

Dental PPO

Coverage to help you
keep smiling



Accident



Disability



Dental



Critical Illness



Vision

SureBridgeSM offers PPO dental plans that complement most health insurance plans and provide a range of covered services and savings that are designed to fit your specific budget and needs.

SureBridge dental plans offer coverage options for preventive/diagnostic, basic and major restorative services through Careington's Maximum Care Network of 135,000 providers. By using these providers, you can also save an additional 5% to 20% on orthodontic and cosmetic procedures.

SureBridge Dental insurance plans:

- Provide customizable protection for you and your family to fit any budget
- Complement your existing health insurance plan
- Give you access to additional savings through in-network providers

Contact your local agent or visit SureBridgeinsurance.com to learn more about how you can customize or combine multiple plans to fit your specific budget and needs.

Dental PPO

Benefits*	Premiere	Basic
Overview		
• Calendar year Deductible	\$50/ basic and major 3 max per family	\$100/ basic 3 max per family
• Calendar year Maximum	\$1,200/person \$6,000/family	\$1,000/person \$5,000/family
Preventive	100% No waiting period	100% No waiting period
Basic	80% 6 month waiting period	50% 6 month waiting period
Major	60% 12 month waiting period	Careington Discount [†]
Orthodontia	Careington Discount [†]	Careington Discount [†]

*Certain services include limitations. Benefits are reduced for non-network providers. See plan for details.

[†] Services are provided through discount program only and not insurance. This program provides discounts only at certain contracted providers. You are obligated to pay all fees at the time of service, but will receive a discount from those providers who have contracted with Careington. The program does not make payments directly to the providers of dental services.

SureBridge is a brand name used for supplemental insurance products underwritten, and administered, by The Chesapeake Life Insurance Company. The administrative offices of The Chesapeake Life Insurance Company are located in North Richland Hills, TX. Insurance product availability may vary by state. For premium costs and further details of the coverage, including exclusions, any reductions or limitations and the terms under which the Policy may be continued in force, please contact your licensed insurance agent/producer. © 2011 The Chesapeake Life Insurance Company.

CH-26121-IP (04/11), or its state variation.
SB/000019 Exp. 08/12

THE CHESAPEAKE LIFE INSURANCE COMPANY®

A Stock Company

(Hereinafter called: the Company, We, Our or Us)

Home Office: Oklahoma City, Oklahoma

Administrative Office: P.O. Box 982010

North Richland Hills, Texas 76182-8010

Customer Service: 1-800-815-8535

DENTAL INSURANCE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY OUTLINE OF COVERAGE FOR POLICY FORM CH-26121-IP (04/11) (B) OR

- 1. READ YOUR POLICY CAREFULLY:** This Outline of Coverage provides a very brief description of the important features of Your Policy. This is not the insurance contract, and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both You and Us. It is, therefore, important that You READ YOUR POLICY CAREFULLY!
- 2. DENTAL INSURANCE POLICY** – The Policy is intended to provide benefits for Type I and II dental services and procedures when received by an Insured Person. Unless otherwise stated within the Policy, all benefits are subject to the Waiting Period, if any, Deductible, if any, Benefit Maximum, Limitations & Exclusions, and all other provisions of the Policy.
- 3. SCHEDULE OF BENEFITS** – Benefits are payable under the Policy as follows:

WAITING PERIODS:

TYPE I Covered Expenses

No Waiting Period

TYPE II Covered Expenses

6 Month Waiting Period

DEDUCTIBLE, PER INSURED PERSON, PER CALENDAR YEAR:

TYPE I Covered Expenses

None

TYPE II Covered Expenses

\$100

Deductible Family Limit:

3 Per Family each Calendar Year

CALENDAR YEAR BENEFIT MAXIMUM, PER INSURED PERSON:

TYPE I and II Covered Expenses

\$1,000

CALENDAR YEAR BENEFIT MAXIMUM, PER FAMILY:

TYPE I and II Covered Expenses

\$5,000

BENEFITS

TYPE I COVERED EXPENSES:

(Includes the Preventive and Diagnostic Services as shown in the Policy. Certain services/procedures are subject to limitations.)

Coinurance

Network Provider

Non-Network Provider

100%

80%

TYPE II COVERED EXPENSES:

(Includes the Preventive, Diagnostic, Restorative, and Adjunctive Services as shown in the Policy. Certain services/procedures are subject to limitations)

Coinurance

Network Provider

Non-Network Provider

50%

50%

- 4. BENEFITS** – Benefits are payable under the Policy for Type I and II dental procedures when received by an Insured Person. Unless otherwise stated in the Policy, all benefits are subject to:
1. The Waiting Period shown in the POLICY SCHEDULE (if any);
 2. The Deductible shown in the POLICY SCHEDULE (if any);
 3. Any Benefit Maximums shown in the POLICY SCHEDULE;
 4. The LIMITATIONS AND EXCLUSIONS; and
 5. All other provisions of the Policy.

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

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

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

A Covered Expense is considered to be incurred on the date the service is performed.

- 5. PREFERRED PROVIDER ORGANIZATION (PPO) - To minimize out-of-pocket costs, it is important that the Insured Person receives services from a Network Provider.**

Network Providers and Non-Network Providers. The Policy provides benefits for Covered Expenses obtained from both Network Providers and Non-Network Providers.

Using a Network Provider May Lower Costs. If an Insured Person uses the services of a Non-Network Provider, the Coinsurance amount may be less than that which would have otherwise been considered for Covered Expenses received from a Network Provider. Covered Expenses rendered by a Non-Network Provider may cost the Insured Person more than Covered Expenses rendered by a Network Provider. Covered Expenses for a Non-Network Provider's services may be substantially lower than the actual charges. The Insured Person's responsibility includes the portion of the expense not payable under the Policy, plus all of the Non-Network Provider's charges that exceed the Covered Expense.

- 6. EXCLUSIONS & LIMITATIONS – We will not provide any benefits for charges arising directly or indirectly, in whole or in part, from:**

1. Treatment, care, services or supplies for which benefits are not specifically provided for in the Policy;
2. Charges exceeding the Maximum Benefit Amount, if any;
3. Attempted suicide or any intentionally self-inflicted injury;
4. Directly or indirectly engaging in illegal activity;
5. Treatment of disturbances of the temporomandibular joint (TMJ);
6. A service not furnished by a Dentist, UNLESS by a dental hygienist under the Dentist's supervision and x-rays are ordered by the Dentist;
7. Cosmetic procedures;
8. Plaque control; completion of claim forms; broken appointments; prescription or take-home fluoride; or diagnostic photographs;
9. Oral/facial images, including intra- and extra-oral images;
10. Pulp vitality tests;
11. Chairside, labial veneers (laminates);
12. Regional block anesthesia;
13. Hospital, house, or extended care facility calls;
14. Office visits for the purpose of observation, during or after regularly scheduled hours;
15. Office visits outside of regularly scheduled hours;
16. Enamel microabrasions;
17. Services not completed by the end of the month in which coverage terminates;
18. Procedures that are begun, but not completed;
19. Those services for which there would be no charge in the absence of insurance or for any service or treatment provided without charge;
20. Services in connection with war or any act of war, whether declared or undeclared, or condition contracted or accident occurring while on full-time active duty in the armed forces of any country or combination of countries;
21. Care or treatment of a condition for which benefits are payable under any Workers' Compensation Act or similar law;
22. Orthodontic procedures;

23. Covered Expenses for which an Insured Person is not legally obligated to pay; or
24. Experimental/Investigational treatment.

- 7. RENEWABILITY** – The Policy is guaranteed renewable to age 65, subject to the Company's right to discontinue or terminate the coverage as provided in the TERMINATION OF COVERAGE section of the Policy. Subject to prior approval by the Oregon Insurance Division, the Company reserves the right to change the applicable table of premium rates on a Class Basis.
- 8. BEGINNING OF COVERAGE** - Once We have approved Your application based upon the information You provided therein, the Effective Date of Coverage for You and those Eligible Dependents listed in the application and accepted by Us will be the POLICY DATE shown in the POLICY SCHEDULE.
- 9. TERMINATION OF COVERAGE –**

You

Your coverage will terminate and no further benefits will be payable under the Policy and any attached Riders, if any:

1. at the end of the period for which premium has been paid;
2. if Your mode of premium is monthly, at the end of the period through which premium has been paid following Our receipt of Your request of termination;
3. if Your mode of premium is other than monthly, upon the next monthly anniversary day following Our receipt of Your request of termination. Premium will be refunded for any amounts paid beyond the termination date;
4. on the date of fraud or misrepresentation by You;
5. on the date We elect to discontinue this plan or type of coverage;
6. on the date We elect to discontinue all coverage in Your state;
7. on the date an Insured Person is no longer a permanent resident of the United States; or
8. on the date You reach age 65.

Covered Dependents

Your Covered Dependent's coverage will terminate under the Policy on:

1. the date Your coverage terminates, except as provided in the SPECIAL CONTINUATION FOR DEPENDENTS provision;
2. the date such dependent ceases to be an Eligible Dependent; or
3. the date We receive Your written request to terminate a Covered Dependent's coverage.

The attainment of the limiting age for an Eligible Dependent will not cause coverage to terminate while that person is and continues to be both:

1. incapable of self-sustaining employment by reason of mental or physical handicap; and
2. Chiefly Dependent on You for support and maintenance. For the purpose of this provision "Chiefly Dependent" means the Eligible Dependent receives the majority of his or her financial support from You.

We will require that You provide proof that the dependent is in fact a disabled and dependent person at least 31 days prior to the date upon which the dependent would otherwise reach the limiting age, and thereafter We may require such proof not more frequently than annually. In the absence of such proof We may terminate the coverage of such person after the attainment of the limiting age.

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

Premium Due (at time of application) \$ _____

THE CHESAPEAKE LIFE INSURANCE COMPANY®

A Stock Company

(Hereinafter called: the Company, We, Our or Us)

Home Office: Oklahoma City, Oklahoma

Administrative Office: P.O. Box 982010

North Richland Hills, Texas 76182-8010

Customer Service: 1-800-815-8535

DENTAL INSURANCE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY OUTLINE OF COVERAGE FOR POLICY FORM CH-26121-IP (04/11) (P) OR

- 1. READ YOUR POLICY CAREFULLY:** This Outline of Coverage provides a very brief description of the important features of Your Policy. This is not the insurance contract, and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both You and Us. It is, therefore, important that You READ YOUR POLICY CAREFULLY!
- 2. DENTAL INSURANCE POLICY** – The Policy is intended to provide benefits for Type I, II, and III dental services and procedures when received by an Insured Person. Unless otherwise stated within the Policy, all benefits are subject to the Waiting Period, if any, Deductible, if any, Benefit Maximum, Limitations & Exclusions, and all other provisions of the Policy.
- 3. SCHEDULE OF BENEFITS** – Benefits are payable under the Policy as follows:

WAITING PERIODS:

TYPE I Covered Expenses	No Waiting Period
TYPE II Covered Expenses	6 Month Waiting Period
TYPE III Covered Expenses	12 Month Waiting Period

DEDUCTIBLE, PER INSURED PERSON, PER CALENDAR YEAR:

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

CALENDAR YEAR BENEFIT MAXIMUM, PER INSURED PERSON:

TYPE I, II and III Covered Expenses	\$1,200
-------------------------------------	---------

CALENDAR YEAR BENEFIT MAXIMUM, PER FAMILY:

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

COVERED EXPENSES

TYPE I COVERED EXPENSES:

(Includes the Preventive and Diagnostic Services as shown in the Policy. Certain services/procedures are subject to limitations.)

Coinsurance	Network Provider	Non-Network Provider
	100%	80%

TYPE II COVERED EXPENSES:

(Includes the Preventive, Diagnostic, Restorative, and Adjunctive Services as shown in the Policy. Certain services/procedures are subject to limitations.)

Coinsurance	Network Provider	Non-Network Provider
	80%	60%

TYPE III COVERED EXPENSES:

(Includes the Restorative, Endodontics, Periodontics, Prosthodontics and Oral Surgery Services as shown in the Policy. Certain services/procedures are subject to limitations.)

Coinsurance

Network Provider

60%

Non-Network Provider

50%

- 4. BENEFITS** – Benefits are payable under the Policy for Type I, II, and III dental procedures when received by an Insured Person. Unless otherwise stated in the Policy, all benefits are subject to:
1. The Waiting Period shown in the POLICY SCHEDULE (if any);
 2. The Deductible shown in the POLICY SCHEDULE (if any);
 3. Any Benefit Maximums shown in the POLICY SCHEDULE;
 4. The LIMITATIONS AND EXCLUSIONS; and
 5. All other provisions of the Policy.

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

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

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

A Covered Expense is considered to be incurred on the date the service is performed unless otherwise stated below:

1. Full and partial dentures – on the date the final impression is taken;
2. Fixed bridges, crowns, inlays and onlays – on the date the teeth are first prepared;
3. Root canal therapy – on the date the pulp chamber is opened; or
4. Periodontal surgery – on the date surgery is performed.

- 5. PREFERRED PROVIDER ORGANIZATION (PPO) - To minimize out-of-pocket costs, it is important that the Insured Person receives services from a Network Provider.**

Network Providers and Non-Network Providers. The Policy provides benefits for Covered Expenses obtained from both Network Providers and Non-Network Providers.

Using a Network Provider May Lower Costs. If an Insured Person uses the services of a Non-Network Provider, the Coinsurance amount may be less than that which would have otherwise been considered for Covered Expenses received from a Network Provider. Covered Expenses rendered by a Non-Network Provider may cost the Insured Person more than Covered Expenses rendered by a Network Provider. Covered Expenses for a Non-Network Provider's services may be substantially lower than the actual charges. The Insured Person's responsibility includes the portion of the expense not payable under the Policy, plus all of the Non-Network Provider's charges that exceed the Covered Expense.

- 6. EXCLUSIONS & LIMITATIONS – We will not provide any benefits for charges arising directly or indirectly, in whole or in part, from:**

1. Treatment, care, services or supplies for which benefits are not specifically provided for in the Policy;
2. Charges exceeding the Maximum Benefit Amount, if any;
3. Attempted suicide or any intentionally self-inflicted injury;
4. Directly or indirectly engaging in illegal activity;
5. Treatment of disturbances of the temporomandibular joint (TMJ);
6. A service not furnished by a Dentist, UNLESS by a dental hygienist under the Dentist's supervision and x-rays are ordered by the Dentist;
7. Cosmetic procedures, UNLESS due to an injury or for congenital / developmental malformation. Facing on crowns, or pontics, posterior to the second bicuspid is considered cosmetic;
8. The replacement of full and partial dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function;
9. Implants; replacement of lost or stolen appliances; replacement of orthodontic retainers; athletic mouth-guards; precision or semi-precision attachments; denture duplication; or splinting;
10. Plaque control; completion of claim forms; broken appointments; prescription or take-home fluoride; or diagnostic photographs;
11. Replacement of any prosthetic appliance, crown, inlay, or onlay restoration, or fixed bridge within 5 years of the date of the last replacement, UNLESS due to an injury;

12. Oral/facial images, including intra- and extra-oral images;
13. Pulp vitality tests;
14. Post removals UNLESS in conjunction with endodontic therapy;
15. Chairside, labial veneers (laminates);
16. Intentional re-implantation, including necessary splinting;
17. Surgical procedure for isolation of tooth with rubber dam;
18. Canal preparation and fitting of performed dowel or post;
19. Regional block anesthesia;
20. Hospital, house, or extended care facility calls;
21. Office visits for the purpose of observation, during or after regularly scheduled hours;
22. Office visits outside of regularly scheduled hours;
23. Enamel microabrasions;
24. An initial placement of a partial or full removable denture or fixed bridgework if it involves the replacement of one or more natural teeth lost before coverage was effective under the Policy. This limitation does not apply if replacement includes a natural tooth extracted while covered under the Policy;
25. Services not completed by the end of the month in which coverage terminates;
26. Procedures that are begun, but not completed;
27. Those services for which there would be no charge in the absence of insurance or for any service or treatment provided without charge;
28. Services in connection with war or any act of war, whether declared or undeclared, or condition contracted or accident occurring while on full-time active duty in the armed forces of any country or combination of countries;
29. Care or treatment of a condition for which benefits are payable under any Workers' Compensation Act or similar law;
30. Orthodontic procedures;
31. Covered Expenses for which an Insured Person is not legally obligated to pay; or
32. Experimental/Investigational treatment.

Tooth Missing But Not Replaced Rule

Coverage for the first installation of removable dentures; fixed bridgework and other Type III Prosthetic or Prosthodontic services are subject to the requirements that such removable dentures; fixed bridgework and other prosthetic services are (1) needed to replace one or more natural teeth that were removed while the Policy was in force for the Insured Person; and (2) are not abutments to a partial denture; removable bridge; or fixed bridge installed during the prior 8 years.

7. **RENEWABILITY** – The Policy is guaranteed renewable to age 65, subject to the Company's right to discontinue or terminate the coverage as provided in the TERMINATION OF COVERAGE section of the Policy. Subject to prior approval by the Oregon Insurance Division, the Company reserves the right to change the applicable table of premium rates on a Class Basis.
8. **BEGINNING OF COVERAGE** - Once We have approved Your application based upon the information You provided therein, the Effective Date of Coverage for You and those Eligible Dependents listed in the application and accepted by Us will be the POLICY DATE shown in the POLICY SCHEDULE.
9. **TERMINATION OF COVERAGE –**

You

Your coverage will terminate and no further benefits will be payable under the Policy and any attached Riders, if any:

1. at the end of the period for which premium has been paid;
2. if Your mode of premium is monthly, at the end of the period through which premium has been paid following Our receipt of Your request of termination;
3. if Your mode of premium is other than monthly, upon the next monthly anniversary day following Our receipt of Your request of termination. Premium will be refunded for any amounts paid beyond the termination date;
4. on the date of fraud or misrepresentation by You;
5. on the date We elect to discontinue this plan or type of coverage;
6. on the date We elect to discontinue all coverage in Your state;
7. on the date an Insured Person is no longer a permanent resident of the United States; or
8. on the date You reach age 65.

Covered Dependents

Your Covered Dependent's coverage will terminate under the Policy on:

1. the date Your coverage terminates, except as provided in the SPECIAL CONTINUATION FOR DEPENDENTS provision;
2. the date such dependent ceases to be an Eligible Dependent; or
3. the date We receive Your written request to terminate a Covered Dependent's coverage.

The attainment of the limiting age for an Eligible Dependent will not cause coverage to terminate while that person is and continues to be both:

1. incapable of self-sustaining employment by reason of mental or physical handicap; and
2. Chiefly Dependent on You for support and maintenance. For the purpose of this provision "Chiefly Dependent" means the Eligible Dependent receives the majority of his or her financial support from You.

We will require that You provide proof that the dependent is in fact a disabled and dependent person at least 31 days prior to the date upon which the dependent would otherwise reach the limiting age, and thereafter We may require such proof not more frequently than annually. In the absence of such proof We may terminate the coverage of such person after the attainment of the limiting age.

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

Premium Due (at time of application) \$ _____