



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

Notice to Agents Regarding Specimen Policies

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

Sample Contract
v.0710

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

Dental Preventive Benefits:

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

Procedure Code	Dental Preventive Services
00120	Periodic oral evaluation
00140	Limited oral evaluation - problem focused
00150	Comprehensive Oral Exam - new or established patient
00160	Detailed and extensive oral evaluation - problem focused, by report
00210	Intraoral - complete series (including bitewings)
00220	Intraoral - periapical first film
00230	Intraoral - periapical each additional film
00240	Intraoral - occlusal film
00250	Extraoral - first film
00260	Extraoral - each additional film
00270	Bitewing - single film
00272	Bitewings - two films
00274	Bitewings - four films
00330	Panoramic film
00340	Cephalometric film
00415	Bacteriologic studies for determination of pathologic agents
00460	Pulp vitality tests
00470	Diagnostic casts
00471	Diagnostic photographs
00501	Histopathologic Examinations
09310	Consultation (diagnostic service provided by Dentist or physician other than practitioner)
01110	Prophylaxis - adult
01120	Prophylaxis - child
01201	Topical application of fluoride (including prophylaxis) - child
01203	Topical application of fluoride (prophylaxis not included) - child
01204	Topical application of fluoride (prophylaxis not included) - adult
01205	Topical application of fluoride (including prophylaxis) - adult
01351	Sealant - per tooth
01510	Space maintainer - fixed - unilateral
01515	Space maintainer - fixed - bilateral
01520	Space maintainer - removable - unilateral
01525	Space maintainer - removable - bilateral
01550	Re-cementation of space maintainer

Basic Dental Services Benefits:

Benefits for all covered Basic Dental Services rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of \$1,500 per Covered Person.

All benefits for covered Basic Dental Services are subject to the Basic and Major Services Combined Maximum Benefit Limitation shown on this Policy Schedule.

The Scheduled Benefits shown below will be reduced by 50% for any covered procedure rendered during the first Policy Year following the Effective Date.

Procedure Code	Basic Dental Services	Scheduled Benefit
09110	Palliative (emergency) treatment of dental pain - minor procedure	\$70
09220	Deep sedation/general anesthesia - first 30 minutes	\$275
09221	Deep sedation/general anesthesia - each additional 15 minutes	\$100
02140	Amalgam - one surface, primary or permanent	\$90
02150	Amalgam - two surfaces - primary or permanent	\$110
02160	Amalgam - three surfaces - primary or permanent	\$140
02161	Amalgam - four or more surfaces, primary or permanent	\$160
02330	Resin-based composite - one surface, anterior	\$110
02331	Resin-based composite - two surface, anterior	\$140
02332	Resin-based composite - three surfaces, anterior	\$160
02335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	\$190
02336	Resin-based composite crown (anterior-primary)	\$190
02391	Resin-based composite - one surface, posterior - permanent or primary	\$120
02392	Resin-based composite - two surfaces, posterior - permanent or primary	\$150
02393	Resin-based composite - three surfaces, posterior - permanent or primary	\$190
02394	Resin-based composite - four or more surfaces, posterior	\$225
02410	Gold foil - one surface	\$100
02420	Gold foil - two surfaces	\$375
07111	Coronal re-cement - deciduous tooth	\$80
07140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$100
05410	Adjust complete denture - maxillary	\$55
05411	Adjust complete denture - mandibular	\$55
05421	Adjust partial denture - maxillary	\$55
05422	Adjust partial denture - mandibular	\$55
05510	Repair broken complete denture base	\$120
05520	Replace missing or broken teeth - complete denture (each tooth)	\$100
05610	Repair resin denture base	\$120
05620	Repair cast framework	\$150
05630	Repair or replace broken clasp	\$150
05640	Replace broken teeth - per tooth	\$100
05650	Add tooth to existing partial denture	\$120
05660	Add clasp to existing partial denture	\$150
05670	Replace all teeth and acrylic on cast metal framework (maxillary)	\$350
05671	Replace all teeth and acrylic on cast metal framework (mandibular)	\$350
05710	Rebase complete maxillary denture	\$350
05711	Rebase complete mandibular denture	\$350
05720	Rebase maxillary partial denture	\$350
05721	Rebase mandibular partial denture	\$350
05730	Reline complete maxillary denture (chairside)	\$200

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

Major Dental Services Benefits:

Benefits for all covered Major Dental Services rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of \$1,500 per Covered Person.

All benefits for covered Major Dental Services are subject to the Basic and Major Services Combined Maximum Benefit Limitation shown on this Policy Schedule.

The Scheduled Benefits shown below will be reduced by 50% for any covered procedure rendered during the first Policy Year following the Effective Date.

Procedure Code	Major Dental Services	Scheduled Benefits
02510	Inlay - metallic - one surface	\$280
02520	Inlay - metallic - two surfaces	\$330
02530	Inlay - metallic - three or more surfaces	\$375
02543	Onlay - metallic - three surfaces	\$375
02544	Onlay - metallic - four or more surfaces	\$375
02610	Inlay - porcelain/ceramic - one surface	\$350
02620	Inlay - porcelain/ceramic - two surfaces	\$350
02630	Inlay - porcelain/ceramic - three or more surfaces	\$375
02642	Onlay - porcelain/ceramic - two surfaces	\$375
02643	Onlay - porcelain/ceramic - three surfaces	\$375
02644	Onlay - porcelain/ceramic - four or more surfaces	\$375
02650	Inlay - resin-based composite - one surface	\$225
02651	Inlay - resin based composite - two surfaces	\$260
02662	Onlay - resin based composite - two surfaces	\$240
02663	Onlay - resin based composite - three surfaces	\$280
02910	Re-cement inlay	\$40
02940	Sedative Filling	\$40
02951	Pin retention - per tooth, in addition to restoration	\$20
02710	Crown - resin laboratory	\$190
02720	Crown - resin with high noble metal	\$450
02721	Crown - resin with predominantly base metal	\$450
02722	Crown - resin with noble metal	\$450
02740	Crown - porcelain/ceramic substrate	\$450
02750	Crown - porcelain fused to high noble metal	\$450
02751	Crown - porcelain fused to predominantly base metal	\$450
02752	Crown - porcelain fused to noble metal	\$450
02780	Crown - 3/4 case high noble metal	\$450
02781	Crown - 3/4 case predominantly base metal	\$450
02782	Crown - 3/4 cast noble metal	\$450

02790	Crown porcelain	\$450
02791	Crown - full cast predominantly base metal	\$450
02792	Crown - full cast noble metal	\$450
02810	Crown - 3/4 cast metallic	\$450
02920	Re-cement crown	\$40
02930	Prefabricated stainless steel crown - primary tooth	\$110
02931	Prefabricated stainless steel crown - permanent tooth	\$125
02932	Prefabricated resin crown	\$140
02933	Prefabricated stainless steel crown with resin window	\$150
02940	Sedative filling	\$40
02950	Core buildup, including any pins	\$100
02952	Cast post and core in addition to crown	\$150
0295	Prefabricated post and core in addition to crown	\$135
02970	Temporary crown (fractured tooth)	\$95
03110	Pulp cap - direct (excluding final restoration)	\$30
03120	Pulp cap - indirect (excluding final restoration)	\$30
03220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medication	\$70
03310	Anterior (excluding final restoration)	\$225
03320	Bicuspid (excluding final restoration)	\$300
03330	Molar (excluding final restoration)	\$375
03346	Retreatment of previous root canal therapy - anterior	\$225
03347	Retreatment of previous root canal therapy - bicuspid	\$250
03348	Retreatment of previous root canal therapy - molar	\$400
03410	Apicoectomy/periradicular surgery - anterior	\$175
03421	Apicoectomy/periradicular surgery - bicuspid (first root)	\$300
03425	Apicoectomy/periradicular surgery - molar (first root)	\$350
03426	Apicoectomy/periradicular surgery - (each additional root)	\$145
03430	Retrograde filling - per root	\$105
03450	Root amputation - per root	\$200
03920	Hemisection (including any root removal), not including root canal therapy	\$150
00180	Comprehensive periodontal evaluation - new or established patient	\$30
04210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	\$165
04211	Gingivectomy or gingivoplasty - one to three teeth - per quadrant	\$65
04240	Gingival flap procedure, including root planning - four or more contiguous teeth or bounded teeth spaces per quadrant	\$275
04249	Clinical crown lengthening - hard tissue	\$300
04260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	\$325
04261	Osseous surgery (including flap entry and closure) - one to three teeth, per quadrant	\$200
04263	Bone replacement graft - first site in quadrant	\$150
04264	Bone replacement graft - each additional site in quadrant	\$75
04270	Pedicle soft tissue graft procedure	\$300
04271	Free soft tissue graft procedure (including donor site surgery)	\$300
04341	Periodontal scaling and root planning - four or more contiguous teeth or bounded teeth spaces per quadrant	\$95

04355	Full mouth debridement to enable comprehensive evaluation and diagnosis	\$65
04910	Periodontal maintenance	\$60
05110	Complete denture - maxillary	\$375
05120	Complete denture - mandibular	\$375
05130	Immediate denture - maxillary	\$400
05140	Immediate denture - mandibular	\$400
05211	Maxillary partial denture - resin base (including any conventional clasps, rests, and teeth)	\$375
05212	Mandibular partial denture - resin base (including any conventional clasps, rests, and teeth)	\$375
05213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)	\$400
05214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)	\$400
05281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	\$275
06210	Pontic - cast high noble metal	\$375
06211	Pontic - cast predominantly base metal	\$375
06212	Pontic - cast noble metal	\$375
06240	Pontic - porcelain fused to high noble metal	\$375
06241	Pontic - porcelain fused to predominantly base metal	\$375
06242	Pontic - porcelain fused to noble metal	\$375
06250	Pontic - resin with high noble metal	\$375
06251	Pontic - resin with predominantly base metal	\$375
06252	Pontic - with noble metal	\$375
06545	Retainer - cast metal for resin bonded fixed prostheses	\$175
06602	Inlay - cast high noble metal, two surfaces	\$375
06603	Inlay - cast high noble metal, three or more surfaces	\$375
06604	Inlay - cast predominantly base metal, two surfaces	\$375
06605	Inlay - cast predominantly base metal, three or more surfaces	\$375
06606	Inlay - cast noble metal, two surfaces	\$375
06607	Inlay - cast noble metal three or more surfaces	\$375
06610	Onlay - cast high noble metal, two surfaces	\$375
06611	Onlay - cast high noble metal, three or more surfaces	\$375
0661	Onlay - cast predominantly base metal, two surfaces	\$375
06613	Onlay - cast predominantly base metal, three or more surfaces	\$375
06614	Onlay - cast noble metal, two surfaces	\$375
06615	Onlay - cast noble metal, three or more surfaces	\$375
06720	Crown - resin with high noble metal	\$375
06721	Crown - resin with predominantly base metal	\$375
06722	Crown - resin with noble metal	\$375
06740	Crown - porcelain/ceramic	\$375
06750	Crown - porcelain fused to high noble metal	\$375
06751	Crown - porcelain fused to predominantly base metal	\$375
06752	Crown - porcelain fused to noble metal	\$375
06780	Crown - 3/4 cast high noble metal	\$375
06781	Crown - 3/4 cast predominantly base metal	\$375

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

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

AGENT INFORMATION

NAME

AARON SMITH

ADDRESS & TELEPHONE NUMBER

4309 S Louise Avenue
Sioux Falls SD 57106-3142
(605)361-3515

Sample Contract
v.0710

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

DENTAL INDEMNITY INSURANCE POLICY

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

This Policy is guaranteed renewable until attainment of age 70 years. We may change premium for this Policy upon renewal.

The insurance described in this Policy is effective on the date shown in the Policy Schedule for each Covered Person. Insurance will begin and end at 12:01 a.m. local time at the Policyholder's state of residence on that date. This Policy is evidence of Your coverage. This Policy is issued and delivered in the State of Texas.

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

RIGHT TO EXAMINE POLICY FOR 30 DAYS

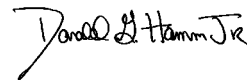
If You are not satisfied, return the Policy to Us or Our agent within 30 days after You have received it. All premiums will be refunded and Your coverage will be void from the Effective Date.

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

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



Secretary



President

**This Policy automatically renews except for as stated in the
Effective Date and Termination Date section.**

Read Your Policy carefully to understand coverage limitations and termination provisions.

IMPORTANT NOTICE	AVISO IMPORTANTE
<p>1. To obtain information or make a complaint:</p> <p>2. You may call Our toll-free telephone number for information or to make a complaint at:</p> <p style="text-align: center;">1-866-387-0484</p> <p>3. You may also write to Us at:</p> <p>P.O. Box 3089, Milwaukee, WI 53201-3089</p> <p>4. You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:</p> <p style="text-align: center;">1-800-252-3439</p> <p>5. You may write the Texas Department of Insurance at:</p> <p>P. O. Box 149104</p> <p>Austin, TX 78714-9104</p> <p>FAX#: (512) 475-1771</p> <p>Web: http://www.tdi.state.tx.us</p> <p>E-mail: ConsumerProtection@tdi.state.tx.us</p> <p>6. PREMIUM OR CLAIM DISPUTES: Should You have a dispute concerning Your premium or about a claim, You should contact Our Member Services Department first. If the dispute is not resolved, You may contact the Texas Department of Insurance.</p> <p>7. ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.</p>	<p>Para obtener informacion o para someter una queja:</p> <p>Usted puede llamar al numero de telefono gratis de compania's para informacion o para someter una queja al:</p> <p style="text-align: center;">1-866-387-0484</p> <p>Usted tambien puede escribir a compania:</p> <p>P.O. Box 3089, Milwaukee, WI 53201-3089</p> <p>Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al:</p> <p style="text-align: center;">1-800-252-3439</p> <p>Puede escribir al Departamento de Seguros de Texas:</p> <p>P.O. Box 149104</p> <p>Austin, TX 78714-9104</p> <p>FAX#: (512) 475-1771</p> <p>Web: http://www.tdi.state.tx.us</p> <p>E-mail: ConsumerProtection@tdi.state.tx.us</p> <p>DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el Departamento para Nuestros Miembros de compania primero. Si no se resuelve la disputa puede entonces comunicarse con el departamento (TDI).</p> <p>UNA ESTE AVISO A SU POLIZA: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.</p>

GUIDE TO YOUR COVERAGE

The sections of the Policy appear in the following order:

- I Definitions
- II Dental Indemnity Insurance Benefits
- III Exclusions and Limitations
- IV Claim Provisions
- V Premium Provisions
- VI Effective Date and Termination Date
- VII Other Provisions

Sample Contract
v.0710

I. Definitions

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

Accident or Accidental

Accidental bodily Injury sustained by a Covered Person that is the direct cause of a loss, independent of disease, dental infirmity or any other cause and that occurs while this Policy is in force. An Accident does not include harm resulting from a Sickness.

Basic Dental Services

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

Benefit Waiting Period

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

Calendar Year

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

Cosmetic Services

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

Covered Dependent

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

Covered Person

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

Dentally Necessary and Dental Necessity

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

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

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

Dentist

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

his or her license and in the geographic area in which he or she is licensed.

Dental Hygienist

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

Dental Preventive Services

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

Dependent

A Dependent is:

1. The Policyholder's lawful spouse; or
2. The Policyholder's or spouse's naturally born child, legally adopted child, a child that is placed for adoption with the Policyholder or spouse, a child for which the Policyholder or spouse is a party to a suit in which the Policyholder or spouse seeks to adopt the child, a stepchild, a child for whom a court order requires the Policyholder or spouse to provide dental insurance, or a child for whom the Policyholder or spouse is the legal guardian:
 - a. Who is unmarried and age 24 or younger; or;
 - b. Who is an unmarried grandchild of the Policyholder or spouse and who is age 24 or younger and dependent upon the Policyholder or spouse for federal income tax purposes at time of the child's application for coverage.

If Your unmarried child is age 25 or older, the child will be considered a Dependent if You give Us proof that the child is not capable of self-sustaining employment because of mental incapacity or physical handicap. The child must also be chiefly dependent on the Policyholder or spouse for support and maintenance. You must give Us proof that the child meets these requirements at the same time that You first enroll for coverage under this plan or within 31 days after the child reaches the normal age for termination. Additional proof may be requested periodically, but not more often than annually after the 2-year period following the date the child reaches the normal age for termination.

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

- a. Attains age 25; or
- b. Marries; or
- c. Is over age 25 and is capable of self-sustaining employment because he or she is no longer mentally incapacitated or physically handicapped.

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

Effective Date

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

Emergency Dental Treatment

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

Experimental or Investigational Services

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

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

Family Plan

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

Functioning Natural Tooth (Teeth)

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

Home Office

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

Immediate Family Member

An Immediate Family Member is:

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

Injury

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

Major Dental Services

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

Policy

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

Policyholder

The person listed on the Policy Schedule as the Policyholder.

Policy Year

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

Sickness

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

Single Plan

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

We, Us, Our, Our Company

Time Insurance Company or its administrator.

You, Your, Yours

The person listed on the Policy Schedule as the Policyholder.

Sample Contract
v.0710

II. Dental Indemnity Insurance Benefits

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

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

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

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

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

Dental Preventive Benefits

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

Basic Dental Services Benefits

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

Major Dental Services Benefits

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

III. Exclusions and Limitations

Limited Benefits

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

Exclusions

We will not pay benefits for any of the following:

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

- f. voluntary use of any controlled substance, as defined by statute, except when administered in accordance with the advice of the Covered Person's health care practitioner.
 - g. riding in any aircraft not licensed to carry passengers or not operated by a duly licensed pilot.
20. procedures rendered before the Effective Date or after the termination date of coverage.
21. orthodontic treatment and services.

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IV. Claim Provisions

Proof of Loss

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

We must receive written or electronic notice of the services that were received for which the claim is made. Notice must be provided to Us within 90 days after a covered loss occurs or as soon as reasonably possible. Unless You are declared incompetent by a court of law, written or electronic proof of loss must be sent to Us within 15 months of the date of loss.

The proof of loss must include all of the following:

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

Upon receipt of a notice of claim, we will furnish you such forms as are usually furnished by us for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice you will have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

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

Right to Collect Information

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

1. authorize the release of all medical and dental records to Us and other information We requested.
2. provide Us with information We requested about pending claims.
3. provide Us with information that is accurate and complete.
4. have any examination completed as requested by Us.
5. provide reasonable cooperation to any requests made by Us.

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

Physical Examination

We have the right to have a provider of Our choice examine a Covered Person at any time regarding a claim for benefits. These exams will be paid by Us.

Payment of Benefits

Benefits will be paid when We receive due written or electronic proof of loss, subject to any time period requirements under state law. Benefits for services provided will be paid to the Policyholder unless they have been assigned to a provider. Any benefits unpaid at Your death will be paid at Our option to Your spouse, Your estate or the providers of the services.

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

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

Overpayment

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

Payment of Benefits to the Texas Department of Human Services

All benefits paid on behalf of a child or children under this policy must be paid to the Texas Department of Human Services whenever; (a) the Texas Department of Human Services is paying under the Human Resources Code, Chapter 31 or 32, i.e., financial and medical assistance service program administered pursuant to the Human Resources Code; (b) the parent who purchased this policy has possession or access to the child pursuant to a court order, or is not entitled to access or possession and is required to pay child support; and c) We receive, at Our Home Office, written notice affixed to the insurance claim when the claim is first submitted, which states that all benefits paid pursuant to this provision must be paid directly to the Texas Department of Human Services.

Rights of Administration

We maintain Our ability to determine Our rights and obligations under this plan including, without limitation, the eligibility for and amount of any benefits payable.

Claims Involving Fraud or Intentional Misrepresentation of Material Fact

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

A claim will not be honored if the Covered Person or the provider of the charges will not, or cannot, provide adequate documentation to substantiate that treatment was rendered for the claim submitted. If the Covered Person, or anyone acting on the Covered Person's behalf, knowingly files a fraudulent claim, claims may be denied in whole or in part, coverage may be terminated or rescinded, and the Covered Person may be subject to civil and/or criminal penalties.

Workers' Compensation Not Affected

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

Claim Appeal

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

V. Premium Provisions

Consideration

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

Premium Payment

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

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

Grace Period

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

Reinstatement

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

1. the lapse was not more than 180 days.
2. You submit an application/enrollment form for reinstatement to Us along with the required premium payment. Submission of premium to Your agent is not submission of premium to Us. We may require payment of unpaid premium during the lapsed period, but not to any period prior to the date occurring 60 days before the reinstatement date.
3. We approve Your application/enrollment form for reinstatement.

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

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

Covered Dependent Conversion

A Covered Dependent may be eligible to convert to another similar dental plan that We issue in the Covered Dependent's state of residence at the time coverage terminates under this plan if:

1. The Covered Dependent's insurance terminates due to a valid decree of divorce between the Policyholder and the Covered Dependent. The Covered Dependent will be issued a policy, which We are currently issuing, that most nearly approximates the coverage of this Policy, without evidence of insurability and with the same effective date as the Covered Dependent's coverage under this Policy; or
2. The Covered Dependent's insurance terminates due to the death of the Policyholder, except in the case of the Policyholder's spouse who then becomes the successor Policyholder; or
3. A Covered Dependent child's insurance terminates because the child no longer meets the eligibility requirements for a Dependent.

To obtain conversion coverage, the Covered Dependent must submit a written enrollment form and the required premium to Us within 31 days after coverage under this plan terminates. Evidence of insurability will not be required. Coverage will be provided on the dental insurance form that We select for providing conversion coverage at that time. However, the conversion plan may provide different benefit levels, covered services and premium rates.

If written enrollment is not made within 31 days following the termination of insurance under this plan, conversion coverage may not be available.

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

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VI. Effective Date and Termination Date

Eligibility and Effective Date of Policyholder

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

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

Eligibility and Effective Date of Dependents

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

- a. **Adding a Newborn Child:** A newborn Dependent child can be added on the date the child was born. You must notify Us of the birth of the child and We must receive any required additional premium within 31 days of birth. The Effective Date of coverage will be 12:01 a.m. local time at the Policyholder's state of residence on the date the child is born. If these requirements are not met, Your newborn child will be covered for Sickness or Injury, including the necessary care and treatment of medically diagnosed congenital defects, for the first 31 days from birth. If coverage is not added within the 31-day period, and any required additional premium is not received as required under this Policy, the coverage for the newborn will terminate after the 31 days.
- b. **Adding an Adopted Child:** A newly adopted child can be added on the earlier of: 1) the date the child is placed with the Policyholder or spouse in anticipation of legal adoption and the Policyholder or spouse assumes a legal obligation for support of the child; or 2) the date the Policyholder or spouse is party in a suit in which adoption of the child is sought. You must notify Us of the placement for adoption of the child or when the Policyholder or spouse is party in a suit in which adoption of the child is sought and We must receive any required additional premium within 31 days of the placement for adoption or when the Policyholder or spouse is party in a suit in which adoption of the child is sought. The Effective Date of coverage will be 12:01 a.m. local time at the Policyholder's state of residence on the date the child is placed for adoption or when the Policyholder or spouse is party in a suit in which adoption of the child is sought. If these requirements are not met, Your newly adopted child will be covered for Sickness or Injury only for the first 31 days from placement for adoption or when the Policyholder or spouse is party in a suit in which adoption of the child is sought. A child is no longer considered adopted if, prior to legal adoption, You relinquish legal obligation for support of the child and the child is removed from placement or when the Policyholder or spouse is no longer party to a suit in which adoption of the child is sought.
- c. **Adding a Child for Whom a Court Order Requires You to Provide Dental Insurance:** A child for whom a court order requires the Policyholder or spouse to provide dental insurance will be covered for the first 31 days for the time We received a copy of the dental support order or notice of a dental support order. Any required additional premium must be received within 31 days from Our notice or receipt of the court order. If these requirements are not met, the child will only be covered for the first 31 days from the date We receive the dental support order or notice of the dental support order.
- d. **Adding Any Other Dependent:** To add any other Dependent, an application/enrollment form must be completed and sent to Us along with any required premium. Evidence of insurability must also be provided. The Effective Date of coverage will be 12:01 a.m. local time in the state of issuance on the Effective Date approved by Us.

Termination Date of Coverage

The Policyholder may cancel this coverage at any time by sending Us written notice or calling Our office.

Upon cancellation, We will return the unearned portion of any premium paid, in accordance with the laws in the Policyholder's state of residence.

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

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

If We accept premium for coverage extending beyond the date, age or event specified for termination as to a Dependent Covered Person, coverage for such Covered Person shall continue during the period for which an identifiable premium was accepted, except where such acceptance was predicated on a misstatement of age (see the Misstatements provision of Other Provisions).

If coverage terminates due to the death of the Policyholder, the spouse of the Policyholder will become the named Policyholder provided the spouse is a Covered Person under the Policy on the date of death. If Your spouse is no longer eligible for coverage under this Policy due to divorce, Your former spouse will be eligible to obtain a similar policy. Evidence of insurability will not be required, but written application must be made within 60 days after Your former spouse's coverage terminates. The effective date of coverage for Your former spouse will be the initial Effective Date assigned to this Policy.

VII. Other Provisions

Assignment

A Covered Person's right to benefits under this Policy is assignable. A signed copy of the assignment must be sent to Our Home Office in a form acceptable to Us. The assignment is subject to any payment made or other action taken before We receive the assignment. Any benefits We pay directly to the designated Dentist or Dental Hygienist pursuant to an assignment shall discharge Our obligation to pay those benefits.

Modification of Policy or Coverage

The Policy may be changed at any time. We will give You 90 days notice prior to any change. No change in the Policy will be valid unless approved by one of Our executive officers and provided for inclusion with this Policy. No agent or other employee of Our Company has authority to waive or change any plan provision or waive any other applicable enrollment or application requirements.

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

Clerical Error

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

Conformity with State Statutes

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

Enforcement of Plan Provisions

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

Entire Contract

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

Representations

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

Discounted or Free Non-Insurance Programs

We may elect to furnish or participate in programs with other organizations which furnish Policyholders that meet common criteria or requirements determined by Us with discount cards or other programs that may be offered or provided to Covered Persons at no charge or a reduced charge for a period of time determined by Us.

Misstatements

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

Incontestability and Time Limit on Certain Defenses

Within the first two years after the Effective Date of coverage, We have the right to rescind or modify Your Policy of insurance coverage and/or deny a claim for a Covered Person if the application/enrollment form contains an omission or intentional misrepresentation of material fact. We also reserve the right to rescind a Policy of insurance and/or deny a claim for a fraudulent misstatement or omission at any time during the coverage period.

Legal Action and Forum

No suit or action at law or in equity may be brought to recover benefits under this plan before the 61st day after the date written proof of loss has been provided in accordance with this Policy. No suit or action at law or in equity can be brought later than 3 years from the date written proof of loss is required to be provided.

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

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

THE POLICY PROVIDES LIMITED BENEFITS

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

THIS IS NOT A MEDICARE SUPPLEMENT POLICY

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

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

DENTAL COVERAGE INFORMATION

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

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

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

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

EXCLUSIONS AND LIMITATIONS:

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

We will not pay benefits for any of the following:

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

RENEWABILITY PROVISION: The policy is guaranteed renewable until 12:01 a.m. local time at the

Policyholder's state of residence on the earliest of the following dates:

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

PREMIUM INFORMATION	
Premium Payment Mode:	QUARTERLY
INITIAL QUARTERLY PREMIUM AMOUNT:	\$10.94
INITIAL ANNUAL PREMIUM AMOUNT:	\$203.76

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

Licensed Agent's Signature

Date

IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE, ACCIDENT, HEALTH AND HOSPITAL SERVICE INSURANCE GUARANTY ASSOCIATION

Texas law establishes a system, administered by the Texas Life, Accident, Health and Hospital Service Insurance Guaranty Association (the "Association"), to protect policyholders if their life or health insurance company fails to or cannot meet its contractual obligations. Only the policyholders of insurance companies which are members of the Association are eligible for this protection. However, even if a company is a member of the Association, protection is limited and policyholders must meet certain guidelines to quality. (The law is found in the Texas Insurance Code, Article 21.28-D.)

BECAUSE OF STATUTORY LIMITATIONS ON POLICYHOLDER PROTECTION, IT IS POSSIBLE THAT THE ASSOCIATION MAY NOT COVER YOUR POLICY OR MAY NOT COVER YOUR POLICY IN FULL.

Eligibility for Protection by the Association

When an insurance company which is a member of the Association is designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- residents of Texas at the time that their insurance company is impaired
- residents of other states, ONLY if the following conditions are met:
 - 1) The policyholder has a policy with a company based in Texas;
 - 2) The company has never held a license in the policyholder's state of residence;
 - 3) The policyholder's state of residence has a similar guaranty association; and
 - 4) The policyholder is not eligible for coverage by the guaranty association of the policyholder's state of residence

Limits of Protection by the Association**Accident, Accident and Health, or Health Insurance:**

- up to a total of \$200,000 for one or more policies for each individual covered.

Life Insurance:

- net cash surrender value up to a total of \$100,000 under one or more policies on any one life; or
- death benefits up to a total of \$300,000 under one or more policies on any one life.

Individual Annuities:

- net cash surrender amount up to a total of \$100,000 under one or more policies owned by one contract holder.

Group Annuities:

- net cash surrender amount up to \$100,000 in allocated benefits under one or more policies owned by one contract holder;
- net cash surrender amount up to \$5,000,000 in unallocated benefits under one contract holder regardless of the number of contracts.

THE INSURANCE COMPANY AND ITS AGENTS ARE PROHIBITED BY LAW FROM USING THE EXISTENCE OF THE ASSOCIATION FOR THE PURPOSE OF SALES, SOLICITATION, OR INDUCEMENT TO PURCHASE ANY FORM OF INSURANCE.

When you are selecting an insurance company, you should not rely on coverage by the Association.

Texas Life, Accident Health and Hospital
Service Insurance Guaranty Association
301 Congress, Suite 500
Austin, Texas 78701
800-982-6362

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439

Sample Contract
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