The following Outline of Coverage applies to 1000 and 1000 Plus plans. On page 1 under the Important note, "Reasonable and Customary Charge" or "Maximum Allowable Cost" applies based on the zip code in which you live and the plans available in your area. If you purchase a 1000 Plus plan, Reasonable and Customary Charge" applies. If you purchase a 1000 plan, "Maximum Allowable Cost" applies.

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 31382
Salt Lake City, Utah 84131-0382
Customer Service: 1-800-815-8535
www.uhcmemberhub.com

DENTAL INSURANCE POLICY
OUTLINE OF COVERAGE FOR POLICY FORM CH-26155-IP (06/22) ME

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, Exclusions & Limitations, and all other provisions of the Policy.

3. **SCHEDULE OF BENEFITS** – Benefits are payable under the Policy as follows:

DENTAL BENEFIT DEDUCTIBLE, PER INSURED PERSON: $100 per Policy Year

DENTAL BENEFIT MAXIMUM, PER INSURED PERSON: $1,000 per Policy Year

IMPORTANT: *Non-Network Providers may bill You for any amount up to the billed charge after We have paid benefits due under the Policy. Non-Network Provider reimbursement of Covered Expenses will be limited to the ☐Reasonable and Customary Charge ☐Maximum Allowable Cost. Network Providers have agreed to discounted pricing for Covered Expenses with no additional billing to You other than Coinsurance Percentage, and Deductible amounts.*

DENTAL BENEFITS	**Network Provider**	**Non-Network Provider**
Type I Preventive Covered Expenses	100%	100%
Type II Basic Covered Expenses		
First Policy Year	60%	60%
Second and following Policy Year(s)	80%	80%
Type III Major Covered Expenses		
First Policy Year	15%	15%
Second and following Policy Year(s)	50%	50%

RIDER BENEFITS

VISION BENEFIT RIDER	**Network Provider**	**Non-Network Provider**
Routine Vision Examination	100%	100% up to $50 allowance

(limited to one Routine Vision Examination per Policy Year, per Insured Person.)

Eyeglass Lenses

(limited to one purchase per Policy Year, per Insured Person.)

Single Vision Lenses	$10 copay then 100%	100% up to $40 allowance
Bifocal Lenses	$10 copay then 100%	100% up to $60 allowance
Trifocal Lenses	$10 copay then 100%	100% up to $80 allowance

Eyeglass Frame *(limited to one purchase per Policy Year, per Insured Person.)*	up to $150 allowance	up to $75 allowance
Contact Lenses *(limited to one purchase of up to a 12 month supply per Policy Year, per Insured Person.)*	$10 copay, up to $150 allowance	up to $105 allowance

4. BENEFITS – Benefits are payable in accordance with the Benefits shown in the POLICY SCHEDULE – SCHEDULE OF BENEFITS, while an Insured Person's coverage is in force under the Policy. Unless otherwise stated herein, all Benefits are subject to:

1. The Dental Benefit Deductible shown in the POLICY SCHEDULE (if any);
2. Any Benefit Maximums shown in the POLICY SCHEDULE;
3. The EXCLUSIONS AND LIMITATIONS; and
4. All other provisions of the Policy.

DENTAL BENEFITS: Dental Covered Expenses include Type I, II, and III Dental Services and procedures described in the Policy when received by an Insured Person, payable in accordance with the Benefits shown in the POLICY SCHEDULE – SCHEDULE OF BENEFITS.

To be a Dental 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 either in independent practice or under the supervision and direction of a Dentist.

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

5. EXCLUSIONS & LIMITATIONS – No benefits will be paid for any service or treatment for which charges Incurred are not identified and included as Covered Expenses under the Policy. You will be fully responsible for payment for any services for which charges Incurred are not Covered Expenses under the Policy**:**

The Policy does not pay benefits for any service or treatment caused by, resulting from, for, which are, or relating to any of the following:

1. Not a Covered Expense or for which no charge is made.
2. Fees/surcharges imposed on the Insured Person by a provider but that are actually the responsibility of the provider to pay.
3. In excess of the frequency limitations or maximum benefits as shown on the POLICY SCHEDULE.
4. Covered Expenses which exceed the Non-Network Provider reimbursement, as shown on the POLICY SCHEDULE.
5. Which no benefit is described in the Policy or on the POLICY SCHEDULE.
6. A Dental Service that is not rendered or that is not rendered within the scope of the Dentist's license.
7. Billed for incision and drainage if the involved abscessed tooth is removed on the same date of service.
8. Telephone consultations or for failure to keep a scheduled appointment.
9. Any service Incurred directly or indirectly as a result of the Insured Person being intoxicated, as defined by applicable state law in the state in which the Loss occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a Physician or voluntary taking of any over the counter drug unless taken in accordance with the manufacturer's recommended dosage.

10. Experimental or Investigational Treatment or for complications there from, including expenses that might otherwise be covered if they were not Incurred in conjunction with, as a result of, or while receiving Experimental or Investigational Treatment.
11. Which arise out of, or in the course of, employment for wage or profit, if the Insured Person is insured, or is required to be insured, by workers' compensation insurance pursuant to the applicable state or federal law.
12. Intentionally self-inflicted bodily harm (whether the Insured Person is sane or insane).
13. Any act of declared or undeclared war.
14. The Insured Person taking part in a riot.
15. The Insured Person's commission or attempt to commit a felony, whether or not charged.
16. Provided by a government plan, program, hospital or other facility, unless by law an Insured Person must pay and it is otherwise a Covered Expense or which by law must be provided by an educational institution.
17. Provided without cost to an Insured Person in the absence of insurance covering the charge.
18. Provided by an Immediate Family member or someone who ordinarily resides with an Insured Person.
19. Provided prior to the Effective Date or after the termination date of the Policy.
20. Received outside of the United States, except for a Dental Emergency.
21. Related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
22. Teeth that can be restored by other means; for purposes of periodontal splinting; to correct abrasion, erosion, attrition, bruxism, abfraction, or for desensitization; or teeth that are not periodontally sound or have a questionable prognosis as determined by Us.
23. Performed for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that are performed primarily to improve physical appearance such as internal/ external bleaching, veneers.)
24. Maxillofacial prosthetics and related services.
25. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or congenital anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
26. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
27. Changing vertical dimension; restoring occlusion; bite analysis, congenital malformation.
28. Orthognathic surgery.
29. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
30. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal.
31. Treatment of malignant neoplasms or congenital anomalies of hard or soft tissue, including excision.
32. Replacement of full or partial removable dentures, bridges, crowns, inlays, onlays or veneers which can be repaired or restored to natural function.
33. Mouthguards; precision or semi-precision attachments; duplicate dentures; harmful habit appliances; occlusal guard; replacement of lost or stolen appliances; treatment splints; bruxism appliance; sleep disorder appliance.
34. Oral hygiene instructions; plaque control; charges for completing dental claim forms; photographs; any dental supplies including but not limited to take-home fluoride; sterilization fees; diagnostic casts; treatment of halitosis and any related procedures; lab procedures.
35. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the Insured Persons dental visit.
36. Initial placement of full or partial dentures or bridges and related services, to replace functional natural teeth that are: (a) congenitally missing; or (b) lost before insurance under the Policy is in effect.

    However, benefits are available for Covered Expenses for initial placement of full or partial dentures or bridges to replace loss of functional natural teeth, including necessary adjustments during the first 6 months following the date of placement, only if: (a) the teeth were lost while the Insured Person was under the Policy and the

placement is within 12 months of the date of the loss of the teeth; or (b) the extraction took place while the Insured Person was both under age 16 and insured under the Policy.

37. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
38. Replacement within 60 consecutive months of the last placement for full and partial dentures and replacement within 60 consecutive months of the last placement for crowns, bridges, inlays, onlays and veneers. This exclusion does not apply if the replacement is necessary because of extraction of a functioning natural tooth; or a present crown, bridge, or denture is temporary and a permanent crown, bridge or denture is installed within 12 months from the date the temporary service was installed.
39. Replacement of crowns, bridges, dentures and fixed or removable prosthetic appliances, implants, implant crowns, implant prosthesis and implant supporting structures (such as connectors), inserted prior to plan coverage unless the Insured Person has been insured under the plan for 12 continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12-month period, Dental Services associated with the addition will be covered when the service is a Covered Expense.
40. Replacement of complete dentures, fixed and removable partial dentures or crowns, implants, implant crowns, implant prosthesis and implant supporting structures (such as connectors), if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is necessary because of the Insured Person's non-compliance, the Insured Person is liable for the cost of the replacement.
41. Dental implants and any related procedures.
42. Hospital or other facility charges and related anesthesia charges.
43. Removal of sound functional restorations; temporary crowns and temporary prosthetics; provisional crowns and provisional prosthesis.
44. Altering vertical dimension and/or restoring or maintaining occlusion. Such procedures include, but are not limited to, equilibrium, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.
45. Non-intravenous conscious sedation, analgesia, anxiolysis, inhalation of nitrous oxide and conscious sedation.
46. Charges for Dental Services that are not documented in the Dentist records, that are not directly associated with dental disease, or that are not performed in a dental setting.
47. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
48. Bone grafts, guided tissue regeneration, biologic materials to aid in soft and osseous tissue regeneration when performed in edentulous (toothless areas, ridge augmentation or preservations).
49. Two or more Dental Services are submitted and the Dental Services are considered part of the same Dental Service to one another, We will pay the most comprehensive Dental Service.
50. Two or more Dental Services are submitted on the same day and the Dental Services are considered mutually exclusive (when one Dental Service contradicts the need for the other Dental Service), We will pay for the Dental Service that represents the final treatment.
51. Surgical extractions of wisdom teeth.

6. 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.

7. 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.

8. TERMINATION OF COVERAGE –

You

Your coverage will terminate and no benefits will be payable under the Policy and any attached riders, if any, on the earliest of:

1. Nonpayment of premiums when due (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 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 You:
   a. perform an act or practice that constitutes fraud; or
   b. make an intentional misrepresentation of material fact, relating in any way to the coverage provided under the Policy, including claims for benefits under the Policy;
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. The date of Your death, if this is a primary insured only Policy.

Covered Dependents

Your Covered Dependent's coverage will terminate under the Policy and any attached riders on:

1. The date Your coverage terminates;
2. At the end of the month following the date such dependent ceases to be an Eligible Dependent;
3. On the date the Covered Dependent:
   a. performs an act or practice that constitutes fraud; or
   b. makes an intentional misrepresentation of material fact, relating in any way to the coverage provided under the Policy, including claims for benefits under the Policy.

9. RIDER BENEFITS –

Vision Benefit Rider (Form CH-26156-IR) - Subject to the frequency limitations shown in the POLICY SCHEDULE, the following Vision Services are available to an Insured Person, but only when each service is a Covered Expense: 1) Routine Vision Examinations. 2) Eyeglass Lenses as prescribed by a Vision Provider. 3) Eyeglass Frame and its fitting and subsequent adjustments to maintain comfort and efficiency. 4) Contact Lenses, including Contact Lens Fitting and Evaluation.

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 You written notice of at least 60 days prior to the effective date of the new rates. Each premium will be based on the rate table in effect on that premium's due date.

Premium Due (at time of application) $ _____

The following Outline of Coverage applies to 2000/3000 and 2000/3000 Plus plans. On page 1 under the Important note, "Reasonable and Customary Charge" or "Maximum Allowable Cost" applies based on the zip code in which you live and the plans available in your area. If you purchase a 2000/3000 Plus plan, Reasonable and Customary Charge" applies. If you purchase a 2000/3000 plan, "Maximum Allowable Cost" applies.

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 31382
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DENTAL INSURANCE POLICY
OUTLINE OF COVERAGE FOR POLICY FORM CH-26155-IP (06/22) ME

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, Exclusions & Limitations, and all other provisions of the Policy.

3. **SCHEDULE OF BENEFITS** – Benefits are payable under the Policy as follows:

DENTAL BENEFIT DEDUCTIBLE, PER INSURED PERSON: $100 per Policy Year

DENTAL BENEFIT MAXIMUM, PER INSURED PERSON: ☐$2,000 ☐$3,000 per Policy Year
(The Dental Benefit Maximum is separate from and not subject to the Implant Maximum Lifetime Benefit listed below.)

Implant Maximum Lifetime Benefit, per Insured Person: $1,500
(The Implant Maximum Lifetime Benefit is separate from and not subject to the Dental Benefit Maximum listed above.)

Implant Waiting Period, per Insured Person (not applicable if under age 19): 12 months

IMPORTANT: *Non-Network Providers may bill You for any amount up to the billed charge after We have paid benefits due under the Policy. Non-Network Provider reimbursement of Covered Expenses will be limited to the ☐Reasonable and Customary Charge ☐Maximum Allowable Cost. Network Providers have agreed to discounted pricing for Covered Expenses with no additional billing to You other than Coinsurance Percentage, and Deductible amounts.*

DENTAL BENEFITS	**Network Provider**	**Non-Network Provider**
Type I Preventive Covered Expenses	100%	100%
Type II Basic Covered Expenses		
First Policy Year	60%	60%
Second and following Policy Year(s)	80%	80%
Type III Major Covered Expenses		
First Policy Year	15%	15%
Second and following Policy Year(s)	50%	50%

RIDER BENEFITS

VISION BENEFIT RIDER	**Network Provider**	**Non-Network Provider**
Routine Vision Examination	100%	100% up to $50 allowance
(limited to one Routine Vision Examination per Policy Year, per Insured Person.)		
Eyeglass Lenses		
(limited to one purchase per Policy Year, per Insured Person.)		
Single Vision Lenses	$10 copay then 100%	100% up to $40 allowance
Bifocal Lenses	$10 copay then 100%	100% up to $60 allowance
Trifocal Lenses	$10 copay then 100%	100% up to $80 allowance
Eyeglass Frame	up to $150 allowance	up to $75 allowance
(limited to one purchase per Policy Year, per Insured Person.)		
Contact Lenses	$10 copay, up to $150 allowance	up to $105 allowance
(limited to one purchase of up to a 12 month supply per Policy Year, per Insured Person.)		

4. BENEFITS – Benefits are payable in accordance with the Benefits shown in the POLICY SCHEDULE – SCHEDULE OF BENEFITS, while an Insured Person's coverage is in force under the Policy. Unless otherwise stated herein, all Benefits are subject to:

1. The Waiting Period shown in the POLICY SCHEDULE (if any);
2. The Dental Benefit Deductible shown in the POLICY SCHEDULE (if any);
3. Any Benefit Maximums shown in the POLICY SCHEDULE;
4. The EXCLUSIONS AND LIMITATIONS; and
5. All other provisions of the Policy.

DENTAL BENEFITS: Dental Covered Expenses include Type I, II, and III Dental Services and procedures described in the Policy when received by an Insured Person, payable in accordance with the Benefits shown in the POLICY SCHEDULE – SCHEDULE OF BENEFITS.

To be a Dental 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 either in independent practice or under the supervision and direction of a Dentist.

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

5. EXCLUSIONS & LIMITATIONS – No benefits will be paid for any service or treatment for which charges Incurred are not identified and included as Covered Expenses under the Policy. You will be fully responsible for payment for any services for which charges Incurred are not Covered Expenses under the Policy**:**

The Policy does not pay benefits for any service or treatment caused by, resulting from, for, which are, or relating to any of the following:

1. Not a Covered Expense or for which no charge is made.
2. Fees/surcharges imposed on the Insured Person by a provider but that are actually the responsibility of the provider to pay.
3. In excess of the frequency limitations or maximum benefits as shown on the POLICY SCHEDULE.
4. Covered Expenses Incurred during the Waiting Period.
5. Covered Expenses which exceed the Non-Network Provider reimbursement, as shown on the POLICY SCHEDULE.
6. Which no benefit is described in the Policy or on the POLICY SCHEDULE.
7. A Dental Service that is not rendered or that is not rendered within the scope of the Dentist's license.

8. Billed for incision and drainage if the involved abscessed tooth is removed on the same date of service.
9. Telephone consultations or for failure to keep a scheduled appointment.
10. Any service Incurred directly or indirectly as a result of the Insured Person being intoxicated, as defined by applicable state law in the state in which the Loss occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a Physician or voluntary taking of any over the counter drug unless taken in accordance with the manufacturer's recommended dosage.
11. Experimental or Investigational Treatment or for complications there from, including expenses that might otherwise be covered if they were not Incurred in conjunction with, as a result of, or while receiving Experimental or Investigational Treatment.
12. Which arise out of, or in the course of, employment for wage or profit, if the Insured Person is insured, or is required to be insured, by workers' compensation insurance pursuant to the applicable state or federal law.
13. Intentionally self-inflicted bodily harm (whether the Insured Person is sane or insane).
14. Any act of declared or undeclared war.
15. The Insured Person taking part in a riot.
16. The Insured Person’s commission or attempt to commit a felony, whether or not charged.
17. Provided by a government plan, program, hospital or other facility, unless by law an Insured Person must pay and it is otherwise a Covered Expense or which by law must be provided by an educational institution.
18. Provided without cost to an Insured Person in the absence of insurance covering the charge.
19. Provided by an Immediate Family member or someone who ordinarily resides with an Insured Person.
20. Provided prior to the Effective Date or after the termination date of the Policy.
21. Received outside of the United States, except for a Dental Emergency.
22. Related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
23. Teeth that can be restored by other means; for purposes of periodontal splinting; to correct abrasion, erosion, attrition, bruxism, abfraction, or for desensitization; or teeth that are not periodontally sound or have a questionable prognosis as determined by Us.
24. Performed for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that are performed primarily to improve physical appearance such as internal/ external bleaching, veneers.)
25. Maxillofacial prosthetics and related services.
26. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or congenital anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
27. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
28. Changing vertical dimension; restoring occlusion; bite analysis, congenital malformation.
29. Orthognathic surgery.
30. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
31. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal.
32. Treatment of malignant neoplasms or congenital anomalies of hard or soft tissue, including excision.
33. Replacement of full or partial removable dentures, bridges, crowns, inlays, onlays or veneers which can be repaired or restored to natural function.
34. Mouthguards; precision or semi-precision attachments; duplicate dentures; harmful habit appliances; occlusal guard; replacement of lost or stolen appliances; treatment splints; bruxism appliance; sleep disorder appliance.

35. Oral hygiene instructions; plaque control; charges for completing dental claim forms; photographs; any dental supplies including but not limited to take-home fluoride; sterilization fees; diagnostic casts; treatment of halitosis and any related procedures; lab procedures.
36. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the Insured Persons dental visit.
37. Initial placement of full or partial dentures or bridges and related services, to replace functional natural teeth that are: (a) congenitally missing; or (b) lost before insurance under the Policy is in effect.

    However, benefits are available for Covered Expenses for initial placement of full or partial dentures or bridges to replace loss of functional natural teeth, including necessary adjustments during the first 6 months following the date of placement, only if: (a) the teeth were lost while the Insured Person was under the Policy and the placement is within 12 months of the date of the loss of the teeth; or (b) the extraction took place while the Insured Person was both under age 16 and insured under the Policy.
38. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
39. Replacement within 60 consecutive months of the last placement for full and partial dentures and replacement within 60 consecutive months of the last placement for crowns, bridges, inlays, onlays and veneers. This exclusion does not apply if the replacement is necessary because of extraction of a functioning natural tooth; or a present crown, bridge, or denture is temporary and a permanent crown, bridge or denture is installed within 12 months from the date the temporary service was installed.
40. Replacement of crowns, bridges, dentures and fixed or removable prosthetic appliances, implants, implant crowns, implant prosthesis and implant supporting structures (such as connectors), inserted prior to plan coverage unless the Insured Person has been insured under the plan for 12 continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12-month period, Dental Services associated with the addition will be covered when the service is a Covered Expense.
41. Replacement of complete dentures, fixed and removable partial dentures or crowns, implants, implant crowns, implant prosthesis and implant supporting structures (such as connectors), if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is necessary because of the Insured Person's non-compliance, the Insured Person is liable for the cost of the replacement.
42. Hospital or other facility charges and related anesthesia charges.
43. Removal of sound functional restorations; temporary crowns and temporary prosthetics; provisional crowns and provisional prosthesis.
44. Altering vertical dimension and/or restoring or maintaining occlusion. Such procedures include, but are not limited to, equilibrium, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.
45. Non-intravenous conscious sedation, analgesia, anxiolysis, inhalation of nitrous oxide and conscious sedation.
46. Charges for Dental Services that are not documented in the Dentist records, that are not directly associated with dental disease, or that are not performed in a dental setting.
47. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
48. Bone grafts, guided tissue regeneration, biologic materials to aid in soft and osseous tissue regeneration when performed in edentulous (toothless areas, ridge augmentation or preservations).
49. Two or more Dental Services are submitted and the Dental Services are considered part of the same Dental Service to one another, We will pay the most comprehensive Dental Service.
50. Two or more Dental Services are submitted on the same day and the Dental Services are considered mutually exclusive (when one Dental Service contradicts the need for the other Dental Service), We will pay for the Dental Service that represents the final treatment.
51. Surgical extractions of wisdom teeth.

6. 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.

7. **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.

8. **TERMINATION OF COVERAGE –**

You

Your coverage will terminate and no benefits will be payable under the Policy and any attached riders, if any, on the earliest of:

1. Nonpayment of premiums when due (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 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 You:
   a. perform an act or practice that constitutes fraud; or
   b. make an intentional misrepresentation of material fact, relating in any way to the coverage provided under the Policy, including claims for benefits under the Policy;
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. The date of Your death, if this is a primary insured only Policy.

Covered Dependents

Your Covered Dependent's coverage will terminate under the Policy and any attached riders on:

1. The date Your coverage terminates;
2. At the end of the month following the date such dependent ceases to be an Eligible Dependent;
3. On the date the Covered Dependent:
   a. performs an act or practice that constitutes fraud; or
   b. makes an intentional misrepresentation of material fact, relating in any way to the coverage provided under the Policy, including claims for benefits under the Policy.

9. **RIDER BENEFITS –**

Vision Benefit Rider (Form CH-26156-IR) - Subject to the frequency limitations shown in the POLICY SCHEDULE, the following Vision Services are available to an Insured Person, but only when each service is a Covered Expense: 1) Routine Vision Examinations. 2) Eyeglass Lenses as prescribed by a Vision Provider. 3) Eyeglass Frame and its fitting and subsequent adjustments to maintain comfort and efficiency. 4) Contact Lenses, including Contact Lens Fitting and Evaluation.

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 You written notice of at least 60 days prior to the effective date of the new rates. Each premium will be based on the rate table in effect on that premium's due date.

Premium Due (at time of application) $ _____