SureBridge®
Underwritten by
The Chesapeake Life Insurance Company®

Dental Coverage

PPO Dental

Coverage to help you keep a healthy smile.

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**.

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[1]

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

Large network of dentists and specialists to choose from. **Visit ChesapeakePlus.com** to view a list of in-network providers[1]

Affordable premiums that do not increase as you get older with Basic coverage **starting at $19 per month**[2]

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

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BENEFITS - Network Provider[1]	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	60% 12 month waiting period*	60% 12 month waiting period*
*Type III services are considered a covered expense under the Basic Plan ***only*** when received by your covered dependent for the care and treatment of cleft lip and cleft palate.		
• Type IV	60% 12 month waiting period	60% 12 month waiting period
Type IV services are considered a covered expense under the Basic and Premiere Plans ***only*** when received by your covered dependent for the care and treatment of cleft lip and cleft palate.		
Calendar year deductible (Applies to Type II, III and IV 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

Adult	$19^{00}	$39^{00}
Dependent Child	$16^{00}	$28^{00}

See the following pages for Type I - Type IV covered services details | The chart above is only an illustration of benefit and premium options per covered person | Visit 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.

[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 of each service or procedure. To fully understand the coverage provided under the Policy, you should read your Policy carefully.

Type I Covered Services[1]

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

Preventive:

- Prophylaxis - once every six months
- Topical Flouride - once every 12 months, up to age 16
- Sealants - once every 36 months, up to age 16

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 6 month waiting period:

Preventive:

- Space maintainers - up to age six

Diagnostic:

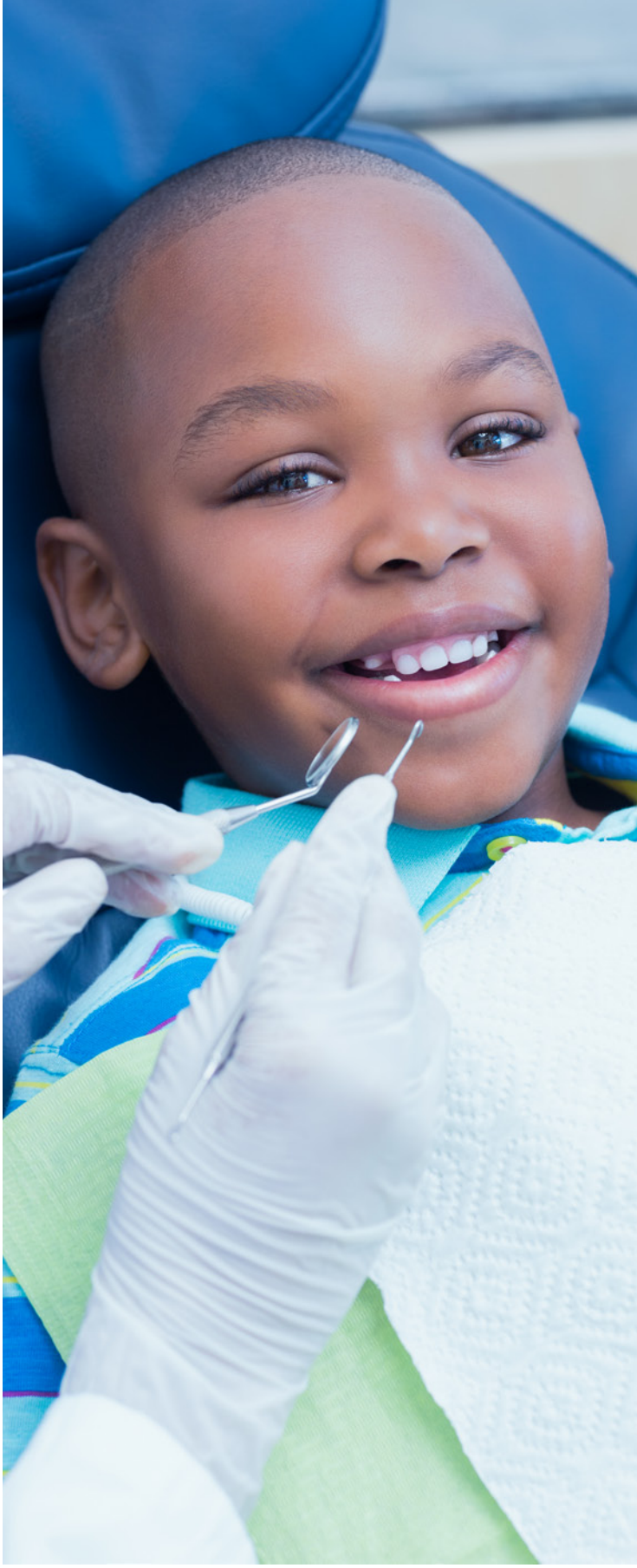
- Intraoral films, extraoral films and panoramic film - once every 36 months

Restorative:

- Amalgam, primary or permanent & resin-based composite

Adjunctive:

- Palliative (emergency) treatment of pain
- Fixed partial denture sectioning
- Local anesthesia
- Analgesia - up to age 13
- 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[3]

Premiere plan includes the following services with a 12 month waiting period, unless otherwise stated. Type III services are considered a covered expense under the Basic plan with a 12 month waiting period ***only*** when received by your covered dependent for the care and treatment of cleft lip and cleft palate.

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

Type IV Covered Services[2]

Includes a 12 month waiting period, unless otherwise stated, under the Basic and Premiere plans ***only*** when received by your covered dependent for the care and treatment of cleft lip and cleft palate.

Diagnostic and Orthodontic:

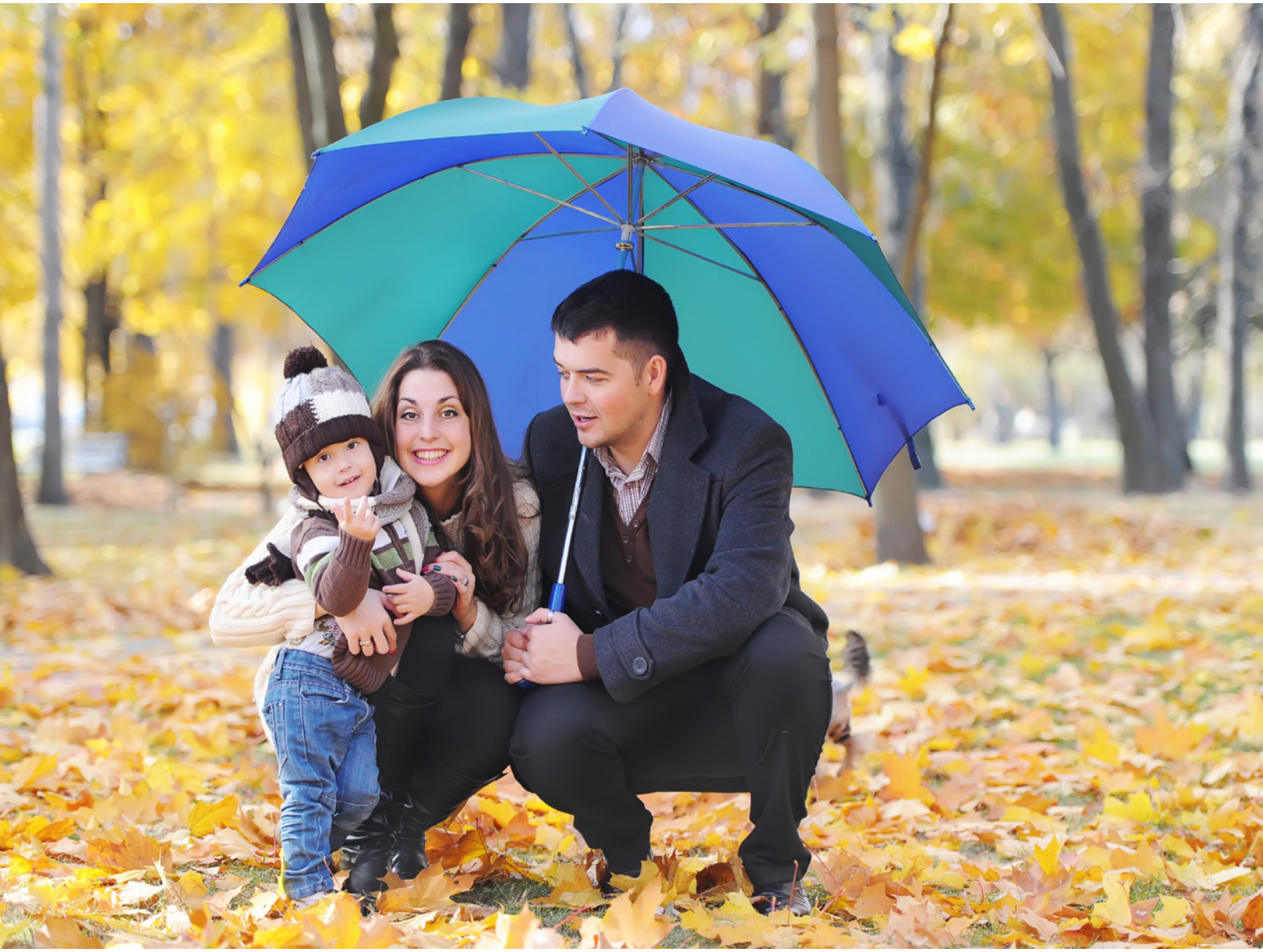
- In accordance with the American Dental Academy (ADA) Current Dental Terminology (CDT) Guidelines as shown in the Policy ***only*** when received by your covered dependent for the care of cleft lip and cleft palate.

[1]Type III services for Premiere plan only are covered at 60% in-network and 50% non-network | [2]Type IV Covered Expenses for Premiere Plan and Basic Plan 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) (B) SC and CH-26121-IP (01/12) (P) SC. | 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.



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) SC

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 and TYPE IV Covered Expenses	12 Month Waiting Period

DEDUCTIBLE, PER INSURED PERSON, PER CALENDAR YEAR:

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

CALENDAR YEAR BENEFIT MAXIMUM, PER INSURED PERSON:

TYPE I, II, III and IV Covered Expenses	$1,200

CALENDAR YEAR BENEFIT MAXIMUM, PER FAMILY:

TYPE I, II, III and IV 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%

TYPE IV COVERED EXPENSES:

(Includes Diagnostic and Orthodontic Services in accordance with the American Dental Academy (ADA) Current Dental Terminology (CDT) Guidelines as shown in the Policy when received by Your Covered Dependent for the care and treatment of Cleft Lip and Cleft Palate)

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. Benefits will also be payable under this Policy for the following Type IV dental services and procedures when received by Your Covered Dependent(s) for the care and treatment of Cleft Lip and Cleft Palate. Unless otherwise stated in the Policy, 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 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 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, except for necessary care and treatment of Your Covered Dependent(s) Cleft Lip and Cleft Palate;
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. 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 – We reserve the right to change the table of premiums, on a Class Basis, becoming due under the Policy at any time and from time to time; 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) (B) SC

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.

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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
TYPE III and TYPE IV Covered Expenses	12 Month Waiting Period

DEDUCTIBLE, PER INSURED PERSON, PER CALENDAR YEAR:

TYPE I Covered Expenses	None
TYPE II, III and IV Covered Expenses	$100
Deductible Family Limit:	3 Per Family each Calendar Year

CALENDAR YEAR BENEFIT MAXIMUM, PER INSURED PERSON:

TYPE I, II, III and IV Covered Expenses	$1,000

CALENDAR YEAR BENEFIT MAXIMUM, PER FAMILY:

TYPE I, II, III and IV 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%

BENEFITS

TYPE III COVERED EXPENSES:

(Includes Restorative, Endodontics, Periodontics, Prosthodontics and Oral Surgery Services as shown in the Policy when received by Your Covered Dependent for the care and treatment of Cleft Lip and Cleft Palate)

Coinsurance	Network Provider	Non-Network Provider
	60%	50%

TYPE IV COVERED EXPENSES:

(Includes Diagnostic and Orthodontic Services in accordance with the American Dental Academy (ADA) Current Dental Terminology (CDT) Guidelines as shown in the Policy when received by Your Covered Dependent for the care and treatment of Cleft Lip and Cleft Palate)

Coinsurance	Network Provider	Non-Network Provider
	60%	50%

4. **BENEFITS –** Benefits are payable under the Policy for Type I and II dental procedures when received by an Insured Person. Benefits will also be payable under the Policy for the following Type III and Type IV dental services and procedures when received by Your Covered Dependent(s) for the care and treatment of Cleft Lip and Cleft Palate. Unless otherwise stated in the Policy, 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.

   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 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, except for necessary care and treatment of Your Covered Dependent(s) Cleft Lip and Cleft Palate;
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. 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 – We reserve the right to change the table of premiums, on a Class Basis, becoming due under the Policy at any time and from time to time; 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) $ _____

Navigate Life's Twists & Turns

with the SureBridge portfolio of supplemental and life insurance products

Accident | Dental | Disability | Fixed Indemnity
Illness | Life | Metal Gap | Vision

SureBridgeInsurance.com
(800) 815-8535

Weekdays 8:00 a.m. to 5:00 p.m. in all time zones

SureBridge®
Underwritten by
The Chesapeake Life Insurance Company®

About Us

SureBridge is one of the leading brands of supplemental insurance coverage in the United States, helping to provide financial security for Americans of all ages and their families. Our comprehensive portfolio of products is available from licensed insurance agents in 46 states and the District of Columbia and is available through HealthMarkets Insurance Agency Inc., as well as through other unaffiliated insurance distributors. SureBridge policyholders can receive direct cash benefits for expenses caused by unexpected medical issues, sustained illnesses, and end-of-life challenges.

The SureBridge portfolio includes dental, vision, and other insurance plans that complement an individual's health insurance. These plans help provide an additional layer of protection in the event of accidental injury, catastrophic illness, hospitalization, or cancer.