

Dental Insurance Plan Coverage Schedule

Class A. Preventive Services Include:

- two routine examinations of mouth and teeth per calendar year;
- two prophylaxis (cleaning, scaling and polishing teeth) per calendar year;
- one topical fluoride per calendar year; to age 16;
- one diagnostic x-rays, full or panoramic in any 3 year period;
- bitewing x-rays, 2 per calendar year.

Class B. Basic Services, Include:

- simple extraction of teeth;
- pin retention of fillings;
- fillings of amalgam, silicate, acrylic, synthetic porcelain and composite filling materials
- (restorations of mesiolingual, distolingual, mesio buccal and distobuccal surfaces; considered single surface restorations);
- antibiotic injections administered by Dentist
- oral surgery, including postoperative care for:
 1. removal of teeth, including impacted teeth;
 2. extraction of tooth root,
 3. alveolectomy, alveoplasty, and frenectomy;
 4. excision of pericoronal gingiva, exostosis, or hyperplastic tissue, and excision of oral tissue for biopsy; reimplantation or transplantation of a natural tooth; and excision of a tumor or cyst and incision and drainage of an abscess or cyst.

Class C.

- **Major Services Include:**
- endodontic treatment of disease of the tooth, pulp, root, and related tissue, as follows:
 1. root canal therapy (not covered, if pulp chamber was opened before covered);
 2. pulpotomy;
 3. apicoectomy; and
 4. retrograde filling

■ periodontic services, limited to:

1. two prophylaxis following surgery per calendar year;
2. root scaling and planning, once per quadrant of mouth in any 6 month period;
3. occlusal adjustment, performed with covered surgery;
4. gingivectomy, gingival curettage, and mucogingival;
5. osseous surgery including flap entry and closure;
6. pedicle or free soft tissue grafts; and
7. one appliance (night guards) in 5-year period.

■ one study models in 3 year period;

- crown build-up for non-vital teeth;
- recementing inlays, onlays and crowns;
- one repair of dentures or bridges in any 2 year period, limited to 20% of cost of replacement;
- general anesthesia and analgesic, including intravenous sedation, for oral surgery;

■ restoration services, limited to:

1. gold or porcelain inlays, onlay, and crowns for tooth with extensive caries or fracture that is unable to be restored with an amalgam, silicate, acrylic, synthetic porcelain, or composite filling material.
2. replacement of existing inlay, onlay, or crown, after 5 years of the restoration initially placed or last replaced. This limitation will not apply if replacement is necessary due to the extraction of functioning natural teeth while covered.
3. stainless steel crowns.
4. post and core.

■ prosthetic services, limited to:

1. initial placement of dentures or fixed bridgework (including acid etch metal bridges), when denture or bridgework includes replacement of a natural tooth extracted or lost while covered under the Policy. This limitation ends after covered under the Policy for 36 months.
2. replacement of dentures or fixed bridgework that cannot be repaired after 5 years from the date of placed or last replaced.
3. addition of teeth to existing partial denture, only if to replace natural teeth extracted or lost while covered under the Policy. This limitation will not apply after covered under the Policy for 36 months.
4. relining or rebasing of existing removable dentures, only after one year from date the denture was placed and only once in any 2-year period.

G E N E R A L P R O V I S I O N S

Payment: Employer must payroll deduct premiums.

Participation: Groups must have three eligible and at least one employee enrolling to qualify.

Credit For Prior Time (CPT): CPT is available for insureds and dependents who were covered under the employers' immediately preceding dental plan (with no break in coverage). CPT is applied on a per person basis for dental.

Eligible Expenses: Expenses must be incurred while the Policy is in force and the person is covered. The dental services must be performed by a licensed dentist, a licensed physician performing dental services within the scope of his license, or a licensed dental hygienist acting under the supervision and direction of a Dentist.

Expenses Not Covered: No benefits will be paid for expenses incurred

- for overdentures and associated procedures.
- for charges in excess of those considered reasonable and customary.
- for cosmetic procedures.
- for the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function.
- for implants, and for partial or full or stolon appliances
- replacement of retainers
- precision or semi-precision attachments
- for oral hygiene instructions, and for:
 - plaque control
 - completion of a claim form
 - acid etch

■ for services not completed by the end of the month in which coverage ends, unless continuation of coverage has been requested and accepted by Us.

■ for procedures that are begun, but not completed.

■ for services and treatment provided without charge or for which there would be no charge in the absence of insurance.

■ for services in connection with war or any act of war, whether declared or undeclared, or condition contracted or accident occurring while on full-time active duty in the armed forces of any country or combination of countries.

■ for a condition covered under any Worker's Compensation Act or similar law.

■ that are applied toward satisfaction of a Deductible, if any.

■ that are generally considered by the dental profession as experimental or investigational.

■ or the treatment of cleft palate and anodontia.

■ for services or supplies payable under any medical expense plan.

■ for orthodontia, unless included by rider.

■ prior to the date the insured is covered under the Policy.

■ for diagnosis or treatment of TMJ.

■ for hospital services

■ for any unannounced age 19 years of age and over unless he is dependent upon 12-year old child for support, while a full-time student in high school, junior college, college or university. Any exception for a full-time student will end at age 23.

■ during any waiting period we require, when You voluntarily end Your insurance and re-enroll at a later date. Your waiting period is 2 years and begins on the date Your coverage first ended.

■ charges for infection control, sterilization and waste disposal.

Alternate Benefit: If: 1) We determine that a less expensive alternate procedure, service or Course of Treatment can be performed in place of the proposed treatment to correct a dental condition, and 2) the alternative treatment will produce a professionally satisfactory result, then the maximum we will allow will be the charge for the less expensive treatment.

Pretreatment Review: If the Course of Treatment will exceed the amount shown in the Coverage Schedule, We will require prior review. We must be given the Dentist's treatment plan consisting of a description of the planned treatment with estimated charges and diagnostic x-rays. We will determine Eligible Expenses and state how much We will pay for the treatment. Our determination may suggest an alternate less expensive Course of Treatment if it will produce professionally-satisfactory results. If You do not request a pretreatment review We will pay for the least expensive method of treatment regardless of the method actually used.

Maximum Calendar Year Limit: The maximum limit payable for all Eligible Expenses in any calendar year is shown in the Coverage Schedule. The Maximum Calendar Year Limit, if any, will apply to each person covered under the Policy.

Deductible: The Deductible is an amount of charges You must incur for Yourself or on behalf of Your insured dependent before We start paying benefits.

Termination of Coverage: Coverage terminates on the earliest of the following dates: the last day of the month in which You cease to be eligible for coverage, the last day of the month in which Your dependent ceases to be eligible for coverage, or the last day of the Grace Period, the last day of the month for which a premium has been paid by you or on your behalf, or the date the policy ends.

Notice: This brochure provides a brief description of some important features of the plan. It is not the Insurance Contract, nor does it represent the Insurance Contract. A full explanation of benefits, exceptions and limitations is contained in the Certificate of Insurance under Policy Form GH-1112, which is issued to the Employers Voluntary Benefit Insurance Trust.

NEW!

Voluntary Dental & Vision Insurance Plans

-ONE PERSON CAN ENROLL-

For groups of 3 or more,
only 1 employee needs to enroll!

- ▶ No network
- ▶ Great benefits
- ▶ Only 1 enrollee needed
- ▶ Competitive Commissions
- ▶ Takeover available
- ▶ Participation discounts
- ▶ Write dental, vision, or both!
- ▶ Easy enrollment

Security Life
INSURANCE COMPANY OF AMERICA
MINNETONKA, MINNESOTA



REVISED 5/14/09

D E N T A L * *

	Plan 1	Plan 2	Plan 3
Deductible Class B & C Only	\$50	\$50	\$100
Class A—Preventative	100%	80%	100%
Class B—Basic	80%	80%	50%
Class C — Major	50%	50%	50%
Class D—Ortho	Optional	Optional	Optional
Annual Maximum (\$1500 optional)	\$1000	\$1000	\$1000
Waiting Periods	Class A = 3 months Class B = 6 months Class C = 12 months Class D = 12 months	Class A = 3 months Class B = 6 months Class C = 12 months Class D = 12 months	Class A = 3 months Class B = 6 months Class C = 12 months Class D = 12 months
Base Rates	Single = \$44.72 EE + 1 = \$87.85 Family = \$124.52	Single = \$39.93 EE + 1 = \$78.44 Family = \$111.19	Single = \$39.92 EE + 1 = \$78.42 Family = \$111.14

V I S I O N * *

Service*	Benefit	Plan 1	Plan 2
Eye Exam	\$40.00	12 Months	12 Months
Single Pair Lens	\$60.00	12 Months	24 Months
Bifocal Pair Lens	\$90.00	12 Months	24 Months
Trifocal Pair Lens	\$130.00	12 Months	24 Months
Progressive Pair Lens	\$150.00	12 Months	24 Months
Contacts (pair)	\$90.00	12 Months	24 Months
Frames	\$45.00	12 Months	24 Months

*Contact lens benefit is in lieu of other material benefits. Benefit for one contact lens is half of benefit year allowance.

**The Above Rates Do Not Include a \$10 Monthly Fee, Which Will Be Reflected On the Billing Invoice.

A R E A F A C T O R

Area	Factor	Area	Factor	Area	Factor
1	0.83	4	1.10	7	1.46
2	0.91	5	1.21	8	1.61
3	1.0	6	1.33		

Please refer to "Area Designation" insert to determine Area

**R A T E
C A L C U L A T I O N**

**D E N T A L
V O L U N T A R Y R A T E S**

	Base Rate	Area Factor	Optional Factors	Optional Factors	Total
Single	X	X	X	X	=
EE+1	X	X	X	X	=
Family	X	X	X	X	=

V I S I O N

Single	Plan 1	Plan 2
EE+1	\$4.50	\$4.00
Family	\$9.00	\$8.00
	\$12.30	\$11.00

Total Monthly Cost:

Optional Factors:
 Takeover Factor: Add 1.09%
 Ortho Takeover Factor: 1.50%
 \$1500 Dental Max: Add 1.10%
 Orthodontics: EE + 1 = \$7.62
 Family = \$13.16

Rate Calc with Ortho:
 E+1= Total E+1 Rate + 7.62 x Optional Factors
 Family= Total Family Rate + 13.16 x Optional Factors
 Rates valid for quoting 7/1/2009 – 3/31/2010.

Call for employer-paid rates.

The Above Rates Do Not Include a \$10 Monthly Fee,
 Which Will Be Reflected on the Billing Invoice.

A r e a D e s i g n a t i o n b y S t a t e & Z i p

State Zip(first 3 digits)	Area Zip(first 3 digits)	State Zip(first 3 digits)	Area Zip(first 3 digits)
AK 995-996	8	MD All Other	4
AK All Other	6	MD 206-207	2
AL All Other	1	MD 209-211	2
AL 350-355	3	MD 217	3
AL 359	3	MI All Other	1
AR All Areas	1	MI 480-483	2
AZ All Other	1	MI 488-489	3
AZ 856-857	2	MI 490-491	2
AZ 864	2	MN All Other	1
CA All Other	5	MN 553-558	2
CA 900-905	7	MN 564	2
CA 906-914	6	MN 566	2
CA 915-916	8	MO All Other	1
CA 917-918	4	MO 640-641	2
CA 919-927	6	MO 644-649	2
CA 930-934	6	MS All Other	1
CA 939	6	MS 390-392	2
CA 943-948	4	MT All Other	3
CA 949	6	MT 590-591	1
CA 956-958	3	MT 599	2
CA 959	4	NC All Other	1
CA 961	6	NC 277	2
CO All Other	1	NC 286	3
CO 803	4	NC 287-289	2
CO 808-810	4	ND All Other	1
DC All Areas	6	ND 580-581	2
DE All Areas	2	NE All Areas	1
GA All Other	1	NE All Other	1
GA 300-303	2	NM 881	2
HI All Areas	3	NM 882	5
IA All Areas	1	NV All Other	4
ID All Areas	1	NV 890-891	2
IL All Other	1	NV 894-895	6
IL 600-605	2	NV 898	6
IL 606-608	3	OH All Areas	1
IN All Other	1	OK All Other	1
IN 463-464	2	OK 740-743	2
IN 473	3	OR All Other	2
KS All Other	1	OR 977	3
KS 660-662	2	OR 978	1
KY All Areas	1	PA All Other	1
LA All Other	1	PA 170-178	2
LA 707-711	2	PA 182-187	2
LA 712	3	PA 190-192	3
SC All Areas	1	TN All Other	1
TN All Other	1	TN 373-374	2
TN 373-374	2	TN 373-374	2
TX All Other	2	TX All Other	2
TX 751-753	3	TX 751-753	3
TX 754	4	TX 754	4
TX 756-757	1	TX 756-757	1
TX 776-777	1	TX 776-777	1
UT All Areas	1	UT All Areas	1
VA All Other	4	VA All Other	4
VA 201	5	VA 201	5
VA 220-221	5	VA 220-221	5
VA 222-223	6	VA 222-223	6
VA 224-225	1	VA 224-225	1
VA 228-229	2	VA 228-229	2
VA 230-232	1	VA 230-232	1
VA 233-237	5	VA 233-237	5
VA 240-244	2	VA 240-244	2
VA All Other	5	VA All Other	5
WA 982-984	4	WA 982-984	4
WA 990-992	3	WA 990-992	3
WA 993	6	WA 993	6
WI All Areas	1	WI All Areas	1
WV All Other	2	WV All Other	2
WV 255-257	4	WV 255-257	4
WV 262-265	3	WV 262-265	3
WY All Areas	1	WY All Areas	1