Supplemental Dental and Vision Insurance Plans

Washington
This brochure provides only summary information. The information contained herein is accurate at the time of print. These plans are not intended as a replacement for accident and sickness health insurance and should not be construed as such.

For a complete listing of benefits, exclusions and limitations, please refer to your Policy. In the event of any discrepancies contained in this brochure, the terms and conditions contained in the Policy documents shall govern.
Core V Solutions, a CAREINGTON International Company (CAREINGTON) administers the dental insurance plans on behalf of The Chesapeake Life Insurance Company®, a HealthMarkets® Company. In addition, CAREINGTON has added a discount program which offers additional cost saving opportunities to eligible members. Refer to your dental Policy, upon receipt, for details, exclusions and limitations.

The dental insurance plans provide benefits on a scheduled basis. All amounts beyond the benefits payable, as shown in the Policy schedule, are the insured person's responsibility. If the actual charge is less than the scheduled benefit amount, the actual charge for the procedure or service will be paid.

**CAREINGTON Discount Program Provides**

- Members have access to a discounted fee schedule at over 135,000 providers nationwide
- Save 15% to 60% on most dental procedures
- Orthodontics included at a minimum of 5% to 20% savings for both children and adults
- Cosmetic procedures will receive a minimum of 5% to 20% savings with no waiting period.

**CAREINGTON's Value and Flexibility**

While an insured can go to any dentist they choose, using a dental provider in the CAREINGTON discount network enables you to lower your out-of-pocket costs and maximize your savings on most covered services. Once a member has exhausted their insurance benefits, they will continue to receive discounts for services as long as they utilize a CAREINGTON DENTAL discount provider.

For additional cost saving opportunities, follow these simple steps:

1. Locate a CAREINGTON DENTAL discount provider near you by calling **1-888-878-8959** (Mon. – Fri., 7AM – 7PM CST) or use the provider locator available online at dental.chesapeakeplus.com
2. Schedule an appointment with a discount provider and present your ID card. Your CAREINGTON provider will take care of the rest.

**DENTAL INSURANCE OPTIONS**

<table>
<thead>
<tr>
<th>Diagnosis Category</th>
<th>Package Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive/Diagnostic</td>
<td><strong>GOLD</strong></td>
</tr>
<tr>
<td>(No deductible for preventive and diagnostics and no waiting period for most services)</td>
<td>Covered Benefits</td>
</tr>
<tr>
<td>Basic Restorative</td>
<td></td>
</tr>
<tr>
<td>Major Restorative</td>
<td></td>
</tr>
<tr>
<td>Orthodontia (Adolescent and Adult)</td>
<td>$1,200 Lifetime maximum ($50/Month maximum reimbursement)</td>
</tr>
<tr>
<td><strong>SILVER</strong></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Category</td>
<td>Package Benefit</td>
</tr>
<tr>
<td>Preventive/Diagnostic</td>
<td><strong>SILVER</strong></td>
</tr>
<tr>
<td>(No deductible for preventive and diagnostics and no waiting period for most services)</td>
<td>Covered Benefits</td>
</tr>
<tr>
<td>Basic Restorative</td>
<td></td>
</tr>
<tr>
<td>Major Restorative</td>
<td></td>
</tr>
<tr>
<td>Orthodontia (Adolescent and Adult)</td>
<td>All Services Discount Only</td>
</tr>
<tr>
<td><strong>BRONZE</strong></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Category</td>
<td>Package Benefit</td>
</tr>
<tr>
<td>Preventive/Diagnostic</td>
<td><strong>BRONZE</strong></td>
</tr>
<tr>
<td>(No deductible for preventive and diagnostics and no waiting period for most services)</td>
<td>Covered Benefit</td>
</tr>
<tr>
<td>Basic Restorative</td>
<td></td>
</tr>
<tr>
<td>Major Restorative</td>
<td></td>
</tr>
<tr>
<td>Orthodontia (Adolescent and Adult)</td>
<td>All Services Discount Only</td>
</tr>
<tr>
<td>Deductible</td>
<td>$100 Calendar year, per person</td>
</tr>
<tr>
<td>Annual Maximum</td>
<td>$1,000 per person</td>
</tr>
</tbody>
</table>

*All insurance benefits are subject to the scheduled benefit amounts, deductible, benefit maximums, waiting periods, and exclusions and limitations. If more than one type of service can be used to treat a condition, we have the right to base benefits on the least expensive service that is within the range of professionally adequate standards of dental practice. Procedure fees will not be reduced for any dental provider who is not in the network.*

Form CH-26099-IP (11/09) WA

*This program is administered by Core Five Solutions, 7400 Gaylord Pkwy, Frisco, TX 75034, and has no liability for providing or guaranteeing service or the quality of service.*
Save on eye care and eyewear at thousands of participating providers nationwide
Chesapeake understands that regular scheduled eye examinations play a crucial role in ensuring healthy vision and overall good health. By offering the vision plan with EyeMed Vision Care’s Select Network, you save on both eye care and eyewear needs. You benefit from lower out-of-pocket costs on routine eye examinations and materials. It’s easy and convenient!

Save on eye care and eyewear at thousands of participating providers nationwide. The chart in the following column is a brief overview of your covered benefit plan and additional savings.

You have the ability to choose from thousands of independent and optical retail providers nationwide. EyeMed Vision Care providers are located in many large retail stores such as JCPenney®, Target®, Sears®, LensCrafters®, Pearle Vision® and other independent private practitioners.

**To locate a provider, follow these simple steps:**

1) Call Eyemed Vision Care direct at **1-866-723-0514**
   (Mon.-Sat, 8AM-11PM; Sun., 11AM-8PM)

   or

2) Log on to [www.eyemedvisioncare.com](http://www.eyemedvisioncare.com)
   - Locate a Provider
   - In the drop box, choose the “Select” Network
   - Enter your zip code, then you will see a listing of providers near you

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**Form CH-26023-IP (5/07) WA. Benefits subject to change without notice.**

The Vision Benefit Program benefits above are underwritten by The Chesapeake Life Insurance Company®.

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### Vision Plan: Exams and Eyewear*

<table>
<thead>
<tr>
<th>NETWORK EYE EXAMS</th>
<th>100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>NON-NETWORK EYE EXAMS</td>
<td>100% up to $30</td>
</tr>
</tbody>
</table>

Comprehensive eye examination including dilation, as necessary. (Limited to one exam per 12-month period with option to purchase eyeglasses or contact lenses. Any other procedures are the responsibility of the member.)

### Lenses Overview

<table>
<thead>
<tr>
<th>Services</th>
<th>Member Cost (When using a network provider)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lenses</td>
<td></td>
</tr>
<tr>
<td>Single, Bifocal, Trifocal Vision Lenses</td>
<td><strong>$0</strong> copay</td>
</tr>
</tbody>
</table>

Standard uncoated plastic lenses are covered at 100% once every 12 months at participating EyeMed Vision Care’s Select Network of providers. This includes single, bifocal or trifocal lenses. (Contact lenses are available in lieu of eyeglasses every 12 months.)

### Contact Lenses

<table>
<thead>
<tr>
<th>Services</th>
<th>Member Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Disposable</td>
<td><strong>$0</strong> up to <strong>$40</strong></td>
</tr>
<tr>
<td>Disposable</td>
<td><strong>$0</strong> up to <strong>$40</strong></td>
</tr>
<tr>
<td>Therapeutic</td>
<td><strong>$0</strong> up to <strong>$40</strong></td>
</tr>
</tbody>
</table>

Standard contact lens fitting — Spherical clear contact lenses in conventional wear and planned replacement (examples include but not limited to disposable, frequent replacement, etc.). Premium contact lens fitting — all lens designs, supplies, and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.). Contact lens examinations require additional fees.

*The savings program is administered by EyeMed Vision Care, 4000 Luxottica Place, Mason, OH 45040, and has no liability for providing or guaranteeing service or the quality of service.
ADDITIONAL SAVINGS PROVIDED BY EYEMED VISION CARE

EyeMed Vision Care's Select Network saves you money on all of your eye care and eyewear needs. From frames and lens options to nonprescription glasses and sunglasses, members and their families never have to pay full price with the discounts provided by this vision plan.

Best of all, members can use these benefits as often as you like at any participating provider location. It is one more way that Chesapeake and EyeMed promotes vision wellness for our members.

EyeMed Exclusions & Limitations

Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing • Aniseikonic lenses • Medical and/or surgical treatment of the eye, eyes or supporting structures • Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under plan • Services provided as a result of any Workers' Compensation Law • Plano nonprescription lenses and non-prescription sunglasses (except for 20% discount) • Services or materials provided by any other group benefit providing for vision care • Two pair of glasses in lieu of bifocals or trifocals

<table>
<thead>
<tr>
<th>Services</th>
<th>Member Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frames</td>
<td>60% of retail</td>
</tr>
<tr>
<td>Standard Polycarbonate</td>
<td>$40</td>
</tr>
<tr>
<td>Standard Scratch-Resistance</td>
<td>$15</td>
</tr>
<tr>
<td>Tints (Solid and Gradient)</td>
<td>$15</td>
</tr>
<tr>
<td>Standard Progressive Lenses</td>
<td>$65</td>
</tr>
<tr>
<td>UV Coating</td>
<td>$15</td>
</tr>
<tr>
<td>Standard Anti-Reflective</td>
<td>$45</td>
</tr>
<tr>
<td>Other Lens Options</td>
<td>80% of retail</td>
</tr>
<tr>
<td>Nonprescription Glasses and Sunglasses</td>
<td>80% of retail</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Services</th>
<th>Member Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>LASIK or PRK Vision Correction</td>
<td>15% off retail or 5% off promotional price</td>
</tr>
</tbody>
</table>

1EyeMed is a discount program only and not insurance. This program provides discounts only at certain contracted providers. You are obligated to pay all health care fees at the time of service, but will receive a discount from those providers who have contracted with the discount plan organization. The program does not make payments directly to the providers of medical services.

Members will receive a 20% discount on remaining balance at participating providers beyond plan coverage, which may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed's Providers' professional services or contact lenses. Discounts do not apply for benefits provided by other group benefit plans. Allowances are a one-time use benefit, no remaining balance. Broken materials are not covered. Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the insurance benefit has been used. Initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com. Contact lens benefit allowance is not applicable to this service.
Termination of Coverage

Your coverage will terminate and no benefits will be paid under the Policy or any attached riders: • At the end of the period for which premium has been paid • 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 • 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 • On the date of fraud or misrepresentation by you • On the date we elect to discontinue this plan or type of coverage • On the date we elect to discontinue all coverage in your state • On the date an insured person is no longer a permanent resident of the United States or • On the date you reach the age of 65, (or become eligible for Medicare, whichever comes first, applies to Vision plan only).

Covered Dependents: Your covered dependent’s coverage will terminate under the Policy on: • The date your coverage terminates • The date such dependent ceases to be an eligible dependent or • The date we receive your written request to terminate a covered dependent’s coverage.
1. **READ YOUR POLICY CAREFULLY!** This Outline of Coverage provides a very brief description of some 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. Vision Benefit Coverage is designed to provide You or Your Covered Dependents with coverage paying benefits only when certain losses are incurred for vision services and supplies. Coverage is provided for the benefits described in the BENEFITS section below. The benefits described may be limited as outlined in the EXCLUSIONS AND LIMITATIONS section.

3. **BENEFITS PROVIDED.** While the Policy is in force, benefits are provided for the Vision Care services and supplies shown in the Policy Schedule. Charges must be incurred for a Comprehensive Eye Examination, Corrective Spectacle Lenses and/or Corrective Contact Lenses as provided for by an authorized provider (i.e., ophthalmologist, optometrist, or optical dispensary). Payment of benefits for any such service or supply will be made in accordance with the specified Benefit Payment Rate. The Benefit Payment Rate is the maximum amount of Covered Expenses We will pay for each occurrence or purchase of a supply or service.

Covered Expenses include the following:

<table>
<thead>
<tr>
<th>BENEFITS</th>
<th>BENEFIT PAYMENT RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Network Provider</strong></td>
<td><strong>Non- Network Provider</strong></td>
</tr>
<tr>
<td>Comprehensive Eye Examination</td>
<td>100%</td>
</tr>
<tr>
<td>(Limited to one Comprehensive Eye Examination every 12 months from last date of service, per Insured Person.)</td>
<td></td>
</tr>
<tr>
<td>Corrective Spectacle Lenses (standard, uncoated plastic lenses) (Limited to one purchase every 12 months from last date of service, per Insured Person.)</td>
<td></td>
</tr>
<tr>
<td>Single Vision Lenses</td>
<td>100%</td>
</tr>
<tr>
<td>Bifocal Lenses</td>
<td>100%</td>
</tr>
<tr>
<td>Trifocal Lenses</td>
<td>100%</td>
</tr>
<tr>
<td>Corrective Contact Lenses</td>
<td></td>
</tr>
<tr>
<td>(In lieu of corrective spectacle lenses; limited to one purchase every 12 months from last date of service, per Insured Person.)</td>
<td></td>
</tr>
<tr>
<td>Non-disposable</td>
<td>100% up to $40</td>
</tr>
<tr>
<td>Disposable</td>
<td>100% up to $40</td>
</tr>
<tr>
<td>Therapeutic</td>
<td>100%</td>
</tr>
<tr>
<td>Frames</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Contact Lens Fitting</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Follow-Up Visits</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

CH-26023-IP (5/07) OC WA
4. LIMITATIONS AND EXCLUSIONS. Certain expenses that You or Your Covered Dependents may incur for vision care do not qualify as Covered Expenses under the Policy. The Policy does not cover the following:

1. orthoptic or vision training and any associated supplemental testing;
2. plano lenses;
3. lens coating;
4. two pair of glasses, in lieu of bifocals or trifocals;
5. medical or surgical treatment of the eyes;
6. any type of corrective vision surgery, including LASIK surgery;
7. any eye examination, or any corrective eyewear, required by an employer as a condition of employment;
8. any services or supplies when paid under any Worker’s Compensation or similar law;
9. no-line bifocal or progressive lenses;
10. photochromic, transition, or polycarbonate lenses;
11. lenticular lenses;
12. sub-normal vision aids or non-prescription lenses;
13. services rendered or supplies purchased outside the U.S. or Canada, unless the Insured Person resides in the U.S. or Canada and the charges are incurred while on a business or pleasure trip;
14. eyeglasses when the change in prescription is less than .5 Diopter;
15. non-conventional treatment or device;
16. eyeglass lens treatments, including “add-ons”, UV coating, anti-reflective coating, scratch resistant coating, tinting, edge polishing
17. oversized lenses;
18. high index lenses of any material type;
19. fitting for contact lenses;
20. follow-up visits;
21. frames for corrective spectacle lenses; or
22. charges incurred after the Policy has terminated or coverage has ended.

LIMITATIONS
Covered Expenses for services and supplies will be limited to once every 12 months from the last date of service.

5. RENEWAL CONDITIONS. The Policy is not guaranteed renewable; however, it is 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. The amount of premium for the Policy may change by reason of an increase in the age of an Insured Person.

6. PREMIUMS. Premiums are payable to the Company at our Administrative office. The Company reserves the right to change the table of premiums on a class basis, becoming due under the Policy at any time provided 45 days advance written notice is given.

Premium Due (at time of application) $ _____________________
DENTAL INSURANCE POLICY
OUTLINE OF COVERAGE FOR POLICY FORM CH-26099-IP (11/09) WA

A. 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!

B. Dental Insurance Policy – This plan is designed to provide limited dental expense coverage based on American Dental Association Codes (ADA Codes), up to the scheduled amounts shown in the POLICY SCHEDULE / SCHEDULE OF BENEFITS.

C. Schedule of Benefits - Benefits are payable under the Policy for the Covered Expenses listed in the POLICY SCHEDULE / SCHEDULE OF BENEFITS.

DEDUCTIBLE: None

COVERED EXPENSES: Includes coverage for the preventive and diagnostic dental benefits outlined in the POLICY SCHEDULE / SCHEDULE OF BENEFITS. Benefits are based on ADA code, and unless otherwise noted, are subject to the scheduled benefit amounts, Deductible, Limitations and/or Waiting Periods as shown in the POLICY SCHEDULE / SCHEDULE OF BENEFITS.

LIMITATIONS: Certain ADA Codes are subject to a limitation, as shown in the POLICY SCHEDULE / SCHEDULE OF BENEFITS

WAITING PERIODS: None

D. BENEFITS - Benefits are payable under the Policy for the Covered Expenses listed in the POLICY SCHEDULE / SCHEDULE OF BENEFITS that are received by an Insured Person. Unless otherwise stated herein, all benefits are subject to:

1. the scheduled benefit amount shown in the POLICY SCHEDULE / SCHEDULE OF BENEFITS. If the actual charge is less than the scheduled benefit amount, then the actual charge for the procedure or service will be paid;
2. any benefit or Lifetime Maximums shown in the POLICY SCHEDULE / SCHEDULE OF BENEFITS;
3. the LIMITATIONS AND EXCLUSIONS; and
4. all other provisions of the Policy.

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

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

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

CH-26099-IP (11/09) OC WA  Bronze
Alternate Treatment

If more than one type of service can be used to treat a condition, We have the right to base benefits on the least expensive service which is within the range of professionally adequate standards of dental practice. In the case of bilateral multiple adjacent missing teeth, the benefit amount will be based on a removable partial denture.

E. LIMITATIONS AND EXCLUSIONS - We will not provide any benefits for any loss caused by or resulting from:

1. any portion of a charge for any service not listed as a Covered Expense in the POLICY SCHEDULE / SCHEDULE OF BENEFITS;
2. care, treatment, services or supplies that exceed the scheduled benefit amount;
3. treatment of disturbances of the temporomandibular joint (TMJ);
4. a service not furnished by a Dentist, unless by a dental hygienist or denturist under the Dentist's supervision and x-rays are ordered by the Dentist;
5. cosmetic procedures, unless due to an injury or for congenital or developmental malformation. Facing on crowns, or pontics, posterior to the second bicuspid is considered cosmetic;
6. the replacement of full and partial dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function;
7. implants; replacement of lost or stolen appliances; replacement of orthodontic retainers; athletic mouthguards; precision or semi-precision attachments; denture duplication; or splinting;
8. plaque control; completion of claim forms; broken appointments; prescription or take-home fluoride; or diagnostic photographs;
9. replacement of any prosthetic appliance, crown, inlay, or onlay restoration, or fixed bridge within 5 years of the date of the last replacement, unless due to an injury;
10. an initial placement of a partial or full removable denture or fixed bridgework if it involves the replacement of one or more natural teeth lost before coverage was effective under the Policy. This limitation does not apply if replacement includes a natural tooth extracted while covered under the Policy;
11. services not completed by the end of the month in which coverage terminates;
12. procedures that are begun, but not completed;
13. those services for which there would be no charge in the absence of insurance or for any service or treatment provided without charge;
14. services in connection with war or any act of war, whether declared or undeclared, or condition contracted or accident occurring while on full-time active duty in the armed forces of any country or combination of countries;
15. care or treatment of a condition for which benefits are payable under any Workers’ Compensation Act or similar law;
16. orthodontic procedures; or
17. Covered Expenses for which an Insured Person is not legally obligated to pay.

F. RENEWABILITY - The Policy is not guaranteed renewable; however, it is 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. On each anniversary of the Policy Date, the premium for the Policy may change in amount by reason of an increase in the age of an Insured Person.
G. **PREMIUMS** - We reserve the right to change the table of premiums, on a Class Basis, becoming due under the Policy at any time and from time to time; provided, We have given the Insured Person written notice of at least 31 days prior to the effective date of the new rates. Such change will be on a Class Basis. The premium for the Policy may change in amount by reason of an increase in the Attained Age of the Insured Person.

<table>
<thead>
<tr>
<th>Mode of Payment</th>
<th>Initial Premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly (Bank Draft)</td>
<td>$_______________</td>
</tr>
<tr>
<td>Quarterly</td>
<td>$_______________</td>
</tr>
<tr>
<td>Semiannually</td>
<td>$_______________</td>
</tr>
<tr>
<td>Annually</td>
<td>$_______________</td>
</tr>
</tbody>
</table>

TOTAL $_______________

H. **GRACE PERIOD** - There is a grace period of 31 days for the payment of any premiums due, except the first. At the end of the 31 day grace period, We may cancel the Policy without further notice. During the grace period, the contract will remain in force; however, the Company is not obligated to pay any claims incurred by Insured Persons during the grace period, unless and until the premium due is received during the grace period.

CH-26099-IP (11/09) OC WA  Bronze
DENTAL INSURANCE POLICY
OUTLINE OF COVERAGE FOR POLICY FORM CH-26099-IP (11/09) WA

A. 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!

B. Dental Insurance Policy – This plan is designed to provide limited dental expense coverage based on American Dental Association Codes (ADA Codes), up to the scheduled amounts shown in the POLICY SCHEDULE / SCHEDULE OF BENEFITS.

C. Schedule of Benefits - Benefits are payable under the Policy for the Covered Expenses listed in the POLICY SCHEDULE / SCHEDULE OF BENEFITS.

ANNUAL DEDUCTIBLE: $100 per Insured Person
Deductible does not apply to Diagnostic Evaluation, Diagnostic X-Ray, Diagnostic Services or Preventive/Prophy Services

ANNUAL BENEFIT MAXIMUM: $1,000 per Insured Person

COVERED EXPENSES: Includes coverage for preventive, diagnostic, restorative and major procedure dental benefits outlined in the POLICY SCHEDULE / SCHEDULE OF BENEFITS. Benefits are based on ADA code, and unless otherwise noted, are subject to the scheduled benefit amounts, Deductible, Limitations and/or Waiting Periods as shown in the POLICY SCHEDULE / SCHEDULE OF BENEFITS.

LIMITATIONS: Certain ADA Codes are subject to a limitation, as shown in the POLICY SCHEDULE / SCHEDULE OF BENEFITS

WAITING PERIODS: Certain ADA Codes are subject to a Waiting Period, as shown in the POLICY SCHEDULE / SCHEDULE OF BENEFITS
D. **BENEFITS** - Benefits are payable under the Policy for the Covered Expenses listed in the POLICY SCHEDULE / SCHEDULE OF BENEFITS that are received by an Insured Person. Unless otherwise stated herein, all benefits are subject to:

1. the scheduled benefit amount shown in the POLICY SCHEDULE / SCHEDULE OF BENEFITS. If the actual charge is less than the scheduled benefit amount, then the actual charge for the procedure or service will be paid;
2. the Deductibles shown in the POLICY SCHEDULE / SCHEDULE OF BENEFITS;
3. any benefit or Lifetime Maximums shown in the POLICY SCHEDULE / SCHEDULE OF BENEFITS;
4. the LIMITATIONS AND EXCLUSIONS; and
5. all other provisions of the Policy.

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

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

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

A Covered Expense is considered to be incurred on the following dates:

1. full and partial dentures – on the date the final impression is taken;
2. fixed bridges, crowns, inlays and onlays – on the date the teeth are first prepared;
3. root canal therapy – on the date the pulp chamber is opened;
4. periodontal surgery – on the date surgery is performed; or
5. all other services – on the date the service is performed.

**Alternate Treatment**

If more than one type of service can be used to treat a condition, We have the right to base benefits on the least expensive service which is within the range of professionally adequate standards of dental practice. In the case of bilateral multiple adjacent missing teeth, the benefit amount will be based on a removable partial denture.

E. **LIMITATIONS AND EXCLUSIONS** - We will not provide any benefits for any loss caused by or resulting from:

1. any portion of a charge for any service not listed as a Covered Expense in the POLICY SCHEDULE / SCHEDULE OF BENEFITS;
2. care, treatment, services or supplies that exceed the scheduled benefit amount;
3. treatment of disturbances of the temporomandibular joint (TMJ);
4. a service not furnished by a Dentist, unless by a dental hygienist or denturist under the Dentist’s supervision and x-rays are ordered by the Dentist;
5. cosmetic procedures, unless due to an injury or for congenital or developmental malformation. Facing on crowns, or pontics, posterior to the second bicuspid is considered cosmetic;
6. the replacement of full and partial dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function;
7. implants; replacement of lost or stolen appliances; replacement of orthodontic retainers; athletic mouthguards; precision or semi-precision attachments; denture duplication; or splinting;
8. plaque control; completion of claim forms; broken appointments; prescription or take-home fluoride; or diagnostic photographs;
9. replacement of any prosthetic appliance, crown, inlay, or onlay restoration, or fixed bridge within 5 years of the date of the last replacement, unless due to an injury;
10. an initial placement of a partial or full removable denture or fixed bridgework if it involves the replacement of one or more natural teeth lost before coverage was effective under the Policy. This limitation does not apply if replacement includes a natural tooth extracted while covered under the Policy;
11. services not completed by the end of the month in which coverage terminates;
12. procedures that are begun, but not completed;
13. those services for which there would be no charge in the absence of insurance or for any service or treatment provided without charge;
14. services in connection with war or any act of war, whether declared or undeclared, or condition contracted or accident occurring while on full-time active duty in the armed forces of any country or combination of countries;
15. care or treatment of a condition for which benefits are payable under any Workers’ Compensation Act or similar law;
16. charges that are applied toward the satisfaction of a Deductible, if any;
17. orthodontic procedures; or
18. Covered Expenses for which an Insured Person is not legally obligated to pay.

F. RENEWABILITY - The Policy is not guaranteed renewable; however, it is 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. On each anniversary of the Policy Date, the premium for the Policy may change in amount by reason of an increase in the age of an Insured Person.

G. PREMIUMS - We reserve the right to change the table of premiums, on a Class Basis, becoming due under the Policy at any time and from time to time; provided, We have given the Insured Person written notice of at least 31 days prior to the effective date of the new rates. Such change will be on a Class Basis. The premium for the Policy may change in amount by reason of an increase in the Attained Age of the Insured Person.

Premiums - based on the mode of payment, checked below, the initial premiums are as follows:

- Monthly (Bank Draft)
- Quarterly
- Semiannually
- Annually

Policy CH-26099-IP (11/09) WA, described above

<table>
<thead>
<tr>
<th>Payment Mode</th>
<th>Initial Premium</th>
</tr>
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| TOTAL | $______________ |

H. GRACE PERIOD - There is a grace period of 31 days for the payment of any premiums due, except the first. At the end of the 31 day grace period, We may cancel the Policy without further notice. During the grace period, the contract will remain in force; however, the Company is not obligated to pay any claims incurred by Insured Persons during the grace period, unless and until the premium due is received during the grace period.
DENTAL INSURANCE POLICY
OUTLINE OF COVERAGE FOR POLICY FORM CH-26099-IP (11/09) WA

A. 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!

B. Dental Insurance Policy – This plan is designed to provide limited dental expense coverage based on American Dental Association Codes (ADA Codes), up to the scheduled amounts shown in the POLICY SCHEDULE / SCHEDULE OF BENEFITS.

C. Schedule of Benefits - Benefits are payable under the Policy for the Covered Expenses listed in the POLICY SCHEDULE / SCHEDULE OF BENEFITS.

LIFETIME DEDUCTIBLE: $100 per Insured Person
Deductible does not apply to Diagnostic Evaluation, Diagnostic X-Ray, Diagnostic Services or Preventive/Prophy Services

ANNUAL BENEFIT MAXIMUM: $1,200 per Insured Person
(Excludes Orthodontics)

MONTHLY ORTHODONTICS BENEFIT MAXIMUM: $50 per Insured Person
(Counts toward Orthodontics Lifetime Maximum)

ORTHODONTICS LIFETIME MAXIMUM: $1,200 per Insured Person

COVERED EXPENSES: Includes coverage for preventive, diagnostic, restorative, major procedure and orthodontic dental benefits outlined in the POLICY SCHEDULE / SCHEDULE OF BENEFITS. Benefits are based on ADA code, and unless otherwise noted, are subject to the scheduled benefit amounts, Deductible, Limitations and/or Waiting Periods as shown in the POLICY SCHEDULE / SCHEDULE OF BENEFITS.

LIMITATIONS: Certain ADA Codes are subject to a limitation, as shown in the POLICY SCHEDULE / SCHEDULE OF BENEFITS

WAITING PERIODS: Certain ADA Codes are subject to a Waiting Period, as shown in the POLICY SCHEDULE / SCHEDULE OF BENEFITS

CH-26099-IP (11/09) OC WA Gold
D. BENEFITS - Benefits are payable under the Policy for the Covered Expenses listed in the POLICY SCHEDULE / SCHEDULE OF BENEFITS that are received by an Insured Person. Unless otherwise stated herein, all benefits are subject to:

1. the scheduled benefit amount shown in the POLICY SCHEDULE / SCHEDULE OF BENEFITS. If the actual charge is less than the scheduled benefit amount, then the actual charge for the procedure or service will be paid;
2. the Deductibles shown in the POLICY SCHEDULE / SCHEDULE OF BENEFITS;
3. any benefit or Lifetime Maximums shown in the POLICY SCHEDULE / SCHEDULE OF BENEFITS;
4. the LIMITATIONS AND EXCLUSIONS; and
5. all other provisions of the Policy.

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

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

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

A Covered Expense is considered to be incurred on the following dates:

1. full and partial dentures – on the date the final impression is taken;
2. fixed bridges, crowns, inlays and onlays – on the date the teeth are first prepared;
3. root canal therapy – on the date the pulp chamber is opened;
4. periodontal surgery – on the date surgery is performed; or
5. all other services – on the date the service is performed.

Alternate Treatment

If more than one type of service can be used to treat a condition, We have the right to base benefits on the least expensive service which is within the range of professionally adequate standards of dental practice. In the case of bilateral multiple adjacent missing teeth, the benefit amount will be based on a removable partial denture.

E. LIMITATIONS AND EXCLUSIONS - We will not provide any benefits for any loss caused by or resulting from:

1. any portion of a charge for any service not listed as a Covered Expense in the POLICY SCHEDULE / SCHEDULE OF BENEFITS;
2. care, treatment, services or supplies that exceed the scheduled benefit amount;
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