Get the Most Out of Your Dental Insurance

A Simple Guide to Using Your Coverage

Physicians Mutual Insurance Company®

Physicians Mutual® Insurance for all of us.®

Does it matter which dentist I choose?

Unlike some plans that require you to visit particular dentists to get full benefits, our insurance lets you choose any dentist you wish. You don't have to worry about changing dentists if you've found one you like to go to.

Our dental insurance pays the same benefits regardless of the dentist you choose. This gives you a chance to shop around until you find a dentist you like that is reasonably priced, which helps you save money.

To find a dentist, please visit our website: PhysiciansMutual.com/dentist.

What if my dental office thinks it doesn't accept this insurance?

Occasionally, some dental offices say they don't accept our insurance because they're part of a dental network and they know our insurance is not affiliated with that network. But since our insurance is individual dental coverage — not group insurance — you are allowed to use any dentist you wish.

Tell the dental office that our insurance provides the same coverage regardless of what dentist is used. If they still have questions, have them call the toll-free number on the back of our ID card for more information.

What if the dentist won't file my claim?

It's rare that a dentist won't file a claim for you — typically, 98 percent of dentists will file claims for our customers. Yet, if this happens, it's probably because dentists are used to only filing claims on your behalf if you are part of a network. Since our coverage lets you choose your own dentist, he or she may not submit the claim.

In most cases, if your dentist likes to provide the extra service of submitting claims, the payment is sent directly to them and they can bill you for the remaining balance, if any.

If you have our Participating Providers and Preventive Benefits Rider and use an in-network dentist, your dentist will file the claim for you.

If your dentist doesn't file the claim, you can submit it on your own. You have two options:

- **Option 1: Download a claim form from the Customer Center at PhysiciansMutual.com.** After you complete the top portion, have your dentist fill out the bottom. Then, send the form to Ameritas.
- **Option 2: Send Ameritas the original copy of the itemized dental bill** (the one with the dental procedure codes). Be sure to send a cover letter with your contact information and insurance policy/certificate number.

In most cases, when you submit the claim on your own, the benefit check can be sent directly to you. These claims are typically processed within seven days of receiving them.

To file a claim, mail or fax documents to:

Physicians Mutual Insurance Company
Dental Administrator: Ameritas Life Insurance Corp.
P.O. Box 82520
Lincoln, NE 68501

Fax: 1-402-467-7336

Coverage and offer are not available in all states.

New York Exclusions and Limitations: Dental Coverage

Any change in coverage will apply to all policies of this form and class in your state of residence. Your renewal premium can change if the same change is made by us on all policies of this form and class issued in New York and subject to approval by the New York Department of Financial Services. We will not increase your renewal premium unless you request a change in your policy benefits or riders or there is a change in dependent status.

We can terminate your coverage for non-payment of premiums, fraud or misrepresentation of material fact or if we stop offering policies of this form and class.

This policy provides dental insurance only. The expected benefit ratio for this policy is 55%. This ratio is the portion of future premiums that the company expects to return as benefits, when averaged over all people with this policy.

Services covered in this policy must be medically necessary. We will not pay more than the amount of the actual charge for a procedure. No benefits under the Policy are payable (or considered a Covered Expense) for any of the following:

Exclusions:

1) Cosmetic services or surgery, except that cosmetic surgery does not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.
2) Services provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.
3) Services for which no charge is normally made.
4) Illness, treatment or medical condition due to war, declared or undeclared.

Limitations:

1) Any procedure started before coverage takes effect.
2) Any procedure started after the Policy terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Policy terminates.
3) Facings on crowns or pontics beyond the second bicuspid.
4) Replacement of any prosthetic appliance, crown, inlay or onlay restoration, or fixed partial denture within five years of the date of the last placement of these items; unless: replacement is required due to an accidental Injury sustained while coverage is in force; and replacement occurs while such coverage is in force.
5) Initial placement of any prosthetic appliance or fixed partial denture unless placement is needed due to tooth extraction. The extraction of a wisdom tooth will not qualify. The appliance or fixed partial denture includes the replacement of the extracted tooth or teeth.
6) Replacement of lost or stolen appliances.
7) Appliances, restorations, or procedures to: alter vertical dimension; restore or maintain occlusion; or splint or replace tooth structure lost as a result of abrasion or attrition.
8) Orthodontic treatment.
9) Sealants which are: not applied to a permanent molar; applied as of age 17; or reapplied to a molar within three years.
10) Periodontal scaling or root planing unless periodontal disease is confirmed by both X-ray films and pocket depth summaries of each tooth involved.

What is not covered:

The Participating Providers and Preventive Benefits Rider will not pay benefits for: (a) procedures not payable under the certificate/insurance policy; (b) procedures not listed in this Rider Benefits provision; or (c) expenses incurred while this rider is not in force.

If the provider discounted fee at the Participating Provider or the actual charge at a Non-Participating Provider is greater than the benefits paid by us, you are responsible for the difference.