Coverage to help you keep a healthy smile

DID YOU KNOW?

Every $1 in preventive oral care can save $8-50 in restorative and emergency treatments.[1]

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**.

Applying is simple and can be completed in minutes.

PPO Dental At A Glance

- 100% coverage on both plans for many preventive services like cleanings, X-rays and oral exams[2]
- Complements your Original Medicare insurance plan
- Large network of dentists and specialists to choose from. Visit **ChesapeakePlus.com** to view a list of in-network providers.[2]
- Pays up to **$1,200** per person, per calendar year for covered services on the Premiere Plan
- Affordable premiums that do not increase as you get older with Basic coverage **starting at $21[00] per month**[3]

Get coverage for your dental care needs. Apply today!

[1] American Dental Hygienist Association, www. adha.org | [2] Careington Benefit Solutions, a **CARE**INGTON International Company administers the dental insurance plans on behalf of Chesapeake through their extensive **Maximum Care** Network | [3] Premium for an adult Basic PPO Dental plan.

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Underwritten by *The Chesapeake Life Insurance Company®*

PPO Dental

Make sure you are protected with other popular SureBridge products:

Vision

Final Expense Whole Life

BENEFITS - Network Provider[1]	Basic	Premiere
Covered Services	Preventive, diagnostic, restorative and adjunctive services	Preventive, diagnostic, restorative, adjunctive, endodontics, periodontics, prosthodontics and oral 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	Three max per family	Three max per family
• Type I	No Deductible	No Deductible
• Type II	$100 per person	$50 per person
• Type III	Not Covered	$50 per person
Calendar year maximum	$1,000 per person $5,000 per family	$1,200 per person $6,000 per family
MONTHLY PREMIUMS	$21.00	$43.00

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.

[1] 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 usual and customary rate 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 for each service or procedure. To fully understand the coverage provided under the Policy, you should read your Policy carefully.

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Type I Covered Services[1]
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[2]
Premiere and Basic plans include the following services with a six 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 analysis and occlusion adjustment

[1] Type I services for Premiere and Basic plans are covered at 100% in-network and 80% non-network | [2] Type II services for Premiere plan are covered at 80% in-network and 60% non-network. Type II services for Basic plan are covered at 50% for both in-network and non-network.

Type III Covered Services[1]
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; pupal 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

[1] Type III service for Premiere plan only are covered at 60% in-network and 50% 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) OR. | The information contained herein is accurate at the time of publication. This brochure provides only summary information.

Underwritten by *The Chesapeake Life Insurance Company*®

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) (B) OR

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%	80%

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 or denturist 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 rendered by a Non-Network Provider may cost the Insured Person more than Covered Expenses rendered by 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.

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 or 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. Subject to prior approval by the Oregon Insurance Division, the Company reserves the right to change the applicable table of premium rates on a Class Basis.

8. **BEGINNING OF COVERAGE -** Once We have approved Your application 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 and any attached Riders, if any:

1. at the end of the period for which premium has been paid;
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 request of termination;
3. if Your mode of premium is other than monthly, upon the next monthly anniversary day following Our receipt of Your request of termination. Premium will be refunded for any amounts paid beyond the termination date;
4. on the date of fraud or misrepresentation by You;
5. on the date We elect to discontinue this plan or type of coverage;
6. on the date We elect to discontinue all coverage in Your state; or
7. on the date an Insured Person is no longer a permanent resident of the United States.

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.

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. In the absence of such proof We may terminate the coverage of such person after the attainment of the limiting age.

10. **PREMIUMS** – Subject to prior approval by the Oregon Insurance Division, We reserve the right to change the table of premiums, on a Class Basis, becoming due under the Policy as often as permitted by applicable law; provided, We have given the Insured Person written notice of at least 31 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
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) (P) OR

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

CALENDAR YEAR BENEFIT MAXIMUM, PER FAMILY:

TYPE I, II and III Covered Expenses	$6,000

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	Network Provider	Non-Network Provider
	100%	80%

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
	80%	60%

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**	**Non-Network Provider**
	60%	50%

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 or denturist 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 rendered by a Non-Network Provider may cost the Insured Person more than Covered Expenses rendered by 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.

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 or 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. Subject to prior approval by the Oregon Insurance Division, the Company reserves the right to change the applicable table of premium rates on a Class Basis.

8. **BEGINNING OF COVERAGE -** Once We have approved Your application 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 and any attached Riders, if any:

1. at the end of the period for which premium has been paid;
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 request of termination;
3. if Your mode of premium is other than monthly, upon the next monthly anniversary day following Our receipt of Your request of termination. Premium will be refunded for any amounts paid beyond the termination date;
4. on the date of fraud or misrepresentation by You;
5. on the date We elect to discontinue this plan or type of coverage;
6. on the date We elect to discontinue all coverage in Your state; or
7. on the date an Insured Person is no longer a permanent resident of the United States.

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.

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. In the absence of such proof We may terminate the coverage of such person after the attainment of the limiting age.

10. PREMIUMS – Subject to prior approval by the Oregon Insurance Division, We reserve the right to change the table of premiums, on a Class Basis, becoming due under the Policy as often as permitted by applicable law; provided, We have given the Insured Person written notice of at least 31 days prior to the effective date of the new rates. Such change will be on a Class Basis.

Premium Due (at time of application) $ _______________

For more information on SureBridge's supplemental insurance products, please visit

www.SureBridgeInsurance.com

SureBridgeInsurance.com

800-815-8535

Weekdays, 8am to 5pm in all time zones

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