

State: Arkansas **Filing Company:** TruAssure Insurance Company
TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental
Product Name: TruAssure - Dental PPO
Project Name/Number: TruAssure - Dental PPO/TruAssure - Dental PPO-1

Filing at a Glance

Company: TruAssure Insurance Company
Product Name: TruAssure - Dental PPO
State: Arkansas
TOI: H10I Individual Health - Dental
Sub-TOI: H10I.000 Health - Dental
Filing Type: Form/Rate
Date Submitted: 12/11/2012
SERFF Tr Num: MLLM-128748425
SERFF Status: Closed-Approved
State Tr Num:
State Status: Approved-Closed
Co Tr Num: TRUA-0167DDI01-01

Implementation: On Approval
Date Requested:
Author(s): Hazel Delane
Reviewer(s): Donna Lambert (primary)
Disposition Date: 12/28/2012
Disposition Status: Approved
Implementation Date:

State Filing Description:

State: Arkansas **Filing Company:** TruAssure Insurance Company
TOI/Sub-TOI: H101 Individual Health - Dental/H101.000 Health - Dental
Product Name: TruAssure - Dental PPO
Project Name/Number: TruAssure - Dental PPO/TruAssure - Dental PPO-1

General Information

Project Name: TruAssure - Dental PPO	Status of Filing in Domicile: Pending
Project Number: TruAssure - Dental PPO-1	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: The forms are being filed simultaneously in the Company's state of domicile, Illinois,
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 12/28/2012
	State Status Changed: 12/28/2012
Deemer Date:	Created By: Hazel Delane
Submitted By: Hazel Delane	Corresponding Filing Tracking Number: TRUA-0167DDI01-01

Filing Description:
 Re: TruAssure Insurance Company
 NAIC No.: 92525 -----FEIN No.: 36-3757528

Individual Dental Insurance Forms Filing

Form:-----Description:

TruA-1000-AR-----Individual Dental Preferred Provider Organization (PPO)

----- Policy

TruA-1000-PS-Plan1----- Policy Schedule

TruA-1000-PS-Plan2----- Policy Schedule

TruA-1000-PS-Plan3----- Policy Schedule

TruA-1000-PS-Plan4----- Policy Schedule

TruA-1000-PS-Plan5----- Policy Schedule

TruA-1000-SODB-Plan1----- Schedule of Dental Benefits

TruA-1000-SODB-Plan2----- Schedule of Dental Benefits

TruA-1000-SODB-Plan3----- Schedule of Dental Benefits

TruA-1000-SODB-Plan4----- Schedule of Dental Benefits

TruA-1000-SODB-Plan5----- Schedule of Dental Benefits

TruA-1000-App-AR----- Application for Individual Dental PPO Policy

TruA-1000-App-1-AR----- Application for Individual Dental PPO Policy

TruA-1000-App-2-AR----- Application for Individual Dental PPO Policy

TruA-1000-Amend----- Policy Amendment

TruA-1000-OOC----- Dental Only Coverage Outline of Coverage

Dear Sir or Madam:

Milliman, Inc. is submitting the above-referenced forms filing for review and approval on behalf of TruAssure Insurance Company ("the Company"). A letter from the Company authorizing Milliman, Inc. to conduct this filing is included with this submission.

The forms are new and do not replace any previously submitted or approved forms.

The forms are being filed on a general use basis. The forms will be sold in the individual voluntary worksite market and in the individual market on a direct-response basis.

State: Arkansas **Filing Company:** TruAssure Insurance Company
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The Company's state of domicile is Illinois and the forms are also being filed in Illinois.

The forms contain no unusual or controversial features or language that deviate from normal insurance industry standards. The forms have been submitted in "John Doe" fashion and variable data have been duly bracketed. A Statement of Variability is enclosed.

The forms are submitted in final printed format except for slight font and formatting variations that may occur due to the Company's production printers. Further, the Company reserves the right to change colors, font and format of the forms; however, such font changes will never be less than 10-point type.

Form TruA-1000-AR, Individual Dental Preferred Provider Organization (PPO) Policy:

Form TruA-1000-AR is a limited scope preferred provider organization (PPO) dental insurance policy. The policy is guaranteed renewable. Five dental benefit plans are offered under the policy (i.e., Plans 1 through 5); however, only the dental benefit plan elected by the policyholder will be included in the policy when it is issued to the policyholder. (Only one dental plan will be included in the issued policy.) The benefit plans are shown in the Policy Schedule and the Schedule of Dental Benefits forms which are included in this filing and are described below in this Filing Description. The benefit plans offered are as follows:

1. Plans 1, 2 and 3: These plans provides benefits for diagnostic/preventive services, basic services and major services at different benefit levels, as shown in the Policy Schedule forms and the actuarial memorandum.
2. Plan 4: This plan only provides benefits for diagnostic/preventive services.
3. Plan 5: This plan provides benefits for diagnostic/preventive services, basic services and major services. This plan only covers the policyholder's dependent children age 0 to 19.

There are no issue age limits on this policy form, except for Plan 5, a pediatric plan which is available only to dependent children age 0 to 19.

Form TruA-1000-PS-Plan1, Policy Schedule:

Form TruA-1000-PS-Plan1 is the Policy Schedule for Plan 1 dental benefits. The form will be issued with policy form TruA-1000-AR when dental benefit Plan 1 is elected by the policyholder.

Form TruA-1000-PS-Plan2, Policy Schedule:

Form TruA-1000-PS-Plan2 is the Policy Schedule for Plan 2 dental benefits. The form will be issued with policy form TruA-1000-AR when dental benefit Plan 2 is elected by the policyholder

Form TruA-1000-PS-Plan3, Policy Schedule:

Form TruA-1000-PS-Plan3 is the Policy Schedule for Plan 3 dental benefits. The form will be issued with policy form TruA-1000-AR when dental benefit Plan 3 is elected by the policyholder

Form TruA-1000-PS-Plan4, Policy Schedule:

Form TruA-1000-PS-Plan4 is the Policy Schedule for Plan 4 dental benefits. The form will be issued with policy form TruA-1000-AR when dental benefit Plan 4 is elected by the policyholder.

Form TruA-1000-PS-Plan5, Policy Schedule:

Form TruA-1000-PS-Plan5 is the Policy Schedule for Plan 5 dental benefits. The form will be issued with policy form TruA-1000-AR when dental benefit Plan 5 is elected by the policyholder.

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Form TruA-1000-SODB-Plan1, Schedule of Dental Benefits:

Form TruA-1000-SODB-Plan1 is the schedule of dental benefits for Plan 1 dental benefits. The form will be included when Policy Schedule form TruA-1000-PS-Plan1 is issued in policy form TruA-1000-AR.

Form TruA-1000-SODB-Plan2, Schedule of Dental Benefits:

Form TruA-1000-SODB-Plan2 is the schedule of dental benefits for Plan 2 dental benefits. The form will be included when Policy Schedule form TruA-1000-PS-Plan2 is issued in policy form TruA-1000-AR.

Form TruA-1000-SODB-Plan3, Schedule of Dental Benefits:

Form TruA-1000-SODB-Plan3 is the schedule of dental benefits for Plan 3 dental benefits. The form will be included when Policy Schedule form TruA-1000-PS-Plan3 is issued in policy form TruA-1000-AR.

Form TruA-1000-SODB-Plan4, Schedule of Dental Benefits:

Form TruA-1000-SODB-Plan4 is the schedule of dental benefits for Plan 4 dental benefits. The form will be included when Policy Schedule form TruA-1000-PS-Plan4 is issued in policy form TruA-1000-AR.

Form TruA-1000-SODB-Plan5, Schedule of Dental Benefits:

Form TruA-1000-SODB-Plan5 is the schedule of dental benefits for Plan 5 dental benefits. The form will be included when Policy Schedule form TruA-1000-PS-Plan5 is issued in policy form TruA-1000-AR.

Form TruA-1000-App-AR, Application for Individual Dental PPO Policy:

Form TruA-1000-App-AR is the application form that will be used with policy form TruA-1000-AR when an agent is used in the sale. The application form will be used via paper or electronically. The electronic and paper version of the application will be the same form with the same text.

Form TruA-1000-App-1-AR, Application for Individual Dental PPO Policy:

Form TruA-1000-App-1-AR is the application form that will be used with policy form TruA-1000-AR for direct response marketing sales. The application form will be used via paper and electronically. The applicant can complete the application and mail it to the Company.

Form TruA-1000-App-2-AR, Application for Individual Dental PPO Policy:

Form TruA-1000-App-2-AR is the electronic application form that will be used with policy form TruA-1000-AR for direct response marketing sales. The application form will be accessible, completed, and submitted via the Company's website. The electronic signature certification is included in the electronic application form. Some Information in this electronic application form will be provided in "drop-down boxes" to allow ease in completion of the form by the applicant; please refer to Statement of Variability for the information.

TruA-1000-Amend, Policy Amendment:

Form TruA-1000-Amend is the form that will be used to amend policy form TruA-1000-AR. Form TruA-1000-Amend will only be used to change variable text that is specified in the Statement of Variability. The form will not be used to revise non-variable text contained in the subject forms.

TruA-1000-OOC, Dental Only Coverage Outline of Coverage:

Form TruA-1000-OOC is the outline of coverage form that will be used with policy form TruA-1000-AR. Form TruA-1000-OOC will be issued with the policy.

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Also, enclosed are the following items:

1. Actuarial Memorandum and Rates;
2. Certification of Compliance; and
3. Readability Certification.

The required filing fees for the this filing are being paid via EFT with this filing submission.

To the best of our knowledge, this filing is complete and intended to comply with the insurance laws of your jurisdiction.

We appreciate your time and consideration with regard to this filing. Should you have any questions regarding this filing, or require any additional information, please direct all correspondence and questions to my attention. My direct telephone number is 312/499-5728.

Sincerely,

Hazel J. Delane
 Compliance Consultant
 Milliman, Inc.

Company and Contact

Filing Contact Information

Hazel Delane, Compliance Consultant	Hazel.Delane@Milliman.com
2 Conway Park, Ste. 180	312-499-5728 [Phone]
150 Field Drive	847-604-8671 [FAX]
Lake Forest, IL 60045	

Filing Company Information

(This filing was made by a third party - MUSA01)

TruAssure Insurance Company	CoCode: 92525	State of Domicile: Illinois
111 Shuman Boulevard	Group Code:	Company Type: Health
Naperville, IL 60563	Group Name:	Insurance Company
(800) 414-4988 ext. [Phone]	FEIN Number: 36-3757528	State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	\$800.00
Retaliatory?	Yes
Fee Explanation:	16 forms x \$50 = \$800
Per Company:	No

Company	Amount	Date Processed	Transaction #
TruAssure Insurance Company	\$800.00	12/11/2012	65643170

SERFF Tracking #:

MLLM-128748425

State Tracking #:**Company Tracking #:**

TRUA-0167DDI01-01

State:

Arkansas

Filing Company:

TruAssure Insurance Company

TOI/Sub-TOI:

H10I Individual Health - Dental/H10I.000 Health - Dental

Product Name:

TruAssure - Dental PPO

Project Name/Number:

TruAssure - Dental PPO/TruAssure - Dental PPO-1

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	12/28/2012	12/28/2012

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Donna Lambert	12/13/2012	12/13/2012

Response Letters

Responded By	Created On	Date Submitted
Hazel Delane	12/26/2012	12/26/2012

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	"John Doe" Forms	Hazel Delane	12/26/2012	12/26/2012

State: Arkansas
TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental
Product Name: TruAssure - Dental PPO
Project Name/Number: TruAssure - Dental PPO/TruAssure - Dental PPO-1

Filing Company: TruAssure Insurance Company

Disposition

Disposition Date: 12/28/2012

Implementation Date:

Status: Approved

Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
TruAssure Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification	Approved	No
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	Authorization Letter	Approved	Yes
Supporting Document	Statement of Variability	Approved	Yes
Supporting Document (revised)	"John Doe" Forms	Approved	Yes
Supporting Document	"John Doe" Forms	Replaced	Yes
Form (revised)	Individual Dental Preferred Provider Organization (PPO) Policy	Approved	Yes
Form	Individual Dental Preferred Provider Organization (PPO) Policy	Replaced	Yes
Form	TruA-1000-PS-Plan1	Approved	Yes
Form	TruA-1000-PS-Plan2	Approved	Yes

State: Arkansas
TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental
Product Name: TruAssure - Dental PPO
Project Name/Number: TruAssure - Dental PPO/TruAssure - Dental PPO-1

Filing Company: TruAssure Insurance Company

Schedule	Schedule Item	Schedule Item Status	Public Access
Form	TruA-1000-PS-Plan3	Approved	Yes
Form	TruA-1000-PS-Plan4	Approved	Yes
Form	TruA-1000-PS-Plan5	Approved	Yes
Form	TruA-1000-SODB-Plan1	Approved	Yes
Form	TruA-1000-SODB-Plan2	Approved	Yes
Form	TruA-1000-SODB-Plan3	Approved	Yes
Form	TruA-1000-SODB-Plan4	Approved	Yes
Form	TruA-1000-SODB-Plan5	Approved	Yes
Form (revised)	TruA-1000-App-AR	Approved	Yes
Form	TruA-1000-App-AR	Replaced	Yes
Form (revised)	TruA-1000-App-1-AR	Approved	Yes
Form	TruA-1000-App-1-AR	Replaced	Yes
Form (revised)	TruA-1000-App-2-AR	Approved	Yes
Form	TruA-1000-App-2-AR	Replaced	Yes
Form	TruA-1000-Amend	Approved	Yes
Form	TruA-1000-OOC	Approved	Yes
Form	TruA-1000-AR-CN	Approved	Yes
Rate	AR_Rate Sheet_Form Series TruA-1000_11-08-2012 subm	Approved	Yes

State: Arkansas **Filing Company:** TruAssure Insurance Company
TOI/Sub-TOI: H101 Individual Health - Dental/H101.000 Health - Dental
Product Name: TruAssure - Dental PPO
Project Name/Number: TruAssure - Dental PPO/TruAssure - Dental PPO-1

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	12/13/2012
Submitted Date	12/13/2012
Respond By Date	01/16/2012

Dear Hazel Delane,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

- Individual Dental Preferred Provider Organization (PPO) Policy, TruA-1000-AR (Form)

Comments: Page 37, Handicapped Child, A time limit cannot be placed on the notification to the insurer of a the existence of a Handicapped Child. Notification must be made, but it cannot include a time limit. Please remove the 31-day requirement, and see ACA. 23-86-108(4), Arkansas Bulletin 6-2010, and Bulletin 14-81.

Objection 2

- Individual Dental Preferred Provider Organization (PPO) Policy, TruA-1000-AR (Form)

Comments: Please revise the information required by Bulletin 15-2009 to more closely mirror the language contained in that Bulletin. The invitation to call the AID for more information is not sufficient.

Objection 3

- TruA-1000-App-AR, Individual Application for Dental PPO Policy (Form)
- TruA-1000-App-1-AR, Individual Application for Dental PPO Policy (Form)
- TruA-1000-App-2-AR, Individual Application for Dental PPO Policy (Form)

Comments: ACA 23-79-107, Statements as Representations. Please add this required provision.

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Donna Lambert

State: Arkansas
TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental
Product Name: TruAssure - Dental PPO
Project Name/Number: TruAssure - Dental PPO/TruAssure - Dental PPO-1

Filing Company: TruAssure Insurance Company

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	12/26/2012
Submitted Date	12/26/2012

Dear Donna Lambert,

Introduction:

This is in reference to your objection letter dated 12/13/2012.

Response 1

Comments:

To comply with Arkansas requirements, the definition of Handicapped Child has been revised to remove the notification time period.

Related Objection 1

Applies To:

- Individual Dental Preferred Provider Organization (PPO) Policy, TruA-1000-AR (Form)

Comments: Page 37, Handicapped Child, A time limit cannot be placed on the notification to the insurer of a the existence of a Handicapped Child. Notification must be made, but it cannot include a time limit. Please remove the 31-day requirement, and see ACA. 23-86-108(4), Arkansas Bulletin 6-2010, and Bulletin 14-81.

Changed Items:

No Supporting Documents changed.

State: Arkansas
TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental
Product Name: TruAssure - Dental PPO
Project Name/Number: TruAssure - Dental PPO/TruAssure - Dental PPO-1

Filing Company: TruAssure Insurance Company

Form Schedule Item Changes:

Form Schedule Item Changes								
Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Individual Dental Preferred Provider Organization (PPO) Policy	TruA-1000-AR	POL	Initial		54.600	TruA-1000-AR_Individual Dental Preferred Provider Organization_PPO_Policy_12-20-2012 subm.pdf	Date Submitted: 12/26/2012 By: Hazel Delane
<i>Previous Version</i>								
1	Individual Dental Preferred Provider Organization (PPO) Policy	TruA-1000-AR	POL	Initial		54.600	TruA-1000-AR_Individual Dental Preferred Provider Organization_PPO_Policy_12-03-2012 subm.pdf	Date Submitted: 12/11/2012 By: Hazel Delane

No Rate/Rule Schedule items changed.

Response 2

Comments:

To better comply with Bulletin 15 2009, we have removed the AID information from the cover page of form TruA-1000-AR and have placed the information in a separate form, TruA-1000-AR-CN. Therefore, we hereby submit form TruA-1000-AR-CN, Important Information, with this filing. Form TruA-1000-AR-CN will be issued with the policy issuance. The Statement of Variability has also been revised to include the variable text of form TruA-1000-AR-CN.

The newly attached form TruA-1000-AR replaces the previously submitted one.

Related Objection 2

Applies To:

- Individual Dental Preferred Provider Organization (PPO) Policy, TruA-1000-AR (Form)

Comments: Please revise the information required by Bulletin 15-2009 to more closely mirror the language contained in that Bulletin. The invitation to call the AID for more information is not sufficient.

Changed Items:

State: Arkansas

Filing Company:

TruAssure Insurance Company

TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental

Product Name: TruAssure - Dental PPO

Project Name/Number: TruAssure - Dental PPO/TruAssure - Dental PPO-1

No Supporting Documents changed.

Form Schedule Item Changes:

Form Schedule Item Changes								
Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Individual Dental Preferred Provider Organization (PPO) Policy	TruA-1000-AR	POL	Initial		54.600	TruA-1000-AR_Individual Dental Preferred Provider Organization_PPO_Policy_12-20-2012 subm.pdf	Date Submitted: 12/26/2012 By: Hazel Delane
<i>Previous Version</i>								
1	Individual Dental Preferred Provider Organization (PPO) Policy	TruA-1000-AR	POL	Initial		54.600	TruA-1000-AR_Individual Dental Preferred Provider Organization_PPO_Policy_12-03-2012 subm.pdf	Date Submitted: 12/11/2012 By: Hazel Delane
2	TruA-1000-AR-CN	Important Information	OTH	Initial			TruA-1000-AR-CN_Important Information_12-20-2012 subm.pdf	Date Submitted: 12/26/2012 By: Hazel Delane

No Rate/Rule Schedule items changed.

Response 3**Comments:**

The application forms have been revised to include the Statements as Representations required provision. Therefore, the newly attached forms TruA-1000-App-AR, TruA-1000-App-1-AR, and TruA-1000-App-2-AR replace the previously submitted ones.

Related Objection 3

Applies To:

- TruA-1000-App-AR, Individual Application for Dental PPO Policy (Form)
- TruA-1000-App-1-AR, Individual Application for Dental PPO Policy (Form)

SERFF Tracking #:

MLLM-128748425

State Tracking #:

Company Tracking #:

TRUA-0167DDI01-01

State:

Arkansas

Filing Company:

TruAssure Insurance Company

TOI/Sub-TOI:

H10I Individual Health - Dental/H10I.000 Health - Dental

Product Name:

TruAssure - Dental PPO

Project Name/Number:

TruAssure - Dental PPO/TruAssure - Dental PPO-1

- TruA-1000-App-2-AR, Individual Application for Dental PPO Policy (Form)

Comments: ACA 23-79-107, Statements as Representations. Please add this required provision.

Changed Items:

No Supporting Documents changed.

State: Arkansas

Filing Company:

TruAssure Insurance Company

TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental

Product Name: TruAssure - Dental PPO

Project Name/Number: TruAssure - Dental PPO/TruAssure - Dental PPO-1

Form Schedule Item Changes:

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	TruA-1000-App-AR	Individual Application for Dental PPO Policy	AEF	Initial		57.000	TruA-1000-App-AR_Individual Application for Dental PPO Policy_12-20-2012 subm-vb.pdf	Date Submitted: 12/26/2012 By: Hazel Delane

Previous Version

<i>1</i>	<i>TruA-1000-App-AR</i>	<i>Individual Application for Dental PPO Policy</i>	<i>AEF</i>	<i>Initial</i>		<i>57.000</i>	<i>TruA-1000-App-AR_Individual Application for Dental PPO Policy_12-01-2012 subm-vb.pdf</i>	<i>Date Submitted: 12/11/2012 By: Hazel Delane</i>
2	TruA-1000-App-1-AR	Individual Application for Dental PPO Policy	AEF	Initial		57.000	TruA-1000-App-1-AR_Individual Application for Dental PPO Policy_12-20-2012 subm-vb.pdf	Date Submitted: 12/26/2012 By: Hazel Delane

Previous Version

<i>2</i>	<i>TruA-1000-App-1-AR</i>	<i>Individual Application for Dental PPO Policy</i>	<i>AEF</i>	<i>Initial</i>		<i>57.000</i>	<i>TruA-1000-App-1-AR_Individual Application for Dental PPO Policy_12-03-2012 subm-vb.pdf</i>	<i>Date Submitted: 12/11/2012 By: Hazel Delane</i>
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State: Arkansas
 TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental
 Product Name: TruAssure - Dental PPO
 Project Name/Number: TruAssure - Dental PPO/TruAssure - Dental PPO-1

Filing Company: TruAssure Insurance Company

Form Schedule Item Changes:

Form Schedule Item Changes								
Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
3	TruA-1000-App-2-AR	Individual Application for Dental PPO Policy	AEF	Initial		56.300	TruA-1000-App-2-AR_Individual Application for Dental PPO Policy_12-20-2012 subm-vb.pdf	Date Submitted: 12/26/2012 By: Hazel Delane
<i>Previous Version</i>								
3	TruA-1000-App-2-AR	Individual Application for Dental PPO Policy	AEF	Initial		56.300	TruA-1000-App-2-AR_Individual Application for Dental PPO Policy_12-03-2012 subm-vb.pdf	Date Submitted: 12/11/2012 By: Hazel Delane

No Rate/Rule Schedule items changed.

Conclusion:

We appreciate your time and assistance with this filing. If you have any questions, please let us know.

Sincerely,

Hazel Delane

SERFF Tracking #:

MLLM-128748425

State Tracking #:

Company Tracking #:

TRUA-0167DDI01-01

State:

Arkansas

Filing Company:

TruAssure Insurance Company

TOI/Sub-TOI:

H10I Individual Health - Dental/H10I.000 Health - Dental

Product Name:

TruAssure - Dental PPO

Project Name/Number:

TruAssure - Dental PPO/TruAssure - Dental PPO-1

Amendment Letter

Submitted Date:

12/26/2012

Comments:

Donna,

The filing has been amended to add the "John Doe" copies of the application forms which were revised in connection with the objection letter dated 12/13/2012. Therefore, the newly attached "John Doe" copies of forms TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR replace the previously submitted ones.

Your assistance is appreciated. Let us know if you have any questions.

Thank you,

Hazel

Changed Items:

No Form Schedule Items Changed.

No Rate Schedule Items Changed.

SERFF Tracking #:

MLLM-128748425

State Tracking #:**Company Tracking #:**

TRUA-0167DDI01-01

State:

Arkansas

Filing Company:

TruAssure Insurance Company

TOI/Sub-TOI:

H10I Individual Health - Dental/H10I.000 Health - Dental

Product Name:

TruAssure - Dental PPO

Project Name/Number:

TruAssure - Dental PPO/TruAssure - Dental PPO-1

Supporting Document Schedule Item Changes**Satisfied - Item:**

"John Doe" Forms

Comments:**Attachment(s):**

TruA-1000-Amend_Policy Amendment_11-01-2012 subm-G-jd.pdf

TruA-1000-App-AR_Individual Application for Dental PPO Policy_12-20-2012 subm-jd.pdf

TruA-1000-App-1-AR_Individual Application for Dental PPO Policy_12-20-2012 subm-jd.pdf

TruA-1000-App-2-AR_Individual Application for Dental PPO Policy_12-20-2012 subm-jd.pdf

*Previous Version***Satisfied - Item:***"John Doe" Forms***Comments:****Attachment(s):***TruA-1000-Amend_Policy Amendment_11-01-2012 subm-G-jd.pdf**TruA-1000-App-AR_Individual Application for Dental PPO Policy_12-03-2012 subm-jd.pdf**TruA-1000-App-1-AR_Individual Application for Dental PPO Policy_12-03-2012 subm-jd.pdf**TruA-1000-App-2-AR_Individual Application for Dental PPO Policy_12-01-2012 subm-jd.pdf*

State: Arkansas
TOI/Sub-TOI: H101 Individual Health - Dental/H101.000 Health - Dental
Product Name: TruAssure - Dental PPO
Project Name/Number: TruAssure - Dental PPO/TruAssure - Dental PPO-1

Filing Company: TruAssure Insurance Company

Form Schedule

Lead Form Number: TruA-1000-AR

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved 12/28/2012	Individual Dental Preferred Provider Organization (PPO) Policy	TruA-1000-AR	POL	Initial		54.600	TruA-1000-AR_Individual Dental Preferred Provider Organization_PPO_Policy_12-20-2012 subm.pdf
2	Approved 12/13/2012	TruA-1000-PS-Plan1	Policy Schedule	SCH	Initial		0.000	TruA-1000-PS-Plan1_Policy Schedule_11-06-2012 subm.pdf
3	Approved 12/13/2012	TruA-1000-PS-Plan2	Policy Schedule	SCH	Initial		0.000	TruA-1000-PS-Plan2_Policy Schedule_11-06-2012 subm.pdf
4	Approved 12/13/2012	TruA-1000-PS-Plan3	Policy Schedule	SCH	Initial		0.000	TruA-1000-PS-Plan3_Policy Schedule_11-06-2012 subm.pdf
5	Approved 12/13/2012	TruA-1000-PS-Plan4	Policy Schedule	SCH	Initial		0.000	TruA-1000-PS-Plan4_Policy Schedule_11-06-2012 subm.pdf

State: Arkansas

Filing Company:

TruAssure Insurance Company

TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental

Product Name: TruAssure - Dental PPO

Project Name/Number: TruAssure - Dental PPO/TruAssure - Dental PPO-1

Lead Form Number: TruA-1000-AR

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
6	Approved 12/13/2012	TruA-1000-PS-Plan5	Policy Schedule	SCH	Initial		0.000	TruA-1000-PS-Plan5_Policy Schedule_11-06-2012 subm.pdf
7	Approved 12/13/2012	TruA-1000-SODB-Plan1	Schedule of Dental Benefits - Plan 1	SCH	Initial		0.000	TruA-1000-SODB-Plan1_Schedule of Dental Benefits - Plan 1_11-06-2012 subm.pdf
8	Approved 12/13/2012	TruA-1000-SODB-Plan2	Schedule of Dental Benefits - Plan 2	SCH	Initial		0.000	TruA-1000-SODB-Plan2_Schedule of Dental Benefits - Plan 2_11-06-2012 subm.pdf
9	Approved 12/13/2012	TruA-1000-SODB-Plan3	Schedule of Dental Benefits - Plan 3	SCH	Initial		0.000	TruA-1000-SODB-Plan3_Schedule of Dental Benefits - Plan 3_11-06-2012 subm.pdf
10	Approved 12/13/2012	TruA-1000-SODB-Plan4	Schedule of Dental Benefits - Plan 4	SCH	Initial		0.000	TruA-1000-SODB-Plan4_Schedule of Dental Benefits - Plan 4_11-06-2012 subm.pdf

State: Arkansas

Filing Company:

TruAssure Insurance Company

TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental

Product Name: TruAssure - Dental PPO

Project Name/Number: TruAssure - Dental PPO/TruAssure - Dental PPO-1

Lead Form Number: TruA-1000-AR

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
11	Approved 12/13/2012	TruA-1000-SODB-Plan5	Schedule of Dental Benefits - Plan 5	SCH	Initial		0.000	TruA-1000-SODB-Plan5_Schedule of Dental Benefits - Plan5_11-06-2012 subm.pdf
12	Approved 12/28/2012	TruA-1000-App-AR	Individual Application for Dental PPO Policy	AEF	Initial		57.000	TruA-1000-App-AR_Individual Application for Dental PPO Policy_12-20-2012 subm-vb.pdf
13	Approved 12/28/2012	TruA-1000-App-1-AR	Individual Application for Dental PPO Policy	AEF	Initial		57.000	TruA-1000-App-1-AR_Individual Application for Dental PPO Policy_12-20-2012 subm-vb.pdf
14	Approved 12/28/2012	TruA-1000-App-2-AR	Individual Application for Dental PPO Policy	AEF	Initial		56.300	TruA-1000-App-2-AR_Individual Application for Dental PPO Policy_12-20-2012 subm-vb.pdf

State: Arkansas

Filing Company:

TruAssure Insurance Company

TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental

Product Name: TruAssure - Dental PPO

Project Name/Number: TruAssure - Dental PPO/TruAssure - Dental PPO-1

Lead Form Number: TruA-1000-AR

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
15	Approved 12/13/2012	TruA-1000-Amend	Policy Amendment	POLA	Initial		54.600	TruA-1000- Amend_Policy Amendment_11- 01-2012 subm-G- vb.pdf
16	Approved 12/13/2012	TruA-1000-OOC	Dental Only Coverage Outline of Coverage	OUT	Initial		0.000	TruA-1000- OOC_Dental Only Coverage Outline of Coverage_11- 21-2012 subm.pdf
17	Approved 12/28/2012	TruA-1000-AR-CN	Important Information	OTH	Initial			TruA-1000-AR- CN_Important Information_12-20- 2012 subm.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages

TruAssure Insurance Company

[111 Shuman Boulevard
Naperville, IL 60563
(800) 414-4988]

INDIVIDUAL DENTAL PREFERRED PROVIDER ORGANIZATION (PPO) POLICY

In this Policy, the Policyholder is referred to as "You" or "Your". The TruAssure Insurance Company is referred to as "We", "Our", "Us", or "the Company".

THIS IS A LEGAL CONTRACT BETWEEN YOU AND US. READ YOUR POLICY CAREFULLY.

We will pay the benefits set forth in this Policy. Benefit payments are governed by all the terms, conditions and limitations of this Policy. This Policy is effective on the Policy Effective Date shown in the Schedule of Benefits at 12:01 a.m. local time at Your home address. This Policy is issued in consideration of the application for this Policy and the payment of the initial premium.

RIGHT TO EXAMINE THE POLICY: If, for any reason, You are not completely satisfied with this Policy, You may cancel this Policy by returning it to Us or to any agent appointed by Us within 10 days after You receive it. Returning this Policy to Us will void it from the effective date of this Policy, and We will promptly refund Your entire premium payment, including any policy fee or other charges.

NOTICE TO BUYER: THIS POLICY PROVIDES DENTAL COVERAGE ONLY.

GUARANTEED RENEWABLE: This Policy is guaranteed renewable and will continue in effect as long as the Policyholder pays the Premiums when due or within the Grace Period in accordance with the terms and conditions of this Policy. Your premium can be changed only if We change it on all similar policies in force in Your state. If the Premium is changed, We will give You at least 45 days written notice of any change in the Premium.

Signed by TruAssure Insurance Company.

 President	 Secretary
--	---

**This is a Limited-Scope Dental Policy
Non-Participating**

IMPORTANT NOTICE

PLEASE READ THE COPY OF THE APPLICATION ATTACHED TO THIS POLICY. IF ANY INFORMATION ON THE APPLICATION IS NOT TRUE AND COMPLETE, WRITE TO US AT OUR HOME OFFICE LOCATED AT THE ABOVE ADDRESS WITHIN 10 DAYS. THE APPLICATION IS A PART OF THIS POLICY. THIS POLICY IS ISSUED ON THE BASIS THAT THE ANSWERS TO ALL QUESTIONS AND THE INFORMATION SHOWN ON THE APPLICATION ARE CORRECT AND COMPLETE. IF YOUR ANSWERS ARE INCORRECT OR UNTRUE, WE MAY HAVE THE RIGHT TO DENY DENTAL BENEFITS OR RESCIND YOUR POLICY.

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INTRODUCTION

TruAssure Insurance Company ("TruAssure") is pleased to provide You with this Policy. Our goal is to improve oral health by making dental care more affordable. Good oral health is essential to maintaining good general health. This Policy uses the Delta Dental PPOSM Network and Delta Dental Premier[®] to provide In-Network dental providers for Your dental care.

About Your Policy

TruAssure is pleased to bring these important *Dental Benefits* to You and any Dependents that You have enrolled for coverage under this Policy.

This Policy is issued by TruAssure and delivered in the state where You reside. All terms, conditions, and other provisions of this Policy are governed by the state's laws applicable to limited-scope dental policies. All *Dental Benefits* are paid according to the terms, conditions and other provisions of this Policy. TruAssure's payment of Your dental claims may be less than the *Dentist's* charge. Please see Section 5, *How Your Dental Plan Works*, for information on the level of benefits paid under Your Policy.

Please read this Policy carefully and completely and refer to it should You have questions on Your dental coverage. This Policy, including any endorsements and application, is Our complete agreement with You and will govern Your dental coverage. No statement by You in Your application for this Policy shall void the contract or be used in any legal proceeding unless such application or an exact copy of the application is included in or attached to this Policy. No agent or representative of TruAssure, other than an officer designated in this Policy, is authorized to change this Policy or waive any of its provisions.

To help make the information easier to understand, We use the words "You" and "Your" to refer to You, the Policyholder. We use the words "Covered Dependent" to refer to Your family members who are insured under this Policy. We also use the word "Covered Individual" to refer to You and/or Your Covered Dependents. "We", "Us" and "Our" refers to TruAssure Insurance Company. Each term in this Policy that is capitalized has a special meaning and is defined in Section 1, *Definitions*.

We encourage You to read Your Policy to get the most out of Your coverage. The more You understand Your dental coverage, the more You will know what dental services are covered and what You may owe Your Dentist.

Who Do You Contact for Assistance?

Many questions about Your dental coverage can be answered by accessing Our Web Site as shown in the Policy Schedule. Alternatively, Our automated phone system is available 24 hours a day, seven days a week. A touch-tone phone is required. You can check claim status and obtain *Dentist* referral information on the Web site or through the automated phone system. Your questions may be answered most quickly by use of the Web site or automated system. The telephone number is shown in the *Policy Schedule*. You also may contact Us at Our toll-free number shown in the *Policy Schedule* to speak to a customer service representative for questions concerning eligibility, benefits information, status of Your claim, or general information. Our customer service representatives are available Monday through Friday during Our normal business hours. We also have a message center, available 24 hours a day, seven (7) days a week, where You can leave a voice-mail message and have a customer service representative call You back the next business day. You can also e-mail customer service at the Web Site address shown in the *Policy Schedule*.

POLICY SCHEDULE

[TruAssure Insurance Company Web Site: [www.truassure.com]]
[For Questions or Claim Inquiries, please call: [1-800-414-4988]]
[For Automated Phone System, please call: [1-800-323-1743]]
[Customer Service E-mail Address: [CSI@truassure.com]]

Policy Number: [123456]
Policyholder: [John Doe]
Dental Coverage Plan: [Plan 1]
Benefit Period: [November 1 through October 31 of each year]
Type of Coverage: [Family]
Initial Premium: [\$162.00]
Premium Payment Mode: [Monthly]
Policy Effective Date: [November 1, 2012]
Policy Anniversary Date: [November 1 of each year]

DENTAL BENEFITS

A Covered Individual has the right to obtain Covered Dental Services from the Dentist of his or her choice. However, if a Covered Individual selects an Out-of-Network Dentist, he or she will be responsible for the difference between that provider's Submitted Amount and the benefit amount payable under this Policy. (Refer to Section 5, *How Your Dental Plan Works*, for more details.)

<u>Dental Coverage Plan: [Plan 1]</u>	<u>In-Network</u>	<u>Out-of-Network</u>
Annual Maximum per Benefit Period (per Covered Individual per Benefit Period)	[\$2,000]	[\$2,000]
Deductible (per Covered Individual per Benefit Period)	[\$50]	[\$50]
*Diagnostic Preventive Services	[100%]	[100%]
*Basic Services[– [6] month waiting period]	[80%]	[80%]
*Major Services[– [12] month waiting period]	[50%]	[50%]

*Refer to the Schedule of Dental Benefits for the list of Covered Dental Benefits.

SCHEDULE OF DENTAL BENEFITS – [PLAN [1]]

This Schedule of Dental Benefits provides the list of dental procedures that are Covered Dental Services under this Policy. This Schedule indicates: (1) the covered dental procedure; (2) the Co-payment We will pay for each covered dental procedure; (3) any specific coverage limits, as applicable; and (4) if the Deductible applies to a Covered Dental Procedure. Also, refer to the *Policy Schedule*.)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
DIAGNOSTIC SERVICES						
Oral evaluations (includes limited – problem focused and re-evaluation – limited, problem focused)	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Comprehensive oral evaluation – new or established patient: <i>once per Dentist</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Detailed and extensive oral evaluation – problem focused, by report: <i>once per Dentist</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Comprehensive periodontal evaluation – new or established patient: <i>once per Dentist</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Periodic oral evaluations: <i>twice per Benefit Period</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Intra-oral – periapical radiographs	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Bitewing x-rays (not including vertical bitewings): <i>[once] per Benefit Period</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Complete full-mouth x-rays: <i>once in a 36-month interval</i> . <i>A full-mouth x-ray includes bitewing x-rays. Panoramic x-rays in conjunction with any other x-ray, or any combination of intraoral x-rays on the same date for which the total approved amount equals or exceeds the approved amount for a full-mouth x-ray, is considered a full mouth x-ray. One full-mouth x-ray, one set of vertical bitewings, or one panoramic x-ray is a covered benefit in a 36-month interval.</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Diagnostic casts: <i>when rendered more than 30 days prior to definitive treatment</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Pulp vitality tests: <i>once per visit</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
<i>If additional detailed or comprehensive oral evaluations are billed by the same Dentist, the level of benefits will be limited to that of a periodic oral evaluation. Detailed or comprehensive oral evaluations count toward the Benefit Period maximum of two oral evaluations.</i>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [1]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
PREVENTIVE SERVICES						
Dental prophylaxis (cleaning): <i>twice per Benefit Period*</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Topical fluoride applications: <i>once per Benefit Period, for Covered Dependent Children under age [16]</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Space Maintainers: <i>once per lifetime for Covered Dependent Children under age [14].</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Recementation of space maintainers: <i>once per Benefit Period.</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Sealants: <i>applied once per tooth to first and second permanent molars which are free of caries (cavities) and restorations; for Covered Dependent Children under age [16].</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
<p><i>*With an indicator for diabetes, high risk cardiac conditions, or kidney failure or dialysis conditions, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis or [periodontal maintenance]) per Benefit Period.</i></p> <p><i>*With an indicator for periodontal disease, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis or [periodontal maintenance]) per Benefit Period and for topical application for fluoride at the frequency stated in this Schedule of Dental Benefits.</i></p> <p><i>*With an indicator for suppressed immune system conditions of cancer-related chemotherapy and/or radiation, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis or [periodontal maintenance]) per Benefit Period and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.</i></p> <p><i>*With an indicator for pregnancy, the Covered Individual will be eligible for one additional cleaning (prophylaxis or [periodontal maintenance]) during the time of pregnancy.</i></p>						

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
BASIC SERVICES: ROUTINE AND RESTORATIVE SERVICES						
[Waiting Period – 6 Months]						
Simple Extractions	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Amalgam and resin-based composite fillings: <i>[once] per surface in a 12-month interval.</i>	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Sedative filling	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Pin retention	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
<p><i>When an inlay is requested or placed, the level of benefits will be limited to that of an amalgam filling. Sedative fillings are a Covered Dental Benefit once per tooth per lifetime. When multiple pins are requested or placed, the level of benefits will be limited to one pin per tooth.</i></p>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [1]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: RESTORATIVE SERVICES						
[Waiting Period – 12 Months]						
Onlays (permanent teeth only)	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Crowns and ceramic restorations (permanent teeth only)	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Recementation of inlays, onlays, partial coverage restorations, cast or prefabricated posts and cores and crowns.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Cast or prefabricated post and core; core build-up.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Additional procedures to construct new crown under existing partial denture framework.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: ENDODONTIC SERVICES						
[Waiting Period – 12 months]						
Pulpal and root canal therapy	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
<p><i>When endodontic therapy is performed on primary teeth, the level of benefits will be limited to that of a pulpotomy, except where radiographs indicate there is no permanent successor tooth and the primary tooth demonstrates sufficient intact root structure.</i></p> <p><i>Retreatment of root canal therapy 24 months of initial treatment is not a Covered Dental Benefit.</i></p> <p><i>When incomplete endodontic therapy is billed because the Covered Individual has been referred to an endodontist for completion of endodontic treatment, the level of benefits will be limited to that of a pupal debridement.</i></p> <p><i>Pupal therapy (resorbable filling) is a Covered Dental Benefit once per tooth per lifetime.</i></p>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [1]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: SURGICAL PERIODONTIC SERVICES [Waiting Period – 12 months]						
Gingivectomy or gingivoplasty; gingival flap procedure.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Clinical crown lengthening – hard tissue.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Guided tissue regeneration, per site: <i>only when performed in association with natural teeth.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Bone replacement and soft tissue grafts.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
MAJOR SERVICES: NON-SURGICAL PERIODONTIC SERVICES [Waiting Period – 12 months]						
Periodontal scaling and root planning.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Full-mouth debridement to enable comprehensive evaluation and diagnosis: <i>once per lifetime.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Periodontal maintenance: <i>twice per Benefit Period*</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
<i>Periodontal therapy includes treatment of diseases of the gums and bone supporting the teeth once per quadrant in any 24-month interval.</i>						
<i>*With an indicator for diabetes, high risk cardiac conditions, or kidney failure or dialysis conditions, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period.</i>						
<i>*With an indicator for periodontal disease, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period and for topical application for fluoride at the frequency stated in this Schedule of Dental Benefits.</i>						
<i>*With an indicator for suppressed immune system conditions of cancer-related chemotherapy and/or radiation, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.</i>						
<i>*With an indicator for pregnancy, the Covered Individual will be eligible for one additional cleaning (prophylaxis [or periodontal maintenance]) during the time of pregnancy.</i>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [1]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: REMOVAL PROSTHODONTIC SERVICES						
[Waiting Period – 12 months]						
Complete and partial dentures.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Adjustments to complete and partial dentures.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Repairs to complete and partial dentures.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Replace missing or broken teeth.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Add tooth or clasp to existing partial denture.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Replace all teeth and acrylic on cast metal framework.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Denture rebase: <i>once in a 24-month interval.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Denture reline: <i>once in a 24-month interval.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
MAJOR SERVICES: FIXED PROSTHODONTIC SERVICES (BRIDGES)						
[Waiting Period – 12 months]						
Pontics	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Fixed partial denture retainers – inlays/onlays (inlays/onlays placed as abutments, i.e., to retain or support fixed partial dentures).	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Fixed partial denture retainers – crowns (crowns placed as abutments, i.e., to retain or support fixed partial dentures).	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Recement fixed partial denture.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Cast or refabricated post and core; core build-up.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
<p><i>When a fixed partial denture is requested or placed and three or more teeth are missing in a dental arch, the level of benefits will be limited to that of a removable partial denture. The placement of any additional appliance in the same arch within 60 months following placement of the initial appliance is not a Covered Dental Benefit.</i></p> <p><i>When the edentulous space between teeth exceeds 100% of the size of the original tooth, the level of benefits will be limited to that of a removable partial denture.</i></p> <p><i>When a fixed partial denture and a removable partial denture are requested or placed in the same arch, the level of benefits will be limited to that of a removable partial denture.</i></p> <p><i>If, in the construction of a prosthodontics appliance, personalized or special techniques including, but not limited to, tooth supported dentures, precision attachments or stress breakers, are elected, the level of benefits will be limited to that of a conventional prosthodontics appliance.</i></p> <p><i>When a porcelain/ceramic inlay is requested or placed as abutment (i.e., to retain or support a fixed partial denture), the level of benefits will be limited to that of a cast metal inlay.</i></p>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [1]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: ORAL SURGERY						
[Waiting Period – 12 months]						
Simple extractions.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Surgical removal of reputed tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Removal of impacted tooth – soft tissue.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Removal of impacted tooth – partially bony.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Removal of impacted tooth – completely bony.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Tooth reimplantation/stabilization of accidentally evulsed or displaced tooth and/or alveolus.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Surgical access of an unerupted tooth.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Biopsy of oral tissue: brush biopsy.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Alveoloplasty – per quadrant.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Vestibuloplasty – ridge extension.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Surgical excision of soft tissue lesions.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Surgical excision of intra-osseous lesions.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Other covered surgical/repair procedures: Removal of exostosis, torus palatinus or torus mandibularis; incision and drainage of abscess – intraoral soft tissue; frenulectomy or frenuoplasty; excision of hyperplastic tissue or pericoronal gingiva; surgical reduction of osseous or fibrous tuberosity.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
<i>Oral Surgery includes extractions and other listed oral surgery procedures (Including pre- and post-operative care) only when provided in a Dentist's office.</i>						
MAJOR SERVICES: ADJUNCTIVE GENERAL SERVICES						
[Waiting Period – 12 months]						
Palliative (emergency) treatment of dental pain – minor procedure.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Deep sedation/general anesthesia: <i>when provided by a Dentist in conjunction with Oral Surgery (surgical procedures) other than simple extractions.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Intravenous conscious sedation/analgesia: <i>when provided in conjunction with Oral Surgery (surgical procedures) other than simple extractions.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Consultations	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]

POLICY SCHEDULE

[TruAssure Insurance Company Web Site: [www.truassure.com]]
 [For Questions or Claim Inquiries, please call: [1-800-414-4988]]
 [For Automated Phone System, please call: [1-800-323-1743]]
 [Customer Service E-mail Address: [CSI@truassure.com]]

Policy Number: [123456]
Policyholder: [John Doe]
Dental Coverage Plan: [Plan 2]
Benefit Period: [November 1 through October 31 of each year]
Type of Coverage: [Family]
Initial Premium: [\$132.09]
Premium Payment Mode: [Monthly]
Policy Effective Date: [November 1, 2012]
Policy Anniversary Date: [November 1 of each year]

DENTAL BENEFITS

A Covered Individual has the right to obtain Covered Dental Services from the Dentist of his or her choice. However, if a Covered Individual selects an Out-of-Network Dentist, he or she will be responsible for the difference between that provider's Submitted Amount and the benefit amount payable under this Policy. (Refer to Section 5, *How Your Dental Plan Works*, for more details.)

<u>Dental Coverage Plan: [Plan 2]</u>	<u>In-Network</u>	<u>Out-of-Network</u>
Annual Maximum per Benefit Period <i>(per Covered Individual per Benefit Period)</i>	[\$1,500]	[\$1,500]
Deductible <i>(per Covered Individual per Benefit Period)</i>	[\$50]	[\$50]
*Diagnostic Preventive Services	[100%]	[100%]
*Basic Services[– [6] month waiting period]	[50%]	[50%]
*Major Services[– [12] month waiting period]	[50%]	[50%]

**Refer to the Schedule of Dental Benefits for the list of Covered Dental Benefits.*

SCHEDULE OF DENTAL BENEFITS – [PLAN [2]]

This Schedule of Dental Benefits provides the list of dental procedures that are Covered Dental Services under this Policy. This Schedule indicates: (1) the covered dental procedure; (2) the Co-payment We will pay for each covered dental procedure; (3) any specific coverage limits, as applicable; and (4) if the Deductible applies to a Covered Dental Procedure. Also, refer to the *Policy Schedule*.)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
DIAGNOSTIC SERVICES						
Oral evaluations (includes limited – problem focused and re-evaluation – limited, problem focused)	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Comprehensive oral evaluation – new or established patient: <i>once per Dentist</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Detailed and extensive oral evaluation – problem focused, by report: <i>once per Dentist</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Comprehensive periodontal evaluation – new or established patient: <i>once per Dentist</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Periodic oral evaluations: <i>twice per Benefit Period</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Intra-oral – periapical radiographs	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Bitewing x-rays (not including vertical bitewings): <i>[once] per Benefit Period</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Complete full-mouth x-rays: <i>once in a 36-month interval</i> . <i>A full-mouth x-ray includes bitewing x-rays. Panoramic x-rays in conjunction with any other x-ray, or any combination of intraoral x-rays on the same date for which the total approved amount equals or exceeds the approved amount for a full-mouth x-ray, is considered a full mouth x-ray. One full-mouth x-ray, one set of vertical bitewings, or one panoramic x-ray is a covered benefit in a 36-month interval.</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Diagnostic casts: <i>when rendered more than 30 days prior to definitive treatment</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Pulp vitality tests: <i>once per visit</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
<i>If additional detailed or comprehensive oral evaluations are billed by the same Dentist, the level of benefits will be limited to that of a periodic oral evaluation. Detailed or comprehensive oral evaluations count toward the Benefit Period maximum of two oral evaluations.</i>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [2]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
PREVENTIVE SERVICES						
Dental prophylaxis (cleaning): <i>twice per Benefit Period*</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Topical fluoride applications: <i>once per Benefit Period, for Covered Dependent Children under age [16]</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Space Maintainers: <i>once per lifetime for Covered Dependent Children under age [14].</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Recementation of space maintainers: <i>once per Benefit Period.</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Sealants: <i>applied once per tooth to first and second permanent molars which are free of caries (cavities) and restorations; for Covered Dependent Children under age [16].</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
<p><i>*With an indicator for diabetes, high risk cardiac conditions, or kidney failure or dialysis conditions, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period.</i></p> <p><i>*With an indicator for periodontal disease, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period and for topical application for fluoride at the frequency stated in this Schedule of Dental Benefits.</i></p> <p><i>*With an indicator for suppressed immune system conditions of cancer-related chemotherapy and/or radiation, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.</i></p> <p><i>*With an indicator for pregnancy, the Covered Individual will be eligible for one additional cleaning (prophylaxis [or periodontal maintenance]) during the time of pregnancy.</i></p>						

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
BASIC SERVICES: ROUTINE AND RESTORATIVE SERVICES						
[Waiting Period – 6 Months]						
Simple Extractions	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Amalgam and resin-based composite fillings: <i>[once] per surface in a 12-month interval.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Sedative filling	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Pin retention	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
<p><i>When an inlay is requested or placed, the level of benefits will be limited to that of an amalgam filling. Sedative fillings are a Covered Dental Benefit once per tooth per lifetime. When multiple pins are requested or placed, the level of benefits will be limited to one pin per tooth.</i></p>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [2]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: RESTORATIVE SERVICES						
[Waiting Period – 12 Months]						
Onlays (permanent teeth only)	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Crowns and ceramic restorations (permanent teeth only)	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Recementation of inlays, onlays, partial coverage restorations, cast or prefabricated posts and cores and crowns.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Cast or prefabricated post and core; core build-up.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Additional procedures to construct new crown under existing partial denture framework.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: ENDODONTIC SERVICES						
[Waiting Period – 12 months]						
Pulpal and root canal therapy	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
<p><i>When endodontic therapy is performed on primary teeth, the level of benefits will be limited to that of a pulpotomy, except where radiographs indicate there is no permanent successor tooth and the primary tooth demonstrates sufficient intact root structure.</i></p> <p><i>Retreatment of root canal therapy 24 months of initial treatment is not a Covered Dental Benefit.</i></p> <p><i>When incomplete endodontic therapy is billed because the Covered Individual has been referred to an endodontist for completion of endodontic treatment, the level of benefits will be limited to that of a pupal debridement.</i></p> <p><i>Pupal therapy (resorbable filling) is a Covered Dental Benefit once per tooth per lifetime.</i></p>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [2]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: SURGICAL PERIODONTIC SERVICES						
[Waiting Period – 12 months]						
Gingivectomy or gingivoplasty; gingival flap procedure.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Clinical crown lengthening – hard tissue.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Guided tissue regeneration, per site: <i>only when performed in association with natural teeth.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Bone replacement and soft tissue grafts.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
MAJOR SERVICES: NON-SURGICAL PERIODONTIC SERVICES						
[Waiting Period – 12 months]						
Periodontal scaling and root planning.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Full-mouth debridement to enable comprehensive evaluation and diagnosis: <i>once per lifetime.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Periodontal maintenance: <i>twice per Benefit Period*</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
<i>Periodontal therapy includes treatment of diseases of the gums and bone supporting the teeth once per quadrant in any 24-month interval.</i>						
<i>*With an indicator for diabetes, high risk cardiac conditions, or kidney failure or dialysis conditions, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period.</i>						
<i>*With an indicator for periodontal disease, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period and for topical application for fluoride at the frequency stated in this Schedule of Dental Benefits.</i>						
<i>*With an indicator for suppressed immune system conditions of cancer-related chemotherapy and/or radiation, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.</i>						
<i>*With an indicator for pregnancy, the Covered Individual will be eligible for one additional cleaning (prophylaxis [or periodontal maintenance]) during the time of pregnancy.</i>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [2]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: REMOVAL PROSTHODONTIC SERVICES						
[Waiting Period – 12 months]						
Complete and partial dentures.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Adjustments to complete and partial dentures.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Repairs to complete and partial dentures.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Replace missing or broken teeth.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Add tooth or clasp to existing partial denture.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Replace all teeth and acrylic on cast metal framework.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Denture rebase: <i>once in a 24-month interval.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Denture reline: <i>once in a 24-month interval.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
MAJOR SERVICES: FIXED PROSTHODONTIC SERVICES (BRIDGES)						
[Waiting Period – 12 months]						
Pontics	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Fixed partial denture retainers – inlays/onlays (inlays/onlays placed as abutments, i.e., to retain or support fixed partial dentures).	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Fixed partial denture retainers – crowns (crowns placed as abutments, i.e., to retain or support fixed partial dentures).	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Recent fixed partial denture.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Cast or refabricated post and core; core build-up.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
<p><i>When a fixed partial denture is requested or placed and three or more teeth are missing in a dental arch, the level of benefits will be limited to that of a removable partial denture. The placement of any additional appliance in the same arch within 60 months following placement of the initial appliance is not a Covered Dental Benefit.</i></p> <p><i>When the edentulous space between teeth exceeds 100% of the size of the original tooth, the level of benefits will be limited to that of a removable partial denture.</i></p> <p><i>When a fixed partial denture and a removable partial denture are requested or placed in the same arch, the level of benefits will be limited to that of a removable partial denture.</i></p> <p><i>If, in the construction of a prosthodontics appliance, personalized or special techniques including, but not limited to, tooth supported dentures, precision attachments or stress breakers, are elected, the level of benefits will be limited to that of a conventional prosthodontics appliance.</i></p> <p><i>When a porcelain/ceramic inlay is requested or placed as abutment (i.e., to retain or support a fixed partial denture), the level of benefits will be limited to that of a cast metal inlay.</i></p>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [2]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: ORAL SURGERY						
[Waiting Period – 12 months]						
Simple extractions.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Surgical removal of reputed tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Removal of impacted tooth – soft tissue.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Removal of impacted tooth – partially bony.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Removal of impacted tooth – completely bony.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Tooth reimplantation/stabilization of accidentally evulsed or displaced tooth and/or alveolus.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Surgical access of an unerupted tooth.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Biopsy of oral tissue: brush biopsy.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Alveoloplasty – per quadrant.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Vestibuloplasty – ridge extension.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Surgical excision of soft tissue lesions.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Surgical excision of intra-osseous lesions.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Other covered surgical/repair procedures: Removal of exostosis, torus palatinus or torus mandibularis; incision and drainage of abscess – intraoral soft tissue; frenulectomy or frenuoplasty; excision of hyperplastic tissue or pericoronal gingiva; surgical reduction of osseous or fibrous tuberosity.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
<i>Oral Surgery includes extractions and other listed oral surgery procedures (Including pre- and post-operative care) only when provided in a Dentist's office.</i>						
MAJOR SERVICES: ADJUNCTIVE GENERAL SERVICES						
[Waiting Period – 12 months]						
Palliative (emergency) treatment of dental pain – minor procedure.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Deep sedation/general anesthesia: <i>when provided by a Dentist in conjunction with Oral Surgery (surgical procedures) other than simple extractions.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Intravenous conscious sedation/analgesia: <i>when provided in conjunction with Oral Surgery (surgical procedures) other than simple extractions.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Consultations	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]

POLICY SCHEDULE

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 [For Automated Phone System, please call: [1-800-323-1743]]
 [Customer Service E-mail Address: [CSI@truassure.com]]

Policy Number: [123456]
Policyholder: [John Doe]
Dental Coverage Plan: [Plan 3]
Benefit Period: [November 1 through October 31 of each year]
Type of Coverage: [Family]
Initial Premium: [\$101.86]
Premium Payment Mode: [Monthly]
Policy Effective Date: [November 1, 2012]
Policy Anniversary Date: [November 1 of each year]

DENTAL BENEFITS

A Covered Individual has the right to obtain Covered Dental Services from the Dentist of his or her choice. However, if a Covered Individual selects an Out-of-Network Dentist, he or she will be responsible for the difference between that provider's Submitted Amount and the benefit amount payable under this Policy. (Refer to Section 5, *How Your Dental Plan Works*, for more details.)

<u>Dental Coverage Plan: [Plan 3]</u>	<u>In-Network</u>	<u>Out-of-Network</u>
Annual Maximum per Benefit Period <i>(per Covered Individual per Benefit Period)</i>	[\$1,000]	[\$1,000]
Deductible <i>(per Covered Individual per Benefit Period)</i>	[\$75]	[\$75]
*Diagnostic Preventive Services	[90%]	[90%]
*Basic Services[– [6] month waiting period]	[50%]	[50%]
*Major Services[– [12] month waiting period]	[50%]	[50%]

**Refer to the Schedule of Dental Benefits for the list of Covered Dental Benefits.*

SCHEDULE OF DENTAL BENEFITS – [PLAN [3]]

This Schedule of Dental Benefits provides the list of dental procedures that are Covered Dental Services under this Policy. This Schedule indicates: (1) the covered dental procedure; (2) the Co-payment We will pay for each covered dental procedure; (3) any specific coverage limits, as applicable; and (4) if the Deductible applies to a Covered Dental Procedure. Also, refer to the *Policy Schedule*.)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
DIAGNOSTIC SERVICES						
Oral evaluations (includes limited – problem focused and re-evaluation – limited, problem focused)	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
Comprehensive oral evaluation – new or established patient: <i>once per Dentist</i> .	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
Detailed and extensive oral evaluation – problem focused, by report: <i>once per Dentist</i> .	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
Comprehensive periodontal evaluation – new or established patient: <i>once per Dentist</i> .	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
Periodic oral evaluations: <i>twice per Benefit Period</i>	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
Intra-oral – periapical radiographs	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
Bitewing x-rays (not including vertical bitewings): <i>[once] per Benefit Period</i> .	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
Complete full-mouth x-rays: <i>once in a 36-month interval</i> . <i>A full-mouth x-ray includes bitewing x-rays. Panoramic x-rays in conjunction with any other x-ray, or any combination of intraoral x-rays on the same date for which the total approved amount equals or exceeds the approved amount for a full-mouth x-ray, is considered a full mouth x-ray. One full-mouth x-ray, one set of vertical bitewings, or one panoramic x-ray is a covered benefit in a 36-month interval.</i>	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
Diagnostic casts: <i>when rendered more than 30 days prior to definitive treatment</i> .	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
Pulp vitality tests: <i>once per visit</i> .	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
<i>If additional detailed or comprehensive oral evaluations are billed by the same Dentist, the level of benefits will be limited to that of a periodic oral evaluation. Detailed or comprehensive oral evaluations count toward the Benefit Period maximum of two oral evaluations.</i>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [3]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
PREVENTIVE SERVICES						
Dental prophylaxis (cleaning): <i>twice per Benefit Period*</i>	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
Topical fluoride applications: <i>once per Benefit Period, for Covered Dependent Children under age [16]</i>	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
Space Maintainers: <i>once per lifetime for Covered Dependent Children under age [14].</i>	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
Recementation of space maintainers: <i>once per Benefit Period.</i>	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
Sealants: <i>applied once per tooth to first and second permanent molars which are free of caries (cavities) and restorations; for Covered Dependent Children under age [16].</i>	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
<p><i>*With an indicator for diabetes, high risk cardiac conditions, or kidney failure or dialysis conditions, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period.</i></p> <p><i>*With an indicator for periodontal disease, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period and for topical application for fluoride at the frequency stated in this Schedule of Dental Benefits.</i></p> <p><i>*With an indicator for suppressed immune system conditions of cancer-related chemotherapy and/or radiation, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.</i></p> <p><i>*With an indicator for pregnancy, the Covered Individual will be eligible for one additional cleaning (prophylaxis [or periodontal maintenance]) during the time of pregnancy.</i></p>						

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
BASIC SERVICES: ROUTINE AND RESTORATIVE SERVICES						
[Waiting Period – 6 Months]						
Simple Extractions	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Amalgam and resin-based composite fillings: <i>[once] per surface in a 12-month interval.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Sedative filling	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Pin retention	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
<p><i>When an inlay is requested or placed, the level of benefits will be limited to that of an amalgam filling. Sedative fillings are a Covered Dental Benefit once per tooth per lifetime. When multiple pins are requested or placed, the level of benefits will be limited to one pin per tooth.</i></p>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [3]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: RESTORATIVE SERVICES						
[Waiting Period – 12 Months]						
Onlays (permanent teeth only)	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Crowns and ceramic restorations (permanent teeth only)	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Recementation of inlays, onlays, partial coverage restorations, cast or prefabricated posts and cores and crowns.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Cast or prefabricated post and core; core build-up.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Additional procedures to construct new crown under existing partial denture framework.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: ENDODONTIC SERVICES						
[Waiting Period – 12 months]						
Pulpal and root canal therapy	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
<p><i>When endodontic therapy is performed on primary teeth, the level of benefits will be limited to that of a pulpotomy, except where radiographs indicate there is no permanent successor tooth and the primary tooth demonstrates sufficient intact root structure.</i></p> <p><i>Retreatment of root canal therapy 24 months of initial treatment is not a Covered Dental Benefit.</i></p> <p><i>When incomplete endodontic therapy is billed because the Covered Individual has been referred to an endodontist for completion of endodontic treatment, the level of benefits will be limited to that of a pupal debridement.</i></p> <p><i>Pupal therapy (resorbable filling) is a Covered Dental Benefit once per tooth per lifetime.</i></p>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [3]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: SURGICAL PERIODONTIC SERVICES [Waiting Period – 12 months]						
Gingivectomy or gingivoplasty; gingival flap procedure.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Clinical crown lengthening – hard tissue.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Guided tissue regeneration, per site: <i>only when performed in association with natural teeth.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Bone replacement and soft tissue grafts.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
MAJOR SERVICES: NON-SURGICAL PERIODONTIC SERVICES [Waiting Period – 12 months]						
Periodontal scaling and root planning.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Full-mouth debridement to enable comprehensive evaluation and diagnosis: <i>once per lifetime.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Periodontal maintenance: <i>twice per Benefit Period*</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
<i>Periodontal therapy includes treatment of diseases of the gums and bone supporting the teeth once per quadrant in any 24-month interval.</i>						
<i>*With an indicator for diabetes, high risk cardiac conditions, or kidney failure or dialysis conditions, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis or [periodontal maintenance]) per Benefit Period.</i>						
<i>*With an indicator for periodontal disease, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis or [periodontal maintenance]) per Benefit Period and for topical application for fluoride at the frequency stated in this Schedule of Dental Benefits.</i>						
<i>*With an indicator for suppressed immune system conditions of cancer-related chemotherapy and/or radiation, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis or [periodontal maintenance]) per Benefit Period and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.</i>						
<i>*With an indicator for pregnancy, the Covered Individual will be eligible for one additional cleaning (prophylaxis or [periodontal maintenance]) during the time of pregnancy.</i>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [3]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: REMOVAL PROSTHODONTIC SERVICES						
[Waiting Period – 12 months]						
Complete and partial dentures.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Adjustments to complete and partial dentures.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Repairs to complete and partial dentures.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Replace missing or broken teeth.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Add tooth or clasp to existing partial denture.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Replace all teeth and acrylic on cast metal framework.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Denture rebase: <i>once in a 24-month interval.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Denture reline: <i>once in a 24-month interval.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
MAJOR SERVICES: FIXED PROSTHODONTIC SERVICES (BRIDGES)						
[Waiting Period – 12 months]						
Pontics	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Fixed partial denture retainers – inlays/onlays (inlays/onlays placed as abutments, i.e., to retain or support fixed partial dentures).	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Fixed partial denture retainers – crowns (crowns placed as abutments, i.e., to retain or support fixed partial dentures).	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Recent fixed partial denture.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Cast or refabricated post and core; core build-up.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
<p><i>When a fixed partial denture is requested or placed and three or more teeth are missing in a dental arch, the level of benefits will be limited to that of a removable partial denture. The placement of any additional appliance in the same arch within 60 months following placement of the initial appliance is not a Covered Dental Benefit.</i></p> <p><i>When the edentulous space between teeth exceeds 100% of the size of the original tooth, the level of benefits will be limited to that of a removable partial denture.</i></p> <p><i>When a fixed partial denture and a removable partial denture are requested or placed in the same arch, the level of benefits will be limited to that of a removable partial denture.</i></p> <p><i>If, in the construction of a prosthodontics appliance, personalized or special techniques including, but not limited to, tooth supported dentures, precision attachments or stress breakers, are elected, the level of benefits will be limited to that of a conventional prosthodontics appliance.</i></p> <p><i>When a porcelain/ceramic inlay is requested or placed as abutment (i.e., to retain or support a fixed partial denture), the level of benefits will be limited to that of a cast metal inlay.</i></p>						

SCHEDULE OF DENTAL BENEFITS – [PLAN 3]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: ORAL SURGERY						
[Waiting Period – 12 months]						
Simple extractions.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Surgical removal of reputed tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Removal of impacted tooth – soft tissue.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Removal of impacted tooth – partially bony.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Removal of impacted tooth – completely bony.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Tooth reimplantation/stabilization of accidentally evulsed or displaced tooth and/or alveolus.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Surgical access of an unerupted tooth.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Biopsy of oral tissue: brush biopsy.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Alveoloplasty – per quadrant.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Vestibuloplasty – ridge extension.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Surgical excision of soft tissue lesions.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Surgical excision of intra-osseous lesions.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Other covered surgical/repair procedures: Removal of exostosis, torus palatinus or torus mandibularis; incision and drainage of abscess – intraoral soft tissue; frenulectomy or frenuoplasty; excision of hyperplastic tissue or pericoronal gingiva; surgical reduction of osseous or fibrous tuberosity.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
<i>Oral Surgery includes extractions and other listed oral surgery procedures (Including pre- and post-operative care) only when provided in a Dentist's office.</i>						
MAJOR SERVICES: ADJUNCTIVE GENERAL SERVICES						
[Waiting Period – 12 months]						
Palliative (emergency) treatment of dental pain – minor procedure.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Deep sedation/general anesthesia: <i>when provided by a Dentist in conjunction with Oral Surgery (surgical procedures) other than simple extractions.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Intravenous conscious sedation/analgesia: <i>when provided in conjunction with Oral Surgery (surgical procedures) other than simple extractions.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Consultations	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]

POLICY SCHEDULE

[TruAssure Insurance Company Web Site: [www.truassure.com]]
[For Questions or Claim Inquiries, please call: [1-800-414-4988]]
[For Automated Phone System, please call: [1-800-323-1743]]
[Customer Service E-mail Address: [CSI@truassure.com]]

Policy Number: [123456]
Policyholder: [John Doe]
Dental Coverage Plan: [Plan 4]
Benefit Period: [November 1 through October 31 of each year]
Type of Coverage: [Family]
Initial Premium: [\$76.10]
Premium Payment Mode: [Monthly]
Policy Effective Date: [November 1, 2012]
Policy Anniversary Date: [November 1 of each year]

DENTAL BENEFITS

A Covered Individual has the right to obtain Covered Dental Services from the Dentist of his or her choice. However, if a Covered Individual selects an Out-of-Network Dentist, he or she will be responsible for the difference between that provider's Submitted Amount and the benefit amount payable under this Policy. (Refer to Section 5, *How Your Dental Plan Works*, for more details.)

<u>Dental Coverage Plan: [Plan 4]</u>	<u>In-Network</u>	<u>Out-of-Network</u>
Annual Maximum per Benefit Period (per Covered Individual per Benefit Period)	[\$500]	[\$500]
Deductible (per Covered Individual per Benefit Period)	[\$25]	[\$25]
*Diagnostic Preventive Services	[100%]	[100%]

*Refer to the Schedule of Dental Benefits for the list of Covered Dental Benefits.

SCHEDULE OF DENTAL BENEFITS – [PLAN [4]]

This Schedule of Dental Benefits provides the list of dental procedures that are Covered Dental Services under this Policy. This Schedule indicates: (1) the covered dental procedure; (2) the Co-payment We will pay for each covered dental procedure; (3) any specific coverage limits, as applicable; and (4) if the Deductible applies to a Covered Dental Procedure. Also, refer to the *Policy Schedule*.)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
DIAGNOSTIC SERVICES						
Oral evaluations (includes limited – problem focused and re-evaluation – limited, problem focused)	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Comprehensive oral evaluation – new or established patient: <i>once per Dentist</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Detailed and extensive oral evaluation – problem focused, by report: <i>once per Dentist</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Comprehensive periodontal evaluation – new or established patient: <i>once per Dentist</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Periodic oral evaluations: <i>twice per Benefit Period</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Intra-oral – periapical radiographs	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Bitewing x-rays (not including vertical bitewings): <i>[once] per Benefit Period</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Complete full-mouth x-rays: <i>once in a 36-month interval</i> . <i>A full-mouth x-ray includes bitewing x-rays. Panoramic x-rays in conjunction with any other x-ray, or any combination of intraoral x-rays on the same date for which the total approved amount equals or exceeds the approved amount for a full-mouth x-ray, is considered a full mouth x-ray. One full-mouth x-ray, one set of vertical bitewings, or one panoramic x-ray is a covered benefit in a 36-month interval.</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Diagnostic casts: <i>when rendered more than 30 days prior to definitive treatment</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Pulp vitality tests: <i>once per visit</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
<i>If additional detailed or comprehensive oral evaluations are billed by the same Dentist, the level of benefits will be limited to that of a periodic oral evaluation. Detailed or comprehensive oral evaluations count toward the Benefit Period maximum of two oral evaluations.</i>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [4]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
PREVENTIVE SERVICES						
Dental prophylaxis (cleaning): <i>twice per Benefit Period*</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Topical fluoride applications: <i>once per Benefit Period, for Covered Dependent Children under age [19]</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Recementation of space maintainers: <i>once per Benefit Period.</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Sealants: <i>applied once per tooth to first and second permanent molars which are free of caries (cavities) and restorations; for Covered Dependent Children under age [20].</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
<p><i>*With an indicator for diabetes, high risk cardiac conditions, or kidney failure or dialysis conditions, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis or [periodontal maintenance] per Benefit Period.</i></p> <p><i>*With an indicator for periodontal disease, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis or [periodontal maintenance]) per Benefit Period and for topical application for fluoride at the frequency stated in this Schedule of Dental Benefits.</i></p> <p><i>*With an indicator for suppressed immune system conditions of cancer-related chemotherapy and/or radiation, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis or [periodontal maintenance]) per Benefit Period and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.</i></p> <p><i>*With an indicator for pregnancy, the Covered Individual will be eligible for one additional cleaning (prophylaxis or [periodontal maintenance]) during the time of pregnancy.</i></p>						

POLICY SCHEDULE

[TruAssure Insurance Company Web Site: [www.truassure.com]]
 [For Questions or Claim Inquiries, please call: [1-800-414-4988]]
 [For Automated Phone System, please call: [1-800-323-1743]]
 [Customer Service E-mail Address: [CSI@truassure.com]]

Policy Number: [123456]
Policyholder: [John Doe]
Dental Coverage Plan: [Plan 5]
Type of Coverage: [Dependent Children through Age 18 Only]
 Number of Dependent Children Under age 19: [1, Susan Doe]
Benefit Period: [November 1 through October 31 of each year]
Initial Premium: [\$41.63]
Premium Payment Mode: [Monthly]
Policy Effective Date: [November 1, 2012]
Policy Anniversary Date: [November 1 of each year]

PEDIATRIC DENTAL BENEFITS

This Pediatric Dental Plan only covers Your Covered Dependent Children under age 19. You have the right to obtain Covered Dental Services for Your Covered Dependent Children from the Dentist of Your choice. However, if You select an Out-of-Network Dentist, You will be responsible for the difference between that provider's Submitted Amount and the benefit amount payable under this Policy. (Refer to Section 5, *How Your Dental Plan Works*, for more details.)

<u>Dental Coverage Plan: [Plan 5]</u>	<u>In-Network</u>	<u>Out-of-Network</u>
Annual Maximum per Benefit Period <i>(per Covered Individual per Benefit Period)</i>	[\$1,000]	[\$1,000]
Deductible <i>(per Covered Individual per Benefit Period)</i>	[None]	[None]
*Diagnostic Preventive Services	[100%]	[100%]
*Basic Services[– [6] month waiting period]	[80%]	[80%]
*Major Services[– [12] month waiting period]	[80%]	[80%]

**Refer to the Schedule of Dental Benefits for the list of Covered Dental Benefits.*

SCHEDULE OF DENTAL BENEFITS – [PLAN [5]]

This Schedule of Dental Benefits provides the list of dental procedures that are Covered Dental Services under this Policy. This Schedule indicates: (1) the covered dental procedure; (2) the Co-payment We will pay for each covered dental procedure; (3) any specific coverage limits, as applicable; and (4) if the Deductible applies to a Covered Dental Procedure. Also, refer to the *Policy Schedule*.)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
DIAGNOSTIC SERVICES						
Oral evaluations (includes limited – problem focused and re-evaluation – limited, problem focused)	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Comprehensive oral evaluation – new or established patient: <i>once per Dentist</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Detailed and extensive oral evaluation – problem focused, by report: <i>once per Dentist</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Comprehensive periodontal evaluation – new or established patient: <i>once per Dentist</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Periodic oral evaluations: <i>twice per Benefit Period</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Intra-oral – periapical radiographs.	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Bitewing x-rays (not including vertical bitewings): <i>[once] per Benefit Period</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Complete full-mouth x-rays: <i>once in a 36-month interval</i> . <i>A full-mouth x-ray includes bitewing x-rays. Panoramic x-rays in conjunction with any other x-ray, or any combination of intraoral x-rays on the same date for which the total approved amount equals or exceeds the approved amount for a full-mouth x-ray, is considered a full mouth x-ray. One full-mouth x-ray, one set of vertical bitewings, or one panoramic x-ray is a covered benefit in a 36-month interval.</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Diagnostic casts: <i>when rendered more than 30 days prior to definitive treatment</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Pulp vitality tests: <i>once per visit</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
<i>If additional detailed or comprehensive oral evaluations are billed by the same Dentist, the level of benefits will be limited to that of a periodic oral evaluation. Detailed or comprehensive oral evaluations count toward the Benefit Period maximum of two oral evaluations.</i>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [5]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
PREVENTIVE SERVICES						
Dental prophylaxis (cleaning): <i>twice per Benefit Period*</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Topical fluoride applications: <i>once per Benefit Period, for Covered Dependent Children under age [18]</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Recementation of space maintainers: <i>once per Benefit Period.</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Sealants: <i>applied once per tooth to first and second permanent molars which are free of caries (cavities) and restorations; for Covered Dependent Children under age [18].</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
<p><i>*With an indicator for diabetes, high risk cardiac conditions, or kidney failure or dialysis conditions, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis or [periodontal maintenance] per Benefit Period.</i></p> <p><i>*With an indicator for periodontal disease, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis or [periodontal maintenance]) per Benefit Period and for topical application for fluoride at the frequency stated in this Schedule of Dental Benefits.</i></p> <p><i>*With an indicator for suppressed immune system conditions of cancer-related chemotherapy and/or radiation, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis or [periodontal maintenance]) per Benefit Period and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.</i></p> <p><i>*With an indicator for pregnancy, the Covered Individual will be eligible for one additional cleaning (prophylaxis or [periodontal maintenance]) during the time of pregnancy.</i></p>						

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
BASIC SERVICES: ROUTINE AND RESTORATIVE SERVICES						
[Waiting Period – 6 Months]						
Simple Extractions	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Amalgam and resin-based composite fillings: <i>[once] per surface in a 12-month interval.</i>	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Sedative filling	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Pin retention	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
<p><i>When an inlay is requested or placed, the level of benefits will be limited to that of an amalgam filling. Sedative fillings are a Covered Dental Benefit once per tooth per lifetime. When multiple pins are requested or placed, the level of benefits will be limited to one pin per tooth.</i></p>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [5]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: RESTORATIVE SERVICES						
[Waiting Period – 12 Months]						
Crowns and ceramic restorations (permanent teeth only)	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Cast or prefabricated post and core; core build-up.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Additional procedures to construct new crown under existing partial denture framework.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: ENDODONTIC SERVICES						
Pulpal and root canal therapy	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
<p><i>When endodontic therapy is performed on primary teeth, the level of benefits will be limited to that of a pulpotomy, except where radiographs indicate there is no permanent successor tooth and the primary tooth demonstrates sufficient intact root structure.</i></p> <p><i>Retreatment of root canal therapy 24 months of initial treatment is not a Covered Dental Benefit.</i></p> <p><i>When incomplete endodontic therapy is billed because the Covered Individual has been referred to an endodontist for completion of endodontic treatment, the level of benefits will be limited to that of a pupal debridement.</i></p> <p><i>Pupal therapy (resorbable filling) is a Covered Dental Benefit once per tooth per lifetime.</i></p>						

SCHEDULE OF DENTAL BENEFITS – [PLAN 5]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: ORAL SURGERY						
Simple extractions.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Surgical removal of reputed tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Removal of impacted tooth – soft tissue.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Removal of impacted tooth – partially bony.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Removal of impacted tooth – completely bony.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Tooth reimplantation/stabilization of accidentally evulsed or displaced tooth and/or alveolus.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Surgical access of an unerupted tooth.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Biopsy of oral tissue: brush biopsy.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Alveoloplasty – per quadrant.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Vestibuloplasty – ridge extension.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Surgical excision of soft tissue lesions.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Surgical excision of intra-osseous lesions.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Other covered surgical/repair procedures: Removal of exostosis, torus palatinus or torus mandibularis; incision and drainage of abscess – intraoral soft tissue; frenulectomy or frenuoplasty; excision of hyperplastic tissue or pericoronal gingiva; surgical reduction of osseous or fibrous tuberosity.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
<i>Oral Surgery includes extractions and other listed oral surgery procedures (Including pre- and post-operative care) only when provided in a Dentist's office.</i>						
MAJOR SERVICES: ADJUNCTIVE GENERAL SERVICES						
Palliative (emergency) treatment of dental pain – minor procedure.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Deep sedation/general anesthesia: <i>when provided by a Dentist in conjunction with Oral Surgery (surgical procedures) other than simple extractions.</i>	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Intravenous conscious sedation/analgesia: <i>when provided in conjunction with Oral Surgery (surgical procedures) other than simple extractions.</i>	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Consultations	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]

SECTION 1: DEFINITIONS

The following are key words used in this Policy. When they are used, they are capitalized. Also, some terms are capitalized and described within this Policy Schedule or the provisions in which they appear in this Policy.

Allowed Amount means the Scheduled Fee. The Scheduled Fee is the amount used to calculate Your portion of the dental coverage payment for which You are responsible.

Annual Maximum Benefit means the maximum benefit payable under this Policy for each Covered Individual per Benefit Period. All Covered Dental Services are subject to the Annual Maximum Benefit. No benefits will be paid under this Policy after the Annual Maximum Benefit has been reached. The Annual Maximum Benefit is shown in the Policy Schedule.

Approved Amount means the amount that the Dentist has agreed to accept as full payment for treatment.

1. For a Delta Dental PPO Dentist, the Approved Amount is the Scheduled Fee;
2. For a Delta Dental Premier Dentist, the Approved Amount is the Maximum Plan Allowance; and
3. For an Out-of-Network Dentist, the Approved Amount is the Submitted Fee.

Benefit Period means the twelve-month period specified in the Policy Schedule during which We pay benefits for Covered Dental Services. It is also the time during which Deductibles, Annual Maximum Benefit, and Coverage Limits are calculated and applied.

Co-Payment means the designated portion (fixed percentage) of the Allowed Amount We are contractually obligated to pay for a covered dental procedure, up to the Annual Maximum Benefit. The Patient Co-Payment is the portion (fixed percentage) of the Allowed Amount remaining after Our Co-Payment.

Covered Dental Service means the dental procedures and services payable under this Policy. Covered Dental Services will be paid in accordance with the Dental Benefit for the particular dental procedure or service, subject to the Deductible, Co-Payments, Annual Maximum Benefit, exclusions and limitations contained in this Policy.

Covered Dependent means the Policyholder's spouse or Domestic Partner and any Dependent Children (as defined in this Policy) who are insured under this Policy. A Covered Dependent must be listed on the application for this Policy and approved by Us. The required premium for the Covered Dependent's coverage under this Policy must be paid to Us.

Coverage Limits means the Annual Maximum Benefit specified in the Policy Schedule.

Covered Individual means the Policyholder or any Dependent of the Policyholder who is insured under this Policy. Coverage for the Policyholder and any Covered Dependent is subject to: (1) payment of the required premium for coverage under this Policy; and (2) the provisions of *Section 3: WHEN COVERAGE BEGINS AND ENDS*.

Date of Service means the date treatment is COMPLETED for any particular Dental Benefit for the purpose of allocating the particular Dental Benefit to the appropriate Benefit Period and paying claims made under this Policy.

Deductible means the amount specified in the Policy Schedule which a Covered Individual is required to pay before designated Dental Benefits are payable under this Policy.

Delta Dental PPOSM Network and Delta Dental Premier[®] Network mean the dental networks used for In-Network dental services under this Policy. A Covered Individual may elect to obtain services through either network.

Dental Benefit means the amount We pay for a Covered Dental Service, subject to the applicable Deductible, Co-Payment, Annual Maximum Benefit, and exclusions and limitations contained in this Policy.

Dentist means an individual licensed to practice dentistry at the time and in the place where services are provided.

Dependent means Your:

1. Spouse or Domestic Partner; and
2. Eligible Dependent Children.

Dependent Children means the Policyholder's eligible children who are:

1. Under age 27, regardless of their place of residence, marital status or student status; including: (a) newborn children; (b) stepchildren; (c) legally adopted children; (d) children placed for adoption with the Policyholder in accordance with applicable state or federal law; (e) foster children; and (f) children for whom the Policyholder is a legal guardian substantiated by a court order; and
2. Unmarried and between age 27 to age 30, and who: (a) are residents of the same state as the Policyholder; (b) served as a member of the U.S. Armed Forces (active or reserve); and (c) have received a release or discharge other than dishonorable. The Policyholder must provide Us with proof of military service (U.S. Government Form DD2-14, Certificate of Release or Discharge from Active Duty) for such Dependent Child; and
3. Unmarried dependent Handicap Children age 27 and over. Refer to the definition of *Handicapped Child*.

Domestic Partner means a person with whom You have entered into a Domestic Partnership or Civil Union in accordance with state law where You reside.

Domestic Partnership and **Civil Union** mean a long-term committed relationship of indefinite duration with a person which meets the following criteria:

1. You and Your Domestic Partner have lived together for at least 12 months;
2. Neither You nor Your Domestic Partner is married to anyone else or has another domestic partner;
3. Your Domestic Partner is at least 18 years of age;
4. Your Domestic Partner resides with You and intends to do so indefinitely;
5. You and Your Domestic Partner have an exclusive mutual commitment that is intended to be permanent;
6. You and Your Domestic Partner are jointly responsible for each other's common welfare and share financial obligations; and
7. You and Your Domestic Partner meet the requirements for a Domestic Partnership or Civil Union in the state where You reside, if any.

Family Coverage means coverage for: (1) You; and (2) Your spouse or Domestic Partner; and/or (3) one or more Dependent Children.

Fee Adjustment means the difference, if any, between the Submitted Amount and the Approved Amount.

Fee Schedule or Scheduled Fee means the amount that a Dentist in the Delta Dental PPO Network agrees contractually to accept as full payment for covered procedures. The Fee Schedule for covered procedures. The Fee Schedule for covered procedures is listed in a table provided to Dentists who participate in the Delta Dental PPO Network.

Handicapped Child means Your unmarried Dependent Child age 27 or older who was a Covered Dependent Child prior to attaining age 27 and remains dependent on You for support and maintenance because he or she is and continues to be both incapable of:

1. Self-sustaining employment by reason of mental retardation or physical handicap; and
2. Chiefly dependent upon You for support and maintenance.

Proof of such incapacity and dependency must be furnished to Us by You when the child attains the limiting age. Subsequently, We may require proof that the child continues to be so handicapped, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

Comment [HD1]: ACA. 23-86-108(4), Arkansas Bulletin

In-Network means services provided by Preferred Providers who contracted with Delta Dental PPO Network or the Delta Dental Premier Network to provide services to Covered Individuals under this Policy.

Maximum Plan Allowance means the amount that a Delta Dental Premier Dentist agrees contractually to accept as full payment for covered procedures. The Maximum Plan Allowance is calculated as a percentile of billed fees and is shown as the Approved Amount on the Explanation of Benefits (EOB) determination.

Non-Preferred Provider means a licensed dentist who does not have a participation contract in effect with the Delta Dental PPO Network or the Delta Dental Premier Network to provide services to Covered Individuals under this Policy. When dental services are provided by a Non-Preferred Provider, the services provided are Out-of-Network.

Our Payment means the amount that TruAssure Insurance Company pays for the Covered Dental Services listed on a claim.

Out-of-Network means services provided by Non-Preferred Providers. Non-Preferred Providers are not contracted with Delta Dental PPO Network or the Delta Dental Premier Network to provide services to Covered Individuals under this Policy.

Patient Payment means the amount the patient (*the Covered Individual*) is obligated to pay the Dentist for the service(s) listed on his or her claim. The Patient Payment shown on an Explanation of Benefits (EOB) represents the amount the patient is obligated to pay based on the benefits provided under this Policy. The Patient Payment may be different from what is shown on the EOB if the Covered Individual also has coverage under another dental policy or plan.

Policy means this Policy issued by Us to You, the Policyholder. This Policy includes: (1) any appendices, endorsements, or riders issued and attached to this Policy; and (2) the completed application(s) attached to this Policy. Application means the application(s) for this Policy.

Policy Anniversary Date means the same day and month as the Policy Effective Date for each succeeding year this Policy remains in force. The Policy Anniversary Date is shown in the Policy Schedule.

Policy Effective Date means the date on which this Policy becomes effective. The Policy Effective Date is shown in the Policy Schedule.

Policyholder means the person who has: (1) completed and signed the application necessary for coverage under this Policy; (2) been approved by Us for coverage and this Policy; and (3) paid the appropriate initial premium for this Policy; and (3) paid the appropriate initial premium for this Policy. The Policyholder is the owner of this Policy. The name of the Policyholder is shown in the Policy Schedule.

Preferred Provider means a licensed dentist who has a participation contract in effect with the Delta Dental PPO Network or the Delta Dental Premier Network to provide services to Covered Individuals under this Policy. The preferred provider's participation contract must be in effect with Delta Dental PPO Network or the Delta Dental Premier Network at the time Covered Dental Services are provided to the Covered Individual in order for benefits to be eligible for In-Network benefits.

Pretreatment Estimate means an estimate for the coverage afforded for the dental plan benefits provided under this Policy prior to such services being rendered.

Submitted Amount means the amount billed or charged by the Dentist on a submitted claim.

SECTION 2: WHO CAN BE COVERED UNDER THIS DENTAL POLICY

What You Should Know About Who Is Covered

Who is the Covered Policyholder?

The person in whose name this Policy is issued is the Policyholder. The Policyholder is covered under this Policy unless the Type of Coverage was elected for Dependent Coverage only. The name of the Policyholder and the Type of Coverage elected are shown in the Policy Schedule.

If, after coverage is effective under this Policy, the Policyholder is called to active duty in the military:

1. This Policy will terminate if only the Policyholder is covered under this Policy at the time the Policyholder is called to active duty. The Policyholder must reapply for coverage when his or her active duty ceases; or
2. This Policy will remain in force if the Policyholder has Covered Dependents and the Covered Dependents remain insured under this Policy. Upon the Policyholder's return to civilian status, his or her coverage under this Policy will be reinstated.

Are Dependents Covered?

If You, as the Policyholder, are enrolled for Family Coverage, the following Dependents may also be covered under this Policy:

1. Your spouse or Domestic Partner; and
2. Your eligible Dependent Children as defined in Section 1, *Definitions*.

Dependent Child Coverage Only

If You elected Dependent Child Coverage only, Your eligible Dependent Children will be covered under this Policy, if they are enrolled and approved by Us.

Are Dependents in the Military Eligible for Coverage?

Dependents in military service are not eligible for coverage under this Policy. If a Covered Dependent is called to active duty, his or her coverage under this Policy will terminate on the date he or she departs for active duty. Upon his or her return to civilian status, the Dependent will be reinstated effective on the date his or her active military status ceases if this Policy are still in effect. You must give Us a status change form for these changes.

SECTION 3: WHEN COVERAGE BEGINS AND ENDS

When Coverage Begins

What is the Effective Date of Coverage?

1. You, the Policyholder, are covered under this Policy as follows:
 - a. Upon Our approval of Your application and remittance of the required premium payment. When We receive Your application form and premium payment prior to the 20th of the month, coverage will be effective the first day of the month immediately following receipt. When received after the 20th and the last day of the month, coverage will be effective the first day of the second month following receipt. Your effective date of coverage is the same as the Policy Effective Date shown in the Policy Schedule.
 - b. After satisfaction of the Benefit Waiting Period, if applicable, as outlined in the Schedule of Dental Benefits.
2. Eligible Dependents are covered under this Policy as follows:
 - a. On the date Your coverage is effective;
 - b. On a Policy Anniversary Date allowing You to make coverage changes. Coverage for the Dependent will then be effective on that Policy Anniversary Date.
 - c. On the date the Dependent is eligible for coverage, meaning: (1) birth; (2) adoption; (3) placement for foster care; (4) placement for adoption with You and for whom the application and approval procedures for adoption have been completed; (5) a marriage that results in the spouse or Domestic Partner and stepchildren being added to coverage; and (6) those required to be covered by court order.
 - d. After satisfaction of the Benefit Waiting Period, if applicable, as outlined in the Schedule of Dental Benefits.

How do You Enroll Dependents After the Policy Effective Date?

If You do not enroll Your Dependents when they are first eligible and later have a Dependent as a result of :

1. Marriage or the establishment of a Domestic Partnership;
2. Birth;
3. Adoption or placement for adoption; or
4. Placement for foster care;

the Dependent may be enrolled for coverage within the time period indicated below in the *Adding a Dependent Due to Marriage/Domestic Partnership, Adding a Dependent Child, and Adding a Dependent Due to Court Order* provisions.

Adding a Dependent Due to Marriage/Domestic Partnership: If You have a new Dependent due to marriage or the establishment of a Domestic Partnership, the effective date of coverage for the eligible Dependent will be the first of the month following the event, provided We receive a status change form and approve the Dependent for coverage under this Policy. You must submit a completed status change form within thirty-one (31) days from the date of marriage or establishment of Domestic Partnership. You may obtain a status change form from Us. If there is a change in premium, it will be included in the first billing date after the change adjusted back to the effective month of the change.

Adding a Dependent Child: If You have a Dependent Child as a result of:

1. Birth;
- 2.
3. Filing of a petition for adoption; or
4. Placement for foster care;

Comment [HD2]: Ins Code 23-79-129

Comment [HD3]: Ins Code 23-79-137

the effective date of coverage for the new Dependent Child will be the date of: (a) birth if You enroll the child within 90 days of the date of his or her birth or before the next premium due date, whichever is later; (b) the filing a petition for an adopted child if You enroll the child within sixty (60) days after the filing of such petition for adoption; (c) birth of an adopted child if the petition for adoption and Your enrollment of the child for coverage is filed within sixty (60) days after the birth of the child; or (d) placement for foster care if You enroll the child within 31 days of placement. You must submit to Us a status change form within the time period specified, otherwise coverage will not be provided under this Policy. If there is a change in premium, it will be included on the first billing date after the change adjusted back to the effective month of the change.

Adding a Dependent Due to Court Order: If a court orders You to provide coverage for a Dependent, the effective date of coverage for the Dependent will be the first billing date after We receive and approve the status change form. The status change form must be submitted to Us within thirty-one (31) days after the court order is issued. If there is a change in premium, it will be included on the first billing date after the change adjusted back to the effective month of the change.

How Long Is Coverage Effective Under This Policy?

This Policy is written for a period of 12 months beginning on the Policy Effective Date. You may elect to continue this Policy or discontinue this Policy effective on any Policy Anniversary Date. Coverage under this Policy will be continued if You elect to continue this Policy. If You elect to discontinue this Policy, You must provide Us with a written notice 45 days in advance of the termination date.

When You are no longer eligible for coverage: Your coverage and the coverage for Your Covered Dependents, if any, will terminate on the last day of the month upon the occurrence of the following events:

1. The date You enter active duty in the military service. However, if You retain coverage for Your Covered Dependents, this Policy will remain in force to insure Your Covered Dependents provided the required premiums continue to be paid;
2. The date of Your death;
3. The date this Policy is terminated.

No coverage will be available to You upon attainment of a limiting age for a benefit specified in the Policy Schedule.

When Your Covered Dependents are no longer eligible for coverage: The coverage of any of Your Covered Dependents will terminate on the last day of the month upon the occurrence of the following events:

1. The date Your Covered Dependent no longer meets the eligibility requirements specified in this Policy;
2. The date: (a) Your spouse is no longer an eligible Dependent as a result of a divorce decree or legal separation; or (b) You and Your Domestic Partner are no longer in a Domestic Partnership relationship;
3. The date Your Dependent Child reaches his or her 27th birthday;
4. The date Your Dependent enters active duty in the military;
5. The date of Your Death; or
6. The date this Policy terminates.

No coverage will be available for a Covered Dependent upon attainment of the limiting age for a benefit specified in the Policy Schedule.

When May We Rescind this Policy?

If You commit fraud or misrepresent material information on an application for this Policy, this Policy will be rescinded and will be considered as never having been in effect. Any premiums paid for coverage for the ineligible person will be refunded minus any claims paid for that person. We are entitled to recover the claim amounts that exceed the amount of premium paid.

When Can We Terminate this Policy?

We will terminate this Policy at 12:01 a.m. at Your home on the earliest of the following:

1. On any Policy Anniversary Date this Policy is not renewed;
2. If You fail to pay the required premium payment when due, subject to the Grace Period; or
3. For any other reason for termination of this Policy as specified in this Policy, provided We give You at least forty-five (45 days) prior written notice.

What Is Our Responsibility for Payment of Claims if this Policy Terminates?

We will only pay a claim for dental services received and completed prior to the termination date of this Policy; however, such claim must be submitted to Us by You or Your Dentist within twelve (12) months after the date services were completed. We are not required to pay benefits for Covered Dental Services provided to a Covered Individual after the date this Policy terminates for any reason.

SECTION 4: HOW YOUR DENTAL PLAN WORKS

What You Should Know About Selecting a Dentist

May You go to any Dentist?

Yes. You may choose to go to any licensed Dentist whenever You need dental care. Whatever Dentist You choose, You will receive some level of benefits for Covered Dental Services. However, there are

advantages when You receive treatment from a Dentist participating in one of Our networks – either the Delta Dental PPO Network or the Delta Dental Premier Network.

What are the advantages of going to a Dentist who participates in the Delta Dental PPO Network?

1. Dentists participating in the Delta Dental PPO Network are obligated to accept the lesser of the Dentist’s Submitted Amount or the Scheduled Fee as full payment for Covered Dental Services under this Policy.
2. You are not responsible for charges exceeding the Approved Amount for Covered Dental Services. Any difference between the Dentist’s Submitted Amount and the Approved Amount is called the Fee Adjustment, and is money You save. You only are responsible for the applicable Deductible and patient Co-payment amounts. This payment arrangement means that Your out-of-pocket costs are likely to be less.
3. We automatically pay Dentists in the Delta Dental PPO Network directly, so You do not have to pay the whole bill up front and wait for reimbursement. Therefore, You do not have to file a claim for the Covered Dental Services.

What happens if You choose a Dentist who does not participate in the Delta Dental PPO Network?

When You choose a Dentist who participates in the Delta Dental Premier Network: If the Dentist You select does not participate in the Delta Dental PPO Network, You may still reduce Your out-of-pocket costs, if You go to a Dentist who participates in the Delta Dental Premier Network. Delta Dental Premier Network serves as a “safety net” providing out-of-network, out-of-pocket protection for You.

A Dentist participating in the Delta Dental Premier Network is obligateded to accept the lesser of the Dentist’s Submitted Amount or the Maximum Plan Allowance as full payment for Covered Dental Services. That amount is what We refer to as the Approved Amount. You are responsible for the applicable Deductible and patient Co-payment amounts, plus the difference between the Approved Amount and the Allowed Amount. While the Fee Adjustment may not be as great as with Dentists who participate in the Delta Dental PPO Network, and the patient Co-payment amount may be somewhat higher, You can still save money. In addition, We automatically pay Dentists who participate in the Delta Dental Premier Network directly, so You do not have to pay the whole bill up front and wait for reimbursement. Therefore, You do not have to file a claim for Covered Dental Services provided by a Dentist in the Delta Dental Premier Network.

When You choose a Dentist who does not participate in the Delta Dental PPO Network or Delta Dental Premier Network: If the Dentist You select does not participate in the Delta Dental PPO Network or the Delta Dental Premier Network, You will be responsible for the difference between Your Dentist’s Submitted amount and Our Payment. The amount We use to calculate the payment, that is the Allowed Amount, will be the lesser of the Dentist’s Submitted Amount and the Scheduled Fee.

Depending on the Dentist You choose, what would be an example of Your out-of-pocket costs?

If you choose a Dentist in the Delta Dental PPO Network:

Submitted Amount:	\$700
Fee Adjustment:	\$200
Approved Amount (Fee Schedule)	\$500
Allowed Amount (Fee Schedule)	\$500
Deductible Applied:	satisfied

<i>Our Co-Payment Amount:</i>	50%
<i>Patient Payment:</i>	\$250
<i>Our Payment:</i>	\$250

Because this Dentist has agreed to accept the Scheduled Fee as full payment for covered procedures (Approved Amount), You cannot be charged the \$200 difference (Fee Adjustment).

If You choose a Dentist who is not in the Delta Dental PPO Network, but is participating in the Delta Dental Premier Network:

<i>Submitted Amount:</i>	\$700
<i>Fee Adjustment:</i>	\$100
<i>Approved Amount (Maximum Plan Allowance)</i>	\$600
<i>Allowed Amount (Fee Schedule)</i>	\$500
<i>Deductible Applied:</i>	satisfied
<i>Our Co-Payment Amount:</i>	50%
<i>Patient Payment:</i>	\$350
<i>Our Payment:</i>	\$250

Because this Dentist accepted Delta Dental's Maximum Plan Allowance (Approved Amount) as payment in full, You cannot be charged the \$100 difference (Fee Adjustment).

If You choose a Dentist who does not participate in either the Delta Dental PPO Network or the Delta Dental Premier Network:

<i>Submitted Amount:</i>	\$700
<i>Fee Adjustment:</i>	\$0
<i>Approved Amount (Submitted Amount)</i>	\$700
<i>Allowed Amount (Fee Schedule)</i>	\$500
<i>Deductible Applied:</i>	satisfied
<i>Our Co-Payment Amount:</i>	50%
<i>Patient Payment:</i>	\$450
<i>Our Payment:</i>	\$250

What You Should Know About Our Payment of Benefits

How will You be notified of Our Payment determination?

If You or a Covered Dependent makes a claim for benefits under this Policy, and the claim is denied in whole or in part, You will received written notification within 30 days after We receive a completed claim form, unless special circumstances require an extension of time for processing. The claim decision will be sent on a form entitled, "Explanation of Benefits Statement" (EOB).

You will receive this Explanation of Benefits Statement, if You have to pay any portion of the claim, or if payment is issued directly to You for an out-of-network claim. If Your payment responsibility is zero and We issue payment directly to the Dentist, You will not receive an Explanation of Benefits Statement because Your claim has been paid in full. However, You may still check claim status on Our Web Site or by using the automated phone system.

Because Dentists who do not participate in the Delta Dental PPO Network or the Delta Dental Premier Network do not have agreements with Us, You will be responsible for the difference between Our Payment and Your Dentist's Submitted Amount.

How can You find out if Your regular Dentist is a participating Dentist in the Delta Dental PPO Network or Delta Dental Premier Network, or get a list of Dentists near You?

We offer two easy ways to locate a participating Dentist 24 hours a day, 7 days a week. You can either:

1. Search Our online Dentist directory at Our Web Site address indicated in the Policy Schedule; or
2. Use the automated phone system by calling the telephone number indicated in the Policy Schedule.

Using either method, You can request a list of participating Dentists or specialists within a designated area. Participating Dentist information can be obtained nationwide. You should keep in mind that there are two categories of participating Dentists: Delta Dental PPO Network and Delta Dental Premier Network. We also recommend that You check with Your Dentist to confirm whether he or she participates in the Delta Dental PPO Network or Delta Dental Premier Network.

May You assign Your benefits to the Dentist?

We will automatically make benefit payment for services rendered by a Dentist who participates in the Delta Dental PPO Network or Delta Dental Premier Network directly to the Dentist. If You go to a Dentist who does not participate in the Delta Dental PPO Network or Delta Dental Premier Network, You may assign Your benefits to that Dentist. However, if You do not assign Your right to receive payment to the Dentist or Your Dentist does not accept assignment of benefits, We will issue payment directly to You, and You may have to pay the entire bill in advance. In this event, You will have to file a claim for services with Us.

Are there any reimbursement limitations?

Indemnity in the form of cash will not be paid to You as reimbursement for payments made by You to a Dentist and for which We are liable at the time of such payment.

What You Should Know About Pre-Treatment Estimates

Are You required to submit a Pre-Treatment Estimate before beginning treatment?

Although Pre-Treatment Estimates are not required, We strongly recommend that You ask Your Dentist to submit Pre-Treatment Estimate for treatment costing \$200 or more. The Pre-Treatment Estimate lets You know in advance whether the requested services are covered under this Policy. Often patients believe a service is covered if their Dentist provided it. This is not always the case.

What does a Pre-Treatment Estimate need to include?

A Pre-Treatment Estimate must describe the procedures and services that the treating Dentist plans to perform, including the actual fees to be charged for each procedure or service. We require the submission of the following information to provide You with an estimate of Your Dental Benefits.

Required Documentation	Procedure/Service Planned (or Received)
Full mouth radiographs	Non-surgical and surgical periodontics
Full arch periapical radiographs	Osseous fractures and fixed bridgework
Periapical radiographs	Surgical extractions and cast restorations
Narrative	Consultations, palliative treatment and general anesthesia
Histopathology and/or hospital report	Biopsies and the surgical excision of Tissue

What happens after a Pre-Treatment Estimate request is submitted?

We will review the request, along with any required documentation submitted by the treating Dentist. We will then issue a Pre-Treatment Estimate outlining the estimated level of payment under this Policy. Please keep in mind that a Pre-Treatment Estimate is only an estimate and not a guarantee of payment. Estimated benefits may be reduced after completion of treatment due to changes in Your or Your Dependent's eligibility, application of Deductibles and Maximum Coverage Limits.

In addition, a Pre-Treatment Estimate does not take into consideration other coverage You may have; We coordinate benefits after treatment is completed and a claim is submitted for payment. An estimate made by Us imposes no restrictions on the method of treatment by Your treating Dentist and only relates to the level of benefit that We cover under this Policy.

SECTION 5: YOUR COVERED DENTAL SERVICES AND DENTAL BENEFITS

What You Should Know About the Benefits Covered Under this Policy

What services are covered under this Policy?

Dental services covered under this Policy are shown in the Policy Schedule and the Schedule of Dental Benefits.

What services are not covered under this Policy?

Not all services that Your Dentist performs may be covered under this Policy. See Section 8, *What Are the Policy Exclusions and Limitations?*, for a list of services that are not covered (excluded from coverage) under this Policy.

Are covered procedures subject to any contract limitations or payment policies?

Yes. We apply certain contract limitations or payment policies for the procedures covered under this Policy. For example, there are frequency limitations associated with certain procedures such as teeth cleaning. More frequent teeth cleaning is not a benefit even if Your Dentist states that the treatment is necessary and appropriate. This does not mean that We consider more frequent cleanings unnecessary or inappropriate; rather, this is simply a limitation on how often benefits are paid for cleanings under this Policy.

What is an alternate benefit provisions and how does it work?

There are times when there are multiple ways to treat a dental condition. The payment policies may cover only one way. This does not mean that Your Dentist made an inappropriate recommendation.

In fact, You may use Our Payment toward another method of treatment. But since Our Payment is the same no matter which treatment You choose, You may have higher out-of-pocket expenses if You choose a treatment that costs more.

What amounts do You have to pay for dental benefits under this Policy?

Deductible: This is the fixed dollar amount You pay for Covered Dental Services in a Benefit Period before We pay benefits under this Policy. The Deductible is shown in the Policy Schedule. It must be satisfied by each Covered Individual each Benefit Period.

Co-payment: This is the portion of the benefit that the Covered Individual has to pay. For example, if the benefit payable under this Policy for covered dental expenses is 80%, the Covered Individual would be responsible for 20% of the incurred expenses. The Co-payment amounts are shown in the Policy Schedule and the Schedule of Dental Benefits.

Coverage Limits: This the Annual Maximum Benefit that any Covered Individual is eligible to receive for Covered Dental Services in a Benefit Period or a benefit amount that is payable up to a specific age. Coverage Limits are shown in the Policy Schedule and the Schedule of Dental Benefits.

SECTION 6: WHAT ARE THE PREMIUM REQUIREMENTS?

How do You make Premium Payments?

Premiums for this Policy must be paid to Us. The premium applicable to this Policy is shown in the Policy Schedule.

Premiums are to be paid electronically to Us using Your checking/savings account or credit card. If You select as Your method of payment checking/savings account, then Your first premium is to be paid by check. Premiums due for the premium mode selected in Your application – annually, semi-annually, quarterly or monthly – will be drawn or charged on the first day of the month premium is due for this Policy.

If the premium due amount is dishonored by Your bank or credit card, You may be assessed a \$25.00 service charge, and subsequent payment of any premium due will not keep this Policy in force, except as provided in the Grace Period. If any premium due is not received by Us before or at the end of the Grace Period, this Policy will automatically terminate at the end of the period for which the last premium was paid.

Are Claim Payments Affected by Unpaid Premium?

Yes. Upon the payment of a claim under this Policy, any premium then due and unpaid may be deducted from the Covered Individual's claim payment.

What is the Grace Period?

After the first premium, if a premium is not paid on or before the date it is due, it may be paid during the next 31 days. These 31 days are called the Grace Period. This Policy will remain in force during the Grace Period. However, charges incurred for Covered Dental Services during the Grace Period will not be paid unless the premium due is paid by the end of the Grace Period. If any premium is unpaid at the end of the Grace Period, coverage will automatically terminate retroactively to the last day for which premium was paid.

Can the Company Change the Premium Rates?

Subject to the rate requirements in the state in which this Policy is issued, We may change the rates for this Policy on any Policy Anniversary Date. Any rate change will be made only when We change the rates for all policies in the same rate class on the same form as this Policy that are issued in the same state as this Policy. We will give You at least 45 days advance written notice prior to the effective date of any rate change. The rates will never be changed due to a change in Your age or health.

When is a Premium Refund Applicable?

In the event this Policy is terminated due to Your death, We will refund any portion of the unearned premium to Your beneficiary or Your estate.

If this Policy is Terminated, Can It be Reinstated?

If this Policy terminates due to failure to pay Premium within the time granted for You to make payment as provided in this Policy, a subsequent acceptance of premium by Us or by any agent authorized by Us to accept such premium, without requiring an application for reinstatement, will reinstate this Policy. However, if We or any agent authorized by Us requires an application for reinstatement and issues a conditional receipt for the premium paid, this Policy will be reinstated upon Our approval of such application or, lacking such approval, upon the 45th day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application.

The reinstated Policy will only cover expenses for Covered Dental Services that are incurred after the Reinstatement date of the Policy.

In all other respects, the rights of all parties will remain the same, subject to any provisions noted on or attached to the reinstated Policy. Any premium We accept in connection with the reinstatement will be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

The statements made in the application for the reinstated Policy will be measured from the effective date of the reinstatement with respect to the time periods stated in the *Time Limit on Certain Defenses* provision appearing in Section 9, *General Provisions*.

SECTION 7: WHAT ARE THE POLICY EXCLUSIONS AND LIMITATIONS?

The following are the exclusions and limitations for dental services, unless specifically provided as a Covered Dental Service as shown in the Policy Schedule and Schedule of Dental Benefits.

Exclusions That Apply to Diagnostic Services

Pulp vitality tests billed with any service are not Covered Dental Services, except:

1. An emergency exam; or
2. Palliative treatment.

Exclusions That Apply to Preventive Services

Recementation of a space maintainer with six (6) months of the initial placement is not a Covered Dental Service.

Exclusions That Apply to Restorative Services

1. Fillings are not a Covered Dental Service when crowns are allowed for the same teeth.
2. Replacement of any existing cast restoration (crowns, onlays, ceramic restorations) with any type of cast restoration within sixty (60) months following initial placement of existing restoration is not a Covered Dental Service.
3. Replacement of a stainless steel crown with any type of cast restoration is not a Covered Dental Service by the same dental provider (e.g., dental office or Dentist) within 24 months following the initial placement.
4. A cast restoration is a Covered Dental Service only in the presence of radiographic evidence of decay or missing tooth structure. Restorations placed for any other purpose, including, but not limited to, cosmetics, abrasion, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformations of teeth, or the anticipation of future fractures, are not a Covered Dental Service.
5. When there is a radiographic evidence of sufficient vertical height (more than three millimeters above the crestal bone) on a tooth to support a cast restoration, a crown build-up is not a Covered Dental Service.
6. The repair of any component of a cast restoration is not a Covered Dental Service.
7. Recementation of inlays, onlays, partial coverage restorations, case and prefabricated posts and cores and crowns by the same dental provider (e.g., dental office or Dentist) within six (6) months of initial placement is not a Covered Dental Service.
8. Additional procedures to construct a new crown under the existing partial denture framework within six (6) months following initial placement is not a Covered Dental Service.
9. When a sedative filling is requested or placed on the same date as a permanent filling, the sedative filling is not a Covered Dental Service.

Exclusions That Apply to Diagnostic Services

1. When a benefit has been issued for endodontic services, retreatment of the same tooth within two (2) years is not a Covered Dental Service.
2. Endodontic procedures performed in conjunction with complete removable prosthodontics appliances are not Covered Dental Services.

Exclusions That Apply to Periodontic Services

1. Guided tissue regeneration billed in conjunction with implantology, ridge augmentation/sinus lift, extractions or periradicular surgery/apicoectomy is not a Covered Dental Service.
2. Crown lengthening or gingivoplasty, if not performed at least four weeks prior to crown preparation, is not a Covered Dental Service.
3. Bone replacement grafts performed in conjunction with extractions or implants are not a Covered Dental Service.
4. Periodontal splinting to restore occlusion is not a Covered Dental Service.

Exclusions That Apply to Prosthodontic Services

1. Replacement of any existing prosthodontics appliance (cast restorations, fixed partial dentures, removable partial dentures, complete denture) with any prosthodontics appliance within sixty (60) months following initial placement of existing appliance is not a Covered Dental Service.
2. When a fixed partial denture and a removable partial denture are requested or placed in the same arch, the fixed partial denture is not a Covered Dental Service.
3. Any prosthodontic appliance connected to an implant is not a Covered Dental Service.
4. Reline or rebase of an existing appliance within six (6) months following initial replacement is not a Covered Dental Service.
5. Fixed or removable prosthodontics for a Covered Individual under age 16 is not a Covered Dental Service.
6. Tissue conditioning is not a Covered Dental Service.
7. When the edentulous (toothless) space between teeth is less than 50% of the size of the missing tooth, a pontic is not a Covered Dental Service.

General Exclusions (Applies to all Covered Dental Services)

Under this Policy, coverage is NOT provided for the following:

1. Services compensable under Worker's Compensation or Employer's Liability Laws.
2. Services provided or paid for by any governmental agency or under any governmental program or law, except as to charges which the Covered Individual is legally obligated to pay. This exception extends to any benefits provided under the U.S. Social Security Act and its Amendments.
3. Services performed to correct developmental malformation including, but not limited to: (a) cleft palate; (b) mandibular prognathism; (c) enamel hypoplasia; (d) fluorosis; and (e) congenitally missing teeth. This exclusion does not apply to newborn infants.
4. Services performed for purely cosmetic purposes, including, but not limited to: (a) tooth-colored veneers; (b) bonding; (c) porcelain restorations; and (d) microabrasion. Orthodontic care benefits provided under this Policy will fall within this exclusion unless such benefits are provided by endorsement and You elected Family Coverage. In no event will a Covered Individual age 19 or over be able to receive orthodontic care benefits.
5. Charges for services completed prior to the date the prior to the date the Covered Individual became insured under this Policy.
6. Services for anesthetists or anesthesiologists.
7. Temporary procedures.
8. Any procedure requested or performed on a tooth when radiographs indicate that less than 40% of the root is supported by bone.
9. Services performed on non-functional teeth (second or third molar without an opposing tooth).
10. Services performed on deciduous (primary) teeth near exfoliation.
11. Drugs or the administration of drugs, except for general anesthesia.
12. Procedures deemed experimental or investigational by the American Dental Association, for which there is no procedure code, or which are inconsistent with Current Dental Terminology coding and nomenclature.
13. Services with respect to any disturbance of the temporomandibular joint (jaw joint).
14. Procedures, techniques or materials related to implantology or edentulous (toothless) ridge enhancement.
15. Procedures that We consider to be included in the fees for other procedures. For such procedures, a separate payment will not be made under this Policy. A Dentist in the Delta Dental PPO Network or Delta Dental Premier Network may not bill the Covered Individual for such procedures.

16. The completion of claim forms and submission of required information, not otherwise covered, for determination of benefits.
17. Infection control procedures and fees associated with compliance with Occupational Safety and Health Administration (OSHA) requirements.
18. Broken appointments.
19. Services and supplies for any illness or injury occurring on or after the Covered Individual's effective date of coverage under this Policy as a result of war or an act of war.
20. Services for, or in connection with, an intentional self-inflicted injury or illness while sane or insane, except when due to domestic violence or a medical (including both physical and mental) health condition.
21. Services and supplies received from either: (1) a Covered Individual's spouse or Domestic Partner or other relative; (2) a relative of the Covered Dependent Spouse or Domestic Partner; or (3) any individual who ordinarily resides such Covered Individual's home or any such similar person.
22. Services for, or in connection with, an injury or illness arising out of the participation in, or in consequence of having participated in, a riot, insurrection or civil disturbance or the commission of a felony.
23. Charges for services for inpatient/outpatient hospitalization.
24. Services or supplies for oral hygiene or plague control programs.
25. Services or supplies to correct harmful habits.

SECTION 8: WHAT YOU SHOULD KNOW ABOUT CLAIMS

What You Should Know About Filing Claims

When do You file a claim

After a Covered Individual receives Covered Dental Services, he or she should file a claim only if his or her Dentist has not filed one for him or her.

Dental providers participating in the Delta Dental PPO Network and Delta Dental Premier Network will automatically file a claim directly to Us on behalf of the Covered Individual for whom they provided treatment for Covered Dental Services. Therefore, the Covered Individual is not required to complete and submit a claim form to Us.

If the Covered Individual uses the services of an Out-of-Network provider, he or she must submit to Us a completed claim form, unless the provider completes and submits the claim to Us on behalf of the Covered Individual.

If the Covered Individual must file a claim with Us, the claim should not be submitted to Us until the Covered Dental Service is completely finished. A claim should not be filed for payment before the Covered Dental Service is completed.

Notice of Claim

Written notice of claim must be given to Us within 20 days after the occurrence or commencement of any loss covered by this Policy, or as soon thereafter as is reasonably possible. Notice given by, or on behalf of, the Covered Individual or the beneficiary to Us at Our home office address shown on the cover page of this Policy, or to any of Our authorized agents, with information sufficient to identify the Covered Individual, will be deemed notice to Us.

Claim Forms

We, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by Us for filing proofs of loss. If such forms are not furnished to the claimant within fifteen (15) days after the giving of such notice, the claimant will be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in this Policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

You can also download a claim form from Our Web Site. The Web Site address is shown in the Policy Schedule.

Proof of Loss

Written proof of loss must be given to Us at Our home address shown on the cover page of this Policy within one year of the date of loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible, and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Time Payment of Claims

Benefits payable under this Policy for any loss will be paid immediately upon receipt of due written proof of such loss.

Payment of Claims

We will pay benefits to You when Covered Dental Services are provided by a Non-Preferred Provider, unless the claim payment has been assigned to the Non-Preferred Provider. No claim payment will be paid to You when Covered Dental Services are provided by a Preferred Provider.

What Documentation Must Accompany a Claim for Payment?

Pre-Treatment Estimate Documentation: If a Pre-Treatment Estimate is not submitted, We require the submission of the same documentation for a claim payment as needed for a Pre-Treatment Estimate. (Refer to the Required Documentation chart appearing under the provision entitled *What You Should Know about Pre-Treatment Estimates* in Section 4.

Non-Preferred Provider Claims: We will need written proof of the expenses incurred for Covered Dental Services provided by a Non-Preferred Provider for which claim is being made. Such written proof is to include: (1) the occurrence; (2) the character; and (3) the extent of the dental services. Also, refer to the *Proof of Loss* provision.

Where Are Claims Filed for Payment

The Covered Individual can complete the claim form and mail it to our Home Office address shown on the cover page of this Policy. A separate claim form must be submitted for each Covered Individual who receives Covered Dental Services.

What You Should Know About Claim Determinations and Appeal Procedures

How will You know when claims are processed?

When the Dentist is paid directly: Unless the Covered Individual's payment responsibility is zero, the Covered Individual will receive an Explanation of Benefits that describes the services his or her Dentist submitted and the benefits that this Policy covers. The treating Dentist will receive an Explanation of Payment along with the payment.

When You are paid directly: Along with Your payment, We will provide You with an Explanation of Payment that describes:

1. The services the treating Dentist submitted for You or Your Covered Dependent; and
2. The Covered Dental Services insured under this Policy.

You can also check claim status on Our Web Site or through Our automated phone system. Our Web Site address and automated phone system telephone number are shown in the Policy Schedule.

How do You appeal a denied claim?

If You have questions about the denial of Your or Your Covered Dependent's claim for benefits, You should contact Us at the toll-free telephone number shown in the Policy Schedule. Because most questions about benefits can be answered informally, We encourage You and Your Covered Dependents first try to resolve any problem by talking with one of Our customer service representatives. However, You or Your Covered Dependents have the right to file an appeal requesting that We formally review Our benefits determination.

You may file an appeal of a claim that is denied in whole or in part by written request within 180 days from the date of the denial notice. Send Your written request for review to the attention of the "Reevaluation Committee, TruAssure Insurance Company", at Our Home Office address shown on the cover page of this Policy.

You or Your Covered Dependent should provide the reasons why You disagree with Our benefits determination and include any additional documents or records in support of Your appeal. You should include Your name, the Covered Dependent's name if applicable, and Your Policy Number or member ID on all documents and supporting documents.

SECTION 9: GENERAL PROVISIONS

Entire Contract; Changes

This Policy including the application, including the endorsements and attached papers, if any, constitutes the entire contract of insurance. No change in this Policy will be valid until approved by an executive officer of the Company and unless such approval be endorsed in or attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

Time Limit on Certain Defenses

After three (3) years from the Policy Effective Date of this Policy no misstatements, except fraudulent misstatements, made by the applicant in the application for this Policy will be used to void this Policy or to

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Comment [HD4]: Ins Code 23-85-107(1)

deny a claim for loss incurred or disability (as defined in this Policy) commencing after the expiration of such three-year period.

Representations

In the absence of fraud, any statement made by You will be deemed a representation and not a warranty. Such statement may not be used in defense of a claim, unless it is contained in a signed application.

What Are the Time Limits on Legal Actions?

Legal Actions: No action will be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action will be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

Can this Policy be Assigned?

This Policy cannot be assigned.

When Can Beneficiary Changes Be Made?

Change of Beneficiary: Unless You make an irrevocable designation of beneficiary, the right to change a beneficiary is reserved to You. The consent of the beneficiary, or beneficiaries, will not be requisite to surrender or assignment of this Policy or to any change of beneficiary, or beneficiaries, or to any other changes in this Policy.

Conformity with State Statutes

Any provision of this Policy which, on its Policy Effective Date, is in conflict with the statutes of the state, District of Columbia, or territory in which You reside on such date is hereby amended to conform to the minimum requirements of such statutes.

Comment [HD5]: Ins Code 23-85-124

INDIVIDUAL DENTAL PREFERRED PROVIDER ORGANIZATION (PPO) POLICY

**This is a Limited-Scope Dental Policy
Guaranteed Renewable
Non-Participating**

TruA-1000-AR

POLICY SCHEDULE

[TruAssure Insurance Company Web Site: [www.truassure.com]]

[For Questions or Claim Inquiries, please call: [1-800-414-4988]]

[For Automated Phone System, please call: [1-800-323-1743]]

[Customer Service E-mail Address: [CSI@truassure.com]]

Policy Number: [123456]
Policyholder: [John Doe]
Dental Coverage Plan: [Plan 1]
Benefit Period: [November 1 through October 31 of each year]
Type of Coverage: [Family]
Initial Premium: [\$162.00]
Premium Payment Mode: [Monthly]
Policy Effective Date: [November 1, 2012]
Policy Anniversary Date: [November 1 of each year]

DENTAL BENEFITS

A Covered Individual has the right to obtain Covered Dental Services from the Dentist of his or her choice. However, if a Covered Individual selects an Out-of-Network Dentist, he or she will be responsible for the difference between that provider's Submitted Amount and the benefit amount payable under this Policy. (Refer to Section 5, *How Your Dental Plan Works*, for more details.)

Dental Coverage Plan: [Plan 1]	<u>In-Network</u>	<u>Out-of-Network</u>
Annual Maximum per Benefit Period <i>(per Covered Individual per Benefit Period)</i>	[\$2,000]	[\$2,000]
Deductible <i>(per Covered Individual per Benefit Period)</i>	[\$50]	[\$50]
*Diagnostic Preventive Services	[100%]	[100%]
*Basic Services[– [6] month waiting period]	[80%]	[80%]
*Major Services[– [12] month waiting period]	[50%]	[50%]

**Refer to the Schedule of Dental Benefits for the list of Covered Dental Benefits.*

POLICY SCHEDULE

[TruAssure Insurance Company Web Site: [www.truassure.com]]

[For Questions or Claim Inquiries, please call: [1-800-414-4988]]

[For Automated Phone System, please call: [1-800-323-1743]]

[Customer Service E-mail Address: [CSI@truassure.com]]

Policy Number: [123456]
Policyholder: [John Doe]
Dental Coverage Plan: [Plan 2]
Benefit Period: [November 1 through October 31 of each year]
Type of Coverage: [Family]
Initial Premium: [\$132.09]
Premium Payment Mode: [Monthly]
Policy Effective Date: [November 1, 2012]
Policy Anniversary Date: [November 1 of each year]

DENTAL BENEFITS

A Covered Individual has the right to obtain Covered Dental Services from the Dentist of his or her choice. However, if a Covered Individual selects an Out-of-Network Dentist, he or she will be responsible for the difference between that provider's Submitted Amount and the benefit amount payable under this Policy. (Refer to Section 5, *How Your Dental Plan Works*, for more details.)

Dental Coverage Plan: [Plan 2]	<u>In-Network</u>	<u>Out-of-Network</u>
Annual Maximum per Benefit Period (per Covered Individual per Benefit Period)	[\$1,500]	[\$1,500]
Deductible (per Covered Individual per Benefit Period)	[\$50]	[\$50]
*Diagnostic Preventive Services	[100%]	[100%]
*Basic Services[– [6] month waiting period]	[50%]	[50%]
*Major Services[– [12] month waiting period]	[50%]	[50%]

*Refer to the Schedule of Dental Benefits for the list of Covered Dental Benefits.

POLICY SCHEDULE

[TruAssure Insurance Company Web Site: [www.truassure.com]]

[For Questions or Claim Inquiries, please call: [1-800-414-4988]]

[For Automated Phone System, please call: [1-800-323-1743]]

[Customer Service E-mail Address: [CSI@truassure.com]]

Policy Number: [123456]
Policyholder: [John Doe]
Dental Coverage Plan: [Plan 3]
Benefit Period: [November 1 through October 31 of each year]
Type of Coverage: [Family]
Initial Premium: [\$101.86]
Premium Payment Mode: [Monthly]
Policy Effective Date: [November 1, 2012]
Policy Anniversary Date: [November 1 of each year]

DENTAL BENEFITS

A Covered Individual has the right to obtain Covered Dental Services from the Dentist of his or her choice. However, if a Covered Individual selects an Out-of-Network Dentist, he or she will be responsible for the difference between that provider's Submitted Amount and the benefit amount payable under this Policy. (Refer to Section 5, *How Your Dental Plan Works*, for more details.)

Dental Coverage Plan: [Plan 3]	<u>In-Network</u>	<u>Out-of-Network</u>
Annual Maximum per Benefit Period (per Covered Individual per Benefit Period)	[\$1,000]	[\$1,000]
Deductible (per Covered Individual per Benefit Period)	[\$75]	[\$75]
*Diagnostic Preventive Services	[90%]	[90%]
*Basic Services[– [6] month waiting period]	[50%]	[50%]
*Major Services[– [12] month waiting period]	[50%]	[50%]

*Refer to the Schedule of Dental Benefits for the list of Covered Dental Benefits.

POLICY SCHEDULE

[TruAssure Insurance Company Web Site: [www.truassure.com]]

[For Questions or Claim Inquiries, please call: [1-800-414-4988]]

[For Automated Phone System, please call: [1-800-323-1743]]

[Customer Service E-mail Address: [CSI@truassure.com]]

Policy Number: [123456]
Policyholder: [John Doe]
Dental Coverage Plan: [Plan 4]
Benefit Period: [November 1 through October 31 of each year]
Type of Coverage: [Family]
Initial Premium: [\$76.10]
Premium Payment Mode: [Monthly]
Policy Effective Date: [November 1, 2012]
Policy Anniversary Date: [November 1 of each year]

DENTAL BENEFITS

A Covered Individual has the right to obtain Covered Dental Services from the Dentist of his or her choice. However, if a Covered Individual selects an Out-of-Network Dentist, he or she will be responsible for the difference between that provider's Submitted Amount and the benefit amount payable under this Policy. (Refer to Section 5, *How Your Dental Plan Works*, for more details.)

Dental Coverage Plan: [Plan 4]	<u>In-Network</u>	<u>Out-of-Network</u>
Annual Maximum per Benefit Period (per Covered Individual per Benefit Period)	[\$500]	[\$500]
Deductible (per Covered Individual per Benefit Period)	[\$25]	[\$25]
*Diagnostic Preventive Services	[100%]	[100%]

*Refer to the Schedule of Dental Benefits for the list of Covered Dental Benefits.

POLICY SCHEDULE

[TruAssure Insurance Company Web Site: [www.truassure.com]]

[For Questions or Claim Inquiries, please call: [1-800-414-4988]]

[For Automated Phone System, please call: [1-800-323-1743]]

[Customer Service E-mail Address: [CSI@truassure.com]]

Policy Number: [123456]
Policyholder: [John Doe]
Dental Coverage Plan: [Plan 5]
Type of Coverage: [Dependent Children through Age 18 Only]
Number of Dependent
Children Under age 19: [1[, Susan Doe]]
Benefit Period: [November 1 through October 31 of each year]
Initial Premium: [\$41.63]
Premium Payment Mode: [Monthly]
Policy Effective Date: [November 1, 2012]
Policy Anniversary Date: [November 1 of each year]

PEDIATRIC DENTAL BENEFITS

This Pediatric Dental Plan only covers Your Covered Dependent Children under age 19. You have the right to obtain Covered Dental Services for Your Covered Dependent Children from the Dentist of Your choice. However, if You select an Out-of-Network Dentist, You will be responsible for the difference between that provider's Submitted Amount and the benefit amount payable under this Policy. (Refer to Section 5, *How Your Dental Plan Works*, for more details.)

<u>Dental Coverage Plan: [Plan 5]</u>	<u>In-Network</u>	<u>Out-of-Network</u>
Annual Maximum per Benefit Period (per Covered Individual per Benefit Period)	[\$1,000]	[\$1,000]
Deductible (per Covered Individual per Benefit Period)	[None]	[None]
*Diagnostic Preventive Services	[100%]	[100%]
*Basic Services[– [6] month waiting period]	[80%]	[80%]
*Major Services[– [12] month waiting period]	[80%]	[80%]

**Refer to the Schedule of Dental Benefits for the list of Covered Dental Benefits.*

SCHEDULE OF DENTAL BENEFITS – [PLAN [1]]

This Schedule of Dental Benefits provides the list of dental procedures that are Covered Dental Services under this Policy. This Schedule indicates: (1) the covered dental procedure; (2) the Co-payment We will pay for each covered dental procedure; (3) any specific coverage limits, as applicable; and (4) if the Deductible applies to a Covered Dental Procedure. Also, refer to the *Policy Schedule*.)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
DIAGNOSTIC SERVICES						
Oral evaluations (includes limited – problem focused and re-evaluation – limited, problem focused)	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Comprehensive oral evaluation – new or established patient: <i>once per Dentist</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Detailed and extensive oral evaluation – problem focused, by report: <i>once per Dentist</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Comprehensive periodontal evaluation – new or established patient: <i>once per Dentist</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Periodic oral evaluations: <i>twice per Benefit Period</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Intra-oral – periapical radiographs	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Bitewing x-rays (not including vertical bitewings): <i>[once] per Benefit Period</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Complete full-mouth x-rays: <i>once in a 36-month interval</i> . <i>A full-mouth x-ray includes bitewing x-rays. Panoramic x-rays in conjunction with any other x-ray, or any combination of intraoral x-rays on the same date for which the total approved amount equals or exceeds the approved amount for a full-mouth x-ray, is considered a full mouth x-ray. One full-mouth x-ray, one set of vertical bitewings, or one panoramic x-ray is a covered benefit in a 36-month interval.</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Diagnostic casts: <i>when rendered more than 30 days prior to definitive treatment</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Pulp vitality tests: <i>once per visit</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
<i>If additional detailed or comprehensive oral evaluations are billed by the same Dentist, the level of benefits will be limited to that of a periodic oral evaluation. Detailed or comprehensive oral evaluations count toward the Benefit Period maximum of two oral evaluations.</i>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [1]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
PREVENTIVE SERVICES						
Dental prophylaxis (cleaning): <i>twice per Benefit Period*</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Topical fluoride applications: <i>once per Benefit Period, for Covered Dependent Children under age [16]</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Space Maintainers: <i>once per lifetime for Covered Dependent Children under age [14].</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Recementation of space maintainers: <i>once per Benefit Period.</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Sealants: <i>applied once per tooth to first and second permanent molars which are free of caries (cavities) and restorations; for Covered Dependent Children under age [16].</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
<p><i>*With an indicator for diabetes, high risk cardiac conditions, or kidney failure or dialysis conditions, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis or [periodontal maintenance] per Benefit Period.</i></p> <p><i>*With an indicator for periodontal disease, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis or [periodontal maintenance]) per Benefit Period and for topical application for fluoride at the frequency stated in this Schedule of Dental Benefits.</i></p> <p><i>*With an indicator for suppressed immune system conditions of cancer-related chemotherapy and/or radiation, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis or [periodontal maintenance]) per Benefit Period and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.</i></p> <p><i>*With an indicator for pregnancy, the Covered Individual will be eligible for one additional cleaning (prophylaxis or [periodontal maintenance]) during the time of pregnancy.</i></p>						

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
BASIC SERVICES: ROUTINE AND RESTORATIVE SERVICES						
[Waiting Period – 6 Months]						
Simple Extractions	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Amalgam and resin-based composite fillings: <i>[once] per surface in a 12-month interval.</i>	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Sedative filling	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Pin retention	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
<p><i>When an inlay is requested or placed, the level of benefits will be limited to that of an amalgam filling. Sedative fillings are a Covered Dental Benefit once per tooth per lifetime. When multiple pins are requested or placed, the level of benefits will be limited to one pin per tooth.</i></p>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [1]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: RESTORATIVE SERVICES						
[Waiting Period – 12 Months]						
Onlays (permanent teeth only)	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Crowns and ceramic restorations (permanent teeth only)	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Recementation of inlays, onlays, partial coverage restorations, cast or prefabricated posts and cores and crowns.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Cast or prefabricated post and core; core build-up.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Additional procedures to construct new crown under existing partial denture framework.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: ENDODONTIC SERVICES						
[Waiting Period – 12 months]						
Pulpal and root canal therapy	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
<p><i>When endodontic therapy is performed on primary teeth, the level of benefits will be limited to that of a pulpotomy, except where radiographs indicate there is no permanent successor tooth and the primary tooth demonstrates sufficient intact root structure.</i></p> <p><i>Retreatment of root canal therapy 24 months of initial treatment is not a Covered Dental Benefit.</i></p> <p><i>When incomplete endodontic therapy is billed because the Covered Individual has been referred to an endodontist for completion of endodontic treatment, the level of benefits will be limited to that of a pupal debridement.</i></p> <p><i>Pupal therapy (resorbable filling) is a Covered Dental Benefit once per tooth per lifetime.</i></p>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [1]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: SURGICAL PERIODONTIC SERVICES						
[Waiting Period – 12 months]						
Gingivectomy or gingivoplasty; gingival flap procedure.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Clinical crown lengthening – hard tissue.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Guided tissue regeneration, per site: <i>only when performed in association with natural teeth.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Bone replacement and soft tissue grafts.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
MAJOR SERVICES: NON-SURGICAL PERIODONTIC SERVICES						
[Waiting Period – 12 months]						
Periodontal scaling and root planning.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Full-mouth debridement to enable comprehensive evaluation and diagnosis: <i>once per lifetime.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Periodontal maintenance: <i>twice per Benefit Period*</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
<p><i>Periodontal therapy includes treatment of diseases of the gums and bone supporting the teeth once per quadrant in any 24-month interval.</i></p> <p><i>*With an indicator for diabetes, high risk cardiac conditions, or kidney failure or dialysis conditions, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period.</i></p> <p><i>*With an indicator for periodontal disease, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period and for topical application for fluoride at the frequency stated in this Schedule of Dental Benefits.</i></p> <p><i>*With an indicator for suppressed immune system conditions of cancer-related chemotherapy and/or radiation, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.</i></p> <p><i>*With an indicator for pregnancy, the Covered Individual will be eligible for one additional cleaning (prophylaxis [or periodontal maintenance]) during the time of pregnancy.</i></p>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [1]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: REMOVAL PROSTHODONTIC SERVICES						
[Waiting Period – 12 months]						
Complete and partial dentures.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Adjustments to complete and partial dentures.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Repairs to complete and partial dentures.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Replace missing or broken teeth.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Add tooth or clasp to existing partial denture.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Replace all teeth and acrylic on cast metal framework.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Denture rebase: <i>once in a 24-month interval.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Denture reline: <i>once in a 24-month interval.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
MAJOR SERVICES: FIXED PROSTHODONTIC SERVICES (BRIDGES)						
[Waiting Period – 12 months]						
Pontics	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Fixed partial denture retainers – inlays/onlays (inlays/onlays placed as abutments, i.e., to retain or support fixed partial dentures).	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Fixed partial denture retainers – crowns (crowns placed as abutments, i.e., to retain or support fixed partial dentures).	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Recement fixed partial denture.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Cast or refabricated post and core; core build-up.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
<p><i>When a fixed partial denture is requested or placed and three or more teeth are missing in a dental arch, the level of benefits will be limited to that of a removable partial denture. The placement of any additional appliance in the same arch within 60 months following placement of the initial appliance is not a Covered Dental Benefit.</i></p> <p><i>When the edentulous space between teeth exceeds 100% of the size of the original tooth, the level of benefits will be limited to that of a removable partial denture.</i></p> <p><i>When a fixed partial denture and a removable partial denture are requested or placed in the same arch, the level of benefits will be limited to that of a removable partial denture.</i></p> <p><i>If, in the construction of a prosthodontics appliance, personalized or special techniques including, but not limited to, tooth supported dentures, precision attachments or stress breakers, are elected, the level of benefits will be limited to that of a conventional prosthodontics appliance.</i></p> <p><i>When a porcelain/ceramic inlay is requested or placed as abutment (i.e., to retain or support a fixed partial denture), the level of benefits will be limited to that of a cast metal inlay.</i></p>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [1]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: ORAL SURGERY						
[Waiting Period – 12 months]						
Simple extractions.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Surgical removal of reputed tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Removal of impacted tooth – soft tissue.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Removal of impacted tooth – partially bony.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Removal of impacted tooth – completely bony.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Tooth reimplantation/stabilization of accidentally evulsed or displaced tooth and/or alveolus.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Surgical access of an unerupted tooth.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Biopsy of oral tissue: brush biopsy.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Alveoloplasty – per quadrant.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Vestibuloplasty – ridge extension.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Surgical excision of soft tissue lesions.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Surgical excision of intra-osseous lesions.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Other covered surgical/repair procedures: Removal of exostosis, torus palatinus or torus mandibularis; incision and drainage of abscess – intraoral soft tissue; frenulectomy or frenuoplasty; excision of hyperplastic tissue or pericoronal gingiva; surgical reduction of osseous or fibrous tuberosity.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
<i>Oral Surgery includes extractions and other listed oral surgery procedures (Including pre- and post-operative care) only when provided in a Dentist's office.</i>						
MAJOR SERVICES: ADJUNCTIVE GENERAL SERVICES						
[Waiting Period – 12 months]						
Palliative (emergency) treatment of dental pain – minor procedure.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Deep sedation/general anesthesia: <i>when provided by a Dentist in conjunction with Oral Surgery (surgical procedures) other than simple extractions.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Intravenous conscious sedation/analgesia: <i>when provided in conjunction with Oral Surgery (surgical procedures) other than simple extractions.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Consultations	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]

SCHEDULE OF DENTAL BENEFITS – [PLAN [2]]

This Schedule of Dental Benefits provides the list of dental procedures that are Covered Dental Services under this Policy. This Schedule indicates: (1) the covered dental procedure; (2) the Co-payment We will pay for each covered dental procedure; (3) any specific coverage limits, as applicable; and (4) if the Deductible applies to a Covered Dental Procedure. Also, refer to the *Policy Schedule*.)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
DIAGNOSTIC SERVICES						
Oral evaluations (includes limited – problem focused and re-evaluation – limited, problem focused)	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Comprehensive oral evaluation – new or established patient: <i>once per Dentist</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Detailed and extensive oral evaluation – problem focused, by report: <i>once per Dentist</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Comprehensive periodontal evaluation – new or established patient: <i>once per Dentist</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Periodic oral evaluations: <i>twice per Benefit Period</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Intra-oral – periapical radiographs	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Bitewing x-rays (not including vertical bitewings): <i>[once] per Benefit Period</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Complete full-mouth x-rays: <i>once in a 36-month interval</i> . <i>A full-mouth x-ray includes bitewing x-rays. Panoramic x-rays in conjunction with any other x-ray, or any combination of intraoral x-rays on the same date for which the total approved amount equals or exceeds the approved amount for a full-mouth x-ray, is considered a full mouth x-ray. One full-mouth x-ray, one set of vertical bitewings, or one panoramic x-ray is a covered benefit in a 36-month interval.</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Diagnostic casts: <i>when rendered more than 30 days prior to definitive treatment</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Pulp vitality tests: <i>once per visit</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
<i>If additional detailed or comprehensive oral evaluations are billed by the same Dentist, the level of benefits will be limited to that of a periodic oral evaluation. Detailed or comprehensive oral evaluations count toward the Benefit Period maximum of two oral evaluations.</i>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [2]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
PREVENTIVE SERVICES						
Dental prophylaxis (cleaning): <i>twice per Benefit Period*</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Topical fluoride applications: <i>once per Benefit Period, for Covered Dependent Children under age [16]</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Space Maintainers: <i>once per lifetime for Covered Dependent Children under age [14].</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Recreation of space maintainers: <i>once per Benefit Period.</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Sealants: <i>applied once per tooth to first and second permanent molars which are free of caries (cavities) and restorations; for Covered Dependent Children under age [16].</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
<p><i>*With an indicator for diabetes, high risk cardiac conditions, or kidney failure or dialysis conditions, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period.</i></p> <p><i>*With an indicator for periodontal disease, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period and for topical application for fluoride at the frequency stated in this Schedule of Dental Benefits.</i></p> <p><i>*With an indicator for suppressed immune system conditions of cancer-related chemotherapy and/or radiation, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.</i></p> <p><i>*With an indicator for pregnancy, the Covered Individual will be eligible for one additional cleaning (prophylaxis [or periodontal maintenance]) during the time of pregnancy.</i></p>						

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
BASIC SERVICES: ROUTINE AND RESTORATIVE SERVICES						
[Waiting Period – 6 Months]						
Simple Extractions	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Amalgam and resin-based composite fillings: <i>[once] per surface in a 12-month interval.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Sedative filling	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Pin retention	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
<p><i>When an inlay is requested or placed, the level of benefits will be limited to that of an amalgam filling. Sedative fillings are a Covered Dental Benefit once per tooth per lifetime. When multiple pins are requested or placed, the level of benefits will be limited to one pin per tooth.</i></p>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [2]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: RESTORATIVE SERVICES						
[Waiting Period – 12 Months]						
Onlays (permanent teeth only)	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Crowns and ceramic restorations (permanent teeth only)	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Recementation of inlays, onlays, partial coverage restorations, cast or prefabricated posts and cores and crowns.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Cast or prefabricated post and core; core build-up.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Additional procedures to construct new crown under existing partial denture framework.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: ENDODONTIC SERVICES						
[Waiting Period – 12 months]						
Pulpal and root canal therapy	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
<p><i>When endodontic therapy is performed on primary teeth, the level of benefits will be limited to that of a pulpotomy, except where radiographs indicate there is no permanent successor tooth and the primary tooth demonstrates sufficient intact root structure.</i></p> <p><i>Retreatment of root canal therapy 24 months of initial treatment is not a Covered Dental Benefit.</i></p> <p><i>When incomplete endodontic therapy is billed because the Covered Individual has been referred to an endodontist for completion of endodontic treatment, the level of benefits will be limited to that of a pupal debridement.</i></p> <p><i>Pupal therapy (resorbable filling) is a Covered Dental Benefit once per tooth per lifetime.</i></p>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [2]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: SURGICAL PERIODONTIC SERVICES [Waiting Period – 12 months]						
Gingivectomy or gingivoplasty; gingival flap procedure.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Clinical crown lengthening – hard tissue.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Guided tissue regeneration, per site: <i>only when performed in association with natural teeth.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Bone replacement and soft tissue grafts.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
MAJOR SERVICES: NON-SURGICAL PERIODONTIC SERVICES [Waiting Period – 12 months]						
Periodontal scaling and root planning.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Full-mouth debridement to enable comprehensive evaluation and diagnosis: <i>once per lifetime.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Periodontal maintenance: <i>twice per Benefit Period*</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
<p><i>Periodontal therapy includes treatment of diseases of the gums and bone supporting the teeth once per quadrant in any 24-month interval.</i></p> <p><i>*With an indicator for diabetes, high risk cardiac conditions, or kidney failure or dialysis conditions, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period.</i></p> <p><i>*With an indicator for periodontal disease, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period and for topical application for fluoride at the frequency stated in this Schedule of Dental Benefits.</i></p> <p><i>*With an indicator for suppressed immune system conditions of cancer-related chemotherapy and/or radiation, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.</i></p> <p><i>*With an indicator for pregnancy, the Covered Individual will be eligible for one additional cleaning (prophylaxis [or periodontal maintenance]) during the time of pregnancy.</i></p>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [2]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: REMOVAL PROSTHODONTIC SERVICES						
[Waiting Period – 12 months]						
Complete and partial dentures.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Adjustments to complete and partial dentures.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Repairs to complete and partial dentures.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Replace missing or broken teeth.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Add tooth or clasp to existing partial denture.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Replace all teeth and acrylic on cast metal framework.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Denture rebase: <i>once in a 24-month interval.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Denture reline: <i>once in a 24-month interval.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
MAJOR SERVICES: FIXED PROSTHODONTIC SERVICES (BRIDGES)						
[Waiting Period – 12 months]						
Pontics	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Fixed partial denture retainers – inlays/onlays (inlays/onlays placed as abutments, i.e., to retain or support fixed partial dentures).	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Fixed partial denture retainers – crowns (crowns placed as abutments, i.e., to retain or support fixed partial dentures).	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Recement fixed partial denture.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Cast or refabricated post and core; core build-up.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
<p><i>When a fixed partial denture is requested or placed and three or more teeth are missing in a dental arch, the level of benefits will be limited to that of a removable partial denture. The placement of any additional appliance in the same arch within 60 months following placement of the initial appliance is not a Covered Dental Benefit.</i></p> <p><i>When the edentulous space between teeth exceeds 100% of the size of the original tooth, the level of benefits will be limited to that of a removable partial denture.</i></p> <p><i>When a fixed partial denture and a removable partial denture are requested or placed in the same arch, the level of benefits will be limited to that of a removable partial denture.</i></p> <p><i>If, in the construction of a prosthodontics appliance, personalized or special techniques including, but not limited to, tooth supported dentures, precision attachments or stress breakers, are elected, the level of benefits will be limited to that of a conventional prosthodontics appliance.</i></p> <p><i>When a porcelain/ceramic inlay is requested or placed as abutment (i.e., to retain or support a fixed partial denture), the level of benefits will be limited to that of a cast metal inlay.</i></p>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [2]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies			
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network	
MAJOR SERVICES: ORAL SURGERY							
[Waiting Period – 12 months]							
Simple extractions.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]	
Surgical removal of reputed tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]	
Removal of impacted tooth – soft tissue.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]	
Removal of impacted tooth – partially bony.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]	
Removal of impacted tooth – completely bony.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]	
Tooth reimplantation/stabilization of accidentally evulsed or displaced tooth and/or alveolus.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]	
Surgical access of an unerupted tooth.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]	
Biopsy of oral tissue: brush biopsy.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]	
Alveoloplasty – per quadrant.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]	
Vestibuloplasty – ridge extension.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]	
Surgical excision of soft tissue lesions.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]	
Surgical excision of intra-osseous lesions.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]	
Other covered surgical/repair procedures: Removal of exostosis, torus palatinus or torus mandibularis; incision and drainage of abscess – intraoral soft tissue; frenulectomy or frenuoplasty; excision of hyperplastic tissue or pericoronal gingiva; surgical reduction of osseous or fibrous tuberosity.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]	
<i>Oral Surgery includes extractions and other listed oral surgery procedures (Including pre- and post-operative care) only when provided in a Dentist's office.</i>							
MAJOR SERVICES: ADJUNCTIVE GENERAL SERVICES							
[Waiting Period – 12 months]							
Palliative (emergency) treatment of dental pain – minor procedure.	[50%]		[50%]	[50%]	[Yes]	[Yes]	[Yes]
Deep sedation/general anesthesia: <i>when provided by a Dentist in conjunction with Oral Surgery (surgical procedures) other than simple extractions.</i>	[50%]		[50%]	[50%]	[Yes]	[Yes]	[Yes]
Intravenous conscious sedation/analgesia: <i>when provided in conjunction with Oral Surgery (surgical procedures) other than simple extractions.</i>	[50%]		[50%]	[50%]	[Yes]	[Yes]	[Yes]
Consultations	[50%]		[50%]	[50%]	[Yes]	[Yes]	[Yes]

SCHEDULE OF DENTAL BENEFITS – [PLAN [3]]

This Schedule of Dental Benefits provides the list of dental procedures that are Covered Dental Services under this Policy. This Schedule indicates: (1) the covered dental procedure; (2) the Co-payment We will pay for each covered dental procedure; (3) any specific coverage limits, as applicable; and (4) if the Deductible applies to a Covered Dental Procedure. Also, refer to the *Policy Schedule*.)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
DIAGNOSTIC SERVICES						
Oral evaluations (includes limited – problem focused and re-evaluation – limited, problem focused)	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
Comprehensive oral evaluation – new or established patient: <i>once per Dentist</i> .	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
Detailed and extensive oral evaluation – problem focused, by report: <i>once per Dentist</i> .	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
Comprehensive periodontal evaluation – new or established patient: <i>once per Dentist</i> .	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
Periodic oral evaluations: <i>twice per Benefit Period</i>	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
Intra-oral – periapical radiographs	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
Bitewing x-rays (not including vertical bitewings): <i>[once] per Benefit Period</i> .	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
Complete full-mouth x-rays: <i>once in a 36-month interval</i> . <i>A full-mouth x-ray includes bitewing x-rays. Panoramic x-rays in conjunction with any other x-ray, or any combination of intraoral x-rays on the same date for which the total approved amount equals or exceeds the approved amount for a full-mouth x-ray, is considered a full mouth x-ray. One full-mouth x-ray, one set of vertical bitewings, or one panoramic x-ray is a covered benefit in a 36-month interval.</i>	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
Diagnostic casts: <i>when rendered more than 30 days prior to definitive treatment</i> .	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
Pulp vitality tests: <i>once per visit</i> .	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
<i>If additional detailed or comprehensive oral evaluations are billed by the same Dentist, the level of benefits will be limited to that of a periodic oral evaluation. Detailed or comprehensive oral evaluations count toward the Benefit Period maximum of two oral evaluations.</i>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [3]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
PREVENTIVE SERVICES						
Dental prophylaxis (cleaning): <i>twice per Benefit Period*</i>	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
Topical fluoride applications: <i>once per Benefit Period, for Covered Dependent Children under age [16]</i>	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
Space Maintainers: <i>once per lifetime for Covered Dependent Children under age [14].</i>	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
Recreation of space maintainers: <i>once per Benefit Period.</i>	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
Sealants: <i>applied once per tooth to first and second permanent molars which are free of caries (cavities) and restorations; for Covered Dependent Children under age [16].</i>	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
<p><i>*With an indicator for diabetes, high risk cardiac conditions, or kidney failure or dialysis conditions, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period.</i></p> <p><i>*With an indicator for periodontal disease, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period and for topical application for fluoride at the frequency stated in this Schedule of Dental Benefits.</i></p> <p><i>*With an indicator for suppressed immune system conditions of cancer-related chemotherapy and/or radiation, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.</i></p> <p><i>*With an indicator for pregnancy, the Covered Individual will be eligible for one additional cleaning (prophylaxis [or periodontal maintenance]) during the time of pregnancy.</i></p>						

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
BASIC SERVICES: ROUTINE AND RESTORATIVE SERVICES						
[Waiting Period – 6 Months]						
Simple Extractions	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Amalgam and resin-based composite fillings: <i>[once] per surface in a 12-month interval.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Sedative filling	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Pin retention	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
<p><i>When an inlay is requested or placed, the level of benefits will be limited to that of an amalgam filling. Sedative fillings are a Covered Dental Benefit once per tooth per lifetime. When multiple pins are requested or placed, the level of benefits will be limited to one pin per tooth.</i></p>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [3]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: RESTORATIVE SERVICES						
[Waiting Period – 12 Months]						
Onlays (permanent teeth only)	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Crowns and ceramic restorations (permanent teeth only)	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Recementation of inlays, onlays, partial coverage restorations, cast or prefabricated posts and cores and crowns.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Cast or prefabricated post and core; core build-up.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Additional procedures to construct new crown under existing partial denture framework.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: ENDODONTIC SERVICES						
[Waiting Period – 12 months]						
Pulpal and root canal therapy	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
<p><i>When endodontic therapy is performed on primary teeth, the level of benefits will be limited to that of a pulpotomy, except where radiographs indicate there is no permanent successor tooth and the primary tooth demonstrates sufficient intact root structure.</i></p> <p><i>Retreatment of root canal therapy 24 months of initial treatment is not a Covered Dental Benefit.</i></p> <p><i>When incomplete endodontic therapy is billed because the Covered Individual has been referred to an endodontist for completion of endodontic treatment, the level of benefits will be limited to that of a pupal debridement.</i></p> <p><i>Pupal therapy (resorbable filling) is a Covered Dental Benefit once per tooth per lifetime.</i></p>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [3]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: SURGICAL PERIODONTIC SERVICES						
[Waiting Period – 12 months]						
Gingivectomy or gingivoplasty; gingival flap procedure.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Clinical crown lengthening – hard tissue.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Guided tissue regeneration, per site: <i>only when performed in association with natural teeth.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Bone replacement and soft tissue grafts.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
MAJOR SERVICES: NON-SURGICAL PERIODONTIC SERVICES						
[Waiting Period – 12 months]						
Periodontal scaling and root planning.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Full-mouth debridement to enable comprehensive evaluation and diagnosis: <i>once per lifetime.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Periodontal maintenance: <i>twice per Benefit Period*</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
<p><i>Periodontal therapy includes treatment of diseases of the gums and bone supporting the teeth once per quadrant in any 24-month interval.</i></p> <p><i>*With an indicator for diabetes, high risk cardiac conditions, or kidney failure or dialysis conditions, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis or [periodontal maintenance] per Benefit Period.</i></p> <p><i>*With an indicator for periodontal disease, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis or [periodontal maintenance]) per Benefit Period and for topical application for fluoride at the frequency stated in this Schedule of Dental Benefits.</i></p> <p><i>*With an indicator for suppressed immune system conditions of cancer-related chemotherapy and/or radiation, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis or [periodontal maintenance]) per Benefit Period and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.</i></p> <p><i>*With an indicator for pregnancy, the Covered Individual will be eligible for one additional cleaning (prophylaxis or [periodontal maintenance]) during the time of pregnancy.</i></p>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [3]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: REMOVAL PROSTHODONTIC SERVICES						
[Waiting Period – 12 months]						
Complete and partial dentures.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Adjustments to complete and partial dentures.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Repairs to complete and partial dentures.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Replace missing or broken teeth.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Add tooth or clasp to existing partial denture.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Replace all teeth and acrylic on cast metal framework.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Denture rebase: <i>once in a 24-month interval.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Denture reline: <i>once in a 24-month interval.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
MAJOR SERVICES: FIXED PROSTHODONTIC SERVICES (BRIDGES)						
[Waiting Period – 12 months]						
Pontics	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Fixed partial denture retainers – inlays/onlays (inlays/onlays placed as abutments, i.e., to retain or support fixed partial dentures).	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Fixed partial denture retainers – crowns (crowns placed as abutments, i.e., to retain or support fixed partial dentures).	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Recement fixed partial denture.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Cast or refabricated post and core; core build-up.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
<p><i>When a fixed partial denture is requested or placed and three or more teeth are missing in a dental arch, the level of benefits will be limited to that of a removable partial denture. The placement of any additional appliance in the same arch within 60 months following placement of the initial appliance is not a Covered Dental Benefit.</i></p> <p><i>When the edentulous space between teeth exceeds 100% of the size of the original tooth, the level of benefits will be limited to that of a removable partial denture.</i></p> <p><i>When a fixed partial denture and a removable partial denture are requested or placed in the same arch, the level of benefits will be limited to that of a removable partial denture.</i></p> <p><i>If, in the construction of a prosthodontics appliance, personalized or special techniques including, but not limited to, tooth supported dentures, precision attachments or stress breakers, are elected, the level of benefits will be limited to that of a conventional prosthodontics appliance.</i></p> <p><i>When a porcelain/ceramic inlay is requested or placed as abutment (i.e., to retain or support a fixed partial denture), the level of benefits will be limited to that of a cast metal inlay.</i></p>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [3]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: ORAL SURGERY						
[Waiting Period – 12 months]						
Simple extractions.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Surgical removal of reputed tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Removal of impacted tooth – soft tissue.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Removal of impacted tooth – partially bony.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Removal of impacted tooth – completely bony.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Tooth reimplantation/stabilization of accidentally evulsed or displaced tooth and/or alveolus.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Surgical access of an unerupted tooth.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Biopsy of oral tissue: brush biopsy.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Alveoloplasty – per quadrant.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Vestibuloplasty – ridge extension.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Surgical excision of soft tissue lesions.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Surgical excision of intra-osseous lesions.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Other covered surgical/repair procedures: Removal of exostosis, torus palatinus or torus mandibularis; incision and drainage of abscess – intraoral soft tissue; frenulectomy or frenuoplasty; excision of hyperplastic tissue or pericoronal gingiva; surgical reduction of osseous or fibrous tuberosity.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
<i>Oral Surgery includes extractions and other listed oral surgery procedures (Including pre- and post-operative care) only when provided in a Dentist's office.</i>						
MAJOR SERVICES: ADJUNCTIVE GENERAL SERVICES						
[Waiting Period – 12 months]						
Palliative (emergency) treatment of dental pain – minor procedure.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Deep sedation/general anesthesia: <i>when provided by a Dentist in conjunction with Oral Surgery (surgical procedures) other than simple extractions.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Intravenous conscious sedation/analgesia: <i>when provided in conjunction with Oral Surgery (surgical procedures) other than simple extractions.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Consultations	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]

SCHEDULE OF DENTAL BENEFITS – [PLAN [4]]

This Schedule of Dental Benefits provides the list of dental procedures that are Covered Dental Services under this Policy. This Schedule indicates: (1) the covered dental procedure; (2) the Co-payment We will pay for each covered dental procedure; (3) any specific coverage limits, as applicable; and (4) if the Deductible applies to a Covered Dental Procedure. Also, refer to the *Policy Schedule*.)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
DIAGNOSTIC SERVICES						
Oral evaluations (includes limited – problem focused and re-evaluation – limited, problem focused)	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Comprehensive oral evaluation – new or established patient: <i>once per Dentist</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Detailed and extensive oral evaluation – problem focused, by report: <i>once per Dentist</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Comprehensive periodontal evaluation – new or established patient: <i>once per Dentist</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Periodic oral evaluations: <i>twice per Benefit Period</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Intra-oral – periapical radiographs	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Bitewing x-rays (not including vertical bitewings): <i>[once] per Benefit Period</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Complete full-mouth x-rays: <i>once in a 36-month interval</i> . <i>A full-mouth x-ray includes bitewing x-rays. Panoramic x-rays in conjunction with any other x-ray, or any combination of intraoral x-rays on the same date for which the total approved amount equals or exceeds the approved amount for a full-mouth x-ray, is considered a full mouth x-ray. One full-mouth x-ray, one set of vertical bitewings, or one panoramic x-ray is a covered benefit in a 36-month interval.</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Diagnostic casts: <i>when rendered more than 30 days prior to definitive treatment</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Pulp vitality tests: <i>once per visit</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
<i>If additional detailed or comprehensive oral evaluations are billed by the same Dentist, the level of benefits will be limited to that of a periodic oral evaluation. Detailed or comprehensive oral evaluations count toward the Benefit Period maximum of two oral evaluations.</i>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [4]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
PREVENTIVE SERVICES						
Dental prophylaxis (cleaning): <i>twice per Benefit Period*</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Topical fluoride applications: <i>once per Benefit Period, for Covered Dependent Children under age [19]</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Recementation of space maintainers: <i>once per Benefit Period.</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Sealants: <i>applied once per tooth to first and second permanent molars which are free of caries (cavities) and restorations; for Covered Dependent Children under age [20].</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
<p><i>*With an indicator for diabetes, high risk cardiac conditions, or kidney failure or dialysis conditions, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis or [periodontal maintenance] per Benefit Period.</i></p> <p><i>*With an indicator for periodontal disease, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis or [periodontal maintenance]) per Benefit Period and for topical application for fluoride at the frequency stated in this Schedule of Dental Benefits.</i></p> <p><i>*With an indicator for suppressed immune system conditions of cancer-related chemotherapy and/or radiation, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis or [periodontal maintenance]) per Benefit Period and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.</i></p> <p><i>*With an indicator for pregnancy, the Covered Individual will be eligible for one additional cleaning (prophylaxis or [periodontal maintenance]) during the time of pregnancy.</i></p>						

SCHEDULE OF DENTAL BENEFITS – [PLAN 5]]

This Schedule of Dental Benefits provides the list of dental procedures that are Covered Dental Services under this Policy. This Schedule indicates: (1) the covered dental procedure; (2) the Co-payment We will pay for each covered dental procedure; (3) any specific coverage limits, as applicable; and (4) if the Deductible applies to a Covered Dental Procedure. Also, refer to the *Policy Schedule*.)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
DIAGNOSTIC SERVICES						
Oral evaluations (includes limited – problem focused and re-evaluation – limited, problem focused)	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Comprehensive oral evaluation – new or established patient: <i>once per Dentist</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Detailed and extensive oral evaluation – problem focused, by report: <i>once per Dentist</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Comprehensive periodontal evaluation – new or established patient: <i>once per Dentist</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Periodic oral evaluations: <i>twice per Benefit Period</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Intra-oral – periapical radiographs.	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Bitewing x-rays (not including vertical bitewings): <i>[once] per Benefit Period</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Complete full-mouth x-rays: <i>once in a 36-month interval</i> . <i>A full-mouth x-ray includes bitewing x-rays. Panoramic x-rays in conjunction with any other x-ray, or any combination of intraoral x-rays on the same date for which the total approved amount equals or exceeds the approved amount for a full-mouth x-ray, is considered a full mouth x-ray. One full-mouth x-ray, one set of vertical bitewings, or one panoramic x-ray is a covered benefit in a 36-month interval.</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Diagnostic casts: <i>when rendered more than 30 days prior to definitive treatment</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Pulp vitality tests: <i>once per visit</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
<i>If additional detailed or comprehensive oral evaluations are billed by the same Dentist, the level of benefits will be limited to that of a periodic oral evaluation. Detailed or comprehensive oral evaluations count toward the Benefit Period maximum of two oral evaluations.</i>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [5]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
PREVENTIVE SERVICES						
Dental prophylaxis (cleaning): <i>twice per Benefit Period*</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Topical fluoride applications: <i>once per Benefit Period, for Covered Dependent Children under age [18]</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Recementation of space maintainers: <i>once per Benefit Period.</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Sealants: <i>applied once per tooth to first and second permanent molars which are free of caries (cavities) and restorations; for Covered Dependent Children under age [18].</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
<p><i>*With an indicator for diabetes, high risk cardiac conditions, or kidney failure or dialysis conditions, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis or [periodontal maintenance] per Benefit Period.</i></p> <p><i>*With an indicator for periodontal disease, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis or [periodontal maintenance]) per Benefit Period and for topical application for fluoride at the frequency stated in this Schedule of Dental Benefits.</i></p> <p><i>*With an indicator for suppressed immune system conditions of cancer-related chemotherapy and/or radiation, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis or [periodontal maintenance]) per Benefit Period and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.</i></p> <p><i>*With an indicator for pregnancy, the Covered Individual will be eligible for one additional cleaning (prophylaxis or [periodontal maintenance]) during the time of pregnancy.</i></p>						

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
BASIC SERVICES: ROUTINE AND RESTORATIVE SERVICES						
[Waiting Period – 6 Months]						
Simple Extractions	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Amalgam and resin-based composite fillings: <i>[once] per surface in a 12-month interval.</i>	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Sedative filling	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Pin retention	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
<p><i>When an inlay is requested or placed, the level of benefits will be limited to that of an amalgam filling. Sedative fillings are a Covered Dental Benefit once per tooth per lifetime. When multiple pins are requested or placed, the level of benefits will be limited to one pin per tooth.</i></p>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [5]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: RESTORATIVE SERVICES						
[Waiting Period – 12 Months]						
Crowns and ceramic restorations (permanent teeth only)	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Cast or prefabricated post and core; core build-up.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Additional procedures to construct new crown under existing partial denture framework.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: ENDODONTIC SERVICES						
Pulpal and root canal therapy	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]

When endodontic therapy is performed on primary teeth, the level of benefits will be limited to that of a pulpotomy, except where radiographs indicate there is no permanent successor tooth and the primary tooth demonstrates sufficient intact root structure.

Retreatment of root canal therapy 24 months of initial treatment is not a Covered Dental Benefit.

When incomplete endodontic therapy is billed because the Covered Individual has been referred to an endodontist for completion of endodontic treatment, the level of benefits will be limited to that of a pupal debridement.

Pupal therapy (resorbable filling) is a Covered Dental Benefit once per tooth per lifetime.

SCHEDULE OF DENTAL BENEFITS – [PLAN [5]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: ORAL SURGERY						
Simple extractions.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Surgical removal of reputed tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Removal of impacted tooth – soft tissue.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Removal of impacted tooth – partially bony.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Removal of impacted tooth – completely bony.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Tooth reimplantation/stabilization of accidentally evulsed or displaced tooth and/or alveolus.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Surgical access of an unerupted tooth.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Biopsy of oral tissue: brush biopsy.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Alveoloplasty – per quadrant.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Vestibuloplasty – ridge extension.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Surgical excision of soft tissue lesions.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Surgical excision of intra-osseous lesions.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Other covered surgical/repair procedures: Removal of exostosis, torus palatinus or torus mandibularis; incision and drainage of abscess – intraoral soft tissue; frenulectomy or frenuoplasty; excision of hyperplastic tissue or pericoronal gingiva; surgical reduction of osseous or fibrous tuberosity.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
<i>Oral Surgery includes extractions and other listed oral surgery procedures (Including pre- and post-operative care) only when provided in a Dentist's office.</i>						
MAJOR SERVICES: ADJUNCTIVE GENERAL SERVICES						
Palliative (emergency) treatment of dental pain – minor procedure.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Deep sedation/general anesthesia: <i>when provided by a Dentist in conjunction with Oral Surgery (surgical procedures) other than simple extractions.</i>	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Intravenous conscious sedation/analgesia: <i>when provided in conjunction with Oral Surgery (surgical procedures) other than simple extractions.</i>	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Consultations	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]

TruAssure Insurance Company

[111 Shuman Boulevard, Naperville IL 60563
(800) 414-4988]

Application for Individual Dental PPO Policy

Please type or print in black ink.

Last Name:		First Name:		Middle Initial:	Date of Birth:
Home Address (Mailing):		City:	State:	Zip Code:	Phone Number (with area code): ()
E-Mail Address:		Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>		Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single	
Reason for Application: <input type="checkbox"/> Initial Application <input type="checkbox"/> Change of Dependent(s) <input type="checkbox"/> Change in Coverage Type <input type="checkbox"/> Policy Reinstatement					
Payment Options: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly <input type="checkbox"/> Monthly EFT <input type="checkbox"/> Credit Card					
Select Dental Plan: <input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 5 (Dental Plan for Dependent Children to Age 19 Only)					
Select Type of Coverage: <input type="checkbox"/> Single <input type="checkbox"/> Two-Person <input type="checkbox"/> Family (Three or more persons) <input type="checkbox"/> Dependent Children to Age 19 Only					
Monthly Rates:	Plan 1	Plan 2	Plan 3	Plan 4	
Single:	\$	\$	\$	\$	
Two-Person:	\$	\$	\$	\$	
Family:	\$	\$	\$	\$	
Monthly Rates – Plan 5: (Dependent Children to Age 19 Only)	Number of Dependent Children Under Age 19 to be Insured:	Premium Rate Per Child: \$		Total Monthly Rate for Plan 5: \$ _____	
PLEASE LIST ALL ELIGIBLE DEPENDENT(S) TO BE COVERED UNDER THE POLICY.					
First Name	Last Name (If different from Applicant)	Date of Birth MM/DD/YYYY	Relationship to Applicant	Gender	
				<input type="checkbox"/> M <input type="checkbox"/> F	
				<input type="checkbox"/> M <input type="checkbox"/> F	
				<input type="checkbox"/> M <input type="checkbox"/> F	
				<input type="checkbox"/> M <input type="checkbox"/> F	
				<input type="checkbox"/> M <input type="checkbox"/> F	
CHANGE OF COVERAGE: Please check events requiring Policy changes.					
<input type="checkbox"/> Add Dependent due to: <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Marriage <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> Handicapped Dependent <input type="checkbox"/> Other _____ List Names of new Dependent(s) above.					
<input type="checkbox"/> Drop Dependent (list below) due to: <input type="checkbox"/> Age <input type="checkbox"/> Death <input type="checkbox"/> Other Coverage Elsewhere Name of Dependent: _____					
<input type="checkbox"/> Name Change: Former Name: _____ New Name: _____					

Address Change: Former Address _____
New Address: _____
 Change in Type of Coverage: Single Two-Person Family Dependent Child to Age 19

PAYMENT INSTRUCTIONS:

Choose your payment method: Bank Account Credit Card

A check must be submitted for the first payment on your policy if you choose bank account as your method of payment. Thereafter, all premiums must be paid electronically using your checking/savings account. If your method of payment is credit card, all premiums are to be paid by credit card. Premiums will be drawn or charged on the 1st of the month.

Please complete the following information if you choose to have deductions automatically taken monthly, quarterly, semiannually, annually for premium payments from an account you designate:

Name of Financial Institution: _____

Financial Institution's City, State & ZIP Code: _____

Type of Account (Choose one): Checking Savings. Name on Account: _____

Bank Routing Number: _____ Bank Account Number: _____

Please attach a voided check or deposit slip from your designated account if you choose to have deductions for verification.

Please complete the following information for payment by Credit Card:

Card Type: Visa MasterCard Discover American Express

Name on Card: _____

Card Number: _____

Expiration Date: ____ month ____ year. Security Code: _____]

I hereby authorize TruAssure Insurance Company to withdraw funds from the above-listed bank account or debit my credit card for the payment of my dental insurance premiums.

Signed: _____ Date: _____

I understand that any transaction that is dishonored by my bank/credit card intended for payment to TruAssure Insurance Company, may be assessed a \$25.00 service charge by TruAssure Insurance Company.

In making this application to TruAssure Insurance Company ("TruAssure"), for the dental coverage policy, I agree and understand that this application will become part of the Policy, and I agree to be bound by the terms of the Policy issued by TruAssure. I further agree that the coverage requested is subject to the approval of TruAssure and that no agent or representative has authority to make changes or modify this application for coverage. I hereby certify that all of the information contained in this application is true and correct to the best of my knowledge. I further understand that any intentional omission or misrepresentation of submitted data may cause this application and subsequent Policy to be null and void.

Please Note: Applications must be received by the 20th of the month to be effective the 1st of the following month. Applications received after the 20th will be effective the first of the month after the next month. *Coverage is contingent upon underwriting acceptance.*

Statements as Representations: Statements made in this application or in negotiations for the policy by or in behalf of the applicant (proposed Policyholder) are representations and not warranties. Misrepresentations, omissions, concealment of facts, and incorrect statements will not prevent a recovery under the policy unless either: (1) fraudulent; or (2) material either to the acceptance of the risk or to the hazard assumed by Us.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines or confinement in prison, or any combination thereof.

Applicant Signature

Date

Agent Signature

Date

Printed Name of Agent

Agent License Number

TruAssure Insurance Company

[111 Shuman Boulevard, Naperville IL 60563
(800) 414-4988]

Application for Individual Dental PPO Policy

Please type or print in black ink.

Last Name:		First Name:		Middle Initial:	Date of Birth:
Home Address (Mailing):		City:	State:	Zip Code:	Phone Number (with area code): ()
E-Mail Address:		Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>		Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single	
Reason for Application: <input type="checkbox"/> Initial Application <input type="checkbox"/> Change of Dependent(s) <input type="checkbox"/> Change in Coverage Type <input type="checkbox"/> Policy Reinstatement					
Payment Options: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly <input type="checkbox"/> Monthly EFT <input type="checkbox"/> Credit Card					
Select Dental Plan: <input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 5 (Dental Plan for Dependent Children to Age 19 Only)					
Select Type of Coverage: <input type="checkbox"/> Single <input type="checkbox"/> Two-Person <input type="checkbox"/> Family (Three or more persons) <input type="checkbox"/> Dependent Children to Age 19 Only					
Monthly Rates:	Plan 1	Plan 2	Plan 3	Plan 4	
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First Name	Last Name (If different from Applicant)	Date of Birth MM/DD/YYYY	Relationship to Applicant	Gender	
				<input type="checkbox"/> M <input type="checkbox"/> F	
				<input type="checkbox"/> M <input type="checkbox"/> F	
				<input type="checkbox"/> M <input type="checkbox"/> F	
				<input type="checkbox"/> M <input type="checkbox"/> F	
				<input type="checkbox"/> M <input type="checkbox"/> F	
CHANGE OF COVERAGE: Please check events requiring Policy changes.					
<input type="checkbox"/> Add Dependent due to: <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Marriage <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> Handicapped Dependent <input type="checkbox"/> Other _____ List Names of new Dependent(s) above.					
<input type="checkbox"/> Drop Dependent (list below) due to: <input type="checkbox"/> Age <input type="checkbox"/> Death <input type="checkbox"/> Other Coverage Elsewhere Name of Dependent: _____					
<input type="checkbox"/> Name Change: Former Name: _____ New Name: _____					

Address Change: Former Address _____
New Address: _____
 Change in Type of Coverage: Single Two-Person Family Dependent Child to Age 19

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Financial Institution's City, State & ZIP Code: _____

Type of Account (Choose one): Checking Savings. Name on Account: _____

Bank Routing Number: _____ Bank Account Number: _____

Please attach a voided check or deposit slip from your designated account if you choose to have deductions for verification.

Please complete the following information for payment by Credit Card:

Card Type: Visa MasterCard Discover American Express

Name on Card: _____

Card Number: _____

Expiration Date: ____ month ____ year. Security Code: _____]

I hereby authorize TruAssure Insurance Company to withdraw funds from the above-listed bank account or debit my credit card for the payment of my dental insurance premiums.

Signed: _____ Date: _____

I understand that any transaction that is dishonored by my bank/credit card intended for payment to TruAssure Insurance Company, may be assessed a \$25.00 service charge by TruAssure Insurance Company.

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Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines or confinement in prison, or any combination thereof.

Applicant Signature

Date

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Home Address (Mailing):		City:	State:	Zip Code:	Phone Number (with area code): ()
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				<input type="checkbox"/> M <input type="checkbox"/> F	
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Name of Financial Institution: _____

Financial Institution's City, State & ZIP Code: _____

Type of Account (Choose one): Checking Savings. Name on Account: _____

Bank Routing Number: _____ Bank Account Number: _____

For verification, please mail us a voided check or deposit slip from your designated account if you choose to have deductions, and include a copy of your completed application.

Please complete the following information for payment by Credit Card:

Card Type: Visa MasterCard Discover American Express

Name on Card: _____

Card Number: _____

Expiration Date: ____ month ____ year. Security Code: _____]

I, the Applicant, certify that by selecting "I agree" in the Electronic Signature box below that I am the Applicant named in this Application and that it is my digital signature signifying my agreement to authorize TruAssure Insurance Company to withdraw funds from the above-listed bank account or debit my credit card for the payment of my dental insurance premiums.

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Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines or confinement in prison, or any combination thereof.

Electronic Signature of Applicant:

I, the Applicant, certify that by selecting "I agree" in this Electronic Signature box that I am the Applicant named in this Application and that this is my digital signature signifying my agreement to: (1) apply for the Individual Dental Insurance Policy selected in this Application; and (2) authorize TruAssure Insurance Company to withdraw funds from the above-listed bank account or debit my credit card for the payment of my dental insurance premiums.

Select 
I Agree
Date Signed: <input type="text"/>
SUBMIT

**TruAssure Insurance Company
[111 Shuman Boulevard
Naperville, IL 60563
(800) 414-4988]**

Policy Amendment

Policy: Individual Dental Preferred Provider Organization (PPO) Insurance Policy

Policy Number: [12345]

Effective Date of Amendment: [January 1, 2013]

The Policy is amended as of the effective date of this Amendment as follows: [

1. Policy Schedule, form TruA-1000-PS-Plan4, is hereby deleted and replaced by Policy Schedule form TruA-1000-PS-Plan1.
2. Schedule of Dental Benefits, form TruA-1000-SODB-Plan4, for Dental Plan 4, is hereby deleted and replaced by the Schedule of Dental Benefits, form TruA-1000-SODB-Plan1, for Dental Plan 1.]

Except as amended above, the Policy remains unchanged. This Amendment is to be retained with the Policy.

Accepted by Policyholder:

Signature

Date

Signed for TruAssure Insurance Company.



President



Secretary

TruAssure Insurance Company

[111 Shuman Boulevard
Naperville, IL 60563
(800) 414-4988]

DENTAL ONLY COVERAGE

OUTLINE OF COVERAGE Policy Form Series TruA-1000

- (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 your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!
- (2) *Limited-Scope Dental Only Coverage* — Policies of this category are designed to provide, to persons, DENTAL ONLY coverage.
- (3) *Brief Description of Benefits* — The dental policy is a limited Preferred Provider Organization (PPO) dental policy that includes diagnostic preventive services, basic services, and/or major services; the actual benefits provided under the policy depends on the dental plan you select. Below is a brief summary of the dental benefit plans offered under the policy:

DENTAL BENEFIT PLANS					
In-Network or Out-of-Network					
*Plan	Annual Maximum per Benefit Period	Deductible per Covered Person per Benefit Period	Diagnostic Preventive Services	Basic Services (6 month waiting period)	Major Services (12 month waiting period)
Plan 1	\$2,000	\$50	100%	80%	50%
Plan 2	\$1,500	\$50	100%	50%	50%
Plan 3	\$1,000	\$75	90%	50%	50%
Plan 4	\$500	\$25	100%	Not Covered	Not Covered
Plan 5 (Dependent Children to Age 19 Only)	\$1,000	None	100%	80%	80%

**Refer to the Schedule of Dental Benefits in your policy for the list of Covered Dental Benefits for the Dental Plan you selected.*

The Preferred Provider Networks used under the policy are the Delta Dental PPO Network and the Delta Dental Premier Network. However, you may obtain dental care for covered dental services from any licensed dentist. Whatever dentist you choose, you will receive some level of benefits for Covered Dental Services. However, there are advantages when you receive treatment from a dentist participating in either the Delta Dental PPO Network or the Delta Dental Premier Network.

If the dentist you select does not participate in the Delta Dental PPO Network or the Delta Dental Premier Network, you will be responsible for the difference between your Dentist's Submitted amount

and Our Payment. The amount We use to calculate the payment, that is the Allowed Amount, will be the lesser of the Dentist's Submitted Amount and the Scheduled Fee.

(4) *Exclusions and Limitations* — The following are the exclusions and limitations for dental services, unless specifically provided as a Covered Dental Service as shown in the Policy Schedule and Schedule of Dental Benefits.

Exclusions That Apply to Diagnostic Services:

- Pulp vitality tests billed with any service are not Covered Dental Services, except:
 - An emergency exam; or
 - Palliative treatment.

Exclusions That Apply to Preventive Services:

- Recementation of a space maintainer with six (6) months of the initial placement is not a Covered Dental Service.

Exclusions That Apply to Restorative Services

- Fillings are not a Covered Dental Service when crowns are allowed for the same teeth.
- Replacement of any existing cast restoration (crowns, onlays, ceramic restorations) with any type of cast restoration within sixty (60) months following initial placement of existing restoration is not a Covered Dental Service.
- Replacement of a stainless steel crown with any type of cast restoration is not a Covered Dental Service by the same dental provider (e.g., dental office or Dentist) within 24 months following the initial placement.
- A cast restoration is a Covered Dental Service only in the presence of radiographic evidence of decay or missing tooth structure. Restorations placed for any other purpose, including, but not limited to, cosmetics, abrasion, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformations of teeth, or the anticipation of future fractures, are not a Covered Dental Service.
- When there is a radiographic evidence of sufficient vertical height (more than three millimeters above the crestal bone) on a tooth to support a cast restoration, a crown build-up is not a Covered Dental Service.
- The repair of any component of a cast restoration is not a Covered Dental Service.
- Recementation of inlays, onlays, partial coverage restorations, case and prefabricated posts and cores and crowns by the same dental provider (e.g., dental office or Dentist) within six (6) months of initial placement is not a Covered Dental Service.
- Additional procedures to construct a new crown under the existing partial denture framework within six (6) months following initial placement is not a Covered Dental Service.
- When a sedative filling is requested or placed on the same date as a permanent filling, the sedative filling is not a Covered Dental Service.

Exclusions That Apply to Diagnostic Services

- When a benefit has been issued for endodontic services, retreatment of the same tooth within two (2) years is not a Covered Dental Service.
- Endodontic procedures performed in conjunction with complete removable prosthodontics appliances are not Covered Dental Services.

Exclusions That Apply to Periodontic Services

- Guided tissue regeneration billed in conjunction with implantology, ridge augmentation/sinus lift, extractions or periradicular surgery/apicoectomy is not a Covered Dental Service.
- Crown lengthening or gingivoplasty, if not performed at least four weeks prior to crown preparation, is not a Covered Dental Service.
- Bone replacement grafts performed in conjunction with extractions or implants are not a Covered Dental Service.
- Periodontal splinting to restore occlusion is not a Covered Dental Service.

Exclusions That Apply to Prosthodontic Services

- Replacement of any existing prosthodontics appliance (cast restorations, fixed partial dentures, removable partial dentures, complete denture) with any prosthodontics appliance within sixty (60) months following initial placement of existing appliance is not a Covered Dental Service.
- When a fixed partial denture and a removable partial denture are requested or placed in the same arch, the fixed partial denture is not a Covered Dental Service.
- Any prosthodontic appliance connected to an implant is not a Covered Dental Service.
- Reline or rebase of an existing appliance within six (6) months following initial replacement is not a Covered Dental Service.
- Fixed or removable prosthodontics for a Covered Individual under age 16 is not a Covered Dental Service.
- Tissue conditioning is not a Covered Dental Service.
- When the edentulous (toothless) space between teeth is less than 50% of the size of the missing tooth, a pontic is not a Covered Dental Service.

General Exclusions (Applies to all Covered Dental Services)

Under the Policy, coverage is NOT provided for the following:

- Services compensable under Worker's Compensation or Employer's Liability Laws.
- Services provided or paid for by any governmental agency or under any governmental program or law, except as to charges which the Covered Individual is legally obligated to pay. This exception extends to any benefits provided under the U.S. Social Security Act and its Amendments.
- Services performed to correct developmental malformation including, but not limited to: (a) cleft palate; (b) mandibular prognathism; (c) enamel hypoplasia; (d) fluorosis; and (e) congenitally missing teeth. This exclusion does not apply to newborn infants.
- Services performed for purely cosmetic purposes, including, but not limited to: (a) tooth-colored veneers; (b) bonding; (c) porcelain restorations; and (d) microabrasion. Orthodontic care benefits provided under the policy will fall within this exclusion unless such benefits are provided by endorsement and you elected Family Coverage. In no event will a Covered Individual age 19 or over be able to receive orthodontic care benefits.
- Charges for services completed prior to the date the prior to the date the Covered Individual became insured under the policy.
- Services for anesthesiologists or anesthesiologists.
- Temporary procedures.
- Any procedure requested or performed on a tooth when radiographs indicate that less than 40% of the root is supported by bone.
- Services performed on non-functional teeth (second or third molar without an opposing tooth).
- Services performed on deciduous (primary) teeth near exfoliation.

- Drugs or the administration of drugs, except for general anesthesia.
- Procedures deemed experimental or investigational by the American Dental Association, for which there is no procedure code, or which are inconsistent with Current Dental Terminology coding and nomenclature.
- Services with respect to any disturbance of the temporomandibular joint (jaw joint).
- Procedures, techniques or materials related to implantology or edentulous (toothless) ridge enhancement.
- Procedures that We consider to be included in the fees for other procedures. For such procedures, a separate payment will not be made under the policy. A Dentist in the Delta Dental PPO Network or Delta Dental Premier Network may not bill the Covered Individual for such procedures.
- The completion of claim forms and submission of required information, not otherwise covered, for determination of benefits.
- Infection control procedures and fees associated with compliance with Occupational Safety and Health Administration (OHS) requirements.
- Broken appointments.
- Services and supplies for any illness or injury occurring on or after the Covered Individual's effective date of coverage under the policy as a result of war or an act of war.
- Services for, or in connection with, an intentional self-inflicted injury or illness while sane or insane, except when due to domestic violence or a medical (including both physical and mental) health condition.
- Services and supplies received from either: (1) a Covered Individual's spouse or Domestic Partner or other relative; (2) a relative of the Covered Dependent Spouse or Domestic Partner; or (3) any individual who ordinarily resides such Covered Individual's home or any such similar person.
- Services for, or in connection with, an injury or illness arising out of the participation in, or in consequence of having participated in, a riot, insurrection or civil disturbance or the commission of a felony.
- Charges for services for inpatient/outpatient hospitalization.
- Services or supplies for oral hygiene or plague control programs.
- Services or supplies to correct harmful habits.

(5) *Renewability* — The policy is Guaranteed Renewable. The policy is written for a period of 12 months beginning on the Policy Effective Date. You may elect to continue the Policy or discontinue the Policy effective on any Policy Anniversary Date. Coverage under the policy will be continued if you elect to continue the policy.

(6) *Premium* — Premiums for the policy must be paid to Us. The premiums for the policy are shown in the Policy Schedule. If you do not pay the premiums when due, the policy will terminate subject to the Grace Period. The premium due date is based on: (a) the Policy Effective Date shown in the Policy Schedule; and (b) the Premium Payment Mode, which is how often you pay the premiums, is shown in the Policy Schedule.

Premiums are based on the following: (1) type of coverage elected; and (2) dental benefit plan elected. Your elections are shown in the Policy Schedule.

PLEASE REFER TO YOUR POLICY FOR COMPLETE DETAILS OF THE COVERAGE PROVIDED UNDER THE POLICY.

IMPORTANT INFORMATION

Policyholder Service Office of Company TruAssure Insurance Company

Address: [111 Shuman Boulevard, Naperville, IL 60563]

Telephone Number: [(800) 414-4988]

[Name of Agent: _____]

Address: _____

Telephone Number: _____]

If we at TruAssure Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201
[(501) 371-2640 or (800) 852-5494]

SERFF Tracking #:

MLLM-128748425

State Tracking #:

Company Tracking #:

TRUA-0167DDI01-01

State: Arkansas

Filing Company:

TruAssure Insurance Company

TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental

Product Name: TruAssure - Dental PPO

Project Name/Number: TruAssure - Dental PPO/TruAssure - Dental PPO-1

Rate Information

Rate data applies to filing.

Filing Method:

Rate Change Type: %

Overall Percentage of Last Rate Revision: %

Effective Date of Last Rate Revision:

Filing Method of Last Filing:

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
TruAssure Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

SERFF Tracking #:

MLLM-128748425

State Tracking #:

Company Tracking #:

TRUA-0167DDI01-01

State: Arkansas

Filing Company:

TruAssure Insurance Company

TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental

Product Name: TruAssure - Dental PPO

Project Name/Number: TruAssure - Dental PPO/TruAssure - Dental PPO-1

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1	Approved 12/28/2012	AR_Rate Sheet_Form Series TruA-1000_11-08-2012 subm	TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4 and TruA-1000-SODB-Plan5	New		AR_Rate Sheet_Form Series TruA-1000_11-30-2012 subm.pdf



TruAssure Insurance Company

**Monthly Premium Rates
and
Quarterly Trends**

Table A below lists the monthly premiums for each of the 5 plans for the state of Arkansas.

Table B below lists the quarterly claim trends applied to the premiums in Table A to develop the premiums for policies issued between December 1, 2012 and November 30, 2013. Premiums for policies issued after this period may be developed by applying the quarterly claims trend in the same fashion.

Table A

Plan/Tier	Arkansas Monthly Tiered Premiums
Plan 1	
Single	\$35.54
Two Party	\$69.72
Family	\$123.84
Plan 2	
Single	\$29.28
Two Party	\$57.43
Family	\$102.02
Plan 3	
Single	\$22.92
Two Party	\$44.96
Family	\$79.85
Plan 4	
Single	\$16.84
Two Party	\$33.05
Family	\$58.70
Plan 5	
Per Child	\$34.93



Table B

<u>Quarter</u>			<u>Trend Applied to</u>
<u>Quarter</u>	<u>Start Date</u>	<u>End Date</u>	<u>Table A Rates</u>
1	12/1/2012	2/28/2013	101.1%
2	3/1/2013	5/31/2013	102.2%
3	6/1/2013	8/31/2013	103.4%
4	9/1/2013	11/30/2013	104.5%

Premiums for subsequent quarters should continue to be trended at the rate of 1.1% per quarter.

SERFF Tracking #:

MLLM-128748425

State Tracking #:

Company Tracking #:

TRUA-0167DDI01-01

State: Arkansas

Filing Company:

TruAssure Insurance Company

TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental

Product Name: TruAssure - Dental PPO

Project Name/Number: TruAssure - Dental PPO/TruAssure - Dental PPO-1

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved	12/28/2012
Comments:			
Attachment(s):			
Readability Certification_AR_12-03-2012 subm.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved	12/28/2012
Comments:	The application forms to be used with the policy are attached to the Form Schedule Tab.		

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved	12/28/2012
Comments:	The Outline of Coverage form is also attached to the Form Schedule Tab.		
Attachment(s):			
TruA-1000-OOC_Dental Only Coverage Outline of Coverage_11-21-2012 subm.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Authorization Letter	Approved	12/28/2012
Comments:			
Attachment(s):			
TruAssure Authorization Letter_07-17-2012_072512.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variability	Approved	12/28/2012
Comments:			
Attachment(s):			
Statement of Variability_AR_12-03-2012 subm.pdf			

Item Status:

Status Date:

SERFF Tracking #:

MLLM-128748425

State Tracking #:**Company Tracking #:**

TRUA-0167DDI01-01

State: Arkansas**Filing Company:**

TruAssure Insurance Company

TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental**Product Name:** TruAssure - Dental PPO**Project Name/Number:** TruAssure - Dental PPO/TruAssure - Dental PPO-1

Satisfied - Item:	"John Doe" Forms	Approved	12/28/2012
Comments:			
Attachment(s):			
TruA-1000-Amend_Policy Amendment_11-01-2012 subm-G-jd.pdf			
TruA-1000-App-AR_Individual Application for Dental PPO Policy_12-20-2012 subm-jd.pdf			
TruA-1000-App-1-AR_Individual Application for Dental PPO Policy_12-20-2012 subm-jd.pdf			
TruA-1000-App-2-AR_Individual Application for Dental PPO Policy_12-20-2012 subm-jd.pdf			

TruAssure Insurance Company

READABILITY CERTIFICATION

This is to certify that the forms listed below have achieved the minimum Flesch Reading Ease Score required by your state.

<u>FORM TITLE</u>	<u>FORM NUMBER</u>	<u>FLESCH SCORE</u>
Individual Dental Preferred Provider Organization (PPO) Insurance Policy and Policy Amendment	TruA-1000-AR and TruA-1000-Amend	54.6
Application for Individual Dental PPO Policy	TruA-1000-App-AR	57.0
Application for Individual Dental PPO Policy	TruA-1000-App-1-AR	57.0
Application for Individual Dental PPO Policy	TruA-1000-App-2-AR	56.3



Bernard Glossy
President and CEO

Date: December 3, 2012

TruAssure Insurance Company

[111 Shuman Boulevard
Naperville, IL 60563
(800) 414-4988]

DENTAL ONLY COVERAGE

OUTLINE OF COVERAGE Policy Form Series TruA-1000

- (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 your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!
- (2) *Limited-Scope Dental Only Coverage* — Policies of this category are designed to provide, to persons, DENTAL ONLY coverage.
- (3) *Brief Description of Benefits* — The dental policy is a limited Preferred Provider Organization (PPO) dental policy that includes diagnostic preventive services, basic services, and/or major services; the actual benefits provided under the policy depends on the dental plan you select. Below is a brief summary of the dental benefit plans offered under the policy:

DENTAL BENEFIT PLANS					
In-Network or Out-of-Network					
*Plan	Annual Maximum per Benefit Period	Deductible per Covered Person per Benefit Period	Diagnostic Preventive Services	Basic Services (6 month waiting period)	Major Services (12 month waiting period)
Plan 1	\$2,000	\$50	100%	80%	50%
Plan 2	\$1,500	\$50	100%	50%	50%
Plan 3	\$1,000	\$75	90%	50%	50%
Plan 4	\$500	\$25	100%	Not Covered	Not Covered
Plan 5 (Dependent Children to Age 19 Only)	\$1,000	None	100%	80%	80%

**Refer to the Schedule of Dental Benefits in your policy for the list of Covered Dental Benefits for the Dental Plan you selected.*

The Preferred Provider Networks used under the policy are the Delta Dental PPO Network and the Delta Dental Premier Network. However, you may obtain dental care for covered dental services from any licensed dentist. Whatever dentist you choose, you will receive some level of benefits for Covered Dental Services. However, there are advantages when you receive treatment from a dentist participating in either the Delta Dental PPO Network or the Delta Dental Premier Network.

If the dentist you select does not participate in the Delta Dental PPO Network or the Delta Dental Premier Network, you will be responsible for the difference between your Dentist's Submitted amount

and Our Payment. The amount We use to calculate the payment, that is the Allowed Amount, will be the lesser of the Dentist's Submitted Amount and the Scheduled Fee.

(4) *Exclusions and Limitations* — The following are the exclusions and limitations for dental services, unless specifically provided as a Covered Dental Service as shown in the Policy Schedule and Schedule of Dental Benefits.

Exclusions That Apply to Diagnostic Services:

- Pulp vitality tests billed with any service are not Covered Dental Services, except:
 - An emergency exam; or
 - Palliative treatment.

Exclusions That Apply to Preventive Services:

- Recementation of a space maintainer with six (6) months of the initial placement is not a Covered Dental Service.

Exclusions That Apply to Restorative Services

- Fillings are not a Covered Dental Service when crowns are allowed for the same teeth.
- Replacement of any existing cast restoration (crowns, onlays, ceramic restorations) with any type of cast restoration within sixty (60) months following initial placement of existing restoration is not a Covered Dental Service.
- Replacement of a stainless steel crown with any type of cast restoration is not a Covered Dental Service by the same dental provider (e.g., dental office or Dentist) within 24 months following the initial placement.
- A cast restoration is a Covered Dental Service only in the presence of radiographic evidence of decay or missing tooth structure. Restorations placed for any other purpose, including, but not limited to, cosmetics, abrasion, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformations of teeth, or the anticipation of future fractures, are not a Covered Dental Service.
- When there is a radiographic evidence of sufficient vertical height (more than three millimeters above the crestal bone) on a tooth to support a cast restoration, a crown build-up is not a Covered Dental Service.
- The repair of any component of a cast restoration is not a Covered Dental Service.
- Recementation of inlays, onlays, partial coverage restorations, case and prefabricated posts and cores and crowns by the same dental provider (e.g., dental office or Dentist) within six (6) months of initial placement is not a Covered Dental Service.
- Additional procedures to construct a new crown under the existing partial denture framework within six (6) months following initial placement is not a Covered Dental Service.
- When a sedative filling is requested or placed on the same date as a permanent filling, the sedative filling is not a Covered Dental Service.

Exclusions That Apply to Diagnostic Services

- When a benefit has been issued for endodontic services, retreatment of the same tooth within two (2) years is not a Covered Dental Service.
- Endodontic procedures performed in conjunction with complete removable prosthodontics appliances are not Covered Dental Services.

Exclusions That Apply to Periodontic Services

- Guided tissue regeneration billed in conjunction with implantology, ridge augmentation/sinus lift, extractions or periradicular surgery/apicoectomy is not a Covered Dental Service.
- Crown lengthening or gingivoplasty, if not performed at least four weeks prior to crown preparation, is not a Covered Dental Service.
- Bone replacement grafts performed in conjunction with extractions or implants are not a Covered Dental Service.
- Periodontal splinting to restore occlusion is not a Covered Dental Service.

Exclusions That Apply to Prosthodontic Services

- Replacement of any existing prosthodontics appliance (cast restorations, fixed partial dentures, removable partial dentures, complete denture) with any prosthodontics appliance within sixty (60) months following initial placement of existing appliance is not a Covered Dental Service.
- When a fixed partial denture and a removable partial denture are requested or placed in the same arch, the fixed partial denture is not a Covered Dental Service.
- Any prosthodontic appliance connected to an implant is not a Covered Dental Service.
- Reline or rebase of an existing appliance within six (6) months following initial replacement is not a Covered Dental Service.
- Fixed or removable prosthodontics for a Covered Individual under age 16 is not a Covered Dental Service.
- Tissue conditioning is not a Covered Dental Service.
- When the edentulous (toothless) space between teeth is less than 50% of the size of the missing tooth, a pontic is not a Covered Dental Service.

General Exclusions (Applies to all Covered Dental Services)

Under the Policy, coverage is NOT provided for the following:

- Services compensable under Worker's Compensation or Employer's Liability Laws.
- Services provided or paid for by any governmental agency or under any governmental program or law, except as to charges which the Covered Individual is legally obligated to pay. This exception extends to any benefits provided under the U.S. Social Security Act and its Amendments.
- Services performed to correct developmental malformation including, but not limited to: (a) cleft palate; (b) mandibular prognathism; (c) enamel hypoplasia; (d) fluorosis; and (e) congenitally missing teeth. This exclusion does not apply to newborn infants.
- Services performed for purely cosmetic purposes, including, but not limited to: (a) tooth-colored veneers; (b) bonding; (c) porcelain restorations; and (d) microabrasion. Orthodontic care benefits provided under the policy will fall within this exclusion unless such benefits are provided by endorsement and you elected Family Coverage. In no event will a Covered Individual age 19 or over be able to receive orthodontic care benefits.
- Charges for services completed prior to the date the prior to the date the Covered Individual became insured under the policy.
- Services for anesthesiologists or anesthesiologists.
- Temporary procedures.
- Any procedure requested or performed on a tooth when radiographs indicate that less than 40% of the root is supported by bone.
- Services performed on non-functional teeth (second or third molar without an opposing tooth).
- Services performed on deciduous (primary) teeth near exfoliation.

- Drugs or the administration of drugs, except for general anesthesia.
- Procedures deemed experimental or investigational by the American Dental Association, for which there is no procedure code, or which are inconsistent with Current Dental Terminology coding and nomenclature.
- Services with respect to any disturbance of the temporomandibular joint (jaw joint).
- Procedures, techniques or materials related to implantology or edentulous (toothless) ridge enhancement.
- Procedures that We consider to be included in the fees for other procedures. For such procedures, a separate payment will not be made under the policy. A Dentist in the Delta Dental PPO Network or Delta Dental Premier Network may not bill the Covered Individual for such procedures.
- The completion of claim forms and submission of required information, not otherwise covered, for determination of benefits.
- Infection control procedures and fees associated with compliance with Occupational Safety and Health Administration (OSHA) requirements.
- Broken appointments.
- Services and supplies for any illness or injury occurring on or after the Covered Individual's effective date of coverage under the policy as a result of war or an act of war.
- Services for, or in connection with, an intentional self-inflicted injury or illness while sane or insane, except when due to domestic violence or a medical (including both physical and mental) health condition.
- Services and supplies received from either: (1) a Covered Individual's spouse or Domestic Partner or other relative; (2) a relative of the Covered Dependent Spouse or Domestic Partner; or (3) any individual who ordinarily resides such Covered Individual's home or any such similar person.
- Services for, or in connection with, an injury or illness arising out of the participation in, or in consequence of having participated in, a riot, insurrection or civil disturbance or the commission of a felony.
- Charges for services for inpatient/outpatient hospitalization.
- Services or supplies for oral hygiene or plague control programs.
- Services or supplies to correct harmful habits.

(5) **Renewability** — The policy is Guaranteed Renewable. The policy is written for a period of 12 months beginning on the Policy Effective Date. You may elect to continue the Policy or discontinue the Policy effective on any Policy Anniversary Date. Coverage under the policy will be continued if you elect to continue the policy.

(6) **Premium** — Premiums for the policy must be paid to Us. The premiums for the policy are shown in the Policy Schedule. If you do not pay the premiums when due, the policy will terminate subject to the Grace Period. The premium due date is based on: (a) the Policy Effective Date shown in the Policy Schedule; and (b) the Premium Payment Mode, which is how often you pay the premiums, is shown in the Policy Schedule.

Premiums are based on the following: (1) type of coverage elected; and (2) dental benefit plan elected. Your elections are shown in the Policy Schedule.

PLEASE REFER TO YOUR POLICY FOR COMPLETE DETAILS OF THE COVERAGE PROVIDED UNDER THE POLICY.



TruAssure Insurance Company
111 Shuman Boulevard
Naperville, IL 60563

July 17, 2012

Hazel J. Delane
Compliance Consultant
Milliman, Inc.
Two Conway Park
150 Field Drive, Suite 180
Lake Forest, IL 60045

Re: State Insurance Filings

Dear Ms. Delane:

This letter will serve as authorization from TruAssure Insurance Company for employees of Milliman, Inc. to file policy forms and respond to inquiries on our behalf with the state insurance departments and jurisdictions where TruAssure Insurance Company is authorized to do business.

Sincerely,

A handwritten signature in black ink, appearing to read "Brendan Gussy".

Signature of Officer

The name "Brendan Gussy" written in a cursive, handwritten style.

Printed Name of Officer

The title "PRIS/CEO" written in a cursive, handwritten style.

Title of Officer

TRUASSURE INSURANCE COMPANY

Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

The variable data in the subject forms is denoted by variable brackets.

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-AR	Individual Dental Preferred Provider Organization (PPO) Policy	Cover	<p>The variable text is as follows:</p> <ul style="list-style-type: none"> • “Company Address”: The Company’s address and telephone number are variable and may be changed if the address or telephone number change. The Company’s actual address and telephone number will always be indicated. • “Officer Signatures and Titles”: The officer signatures and titles are variable and may be changed. The actual signatures and titles of the Company’s officers (e.g., Chief Executive Officer, or President and Secretary, or the signatures and titles of other authorized officers will be indicated.
TruA-1000-AR	Individual Dental Preferred Provider Organization (PPO) Policy	Table of Contents	<p>The page number locations of the policy provisions are variable and may be changed due to formatting changes.</p>
TruA-1000-PS-Plan1	Policy Schedule	Page 3	<p>The variable text is as follows:</p> <ul style="list-style-type: none"> • “TruAssure Insurance Company Web Site”: The Web Site address “www.truassure.com” that is indicated for the “TruAssure Insurance Company Web Site” text is variable and may be changed if the Web Site address changes. • “For Questions or Claim Inquiries please call”: The telephone number “1-800-414-4988” that is indicated for the “For Questions or Claim Inquiries please call” text is variable and may be changed if the telephone number changes. • “For Automated Phone System, please call”: The

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
			<p>telephone number “1-800-323-1743” that is indicated for the “For Automated Phone System, please call” text is variable and may be changed if the telephone number changes.</p>
TruA-1000-PS-Plan1	Policy Schedule (continued)	Page 3 (continued)	<ul style="list-style-type: none"> • “Customer Service E-mail Address”: : The Web Site address “CSI@truassure.com” that is indicated for the “Customer Service E-mail Address” text is variable and may be changed if the Web Site address changes. • “Policy Number”: The policy number is variable. The actual policy number assigned to the policy will be indicated. • “Dental Coverage Plan”: The dental coverage plan is variable. The dental coverage plan, “Plan 1”, is variable. The “Plan 1” text may be changed to “Benefit Plan 1”, “Dental Plan 1”, or “Dental Coverage Plan 1”. • “Policyholder”: The name of the policyholder is variable. The actual name of the policy’s owner will be indicated. • “Type of Coverage”: The type of coverage information is variable. The type of coverage text may be: “Individual”, “Single”, “Two Persons“, “Two Party”, or “Family”. • “Initial Premium”: The initial premium amount is variable. The actual initial premium amount due/paid for the policy will be indicated. • “Premium Payment Mode”: The type of premium payment

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
			mode is variable. The premium payment mode may be “Monthly”, “Quarterly”, “Semi-Annually”, or “Annually”.
TruA-1000-PS-Plan1	Policy Schedule (continued)	Page 3 (continued)	<ul style="list-style-type: none"> • “Policy Effective Date”: The policy effective date is variable. The actual policy effective date of the policy will be indicated. • “Policy Anniversary Date”: The policy anniversary date is variable. The actual policy anniversary date for the policy will be indicated. • “Dental Coverage Plan”: The dental coverage plan is variable. The dental coverage plan, “Plan 1”, is variable. The “Plan 1” text may be changed to “Benefit Plan 1”, “Dental Plan 1”, or “Dental Coverage Plan 1”. • “Annual Maximum per Benefit Period”: The annual maximum per benefit period amount is variable. The annual maximum per benefit period will be “\$2,000” for both in-network and out-of-network, or another amount filed with and approved by the Department prior to use. • “Deductible”: The deductible amount is variable. The amount of the deductible will be “\$50.00” for both in-network and out-of-network, or another amount filed with and approved by the Department prior to use. • “Diagnostic/Preventive”: The benefit amount of “100%” is variable. The benefit amount will be “100%” for both in-network and out-of-network, or another amount filed with and

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
			approved by the Department prior to use.
TruA-1000-PS-Plan1	Policy Schedule (continued)	Page 3 (continued)	<ul style="list-style-type: none"> <li data-bbox="1203 524 2016 792">• “Basic Services”: The waiting period of “6” months is variable. The waiting period will be “6” months or another time period filed with and approved by the Department prior to use. The benefit percentage amount of “80%” is variable. The benefit percentage amount will be “80%” for both in-network and out-of-network, or another amount filed with and approved by the Department prior to use. <li data-bbox="1203 824 2016 1092">• “Major Services”: The waiting period of “12” months is variable. The waiting period will be “12” months or another time period filed with and approved by the Department prior to use. The benefit percentage amount of “50%” is variable. The benefit percentage amount will be “50%” for both in-network and out-of-network, or another amount filed with and approved by the Department prior to use.

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-PS-Plan 2	Policy Schedule	Page 3	<p>The variable text is as follows:</p> <ul style="list-style-type: none"> • “TruAssure Insurance Company Web Site”: The Web Site address “www.truassure.com” that is indicated for the “TruAssure Insurance Company Web Site” text is variable and may be changed if the Web Site address changes. • “For Questions or Claim Inquiries please call”: The telephone number “1-800-414-4988” that is indicated for the “For Questions or Claim Inquiries please call” text is variable and may be changed if the telephone number changes. • “For Automated Phone System, please call”: The telephone number “1-800-323-1743” that is indicated for the “For Automated Phone System, please call” text is variable and may be changed if the telephone number changes. • “For Automated Phone System, please call”: The telephone number “1-800-323-1743” that is indicated for the “For Automated Phone System, please call” text is variable and may be changed if the telephone number changes. • Customer Service E-mail Address: : The Web Site address “CSI@truassure.com” that is indicated for the “Customer Service E-mail Address” text is variable and may be changed if the Web Site address changes.

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-PS-Plan2	Policy Schedule (continued)	Page 3 (continued)	<ul style="list-style-type: none"> • “Policy Number”: The policy number is variable. The actual policy number assigned to the policy will be indicated. • “Dental Coverage Plan”: The dental coverage plan is variable. The dental coverage plan, “Plan 2”, is variable. The “Plan 2” text may be changed to “Benefit Plan 2”, “Dental Plan 2”, or “Dental Coverage Plan 2”. • “Policyholder”: The name of the policyholder is variable. The actual name of the policy’s owner will be indicated. • “Type of Coverage”: The type of coverage information is variable. The type of coverage text may be: “Individual”, “Single”, “Two Persons”, “Two Party”, or “Family”. • “Initial Premium”: The initial premium amount is variable. The actual initial premium amount due/paid for the policy will be indicated.
TruA-1000-PS-Plan2	Policy Schedule (continued)	Page 3 (continued)	<ul style="list-style-type: none"> • “Premium Payment Mode”: The type of premium payment mode is variable. The premium payment mode may be “Monthly”, “Quarterly”, “Semi-Annually”, or “Annually”. • “Policy Effective Date”: The policy effective date is variable. The actual policy effective date of the policy will be indicated. • “Policy Anniversary Date”: The policy anniversary date is variable. The actual policy anniversary date for the policy will be indicated.

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-PS-Plan2	Policy Schedule (continued)	Page 3 (continued)	<ul style="list-style-type: none"> • “Dental Coverage Plan”: The dental coverage plan is variable. The dental coverage plan, “Plan 2”, is variable. The “Plan 2” text may be changed to “Benefit Plan 2”, “Dental Plan 2”, or “Dental Coverage Plan 2”. • “Annual Maximum per Benefit Period”: The annual maximum per benefit period amount is variable. The annual maximum per benefit period will be “\$1,500” for both in-network and out-of-network, or another amount filed with and approved by the Department prior to use. • “Deductible”: The deductible amount is variable. The amount of the deductible will be “\$50.00” for both in-network and out-of-network, or another amount filed with and approved by the Department prior to use. • “Diagnostic/Preventive”: The benefit amount of “100%” is variable. The benefit amount will be “100%” for both in-network and out-of-network, or another amount filed with and approved by the Department prior to use. • “Basic Services”: The waiting period of “6” months is variable. The waiting period will be “6” months or another time period filed with and approved by the Department prior to use. <p>The benefit percentage amount of “50%” is variable. The benefit percentage amount will be “50%” for both in-network and out-of-network, or another amount filed with and approved by the Department prior to use.</p>

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-PS-Plan2	Policy Schedule (continued)	Page 3 (continued)	<ul style="list-style-type: none"> • “Major Services”: The waiting period of “12” months is variable. The waiting period will be “12” months or another time period filed with and approved by the Department prior to use. The benefit percentage amount of “50%” is variable. The benefit percentage amount will be “50%” for both in-network and out-of-network, or another amount filed with and approved by the Department prior to use.
TruA-1000-PS-Plan3	Policy Schedule (continued)	Page 3	<p>The variable text is as follows:</p> <ul style="list-style-type: none"> • “TruAssure Insurance Company Web Site”: The Web Site address “www.truassure.com” that is indicated for the “TruAssure Insurance Company Web Site” text is variable and may be changed if the Web Site address changes. • “For Questions or Claim Inquiries please call”: The telephone number “1-800-414-4988” that is indicated for the “For Questions or Claim Inquiries please call” text is variable and may be changed if the telephone number changes. • “For Automated Phone System, please call”: The telephone number “1-800-323-1743” that is indicated for the “For Automated Phone System, please call” text is variable and may be changed if the telephone number changes.

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-PS-Plan3	Policy Schedule (continued)	Page 3 (continued)	<ul style="list-style-type: none"> • “For Automated Phone System, please call”: The telephone number “1-800-323-1743” that is indicated for the “For Automated Phone System, please call” text is variable and may be changed if the telephone number changes. • Customer Service E-mail Address: : The Web Site address “CSI@truassure.com” that is indicated for the “Customer Service E-mail Address” text is variable and may be changed if the Web Site address changes. • “Policy Number”: The policy number is variable. The actual policy number assigned to the policy will be indicated. • “Dental Coverage Plan”: The dental coverage plan is variable. The dental coverage plan, “Plan 3”, is variable. The “Plan 3” text may be changed to “Benefit Plan 3”, “Dental Plan 2”, or “Dental Coverage Plan 3. • “Policyholder”: The name of the policyholder is variable. The actual name of the policy’s owner will be indicated. • “Type of Coverage”: The type of coverage information is variable. The type of coverage text may be: “Individual”, “Single”, “Two Persons”, “Two Party”, or “Family”. • “Initial Premium”: The initial premium amount is variable. The actual initial premium amount due/paid for the policy will be indicated.

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-PS-Plan3	Policy Schedule (continued)	Page 3 (continued)	<ul style="list-style-type: none"> • “Premium Payment Mode”: The type of premium payment mode is variable. The premium payment mode may be “Monthly”, “Quarterly”, “Semi-Annually”, or “Annually”. • “Policy Effective Date”: The policy effective date is variable. The actual policy effective date of the policy will be indicated. • “Policy Anniversary Date”: The policy anniversary date is variable. The actual policy anniversary date for the policy will be indicated. • “Dental Coverage Plan”: The dental coverage plan is variable. The dental coverage plan, “Plan 3”, is variable. The “Plan 3” text may be changed to “Benefit Plan 3”, “Dental Plan 3”, or “Dental Coverage Plan 3”. • “Annual Maximum per Benefit Period”: The annual maximum per benefit period amount is variable. The annual maximum per benefit period will be “\$1,000” for both in-network and out-of-network, or another amount filed with and approved by the Department prior to use. • “Deductible”: The deductible amount is variable. The amount of the deductible will be “\$75.00” for both in-network and out-of-network, or another amount filed with and approved by the Department prior to use.

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-PS-Plan3	Policy Schedule (continued)	Page 3 (continued)	<ul style="list-style-type: none"> <li data-bbox="1220 418 1999 553">• “Diagnostic/Preventive”: The benefit amount of “90%” is variable. The benefit amount will be “90%” for both in-network and out-of-network, or another amount filed with and approved by the Department prior to use. <li data-bbox="1220 578 1999 833">• “Basic Services”: The waiting period of “6” months is variable. The waiting period will be “6” months or another time period filed with and approved by the Department prior to use. The benefit percentage amount of “50%” is variable. The benefit percentage amount will be “50%” for both in-network and out-of-network, or another amount filed with and approved by the Department prior to use. <li data-bbox="1220 873 1999 1179">• “Major Services”: The waiting period of “12” months is variable. The waiting period will be “12” months or another time period filed with and approved by the Department prior to use. The benefit percentage amount of “50%” is variable. The benefit percentage amount will be “50%” for both in-network and out-of-network, or another amount filed with and approved by the Department prior to use.

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-PS-Plan4	Policy Schedule (continued)	Page 3	<p>The variable text is as follows:</p> <ul style="list-style-type: none"> • “TruAssure Insurance Company Web Site”: The Web Site address “www.truassure.com” that is indicated for the “TruAssure Insurance Company Web Site” text is variable and may be changed if the Web Site address changes. • “For Questions or Claim Inquiries please call”: The telephone number “1-800-414-4988” that is indicated for the “For Questions or Claim Inquiries please call” text is variable and may be changed if the telephone number changes. • “For Automated Phone System, please call”: The telephone number “1-800-323-1743” that is indicated for the “For Automated Phone System, please call” text is variable and may be changed if the telephone number changes. • “For Automated Phone System, please call”: The telephone number “1-800-323-1743” that is indicated for the “For Automated Phone System, please call” text is variable and may be changed if the telephone number changes. • Customer Service E-mail Address: : The Web Site address “CSI@truassure.com” that is indicated for the “Customer Service E-mail Address” text is variable and may be changed if the Web Site address changes.

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-PS-Plan4	Policy Schedule (continued)	Page 3 (continued)	<ul style="list-style-type: none"> • “Policy Number”: The policy number is variable. The actual policy number assigned to the policy will be indicated. • “Dental Coverage Plan”: The dental coverage plan is variable. The dental coverage plan, “Plan 4”, is variable. The “Plan 4” text may be changed to “Benefit Plan 4”, “Dental Plan 4”, or “Dental Coverage Plan 4”. • “Policyholder”: The name of the policyholder is variable. The actual name of the policy’s owner will be indicated. • “Type of Coverage”: The type of coverage information is variable. The type of coverage text may be: “Individual”, “Single”, “Two Persons”, “Two Party”, or “Family”. • “Initial Premium”: The initial premium amount is variable. The actual initial premium amount due/paid for the policy will be indicated.
TruA-1000-PS-Plan4	Policy Schedule (continued)	Page 3 (continued)	<ul style="list-style-type: none"> • “Premium Payment Mode”: The type of premium payment mode is variable. The premium payment mode may be “Monthly”, “Quarterly”, “Semi-Annually”, or “Annually”. • “Policy Effective Date”: The policy effective date is variable. The actual policy effective date of the policy will be indicated.

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-PS-Plan4	Policy Schedule (continued)	Page 3 (continued)	<ul style="list-style-type: none"> • “Policy Anniversary Date”: The policy anniversary date is variable. The actual policy anniversary date for the policy will be indicated. • “Dental Coverage Plan”: The dental coverage plan is variable. The dental coverage plan, “Plan 4”, is variable. The “Plan 4” text may be changed to “Benefit Plan 4”, “Dental Plan 4”, or “Dental Coverage Plan 4”. • “Annual Maximum per Benefit Period”: The annual maximum per benefit period amount is variable. The annual maximum per benefit period will be “\$500” for both in-network and out-of-network, or another amount filed with and approved by the Department prior to use. • “Deductible”: The deductible amount is variable. The amount of the deductible will be “\$25.00” for both in-network and out-of-network, or another amount filed with and approved by the Department prior to use. • “Diagnostic/Preventive”: The benefit amount of “100%” is variable. The benefit amount will be “100%” for both in-network and out-of-network, or another amount filed with and approved by the Department prior to use.

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-PS-Plan5	Policy Schedule (continued)	Page 3	<p>The variable text is as follows:</p> <ul style="list-style-type: none"> • “TruAssure Insurance Company Web Site”: The Web Site address “www.truassure.com” that is indicated for the “TruAssure Insurance Company Web Site” text is variable and may be changed if the Web Site address changes. • “For Questions or Claim Inquiries please call”: The telephone number “1-800-414-4988” that is indicated for the “For Questions or Claim Inquiries please call” text is variable and may be changed if the telephone number changes. • “For Automated Phone System, please call”: The telephone number “1-800-323-1743” that is indicated for the “For Automated Phone System, please call” text is variable and may be changed if the telephone number changes. • “For Automated Phone System, please call”: The telephone number “1-800-323-1743” that is indicated for the “For Automated Phone System, please call” text is variable and may be changed if the telephone number changes. • Customer Service E-mail Address: : The Web Site address “CSI@truassure.com” that is indicated for the “Customer Service E-mail Address” text is variable and may be changed if the Web Site address changes.

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-PS-Plan5	Policy Schedule (continued)	Page 3 (continued)	<ul style="list-style-type: none"> • “Policy Number”: The policy number is variable. The actual policy number assigned to the policy will be indicated. • “Dental Coverage Plan”: The dental coverage plan is variable. The dental coverage plan, “Plan 5”, is variable. The “Plan 5” text may be changed to “Benefit Plan 5”, “Dental Plan 5”, or “Dental Coverage Plan 5. • “Policyholder”: The name of the policyholder is variable. The actual name of the policy’s owner will be indicated. • “Type of Coverage”: The type of coverage information is variable. The type of coverage text will be “Dependent Children to Age 19 Only”. The type of coverage information may be changed to “Individual”, “Single”, “Two Persons”, “Two Party”, or “Family” if they are filed with and approved by the Department prior to use. • “Initial Premium”: The initial premium amount is variable. The actual initial premium amount due/paid for the policy will be indicated. • “Premium Payment Mode”: The type of premium payment mode is variable. The premium payment mode may be “Monthly”, “Quarterly”, “Semi-Annually”, or “Annually”.

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-PS-Plan5	Policy Schedule (continued)	Page 3 (continued)	<ul style="list-style-type: none"> • “Policy Effective Date”: The policy effective date is variable. The actual policy effective date of the policy will be indicated. • “Policy Anniversary Date”: The policy anniversary date is variable. The actual policy anniversary date for the policy will be indicated. • “Dental Coverage Plan”: The dental coverage plan is variable. The dental coverage plan, “Plan 5”, is variable. The “Plan 5” text may be changed to “Benefit Plan 5”, “Dental Plan 5”, or “Dental Coverage Plan 5”. • “Annual Maximum per Benefit Period”: The annual maximum per benefit period amount is variable. The annual maximum per benefit period will be “\$1,000” for both in-network and out-of-network, or another amount filed with and approved by the Department prior to use. • “Deductible”: The deductible amount, “None”, for in-network and out-of-network is variable. The deductible may be change to a dollar amount if it is filed with and approved by the Department prior to use. • “Diagnostic/Preventive”: The benefit amount of “100%” is variable. The benefit amount will be “100%” for both in-network and out-of-network, or another amount filed with and approved by the Department prior to use.

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-PS-Plan5	Policy Schedule (continued)	Page 3 (continued)	<ul style="list-style-type: none"> • “Basic Services”: The waiting period of “6” months is variable. The waiting period will be “6” months or another time period filed with and approved by the Department prior to use. The benefit percentage amount of “80%” is variable. The benefit percentage amount will be “80%” for both in-network and out-of-network, or another amount filed with and approved by the Department prior to use. • “Major Services”: The waiting period of “12” months is variable. The waiting period will be “12” months or another time period filed with and approved by the Department prior to use. The benefit percentage amount of “80%” is variable. The benefit percentage amount will be “80%” for both in-network and out-of-network, or another amount filed with and approved by the Department prior to use.
TruA-1000-SODB-Plan1	Schedule of Dental Benefits	Page 3-A	<p>The variable text is as follows:</p> <p>Form Title: “Plan1” appearing in the form title, Schedule of Dental Benefits – Plan 1” is variable. The “Plan 1” text may be changed to “Benefit Plan 1”, “Dental Plan 1”, or “Dental Coverage Plan 1”.</p>

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-SODB-Plan1 (continued)	Schedule of Dental Benefits	Diagnostic Services/Page 3 (continued)	<p>Diagnostic Services:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 100%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use. • “Deductible Applies”: The Deductible Applies information text, “Yes”, is variable. The text may be changed to “No” if the benefits for dental plan 1 are changed. The Company will file any changes to the form with the Department for approval prior to use. • “Bitewing x-rays (not including vertical bitewings): [once] per Benefit Period”: The word “once” is variable and may be changed to “twice”; if such change affects the premium rate, the Company will file the applicable premium rate for the benefit change with the Department for approval prior to use.
TruA-1000-SODB-Plan1 (continued)	Schedule of Dental Benefits	Preventative Services/Page 3	<p>Preventative Services: The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 100%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use.

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-SODB-Plan1	Schedule of Dental Benefits	Preventative Services/Page 3 (continued)	<ul style="list-style-type: none"> • “Deductible Applies”: The Deductible Applies information text, “Yes”, is variable. The text may be changed to “No” if the benefits for dental plan 1 are changed. The Company will file any changes to the form with the Department for approval prior to use. • “Topical fluoride applications: <i>once per Benefit Period, for Covered Dependent Children under age [16]</i>”: Age “16” is variable and may be changed to an age ranging from “age 14” to “age 26”. if such change affects the premium rate, the Company will file the applicable premium rate for the benefit change with the Department for approval prior to use • “Space Maintainers: <i>once per lifetime for Covered Dependent Children under age [14]</i>”: Age “14” is variable and may be changed to an age ranging from “age 14” to “age 26”. If the age change affects the premium rate, the Company will file the applicable premium rate for the age change with the Department for approval prior to use. • “Sealants: <i>applied once per tooth to first and second permanent molars which are free of caries (cavities) and restorations; for Covered Dependent Children under age [16]</i>”: Age “16” is variable and may be changed to an age ranging from “age 14” to “age 26”. If the age change affects the premium rate, the Company will file the applicable premium rate for the age change with the Department for approval prior to use.

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-SODB-Plan1 (continued)	Schedule of Dental Benefits	Basic Services: Routine and Restorative Services	<p>Basic Services: Routine and Restorative Services: The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 80%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use. • “Deductible Applies”: The Deductible Applies information text, “Yes”, is variable. The text may be changed to “No” if the benefits for dental plan 1 are changed. The Company will file any changes to the form with the Department for approval prior to use. • “Waiting Period – 6 Months”: The “Waiting Period – 6 Months” text is variable. The text may be included or excluded in its entirety, or the “6 Months” time period may be changed to “3 Months” or “12 Months”. If such change affects the premium rate, the Company will file the applicable premium rate for the benefit change with the Department for approval prior to use
TruA-1000-SODB-Plan1 (continued)	Schedule of Dental Benefits	Major Services: Restorative Services/Page 3	<p>Major Services: Restorative Services: The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 50%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-SODB-Plan1 (continued)	Schedule of Dental Benefits	Major Services: Restorative Services/Page 3 (continued)	<p>to use.</p> <ul style="list-style-type: none"> • “Deductible Applies”: The Deductible Applies information text, “Yes”, is variable. The text may be changed to “No” if the benefits for dental plan 1 are changed. The Company will file any changes to the form with the Department for approval prior to use. • “Waiting Period – 12 Months”: The “Waiting Period – 12 Months” text is variable. The text may be included or excluded in its entirety, or the “12 Months” time period may be changed to “3 Months” or “6 Months”. If such change affects the premium rate, the Company will file the applicable premium rate for the benefit change with the Department for approval prior to use.
TruA-1000-SODB-Plan1 (continued)	Schedule of Dental Benefits	Major Services: Endodontic Services/Page 3	<p>Major Services: Endodontic Services: The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 50%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use. • “Deductible Applies”: The Deductible Applies information text, “Yes”, is variable. The text may be changed to “No” if the benefits for dental plan 1 are changed. The Company will file any changes to the form with the Department for approval prior to use.

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-SODB-Plan1 (continued)	Schedule of Dental Benefits	Major Services: Endodontic Services/Page 3 (continued)	<ul style="list-style-type: none"> • “Waiting Period – 12 Months”: The “Waiting Period – 12 Months” text is variable. The text may be included or excluded in its entirety, or the “12 Months” time period may be changed to “3 Months” or “6 Months”. If such change affects the premium rate, the Company will file the applicable premium rate for the benefit change with the Department for approval prior to use.
TruA-1000-SODB-Plan1 (continued)	Schedule of Dental Benefits	Major Services: Surgical Periodontic Services/Page 3	<p>Major Services: Surgical Periodontic Services: The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 50%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use. • “Deductible Applies”: The Deductible Applies information text, “Yes”, is variable. The text may be changed to “No” if the benefits for dental plan 1 are changed. The Company will file any changes to the form with the Department for approval prior to use. • “Waiting Period – 12 Months”: The “Waiting Period – 12 Months” text is variable. The text may be included or excluded in its entirety, or the “12 Months” time period may be changed to “3 Months” or “6 Months”. If the waiting period change affects the premium rate, the Company will file the applicable premium rate for the benefit change with the Department for approval prior to use.

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-SODB-Plan1 (continued)	Schedule of Dental Benefits	Major Services: Non-Surgical Periodontic Services/Page 3	<p>Major Services: Non-Surgical Periodontic Services: The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 50%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use. • “Deductible Applies”: The Deductible Applies information text, “Yes”, is variable. The text may be changed to “No” if the benefits for dental plan 1 are changed. The Company will file any changes to the form with the Department for approval prior to use. • “Waiting Period – 12 Months”: The “Waiting Period – 12 Months” text is variable. The text may be included or excluded in its entirety, or the “12 Months” time period may be changed to “3 Months” or “6 Months”. If the waiting period change affects the premium rate, the Company will file the applicable premium rate for the waiting period change with the Department for approval prior to use.

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-SODB-Plan1 (continued)	Schedule of Dental Benefits	Major Services: Non-Surgical Periodontic Services/Page 3 (continued)	<ul style="list-style-type: none"> • Asterisked Reference Text: The following asterisked text contains the variable text of “<i>or periodontal maintenance</i>” which may be included or excluded. • <i>*With an indicator for diabetes, high risk cardiac conditions, or kidney failure or dialysis conditions, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period.</i> • <i>*With an indicator for periodontal disease, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period and for topical application for fluoride at the frequency stated in this Schedule of Dental Benefits.</i> • <i>*With an indicator for suppressed immune system conditions of cancer-related chemotherapy and/or radiation, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.</i> • <i>*With an indicator for pregnancy, the Covered Individual will be eligible for one additional cleaning (prophylaxis [or periodontal maintenance]) during the time of pregnancy.</i>

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-SODB-Plan1 (continued)	Schedule of Dental Benefits	Major Services: Removable Prosthodontic Services/Page 3 (continued)	<p>Major Services: Removal Prosthodontic Services: The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 50%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use. • “Deductible Applies”: The Deductible Applies information text, “Yes”, is variable. The text may be changed to “No” if the benefits for dental plan 1 are changed. The Company will file any changes to the form with the Department for approval prior to use. • “Waiting Period – 12 Months”: The “Waiting Period – 12 Months” text is variable. The text may be included or excluded in its entirety, or the “12 Months” time period may be changed to “3 Months” or “6 Months”. If the waiting period change affects the premium rate, the Company will file the applicable premium rate for the waiting period change with the Department for approval prior to use.
TruA-1000-SODB-Plan1 (continued)	Schedule of Dental Benefits	Major Services: Fixed Prosthodontic Services (Bridges)/Page 3	<p>Major Services: Fixed Prosthodontic Services (Bridges): The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 50%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use.

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-SODB-Plan1 (continued)	Schedule of Dental Benefits	Major Services: Fixed Prosthodontic Services (Bridges)/Page 3 (continued)	<ul style="list-style-type: none"> • “Deductible Applies”: The Deductible Applies information text, “Yes”, is variable. The text may be changed to “No” if the benefits for dental plan 1 are changed. The Company will file any changes to the form with the Department for approval prior to use. • “Waiting Period – 12 Months”: The “Waiting Period – 12 Months” text is variable. The text may be included or excluded in its entirety, or the “12 Months” time period may be changed to “3 Months” or “6 Months”. If the waiting period change affects the premium rate, the Company will file the applicable premium rate for the waiting period change with the Department for approval prior to use.
TruA-1000-SODB-Plan1 (continued)	Schedule of Dental Benefits	Major Services: Oral Surgery/Page 3	<p>Major Services: Fixed Oral Surgery: The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 50%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use. • “Deductible Applies”: The Deductible Applies information text, “Yes”, is variable. The text may be changed to “No” if the benefits for dental plan 1 are changed. The Company will file any changes to the form with the Department for approval prior to use.

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-SODB-Plan1 (continued)	Schedule of Dental Benefits	Major Services: Oral Surgery/Page 3 (continued)	<ul style="list-style-type: none"> • “Waiting Period – 12 Months”: The “Waiting Period – 12 Months” text is variable. The text may be included or excluded in its entirety, or the “12 Months” time period may be changed to “3 Months” or “6 Months”. If the waiting period change affects the premium rate, the Company will file the applicable premium rate for the waiting period change with the Department for approval prior to use.
TruA-1000-SODB-Plan1 (continued)	Schedule of Dental Benefits	Major Services: Adjunctive General Services/Page 3	<p>Major Services: Adjunctive General Services: The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 50%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use. • “Deductible Applies”: The Deductible Applies information text, “Yes”, is variable. The text may be changed to “No” if the benefits for dental plan 1 are changed. The Company will file any changes to the form with the Department for approval prior to use. • Waiting Period – 12 Months: The “Waiting Period – 12 Months” text is variable. The text may be included or excluded in its entirety, or the “12 Months” time period may be changed to “3 Months” or “6 Months”. If the waiting period change affects the premium rate, the Company will file the change with the Department for approval prior to use.

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-SODB-Plan2	Schedule of Dental Benefits	Page 3	<p>The variable text is as follows:</p> <p>Form Title: “Plan2” appearing in the form title, Schedule of Dental Benefits – Plan 2” is variable. The “Plan 2” text may be changed to “Benefit Plan 2”, “Dental Plan 2”, or “Dental Coverage Plan 2”.</p>
TruA-1000-SODB-Plan2 (continued)	Schedule of Dental Benefits	Diagnostic Services/Page 3	<p>Diagnostic Services: The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 100%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use. • “Deductible Applies”: The Deductible Applies information text, “Yes”, is variable. The text may be changed to “No” if the benefits for dental plan 2 are changed. The Company will file any changes to the form with the Department for approval prior to use. • “Bitewing x-rays (not including vertical bitewings): [once] per Benefit Period”: The word “once” is variable and may be changed to “twice”; if such change affects the premium rate, the Company will file the applicable premium rate for the benefit change with the Department for approval prior to use.

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-SODB-Plan2 (continued)	Schedule of Dental Benefits	Preventative Services/Page 3	<p>Preventative Services: The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 100%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use. • “Deductible Applies”: The Deductible Applies information text, “Yes”, is variable. The text may be changed to “No” if the benefits for dental plan 2 are changed. The Company will file any changes to the form with the Department for approval prior to use. • “Topical fluoride applications: <i>once per Benefit Period, for Covered Dependent Children under age [16]</i>”: Age “16” is variable and may be changed to an age ranging from “age 14” to “age 26”. If the age change affects the premium rate, the Company will file the applicable premium rate for the age change with the Department for approval prior to use. • “Space Maintainers: <i>once per lifetime for Covered Dependent Children under age [14]</i>”: Age “14” is variable and may be changed to an age ranging from “age 14” to “age 26”. If the age change affects the premium rate, the Company will file the applicable premium rate for the age change with the Department for approval prior to use.

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-SODB-Plan2	Schedule of Dental Benefits	Preventative Services/Page 3 (continued)	<ul style="list-style-type: none"> • “Sealants: applied once per tooth to first and second permanent molars which are free of caries (cavities) and restorations; for Covered Dependent Children under age [16]”: Age “16” is variable and may be changed to an age ranging from “age 14” to “age 26”. If the age change affects the premium rate, the Company will file the applicable premium rate for the age change with the Department for approval prior to use.
TruA-1000-SODB-Plan2 (continued)	Schedule of Dental Benefits	Basic Services: Routine and Restorative Services	<p>Basic Services: Routine and Restorative Services: The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 50%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use. • “Deductible Applies”: The Deductible Applies information text, “Yes”, is variable. The text may be changed to “No” if the benefits for dental plan 2 are changed. The Company will file any changes to the form with the Department for approval prior to use. • “Waiting Period – 6 Months”: The “Waiting Period – 6 Months” text is variable. The text may be included or excluded in its entirety, or the “6 Months” time period may be changed to “3 Months” or “12 Months”. If the waiting period change affects the premium rate, the Company will file the applicable premium rate for the waiting period change with the Department for approval prior to use.

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-SODB-Plan2 (continued)	Schedule of Dental Benefits	Major Services: Restorative Services/Page 3	<p>Major Services: Restorative Services: The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 50%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use. • “Deductible Applies”: The Deductible Applies information text, “Yes”, is variable. The text may be changed to “No” if the benefits for dental plan 2 are changed. The Company will file any changes to the form with the Department for approval prior to use. • “Waiting Period – 12 Months”: The “Waiting Period – 12 Months” text is variable. The text may be included or excluded in its entirety, or the “12 Months” time period may be changed to “3 Months” or “6 Months”. If the waiting period change affects the premium rate, the Company will file the applicable premium rate for the waiting period change with the Department for approval prior to use.

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-SODB-Plan2 (continued)	Schedule of Dental Benefits	Major Services: Endodontic Services/Page 3	<p>Major Services: Endodontic Services: The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 50%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use. • “Deductible Applies”: The Deductible Applies information text, “Yes”, is variable. The text may be changed to “No” if the benefits for dental plan 2 are changed. The Company will file any changes to the form with the Department for approval prior to use. • “Waiting Period – 12 Months”: The “Waiting Period – 12 Months” text is variable. The text may be included or excluded in its entirety, or the “12 Months” time period may be changed to “3 Months” or “6 Months”. If the waiting period change affects the premium rate, the Company will file the applicable premium rate for the waiting period change with the Department for approval prior to use.
TruA-1000-SODB-Plan2	Schedule of Dental Benefits	Major Services:	Major Services: Surgical Periodontic Services: The variable

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
(continued)		Surgical Periodontic Services/Page 3	<p>text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 50%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use. • “Deductible Applies”: The Deductible Applies information text, “Yes”, is variable. The text may be changed to “No” if the benefits for dental plan 2 are changed. The Company will file any changes to the form with the Department for approval prior to use. • “Waiting Period – 12 Months”: The “Waiting Period – 12 Months” text is variable. The text may be included or excluded in its entirety, or the “12 Months” time period may be changed to “3 Months” or “6 Months”. If the waiting period change affects the premium rate, the Company will file the applicable premium rate for the waiting period change with the Department for approval prior to use.
TruA-1000-SODB-Plan2	Schedule of Dental Benefits	Major Services: Non-Surgical Periodontic Services/Page 3	<p>Major Services: Non-Surgical Periodontic Services: The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 50%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use.

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-SODB-Plan2 (continued)	Schedule of Dental Benefits	Major Services: Non-Surgical Periodontic Services/Page 3 (continued)	<ul style="list-style-type: none"> • “Deductible Applies”: The Deductible Applies information text, “Yes”, is variable. The text may be changed to “No” if the benefits for dental plan 2 are changed. The Company will file any changes to the form with the Department for approval prior to use. • “Waiting Period – 12 Months”: The “Waiting Period – 12 Months” text is variable. The text may be included or excluded in its entirety, or the “12 Months” time period may be changed to “3 Months” or “6 Months”. If the waiting period change affects the premium rate, the Company will file the applicable premium rate for the waiting period change with the Department for approval prior to use.
TruA-1000-SODB-Plan2 (continued)	Schedule of Dental Benefits	Major Services: Non-Surgical Periodontic Services/Page 3 (continued)	<ul style="list-style-type: none"> • Asterisked Reference Text: The following asterisked text contains the variable text of “<i>or periodontal maintenance</i>” which may be included or excluded. <ul style="list-style-type: none"> • <i>*With an indicator for diabetes, high risk cardiac conditions, or kidney failure or dialysis conditions, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period.</i> • <i>*With an indicator for periodontal disease, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period and for topical application for fluoride at the frequency stated in this Schedule of Dental Benefits.</i>

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
			<ul style="list-style-type: none"> • <i>*With an indicator for suppressed immune system conditions of cancer-related chemotherapy and/or radiation, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.</i> • <i>*With an indicator for pregnancy, the Covered Individual will be eligible for one additional cleaning (prophylaxis [or periodontal maintenance]) during the time of pregnancy.</i>
TruA-1000-SODB-Plan2 (continued)	Schedule of Dental Benefits	Major Services: Removable Prosthetic Services/Page 3	<p>Major Services: Removal Prosthetic Services: The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 50%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use. • “Deductible Applies”: The Deductible Applies information text, “Yes”, is variable. The text may be changed to “No” if the benefits for dental plan 2 are changed. The Company will file any changes to the form with the Department for approval prior to use.

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-SODB-Plan2 (continued)	Schedule of Dental Benefits	Major Services: Removable Prosthodontic Services/Page 3 (continued)	<ul style="list-style-type: none"> • “Waiting Period – 12 Months”: The “Waiting Period – 12 Months” text is variable. The text may be included or excluded in its entirety, or the “12 Months” time period may be changed to “3 Months” or “6 Months”. If the waiting period change affects the premium rate, the Company will file the applicable premium rate for the waiting period change with the Department for approval prior to use.
TruA-1000-SODB-Plan2 (continued)	Schedule of Dental Benefits	Major Services: Fixed Prosthodontic Services (Bridges)/Page 3	<p>Major Services: Fixed Prosthodontic Services (Bridges): The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 50%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use.
TruA-1000-SODB-Plan2 (continued)	Schedule of Dental Benefits	Major Services: Fixed Prosthodontic Services (Bridges)/Page 3 (continued)	<ul style="list-style-type: none"> • “Deductible Applies”: The Deductible Applies information text, “Yes”, is variable. The text may be changed to “No” if the benefits for dental plan 2 are changed. The Company will file any changes to the form with the Department for approval prior to use. • “Waiting Period – 12 Months”: The “Waiting Period – 12 Months” text is variable. The text may be included or excluded in its entirety, or the “12 Months” time period may be changed to “3 Months” or “6 Months”. If the waiting period change affects the premium rate, the Company will file the applicable premium rate for the waiting period change with the Department for approval prior to use.

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-SODB-Plan2 (continued)	Schedule of Dental Benefits	Major Services: Oral Surgery/Page 3	<p>Major Services: Fixed Oral Surgery: The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 50%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use. • “Deductible Applies”: The Deductible Applies information text, “Yes”, is variable. The text may be changed to “No” if the benefits for dental plan 2 are changed. The Company will file any changes to the form with the Department for approval prior to use.
TruA-1000-SODB-Plan2 (continued)	Schedule of Dental Benefits	Major Services: Oral Surgery/Page 3 (continued)	<ul style="list-style-type: none"> • “Waiting Period – 12 Months”: The “Waiting Period – 12 Months” text is variable. The text may be included or excluded in its entirety, or the “12 Months” time period may be changed to “3 Months” or “6 Months”. If the waiting period change affects the premium rate, the Company will file the applicable premium rate for the waiting period change with the Department for approval prior to use.

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-SODB-Plan2 (continued)	Schedule of Dental Benefits	Major Services: Adjunctive General Services/Page 3	<p>Major Services: Adjunctive General Services: The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 50%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use. • “Deductible Applies”: The Deductible Applies information text, “Yes”, is variable. The text may be changed to “No” if the benefits for dental plan 2 are changed. The Company will file any changes to the form with the Department for approval prior to use. • Waiting Period – 12 Months”: The “Waiting Period – 12 Months” text is variable. The text may be included or excluded in its entirety, or the “12 Months” time period may be changed to “3 Months” or “6 Months”. If the waiting period change affects the premium rate, the Company will file the applicable premium rate for the waiting period change with the Department for approval prior to use.
TruA-1000-SODB-Plan3	Schedule of Dental Benefits	Page 3	<p>The variable text is as follows:</p> <p>Form Title: “Plan3” appearing in the form title, Schedule of Dental Benefits – Plan 3” is variable. The “Plan 3” text may be changed to “Benefit Plan 3”, “Dental Plan 3”, or “Dental Coverage Plan 3”.</p>

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-SODB-Plan3 (continued)	Schedule of Dental Benefits	Diagnostic Services/Page 3	<p>Diagnostic Services: The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 90%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use. • “Deductible Applies”: The Deductible Applies information text, “Yes”, is variable. The text may be changed to “No” if the benefits for dental plan 3 are changed. The Company will file any changes to the form with the Department for approval prior to use. • “Bitewing x-rays (not including vertical bitewings): [once] per Benefit Period”: The word “once” is variable and may be changed to “twice”; if such change affects the premium rate, the Company will file the applicable premium rate for the benefit change with the Department for approval prior to use.
TruA-1000-SODB-Plan3 (continued)	Schedule of Dental Benefits	Preventative Services/Page 3	<p>Preventative Services: The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 90%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use.

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-SODB-Plan3	Schedule of Dental Benefits	Preventative Services/Page 3 (continued)	<ul style="list-style-type: none"> • “Deductible Applies”: The Deductible Applies information text, “Yes”, is variable. The text may be changed to “No” if the benefits for dental plan 3 are changed. The Company will file any changes to the form with the Department for approval prior to use. • “Topical fluoride applications: <i>once per Benefit Period, for Covered Dependent Children under age [16]</i>”: Age “16” is variable and may be changed to an age ranging from “age 14” to “age 26”. If the age change affects the premium rate, the Company will file the applicable premium rate for the age change with the Department for approval prior to use. • “Space Maintainers: <i>once per lifetime for Covered Dependent Children under age [14]</i>”: Age “14” is variable and may be changed to an age ranging from “age 14” to “age 26”. If the age change affects the premium rate, the Company will file the applicable premium rate for the age change with the Department for approval prior to use. • “Sealants: <i>applied once per tooth to first and second permanent molars which are free of caries (cavities) and restorations; for Covered Dependent Children under age [16]</i>”: Age “16” is variable and may be changed to an age ranging from “age 14” to “age 26”. If the age change affects the premium rate, the Company will file the applicable premium rate for the age change with the Department for approval prior to use.

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-SODB-Plan3 (continued)	Schedule of Dental Benefits	Basic Services: Routine and Restorative Services	<p>Basic Services: Routine and Restorative Services: The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 50%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use. • “Deductible Applies”: The Deductible Applies information text, “Yes”, is variable. The text may be changed to “No” if the benefits for dental plan 3 are changed. The Company will file any changes to the form with the Department for approval prior to use. • “Waiting Period – 6 Months”: The “Waiting Period – 6 Months” text is variable. The text may be included or excluded in its entirety, or the “6 Months” time period may be changed to “3 Months” or “12 Months”. If the waiting period change affects the premium rate, the Company will file the applicable premium rate for the waiting period change with the Department for approval prior to use.
TruA-1000-SODB-Plan3 (continued)	Schedule of Dental Benefits	Major Services: Restorative Services/Page 3	<p>Major Services: Restorative Services: The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 50%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use.

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-SODB-Plan3 (continued)	Schedule of Dental Benefits	Major Services: Restorative Services/Page 3 (continued)	<ul style="list-style-type: none"> • “Deductible Applies”: The Deductible Applies information text, “Yes”, is variable. The text may be changed to “No” if the benefits for dental plan 3 are changed. The Company will file any changes to the form with the Department for approval prior to use. • “Waiting Period – 12 Months”: The “Waiting Period – 12 Months” text is variable. The text may be included or excluded in its entirety, or the “12 Months” time period may be changed to “3 Months” or “6 Months”. If the waiting period change affects the premium rate, the Company will file the applicable premium rate for the waiting period change with the Department for approval prior to use.
TruA-1000-SODB-Plan3 (continued)	Schedule of Dental Benefits	Major Services: Endodontic Services/Page 3	<p>Major Services: Endodontic Services: The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 50%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use. • “Deductible Applies”: The Deductible Applies information text, “Yes”, is variable. The text may be changed to “No” if the benefits for dental plan 3 are changed. The Company will file any changes to the form with the Department for approval prior to use.

TRUASSURE INSURANCE COMPANY

Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-SODB-Plan3 (continued)	Schedule of Dental Benefits	Major Services: Endodontic Services/Page 3 (continued)	<ul style="list-style-type: none"> • “Waiting Period – 12 Months”: The “Waiting Period – 12 Months” text is variable. The text may be included or excluded in its entirety, or the “12 Months” time period may be changed to “3 Months” or “6 Months”. If the waiting period change affects the premium rate, the Company will file the applicable premium rate for the waiting period change with the Department for approval prior to use.
TruA-1000-SODB-Plan3 (continued)	Schedule of Dental Benefits	Major Services: Surgical Periodontic Services/Page 3	<p>Major Services: Surgical Periodontic Services: The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 50%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use. • “Deductible Applies”: The Deductible Applies information text, “Yes”, is variable. The text may be changed to “No” if the benefits for dental plan 3 are changed. The Company will file any changes to the form with the Department for approval prior to use. • “Waiting Period – 12 Months”: The “Waiting Period – 12 Months” text is variable. The text may be included or excluded in its entirety, or the “12 Months” time period may be changed to “3 Months” or “6 Months”. If the waiting period change affects the premium rate, the Company will file the applicable premium rate for the waiting period change with the Department for approval prior to use.

TRUASSURE INSURANCE COMPANY

Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-SODB-Plan3	Schedule of Dental Benefits	Major Services: Non-Surgical Periodontic Services/Page 3	<p>Major Services: Non-Surgical Periodontic Services: The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 50%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use. • “Deductible Applies”: The Deductible Applies information text, “Yes”, is variable. The text may be changed to “No” if the benefits for dental plan 3 are changed. The Company will file any changes to the form with the Department for approval prior to use. • “Waiting Period – 12 Months”: The “Waiting Period – 12 Months” text is variable. The text may be included or excluded in its entirety, or the “12 Months” time period may be changed to “3 Months” or “6 Months”. If the waiting period change affects the premium rate, the Company will file the applicable premium rate for the waiting period change with the Department for approval prior to use.

TRUASSURE INSURANCE COMPANY

Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-SODB-Plan3 (continued)	Schedule of Dental Benefits	Major Services: Non-Surgical Periodontic Services/Page 3 (continued)	<ul style="list-style-type: none"> • Asterisked Reference Text: The following asterisked text contains the variable text of “<i>or periodontal maintenance</i>” which may be included or excluded. • <i>*With an indicator for diabetes, high risk cardiac conditions, or kidney failure or dialysis conditions, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period.</i> • <i>*With an indicator for periodontal disease, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period and for topical application for fluoride at the frequency stated in this Schedule of Dental Benefits.</i> • <i>*With an indicator for suppressed immune system conditions of cancer-related chemotherapy and/or radiation, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.</i> • <i>*With an indicator for pregnancy, the Covered Individual will be eligible for one additional cleaning (prophylaxis [or periodontal maintenance]) during the time of pregnancy.</i>

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-SODB-Plan3 (continued)	Schedule of Dental Benefits	Major Services: Removable Prosthodontic Services/Page 3	<p>Major Services: Removal Prosthodontic Services: The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 50%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use. • “Deductible Applies”: The Deductible Applies information text, “Yes”, is variable. The text may be changed to “No” if the benefits for dental plan 3 are changed. The Company will file any changes to the form with the Department for approval prior to use. • “Waiting Period – 12 Months”: The “Waiting Period – 12 Months” text is variable. The text may be included or excluded in its entirety, or the “12 Months” time period may be changed to “3 Months” or “6 Months”. If the waiting period change affects the premium rate, the Company will file the applicable premium rate for the waiting period change with the Department for approval prior to use.
TruA-1000-SODB-Plan3 (continued)	Schedule of Dental Benefits	Major Services: Fixed Prosthodontic Services (Bridges)/Page 3	<p>Major Services: Fixed Prosthodontic Services (Bridges): The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 50%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use.

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-SODB-Plan3 (continued)	Schedule of Dental Benefits	Major Services: Fixed Prosthodontic Services (Bridges)/Page 3 (continued)	<ul style="list-style-type: none"> • “Deductible Applies”: The Deductible Applies information text, “Yes”, is variable. The text may be changed to “No” if the benefits for dental plan 3 are changed. The Company will file any changes to the form with the Department for approval prior to use. • “Waiting Period – 12 Months”: The “Waiting Period – 12 Months” text is variable. The text may be included or excluded in its entirety, or the “12 Months” time period may be changed to “3 Months” or “6 Months”. If the waiting period change affects the premium rate, the Company will file the applicable premium rate for the waiting period change with the Department for approval prior to use.
TruA-1000-SODB-Plan3 (continued)	Schedule of Dental Benefits	Major Services: Oral Surgery/Page 3	<p>Major Services: Fixed Oral Surgery: The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 50%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use. • “Deductible Applies”: The Deductible Applies information text, “Yes”, is variable. The text may be changed to “No” if the benefits for dental plan 3 are changed. The Company will file any changes to the form with the Department for approval prior to use.

TRUASSURE INSURANCE COMPANY

Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-SODB-Plan3 (continued)	Schedule of Dental Benefits	Major Services: Oral Surgery/Page 3 (continued)	<ul style="list-style-type: none"> • “Waiting Period – 12 Months”: The “Waiting Period – 12 Months” text is variable. The text may be included or excluded in its entirety, or the “12 Months” time period may be changed to “3 Months” or “6 Months”. If the waiting period change affects the premium rate, the Company will file the applicable premium rate for the waiting period change with the Department for approval prior to use.
TruA-1000-SODB-Plan3 (continued)	Schedule of Dental Benefits	Major Services: Adjunctive General Services/Page 3	<p>Major Services: Adjunctive General Services: The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 50%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use. • “Deductible Applies”: The Deductible Applies information text, “Yes”, is variable. The text may be changed to “No” if the benefits for dental plan 3 are changed. The Company will file any changes to the form with the Department for approval prior to use. • Waiting Period – 12 Months: The “Waiting Period – 12 Months” text is variable. The text may be included or excluded in its entirety, or the “12 Months” time period may be changed to “3 Months” or “6 Months”. If the waiting period change affects the premium rate, the Company will file the applicable premium rate for the waiting period change with the Department for approval prior to use.

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-SODB-Plan4	Schedule of Dental Benefits	Page 3	<p>The variable text is as follows:</p> <p>Form Title: “Plan4” appearing in the form title, Schedule of Dental Benefits – Plan 4” is variable. The “Plan 4” text may be changed to “Benefit Plan 4”, “Dental Plan 4”, or “Dental Coverage Plan 4”.</p>
TruA-1000-SODB-Plan4 (continued)	Schedule of Dental Benefits	Diagnostic Services/Page 3	<p>Diagnostic Services: The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 100%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use. • “Deductible Applies”: The Deductible Applies information text, “Yes”, is variable. The text may be changed to “No” if the benefits for dental plan 4 are changed. The Company will file any changes to the form with the Department for approval prior to use. • “Bitewing x-rays (not including vertical bitewings): [once] per Benefit Period”: The word “once” is variable and may be changed to “twice”; if such change affects the premium rate, the Company will file the applicable premium rate for the benefit change with the Department for approval prior to use.

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-SODB-Plan4 (continued)	Schedule of Dental Benefits	Preventative Services/Page 3	<p>Preventative Services: The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 100%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use. • “Deductible Applies”: The Deductible Applies information text, “Yes”, is variable. The text may be changed to “No” if the benefits for dental plan 4 are changed. The Company will file any changes to the form with the Department for approval prior to use. • “Topical fluoride applications: <i>once per Benefit Period, for Covered Dependent Children under age [16]</i>”: Age “16” is variable and may be changed to an age ranging from “age 14” to “age 26”. If the age change affects the premium rate, the Company will file the applicable premium rate for the age change with the Department for approval prior to use. • “Space Maintainers: <i>once per lifetime for Covered Dependent Children under age [14]</i>”: Age “14” is variable and may be changed to an age ranging from “age 14” to “age 26”. If the age change affects the premium rate, the Company will file the applicable premium rate for the age change with the Department for approval prior to use.

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-SODB-Plan4 (continued)	Schedule of Dental Benefits	Preventative Services/Page 3 (continued)	<ul style="list-style-type: none"> • “Sealants: applied once per tooth to first and second permanent molars which are free of caries (cavities) and restorations; for Covered Dependent Children under age [16]”: Age “16” is variable and may be changed to an age ranging from “age 14” to “age 26”. If the age change affects the premium rate, the Company will file the applicable premium rate for the age change with the Department for approval prior to use.
TruA-1000-SODB-Plan5	Schedule of Dental Benefits	Page 3	<p>The variable text is as follows:</p> <p>Form Title: “Plan5” appearing in the form title, Schedule of Dental Benefits – Plan 5” is variable. The “Plan 5” text may be changed to “Benefit Plan 5”, “Dental Plan 5”, or “Dental Coverage Plan 5”.</p>
TruA-1000-SODB-Plan5 (continued)	Schedule of Dental Benefits	Diagnostic Services/Page 3	<p>Diagnostic Services: The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 100%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use. • “Deductible Applies”: The Deductible Applies information text, “No”, is variable. The text may be changed to “Yes” if the benefits for dental plan 5 are changed. The Company will file any changes to the form with the Department for approval prior to use.

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-SODB-Plan5 (continued)	Schedule of Dental Benefits	Diagnostic Services/Page 3 (continued)	<ul style="list-style-type: none"> • “Bitewing x-rays (not including vertical bitewings): [once] per Benefit Period”: The word “once” is variable and may be changed to “twice”; if such change affects the premium rate, the Company will file the applicable premium rate for the benefit change with the Department for approval prior to use.
TruA-1000-SODB-Plan5 (continued)	Schedule of Dental Benefits	Preventative Services/Page 3	<p>Preventative Services: The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 100%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use. • “Deductible Applies”: The Deductible Applies information text, “No”, is variable. The text may be changed to “Yes” if the benefits for dental plan 5 are changed. The Company will file any changes to the form with the Department for approval prior to use. • “Topical fluoride applications: once per Benefit Period, for Covered Dependent Children under age [16]”: Age “16” is variable and may be changed to an age ranging from “age 14” to “age 26”. If the age change affects the premium rate, the Company will file the applicable premium rate for the age change with the Department for approval prior to use.

TRUASSURE INSURANCE COMPANY

Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-SODB-Plan5	Schedule of Dental Benefits	Preventative Services/Page 3 (continued)	<ul style="list-style-type: none"> • “Space Maintainers: <i>once per lifetime for Covered Dependent Children under age [14]</i>”: Age “14” is variable and may be changed to an age ranging from “age 14” to “age 26”. If the age change affects the premium rate, the Company will file the applicable premium rate for the age change with the Department for approval prior to use. “Sealants: <i>applied once per tooth to first and second permanent molars which are free of caries (cavities) and restorations; for Covered Dependent Children under age [16]</i>”: Age “16” is variable and may be changed to an age ranging from “age 14” to “age 26”. If the age change affects the premium rate, the Company will file the applicable premium rate for the age change with the Department for approval prior to use.
TruA-1000-SODB-Plan5 (continued)	Schedule of Dental Benefits	Basic Services: Routine and Restorative Services/Page 3	<p>Basic Services: Routine and Restorative Services: The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 80%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use. • “Deductible Applies”: The Deductible Applies information text, “No”, is variable. The text may be changed to “Yes” if the benefits for dental plan 5 are changed. The Company will file any changes to the form with the Department for approval prior to use.

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-SODB-Plan5 (continued)	Schedule of Dental Benefits	Basic Services: Routine and Restorative Services/Page 3 (continued)	<ul style="list-style-type: none"> • “Waiting Period – 6 Months”: The “Waiting Period – 6 Months” text is variable. The text may be included or excluded in its entirety, or the “6 Months” time period may be changed to “3 Months” or “12 Months”. If the waiting period change affects the premium rate, the Company will file the applicable premium rate for the waiting period change with the Department for approval prior to use.
TruA-1000-SODB-Plan5 (continued)	Schedule of Dental Benefits	Major Services: Restorative Services/Page 3	<p>Major Services: Restorative Services: The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 80%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use. • “Deductible Applies”: The Deductible Applies information text, “No”, is variable. The text may be changed to “Yes” if the benefits for dental plan 5 are changed. The Company will file any changes to the form with the Department for approval prior to use. • “Waiting Period – 12 Months”: The “Waiting Period – 12 Months” text is variable. The text may be included or excluded in its entirety, or the “12 Months” time period may be changed to “3 Months” or “6 Months”. If the waiting period change affects the premium rate, the Company will file the applicable premium rate for the waiting period change with the Department for approval prior to use.

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-SODB-Plan5 (continued)	Schedule of Dental Benefits	Major Services: Endodontic Services/Page 3	<p>Major Services: Endodontic Services: The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 80%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use. • “Deductible Applies”: The Deductible Applies information text, “No”, is variable. The text may be changed to “Yes” if the benefits for dental plan 5 are changed. The Company will file any changes to the form with the Department for approval prior to use. • “Waiting Period – 12 Months”: The “Waiting Period – 12 Months” text is variable. The text may be included or excluded in its entirety, or the “12 Months” time period may be changed to “3 Months” or “6 Months”. If the waiting period change affects the premium rate, the Company will file the applicable premium rate for the waiting period change with the Department for approval prior to use.
TruA-1000-SODB-Plan5 (continued)	Schedule of Dental Benefits	Major Services: Surgical Periodontic Services/Page 3	<p>Major Services: Surgical Periodontic Services: The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 80%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use.

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Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-SODB-Plan5 (continued)	Schedule of Dental Benefits	Major Services: Surgical Periodontic Services/Page 3 (continued)	<ul style="list-style-type: none"> • “Deductible Applies”: The Deductible Applies information text, “No”, is variable. The text may be changed to “Yes” if the benefits for dental plan 5 are changed. The Company will file any changes to the form with the Department for approval prior to use. • “Waiting Period – 12 Months”: The “Waiting Period – 12 Months” text is variable. The text may be included or excluded in its entirety, or the “12 Months” time period may be changed to “3 Months” or “6 Months”. If the waiting period change affects the premium rate, the Company will file the applicable premium rate for the waiting period change with the Department for approval prior to use.
TruA-1000-SODB-Plan5	Schedule of Dental Benefits	Major Services: Non-Surgical Periodontic Services/Page 3	<p>Major Services: Non-Surgical Periodontic Services: The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 80%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use. • “Deductible Applies”: The Deductible Applies information text, “No”, is variable. The text may be changed to “Yes” if the benefits for dental plan 5 are changed. The Company will file any changes to the form with the Department for approval prior to use.

TRUASSURE INSURANCE COMPANY

Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-SODB-Plan5 (continued)	Schedule of Dental Benefits	Major Services: Non-Surgical Periodontic Services/Page 3 (continued)	<ul style="list-style-type: none"> • “Waiting Period – 12 Months”: The “Waiting Period – 12 Months” text is variable. The text may be included or excluded in its entirety, or the “12 Months” time period may be changed to “3 Months” or “6 Months”. If the waiting period change affects the premium rate, the Company will file the applicable premium rate for the waiting period change with the Department for approval prior to use.
TruA-1000-SODB-Plan5 (continued)	Schedule of Dental Benefits	Major Services: Non-Surgical Periodontic Services/Page 3 (continued)	<ul style="list-style-type: none"> • Asterisked Reference Text: The following asterisked text contains the variable text of “<i>or periodontal maintenance</i>” which may be included or excluded. <ul style="list-style-type: none"> • <i>*With an indicator for diabetes, high risk cardiac conditions, or kidney failure or dialysis conditions, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period.</i> • <i>*With an indicator for periodontal disease, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period and for topical application for fluoride at the frequency stated in this Schedule of Dental Benefits.</i> • <i>*With an indicator for suppressed immune system conditions of cancer-related chemotherapy and/or radiation, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal</i>

TRUASSURE INSURANCE COMPANY

Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
			<p><i>maintenance]) per Benefit Period and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.</i></p> <ul style="list-style-type: none"> <i>*With an indicator for pregnancy, the Covered Individual will be eligible for one additional cleaning (prophylaxis [or periodontal maintenance]) during the time of pregnancy.</i>
TruA-1000-SODB-Plan5 (continued)	Schedule of Dental Benefits	Major Services: Removable Prosthodontic Services/Page 3	<p>Major Services: Removal Prosthodontic Services: The variable text is as follows:</p> <ul style="list-style-type: none"> “Co-Payment Percentage”: The Co-Payment Percentage of 80%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use. “Deductible Applies”: The Deductible Applies information text, “No”, is variable. The text may be changed to “Yes” if the benefits for dental plan 5 are changed. The Company will file any changes to the form with the Department for approval prior to use.
TruA-1000-SODB-Plan2 (continued)	Schedule of Dental Benefits	Major Services: Removable Prosthodontic Services/Page 3 (continued)	<ul style="list-style-type: none"> “Waiting Period – 12 Months”: The “Waiting Period – 12 Months” text is variable. The text may be included or excluded in its entirety, or the “12 Months” time period may be changed to “3 Months” or “6 Months”. If the waiting period change affects the premium rate, the Company will file the applicable premium rate for the waiting period change with the Department for approval prior to use.

TRUASSURE INSURANCE COMPANY

Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-SODB-Plan5 (continued)	Schedule of Dental Benefits	Major Services: Fixed Prosthodontic Services (Bridges)/Page 3	<p>Major Services: Fixed Prosthodontic Services (Bridges): The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 80%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use. • “Deductible Applies”: The Deductible Applies information text, “No”, is variable. The text may be changed to “Yes” if the benefits for dental plan 5 are changed. The Company will file any changes to the form with the Department for approval prior to use. • “Waiting Period – 12 Months”: The “Waiting Period – 12 Months” text is variable. The text may be included or excluded in its entirety, or the “12 Months” time period may be changed to “3 Months” or “6 Months”. If the waiting period change affects the premium rate, the Company will file the applicable premium rate for the waiting period change with the Department for approval prior to use.

TRUASSURE INSURANCE COMPANY

Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-SODB-Plan5 (continued)	Schedule of Dental Benefits	Major Services: Oral Surgery/Page 3	<p>Major Services: Fixed Oral Surgery: The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 80%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use. • “Deductible Applies”: The Deductible Applies information text, “No”, is variable. The text may be changed to “Yes” if the benefits for dental plan 5 are changed. The Company will file any changes to the form with the Department for approval prior to use. • “Waiting Period – 12 Months”: The “Waiting Period – 12 Months” text is variable. The text may be included or excluded in its entirety, or the “12 Months” time period may be changed to “3 Months” or “6 Months”. If the waiting period change affects the premium rate, the Company will file the applicable premium rate for the waiting period change with the Department for approval prior to use.

TRUASSURE INSURANCE COMPANY

Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-SODB-Plan5 (continued)	Schedule of Dental Benefits	Major Services: Adjunctive General Services/Page 3	<p>Major Services: Adjunctive General Services: The variable text is as follows:</p> <ul style="list-style-type: none"> • “Co-Payment Percentage”: The Co-Payment Percentage of 80%, for Delta Dental PPO, Delta Dental Premier, and Out-of-Network is variable and may be changed to another benefit amount if it is filed with and approved by the Department prior to use. • “Deductible Applies”: The Deductible Applies information text, “No”, is variable. The text may be changed to “Yes” if the benefits for dental plan 5 are changed. The Company will file any changes to the form with the Department for approval prior to use. • Waiting Period – 12 Months”: The “Waiting Period – 12 Months” text is variable. The text may be included or excluded in its entirety, or the “12 Months” time period may be changed to “3 Months” or “6 Months”. If the waiting period change affects the premium rate, the Company will file the applicable premium rate for the waiting period change with the Department for approval prior to use.

TRUASSURE INSURANCE COMPANY

Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-Amend	Policy Amendment	Page 1	<p>The form only will be used to modify the policy in accordance with the variable text provided in this Statement of Variability. The form will not be used to change any other non-variable text or amounts nor will it be used to add any information that has not been filed with and approved by the Department. Additionally, the following text is variable text:</p> <ul style="list-style-type: none"> • “Company Address”: The Company’s address and telephone number are variable and may be changed if the address or telephone number change. The Company’s actual address and telephone number will always be indicated. • “Policy Number”: The Policy Number is variable. The actual policy number assigned to the policy will be indicated. • “Effective Date of Amendment”: The Effective Date of Amendment is variable. The actual date of the policy amendment will be indicated. • “Officer Signatures and Titles”: The officer signatures and titles are variable and may be changed. The actual signatures and titles of the Company’s officers (e.g., Chief Executive Officer, or President and Secretary, or the signatures and titles of other authorized officers will be indicated.

TRUASSURE INSURANCE COMPANY

Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-App-AR	Application for Individual Dental PPO Policy	Page 1	<p>The variable text is as follows:</p> <ul style="list-style-type: none"> • “Company Address”: The Company’s address and telephone number are variable and may be changed if the address or telephone number change. The Company’s actual address and telephone number will always be indicated.
TruA-1000-App-1-AR	Application for Individual Dental PPO Policy	Page 1	<p>The variable text is as follows:</p> <ul style="list-style-type: none"> • “Company Address”: The Company’s address and telephone number are variable and may be changed if the address or telephone number change. The Company’s actual address and telephone number will always be indicated.
TruA-1000-App-2-AR	Application for Individual Dental PPO Policy	Page 1	<p>The variable text is as follows:</p> <ul style="list-style-type: none"> • “Company Address”: The Company’s address and telephone number are variable and may be changed if the address or telephone number change. The Company’s actual address and telephone number will always be indicated.

TRUASSURE INSURANCE COMPANY

Statement of Variability for Forms:

TruA-1000-AR, TruA-1000-PS-Plan1, TruA-1000-PS-Plan2, TruA-1000-PS-Plan3, TruA-1000-PS-Plan4, TruA-1000-PS-Plan5, TruA-1000-SODB-Plan1, TruA-1000-SODB-Plan2, TruA-1000-SODB-Plan3, TruA-1000-SODB-Plan4, TruA-1000-SODB-Plan5, TruA-1000-Amend, TruA-1000-App-AR, TruA-1000-App-1-AR, TruA-1000-App-2-AR, and TruA-1000-OOC

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
TruA-1000-App-2 (continued)	Application for Individual Dental PPO Policy	Page 2	<ul style="list-style-type: none"> • Electronic Signature Box: <ul style="list-style-type: none"> • “Select/I Agree” button: The applicant will click on the “Select” button to certify his or her digital signature to apply for the dental insurance and authorization to withdraw funds from listed bank, debit or credit card accounts. • “Date Signed”: The date can be entered by typing in the date or a drop-down box showing with calendar can be used to clicked on the appropriate date. • “Submit” button: The applicant will click the “Submit” button to submit the application to the Company.
TruA-1000-OOC	Dental Only Coverage Outline of Coverage	1	<p>The variable text is as follows:</p> <ul style="list-style-type: none"> • “Company Address”: The Company’s address and telephone number are variable and may be changed if the address or telephone number change. The Company’s actual address and telephone number will always be indicated.

**TruAssure Insurance Company
111 Shuman Boulevard
Naperville, IL 60563
(800) 414-4988**

Policy Amendment

Policy: Individual Dental Preferred Provider Organization (PPO) Insurance Policy

Policy Number: C-12345

Effective Date of Amendment: January 1, 2013

The Policy is amended as of the effective date of this Amendment as follows:

1. Policy Schedule, form TruA-1000-PS-Plan4, is hereby deleted and replaced by Policy Schedule form TruA-1000-PS-Plan1.
2. Schedule of Dental Benefits, form TruA-1000-SODB-Plan4, for Dental Plan 4, is hereby deleted and replaced by the Schedule of Dental Benefits, form TruA-1000-SODB-Plan1, for Dental Plan 1.

Except as amended above, the Policy remains unchanged. This Amendment is to be retained with the Policy.

Accepted by Policyholder:



Signature

January 5, 2013

Date

Signed for TruAssure Insurance Company.



President



Secretary

TruAssure Insurance Company

111 Shuman Boulevard, Naperville IL 60563
(800) 414-4988

Application for Individual Dental PPO Policy

Please type or print in black ink.

Last Name: Adams		First Name: John		Middle Initial: H	Date of Birth: 03/01/1977
Home Address (Mailing): 123 Main Street		City: Any City	State: Any State	Zip Code: 00000	Phone Number (with area code) (999) 123-4567
E-Mail Address:			Gender: Male <input checked="" type="checkbox"/> Female <input type="checkbox"/>		Marital Status: <input checked="" type="checkbox"/> Married <input type="checkbox"/> Single
Reason for Application: <input checked="" type="checkbox"/> Initial Application <input type="checkbox"/> Change of Dependent(s) <input type="checkbox"/> Change in Coverage Type <input type="checkbox"/> Policy Reinstatement					
Payment Options: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-annual <input type="checkbox"/> Quarterly <input checked="" type="checkbox"/> Monthly <input type="checkbox"/> Monthly EFT <input type="checkbox"/> Credit Card					
Select Dental Plan: <input checked="" type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 5 (Dental Plan for Dependent Children to Age 19 Only)					
Select Type of Coverage: <input type="checkbox"/> Single <input type="checkbox"/> Two-Person <input checked="" type="checkbox"/> Family (Three or more persons) <input type="checkbox"/> Dependent Children to Age 19 Only					
Monthly Rates:		Plan 1	Plan 2	Plan 3	Plan 4
Single:		\$	\$	\$	\$
Two-Person:		\$	\$	\$	\$
Family:		\$162.00	\$	\$	\$
Monthly Rates – Plan 5: (Dependent Children to Age 19 Only)		Number of Dependent Children Under Age 19 to be Insured:		Premium Rate Per Child: \$	Total Monthly Rate for Plan 5: \$
PLEASE LIST ALL ELIGIBLE DEPENDENT(S) TO BE COVERED UNDER THE POLICY.					
First Name	Last Name (If different from Applicant)	Date of Birth MM/DD/YYYY	Relationship to Applicant	Gender	
Jane		12/08/1977	Wife	<input type="checkbox"/> M <input checked="" type="checkbox"/> F	
Paul		06/15/1999	Son	<input checked="" type="checkbox"/> M <input type="checkbox"/> F	
Sally		10/28/2005	Daughter	<input type="checkbox"/> M <input checked="" type="checkbox"/> F	
				<input type="checkbox"/> M <input type="checkbox"/> F	
				<input type="checkbox"/> M <input type="checkbox"/> F	
CHANGE OF COVERAGE: Please check events requiring Policy changes.					
<input type="checkbox"/> Add Dependent due to: <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Marriage <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> Handicapped Dependent <input type="checkbox"/> Other _____ List Names of new Dependent(s) above.					
<input type="checkbox"/> Drop Dependent (list below) due to: <input type="checkbox"/> Age <input type="checkbox"/> Death <input type="checkbox"/> Other Coverage Elsewhere Name of Dependent: _____					
<input type="checkbox"/> Name Change: Former Name: _____ New Name: _____					

Address Change: Former Address _____
New Address: _____
 Change in Type of Coverage: Single Two-Person Family Dependent Child to Age 19

PAYMENT INSTRUCTIONS:

Choose your payment method: Bank Account Credit Card

A check must be submitted for the first payment on your policy if you choose bank account as your method of payment. Thereafter, all premiums must be paid electronically using your checking/savings account. If your method of payment is credit card, all premiums are to be paid by credit card. Premiums will be drawn or charged on the 1st of the month.

Please complete the following information if you choose to have deductions automatically taken monthly, quarterly, semiannually, annually for premium payments from an account you designate:

Name of Financial Institution: Great Bank of Any City

Financial Institution's City, State & ZIP Code: Any City, Any State, 00000

Type of Account (Choose one): Checking Savings. Name on Account: John Henry Adams

Bank Routing Number: 000123456 Bank Account Number: 10203040

Please attach a voided check or deposit slip from your designated account if you choose to have deductions for verification.

Please complete the following information for payment by Credit Card:

Card Type: Visa MasterCard Discover American Express

Name on Card: _____

Card Number: _____

Expiration Date: ____ month ____ year. Security Code: _____]

I hereby authorize TruAssure Insurance Company to withdraw funds from the above-listed bank account or debit my credit card for the payment of my dental insurance premiums.



Signed: _____ Date: November 1, 2012

I understand that any transaction that is dishonored by my bank/credit card intended for payment to TruAssure Insurance Company, may be assessed a \$25.00 service charge by TruAssure Insurance Company.

In making this application to TruAssure Insurance Company ("TruAssure"), for the dental coverage policy, I agree and understand that this application will become part of the Policy, and I agree to be bound by the terms of the Policy issued by TruAssure. I further agree that the coverage requested is subject to the approval of TruAssure and that no agent or representative has authority to make changes or modify this application for coverage. I hereby certify that all of the information contained in this application is true and correct to the best of my knowledge. I further understand that any intentional omission or misrepresentation of submitted data may cause this application and subsequent Policy to be null and void.

Please Note: Applications must be received by the 20th of the month to be effective the 1st of the following month. Applications received after the 20th will be effective the first of the month after the next month. *Coverage is contingent upon underwriting acceptance.*

Statements as Representations: Statements made in this application or in negotiations for the policy by or in behalf of the applicant (proposed Policyholder) are representations and not warranties. Misrepresentations, omissions, concealment of facts, and incorrect statements will not prevent a recovery under the policy unless either: (1) fraudulent; or (2) material either to the acceptance of the risk or to the hazard assumed by Us.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines or confinement in prison, or any combination thereof.

John Henry Adams

Applicant Signature

November 1, 2012

Date

Chris Jessie Taylor

Agent Signature

November 1, 2012

Date

Chris Jessie Taylor
Printed Name of Agent

November 1, 2012
Agent License Number

TruAssure Insurance Company

111 Shuman Boulevard, Naperville IL 60563
(800) 414-4988

Application for Individual Dental PPO Policy

Please type or print in black ink.

Last Name: Adams		First Name: John		Middle Initial: H	Date of Birth: 03/01/1977
Home Address (Mailing): 123 Main Street		City: Any City	State: Any State	Zip Code: 00000	Phone Number (with area code) (999) 123-4567
E-Mail Address:			Gender: Male <input checked="" type="checkbox"/> Female <input type="checkbox"/>		Marital Status: <input checked="" type="checkbox"/> Married <input type="checkbox"/> Single
Reason for Application: <input checked="" type="checkbox"/> Initial Application <input type="checkbox"/> Change of Dependent(s) <input type="checkbox"/> Change in Coverage Type <input type="checkbox"/> Policy Reinstatement					
Payment Options: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-annual <input type="checkbox"/> Quarterly <input checked="" type="checkbox"/> Monthly <input type="checkbox"/> Monthly EFT <input type="checkbox"/> Credit Card					
Select Dental Plan: <input checked="" type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 5 (Dental Plan for Dependent Children to Age 19 Only)					
Select Type of Coverage: <input type="checkbox"/> Single <input type="checkbox"/> Two-Person <input checked="" type="checkbox"/> Family (Three or more persons) <input type="checkbox"/> Dependent Children to Age 19 Only					
Monthly Rates:		Plan 1	Plan 2	Plan 3	Plan 4
Single:		\$	\$	\$	\$
Two-Person:		\$	\$	\$	\$
Family:		\$162.00	\$	\$	\$
Monthly Rates – Plan 5: (Dependent Children to Age 19 Only)		Number of Dependent Children Under Age 19 to be Insured:		Premium Rate Per Child: \$	Total Monthly Rate for Plan 5: \$
PLEASE LIST ALL ELIGIBLE DEPENDENT(S) TO BE COVERED UNDER THE POLICY.					
First Name	Last Name (If different from Applicant)	Date of Birth MM/DD/YYYY	Relationship to Applicant	Gender	
Jane		12/08/1977	Wife	<input type="checkbox"/> M <input checked="" type="checkbox"/> F	
Paul		06/15/1999	Son	<input checked="" type="checkbox"/> M <input type="checkbox"/> F	
Sally		10/28/2005	Daughter	<input type="checkbox"/> M <input checked="" type="checkbox"/> F	
				<input type="checkbox"/> M <input type="checkbox"/> F	
				<input type="checkbox"/> M <input type="checkbox"/> F	
CHANGE OF COVERAGE: Please check events requiring Policy changes.					
<input type="checkbox"/> Add Dependent due to: <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Marriage <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> Handicapped Dependent <input type="checkbox"/> Other _____ List Names of new Dependent(s) above.					
<input type="checkbox"/> Drop Dependent (list below) due to: <input type="checkbox"/> Age <input type="checkbox"/> Death <input type="checkbox"/> Other Coverage Elsewhere Name of Dependent: _____					
<input type="checkbox"/> Name Change: Former Name: _____ New Name: _____					

Address Change: Former Address _____
New Address: _____
 Change in Type of Coverage: Single Two-Person Family Dependent Child to Age 19

PAYMENT INSTRUCTIONS:

Choose your payment method: Bank Account Credit Card

A check must be submitted for the first payment on your policy if you choose bank account as your method of payment. Thereafter, all premiums must be paid electronically using your checking/savings account. If your method of payment is credit card, all premiums are to be paid by credit card. Premiums will be drawn or charged on the 1st of the month.

Please complete the following information if you choose to have deductions automatically taken monthly, quarterly, semiannually, annually for premium payments from an account you designate:

Name of Financial Institution: Great Bank of Any City

Financial Institution's City, State & ZIP Code: Any City, Any State, 00000

Type of Account (Choose one): Checking Savings. Name on Account: John Henry Adams

Bank Routing Number: 000123456 Bank Account Number: 10203040

Please attach a voided check or deposit slip from your designated account if you choose to have deductions for verification.

Please complete the following information for payment by Credit Card:

Card Type: Visa MasterCard Discover American Express

Name on Card: _____

Card Number: _____

Expiration Date: ____ month ____ year. Security Code: _____]

I hereby authorize TruAssure Insurance Company to withdraw funds from the above-listed bank account or debit my credit card for the payment of my dental insurance premiums.



Signed: _____ Date: November 1, 2012

I understand that any transaction that is dishonored by my bank/credit card intended for payment to TruAssure Insurance Company, may be assessed a \$25.00 service charge by TruAssure Insurance Company.

In making this application to TruAssure Insurance Company ("TruAssure"), for the dental coverage policy, I agree and understand that this application will become part of the Policy, and I agree to be bound by the terms of the Policy issued by TruAssure. I further agree that the coverage requested is subject to the approval of TruAssure and that no agent or representative has authority to make changes or modify this application for coverage. I hereby certify that all of the information contained in this application is true and correct to the best of my knowledge. I further understand that any intentional omission or misrepresentation of submitted data may cause this application and subsequent Policy to be null and void.

Please Note: Applications must be received by the 20th of the month to be effective the 1st of the following month. Applications received after the 20th will be effective the first of the month after the next month. *Coverage is contingent upon underwriting acceptance.*

Statements as Representations: Statements made in this application or in negotiations for the policy by or in behalf of the applicant (proposed Policyholder) are representations and not warranties. Misrepresentations, omissions, concealment of facts, and incorrect statements will not prevent a recovery under the policy unless either: (1) fraudulent; or (2) material either to the acceptance of the risk or to the hazard assumed by Us.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines or confinement in prison, or any combination thereof.

John Henry Adams

Applicant Signature

November 1, 2012

Date

TruAssure Insurance Company

111 Shuman Boulevard, Naperville IL 60563
(800) 414-4988

Application for Individual Dental PPO Policy

Please type or print in black ink.

Last Name: Adams		First Name: John		Middle Initial: H	Date of Birth: 03/01/1977
Home Address (Mailing): 123 Main Street		City: Any City	State: Any State	Zip Code: 00000	Phone Number (with area code) (999) 123-4567
E-Mail Address:			Gender: Male <input checked="" type="checkbox"/> Female <input type="checkbox"/>		Marital Status: <input checked="" type="checkbox"/> Married <input type="checkbox"/> Single
Reason for Application: <input checked="" type="checkbox"/> Initial Application <input type="checkbox"/> Change of Dependent(s) <input type="checkbox"/> Change in Coverage Type <input type="checkbox"/> Policy Reinstatement					
Payment Options: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-annual <input type="checkbox"/> Quarterly <input checked="" type="checkbox"/> Monthly <input type="checkbox"/> Monthly EFT <input type="checkbox"/> Credit Card					
Select Dental Plan: <input checked="" type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 5 (Dental Plan for Dependent Children to Age 19 Only)					
Select Type of Coverage: <input type="checkbox"/> Single <input type="checkbox"/> Two-Person <input checked="" type="checkbox"/> Family (Three or more persons) <input type="checkbox"/> Dependent Children to Age 19 Only					
Monthly Rates:	Plan 1	Plan 2	Plan 3	Plan 4	
Single:	\$	\$	\$	\$	
Two-Person:	\$	\$	\$	\$	
Family:	\$162.00	\$	\$	\$	
Monthly Rates – Plan 5: (Dependent Children to Age 19 Only)	Number of Dependent Children Under Age 19 to be Insured:		Premium Rate Per Child: \$		Total Monthly Rate for Plan 5: \$
PLEASE LIST ALL ELIGIBLE DEPENDENT(S) TO BE COVERED UNDER THE POLICY.					
First Name	Last Name (If different from Applicant)	Date of Birth MM/DD/YYYY	Relationship to Applicant	Gender	
Jane		12/08/1977	Wife	<input type="checkbox"/> M <input checked="" type="checkbox"/> F	
Paul		06/15/1999	Son	<input checked="" type="checkbox"/> M <input type="checkbox"/> F	
Sally		10/28/2005	Daughter	<input type="checkbox"/> M <input checked="" type="checkbox"/> F	
				<input type="checkbox"/> M <input type="checkbox"/> F	
				<input type="checkbox"/> M <input type="checkbox"/> F	
CHANGE OF COVERAGE: Please check events requiring Policy changes.					
<input type="checkbox"/> Add Dependent due to: <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Marriage <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> Handicapped Dependent <input type="checkbox"/> Other _____ List Names of new Dependent(s) above.					
<input type="checkbox"/> Drop Dependent (list below) due to: <input type="checkbox"/> Age <input type="checkbox"/> Death <input type="checkbox"/> Other Coverage Elsewhere Name of Dependent: _____					
<input type="checkbox"/> Name Change: Former Name: _____ New Name: _____					

Address Change: Former Address _____
New Address: _____
 Change in Type of Coverage: Single Two-Person Family Dependent Child to Age 19

PAYMENT INSTRUCTIONS:

Choose your payment method: Bank Account Credit Card

A check must be submitted for the first payment on your policy if you choose bank account as your method of payment. Thereafter, all premiums must be paid electronically using your checking/savings account. If your method of payment is credit card, all premiums are to be paid by credit card. Premiums will be drawn or charged on the 1st of the month.

Please complete the following information if you choose to have deductions automatically taken monthly, quarterly, semiannually, annually for premium payments from an account you designate:

Name of Financial Institution: Great Bank of Any City

Financial Institution's City, State & ZIP Code: Any City, Any State, 00000

Type of Account (Choose one): Checking Savings. Name on Account: John Henry Adams

Bank Routing Number: 000123456 Bank Account Number: 10203040

For verification, please mail us a voided check or deposit slip from your designated account if you choose to have deductions, and include a copy of your completed application.

Please complete the following information for payment by Credit Card:

Card Type: Visa MasterCard Discover American Express

Name on Card: _____

Card Number: _____

Expiration Date: ____ month ____ year. Security Code: _____]

I, the Applicant, certify that by selecting "I agree" in the Electronic Signature box below that I am the Applicant named in this Application and that it is my digital signature signifying my agreement to authorize TruAssure Insurance Company to withdraw funds from the above-listed bank account or debit my credit card for the payment of my dental insurance premiums.

I understand that any transaction that is dishonored by my bank/credit card intended for payment to TruAssure Insurance Company, may be assessed a \$25.00 service charge by TruAssure Insurance Company.

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Statements as Representations: Statements made in this application or in negotiations for the policy by or in behalf of the applicant (proposed Policyholder) are representations and not warranties. Misrepresentations, omissions, concealment of facts, and incorrect statements will not prevent a recovery under the policy unless either: (1) fraudulent; or (2) material either to the acceptance of the risk or to the hazard assumed by Us.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines or confinement in prison, or any combination thereof.

Electronic Signature of Applicant:

I, the Applicant, certify that by selecting "I agree" in this Electronic Signature box that I am the Applicant named in this Application and that this is my digital signature signifying my agreement to: (1) apply for the Individual Dental Insurance Policy selected in this Application; and (2) authorize TruAssure Insurance Company to withdraw funds from the above-listed bank account or debit my credit card for the payment of my dental insurance premiums.

Select 
I Agree
Date Signed: <input type="text"/>
SUBMIT

State: Arkansas
TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental
Product Name: TruAssure - Dental PPO
Project Name/Number: TruAssure - Dental PPO/TruAssure - Dental PPO-1

Filing Company: TruAssure Insurance Company

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
12/11/2012	Replaced 12/28/2012	Supporting Document	"John Doe" Forms	12/26/2012	TruA-1000-Amend_Policy Amendment_11-01-2012 subm-G-jd.pdf TruA-1000-App-AR_Individual Application for Dental PPO Policy_12-03-2012 subm-jd.pdf (Superseded) TruA-1000-App-1-AR_Individual Application for Dental PPO Policy_12-03-2012 subm-jd.pdf (Superseded) TruA-1000-App-2-AR_Individual Application for Dental PPO Policy_12-01-2012 subm-jd.pdf (Superseded)
12/11/2012	Replaced 12/28/2012	Form	Individual Dental Preferred Provider Organization (PPO) Policy	12/26/2012	TruA-1000-AR_Individual Dental Preferred Provider Organization_PPO_Policy_12-03-2012 subm.pdf (Superseded)
12/11/2012	Replaced 12/28/2012	Form	TruA-1000-App-AR	12/26/2012	TruA-1000-App-AR_Individual Application for Dental PPO Policy_12-01-2012 subm-vb.pdf (Superseded)

SERFF Tracking #:

MLLM-128748425

State Tracking #:**Company Tracking #:**

TRUA-0167DDI01-01

State:

Arkansas

Filing Company:

TruAssure Insurance Company

TOI/Sub-TOI:

H10I Individual Health - Dental/H10I.000 Health - Dental

Product Name:

TruAssure - Dental PPO

Project Name/Number:

TruAssure - Dental PPO/TruAssure - Dental PPO-1

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
12/11/2012	Replaced 12/28/2012	Form	TruA-1000-App-1-AR	12/26/2012	TruA-1000-App-1-AR_Individual Application for Dental PPO Policy_12-03-2012 subm-vb.pdf (Superseded)
12/11/2012	Replaced 12/28/2012	Form	TruA-1000-App-2-AR	12/26/2012	TruA-1000-App-2-AR_Individual Application for Dental PPO Policy_12-03-2012 subm-vb.pdf (Superseded)

TruAssure Insurance Company

111 Shuman Boulevard, Naperville IL 60563
(800) 414-4988

Application for Individual Dental PPO Policy

Please type or print in black ink.

Last Name: Adams		First Name: John		Middle Initial: H	Date of Birth: 03/01/1977
Home Address (Mailing): 123 Main Street		City: Any City	State: Any State	Zip Code: 00000	Phone Number (with area code) (999) 123-4567
E-Mail Address:			Gender: Male <input checked="" type="checkbox"/> Female <input type="checkbox"/>		Marital Status: <input checked="" type="checkbox"/> Married <input type="checkbox"/> Single
Reason for Application: <input checked="" type="checkbox"/> Initial Application <input type="checkbox"/> Change of Dependent(s) <input type="checkbox"/> Change in Coverage Type <input type="checkbox"/> Policy Reinstatement					
Payment Options: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-annual <input type="checkbox"/> Quarterly <input checked="" type="checkbox"/> Monthly <input type="checkbox"/> Monthly EFT <input type="checkbox"/> Credit Card					
Select Dental Plan: <input checked="" type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 5 (Dental Plan for Dependent Children to Age 19 Only)					
Select Type of Coverage: <input type="checkbox"/> Single <input type="checkbox"/> Two-Person <input checked="" type="checkbox"/> Family (Three or more persons) <input type="checkbox"/> Dependent Children to Age 19 Only					
Monthly Rates:	Plan 1	Plan 2	Plan 3	Plan 4	
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Monthly Rates – Plan 5: (Dependent Children to Age 19 Only)	Number of Dependent Children Under Age 19 to be Insured:		Premium Rate Per Child: \$		Total Monthly Rate for Plan 5: \$
PLEASE LIST ALL ELIGIBLE DEPENDENT(S) TO BE COVERED UNDER THE POLICY.					
First Name	Last Name (If different from Applicant)	Date of Birth MM/DD/YYYY	Relationship to Applicant	Gender	
Jane		12/08/1977	Wife	<input type="checkbox"/> M <input checked="" type="checkbox"/> F	
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Bank Routing Number: 000123456 Bank Account Number: 10203040

Please attach a voided check or deposit slip from your designated account if you choose to have deductions for verification.

Please complete the following information for payment by Credit Card:

Card Type: Visa MasterCard Discover American Express

Name on Card: _____

Card Number: _____

Expiration Date: ____ month ____ year. Security Code: _____]

I hereby authorize TruAssure Insurance Company to withdraw funds from the above-listed bank account or debit my credit card for the payment of my dental insurance premiums.



Signed: _____ Date: November 1, 2012

I understand that any transaction that is dishonored by my bank/credit card intended for payment to TruAssure Insurance Company, may be assessed a \$25.00 service charge by TruAssure Insurance Company.

In making this application to TruAssure Insurance Company ("TruAssure"), for the dental coverage policy, I agree and understand that this application will become part of the Policy, and I agree to be bound by the terms of the Policy issued by TruAssure. I further agree that the coverage requested is subject to the approval of TruAssure and that no agent or representative has authority to make changes or modify this application for coverage. I hereby certify that all of the information contained in this application is true and correct to the best of my knowledge. I further understand that any intentional omission or misrepresentation of submitted data may cause this application and subsequent Policy to be null and void.

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John Henry Adams

Applicant Signature

November 1, 2012
Date

Chris Jessie Taylor

Agent Signature

November 1, 2012
Date

Chris Jessie Taylor
Printed Name of Agent

November 1, 2012
Agent License Number

TruAssure Insurance Company

111 Shuman Boulevard, Naperville IL 60563
(800) 414-4988

Application for Individual Dental PPO Policy

Please type or print in black ink.

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Applicant Signature

November 1, 2012
Date

TruAssure Insurance Company

111 Shuman Boulevard, Naperville IL 60563
(800) 414-4988

Application for Individual Dental PPO Policy

Please type or print in black ink.

Last Name: Adams		First Name: John		Middle Initial: H	Date of Birth: 03/01/1977
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Select 
I Agree
Date Signed: <input type="text"/>
SUBMIT

TruAssure Insurance Company

[111 Shuman Boulevard, Naperville, IL 60563, (800) 414-4988]

INDIVIDUAL DENTAL PREFERRED PROVIDER ORGANIZATION (PPO) POLICY

In this Policy, the Policyholder is referred to as "You" or "Your". The TruAssure Insurance Company is referred to as "We", "Our", "Us", or "the Company".

THIS IS A LEGAL CONTRACT BETWEEN YOU AND US. READ YOUR POLICY CAREFULLY.

We will pay the benefits set forth in this Policy. Benefit payments are governed by all the terms, conditions and limitations of this Policy. This Policy is effective on the Policy Effective Date shown in the Schedule of Benefits at 12:01 a.m. local time at Your home address. This Policy is issued in consideration of the application for this Policy and the payment of the initial premium.

RIGHT TO EXAMINE THE POLICY: If, for any reason, You are not completely satisfied with this Policy, You may cancel this Policy by returning it to Us or to any agent appointed by Us within 10 days after You receive it. Returning this Policy to Us will void it from the effective date of this Policy, and We will promptly refund Your entire premium payment, including any policy fee or other charges.

NOTICE TO BUYER: THIS POLICY PROVIDES DENTAL COVERAGE ONLY.

GUARANTEED RENEWABLE: This Policy is guaranteed renewable and will continue in effect as long as the Policyholder pays the Premiums when due or within the Grace Period in accordance with the terms and conditions of this Policy. Your premium can be changed only if We change it on all similar policies in force in Your state. If the Premium is changed, We will give You at least 45 days written notice of any change in the Premium.

Signed by TruAssure Insurance Company.

 _____ President	 _____ Secretary
---	--

This is a Limited-Scope Dental Policy
Non-Participating

IMPORTANT NOTICE

PLEASE READ THE COPY OF THE APPLICATION ATTACHED TO THIS POLICY. IF ANY INFORMATION ON THE APPLICATION IS NOT TRUE AND COMPLETE, WRITE TO US AT OUR HOME OFFICE LOCATED AT THE ABOVE ADDRESS WITHIN 10 DAYS. THE APPLICATION IS A PART OF THIS POLICY. THIS POLICY IS ISSUED ON THE BASIS THAT THE ANSWERS TO ALL QUESTIONS AND THE INFORMATION SHOWN ON THE APPLICATION ARE CORRECT AND COMPLETE. IF YOUR ANSWERS ARE INCORRECT OR UNTRUE, WE MAY HAVE THE RIGHT TO DENY DENTAL BENEFITS OR RESCIND YOUR POLICY.

For additional information you may contact the Arkansas Department of Insurance

Arkansas Department of Insurance
1200 West Third Street
Little Rock, Arkansas 72201-1904

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INTRODUCTION

TruAssure Insurance Company ("TruAssure") is pleased to provide You with this Policy. Our goal is to improve oral health by making dental care more affordable. Good oral health is essential to maintaining good general health. This Policy uses the Delta Dental PPOSM Network and Delta Dental Premier[®] to provide In-Network dental providers for Your dental care.

About Your Policy

TruAssure is pleased to bring these important *Dental Benefits* to You and any Dependents that You have enrolled for coverage under this Policy.

This Policy is issued by TruAssure and delivered in the state where You reside. All terms, conditions, and other provisions of this Policy are governed by the state's laws applicable to limited-scope dental policies. All *Dental Benefits* are paid according to the terms, conditions and other provisions of this Policy. TruAssure's payment of Your dental claims may be less than the *Dentist's* charge. Please see Section 5, *How Your Dental Plan Works*, for information on the level of benefits paid under Your Policy.

Please read this Policy carefully and completely and refer to it should You have questions on Your dental coverage. This Policy, including any endorsements and application, is Our complete agreement with You and will govern Your dental coverage. No statement by You in Your application for this Policy shall void the contract or be used in any legal proceeding unless such application or an exact copy of the application is included in or attached to this Policy. No agent or representative of TruAssure, other than an officer designated in this Policy, is authorized to change this Policy or waive any of its provisions.

To help make the information easier to understand, We use the words "You" and "Your" to refer to You, the Policyholder. We use the words "Covered Dependent" to refer to Your family members who are insured under this Policy. We also use the word "Covered Individual" to refer to You and/or Your Covered Dependents. "We", "Us" and "Our" refers to TruAssure Insurance Company. Each term in this Policy that is capitalized has a special meaning and is defined in Section 1, *Definitions*.

We encourage You to read Your Policy to get the most out of Your coverage. The more You understand Your dental coverage, the more You will know what dental services are covered and what You may owe Your Dentist.

Who Do You Contact for Assistance?

Many questions about Your dental coverage can be answered by accessing Our Web Site as shown in the Policy Schedule. Alternatively, Our automated phone system is available 24 hours a day, seven days a week. A touch-tone phone is required. You can check claim status and obtain *Dentist* referral information on the Web site or through the automated phone system. Your questions may be answered most quickly by use of the Web site or automated system. The telephone number is shown in the *Policy Schedule*. You also may contact Us at Our toll-free number shown in the *Policy Schedule* to speak to a customer service representative for questions concerning eligibility, benefits information, status of Your claim, or general information. Our customer service representatives are available Monday through Friday during Our normal business hours. We also have a message center, available 24 hours a day, seven (7) days a week, where You can leave a voice-mail message and have a customer service representative call You back the next business day. You can also e-mail customer service at the Web Site address shown in the *Policy Schedule*.

POLICY SCHEDULE

[TruAssure Insurance Company Web Site: [www.truassure.com]]
[For Questions or Claim Inquiries, please call: [1-800-414-4988]]
[For Automated Phone System, please call: [1-800-323-1743]]
[Customer Service E-mail Address: [CSI@truassure.com]]

Policy Number: [123456]
Policyholder: [John Doe]
Dental Coverage Plan: [Plan 1]
Benefit Period: [November 1 through October 31 of each year]
Type of Coverage: [Family]
Initial Premium: [\$162.00]
Premium Payment Mode: [Monthly]
Policy Effective Date: [November 1, 2012]
Policy Anniversary Date: [November 1 of each year]

DENTAL BENEFITS

A Covered Individual has the right to obtain Covered Dental Services from the Dentist of his or her choice. However, if a Covered Individual selects an Out-of-Network Dentist, he or she will be responsible for the difference between that provider's Submitted Amount and the benefit amount payable under this Policy. (Refer to Section 5, *How Your Dental Plan Works*, for more details.)

<u>Dental Coverage Plan: [Plan 1]</u>	<u>In-Network</u>	<u>Out-of-Network</u>
Annual Maximum per Benefit Period <i>(per Covered Individual per Benefit Period)</i>	[\$2,000]	[\$2,000]
Deductible <i>(per Covered Individual per Benefit Period)</i>	[\$50]	[\$50]
*Diagnostic Preventive Services	[100%]	[100%]
*Basic Services[– [6] month waiting period]	[80%]	[80%]
*Major Services[– [12] month waiting period]	[50%]	[50%]

**Refer to the Schedule of Dental Benefits for the list of Covered Dental Benefits.*

SCHEDULE OF DENTAL BENEFITS – [PLAN [1]]

This Schedule of Dental Benefits provides the list of dental procedures that are Covered Dental Services under this Policy. This Schedule indicates: (1) the covered dental procedure; (2) the Co-payment We will pay for each covered dental procedure; (3) any specific coverage limits, as applicable; and (4) if the Deductible applies to a Covered Dental Procedure. Also, refer to the *Policy Schedule*.)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
DIAGNOSTIC SERVICES						
Oral evaluations (includes limited – problem focused and re-evaluation – limited, problem focused)	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Comprehensive oral evaluation – new or established patient: <i>once per Dentist</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Detailed and extensive oral evaluation – problem focused, by report: <i>once per Dentist</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Comprehensive periodontal evaluation – new or established patient: <i>once per Dentist</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Periodic oral evaluations: <i>twice per Benefit Period</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Intra-oral – periapical radiographs	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Bitewing x-rays (not including vertical bitewings): <i>[once] per Benefit Period</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Complete full-mouth x-rays: <i>once in a 36-month interval</i> . <i>A full-mouth x-ray includes bitewing x-rays. Panoramic x-rays in conjunction with any other x-ray, or any combination of intraoral x-rays on the same date for which the total approved amount equals or exceeds the approved amount for a full-mouth x-ray, is considered a full mouth x-ray. One full-mouth x-ray, one set of vertical bitewings, or one panoramic x-ray is a covered benefit in a 36-month interval.</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Diagnostic casts: <i>when rendered more than 30 days prior to definitive treatment</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Pulp vitality tests: <i>once per visit</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
<i>If additional detailed or comprehensive oral evaluations are billed by the same Dentist, the level of benefits will be limited to that of a periodic oral evaluation. Detailed or comprehensive oral evaluations count toward the Benefit Period maximum of two oral evaluations.</i>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [1]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
PREVENTIVE SERVICES						
Dental prophylaxis (cleaning): <i>twice per Benefit Period*</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Topical fluoride applications: <i>once per Benefit Period, for Covered Dependent Children under age [16]</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Space Maintainers: <i>once per lifetime for Covered Dependent Children under age [14].</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Recementation of space maintainers: <i>once per Benefit Period.</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Sealants: <i>applied once per tooth to first and second permanent molars which are free of caries (cavities) and restorations; for Covered Dependent Children under age [16].</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
<p><i>*With an indicator for diabetes, high risk cardiac conditions, or kidney failure or dialysis conditions, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis or [periodontal maintenance]) per Benefit Period.</i></p> <p><i>*With an indicator for periodontal disease, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis or [periodontal maintenance]) per Benefit Period and for topical application for fluoride at the frequency stated in this Schedule of Dental Benefits.</i></p> <p><i>*With an indicator for suppressed immune system conditions of cancer-related chemotherapy and/or radiation, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis or [periodontal maintenance]) per Benefit Period and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.</i></p> <p><i>*With an indicator for pregnancy, the Covered Individual will be eligible for one additional cleaning (prophylaxis or [periodontal maintenance]) during the time of pregnancy.</i></p>						

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
BASIC SERVICES: ROUTINE AND RESTORATIVE SERVICES						
[Waiting Period – 6 Months]						
Simple Extractions	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Amalgam and resin-based composite fillings: <i>[once] per surface in a 12-month interval.</i>	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Sedative filling	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Pin retention	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
<p><i>When an inlay is requested or placed, the level of benefits will be limited to that of an amalgam filling. Sedative fillings are a Covered Dental Benefit once per tooth per lifetime. When multiple pins are requested or placed, the level of benefits will be limited to one pin per tooth.</i></p>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [1]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: RESTORATIVE SERVICES						
[Waiting Period – 12 Months]						
Onlays (permanent teeth only)	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Crowns and ceramic restorations (permanent teeth only)	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Recementation of inlays, onlays, partial coverage restorations, cast or prefabricated posts and cores and crowns.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Cast or prefabricated post and core; core build-up.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Additional procedures to construct new crown under existing partial denture framework.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: ENDODONTIC SERVICES						
[Waiting Period – 12 months]						
Pulpal and root canal therapy	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
<p><i>When endodontic therapy is performed on primary teeth, the level of benefits will be limited to that of a pulpotomy, except where radiographs indicate there is no permanent successor tooth and the primary tooth demonstrates sufficient intact root structure.</i></p> <p><i>Retreatment of root canal therapy 24 months of initial treatment is not a Covered Dental Benefit.</i></p> <p><i>When incomplete endodontic therapy is billed because the Covered Individual has been referred to an endodontist for completion of endodontic treatment, the level of benefits will be limited to that of a pupal debridement.</i></p> <p><i>Pupal therapy (resorbable filling) is a Covered Dental Benefit once per tooth per lifetime.</i></p>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [1]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: SURGICAL PERIODONTIC SERVICES [Waiting Period – 12 months]						
Gingivectomy or gingivoplasty; gingival flap procedure.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Clinical crown lengthening – hard tissue.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Guided tissue regeneration, per site: <i>only when performed in association with natural teeth.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Bone replacement and soft tissue grafts.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
MAJOR SERVICES: NON-SURGICAL PERIODONTIC SERVICES [Waiting Period – 12 months]						
Periodontal scaling and root planning.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Full-mouth debridement to enable comprehensive evaluation and diagnosis: <i>once per lifetime.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Periodontal maintenance: <i>twice per Benefit Period*</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
<i>Periodontal therapy includes treatment of diseases of the gums and bone supporting the teeth once per quadrant in any 24-month interval.</i>						
<i>*With an indicator for diabetes, high risk cardiac conditions, or kidney failure or dialysis conditions, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period.</i>						
<i>*With an indicator for periodontal disease, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period and for topical application for fluoride at the frequency stated in this Schedule of Dental Benefits.</i>						
<i>*With an indicator for suppressed immune system conditions of cancer-related chemotherapy and/or radiation, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.</i>						
<i>*With an indicator for pregnancy, the Covered Individual will be eligible for one additional cleaning (prophylaxis [or periodontal maintenance]) during the time of pregnancy.</i>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [1]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: REMOVAL PROSTHODONTIC SERVICES						
[Waiting Period – 12 months]						
Complete and partial dentures.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Adjustments to complete and partial dentures.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Repairs to complete and partial dentures.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Replace missing or broken teeth.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Add tooth or clasp to existing partial denture.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Replace all teeth and acrylic on cast metal framework.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Denture rebase: <i>once in a 24-month interval.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Denture reline: <i>once in a 24-month interval.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
MAJOR SERVICES: FIXED PROSTHODONTIC SERVICES (BRIDGES)						
[Waiting Period – 12 months]						
Pontics	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Fixed partial denture retainers – inlays/onlays (inlays/onlays placed as abutments, i.e., to retain or support fixed partial dentures).	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Fixed partial denture retainers – crowns (crowns placed as abutments, i.e., to retain or support fixed partial dentures).	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Recement fixed partial denture.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Cast or refabricated post and core; core build-up.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
<p><i>When a fixed partial denture is requested or placed and three or more teeth are missing in a dental arch, the level of benefits will be limited to that of a removable partial denture. The placement of any additional appliance in the same arch within 60 months following placement of the initial appliance is not a Covered Dental Benefit.</i></p> <p><i>When the edentulous space between teeth exceeds 100% of the size of the original tooth, the level of benefits will be limited to that of a removable partial denture.</i></p> <p><i>When a fixed partial denture and a removable partial denture are requested or placed in the same arch, the level of benefits will be limited to that of a removable partial denture.</i></p> <p><i>If, in the construction of a prosthodontics appliance, personalized or special techniques including, but not limited to, tooth supported dentures, precision attachments or stress breakers, are elected, the level of benefits will be limited to that of a conventional prosthodontics appliance.</i></p> <p><i>When a porcelain/ceramic inlay is requested or placed as abutment (i.e., to retain or support a fixed partial denture), the level of benefits will be limited to that of a cast metal inlay.</i></p>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [1]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: ORAL SURGERY						
[Waiting Period – 12 months]						
Simple extractions.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Surgical removal of reputed tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Removal of impacted tooth – soft tissue.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Removal of impacted tooth – partially bony.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Removal of impacted tooth – completely bony.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Tooth reimplantation/stabilization of accidentally evulsed or displaced tooth and/or alveolus.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Surgical access of an unerupted tooth.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Biopsy of oral tissue: brush biopsy.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Alveoloplasty – per quadrant.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Vestibuloplasty – ridge extension.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Surgical excision of soft tissue lesions.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Surgical excision of intra-osseous lesions.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Other covered surgical/repair procedures: Removal of exostosis, torus palatinus or torus mandibularis; incision and drainage of abscess – intraoral soft tissue; frenulectomy or frenuoplasty; excision of hyperplastic tissue or pericoronal gingiva; surgical reduction of osseous or fibrous tuberosity.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
<i>Oral Surgery includes extractions and other listed oral surgery procedures (Including pre- and post-operative care) only when provided in a Dentist's office.</i>						
MAJOR SERVICES: ADJUNCTIVE GENERAL SERVICES						
[Waiting Period – 12 months]						
Palliative (emergency) treatment of dental pain – minor procedure.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Deep sedation/general anesthesia: <i>when provided by a Dentist in conjunction with Oral Surgery (surgical procedures) other than simple extractions.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Intravenous conscious sedation/analgesia: <i>when provided in conjunction with Oral Surgery (surgical procedures) other than simple extractions.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Consultations	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]

POLICY SCHEDULE

[TruAssure Insurance Company Web Site: [www.truassure.com]]
[For Questions or Claim Inquiries, please call: [1-800-414-4988]]
[For Automated Phone System, please call: [1-800-323-1743]]
[Customer Service E-mail Address: [CSI@truassure.com]]

Policy Number: [123456]
Policyholder: [John Doe]
Dental Coverage Plan: [Plan 2]
Benefit Period: [November 1 through October 31 of each year]
Type of Coverage: [Family]
Initial Premium: [\$132.09]
Premium Payment Mode: [Monthly]
Policy Effective Date: [November 1, 2012]
Policy Anniversary Date: [November 1 of each year]

DENTAL BENEFITS

A Covered Individual has the right to obtain Covered Dental Services from the Dentist of his or her choice. However, if a Covered Individual selects an Out-of-Network Dentist, he or she will be responsible for the difference between that provider's Submitted Amount and the benefit amount payable under this Policy. (Refer to Section 5, *How Your Dental Plan Works*, for more details.)

<u>Dental Coverage Plan: [Plan 2]</u>	<u>In-Network</u>	<u>Out-of-Network</u>
Annual Maximum per Benefit Period (per Covered Individual per Benefit Period)	[\$1,500]	[\$1,500]
Deductible (per Covered Individual per Benefit Period)	[\$50]	[\$50]
*Diagnostic Preventive Services	[100%]	[100%]
*Basic Services[– [6] month waiting period]	[50%]	[50%]
*Major Services[– [12] month waiting period]	[50%]	[50%]

*Refer to the Schedule of Dental Benefits for the list of Covered Dental Benefits.

SCHEDULE OF DENTAL BENEFITS – [PLAN [2]]

This Schedule of Dental Benefits provides the list of dental procedures that are Covered Dental Services under this Policy. This Schedule indicates: (1) the covered dental procedure; (2) the Co-payment We will pay for each covered dental procedure; (3) any specific coverage limits, as applicable; and (4) if the Deductible applies to a Covered Dental Procedure. Also, refer to the *Policy Schedule*.)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
DIAGNOSTIC SERVICES						
Oral evaluations (includes limited – problem focused and re-evaluation – limited, problem focused)	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Comprehensive oral evaluation – new or established patient: <i>once per Dentist</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Detailed and extensive oral evaluation – problem focused, by report: <i>once per Dentist</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Comprehensive periodontal evaluation – new or established patient: <i>once per Dentist</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Periodic oral evaluations: <i>twice per Benefit Period</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Intra-oral – periapical radiographs	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Bitewing x-rays (not including vertical bitewings): <i>[once] per Benefit Period</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Complete full-mouth x-rays: <i>once in a 36-month interval</i> . <i>A full-mouth x-ray includes bitewing x-rays. Panoramic x-rays in conjunction with any other x-ray, or any combination of intraoral x-rays on the same date for which the total approved amount equals or exceeds the approved amount for a full-mouth x-ray, is considered a full mouth x-ray. One full-mouth x-ray, one set of vertical bitewings, or one panoramic x-ray is a covered benefit in a 36-month interval.</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Diagnostic casts: <i>when rendered more than 30 days prior to definitive treatment</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Pulp vitality tests: <i>once per visit</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
<i>If additional detailed or comprehensive oral evaluations are billed by the same Dentist, the level of benefits will be limited to that of a periodic oral evaluation. Detailed or comprehensive oral evaluations count toward the Benefit Period maximum of two oral evaluations.</i>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [2]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
PREVENTIVE SERVICES						
Dental prophylaxis (cleaning): <i>twice per Benefit Period*</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Topical fluoride applications: <i>once per Benefit Period, for Covered Dependent Children under age [16]</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Space Maintainers: <i>once per lifetime for Covered Dependent Children under age [14].</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Recementation of space maintainers: <i>once per Benefit Period.</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Sealants: <i>applied once per tooth to first and second permanent molars which are free of caries (cavities) and restorations; for Covered Dependent Children under age [16].</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
<p><i>*With an indicator for diabetes, high risk cardiac conditions, or kidney failure or dialysis conditions, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period.</i></p> <p><i>*With an indicator for periodontal disease, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period and for topical application for fluoride at the frequency stated in this Schedule of Dental Benefits.</i></p> <p><i>*With an indicator for suppressed immune system conditions of cancer-related chemotherapy and/or radiation, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.</i></p> <p><i>*With an indicator for pregnancy, the Covered Individual will be eligible for one additional cleaning (prophylaxis [or periodontal maintenance]) during the time of pregnancy.</i></p>						

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
BASIC SERVICES: ROUTINE AND RESTORATIVE SERVICES						
[Waiting Period – 6 Months]						
Simple Extractions	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Amalgam and resin-based composite fillings: <i>[once] per surface in a 12-month interval.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Sedative filling	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Pin retention	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
<p><i>When an inlay is requested or placed, the level of benefits will be limited to that of an amalgam filling. Sedative fillings are a Covered Dental Benefit once per tooth per lifetime. When multiple pins are requested or placed, the level of benefits will be limited to one pin per tooth.</i></p>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [2]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: RESTORATIVE SERVICES						
[Waiting Period – 12 Months]						
Onlays (permanent teeth only)	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Crowns and ceramic restorations (permanent teeth only)	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Recementation of inlays, onlays, partial coverage restorations, cast or prefabricated posts and cores and crowns.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Cast or prefabricated post and core; core build-up.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Additional procedures to construct new crown under existing partial denture framework.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: ENDODONTIC SERVICES						
[Waiting Period – 12 months]						
Pulpal and root canal therapy	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
<p><i>When endodontic therapy is performed on primary teeth, the level of benefits will be limited to that of a pulpotomy, except where radiographs indicate there is no permanent successor tooth and the primary tooth demonstrates sufficient intact root structure.</i></p> <p><i>Retreatment of root canal therapy 24 months of initial treatment is not a Covered Dental Benefit.</i></p> <p><i>When incomplete endodontic therapy is billed because the Covered Individual has been referred to an endodontist for completion of endodontic treatment, the level of benefits will be limited to that of a pupal debridement.</i></p> <p><i>Pupal therapy (resorbable filling) is a Covered Dental Benefit once per tooth per lifetime.</i></p>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [2]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: SURGICAL PERIODONTIC SERVICES						
[Waiting Period – 12 months]						
Gingivectomy or gingivoplasty; gingival flap procedure.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Clinical crown lengthening – hard tissue.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Guided tissue regeneration, per site: <i>only when performed in association with natural teeth.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Bone replacement and soft tissue grafts.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
MAJOR SERVICES: NON-SURGICAL PERIODONTIC SERVICES						
[Waiting Period – 12 months]						
Periodontal scaling and root planning.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Full-mouth debridement to enable comprehensive evaluation and diagnosis: <i>once per lifetime.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Periodontal maintenance: <i>twice per Benefit Period*</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
<i>Periodontal therapy includes treatment of diseases of the gums and bone supporting the teeth once per quadrant in any 24-month interval.</i>						
<i>*With an indicator for diabetes, high risk cardiac conditions, or kidney failure or dialysis conditions, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period.</i>						
<i>*With an indicator for periodontal disease, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period and for topical application for fluoride at the frequency stated in this Schedule of Dental Benefits.</i>						
<i>*With an indicator for suppressed immune system conditions of cancer-related chemotherapy and/or radiation, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.</i>						
<i>*With an indicator for pregnancy, the Covered Individual will be eligible for one additional cleaning (prophylaxis [or periodontal maintenance]) during the time of pregnancy.</i>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [2]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: REMOVAL PROSTHODONTIC SERVICES						
[Waiting Period – 12 months]						
Complete and partial dentures.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Adjustments to complete and partial dentures.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Repairs to complete and partial dentures.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Replace missing or broken teeth.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Add tooth or clasp to existing partial denture.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Replace all teeth and acrylic on cast metal framework.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Denture rebase: <i>once in a 24-month interval.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Denture reline: <i>once in a 24-month interval.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
MAJOR SERVICES: FIXED PROSTHODONTIC SERVICES (BRIDGES)						
[Waiting Period – 12 months]						
Pontics	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Fixed partial denture retainers – inlays/onlays (inlays/onlays placed as abutments, i.e., to retain or support fixed partial dentures).	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Fixed partial denture retainers – crowns (crowns placed as abutments, i.e., to retain or support fixed partial dentures).	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Recent fixed partial denture.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Cast or refabricated post and core; core build-up.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
<p><i>When a fixed partial denture is requested or placed and three or more teeth are missing in a dental arch, the level of benefits will be limited to that of a removable partial denture. The placement of any additional appliance in the same arch within 60 months following placement of the initial appliance is not a Covered Dental Benefit.</i></p> <p><i>When the edentulous space between teeth exceeds 100% of the size of the original tooth, the level of benefits will be limited to that of a removable partial denture.</i></p> <p><i>When a fixed partial denture and a removable partial denture are requested or placed in the same arch, the level of benefits will be limited to that of a removable partial denture.</i></p> <p><i>If, in the construction of a prosthodontics appliance, personalized or special techniques including, but not limited to, tooth supported dentures, precision attachments or stress breakers, are elected, the level of benefits will be limited to that of a conventional prosthodontics appliance.</i></p> <p><i>When a porcelain/ceramic inlay is requested or placed as abutment (i.e., to retain or support a fixed partial denture), the level of benefits will be limited to that of a cast metal inlay.</i></p>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [2]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: ORAL SURGERY						
[Waiting Period – 12 months]						
Simple extractions.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Surgical removal of reputed tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Removal of impacted tooth – soft tissue.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Removal of impacted tooth – partially bony.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Removal of impacted tooth – completely bony.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Tooth reimplantation/stabilization of accidentally evulsed or displaced tooth and/or alveolus.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Surgical access of an unerupted tooth.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Biopsy of oral tissue: brush biopsy.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Alveoloplasty – per quadrant.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Vestibuloplasty – ridge extension.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Surgical excision of soft tissue lesions.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Surgical excision of intra-osseous lesions.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Other covered surgical/repair procedures: Removal of exostosis, torus palatinus or torus mandibularis; incision and drainage of abscess – intraoral soft tissue; frenulectomy or frenuoplasty; excision of hyperplastic tissue or pericoronal gingiva; surgical reduction of osseous or fibrous tuberosity.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
<i>Oral Surgery includes extractions and other listed oral surgery procedures (Including pre- and post-operative care) only when provided in a Dentist's office.</i>						
MAJOR SERVICES: ADJUNCTIVE GENERAL SERVICES						
[Waiting Period – 12 months]						
Palliative (emergency) treatment of dental pain – minor procedure.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Deep sedation/general anesthesia: <i>when provided by a Dentist in conjunction with Oral Surgery (surgical procedures) other than simple extractions.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Intravenous conscious sedation/analgesia: <i>when provided in conjunction with Oral Surgery (surgical procedures) other than simple extractions.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Consultations	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]

POLICY SCHEDULE

[TruAssure Insurance Company Web Site: [www.truassure.com]]
[For Questions or Claim Inquiries, please call: [1-800-414-4988]]
[For Automated Phone System, please call: [1-800-323-1743]]
[Customer Service E-mail Address: [CSI@truassure.com]]

Policy Number: [123456]
Policyholder: [John Doe]
Dental Coverage Plan: [Plan 3]
Benefit Period: [November 1 through October 31 of each year]
Type of Coverage: [Family]
Initial Premium: [\$101.86]
Premium Payment Mode: [Monthly]
Policy Effective Date: [November 1, 2012]
Policy Anniversary Date: [November 1 of each year]

DENTAL BENEFITS

A Covered Individual has the right to obtain Covered Dental Services from the Dentist of his or her choice. However, if a Covered Individual selects an Out-of-Network Dentist, he or she will be responsible for the difference between that provider's Submitted Amount and the benefit amount payable under this Policy. (Refer to Section 5, *How Your Dental Plan Works*, for more details.)

<u>Dental Coverage Plan: [Plan 3]</u>	<u>In-Network</u>	<u>Out-of-Network</u>
Annual Maximum per Benefit Period (per Covered Individual per Benefit Period)	[\$1,000]	[\$1,000]
Deductible (per Covered Individual per Benefit Period)	[\$75]	[\$75]
*Diagnostic Preventive Services	[90%]	[90%]
*Basic Services[– [6] month waiting period]	[50%]	[50%]
*Major Services[– [12] month waiting period]	[50%]	[50%]

*Refer to the Schedule of Dental Benefits for the list of Covered Dental Benefits.

SCHEDULE OF DENTAL BENEFITS – [PLAN [3]]

This Schedule of Dental Benefits provides the list of dental procedures that are Covered Dental Services under this Policy. This Schedule indicates: (1) the covered dental procedure; (2) the Co-payment We will pay for each covered dental procedure; (3) any specific coverage limits, as applicable; and (4) if the Deductible applies to a Covered Dental Procedure. Also, refer to the *Policy Schedule*.)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
DIAGNOSTIC SERVICES						
Oral evaluations (includes limited – problem focused and re-evaluation – limited, problem focused)	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
Comprehensive oral evaluation – new or established patient: <i>once per Dentist</i> .	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
Detailed and extensive oral evaluation – problem focused, by report: <i>once per Dentist</i> .	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
Comprehensive periodontal evaluation – new or established patient: <i>once per Dentist</i> .	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
Periodic oral evaluations: <i>twice per Benefit Period</i>	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
Intra-oral – periapical radiographs	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
Bitewing x-rays (not including vertical bitewings): <i>[once] per Benefit Period</i> .	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
Complete full-mouth x-rays: <i>once in a 36-month interval</i> . <i>A full-mouth x-ray includes bitewing x-rays. Panoramic x-rays in conjunction with any other x-ray, or any combination of intraoral x-rays on the same date for which the total approved amount equals or exceeds the approved amount for a full-mouth x-ray, is considered a full mouth x-ray. One full-mouth x-ray, one set of vertical bitewings, or one panoramic x-ray is a covered benefit in a 36-month interval.</i>	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
Diagnostic casts: <i>when rendered more than 30 days prior to definitive treatment</i> .	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
Pulp vitality tests: <i>once per visit</i> .	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
<i>If additional detailed or comprehensive oral evaluations are billed by the same Dentist, the level of benefits will be limited to that of a periodic oral evaluation. Detailed or comprehensive oral evaluations count toward the Benefit Period maximum of two oral evaluations.</i>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [3]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
PREVENTIVE SERVICES						
Dental prophylaxis (cleaning): <i>twice per Benefit Period*</i>	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
Topical fluoride applications: <i>once per Benefit Period, for Covered Dependent Children under age [16]</i>	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
Space Maintainers: <i>once per lifetime for Covered Dependent Children under age [14].</i>	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
Recementation of space maintainers: <i>once per Benefit Period.</i>	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
Sealants: <i>applied once per tooth to first and second permanent molars which are free of caries (cavities) and restorations; for Covered Dependent Children under age [16].</i>	[90%]	[90%]	[90%]	[Yes]	[Yes]	[Yes]
<p><i>*With an indicator for diabetes, high risk cardiac conditions, or kidney failure or dialysis conditions, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period.</i></p> <p><i>*With an indicator for periodontal disease, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period and for topical application for fluoride at the frequency stated in this Schedule of Dental Benefits.</i></p> <p><i>*With an indicator for suppressed immune system conditions of cancer-related chemotherapy and/or radiation, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis [or periodontal maintenance]) per Benefit Period and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.</i></p> <p><i>*With an indicator for pregnancy, the Covered Individual will be eligible for one additional cleaning (prophylaxis [or periodontal maintenance]) during the time of pregnancy.</i></p>						

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
BASIC SERVICES: ROUTINE AND RESTORATIVE SERVICES						
[Waiting Period – 6 Months]						
Simple Extractions	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Amalgam and resin-based composite fillings: <i>[once] per surface in a 12-month interval.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Sedative filling	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Pin retention	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
<p><i>When an inlay is requested or placed, the level of benefits will be limited to that of an amalgam filling. Sedative fillings are a Covered Dental Benefit once per tooth per lifetime. When multiple pins are requested or placed, the level of benefits will be limited to one pin per tooth.</i></p>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [3]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: RESTORATIVE SERVICES						
[Waiting Period – 12 Months]						
Onlays (permanent teeth only)	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Crowns and ceramic restorations (permanent teeth only)	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Recementation of inlays, onlays, partial coverage restorations, cast or prefabricated posts and cores and crowns.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Cast or prefabricated post and core; core build-up.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Additional procedures to construct new crown under existing partial denture framework.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: ENDODONTIC SERVICES						
[Waiting Period – 12 months]						
Pulpal and root canal therapy	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
<p><i>When endodontic therapy is performed on primary teeth, the level of benefits will be limited to that of a pulpotomy, except where radiographs indicate there is no permanent successor tooth and the primary tooth demonstrates sufficient intact root structure.</i></p> <p><i>Retreatment of root canal therapy 24 months of initial treatment is not a Covered Dental Benefit.</i></p> <p><i>When incomplete endodontic therapy is billed because the Covered Individual has been referred to an endodontist for completion of endodontic treatment, the level of benefits will be limited to that of a pupal debridement.</i></p> <p><i>Pupal therapy (resorbable filling) is a Covered Dental Benefit once per tooth per lifetime.</i></p>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [3]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: SURGICAL PERIODONTIC SERVICES [Waiting Period – 12 months]						
Gingivectomy or gingivoplasty; gingival flap procedure.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Clinical crown lengthening – hard tissue.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Guided tissue regeneration, per site: <i>only when performed in association with natural teeth.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Bone replacement and soft tissue grafts.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
MAJOR SERVICES: NON-SURGICAL PERIODONTIC SERVICES [Waiting Period – 12 months]						
Periodontal scaling and root planning.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Full-mouth debridement to enable comprehensive evaluation and diagnosis: <i>once per lifetime.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Periodontal maintenance: <i>twice per Benefit Period*</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
<i>Periodontal therapy includes treatment of diseases of the gums and bone supporting the teeth once per quadrant in any 24-month interval.</i>						
<i>*With an indicator for diabetes, high risk cardiac conditions, or kidney failure or dialysis conditions, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis or [periodontal maintenance]) per Benefit Period.</i>						
<i>*With an indicator for periodontal disease, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis or [periodontal maintenance]) per Benefit Period and for topical application for fluoride at the frequency stated in this Schedule of Dental Benefits.</i>						
<i>*With an indicator for suppressed immune system conditions of cancer-related chemotherapy and/or radiation, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis or [periodontal maintenance]) per Benefit Period and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.</i>						
<i>*With an indicator for pregnancy, the Covered Individual will be eligible for one additional cleaning (prophylaxis or [periodontal maintenance]) during the time of pregnancy.</i>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [3]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: REMOVAL PROSTHODONTIC SERVICES						
[Waiting Period – 12 months]						
Complete and partial dentures.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Adjustments to complete and partial dentures.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Repairs to complete and partial dentures.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Replace missing or broken teeth.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Add tooth or clasp to existing partial denture.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Replace all teeth and acrylic on cast metal framework.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Denture rebase: <i>once in a 24-month interval.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Denture reline: <i>once in a 24-month interval.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
MAJOR SERVICES: FIXED PROSTHODONTIC SERVICES (BRIDGES)						
[Waiting Period – 12 months]						
Pontics	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Fixed partial denture retainers – inlays/onlays (inlays/onlays placed as abutments, i.e., to retain or support fixed partial dentures).	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Fixed partial denture retainers – crowns (crowns placed as abutments, i.e., to retain or support fixed partial dentures).	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Recent fixed partial denture.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Cast or refabricated post and core; core build-up.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
<p><i>When a fixed partial denture is requested or placed and three or more teeth are missing in a dental arch, the level of benefits will be limited to that of a removable partial denture. The placement of any additional appliance in the same arch within 60 months following placement of the initial appliance is not a Covered Dental Benefit.</i></p> <p><i>When the edentulous space between teeth exceeds 100% of the size of the original tooth, the level of benefits will be limited to that of a removable partial denture.</i></p> <p><i>When a fixed partial denture and a removable partial denture are requested or placed in the same arch, the level of benefits will be limited to that of a removable partial denture.</i></p> <p><i>If, in the construction of a prosthodontics appliance, personalized or special techniques including, but not limited to, tooth supported dentures, precision attachments or stress breakers, are elected, the level of benefits will be limited to that of a conventional prosthodontics appliance.</i></p> <p><i>When a porcelain/ceramic inlay is requested or placed as abutment (i.e., to retain or support a fixed partial denture), the level of benefits will be limited to that of a cast metal inlay.</i></p>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [3]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: ORAL SURGERY						
[Waiting Period – 12 months]						
Simple extractions.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Surgical removal of reputed tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Removal of impacted tooth – soft tissue.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Removal of impacted tooth – partially bony.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Removal of impacted tooth – completely bony.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Tooth reimplantation/stabilization of accidentally evulsed or displaced tooth and/or alveolus.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Surgical access of an unerupted tooth.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Biopsy of oral tissue: brush biopsy.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Alveoloplasty – per quadrant.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Vestibuloplasty – ridge extension.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Surgical excision of soft tissue lesions.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Surgical excision of intra-osseous lesions.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Other covered surgical/repair procedures: Removal of exostosis, torus palatinus or torus mandibularis; incision and drainage of abscess – intraoral soft tissue; frenulectomy or frenuoplasty; excision of hyperplastic tissue or pericoronal gingiva; surgical reduction of osseous or fibrous tuberosity.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
<i>Oral Surgery includes extractions and other listed oral surgery procedures (Including pre- and post-operative care) only when provided in a Dentist's office.</i>						
MAJOR SERVICES: ADJUNCTIVE GENERAL SERVICES						
[Waiting Period – 12 months]						
Palliative (emergency) treatment of dental pain – minor procedure.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Deep sedation/general anesthesia: <i>when provided by a Dentist in conjunction with Oral Surgery (surgical procedures) other than simple extractions.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Intravenous conscious sedation/analgesia: <i>when provided in conjunction with Oral Surgery (surgical procedures) other than simple extractions.</i>	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Consultations	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]

POLICY SCHEDULE

[TruAssure Insurance Company Web Site: [www.truassure.com]]
[For Questions or Claim Inquiries, please call: [1-800-414-4988]]
[For Automated Phone System, please call: [1-800-323-1743]]
[Customer Service E-mail Address: [CSI@truassure.com]]

Policy Number: [123456]
Policyholder: [John Doe]
Dental Coverage Plan: [Plan 4]
Benefit Period: [November 1 through October 31 of each year]
Type of Coverage: [Family]
Initial Premium: [\$76.10]
Premium Payment Mode: [Monthly]
Policy Effective Date: [November 1, 2012]
Policy Anniversary Date: [November 1 of each year]

DENTAL BENEFITS

A Covered Individual has the right to obtain Covered Dental Services from the Dentist of his or her choice. However, if a Covered Individual selects an Out-of-Network Dentist, he or she will be responsible for the difference between that provider's Submitted Amount and the benefit amount payable under this Policy. (Refer to Section 5, *How Your Dental Plan Works*, for more details.)

<u>Dental Coverage Plan: [Plan 4]</u>	<u>In-Network</u>	<u>Out-of-Network</u>
Annual Maximum per Benefit Period (per Covered Individual per Benefit Period)	[\$500]	[\$500]
Deductible (per Covered Individual per Benefit Period)	[\$25]	[\$25]
*Diagnostic Preventive Services	[100%]	[100%]

*Refer to the Schedule of Dental Benefits for the list of Covered Dental Benefits.

SCHEDULE OF DENTAL BENEFITS – [PLAN [4]]

This Schedule of Dental Benefits provides the list of dental procedures that are Covered Dental Services under this Policy. This Schedule indicates: (1) the covered dental procedure; (2) the Co-payment We will pay for each covered dental procedure; (3) any specific coverage limits, as applicable; and (4) if the Deductible applies to a Covered Dental Procedure. Also, refer to the *Policy Schedule*.)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
DIAGNOSTIC SERVICES						
Oral evaluations (includes limited – problem focused and re-evaluation – limited, problem focused)	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Comprehensive oral evaluation – new or established patient: <i>once per Dentist</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Detailed and extensive oral evaluation – problem focused, by report: <i>once per Dentist</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Comprehensive periodontal evaluation – new or established patient: <i>once per Dentist</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Periodic oral evaluations: <i>twice per Benefit Period</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Intra-oral – periapical radiographs	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Bitewing x-rays (not including vertical bitewings): <i>[once] per Benefit Period</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Complete full-mouth x-rays: <i>once in a 36-month interval</i> . <i>A full-mouth x-ray includes bitewing x-rays. Panoramic x-rays in conjunction with any other x-ray, or any combination of intraoral x-rays on the same date for which the total approved amount equals or exceeds the approved amount for a full-mouth x-ray, is considered a full mouth x-ray. One full-mouth x-ray, one set of vertical bitewings, or one panoramic x-ray is a covered benefit in a 36-month interval.</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Diagnostic casts: <i>when rendered more than 30 days prior to definitive treatment</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Pulp vitality tests: <i>once per visit</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
<i>If additional detailed or comprehensive oral evaluations are billed by the same Dentist, the level of benefits will be limited to that of a periodic oral evaluation. Detailed or comprehensive oral evaluations count toward the Benefit Period maximum of two oral evaluations.</i>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [4]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
PREVENTIVE SERVICES						
Dental prophylaxis (cleaning): <i>twice per Benefit Period*</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Topical fluoride applications: <i>once per Benefit Period, for Covered Dependent Children under age [19]</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Recementation of space maintainers: <i>once per Benefit Period.</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Sealants: <i>applied once per tooth to first and second permanent molars which are free of caries (cavities) and restorations; for Covered Dependent Children under age [20].</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
<p><i>*With an indicator for diabetes, high risk cardiac conditions, or kidney failure or dialysis conditions, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis or [periodontal maintenance] per Benefit Period.</i></p> <p><i>*With an indicator for periodontal disease, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis or [periodontal maintenance]) per Benefit Period and for topical application for fluoride at the frequency stated in this Schedule of Dental Benefits.</i></p> <p><i>*With an indicator for suppressed immune system conditions of cancer-related chemotherapy and/or radiation, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis or [periodontal maintenance]) per Benefit Period and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.</i></p> <p><i>*With an indicator for pregnancy, the Covered Individual will be eligible for one additional cleaning (prophylaxis or [periodontal maintenance]) during the time of pregnancy.</i></p>						

POLICY SCHEDULE

[TruAssure Insurance Company Web Site: [www.truassure.com]]
 [For Questions or Claim Inquiries, please call: [1-800-414-4988]]
 [For Automated Phone System, please call: [1-800-323-1743]]
 [Customer Service E-mail Address: [CSI@truassure.com]]

Policy Number: [123456]
Policyholder: [John Doe]
Dental Coverage Plan: [Plan 5]
Type of Coverage: [Dependent Children through Age 18 Only]
 Number of Dependent Children Under age 19: [1, Susan Doe]
Benefit Period: [November 1 through October 31 of each year]
Initial Premium: [\$41.63]
Premium Payment Mode: [Monthly]
Policy Effective Date: [November 1, 2012]
Policy Anniversary Date: [November 1 of each year]

PEDIATRIC DENTAL BENEFITS

This Pediatric Dental Plan only covers Your Covered Dependent Children under age 19. You have the right to obtain Covered Dental Services for Your Covered Dependent Children from the Dentist of Your choice. However, if You select an Out-of-Network Dentist, You will be responsible for the difference between that provider's Submitted Amount and the benefit amount payable under this Policy. (Refer to Section 5, *How Your Dental Plan Works*, for more details.)

<u>Dental Coverage Plan: [Plan 5]</u>	<u>In-Network</u>	<u>Out-of-Network</u>
Annual Maximum per Benefit Period <i>(per Covered Individual per Benefit Period)</i>	[\$1,000]	[\$1,000]
Deductible <i>(per Covered Individual per Benefit Period)</i>	[None]	[None]
*Diagnostic Preventive Services	[100%]	[100%]
*Basic Services[– [6] month waiting period]	[80%]	[80%]
*Major Services[– [12] month waiting period]	[80%]	[80%]

**Refer to the Schedule of Dental Benefits for the list of Covered Dental Benefits.*

SCHEDULE OF DENTAL BENEFITS – [PLAN [5]]

This Schedule of Dental Benefits provides the list of dental procedures that are Covered Dental Services under this Policy. This Schedule indicates: (1) the covered dental procedure; (2) the Co-payment We will pay for each covered dental procedure; (3) any specific coverage limits, as applicable; and (4) if the Deductible applies to a Covered Dental Procedure. Also, refer to the *Policy Schedule*.)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
DIAGNOSTIC SERVICES						
Oral evaluations (includes limited – problem focused and re-evaluation – limited, problem focused)	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Comprehensive oral evaluation – new or established patient: <i>once per Dentist</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Detailed and extensive oral evaluation – problem focused, by report: <i>once per Dentist</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Comprehensive periodontal evaluation – new or established patient: <i>once per Dentist</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Periodic oral evaluations: <i>twice per Benefit Period</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Intra-oral – periapical radiographs.	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Bitewing x-rays (not including vertical bitewings): <i>[once] per Benefit Period</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Complete full-mouth x-rays: <i>once in a 36-month interval</i> . <i>A full-mouth x-ray includes bitewing x-rays. Panoramic x-rays in conjunction with any other x-ray, or any combination of intraoral x-rays on the same date for which the total approved amount equals or exceeds the approved amount for a full-mouth x-ray, is considered a full mouth x-ray. One full-mouth x-ray, one set of vertical bitewings, or one panoramic x-ray is a covered benefit in a 36-month interval.</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Diagnostic casts: <i>when rendered more than 30 days prior to definitive treatment</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Pulp vitality tests: <i>once per visit</i> .	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
<i>If additional detailed or comprehensive oral evaluations are billed by the same Dentist, the level of benefits will be limited to that of a periodic oral evaluation. Detailed or comprehensive oral evaluations count toward the Benefit Period maximum of two oral evaluations.</i>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [5]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
PREVENTIVE SERVICES						
Dental prophylaxis (cleaning): <i>twice per Benefit Period*</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Topical fluoride applications: <i>once per Benefit Period, for Covered Dependent Children under age [18]</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Recementation of space maintainers: <i>once per Benefit Period.</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
Sealants: <i>applied once per tooth to first and second permanent molars which are free of caries (cavities) and restorations; for Covered Dependent Children under age [18].</i>	[100%]	[100%]	[100%]	[Yes]	[Yes]	[Yes]
<p><i>*With an indicator for diabetes, high risk cardiac conditions, or kidney failure or dialysis conditions, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis or [periodontal maintenance]) per Benefit Period.</i></p> <p><i>*With an indicator for periodontal disease, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis or [periodontal maintenance]) per Benefit Period and for topical application for fluoride at the frequency stated in this Schedule of Dental Benefits.</i></p> <p><i>*With an indicator for suppressed immune system conditions of cancer-related chemotherapy and/or radiation, the Covered Individual will be eligible for any combination of four cleanings (prophylaxis or [periodontal maintenance]) per Benefit Period and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.</i></p> <p><i>*With an indicator for pregnancy, the Covered Individual will be eligible for one additional cleaning (prophylaxis or [periodontal maintenance]) during the time of pregnancy.</i></p>						

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
BASIC SERVICES: ROUTINE AND RESTORATIVE SERVICES						
[Waiting Period – 6 Months]						
Simple Extractions	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Amalgam and resin-based composite fillings: <i>[once] per surface in a 12-month interval.</i>	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Sedative filling	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Pin retention	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
<p><i>When an inlay is requested or placed, the level of benefits will be limited to that of an amalgam filling. Sedative fillings are a Covered Dental Benefit once per tooth per lifetime. When multiple pins are requested or placed, the level of benefits will be limited to one pin per tooth.</i></p>						

SCHEDULE OF DENTAL BENEFITS – [PLAN [5]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: RESTORATIVE SERVICES						
[Waiting Period – 12 Months]						
Crowns and ceramic restorations (permanent teeth only)	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Cast or prefabricated post and core; core build-up.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]
Additional procedures to construct new crown under existing partial denture framework.	[50%]	[50%]	[50%]	[Yes]	[Yes]	[Yes]

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: ENDODONTIC SERVICES						
Pulpal and root canal therapy	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
<p><i>When endodontic therapy is performed on primary teeth, the level of benefits will be limited to that of a pulpotomy, except where radiographs indicate there is no permanent successor tooth and the primary tooth demonstrates sufficient intact root structure.</i></p> <p><i>Retreatment of root canal therapy 24 months of initial treatment is not a Covered Dental Benefit.</i></p> <p><i>When incomplete endodontic therapy is billed because the Covered Individual has been referred to an endodontist for completion of endodontic treatment, the level of benefits will be limited to that of a pupal debridement.</i></p> <p><i>Pupal therapy (resorbable filling) is a Covered Dental Benefit once per tooth per lifetime.</i></p>						

SCHEDULE OF DENTAL BENEFITS – [PLAN 5]] (continued)

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
MAJOR SERVICES: ORAL SURGERY						
Simple extractions.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Surgical removal of reputed tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Removal of impacted tooth – soft tissue.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Removal of impacted tooth – partially bony.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Removal of impacted tooth – completely bony.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Tooth reimplantation/stabilization of accidentally evulsed or displaced tooth and/or alveolus.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Surgical access of an unerupted tooth.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Biopsy of oral tissue: brush biopsy.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Alveoloplasty – per quadrant.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Vestibuloplasty – ridge extension.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Surgical excision of soft tissue lesions.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Surgical excision of intra-osseous lesions.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Other covered surgical/repair procedures: Removal of exostosis, torus palatinus or torus mandibularis; incision and drainage of abscess – intraoral soft tissue; frenulectomy or frenuoplasty; excision of hyperplastic tissue or pericoronal gingiva; surgical reduction of osseous or fibrous tuberosity.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
<i>Oral Surgery includes extractions and other listed oral surgery procedures (Including pre- and post-operative care) only when provided in a Dentist's office.</i>						
MAJOR SERVICES: ADJUNCTIVE GENERAL SERVICES						
Palliative (emergency) treatment of dental pain – minor procedure.	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Deep sedation/general anesthesia: <i>when provided by a Dentist in conjunction with Oral Surgery (surgical procedures) other than simple extractions.</i>	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Intravenous conscious sedation/analgesia: <i>when provided in conjunction with Oral Surgery (surgical procedures) other than simple extractions.</i>	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]
Consultations	[80%]	[80%]	[80%]	[Yes]	[Yes]	[Yes]

SECTION 1: DEFINITIONS

The following are key words used in this Policy. When they are used, they are capitalized. Also, some terms are capitalized and described within this Policy Schedule or the provisions in which they appear in this Policy.

Allowed Amount means the Scheduled Fee. The Scheduled Fee is the amount used to calculate Your portion of the dental coverage payment for which You are responsible.

Annual Maximum Benefit means the maximum benefit payable under this Policy for each Covered Individual per Benefit Period. All Covered Dental Services are subject to the Annual Maximum Benefit. No benefits will be paid under this Policy after the Annual Maximum Benefit has been reached. The Annual Maximum Benefit is shown in the Policy Schedule.

Approved Amount means the amount that the Dentist has agreed to accept as full payment for treatment.

1. For a Delta Dental PPO Dentist, the Approved Amount is the Scheduled Fee;
2. For a Delta Dental Premier Dentist, the Approved Amount is the Maximum Plan Allowance; and
3. For an Out-of-Network Dentist, the Approved Amount is the Submitted Fee.

Benefit Period means the twelve-month period specified in the Policy Schedule during which We pay benefits for Covered Dental Services. It is also the time during which Deductibles, Annual Maximum Benefit, and Coverage Limits are calculated and applied.

Co-Payment means the designated portion (fixed percentage) of the Allowed Amount We are contractually obligated to pay for a covered dental procedure, up to the Annual Maximum Benefit. The Patient Co-Payment is the portion (fixed percentage) of the Allowed Amount remaining after Our Co-Payment.

Covered Dental Service means the dental procedures and services payable under this Policy. Covered Dental Services will be paid in accordance with the Dental Benefit for the particular dental procedure or service, subject to the Deductible, Co-Payments, Annual Maximum Benefit, exclusions and limitations contained in this Policy.

Covered Dependent means the Policyholder's spouse or Domestic Partner and any Dependent Children (as defined in this Policy) who are insured under this Policy. A Covered Dependent must be listed on the application for this Policy and approved by Us. The required premium for the Covered Dependent's coverage under this Policy must be paid to Us.

Coverage Limits means the Annual Maximum Benefit specified in the Policy Schedule.

Covered Individual means the Policyholder or any Dependent of the Policyholder who is insured under this Policy. Coverage for the Policyholder and any Covered Dependent is subject to: (1) payment of the required premium for coverage under this Policy; and (2) the provisions of *Section 3: WHEN COVERAGE BEGINS AND ENDS*.

Date of Service means the date treatment is COMPLETED for any particular Dental Benefit for the purpose of allocating the particular Dental Benefit to the appropriate Benefit Period and paying claims made under this Policy.

Deductible means the amount specified in the Policy Schedule which a Covered Individual is required to pay before designated Dental Benefits are payable under this Policy.

Delta Dental PPOSM Network and Delta Dental Premier[®] Network mean the dental networks used for In-Network dental services under this Policy. A Covered Individual may elect to obtain services through either network.

Dental Benefit means the amount We pay for a Covered Dental Service, subject to the applicable Deductible, Co-Payment, Annual Maximum Benefit, and exclusions and limitations contained in this Policy.

Dentist means an individual licensed to practice dentistry at the time and in the place where services are provided.

Dependent means Your:

1. Spouse or Domestic Partner; and
2. Eligible Dependent Children.

Dependent Children means the Policyholder's eligible children who are:

1. Under age 27, regardless of their place of residence, marital status or student status; including: (a) newborn children; (b) stepchildren; (c) legally adopted children; (d) children placed for adoption with the Policyholder in accordance with applicable state or federal law; (e) foster children; and (f) children for whom the Policyholder is a legal guardian substantiated by a court order; and
2. Unmarried and between age 27 to age 30, and who: (a) are residents of the same state as the Policyholder; (b) served as a member of the U.S. Armed Forces (active or reserve); and (c) have received a release or discharge other than dishonorable. The Policyholder must provide Us with proof of military service (U.S. Government Form DD2-14, Certificate of Release or Discharge from Active Duty) for such Dependent Child; and
3. Unmarried dependent Handicap Children age 27 and over. Refer to the definition of *Handicapped Child*.

Domestic Partner means a person with whom You have entered into a Domestic Partnership or Civil Union in accordance with state law where You reside.

Domestic Partnership and **Civil Union** mean a long-term committed relationship of indefinite duration with a person which meets the following criteria:

1. You and Your Domestic Partner have lived together for at least 12 months;
2. Neither You nor Your Domestic Partner is married to anyone else or has another domestic partner;
3. Your Domestic Partner is at least 18 years of age;
4. Your Domestic Partner resides with You and intends to do so indefinitely;
5. You and Your Domestic Partner have an exclusive mutual commitment that is intended to be permanent;
6. You and Your Domestic Partner are jointly responsible for each other's common welfare and share financial obligations; and
7. You and Your Domestic Partner meet the requirements for a Domestic Partnership or Civil Union in the state where You reside, if any.

Family Coverage means coverage for: (1) You; and (2) Your spouse or Domestic Partner; and/or (3) one or more Dependent Children.

Fee Adjustment means the difference, if any, between the Submitted Amount and the Approved Amount.

Fee Schedule or Scheduled Fee means the amount that a Dentist in the Delta Dental PPO Network agrees contractually to accept as full payment for covered procedures. The Fee Schedule for covered procedures. The Fee Schedule for covered procedures is listed in a table provided to Dentists who participate in the Delta Dental PPO Network.

Handicapped Child means Your unmarried Dependent Child age 27 or older who was a Covered Dependent Child prior to attaining age 27 and remains dependent on You for support and maintenance because he or she is and continues to be both incapable of:

1. Self-sustaining employment by reason of mental retardation or physical handicap; and
2. Chiefly dependent upon You for support and maintenance.

Proof of such incapacity and dependency must be furnished to Us by You within thirty-one (31) days of the child's attainment of the limiting age. Subsequently, We may require proof that the child continues to be so handicapped, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

In-Network means services provided by Preferred Providers who contracted with Delta Dental PPO Network or the Delta Dental Premier Network to provide services to Covered Individuals under this Policy.

Maximum Plan Allowance means the amount that a Delta Dental Premier Dentist agrees contractually to accept as full payment for covered procedures. The Maximum Plan Allowance is calculated as a percentile of billed fees and is shown as the Approved Amount on the Explanation of Benefits (EOB) determination.

Non-Preferred Provider means a licensed dentist who does not have a participation contract in effect with the Delta Dental PPO Network or the Delta Dental Premier Network to provide services to Covered Individuals under this Policy. When dental services are provided by a Non-Preferred Provider, the services provided are Out-of-Network.

Our Payment means the amount that TruAssure Insurance Company pays for the Covered Dental Services listed on a claim.

Out-of-Network means services provided by Non-Preferred Providers. Non-Preferred Providers are not contracted with Delta Dental PPO Network or the Delta Dental Premier Network to provide services to Covered Individuals under this Policy.

Patient Payment means the amount the patient (*the Covered Individual*) is obligated to pay the Dentist for the service(s) listed on his or her claim. The Patient Payment shown on an Explanation of Benefits (EOB) represents the amount the patient is obligated to pay based on the benefits provided under this Policy. The Patient Payment may be different from what is shown on the EOB if the Covered Individual also has coverage under another dental policy or plan.

Policy means this Policy issued by Us to You, the Policyholder. This Policy includes: (1) any appendices, endorsements, or riders issued and attached to this Policy; and (2) the completed application(s) attached to this Policy. Application means the application(s) for this Policy.

Policy Anniversary Date means the same day and month as the Policy Effective Date for each succeeding year this Policy remains in force. The Policy Anniversary Date is shown in the Policy Schedule.

Policy Effective Date means the date on which this Policy becomes effective. The Policy Effective Date is shown in the Policy Schedule.

Policyholder means the person who has: (1) completed and signed the application necessary for coverage under this Policy; (2) been approved by Us for coverage and this Policy; and (3) paid the appropriate initial premium for this Policy; and (3) paid the appropriate initial premium for this Policy. The Policyholder is the owner of this Policy. The name of the Policyholder is shown in the Policy Schedule.

Preferred Provider means a licensed dentist who has a participation contract in effect with the Delta Dental PPO Network or the Delta Dental Premier Network to provide services to Covered Individuals under this Policy. The preferred provider's participation contract must be in effect with Delta Dental PPO Network or the Delta Dental Premier Network at the time Covered Dental Services are provided to the Covered Individual in order for benefits to be eligible for In-Network benefits.

Pretreatment Estimate means an estimate for the coverage afforded for the dental plan benefits provided under this Policy prior to such services being rendered.

Submitted Amount means the amount billed or charged by the Dentist on a submitted claim.

SECTION 2: WHO CAN BE COVERED UNDER THIS DENTAL POLICY

What You Should Know About Who Is Covered

Who is the Covered Policyholder?

The person in whose name this Policy is issued is the Policyholder. The Policyholder is covered under this Policy unless the Type of Coverage was elected for Dependent Coverage only. The name of the Policyholder and the Type of Coverage elected are shown in the Policy Schedule.

If, after coverage is effective under this Policy, the Policyholder is called to active duty in the military:

1. This Policy will terminate if only the Policyholder is covered under this Policy at the time the Policyholder is called to active duty. The Policyholder must reapply for coverage when his or her active duty ceases; or
2. This Policy will remain in force if the Policyholder has Covered Dependents and the Covered Dependents remain insured under this Policy. Upon the Policyholder's return to civilian status, his or her coverage under this Policy will be reinstated.

Are Dependents Covered?

If You, as the Policyholder, are enrolled for Family Coverage, the following Dependents may also be covered under this Policy:

1. Your spouse or Domestic Partner; and
2. Your eligible Dependent Children as defined in Section 1, *Definitions*.

Dependent Child Coverage Only

If You elected Dependent Child Coverage only, Your eligible Dependent Children will be covered under this Policy, if they are enrolled and approved by Us.

Are Dependents in the Military Eligible for Coverage?

Dependents in military service are not eligible for coverage under this Policy. If a Covered Dependent is called to active duty, his or her coverage under this Policy will terminate on the date he or she departs for active duty. Upon his or her return to civilian status, the Dependent will be reinstated effective on the date his or her active military status ceases if this Policy are still in effect. You must give Us a status change form for these changes.

SECTION 3: WHEN COVERAGE BEGINS AND ENDS

When Coverage Begins

What is the Effective Date of Coverage?

1. You, the Policyholder, are covered under this Policy as follows:
 - a. Upon Our approval of Your application and remittance of the required premium payment. When We receive Your application form and premium payment prior to the 20th of the month, coverage will be effective the first day of the month immediately following receipt. When received after the 20th and the last day of the month, coverage will be effective the first day of the second month following receipt. Your effective date of coverage is the same as the Policy Effective Date shown in the Policy Schedule.
 - b. After satisfaction of the Benefit Waiting Period, if applicable, as outlined in the Schedule of Dental Benefits.
2. Eligible Dependents are covered under this Policy as follows:
 - a. On the date Your coverage is effective;
 - b. On a Policy Anniversary Date allowing You to make coverage changes. Coverage for the Dependent will then be effective on that Policy Anniversary Date.
 - c. On the date the Dependent is eligible for coverage, meaning: (1) birth; (2) adoption; (3) placement for foster care; (4) placement for adoption with You and for whom the application and approval procedures for adoption have been completed; (5) a marriage that results in the spouse or Domestic Partner and stepchildren being added to coverage; and (6) those required to be covered by court order.
 - d. After satisfaction of the Benefit Waiting Period, if applicable, as outlined in the Schedule of Dental Benefits.

How do You Enroll Dependents After the Policy Effective Date?

If You do not enroll Your Dependents when they are first eligible and later have a Dependent as a result of :

1. Marriage or the establishment of a Domestic Partnership;
2. Birth;
3. Adoption or placement for adoption; or
4. Placement for foster care;

the Dependent may be enrolled for coverage within the time period indicated below in the *Adding a Dependent Due to Marriage/Domestic Partnership*, *Adding a Dependent Child*, and *Adding a Dependent Due to Court Order* provisions.

Adding a Dependent Due to Marriage/Domestic Partnership: If You have a new Dependent due to marriage or the establishment of a Domestic Partnership, the effective date of coverage for the eligible Dependent will be the first of the month following the event, provided We receive a status change form and approve the Dependent for coverage under this Policy. You must submit a completed status change form within thirty-one (31) days from the date of marriage or establishment of Domestic Partnership. You may obtain a status change form from Us. If there is a change in premium, it will be included in the first billing date after the change adjusted back to the effective month of the change.

Adding a Dependent Child: If You have a Dependent Child as a result of:

1. Birth;
- 2.
3. Filing of a petition for adoption; or
4. Placement for foster care;

Comment [HD1]: Ins Code 23-79-129

Comment [HD2]: Ins Code 23-79-137

the effective date of coverage for the new Dependent Child will be the date of: (a) birth if You enroll the child within 90 days of the date of his or her birth or before the next premium due date, whichever is later; (b) the filing a petition for an adopted child if You enroll the child within sixty (60) days after the filing of such petition for adoption; (c) birth of an adopted child if the petition for adoption and Your enrollment of the child for coverage is filed within sixty (60) days after the birth of the child; or (d) placement for foster care if You enroll the child within 31 days of placement. You must submit to Us a status change form within the time period specified, otherwise coverage will not be provided under this Policy. If there is a change in premium, it will be included on the first billing date after the change adjusted back to the effective month of the change.

Adding a Dependent Due to Court Order: If a court orders You to provide coverage for a Dependent, the effective date of coverage for the Dependent will be the first billing date after We receive and approve the status change form. The status change form must be submitted to Us within thirty-one (31) days after the court order is issued. If there is a change in premium, it will be included on the first billing date after the change adjusted back to the effective month of the change.

How Long Is Coverage Effective Under This Policy?

This Policy is written for a period of 12 months beginning on the Policy Effective Date. You may elect to continue this Policy or discontinue this Policy effective on any Policy Anniversary Date. Coverage under this Policy will be continued if You elect to continue this Policy. If You elect to discontinue this Policy, You must provide Us with a written notice 45 days in advance of the termination date.

When You are no longer eligible for coverage: Your coverage and the coverage for Your Covered Dependents, if any, will terminate on the last day of the month upon the occurrence of the following events:

1. The date You enter active duty in the military service. However, if You retain coverage for Your Covered Dependents, this Policy will remain in force to insure Your Covered Dependents provided the required premiums continue to be paid;
2. The date of Your death;
3. The date this Policy is terminated.

No coverage will be available to You upon attainment of a limiting age for a benefit specified in the Policy Schedule.

When Your Covered Dependents are no longer eligible for coverage: The coverage of any of Your Covered Dependents will terminate on the last day of the month upon the occurrence of the following events:

1. The date Your Covered Dependent no longer meets the eligibility requirements specified in this Policy;
2. The date: (a) Your spouse is no longer an eligible Dependent as a result of a divorce decree or legal separation; or (b) You and Your Domestic Partner are no longer in a Domestic Partnership relationship;
3. The date Your Dependent Child reaches his or her 27th birthday;
4. The date Your Dependent enters active duty in the military;
5. The date of Your Death; or
6. The date this Policy terminates.

No coverage will be available for a Covered Dependent upon attainment of the limiting age for a benefit specified in the Policy Schedule.

When May We Rescind this Policy?

If You commit fraud or misrepresent material information on an application for this Policy, this Policy will be rescinded and will be considered as never having been in effect. Any premiums paid for coverage for the ineligible person will be refunded minus any claims paid for that person. We are entitled to recover the claim amounts that exceed the amount of premium paid.

When Can We Terminate this Policy?

We will terminate this Policy at 12:01 a.m. at Your home on the earliest of the following:

1. On any Policy Anniversary Date this Policy is not renewed;
2. If You fail to pay the required premium payment when due, subject to the Grace Period; or
3. For any other reason for termination of this Policy as specified in this Policy, provided We give You at least forty-five (45 days) prior written notice.

What Is Our Responsibility for Payment of Claims if this Policy Terminates?

We will only pay a claim for dental services received and completed prior to the termination date of this Policy; however, such claim must be submitted to Us by You or Your Dentist within twelve (12) months after the date services were completed. We are not required to pay benefits for Covered Dental Services provided to a Covered Individual after the date this Policy terminates for any reason.

SECTION 4: HOW YOUR DENTAL PLAN WORKS

What You Should Know About Selecting a Dentist

May You go to any Dentist?

Yes. You may choose to go to any licensed Dentist whenever You need dental care. Whatever Dentist You choose, You will receive some level of benefits for Covered Dental Services. However, there are

advantages when You receive treatment from a Dentist participating in one of Our networks – either the Delta Dental PPO Network or the Delta Dental Premier Network.

What are the advantages of going to a Dentist who participates in the Delta Dental PPO Network?

1. Dentists participating in the Delta Dental PPO Network are obligated to accept the lesser of the Dentist’s Submitted Amount or the Scheduled Fee as full payment for Covered Dental Services under this Policy.
2. You are not responsible for charges exceeding the Approved Amount for Covered Dental Services. Any difference between the Dentist’s Submitted Amount and the Approved Amount is called the Fee Adjustment, and is money You save. You only are responsible for the applicable Deductible and patient Co-payment amounts. This payment arrangement means that Your out-of-pocket costs are likely to be less.
3. We automatically pay Dentists in the Delta Dental PPO Network directly, so You do not have to pay the whole bill up front and wait for reimbursement. Therefore, You do not have to file a claim for the Covered Dental Services.

What happens if You choose a Dentist who does not participate in the Delta Dental PPO Network?

When You choose a Dentist who participates in the Delta Dental Premier Network: If the Dentist You select does not participate in the Delta Dental PPO Network, You may still reduce Your out-of-pocket costs, if You go to a Dentist who participates in the Delta Dental Premier Network. Delta Dental Premier Network serves as a “safety net” providing out-of-network, out-of-pocket protection for You.

A Dentist participating in the Delta Dental Premier Network is obligateded to accept the lesser of the Dentist’s Submitted Amount or the Maximum Plan Allowance as full payment for Covered Dental Services. That amount is what We refer to as the Approved Amount. You are responsible for the applicable Deductible and patient Co-payment amounts, plus the difference between the Approved Amount and the Allowed Amount. While the Fee Adjustment may not be as great as with Dentists who participate in the Delta Dental PPO Network, and the patient Co-payment amount may be somewhat higher, You can still save money. In addition, We automatically pay Dentists who participate in the Delta Dental Premier Network directly, so You do not have to pay the whole bill up front and wait for reimbursement. Therefore, You do not have to file a claim for Covered Dental Services provided by a Dentist in the Delta Dental Premier Network.

When You choose a Dentist who does not participate in the Delta Dental PPO Network or Delta Dental Premier Network: If the Dentist You select does not participate in the Delta Dental PPO Network or the Delta Dental Premier Network, You will be responsible for the difference between Your Dentist’s Submitted amount and Our Payment. The amount We use to calculate the payment, that is the Allowed Amount, will be the lesser of the Dentist’s Submitted Amount and the Scheduled Fee.

Depending on the Dentist You choose, what would be an example of Your out-of-pocket costs?

If you choose a Dentist in the Delta Dental PPO Network:

Submitted Amount:	\$700
Fee Adjustment:	\$200
Approved Amount (Fee Schedule)	\$500
Allowed Amount (Fee Schedule)	\$500
Deductible Applied:	satisfied

<i>Our Co-Payment Amount:</i>	50%
<i>Patient Payment:</i>	\$250
<i>Our Payment:</i>	\$250

Because this Dentist has agreed to accept the Scheduled Fee as full payment for covered procedures (Approved Amount), You cannot be charged the \$200 difference (Fee Adjustment).

If You choose a Dentist who is not in the Delta Dental PPO Network, but is participating in the Delta Dental Premier Network:

<i>Submitted Amount:</i>	\$700
<i>Fee Adjustment:</i>	\$100
<i>Approved Amount (Maximum Plan Allowance)</i>	\$600
<i>Allowed Amount (Fee Schedule)</i>	\$500
<i>Deductible Applied:</i>	satisfied
<i>Our Co-Payment Amount:</i>	50%
<i>Patient Payment:</i>	\$350
<i>Our Payment:</i>	\$250

Because this Dentist accepted Delta Dental's Maximum Plan Allowance (Approved Amount) as payment in full, You cannot be charged the \$100 difference (Fee Adjustment).

If You choose a Dentist who does not participate in either the Delta Dental PPO Network or the Delta Dental Premier Network:

<i>Submitted Amount:</i>	\$700
<i>Fee Adjustment:</i>	\$0
<i>Approved Amount (Submitted Amount)</i>	\$700
<i>Allowed Amount (Fee Schedule)</i>	\$500
<i>Deductible Applied:</i>	satisfied
<i>Our Co-Payment Amount:</i>	50%
<i>Patient Payment:</i>	\$450
<i>Our Payment:</i>	\$250

What You Should Know About Our Payment of Benefits

How will You be notified of Our Payment determination?

If You or a Covered Dependent makes a claim for benefits under this Policy, and the claim is denied in whole or in part, You will received written notification within 30 days after We receive a completed claim form, unless special circumstances require an extension of time for processing. The claim decision will be sent on a form entitled, "Explanation of Benefits Statement" (EOB).

You will receive this Explanation of Benefits Statement, if You have to pay any portion of the claim, or if payment is issued directly to You for an out-of-network claim. If Your payment responsibility is zero and We issue payment directly to the Dentist, You will not receive an Explanation of Benefits Statement because Your claim has been paid in full. However, You may still check claim status on Our Web Site or by using the automated phone system.

Because Dentists who do not participate in the Delta Dental PPO Network or the Delta Dental Premier Network do not have agreements with Us, You will be responsible for the difference between Our Payment and Your Dentist's Submitted Amount.

How can You find out if Your regular Dentist is a participating Dentist in the Delta Dental PPO Network or Delta Dental Premier Network, or get a list of Dentists near You?

We offer two easy ways to locate a participating Dentist 24 hours a day, 7 days a week. You can either:

1. Search Our online Dentist directory at Our Web Site address indicated in the Policy Schedule; or
2. Use the automated phone system by calling the telephone number indicated in the Policy Schedule.

Using either method, You can request a list of participating Dentists or specialists within a designated area. Participating Dentist information can be obtained nationwide. You should keep in mind that there are two categories of participating Dentists: Delta Dental PPO Network and Delta Dental Premier Network. We also recommend that You check with Your Dentist to confirm whether he or she participates in the Delta Dental PPO Network or Delta Dental Premier Network.

May You assign Your benefits to the Dentist?

We will automatically make benefit payment for services rendered by a Dentist who participates in the Delta Dental PPO Network or Delta Dental Premier Network directly to the Dentist. If You go to a Dentist who does not participate in the Delta Dental PPO Network or Delta Dental Premier Network, You may assign Your benefits to that Dentist. However, if You do not assign Your right to receive payment to the Dentist or Your Dentist does not accept assignment of benefits, We will issue payment directly to You, and You may have to pay the entire bill in advance. In this event, You will have to file a claim for services with Us.

Are there any reimbursement limitations?

Indemnity in the form of cash will not be paid to You as reimbursement for payments made by You to a Dentist and for which We are liable at the time of such payment.

What You Should Know About Pre-Treatment Estimates

Are You required to submit a Pre-Treatment Estimate before beginning treatment?

Although Pre-Treatment Estimates are not required, We strongly recommend that You ask Your Dentist to submit Pre-Treatment Estimate for treatment costing \$200 or more. The Pre-Treatment Estimate lets You know in advance whether the requested services are covered under this Policy. Often patients believe a service is covered if their Dentist provided it. This is not always the case.

What does a Pre-Treatment Estimate need to include?

A Pre-Treatment Estimate must describe the procedures and services that the treating Dentist plans to perform, including the actual fees to be charged for each procedure or service. We require the submission of the following information to provide You with an estimate of Your Dental Benefits.

Required Documentation	Procedure/Service Planned (or Received)
Full mouth radiographs	Non-surgical and surgical periodontics
Full arch periapical radiographs	Osseous fractures and fixed bridgework
Periapical radiographs	Surgical extractions and cast restorations
Narrative	Consultations, palliative treatment and general anesthesia
Histopathology and/or hospital report	Biopsies and the surgical excision of Tissue

What happens after a Pre-Treatment Estimate request is submitted?

We will review the request, along with any required documentation submitted by the treating Dentist. We will then issue a Pre-Treatment Estimate outlining the estimated level of payment under this Policy. Please keep in mind that a Pre-Treatment Estimate is only an estimate and not a guarantee of payment. Estimated benefits may be reduced after completion of treatment due to changes in Your or Your Dependent's eligibility, application of Deductibles and Maximum Coverage Limits.

In addition, a Pre-Treatment Estimate does not take into consideration other coverage You may have; We coordinate benefits after treatment is completed and a claim is submitted for payment. An estimate made by Us imposes no restrictions on the method of treatment by Your treating Dentist and only relates to the level of benefit that We cover under this Policy.

SECTION 5: YOUR COVERED DENTAL SERVICES AND DENTAL BENEFITS

What You Should Know About the Benefits Covered Under this Policy

What services are covered under this Policy?

Dental services covered under this Policy are shown in the Policy Schedule and the Schedule of Dental Benefits.

What services are not covered under this Policy?

Not all services that Your Dentist performs may be covered under this Policy. See Section 8, *What Are the Policy Exclusions and Limitations?*, for a list of services that are not covered (excluded from coverage) under this Policy.

Are covered procedures subject to any contract limitations or payment policies?

Yes. We apply certain contract limitations or payment policies for the procedures covered under this Policy. For example, there are frequency limitations associated with certain procedures such as teeth cleaning. More frequent teeth cleaning is not a benefit even if Your Dentist states that the treatment is necessary and appropriate. This does not mean that We consider more frequent cleanings unnecessary or inappropriate; rather, this is simply a limitation on how often benefits are paid for cleanings under this Policy.

What is an alternate benefit provisions and how does it work?

There are times when there are multiple ways to treat a dental condition. The payment policies may cover only one way. This does not mean that Your Dentist made an inappropriate recommendation.

In fact, You may use Our Payment toward another method of treatment. But since Our Payment is the same no matter which treatment You choose, You may have higher out-of-pocket expenses if You choose a treatment that costs more.

What amounts do You have to pay for dental benefits under this Policy?

Deductible: This is the fixed dollar amount You pay for Covered Dental Services in a Benefit Period before We pay benefits under this Policy. The Deductible is shown in the Policy Schedule. It must be satisfied by each Covered Individual each Benefit Period.

Co-payment: This is the portion of the benefit that the Covered Individual has to pay. For example, if the benefit payable under this Policy for covered dental expenses is 80%, the Covered Individual would be responsible for 20% of the incurred expenses. The Co-payment amounts are shown in the Policy Schedule and the Schedule of Dental Benefits.

Coverage Limits: This the Annual Maximum Benefit that any Covered Individual is eligible to receive for Covered Dental Services in a Benefit Period or a benefit amount that is payable up to a specific age. Coverage Limits are shown in the Policy Schedule and the Schedule of Dental Benefits.

SECTION 6: WHAT ARE THE PREMIUM REQUIREMENTS?

How do You make Premium Payments?

Premiums for this Policy must be paid to Us. The premium applicable to this Policy is shown in the Policy Schedule.

Premiums are to be paid electronically to Us using Your checking/savings account or credit card. If You select as Your method of payment checking/savings account, then Your first premium is to be paid by check. Premiums due for the premium mode selected in Your application – annually, semi-annually, quarterly or monthly – will be drawn or charged on the first day of the month premium is due for this Policy.

If the premium due amount is dishonored by Your bank or credit card, You may be assessed a \$25.00 service charge, and subsequent payment of any premium due will not keep this Policy in force, except as provided in the Grace Period. If any premium due is not received by Us before or at the end of the Grace Period, this Policy will automatically terminate at the end of the period for which the last premium was paid.

Are Claim Payments Affected by Unpaid Premium?

Yes. Upon the payment of a claim under this Policy, any premium then due and unpaid may be deducted from the Covered Individual's claim payment.

What is the Grace Period?

After the first premium, if a premium is not paid on or before the date it is due, it may be paid during the next 31 days. These 31 days are called the Grace Period. This Policy will remain in force during the Grace Period. However, charges incurred for Covered Dental Services during the Grace Period will not be paid unless the premium due is paid by the end of the Grace Period. If any premium is unpaid at the end of the Grace Period, coverage will automatically terminate retroactively to the last day for which premium was paid.

Can the Company Change the Premium Rates?

Subject to the rate requirements in the state in which this Policy is issued, We may change the rates for this Policy on any Policy Anniversary Date. Any rate change will be made only when We change the rates for all policies in the same rate class on the same form as this Policy that are issued in the same state as this Policy. We will give You at least 45 days advance written notice prior to the effective date of any rate change. The rates will never be changed due to a change in Your age or health.

When is a Premium Refund Applicable?

In the event this Policy is terminated due to Your death, We will refund any portion of the unearned premium to Your beneficiary or Your estate.

If this Policy is Terminated, Can It be Reinstated?

If this Policy terminates due to failure to pay Premium within the time granted for You to make payment as provided in this Policy, a subsequent acceptance of premium by Us or by any agent authorized by Us to accept such premium, without requiring an application for reinstatement, will reinstate this Policy. However, if We or any agent authorized by Us requires an application for reinstatement and issues a conditional receipt for the premium paid, this Policy will be reinstated upon Our approval of such application or, lacking such approval, upon the 45th day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application.

The reinstated Policy will only cover expenses for Covered Dental Services that are incurred after the Reinstatement date of the Policy.

In all other respects, the rights of all parties will remain the same, subject to any provisions noted on or attached to the reinstated Policy. Any premium We accept in connection with the reinstatement will be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

The statements made in the application for the reinstated Policy will be measured from the effective date of the reinstatement with respect to the time periods stated in the *Time Limit on Certain Defenses* provision appearing in Section 9, *General Provisions*.

SECTION 7: WHAT ARE THE POLICY EXCLUSIONS AND LIMITATIONS?

The following are the exclusions and limitations for dental services, unless specifically provided as a Covered Dental Service as shown in the Policy Schedule and Schedule of Dental Benefits.

Exclusions That Apply to Diagnostic Services

Pulp vitality tests billed with any service are not Covered Dental Services, except:

1. An emergency exam; or
2. Palliative treatment.

Exclusions That Apply to Preventive Services

Recementation of a space maintainer with six (6) months of the initial placement is not a Covered Dental Service.

Exclusions That Apply to Restorative Services

1. Fillings are not a Covered Dental Service when crowns are allowed for the same teeth.
2. Replacement of any existing cast restoration (crowns, onlays, ceramic restorations) with any type of cast restoration within sixty (60) months following initial placement of existing restoration is not a Covered Dental Service.
3. Replacement of a stainless steel crown with any type of cast restoration is not a Covered Dental Service by the same dental provider (e.g., dental office or Dentist) within 24 months following the initial placement.
4. A cast restoration is a Covered Dental Service only in the presence of radiographic evidence of decay or missing tooth structure. Restorations placed for any other purpose, including, but not limited to, cosmetics, abrasion, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformations of teeth, or the anticipation of future fractures, are not a Covered Dental Service.
5. When there is a radiographic evidence of sufficient vertical height (more than three millimeters above the crestal bone) on a tooth to support a cast restoration, a crown build-up is not a Covered Dental Service.
6. The repair of any component of a cast restoration is not a Covered Dental Service.
7. Recementation of inlays, onlays, partial coverage restorations, case and prefabricated posts and cores and crowns by the same dental provider (e.g., dental office or Dentist) within six (6) months of initial placement is not a Covered Dental Service.
8. Additional procedures to construct a new crown under the existing partial denture framework within six (6) months following initial placement is not a Covered Dental Service.
9. When a sedative filling is requested or placed on the same date as a permanent filling, the sedative filling is not a Covered Dental Service.

Exclusions That Apply to Diagnostic Services

1. When a benefit has been issued for endodontic services, retreatment of the same tooth within two (2) years is not a Covered Dental Service.
2. Endodontic procedures performed in conjunction with complete removable prosthodontics appliances are not Covered Dental Services.

Exclusions That Apply to Periodontic Services

1. Guided tissue regeneration billed in conjunction with implantology, ridge augmentation/sinus lift, extractions or periradicular surgery/apicoectomy is not a Covered Dental Service.
2. Crown lengthening or gingivoplasty, if not performed at least four weeks prior to crown preparation, is not a Covered Dental Service.
3. Bone replacement grafts performed in conjunction with extractions or implants are not a Covered Dental Service.
4. Periodontal splinting to restore occlusion is not a Covered Dental Service.

Exclusions That Apply to Prosthodontic Services

1. Replacement of any existing prosthodontics appliance (cast restorations, fixed partial dentures, removable partial dentures, complete denture) with any prosthodontics appliance within sixty (60) months following initial placement of existing appliance is not a Covered Dental Service.
2. When a fixed partial denture and a removable partial denture are requested or placed in the same arch, the fixed partial denture is not a Covered Dental Service.
3. Any prosthodontic appliance connected to an implant is not a Covered Dental Service.
4. Reline or rebase of an existing appliance within six (6) months following initial replacement is not a Covered Dental Service.
5. Fixed or removable prosthodontics for a Covered Individual under age 16 is not a Covered Dental Service.
6. Tissue conditioning is not a Covered Dental Service.
7. When the edentulous (toothless) space between teeth is less than 50% of the size of the missing tooth, a pontic is not a Covered Dental Service.

General Exclusions (Applies to all Covered Dental Services)

Under this Policy, coverage is NOT provided for the following:

1. Services compensable under Worker's Compensation or Employer's Liability Laws.
2. Services provided or paid for by any governmental agency or under any governmental program or law, except as to charges which the Covered Individual is legally obligated to pay. This exception extends to any benefits provided under the U.S. Social Security Act and its Amendments.
3. Services performed to correct developmental malformation including, but not limited to: (a) cleft palate; (b) mandibular prognathism; (c) enamel hypoplasia; (d) fluorosis; and (e) congenitally missing teeth. This exclusion does not apply to newborn infants.
4. Services performed for purely cosmetic purposes, including, but not limited to: (a) tooth-colored veneers; (b) bonding; (c) porcelain restorations; and (d) microabrasion. Orthodontic care benefits provided under this Policy will fall within this exclusion unless such benefits are provided by endorsement and You elected Family Coverage. In no event will a Covered Individual age 19 or over be able to receive orthodontic care benefits.
5. Charges for services completed prior to the date the prior to the date the Covered Individual became insured under this Policy.
6. Services for anesthetists or anesthesiologists.
7. Temporary procedures.
8. Any procedure requested or performed on a tooth when radiographs indicate that less than 40% of the root is supported by bone.
9. Services performed on non-functional teeth (second or third molar without an opposing tooth).
10. Services performed on deciduous (primary) teeth near exfoliation.
11. Drugs or the administration of drugs, except for general anesthesia.
12. Procedures deemed experimental or investigational by the American Dental Association, for which there is no procedure code, or which are inconsistent with Current Dental Terminology coding and nomenclature.
13. Services with respect to any disturbance of the temporomandibular joint (jaw joint).
14. Procedures, techniques or materials related to implantology or edentulous (toothless) ridge enhancement.
15. Procedures that We consider to be included in the fees for other procedures. For such procedures, a separate payment will not be made under this Policy. A Dentist in the Delta Dental PPO Network or Delta Dental Premier Network may not bill the Covered Individual for such procedures.

16. The completion of claim forms and submission of required information, not otherwise covered, for determination of benefits.
17. Infection control procedures and fees associated with compliance with Occupational Safety and Health Administration (OSHA) requirements.
18. Broken appointments.
19. Services and supplies for any illness or injury occurring on or after the Covered Individual's effective date of coverage under this Policy as a result of war or an act of war.
20. Services for, or in connection with, an intentional self-inflicted injury or illness while sane or insane, except when due to domestic violence or a medical (including both physical and mental) health condition.
21. Services and supplies received from either: (1) a Covered Individual's spouse or Domestic Partner or other relative; (2) a relative of the Covered Dependent Spouse or Domestic Partner; or (3) any individual who ordinarily resides such Covered Individual's home or any such similar person.
22. Services for, or in connection with, an injury or illness arising out of the participation in, or in consequence of having participated in, a riot, insurrection or civil disturbance or the commission of a felony.
23. Charges for services for inpatient/outpatient hospitalization.
24. Services or supplies for oral hygiene or plague control programs.
25. Services or supplies to correct harmful habits.

SECTION 8: WHAT YOU SHOULD KNOW ABOUT CLAIMS

What You Should Know About Filing Claims

When do You file a claim

After a Covered Individual receives Covered Dental Services, he or she should file a claim only if his or her Dentist has not filed one for him or her.

Dental providers participating in the Delta Dental PPO Network and Delta Dental Premier Network will automatically file a claim directly to Us on behalf of the Covered Individual for whom they provided treatment for Covered Dental Services. Therefore, the Covered Individual is not required to complete and submit a claim form to Us.

If the Covered Individual uses the services of an Out-of-Network provider, he or she must submit to Us a completed claim form, unless the provider completes and submits the claim to Us on behalf of the Covered Individual.

If the Covered Individual must file a claim with Us, the claim should not be submitted to Us until the Covered Dental Service is completely finished. A claim should not be filed for payment before the Covered Dental Service is completed.

Notice of Claim

Written notice of claim must be given to Us within 20 days after the occurrence or commencement of any loss covered by this Policy, or as soon thereafter as is reasonably possible. Notice given by, or on behalf of, the Covered Individual or the beneficiary to Us at Our home office address shown on the cover page of this Policy, or to any of Our authorized agents, with information sufficient to identify the Covered Individual, will be deemed notice to Us.

Claim Forms

We, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by Us for filing proofs of loss. If such forms are not furnished to the claimant within fifteen (15) days after the giving of such notice, the claimant will be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in this Policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

You can also download a claim form from Our Web Site. The Web Site address is shown in the Policy Schedule.

Proof of Loss

Written proof of loss must be given to Us at Our home address shown on the cover page of this Policy within one year of the date of loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible, and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Time Payment of Claims

Benefits payable under this Policy for any loss will be paid immediately upon receipt of due written proof of such loss.

Payment of Claims

We will pay benefits to You when Covered Dental Services are provided by a Non-Preferred Provider, unless the claim payment has been assigned to the Non-Preferred Provider. No claim payment will be paid to You when Covered Dental Services are provided by a Preferred Provider.

What Documentation Must Accompany a Claim for Payment?

Pre-Treatment Estimate Documentation: If a Pre-Treatment Estimate is not submitted, We require the submission of the same documentation for a claim payment as needed for a Pre-Treatment Estimate. (Refer to the Required Documentation chart appearing under the provision entitled *What You Should Know about Pre-Treatment Estimates* in Section 4.

Non-Preferred Provider Claims: We will need written proof of the expenses incurred for Covered Dental Services provided by a Non-Preferred Provider for which claim is being made. Such written proof is to include: (1) the occurrence; (2) the character; and (3) the extent of the dental services. Also, refer to the *Proof of Loss* provision.

Where Are Claims Filed for Payment

The Covered Individual can complete the claim form and mail it to our Home Office address shown on the cover page of this Policy. A separate claim form must be submitted for each Covered Individual who receives Covered Dental Services.

What You Should Know About Claim Determinations and Appeal Procedures

How will You know when claims are processed?

When the Dentist is paid directly: Unless the Covered Individual's payment responsibility is zero, the Covered Individual will receive an Explanation of Benefits that describes the services his or her Dentist submitted and the benefits that this Policy covers. The treating Dentist will receive an Explanation of Payment along with the payment.

When You are paid directly: Along with Your payment, We will provide You with an Explanation of Payment that describes:

1. The services the treating Dentist submitted for You or Your Covered Dependent; and
2. The Covered Dental Services insured under this Policy.

You can also check claim status on Our Web Site or through Our automated phone system. Our Web Site address and automated phone system telephone number are shown in the Policy Schedule.

How do You appeal a denied claim?

If You have questions about the denial of Your or Your Covered Dependent's claim for benefits, You should contact Us at the toll-free telephone number shown in the Policy Schedule. Because most questions about benefits can be answered informally, We encourage You and Your Covered Dependents first try to resolve any problem by talking with one of Our customer service representatives. However, You or Your Covered Dependents have the right to file an appeal requesting that We formally review Our benefits determination.

You may file an appeal of a claim that is denied in whole or in part by written request within 180 days from the date of the denial notice. Send Your written request for review to the attention of the "Reevaluation Committee, TruAssure Insurance Company", at Our Home Office address shown on the cover page of this Policy.

You or Your Covered Dependent should provide the reasons why You disagree with Our benefits determination and include any additional documents or records in support of Your appeal. You should include Your name, the Covered Dependent's name if applicable, and Your Policy Number or member ID on all documents and supporting documents.

SECTION 9: GENERAL PROVISIONS

Entire Contract; Changes

This Policy including the application, including the endorsements and attached papers, if any, constitutes the entire contract of insurance. No change in this Policy will be valid until approved by an executive officer of the Company and unless such approval be endorsed in or attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

Time Limit on Certain Defenses

After three (3) years from the Policy Effective Date of this Policy no misstatements, except fraudulent misstatements, made by the applicant in the application for this Policy will be used to void this Policy or to deny a claim for loss incurred or disability (as defined in this Policy) commencing after the expiration of such three-year period.

Comment [HD3]: Ins Code 23-85-107(1)

Representations

In the absence of fraud, any statement made by You will be deemed a representation and not a warranty. Such statement may not be used in defense of a claim, unless it is contained in a signed application.

What Are the Time Limits on Legal Actions?

Legal Actions: No action will be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action will be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

Can this Policy be Assigned?

This Policy cannot be assigned.

When Can Beneficiary Changes Be Made?

Change of Beneficiary: Unless You make an irrevocable designation of beneficiary, the right to change a beneficiary is reserved to You. The consent of the beneficiary, or beneficiaries, will not be requisite to surrender or assignment of this Policy or to any change of beneficiary, or beneficiaries, or to any other changes in this Policy.

Conformity with State Statutes

Any provision of this Policy which, on its Policy Effective Date, is in conflict with the statutes of the state, District of Columbia, or territory in which You reside on such date is hereby amended to conform to the minimum requirements of such statutes.

Comment [HD4]: Ins Code 23-85-124

INDIVIDUAL DENTAL PREFERRED PROVIDER ORGANIZATION (PPO) POLICY

**This is a Limited-Scope Dental Policy
Guaranteed Renewable
Non-Participating**

TruA-1000-AR

TruAssure Insurance Company

[111 Shuman Boulevard, Naperville IL 60563
(800) 414-4988]

Application for Individual Dental PPO Policy

Please type or print in black ink.

Last Name:		First Name:		Middle Initial:	Date of Birth:
Home Address (Mailing):		City:	State:	Zip Code:	Phone Number (with area code): ()
E-Mail Address:		Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>		Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single	
Reason for Application: <input type="checkbox"/> Initial Application <input type="checkbox"/> Change of Dependent(s) <input type="checkbox"/> Change in Coverage Type <input type="checkbox"/> Policy Reinstatement					
Payment Options: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly <input type="checkbox"/> Monthly EFT <input type="checkbox"/> Credit Card					
Select Dental Plan: <input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 5 (Dental Plan for Dependent Children to Age 19 Only)					
Select Type of Coverage: <input type="checkbox"/> Single <input type="checkbox"/> Two-Person <input type="checkbox"/> Family (Three or more persons) <input type="checkbox"/> Dependent Children to Age 19 Only					
Monthly Rates:	Plan 1	Plan 2	Plan 3	Plan 4	
Single:	\$	\$	\$	\$	
Two-Person:	\$	\$	\$	\$	
Family:	\$	\$	\$	\$	
Monthly Rates – Plan 5: (Dependent Children to Age 19 Only)	Number of Dependent Children Under Age 19 to be Insured:	Premium Rate Per Child: \$		Total Monthly Rate for Plan 5: \$ _____	
PLEASE LIST ALL ELIGIBLE DEPENDENT(S) TO BE COVERED UNDER THE POLICY.					
First Name	Last Name (If different from Applicant)	Date of Birth MM/DD/YYYY	Relationship to Applicant	Gender	
				<input type="checkbox"/> M <input type="checkbox"/> F	
				<input type="checkbox"/> M <input type="checkbox"/> F	
				<input type="checkbox"/> M <input type="checkbox"/> F	
				<input type="checkbox"/> M <input type="checkbox"/> F	
				<input type="checkbox"/> M <input type="checkbox"/> F	
CHANGE OF COVERAGE: Please check events requiring Policy changes.					
<input type="checkbox"/> Add Dependent due to: <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Marriage <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> Handicapped Dependent <input type="checkbox"/> Other _____					
List Names of new Dependent(s) above.					
<input type="checkbox"/> Drop Dependent (list below) due to: <input type="checkbox"/> Age <input type="checkbox"/> Death <input type="checkbox"/> Other Coverage Elsewhere Name of Dependent: _____					
<input type="checkbox"/> Name Change: Former Name: _____ New Name: _____					

Address Change: Former Address _____
New Address: _____
 Change in Type of Coverage: Single Two-Person Family Dependent Child to Age 19

PAYMENT INSTRUCTIONS:

Choose your payment method: Bank Account Credit Card

A check must be submitted for the first payment on your policy if you choose bank account as your method of payment. Thereafter, all premiums must be paid electronically using your checking/savings account. If your method of payment is credit card, all premiums are to be paid by credit card. Premiums will be drawn or charged on the 1st of the month.

Please complete the following information if you choose to have deductions automatically taken monthly, quarterly, semiannually, annually for premium payments from an account you designate:

Name of Financial Institution: _____

Financial Institution's City, State & ZIP Code: _____

Type of Account (Choose one): Checking Savings. Name on Account: _____

Bank Routing Number: _____ Bank Account Number: _____

Please attach a voided check or deposit slip from your designated account if you choose to have deductions for verification.

Please complete the following information for payment by Credit Card:

Card Type: Visa MasterCard Discover American Express

Name on Card: _____

Card Number: _____

Expiration Date: ____ month ____ year. Security Code: _____]

I hereby authorize TruAssure Insurance Company to withdraw funds from the above-listed bank account or debit my credit card for the payment of my dental insurance premiums.

Signed: _____ Date: _____

I understand that any transaction that is dishonored by my bank/credit card intended for payment to TruAssure Insurance Company, may be assessed a \$25.00 service charge by TruAssure Insurance Company.

In making this application to TruAssure Insurance Company ("TruAssure"), for the dental coverage policy, I agree and understand that this application will become part of the Policy, and I agree to be bound by the terms of the Policy issued by TruAssure. I further agree that the coverage requested is subject to the approval of TruAssure and that no agent or representative has authority to make changes or modify this application for coverage. I hereby certify that all of the information contained in this application is true and correct to the best of my knowledge. I further understand that any intentional omission or misrepresentation of submitted data may cause this application and subsequent Policy to be null and void.

Please Note: Applications must be received by the 20th of the month to be effective the 1st of the following month. Applications received after the 20th will be effective the first of the month after the next month. *Coverage is contingent upon underwriting acceptance.*

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines or confinement in prison, or any combination thereof.

Applicant Signature

Date

Agent Signature

Date

Printed Name of Agent

Agent License Number

TruAssure Insurance Company

[111 Shuman Boulevard, Naperville IL 60563
(800) 414-4988]

Application for Individual Dental PPO Policy

Please type or print in black ink.

Last Name:		First Name:		Middle Initial:	Date of Birth:
Home Address (Mailing):		City:	State:	Zip Code:	Phone Number (with area code): ()
E-Mail Address:		Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>		Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single	
Reason for Application: <input type="checkbox"/> Initial Application <input type="checkbox"/> Change of Dependent(s) <input type="checkbox"/> Change in Coverage Type <input type="checkbox"/> Policy Reinstatement					
Payment Options: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly <input type="checkbox"/> Monthly EFT <input type="checkbox"/> Credit Card					
Select Dental Plan: <input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 5 (Dental Plan for Dependent Children to Age 19 Only)					
Select Type of Coverage: <input type="checkbox"/> Single <input type="checkbox"/> Two-Person <input type="checkbox"/> Family (Three or more persons) <input type="checkbox"/> Dependent Children to Age 19 Only					
Monthly Rates:	Plan 1	Plan 2	Plan 3	Plan 4	
Single:	\$	\$	\$	\$	
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Monthly Rates – Plan 5: (Dependent Children to Age 19 Only)	Number of Dependent Children Under Age 19 to be Insured:		Premium Rate Per Child: \$		Total Monthly Rate for Plan 5: \$ _____
PLEASE LIST ALL ELIGIBLE DEPENDENT(S) TO BE COVERED UNDER THE POLICY.					
First Name	Last Name (If different from Applicant)	Date of Birth MM/DD/YYYY	Relationship to Applicant	Gender	
				<input type="checkbox"/> M <input type="checkbox"/> F	
				<input type="checkbox"/> M <input type="checkbox"/> F	
				<input type="checkbox"/> M <input type="checkbox"/> F	
				<input type="checkbox"/> M <input type="checkbox"/> F	
				<input type="checkbox"/> M <input type="checkbox"/> F	
CHANGE OF COVERAGE: Please check events requiring Policy changes.					
<input type="checkbox"/> Add Dependent due to: <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Marriage <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> Handicapped Dependent <input type="checkbox"/> Other _____ List Names of new Dependent(s) above.					
<input type="checkbox"/> Drop Dependent (list below) due to: <input type="checkbox"/> Age <input type="checkbox"/> Death <input type="checkbox"/> Other Coverage Elsewhere Name of Dependent: _____					
<input type="checkbox"/> Name Change: Former Name: _____ New Name: _____					

Address Change: Former Address _____
New Address: _____
 Change in Type of Coverage: Single Two-Person Family Dependent Child to Age 19

PAYMENT INSTRUCTIONS:

Choose your payment method: Bank Account Credit Card

A check must be submitted for the first payment on your policy if you choose bank account as your method of payment. Thereafter, all premiums must be paid electronically using your checking/savings account. If your method of payment is credit card, all premiums are to be paid by credit card. Premiums will be drawn or charged on the 1st of the month.

Please complete the following information if you choose to have deductions automatically taken monthly, quarterly, semiannually, annually for premium payments from an account you designate:

Name of Financial Institution: _____

Financial Institution's City, State & ZIP Code: _____

Type of Account (Choose one): Checking Savings. Name on Account: _____

Bank Routing Number: _____ Bank Account Number: _____

Please attach a voided check or deposit slip from your designated account if you choose to have deductions for verification.

Please complete the following information for payment by Credit Card:

Card Type: Visa MasterCard Discover American Express

Name on Card: _____

Card Number: _____

Expiration Date: ____ month ____ year. Security Code: _____]

I hereby authorize TruAssure Insurance Company to withdraw funds from the above-listed bank account or debit my credit card for the payment of my dental insurance premiums.

Signed: _____ Date: _____

I understand that any transaction that is dishonored by my bank/credit card intended for payment to TruAssure Insurance Company, may be assessed a \$25.00 service charge by TruAssure Insurance Company.

In making this application to TruAssure Insurance Company ("TruAssure"), for the dental coverage policy, I agree and understand that this application will become part of the Policy, and I agree to be bound by the terms of the Policy issued by TruAssure. I further agree that the coverage requested is subject to the approval of TruAssure and that no agent or representative has authority to make changes or modify this application for coverage. I hereby certify that all of the information contained in this application is true and correct to the best of my knowledge. I further understand that any intentional omission or misrepresentation of submitted data may cause this application and subsequent Policy to be null and void.

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Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines or confinement in prison, or any combination thereof.

Applicant Signature

Date

TruAssure Insurance Company

[111 Shuman Boulevard, Naperville IL 60563
(800) 414-4988]

Application for Individual Dental PPO Policy

Please type or print in black ink.

Last Name:		First Name:		Middle Initial:	Date of Birth:
Home Address (Mailing):		City:	State:	Zip Code:	Phone Number (with area code): ()
E-Mail Address:		Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>		Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single	
Reason for Application: <input type="checkbox"/> Initial Application <input type="checkbox"/> Change of Dependent(s) <input type="checkbox"/> Change in Coverage Type <input type="checkbox"/> Policy Reinstatement					
Payment Options: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly <input type="checkbox"/> Monthly EFT <input type="checkbox"/> Credit Card					
Select Dental Plan: <input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 5 (Dental Plan for Dependent Children to Age 19 Only)					
Select Type of Coverage: <input type="checkbox"/> Single <input type="checkbox"/> Two-Person <input type="checkbox"/> Family (Three or more persons) <input type="checkbox"/> Dependent Children to Age 19 Only					
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				<input type="checkbox"/> M <input type="checkbox"/> F	
				<input type="checkbox"/> M <input type="checkbox"/> F	
				<input type="checkbox"/> M <input type="checkbox"/> F	
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Please complete the following information if you choose to have deductions automatically taken monthly, quarterly, semiannually, annually for premium payments from an account you designate:

Name of Financial Institution: _____

Financial Institution's City, State & ZIP Code: _____

Type of Account (Choose one): Checking Savings. Name on Account: _____

Bank Routing Number: _____ Bank Account Number: _____

For verification, please mail us a voided check or deposit slip from your designated account if you choose to have deductions, and include a copy of your completed application.

Please complete the following information for payment by Credit Card:

Card Type: Visa MasterCard Discover American Express

Name on Card: _____

Card Number: _____

Expiration Date: ____ month ____ year. Security Code: _____]

I, the Applicant, certify that by selecting "I agree" in the Electronic Signature box below that I am the Applicant named in this Application and that it is my digital signature signifying my agreement to authorize TruAssure Insurance Company to withdraw funds from the above-listed bank account or debit my credit card for the payment of my dental insurance premiums.

I understand that any transaction that is dishonored by my bank/credit card intended for payment to TruAssure Insurance Company, may be assessed a \$25.00 service charge by TruAssure Insurance Company.

In making this application to TruAssure Insurance Company ("TruAssure"), for the dental coverage policy, I agree and understand that this application will become part of the Policy, and I agree to be bound by the terms of the Policy issued by TruAssure. I further agree that the coverage requested is subject to the approval of TruAssure and that no agent or representative has authority to make changes or modify this application for coverage. I hereby certify that all of the information contained in this application is true and correct to the best of my knowledge. I further understand that any intentional omission or misrepresentation of submitted data may cause this application and subsequent Policy to be null and void.

Please Note: Applications must be received by the 20th of the month to be effective the 1st of the following month. Applications received after the 20th will be effective the first of the month after the next month. *Coverage is contingent upon underwriting acceptance.*

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines or confinement in prison, or any combination thereof.

Electronic Signature of Applicant:

I, the Applicant, certify that by selecting "I agree" in this Electronic Signature box that I am the Applicant named in this Application and that this is my digital signature signifying my agreement to: (1) apply for the Individual Dental Insurance Policy selected in this Application; and (2) authorize TruAssure Insurance Company to withdraw funds from the above-listed bank account or debit my credit card for the payment of my dental insurance premiums.

Select 
I Agree
Date Signed: <input type="text"/>
SUBMIT