PRIMESTAR℠

PERSONAL Dental Insurance Plans

Underwritten by Security Life Insurance Company of America, 10901 Red Circle Drive, Minnetonka, Minnesota, 55343

DENTAL

Class A - Preventive Services	Select	Premier	Elite
Initial & Periodic Exams (2/year), Cleanings (2/year), Fluoride Treatments (to age 16), Sealants (no age limitation)			
Benefit Year One	75%	100%	100%
Benefit Year Two	85%	100%	100%
Benefit Year Three & Each Year Thereafter	100%	100%	100%
Deductible – Lifetime per Insured	$50	$50	$50
Class B - Basic Services	**Select**	**Premier**	**Elite**
X-Rays, Fillings, Simple Extractions			
Benefit Year One	25%	35%	35%
Benefit Year Two	35%	50%	65%
Benefit Year Three & Each Year Thereafter	50%	65%	80%
Deductible – per Calendar Year††	$50/Year	$50/Year	$50/Year
Class C - Major Services	**Select**	**Premier**	**Elite**
Oral Surgery, Endodontics, Periodontics, Crowns, Bridges, Dentures			
Benefit Year One	10%	10%	15%
Benefit Year Two	25%	25%	50%
Benefit Year Three & Each Year Thereafter	50%	50%	50%
Deductible – per Calendar Year††	$50/Year	$50/Year	$50/Year
Class D - Orthodontic Services	**Select**	**Premier**	**Elite**
Straightening of Teeth (for children under age 19)			
Benefit Year One	–	0%	–
Benefit Year Two	–	0%	–
Benefit Year Three & Each Year Thereafter	–	50%	–
Calendar Year Maximum for Classes A, B & 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	–

VISION RIDER – OPTIONAL*

Class A - Vision Exams (1/year)	Select	Premier	Elite
Benefit (Waiting Period: None)	85%	85%	100%
Class B - Lenses & Frames (1 pair/2 years)	**Select**	**Premier**	**Elite**
Benefit (Waiting Period: 15 Months)	50%	50%	50%
Class C - Contact Lenses (1 pair/2 years)	**Select**	**Premier**	**Elite**
In lieu of frames and lenses Benefit (Waiting Period: 15 Months)	50%	50%	50%
Plan Detail – Classes A, B & C	**Select**	**Premier**	**Elite**
Calendar Year Deductible	$50/Year	$50/Year	$50/Year
Calendar Year Maximum	$150/Year	$150/Year	$200/Year

- No Enrollment Fee
- Optional Vision Coverage
- Includes Coverage for All Ages
- Freedom to Choose Any Dentist – Optional Network Available for Additional Savings
- Up to $2,000 Annual Maximum

PrimeStar Dental plans come with a 30 Day Customer Satisfaction Guarantee. If you are not satisfied with your plan for any reason, you have 30 days after your plan becomes effective to cancel. Any premium paid will be fully refunded provided no covered services have been rendered. If services have been provided, you may still cancel your policy; however, the premium paid will not be eligible for reimbursement.

MAXIMUM CARE NETWORK: With over 200,000 dental locations nationwide, the Maximum Care Network can help you save up to 50% on routine and major dental procedures, in addition to helping you manage your annual maximums. Search providers at **careington.com/co/maxcare**. This option is not available in ID, NJ, or WA. Security Life will be held harmless in the event that the provider network does not have the appropriate state licensure or that the provider does not honor the network's discount.

†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

††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

***VISION RIDER:** Not a standalone benefit. Option available at an additional cost.

TWO WAYS TO ENROLL

Online

Online at **SecurityLife.com/Personal-Plans.** Online enrollment requires an agent authorization number (AAN). This eight-digit number can be obtained from your agent or by calling 800.328.4667.

Mail

Complete the enrollment form and mail to our office (see full instructions on the enrollment form).

DENTAL EXCLUSIONS AND LIMITATIONS

- Charges in excess of those considered Reasonable and Customary.
- Cosmetic procedures.
- The replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function.
- Implants and for replacement of lost or stolen appliances, replacement of retainers, athletic mouthguards, precision or semi-precision attachments, denture duplication.
- 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.
- Overdentures and associated procedures.
- Oral hygiene instructions, and for: plaque control, completion of a claim form, acid etch, broken appointments, prescription or take-home fluoride, or diagnostic photographs.
- Services not completed by the end of the month in which coverage ends unless continuation of coverage has been requested and accepted by Us.
- Procedures that are begun, but not completed.
- Services and treatment provided without charge, or for which there would be no charge in the absence of insurance.
- 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.
- 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.
- The treatment of cleft palate and anodontia.
- Services or supplies payable under any medical expense plan.
- Orthodontia, unless included within the Coverage Schedule.
- Services rendered prior to the date the Insured is covered under the Policy.
- The diagnosis or treatment of Temporomandibular Joint Dysfunction (TMJD).
- Hospital services.
- 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 EXCLUSIONS AND LIMITATIONS

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 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.
- Services or materials not listed as an Eligible Expense.

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GENERAL INFORMATION

ELIGIBILITY

Individuals, 18 years of age or older, plus their eligible dependents (spouse and unmarried children from birth to age 26). This is subject to individual state regulations.

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.

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 alternate treatment will produce a professionally satisfactory result; then the maximum We will allow will be the charges for the less expensive treatment.

REASONABLE AND CUSTOMARY

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

PREMIER DENTAL AND VISION PLAN IS NOT AVAILABLE IN SOUTH DAKOTA. OPTIONAL VISION BENEFITS NOT AVAILABLE IN MARYLAND.

The plans provide for an increase in coinsurance levels based upon each Benefit Year of coverage. Benefit Year begins with each insured's effective date and continues for 12 months. Each primary insured and dependent will have their own Benefit Year beginning with their specific effective date of coverage.

SECURITYLIFE
INSURANCE COMPANY OF AMERICA

This provides a very brief description of some of the important features of the insurance policy. It is not the insurance policy and does not represent it. A full explanation of benefits, exceptions and limitations is contained in the Group Dental Policy Form GH-1112 and Vision Rider GHR-1112 (Vision). Premium rates may change upon renewal. This policy is renewable at the option of the Company. This product may not be available in all states and is subject to individual state regulations.

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Brought to you by:

PRIMESTAR PERSONAL DENTAL

PREMIUM RATE TABLE
FOR
FLORIDA

For effective dates November 1, 2011 through July 1, 2013

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 3	Area 4	Area 5
UNDER AGE 65	ELITE	Applicant Only	$ 30.00	$ 36.00	$ 40.00	$ 44.00
		Applicant+Spouse	$ 63.00	$ 76.00	$ 84.00	$ 92.00
		Applicant+ Child(ren)	$ 69.00	$ 83.00	$ 91.00	$ 100.00
		Applicant + Family	$ 106.00	$ 128.00	$ 141.00	$ 155.00
	PREMIER	Applicant Only	$ 26.00	$ 31.00	$ 34.00	$ 38.00
		Applicant+Spouse	$ 53.00	$ 64.00	$ 70.00	$ 77.00
		Applicant+ Child(ren)	$ 62.00	$ 75.00	$ 83.00	$ 91.00
		Applicant + Family	$ 94.00	$ 113.00	$ 124.00	$ 137.00
	SELECT	Applicant Only	$ 24.00	$ 29.00	$ 32.00	$ 35.00
		Applicant+Spouse	$ 46.00	$ 55.00	$ 61.00	$ 67.00
		Applicant+ Child(ren)	$ 47.00	$ 57.00	$ 63.00	$ 69.00
		Applicant + Family	$ 76.00	$ 92.00	$ 101.00	$ 111.00
65 AND OVER	ELITE	Applicant Only	$ 34.00	$ 41.00	$ 45.00	$ 50.00
		Applicant+Spouse	$ 71.00	$ 85.00	$ 94.00	$ 103.00
	PREMIER	Applicant Only	$ 28.00	$ 34.00	$ 37.00	$ 41.00
		Applicant+Spouse	$ 60.00	$ 72.00	$ 79.00	$ 87.00
	SELECT	Applicant Only	$ 25.00	$ 30.00	$ 33.00	$ 36.00
		Applicant+Spouse	$ 53.00	$ 64.00	$ 70.00	$ 77.00

Optional Vision Rates for Under Age 65						
Elite Plan	Applicant Only	$ 6.00		Premier & Select Plans	Applicant Only	$ 5.00
	Applicant+Spouse	$ 13.00			Applicant+Spouse	$ 10.00
	Applicant+ Child(ren)	$ 13.00			Applicant+ Child(ren)	$ 10.00
	Applicant + Family	$ 17.00			Applicant + Family	$ 13.00
Optional Vision Rates for Age 65 and Over						
Elite Plan	Applicant Only	$ 6.00		Premier & Select Plans	Applicant Only	$ 5.00
	Applicant+Spouse	$ 12.00			Applicant+Spouse	$ 10.00

ZIP CODE AREA CHART			
Florida			
Zip	**Area**	**Zip**	**Area**
320	1	338	1
322	1	344	1
326-329	1	347	1
330-332	5	All Others	3
334	4		