Recementation of Cast Crowns/Inlays/Onlays/Labial Veneers • Implants	60%	60%
Child Orthodontia • Harmful Habit Appliances	50%	50%

The plan pays the percentage shown after the deductible is satisfied up to the maximum. Additional information about the benefits and covered services of this plan will be included in the certificate booklet, which you will receive after enrolling for this coverage. Please contact your employer or benefits administrator if you have questions prior to enrolling.

The plan provides the same coverage levels for both In-Network and Out-Network services. However, because In-Network providers offer their services at predetermined fees, out-of-pocket expenses may be lower for plan members when receiving covered services from an In-Network provider.

The Maximum Allowance for Out-Network Services is based on the 90th Percentile as determined by Mutual of Omaha. Charges that exceed the Maximum Allowance (as defined in the certificate booklet) for any covered dental service are not considered.

LIMITATIONS	
Information about the limitations and exclusions for this plan will be included in the certificate booklet, which you will receive after enrolling for this coverage. Please contact your employer or Benefits Administrator if you have any questions prior to enrolling.	
• Exams – 2 services in a 12 month period.	
• Bitewing X-rays – 4 films in a 12 month period.	
• Full Mouth X-rays or Panoramic Film – 1 in any 60 month period.	
• Fluoride – For dependent children up to age 14. 2 services in a 12 month period.	
• Harmful Habit Appliance – For dependent children up to age 14.	
• Cleaning/Prophylaxis – 2 services in a 12 month period.	
• Sealants – For dependent children up to age 14; one per permanent bicuspid or molar tooth in any 36 month period.	
• Brush Biopsy/Cancer Screen – 2 services in a 12 month period.	
• Space Maintainers – For dependent children up to age 14, includes recementations and removal.	
• Fillings – Composite fillings on molars are limited to the amount otherwise payable for an amalgam filling. Replacement once in a 12 month period.	
• Stainless Steel Crowns – For dependent children up to age 16; one per tooth per lifetime. Not for temporary restoration.	
• Periodontal Maintenance – 2 services in a 12 month period in addition to routine cleaning. Following active periodontal treatment only.	
• Cast Crowns, Inlays, Onlays, Labial Veneers – Replacement allowed once in 5 years.	
• Bridges – Replacement allowed once in 5 years.	
• Dentures – Replacement allowed once in 5 years.	
• Implants – 1 per tooth per lifetime.	
• Orthodontia – Includes case workup, all appliances and one set of retainers. Braces/Appliances must be placed prior to the dependent child turning age 26 for orthodontic benefits to be payable.	
SERVICES	
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.

Frequently Asked Questions

Who is eligible for this insurance?

You must be actively working (performing all normal duties of your job) at least 30 hours per week.

When does my coverage begin?

Complete enrollment information must be submitted to us through your Benefits Administrator *prior* to the requested effective date. Enrollment will be accepted within 31 days following the day you become eligible; however your effective date will then be the first of the following month.

When does my coverage begin for my dependents?

A Dependent child is considered eligible for insurance at birth and may be added to your policy at any time up to the child's third birthday. If we do not receive notification of the child's enrollment by age 3, you will be required to wait until the next Subsequent Enrollment Period to enroll the child.

If I enroll now, can I change or drop my coverage at any time?

Your enrollment in this coverage is for a 12 month Policy Year. During the Policy Year, you may drop coverage, or add or remove dependents, or terminate coverage within 31 days of a qualifying Life Change Event (as defined in the Certificate). These events include the birth of a child, pending adoption, marriage, divorce or loss of other coverage.

IMPORTANT NOTICE

CALIFORNIA SUMMARY OF DENTAL BENEFITS AND COVERAGE DISCLOSURE MATRIX

California Department of Insurance (DOI) Emergency Regulation 2239.10

The following matrix is intended to be used to help you compare your dental benefits and what you will pay for covered dental services. This is a summary only and does not include the premium costs for this dental benefit package.

Please refer to the certificate booklet for a full explanation of your plan's benefits, exclusions, limitations and reductions. Should there be any discrepancy between the certificate booklet and this summary, the certificate booklet will prevail.

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Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Insurer Name: United of Omaha Life Insurance Company
Policy Type: PPO
Effective Date: January 1, 2025

Plan Name: Dental for All Eligible Employees
Insurer Phone #: 1-800-927-9197
Insurer Website: www.mutualofomaha.com/dental

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND WHAT YOU WILL PAY FOR COVERED SERVICES. THIS IS A SUMMARY ONLY AND DOES NOT INCLUDE THE PREMIUM COSTS OF THIS DENTAL BENEFITS PACKAGE. PLEASE CONSULT YOUR EVIDENCE OF COVERAGE AND DENTAL CONTRACT FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. FOR MORE INFORMATION ABOUT YOUR COVERAGE, VISIT THE INSURER WEBSITE WWW.MUTUALOFOMAHA.COM/DENTAL OR CALL 1-800-927-9197.

THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

Deductible	All Providers
Dental	Individual: $0 Family:

- The deductible applies to all services except Type A.
- A **deductible** is the amount you are required to pay for covered dental services each policy year before the insurer begins to pay for the cost of covered dental treatment.
- **In-network services** are dental care services provided by dentists or other licensed dental care providers that contract with your insurer for alternative rates of payment for dental services.
- **Out-of-network services** are dental care services provided by dentists or other licensed dental care providers that are not contracted with your insurer for alternative rates of payment.

Part III: MAXIMUMS POLICY WILL PAY

Maximums	All Providers
Annual Maximum	$1,500
Lifetime Maximum for Orthodontia	$1,000

- **Annual maximum** is the maximum dollar amount your policy will pay toward the cost of dental care within a specific period of time, usually a consecutive 12-month or calendar year period.
- **Lifetime maximum** means the maximum dollar amount your policy providing dental benefits will pay for the life of the enrollee. Lifetime maximums usually apply to specific services, such as orthodontic treatment.

Part IV: WAITING PERIODS

Waiting Periods: A waiting period is the amount of time that must pass before you are eligible to receive benefits for all or certain dental treatments.

Part V: WHAT YOU WILL PAY

All copayments and coinsurance costs shown in this chart apply after your deductible has been met, if a deductible applies. The Common Dental Procedures fit into one of the following applicable categories: Preventive & Diagnostic, Basic or Major. The Benefit Limitations and Exclusions column includes common limitations and exclusions only. For a full list, see the full disclosure document referenced in the Benefit Limitations and Exclusions column.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusion
Oral Exam	Type A	100%	100%	2 services in a 12 month period.
Bitewing X-ray	Type A	100%	100%	4 x-rays in a 12 month period.
Cleaning	Type A	100%	100%	2 services in a 12 month period.
Filling	Type B	80%	80%	Benefits are payable for amalgam (silver) and composite/resin (white) fillings. Composite fillings on molars are limited to the amount otherwise payable for an amalgam filling. Replacement of fillings allowed once in a 12 month period.
Simple Extraction	Type B	80%	80%	Benefits are payable for simple extractions of erupted teeth.
Root Canal	Type B	80%	80%	Benefits are payable for services such as pulpal therapy and root canal therapy. Retreatment of a root canal is payable once in a lifetime and only after 12 months have passed since the original root canal was completed.

Scaling and Root Planing	Type B	80%	80%	Benefits are payable for non-surgical services such as scaling and root planning. Services are limited to one service per area of the mouth in a 24 month period.
Ceramic Crown	Not Covered			
Removable Partial Denture	Type C	60%	60%	Benefits are payable for final dentures.
Orthodontia	Orthodontia	50%	50%	Benefits are payable for orthodontic services including x-rays, case work up, consultation, appliances, and post-treatment retention. Orthodontic treatment is deemed to have begun at the time of banding and/or when other orthodontic appliances are initially placed in connection with a current course of treatment.

Part VI: COVERAGE EXAMPLES

THESE EXAMPLES DO NOT REPRESENT A COST ESTIMATOR OR GUARANTEE OF PAYMENT. The examples provided represent commonly used services in the categories of Diagnostic and Preventive, Basic and Major Services for illustrative purposes and to compare this policy to other dental products you may be considering. Your actual costs will likely be different from those shown in the chart below depending on the actual policies you receive, the prices your providers charge and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and the summary of excluded services under the plan.

Dana Has a Dental Appointment with a New Dentist	Sam Needs a Tooth Filled	Maria Needs a Crown
New Patient exam, x-rays (FMX) and cleaning	Resin-based composite – one surface, posterior	Crown – porcelain/ceramic substrate

Dana's Visit	Dana's Cost	Sam's Visit	Sam's Cost	Maria's Visit	Maria's Cost
Total Cost of Care	In-network: $250 Out-of-network: $450	Total Cost of Care	In-network: $150 Out-of-network: $250	Total Cost of Care	In-network: $950 Out-of-network: $1,400

Deductible	In-network: $0 Out-of-network: $0	Deductible	In-network: $0 Out-of-network: $0	Deductible	In-network: $0 Out-of-network: $0
Annual Maximum (Plan Will Pay)	In-network: $1,500 Out-of-network: Yes, $1,500, the cost-sharing could be higher. Contact your plan.	Annual Maximum (Plan Will Pay)	In-network: $1,500 Out-of-network: Yes, $1,500, the cost-sharing could be higher. Contact your plan.	Annual Maximum (Plan Will Pay)	In-network: $1,500 Out-of-network: Yes, $1,500, the cost-sharing could be higher. Contact your plan.
Dana's Visit	**Dana's Cost**	**Sam's Visit**	**Sam's Cost**	**Maria's Visit**	**Maria's Cost**
Patient Cost (copayment or coinsurance)	In-network: 100% Out-of-network: 100%	Patient Cost (copayment or coinsurance)	In-network: 80% Out-of-network: 80%	Patient Cost (copayment or coinsurance)	In-network: 60% Out-of-network: 60%
In this example, Dana would pay (includes copays/coin-surance and deductible, if applicable):	**In-network:** $0 **Out-of-network:** $0	**In this example, Sam would pay (includes copays/coin-surance and deductible, if applicable):**	**In-network:** $30 **Out-of-network:** $50	**In this example, Maria would pay (includes copays/coin-surance and deductible, if applicable):**	**In-network:** $380 **Out-of-network:** $560
Summary of what is not covered or subject to a limitation.	This example assumes exams, full mouth x-rays and cleanings are covered as Type A services.	Summary of what is not covered or subject to a limitation.	This example assumes resin-based composite fillings on posterior teeth is a covered service as outlined in the certificate booklet.	Summary of what is not covered or subject to a limitation.	This example assumes porcelain crowns are a covered service as outlined in the certificate booklet.