Mutual of Omaha

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 Legacy Transportation Services Inc., 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.



HIGH PLAN

With this dental plan, you have a choice in coverage levels, either the High Plan or the Low Plan. The High Plan offers a higher level of coverage (ex. a larger benefit percentage is available for covered services), with more costly premiums than the Low Plan. The Low Plan offers a lower level of coverage, with more affordable premiums than the High Plan. You have the flexibility to enroll for the plan that best meets you and your dependents dental health needs.

ELIGIBILITY - DENTAL: ALL ELIGIBLE EMPLOYEES ELECTING HIGH	
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.

CALENDAR YEAR DEDUCTIBLES AND MAXIMUMS	IN-NETWORK	OUT-NETWORK
Type A	Waived	Waived
Type B & C Deductible		
Individual	$50	$100
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 • Fluoride Treatments • Cleaning/Prophylaxis • Sealants • Space Maintainers • Brush Biopsy/Cancer Screening • Full Mouth X-rays, Panoramic Film	100%	100%
Type B Services • All Other X-Rays • 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	50%	50%
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.

This plan provides different coverage levels for In-Network and Out-Network services. By using an In-Network provider, plan members will save more through the predetermined fee arrangement and better benefit coverage.

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.

ROLLOVER BENEFIT PROVISION

The Rollover Benefit provision allows you and your dependents to save your dental benefit dollars for when you need them most. With this provision, Mutual of Omaha will “roll over” a percentage of the Policy Year Maximum Benefit for each insured person in a given calendar year, increasing the following Policy Year maximum for that insured person (subject to certain conditions). Rollover calculations are determined based on In-Network provisions.

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 – 1 service in a 6 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 – 2 services in a 12 month period. An additional 2 services if required for documented medical reasons.
- 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.
- 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 10 years.
- Bridges – Replacement allowed once in 10 years.
- Dentures – Replacement allowed once in 10 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.

PREMIUM AMOUNTS AND ENROLLING FOR COVERAGE

Coverage Tier	Premium Amount (52 Payroll Deductions Per Year)
Employee/Member	$4.42
Employee/Member + Spouse	$8.97
Employee/Member + Child(ren)	$10.30
Employee/Member + Family	$15.75

To enroll for dental coverage:

1) Using the table above, first identify the tier of coverage you wish to enroll for. Options are available that provide coverage for you (the employee) only, or for you and your family. The amount listed in the Premium Amount column is the cost per paycheck for each tier of coverage.
2) Locate the Dental Coverage election section on your enrollment form. Place a √ or an *x* in the Yes box next to the tier of coverage you wish to enroll for, then insert the Premium Amount for the tier you select into the Premium Amount column (if the premium amount is not already available on the form).
3) If you are enrolling for coverage for your dependents, complete the Dependent Information section of the enrollment form.

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.

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.

This information describes some of the features of the benefits plan. Benefits may not be available in all states. Please refer to the certificate booklet for a full explanation of the plan's benefits, exclusions, limitations and reductions. Should there be any discrepancy between the certificate booklet and this summary, the certificate booklet will prevail. Availability of benefits is subject to final acceptance and approval of the group application by the underwriting company. Dental insurance is underwritten by Mutual of Omaha Insurance Company or United of Omaha Life Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, NE 68175, 1-800-769-7159. United of Omaha Insurance Company is licensed nationwide, except in New York Policy form number: G2018MP or state equivalent (In NC: G2018MP NC).

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, 2026

Plan Name: Dental for Dental: All Eligible Employees Electing High
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	In-Network	Out-of-Network
Dental	Individual: $50 Family: $150	Individual: $100 Family: $300

- 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	In-Network	Out-of-Network
Annual Maximum	$1,500	Yes, $1,500, the cost sharing could be higher. Contact your plan.
Lifetime Maximum for Orthodontia	$1,000	Yes, $1,000, the cost sharing could be higher. Contact your plan.

- **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%	1 service in a 6 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. 2 additional cleanings in a 12 month period for any Insured Person when Medically Necessary due to pregnancy, heart disease, or diabetes.
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	50%	50%	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: $50 Out-of-network: $100	Deductible	In-network: $50 Out-of-network: $100	Deductible	In-network: $50 Out-of-network: $100
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: 50% Out-of-network: 50%
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:** $70 **Out-of-network:** $130	**In this example, Maria would pay (includes copays/coin-surance and deductible, if applicable):**	**In-network:** $500 **Out-of-network:** $750
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.