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

April 3, 2014

Robert McCleve
PO Box 1044
Missoula MT 59806

Dear Robert McCleve,

Welcome to Time Insurance Company! We know selecting your health insurance is an important decision, and we're honored to have you as a customer. To get you started, this welcome packet includes:

- Supplemental insurance contract with complete details of your plan.
- Printable Dental ID cards - you'll receive your permanent Dental ID cards by mail shortly
- A copy of your application; it is important to review the application and ensure all information on it is accurate and complete. We relied on the information you provided in your medical or fixed indemnity application to issue your supplemental Dental policy. If any information is incorrect or unclear, contact us immediately at 800-596-0049.

The plan you have chosen is a supplemental Dental Policy that pays you specified set dollar amounts for covered services without regard to the cost of services rendered.

Your Dental plan benefits help pay for both preventive and corrective dental care. The Dental plan is easy to use and promotes good dental hygiene which can save you money. The plan benefits include:

- Visit any dentist - no network restrictions
- Preventive benefits pay a flat amount toward your visit every six months
- Preventive and basic benefits are available right away
- You can receive cash benefits directly, or assign the benefits to your dentist

Supplemental insurance plans, alone or in combination with other supplemental plans are not major medical coverage and are not Minimum Essential Coverage under Healthcare Reform Law.

We want you to be happy with your plan, so we provide you with a 30-day right to examine period. If you're not satisfied during that time, we'll return your premium.

Thank you for choosing Assurant Health. We appreciate your business. If you have any questions, please contact us at 1-866-387-0484 Monday through Friday from 7:30 a.m. to 5:30 p.m. CST.

Sincerely,

Assurant Health

IMPORTANT: These are your insurance ID Cards

ASSURANT Health

Robert McCleve
PO Box 1044
Missoula MT 59806

Dear Robert McCleve:

Thank you for choosing Dental Coverage from Assurant Health. Here are your new insurance identification cards. Remove them, fold and cut them at the center, and carry them with you. Please replace any old cards with these. To ensure proper claims handling, please show your card to your providers.

Thank you for your business. If you have questions about your new cards, please call Customer Service at the number on the back.

Effective: April 15, 2014

If you are viewing this information online, you'll receive your permanent insurance identification cards in the mail shortly.

ASSURANT Health **Dental ID Card**

Plan/Group Number: 0062090969

Robert McCleve Eff. Date 04/15/2014

Underwritten by Time Insurance Company

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Plan/Group Number: 0062090969

Robert McCleve Eff. Date 04/15/2014

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Plan/Group Number: 0062090969

Robert McCleve Eff. Date 04/15/2014

Underwritten by Time Insurance Company

Dental Coverage
This is a scheduled dental benefit plan that provides a set payment amount for covered services. Waiting Periods may apply.
Refer to your Policy and Policy Benefit Schedule for annual maximums and a list of covered benefits.

Claims Correspondence
Submit Electronic Claims to Payer ID ASHC1
or Mail / Fax claims or correspondence to:
Assurant Health, P.O. Box 2829, Clinton, IA 52733-2829
Fax: 1-608-373-9503

If you have questions about your coverage, please contact Customer Service at 1-866-387-0484

www.assuranthealth.com
THIS CARD IS NOT A GUARANTEE OF PAYMENT

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

POLICY SCHEDULE
DENTAL INDEMNITY INSURANCE
with Major Dental Services

Policy Number: 0062090969

Policyholder: Robert McCleve Effective Date: 04/15/2014

Policyholder Address: PO Box 1044
Missoula MT 59806

INITIAL ANNUAL PREMIUM: $382.56
PAYMENT OPTION: MONTHLY
INITIAL MONTHLY PREMIUM: $31.88

The benefits listed on this Policy Schedule are for each Covered Person unless otherwise indicated.

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

Dental Preventive Benefits:	
We will pay one Dental Preventive Benefit of $100, regardless of the number of visits to a Dentist or Dental Hygienist or the number of services received, every 150 calendar days. Dental Preventive Benefits are limited to a maximum benefit of $200 per Calendar Year.	
Procedure Code	**Dental Preventive Services**
00120	Periodic oral evaluation
00140	Limited oral evaluation - problem focused
00150	Comprehensive Oral Exam - new or established patient
00160	Detailed and extensive oral evaluation - problem focused, by report
00210	Intraoral - complete series (including bitewings)
00220	Intraoral - periapical first film
00230	Intraoral - periapical each additional film
00240	Intraoral - occlusal film
00250	Extraoral - first film
00260	Extraoral - each additional film
00270	Bitewing - single film
00272	Bitewings - two films
00274	Bitewings - four films
00330	Panoramic film
00340	Cephalometric film
00415	Bacteriologic studies for determination of pathologic agents
00460	Pulp vitality tests
00470	Diagnostic casts
00471	Diagnostic photographs
00501	Histopathologic Examinations
09310	Consultation (diagnostic service provided by Dentist or physician other than practitioner)
01110	Prophylaxis - adult
01120	Prophylaxis - child
01201	Topical application of fluoride (including prophylaxis) - child
01203	Topical application of fluoride (prophylaxis not included) - child
01204	Topical application of fluoride (prophylaxis not included) - adult
01205	Topical application of fluoride (including prophylaxis) - adult
01351	Sealant - per tooth
01510	Space maintainer - fixed - unilateral
01515	Space maintainer - fixed - bilateral
01520	Space maintainer - removable - unilateral
01525	Space maintainer - removable - bilateral
01550	Recementation of space maintainer

Basic Dental Services Benefits:		
Benefits for all covered Basic Dental Services rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of $1,500 per Covered Person.		
All benefits for covered Basic Dental Services are subject to the Basic and Major Services Combined Maximum Benefit Limitation shown on this Policy Schedule.		
The Scheduled Benefits shown below will be reduced by 50% for any covered procedure rendered during the first Policy Year following the Effective Date.		
Procedure Code	**Basic Dental Services**	**Scheduled Benefit**
09110	Palliative (emergency) treatment of dental pain - minor procedure	$70
09220	Deep sedation/general anesthesia - first 30 minutes	$275
09221	Deep sedation/general anesthesia - each additional 15 minutes	$100
02140	Amalgam - one surface - primary or permanent	$90
02150	Amalgam - two surfaces - primary or permanent	$110
02160	Amalgam - three surfaces - primary or permanent	$140
02161	Amalgam - four or more surfaces - primary or permanent	$160
02330	Resin-based composite - one surface, anterior	$110
02331	Resin-based composite - two surfaces, anterior	$140
02332	Resin-based composite - three surfaces, anterior	$160
02335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$190
02336	Resin-based composite crown (anterior-primary)	$190
02391	Resin-based composite - one surface, posterior - permanent or primary	$120
02392	Resin-based composite - two surfaces, posterior - permanent or primary	$150
02393	Resin-based composite - three surfaces, posterior - permanent or primary	$190
02394	Resin-based composite - four or more surfaces, posterior	$225
02410	Gold foil - one surface	$100
02420	Gold foil - two surfaces	$375
07111	Coronal recement - deciduous tooth	$80
07140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$100
05410	Adjust complete denture - maxillary	$55
05411	Adjust complete denture - mandibular	$55
05421	Adjust partial denture - maxillary	$55
05422	Adjust partial denture - mandibular	$55
05510	Repair broken complete denture base	$120
05520	Replace missing or broken teeth - complete denture (each tooth)	$100
05610	Repair resin denture base	$120
05620	Repair cast framework	$150
05630	Repair or replace broken clasp	$150
05640	Replace broken teeth - per tooth	$100
05650	Add tooth to existing partial denture	$120
05660	Add clasp to existing partial denture	$150
05670	Replace all teeth and acrylic on cast metal framework (maxillary)	$350
05671	Replace all teeth and acrylic on cast metal framework (mandibular)	$350
05710	Rebase complete maxillary denture	$350
05711	Rebase complete mandibular denture	$350
05720	Rebase maxillary partial denture	$350
05721	Rebase mandibular partial denture	$350
05730	Reline complete maxillary denture (chairside)	$200

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

Major Dental Services Benefits:		
Benefits for all covered Major Dental Services rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of $1,500 per Covered Person.		
All benefits for covered Major Dental Services are subject to the Basic and Major Services Combined Maximum Benefit Limitation shown on this Policy Schedule.		
Major Dental Services Benefit Waiting Period: Major Dental Services Benefits under this Policy are only payable for covered procedures rendered after 180 calendar days from the Effective Date.		
The Scheduled Benefits shown below will be reduced by 50% for any covered procedure rendered during the 180 calendar day period following the end of the Benefit Waiting Period.		
Procedure Code	**Major Dental Services**	**Scheduled Benefits**
02510	Inlay - metallic - one surface	$280
02520	Inlay - metallic - two surfaces	$330
02530	Inlay - metallic - three or more surfaces	$375
02543	Onlay - metallic - three surfaces	$375
02544	Onlay - metallic - four or more surfaces	$375
02610	Inlay - porcelain/ceramic - one surface	$350
02620	Inlay - porcelain/ceramic - two surfaces	$350
02630	Inlay - porcelain/ceramic - three or more surfaces	$375
02642	Onlay - porcelain/ceramic - two surfaces	$375
02643	Onlay - porcelain/ceramic - three surfaces	$375
02644	Onlay - porcelain/ceramic - four or more surfaces	$375
02650	Inlay - resin based composite - one surface	$225
02651	Inlay - resin based composite - two surfaces	$260
02662	Onlay - resin based composite - two surfaces	$240
02663	Onlay - resin based composite - three surfaces	$280
02910	Recement inlay	$40
02940	Sedative Filling	$40
02951	Pin retention - per tooth, in addition to restoration	$20
02710	Crown - resin laboratory	$190
02720	Crown - resin with high noble metal	$450
02721	Crown - resin with predominantly base metal	$450
02722	Crown - resin with noble metal	$450
02740	Crown - porcelain/ceramic substrate	$450
02750	Crown - porcelain fused to high noble metal	$450
02751	Crown - porcelain fused to predominantly base metal	$450

02752	Crown - porcelain fused to noble metal	$450
02780	Crown - 3/4 cast high noble metal	$450
02781	Crown - 3/4 cast predominantly base metal	$450
02782	Crown - 3/4 cast noble metal	$450
02790	Crown - porcelain	$450
02791	Crown - full cast predominantly base metal	$450
02792	Crown - full cast noble metal	$450
02810	Crown - 3/4 cast metallic	$450
02920	Recement crown	$40
02930	Prefabricated stainless steel crown - primary tooth	$110
02931	Prefabricated stainless steel crown - permanent tooth	$125
02932	Prefabricated resin crown	$140
02933	Prefabricated stainless steel crown with resin window	$150
02940	Sedative filling	$40
02950	Core buildup, including any pins	$100
02952	Cast post and core in addition to crown	$150
02954	Prefabricated post and core in addition to crown	$135
02970	Temporary crown (fractured tooth)	$95
03110	Pulp cap - direct (excluding final restoration)	$30
03120	Pulp cap - indirect (excluding final restoration)	$30
03220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medication	$70
03310	Anterior (excluding final restoration)	$225
03320	Bicuspid (excluding final restoration)	$300
03330	Molar (excluding final restoration)	$375
03346	Retreatment of previous root canal therapy - anterior	$225
03347	Retreatment of previous root canal therapy - bicuspid	$250
03348	Retreatment of previous root canal therapy - molar	$400
03410	Apicoectomy/periradicular surgery - anterior	$175
03421	Apicoectomy/periradicular surgery - bicuspid (first root)	$300
03425	Apicoectomy/periradicular surgery - molar (first root)	$350
03426	Apicoectomy/periradicular surgery - (each additional root)	$145
03430	Retrograde filling - per root	$105
03450	Root amputation - per root	$200
03920	Hemisection (including any root removal), not including root canal therapy	$150
00180	Comprehensive periodontal evaluation - new or established patient	$30
04210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	$165
04211	Gingivectomy or gingivoplasty - one to three teeth per quadrant	$65
04240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	$275
04249	Clinical crown lengthening - hard tissue	$300
04260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	$325

04261	Osseous surgery (including flap entry and closure) - one to three teeth per quadrant	$200
04263	Bone replacement graft - first site in quadrant	$150
04264	Bone replacement graft - each additional site in quadrant	$75
04270	Pedicle soft tissue graft procedure	$300
04271	Free soft tissue graft procedure (including donor site surgery)	$300
04341	Periodontal scaling and root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	$95
04355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$65
04910	Periodontal maintenance	$60
05110	Complete denture - maxillary	$375
05120	Complete denture - mandibular	$375
05130	Immediate denture - maxillary	$400
05140	Immediate denture - mandibular	$400
05211	Maxillary partial denture - resin base (including any conventional clasps, rests, and teeth)	$375
05212	Mandibular partial denture - resin base (including any conventional clasps, rests, and teeth)	$375
05213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)	$400
05214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)	$400
05281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	$275
06210	Pontic - cast high noble metal	$375
06211	Pontic - cast predominantly base metal	$375
06212	Pontic - cast noble metal	$375
06240	Pontic - porcelain fused to high noble metal	$375
06241	Pontic - porcelain fused to predominantly base metal	$375
06242	Pontic - porcelain fused to noble metal	$375
06250	Pontic - resin with high noble metal	$375
06251	Pontic - resin with predominantly base metal	$375
06252	Pontic - with noble metal	$375
06545	Retainer - cast metal for resin bonded fixed prosthesis	$175
06602	Inlay - cast high noble metal, two surfaces	$375
06603	Inlay - cast high noble metal, three or more surfaces	$375
06604	Inlay - cast predominantly base metal, two surfaces	$375
06605	Inlay - cast predominantly base metal, three or more surfaces	$375
06606	Inlay - cast noble metal, two surfaces	$375
06607	Inlay - cast noble metal, three or more surfaces	$375
06610	Onlay - cast high noble metal, two surfaces	$375
06611	Onlay - cast high noble metal, three or more surfaces	$375
06612	Onlay - cast predominantly base metal, two surfaces	$375
06613	Onlay - cast predominantly base metal, three or more surfaces	$375
06614	Onlay - cast noble metal, two surfaces	$375
06615	Onlay - cast noble metal, three or more surfaces	$375
06720	Crown - resin with high noble metal	$375
06721	Crown - resin with predominantly base metal	$375
06722	Crown - resin with noble metal	$375
06740	Crown - porcelain/ceramic	$375

06750	Crown - porcelain fused to high noble metal	$375
06751	Crown - porcelain fused to predominantly base metal	$375
06752	Crown - porcelain fused to noble metal	$375
06780	Crown - 3/4 cast high noble metal	$375
06781	Crown - 3/4 cast predominantly base metal	$375
06782	Crown - 3/4 cast noble metal	$375
06783	Crown - 3/4 cast porcelain/ceramic	$375
06790	Crown - full cast high noble metal	$375
06791	Crown - full cast predominantly base metal	$375
06792	Crown - full cast noble metal	$375
07210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$95
07220	Removal of impacted tooth - soft tissue	$120
07230	Removal of impacted tooth - partially bony	$160
07240	Removal of impacted tooth - completely bony	$185
07241	Removal of impacted tooth - completely bony, with unusual surgical complications	$200
07250	Surgical removal of residual tooth roots (cutting procedure)	$100
07260	Oroantral fistula closure	$800
07270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$200
07280	Surgical access of unerupted tooth	$200
07281	Surgical exposure of impacted or unerupted tooth to aid eruption	$165
07285	Biopsy of oral tissue - hard (bone, tooth)	$325
07286	Biopsy of oral tissue - soft (all others)	$165
07310	Alveoloplasty in conjunction with extractions - per quadrant	$110
07320	Alveoloplasty not in conjunction with extractions - per quadrant	$400
07340	Vestibuloplasty - ridge extension (secondary epithelialization)	$750
07350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachments and management of hypertrophied tissue)	$1000
07410	Excision of benign lesion up to 1.25 cm	$165
07411	Excision of benign lesion greater than 1.25 cm	$500
07413	Excision of malignant lesion up to 1.25 cm	$165
07414	Excision of malignant lesion greater than 1.25 cm	$550
07450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$165
07451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$500
07460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	$325
07461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$500
07471	Removal of lateral exostosis (maxilla or mandible)	$325
07510	Incision and drainage of abscess - intraoral soft tissue	$100
07520	Incision and drainage of abscess - extraoral soft tissue	$450
07530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	$165

07540	Removal of reaction producing foreign bodies, musculoskeletal system	$200
07550	Partial ostectomy/sequestrectomy for removal of non-vital bone	$125
07560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$825
07960	Frenulectomy (frenectomy or frenotomy) - separate procedure	$200
07970	Excision of hyperplastic tissue - per arch	$200
07971	Excision of pericoronal gingival	$75
07972	Surgical reduction of fibrous tuberosity	$250
07980	Sialodochoplasty	$275

AGENT INFORMATION

NAME
ASSURANT HEALTH DIRECT SALES

ADDRESS & TELEPHONE NUMBER
501 W Michigan
Milwaukee WI 53201
(800)360-4671

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

DENTAL INDEMNITY INSURANCE POLICY
with Major Dental Services

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

The insurance described in this Policy is effective on the date shown in the Policy Schedule only if You are eligible for the insurance, become insured, and remain insured subject to the terms, limits and conditions of this plan. This Policy is evidence of Your coverage. This Policy is issued and delivered in the State of Montana.

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

RIGHT TO EXAMINE POLICY FOR 30 DAYS

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

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

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

Secretary

President

We may change premium for this Policy if We change premiums for all policies within the same class.

This Policy automatically renews except for as stated in the
Effective Date and Termination Date section.
Read Your Policy carefully to understand coverage limitations and termination provisions.
This Policy contains a Benefit Waiting Period for Major Dental Services Benefits.

GUIDE TO YOUR COVERAGE

The sections of the Policy appear in the following order:

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

I. Definitions

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

Accident or Accidental
Any event that meets all of the following requirements:

1. it causes harm to the physical structure of the body.

2. it results from an external agent or trauma.

3. it is the direct cause of a loss, independent of disease, dental infirmity or any other cause.

4. it is definite as to time and place.

5. it happens involuntarily, or entails unforeseen consequences if it is the result of an intentional act.

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

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

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

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

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

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

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

1. is appropriate and consistent with the diagnosis and does not exceed in scope, duration or intensity that level of care that is needed to provide safe, adequate and appropriate diagnosis and treatment of the dental condition; and

2. is commonly accepted as proper care or treatment of the condition in accordance with United States dental standards and federal government guidelines; and

3. can reasonably be expected to result in or contribute substantially to the improvements of a condition; and

4. is provided in the most conservative manner or in the least intensive setting without adversely affecting the condition or the quality of dental care provided.

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

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

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

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

Dependent
A Dependent is:

1. the Policyholder's lawful spouse; or

2. the Policyholder's naturally born child, legally adopted child, a child that is placed for adoption with the Policyholder, a stepchild or a child for whom the Policyholder is the legal guardian:

    a. who is unmarried; and
    b. who is under 25 years of age; and
    c. who is not an employee eligible for coverage under a group health plan offered by the child's employer for which the child's premium contribution amount is no greater than the premium amount for coverage as a dependent under this plan; and
    d. who is not a named subscriber, insured, enrollee, or covered individual under any other individual health insurance coverage, group health plan, government plan, church plan, or group health insurance; and
    e. who is not entitled to benefits under 42 U.S.C. 1395, et seq (Medicare); and
    f. for whom the covered parent has requested coverage

If Your unmarried child is age 25 or older, the child will be considered a Dependent if You give Us proof that:

1. the child is a full-time student at an accredited educational institution, college or university. A student will be considered full-time if the student meets the standards for full-time status at the school the student is attending. A student will be considered full-time during regular vacation periods that interrupt, but do not terminate, the continuous full-time course of study; or

2. the child is not capable of self-sustaining employment by reason if mental retardation or physical disability. The child must also be chiefly dependent on the Policyholder for support and maintenance. You must give Us proof that the child meets these requirements at the same time that You first enroll for coverage under this plan or within 31 days after the child reaches the normal age for termination. Additional proof may be requested periodically but not more often than annually after the 2-year period following the date the child reaches the normal age for termination.

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

1. is no longer a full-time student; or

2. ceases to be claimed as an exemption on the Policyholder's federal income tax return, except for a Dependent child who is a full-time student; or

3. attains age 25; or

4. marries; or

5. is age 25 or older and is capable of self-sustaining employment because he or she no longer has mental retardation or a physical disability.

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

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

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

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

1. not proven to be of benefit for diagnosis or treatment of the dental condition; or

2. not generally used or recognized by the medical or dental community as safe, effective and appropriate for diagnosis or treatment; or

3. in the research or investigational stage, provided or performed in a special setting for research purposes or under a controlled environment or clinical protocol; or

4. obsolete or ineffective for the treatment; or

5. medications used for non-FDA approved indications and/or dosage regimens.

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

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

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

Immediate Family Member
An Immediate Family Member is:

1. You or Your spouse; or

2. the children, brothers, sisters and parents of either You or Your spouse; or

3. the spouses of the children, brothers and sisters of You and Your spouse; or

4. anyone with whom a Policyholder has a relationship based on a legal guardianship.

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

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

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

Policyholder
The person listed on the Policy Schedule as the Policyholder.

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

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

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

We, Us, Our, Our Company
Time Insurance Company or its administrator.

You, Your, Yours
The person listed on the Policy Schedule as the Policyholder.

II. Dental Indemnity Insurance Benefits

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

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

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

Benefits are available from the first day Covered Charges are incurred for a Dental Injury that is sustained on or after the Covered Person's Effective Date.

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

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

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

Major Dental Services Benefits
We will pay the Scheduled Benefit for Major Dental Services as shown on the Policy Schedule. Major Dental Services Benefits under this Policy are only payable for covered procedures rendered after 180 calendar days from the Effective Date. The Scheduled Benefits shown on the Policy Schedule will be reduced by 50% for any covered procedure rendered during the 180 calendar day period following the end of the Benefit Waiting Period. Thereafter the full Scheduled Benefit will be paid for covered Major Dental Services. All benefits for Major Dental Services rendered during the same Calendar Year are subject to the maximum Calendar Year benefit for Major Dental Services shown on the Policy Schedule. All benefits for covered Major Dental Services are subject to the Basic and Major Services Combined Maximum Benefit Limitation shown on the Policy Schedule.

III. Exclusions and Limitations

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

Exclusions
We will not pay benefits for any of the following:

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

f. voluntary use of any controlled substance, as defined by statute, except when administered in accordance with the advice of the Covered Person's health care practitioner.
g. riding in any aircraft not licensed to carry passengers or not operated by a duly licensed pilot.
h. charges for treatment or services required due to an Injury sustained in operating a motor vehicle while the Covered Person's blood alcohol level, as defined by law, was .08 or higher. This exclusion applies whether or not the Covered Person is charged with any violation in connection with the Accident.

20. procedures rendered before the Effective Date or after the termination date of coverage.

21. orthodontic treatment and services.

IV. Claim Provisions

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

We must receive written or electronic notice of the services that were received for which the claim is made. Notice must be provided to Us within 6 months after a covered loss occurs or as soon as reasonably possible. Except in the absence of legal capacity, written or electronic proof of loss must be sent to Us within 12 months of the date of loss.

The proof of loss must include all of the following:

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

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

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

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

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

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

Payment of Benefits
Benefits will be paid within 30 days when We receive acceptable due written or electronic proof of loss, subject to any time period requirements under state law. Benefits for services provided will be paid to the Policyholder unless they have been assigned to a provider. Any benefits unpaid at Your death will be

paid at Our option to Your spouse, Your estate or the providers of the services.

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

Benefits will be paid in accordance with the Dental Indemnity Insurance Benefits section. Payment by Us does not constitute any assumption of liability for further coverage under this plan.

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

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

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

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

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

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

V. Premium Provisions

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

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

Your premium may be adjusted no more frequently than once during a 12 month period based on different factors including, but not limited to, Your geographic area, payment method and plan design. All premium adjustments will be made to individuals on the basis of shared characteristics. The premium may also change if You add or delete Covered Dependents, change the payment method, otherwise change the coverage or necessitated by a state or federal law, court decision, or rule adopted by an agency of competent jurisdiction of the state or federal government. The mode of payment (monthly, quarterly or other) is subject to change.

Notice of a premium adjustment will be provided at least 45 days in advance. If the requisite notice is not provided, the plan will remain in effect at the existing premium until the full notice period has expired or until the effective date of your replacement plan, whichever occurs first.

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

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

1. the lapse was not more than 180 days.

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

3. We approve Your application/enrollment form for reinstatement.

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

Sickness or conditions diagnosed between the lapse date and the tenth day following the date of reinstatement.

In all other respects, You and Our Company will have the same rights as existed under this plan before the coverage lapsed, subject to any plan provisions.

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

1. the Covered Dependent's insurance terminates due to a valid decree of divorce, annulment of marriage or legal separation, between the Policyholder and the Covered Dependent; or

2. the Covered Dependent's insurance terminates due to the death of the Policyholder; or

3. a Covered Dependent child's insurance terminates because the child no longer meets the eligibility requirements for a Dependent.

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

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

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

VI. Effective Date and Termination Date

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

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

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

1. **Adding a Newborn Child:** You must call Our office or send Us written notice of the birth of the child and We must receive any required additional premium within 60 days of birth. The Effective Date of coverage will be 12:01 a.m. local time at the Policyholder's state of residence on the date the child is born. If these requirements are not met, Your newborn child will be covered only for the first 31 days from birth.

2. **Adding an Adopted Child or Child Placed for Adoption:** A newly adopted child can be added on the date the child is placed with the Policyholder in anticipation of legal adoption and the Policyholder assumes a legal obligation for support of the child. You must call Our office or send Us written notice of the placement for adoption of the child and We must receive any required additional premium within 60 days of the placement for adoption. The Effective Date of coverage will be 12:01 a.m. local time at the Policyholder's state of residence on the date the child is placed for adoption. If these requirements are not met, Your newly adopted child will be covered for only for the first 31 days from the earlier of adoption or placement for adoption. A child is no longer considered adopted if, prior to legal adoption, You relinquish legal obligation for support of the child and the child is removed from placement.

3. **Adding Any Other Dependent:** To add any other Dependent, an application/enrollment form must be completed and sent to Us along with any required premium. Evidence of insurability must also be provided. The Effective Date of coverage will be 12:01 a.m. local time in the state of issuance on the Effective Date approved by Us.

Termination Date of Coverage
The Policyholder may cancel this coverage at any time by sending Us written notice or calling Our office. Upon cancellation, We will return the unearned portion of any premium paid, in accordance with the laws in the Policyholder's state of residence.

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

1. the date We receive a request in writing or by telephone to terminate this plan or on a later date that is requested by the Policyholder for termination.

2. the date We receive a request in writing or by telephone to terminate coverage for a Covered Dependent or on a later date that is requested by the Policyholder for termination of a Covered Dependent.

3. the date this plan lapses for nonpayment of premium per the Grace Period provision in the Premium Provisions section.

4. the date there is fraud or material misrepresentation made by or with the knowledge of any Covered Person applying for this coverage or filing a claim for benefits.

5. the date all policies with the same form number as this Policy are non-renewed in the state in which this Policy was issued or the state in which the Policyholder presently resides.

6. the date We terminate or non-renew dental insurance coverage in the individual market in the state in which this Policy was issued or the state in which You presently reside. We will give You advance notice, as required by state law, of the termination of Your coverage.

7. for a Covered Dependent: on the date a Covered Dependent no longer meets the Dependent definition in this plan.

Written notice will be provided at least 30 days in advance of cancellation for nonpayment of premium or 90 days in advance of cancellation for any other reason other than nonpayment of premium or fraud or material misrepresentation in the application.

VII. Other Provisions

Assignment
A Covered Person's right to benefits under this Policy is assignable. A signed copy of the assignment must be sent to Our Home Office in a form acceptable to Us. The assignment is subject to any payment made or other action taken before We receive the assignment.

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

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

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

Conformity with Montana Statutes
The provisions of this plan conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of this plan.

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

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

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

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

Incontestability and Time Limit on Certain Defenses

After two years from the Effective Date of this Policy no misstatements, except fraudulent misstatements, made by the Covered Person in the enrollment form will be used to void the Policy or deny a claim. We also reserve the right to rescind a Policy of insurance and/or deny a claim for a fraudulent misstatement or omission at any time during the coverage period.

Legal Action and Forum

No suit or action at law or in equity may be brought to recover benefits under this plan until the exhaustion of administrative remedies. You agree that You will not file a suit or legal action against Us for any breach of this agreement or denial of benefits without first submitting the dispute through Our claims review process. No suit or action at law or in equity can be brought later than 3 years from the date loss is incurred.

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

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

Notice of privacy practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.
(effective date April 14, 2003)
Assurant Health is required by law to maintain the privacy of protected health information and to provide individuals with this notice of our legal duties and privacy practices. Assurant Health is required to abide by the terms of the Notice.

Who we are

In business since 1892, Assurant Health provides health insurance coverage nationwide to individuals, families and small businesses. Assurant Health develops and provides a wide range of individual medical, small group, short term and student health insurance products, as well as non-insurance products. Assurant Health also provides consumer choice products such as Health Savings Accounts and Health Reimbursement Arrangements. Assurant Health is headquartered in Milwaukee, Wis., with operations offices in Minnesota, Idaho and Florida, as well as sales offices across the country. Assurant Health is the brand name for products underwritten and issued by Time Insurance Company. The Assurant Health website is **www.assuranthealth.com**. Assurant Health is part of Assurant, which offers specialized insurance products and related services in North America and selected other markets.

Information we collect

To serve your health insurance needs, Assurant Health collects information about you. We may collect this information directly from you orally or on applications or other forms. We also collect information from third parties such as your agent or broker, your current or former health care providers and consumer reporting agencies. In addition, this information may include your transactions with Assurant Health, its affiliates and others. It is impossible to describe every type of information that we collect, but here are some examples: your name, age, address, Social Security number, telephone number, occupation and other demographic information about you and your family; whether you are a past or present customer with us, or if you ever applied for an insurance product or service from us, as well as your history of other insurance coverage and applications (if you apply online, information is collected through an Internet "cookie," an information-collecting device from a web server); your past, present or future physical, mental or behavioral health or condition; your health care history; your history of insurance coverage, premiums, claims and payments through Assurant Health; information from consumer reporting agencies and data collection agencies.

How Assurant Health may use and disclose information about you

We use and disclose information about you in serving your health insurance needs. It is impossible to describe every type of information that we use or disclose but we have provided some examples of how we use this information to provide services to you and your dependents. Other types of use or disclosure of your protected health information that are not categorized in this notice including uses and disclosures of psychotherapy notes, uses and disclosures of protected health information for marketing purposes, and disclosures that constitute a sale of protected health information may only be made with your written authorization, which you may revoke at any time by writing us at the address identified on the authorization.

Treatment: Your health care provider may ask us to use or disclose protected health information in

connection with treatment, including the provision, coordination, or management of health care and related services.

Payment: We may use and disclose protected health information for payment purposes, including billing, review of health care services, determining whether a service is "medically necessary" and for utilization review. For instance, a doctor or health facility involved in your care may forward a claim to us with your protected health information. Assurant Health must have this health information to process your claims.

Health care operations: Assurant Health may use and disclose protected health information as part of our health care operations. For example, we may use and disclose information in the underwriting process, renewal process, quality assessment activities or accreditation and certification. We are prohibited from using or disclosing your protected health information that is genetic information for underwriting purposes.

Plan sponsors: If you are enrolled in a group health plan, Assurant Health may provide protected health information to the plan sponsor. For instance, we may share enrollment or disenrollment information with your employer.

Health-related benefits and services: We may, from time to time, contact you about treatment alternatives or other health-related benefits, products or services that may be of interest to you, and for case management or care coordination.

Business associates: Assurant Health works with companies and consultants who perform a wide variety of functions on our behalf. For example, we work with financial institutions such as agents, brokers, insurance distributors, reinsurers and excess loss insurers, non-financial institutions such as health care providers, detectors of fraud, auditors, insurance support organizations, claims handlers, underwriters, and others such as information technology specialists and consultants. At times it may be necessary for us to provide your protected health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to provide written assurances to us that they will appropriately safeguard the privacy of your protected health information.

Individuals involved in your care or payment: We may use or disclose protected health information to you or other family members who are covered under your health insurance policy regarding your care or payment related to your care. If you object to our use or disclosure of your protected health information in communications with other family members covered under your health insurance policy, please contact our customer service department and ask for the Right to Restrictions form, or visit our website at www.assuranthealth.com. This request must be made in writing and signed by you or your legally authorized representative.

Permitted or required by law: Assurant Health may release information when requested by law enforcement officials or when permitted or required by law. If you are involved in a lawsuit or dispute, Assurant Health may need to disclose protected health information in response to a court or administrative order.

More stringent laws: Assurant Health offers health coverage in many states across the nation. In some cases we may be required to follow the state law provisions on use and disclosure of your protected health information, which may be more stringent than those outlined in this notice. Assurant Health has established safeguards to ensure the security and confidentiality of information about you. These safeguards include protection against any anticipated threats or hazards to the security or integrity of the information, as well as protection against the unauthorized access to or use of this information. We restrict access to your information to those employees "who need to know that information" to provide products or services to you or on your behalf. You have the following rights regarding protected health information we maintain about you:

Right to access: You have the right to request to access, inspect or copy your protected health information in a designated record set. A designated record set could include information related to enrollment, premium payment, claims adjudication and medical management.

Right to amend: If you feel that the information we have about you is incorrect, you may ask to have protected health information in a designated record set amended. You have the right to request an amendment as long as the information is kept and created by Assurant Health.

Right to an accounting of disclosures: You have the right to receive an accounting of disclosures of your protected health information made by us in the preceding six years from the date of your request. The accounting will not include disclosures made for purposes of treatment, payment or health care operations, disclosures permitted or required by law, or disclosures to you or to third parties to whom you have authorized disclosure.

Right to request restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. We are not required to agree to a requested restriction.

Right to confidential communications: If you feel that your life may be in danger if Assurant Health contacts you at the address or phone number maintained in our records, you may request that we contact you in a different way or at a different location.

Right to be notified of a breach: You will be notified in the event that your unsecured protected health information is compromised.

If you would like to request to access or amend your personal health information, to request restrictions on use or disclosure, to request confidential communications, or to request an accounting of disclosures, please visit our website at www.assuranthealth.com or contact our Customer Service Department at the number listed below and ask for the appropriate form. Each form must be signed by you or your legally authorized representative. Each of the forms provides additional information relating to your rights.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with Assurant Health or with the Secretary of the Department of Health and Human Services. All complaints must be in writing. You will not be retaliated against for filing a complaint.

Changes to this notice

We reserve the right to make changes to this notice and to make the revised or changed notice effective for protected health information we already have about you as well as any information we receive or create in the future. Any changes to this notice will be posted on our website, and if we make substantial material changes to the notice, we will distribute the revised notice to you or your plan sponsor via mail. You may view a copy of this notice at any time at our website www.assuranthealth.com or you may receive another copy of the notice, or receive further information about this notice, by calling our Customer Service Department. For Time Insurance Company and Union Security Insurance Company, call 866.387.3405. For John Alden Life Insurance Company, call 800.327.0485.

Women's Health and Cancer Rights Act notice

Effective October 21, 1998, the federal Women's Health and Cancer Rights Act requires all health insurance plans that provide coverage for a mastectomy must also provide coverage for the following medical care: reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications at all stages of the mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. Covered benefits are subject to all provisions described in your plan, including but not limited to deductible, copayment, rate of payment, exclusions and limitations.

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

NOTICE OF
PROTECTION PROVIDED BY
MONTANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the Montana Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Montana law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Montana law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits
  - $300,000 in disability income insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection is $300,000 in benefits with respect to any one life regardless of the number of policies or contracts, except with respect to hospital, medical, and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Montana law.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's web site at www.mtlifega.org or contact:

Montana Life and Health Insurance Guaranty Association
PO Box 951
Oconomowoc, WI 53066-0951
877-678-1048 or
administrator@mtlifega.org

Montana Department of Insurance
State Auditor's Office
840 Helena Ave.
Helena, MT 59601
406-444-2040

Insurance companies and agents are not allowed by Montana law to use the existence of the Association

or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage.

If there is any inconsistency between this notice and Montana law, then Montana law will control.

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

DENTAL INDEMNITY INSURANCE
with Major Dental Services
OUTLINE OF COVERAGE FOR
POLICY FORM 8079.POL.MAJ.MT

THE POLICY PROVIDES LIMITED BENEFITS

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

THIS IS NOT A MEDICARE SUPPLEMENT POLICY

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

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

DENTAL COVERAGE INFORMATION

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

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

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

Major Dental Services Benefits: We will pay the Scheduled Benefit for Major Dental Services as shown on the Policy Schedule. Major Dental Services Benefits under this Policy are only payable for covered procedures rendered after 180 calendar days from the Effective Date. The Scheduled Benefits shown on the Policy Schedule will be reduced by 50% for any covered procedure rendered during the 180 calendar day period following the end of the Benefit Waiting Period. Thereafter the full Scheduled Benefit will be paid for covered Major Dental Services. All benefits for Major Dental Services rendered during the same Calendar Year are subject to a maximum Calendar Year benefit limitation of 1500.0. All benefits for covered Major Dental Services are subject to the Basic and Major Services Combined Maximum Benefit.

EXCLUSIONS AND LIMITATIONS:

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

We will not pay benefits for any of the following:

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

while the Covered Person's blood alcohol level, as defined by law, was .08 or higher. This exclusion applies whether or not the Covered Person is charged with any violation in connection with the Accident.

20. procedures rendered before the Effective Date or after the termination date of coverage.

21. orthodontic treatment and services.

RENEWABILITY PROVISION: The policy is guaranteed renewable until 12:01 a.m. local time at the Policyholder's state of residence on the earliest of the following dates:

1. the date We receive a request in writing or by telephone to terminate this plan or on a later date that is requested by the Policyholder for termination.

2. the date We receive a request in writing or by telephone to terminate coverage for a Covered Dependent or on a later date that is requested by the Policyholder for termination of a Covered Dependent.

3. the date this plan lapses for nonpayment of premium per the Grace Period provision in the Premium Provisions section.

4. the date there is fraud or material misrepresentation made by or with the knowledge of any Covered Person applying for this coverage or filing a claim for benefits.

5. the date all policies with the same form mumber as this Policy are non-renewed in the state in which this Policy was issued or the state in which the Policyholder presently resides.

6. the date We terminate or non-renew dental insurance coverage in the individual market in the state in which this Policy was issued or the state in which You presently reside. We will give You advance notice, as required by state law, of the termination of Your coverage.

7. for a Covered Dependent: on the date a Covered Dependent no longer meets the Dependent definition in this plan.

Written notice will be provided at least 30 days in advance of cancellation for nonpayment of premium or 90 days in advance of cancellation for any other reason other than nonpayment of premium or fraud or material misrepresentation in the application.

PREMIUM INFORMATION	
Premium Payment Mode: MONTHLY	
INITIAL MODAL PREMIUM AMOUNT:	$31.88
INITIAL ANNUAL PREMIUM AMOUNT:	$382.56

Your premium may be adjusted no more frequently than once during a 12 month period based on different factors including, but not limited to, Your geographic area, payment method and plan design. All premium adjustments will be made to individuals on the basis of shared characteristics. The premium may also change if You add or delete Covered Dependents, change the payment method, otherwise change the coverage or necessitated by a state or federal law, court decision or rule adopted by an agency of competent jurisdiction of the state or federal government.

Notice of a premium adjustment will be provided at least 45 days in advance. If the requisite notice is not provided, the plan will remain in effect at the existing premium until the full notice period has expired or until the effective date of your replacement plan, whichever occurs first.

Licensed Agent's Signature

Date