

PHYSICIANS MUTUAL INSURANCE COMPANY

2600 DODGE • OMAHA, NEBRASKA 68131

(called "We", "Us", "Our", or "the Company")

INDIVIDUAL DENTAL POLICY

This Policy IS NOT A MEDICARE SUPPLEMENT POLICY. It is not designed to fit with Medicare. It may not fit all gaps in Medicare and may duplicate some Medicare benefits. If you are eligible for Medicare, review the Guide to Health Insurance for People on Medicare available from Us. If you decide to consider buying this Policy, be sure You understand what it covers, what it does not cover, and whether it duplicates coverage You already have.

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CONSIDERATION

This Policy is issued in consideration of the first premium paid. It is issued to the Insured shown in the Schedule ("You", "Your", or "Insured.")

IMPORTANT NOTICE

RIGHT TO RETURN: You have 31 days to examine the Policy. If You return it within 31 days after You receive it, We will return Your money. Then, it is void as if no Policy had been issued. You may cancel Your Policy after 31 days of receiving it by giving Us written notice effective the date We receive such notice or on the date You specify if later. We will then refund the excess of premium paid above the pro rata premium for the expired time. Cancellation will be without prejudice to any claim originating prior to the effective date of cancellation.

ENTIRE CONTRACT

This Policy is between Physicians Mutual Insurance Company and the Insured shown in the Schedule. The entire contract is the Policy, the Application, the Schedule and any Riders signed by a Company Officer. No change in this Policy will be effective until approved by a Company Officer. This approval must be noted on or attached to this Policy. No Agent can change any of its terms.

RENEWAL AGREEMENT

This Policy is renewable or will continue in force, at Your option unless:

1. Your Renewal Premium is not received before the Grace Period ends;
2. We refuse to renew all Policies of this form in Your state of residence; or
3. After the Policy Effective Date, You perform an act or practice that constitutes fraud or make an intentional misrepresentation of material fact under the terms of this Policy.

No refusal of renewal will affect an existing claim, except for item (3) above.

PREMIUM AND BENEFIT CHANGES

PREMIUM CHANGES: We may change Your renewal premium for this Policy or attached Riders, but only if the same change is made by Us on all Policies of this form and class in the state where You live. In addition, We can change Your renewal premium if You request a change in Your Policy benefits or Riders or there is a change in dependent status. Your Renewal premium will change with the first modal payment due on or after the premium change is effective.

GRACE PERIOD: You have 31 days after the due date to pay each Renewal premium. The Policy stays in effect during this Grace Period. If We do not receive Your Renewal premium before the Grace Period ends, Your coverage stops at the end of the Grace Period. This is a Lapse and Your Policy is no longer in force. A Grace Period does not apply if You cancel Your Policy.

REINSTATEMENT: Once Your Policy lapses We may or may not put it back in force (reinstate) at Our option. If We accept a late premium and do not require an Application, Your Policy is reinstated. If We require an Application, Your Policy is reinstated when We approve the Application, or (unless We have already disapproved it in writing) on the 45th day after We receive the Application, whichever is earlier. No coverage is in effect during the period of Lapse.

The reinstated Policy will cover only loss resulting from an Injury that occurs after the date of Reinstatement and loss resulting from Sickness that begins more than ten (10) days after the date of Reinstatement. In all other respects, the Policy remains the same except for any provisions noted on or attached to the reinstated Policy.

BENEFIT CHANGES: We can change the coverage provided by this Policy without the consent of You or any other person beneficially interested but only if the same change is made on all Policies of this form and class in the state where You live. Such changes may include, but are not limited to, Covered Expenses, Policy Year Maximum, [Coinsurance], [Lifetime Maximum Benefit for Implants and Implant Services], Deductible and Waiting Periods. Your coverage will change with the first modal payment due on or after the coverage change is effective.

COVERED PERSONS

YOU: If shown as the Insured in the Schedule. If You die, Your Spouse, if covered, becomes the Insured.

SPOUSE: If shown in the Schedule. Spouse coverage stops upon divorce or annulment. Any premium paid for Spouse coverage after the effective date of a divorce or annulment will be refunded.

CHILDREN: If shown in the Schedule. Children must be unmarried and under the age of nineteen (19). Coverage will remain in effect after age nineteen (19) while a child is incapable of self-support due to a mental retardation or physical handicap and notice of the handicap is received by Us within thirty-one (31) days of the child's attainment of the limiting age. When a child marries or becomes nineteen (19) coverage stops when the current premium period ends. An unmarried full-time student may remain covered under this Policy until age twenty-three (23), provided he or she is in an accredited technical or vocational school or college and dependent on You or Your Spouse for his or her financial support.

The Insured's Children include any natural, step, or legally adopted Children. Included is a child in the custody of the Insured under court order vesting temporary care to the Insured, regardless of whether a final order granting adoption is ultimately issued.

NEWBORN AND ADOPTED CHILDREN: A child of You or Your Spouse born after the Policy Effective Date is covered automatically from birth. An adopted child is also automatically covered from the date custody of the child is granted to You or Your Spouse. If Children's coverage is not shown in the Schedule, coverage for newborn and newly adopted children will stop after sixty (60) days unless You have requested Children's coverage and paid any needed premium.

DEFINITIONS

INJURY: Means bodily injury caused by an accident independent of disease or bodily infirmity or any other causes. Such accident must occur while this Policy is in force for the Covered Person.

PROVIDER: Any person who is licensed by the law of the state in which treatment is provided within the scope of the license, is not living with the Covered Person, and is not related to the Covered Person by blood or marriage.

SICKNESS: Means a disease, disorder, illness, or physical condition which first manifests itself after the Policy Effective Date and while the Policy is in force for the Covered Person.

BENEFIT PROVISIONS

We will determine dental benefits according to the terms of the Policy. An Insured person has the freedom of choice to receive treatment from any Provider.

[**COINSURANCE:** Shared responsibility between the Covered Person and Us. The percentage We will pay toward Covered Expenses for services is shown on the Schedule.]

DEDUCTIBLE AMOUNT: The Deductible Amount, if any, is shown in the Schedule. This is an amount of Covered Expenses for which no benefits are payable each Policy Year. It applies separately to the Covered Expenses incurred by each Covered Person. Benefits will only be paid for Covered Expenses once the Deductible Amount has been met.

DETERMINING BENEFITS: The benefits payable will be determined by totaling all of the Covered Expenses for a Covered Person for each coverage type as shown on the Schedule. This amount is reduced by the Deductible, if any. [The result is then multiplied by any applicable Coinsurance Percentage(s) shown in the Schedule.] Benefits are also subject to any maximum benefit shown in the Schedule.

COVERED EXPENSE(S): Covered Expenses include only those Expenses Incurred for the following:

1. Dental procedures performed by a Provider.
2. Dental procedures listed on the Schedule.
3. Dental procedures incurred at the end of the Waiting Periods shown in the Schedule.
4. Dental procedures not specifically excluded or otherwise limited by the provisions of this Policy.

Covered Expenses are subject to Limitations. See the Limitations and Schedule.

For services at Participating Providers, benefits payable for Covered Expenses will be based on the lesser of any of the following.

1. The actual charge of the Provider; or
2. The Maximum Covered Expense, if any, shown for each procedure on the Schedule or any attached rider; or
3. The Maximum Allowable Charge.

For services at Non-Participating Providers, benefits payable for Covered Expenses will be based on the lesser

of any of the following.

1. The actual charge of the Provider; or
2. The Maximum Covered Expense, if any, shown for each procedure on the Schedule or any attached rider; or
3. The Maximum Allowable Charge for those services that do not have a Maximum Covered Expense shown in the Schedule.

MAXIMUM ALLOWABLE CHARGE: The Maximum Allowable Charge is the charge accepted by dentists who are Participating Providers. It is reviewed and updated periodically to reflect increasing Provider fees.

MAXIMUM COVERED EXPENSE: The Maximum Covered Expense is a scheduled dollar amount per procedure as shown in the Schedule.

ALTERNATIVE PROCEDURES: If two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care then the amount of the Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. This provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate alternative procedure is available. You may choose to apply the alternate benefit amount determined under this provision toward payment of the received treatment.

We may request existing dental X-rays or any other existing diagnostic aids for the purpose of determining benefits payable under the Policy.

EXPENSES INCURRED: Amounts due for services provided. An expense is incurred at the time the impression is made for an appliance or change to an appliance. An expense is incurred at the time the tooth or teeth are prepared for a prosthetic crown, appliance, or fixed partial denture. For root canal therapy, an expense is incurred at the time the pulp chamber is opened. All other expenses are incurred at the time the service is rendered or a supply furnished.

[LIFETIME MAXIMUM BENEFIT FOR IMPLANTS AND IMPLANT SERVICES: The total maximum amount we will pay for Implants and Implant Services as categorized on the Schedule. This maximum benefit is shown on the Schedule and applies over the lifetime of the Policy.]

PARTICIPATING AND NON-PARTICIPATING PROVIDERS: A Participating Provider is a Provider who has entered into an agreement to provide services to Insureds at a specific fee. A Participating Provider is also referred to as a "Network Provider". The terms and conditions of the agreement with Our Network Providers are available upon request. You are required to pay the difference between the plan payment and the lesser of the Participating Provider's actual fee or contracted fee for covered services. A Non-Participating Provider is any other Provider and may also be referred to as an "Out-of-Network Provider". You are required to pay the difference between the plan payment and the Provider's actual fee for covered services. Therefore, the out-of-pocket expenses may be lower for services by a Participating Provider.

POLICY YEAR:

1. First Policy Year: The twelve (12) month period that begins on the Policy Effective Date and ends at the end of the day before the anniversary of the Policy Effective Date.
2. Each Subsequent Year: Every twelve (12) month period following the First Policy Year.

POLICY YEAR MAXIMUM: The maximum amount payable for each Covered Person per Policy Year. The Policy Year Maximum amount, if any, is shown on the Schedule. No further benefits are payable once the Policy Year Maximum is reached.

WAITING PERIOD(S): A Waiting Period means a period of time after the Policy Effective Date during which expenses incurred by Covered Persons for certain types of dental procedures are not covered. Any Waiting Periods applicable to Your coverage are shown in the Schedule. If a Covered Person is added to the Policy's coverage after the Policy Effective Date, any applicable Waiting Periods shall begin with respect to that Covered Person on the date such Covered Person's coverage takes effect. This does not apply to newborn or newly adopted children when Children's coverage is shown in the Schedule.

LIMITATIONS

No benefits under the Policy are payable (or considered a Covered Expense) for any of the following:

1. Services performed during any Waiting Period.
2. Initial placement of any prosthetic appliance or fixed partial denture unless such placement is needed because of the extraction of one or more teeth while the Covered Person is insured under this contract. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such appliance or fixed partial denture must include the replacement of the extracted tooth or teeth.
3. Replacement of any prosthetic appliance, crown, inlay or onlay restoration, or fixed partial denture within five years of the date of the last placement of these items; unless: (a) replacement is required due to an accidental Injury sustained while a Covered Person's coverage is in force; and (b) replacement occurs while such Covered Person's coverage is in force.
4. Appliances, restorations, or procedures to: (a) alter vertical dimension; (b) restore or maintain occlusion; or (c) splint or replace tooth structure lost as a result of abrasion or attrition.
5. Any procedure started after the Covered Person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than ninety (90) days after the Covered Person's insurance under this contract terminates.
6. Any procedure started before the Covered Person was insured under this contract.
7. Replacement of lost or stolen appliances.
8. Any treatment which is for cosmetic purposes.
9. Any procedure not shown in the Schedule (Frequency limitations may apply).
10. Orthodontic treatment.
11. Injury or Sickness arising out of, or in the course of, work for wage or profit, for which the Covered Person receives benefits under any Worker's Compensation Act or similar laws.
12. Charges for which the Covered Person is not liable or which would not have been made had no insurance been in force, except for those benefits paid under Medicaid.
13. Services which are not required for necessary care and treatment or are not within the generally accepted parameters of care.

GENERAL PROVISIONS

ADDITIONAL GOODS & SERVICES: From time to time We may arrange for third-party service providers to provide You access to discounted goods and/or services. There is no additional cost to You. We are not responsible for delivery, failure or negligence issues associated with these goods and services. To access details about these discounts and third-party service providers, You may contact Us directly. Access to these goods and services will discontinue upon termination of Your insurance or the termination of our arrangements with the providers, whichever comes first.

ANNUAL MEETINGS: The annual meeting is held at 12 o'clock, noon, on the third Saturday of February at the Home Office.

CHANGE OF BENEFICIARY: Unless the Insured makes an irrevocable designation of beneficiary, the Insured has the right to change the beneficiary under this Policy. Consent of a beneficiary is not required to surrender this Policy, for the assignment of the Policy, to change a beneficiary, or to make any other changes in the Policy.

CLAIM FORMS: Claim Forms are to be used for filing proofs of loss. They will be supplied to the person making claim within fifteen (15) days of notice of loss.

If Claim Forms are not supplied within this fifteen (15) day period, a claimant may submit Proof Of Loss as follows:

1. in writing; and;
2. setting forth the occurrence, character, and extent of the loss.

Authorization for release of medical information to Us will also be required when submitting a claim.

CONFORMITY WITH STATE AND FEDERAL LAW: Any provision of this Policy that, on its effective date, is in conflict with the law of the federal government or the state in which You reside on such date is by this clause effectively amended to conform to the minimum requirements of such law.

DIVIDENDS: This Policy is non-participating and does not pay dividends.

LEGAL ACTIONS: No legal action may be brought to recover under the Policy:

1. within sixty (60) days after written Proofs Of Loss have been furnished as required; or
2. after three (3) years from the time written Proofs Of Loss are required to be furnished.

NOTICE OF CLAIM: Notice must be given to Our administrator within thirty (30) days of the start of a loss. This notice can be given to Our administrator, [Ameritas Life Insurance Corp., P.O. Box 82520, Lincoln, NE 68501], or a subsequent address provided by Us. Notice should include Your name and the Policy number. If it is not reasonably possible to give notice within that time, the claim may not be declined or reduced due to the delay.

OTHER COVERAGE: You may not have more than one plan of dental coverage with the Company. If We issue You more than one plan in error, You, Your beneficiary or Your estate may select which plan should remain in force. We will refund all premiums You paid for all other such policies.

PAYMENT OF CLAIM: Claim payments for all benefits are payable to the Insured unless otherwise specified by a written assignment of benefits or if services were provided by a Participating Provider.

If a claim is unpaid at the Insured's death, it will be paid to the Insured's estate. The following applies if a benefit is payable to either the Insured's estate or an Insured who is not legally capable of accepting it. All or part of the benefits can be paid to any of the following relatives that the Company determines to be equitably entitled to it:

1. spouse;
2. children;
3. parents; and
4. brothers and sisters.

Any payment, made in good faith, fully discharges the Company to the extent of the payment.

PERIODS OF INSURANCE: All periods of insurance begin at 12:01 A.M., Standard Time at Your residence. Each time You renew Your Policy by paying the premium within the 31 day Grace Period, the new period begins when the old period ends. It ends at 12:01 A.M., the same Standard Time, on the renewal date.

PHYSICAL EXAMINATION AND AUTOPSY: The Company, at its expense, has the right to examine a person as often as reasonably necessary while a claim is pending. The Company, at its expense, may require an autopsy unless prohibited by law.

PROOF OF LOSS: Written Proof Of Loss must be given within ninety (90) days after the date of such loss. However, if it is not reasonably possible to give written Proof Of Loss in the time required, We will not reduce or deny the claim for this reason if the Proof Of Loss is filed as soon as reasonably possible. In any event, the Proof Of Loss required must be given no later than fifteen (15) months after the loss occurred, unless the claimant was legally incapacitated.

TIME LIMIT ON CERTAIN DEFENSES: After the second anniversary of the date this Policy is issued, a misstatement, other than a fraudulent misstatement, made by the applicant in the application for the Policy may not be used to void the Policy or to deny a claim for loss incurred or disability beginning after that anniversary. A claim for a loss incurred beginning after two (2) years from the date of issue of this policy will not be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss existed before the effective date of coverage from this policy.

TIME OF CLAIM PAYMENT: We will pay all claims due immediately upon receipt of written Proof of Loss.

UTILIZATION REVIEW PROGRAM: Generally, utilization review means a set of criteria designed to evaluate the medical necessity, appropriateness, or efficiency of health care services. We have established a Utilization Review Program to ensure that any guidelines and criteria used are clearly documented and applied. The program was developed in conjunction with licensed dentists and is reviewed at least annually to ensure that criteria are applied consistently and are current with dental technology, evidence-based research and any dental trends.

Signed, for Physicians Mutual Insurance Company,

Robert A. Reed, Jr.

President and CEO