Assurant Health
501 W. Michigan Street
P.O. Box 624
Milwaukee, WI 53201-0624
800-800-1212

Notice to Agents Regarding Specimen Policies

This specimen policy is provided as a reference tool for agent or internal use only. Please refer to the revision date to find the latest version as this document is occasionally updated. Please note that the enclosed Benefit Summary does not include policy specific variable information. Also, state specific benefits may not be included in this specimen. Finally, this document should not be used to identify benefits. For a complete listing of benefits, exclusions and limitations, please refer to the issued contract. In the event there are discrepancies with the information in this document, the terms and conditions of the issued contract will govern.

Time Insurance Company
501 W. Michigan Street
P.O. Box 624
Milwaukee, WI 53201-0624

POLICY SCHEDULE
DENTAL INDEMNITY INSURANCE

Policy Number:	0000682710		
Policyholder:	John Doe	Effective Date:	09/15/2010
Policyholder Address:	PO Box 1088 Savannah GA 31402-1088		
Covered Dependent:	Dep 1 Doe	Effective Date:	09/15/2010

INITIAL ANNUAL PREMIUM: $543.78
PAYMENT OPTION: ANNUALLY
INITIAL ANNUAL PREMIUM: $543.78

The benefits listed on this Policy Schedule are for each Covered Person unless otherwise indicated.

Basic and Major Services Combined Maximum Benefit Limitation: Benefits for all covered Basic Dental Services and Major Dental Services combined are limited to a maximum Calendar Year benefit of $1,500 per Covered Person. This benefit limitation is in addition to any other maximum benefit limitation specified below.

Dental Preventive Benefits:	
We will pay one Dental Preventive Benefit of $100, regardless of the number of visits to a Dentist or Dental Hygienist or the number of services received, every 150 calendar days. Dental Preventive Benefits are limited to a maximum benefit of $200 per Calendar Year.	
Procedure Code	**Dental Preventive Services**
00120	Periodic oral evaluation
00140	Limited oral evaluation - problem focused
00150	Comprehensive Oral Exam - new or established patient
00160	Detailed and extensive oral evaluation - problem focused, by report
00210	Intraoral - complete series (including bitewings)
00220	Intraoral - periapical first film
00230	Intraoral - periapical each additional film
00240	Intraoral - occlusal film
00250	Extraoral - first film
00260	Extraoral - each additional film
00270	Bitewing - single film
00272	Bitewings - two films
00274	Bitewings - four films
00330	Panoramic film
00340	Cephalometric film
00415	Bacteriologic studies for determination of pathologic agents
00460	Pulp vitality tests
00470	Diagnostic casts
00471	Diagnostic photographs
00501	Histopathologic Examinations
09310	Consultation (diagnostic service provided by Dentist or physician other than practitioner)
01110	Prophylaxis - adult
01120	Prophylaxis - child
01201	Topical application of fluoride (including prophylaxis) - child
01203	Topical application of fluoride (prophylaxis not included) - child
01204	Topical application of fluoride (prophylaxis not included) - adult
01205	Topical application of fluoride (including prophylaxis) - adult
01351	Sealant - per tooth
01510	Space maintainer - fixed - unilateral
01515	Space maintainer - fixed - bilateral
01520	Space maintainer - removable - unilateral
01525	Space maintainer - removable - bilateral
01550	Recementation of space maintainer

Basic Dental Services Benefits:		
Benefits for all covered Basic Dental Services rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of $1,500 per Covered Person.		
All benefits for covered Basic Dental Services are subject to the Basic and Major Services Combined Maximum Benefit Limitation shown on this Policy Schedule.		
The Scheduled Benefits shown below will be reduced by 50% for any covered procedure rendered during the first Policy Year following the Effective Date.		
Procedure Code	**Basic Dental Services**	**Scheduled Benefit**
09110	Palliative (emergency) treatment of dental pain - minor procedure	$70
09220	Deep sedation/general anesthesia - first 30 minutes	$275
09221	Deep sedation/general anesthesia - each additional 15 minutes	$100
02140	Amalgam - one surface - primary or permanent	$90
02150	Amalgam - two surfaces - primary or permanent	$110
02160	Amalgam - three surfaces - primary or permanent	$140
02161	Amalgam - four or more surfaces - primary or permanent	$160
02330	Resin-based composite - one surface, anterior	$110
02331	Resin-based composite - two surfaces, anterior	$140
02332	Resin-based composite - three surfaces, anterior	$160
02335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$190
02336	Resin-based composite crown (anterior-primary)	$190
02391	Resin-based composite - one surface, posterior - permanent or primary	$120
02392	Resin-based composite - two surfaces, posterior - permanent or primary	$150
02393	Resin-based composite - three surfaces, posterior - permanent or primary	$190
02394	Resin-based composite - four or more surfaces, posterior	$225
02410	Gold foil - one surface	$100
02420	Gold foil - two surfaces	$375
07111	Coronal remnant - deciduous tooth	$80
07140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$100
05410	Adjust complete denture - maxillary	$55
05411	Adjust complete denture - mandibular	$55
05421	Adjust partial denture - maxillary	$55
05422	Adjust partial denture - mandibular	$55
05510	Repair broken complete denture base	$120
05520	Replace missing or broken teeth - complete denture (each tooth)	$100
05610	Repair resin denture base	$120
05620	Repair cast framework	$150
05630	Repair or replace broken clasp	$150
05640	Replace broken teeth - per tooth	$100
05650	Add tooth to existing partial denture	$120
05660	Add clasp to existing partial denture	$150
05670	Replace all teeth and acrylic on cast metal framework (maxillary)	$350
05671	Replace all teeth and acrylic on cast metal framework (mandibular)	$350
05710	Rebase complete maxillary denture	$350
05711	Rebase complete mandibular denture	$350
05720	Rebase maxillary partial denture	$350
05721	Rebase mandibular partial denture	$350
05730	Reline complete maxillary denture (chairside)	$200

05731	Reline complete mandibular denture (chairside)	$200
05740	Reline maxillary partial denture (chairside)	$200
05741	Reline mandibular partial denture (chairside)	$200
05750	Reline complete maxillary denture (laboratory)	$300
05751	Reline complete mandibular denture (laboratory)	$300
05760	Reline maxillary partial denture (laboratory)	$300
05761	Reline mandibular partial denture (laboratory)	$300
05850	Tissue conditioning, maxillary	$100
05851	Tissue conditioning, mandibular	$100
06930	Recement fixed partial denture	$100

Major Dental Services Benefits:		
Benefits for all covered Major Dental Services rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of $1,500 per Covered Person.		
All benefits for covered Major Dental Services are subject to the Basic and Major Services Combined Maximum Benefit Limitation shown on this Policy Schedule.		
The Scheduled Benefits shown below will be reduced by 50% for any covered procedure rendered during the first Policy Year following the Effective Date.		
Procedure Code	**Major Dental Services**	**Scheduled Benefits**
02510	Inlay - metallic - one surface	$280
02520	Inlay - metallic - two surfaces	$330
02530	Inlay - metallic - three or more surfaces	$375
02543	Onlay - metallic - three surfaces	$375
02544	Onlay - metallic - four or more surfaces	$375
02610	Inlay - porcelain/ceramic - one surface	$350
02620	Inlay - porcelain/ceramic - two surfaces	$350
02630	Inlay - porcelain/ceramic - three or more surfaces	$375
02642	Onlay - porcelain/ceramic - two surfaces	$375
02643	Onlay - porcelain/ceramic - three surfaces	$375
02644	Onlay - porcelain/ceramic - four or more surfaces	$375
02650	Inlay - resin based composite - one surface	$225
02651	Inlay - resin based composite - two surfaces	$260
02662	Onlay - resin based composite - two surfaces	$240
02663	Onlay - resin based composite - three surfaces	$280
02910	Recement inlay	$40
02940	Sedative Filling	$40
02951	Pin retention - per tooth, in addition to restoration	$20
02710	Crown - resin laboratory	$190
02720	Crown - resin with high noble metal	$450
02721	Crown - resin with predominantly base metal	$450
02722	Crown - resin with noble metal	$450
02740	Crown - porcelain/ceramic substrate	$450
02750	Crown - porcelain fused to high noble metal	$450
02751	Crown - porcelain fused to predominantly base metal	$450
02752	Crown - porcelain fused to noble metal	$450
02780	Crown - 3/4 cast high noble metal	$450
02781	Crown - 3/4 cast predominantly base metal	$450
02782	Crown - 3/4 cast noble metal	$450

02790	Crown - porcelain	$450
02791	Crown - full cast predominantly base metal	$450
02792	Crown - full cast noble metal	$450
02810	Crown - 3/4 cast metallic	$450
02920	Recement crown	$40
02930	Prefabricated stainless steel crown - primary tooth	$110
02931	Prefabricated stainless steel crown - permanent tooth	$125
02932	Prefabricated resin crown	$140
02933	Prefabricated stainless steel crown with resin window	$150
02940	Sedative filling	$40
02950	Core buildup, including any pins	$100
02952	Cast post and core in addition to crown	$150
02954	Prefabricated post and core in addition to crown	$135
02970	Temporary crown (fractured tooth)	$95
03110	Pulp cap - direct (excluding final restoration)	$30
03120	Pulp cap - indirect (excluding final restoration)	$30
03220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medication	$70
03310	Anterior (excluding final restoration)	$225
03320	Bicuspid (excluding final restoration)	$300
03330	Molar (excluding final restoration)	$375
03346	Retreatment of previous root canal therapy - anterior	$225
03347	Retreatment of previous root canal therapy - bicuspid	$250
03348	Retreatment of previous root canal therapy - molar	$400
03410	Apicoectomy/periradicular surgery - anterior	$175
03421	Apicoectomy/periradicular surgery - bicuspid (first root)	$300
03425	Apicoectomy/periradicular surgery - molar (first root)	$350
03426	Apicoectomy/periradicular surgery (each additional root)	$145
03430	Retrograde filling - per root	$105
03450	Root amputation - per root	$200
03920	Hemisection (including any root removal), not including root canal therapy	$150
00180	Comprehensive periodontal evaluation - new or established patient	$30
04210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	$165
04211	Gingivectomy or gingivoplasty - one to three teeth per quadrant	$65
04240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	$275
04249	Clinical crown lengthening - hard tissue	$300
04260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	$325
04261	Osseous surgery (including flap entry and closure) - one to three teeth per quadrant	$200
04263	Bone replacement graft - first site in quadrant	$150
04264	Bone replacement graft - each additional site in quadrant	$75
04270	Pedicle soft tissue graft procedure	$300
04271	Free soft tissue graft procedure (including donor site surgery)	$300
04341	Periodontal scaling and root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	$95

04355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$65
04910	Periodontal maintenance	$60
05110	Complete denture - maxillary	$375
05120	Complete denture - mandibular	$375
05130	Immediate denture - maxillary	$400
05140	Immediate denture - mandibular	$400
05211	Maxillary partial denture - resin base (including any conventional clasps, rests, and teeth)	$375
05212	Mandibular partial denture - resin base (including any conventional clasps, rests, and teeth)	$375
05213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)	$400
05214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)	$400
05281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	$275
06210	Pontic - cast high noble metal	$375
06211	Pontic - cast predominantly base metal	$375
06212	Pontic - cast noble metal	$375
06240	Pontic - porcelain fused to high noble metal	$375
06241	Pontic - porcelain fused to predominantly base metal	$375
06242	Pontic - porcelain fused to noble metal	$375
06250	Pontic - resin with high noble metal	$375
06251	Pontic - resin with predominantly base metal	$375
06252	Pontic - with noble metal	$375
06545	Retainer - cast metal for resin bonded fixed prosthesis	$175
06602	Inlay - cast high noble metal, two surfaces	$375
06603	Inlay - cast high noble metal, three or more surfaces	$375
06604	Inlay - cast predominantly base metal, two surfaces	$375
06605	Inlay - cast predominantly base metal, three or more surfaces	$375
06606	Inlay - cast noble metal, two surfaces	$375
06607	Inlay - cast noble metal, three or more surfaces	$375
06610	Onlay - cast high noble metal, two surfaces	$375
06611	Onlay - cast high noble metal, three or more surfaces	$375
06612	Onlay - cast predominantly base metal, two surfaces	$375
06613	Onlay - cast predominantly base metal, three or more surfaces	$375
06614	Onlay - cast noble metal, two surfaces	$375
06615	Onlay - cast noble metal, three or more surfaces	$375
06720	Crown - resin with high noble metal	$375
06721	Crown - resin with predominantly base metal	$375
06722	Crown - resin with noble metal	$375
06740	Crown - porcelain/ceramic	$375
06750	Crown - porcelain fused to high noble metal	$375
06751	Crown - porcelain fused to predominantly base metal	$375
06752	Crown - porcelain fused to noble metal	$375
06780	Crown - 3/4 cast high noble metal	$375
06781	Crown - 3/4 cast predominantly base metal	$375

06782	Crown - 3/4 cast noble metal	$375
06783	Crown - 3/4 cast porcelain/ceramic	$375
06790	Crown - full cast high noble metal	$375
06791	Crown - full cast predominantly base metal	$375
06792	Crown - full cast noble metal	$375
07210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$95
07220	Removal of impacted tooth - soft tissue	$120
07230	Removal of impacted tooth - partially bony	$160
07240	Removal of impacted tooth - completely bony	$185
07241	Removal of impacted tooth - completely bony, with unusual surgical complications	$200
07250	Surgical removal of residual tooth roots (cutting procedure)	$100
07260	Oroantral fistula closure	$800
07270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$200
07280	Surgical access of unerupted tooth	$200
07281	Surgical exposure of impacted or unerupted tooth to aid eruption	$165
07285	Biopsy of oral tissue - hard (bone, tooth)	$325
07286	Biopsy of oral tissue - soft (all others)	$165
07310	Alveoloplasty in conjunction with extractions - per quadrant	$110
07320	Alveoloplasty not in conjunction with extractions - per quadrant	$400
07340	Vestibuloplasty - ridge extension (secondary epithelialization)	$750
07350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment, and management of hypertrophied tissue)	$1000
07410	Excision of benign lesion up to 1.25 cm	$165
07411	Excision of benign lesion greater than 1.25 cm	$500
07413	Excision of malignant lesion up to 1.25 cm	$165
07414	Excision of malignant lesion greater than 1.25 cm	$550
07450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$165
07451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$500
07460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	$325
07461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$500
07471	Removal of lateral exostosis (maxilla or mandible)	$325
07510	Incision and drainage of abscess - intraoral soft tissue	$100
07520	Incision and drainage of abscess - extraoral soft tissue	$450
07530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	$165
07540	Removal of reaction producing foreign bodies, musculoskeletal system	$200
07550	Partial ostectomy/sequestrectomy for removal of non-vital bone	$125
07560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$825
07960	Frenulectomy (frenectomy or frenotomy) - separate procedure	$200
07970	Excision of hyperplastic tissue - per arch	$200

07971	Excision of pericoronal gingival	$75
07972	Surgical reduction of fibrous tuberosity	$250
07980	Sialodochoplasty	$275

AGENT INFORMATION

NAME
AARON SMITH

ADDRESS & TELEPHONE NUMBER
4309 S Louise Avenue
Sioux Falls SD 57106-3142
(605)361-3515

Time Insurance Company
501 W. Michigan Street
P.O. Box 624
Milwaukee, WI 53201-0624

DENTAL INDEMNITY INSURANCE POLICY

Limited Benefit Policy - This plan provides benefits for dental treatment only.

The insurance described in this Policy is effective on the date shown in the Policy Schedule only if You are eligible for the insurance, become insured, and remain insured subject to the terms, limits and conditions of this plan. This Policy is evidence of Your coverage. This Policy is issued and delivered in the State of Georgia.

This Policy is issued based on the statements and agreements in the application/enrollment form and during the enrollment process, any other amendments or supplements and payment of the required premium. This Policy may be changed. If that happens, You will be notified of any such changes.

RIGHT TO EXAMINE POLICY FOR 30 DAYS

If You are not satisfied, return the Policy to Us or Our agent within 30 days after You have received it. All premiums will be refunded and Your coverage will be void from the Effective Date.

IMPORTANT NOTICE CONCERNING STATEMENTS IN YOUR APPLICATION/ENROLLMENT FORM FOR INSURANCE

Please read the copy of the application/enrollment form included with this Policy. We issued this coverage in reliance upon the accuracy and completeness of the information provided in the application/enrollment form and during the enrollment process. If a material omission or misstatement is made in the application/enrollment form, We have the right to deny any claim, rescind the coverage and/or modify the terms of the coverage or the premium amount, subject to the Incontestability and Time Limit on Certain Defenses provision. Carefully check the application/enrollment form and, if any information shown in the application/enrollment form is not correct and complete, write to Us at the address above, within 10 days.

Secretary

President

This Policy is guaranteed renewable until age 70 years. We may change premium for this Policy if We change premiums for all policies within the same class.

This Policy automatically renews except for as stated in the Effective Date and Termination Date section.
Read Your Policy carefully to understand coverage limitations and termination provisions.

GUIDE TO YOUR COVERAGE

The sections of the Policy appear in the following order:

I. Definitions

When reading this Policy, terms with a defined meaning will have the first letter of each word capitalized for easy identification. The capitalized terms used in this plan are defined below. Just because a term is defined does not mean it is covered. Please read the Policy carefully.

Accident or Accidental
Any event that meets all of the following requirements:

1. it causes harm to the physical structure of the body.
2. it results from an external agent or trauma.
3. it is the direct cause of a loss, independent of disease, dental infirmity or any other cause.
4. it is definite as to time and place.
5. it happens involuntarily, or entails unforeseen consequences if it is the result of an intentional act.

Basic Dental Services
Only those dental services specifically listed by procedure code on the Policy Schedule as Basic Dental Services.

Benefit Waiting Period
The period of time coverage must be in force before a Covered Person is eligible for payment of a particular type of benefit. Any applicable Benefit Waiting Period and its term will be shown on the Policy Schedule. Multiple Benefit Waiting Periods may apply and run concurrently under this plan.

Calendar Year
The period beginning on January 1 of any year and ending on December 31 of the same year.

Cosmetic Services
A surgery, procedure, injection, medication, or treatment primarily designed to improve appearance, self-esteem or body image and/or to relieve or prevent social, emotional or psychological distress.

Covered Dependent
A person who meets the definition of a Dependent and is enrolled and eligible to receive benefits under this plan, as shown on the Policy Schedule.

Covered Person
A person who is enrolled and eligible to receive benefits under this plan, as shown on the Policy Schedule.

Dentally Necessary and Dental Necessity
Dental Treatment rendered to diagnose or treat a dental condition unless it is a Dental Preventive Services procedure as stated in the Policy Schedule. The Dental Treatment must be essential for the care of the teeth and supporting tissues. We must determine that such care:

1. is appropriate and consistent with the diagnosis and does not exceed in scope, duration or intensity that level of care that is needed to provide safe, adequate and appropriate diagnosis and treatment of the dental condition; and
2. is commonly accepted as proper care or treatment of the condition in accordance with United States dental standards and federal government guidelines; and
3. can reasonably be expected to result in or contribute substantially to the improvements of a condition; and
4. is provided in the most conservative manner or in the least intensive setting without adversely affecting the condition or the quality of dental care provided.

The fact that a Dental Hygienist, Dentist, or other dental care provider, facility or supplier may prescribe, order, recommend or approve a Dental Treatment does not, of itself, make the Dental Treatment Dentally Necessary for the purpose of determining eligibility under this Policy.

Dentist
A person licensed to practice dentistry by the state, or other geographic area within the United States and its territories, in which the covered procedure is rendered. The Dentist must be practicing within the limits of his or her license and in the geographic area in which he or she is licensed.

Dental Hygienist
A person licensed as dental hygienist by the state, or other geographic area within the United States and its territories, in which the covered procedure is rendered. The Dental Hygienist must be practicing within the limits of his or her license and in the geographic area in which he or she is licensed.

Dental Preventive Services
Only those Dental Preventive Services specifically listed by procedure code on the Policy Schedule as Dental Preventive Services.

Dependent
A Dependent is:

1. the Policyholder's lawful spouse; or

2. the Policyholder's naturally born child, legally adopted child, a child that is placed for adoption with the Policyholder, a stepchild, a child for whom the Policyholder is the legal guardian or a child for whom the Policyholder is required to provide coverage pursuant to a court or administrative order:

    a. who is unmarried; and
    b. who is age 19 or younger.

If Your unmarried child is age 20 or older the child will be considered a Dependent if You give Us proof that:

1. the child has been enrolled for 5 calendar months or more as a full-time student at an accredited educational institution, college or university, and if not so enrolled, would have been eligible to be enrolled and was prevented from being enrolled due to Sickness or Injury. A student will be considered full-time if the student meets the standards for full-time status at the school the student is attending. A student will be considered full-time during regular vacation periods that interrupt, but do not terminate, the continuous full-time course of study; or

2. the child is not capable of self-sustaining employment by reason of mental retardation or physical disability as determined by the Georgia Department of Human Resources and is chiefly dependent on the Policyholder for support and maintenance. You must give Us proof that the child meets these requirements at the same time that You first enroll for coverage under this plan or within 31 days after the child reaches the limiting age for termination. Additional proof may be requested periodically but not more often than annually after the 2-year period following the date the child reaches the limiting age for termination.

A child will no longer be a Dependent on the earliest of the date that he or she:

1. is no longer a full-time student; or

2. is no longer required to be covered pursuant to a court or administrative order; or

3. attains age 26; or

4. marries; or

5. is over the limiting age and is capable of self-sustaining employment because he or she is no longer

incapacitated by reason of mental retardation or physical disability as determined by the Georgia Department of Human Resources.

If only Dependent children are covered under this plan, the youngest child will be considered the Policyholder. All siblings of the Policyholder will be considered Covered Dependents if they meet the requirements above.

Effective Date
The date coverage under this plan begins for a Covered Person as stated on the Policy Schedule. The Covered Person's coverage begins at 12:01 a.m. local time in the state of issuance on the Effective Date approved by Us.

Emergency Dental Treatment
Any Dentally Necessary service, procedure, or supply which is rendered as the direct result of unforeseen events or circumstances which require prompt attention.

Experimental or Investigational Services
Treatment, services, supplies or equipment which, at the time the treatment is rendered, We determine are:

1. not proven to be of benefit for diagnosis or treatment of the dental condition; or
2. not generally used or recognized by the medical or dental community as safe, effective and appropriate for diagnosis or treatment; or
3. in the research or investigational stage, provided or performed in a special setting for research purposes or under a controlled environment or clinical protocol; or
4. obsolete or ineffective for the treatment; or
5. medications used for non-FDA approved indications and/or dosage regimens.

Family Plan
A plan of insurance covering the Policyholder and one or more of the Policyholder's dependents as shown on the Policy Schedule.

Functioning Natural Tooth (Teeth)
A healthy tooth with normal function in the mastication process in the upper or lower arch and that is opposed in the other arch by another tooth or prosthetic replacement. For purposes of this Policy, third molars are not considered Functioning Natural Teeth.

Home Office
Our office in Milwaukee, Wisconsin or other administrative offices as indicated by Us.

Immediate Family Member
An Immediate Family Member is:

1. You or Your spouse; or
2. the children, brothers, sisters and parents of either You or Your spouse; or
3. the spouses of the children, brothers and sisters of You and Your spouse; or
4. anyone with whom a Policyholder has a relationship based on a legal guardianship.

Injury
Accidental bodily damage, independent of all other causes, occurring unexpectedly and unintentionally.

Major Dental Services
Only those dental services specifically listed by procedure code on the Policy Schedule as Major Dental Services.

Policy
The contract issued by Us to the Policyholder for benefit of Covered Persons.

Policyholder
The person listed on the Policy Schedule as the Policyholder.

Policy Year
The period beginning on the month and day of the Effective Date in any year and ending on the same month and day as the Effective Date in the following year.

Sickness
A disease or illness of a Covered Person. Sickness does not include a family history of a disease or illness or a genetic predisposition for the development of a future disease or illness.

Single Plan
A plan of insurance covering only the Policyholder as shown in the Policy Schedule.

We, Us, Our, Our Company
Time Insurance Company or its administrator.

You, Your, Yours
The person listed on the Policy Schedule as the Policyholder.

II. Dental Indemnity Insurance Benefits

WE WILL PAY BENEFITS ONLY FOR THE SERVICES AND SUPPLIES LISTED AS DENTAL BENEFITS IN THIS SECTION OF THE PLAN. HOW BENEFITS ARE PAID AND THE MAXIMUM BENEFIT FOR THE COVERED SERVICES AND SUPPLIES LISTED IN THIS SECTION ARE SHOWN IN THE POLICY SCHEDULE.

REFER TO THE EXCLUSIONS SECTION FOR SERVICES AND SUPPLIES THAT ARE NOT COVERED UNDER THIS POLICY.

Benefits paid under this section are subject to any maximum benefit limitation provided under this plan. Benefits are subject to all the terms, limits and conditions in this plan.

We will not pay benefits for Dental Treatment rendered during a Covered Person's Benefit Waiting Period. A Benefit Waiting Period only applies if it is shown in the Policy Schedule. Benefits are available from the first day Covered Charges are incurred for a Dental Injury that is sustained on or after the Covered Person's Effective Date.

We pay only for Dental Treatment, according to the following classifications and subject to the benefit amounts provided on the Policy Schedule, when Dentally Necessary and provided by a Dentist or Dental Hygienist licensed to perform such procedure or treatment:

Dental Preventive Benefits
We will pay the benefit shown on the Policy Schedule for Dental Preventive Services. All preventive visits must be separated by at least 150 calendar days for benefits to be payable. The benefit amount is paid only once regardless of the number of Dental Preventive Services provided during any one visit. To be eligible for benefits, Dental Preventive Services must be rendered by a licensed Dentist or Dental Hygienist.

Basic Dental Services Benefits
We will pay the Scheduled Benefit for Basic Dental Services as shown on the Policy Schedule. The Scheduled Benefit will be reduced by 50% for all Basic Dental Services rendered during the first Policy Year following the Effective Date of coverage. Thereafter the full Scheduled Benefit will be paid for covered Basic Dental Services. All benefits for Basic Dental Services rendered during the same Calendar Year are subject to the maximum Calendar Year benefit for Basic Dental Services shown on the Policy Schedule. All benefits for covered Basic Dental Services are subject to the Basic and Major Services Combined Maximum Benefit Limitation shown on the Policy Schedule.

Major Dental Services Benefits
We will pay the Scheduled Benefit for Major Dental Services as show on the Policy Schedule. The Scheduled Benefit will be reduced by 50% for all Major Dental Services rendered during the first Policy Year following the Effective Date of coverage. Thereafter the full Scheduled Benefit will be paid for covered Major Dental Services. All benefits for Major Dental Services rendered during the same Calendar Year are subject to the maximum Calendar Year benefit for Major Dental Services shown on the Policy Schedule. All benefits for covered Major Dental Services are subject to the Basic and Major Services Combined Maximum Benefit Limitation shown on the Policy Schedule.

III. Exclusions and Limitations

Limited Benefits
This Policy pays limited, fixed indemnity benefits for Dental Treatments only. See the Policy Schedule for the limited benefit amounts and maximum benefit limitations.

Exclusions
We will not pay benefits for any of the following:

1. any procedure or treatment not shown on the Policy Schedule.
2. any procedure rendered during an applicable Benefit Waiting Period.
3. any amount in excess of a Calendar Year or lifetime maximum benefit limitation.
4. Dental Preventive Benefits when there is less than 150 calendar days between the dates of service for Dental Preventive Services.
5. all Experimental or Investigative Services.
6. any procedure performed by a person other than a Dentist or Dental Hygienist.
7. any procedure performed by a Covered Person's Immediate Family Member.
8. all services that are not Dentally Necessary.
9. repairs to dental work less than 180 calendar days following completion of the initial procedure.
10. prosthetics replaced less than 5 years following the previous placement.
11. crowns replaced less than 5 years following the previous placement.
12. inlays or onlays replaced less than 5 years following the last placement.
13. dental implants or the removal of implants.
14. Cosmetic Services, unless performed to correct a functional disorder.
15. services performed outside the United States and its territories and Canada except for services that are received for Emergency Dental Treatment.
16. replacement of any tooth missing prior to the Effective Date.
17. placement of full or partial dentures, whether removable or fixed, including a Maryland Bridge, unless replacing a Functioning Natural Tooth extracted after the Effective Date and not within a Benefit Waiting Period.
18. for Covered Persons under age 16, inlays, onlays, bridgework or crowns except for stainless steel or plastic crowns.
19. any charge or procedure for treatment required because of Dental Injury or disease due to:
    a. war or any act of war, whether declared or undeclared.
    b. participation in the military service of any country or international organization, including non-military units supporting such forces.
    c. charges for Sickness or Injury caused or aggravated by attempted suicide or intentionally self-inflicted Sickness or Injury.
    d. taking part in a riot or insurrection, or an act of riot or insurrection.
    e. participating in, voluntarily attempting to commit or commission of a felony or engaging in an illegal occupation at the time of an Accident.

f. being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.
g. riding in any aircraft not licensed to carry passengers or not operated by a duly licensed pilot.

h. charges for treatment or services required due to an Injury sustained in operating a motor vehicle while the Covered Person's blood alcohol level, as defined by law, was .08 or higher. This exclusion applies whether or not the Covered Person is charged with any violation in connection with the Accident.

20. procedures rendered before the Effective Date or after the termination date of coverage.

21. orthodontic treatment and services.

IV. Claim Provisions

Most providers will file claims directly with Us. You are responsible for filing a claim with Us if the provider does not file it. The following provisions tell You how to file claims with Us.

Notice of Claim
We must receive written or electronic notice of the services that were received for which the claim is made. Notice must be provided to Us within 60 days after a covered loss occurs or as soon as reasonably possible. Notice given by You or on Your behalf to Us at 501 West Michigan, Milwaukee, Wisconsin, 53203 or any other address which We may provide to You or to any authorized agent of Us, with information sufficient to identify You, shall be deemed notice to Us.

Claim Forms
Upon receipt of a notice of claim, We will furnish to the claimant such forms as are usually furnished for filing proof of loss. If such forms are not furnished within 10 working days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in this Policy for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proof of Loss
Written proof of loss must be furnished to Us at 501 West Michigan, Milwaukee, Wisconsin, 53203 or any other address which We may provide to You. In case of claim for loss for which this Policy provides any periodic payment contingent upon continuing loss, proof of loss must be furnished within 90 days after the termination of the period for which We are liable. In case of claim for any other loss, proof of loss must be furnished within 180 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than 1 year from the time proof is otherwise required.

The proof of loss must include all of the following:

1. Your name and Policy number.
2. the name of the Covered Person who incurred the claim.
3. the name and address of the provider of the services.
4. an itemized bill from the provider of the services that includes the Dental Treatment performed in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature or by narrative description.

When We receive written or electronic proof of loss, We may require additional information. You must furnish all items We decide are necessary to determine Our liability in accordance with the Right to Collect Information provision in this section. We will not pay benefits if the required information or authorization for its release is not furnished to Us. We reserve the right to request X-rays, narratives and other diagnostic information, as We see fit, to determine benefits.

Right to Collect Information
To determine Our liability, We may request additional information from a Covered Person, Dentist, Dental Hygienist, facility, or other individual or entity. A Covered Person must cooperate with Us, and assist Us by obtaining the following information within 30 days of Our request. Charges will be denied if We are unable to determine Our liability because a Covered Person, Dentist, Dental Hygienist, facility, or other individual or entity failed to:

1. authorize the release of all medical and dental records to Us and other information We requested for pending claims under this Policy.
2. provide Us with information We requested about pending claims.

3. provide Us with information that is accurate and complete.

4. have any examination completed as requested by Us.

Such charges may be considered for benefits upon receipt of the requested information, provided all necessary information is received prior to expiration of the time allowed for submission of claim information as set forth in this Claim Provisions section.

Physical Examination
We have the right to have a provider of Our choice examine a Covered Person when and as often as We may reasonably require during the pendency of a claim for benefits. These exams will be paid by Us.

Payment of Claims
Benefits will be paid within 15 working days of Our receipt of due written or electronic proof of loss. Benefits for services provided will be paid to the Policyholder unless they have been assigned to a provider. Any benefits unpaid at Your death will be paid at Our option to Your spouse, Your estate or the providers of the services.

If a claim or a portion of the claim is contested by Us, You shall be notified in writing that the claim is contested or denied within 15 working days after receipt of the claim by Us. The notice that a claim is contested shall identify the contested portion of the claim and the reasons for contesting the claim.

Upon receipt of any additional information requested from You, We will pay or deny the contested portion within 15 working days. All over due payments shall bear simple interest at the rate of 18 percent per year.

We will pay dental claims when coded according to the American Dental Association Uniform Code on Dental Procedures and Nomenclature or Current Dental Terminology (CDT) manual. We will not pay for: charges that are billed separately as professional services when the procedure requires only a technical component; or charges that are billed incorrectly or billed separately but are an integral part of another billed service, as determined by Us; or other claims that are improperly billed; or duplicates of previously received or processed claims.

Any amount We pay in good faith will release Us from further liability for that amount. Payment by Us does not constitute any assumption of liability for further coverage under this plan.

Overpayment
If a benefit is paid under this plan and it is later shown that a lesser amount should have been paid, We will be entitled to recover the excess amount from You or the person or entity receiving the incorrect payment.

Claims Involving Misrepresentation or Fraud
Claims will be denied in whole or in part in the event of misrepresentation or fraud by a Covered Person or a Covered Person's representative. If benefits are paid under this plan and it is later shown the claims for these benefits involved misrepresentation or fraud, We will be entitled to a refund from You or the person or entity receiving the payment.

If the Covered Person, or anyone acting on the Covered Person's behalf, knowingly files a fraudulent claim, claims may be denied in whole or in part, coverage may be terminated or rescinded, and the Covered Person may be subject to civil and/or criminal penalties.

Workers' Compensation Not Affected
Insurance under this plan does not replace or affect any requirements for coverage by workers' compensation insurance. If state law allows, We may participate in a workers' compensation dispute arising from a claim for which We paid benefits.

Claim Appeal
You have the right to request a review of all adverse claim decisions. A review must be requested in writing within 180 days following Your receipt of the notice that the claim was denied or reduced.

V. Premium Provisions

Consideration
This plan is issued based on the statements and agreements in the Covered Person's application/enrollment form and during the enrollment process, any exam of a Covered Person that is required, any other amendments or supplements to the application/enrollment form and payment of the required premium. Each renewal premium is payable on the due date subject to the Grace Period provision in this section.

Premium Payment
The initial premium must be paid on or before the due date for this coverage to be in force. Subsequent premiums are due as billed by Us. Each renewal premium must be received by Us on its due date subject to the Grace Period provision in this section. Premiums must be received in cash or check at Our office on the date due. We may agree to accept premium payment in alternative forms, such as credit card or automatic charge to a bank account. We reserve the right to dishonor any such agreement for payment of premium during the grace period if We tried to obtain payment for the amount due using the alternative method but were unsuccessful.

Your premium may be adjusted from time to time based on different factors including, but not limited to, Your geographic area, payment method and plan design. All premium adjustments will be made to individuals on the basis of shared characteristics. The premium may also change if You add or delete Covered Dependents, change the payment method, move to another zip code or otherwise change the coverage. The mode of payment (monthly, quarterly or other) is subject to change at Our discretion.

Grace Period
There is a grace period of 31 days for the payment of each premium due after the initial premium during which time the Policy will remain in force. If the full premium due is not received at Our Home Office by the end of the grace period, the coverage will end on the date that the grace period ends. If any claims become payable during the grace period, any unpaid premium due will be deducted from the claim payment. If the premium is received during or by the end of the grace period, coverage will continue without interruption unless You call Our office or give Us written notice to cancel the coverage.

Reinstatement
If any premium is not paid within the required time period, coverage for You and any Covered Dependents will lapse. The coverage will be reinstated only if all of the following requirements are met:

1. the lapse was not more than 180 days.

2. You submit an application/enrollment form for reinstatement to Us along with the required premium payment. Submission of premium to Your agent is not submission of premium to Us. We may require payment of unpaid premium during the lapsed period, but not to any period prior to the date occurring 60 days before the reinstatement date.

3. We approve Your application/enrollment form for reinstatement.

The coverage will be reinstated on the date We approve Your application/enrollment form for reinstatement. If We have not responded to Your application/enrollment form for reinstatement by the 45th day after We receive the application/enrollment form, the coverage will be reinstated on that date. If the coverage is reinstated, the loss resulting from an Injury will only be covered only if the Injury is sustained on or after the date of reinstatement. Benefits under the Policy will not be paid for dental Sickness or conditions diagnosed between the lapse date and the tenth day following the date of reinstatement.

In all other respects, You and Our Company will have the same rights as existed under this plan before the coverage lapsed, subject to any provisions included with or attached to this plan in connection with the reinstatement.

Covered Dependent Conversion
A Covered Dependent may be eligible to convert to another dental plan that We issue which provides coverage most nearly similar to the coverage in this Policy in the Covered Dependent's state of residence at

the time coverage terminates under this plan if:

1. the Covered Dependent's insurance terminates due to a valid decree of divorce between the Policyholder and the Covered Dependent; or

2. the Covered Dependent's insurance terminates due to the death of the Policyholder; or

3. a Covered Dependent child's insurance terminates because the child no longer meets the eligibility requirements for a Dependent.

To obtain conversion coverage, the Covered Dependent must submit a written application/enrollment form and the required premium to Us within 45 days after coverage under this plan terminates. Evidence of insurability will not be required. Coverage will be provided on the dental insurance form that We offer for providing conversion coverage at that time. However, the conversion plan may provide different benefit levels, covered services and premium rates. Any and all probationary or waiting periods set forth in the conversion plan shall be considered as being met to the extent coverage was in force under this plan.

If written enrollment is not made within 45 days following the termination of insurance under this plan, conversion coverage may not be available.

The conversion coverage will take effect at 12:01 a.m. local time at the covered person's residence on the day after coverage under this plan terminates. Benefits paid under the new plan cannot exceed any applicable maximum benefit that would have otherwise been paid under the terms of this Policy if coverage under this Policy would have remained in force.

VI. Effective Date and Termination Date

Eligibility and Effective Date of Policyholder
A person who is eligible may elect to be covered under this plan by completing the enrollment process and submitting any required premium. You must be a resident of the state where this plan is issued. Your coverage will take effect at 12:01 a.m. local time in the state of issuance on the Effective Date approved by Us.

If the Policyholder moves to a different state after the Effective Date, We will replace this Policy with a similar plan that is issued in the Policyholder's new state of residence. Coverage under the new plan will be effective on the date the Policyholder becomes a resident of the new state. If the Policyholder moves to a state where We do not provide insurance coverage under a plan similar to this Policy, We reserve the right to terminate this coverage for You and any Covered Dependents.

Eligibility and Effective Date of Dependents
The following information explains how You can obtain coverage for any Dependents that You want to add to Your plan. A Dependent can be added after the Policyholder's Effective Date. To be covered under this plan, a person must meet the Dependent definition in this plan and is subject to the additional requirements below:

1. **Adding a Newborn Child:** You must call Our office or send Us written notice of the birth of the child and We must receive any required additional premium within 60 days of birth. The Effective Date of coverage will be 12:01 a.m. local time at the Policyholder's state of residence on the date the child is born. If these requirements are not met, Your newborn child will be covered only for the first 31 days from birth.

2. **Adding an Adopted Child or Child Placed for Adoption.** A newly adopted child can be added on the date the child is placed with the Policyholder in anticipation of legal adoption and the Policyholder assumes a legal obligation for support of the child or on the date of the final decree of adoption, whichever occurs first. You must call Our office or send Us written notice of the placement for adoption of the child or final decree of adoption and We must receive any required additional premium within 60 days of the placement for adoption or final decree of adoption. The Effective Date of coverage will be 12:01 a.m. local time at the Policyholder's state of residence on the date the child is placed for adoption or final decree of adoption, whichever occurs first. If these requirements are not met, Your newly adopted child will be covered only the first 31 days from the earlier of the final decree of adoption or placement for adoption. A child is no longer considered adopted if, prior to legal adoption, You relinquish legal obligation for support of the child and the child is removed from placement.

3. **Adding Any Other Dependent:** To add any other Dependent, an application/enrollment form must be completed and sent to Us along with any required premium. Evidence of insurability must also be provided. The Effective Date of coverage will be 12:01 a.m. local time in the state of issuance on the Effective Date approved by Us.

Termination Date of Coverage
The Policyholder may cancel this coverage at any time by sending Us written notice or calling Our office. Upon cancellation, We will return the unearned portion of any premium paid, in accordance with the laws in the Policyholder's state of residence.

This coverage will terminate at 12:01 a.m. local time at the Policyholder's state of residence on the earliest of the following dates:

1. the date We receive a request in writing or by telephone to terminate this plan or on a later date that is requested by the Policyholder for termination.

2. the date We receive a request in writing or by telephone to terminate coverage for a Covered Dependent or on a later date that is requested by the Policyholder for termination of a Covered Dependent.

3. the date this plan lapses for nonpayment of premium per the Grace Period provision in the Premium Provisions section.

4. the date there is fraud or material misrepresentation made by or with the knowledge of any Covered Person applying for this coverage.

5. on the date the Policyholder moves to a state where We do not provide insurance coverage under the same plan as this Policy, We reserve the right to terminate this coverage.

6. for a Covered Dependent: on the date a Covered Dependent no longer meets the Dependent definition in this plan.

7. the anniversary date of this Policy following the Policyholder's 70th birthday.

VII. Other Provisions

Assignment
A Covered Person's right to benefits under this Policy is assignable. A signed copy of the assignment must be sent to Our Home Office in a form acceptable to Us. The assignment is subject to any payment made or other action taken before We receive the assignment.

Modification of Policy or Coverage
The Policy may be changed at any time. We will give You 60 days notice prior to any change. We will not change provisions of this Policy without Your written consent. No change in the Policy will be valid unless approved by one of Our executive officers and included with this Policy. No agent or other employee of Our Company has authority to waive or change any plan provision or waive any other applicable enrollment or application requirements.

We may modify the insurance coverage for You and any Covered Dependents. This modification will be consistent with state law and will apply uniformly to all policies in the state of issue with Your plan of coverage. You will be notified of any change.

Clerical Error
If a clerical error is made by Us, it will not affect the insurance to which a Covered Person is entitled. Delay or failure to report termination of any insurance will not continue the insurance in force beyond the date it would have terminated according to this Policy. The premium charges will be adjusted as required, but not for more than two years prior to the date the error was found. If the premium was overpaid, We will refund the difference within 15 working days of the date We become aware that an overpayment of premium has occurred. If the premium was underpaid, the difference must be paid to Us within 60 days of Our notifying You of the error.

Conformity with State Statutes
If this plan, on its Effective Date, is in conflict with any applicable federal laws or laws of the state where it is issued, it is changed to meet the minimum requirements of these laws. In the event that new or applicable state or federal laws are enacted which conflict with current provisions of this plan, the provisions that are affected will be administered in accordance with the new applicable laws, despite anything in the plan to the contrary.

Enforcement of Plan Provisions
Failure by Us to enforce or require compliance with any provision within this plan will not waive, modify or render any provision unenforceable at any other time, whether the circumstances are the same or not.

Entire Contract
This Policy is issued to the Policyholder. The entire contract of insurance includes the Policy, a Covered Person's application/enrollment form, and any riders and endorsements. A copy of the application/enrollment form shall be included when the Policy is issued.

Representations
In the absence of fraud, all statements made on the application/enrollment form will be deemed representations and not warranties. This provision does not preclude defenses based upon provisions relating to eligibility. No statement made in the application/enrollment form will be used in any suit or action at law or equity unless a copy of the application/enrollment form is furnished to the Policyholder, or in the event of death or incapacity of the Policyholder, a copy will be furnished to the Policyholder's beneficiary or personal representative.

Misstatements
If a Covered Person's material information has been misstated and the premium amount would have been different had the correct information been disclosed, an adjustment in premiums may be made based on the corrected information. In addition to adjusting future premiums, We may require payment of past premiums at the adjusted rate to continue coverage. If the Covered Person's age is misstated and coverage would not have been issued based on the Covered Person's true age, Our sole liability will be to refund all of

the premiums paid for that Covered Person's coverage, minus the amount of any benefits paid by Us.

Incontestability and Time Limit on Certain Defenses
Within the first two years after the Effective Date of coverage, We have the right to rescind or modify Your Policy of insurance coverage and/or deny a claim for a Covered Person if the application/enrollment form contains an omission or misrepresentation, whether intended or not, which We determine to be material. We also reserve the right to rescind a Policy of insurance and/or deny a claim for a fraudulent misstatement or omission at any time during the coverage period.

Legal Action
No suit or action at law or in equity may be brought to recover benefits under this plan prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No suit or action at law or in equity can be brought after the expiration of 3 years from the time written proof of loss is required to be furnished.

Time Insurance Company
501 W. Michigan Street
P.O. Box 624
Milwaukee, WI 53201-0624

DENTAL INDEMNITY INSURANCE
OUTLINE OF COVERAGE FOR
POLICY FORM 8079.POL.GA

THE POLICY PROVIDES LIMITED BENEFITS

THE POLICY PROVIDES COVERAGE FOR DENTAL BENEFITS ONLY AND DOES NOT PROVIDE REIMBURSEMENT OF MEDICAL EXPENSES

THIS IS NOT A MEDICARE SUPPLEMENT POLICY

READ YOUR POLICY CAREFULLY: This outline of coverage provides a very brief description of the important features of the Policy. This is not the insurance Policy and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both You and Time Insurance Company. It is, therefore, important that You READ YOUR POLICY CAREFULLY!

DENTAL INDEMNITY COVERAGE: Policies of this category are designed to provide, to the person insured, benefits when specified dental procedures are rendered, subject to any limitations set forth in the Policy and in the amount shown on the Policy Schedule. Coverage is not provided for basic hospital, basic medical-surgical or major medical expenses.

DENTAL COVERAGE INFORMATION

Basic and Major Services Combined Maximum Benefit Limitation: Benefits for all covered Basic Dental Services and Major Dental Services combined are limited to a maximum Calendar Year benefit of $1,500 per Covered Person. This benefit limitation is in addition to any other maximum benefit limitation specified below.

Dental Preventive Benefits: We will pay one Dental Preventive Benefit of $100, regardless of the number of visits to a Dentist or Dental Hygienist or the number of services received, every 150 calendar days. Dental Preventive Benefits are limited to a maximum benefit of $200 per Calendar Year.

Basic Dental Services Benefits: We will pay the Scheduled Benefit for Basic Dental Services as show on the Policy Schedule. The Scheduled Benefit will be reduced by 50% for all Basic Dental Services rendered during the first Policy Year following the Effective Date of coverage. All benefits for Basic Dental Services rendered during the same Calendar Year are subject to a maximum Calendar Year benefit limitation of $1,500. All benefits for covered Basic Dental Services are subject to the Basic and Major Services Combined Maximum Benefit.

Major Dental Services Benefits: We will pay the Scheduled Benefit for Major Dental Services as show on the Policy Schedule. The Scheduled Benefit will be reduced by 50% for all Major Dental Services rendered during the first Policy Year following the Effective Date of coverage. Thereafter the full Scheduled Benefit will be paid for covered Major Dental Services. All benefits for Major Dental Services rendered during the same Calendar Year are subject to a maximum Calendar Year benefit limitation of $1,500. All benefits for covered Major Dental Services are subject to the Basic and Major Services Combined Maximum Benefit.

EXCLUSIONS AND LIMITATIONS:

This Policy pays limited, fixed indemnity benefits for Dental Treatments only. See the Policy Schedule for the limited benefit amounts and maximum benefit limitations.

We will not pay benefits for any of the following:

1. any procedure or treatment not shown on the Policy Schedule.
2. any procedure rendered during an applicable Benefit Waiting Period.
3. any amount in excess of a Calendar Year or lifetime maximum benefit limitation.
4. Dental Preventive Benefits when there is less than 150 calendar days between the dates of service for Dental Preventive Services.
5. all Experimental or Investigative Services.
6. any procedure performed by a person other than a Dentist or Dental Hygienist.
7. any procedure performed by a Covered Person's Immediate Family Member.
8. all services that are not Dentally Necessary.
9. repairs to dental work less than 180 calendar days following completion of the initial procedure.
10. prosthetics replaced less than 5 years following the previous placement.
11. crowns replaced less than 5 years following the previous placement.
12. inlays or onlays replaced less than 5 years following the last placement.
13. dental implants or the removal of implants.
14. Cosmetic Services, unless performed to correct a functional disorder.
15. services performed outside the United States and its territories and Canada except for services that are received for Emergency Dental Treatment.
16. replacement of any tooth missing prior to the Effective Date.
17. placement of full or partial dentures, whether removable or fixed, including a Maryland Bridge, unless replacing a Functioning Natural Tooth extracted after the Effective Date and not within a Benefit Waiting Period.
18. for Covered Persons under age 16, inlays, onlays, bridgework or crowns except for stainless steel or plastic crowns.
19. any charge or procedure for treatment required because of Dental Injury or disease due to:
    a. war or any act of war, whether declared or undeclared.
    b. participation in the military service of any country or international organization, including non-military units supporting such forces.
    c. charges for Sickness or Injury caused or aggravated by attempted suicide or intentionally self-inflicted Sickness or Injury.
    d. taking part in a riot or insurrection, or an act of riot or insurrection.
    e. participating in, voluntarily attempting to commit or commission of a felony or engaging in an illegal occupation at the time of an Accident.
    f. being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.
    g. riding in any aircraft not licensed to carry passengers or not operated by a duly licensed pilot.
    h. charges for treatment or services required due to an Injury sustained in operating a motor vehicle while the Covered Person's blood alcohol level, as defined by law, was .08 or higher. This exclusion applies whether or not the Covered Person is charged with any violation in connection with the Accident.
20. procedures rendered before the Effective Date or after the termination date of coverage.

21. orthodontic treatment and services.

RENEWABILITY PROVISION: The policy is guaranteed renewable until 12:01 a.m. local time at the Policyholder's state of residence on the earliest of the following dates:

1. the date We receive a request in writing or by telephone to terminate this plan or on a later date that is requested by the Policyholder for termination.
2. the date We receive a request in writing or by telephone to terminate coverage for a Covered Dependent or on a later date that is requested by the Policyholder for termination of a Covered Dependent.
3. the date this plan lapses for nonpayment of premium per the Grace Period provision in the Premium Provisions section.
4. the date there is fraud or material misrepresentation made by or with the knowledge of any Covered Person applying for this coverage.
5. on the date the Policyholder moves to a state where We do not provide insurance coverage under the same plan as this Policy, We reserve the right to terminate this coverage.
6. for a Covered Dependent: on the date a Covered Dependent no longer meets the Dependent definition in this plan.
7. the anniversary date of this Policy following the Policyholder's 70th birthday.

PREMIUM INFORMATION	
Premium Payment Mode:	ANNUALLY
INITIAL ANNUAL PREMIUM AMOUNT:	$543.78
INITIAL ANNUAL PREMIUM AMOUNT:	$543.78

Your premium may be adjusted from time to time based on different factors including, but not limited to, Your geographic area, payment method and plan design. All premium adjustments will be made to individuals on the basis of shared characteristics. The premium may also change if You add or delete Covered Dependents, change the payment method, move to another zip code or otherwise change the coverage.

Licensed Agent's Signature

Date