

Dental Coverage for Seniors

# Dental PPO

Dental plans that complement your Original Medicare and product benefits to help protect your dental health.



# Coverage for your dental care needs.

Research shows that oral health and overall health are closely related. So when you keep your teeth healthy, you are also helping to keep your body healthy.

Our **PPO Dental** plan offers coverage options for **preventive/diagnostic, basic and major restorative services** through Careington's Maximum Care network of **200,000 providers**.



## PPO Dental At A Glance



100% coverage for many preventive services like cleanings, X-rays and oral exams<sup>1</sup>



Pays up to **\$1,200** per person, per calendar year for covered services on the Premiere Plan



Complements your Original Medicare insurance plan



Affordable premiums that do not increase as you get older with Basic coverage **starting at \$21.40 per month<sup>2</sup>**



Large network of dentists and specialists to choose from. Visit **ChesapeakePlus.com** to view a list of in-network providers.<sup>1</sup>

<sup>1</sup> Careington Benefit Solutions, a CAREINGTON International Company administers the dental insurance plans on behalf of Chesapeake through their extensive **Maximum Care Network**. | <sup>2</sup> Premium for an adult Basic PPO Dental plan.

**BENEFITS - Network  
Provider<sup>1</sup>****Basic****Premiere**

Covered Services	Preventive, diagnostic, restorative and adjunctive services	Preventive, diagnostic, restorative, adjunctive, endodontics, periodontics, prosthodontics and oral surgery services
• Type I	100% No waiting period	100% No waiting period
• Type II	50% Six month waiting period	80% Six month waiting period*
• Type III	Not covered	60% 12 month waiting period*
Calendar year deductible (Applies to Type II and III only)	\$100 per person Three max per family	\$50 per person Three max per family
Calendar year maximum	\$1,000 per person \$5,000 per family	\$1,200 per person \$6,000 per family

**MONTHLY PREMIUMS****MONTHLY PREMIUMS****\$21<sup>40</sup>****\$43<sup>60</sup>**

See the following pages for Type I, Type II and Type III covered services details. | The chart above is only an illustration of benefit and premium options per covered person. | Visit [ChesapeakePlus.com](http://ChesapeakePlus.com) to view a list of in-network providers. | \*Waiting periods are waived for an insured person previously covered under full dental coverage, provided such prior coverage was in effect for at least 12 consecutive months and is continuous to a date no more than 63 days prior to your application date.

<sup>1</sup> Certain services include limitations. Benefits are reduced for non-network providers. See Policy for details. | Note: If an insured person opts to receive dental services or procedures that are not covered expenses under the Policy, a network provider dentist may charge his or her actual charge for such services or procedures. Prior to providing an insured person dental services or procedures that are not covered expenses, the dentist should provide a treatment plan that includes each anticipated service or procedure to be provided and the estimated cost of each service or procedure. To fully understand the coverage provided under the Policy, you should read your Policy carefully.

## Type I Covered Services<sup>1</sup>

Premiere and Basic plans include the following services with no waiting period:

### Preventive:

- Prophylaxis - once every six months

### Diagnostic:

- Oral evaluations - once every six months
- Bitewing X-rays - once every 12 months
- Vertical bitewings - once every 36 months
- Diagnostic casts

## Type II Covered Services<sup>2</sup>

Premiere and Basic plans include the following services with a 6 month waiting period:

### Diagnostic:

- Intraoral films, extraoral films and panoramic film - once every 36 months

### Restorative:

- Amalgam, primary or permanent and resin-based composite

### Adjunctive:

- Palliative (emergency) treatment of pain
- Fixed partial denture sectioning
- Local anesthesia
- Inhalation of nitrous oxide
- Occlusion and analysis and occlusion adjustment

## Type III Covered Services<sup>3</sup>

Premiere plan only includes the following services with a 12 month waiting period, unless stated otherwise:

### Restorative:

- Inlays and onlays (and recementing, once every 12 months after a six month waiting period)
- Crowns; cast posts and core buildups
- Pin retention in addition to restoration - up to two procedures every 12 months
- Sedative fillings

### Endodontics:

- Pulp caps; therapeutic pulpotomy; pulpal therapy
- Root canal or endodontic therapy

### Oral Surgery:

- Extraction of erupted tooth; removal of impacted tooth
- Tooth transplantation
- Alveoloplasty
- Removal of cyst/tumor 1.25cm and greater
- Incision and drainage of abscess

### Prosthodontics:

- Complete and partial dentures - once every five years for complete dentures to replace missing/broken teeth
- Adjustment and repair of dentures

### Periodontics:

- Gingivectomy/gingivoplasty - once every 36 months
- Gingival flap procedure and osseous surgery - each limited to once every 36 months
- Soft tissue graft procedures
- Periodontal scaling and root planning - limited to four separate quadrants every two years
- Full-mouth debridement to enable evaluation and diagnosis - once every 36 months

<sup>1</sup> Type I services for Premiere and Basic plans are covered at 100% for both in-network and non-network. | <sup>2</sup> Type II services for Premiere plan are covered at 80% for both in-network and non-network. Type II services for Basic plan are covered at 50% for both in-network and non-network. | <sup>3</sup> Type III services for Premiere plan only are covered at 60% for both in-network and non-network. | For a complete listing of benefits, exclusions and limitations, please refer to your Policy. In the event of any discrepancies contained in this brochure, the terms and conditions contained in the Policy documents shall govern. Dental Insurance Preferred Provider Organization (PPO) Policy, form CH-26121-IP (01/12) GA. | The information contained herein is accurate at the time of publication. This brochure provides only summary information.

## Notice to Our Customers About Supplemental Insurance

- The supplemental plan discussed in this document is separate from any health insurance coverage you may have purchased with another insurance company.
- This plan provides optional coverage for an additional premium. It is intended to supplement your health insurance and provide additional protection.
- This plan is not required in order to purchase health insurance with another insurance company.
- This plan should not be used as a substitute for comprehensive health insurance coverage. It is not considered Minimum Essential Coverage under the Affordable Care Act.



## IMPORTANT NOTICE TO PERSONS ON MEDICARE. THIS IS NOT MEDICARE SUPPLEMENT INSURANCE.

**Some health care services paid for by Medicare may also trigger the payment of benefits under the Policy.**

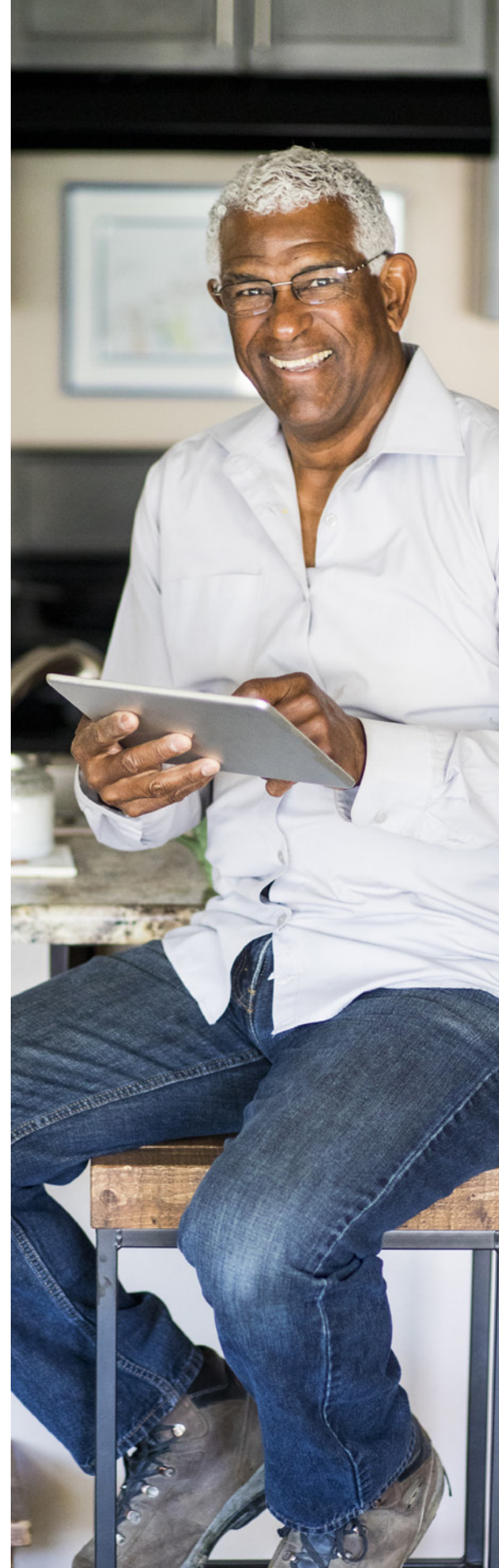
This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- Hospitalization
- Physician services
- Outpatient prescription drugs if you are enrolled in Medicare Part D
- Other approved items and services

### BEFORE YOU BUY THIS INSURANCE

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).



# THE CHESAPEAKE LIFE INSURANCE COMPANY

A Stock Company

(Hereinafter called: the Company, We, Our or Us)

Home Office: Oklahoma City, Oklahoma

Administrative Office: P.O. Box 982010

North Richland Hills, Texas 76182-8010

Customer Service: 1-800-815-8535

## DENTAL INSURANCE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY OUTLINE OF COVERAGE FOR POLICY FORM CH-26121-IP (01/12) GA

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, review the Guide to health Insurance for People With Medicare available from the Company.

- 1. READ YOUR POLICY CAREFULLY:** This Outline of Coverage provides a very brief description of the important features of Your Policy. This is not the insurance contract, and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both You and Us. It is, therefore, important that You READ YOUR POLICY CAREFULLY!
- 2. DENTAL INSURANCE POLICY –** The Policy is intended to provide benefits for Type I, II, and III dental services and procedures when received by an Insured Person. Unless otherwise stated within the Policy, all benefits are subject to the Waiting Period, if any, Deductible, if any, Benefit Maximum, Limitations & Exclusions, and all other provisions of the Policy.
- 3. SCHEDULE OF BENEFITS –** Benefits are payable under the Policy as follows:

### WAITING PERIODS:

TYPE I Covered Expenses	No Waiting Period
TYPE II Covered Expenses	6 Month Waiting Period
TYPE III Covered Expenses	12 Month Waiting Period

### DEDUCTIBLE, PER INSURED PERSON, PER CALENDAR YEAR:

TYPE I Covered Expenses	None
TYPE II and III Covered Expenses	\$50
Deductible Family Limit:	3 Per Family each Calendar Year

### CALENDAR YEAR BENEFIT MAXIMUM, PER INSURED PERSON:

TYPE I, II and III Covered Expenses	\$1,200
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### CALENDAR YEAR BENEFIT MAXIMUM, PER FAMILY:

TYPE I, II and III Covered Expenses	\$6,000
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### COVERED EXPENSES

#### TYPE I COVERED EXPENSES:

*(Includes the Preventive and Diagnostic Services as shown in the Policy. Certain services/procedures are subject to limitations.)*

Coinsurance	<b>Network Provider</b>	<b>Non-Network Provider</b>
	100%	100%

#### TYPE II COVERED EXPENSES:

*(Includes the Preventive, Diagnostic, Restorative, and Adjunctive Services as shown in the Policy. Certain services/procedures are subject to limitations.)*

Coinsurance	<b>Network Provider</b>	<b>Non-Network Provider</b>
	80%	80%

**TYPE III COVERED EXPENSES:**

*(Includes the Restorative, Endodontics, Periodontics, Prosthodontics and Oral Surgery Services as shown in the Policy. Certain services/procedures are subject to limitations.)*

**Coinsurance**

**Network Provider**  
60%

**Non-Network Provider**  
60%

- 4. BENEFITS** – Benefits are payable under the Policy for Type I, II, and III dental procedures when received by an Insured Person. Unless otherwise stated herein, all benefits are subject to:
1. The Waiting Period shown in the POLICY SCHEDULE (if any);
  2. The Deductible shown in the POLICY SCHEDULE (if any);
  3. Any Benefit Maximums shown in the POLICY SCHEDULE;
  4. The LIMITATIONS AND EXCLUSIONS; and
  5. All other provisions of the Policy.

**To be a Covered Expense, the dental service must be performed by:**

1. A licensed Dentist acting within the scope of his/her license;
2. A licensed Physician performing dental services within the scope of his/her license; or
3. A licensed dental hygienist under the supervision and direction of a Dentist

Covered Expenses must be incurred while the Insured Person's coverage under the Policy is in force.

A Covered Expense is considered to be incurred on the date the service is performed unless otherwise stated below:

1. Full and partial dentures – on the date the final impression is taken;
2. Fixed bridges, crowns, inlays and onlays – on the date the teeth are first prepared;
3. Root canal therapy – on the date the pulp chamber is opened; or
4. Periodontal surgery – on the date surgery is performed.

- 5. PREFERRED PROVIDER ORGANIZATION (PPO) - To minimize out-of-pocket costs, it is important that the Insured Person receives services from a Network Provider.**

**Network Providers and Non-Network Providers.** The Policy provides benefits for Covered Expenses obtained from both Network Providers and Non-Network Providers.

**Using a Network Provider May Lower Costs.** If an Insured Person uses the services of a Non-Network Provider, the Coinsurance amount may be less than that which would have otherwise been considered for Covered Expenses received from a Network Provider. Covered Expenses for a Non-Network Provider's services may be substantially lower than the actual charges. The Insured Person's responsibility includes the portion of the expense not payable under the Policy, plus all of the Non-Network Provider's charges that exceed the Covered Expense. A Non-Network Provider may bill You for any charges in excess of the Covered Expenses under the Policy.

- 6. EXCLUSIONS & LIMITATIONS – We will not provide any benefits for charges arising directly or indirectly, in whole or in part, from:**

1. Treatment, care, services or supplies for which benefits are not specifically provided for in the Policy;
2. Charges exceeding the Maximum Benefit Amount, if any;
3. Attempted suicide or any intentionally self-inflicted injury;
4. Directly or indirectly engaging in illegal activity;
5. Treatment of disturbances of the temporomandibular joint (TMJ);
6. A service not furnished by a Dentist, UNLESS by a dental hygienist under the Dentist's supervision and x-rays are ordered by the Dentist;
7. Cosmetic procedures, UNLESS due to an injury or for congenital / developmental malformation. Facing on crowns, or pontics, posterior to the second bicuspid is considered cosmetic;
8. The replacement of full and partial dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function;
9. Implants; replacement of lost or stolen appliances; replacement of orthodontic retainers; athletic mouth-guards; precision or semi-precision attachments; denture duplication; or splinting;
10. Plaque control; completion of claim forms; broken appointments; prescription or take-home fluoride; or diagnostic photographs;
11. Replacement of any prosthetic appliance, crown, inlay, or onlay restoration, or fixed bridge within 5 years of the date of the last replacement, UNLESS due to an injury;



12. Oral/facial images, including intra- and extra-oral images;
13. Pulp vitality tests;
14. Post removals UNLESS in conjunction with endodontic therapy;
15. Chairside, labial veneers (laminates);
16. Intentional re-implantation, including necessary splinting;
17. Surgical procedure for isolation of tooth with rubber dam;
18. Canal preparation and fitting of performed dowel or post;
19. Regional block anesthesia;
20. Hospital, house, or extended care facility calls;
21. Office visits for the purpose of observation, during or after regularly scheduled hours;
22. Office visits outside of regularly scheduled hours;
23. Enamel microabrasions;
24. An initial placement of a partial or full removable denture or fixed bridgework if it involves the replacement of one or more natural teeth lost before coverage was effective under the Policy. This limitation does not apply if replacement includes a natural tooth extracted while covered under the Policy;
25. Services not completed by the end of the month in which coverage terminates;
26. Procedures that are begun, but not completed;
27. Those services for which there would be no charge in the absence of insurance or for any service or treatment provided without charge;
28. Services in connection with war or any act of war, whether declared or undeclared, or condition contracted or accident occurring while on full-time active duty in the armed forces of any country or combination of countries;
29. Care or treatment of a condition for which benefits are payable under any Workers' Compensation Act or similar law;
30. Orthodontic procedures;
31. Covered Expenses for which an Insured Person is not legally obligated to pay; or
32. Experimental/Investigational treatment.

**Tooth Missing But Not Replaced Rule**

Coverage for the first installation of removable dentures; fixed bridgework and other Type III Prosthetic or Prosthodontic services are subject to the requirements that such removable dentures; fixed bridgework and other prosthetic services are (1) needed to replace one or more natural teeth that were removed while the Policy was in force for the Insured Person; and (2) are not abutments to a partial denture; removable bridge; or fixed bridge installed during the prior 8 years.

7. **RENEWABILITY** – The Policy is guaranteed renewable, subject to the Company's right to discontinue or terminate the coverage as provided in the TERMINATION OF COVERAGE section of the Policy. Any change in rates will be effective on the next following premium due date. Please read the Premium Changes provision of the Policy carefully. The Company reserves the right to change the applicable table of premium rates on a Class Basis with a 60 day written notice.
8. **BEGINNING OF COVERAGE** - Once We have approved Your application and received the first premium based upon the information You provided therein, the Effective Date of Coverage for You and those Eligible Dependents listed in the application and accepted by Us will be the POLICY DATE shown in the POLICY SCHEDULE.
9. **TERMINATION OF COVERAGE –**

**You**

Your coverage will terminate and no further benefits will be payable under the Policy:

1. at the end of the period for which premium has been paid, subject to the Grace Period;
2. if Your mode of premium is monthly, at the end of the period through which premium has been paid following Our receipt of Your written request of termination;
3. if Your mode of premium is other than monthly, upon the next monthly anniversary day following Our receipt of Your written request of termination. Premium will be refunded for any amounts paid beyond the termination date;
4. if the Insured Person performs an act or practice, that constitutes fraud or intentional misrepresentation of material fact in applying for or procuring coverage, subject to the Time Limit on Certain Defenses provision appearing under the General Provisions section of the Policy;
5. on the date We elect to discontinue this plan or type of coverage, We will give You at least 90 written days notice before the date coverage will be discontinued. You will be offered an option to purchase any other coverage that We offer without regard to health status;

6. on the date We elect to discontinue all coverage in Your state, We will give You and the Commissioner at least 180 days written notice before the date coverage will be discontinued; or
7. on the date an Insured Person is no longer a permanent resident of the United States.

Any unearned premium which has been paid by You will be refunded on a pro rata basis. Your cancellation shall be without prejudice to any claim originating prior to the effective date of Your cancellation.

**Covered Dependents**

Your Covered Dependent’s coverage will terminate under the Policy on:

1. the date Your coverage terminates, except as provided in the SPECIAL CONTINUATION FOR DEPENDENTS provision;
2. the date such dependent ceases to be an Eligible Dependent; or
3. the date We receive Your written request to terminate a Covered Dependent’s coverage; or
4. the date the Covered Dependent performs an act or practice, which constitutes fraud or intentional misrepresentation of material fact in applying for or procuring coverage, subject to the Time Limit on Certain Defenses provision appearing under the General Provisions section of the Policy.

Any unearned premium which has been paid by You will be refunded on a pro rata basis. Your cancellation shall be without prejudice to any claim originating prior to the effective date of Your cancellation.

The attainment of the limiting age for an Eligible Dependent will not cause coverage to terminate while that person is and continues to be both:

1. incapable of self-sustaining employment by reason of mental or physical handicap; and
2. Chiefly Dependent on You for support and maintenance. For the purpose of this provision “Chiefly Dependent” means the Eligible Dependent receives the majority of his or her financial support from You.

We will require that You provide proof that the dependent is in fact a disabled and dependent person at least 31 days prior to the date upon which the dependent would otherwise reach the limiting age, and thereafter We may require such proof not more frequently than annually after a two year period following the child’s attainment of the limiting age. In the absence of such proof We may terminate the coverage of such person after the attainment of the limiting age within 31 days.

**Extension of Benefits**

If an Insured Person is currently receiving a covered dental service that has not been completed on the date the Policy terminates for any reason other than:

1. non-payment of premiums required in accordance with the terms of the Policy;
2. non-receipt of timely payments of premium required for the Policy, limited to major dental services, subject to the Grace Period; or
3. the Insured Person performing an act or practice that constitutes fraud or intentional misrepresentation of material fact in applying for or procuring coverage, subject to the Time Limit on Certain Defenses provision appearing under the General Provisions section of the Policy; benefits will be extended solely for Covered Expenses incurred by the Insured Person for a covered dental service that has not been completed.

Coverage will be extended to the earliest of the following for Type II and Type III Covered Expenses:

1. the end of the 90 day period immediately following the date of termination of the Policy while the Insured Person is receiving a covered dental service that has not been completed;
2. the date the Insured Persons covered dental service has been completed; or
3. the maximum benefit under the Policy is paid.

Such extended benefits will be subject to the same terms and conditions of the Policy if the Policy had remained in force. This Extension of Benefits provision does not extend the period of time during which an individual is insured under the Policy.

**10. PREMIUMS** – We also reserve the right to change the table of premiums, on a Class Basis, becoming due under the Policy at any Policy anniversary; provided, We have given You written notice of at least 60 days prior to the effective date of the new rates. Such change will be on a Class Basis.

Premium Due (at time of application) \$ \_\_\_\_\_

# THE CHESAPEAKE LIFE INSURANCE COMPANY

A Stock Company

(Hereinafter called: the Company, We, Our or Us)

Home Office: Oklahoma City, Oklahoma

Administrative Office: P.O. Box 982010

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## DENTAL INSURANCE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY OUTLINE OF COVERAGE FOR POLICY FORM CH-26121-IP (01/12) GA

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, review the Guide to health Insurance for People With Medicare available from the Company.

- 1. READ YOUR POLICY CAREFULLY:** This Outline of Coverage provides a very brief description of the important features of Your Policy. This is not the insurance contract, and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both You and Us. It is, therefore, important that You READ YOUR POLICY CAREFULLY!
- 2. DENTAL INSURANCE POLICY –** The Policy is intended to provide benefits for Type I, and II, dental services and procedures when received by an Insured Person. Unless otherwise stated within the Policy, all benefits are subject to the Waiting Period, if any, Deductible, if any, Benefit Maximum, Limitations & Exclusions, and all other provisions of the Policy.
- 3. SCHEDULE OF BENEFITS –** Benefits are payable under the Policy as follows:

### WAITING PERIODS:

TYPE I Covered Expenses

No Waiting Period

TYPE II Covered Expenses

6 Month Waiting Period

### DEDUCTIBLE, PER INSURED PERSON, PER CALENDAR YEAR:

TYPE I Covered Expenses

None

TYPE II Covered Expenses

\$100

Deductible Family Limit:

3 Per Family each Calendar Year

### CALENDAR YEAR BENEFIT MAXIMUM, PER INSURED PERSON:

TYPE I and II Covered Expenses

\$1,000

### CALENDAR YEAR BENEFIT MAXIMUM, PER FAMILY:

TYPE I and II Covered Expenses

\$5,000

### BENEFITS

#### TYPE I COVERED EXPENSES:

*(Includes the Preventive and Diagnostic Services as shown in the Policy. Certain services/procedures are subject to limitations.)*

Coinsurance

Network Provider

Non-Network Provider

100%

100%

#### TYPE II COVERED EXPENSES:

*(Includes the Preventive, Diagnostic, Restorative, and Adjunctive Services as shown in the Policy. Certain services/procedures are subject to limitations)*

Coinsurance

Network Provider

Non-Network Provider

50%

50%

4. **BENEFITS** – Benefits are payable under the Policy for Type I, and II dental procedures when received by an Insured Person. Unless otherwise stated herein, all benefits are subject to:
1. The Waiting Period shown in the POLICY SCHEDULE (if any);
  2. The Deductible shown in the POLICY SCHEDULE (if any);
  3. Any Benefit Maximums shown in the POLICY SCHEDULE;
  4. The LIMITATIONS AND EXCLUSIONS; and
  5. All other provisions of the Policy.

**To be a Covered Expense, the dental service must be performed by:**

1. A licensed Dentist acting within the scope of his/her license;
2. A licensed Physician performing dental services within the scope of his/her license; or
3. A licensed dental hygienist under the supervision and direction of a Dentist

Covered Expenses must be incurred while the Insured Person's coverage under the Policy is in force.

A Covered Expense is considered to be incurred on the date the service is performed.

5. **PREFERRED PROVIDER ORGANIZATION (PPO) - To minimize out-of-pocket costs, it is important that the Insured Person receives services from a Network Provider.**

**Network Providers and Non-Network Providers.** The Policy provides benefits for Covered Expenses obtained from both Network Providers and Non-Network Providers.

**Using a Network Provider May Lower Costs.** If an Insured Person uses the services of a Non-Network Provider, the Coinsurance amount may be less than that which would have otherwise been considered for Covered Expenses received from a Network Provider. Covered Expenses for a Non-Network Provider's services may be substantially lower than the actual charges. The Insured Person's responsibility includes the portion of the expense not payable under the Policy, plus all of the Non-Network Provider's charges that exceed the Covered Expense. A Non-Network Provider may bill You for any charges in excess of the Covered Expenses under the Policy.

6. **EXCLUSIONS & LIMITATIONS – We will not provide any benefits for charges arising directly or indirectly, in whole or in part, from:**

1. Treatment, care, services or supplies for which benefits are not specifically provided for in the Policy;
2. Charges exceeding the Maximum Benefit Amount, if any;
3. Attempted suicide or any intentionally self-inflicted injury;
4. Directly or indirectly engaging in illegal activity;
5. Treatment of disturbances of the temporomandibular joint (TMJ);
6. A service not furnished by a Dentist, UNLESS by a dental hygienist under the Dentist's supervision and x-rays are ordered by the Dentist;
7. Cosmetic procedures;
8. Plaque control; completion of claim forms; broken appointments; prescription or take-home fluoride; or diagnostic photographs;
9. Oral/facial images, including intra- and extra-oral images;
10. Pulp vitality tests;
11. Chairside, labial veneers (laminates);
12. Regional block anesthesia;
13. Hospital, house, or extended care facility calls;
14. Office visits for the purpose of observation, during or after regularly scheduled hours;
15. Office visits outside of regularly scheduled hours;
16. Enamel microabrasions;
17. Services not completed by the end of the month in which coverage terminates;
18. Procedures that are begun, but not completed;
19. Those services for which there would be no charge in the absence of insurance or for any service or treatment provided without charge;
20. Services in connection with war or any act of war, whether declared or undeclared, or condition contracted or accident occurring while on full-time active duty in the armed forces of any country or combination of countries;
21. Care or treatment of a condition for which benefits are payable under any Workers' Compensation Act or similar law;
22. Orthodontic procedures;

- 23. Covered Expenses for which an Insured Person is not legally obligated to pay; or
- 24. Experimental/Investigational treatment.

- 7. **RENEWABILITY** – The Policy is guaranteed renewable, subject to the Company’s right to discontinue or terminate the coverage as provided in the TERMINATION OF COVERAGE section of the Policy. Any change in rates will be effective on the next following premium due date. Please read the Premium Changes provision of the Policy carefully. The Company reserves the right to change the applicable table of premium rates on a Class Basis with a 60 day written notice.
- 8. **BEGINNING OF COVERAGE** - Once We have approved Your application and received the first premium based upon the information You provided therein, the Effective Date of Coverage for You and those Eligible Dependents listed in the application and accepted by Us will be the POLICY DATE shown in the POLICY SCHEDULE.

**9. TERMINATION OF COVERAGE –**

**You**

Your coverage will terminate and no further benefits will be payable under the Policy:

- 1. at the end of the period for which premium has been paid, subject to the Grace Period;
- 2. if Your mode of premium is monthly, at the end of the period through which premium has been paid following Our receipt of Your written request of termination;
- 3. if Your mode of premium is other than monthly, upon the next monthly anniversary day following Our receipt of Your written request of termination. Premium will be refunded for any amounts paid beyond the termination date;
- 4. if the Insured Person performs an act or practice, that constitutes fraud or intentional misrepresentation of material fact in applying for or procuring coverage, subject to the Time Limit on Certain Defenses provision appearing under the General Provisions section of the Policy;
- 5. on the date We elect to discontinue this plan or type of coverage, We will give You at least 90 written days notice before the date coverage will be discontinued. You will be offered an option to purchase any other coverage that We offer without regard to health status;
- 6. on the date We elect to discontinue all coverage in Your state, We will give You and the Commissioner at least 180 days written notice before the date coverage will be discontinued; or
- 7. on the date an Insured Person is no longer a permanent resident of the United States.

Any unearned premium which has been paid by You will be refunded on a pro rata basis. Your cancellation shall be without prejudice to any claim originating prior to the effective date of Your cancellation.

**Covered Dependents**

Your Covered Dependent’s coverage will terminate under the Policy on:

- 1. the date Your coverage terminates, except as provided in the SPECIAL CONTINUATION FOR DEPENDENTS provision;
- 2. the date such dependent ceases to be an Eligible Dependent; or
- 3. the date We receive Your written request to terminate a Covered Dependent’s coverage; or
- 4. the date the Covered Dependent performs an act or practice, which constitutes fraud or intentional misrepresentation of material fact in applying for or procuring coverage, subject to the Time Limit on Certain Defenses provision appearing under the General Provisions section of the Policy.

Any unearned premium which has been paid by You will be refunded on a pro rata basis. Your cancellation shall be without prejudice to any claim originating prior to the effective date of Your cancellation.

The attainment of the limiting age for an Eligible Dependent will not cause coverage to terminate while that person is and continues to be both:

- 1. incapable of self-sustaining employment by reason of mental or physical handicap; and
- 2. Chiefly Dependent on You for support and maintenance. For the purpose of this provision “Chiefly Dependent” means the Eligible Dependent receives the majority of his or her financial support from You.

We will require that You provide proof that the dependent is in fact a disabled and dependent person at least 31 days prior to the date upon which the dependent would otherwise reach the limiting age, and thereafter We may require

such proof not more frequently than annually after a two year period following the child's attainment of the limiting age. In the absence of such proof We may terminate the coverage of such person after the attainment of the limiting age within 31 days.

### **Extension of Benefits**

If an Insured Person is currently receiving a covered dental service that has not been completed on the date the Policy terminates for any reason other than:

1. non-payment of premiums required in accordance with the terms of the Policy;
2. non-receipt of timely payments of premium required for the Policy, limited to major dental services, subject to the Grace Period; or
3. the Insured Person performing an act or practice that constitutes fraud or intentional misrepresentation of material fact in applying for or procuring coverage, subject to the Time Limit on Certain Defenses provision appearing under the General Provisions section of the Policy; benefits will be extended solely for Covered Expenses incurred by the Insured Person for a covered dental service that has not been completed.

Coverage will be extended to the earliest of the following for Type II and Type III Covered Expenses:

1. the end of the 90 day period immediately following the date of termination of the Policy while the Insured Person is receiving a covered dental service that has not been completed;
2. the date the Insured Persons covered dental service has been completed; or
3. the maximum benefit under the Policy is paid.

Such extended benefits will be subject to the same terms and conditions of the Policy if the Policy had remained in force. This Extension of Benefits provision does not extend the period of time during which an individual is insured under the Policy.

- 10. PREMIUMS** – We also reserve the right to change the table of premiums, on a Class Basis, becoming due under the Policy at any Policy anniversary; provided, We have given You written notice of at least 60 days prior to the effective date of the new rates. Such change will be on a Class Basis.

Premium Due (at time of application) \$ \_\_\_\_\_



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