

Group Dental

Employer Paid or Voluntary

Give your employees the competitive advantage of a great smile and good health.

*Put your best smile forward.
Now that's forward thinking!*



SECURITY PPO Dental Plan

A fully-insured group dental plan with enhanced vision care options for qualified firms with at least 2 eligible employees.



SECURITYLIFE

INSURANCE COMPANY OF AMERICA

About Security Life

Security Life Insurance Company of America founded in 1956 in Minneapolis, Minnesota provides an innovative array of ancillary benefits products (primarily dental, vision, disability and life insurance products) to consumers and employer groups and is licensed to sell insurance products in all 50 states (in conjunction with Security Health Insurance Company of America in NY). All products offered by Security Life include unique and flexible features that consumers demand in meeting their ever changing benefit needs.



Offered Exclusively by
National Benefit Consultants, Inc.
Contact us at 1-800-875-1505 or
1-262-746-6977

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

Please contact your agent or
National Benefit Consultants, Inc.
for plan questions.

Dental Plan

With DenteMax PPO Network

Enhanced Vision Care Options Available

Using the DenteMax PPO network of providers offers dental fees averaging 20% - 40% below usual charges. Use of a DenteMax Network provider will provide the insured with savings based on the network discounts DenteMax contracted providers offer. Non-network provider benefits will be reimbursed based on the DenteMax provider fee schedule.

DENTAL HIGHLIGHTS

- FREEDOM TO USE DENTIST OF YOUR CHOICE - In and out-of-network available
- 100% PREVENTATIVE COVERAGE with No Deductible or Waiting Period
- EMPLOYER PAID OR VOLUNTARY PROGRAMS
- 10% DISCOUNT FOR 50% PARTICIPATION on Voluntary Plan
- 5% DISCOUNT FOR DENTAL AND VISION combined application

VALUABLE OPTIONS

- CHOICE OF CALENDAR YEAR MAXIMUMS - \$1,000, \$1,500, \$2,000
- CREDIT FOR PRIOR TIME AVAILABLE
- ORTHODONTIC COVERAGE AVAILABLE for children under age 19
- ORAL SURGERY, ENDODONTICS AND PERIODONTICS SERVICES can be moved from the Class C Major Services category to Class B Basic Services category.

SECURITY – PPO DENTAL INSURANCE PLAN

Class A – Preventive & Diagnostic Services Include:

1. two routine (including any initial exam) examinations of mouth and teeth per calendar year;
2. two prophylaxis (cleaning, scaling and polishing teeth) per calendar year;
3. full mouth or panoramic x-rays once every 3 years;
4. periapical x-rays as necessary;
5. bitewing x-rays, 2 per calendar year;
6. sealants (to age 16);
7. one topical fluoride per calendar year, to age 16; and
8. space maintainers to preserve space between teeth for premature loss of a primary baby tooth. This does not include use for orthodontic treatment.

- Deductible – NONE
- Preventive Benefit Level Coverage – 100%
- Waiting Period - None

Class B – Basic Services Include:

1. simple extraction of teeth;
2. pin retention of fillings;
3. fillings of amalgam, silicate, acrylic, synthetic porcelain and composite filling materials (restorations of mesiolingual, distolingual, mesiobuccal and distobuccal surfaces considered as single surface restorations); and
4. antibiotic injections administered by Dentist.

- Deductible, each calendar year per insured – \$50*
- Basic Benefit Level Coverage – 80%
- Waiting Period – None

Class C – Major Services Include:

1. oral surgery, including postoperative care for:
 - a. removal of teeth, including impacted teeth;
 - b. extraction of tooth root;
 - c. alveolectomy, alveoplasty, and frenectomy;
 - d. excision of pericoronal gingiva, exostosis, or hyperplastic tissue, and excision of oral tissue for biopsy;
 - e. reimplantation or transplantation of a natural tooth; and
 - f. excision of a tumor or cyst and incision and drainage of an abscess or cyst.
2. endodontic treatment of disease of the tooth, pulp, root, and related tissue, as follows:
 - a. root canal therapy (not covered if pulp chamber was opened before coverage effective date);
 - b. pulpotomy;
 - c. apicoectomy; and
 - d. retrograde filling.
3. periodontic services, limited to:
 - a. two prophylaxis following surgery per calendar year;
 - b. root scaling and planing, once per quadrant of mouth in any 6 month period;
 - c. occlusal adjustment, performed with covered surgery;
 - d. gingivectomy, gingival curettage, and mucogingival;
 - e. osseous surgery including flap entry and closure;
 - f. pedicle or free soft tissue grafts; and
 - g. one appliance (night guards) in 5-year period.
4. one study model in 3 year period;
5. crown build-up for non-vital teeth;
6. recementing inlays, onlays and crowns;
7. recementing bridges;

- Deductible, each calendar year per insured – \$50*
- Major Benefit Level Coverage – 50%
- Waiting Period – 12 months**

Note: Employer Buy-up Option – move Oral Surgery, Endodontic and Periodontic services to Class B Basic Coverage. Refer to Employer Election Form.

SECURITY – PPO DENTAL INSURANCE PLAN

Class C – Major Services *continued*:

8. one repair of dentures or bridges in any 2 year period, limited to 20% of cost of replacement;
9. general anesthesia and analgesic, including intravenous sedation, for oral surgery;
10. restoration services, limited to:
 - a. gold or porcelain inlays, onlays, 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;
 - b. 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;
 - c. stainless steel crowns;
 - d. post and core.
11. prosthetic services, limited to:
 - a. 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;
 - b. replacement of dentures or fixed bridgework that cannot be repaired after 5 years from the date of placed or last replaced;
 - c. 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;
 - d. relining or rebasing of existing removable dentures, only after 1 year from date the denture was placed and only once in any 2-year period.

Class D – Optional Orthodontics (If Elected By Group) Services For Insureds Under 19 Years of Age Include:

1. surgical therapy;
2. appliance therapy;
3. functional/myofunctional therapy.

• Deductible, each calendar year – NONE
• Benefit Level Coverage – 50%
• Waiting Period – 12 months**

Maximum Benefit Amount:

Combined per calendar year per person for Classes A, B and C – \$1,000

- ◆ **Note: Employer Buy-Up Option for Combined per Calendar year**
Class A, B and C – \$1,500 or \$2,000

Maximum per calendar year for Class D – \$500 • Lifetime under the policy for Class D – \$1,000

Deductible:

*Class B and C Deductible is combined \$50 each calendar year per insured.

(A maximum of three (3) individual deductibles per family shall apply.)

CREDIT FOR PRIOR TIME (CPT)

Credit towards satisfaction of any waiting period class may be given for the length of time an employee was covered under the employer's prior dental insurance plan provided there is no interruption in coverage between the prior plan and the replacement plan.

The insured applying for CPT must have been covered for the same benefit classes under the prior plan in order to receive credit under the new plan. In other words, if the employer's prior plan did not provide Major or Orthodontic class coverage and the new plan provides both, CPT may not be given for the class not previously provided.

CPT is given individually to each person (employee, spouse, child) covered. Any new employee and/or dependents added on or subsequent to the group's effective date of this coverage will not receive CPT.

GROUP VISION PLAN 1 OR 2 - EMPLOYER TO CHOOSE EITHER

IN NETWORK BENEFITS - The EyeMed Access Network includes such familiar names as **Lenscrafters**, **Pearle Vision**, **Sears Optical**, and **Target Optical** along with thousands of independent optometrists, ophthalmologists and opticians.

Group Vision	PLAN 1 9751991	PLAN 2 9752007
EYE EXAMINATION		
Frequency	Once every 12 months	Once every 12 months
Insureds Co-pay	None	\$10
EYEGGLASS LENSES		
Frequency	Once every 24 months	Once every 12 months
Insureds Co-pay	None	\$10
FRAMES		
Frequency	Once every 24 months	Once every 12 months
Insureds Co-pay	None	\$0
CONTACTS (In Lieu of eyeglass lenses)		
Frequency	Same as eyeglass lenses	Same as eyeglass lenses
Insureds Co-pay	Same as eyeglass lenses	Same as eyeglass lenses

OUT OF NETWORK BENEFITS - The greatest benefit is realized when network providers are used, but members may choose out of network providers, paying the provider and receiving reimbursement from the plan according to the schedule below. Call the toll-free number for a claim form.

Group Vision	PLAN 1	PLAN 2
EYE EXAMINATION		
We Pay Up to	\$30	\$25
FRAMES		
We Pay Up to	\$40	\$40
LENSES – single vision		
We Pay Up to	\$25	\$20
LENSES – bifocal		
We Pay Up to	\$45	\$40
LENSES – trifocal		
We Pay Up to	\$55	\$50
CONTACT LENSES		
We Pay Up to	\$75	\$70

WHAT THE BENEFITS INCLUDE:

Eye Examination - A routine, complete eye examination, refraction, and prescription for eyeglasses. Contact lens examinations require additional fees. If indicated, your doctor may recommend additional procedures, which are the responsibility of the member.

Eyeglass Lenses - Standard uncoated plastic lenses of any size or power.

Frames - Any frame up to a regular retail value of \$100. Frames above \$100 retail are available at an additional charge.

Contact Lenses - Any pair of contact lenses up to a regular retail price of \$100 obtained from a network provider or the mail order program. Contacts above \$100 are available at an additional charge.

ADDITIONAL BENEFITS (In Network Only) LENS OPTIONS (add to lens prices above)

	Co Payment		Co Payment
UV Coating	\$15	Tint	\$15
Scratch Resistance	\$15	Polycarbonate	\$40
Anti-Reflective	\$45	Standard Progressive	\$65
Other Add Ons	20% Retail Discount		

LASIK – NON-INSURED DISCOUNT BENEFIT - The EyeMed Access network provides discounts to insureds interested in LASIK – A LASER VISION CORRECTION PROCEDURE. This non-insured benefit is offered at savings of 15% off the regular retail price or 5% off the promotional price when using the network.



For information or to locate a participating doctor call
866-723-0513
Or visit
www.EnrollWithEyeMed.com/access

This is only a Summary of Benefits. For complete information please see the Certificate of Insurance.
Policy Series GH-1157

SECURITY - PPO DENTAL INSURANCE PLAN

Group Dental Insurance with Enhanced Vision Care Option

ELIGIBILITY

ELIGIBLE EMPLOYEE MEANS

An individual employed by a participating employer who works 20 hours or more per week, and who is considered an employee for Social Security purposes. Partners and Proprietors are also considered to be eligible employees.

ELIGIBLE DEPENDENT MEANS

any of the following persons:

- a. Your spouse; and
- b. Your unmarried child, from birth to age 26
- c. Each unmarried child at least 26 years of age who is dependent upon You for support because he is incapable of self-sustaining employment by reason of mental retardation or physical handicap; who was incapacitated and insured under the Policy on his 26th birthday; and who continues to be incapacitated beyond his 26th birthday.

INELIGIBLE FIRMS

Businesses in existence for less than 12 months, bands or orchestras; barber and beauty shops; cocktail lounges; dental offices/labs; optical offices/labs; entertainers; massage parlors; parking lots and garages; real estate sales; taxi companies; groups where there is no employer/employee relationship; and groups where more than half the employees are related by blood or marriage. *This list of ineligible firms is representative only and not all-inclusive. The insurance company reserves the right to reject any firm.*

GENERAL INFORMATION – DENTAL AND VISION PLANS

PREMIUMS, RENEWABILITY

Rates are subject to change in accordance with the Master Policy. Coverage is renewable as long as eligibility criteria are satisfied and premiums are paid when due.

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.

COORDINATION OF BENEFITS

This Plan will be coordinated with any other group, blanket or franchise plan under which an Individual will receive benefits.

GENERAL INFORMATION – DENTAL PLANS

PARTICIPATION DISCOUNT

In the event the final dental employee participation reaches the greater of 3 employees or 50% of the eligible employees, your monthly premium rates charged may be reduced by 10%. Final approval of this discount is to be made by Company. This discount does not apply to the Employer Paid rates.

EFFECTIVE DATE

When a firm joins the Trust, the insurance for its current employees will be effective on the date approved by the insurance company. Future new employees will become insured on the first of the month following the completion of the probationary period selected by the employer.

A completed enrollment form must be received within 31 days of new employee eligibility. An employee who does not enroll when initially eligible is considered a "late entrant." A late entrant is eligible to enroll in the program as a "new employee" on the Plan's Anniversary Date or immediately if a qualifying event occurs.

BENEFIT PROVISIONS, LIMITATIONS AND EXCLUSIONS – DENTAL AND VISION PLANS

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 Dental Expense, the dental service or procedure must be performed by a licensed Dentist, Physician, or Dental Hygienist. To be an Eligible Vision Expense, the vision service must be performed by an Optometrist, an Ophthalmologist, or an Optician.

EXPENSES INCURRED

An Eligible Dental 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. An Eligible Vision Expense is considered incurred on the date the vision service is performed.

BENEFIT PROVISIONS, LIMITATIONS AND EXCLUSIONS – DENTAL PLANS

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 Maximum Calendar Year Limit, 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. If Course of Treatment is to exceed \$300, prior review is requested.

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 charges for the less expensive treatment.

MISSING TOOTH

When covered under your plan, benefits are provided for placement of dentures, fixed bridgework 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.

DENTAL EXPENSES NOT COVERED

The Policy, under which your certificate is issued, covers services and procedures as described in the Coverage Schedule. Your coverage, under the policy, **does not** cover any miscellaneous separate expense not considered a covered service or procedure.

No benefits will be paid for expenses incurred:

1. For overdentures and associated procedures;
2. For the portion of charges in excess of the Network Provider fee schedule;
3. For cosmetic procedures;
4. For the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function;
5. For implants; and for:
 - a. replacement of lost or stolen appliances;
 - b. replacement of retainers;
 - c. athletic mouthguards;
 - d. precision or semi-precision attachments; or
 - e. denture duplication.
6. For oral hygiene instructions; and for:
 - a. plaque control;
 - b. completion of a claim form;
 - c. acid etch;
 - d. broken appointments;
 - e. prescription or take-home fluoride; or
 - f. diagnostic photographs.
7. 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;
8. For procedures that are begun, but not completed;
9. For services and treatment provided without charge or for which there would be no charge in the absence of insurance;
10. 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;
11. For a condition covered under any Workers' Compensation Act or similar law;
12. That are applied toward satisfaction of a Deductible, if any;
13. That are generally considered by the dental profession as experimental or investigational;
14. For the treatment of cleft palate and anodontia;
15. For services or supplies payable under any medical expense plan;
16. For orthodontia, unless included by rider;
17. Prior to the date the Insured is covered under the Policy;
18. For the diagnosis or treatment of Temporomandibular Joint Dysfunction (TMJD);
19. For hospital services;
20. During any waiting period We require, when 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;
21. Charges for infection control, sterilization, and waste disposal.

VISION EXPENSES NOT COVERED

Limitations – In no event will payment exceed the lesser of: The actual cost of covered Services or Materials; or the limits of the Policy, shown in the Schedule.

1. Orthoptic or vision training and any associated supplemental testing;
2. Plano lenses;
3. Lens Coatings;
4. Two pair of glasses, in lieu of bifocals or trifocals;
5. Medical or surgical treatment of the eyes;
6. Any eye examination, or any corrective eyewear, required by an employer as a condition of employment;
7. Any injury or illness when covered under any Workers' Compensation or similar law, or which is work-related;
8. Customization of bifocal lenses to a progressive or non-lined lens;
9. Photo-chromatic lenses;
10. Sub-normal vision aids or non-prescription lenses;
11. Services rendered or materials purchased outside the U.S. or Canada, unless:
 - a. the Insured resides in the U.S. or Canada; and
 - b. the charges are incurred while on a business or pleasure trip.
12. Charges in excess of the Usual and Customary charge for the Service or Materials;
13. Charges incurred after:
 - a. the Policy ends; or
 - b. the Insured's coverage under the Policy ends, except as stated in the Policy.
14. Experimental or non-conventional treatment or device;
15. Spectacle lens treatments or "add-ons," except solid tints (#1 & #2), and oversize lenses;
16. High Index lenses of any material type;
17. Lost or broken Materials, except when replaced at normal intervals when Services are available.

IMPORTANT NOTICE:

This brochure provides a very brief description of some important features of your Plan. It is not the Insurance Contract nor does it represent the Contract. Some provisions may vary by state. A full explanation of benefits, exceptions and limitations is contained in the Certificate of Insurance under Group Policy Form GH-1112-39080 issued to the Employers' Voluntary Benefit Insurance Trust. This plan may not be available in all states.

No agent has the authority to change any benefits, to bind coverage with Security Life Insurance Company of America or to promise a certain effective date.