COMPANION LIFE INSURANCE COMPANY
7909 Parklane Road, Suite 200 South Carolina 29223-5666
P.O. Box 100102, Columbia, South Carolina 29202-3102
(803) 735-1251

Policy No. 1004

Plan A

Effective Date: February 1, 2002

Policyholder: POORE BROTHERS, INC.

Date of Policy Issue: March 18, 2002

Policy delivered in ARIZONA and subject to the laws of that jurisdiction.

Policy Renewal Dates: February 1 and the same day of each year thereafter.

In consideration of the Application made by the Policyholder, and receipt of any and all Premiums when due, Companion Life Insurance Company agrees to provide the coverage described herein subject to all provisions of this Policy and any amendments added to this Policy.

The first premium is due on the date of issue of this Policy. This Policy shall renew each Policy Renewal Date unless Terminated in accordance with the Policy Termination provision. The Entire Contract provision of this policy determines all rights and Benefits of persons who are insured hereunder.

This page and the pages which follow are all part of this Policy and is fully recited over the signatures shown below.

In witness whereto, Companion Life Insurance Company has caused this Policy to be signed and issued as of this 18th day of March 2002, and shall take effect on the Policy Effective Date specified above.

M. Edward Sellers
President

GROUP DENTAL INSURANCE POLICY
RENEWAL AT OPTION OF THE COMPANY

COMPANION LIFE INSURANCE COMPANY
7909 Parklane Road, Suite 200 South Carolina 29223-5666
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SCHEDULE OF BENEFITS

PPO RIDER

DEFINITIONS:

Preferred Provider Organization: The TDA-PPO

Preferred Provider: A licensed Dentist who has signed an Agreement with Total Dental Administrators, Inc. (TDA) to provide dental services and treatment to Insured Persons at specific fees.

BENEFIT PAYMENT PROVISION:

When an Insured Person receives dental treatment or services from a Preferred Provider, the applicable benefit shall be as provided in this Preferred Benefit Schedule.

This PPO Plan will pay the applicable percentage of the contracted rate as determined by the PPO Agreement between TDA and the Preferred Providers. Any additional amounts due the Preferred Provider for treatment or services, up to the agreed upon contract rate, are the responsibility of the Insured Person receiving said services and/or treatment.

PREFERRED BENEFIT SCHEDULE

Dental Expense Benefits	PPO Percent Payable
Class I Services (Preventive Care)	100%
Class II Services (Basic Care)	80%
Class III Services (Major Care)	50%
Class IV Services (Orthodontia)	50%

All other provisions, benefits and limitations (including deductibles and maximums) remain unchanged by this Rider.

A list of PPO providers can be obtained from your Employer and/or TDA, Inc., 5353 N. 16th St., Suite 120, Phoenix, Arizona 85016, (602) 266-1995 or (800) 422-1995

IN WITNESS WHEREOF, Companion Life Insurance Company has caused this Rider to be executed at its Home Office on the Policy Date of the Policy to which it is attached.

M. Edward Sellers
President

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SCHEDULE OF BENEFITS

The Personal Insurance for each Insured and the Dependent Insurance for each of the Insured dependents will be according to the Insured's Classification shown in this Schedule of Benefits.

CLASSIFICATION: All Full-Time Employees

DENTAL EXPENSE BENEFITS	PERCENT PAYABLE
Class I Services (Preventive Care)	100%
Class II Services (Basic Care)	80%
Class III Services (Major Care)*	50%
Class IV Services (Child Orthodontia)*	50%

Class III Services (Major Care) and Class IV Services (Orthodontia) will be subject to a twelve (12) month Elimination Period, unless waived herein, or takeover/prior insurance credit provision applies.

Twelve (12) month Class III Elimination Period Waived? X YES NO
Twelve (12) month Class IV Elimination Period Waived? X YES NO

If elimination period is not waived, does group qualify for Takeover Credit: YES NO

Takeover Credit means all employees insured on the effective date with continuous coverage from the prior group Dental contract are eligible for the waiting periods to be reduced by the amount of time an employee was insured under the prior plan (plan being replaced).

Individual Deductible for Class II and III Services combined: $50 for each Insured Person each calendar year

Family Deductible for Class II and III Services combined: $150 for each Family unit each calendar year (may be satisfied by any number of family members).

Maximum Benefit for Class I, II & III Services combined: $1,000 each calendar year

Lifetime Maximum Benefit for Class IV (Child Orthodontia) Services: $1,500 (while insured).

Insured Persons are required to make contributions for Employee or Dependent Dental Insurance.

SCHEDULE OF BENEFITS
(Continued)

ELIGIBILITY

Personal Insurance

Each full-time, active employee working at least 30 hours per week for an Employer, including full-time, active owners and partners, is an Employee of the Eligible Class for Personal Insurance.

If a husband and wife are Employees, and if either of them insure their dependent children, then either the husband or wife, whomever so elects, will be considered a dependent of the other. As a dependent, the person will not be an Employee eligible for insurance as an employee, but will be eligible for insurance as a dependent.

Dependent Insurance

Each full-time active employee working at least 30 hours per week for an Employer, including full-time, active owners and partners, who has eligible dependents is an Employee of the Eligible Class for Dependent Insurance.

Either spouse who elects to be a dependent rather than an Employee of the Eligible Class for Personal Insurance, as explained above, is not an Employee of the Eligible Class for Dependent Insurance.

WAITING PERIOD

Employees who become employed by an Employer will qualify for Insurance after completing a specified waiting period of continuous active service. The length of the waiting period is selected by each Employer and must be the same for each employee.

Class I, Management: First day of the month following date of hire.

Class II, All Others: First day of the month following 90 days of full-time employment.

PARTICIPATION

For Insurance on the Employees of an Employer to be placed in force and to remain in force, a minimum number of 3 Employees must be participating at all times.

SCHEDULE OF BENEFITS
(Continued)

Personal Insurance

For Insurance on the Employees of an Employer to be placed in force and to remain in force, a certain percentage of Employees in each Group must be insured at all times.

Percentage of Employees Eligible for Personal Insurance:

	Percentage
Employers with three or more eligible employees	75%

Dependent Insurance

Percentage of Employees Eligible for Dependent Insurance:

	Percentage
Employers with three or more eligible employees	0%

CONTRIBUTIONS

Personal Insurance

An Insured may or may not be required to contribute to the payment of his or her Insurance premiums. Each Employer will make this decision. This decision must be applied equally to all Insureds. The Employer agrees to make the following contribution toward the cost of the employee coverage: Employee 99%

Dependent Insurance

An Insured may or may not be required to contribute to the payment of Insurance premiums for his or her dependents. Each Employer will make this decision. This decision must be applied equally to all Insureds. The Employer agrees to make the following contribution toward the cost of the dependent coverage: Dependent 0%

CONTINUATION OF COVERAGE

An Insured or dependent whose insurance has stopped may be able to continue some or all of the insurance coverages. The sections following explain when and how insurance can be continued. If insurance is continued, it must be according to a plan which does not allow individual selection.

SCHEDULE OF BENEFITS
(Continued)

Federally Required Continuation

Through the Consolidated Omnibus Budget Reconciliation Act (COBRA) the Federal government requires the Employer to provide continuation of coverages to Insureds and/or dependents who would otherwise lose their coverage. There are some groups which are not subject to the law. They are:

1. Groups of less than 20 employees.

2. Certain church plans.

For details, the Insured and/or dependent(s) must contact the person who handles the Employer's insurance matters.

Leave of Absence

For Employees Only

If an Insured's active service terminates because of leave of absence, the insurance will stay in force for two months only if the Employer remits his or her premiums to us and does not cancel the insurance.

Temporary Layoff

For Employees Only

If an Insured's active service terminates because of temporary layoff, the insurance will stay in force for two months only if the Employer remits his or her premium to us and does not cancel the insurance.

If the Employer is subject to COBRA, the rules applicable to COBRA will supersede this layoff continuation.

Injury or Sickness

For Employees Only

If an Insured's active service terminates because of injury or sickness, the insurance will stay in force while he or she is Totally Disabled if the Employer continues to consider the Insured as an employee and remits his or her premiums to us and does not cancel the insurance.

PREMIUMS

METHOD OF PREMIUM PAYMENT. Premiums are payable monthly unless we agree with the Policyholder on some other way of payment. The method of payment may be changed from time to time.

PREMIUM DUE DATE. The Premium Due Date will be the day of the month which conforms numerically with the Anniversary Date or the last day of a month in which there is no day which so conforms. We may, however, agree with the Policyholder that some day other than the day which conforms numerically with the Anniversary Date be considered the Due Date. If we agree with the Policyholder to the payment of premiums on a basis other than monthly, the Premium Due Date will be fixed to match the correct basis. If there is a change in the method of payment or Premium Due Date, a pro rata charge in the premium due will be made.

PAYMENT OF PREMIUMS. The first premium will be due on the Effective Date to cover the period from that date to the first Premium Due Date. Other premiums will be due on or before each Premium Due Date. Premiums are payable at our Home Office or at some other location to which we and the Policyholder agree.

PREMIUM STATEMENTS. A premium statement will be made as of the Premium Due Date showing the premium payable. If premiums are payable on other than a monthly basis, each statement will show any pro rata premium charges and credits in the last premium due to changes in the number of Insureds and in the amount of insurance for which people are insured. This is subject to the rules below.

SIMPLIFIED ACCOUNTING. The premium will start on the Premium Due Date falling on or after the date the insurance or the increase in the insurance is effective for: a) a person becoming insured; or b) an increase in the amount of insurance on any person, other than because of a change in the Schedule of Benefits. The premium will stop on the Premium Due Date falling on or after the date of termination of insurance. The premium will be decreased on the Premium Due Date falling on or after the date of decrease in the amount of insurance if the decrease is not because of a change in the Schedule of Benefits. There will be no pro rata charges or credits for a partial month. If premiums are payable other than monthly, charges and credits will be figured as though the Premium Due Date is monthly.

We will be liable for the return of unearned premiums to the Policyholder only for the 12 months before the date we receive evidence that a return is due.

CALCULATION OF PREMIUMS. The premium due as of any Premium Due Date is the number in force on such date for each class of insurance multiplied by the rate for that class of insurance.

ADJUSTMENTS IN PREMIUM RATES. We may change rates by giving the Policyholder at least 31 days advance written notice. We may change the rates at any time the Schedule of Benefits, or any other terms and conditions of the Policy, are changed. No change will be made in the first 12 months

after the Effective Date unless there is a change in the Schedule of Benefits or a change in any other terms and conditions of the Policy.

Unless the Company and the Group Policyholder agree otherwise, the Company will give at least 31 days advance written notice of any increase in premium rates.

PREMIUM RATE SCHEDULE

	Monthly Dental Rate
Employee Only Coverage	$17.34
Employee and Dependents (Family) Coverage	$51.18

The above rates are guaranteed for twelve (12) months from the Policy's date of issue, unless any of the Policy's terms are changed.

f. each unmarried child age 19 who:

i. becomes Totally Disabled while insured under b. above;
ii. is incapable of self-sustaining employment because of mental retardation or physical handicap;
iii. is primarily dependent on the Insured for support and maintenance.

Coverage for such child will not cease if proof of dependency and disability is given within 31 days after the Company asks for it.

DEPENDENT means all the people who are insured as the dependents of any one Insured.

FAMILY means an Insured and all of his or her legal dependents.

ACTIVE SERVICE means the performance in the customary manner by an employee of all the regular duties of his or her employment with his or her employer on a full-time basis at one of the employer's business establishments or at some location to which the employer's business requires the employee to travel.

TOTAL DISABILITY means the complete inability of:

a. an Insured to perform the duties of any job for which he or she is reasonably fitted by education, training or experience. An Insured will not be Totally Disabled if he or she engages in any job for wage or profit.

b. a dependent to perform the normal activities of a person of like age and sex.

PERSONAL INSURANCE means insurance which provides benefits payable as a result of the treatment, disability, or death of an Insured.

PHYSICIAN means any person who is licensed by the law of the state in which treatment, within the scope of his or her license, is given for the sickness or injury causing the expenses or loss for which claim is made.

DENTAL HYGIENIST means a person who is licensed to practice dental hygiene and who is practicing within the scope of his or her license.
DENTAL PRACTITIONER means a dentist, dental hygienist or a denturist.

DENTIST means a person who is licensed to practice dentistry or oral surgery and who is practicing within the scope of his or her license.

DENTURIST means a person who is licensed to make, fit and repair dentures and who is practicing within the scope of his or her license.

LATE ENTRANT means any person:

a. whose Effective Date of insurance is more than 31 days from the date the person qualifies for insurance, or

b. who has elected to become insured again after cancelling a premium contribution agreement.

CONFINED in an institution means registered as a bed patient, unless stated otherwise.

CALENDAR YEAR means the period from January 1 or any year through December 31 of the same year. But during the first year a person is insured, a calendar year means the period from his or her effective date through December 31 of that year.

EFFECTIVE DATE means the date coverage under this policy becomes effective. The Effective Date for the Policyholder is shown on the policy cover. The Effective Date for an Insured is shown on the individual certificate or is in the Policyholder's records.

All insurance will begin at 12:01 A.M. on the Effective Date. It will end after 11:59 P.M. on the Termination Date. All times are stated as Standard Time of the residence of the Insured.

EFFECTIVE DAY is the day of the Effective Date.

ALLOWABLE CHARGE for a service covered under this Policy means the determination of payable benefits as d eveloped from a statistically valid sample which (a) equitably recognizes geographic variations; (b) is updated periodically; and (c) is collected on the basis of the most current codes and descriptions developed and maintained by recognized authorities.

CONDITIONS FOR PERSONAL INSURANCE

ELIGIBILITY

ELIGIBLE CLASS FOR PERSONAL INSURANCE

The Employee of the Eligible Class for Personal Insurance are shown on the Schedule of Benefits.

Each Employee of the Eligible Class for Personal Insurance (referred to here as "Employee") will qualify for such insurance on the day he or she completes the required waiting period, if any.

WAITING PERIOD

The Waiting Period is shown on the Schedule of Benefits.

An Insured whose eligibility terminates and is established again within 12 months will not have to complete a new waiting period before he or she can qualify for Insurance.

PARTICIPATION REQUIREMENTS

In order for the Policy to be placed in force, and to remain in force, certain participation requirements must be met. These requirements are shown on the Schedule of Benefits.

CONTRIBUTION REQUIREMENTS

The contribution requirements are shown on the Schedule of Benefits.

EFFECTIVE DATE

Each Employee wanting to be insured must sign an enrollment card. We must approve the form to be used for the card. The Effective Date will be the first of the month on or next following:

1. the date on which he or she qualifies for Insurance, if we receive the signed enrollment card on, before or within 31 days after the date he or she qualifies for insurance.

2. the date we accept the Employee for insurance when the Employee is a Late Entrant. The Insured will be subject to any limitation concerning Late Entrants.

BENEFIT CLASSIFICATION CHANGE

If an Insured's status changes so that he or she becomes an Employee of a different Eligible Class, as shown in the Schedule of Benefits, any change in amounts of insurance because of the new class will take effect on the Effective Day of the month on or next following the change.

EXCEPTIONS

An Employee must be in active service on the date the insurance, or any increase in insurance, is to take effect. If not, the insurance will not take effect until the day he or she returns to active service. For this paragraph, an Employee will be in

active service on any regular non-working day if he or she is not totally disabled on that day and if he or she was in active service on the regular working day before that day.

TERMINATION DATE

The insurance on any Insured will automatically terminate on the end of the month falling on or next following the earliest of:

1. the date the Insured ceased to be an Employee;

2. the last day of the period for which the Insured has contributed, if required, to the payment of Insurance premiums;

3. the date coverage for the Insured's Employer is terminated;

4. 90 days after the number of Insureds falls below any participation requirements shown in the Schedule of Benefits; or

5. the date this policy is terminated.

CONTINUATION OF COVERAGE

If an Insured's coverage ceases according to TERMINATION DATE, the insurance coverage may be continued. See the Schedule of Benefits.

CONDITIONS FOR DEPENDENT INSURANCE

ELIGIBILITY

ELIGIBLE CLASS FOR DEPENDENT INSURANCE

The employees of the Eligible Class for dependent insurance are shown on the Schedule of Benefits.

Each employee of the Eligible Class for Dependent Insurance (referred to here as "Employee") is eligible for the Dependent Insurance (referred to here as "Insurance") under this policy and will qualify for this insurance on the latest of:

1. the day he or she qualifies for Personal Insurance;

2. the day he or she first becomes an Employee; or

3. the day he or she first has a dependent.

An employee must be insured for Personal Insurance to insure his or her dependents.

PARTICIPATION REQUIREMENTS

In order for this policy to remain in force for dependents, certain participation requirements must be met. These requirements are shown on the Schedule of Benefits.

CONTRIBUTION REQUIREMENTS

The contribution requirements are shown on the Schedule of Benefits.

EFFECTIVE DATE

Each Insured wishing to insure his or her dependents must sign an enrollment card. We must approve the form to be used for the card. The Effective Date for dependents will be the first of the month on or next following:

1. the date on which the Insured qualifies for Dependent Insurance, if we receive the signed enrollment card on, before or within 31 days after the date he or she qualifies for insurance

2. the date we accept each dependent for insurance when the dependents are Late Entrants. Each dependent will be subject to any limitation concerning Late Entrants.

TERMINATION DATE

The insurance for all of an Insured's dependents will automatically terminate on the end of the month falling on or next following the earliest of:

1. the date on which the Insured's Personal Insurance terminates.

2. the date on which the Insured ceases to be an Employee.

3. the last day of the period for which the Insured has contributed, if required, to the payment of Insurance premiums.

4. the date all Dependent Insurance under this policy is terminated.

5. the date all Dependent Insurance is cancelled for a specific Employer Unit.

6. the date this policy is terminated.

The insurance for any dependent will automatically terminate on the end of the month falling on or next following the date the dependent does not meet the definition of a dependent. See "Definitions."

CONTINUATION OF COVERAGE

If a dependent's coverage ceases according to TERMINATION DATE, the insurance coverage may be continued. See the Schedule of Benefits.

PERSONAL AND DEPENDENT DENTAL CARE INSURANCE
DENTAL EXPENSE BENEFITS

If an Insured under this section incurs Covered Expenses, we will pay benefits as stated below. The benefits will be determined as follows:

a. determine whether the charges are from a Participating Provider or a Non-Participating Provider.
b. the Covered Expenses reported are separated into the correct Class of procedure;
c. then, the Deductible Amount is applied, if any;
d. the remaining amount for each Class is then multiplied by the Coinsurance Percentage for each Class shown in the Schedule of Benefits.

Benefits are subject to the Maximum Amount shown in the Schedule of Benefits and the "Limitations" shown below.

DEDUCTIBLE AMOUNT. The Deductible Amount shown in the Schedule of Benefits is an amount of Covered Expenses for which no benefits are payable. It applies separately to the Covered Expenses incurred by each Insured. Benefits will be paid for only those Covered Expenses which are more than the Deductible amount.

On the date that three members of one family have satisfied their own Deductible Amounts for a Calendar Year, no Covered Expenses incurred after that date by any other family member will be applied toward the satisfaction of any Deductible Amount for the rest of that Calendar Year. No Covered Expense that was incurred prior to such date which was used to satisfy any part of a Deductible Amount will be eligible for reimbursement, however.

MAXIMUM AMOUNT. The Maximum Benefit per Calendar Year shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured each Calendar Year.

PREDETERMINATION OF BENEFITS. If the cost of dental treatment for a family member is to exceed three-hundred dollars ($300.00), a treatment plan must be sent to us before treatment begins. We review the plan and determine the expenses that are covered. We then return the plan to the dental practitioner, showing the amount we expect to pay. We pay only for the procedures that are actually rendered while the family member is insured for this benefit.

No treatment plan is needed for emergency care of an accidental injury or for expenses of three-hundred dollars or less.

COVERED EXPENSES. Covered Expenses means the allowable charges as determined by us incurred by an Insured for the Class I - Preventive, Class II - Basic and Class III –Major **[Class IV – Orthodontic]** Procedures shown on the List of Dental Procedures. But such expenses will be Covered Expenses only to the extent that they are incurred for procedures done by a dentist, dental hygienist, or denturist. These expenses are subject to the "Limitations" shown below.

ALTERNATIVE PROCEDURES. If two or more procedures are adequate and appropriate treatment to correct a certain condition, the amount of the Covered Expense will be the charge for the least expensive procedure.

We may ask that pre-operative dental x-rays be given to us to decide if we are liable for the procedures submitted for consideration. If the x-rays are not given to us, we will have to decide the procedures which would provide professionally adequate restoration, replacement or treatment.. If we then receive the pre-operative dental x-rays and decide that different procedures are more appropriate we will make adjustments that we deem are proper.

EXPENSES INCURRED. 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 crown, bridge or gold restoration. 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.

[PARTICIPATING AND NON-PARTICIPATING PROVIDERS. A Participating Provider is a Dentist who has entered into an agreement to provide at a specific fee services to Insureds. A Non-Participating Provider is any other provider.]

LIMITATIONS.

I. Covered Expenses Will Not Include and No Benefits Will Be Payable:

1. unless this limitation is waived in the Schedule of Benefits contained herein, for Class III Procedures in the first 12 months that the insured is covered under this plan except when replacing another plan with similar benefits which results in 12 months of continuous coverage for Class III Procedures and Takerover Benefits have been approved by Companion Life.

2. in the first twelve months that a person is insured if the person is a Late Entrant; except for exams, cleanings and fluoride application. The benefits are limited to procedures numbered 0120, 0130, 0140, 0150, 1110, 1120, 1201and 1203.

3. for any treatment which is for cosmetic purposes, or to correct congenital malformations, other than medically necessary treatment of congenital cleft in the lip or palate, or both.

4. to replace any prosthetic appliance, crown, inlay or onlay restoration, or fixed bridge within five years of the date of the last placement of these items. But if a replacement is required because of an accidental bodily injury sustained while the Insured is covered under this section, it will be a Covered Expense.

5. for initial placement of any prosthetic appliance or fixed bridge unless such placement is needed because of the extraction of one or more natural teeth while the Insured is covered under this section. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such appliance or fixed bridge must include the replacement of the extracted tooth or teeth.

6. for any procedure begun before the Insured was covered under this section.

7. for any procedure begun after the Insured's insurance under this section terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this section terminates.

8. to replace lost or stolen appliances.

9. for appliances, restorations, or procedures to:

   a. alter vertical dimension;
   b. restore or maintain occlusion;
   c. splint or replace tooth structure lost as a result of abrasion or attrition; or
   d. treat disturbances of the temporomandibular joint.

10. for any procedure which is not shown on the List of Dental Procedures.

11. for education or training in, and supplies used for, dietary or nutritional counseling, personal oral hygiene or dental plaque control.

12. for the completion of claim forms.

13. for orthodontia service, Class IV, when this optional coverage is not elected and the premium is not paid.

In any event, orthodontia covered charges will not include charges:

   a. incurred by employee or spouse, unless adult orthodontia is specifically provided in the Schedule of Benefits; or
   b. incurred by dependent children age 19 or over on the date orthodontia services began; or
   c. for any services payable under any other provisions of the policy; or
   d. for any services in the first 12 months the insured person is covered under the policy, unless waiting period is specifically waived in the Schedule of Benefits.

14. for sealants which are:
    a.not applied to a permanent molar.

b.applied after attaining age 17.
c.applied to a molar more than once.

15. subgingival curettage or root planing (procedure numbers 4220, 4340 and 4341) unless the presence of periodontal disease is confirmed by both x-rays and pocket depth summaries of each tooth involved.

16. because of an injury arising out of, or in the course of, work for wage or profit.

17. by an Insured because of a sickness, injury or condition for which he or she is eligible for benefits under any Worker's Compensation act or similar laws.

18. for charges for which the Insured is not liable or which would not have been made had no insurance been in force.

19. for services which are not recommended by a dentist or which are not required for necessary care and treatment.

20. because of war or any act of war, declared or not.

21. to an Insured if payment is not legal where the Insured is living when expenses are incurred.

22. Any services related to: equilibration; bite registration or bite analysis.

23. Crowns for the purpose of periodontal splinting.

24. Charges for: any implants; precision or semi-precision attachments, and any endodontic treatment associated with it; other customized attachments.

25. for endodontic treatment of the same tooth within a three (3) year period.

26. for root canal retreatment when it has not been demonstrated that unusual morphological or pathological conditions exist and when performed by a non-endodontic specialist.

27. for more than one filling for each tooth surface in a 24 month period.

28. for non-surgical periodontal treatment more than once in a two (2) year period.

29. for surgical periodontal treatment more than once in a three (3) year period.

30. for crown build-ups when less than three (3) of the five (5) tooth surfaces are destroyed.

31. for crown build-ups (pin, bonded, or post and core) more than once in a five (5) year period.

II. Payment For Services Shall Be Limited As Follows:

1. If this plan replaces another plan of similar benefits and is to offer continuous coverage and honor the deductibles satisfied under the prior plan, we limit what we pay to the lesser of: (1) what the prior plan would have paid; or (2) what this plan would usually pay. We will deduct any benefits actually paid by the prior plan under any extension provision.

2. In the first calendar year of this plan, we will reduce this plan's deductibles by the amount of covered charges applied against the prior plan's deductible. And in the first calendar year, we will charge benefits which were paid by the prior plan against this plan's payment limits.

PERSONAL AND DEPENDENT DENTAL CARE INSURANCE

LIST OF DENTAL PROCEDURES

The following is a complete list of the dental procedures for which benefits are payable under this section. **No benefits are payable for a procedure that is not listed.** Please read the section Dental Expense Benefits and "Limitations" for additional coverage information.

CLASS I PROCEDURES - PREVENTIVE

PROC. NO. ***DESCRIPTION OF SERVICE***

VISITS AND EXAMINATIONS.

0120 Periodic oral evaluation.

0140 Limited oral evaluation-problem focused (limited to accidental injury).

0150 Comprehensive oral evaluation.

Two evaluations will be allowed in a 12 month period. An 0120, 0140 and 0150 counts toward this maximum allowance.

1120 Prophylaxis for children under age 14

1110 Prophylaxis for individuals age 14 and over, treatment to include scaling and polishing

Prophylaxis (cleaning) will be allowed once in a 6 month period. An 1110 or 1120 counts toward this maximum allowance.*

1201 Topical application of fluoride, included with prophylaxis (limited to one treatment per year for children under age 19).

1203 Topical application of fluoride excluding prophylaxis.

1201 or 1203: Coverage for fluoride treatment is limited to once in a 12 month period for children under age 19.*

1351 Sealant - per tooth

1351: Coverage is limited to treatment of the occlusal surface of permanent molar teeth once for children under the age of 17.

9110 Emergency palliative treatment.(not a covered procedure if other procedures are reported on same date except diagnostic x-ray films.)

* The frequency is measured forward from the last covered date of service for the procedure.

PROC. NO. ***DESCRIPTION OF SERVICE***

X-RAYS.

0210 Entire denture series, including bitewings.

0330 Panoramic film.

0210 or 0330: Only one of these procedures will be allowed in a 3-year period.*

0220 Periapical radiograph-first film.

0230 Additional film (up to 12), each.

0220 & 0230: Allowed not more than twice in any twelve (12) month period, and only in connection with the diagnosis of a specific condition requiring treatment.*

0240 Intraoral, occlusal film.

0250 Extraoral, first film.

0260 Extraoral, each additional film.

0270 Bitewing, single film

0272 Bitewings-two films.

0274 Bitewings-four films.

Bitewing films are limited to once in a 6 month period. An 0270, 0272 or 0274 counts toward this maximum allowance.*

SPACE MAINTAINERS

1510 Space maintainer-fixed-unilateral.

1515 Space maintainer-fixed-bilateral.

1520 Space maintainer-removable-unilateral.

1525 Space maintainer-removable-bilateral.

1510-1525: Coverage is limited to space maintenance for unerupted teeth and following extraction of primary teeth. Allowances includes all adjustments within 6 months after installation.

1550 Recement space maintainer.

CLASS III PROCEDURES – MAJOR (PLAN A)

[CLASS IV PROCEDURES - ORTHODONTIA

(Only when listed as a benefit in the Schedule of Benefits)

The benefits herein set forth are subject to Lifetime Maximums, Calendar Year Maximums, Deductibles, co-payment percentages as elected by the Policyholder and as shown in the Schedule of Benefits. There is a twelve (12) month waiting period from the date that an Insured Person is covered under this Policy before an Insured Person is eligible for Class IV Benefits unless otherwise waived in the Schedule of Benefits or Takeover of Benefits apply (see Schedule of Benefits). Procedures using appliances (non-surgical) to treat poor alignment of teeth and/or jaws that significantly interfere with their function.

1. Covered Dental Benefits – Orthodontic treatment to an eligible Dependent, unmarried child(ren) to age nineteen (19), when the first orthodontic appliance is placed, [or Employee and/or Employee's Spouse, if Adult Coverage is elected], as follows:

PROC.
NO. ***DESCRIPTION OF SERVICE***

Limited Orthodontic Treatment.
8010 Limited orthodontic treatment of the primary dentition
8011 Limited orthodontic treatment of the transitional dentition
8012 Limited orthodontic treatment of the adolescent dentition
[8040 Limited orthodontic treatment of the adult dentition, applicable to an adult only if adult orthodontics is a covered benefit-see Schedule of Benefits.]

Interceptive Orthodontic Treatment.
8050 Interceptive orthodontic treatment of the primary dentition
8051 Interceptive orthodontic treatment of the transitional dentition

Comprehensive Orthodontic Treatment.
8070 Comprehensive orthodontic treatment of the transitional dentition
8071 Comprehensive orthodontic treatment of the adolescent dentition
[8090 Comprehensive orthodontic treatment of the adult dentition, applicable to an adult only if adult orthodontics is a covered benefit-see Schedule of Benefits.]

2. Special Rules for determining dental benefits for orthodontic treatment-covered orthodontic expenses are deemed to be insured as follows:
   a. 20% on the date the first appliance is placed.
   b. The remaining payment pattern is determined primarily by the Lifetime Maximum and duration of the treatment plan.
   c. Subject to the terms of this Policy, the amount of covered orthodontic expenses is the amount Shown in the treatment plan submitted by the Dentist, subject to later adjustment if the actual cost of orthodontic teatment differs from the amount shown in the treatment plan.]

COORDINATION OF BENEFITS

If an Insured is also covered under one or more other Plans, the benefits payable under this Plan will be coordinated with the benefits payable under those Plans.

BENEFITS SUBJECT TO COORDINATION. All benefits covered under two or more Plans will be coordinated.

EFFECT ON BENEFITS. When coordination applies, we adjust the benefits payable for any Claim Determination Period (period) as follows. The benefits that would be payable for Allowable Expenses incurred in that period under this Plan without coordination are reduced so that the sum of those reduced benefits and the benefits payable for those Allowable Expenses under all other Plans, whether or not claim is made, will not exceed the Allowable Expenses.

If, when we coordinate the benefits of this Plan with those of another Plan, (1) the rules set forth below would require this Plan to set its benefits before the other Plan; and (2) the other Plan coordinates benefits and would set its benefits after the benefits of this Plan have been set; then the benefits of that other Plan will be ignored when setting the benefits of this Plan.

ORDER OF BENEFIT DETERMINATION. The rules used to determine which of the Plans will pay benefits first are:

1. The benefits of a Plan with no coordination will set its benefits before a Plan with coordination.

2. The benefits of a Plan which covers the person other than as a dependent will be set before the benefits of a Plan which covers that person as a dependent.

3. If the claim is made for a dependent child whose parents are not separated or divorced, the benefits of a Plan that covers a child as a dependent of a person whose month and day of birth occurs earlier in a calendar year will be set before the benefits of a Plan that covers that child as a dependent of a person whose month and day of birth occurs later in a calendar year.

   If the month and day of birth of both parents is the same, then the Plan which has covered the parent for the longer period of time will pay its benefits first.

   If the other plan has a rule based on gender of the parent and, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

4. If the claim is made for a dependent child whose parents are separated or divorced, benefits for the child are determined in this order.

   a. first, the Plan of the parent with custody of the child;

   b. then, the Plan of the spouse of the parent with custody of the child; and

   c. finally, the Plan of the parent not having custody of the child.

   But, if there is a court decree which sets financial responsibility for the medical, dental or other health care expenses for the child, the benefits of a Plan which covers the child as a dependent of the parent who is responsible shall be set before the benefits of any other Plan which covers the child as a dependent child.

5. The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) will be set before those of a Plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of the benefits, then this rule is ignored.

6. When the rules above do not apply, the benefits of a Plan which has covered the person for the longer period of time will set before the benefits of a Plan which has covered the person the shorter period of time.

When the benefits of this Plan are reduced, each benefit is reduced, in proportion. It is then charged against any applicable benefit limit of this Plan.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION. We may give or get from any other organization or person any information necessary to decide whether coordination applies. This may be done without the consent of the Insured. Any person claiming benefits under this Plan will be required to give us any information necessary to coordinate benefits.

FACILITY OF PAYMENT. When other Plans make payments which should have been made under this Plan according to the above terms, we will, at our discretion, pay to any organizations making these payments any amounts that we decide will satisfy the intent of the above terms. Amounts paid in this way will be benefits paid under this Plan. We will not be liable to the extent of these payments.

RIGHT OF RECOVERY. When we make payments for Allowable Expenses in excess of the amount that will satisfy the intent of the above terms, we will recover these payments, to the extent of the excess, from any persons or organizations to or for whom payments were made.

DEFINITIONS. The following apply only to this provision of the policy:

1. "Plan" means any of these types of coverage providing dental benefits or services:

   a. group insurance or group type coverage; whether insured or uninsured. This includes:

      i. Blue Cross and Blue Shield
      ii. blanket (other than school accident-type coverage)
      iii. Health Maintenance Organizations (HMO's)
      iv. other prepayment, group practice and individual practice plans.

   b. any coverage under a governmental plan or required or provided by law, except Medicaid.

   Each type of coverage in a. or b. above is a separate Plan. If an arrangement has two or more parts and this coordination applies to only one part, each of the parts is a separate plan.

2. "Allowable Expense" means any necessary, reasonable and customary expense at least a part of which is covered under at least one of the Plans covering the person for whom claim is made.

   When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be both an Allowable Expense and a benefit paid.

3. "Claim Determination Period" means a calendar year or that part of a calendar year during which the person for whom claim is made has been covered under this Plan.

GENERAL PROVISIONS

Dental Insurance

NOTICE OF CLAIM. Written notice of claim must be given to us within 20 days after the accident causing the injury or, in the case of sickness, within 20 days after the event on which claim is based.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Policyholder's name, Insured's name, and policy number. If it will not be reasonably possible to give written notice within the 20 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

CLAIM FORMS. When we receive the notice of claim, we will send the claimant forms for filing proof of loss. If these forms are not furnished within 15 days after the giving of such notice, the claimant will meet our proof of loss requirements by giving us a written statement of the nature and extent of loss within the time limit for filing proofs of loss.

PROOF OF LOSS. Written proof of loss must be given to us within 90 days after the date of the loss for which claim is made. If it was not reasonably possible to give written proof within the 90 day period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible.

PHYSICAL EXAMINATION. We can examine any per-operative dental x-rays while a dental claim is pending to determine the proper procedures to be considered.

TIME OF PAYMENT. We will pay all benefits within 30 days after receipt of acceptable proof of loss. If we fail to pay benefits within this 30-day period, the Insured is entitled to interest at the legal rate from the date the claim is received.

PAYMENT OF BENEFITS. All benefits will be paid to the Insured or the Insured's Designee.

PAYMENT OF CLAIMS. If an Insured dies while dental insurance benefits, if any, are unpaid, we may, at our option, pay the person or institution on whose charges claim is based, any member of the Insured's immediate family or the Insured's estate.

Any equitable payment made in good faith will release us from liability to the extent of payment.

PHYSICIAN-PATIENT RELATIONSHIP. The Insured will have free choice of any physician practicing legally. We will in no way disturb the physician-patient relationship.

LEGAL PROCEEDINGS. No legal action can be brought against us until 60 days after the Insured sends us the required proof of loss. No legal action against us can start more than five years after proof of loss is required.

INCONTESTABILITY. We cannot contest the validity of the policy after one year from the date of issue except for non-payment of premiums. We cannot contest an Insured's insurability after his or her insurance

has been in force for one year while the Insured is alive. Any of the insured's statements that we contest must be in written application signed by the Insured.

WORKER'S COMPENSATION. This policy does not satisfy any requirements for coverage of worker's compensation insurance.

CONFORMITY WITH LAW. Any policy provision which conflicts with the laws of the state in which the policy is issued, when the policy is issued, is automatically changed to meet the minimum requirements of those laws.

ENTIRE CONTRACT: CHANGES. This policy, the attached application of the Policyholder and the applications, if any, of the Insureds are the entire contract. All statements made by the Policyholder or an Insured will, in the absence of fraud, be considered representations and not warranties. No statement made to obtain insurance will be used to void the insurance or reduce the benefits of this policy unless it is in a written application signed by the Policyholder or Insured. A copy of this must have been given to the Policyholder, Insured or Beneficiary, if any.

No change in this policy will be valid unless approved by one of our officers. No agent may change this policy or waive any of its provisions. Any change in this policy will be valid even though an Insured may not have agreed to it.

INSURANCE DATA. The Policyholder will furnish, at our request, data necessary to administer this policy. The data will include, but not be limited to data:

i. necessary to calculate premiums.
ii. necessary to determine a person's effective date or termination date of insurance;
iii. necessary to determine the proper amounts of insurance, or changes in amounts of insurance.

We shall have the right to inspect any of the Policyholder's records which we find necessary to properly administer this policy. Any inspections will be at a time and place convenient to the Policyholder.

We will not refuse to insure a person who is eligible to be insured just because the Policyholder fails or errs in giving us the data necessary to include that person for coverage. Neither will we refuse to change or maintain an amount of insurance for which a person is eligible just because the Policyholder fails or errs in giving the data necessary to change the amount of insurance. But an Insured's insurance will not stay in force nor an amount of insurance be continued after the termination date, according to the Provisions for Personal Insurance, or Dependent Insurance or as shown in the Schedule of Benefits because the Policyholder fails or errs in giving us the necessary data concerning an Insured's termination.

CERTIFICATES. We will issue to the Policyholder, for delivery to each Insured, an individual certificate which will summarize the main features of the insurance which the Insured will receive. This summary will include the terms, if any, limiting coverage or reducing benefits on account of age. It will state to whom the benefits of this policy are payable. Nothing in the certificate will change any of the terms of this policy.

TERMINATION OF THE POLICY. The Policyholder may terminate this policy as of any Premium Due Date giving us written notice before that date.

We may terminate this policy as of any Premium Due Date if the participation of Insureds does not meet the requirements in "Conditions For Personal Insurance". Dependent Insurance, if in this policy, may be terminated if dependent participation does not meet the requirements in "Conditions For Dependent Insurance". Written notice of termination of insurance under this policy must be given to the Policyholder at least 31 days before the date of termination.

If any premium is not paid when due, this policy will automatically be terminated as of the Premium Due Date, except as stated below.

GRACE PERIOD. This policy has a 31 day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the grace period, the policy will stay in force. If the Policyholder has not sent us a written request to terminate the policy and a premium is not paid by the end of the grace period, the policy will terminate at the end of the grace period. If the Policyholder gives us written notice of termination before the premium due date, the policy will be terminated as of the date requested. The Policyholder will be liable for any unpaid premium for the time this policy was in force, *including the grace period.*

CONSIDERATION. This policy is issued to the Policyholder in consideration of the application and the payment of premiums specified in this policy.

TERMS AND CONDITIONS. Payment of any benefit under this policy is subject to the definitions and all other terms of this policy pertinent to the benefit.