



**Optional  
Dental Insurance for Students and their Dependents**

Underwritten by Security Life Insurance Company of America

**Eligible Expenses**

We will pay for Eligible expenses You Incur for yourself or on behalf of your insured Dependent. Expenses must be incurred while the Policy is in force and the person is covered by the Policy. The description of Eligible Expenses is shown in the Coverage Schedule. To be an Eligible Expense, the dental service or procedure must be performed by a licensed Dentist, Physician or Dental Hygienist.

**Expenses Incurred**

An Eligible Expense is considered incurred on the following dates: For full and partial dentures – the date the final impression is taken; for fixed bridges, crowns, inlays and onlays - the date the teeth are first prepared; for root canal therapy - the date the pulp chamber is opened; for periodontal surgery - the date surgery is performed; for all other services - the date the service is performed.

**Deductible Amount**

The calendar year Deductible, if any, is shown in the Coverage Schedule. The Deductible is an amount of eligible charges you must incur for yourself or on behalf of your insured Dependent(s) before we can begin paying benefits.

**Calendar Year Maximum**

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

**Pretreatment Review**

If the Course of Treatment will exceed the amount shown in the Coverage Schedule, We will request 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.



### **Coordination of Benefits**

(Does not apply in Maryland or South Dakota)

If any person under this Policy (referred to as “this Plan”) is also covered under one or more other plans, the benefit under this Plan will be coordinated with benefits payable under all other plans.

### **Alternate Benefits**

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 charges for the less expensive treatment.

### **Missing Tooth**

When covered under your plan, benefits are provided for placement of dentures, fixed bridgework, implants or the addition of teeth to existing dentures only when the service includes replacement of a natural tooth extracted or lost while covered under this plan. This limitation ends after the individual receiving care has been covered under this plan for 36 consecutive months.

### **Eligibility**

Individuals, 18 years of age or older, plus their eligible dependents (spouse and/or unmarried children from birth to age 19; extended to age 23 if child is a full-time student). This is subject to State requirements.

### **Termination of Coverage**

Coverage terminates on the earliest of the following dates: (a) the last day of the month in which You cease to be eligible for coverage; (b) the last day of the month in which Your Dependent is no longer a dependent as defined; (c) subject to the Grace Period, the last day of the month for which a premium has been paid by you or on your behalf; or (d) the date the Master Policy ends.

### **Effective Date**

You and Your Dependents are covered on the later of: the date We accept Your enrollment and determine an effective date; or the date You first acquire a Dependent, if the date is after Your coverage begins.



### **Reasonable and Customary**

Reasonable and Customary means the usual, customary and regular charges for the area where such expenses are incurred.

### **DENTAL EXPENSES NOT COVERED**

- 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 replacement of lost or stolen appliances, replacement of retainers, athletic mouth guards, precision or semi-precision attachments, denture duplication;
- for oral hygiene instructions; and for: plaque control, completion of a claim form, acid etch, broken appointments, prescription or take-home fluoride, or diagnostic photographs;
- 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 generally considered by the dental profession as experimental or investigational;
- for the treatment of cleft palate and anodontia;
- for services or supplies payable under any medical expense plan;



- for orthodontia, unless included within Coverage Schedule;
- for services rendered prior to the date the Insured is covered under the Policy;
- for the diagnosis or treatment of Temporomandibular Joint Dysfunction (TMJD);
- for hospital services;
- for any unmarried child age 19 years of age and over unless he is dependent upon You for support, while a full-time student. A full-time student is one who is enrolled for 12 semester hours for credit in an accredited junior college, college or university. Any exception for a fulltime student will end at age 23;
- if You voluntarily end Your insurance You will not be eligible to re-enroll for a period of 2 years after the date Your coverage first ended;
- charges for infection control, sterilization, and waste disposal.

#### **VISION EXPENSES NOT COVERED**

The cost of a lens in excess of a standard lens will not be covered. A standard lens is any lens which fits a frame with an eye size less than 61mm. Charges for replacement lenses will not be covered unless there is a change in prescription.

The cost of a frame in excess of a standard frame will not be covered. A standard frame is any frame which has a retail value of \$75.00 or less. The cost of replacement frames will not be covered, unless the existing frame is not compatible with the replacement lenses.

In addition to the above, the following expenses are not covered:

- any procedure, service or supply included as a covered medical expense under any group insurance plan, whether benefits are payable as to all or only part of such charges;
- special procedures, such as orthoptics, vision training and subnormal vision aids;
- plano or prescription sunglasses or other special purpose vision aids;
- medical or surgical treatment of the eyes including hospital expenses;
- replacement of lost or broken lenses and/or frames;
- duplicate glasses or lenses or frames; and
- services or material not listed as an Eligible Expense.



**Outline of Optional  
Dental Insurance for Students and their Dependents**

Underwritten by Security Life Insurance Company of America

**Dental Benefits**

<b>Class A – Preventive Services</b>	<b>Elite</b>	<b>Premier</b>	<b>Select</b>
Initial & Periodic Exams (2 per year), Cleanings (2 per year), Fluoride Treatments (to age 16), Sealants (no age limitation)			
Benefit Year One	100%	100%	75%
Benefit Year Two	100%	100%	85%
Benefit Year Three and Each Benefit Year Thereafter	100%	100%	100%
Deductible – Lifetime per Insured	\$50	\$50	\$50
 <b>Class B – Basic Services</b>	 <b>Elite</b>	 <b>Premier</b>	 <b>Select</b>
X-rays, Fillings, simple Extractions			
Benefit Year One	35%	35%	25%
Benefit Year Two	65%	50%	35%
Benefit Year Three and Each Benefit Year Thereafter	80%	65%	50%
Deductible – Each Calendar Year per Insured*	\$50/yr	\$50/yr	\$50/yr
 <b>Class C – Major Services</b>	 <b>Elite</b>	 <b>Premier</b>	 <b>Select</b>
Oral Surgery, Endodontics, Periodontics, Crowns, Bridges, Dentures			
Benefit Year One	15%	10%	10%
Benefit Year Two	50%	25%	25%
Benefit Year Three and Each Benefit Year Thereafter	50%	50%	50%
Deductible – Each Calendar Year per Insured*	\$50/yr	\$50/yr	\$50/yr
 <b>Class D – Orthodontic Services</b>	 <b>Elite</b>	 <b>Premier</b>	 <b>Select</b>
Straightening of Teeth (for children under age 19)	Not		Not
Benefit Year One	Available	0%	Available
Benefit Year Two	Under	0%	Under
Benefit Year Three and Each Benefit Year Thereafter	This Plan	50%	This Plan
 <b>Calendar Year Maximums</b>			
Calendar Year Maximum for Classes A, B and C Combined	\$1,000	\$1,000	\$1,000
Calendar Year Maximum for Class C – Major Services	\$500	\$500	\$500
Calendar year Maximum for Class D	-	\$500	-
Lifetime Maximum Per Child for Class D	-	\$1,000	-

**Calendar Year Maximum Increase Option**

You may increase the Calendar Year Maximum benefit, per individual, for an additional monthly fee

Option 1 – Increase Classes A, B & C to \$1,500 with Class C Major Services limited to \$750

Option 2 – Increase Classes A, B & C to \$2,000 with Class C Major Services limited to \$1,000



**ASSOCIATED  
INSURANCE PLANS**  
INTERNATIONAL, INC.

**DEDUCTIBLE** Class B & C Deductible is combined for each calendar year.  
A maximum of 3 individual deductibles per family shall apply.

**WAITING PERIODS** Class A, B & C None, Class D Orthodontics – 24 months

**OPTIONAL VISION BENEFITS RIDER**

	<b>Elite</b>	<b>Premier</b>	<b>Select</b>
Class A – Vision Exams – 1 per year Benefit Year One and Each Benefit Year Thereafter	100%	85%	85%
Class B – Lenses and Frames – 1 pair every 2 years Benefit Year One and Each Benefit Year Thereafter	50%	50%	50%
Class C – Contact Lenses – 1 pair every 2 years (in lieu of frames and lenses) Benefit Year One and Each Benefit Year Thereafter	50%	50%	50%
Calendar Year Deductible	\$50/yr	\$50/yr	\$50/yr
Calendar Year Maximum for Classes A, B and C	\$200	\$150	\$150
Waiting Periods – Class A – None, Class B & C – 15 Months			

**For more information contact:**

Associated Insurance Plans International, Inc.  
[office@AIPstudentinsurance.com](mailto:office@AIPstudentinsurance.com)  
(800) 452-5772

# PRIMESTAR PERSONAL DENTAL - PREMIUM RATE TABLE

For effective dates March 1, 2010 through October 1, 2010

**FOR ALL STATES EXCEPT MARYLAND, NORTH CAROLINA, NORTH DAKOTA,  
SOUTH DAKOTA, WASHINGTON**

*(Please request separate rate sheets for the above states)*

**Monthly Premiums illustrated are guaranteed for the initial twelve (12) months of coverage. Thereafter, premiums are likely to increase on a semi-annual basis.**

RATE CHART			Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8
<b>UNDER AGE 65</b>	<b>ELITE</b>	Applicant Only	\$ 27.00	\$ 30.00	\$ 32.00	\$ 36.00	\$ 40.00	\$ 44.00	\$ 49.00	\$ 54.00
		Applicant+Spouse	\$ 56.00	\$ 61.00	\$ 67.00	\$ 75.00	\$ 81.00	\$ 90.00	\$ 99.00	\$ 108.00
		Applicant+ Child(ren)	\$ 62.00	\$ 66.00	\$ 73.00	\$ 79.00	\$ 88.00	\$ 96.00	\$ 106.00	\$ 117.00
		Applicant + Family	\$ 95.00	\$ 103.00	\$ 113.00	\$ 124.00	\$ 138.00	\$ 150.00	\$ 166.00	\$ 183.00
	<b>PREMIER</b>	Applicant Only	\$ 23.00	\$ 25.00	\$ 27.00	\$ 30.00	\$ 34.00	\$ 37.00	\$ 41.00	\$ 45.00
		Applicant+Spouse	\$ 47.00	\$ 51.00	\$ 56.00	\$ 63.00	\$ 68.00	\$ 76.00	\$ 83.00	\$ 91.00
		Applicant+ Child(ren)	\$ 56.00	\$ 60.00	\$ 66.00	\$ 72.00	\$ 80.00	\$ 87.00	\$ 96.00	\$ 106.00
		Applicant + Family	\$ 84.00	\$ 91.00	\$ 100.00	\$ 110.00	\$ 122.00	\$ 133.00	\$ 147.00	\$ 162.00
	<b>SELECT</b>	Applicant Only	\$ 20.00	\$ 23.00	\$ 25.00	\$ 26.00	\$ 29.00	\$ 33.00	\$ 36.00	\$ 40.00
		Applicant+Spouse	\$ 41.00	\$ 46.00	\$ 49.00	\$ 56.00	\$ 60.00	\$ 66.00	\$ 72.00	\$ 80.00
		Applicant+ Child(ren)	\$ 43.00	\$ 47.00	\$ 51.00	\$ 56.00	\$ 63.00	\$ 68.00	\$ 76.00	\$ 83.00
		Applicant + Family	\$ 67.00	\$ 75.00	\$ 82.00	\$ 90.00	\$ 99.00	\$ 108.00	\$ 120.00	\$ 131.00
<b>65 AND OVER</b>	<b>ELITE</b>	Applicant Only	\$ 30.00	\$ 32.00	\$ 36.00	\$ 40.00	\$ 44.00	\$ 49.00	\$ 54.00	\$ 57.00
		Applicant+Spouse	\$ 62.00	\$ 67.00	\$ 75.00	\$ 81.00	\$ 90.00	\$ 99.00	\$ 108.00	\$ 119.00
	<b>PREMIER</b>	Applicant Only	\$ 25.00	\$ 27.00	\$ 30.00	\$ 34.00	\$ 37.00	\$ 41.00	\$ 45.00	\$ 48.00
		Applicant+Spouse	\$ 52.00	\$ 56.00	\$ 63.00	\$ 68.00	\$ 76.00	\$ 83.00	\$ 91.00	\$ 100.00
	<b>SELECT</b>	Applicant Only	\$ 22.00	\$ 25.00	\$ 26.00	\$ 29.00	\$ 33.00	\$ 36.00	\$ 40.00	\$ 44.00
		Applicant+Spouse	\$ 46.00	\$ 49.00	\$ 56.00	\$ 61.00	\$ 66.00	\$ 72.00	\$ 80.00	\$ 88.00

Optional Vision Rates for All Ages			
<b>Elite Plan</b>	Applicant Only	\$ 6.00	<b>Premier &amp; Select Plans</b>
	Applicant+Spouse	\$ 13.00	
	Applicant+ Child(ren)	\$ 13.00	
	Applicant + Family	\$ 17.00	
	Applicant Only	\$ 5.00	
	Applicant+Spouse	\$ 10.00	
	Applicant+ Child(ren)	\$ 10.00	
	Applicant + Family	\$ 13.00	

ZIP CODE AREA CHART													
State & Zip	Area	State & Zip	Area	State & Zip	Area	State & Zip	Area	State & Zip	Area	State & Zip	Area	State & Zip	Area
<b>Alabama</b>		<b>California</b>		<b>Illinois</b>		<b>Michigan</b>		<b>Nebraska</b>	1	<b>Pennsylvania</b>		<b>Virginia</b>	
350-355	3	943-948	4	600-605	2	480-483	2	<b>Nevada</b>		170-178	2	222-223	6
359	3	949, 961	6	606-608	3	490-491	2	890-891	2	182-187	2	224-225	1
All Others	1	956-958	3	All Others	1	488-489	3	894-895	6	190-192	3	230-232	1
<b>Alaska</b>		959	4	<b>Indiana</b>		All Others	1	898	6	All Others	1	228-229	2
995-996	8	All Others	5	463-464	2	<b>Minnesota</b>		All Others	4	<b>So. Carolina</b>	1	240-244	2
All Others	6	<b>Colorado</b>		473	3	553-558	2	<b>New Mexico</b>		<b>Tennessee</b>		233-237	5
<b>Arizona</b>		803	4	All Others	1	564, 566	2	881	2	373-374	2	All Others	4
856-857	2	808-810	4	<b>Iowa</b>	1	All Others	1	882	5	All Others	1	<b>West Virginia</b>	
864	2	All Others	1	<b>Kansas</b>		<b>Mississippi</b>		All Others	1	<b>Texas</b>		255-257	4
All Others	1	<b>Delaware</b>	2	660-662	2	390-392	2	<b>Ohio</b>	1	751-753	3	262-265	3
<b>Arkansas</b>	1	<b>Dist Columbia</b>	6	All Others	1	All Others	1	<b>Oklahoma</b>		754	4	All Others	2
<b>California</b>		<b>Georgia</b>		<b>Kentucky</b>	1	<b>Missouri</b>		740-743	2	756-757	1	<b>Wisconsin</b>	1
900-905	7	300-303	2	<b>Louisiana</b>		640-641	2	All Others	1	776-777	1	<b>Wyoming</b>	1
906-914	6	307, 311	2	707-711	2	644-649	2	<b>Oregon</b>		All Others	2		
915-916	8	All Others	1	712	3	All Others	1	977	3	<b>Utah</b>	1		
917-918	4	<b>Hawaii</b>	3	All Others	1	<b>Montana</b>		978	1	<b>Virginia</b>			
919-927	6	<b>Idaho</b>	1			590-591	1	All Others	2	201	5		
930-934	6					599	2			220-221	5		
939	6					All Others	3						

# PRIMESTAR PERSONAL DENTAL

## PREMIUM RATE TABLE FOR MARYLAND

For effective dates March 1, 2010 through October 1, 2010

*Monthly Premiums illustrated are guaranteed for the initial twelve (12) months of coverage. Thereafter, premiums are likely to increase on a semi-annual basis.*

RATE CHART			Zip Codes 206-207 209-211	Zip Code 217	All Other Zip Codes
<b>UNDER AGE 65</b>	<b>ELITE</b>	Applicant Only	\$ 30.00	\$ 32.00	\$ 36.00
		Applicant+Spouse	\$ 61.00	\$ 67.00	\$ 75.00
		Applicant+ Child(ren)	\$ 66.00	\$ 73.00	\$ 79.00
		Applicant + Family	\$ 103.00	\$ 113.00	\$ 124.00
	<b>PREMIER</b>	Applicant Only	\$ 25.00	\$ 27.00	\$ 30.00
		Applicant+Spouse	\$ 51.00	\$ 56.00	\$ 63.00
		Applicant+ Child(ren)	\$ 60.00	\$ 66.00	\$ 72.00
		Applicant + Family	\$ 91.00	\$ 100.00	\$ 110.00
	<b>SELECT</b>	Applicant Only	\$ 23.00	\$ 25.00	\$ 26.00
		Applicant+Spouse	\$ 46.00	\$ 49.00	\$ 56.00
		Applicant+ Child(ren)	\$ 47.00	\$ 51.00	\$ 56.00
		Applicant + Family	\$ 75.00	\$ 82.00	\$ 90.00
<b>65 AND OVER</b>	<b>ELITE</b>	Applicant Only	\$ 32.00	\$ 36.00	\$ 40.00
		Applicant+Spouse	\$ 67.00	\$ 75.00	\$ 81.00
	<b>PREMIER</b>	Applicant Only	\$ 27.00	\$ 30.00	\$ 34.00
		Applicant+Spouse	\$ 56.00	\$ 63.00	\$ 68.00
	<b>SELECT</b>	Applicant Only	\$ 25.00	\$ 26.00	\$ 29.00
		Applicant+Spouse	\$ 49.00	\$ 56.00	\$ 61.00



**PRIMESTAR PERSONAL DENTAL**

**PREMIUM RATE TABLE FOR  
NORTH CAROLINA and NORTH DAKOTA**

**For effective dates March 1, 2010 through October 1, 2010**

*Monthly Premiums illustrated are guaranteed for the initial twelve (12) months of coverage. Thereafter, premiums are likely to increase on a semi-annual basis.*

RATE CHART			Area 1	Area 2	Area 3
UNDER AGE 65	ELITE	Applicant Only	\$ 26.00	\$ 29.00	\$ 31.00
		Applicant+Spouse	\$ 54.00	\$ 59.00	\$ 64.00
		Applicant+ Child(ren)	\$ 60.00	\$ 63.00	\$ 70.00
		Applicant + Family	\$ 91.00	\$ 99.00	\$ 108.00
	PREMIER	Applicant Only	\$ 22.00	\$ 24.00	\$ 26.00
		Applicant+Spouse	\$ 45.00	\$ 49.00	\$ 54.00
		Applicant+ Child(ren)	\$ 54.00	\$ 58.00	\$ 63.00
		Applicant + Family	\$ 81.00	\$ 87.00	\$ 96.00
	SELECT	Applicant Only	\$ 19.00	\$ 22.00	\$ 24.00
		Applicant+Spouse	\$ 39.00	\$ 44.00	\$ 47.00
		Applicant+ Child(ren)	\$ 41.00	\$ 45.00	\$ 49.00
		Applicant + Family	\$ 64.00	\$ 72.00	\$ 79.00
65 AND OVER	ELITE	Applicant Only	\$ 29.00	\$ 31.00	\$ 35.00
		Applicant+Spouse	\$ 60.00	\$ 64.00	\$ 72.00
	PREMIER	Applicant Only	\$ 24.00	\$ 26.00	\$ 29.00
		Applicant+Spouse	\$ 50.00	\$ 54.00	\$ 60.00
	SELECT	Applicant Only	\$ 21.00	\$ 24.00	\$ 25.00
		Applicant+Spouse	\$ 44.00	\$ 47.00	\$ 54.00

Optional Vision Rates for All Ages						
Elite Plan	Applicant Only	\$ 6.00		Premier & Select Plans	Applicant Only	\$ 5.00
	Applicant+Spouse	\$ 12.00			Applicant+Spouse	\$ 10.00
	Applicant+ Child(ren)	\$ 12.00			Applicant+ Child(ren)	\$ 10.00
	Applicant + Family	\$ 16.00			Applicant + Family	\$ 12.00

ZIP CODE AREA CHART			
North Carolina		North Dakota	
Zip	Area	Zip	Area
277	2	580-581	2
286	3	All Others	1
287-289	2		
All Others	1		

**PRIMESTAR PERSONAL DENTAL**

**PREMIUM RATE TABLE  
FOR  
SOUTH DAKOTA**

**For effective dates March 1, 2010 through October 1, 2010**

*Monthly Premiums illustrated are guaranteed for the initial twelve (12) months of coverage. Thereafter, premiums are likely to increase on a semi-annual basis.*

RATE CHART			Zip Codes 572-573	All Other Zip Codes
UNDER AGE 65	ELITE	Applicant Only	\$ 32.00	\$ 27.00
		Applicant+Spouse	\$ 67.00	\$ 56.00
		Applicant+ Child(ren)	\$ 73.00	\$ 62.00
		Applicant + Family	\$ 113.00	\$ 95.00
	SELECT	Applicant Only	\$ 25.00	\$ 20.00
		Applicant+Spouse	\$ 49.00	\$ 41.00
		Applicant+ Child(ren)	\$ 51.00	\$ 43.00
		Applicant + Family	\$ 82.00	\$ 67.00
65 AND OVER	ELITE	Applicant Only	\$ 36.00	\$ 30.00
		Applicant+Spouse	\$ 75.00	\$ 62.00
	SELECT	Applicant Only	\$ 26.00	\$ 22.00
		Applicant+Spouse	\$ 56.00	\$ 46.00

# PRIMESTAR PERSONAL DENTAL

## PREMIUM RATE TABLE FOR WASHINGTON

For effective dates March 1, 2010 through October 1, 2010

*Monthly Premiums illustrated are guaranteed for the initial twelve (12) months of coverage. Thereafter, premiums are likely to increase on an annual basis.*

RATE CHART			Area 3	Area 4	Area 5	Area 6
<b>UNDER AGE 65</b>	<b>ELITE</b>	Applicant Only	\$ 30.00	\$ 33.00	\$ 37.00	\$ 41.00
		Applicant+Spouse	\$ 62.00	\$ 70.00	\$ 75.00	\$ 84.00
		Applicant+ Child(ren)	\$ 68.00	\$ 73.00	\$ 82.00	\$ 89.00
		Applicant + Family	\$ 105.00	\$ 115.00	\$ 128.00	\$ 140.00
	<b>PREMIER</b>	Applicant Only	\$ 25.00	\$ 28.00	\$ 32.00	\$ 34.00
		Applicant+Spouse	\$ 52.00	\$ 59.00	\$ 63.00	\$ 71.00
		Applicant+ Child(ren)	\$ 61.00	\$ 67.00	\$ 74.00	\$ 81.00
		Applicant + Family	\$ 93.00	\$ 102.00	\$ 113.00	\$ 124.00
	<b>SELECT</b>	Applicant Only	\$ 23.00	\$ 24.00	\$ 27.00	\$ 31.00
		Applicant+Spouse	\$ 46.00	\$ 52.00	\$ 56.00	\$ 61.00
		Applicant+ Child(ren)	\$ 47.00	\$ 52.00	\$ 59.00	\$ 63.00
		Applicant + Family	\$ 76.00	\$ 84.00	\$ 92.00	\$ 100.00
<b>65 AND OVER</b>	<b>ELITE</b>	Applicant Only	\$ 33.00	\$ 37.00	\$ 41.00	\$ 46.00
		Applicant+Spouse	\$ 70.00	\$ 75.00	\$ 84.00	\$ 92.00
	<b>PREMIER</b>	Applicant Only	\$ 28.00	\$ 32.00	\$ 34.00	\$ 38.00
		Applicant+Spouse	\$ 59.00	\$ 63.00	\$ 71.00	\$ 77.00
	<b>SELECT</b>	Applicant Only	\$ 24.00	\$ 27.00	\$ 31.00	\$ 33.00
		Applicant+Spouse	\$ 52.00	\$ 57.00	\$ 61.00	\$ 67.00

Optional Vision Rates for All Ages					
<b>Elite Plan</b>	Applicant Only	\$ 6.00	<b>Premier &amp; Select Plans</b>	Applicant Only	\$ 5.00
	Applicant+Spouse	\$ 12.00		Applicant+Spouse	\$ 9.00
	Applicant+ Child(ren)	\$ 12.00		Applicant+ Child(ren)	\$ 9.00
	Applicant + Family	\$ 16.00		Applicant + Family	\$ 12.00

ZIP CODE AREA CHART	
<i>Washington</i>	
Zip	Area
982-984	4
990-992	3
993	6
All Others	5



**THE CO-HEALTH GROUP COLLEGIATE PLAN  
DENTAL/VISION/PHARMACY  
One plan provides discounts for all!**

Discount information can be obtained at the following website:

[www.AIPstudentinsurance.com](http://www.AIPstudentinsurance.com)

The **Co-Health Group Collegiate Plan** has been specially designed to meet the needs of today's College and University students, whether they are incoming freshmen, graduate, evening students, international or domestic students in the United States.

The **Co-Health Benefits Plan** provides discounts in certain health care areas not normally reimbursable by insurance. In the "Collegiate Plan" we are offering Vision, Dental and Pharmacy Discount Programs as a single package of benefits. Here's how the plan works.

First, **it is not an Insurance Plan**. The Co-Health Group Collegiate Plan is a discount Health Care plan offering discounts and savings for Vision, Dental, and Prescription Pharmacy expenses.

Second, you enroll as a member of the "Collegiate Plan". Each of the benefits programs (Vision, Dental, and Prescription Pharmacy) has a network of Providers (for example, there are participating dentists in the Dental Plan). As a member of the Plan, you can go to any of the providers and purchase their products or services on a specially negotiated discount basis. You will receive your discount/savings on the spot. There are no exclusions for "pre-existing" conditions. There are no claim forms to fill out and no paperwork to be filed. Simply show your Co-Health membership Card at the time of your scheduled appointment or at your Pharmacy.

The discounts you will receive are substantial and these savings can be very important to you. The program that makes up the Collegiate Plan (Vision, Dental, and Pharmacy) are also the three most common health areas where you will have unexpected expenses. With our benefits, you can substantially reduce your out-of-pocket expenses. And as an added bonus, you can use our plan benefits anywhere in the United States, except the State of Washington. A brief of Collegiate Plan follows.

**VISION**

A member can go to any one of over 13,000 locations, including all of the national and regional chains plus thousands of independent providers. National Benefits Providers include **Pearl Vision, Nu-Vision, LensCrafters, and Sears**. Discounts range from 10% to 60% on prescription eyeglasses and contact lenses. In addition, our Vision Program has a special Ophthalmic Benefit. Through a national network of Ophthalmologists we provide medical care of the eyes at a 20% discount, including Lasik Surgery, which is still not covered by most insurance plans.

There is a low price guarantee plus 100% guarantee of satisfaction (if, within 30 days of purchase, you are not 100% pleased with your new discount card, you may cancel with a full refund). There is never a limit on the number of purchases that a Co-Health member can make and the Co-Health member's discount always remains the same.



### **DENTAL CO-HEALTH**

This is a Fee per Procedure Discount Plan. The discount averages 15%-50%.

### **SAVINGS EXAMPLES**

	<b>Usual</b>	<b>You Pay</b>	<b>Savings</b>
Routine Exam	\$ 49.00	\$ 29.00	\$ 20.00
Adult Cleaning	\$ 96.00	\$ 56.00	\$ 40.00
Four Bite Wing X-rays	\$ 61.00	\$ 34.00	\$ 27.00
Composite (White) Filling	\$163.00	\$ 84.00	\$ 79.00
Crown (porcelain fused to noble metal)	\$889.00	\$597.00	\$292.00
Extraction (single tooth)	\$157.00	\$ 75.00	\$ 82.00

**You simply show your CO-HEALTH ID Card** and get your discount on the spot. Discounts on all dental specialties are available, including Orthodontic discount benefits. The Aetna Dental Access Discount is, to our knowledge, the finest Discount Plan in the United States. Special rules govern those who live in the State of Washington and this plan is NOT available to residents in the State of Washington at this time. There are more than 25,000 participating dentists throughout the country – the largest Dental Plan in America.

### **PHARMACY**

The **Co-Health Pharmacy Plan** has two basic components: Retail and Mail Order.

**Retail** – Discounts on brand name drugs up to 35%. Discounts on generic range as high as 70% of the manufacturer's suggested retail price. Over 58,000 pharmacies throughout the United States participate in our Co-Health Plan. This means that 95% of all pharmacies in America participate in our Network through our PBM (Pharmacy Benefit Management Company). We are electronically online with all these pharmacies. Our members receive their discounts and savings instantaneously at the point of sale. The list of participating pharmacies includes thousands of independent pharmacies plus most national and regional chains such as **Albertson's, Dominick's Drug Emporium, Duane Reade, Genovese, Medicine Shoppe, Omni, Pathmark, Rite-Aid, Safeway, Shopko, Value Rite, Revco, Walgreens and CVS.**

**Mail Order** – Our members save approximately another 10% by going to our Mail Order pharmacy for maintenance medications.

Our **Co-Health mail order Pharmacy** program is ideal for those who do not have a current Prescription Drug Plan. Most insurance co-pay plans exclude certain "lifestyle" drugs such as Rogaine, Propecia, Viagra and in some cases birth control pills. NOTE: A pharmacy will not honor the Co-Health discount if there is an insurance company or co-pay card also being used, but in some instances the discounted price through our Pharmacy Plan may be less than co-pay on your Insurance Company's drug co-pay card!

The Co-Health Pharmacy Plan also offers many "over the counter" items at terrific discounts, including Vitamins and Supplements.

Co-Health members can go to our network partner's website, [www.sav-rx.com](http://www.sav-rx.com), to review prices for maintenance drugs and over the counter items.



**Co-Health Discount Card  
Annual Cost**

<b>Student Only</b>	<b>Online or Credit</b>	<b>Check by Mail</b>
Dental/Vision/Pharmacy	\$72.00	\$62.00
Dental & Vision	\$62.00	\$52.00
Dental & Pharmacy	\$62.00	\$52.00
Vision & Pharmacy	\$50.00	\$40.00
Dental Only	\$50.00	\$40.00
Vision	\$25.00	\$15.00
Pharmacy Only	\$25.00	\$15.00

  

<b>Family</b>	<b>Online or Credit</b>	<b>Check by Mail</b>
Dental/Vision/Pharmacy	\$98.00	\$88.00
Dental & Vision	\$79.00	\$69.00
Dental & Pharmacy	\$79.00	\$69.00
Vision & Pharmacy	\$71.00	\$61.00
Dental Only	\$70.00	\$60.00
Vision	\$30.00	\$20.00
Pharmacy Only	\$30.00	\$20.00

**CO-HEALTH DISCOUNT CARD  
Questions and Answers**

**Q: What do I receive when I enroll in the plan?**

**A:** You will receive a welcome letter and a laminated identification card. The welcome letter will provide you with all pertinent web addresses so that you can access the Dental, Vision and Pharmacy Network.

**Q: How long does it take to receive my Discount Card?**

**A:** You will receive your Discount Card approximately 3 weeks following receipt of your application and premium.

**Q: When will my Discount Card expire?**

**A:** Your Discount Card will expire one year from the date your card was issued. Upon expiration, you must re-enroll in the plan.

**Q: When can I begin using my Discount Plan?**

**A:** Immediately upon receiving your ID Card in the mail.

**Q: How do I enroll in the plan?**

**A:** You may enroll online and pay your premium by using a major credit card or e-check, by using your bank routing number and your checking account at: [www.AIPstudentinsurance.com](http://www.AIPstudentinsurance.com)

Or, you may complete the application and mail with your check to:

**Associated Insurance Plans International, Inc.**  
28085 Ashley Circle Suite 201  
Libertyville, IL 60048  
[www.AIPstudentinsurance.com](http://www.AIPstudentinsurance.com)  
email: [office@AIPstudentinsurance.com](mailto:office@AIPstudentinsurance.com)  
800-452-5772