
State: Arkansas **Filing Company:** Security Life Insurance Company of America
TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental
Product Name: Individual Dental Insurance Policy
Project Name/Number: Individual Dental Insurance Policy/IP1000

Filing at a Glance

Company: Security Life Insurance Company of America
Product Name: Individual Dental Insurance Policy
State: Arkansas
TOI: H10I Individual Health - Dental
Sub-TOI: H10I.000 Health - Dental
Filing Type: Form/Rate
Date Submitted: 11/12/2012
SERFF Tr Num: SLIA-128766469
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: IP1000

Implementation: On Approval
Date Requested:
Author(s): Tammy Smasal
Reviewer(s): Rosalind Minor (primary)
Disposition Date: 11/13/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas **Filing Company:** Security Life Insurance Company of America
TOI/Sub-TOI: H101 Individual Health - Dental/H101.000 Health - Dental
Product Name: Individual Dental Insurance Policy
Project Name/Number: Individual Dental Insurance Policy/IP1000

General Information

Project Name: Individual Dental Insurance Policy

Project Number: IP1000

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Deemer Date:

Submitted By: Tammy Smasal

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 11/13/2012

State Status Changed: 11/13/2012

Created By: Tammy Smasal

Corresponding Filing Tracking Number:

Filing Description:

Attached are forms to be issued for an individual dental insurance policy with vision and orthodontia rider options. These forms will be used upon approval in the individual dental market on a going forward basis.

The following forms are enclosed for your review.

IP1000-AR - Individual Dental Insurance Policy

One of the three Coverage Schedules will be issued, depending upon the product applied for:

IPS1000 - Individual Dental Coverage Schedule

IPS1000-PPO - Individual Dental Preferred Provider Organization Coverage Schedule

IPS1000-SB - Individual Dental Scheduled Benefits Coverage Schedule

If the Vision Benefit Rider is chosen at the time of application, this Coverage Schedule will be issued:

IPS1000-V - Vision Coverage Schedule

If the product being offered requires or includes optional preferred provider organization networks, this rider will be issued:

IPR1000 - Preferred Provider Organization Rider

If either of the optional riders is chosen at the time of application, the following rider(s) will be issued:

IPR1001 - Vision Benefit Rider

IPR1002 - Orthodontia Benefit Rider

APP-01 - Individual Application

The above referenced forms are new and do not supersede any previously filed forms and may be used with other forms approved in the future. The effective date will be determined by your approval.

The forms are submitted in final printed format except for slight font and formatting variations that may occur due to Security Life product printer configurations. Security Life takes care to assure that printer-based variations are minimized; however, should changes occur, such changes will not alter the content or meaning of any approved form.

To provide flexibility, all variable text is indicated by brackets and described in the attached Statement of Variability. Applicable punctuation and minor grammatical changes may be substituted, if necessary. Variable text will never exclude or limit provisions mandated by your state.

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The company reserves the right to secure signatures to the application by use of electronic signature processes. Please be assured that any electronic processes will comply with the Federal Electronic Signatures in Global and National Commerce Act (E-SIGN) and the state's electronic transactions laws and regulations.

Thank you for your consideration of this filing. If you have any questions, or if you need additional information to complete your review, please call me at 952-945-3563, or send a note electronically to me at tammy.smasal@securitylife.com.

Company and Contact

Filing Contact Information

Tammy Smasal, Senior Compliance Analyst tammy.smasal@securitylife.com
 10901 Red Circle Drive 952-945-3563 [Phone]
 Suite 400
 Minnetonka, MN 55343

Filing Company Information

Security Life Insurance Company of America	CoCode: 68721	State of Domicile: Minnesota
10901 Red Circle Drive	Group Code: 492	Company Type: Life, Accident & Health
Minnetonka, MN 55343-9137	Group Name:	State ID Number:
(952) 544-2121 ext. 3589[Phone]	FEIN Number: 41-0808596	

Filing Fees

Fee Required? Yes
 Fee Amount: \$500.00
 Retaliatory? Yes
 Fee Explanation: AR requires \$50 per rate and per form, or retaliatory fee if greater. 1 rate + 9 forms = 10 x \$50 = \$500. Retaliatory fee = \$250. \$500 > \$250.
 Per Company: No

Company	Amount	Date Processed	Transaction #
Security Life Insurance Company of America	\$500.00	11/12/2012	64800049

SERFF Tracking #:

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IP1000

State:

Arkansas

Filing Company:

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TOI/Sub-TOI:

H101 Individual Health - Dental/H101.000 Health - Dental

Product Name:

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Project Name/Number:

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/13/2012	11/13/2012

State: Arkansas

Filing Company:

Security Life Insurance Company of America

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Disposition

Disposition Date: 11/13/2012

Implementation Date:

Status: Approved-Closed

Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Security Life Insurance Company of America	%	%				%	%

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Form	Individual Dental Insurance Policy	Approved-Closed	Yes
Form	Preferred Provider Coverage Rider	Approved-Closed	Yes
Form	Vision Benefit Rider	Approved-Closed	Yes
Form	Orthodontia Benefit Rider	Approved-Closed	Yes
Form	Coverage Schedule	Approved-Closed	Yes
Form	Coverage Schedule	Approved-Closed	Yes
Form	Coverage Schedule	Approved-Closed	Yes
Form	Vision Coverage Schedule	Approved-Closed	Yes

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Product Name:

Individual Dental Insurance Policy

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Schedule	Schedule Item	Schedule Item Status	Public Access
Form	Individual Insurance Application	Approved-Closed	Yes
Rate	Individual Dental Rate Filing	Approved-Closed	Yes

State: Arkansas

Filing Company:

Security Life Insurance Company of America

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Form Schedule

Lead Form Number: IP1000-AR

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved-Closed 11/13/2012	Individual Dental Insurance Policy	IP1000-AR	POL	Initial		52.400	AR Individual Dental Insurance Policy.pdf
2	Approved-Closed 11/13/2012	Preferred Povider Coverage Rider	IPR1000	POLA	Initial		54.800	Preferred Provider Coverage Rider.pdf
3	Approved-Closed 11/13/2012	Vision Benefit Rider	IPR1001	POLA	Initial		53.700	Vision Benefit Rider.pdf
4	Approved-Closed 11/13/2012	Orthodontia Benefit Rider	IPR1002	POLA	Initial		54.100	Orthodontia Benefit Rider.pdf
5	Approved-Closed 11/13/2012	Coverage Schedule	IPS1000	SCH	Initial		50.500	Coverage Schedule.pdf
6	Approved-Closed 11/13/2012	Coverage Schedule	IPS1000-PPO	SCH	Initial		50.500	Coverage Schedule PPO.pdf
7	Approved-Closed 11/13/2012	Coverage Schedule	IPS1000-SB	SCH	Initial		50.500	Coverage Schedule Sched Plan.pdf
8	Approved-Closed 11/13/2012	Vision Coverage Schedule	IPS1000-V	SCH	Initial		59.200	Coverage Schedule Vision.pdf
9	Approved-Closed 11/13/2012	Individual Insurance Application	APP-01	AEF	Initial		50.300	Individual Application.pdf

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Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages



Security Life Insurance Company of America
[10901 Red Circle Drive
Minnetonka, Minnesota 55343
XXX.XXX.XXXX]

Individual Dental Insurance Policy

We agree to pay the benefit described in this policy in accordance with and subject to the terms and provisions of this policy. This policy takes effect on the **policy effective date**. This policy will terminate in accordance with its provisions.

Right to Cancel: You may cancel this policy by delivering written notice to us and by returning the policy before midnight of the thirtieth (30th) day after the date you receive the policy. Notice given by mail and return of the policy by mail are effective on being postmarked, properly addressed, and postage paid. We will refund all payment made for this policy and both parties will be in the same position as if no policy had been issued.

Important Notice: Unless otherwise stated, benefits are payable only for expenses incurred while your coverage is in force.

The insurance under the policy does not take the place of nor does it affect any requirements for coverage by Worker's Compensation or a similar type of insurance.

Renewability: This policy is renewable at your option unless:

1. Your **premium** is not received before the **grace period** ends;
2. We refuse to renew all policies of this form in your state of residence; or
3. Subject to the **coverage ends** provisions provided in this policy.

If we refuse to renew policies per item 2 above, we will provide 60 days advance notice. No refusal of renewal will affect an existing claim.

This policy is subject to the laws of the state of issue.

Signed for the Company at its home office on the **policy effective date**.

[]
Secretary

[]
President

To obtain information, make an inquiry, or for assistance with a complaint,
please call our toll-free number at the top of this page.

This is a legal document between you and the Company.

Read this policy carefully.

Policy Data Page

Policyholder: [John J. Doe]

Policyholder Address: [123 Main Street, Any town, Any state, 12345]

Policy Effective Date: [09/01/2012]

Premium Mode: [Monthly]

[Dependents Covered:] [names will be listed]

[Enrollment Fee:] [Policy Fee:] [Administrative Fee:] [\$10.00]

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DEFINITIONS

Some of the terms found in this policy are defined below. Additional terms are defined throughout this policy where they are used. Section titles, provision titles, and terms used on the coverage schedule may also be **bolded** to help you easily recognize them.

Child, Children

Your natural, adopted, foster, or step-child.

An “adopted child” is any **child** under the charge, care, and control of you whom you have filed a petition to adopt. An adopted **child** will be subject to the same conditions as a natural **child**.

A “step-child” is a **child** of your spouse who lives within the same household as you or is financially dependent upon you.

Dental Practitioner

A dental assistant, dental hygienist, or dentist who is properly licensed or certified under the laws of the state in which he or she practices, and is operating within the scope of that license or certification.

A **dental practitioner** may not be a member of your family. Members of your family include your parents, step-parents, including in-laws, spouse or former spouse, **domestic partner**, **children**, siblings, aunts, uncles, cousins, nieces, nephews, grandparents, and guardians.

Dependent

Your:

1. spouse;
2. [unmarried] **children** from birth to age [26] [who are primarily **dependent** upon you for support and maintenance]; and
3. **child** after their [26th] birthday if the **child** has been continuously insured and is:
 - a. incapable of self-sustaining employment because of mental or physical incapacity;
 - b. primarily **dependent** upon you for support and maintenance; and
 - c. not married.

In order to continue the **child's** coverage, you must submit to us proof of the **child's** incapacity.

A **child** will also be considered a **dependent** if you are ordered by a court to provide coverage for that **child** and the **child** meets all conditions for eligibility under this policy.

These persons are excluded as **dependents**:

1. your former spouse, if either you or your spouse has obtained a decree of divorce or legal separation (in a state where this is recognized); and
2. a person who is on active duty in the military service of any country.

DEFINITIONS *(continued from the previous page)*

Domestic Partner

Your partner who:

1. is not related to you by blood closer than permitted under applicable state marriage laws;
2. is not married and does not have any other **domestic partners**;
3. is at least eighteen (18) years of age and has the capacity to enter into a contract;
4. shares a residence with you; and
5. is jointly responsible with you for the necessities of life and can produce documentation of at least three of the following as evidence of joint responsibility:
 - a. joint mortgage or joint tenancy on a residential lease;
 - b. joint bank account;
 - c. joint liabilities (e.g. credit cards or car loans);
 - d. joint ownership of significant property (e.g. cars, land, etc.);
 - e. naming of each other as primary beneficiary in wills or life insurance policies;
 - f. written notarized agreements or contracts regarding the relationship, showing mutual support obligations, or joint ownership of assets acquired during the relationship; or
 - g. commitment to a long term relationship with the intention of remaining together indefinitely.

Unless otherwise noted, all references to spouse include **domestic partner**.

Eligible Expenses

Covered dental services and procedures described in this policy.

Insured

You and your **dependents** covered under this policy and for whom a premium is paid.

Reasonable and Customary

The usual, customary and regular charges for the area where such expenses are incurred.

Treatment Plan

A report by your **dental practitioner**, submitted on a form acceptable to us, which includes:

1. an itemized description of the recommended dental procedures using the American Dental Association codes and nomenclature; and
2. a list of charges for each procedure; and
3. the estimated length of treatment.

Waiting Period

The amount of time coverage must be active before we will pay for certain procedures and services. Any applicable **waiting periods** are shown on the **coverage schedule**.

We, Our, Us, or the Company

Security Life Insurance Company of America. The terms we, our, us or the Company may not be bolded throughout this policy.

You, Your, Yourself

The **insured** policyholder. The terms you, your and yourself may not be bolded throughout this policy.

CONDITIONS FOR INSURANCE

Dependent Coverage

You have the option of insuring your **dependents**. You must be covered under this policy in order to insure your **dependents**. After this policy effective date, you may add **dependents** at any time, if they meet the definition and any required change information is provided to us.

CONDITIONS FOR INSURANCE *(continued from the previous page)*

Newborn Infant Coverage

Your newborn **child** is covered from the moment of birth. If any additional premium is required, a notice of birth together with the premium must be submitted to us. This must be done within 90 days after the date of birth to continue coverage beyond the first 90-day period.

Adopted Child Coverage

An adopted **child** is covered from the date of the filing of a petition for adoption or the date of birth. If any premium is required, the petition for adoption together with the premium must be submitted to us. This must be done within 60 days after the date of the filing of the petition for adoption or the date of birth to continue coverage beyond the first 60-day period.

Coverage Ends

Coverage for you and/or your **dependents** will end on the earlier of:

1. the date your **dependent** is no longer a **dependent** as defined; or
2. the last day through which **premium** was paid; or
3. the date this policy ends.

If your and/or your **dependent** coverage ends, it will not prejudice any existing claim.

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.

ELIGIBLE EXPENSES

We will pay for **eligible expenses** you incur for yourself or on behalf of your **insured dependent**. Expenses must be incurred while this policy is in force and the person is covered by this policy. The description of **eligible expenses** is shown on the **coverage schedule**.

To be an **eligible expense**, the dental service or procedure must be performed by a **dental practitioner**.

An **eligible expense** is considered incurred on the following dates:

1. For dentures – the date the final impression is taken.
2. For fixed bridges, crowns, inlays and onlays – the date the teeth are first prepared.
3. For root canal therapy – the date the pulp chamber is opened.
4. For periodontal surgery – the date surgery is performed.
5. For all other services – the date the service is performed.

Predetermination of Benefits

It is recommended that a **treatment plan** be submitted when the total cost of **eligible expenses** for any **insured** is expected to exceed the amount shown on the **coverage schedule**. This should be submitted to us before the work is started. Diagnostic information, x-rays, treatment records and other pertinent information that would be required to support the need for the recommended treatment should be included.

We will review the **treatment plan** and estimate what we will pay. We will then send this information to your **dental practitioner**. If actual services submitted do not agree with the **treatment plan**, or if a **treatment plan** is not sent in, we will base our payment on treatment consistent with **reasonable and customary** charges the area.

Predetermination of benefits is not a guarantee of what we will pay. The estimated benefit payment is based on your current eligibility and benefits in effect at the time of the completed service. Submission of other claims or changes in eligibility or this policy may alter final payment.

ELIGIBLE EXPENSES (continued from the previous page)

Payment is subject to:

1. the work being done as proposed and while coverage is in effect; and
2. payments made by a primary carrier; and
3. all other terms and conditions of this policy.

Emergency dental care, oral examinations, dental x-rays and teeth cleaning as a part of a course of treatment may be performed before a **treatment plan** is submitted.

Alternate Benefit

If we determine that a less expensive procedure, service, or course of treatment that is customarily used to treat the dental problem and recognized by the dental profession to be appropriate according to broadly accepted standards of dental practice, then the maximum we will allow will be the charge for the less expensive treatment.

Maximum Benefit Amount

The maximum limit payable for all **eligible expenses** in any calendar year is shown on the **coverage schedule**. The **calendar year limit** and/or **lifetime maximum**, if any, will apply to each person covered under this policy.

Deductible

The lifetime and calendar year **deductible**, if any, is shown on the **coverage schedule**. The **deductible** is an amount of charges you must incur for yourself or on behalf of your **insured dependent** before we start paying benefits.

PREMIUM PROVISIONS

Change in Premiums

We will give written notice to you at least 60 days in advance of any such change.

Premium Payments

Premiums are payable based on a mode of payment selected by you and agreed to by us. Premiums must be paid to us at our home office or to our authorized representative. The payment of the premium due will keep the coverage under this policy in force to the next premium due date, subject to the **grace period** provision.

Grace Period

A grace period of 31 days measured from the premium due date will be allowed for payment of each premium due after the first premium. The insurance will remain in force during the grace period, as long as premiums are paid. You may be liable to us for all unpaid premiums for any period, including the grace period, during which coverage under this policy was in force as to any covered person. The grace period will not apply if, at least 30 days before the due date, we have delivered or mailed to your last known address written notice of our intent not to renew this policy.

Reinstatement

If this policy is terminated due to a lack of premium payment, you may request reinstatement.

We may accept the premium and reinstate your policy without an application. If we require an application to reinstate, you will be given a conditional receipt for the premium. If the application is approved, this policy will be reinstated as of the approval date. Lacking approval, this policy will be reinstated on the 45th day after the date of the conditional receipt unless we provide you written notice of disapproval.

The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after that date. The **insured** and the Company will have the same rights under the reinstated policy as they had under this policy immediately before the due date of the defaulted premium, subject to any provisions endorsed in this policy or attached to this policy in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to your unpaid premium. No premiums will be applied to any period more than 60 days before the reinstatement date.

CLAIM PROVISIONS

Notice of Claim

We encourage you to notify us of your claim as soon as possible so that a claim decision can be made in a timely manner. Notice must be given to us within 30 days of the date the expenses are incurred, or as soon as reasonably possible. Notice should include the **insured's** name and policy number.

Claim Forms

Should you require a claim form for filing a proof of loss, the forms will be supplied to you within 15 days of notice of the claim.

If you do not receive a claim form within this 15-day period, you may submit a proof of loss by sending us the information in writing, describing the occurrence, character, and extent of the treatment within the time frame in **proof of loss**.

Proof of Loss

You must send us a proof of loss within 90 days after the date the expenses are incurred. We will not decline or reduce a claim if:

1. it is not reasonably possible to give proof within that time; and
2. the proof is submitted within one year from the date specified above. This 1-year period will not apply when you are not legally capable of submitting proof.

All proofs of loss must be satisfactory to us.

Time of Claim Payment

We will pay any benefits we owe you under this policy as soon as we receive and approve your **proof of loss**.

Payment of Claims

All benefits are payable to you. All or any portion of any benefits provided may be paid directly to the person rendering the service, unless you direct otherwise at the time of claim.

If you are not legally capable of accepting a benefit, all or part of the benefit can be paid to your spouse, your estate (if applicable), or a recognized guardian as determined by us. That payment, made in good faith, fully discharges us to the extent of the payment.

Benefits accrued but unpaid before your death will be paid to your estate.

Legal Actions

No legal action may be brought to recover under this policy:

1. within 60 days after you have sent us a written proof of loss; or
2. after 3 years from the time you were required to send us a written proof of loss.

Claim Review and Appeal Procedure

In the event of any claim denial with which you do not agree, you have the right to submit a written request to us at our Home Office asking for a review of the denial of benefits. That request may include documents from your care provider that support your basis for the requested review. Within 30 days after we receive that written request, we will notify you or your representative of the results of the review.

GENERAL PROVISIONS

Entire Contract

This policy, including the application, and any amendments, riders or endorsements, constitute the entire contract of insurance.

Who Can Make Changes in this Policy

Only our President together with our Secretary has the authority to make any changes in this policy. Any change must be in writing.

Right to Contest

All statements made by you are deemed representations and not warranties. No such statement will be used in any contest under this policy unless it is contained in a written instrument and a copy of such instrument is or has been furnished to such person or his beneficiary, if any.

The validity of coverage under this policy cannot be contested, except for non-payment of premiums, after it has been in force for 2 years from its effective date. No statement, except a fraudulent misstatement, made by an **insured** will be used to contest the validity of this coverage after such coverage has been in force for a period of 2 years during such **insured's** lifetime, nor unless it is contained in written instrument, signed by him, and a copy of such instrument is or has been furnished to him, his beneficiary or his representative.

Assignment of this Policy

This policy is not assignable, except with our prior written consent.

Change of Beneficiary

You can change the beneficiary at any time by giving us written notice. The beneficiary's consent is not required for this or any other change in the policy, unless the designation of the beneficiary is irrevocable.

Conformity with Law

Any provision of this policy that, on its effective date, is contrary to any law to which it is subject, is amended to conform to the minimum requirements of such law.

Misstatement of Age

If any **insured** age has been misstated, the benefits will be those the premium paid would have purchase at the correct age.

Physical Examination and Autopsy

At our expense, we have the right to require a physical examination, by a specialist of our choice, on any **insured** as often as reasonably necessary while a claim is pending. At our expense, we may also require an autopsy, unless prohibited by law.

References to Time

All references to time shall mean the time at your place of residency. All periods affecting this policy begin at 12:00 a.m. and end at 11:59 p.m., standard time, at your place of residency.

[Takeover/Credit for Prior Time

You may qualify for takeover benefits. If you were previously covered under a dental insurance plan, that time may be considered as time served for any applicable **waiting periods**. You must supply a valid evidence of coverage letter from the prior carrier indicating the dates you were covered under the prior insurance plan. This must include the termination date of the prior insurance plan that is no more than 30 days prior to the date you applied for coverage under this policy. The benefits under the prior insurance plan must have been similar to the benefits included in this policy.]

PREFERRED PROVIDER COVERAGE RIDER

The Company has issued this rider as a part of the **entire contract**. If there are any conflicts between this rider and the policy, the provisions of this rider will prevail.

DEFINITIONS

The following terms are added to the definitions section.

Participating Dentist

A **dental practitioner** who has entered into a written agreement with a preferred provider organization that we have contracted with to provide dental services.

Non-participating Dentist

A **dental practitioner** who has not entered into a written agreement with a preferred provider organization that we have contracted with.

PREFERRED PROVIDER ORGANIZATION PLAN DESCRIPTION

This section of this rider describes how benefits will be paid for **eligible expenses** incurred for the services of a **participating dentist**. The policy describes how benefits will be paid for **eligible expenses** incurred for the services of a **non-participating dentist**, except as stated in this rider.

We will pay benefits as shown on the **coverage schedule** for eligible expenses incurred by an **insured** if the treatment is rendered, care is given or materials are furnished in, at or by a **participating dentist**. Use of a **participating dentist** does not guarantee that all expenses will be covered under the policy.

If a **non-participating dentist** is used for the following reasons, benefits will be payable as if services were rendered by a **participating dentist**:

1. If emergency care is necessary and it is outside the preferred provider organization's contract area or a **participating dentist** is not available.
2. If a **participating dentist** refers the **insured** to a **non-participating dentist** because the **participating dentist** is unable to render the necessary service.
3. If a **non-participating dentist** is on call in the absence of a **participating dentist**.

Eligible expenses will be paid at the benefit levels for a **non-participating dentist** if an **insured** incurs any **eligible expenses**:

1. for services of a provider who is no longer a **participating dentist**; or
2. when this rider has terminated; or
3. when the **insured** elects not to use the services or supplies of the **participating dentist**.

IMPORTANT NOTICE

To maximize your benefits, you should see a **participating dentist**. Benefits may be lower if you incur **eligible expenses** from a **non-participating dentist**.

This rider terminates with the policy to which it is attached. In all other respects, the provisions, conditions, exceptions, and limitations contained in the policy remain unchanged and apply to this rider.

Signed for the Company at its home office.

SECURITY LIFE INSURANCE COMPANY OF AMERICA

[]
 Secretary

[]
 President

VISION BENEFIT RIDER

The Company has issued this rider as a part of the **entire contract**. If there are any conflicts between this rider and the policy, the provisions of this rider will prevail.

DEFINITIONS

The following term is added to the definitions section.

Vision Provider

An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials.

ELIGIBLE EXPENSES

The following is added to the **eligible expenses** section.

For vision services, we will pay for **eligible expenses** incurred by or on behalf of an **insured** while this rider and the policy are in force and the **insured** is covered. Payment is subject to the applicable **deductible, waiting period**, and any applicable **maximum benefit amount** for this rider shown on the **coverage schedule**.

Eligible expenses include the following vision services:

- Class A.** **Eligible expenses** consist of charges for a complete visual analysis including case history and refraction. These expenses are payable only when an eye refraction is performed.
- Class B.** **Eligible expenses** consist of charges for lenses and frame.
- Class C.** **Eligible expenses** consist of charges for contact lenses and are provided in lieu of lenses and frame benefits, if the visual acuity of the patient is 20/70 or worse in the patient's better eye.

This rider terminates with the policy to which it is attached. In all other respects, the provisions, conditions, exceptions, and limitations contained in the policy remain unchanged and apply to this rider.

Signed for the Company at its home office.

SECURITY LIFE INSURANCE COMPANY OF AMERICA

[]
Secretary

[]
President

ORTHODONTIA BENEFIT RIDER

The Company has issued this rider as a part of the **entire contract**. If there are any conflicts between this rider and the policy, the provisions of this rider will prevail.

DEFINITIONS

The following is added to the definitions section.

Orthodontia Provider

An orthodontist licensed and otherwise qualified to practice orthodontia care and services.

ELIGIBLE EXPENSES

The following is added to the **eligible expenses** section.

Eligible expenses include the **reasonable and customary** charge for the following orthodontia services:

A treatment plan for the correction of any existing malocclusion through the correction of malposed teeth, including diagnosis (with radiographs), extractions (to correct crowding), surgical access of an unerupted tooth, active treatment (including appliances) and retention treatment following active treatment. Replacement of lost, stolen, or broken appliances are not covered.

To be an **eligible expense**, the dental service or procedure must be performed by an **orthodontia provider**.

For orthodontia services, **eligible expenses** are incurred on the date the appliance is placed and then monthly thereafter on the same day of the month as the placement date for as long as active or retentive treatment continues, while this rider and policy are in force.

We will pay **eligible expenses** incurred for orthodontia services in excess of any deductible up to any applicable **maximum benefit amount** for this rider shown on the **coverage schedule**.

This rider terminates with the policy to which it is attached. In all other respects, the provisions, conditions, exceptions, and limitations contained in the policy remain unchanged and apply to this rider.

Signed for the Company in its home office.

SECURITY LIFE INSURANCE COMPANY OF AMERICA

[]
 Secretary

[]
 President

Coverage Schedule

We will pay the usual and customary charge for dental procedures and services after any required deductible amount, as shown below.

[Class A. Preventive Services Include:

Evaluations

1. [Comprehensive or Periodic Oral Evaluations: Limited to [1 evaluation in any 6 consecutive months.] [two evaluations (including any initial exam) per calendar year.] [three evaluations (including any initial exam) per calendar year.]
2. [Emergency Palliative Treatment: Limited to 1 palliative treatment in any 6 consecutive months and payable only if no other service (except x-rays) is rendered.]

X-Rays

1. [Complete series/Panoramic: Limited to 1 panoramic film or complete series (including bitewing films) [in any 60 consecutive months.] [per calendar year.] [per three calendar years.]
2. [Bitewing films: Limited to [1] series consisting of no more than [4] films [in any 12 consecutive months.] [per calendar year.]
3. [Periapical films: Limited to [4] films in any 12 consecutive months.] [1 per calendar year.]
4. [Occlusal films: Limited to [4] films in any 12 consecutive months.] [1 per calendar year.]]

Basic Restorative Services

Insulating base and local anesthesia is considered an integral part of services rendered.]

Fillings:

1. Amalgam Restoration: Limited to 1 filling per tooth surface in any [24] consecutive months. Contiguous surfaces billed separately will be combined as one restorative procedure.
2. Composite Resin (Synthetic) Restoration: Limited to 1 filling per [anterior] tooth surface in any [24] consecutive months. Contiguous surfaces billed separately will be combined as one restorative procedure.
3. Pin Retention: Only in conjunction with amalgam or composite resin restorations and only 1 per tooth.]

Routine Dental Prophylaxis and Fluoride Treatments

1. [Adult Prophylaxis: Limited to [1 treatment in any 6 consecutive months] [1 treatment per calendar year.] [two treatments per calendar year.] [three treatments per calendar year.] [for covered individuals age [15] and over;] [benefit includes scaling and polishing.]
2. [Child Prophylaxis: Limited to [1 treatment in any 6 consecutive months] [1 treatment per calendar year.] [two treatments per calendar year] [three treatments per calendar year] [for covered dependent children under age [15];] [benefit includes scaling and polishing.]
3. [Fluoride Treatments: Limited to [1 topical application in any [6] consecutive months] [1 topical application per calendar year] [two topical applications per calendar year] [three topical applications per calendar year] [for covered dependent children under age [15].]]

Space Maintainers

Limited to initial passive appliance for covered dependent children [under age [14]] for missing primary teeth; includes all adjustments made within 6 months of installation; limited to fixed unilateral, fixed bilateral, and removable bilateral types. Recementation limited to 1 time in any 12 consecutive months.]

Sealants

Limited to the occlusal surface of unrestored permanent molars for covered dependent children [under age [16]]; limited to 1 sealant treatment per tooth in any [48] consecutive months.]

	[First Year	Second Year	Each Year Thereafter
Deductible, [per calendar year] [per lifetime]	\$[50]	\$[50][\\$50/Lifetime]	\$[50]
We pay, after deductible	[100]%	[100]%	[100]%
[Waiting period [None]]]			

[Deductible, [per calendar year] [per lifetime]
We pay, after deductible
[Waiting period [None]]]

[\$50]
[100]%

Maximum benefit amount information prior to Expenses Not Covered section of the Coverage Schedule.]

[Class B. Basic Services Include:

[Evaluations

1. [Limited Oral Evaluation: Limited to 1 evaluation per dental practitioner in any 12 consecutive months and payable only if no other service (except x-rays) is rendered during the evaluation.]
2. [Diagnostic Consultation: Limited to 1 consultation (by a dental practitioner other than the one providing treatment) for each dental specialty in any 12 consecutive months and payable only if no other service (except x-rays) is rendered during the consultation.]
3. [Emergency Palliative Treatment: Limited to 1 palliative treatment in any 6 consecutive months and payable only if no other service (except x-rays) is rendered.]]

[X-Rays

1. [Complete series/Panoramic: Limited to 1 panoramic film or complete series (including bitewing films) [in any 60 consecutive months.] [per calendar year.] [per three calendar years.]
2. [Bitewing films: Limited to [1] series consisting of no more than [4] films [in any 12 consecutive months.] [per calendar year.]
3. [Periapical films: Limited to [4] films in any 12 consecutive months.] [1 per calendar year.]
4. [Occlusal films: Limited to [4] films in any 12 consecutive months.] [1 per calendar year.]]

[Basic Restorative Services

Insulating base and local anesthesia is considered an integral part of services rendered.]

[Fillings:

1. Amalgam Restoration: Limited to 1 filling per tooth surface in any [24] consecutive months. Contiguous surfaces billed separately will be combined as one restorative procedure.
2. Composite Resin (Synthetic) Restoration: Limited to 1 filling per [anterior] tooth surface in any [24] consecutive months. Contiguous surfaces billed separately will be combined as one restorative procedure.
3. Pin Retention: Only in conjunction with amalgam or composite resin restorations and only 1 per tooth.]

[Implants

1. Implants, [but no more than once for the same tooth position in a 60 month period,] [after 36 months of coverage] when needed to replace natural teeth that are lost while you are insured under this policy.
2. Repair of implants, but not more than once in a [24] month period.
3. Implant supported prosthetics, [but no more than once for the same tooth position in a 60 month period,] [after 36 months of coverage] when needed to replace natural teeth that are lost while you are insured under this policy.
4. Repair of implant supported prosthetics, but not more than once in a [24] month period.
5. Replacement of congenitally missing teeth is not covered under your plan unless you are replacing a current prosthetic device.]

Basic Oral Surgery

Local anesthesia and routine follow-up care are considered an integral part of basic oral surgery.

Extractions: Non-surgical extraction, 1 or more teeth.

[Complex Oral Surgery

Local anesthesia and routine follow-up care are considered an integral part of oral surgery.

1. Complex Extractions: Surgical removal of erupted teeth, involving tissue flap and bone removal, removal of residual roots, or impacted teeth.
2. Other Surgical Procedures:
 - a. Alveoplasty,[aveolectomy] per quadrant
 - b. Removal of exostosis

- c. Excision of hyperplastic tissue
- d. Excision of pericoronal gingival per tooth
- e. Excision of tooth related cyst, tumor or neoplasm
- f. Incision and drainage of abscess
- g. [Oroantral fistula closure]
- h. [Frenulectomy or [frenuloplasty]]
- i. [Sialolithotomy for removal of salivary calculus]
- j. [Closure of salivary fistula]
- k. [Sialodochoplasty]
- l. [Maxillary sinusotomy for removal of tooth fragment or foreign body]
- m. [Surgical excision of lesions]
- n. [Vestibuloplasty]
- o. [Surgical exposure of impacted or unerupted tooth to aid eruption]
- p. [Biopsy and exam of tooth related oral tissue]

[Endodontic Services

1. Root canal therapy (not covered, if pulp chamber was opened before coverage began): Non-vital, nerve-dead tooth; local anesthesia and routine follow-up care are considered an integral part of services rendered; limited to 1 root canal treatment per tooth in any [36] consecutive months.
2. Vital pulpotomy: Limited to primary teeth only.
3. [Apexification: Therapeutic apical closure.]
4. Apicoectomy and retrograde filling: As a separate procedure or in conjunction with other endodontic procedures; limited to 1 treatment per tooth in any [36] consecutive months.]

[Periodontal Services

Local anesthesia and routine follow-up care are considered an integral part of services rendered.

[Non-Surgical Services:

1. Periodontal Scaling and Root Planing: As necessary for substantial bone and attachment loss evident on current periodontal charting and radiographs; limited to 1 treatment [per quadrant in any [24] consecutive months.] [per calendar year.]
2. Periodontal Maintenance: Limited to [1 treatment in any 6 consecutive months] [two treatments per calendar year] [(replaces routine dental prophylaxis)] [and only qualifying after 3 months from date of completion of active periodontal treatment, including scaling and root planing.]
3. [Night Guards: Limited to 1 appliance in a 5 year period.]]

[Surgical Services: Limited to 1 periodontal surgical service per quadrant in any [36] consecutive months.

1. Gingivectomy: Per quadrant; limited to less than 3 teeth.
2. Osseous Surgery: Per quadrant; benefit includes all necessary associated surgical procedures.
3. Mucogingival Surgery: Pedicle soft tissue graft; gingival flap procedure; guided tissue regeneration; free soft tissue graft.
4. Bone Replacement Grafts: Only when related to periodontal procedures.
5. Clinical Crown Lengthening: Benefit includes all necessary associated surgical procedures.]]

[Basic Prosthodontic Services

1. Fixed Bridges: Each abutment and each pontic makes up a unit of a bridge. Temporary bridges older than [1] year are considered a permanent appliance.
2. Dentures: Benefit includes all adjustments done by dental practitioner furnishing denture during first [6] months after installation. Temporary dentures older than [1] year are considered a permanent appliance.

Limited to services performed more than 12 months after initial insertion of appliance.

1. Denture Adjustments and Repairs: Adjustments; repairing acrylic dentures, no teeth damage; repairing acrylic dentures and replacing one or more broken teeth; repairing metal dentures to the extent and nature of damage and type of materials involved; replacing one or more broken teeth, no other damage.
2. Denture Rebase: Limited to once per denture in any [[36] consecutive months.] [two year period.]
3. Denture Reline: Limited to once per denture in any [[12] consecutive months.] [two year period.]
4. Tissue Conditioning: Limited to a maximum of 2 treatments per arch in any 12 consecutive months.
5. Addition of Teeth to Partial Dentures: Limited to replace natural teeth lost under this coverage [after [36] months].

6. Crown/Bridge Repair: Limited to extent and nature of damage and type of materials involved.】

[Bridge or denture replacements available only after [8] years from the date of initial installation. No benefits are payable for replacement of third molars or a portion of a tooth lost due to root amputation or hemisection.]

[Other Basic Services

General Anesthesia: Only when medically necessary in conjunction with a covered complex oral surgery procedure.]

[Space Maintainers

Limited to initial passive appliance for covered dependent children [under age [14]] for missing primary teeth; includes all adjustments made within 6 months of installation; limited to fixed unilateral, fixed bilateral, and removable bilateral types. Recementation limited to 1 time in any 12 consecutive months.]

[Sealants

Limited to the occlusal surface of unrestored permanent molars for covered dependent children [under age [16]]; limited to 1 sealant treatment per tooth in any [48] consecutive months.]

	[First Year	Second Year	Each Year Thereafter
Deductible, [per calendar year] [per lifetime]	\$[50]	\$[50][50/Lifetime]	\$[50]
We pay, after deductible	[35]%	[65]%	[80]%
[Waiting period [None]]]			
 [Deductible, [per calendar year] [per lifetime]		\$[50]	
We pay, after deductible		[80]%	
[Waiting period [6 Months]]]			

Maximum benefit amount information prior to Expenses Not Covered section of the Coverage Schedule.】

[Class C. Major Services Include:

Major Restorative Services

Laboratory fabricated restorations and crowns are covered only when needed because of extensive decay or fracture and only when the tooth cannot be restored with a direct placement restoration. Insulating base, temporization and associated gingival treatment are considered an integral part of services rendered.]

[Implants

1. Implants, [but no more than once for the same tooth position in a 60 month period,] [after 36 months of coverage] when needed to replace natural teeth that are lost while you are insured under this policy.
2. Repair of implants, but not more than once in a [24] month period.
3. Implant supported prosthetics, [but no more than once for the same tooth position in a 60 month period,] [after 36 months of coverage] when needed to replace natural teeth that are lost while you are insured under this policy.
4. Repair of implant supported prosthetics, but not more than once in a [24] month period.
5. Replacement of congenitally missing teeth is not covered under your plan unless you are replacing a current prosthetic device.]

Inlays / Onlays / Crowns

Inlay, onlay and crown replacements are payable only after [5] years from the date of initial insertion. Temporary inlays, temporary onlays and prefabricated crowns older than 1 year are considered a permanent appliance and are subject to the [5] year replacement limitations.

1. Crowns: Acrylic with metal; Porcelain; Porcelain with metal; Full cast of ¾ cast metal, other than stainless steel; Cast post and core, in addition to crown but not a thimble coping; Steel post and composite or amalgam core, in addition to crown; Cast dowel pin, one-piece cast with crown, based on type of crown.
2. Prefabricated crowns: only for a permanent tooth fractured as a result of an accident [; or a primary tooth for an insured dependent child [under age [14]]; [limited to one prefabricated crown per lifetime of the tooth.]

3. Labial Veneers: Covered as an alternate treatment to a crown when the tooth would have otherwise qualified for a crown.
4. Recementation: Considered part of original service if done within 1 year of initial placement.

[Complex Oral Surgery

Local anesthesia and routine follow-up care are considered an integral part of oral surgery.

1. Complex Extractions: Surgical removal of erupted teeth, involving tissue flap and bone removal, removal of residual roots, or impacted teeth.
2. Other Surgical Procedures:
 - a. Alveoplasty ,[aveolectomy], per quadrant
 - b. Removal of exostosis
 - c. Excision of hyperplastic tissue
 - d. Excision of pericoronal gingival per tooth
 - e. Excision of tooth related cyst, tumor or neoplasm
 - f. Incision and drainage of abscess
 - g. [Oroantral fistula closure]
 - h. [Frenulectomy [or frenuloplasty]]
 - i. [Sialolithotomy for removal of salivary calculus]
 - j. [Closure of salivary fistula]
 - k. [Sialodochoplasty]
 - l. [Maxillary sinusotomy for removal of tooth fragment or foreign body]
 - m. [Surgical excision of lesions]
 - n. [Vestibuloplasty]
 - o. [Surgical exposure of impacted or unerupted tooth to aid eruption]
 - p. Biopsy and exam of tooth related oral tissue]

[Endodontic Services

1. Root canal therapy (not covered, if pulp chamber was opened before coverage began): Non-vital, nerve-dead tooth; local anesthesia and routine follow-up care are considered an integral part of services rendered; limited to 1 root canal treatment per tooth in any [36] consecutive months.
2. Vital pulpotomy: Limited to primary teeth only.
3. [Apexification: Therapeutic apical closure.]
4. Apicoectomy and retrograde filling: As a separate procedure or in conjunction with other endodontic procedures; limited to 1 treatment per tooth in any [36] consecutive months.]

[Periodontal Services

Local anesthesia and routine follow-up care are considered an integral part of services rendered.

[Non-Surgical Services:

1. Periodontal Scaling and Root Planing: As necessary for substantial bone and attachment loss evident on current periodontal charting and radiographs; limited to 1 treatment [per quadrant [in any [24] consecutive months.] [per calendar year.]
2. Periodontal Maintenance: Limited to [1 treatment in any 6 consecutive months] [two treatments per calendar year] [(replaces routine dental prophylaxis)] [and only qualifying after 3 months from date of completion of active periodontal treatment, including scaling and root planing.]
3. [Night Guards: Limited to 1 appliance in a 5 year period.]]

[Surgical Services: Limited to 1 periodontal surgical service per quadrant in any [36] consecutive months.

1. Gingivectomy: Per quadrant; limited to less than 3 teeth.
2. Osseous Surgery: Per quadrant; benefit includes all necessary associated surgical procedures.
3. Mucogingival Surgery: Pedicle soft tissue graft; gingival flap procedure; guided tissue regeneration; free soft tissue graft.
4. Bone Replacement Grafts: Only when related to periodontal procedures.
5. Clinical Crown Lengthening: Benefit includes all necessary associated surgical procedures.]]

[Prosthodontic Services

1. Fixed Bridges: Each abutment and each pontic makes up a unit of a bridge. Temporary bridges older than [1] year are considered a permanent appliance.

- Dentures: Benefit includes all adjustments done by dental practitioner furnishing denture during first [6] months after installation. Temporary dentures older than [1] year are considered a permanent appliance.

Limited to services performed more than 12 months after initial insertion of appliance.

- Denture Adjustments and Repairs: Adjustments; repairing acrylic dentures, no teeth damage; repairing acrylic dentures and replacing one or more broken teeth; repairing metal dentures to the extent and nature of damage and type of materials involved; replacing one or more broken teeth, no other damage.
- Denture Rebase: Limited to once per denture in any [[36] consecutive months.] [two year period.]
- Denture Reline: Limited to once per denture in any [[12] consecutive months.] [two year period.]
- Tissue Conditioning: Limited to a maximum of 2 treatments per arch in any 12 consecutive months.
- Addition of Teeth to Partial Dentures: Limited to replace natural teeth lost under this coverage [after 36 months].
- Crown/Bridge Repair: Limited to extent and nature of damage and type of materials involved.]

[Bridge or denture replacements available only after [8] years from the date of initial installation. No benefits are payable for replacement of third molars or a portion of a tooth lost due to root amputation or hemisection.]

[Missing Tooth]

If an insured has lost one or more teeth prior to this policy effective date, we will not pay for a prosthetic device that replaces such teeth unless the device also replaces one or more natural teeth lost or extracted while covered under this policy. We will pay for fixed bridges or dentures to replace such missing teeth if teeth were extracted within [6] months of this policy effective date if this policy immediately replaces a prior plan. Replacement of congenitally missing teeth is not covered under your plan unless you are replacing a current fixed bridge or denture. This replacement is subject to contract replacement limits.]

[Other Major Services]

General Anesthesia: Only when medically necessary in conjunction with a covered complex oral surgery procedure.]

[Space Maintainers]

Limited to initial passive appliance for covered dependent children [under age [14]] for missing primary teeth; includes all adjustments made within 6 months of installation; limited to fixed unilateral, fixed bilateral, and removable bilateral types. Recementation limited to 1 time in any 12 consecutive months.]

[Sealants]

Limited to the occlusal surface of unrestored permanent molars for covered dependent children [under age [16]]; limited to 1 sealant treatment per tooth in any [48] consecutive months.]

	[First Year	Second Year	Each Year Thereafter
Deductible, [per calendar year] [per lifetime]	\$[50]	\$[50][50/Lifetime]	\$[50]
We pay, after deductible	[15]%	[50]%	[50]%
[Waiting period [None]]]			
 [Deductible, [per calendar year] [per lifetime]		\$[50]	
We pay, after deductible		[50]%	
[Waiting period [12 months]]]			

Maximum benefit amount information prior to Expenses Not Covered section of the Coverage Schedule.]

[Class D. Orthodontia Services For [Insured(s)] [Dependent(s) Under [19] Years of Age] Include:

- surgical therapy
- appliance therapy
- functional/myofunctional therapy

[First Year	Second Year	Each Year Thereafter
------------------------	------------------------	---------------------------------

Deductible, [per calendar year] [per lifetime]	[None]	[None]	[\$50/Lifetime]	[None]
We pay, after deductible	[None]	[None]	[None]	[50]%
[Waiting period [24 Months]]]				

[Deductible, [per calendar year] [per lifetime]	\$[50]
We pay, after deductible	[50]%]
[Waiting period [24 months]]]	

Maximum benefit amount information prior to Expenses Not Covered section of the Coverage Schedule.]

[Maximum Benefit Amount:

Combined per calendar year limit for Class[es A, B and C]	\$[1,000]
[Maximum per calendar year limit for Class D]	[\$500]
[Lifetime maximum under this policy for Class D]	[\$[1,000]]]

[Class[es A, B and C] deductible is combined \$[50] per calendar year. A maximum of [three (3)] individual deductibles per family shall apply.]

[Maximum Benefit Amount:

	First Year	Second Year	Each Year Thereafter
Combined per calendar year limit for Class[es A, B and C]	\$[1000]	\$[1000]	\$[1000]
[Maximum per calendar year limit for Class D]	[\$[None]	[\$[None]	[\$[1000]
[Lifetime maximum under this policy for Class D - \$[1000]]]			

[Class[es A, B and C] deductible is combined \$[50] per calendar year. A maximum of [three (3)] individual deductibles per family shall apply.]

If course of treatment is to exceed \$[300], prior review is requested.

Expenses Not Covered

Your coverage under this policy does not cover any miscellaneous separate expense not considered a covered service or procedure.

We will not pay or provide alternate benefits for any of the following:

1. [Items, treatments or services:
 - a. not listed as an eligible expense on the Coverage Schedule;
 - b. not prescribed by or performed by or under the direct supervision of a dental practitioner;
 - c. not dentally necessary as determined by us;
 - d. not meeting the accepted standards of dental practice;
 - e. experimental in nature;
 - f. that have a questionable prognosis;
 - g. covered under any medical insurance policy; or
 - h. performed by a member of your or your spouse's family (family includes parents, step-parents, in-laws, spouse or former spouse, domestic partner, children, siblings, aunts, uncles, cousins, nieces, nephews, grandparents, and guardians).
2. Services furnished primarily for cosmetic reasons, including but not limited to:
 - a. specialized techniques, characterizing and personalizing prosthetic devices;
 - b. making facings on prosthetic devices for any tooth in back of the second bicuspid; or
 - c. replacements of restorations performed for cosmetic reasons.
3. Charges for any appliance or service that is used to:
 - a. change vertical dimension;
 - b. restore or maintain occlusion, except to the extent that this policy covers orthodontic treatment;
 - c. splint or stabilize teeth for periodontal reasons; or
 - d. treat disturbances of the temporomandibular joint (TMJ).
4. Charges for any service performed as a result of abrasion, attrition, bruxism, erosion or abfraction.
5. Occlusal, athletic, or night guards.
6. Implantology and related services; implants and all related procedures, including removal of implants.

7. Preventive root canal therapy.
8. Full mouth debridement.
9. Charges for any services that are considered to be an integral part of another service, such as pulp capping, surgical trays, or sutures.
10. Ridge preservation, augmentation, bone grafts and regeneration procedures performed in edentulous sites.
11. Overdentures or precision attachments.
12. Space maintainers and sealants.
13. Preparation and fitting of preformed dowel or post for root canal tooth; pulp cap either directly or indirectly.
14. Duplicate or temporary devices, appliances, and services except as listed as an eligible expense.
15. Replacing a lost, stolen or missing appliance or prosthetic device.
16. Application of chemotherapeutic agents.
17. Oral hygiene, plaque control, diet instruction or infection control.
18. Charges for sterilization of equipment; disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies.
19. Non-emergency services performed outside the United States or Canada.
20. Treatment which is:
 - a. due to an on-the-job or job-related illness or injury; or
 - b. a condition for which benefits are payable by Workers' Compensation or similar laws, whether or not benefits are claimed.
21. Treatment for which no charge is made or for which you are not legally obligated to pay including, but not limited to, treatment (or charges made) by:
 - a. your covered employer, labor union or similar group, in its dental or medical department or clinic;
 - b. a facility owned or run by any government body; or
 - c. any public program, except Medicaid, paid for or sponsored by any government body.
22. Telephone consultations, charges for failure to keep a scheduled appointment, X-ray copy fees, or charges for completion of a claim form.
23. Codes that are by report.
24. Ancillary charges, including but not limited to, hospital, ambulatory surgical center or similar facility; or use of provider office space.
25. Treatment resulting from:
 - a. your participation in a war or an act of war, declared or undeclared;
 - b. your attempting to commit, or committing, an assault or felony;
 - c. your unlawful participation in a riot, rebellion, or insurrection; or
 - d. an intentionally self-inflicted injury while sane or insane.
26. Procedures or treatment not prescribed or performed by or under the direct supervision of an orthodontia provider.】

Benefits are limited as follows:

1. In the event you transfer from the care of one dental practitioner to that of another during the course of treatment, or if more than one dental practitioner performs services for one eligible expense, we shall be liable for not more than the amount we would have been liable for had but one dental practitioner performed the service.
2. In all cases involving eligible expenses in which the dental practitioner and you select a more expensive course of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the eligible expense concerned, payment under the plan will be based on the charge allowed for the lesser procedure.

Coverage Schedule

[For services provided by a Participating Dentist (In-Network) and Non-Participation Dentists (Out-of-Network), we will pay based on the contracted fee amount negotiated with the preferred provider organization, after any required deductible amounts or waiting period as shown below. The insured will be responsible for charges by Out-of-Network in excess of the PPO fee schedule amount, in addition to any applicable co-insurance and deductible.]

[For services provided by a Participating Dentist (In-Network), we will pay based on the contracted fee for service with the preferred provider organization for dental procedures and services after any required deductible amount, as shown below.

For services provided by a Non-Participating Dentist (Out-of-Network), we will pay on the usual and customary (UCR) charge for dental procedures and services after any required deductible amount, as shown below.]

[Class A. Preventive Services Include:

Evaluations

1. [Comprehensive or Periodic Oral Evaluations: Limited to [1 evaluation in any 6 consecutive months.] [two evaluations (including any initial exam) per calendar year.] [three evaluations (including any initial exam) per calendar year.]
2. [Emergency Palliative Treatment: Limited to 1 palliative treatment in any 6 consecutive months and payable only if no other service (except x-rays) is rendered.]

X-Rays

1. [Complete series/Panoramic: Limited to 1 panoramic film or complete series (including bitewing films) [in any 60 consecutive months.] [per calendar year.] [per three calendar years.]
2. [Bitewing films: Limited to [1] series consisting of no more than [4] films [in any 12 consecutive months.] [per calendar year.]
3. [Periapical films: Limited to [4] films in any 12 consecutive months.] [1 per calendar year.]
4. [Occlusal films: Limited to [4] films in any 12 consecutive months.] [1 per calendar year.]]

Basic Restorative Services

Insulating base and local anesthesia is considered an integral part of services rendered.]

Fillings:

1. Amalgam Restoration: Limited to 1 filling per tooth surface in any [24] consecutive months. Contiguous surfaces billed separately will be combined as one restorative procedure.
2. Composite Resin (Synthetic) Restoration: Limited to 1 filling per [anterior] tooth surface in any [24] consecutive months. Contiguous surfaces billed separately will be combined as one restorative procedure.
3. Pin Retention: Only in conjunction with amalgam or composite resin restorations and only 1 per tooth.]

Routine Dental Prophylaxis and Fluoride Treatments

1. [Adult Prophylaxis: Limited to [1 treatment in any 6 consecutive months] [1 treatment per calendar year.] [two treatments per calendar year.] [three treatments per calendar year.] [for covered individuals age [15] and over;] [benefit includes scaling and polishing.]
2. [Child Prophylaxis: Limited to [1 treatment in any 6 consecutive months] [1 treatment per calendar year.] [two treatments per calendar year] [three treatments per calendar year] [for covered dependent children under age [15];] [benefit includes scaling and polishing.]
3. [Fluoride Treatments: Limited to [1 topical application in any [6] consecutive months] [1 topical application per calendar year] [two topical applications per calendar year] [three topical applications per calendar year] [for covered dependent children under age [15].]]

Space Maintainers

Limited to initial passive appliance for covered dependent children [under age [14]] for missing primary teeth; includes all adjustments made within 6 months of installation; limited to fixed unilateral, fixed bilateral, and removable bilateral types. Recementation limited to 1 time in any 12 consecutive months.]

Sealants

Limited to the occlusal surface of unrestored permanent molars for covered dependent children [under age [16]]; limited to 1 sealant treatment per tooth in any [48] consecutive months.]

	<u>Participating Dentist</u>	<u>Non-Participating Dentist</u>
Deductible, [per calendar year] [per lifetime]	\$[50]*	\$[50]*
We pay, after deductible	[100]%	[100]%
[Waiting period [None]]		
<u>Participating Dentist</u>		<u>Non-Participating Dentist</u>
1 st year Pays [100]% of PPO Fees		1 st year Pays [100]% of PPO Fees
2 nd year Pays [100]% of PPO Fees		2 nd year Pays [100]% of PPO Fees
Each year Thereafter Pays [100]% of PPO Fees		Each year Thereafter Pays [100]% of PPO Fees
Deductible, [per calendar year] [per lifetime]	\$[50]*	
We pay, after deductible	[100]%	
[Waiting period [None]]		

Maximum benefit amount information prior to Expenses Not Covered section of the Coverage Schedule.]

[Class B. Basic Services Include:

Evaluations

1. [Limited Oral Evaluation: Limited to 1 evaluation per dental practitioner in any 12 consecutive months and payable only if no other service (except x-rays) is rendered during the evaluation.]
2. [Diagnostic Consultation: Limited to 1 consultation (by a dental practitioner other than the one providing treatment) for each dental specialty in any 12 consecutive months and payable only if no other service (except x-rays) is rendered during the consultation.]
3. [Emergency Palliative Treatment: Limited to 1 palliative treatment in any 6 consecutive months and payable only if no other service (except x-rays) is rendered.]]

X-Rays

1. [Complete series/Panoramic: Limited to 1 panoramic film or complete series (including bitewing films) [in any 60 consecutive months.] [per calendar year.] [per three calendar years.]
2. [Bitewing films: Limited to [1] series consisting of no more than [4] films [in any 12 consecutive months.] [per calendar year.]
3. [Periapical films: Limited to [4] films in any 12 consecutive months.] [1 per calendar year.]
4. [Occlusal films: Limited to [4] films in any 12 consecutive months.] [1 per calendar year.]]

Basic Restorative Services

Insulating base and local anesthesia is considered an integral part of services rendered.]

Fillings:

1. Amalgam Restoration: Limited to 1 filling per tooth surface in any [24] consecutive months. Contiguous surfaces billed separately will be combined as one restorative procedure.
2. Composite Resin (Synthetic) Restoration: Limited to 1 filling per [anterior] tooth surface in any [24] consecutive months. Contiguous surfaces billed separately will be combined as one restorative procedure.
3. Pin Retention: Only in conjunction with amalgam or composite resin restorations and only 1 per tooth.]

Implants

1. Implants, [but no more than once for the same tooth position in a 60 month period,] [after 36 months of coverage] when needed to replace natural teeth that are lost while you are insured under this policy.
2. Repair of implants, but not more than once in a [24] month period.

3. Implant supported prosthetics, [but no more than once for the same tooth position in a 60 month period,] [after 36 months of coverage] when needed to replace natural teeth that are lost while you are insured under this policy.
4. Repair of implant supported prosthetics, but not more than once in a [24] month period.
5. Replacement of congenitally missing teeth is not covered under your plan unless you are replacing a current prosthetic device.]

Basic Oral Surgery

Local anesthesia and routine follow-up care are considered an integral part of basic oral surgery.

Extractions: Non-surgical extraction, 1 or more teeth.

[Complex Oral Surgery

Local anesthesia and routine follow-up care are considered an integral part of oral surgery.

1. Complex Extractions: Surgical removal of erupted teeth, involving tissue flap and bone removal, removal of residual roots, or impacted teeth.
2. Other Surgical Procedures:
 - a. Alveoplasty,[aveolectomy] per quadrant
 - b. Removal of exostosis
 - c. Excision of hyperplastic tissue
 - d. Excision of pericoronal gingival per tooth
 - e. Excision of tooth related cyst, tumor or neoplasm
 - f. Incision and drainage of abscess
 - g. [Oroantral fistula closure]
 - h. [Frenulectomy or [frenuloplasty]]
 - i. [Sialolithotomy for removal of salivary calculus]
 - j. [Closure of salivary fistula]
 - k. [Sialodochoplasty]
 - l. [Maxillary sinusotomy for removal of tooth fragment or foreign body]
 - m. [Surgical excision of lesions]
 - n. [Vestibuloplasty]
 - o. [Surgical exposure of impacted or unerupted tooth to aid eruption]
 - p. Biopsy and exam of tooth related oral tissue]

[Endodontic Services

1. Root canal therapy (not covered, if pulp chamber was opened before coverage began): Non-vital, nerve-dead tooth; local anesthesia and routine follow-up care are considered an integral part of services rendered; limited to 1 root canal treatment per tooth in any [36] consecutive months.
2. Vital pulpotomy: Limited to primary teeth only.
3. [Apexification: Therapeutic apical closure.]
4. Apicoectomy and retrograde filling: As a separate procedure or in conjunction with other endodontic procedures; limited to 1 treatment per tooth in any [36] consecutive months.]

[Periodontal Services

Local anesthesia and routine follow-up care are considered an integral part of services rendered.

[Non-Surgical Services:

1. Periodontal Scaling and Root Planing: As necessary for substantial bone and attachment loss evident on current periodontal charting and radiographs; limited to 1 treatment [per quadrant in any [24] consecutive months.] [per calendar year.]
2. Periodontal Maintenance: Limited to [1 treatment in any 6 consecutive months] [two treatments per calendar year] [(replaces routine dental prophylaxis)] [and only qualifying after 3 months from date of completion of active periodontal treatment, including scaling and root planing.]
3. [Night Guards: Limited to 1 appliance in a 5 year period.]]

[Surgical Services: Limited to 1 periodontal surgical service per quadrant in any [36] consecutive months.

1. Gingivectomy: Per quadrant; limited to less than 3 teeth.
2. Osseous Surgery: Per quadrant; benefit includes all necessary associated surgical procedures.
3. Mucogingival Surgery: Pedicle soft tissue graft; gingival flap procedure; guided tissue regeneration; free soft tissue graft.

4. Bone Replacement Grafts: Only when related to periodontal procedures.
5. Clinical Crown Lengthening: Benefit includes all necessary associated surgical procedures.]]

Basic Prosthodontic Services

1. Fixed Bridges: Each abutment and each pontic makes up a unit of a bridge. Temporary bridges older than [1] year are considered a permanent appliance.
2. Dentures: Benefit includes all adjustments done by dental practitioner furnishing denture during first [6] months after installation. Temporary dentures older than [1] year are considered a permanent appliance.

Limited to services performed more than 12 months after initial insertion of appliance.

1. Denture Adjustments and Repairs: Adjustments; repairing acrylic dentures, no teeth damage; repairing acrylic dentures and replacing one or more broken teeth; repairing metal dentures to the extent and nature of damage and type of materials involved; replacing one or more broken teeth, no other damage.
2. Denture Rebase: Limited to once per denture in any [[36] consecutive months.] [two year period.]
3. Denture Reline: Limited to once per denture in any [[12] consecutive months.] [two year period.]
4. Tissue Conditioning: Limited to a maximum of 2 treatments per arch in any 12 consecutive months.
5. Addition of Teeth to Partial Dentures: Limited to replace natural teeth lost under this coverage [after [36] months].
6. Crown/Bridge Repair: Limited to extent and nature of damage and type of materials involved.]]

[Bridge or denture replacements available only after [8] years from the date of initial installation. No benefits are payable for replacement of third molars or a portion of a tooth lost due to root amputation or hemisection.]

Other Basic Services

General Anesthesia: Only when medically necessary in conjunction with a covered complex oral surgery procedure.]]

Space Maintainers

Limited to initial passive appliance for covered dependent children [under age [14]] for missing primary teeth; includes all adjustments made within 6 months of installation; limited to fixed unilateral, fixed bilateral, and removable bilateral types. Recementation limited to 1 time in any 12 consecutive months.]]

Sealants

Limited to the occlusal surface of unrestored permanent molars for covered dependent children [under age [16]]; limited to 1 sealant treatment per tooth in any [48] consecutive months.]]

	<u>Participating</u> <u>Dentist</u>	<u>Non-Participating</u> <u>Dentist</u>
Deductible, [per calendar year] [per lifetime]	\$[50]*	\$[50]*
We pay, after deductible	[80]%	[80]%
[Waiting period [None]]]		

Participating Dentist

1st year Pays [40]% of PPO Fees
 2nd year Pays [80]% of PPO Fees
 Each year Thereafter Pays [90]% of PPO Fees

Non-Participating Dentist

1st year Pays [40]% of PPO Fees
 2nd year Pays [80]% of PPO Fees
 Each year Thereafter Pays [90]% of PPO Fees

Deductible, [per calendar year] [per lifetime]	\$[50]*
We pay, after deductible	[80]%
[Waiting period [None]]]	

Maximum benefit amount information prior to Expenses Not Covered section of the Coverage Schedule.]]

[Class C. Major Services Include:

Major Restorative Services

Laboratory fabricated restorations and crowns are covered only when needed because of extensive decay or fracture and only when the tooth cannot be restored with a direct placement restoration. Insulating base, temporization and associated gingival treatment are considered an integral part of services rendered.]

[Implants

1. Implants, [but no more than once for the same tooth position in a 60 month period,] [after 36 months of coverage] when needed to replace natural teeth that are lost while you are insured under this policy.
2. Repair of implants, but not more than once in a [24] month period.
3. Implant supported prosthetics, [but no more than once for the same tooth position in a 60 month period,] [after 36 months of coverage] when needed to replace natural teeth that are lost while you are insured under this policy.
4. Repair of implant supported prosthetics, but not more than once in a [24] month period.
5. Replacement of congenitally missing teeth is not covered under your plan unless you are replacing a current prosthetic device.]

Inlays / Onlays / Crowns

Inlay, onlay and crown replacements are payable only after [5] years from the date of initial insertion. Temporary inlays, temporary onlays and prefabricated crowns older than 1 year are considered a permanent appliance and are subject to the [5] year replacement limitations.

1. Crowns: Acrylic with metal; Porcelain; Porcelain with metal; Full cast of $\frac{3}{4}$ cast metal, other than stainless steel; Cast post and core, in addition to crown but not a thimble coping; Steel post and composite or amalgam core, in addition to crown; Cast dowel pin, one-piece cast with crown, based on type of crown.
2. Prefabricated crowns: only for a permanent tooth fractured as a result of an accident [; or a primary tooth for an insured dependent child [under age [14]]; [limited to one prefabricated crown per lifetime of the tooth.]
3. Labial Veneers: Covered as an alternate treatment to a crown when the tooth would have otherwise qualified for a crown.
4. Recementation: Considered part of original service if done within 1 year of initial placement.

[Complex Oral Surgery

Local anesthesia and routine follow-up care are considered an integral part of oral surgery.

1. Complex Extractions: Surgical removal of erupted teeth, involving tissue flap and bone removal, removal of residual roots, or impacted teeth.
2. Other Surgical Procedures:
 - a. Alveoloplasty ,[aveolectomy], per quadrant
 - b. Removal of exostosis
 - c. Excision of hyperplastic tissue
 - d. Excision of pericoronal gingival per tooth
 - e. Excision of tooth related cyst, tumor or neoplasm
 - f. Incision and drainage of abscess
 - g. [Oroantral fistula closure]
 - h. [Frenulectomy [or frenuloplasty]]
 - i. [Sialolithotomy for removal of salivary calculus]
 - j. [Closure of salivary fistula]
 - k. [Sialodochoplasty]
 - l. [Maxillary sinusotomy for removal of tooth fragment or foreign body]
 - m. [Surgical excision of lesions]
 - n. [Vestibuloplasty]
 - o. [Surgical exposure of impacted or unerupted tooth to aid eruption]
 - p. Biopsy and exam of tooth related oral tissue]

[Endodontic Services

1. Root canal therapy (not covered, if pulp chamber was opened before coverage began): Non-vital, nerve-dead tooth; local anesthesia and routine follow-up care are considered an integral part of services rendered; limited to 1 root canal treatment per tooth in any [36] consecutive months.

2. Vital pulpotomy: Limited to primary teeth only.
3. [Apexification: Therapeutic apical closure.]
4. Apicoectomy and retrograde filling: As a separate procedure or in conjunction with other endodontic procedures; limited to 1 treatment per tooth in any [36] consecutive months.]

[Periodontal Services

Local anesthesia and routine follow-up care are considered an integral part of services rendered.

[Non-Surgical Services:

1. Periodontal Scaling and Root Planing: As necessary for substantial bone and attachment loss evident on current periodontal charting and radiographs; limited to 1 treatment [per quadrant [in any [24] consecutive months.] [per calendar year.]
2. Periodontal Maintenance: Limited to [1 treatment in any 6 consecutive months] [two treatments per calendar year] [(replaces routine dental prophylaxis)] [and only qualifying after 3 months from date of completion of active periodontal treatment, including scaling and root planing.]
3. [Night Guards: Limited to 1 appliance in a 5 year period.]]

[Surgical Services: Limited to 1 periodontal surgical service per quadrant in any [36] consecutive months.

1. Gingivectomy: Per quadrant; limited to less than 3 teeth.
2. Osseous Surgery: Per quadrant; benefit includes all necessary associated surgical procedures.
3. Mucogingival Surgery: Pedicle soft tissue graft; gingival flap procedure; guided tissue regeneration; free soft tissue graft.
4. Bone Replacement Grafts: Only when related to periodontal procedures.
5. Clinical Crown Lengthening: Benefit includes all necessary associated surgical procedures.]]

[Prosthodontic Services

1. Fixed Bridges: Each abutment and each pontic makes up a unit of a bridge. Temporary bridges older than [1] year are considered a permanent appliance.
2. Dentures: Benefit includes all adjustments done by dental practitioner furnishing denture during first [6] months after installation. Temporary dentures older than [1] year are considered a permanent appliance.

Limited to services performed more than 12 months after initial insertion of appliance.

1. Denture Adjustments and Repairs: Adjustments; repairing acrylic dentures, no teeth damage; repairing acrylic dentures and replacing one or more broken teeth; repairing metal dentures to the extent and nature of damage and type of materials involved; replacing one or more broken teeth, no other damage.
2. Denture Rebase: Limited to once per denture in any [[36] consecutive months.] [two year period.]
3. Denture Reline: Limited to once per denture in any [[12] consecutive months.] [two year period.]
4. Tissue Conditioning: Limited to a maximum of 2 treatments per arch in any 12 consecutive months.
5. Addition of Teeth to Partial Dentures: Limited to replace natural teeth lost under this coverage [after 36 months].
6. Crown/Bridge Repair: Limited to extent and nature of damage and type of materials involved.]

[Bridge or denture replacements available only after [8] years from the date of initial installation. No benefits are payable for replacement of third molars or a portion of a tooth lost due to root amputation or hemisection.]

[Missing Tooth

If an insured has lost one or more teeth prior to this policy effective date, we will not pay for a prosthetic device that replaces such teeth unless the device also replaces one or more natural teeth lost or extracted while covered under this policy. We will pay for fixed bridges or dentures to replace such missing teeth if teeth were extracted within [6] months of this policy effective date if this policy immediately replaces a prior plan. Replacement of congenitally missing teeth is not covered under your plan unless you are replacing a current fixed bridge or denture. This replacement is subject to contract replacement limits.]

[Other Major Services

General Anesthesia: Only when medically necessary in conjunction with a covered complex oral surgery procedure.]

Space Maintainers

Limited to initial passive appliance for covered dependent children [under age [14]] for missing primary teeth; includes all adjustments made within 6 months of installation; limited to fixed unilateral, fixed bilateral, and removable bilateral types. Recementation limited to 1 time in any 12 consecutive months.]

Sealants

Limited to the occlusal surface of unrestored permanent molars for covered dependent children [under age [16]]; limited to 1 sealant treatment per tooth in any [48] consecutive months.]

	<u>Participating Dentist</u>	<u>Non-Participating Dentist</u>
Deductible, [per calendar year] [per lifetime]	[\$50]*	[\$50]*
We pay, after deductible	[50]%	[50]%
[Waiting period [None]]]		
<u>Participating Dentist</u>	<u>Non-Participating Dentist</u>	
1 st year Pays [20]% of PPO Fees	1 st year Pays [10]% of PPO Fees	
2 nd year Pays [50]% of PPO Fees	2 nd year Pays [50]% of PPO Fees	
Each year Thereafter Pays [60]% of PPO Fees	Each year Thereafter Pays [60]% of PPO Fees	

Deductible, [per calendar year] [per lifetime]	[\$50]
We pay, after deductible	[50]%
[Waiting period [None]]]	

Maximum benefit amount information prior to Expenses Not Covered section of the Coverage Schedule.]

Class D. Orthodontia Services For [Insured(s)] [Dependent(s) Under [19] Years of Age] Include:

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

	<u>Participating Dentist</u>	<u>Non-Participating Dentist</u>
Deductible, [per calendar year] [per lifetime]	[\$50]*	[\$50]*
We pay, after deductible	[50]%	[50]%
[Waiting period [None]]]		
<u>Participating Dentist</u>	<u>Non-Participating Dentist</u>	
1 st year Pays [10]% of PPO Fees	1 st year Pays [10]% of PPO Fees	
2 nd year Pays [25]% of PPO Fees	2 nd year Pays [25]% of PPO Fees	
Each year Thereafter Pays [50]% of PPO Fees	Each year Thereafter Pays [65]% of PPO Fees	

Deductible [per calendar year] [per lifetime]	[\$None]*
We pay, after deductible	[50]%
[Waiting period [None]]]	

Maximum benefit amount information prior to Expenses Not Covered section of the Coverage Schedule.]

[Maximum Benefit Amount (Participating and Non-Participation Benefits Combined): \$[1,000]

Combined per calendar year limit for Class[es A, B and C]	[\$2,000]
[Maximum per calendar year limit for Class C]	[\$500]
[Maximum per calendar year limit for Class D]	[\$500]
[Lifetime maximum under this policy for Class D]	[\$1,000]]

[Maximum Benefit Amount:	1ST YEAR	2ND YEAR	EACH YEAR THEREAFTER
Combined per calendar year limit for Class[es A, B and C]	[\$2,000]	[\$2,000]	[\$2,000]
IPS1000-PPO	[7]		

[Maximum per calendar year limit for Class D]	[\$600]	[\$600]	[\$600]
[Maximum per calendar year limit for Class C]	[\$500]	[\$500]	[\$500]
[Lifetime maximum under this policy for Class D]	[\$1,200]		

[*Class[es A, B, C and D] deductible is combined \$[50] per calendar year. A maximum of [three (3)] individual deductibles per family shall apply.]

[Class [A] \$[50] lifetime deductible – A maximum of [three (3)] individual deductibles per family shall apply.]

[Class[es B and C] deductible is a combined \$[50] per calendar year. A maximum of [three (3)] individual deductibles per family shall apply.]

If course of treatment is to exceed \$[300], prior review is requested.

Expenses Not Covered

Your coverage under this policy does not cover any miscellaneous separate expense not considered a covered service or procedure.

We will not pay or provide alternate benefits for any of the following:

1. [Items, treatments or services:
 - a. not listed as an eligible expense on the Coverage Schedule;
 - b. not prescribed by or performed by or under the direct supervision of a dental practitioner;
 - c. not dentally necessary as determined by us;
 - d. not meeting the accepted standards of dental practice;
 - e. experimental in nature;
 - f. that have a questionable prognosis;
 - g. covered under any medical insurance policy; or
 - h. performed by a member of your or your spouse's family (family includes parents, step-parents, in-laws, spouse or former spouse, domestic partner, children, siblings, aunts, uncles, cousins, nieces, nephews, grandparents, and guardians).
2. Services furnished primarily for cosmetic reasons, including but not limited to:
 - a. specialized techniques, characterizing and personalizing prosthetic devices;
 - b. making facings on prosthetic devices for any tooth in back of the second bicuspid; or
 - c. replacements of restorations performed for cosmetic reasons.
3. Charges for any appliance or service that is used to:
 - a. change vertical dimension;
 - b. restore or maintain occlusion, except to the extent that this policy covers orthodontic treatment;
 - c. splint or stabilize teeth for periodontal reasons; or
 - d. treat disturbances of the temporomandibular joint (TMJ).
4. Charges for any service performed as a result of abrasion, attrition, bruxism, erosion or abfraction.
5. Occlusal, athletic, or night guards.
6. Implantology and related services; implants and all related procedures, including removal of implants.
7. Preventive root canal therapy.
8. Full mouth debridement.
9. Charges for any services that are considered to be an integral part of another service, such as pulp capping, surgical trays, or sutures.
10. Ridge preservation, augmentation, bone grafts and regeneration procedures performed in edentulous sites.
11. Overdentures or precision attachments.
12. Space maintainers and sealants.
13. Preparation and fitting of preformed dowel or post for root canal tooth; pulp cap either directly or indirectly.
14. Duplicate or temporary devices, appliances, and services except as listed as an eligible expense.
15. Replacing a lost, stolen or missing appliance or prosthetic device.
16. Application of chemotherapeutic agents.
17. Oral hygiene, plaque control, diet instruction or infection control.
18. Charges for sterilization of equipment; disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies.
19. Non-emergency services performed outside the United States or Canada.
20. Treatment which is:
 - a. due to an on-the-job or job-related illness or injury; or
 - b. a condition for which benefits are payable by Workers' Compensation or similar laws, whether or not benefits are claimed.

21. Treatment for which no charge is made or for which you are not legally obligated to pay including, but not limited to, treatment (or charges made) by:
 - a. your covered employer, labor union or similar group, in its dental or medical department or clinic;
 - b. a facility owned or run by any government body; or
 - c. any public program, except Medicaid, paid for or sponsored by any government body.
22. Telephone consultations, charges for failure to keep a scheduled appointment, X-ray copy fees, or charges for completion of a claim form.
23. Codes that are by report.
24. Ancillary charges, including but not limited to, hospital, ambulatory surgical center or similar facility; or use of provider office space.
25. Treatment resulting from:
 - a. your participation in a war or an act of war, declared or undeclared;
 - b. your attempting to commit, or committing, an assault or felony;
 - c. your unlawful participation in a riot, rebellion, or insurrection; or
 - d. an intentionally self-inflicted injury while sane or insane.
26. Procedures or treatment not prescribed or performed by or under the direct supervision of an orthodontia provider.]

Benefits are limited as follows:

1. In the event you transfer from the care of one dental practitioner to that of another during the course of treatment, or if more than one dental practitioner performs services for one eligible expense, we shall be liable for not more than the amount we would have been liable for had but one dental practitioner performed the service.
2. In all cases involving eligible expenses in which the dental practitioner and you select a more expensive course of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the eligible expense concerned, payment under the plan will be based on the charge allowed for the lesser procedure.

[Basic Services

Code	Description	Scheduled Amount]
[D0210	Intraoral Xrays- Complete Series (Including Bitewings)	[\$72]
D0220	Intraoral Xrays- Periapical First Film	[\$15]
D0277	Vertical Bitewings Xrays- 7 To 8 Films	[\$57]
D0230	Intraoral Xrays- Periapical Each Additional Film	[\$12]
D0240	Intraoral Xrays- Occlusal Film	[\$20]
D0330	Panoramic Film	[\$67]
D0340	Cephalometric Film	[\$67]
D0470	Diagnostic Casts	[\$60]
D1351	Sealant- Per Tooth (to age 16)	[\$30]
D2140	Amalgam - One Surface, Primary Or Permanent	[\$77]
D2150	Amalgam - Two Surfaces, Primary Or Permanent	[\$94]
D2160	Amalgam - Three Surfaces, Primary Or Permanent	[\$110]
D2161	Amalgam- Four Or More Surfaces, Primary Or Permanent	[\$132]
D2330	Resin-Based Composite - One Surface, Anterior	[\$84]
D2331	Resin-Based Composite - Two Surfaces, Anterior	[\$107]
D2332	Resin-Based Composite - Three Surfaces, Anterior	[\$126]
D2335	Resin-Based Composite- Four Or More Surfaces Or Involving Incisal (Anterior) Angle	[\$151]
D2391	Resin-Based Composite - One Surface, Posterior	[\$96]
D2910	Recement Inlay, Onlay, Or Partial Coverage Restoration	[\$54]
D2920	Recement Crown	[\$54]
D2940	Protective Restoration	[\$57]
D7111	Extraction, Coronal Remnants - Deciduous Tooth	[\$70]
D9110	Palliative (Emergency) Treatment Of Dental Pain- Minor Procedure	[\$60]
D9310	Consultation (Diagnostic Service Provided by Dentist or Physician Other Than Practitioner Providing Treatment)	[\$57]

[Major Services

Code	Description	Scheduled Amount]
[D2510	Inlay - Metallic - One Surface	\$(330]
D2520	Inlay - Metallic - Two Surfaces	\$(346]
D2530	Inlay - Metallic - Three Or More Surfaces	\$(357]
D2542	Onlay - Metallic-Two Surfaces	\$(413]
D2543	Onlay - Metallic-Three Surfaces	\$(424]
D2544	Onlay- Metallic-Four Or More Surfaces	\$(424]
D2610	Inlay - Porcelain/Ceramic - One Surface	\$(364]
D2620	Inlay - Porcelain/Ceramic - Two Surfaces	\$(401]
D2630	Inlay - Porcelain/Ceramic - Three Or More Surfaces	\$(384]
D2643	Onlay - Porcelain/Ceramic - Three Surfaces	\$(454]
D2644	Onlay- Porcelain/Ceramic -Four Or More Surfaces	\$(468]
D2662	Onlay -Resin-Based Composite - Two Surfaces	\$(357]
D2663	Onlay - Resin-Based Composite - Three Surfaces	\$(379]
D2664	Onlay- Resin-Based Composite- Four Or More Surfaces	\$(390]
D2740	Crown - Porcelain/Ceramic Substrate	\$(458]
D2750	Crown - Porcelain Fused To High Noble Metal	\$(421]
D2751	Crown - Porcelain Fused To Predominantly Base Metal	\$(357]
D2752	Crown- Porcelain Fused To Noble Metal	\$(399]
D2780	Crown - 3/4 Cast High Noble Metal	\$(424]
D2783	Crown- 3/4 Porcelain/Ceramic	\$(450]
D2791	Crown - Full Cast Predominantly Base Metal]	\$(366]
D2792	Crown - Full Cast Noble Metal	\$(420]
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	\$(94]
D2931	Prefabricated Stainless Steel Crown- Permanent Tooth	\$(97]
D2932	Prefabricated Resin Crown	\$(116]
D2950	Core Buildup, Including Any Pins	\$(102]
D2951	Pin Retention- Per Tooth, In Addition To Restoration	\$(22]
D2952	Cast Post And Core In Addition To Crown	\$(155]
D2954	Prefabricated Post And Core In Addition To Crown	\$(123]
D2980	Crown Repair, By Report	\$(92]
D3110	Pulp Cap- Direct (Excluding Final Restoration)	\$(29]
D3120	Pulp Cap - Indirect (Excluding Final Restoration)	\$(25]
D3220	Therapeutic Pulpotomy (Excluding Final Restoration)- Removal Of Pulp Coronal To The Dentinocemental Junction And Application Of Medicament	\$(69]
D3221	Pulpal Debridement, Primary And Permanent Teeth	\$(87]
D3230	Pulpal Therapy (Resorbable Filling)- Anterior, Primary Tooth (Excluding Final Restoration)	\$(33]
D3240	Pulpal Therapy (Resorbable Filling)- Posterior, Primary Tooth (Excluding Final Restoration)	\$(87]
D3310	Anterior (Excluding Final Restoration)	\$(277]
D3320	Bicuspid (Excluding Final Restoration)	\$(317]
D3330	Molar (Excluding Final Restoration)	\$(401]
D3332	Incomplete Endodontic Therapy; Inoperable, Unrestorable Or Fractured Tooth	\$(145]
D3346	Retreatment Of Previous Root Canal Therapy- Anterior	\$(335]
D3351	Apexification/Recalcification- Initial Visit (Apical Closure/Calcific Repair Of Perforations, Root Resorption, Etc.)	\$(178]

D3410	Apicoectomy/Periradicular Surgery - Anterior	\$(312)
D3421	Apicoectomy/Periradicular Surgery - Bicuspid (First Root)	\$(312)
D3425	Apicoectomy/Periradicular Surgery- Molar (First Root)	\$(357)
D4210	Gingivectomy Or Gingivoplasty- Four Or More Contiguous Teeth Or Bounded Teeth Spaces Per Quadrant	\$(212)
D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth Or Bounded Teeth Spaces Per Quadrant	\$(83)
D4240	Gingival Flap Procedure, Including Root Planing- Four Or More Contiguous Teeth Or Bounded Teeth Spaces Per Quadrant	\$(268)
D4260	Osseous Surgery (Including Flap Entry And Closure)- Four Or More Contiguous Teeth Or Bounded Teeth Spaces Per Quadrant	\$(424)
D4261	Osseous Surgery (Including Flap Entry And Closure)- One To Three Contiguous Teeth Or Bounded Teeth Spaces Per Quadrant	\$(335)
D4263	Bone Replacement Graft - First Site In Quadrant	\$(178)
D4270	Pedicle Soft Tissue Graft Procedure	\$(392)
D4271	Free Soft Tissue Graft Procedure (Including Donor Site Surgery)	\$(362)
D4273	Subepithelial Connective Tissue Graft Procedures, Per Tooth	\$(335)
D4320	Provisional Splinting - Intracoronal	\$(80)
D4321	Provisional Splinting - Extracoronal	\$(143)
D4341	Periodontal Scaling And Root Planing- Four Or More Teeth Per Quadrant	\$(89)
D4342	Periodontal Scaling And Root Planing- One To Three Teeth Per Quadrant	\$(51)
D4355	Full Mouth Debridement To Enable Comprehensive Evaluation And Diagnosis	\$(67)
D4381	Localized Delivery Of Antimicrobial Agents Via A Controlled Release Vehicle Into Diseased Crevicular Tissue, Per Tooth, By Report	\$(18)
D4910	Periodontal Maintenance	\$(51)
D5110	Complete Denture - Maxillary	\$(535)
D5120	Complete Denture – Mandibular]	\$(535)
D5130	Immediate Denture - Maxillary	\$(51)
D5140	Immediate Denture - Mandibular	\$(490)
D5211	Maxillary Partial Denture - Resin Base (Including Any Conventional Clasps, Rests And Teeth)	\$(454)
D5212	Mandibular Partial Denture - Resin Base (Including Any Conventional Clasps, Rests And Teeth)	\$(517)
D5213	Maxillary Partial Denture- Cast Metal Framework With Resin Denture Bases (including any conventional clasps, rests and teeth)	\$(558)
D5214	Mandibular Partial Denture - Cast Metal Framework With Resin Denture Bases (including any conventional clasps, rests and teeth)	\$(558)
D5281	Removable Unilateral Partial Denture - One Piece Cast Metal (Including Clasps And Teeth)	\$(380)
D5421	Adjust Partial Denture - Maxillary	\$(33)
D5510	Repair Broken Complete Denture Base	\$(67)
D5520	Replace Missing Or Broken Teeth- Complete Denture (Each Tooth)	\$(56)
D5610	Repair Resin Denture Base	\$(67)
D5630	Repair Or Replace Broken Clasp	\$(78)
D5640	Replace Broken Teeth- Per Tooth	\$(58)
D5650	Add Tooth To Existing Partial Denture	\$(71)
D5660	Add Clasp To Existing Partial Denture	\$(89)
D5721	Rebase Mandibular Partial Denture	\$(132)
D5730	Reline Complete Maxillary Denture (Chairside)	\$(132)

D5750	Reline Complete Maxillary Denture (Laboratory)	[\$156]
D5751	Reline Complete Mandibular Denture (Laboratory)	[\$167]
D5761	Reline Mandibular Partial Denture (Laboratory)	[\$158]
D5810	Interim Complete Denture (Maxillary)	[\$275]
D5811	Interim Complete Denture (Mandibular)	[\$275]
D5820	Interim Partial Denture (Maxillary)	[\$234]
D5821	Interim Partial Denture (Mandibular)	[\$234]
D5850	Tissue Conditioning, Maxillary	[\$33]
D6210	Pontic - Cast High Noble Metal	[\$424]
D6240	Pontic - Porcelain Fused To High Noble Metal	[\$399]
D6241	Pontic - Porcelain Fused To Predominantly Base Metal	[\$357]
D6242	Pontic - Porcelain Fused To Noble Metal	[\$383]
D6245	Pontic - Porcelain/Ceramic	[\$401]
D6250	Pontic - Resin With High Noble Metal	[\$379]
D6740	Crown - Porcelain/Ceramic	[\$401]
D6750	Crown - Porcelain Fused To High Noble Metal	[\$404]
D6751	Crown - Porcelain Fused To Predominantly Base Metal	[\$357]
D6752	Crown - Porcelain Fused To Noble Metal	[\$392]
D6790	Crown - Full Cast High Noble Metal	[\$424]
D6791	Crown - Full Cast Predominantly Base Metal	[\$357]
D6930	Recement Fixed Partial Denture	[\$50]
D6980	Fixed Partial Denture Repair, By Report	[\$67]
D7210	Surgical Removal Of Erupted Tooth Requiring Elevation Of Mucoperiosteal Flap And Removal of Bone And/Or Section of Tooth	[\$107]
D7220	Removal Of Impacted Tooth- Soft Tissue	[\$134]
D7230	Removal Of Impacted Tooth - Partially Bony	[\$167]
D7240	Removal Of Impacted Tooth - Completely Bony	[\$201]
D7241	Removal Of Impacted Tooth - Completely Bony, With Unusual Surgical Complications	[\$234]
D7250	Surgical Removal Of Residual Tooth Roots (Cutting Procedure)]	[\$112]
D7270	Tooth Reimplantation And/Or Stabilization of Accidentally Evulsed or Displaced Tooth	[\$256]
D7280	Surgical Access of An Unerupted Tooth	[\$218]
D7286	Biopsy of Oral Tissue- Soft	[\$167]
D7310	Alveoloplasty In Conjunction with Extractions- Per Quadrant	[\$105]
D7320	Alveoloplasty Not In Conjunction With Extractions- Per Quadrant	[\$112]
D7510	Incision And Drainage of Abscess- Intraoral Soft Tissue	[\$78]
D7960	Frenulectomy (Frenectomy of Frenotomy)- Separate Procedure	[\$176]
D9220	Deep Sedation/General Anesthesia- First 30 Minutes	[\$156]
D9230	Analgesia, Anxiolysis, Inhalation of Nitrous Oxide	[\$25]
D9241	Intravenous Conscious Sedation/Analgnesia- First 30 Minutes	[\$138]
D9248	Non-Intravenous Conscious Sedation	[\$33]
D9940	Occlusal Guard, By Report	[\$206]
D9951	Occlusal Adjustment- Limited	[\$33]
D9952	Occlusal Adjustment- Complete	[\$268]

Expenses Not Covered

This policy covers services and procedures as described in this Coverage Schedule. Your coverage, under this policy, does not cover any miscellaneous separate expense not considered a covered service or procedure.

We will not pay or provide alternate benefits for any of the following:

1. [Items, treatments or services:
 - a. not listed as an eligible expense on the Coverage Schedule;
 - b. not prescribed by or performed by or under the direct supervision of a dental practitioner;
 - c. not dentally necessary as determined by us;
 - d. not meeting the accepted standards of dental practice;
 - e. experimental in nature;
 - f. that have a questionable prognosis;
 - g. covered under any medical insurance policy; or
 - h. performed by a member of your or your spouse's family (family includes parents, step-parents, in-laws, spouse or former spouse, domestic partner, children, siblings, aunts, uncles, cousins, nieces, nephews, grandparents, and guardians).
2. Services furnished primarily for cosmetic reasons, including but not limited to:
 - a. specialized techniques, characterizing and personalizing prosthetic devices;
 - b. making facings on prosthetic devices for any tooth in back of the second bicuspid; or
 - c. replacements of restorations performed for cosmetic reasons.
3. Charges for any appliance or service that is used to:
 - a. change vertical dimension;
 - b. restore or maintain occlusion; or
 - c. splint or stabilize teeth for periodontal reasons; or
 - d. treat disturbances of the temporomandibular joint (TMJ).
4. Charges for any service performed as a result of abrasion, attrition, bruxism, erosion or abfraction.
5. Occlusal, athletic, or night guards.
6. Implantology and related services; implants and all related procedures, including removal of implants.
7. Preventive root canal therapy.
8. Full mouth debridement.
9. Charges for any services that are considered to be an integral part of another service, such as pulp capping, surgical trays, or sutures.
10. Ridge preservation, augmentation, bone grafts and regeneration procedures performed in edentulous sites.
11. Overdentures or precision attachments.
12. Space maintainers and sealants.
13. Preparation and fitting of preformed dowel or post for root canal tooth; pulp cap either directly or indirectly.
14. Duplicate or temporary devices, appliances, and services except as listed as an eligible expense.
15. Replacing a lost, stolen or missing appliance or prosthetic device.
16. Application of chemotherapeutic agents.
17. Oral hygiene, plaque control, diet instruction or infection control.
18. Charges for sterilization of equipment; disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies.
19. Non-emergency services performed outside the United States or Canada.
20. Treatment which is:
 - a. due to an on-the-job or job-related illness or injury; or
 - b. a condition for which benefits are payable by Workers' Compensation or similar laws, whether or not benefits are claimed.
21. Treatment for which no charge is made or for which you are not legally obligated to pay including, but not limited to, treatment (or charges made) by:
 - a. your covered employer, labor union or similar group, in its dental or medical department or clinic;
 - b. a facility owned or run by any government body; or
 - c. any public program, except Medicaid, paid for or sponsored by any government body.
22. Telephone consultations, charges for failure to keep a scheduled appointment, X-ray copy fees, or charges for completion of a claim form.
23. Codes that are by report.
24. Ancillary charges, including but not limited to, hospital, ambulatory surgical center or similar facility; or use of provider office space.
25. Treatment resulting from:
 - a. your participation in a war or an act of war, declared or undeclared;
 - b. your attempting to commit, or committing, an assault or felony;

- c. your unlawful participation in a riot, rebellion, or insurrection; or
- d. an intentionally self-inflicted injury while sane or insane.]

Benefits are limited as follows:

1. In the event you transfer from the care of one dental practitioner to that of another during the course of treatment, or if more than one dental practitioner performs services for one eligible expense, we shall be liable for not more than the amount we would have been liable for had but one dental practitioner performed the service.
2. In all cases involving eligible expenses in which the dental practitioner and you select a more expensive course of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the eligible expense concerned, payment under the plan will be based on the charge allowed for the lesser procedure.

Vision Coverage Schedule

We will pay for eligible expenses incurred, subject to the applicable deductible, waiting period, and maximum benefit amount, as shown below.

Class A. Vision Exams - One visit every [[12] months] [per calendar year] [per year].

	[First Year	Second Year	Each Year Thereafter
Deductible, per [policy year] [calendar year] [lifetime]	\$[50]*	\$[50]*[\$50/Lifetime]	\$[50]*
We pay, after deductible	[85]%	[85]%	[85]%
[Waiting period [None]]			

[Deductible, per [policy year] [calendar year] [lifetime]	\$[50]*
[We pay, after deductible	[85]%]
[Waiting period [None]]	
[Maximum we pay after deductible	\$[50]]]

Class B. Lenses and Frame - One (1) pair of lenses every [[24] months] [2 years] [and one (1) frame every [24 months] [2 years]].

	[First Year	Second Year	Each Year Thereafter
Deductible, per [policy year] [calendar year] [lifetime]	\$[50]*	\$[50]*[\$50/Lifetime]	\$[50]*
We pay, after deductible	[50]%	[50]%	[50]%
[Waiting period [6 months]]]			

[Deductible, per [policy year] [calendar year] [lifetime]	\$[50]*
[We pay, after deductible	[50]%]
[Waiting period] [6 months]]	
[Maximum we pay after deductible	
[Frame	\$[65]
[Single Vision	\$[40]
[Bifocal	\$[60]
[Trifocal	\$[70]
[Progressive or Lenticular	\$[100]]]

Class C. Contact Lenses One (1) pair of contact lenses (in lieu of lenses and frame) every [[24] months] [2 years].

	[First Year	Second Year	Each Year Thereafter
Deductible, per [policy year] [calendar year] [lifetime]	\$[50]*	\$[50]*[\$50/Lifetime]	\$[50]*
We pay, after deductible	[50]%	[50]%	[50]%
[Waiting period [6 months]]]			

[Deductible, per [policy year] [calendar year] [lifetime]	\$[50]*
[We pay, after deductible	[50]%]
[Waiting period [6 months]]	
[Maximum we pay after deductible	\$[100]]]

Benefits are limited as follows:

1. In the event you transfer from the care of one vision provider to that of another during the course of treatment, or if more than one vision provider performs services for one eligible expense, we shall be liable for not more than the amount we would have been liable for had but one vision provider performed the service.
2. This policy is designed to cover visual needs rather than cosmetic materials. If you select any of the following, we will pay the basic cost of the allowed lenses: optional cosmetic processes; anti-reflective coating; color coating; mirror coating; scratch coating; blended lenses; cosmetic lenses; laminated lenses; oversize lenses; photochromic lenses, tinted lenses except Pink #1 and Pink #2; progressive multifocal lenses; UV (ultraviolet) protected lenses; certain limitations on low vision care.

[Company Info/address]

[

[Co-branding Company info/Logo]

Individual Insurance Application [Marketing Name]

General Information

Last Name	First Name	Middle Initial
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Address	Date of Birth MM/DD/YYYY
---------	-----------------------------

City	State	Zip	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single
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Telephone Number	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
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Do you have any [dental] [or vision] insurance currently in force? Yes No
 Is the insurance applied for intended to replace any existing insurance with this or any other company? Yes No
 If yes, provide type of policy, number, and name of company:
 If replacement is involved, have you received a replacement form (in states where required by law)? Yes No

Coverage Selection Applicant Only Applicant and Spouse Applicant and Child Applicant and Family
List Dependents Below

Last Name	First Name	Initial	Sex M/F	Age	Date of Birth

[Dental Plan Selection Gold Silver] **[Optional Vision Plan Selection** Plan I Plan II]
[Calendar Year Maximum Selection \$1,000 1,500 (add \$8.00) \$2,000 (add \$11.00)]

Important Information

Effective date-The effective date is the [first of the month] following the day in which the application is received in the Service Center Office.
Identification Card and Policy-Upon receipt of your completed application you will be issued a copy of your policy and Identification Card(s).
 Do not cancel any other dental coverage you may have until you receive written confirmation from Security Life. Please allow 3-4 weeks for processing.

Important Notices (For all states not listed with state specific notices below)

[Any Person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]

The following states require applicants to read and acknowledge the statement for your state below:

<p>[AL, MD: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.</p> <p>CT: I have received a copy of the disclosure material and understand that the results shown, other than the guaranteed minimum values, are not guarantees, promises, or warranties.</p>	<p>FL: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.</p> <p>KS, VT: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.</p>
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SERFF Tracking #:

SLIA-128766469

State Tracking #:

Company Tracking #:

IP1000

State:

Arkansas

Filing Company:

Security Life Insurance Company of America

TOI/Sub-TOI:

H10I Individual Health - Dental/H10I.000 Health - Dental

Product Name:

Individual Dental Insurance Policy

Project Name/Number:

Individual Dental Insurance Policy/IP1000

Rate Information

Rate data applies to filing.

Filing Method:

Review and Approval

Rate Change Type:

Neutral

Overall Percentage of Last Rate Revision:

%

Effective Date of Last Rate Revision:

Filing Method of Last Filing:

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Security Life Insurance Company of America	%	%				%	%

SERFF Tracking #:

SLIA-128766469

State Tracking #:**Company Tracking #:**

IP1000

State:

Arkansas

Filing Company:

Security Life Insurance Company of America

TOI/Sub-TOI:

H101 Individual Health - Dental/H101.000 Health - Dental

Product Name:

Individual Dental Insurance Policy

Project Name/Number:

Individual Dental Insurance Policy/IP1000

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1	Approved-Closed 11/13/2012	Individual Dental Rate Filing	IP1000-AR	New		Individual Dental Rate Filing 10-11-12.pdf

**RATE FILING
FOR
INDIVIDUAL DENTAL POLICY FORM IP1000
SECURITY LIFE INSURANCE COMPANY OF AMERICA
OCTOBER, 2012**

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OUTLINE OF BENEFITS (Sample Plan)

[Class A. Preventive Services Include:

1. Comprehensive or Periodic Oral Evaluations: Limited to two evaluations (including any initial exam) per calendar year;
2. Routine Dental Prophylaxis and Fluoride Treatments: Limited to two treatments per calendar year, benefit includes scaling and polishing;
3. Fluoride Treatments: Limited to 1 topical application per calendar year for covered dependent children under age 16;
4. Sealants, limited to the occlusal surface of unrestored permanent molars for covered dependent children under age 16;

Deductible, each calendar year	\$0
We pay, after Deductible	100%
Waiting Period—None	

Class B. Basic Services Include:

1. Basic Oral Surgery: Local anesthesia and routine follow-up care are considered an integral part of basic oral surgery.
2. Extractions: Non-surgical extraction, 1 or more teeth;
3. X-Rays: Complete series/Panoramic: Limited to 1 panoramic film or complete series (including bitewing films) per calendar year.
4. Fillings: Amalgam restoration: Limited to 1 filling per tooth surface in any [24] consecutive months. Contiguous surfaces billed separately will be combined as one restorative procedure.

Deductible, each calendar year	\$50*
We pay, after Deductible	80%
Waiting Period—6 Months	

Class C.

Major Services Include:

1. Endodontic Services:
 - a. Root canal therapy (not covered, if pulp chamber was opened before coverage began): Non-vital, nerve-dead tooth; local anesthesia and routine follow-up care are considered an integral part of services rendered; limited to 1 root canal treatment per tooth in any 36 consecutive months.
 - b. Vital pulpotomy: Limited to primary teeth only.
 - c. Apicoectomy and retrograde filling: As a separate procedure or in conjunction with other endodontic procedures; limited to 1 treatment per tooth in any 36 consecutive months;
2. Periodontal Services:
 - a. Local anesthesia and routine follow-up care are considered an integral part of services rendered.
 - b. Non-Surgical Services:
 - i. Periodontal Scaling and Root Planing: As necessary for substantial bone and attachment loss evident on current periodontal charting and radiographs; limited to 1 treatment per calendar year.
 - ii. Periodontal Maintenance: Limited to two treatments per calendar year replaces routine dental prophylaxis and only qualifying after 3 months from date of completion of active periodontal treatment, including scaling and root planing.
 - iii. Night Guards: Limited to 1 appliance in a 5 year period;
 - c. Surgical Services: Limited to 1 periodontal surgical service per quadrant in any 36 consecutive months.
 - i. Gingivectomy: Per quadrant; limited to less than 3 teeth.
 - ii. Osseous Surgery: Per quadrant; benefit includes all necessary associated surgical procedures.
 - iii. Mucogingival Surgery: Pedicle soft tissue graft; gingival flap procedure; guided tissue regeneration; free soft tissue graft.
 - iv. Bone Replacement Grafts: Only when related to periodontal procedures.
 - v. Clinical Crown Lengthening: Benefit includes all necessary associated surgical procedures;
3. Prosthodontic Services
 - a. Fixed Bridges: Each abutment and each pontic makes up a unit of a bridge. Temporary bridges older than 1 year are considered a permanent appliance.
 - b. Dentures: Benefit includes all adjustments done by dental practitioner furnishing denture during first 6 months after installation. Temporary dentures older than 1 year are considered a permanent appliance.

Limited to services performed more than 12 months after initial insertion of appliance.

1. Denture Adjustments and Repairs: Adjustments; repairing acrylic dentures, no teeth damage; repairing acrylic dentures and replacing one or more broken teeth; repairing metal dentures to the extent and nature of damage and type of materials involved; replacing one or more broken teeth, no other damage.
2. Denture Rebase: Limited to once per denture in any two year period.
3. Denture Reline: Limited to once per denture in any two year period.
4. Tissue Conditioning: Limited to a maximum of 2 treatments per arch in any 12 consecutive months.
5. Addition of Teeth to Partial Dentures: Limited to replace natural teeth lost under this coverage after 36 months.
6. Crown/Bridge Repair: Limited to extent and nature of damage and type of materials involved.

Bridge or denture replacements available only after 8 years from the date of initial installation. No benefits are payable for replacement of third molars or a portion of a tooth lost due to root amputation or hemisection.

Deductible, each calendar year	\$50*
We pay, after Deductible	50%
Waiting Period—15 Months	

Maximum Benefit Amount:

Combined per calendar year for Classes A, B and C \$1,500

*Class B and C Deductible is a combined \$50 each calendar year.
If Course of Treatment is to exceed \$300, prior review is requested.]

Expenses Not Covered

Your coverage under this policy does not cover any miscellaneous separate expense not considered a covered service or procedure.

We will not pay or provide alternate benefits for any of the following:

1. [Items, treatments or services:
 - a. not listed as an eligible expense on the Coverage Schedule;
 - b. not prescribed by or performed by or under the direct supervision of a dental practitioner;
 - c. not dentally necessary as determined by us;
 - d. not meeting the accepted standards of dental practice;
 - e. experimental in nature;
 - f. that have a questionable prognosis;
 - g. covered under any medical insurance policy; or
 - h. performed by a member of your or your spouse's family (family includes parents, step-parents, in-laws, spouse or former spouse, domestic partner, children, siblings, aunts, uncles, cousins, nieces, nephews, grandparents, and guardians).
2. Services furnished primarily for cosmetic reasons, including but not limited to:
 - a. specialized techniques, characterizing and personalizing prosthetic devices;
 - b. making facings on prosthetic devices for any tooth in back of the second bicuspid; or
 - c. replacements of restorations performed for cosmetic reasons.
3. Charges for any appliance or service that is used to:
 - a. change vertical dimension;
 - b. restore or maintain occlusion, except to the extent that this policy covers orthodontic treatment;
 - c. splint or stabilize teeth for periodontal reasons; or
 - d. treat disturbances of the temporomandibular joint (TMJ).
4. Charges for any service performed as a result of abrasion, attrition, bruxism, erosion or abfraction.
5. Occlusal, athletic, or night guards.
6. Implantology and related services; implants and all related procedures, including removal of implants.
7. Preventive root canal therapy.
8. Full mouth debridement.
9. Charges for any services that are considered to be an integral part of another service, such as pulp capping, surgical trays, or sutures.
10. Ridge preservation, augmentation, bone grafts and regeneration procedures performed in edentulous sites.
11. Overdentures or precision attachments.
12. Space maintainers and sealants.

13. Preparation and fitting of preformed dowel or post for root canal tooth; pulp cap either directly or indirectly.
14. Duplicate or temporary devices, appliances, and services except as listed as an eligible expense.
15. Replacing a lost, stolen or missing appliance or prosthetic device.
16. Application of chemotherapeutic agents.
17. Oral hygiene, plaque control, diet instruction or infection control.
18. Charges for sterilization of equipment; disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies.
19. Non-emergency services performed outside the United States or Canada.
20. Treatment which is:
 - a. due to an on-the-job or job-related illness or injury; or
 - b. a condition for which benefits are payable by Workers' Compensation or similar laws, whether or not benefits are claimed.
21. Treatment for which no charge is made or for which you are not legally obligated to pay including, but not limited to, treatment (or charges made) by:
 - a. your covered employer, labor union or similar group, in its dental or medical department or clinic;
 - b. a facility owned or run by any government body; or
 - c. any public program, except Medicaid, paid for or sponsored by any government body.
22. Telephone consultations, charges for failure to keep a scheduled appointment, X-ray copy fees, or charges for completion of a claim form.
23. Codes that are by report.
24. Ancillary charges, including but not limited to, hospital, ambulatory surgical center or similar facility; or use of provider office space.
25. Treatment resulting from:
 - a. your participation in a war or an act of war, declared or undeclared;
 - b. your attempting to commit, or committing, an assault or felony;
 - c. your unlawful participation in a riot, rebellion, or insurrection; or
 - d. an intentionally self-inflicted injury while sane or insane.
26. Procedures or treatment not prescribed or performed by or under the direct supervision of an orthodontia provider.]

Benefits are limited as follows:

1. In the event you transfer from the care of one dental practitioner to that of another during the course of treatment, or if more than one dental practitioner performs services for one eligible expense, we shall be liable for not more than the amount we would have been liable for had but one dental practitioner performed the service.
2. In all cases involving eligible expenses in which the dental practitioner and you select a more expensive course of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the eligible expense concerned, payment under the plan will be based on the charge allowed for the lesser procedure.

Dental Experience

Recent Claim Costs Per Policy Combined Similar Plans - All States

Year	Cert Holders (annual)	Earned Premium	Incurred Claims	Monthly Per Cert	Loss Ratio
2007	24,411	14,348,441	7,821,824	36.97	54.4%
2008	27,164	15,386,279	8,808,472	37.46	56.3%
2009	28,531	15,111,892	8,809,334	37.02	58.1%
2010	28,006	15,085,480	9,518,664	38.61	62.8%
2011	27,485	16,474,989	10,826,541	41.17	65.4%

[PREMIUM RATE DEVELOPMENT

Base Period	2011
Midpoint of Base Period	7/1/2011
Estimated Average Monthly Claim Costs (Single coverage)	28.15
First Year	18.14
Second Year	32.34
Third Year	33.98
Plan adjustment (higher claim costs)	
Higher Annual Maximum (\$1500)	1.10
Moving Oral Surgery to Basic benefits	1.04
Plan Monthly Claim Costs	32.21
Effective Date	1/1/2013
Effective Date Midpoint	7/1/2013
Trend Factor .61% / Month	1.158
Trended Claims to Effective Date Midpoint	37.30
Desired Loss Ratio (higher than 53%)	60.0%
Required Monthly Premium	62.16

Rates for Effective Date of 1/1/2013 (Region 4, 1.00 Area Factor)

	Distribution	Tier Factor	Rate
Single Rate	54%	1.00	62.00
Single + Child(ren)	9%	2.00	124.00
Single + Spouse	15%	2.08	129.00
Family Rate	22%	3.30	209.00

Monthly	109.97
Annual	1,319.64

Actual rates will reflect adjustments for the appropriate area factors based on Zip Code, adjusting for the plan of benefits, plan type, expenses, effect of a PPO or scheduled benefits, if any and the experience of the product over time.

Renewal rates for Dental Coverage are derived from actual to expected and anticipated Claim Costs.

All new business premium rates are guaranteed for a minimum of twelve months from the effective date of coverage.

Trend of 7.6% annually is used to anticipate claim costs for the initial pricing of a plan. As trend develops in the future, renewal rates will reflect that rate.

Area Factors

1	0.77
2	0.83
3	0.91
4	1.00
5	1.10
6	1.21
7	1.33
8	1.46
9	1.61

Sample Calculation for a Different Area

		<u>Rate for Area 2</u>	
		Area Factor	Rate
Base Rate for Single (Area 4, 1.00)	62.00	X 0.83	= 51.46

Optional Vision Rider Benefit

[Calendar Year Deductible	\$50
Eye Examination	100%
One per Calendar Year	
Waiting Period – None	
Lenses and Frames	50%
One pair every 2 years	
Waiting Period – 15 Months	
Contact Lenses (in lieu of lenses and frames)	50%
One pair or supply every 2 years	
Waiting Period – 15 Months	
Calendar Year Maximum Benefit	\$200

Vision Rider Rates

Applicant Only	\$7.00
Applicant Plus Spouse	\$14.00
Applicant Plus Child(ren)	\$14.00
Applicant Plus Family	\$18.00]

SERFF Tracking #:

SLIA-128766469

State Tracking #:

Company Tracking #:

IP1000

State: Arkansas**Filing Company:**

Security Life Insurance Company of America

TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental**Product Name:** Individual Dental Insurance Policy**Project Name/Number:** Individual Dental Insurance Policy/IP1000

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	11/13/2012
Comments:			
Attachment(s):			
Cert of Readability 11.5.12.pdf			
		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	11/13/2012
Comments:	The application is attached in the Form Schedule tab.		
		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved-Closed	11/13/2012
Comments:			
Attachment(s):			
Outline of Coverage - nationwide.pdf			
		Item Status:	Status Date:
Satisfied - Item:	Statement of Variability	Approved-Closed	11/13/2012
Comments:			
Attachment(s):			
Statement of Variability 11.7.2012.pdf			



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

Certificate of Readability

I hereby certify that the forms listed below have the following readability scores as calculated by the Flesch Reading Ease Test.

Form Number	Flesch Score
IP1000	52.4
IPS1000	50.5 w/ policy forms
IPS1000-PPO	50.5 w/ policy forms
IPS1000-SB	50.5 w/ policy forms
IPS-1000-V	59.2
IPR1000	54.8
IPR1001	53.7
IPR1002	54.1
APP-01	50.3 w/ policy forms

The generic versions of the forms were scored. Any state-specific changes were not substantive enough to affect the generic scores.

Jenny Coig, AVP, Chief Compliance Officer

November 5, 2012

Date



Security Life Insurance Company of America
[10901 Red Circle Drive
Minnetonka, Minnesota 55343
XXX.XXX.XXXX]

OUTLINE OF COVERAGE

INDIVIDUAL DENTAL INSURANCE Policy Form IP1000

Read Your Policy Carefully — This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract, and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

Policy IP1000 provides coverage for dental services. Coverage is segmented into various classes of benefit (Preventive, Basic, Major and Orthodontic if offered), and generally includes specific benefit frequency provisions and benefit **waiting periods**. **Deductibles** and coinsurance percentages apply to the various benefit classes. Please refer to the **coverage schedule** within your Insurance Policy for specific plan details.

Preventive, Basic and Major service categories are limited to a specific **annual maximum benefit amounts**. Orthodontic benefits (if offered) are limited to an **annual** and **lifetime maximum benefit amount**.

Plans may be offered with or without a preferred provider organization, please refer to your Insurance Policy for details.

Rate adjustments can occur at periodic intervals and is generally based on the experience.

Statement of Variability
Security Life Insurance Company of America

Filed forms: Individual Dental Policy IP1000, Preferred Provider Coverage Rider IPR1000, Vision IPR1001, Orthodontia Rider IPR1002, Coverage Schedule IPS1000, Preferred Provider Coverage Schedule IPS1000-PPO, Scheduled Benefit Coverage Schedule IPS1000-SB, Vision Coverage Schedule IPS1000-V, Individual Insurance Application APP-01 **Date: November 1, 2012**

The information displayed is specified by the form number and order of appearance. John Doe applicable information may be combined and categorized together.

Individual Dental Policy IP1000

Page #	Section	Text/Alternate Text/Range	Rationale
Cover	Company address/telephone number/logo	N/A	If the company's address were to change, the new address will be inserted. We will prepare and submit all required filings at the time of any change.
Cover	Company officers titles/signatures	N/A	These names/signatures will change if the officers change. If officer's names change, we will prepare and submit all required filings at the time of any change.
2	Policy Holder Name/ Address/Effective Date	Policy holder specific.	Policy holder specific.
2	Premium Mode	Alternate text options: [Monthly, bi-monthly, weekly, bi-weekly, quarterly, semi-annual, annual]	Based upon policy holder choice.
2	Dependents Covered	Will be displayed if the product allows for dependent coverage, and if dependents were listed/included at the time of application.	Policy holder specific.
2	Enrollment Fee/Policy Fee/Administrative Fee	Will be displayed only if applicable Fee is assessed, otherwise this will entire line will be suppressed. Enrollment Fee Range \$10 - 50	Variable based upon product(s) and/or benefits available, and/or Co-branding/TPA agreement at the time of application.
3	Definitions/Dependent, all references to age	Age [26]; range 26 – 29	Variable to allow for future state and/or nationwide changes in regulation. Variable based upon product(s) and/or benefits available at the time of application.
3	Definitions/Dependent, variable text in items 2, 3 and reference in paragraph under item 3	[unmarried] [who are primarily dependent upon you for support and maintenance] age [26]	Variable to allow for alignment with PPACA requirements. Variable to either be displayed or suppressed. Age Range is the same as first reference to Dependent (above).
8	General Provisions/ Takeover/Credit for Prior Time	Entire section either will be displayed or suppressed.	Variable based upon product(s) and/or benefits available at the time of application.

Preferred Provider Coverage Rider IPR1000, Vision IPR1001, Orthodontia Rider IPR1002

Page #	Section	Alternate Text/Range	Rationale
1	Company officers titles/signatures	N/A	These names/signatures will change if the officers change. If officer's names change, we will prepare and submit all required filings at the time of any change.

In the following Coverage Schedules, the purpose of all variability is to allow for services to be displayed in various Classes, and to allow for various levels of coverage, based upon the coverage and/or product being offered and/or benefits available at the time of application. Once a service within a section is addressed in the table below, any duplicate service/sections will refer to the initial entry. If/when numbered items under a section, and/or within a Class are suppressed or included, numbering will shift as necessary. The Expenses Not Covered section of the form (at the end) will also shift to reflect the suppressed or included services displayed within each Class section.

Coverage Schedule IPS1000

Page #	Section	Current Value	Minimum Value	Maximum Value	Duration	Rationale
1	Class A	N/A	N/A	N/A	All Policy Years	This entire section may be displayed or suppressed, dependent upon the coverage/product being offered.
1	Class A/Evaluations	N/A	N/A	N/A	All Policy Years	Items 1 - 2 each may be displayed, or suppressed. Item 1 – time limits (months vs. calendar years). The applicable time limit will be displayed.
1	Class A/X-Rays	N/A	N/A	N/A	All Policy Years	The entire X-Ray section may be displayed or suppressed. Items 1 – 4 each may be displayed, or suppressed. Time limits (months vs. calendar years), the applicable time limit will be displayed. Number limit of Xray/films; range 1 – 6.
1	Class A/Basic Restorative Services	N/A	N/A	N/A	All Policy Years	Entire section will be displayed, or suppressed.
1	Class A/Fillings	N/A	N/A	N/A	All Policy Years	The entire Fillings section may be displayed or suppressed. Items 1 and 2 [24] consecutive months; range 12-60 months Item 2 - [anterior] may be displayed or suppressed.
1	Class A/Routine Dental Prophylaxis and Fluoride Treatments	N/A	N/A	N/A	All Policy Years	The entire section may be displayed or suppressed. Items 1 – 3 each may be displayed, or suppressed. Time limits (months vs. calendar years), the applicable time limit will be displayed. [for covered individuals age [15] and over;] [benefit includes scaling and polishing.] applicable text will be displayed or suppressed. Age [15]; age range 13 – 18. [6] consecutive months; range 6-12.
1	Class A/Space Maintainers	N/A	N/A	N/A	All Policy Years	The entire section may be displayed or suppressed. [under age [14]] text will either be displayed or suppressed. [14]; age range 13-18.

1	Class A/Sealants	N/A	N/A	N/A	All Policy Years	The entire section may be displayed or suppressed. [under age [16]] text will either be displayed or suppressed. [16]; age range 13-18. [48] consecutive months; range 12 – 60.
1	Class A/ First/Second/Each Year First Deductible Section	N/A	N/A	N/A	All Policy Years	Either this deductible section or the one immediately below will be displayed. [per calendar year] [per lifetime] the applicable timeframe will be displayed.
1	Class A/ First/Second/Each Year Deductible \$ amounts	\$50 \$50	None None	\$250 \$350	Per calendar year Per lifetime	See introductory paragraph prior to this Coverage Schedule table.
1	Class A/ First/Second/Each Year “We pay, after deductible” %	100%	None	100%	All Policy Years	See introductory paragraph prior to this Coverage Schedule table.
1	Class A/ First/Second/Each Year Waiting period	None	None	60 months	All Policy Years	See introductory paragraph prior to this Coverage Schedule table.
1	Class A/Second Deductible Section	N/A	N/A	N/A	All Policy Years	Either this deductible section, or the one immediately above will be displayed. All variable material, \$ amounts, %’s and ranges mirror the deductible information addressed immediately above.
2	Class B	N/A	N/A	N/A	All Policy Years	This entire section may be displayed or suppressed, dependent upon the coverage/product being offered.
2	Class B/ Evaluations	N/A	N/A	N/A	All Policy Years	The entire Evaluations section may be displayed or suppressed. Items 1 – 3 each may be displayed, or suppressed.
2	Class B/X-Rays Basic Restorative Services Fillings	N/A	N/A	N/A	All Policy Years	See Class A/X-rays; Basic Restorative Services; Fillings.
2	Class B/Implants	N/A	N/A	N/A	All Policy Years	The entire Implants section may be displayed or suppressed. Items 1 and 3 either the first or second set of variable text will be displayed, when there is a time limit. If no time limit, both sets of text will be suppressed. Items 2 and 4 [24] months; range 12 – 60 months.
2/3	Class B/Complex Oral Surgery	N/A	N/A	N/A	All Policy Years	The entire section may be displayed or suppressed. 2.a. [aveolectomy] will either be displayed or suppressed. Items g – p will either be displayed or suppressed.

3	Class B/Endodontic Services	N/A	N/A	N/A	All Policy Years	The entire section may be displayed or suppressed. Item 1 and 4 [36] months; range 12 – 60 months. Item 3 may be displayed or suppressed.
3	Class B/Periodontal Services (including Non-Surgical and Surgical Services)	N/A	N/A	N/A	All Policy Years	The entire section may be displayed or suppressed. Non-surgical and Surgical sections may be displayed or suppressed. Time limits (months vs. calendar years), the applicable time limit with text will be displayed. Item 2 (in Non-Surgical) [(replaces routine dental prophylaxis)] may either be displayed or suppressed. Item 3 (in Non-Surgical) may be displayed or suppressed. [24] consecutive months, [36] consecutive months; range 12 – 60 months
3	Class B/Basic Prosthodontic Services	N/A	N/A	N/A	All Policy Years	The entire section may be displayed or suppressed. [1] year; range 1-4 years. During the first [6] months; range 6 – 24 months. Time limits (months vs. calendar years), the applicable time limit with text will be displayed. [12] consecutive months, [36] consecutive months; range 12 – 60 months [Bridge or denture replacements available only after [8] years from the date of initial installation. No benefits are payable for replacement of third molars or a portion of a tooth lost due to root amputation or hemisection.] may be displayed or suppressed. [8] years; range 3- 10 years.
3	Class B/Other Basic Services	N/A	N/A	N/A	All Policy Years	The entire section may be displayed or suppressed.
3/4	Class B/Space Maintainers/Sealants	N/A	N/A	N/A	All Policy Years	See Class A/Space Maintainers/Sealants.
4	Class B/Deductible (both sections)	N/A	N/A	N/A	All Policy Years	See Class A/Deductible (both sections).
4	Class C	N/A	N/A	N/A	All Policy Years	This entire section may be displayed or suppressed, dependent upon the coverage/product being offered.
4	Class C/Implants	N/A	N/A	N/A	All Policy Years	See Class B Implants.
4	Class C/ Inlays/Onlays/Crowns (first paragraph)	5 year(s)	3 year(s)	9 year(s)	All Policy Years	Item 2 [; or a primary tooth for an insured dependent child [under age [14]]; entire text may be displayed or suppressed. [14]; age range 13-18. Item 2 [limited to one prefabrication crown per lifetime for a crown] may be displayed or suppressed.

4/5	Class C/Complex Oral Surgery/Endodontic Services/Periodontal Services	N/A	N/A	N/A	All Policy Years	See Class B/Complex Oral Surgery/Endodontic Services/Periodontal Services
5	Class C/Prosthodontic Services	N/A	N/A	N/A	All Policy Years	See Class B/Prosthodontic Services
5/6	Class C/Missing Tooth	N/A	N/A	N/A	All Policy Years	The entire section may be displayed or suppressed. [6] months; range 6 – 18 months.
6	Class C/Other Major Services/Space Maintainers/Sealants/Deductible (both sections)	N/A	N/A	N/A	All Policy Years	See Class B/Other Basic Services. See Class A/Space Maintainers/Sealants/Deductible (both sections).
6	Class D	N/A	N/A	N/A	All Policy Years	This entire section may be displayed or suppressed, dependent upon the coverage/product being offered.
6	Class D	N/A	N/A	N/A	All Policy Years	[Insured(s)] [Dependent(s) Under [19] Years of Age] each set of text may be displayed, or suppressed. [19] years; range 13- 21.
6	Class D/Deductible (both sections)	N/A	N/A	N/A	All Policy Years	See Class A/Deductible (both sections).
7	Maximum Benefit Amount/first section	\$1000 \$500 \$1000	\$500 \$100 \$250	\$5000 \$5000 \$5000	All Policy Years	Either this maximum benefit amount section or the one immediately below will be displayed. The applicable text will be displayed: Combined calendar year limit for Class[es A, B, and C] [Maximum calendar year for Class D] [Lifetime maximum for Class D] The final paragraph will be displayed or suppressed. Class[es A, B, and C], applicable Classes will be displayed or suppressed. ...combined \$[50] each calendar year. [three (3)] individual deductibles.
7	Maximum Benefit Amount/second section	\$1000 None \$1000	\$500 None \$250	\$5000 \$5000 \$5000	All Policy Years	Either this maximum benefit amount section or the one immediately above will be displayed. The applicable text will be displayed: Combined calendar year limit for Class[es A, B, and C]] 1 st /2 nd /Thereafter [Maximum calendar year for Class D] 1 st /2 nd /Thereafter [Lifetime maximum for Class D] The final paragraph will be displayed or suppressed. Class[es A, B, and C], applicable Classes will be displayed or

		\$50 3	\$25 2	\$200 5		suppressed. ...combined \$[50] each calendar year. [three (3)] individual deductibles.
7	If Course of Treatment is to exceed \$[300], prior review is requested	\$300	\$100	\$500	All Policy Years	See introductory paragraph prior to this Coverage Schedule table.
7/8	Expenses Not Covered	N/A	N/A	N/A	All Policy Years	As indicated in the introductory paragraph, the items within this section will fluctuate based upon the items applicable to the Classes.
All	Page Numbers	N/A	N/A	N/A	All Policy Years	Variable to allow for pagination as items are suppressed or displayed.

As previously indicated, only those items that are different in Coverage Schedule IPS1000-PPO will be addressed below, all other items listed for IPS1000 (above) mirror those for PIS1000-PPO.

Coverage Schedule IPS1000-PPO

Page #	Section	Current Value	Minimum Value	Maximum Value	Duration	Rationale
1	Lead in paragraph/ first and second set of boxed text	N/A	N/A	N/A	All Policy Years	The applicable box of bracketed text will appear.
2	Class A/(first) Participating/Non-Participating Deductible Section	N/A	N/A	N/A	All Policy Years	Either this deductible section or the one immediately below will be displayed. [per calendar year] [per lifetime] the applicable timeframe will be displayed.
2	Class A/Deductible \$ amounts	\$50 \$50	None None	\$250 \$350	Per calendar year Per lifetime	See introductory paragraph prior to this Coverage Schedule table.
2	Class A/ "We pay, after deductible" %	100%	None	100%	All Policy Years	See introductory paragraph prior to this Coverage Schedule table.
2	Class A/ Waiting period	None	None	60 months	All Policy Years	See introductory paragraph prior to this Coverage Schedule table.
2	Class A/(second) Participating/Non-Participating Deductible Section	100% 100	10% 10%	100% 100%	All Policy Years All Policy Years	Either this deductible section, or the one immediately above will be displayed. Participating Dentist - 1 st /2 nd /Each Year Thereafter % Non-Participating Dentist - 1 st /2 nd /Each Year Thereafter % Deductible and Waiting period mirrors info immediately above.
4	Class B/ Participating/Non-Participating Deductible Section (both)	N/A	N/A	N/A	All Policy Years	See Class A/Participating/Non-Participating Deductible (both sections).

6	Class C/ Participating/Non- Participating Deductible Section (both)	N/A	N/A	N/A	All Policy Years	See Class A/Participating/Non-Participating Deductible (both sections).
6/7	Class D/ Participating/Non- Participating Deductible Section (both)	N/A	N/A	N/A	All Policy Years	See Class A/Participating/Non-Participating Deductible (both sections).
7	Maximum Benefit Amount (Participating and Non-Participation Benefits Combined)	\$1000 \$2000 \$500 \$500 \$1000	\$500 \$1000 \$250 \$250 \$500	\$5000 \$5000 \$3000 \$3000 \$5000	All Policy Years	Either this maximum benefit amount section or the one immediately below will be displayed. Combined per calendar year for Class[es A, B and C] the applicable classes will be displayed. The applicable text will be displayed: [Maximum calendar year for Class C] [Maximum calendar year for Class D] [Lifetime maximum for Class D]
7	Maximum Benefit Amount	\$2000 \$600 \$500 \$1200	\$1000 \$300 \$250 \$600	\$5000 \$2500 \$3000 \$5000	All Policy Years	Either this maximum benefit amount section or the one immediately above will be displayed. Combined per calendar year for Class[es A, B and C] the applicable classes will be displayed. The applicable text will be displayed: [Maximum calendar year for Class D] 1 st /2 nd /Thereafter [Maximum calendar year for Class C] 1 st /2 nd /Thereafter [Lifetime maximum for Class D]
8	Maximum Benefit Amount	\$50 3	\$25 2	\$100 5		Any of the three applicable final paragraphs will be displayed or suppressed. Class[es A, B, C, D], applicable Classes will be displayed or suppressed. ...combined \$[50] each calendar year; \$[50] lifetime deductible; combined \$[50] per calendar year.... [three (3)] individual deductibles.
8	If Course of Treatment is to exceed \$[300], prior review is requested	\$300	\$100	\$500	All Policy Years	See introductory paragraph prior to this Coverage Schedule table.
8/9	Expenses Not Covered	N/A	N/A	N/A	All Policy Years	As indicated in the introductory paragraph, the items within this section will fluctuate based upon the items applicable to the Classes, depending on coverage offered.
All	Page Numbers	N/A	N/A	N/A	All Policy Years	Variable to allow for pagination as items are suppressed or displayed, based upon the product being offered.

Coverage Schedule IPS1000-SB

Page #	Section	Current Value	Minimum Value	Maximum Value	Duration	Rationale
1	Maximum limit	\$1000	\$500	\$5000	All Policy Years	Time limits (calendar vs. policy year), the applicable time limit will be displayed.
1	Percentage payable after deductible	100%	10%	100%	All Policy Years	See introductory paragraph prior to the IPS1000 Coverage Schedule table.
1	Deductible – each calendar year per insured	None \$50 \$50 3	None None None 2	\$150 \$250 \$250 5	All Policy Years	Time limits (calendar vs. policy year), the applicable time limit will be displayed. Preventive Services Basic Services Major Services [3 (three) individual]
1	Waiting period	None 3 months 18 months	None None None	12 months 36 months 36 months	All Policy Years	Preventive Services Basic Services Major Services
1	If Course of Treatment is to exceed \$[300], prior review is requested	\$300	\$100	\$500	All Policy Years	See introductory paragraph prior to the IPS1000 Coverage Schedule table.
All pages	Preventive/Basic/Major Services	N/A	N/A	N/A	All Policy Years	These sections may be displayed or suppressed, dependent upon the coverage/product being offered. Similar to the introductory paragraph prior to the IPS1000 Coverage Schedule table, the items within these sections will fluctuate based upon the items applicable to the specific Services displayed (rather than Classes), which is dependent upon coverage offered.
All pages	Preventive/Basic/Major Services/ Code/Description	N/A	N/A	N/A	All Policy Years	The Code and Descriptions columns are managed and may be changed/updated on an annual basis by the American Dental Association, based upon the CDT (current dental terminology) reference book code on dental procedures and nomenclature.
All pages with tables	Preventive/Basic/Major Services/ Scheduled Amount	various	\$10	\$1500	All Policy Years	Variable to allow for the applicable Schedule Amount, per code/description (service) provided.
1	Footnote to Preventive Services	N/A	N/A	N/A	All Policy Years	The applicable time limits (months vs. calendar vs. policy year), and number of services applicable (1, 2 or 3) will be displayed. [6] consecutive months; range 6-36 months.

6/7	Expenses Not Covered	N/A	N/A	N/A	All Policy Years	Similar to the introductory paragraph prior to the IPS1000 Coverage Schedule table, the items within this section will fluctuate based upon the items applicable to the specific Services displayed (rather than Classes), depending on coverage offered.
All	Pagination	N/A	N/A	N/A	All Policy Years	Variable to allow for pagination as items are suppressed or displayed.

Coverage Schedule IPS1000-V

Page #	Section	Current Value	Minimum Value	Maximum Value	Duration	Rationale
1	Class A/Vision Exams	N/A 12 months	N/A 6 months	N/A 36 months	All Policy Years	Time limits (months vs. calendar years vs. year). The applicable time limit will be displayed. [12] months
1	Class A/(first) First/Second/Each Year First Deductible Section	N/A	N/A	N/A	All Policy Years	Either this deductible section or the one immediately below will be displayed. [policy year] [calendar year] [lifetime] the applicable timeframe will be displayed.
1	Class A/ First/Second/Each Year Deductible \$ amounts	\$50 \$50 \$50	None None None	\$200 \$200 \$200	Policy Year Calendar year Lifetime	See introductory paragraph prior to all Coverage Schedule tables.
1	Class A/ First/Second/Each Year "We pay, after deductible" %	85%	10%	100%	All Policy Years	See introductory paragraph prior to all Coverage Schedule tables.
1	Class A/ First/Second/Each Year Waiting period	None	None	36 months	All Policy Years	See introductory paragraph prior to all Coverage Schedule tables.
1	Class A/(second) Deductible Section	N/A \$50	N/A None	N/A \$300	All Policy Years	Either the applicable parts within this deductible section, or the one immediately above will be displayed. All variable material, \$ amounts, %'s and ranges mirror the deductible information addressed immediately above, EXCEPT FOR: MAXIMUM WE PAY AFTER DEDUCTIBLE, will either be displayed or suppressed.
1	Class B/Lenses and Frames	N/A 24 months	N/A 6 months	N/A 36 months	All Policy Years	Time limits (months vs. years). The applicable time limit will be displayed. [24] months
1	Class B/(first) First/Second/Each Year First Deductible Section	N/A	N/A	N/A	All Policy Years	See Class A/Deductible(first) section.

1	Class B/(second) Deductible Section	\$65 \$40 \$60 \$70 \$100	\$30 \$30 \$30 \$30 \$30	\$200 \$200 \$200 \$200 \$200	All Policy Years	See Class A Deductible (second) section, AND ALSO THE FOLLOWING, EITHER WILL BE DISPLAYED OR SUPPRESSED: Frame Single Vision Bifocal Trifocal Progressive or Lenticular
1	Class C/Contact Lenses	N/A 24 months	N/A 6 months	N/A 36 months	All Policy Years	Time limits (months vs. years). The applicable time limit will be displayed. [24] months
1	Class C/(first)(second) Deductible sections	\$100	\$100	\$1000	All Policy Years	See Class A/Deductible (first) Class B (second) sections. MAXIMUM WE PAY AFTER DEDUCTIBLE, will either be displayed or suppressed.
2	Paragraph above Maximum Benefit Amount	\$50 3	None 2	\$200 5	All Policy Years	If applicable, this section will either be displayed or suppressed. Class[es A, B and C], applicable Classes will be displayed or suppressed. ...combined \$[50] per lifetime. [three (3)] individual deductibles.
2	Maximum Benefit Amount (first)	\$150	\$100	\$1250	All Policy Years	If applicable, this section will either be displayed or suppressed. Combined per calendar year for Class[es A, B and C], applicable classes will be displayed or suppressed.
2	Maximum Benefit Amount (second) First/Second/Each Year Thereafter	\$250 \$250 \$250	\$100 \$100 \$100	\$500 \$750 \$1250	First Year Second Year Thereafter	If applicable, this section will either be displayed or suppressed. Class[es A, B and C], applicable Classes will be displayed or suppressed.
2	Paragraph after both Maximum Benefit Amount Sections	\$50 3	None 2	\$200 5	All Policy Years	If applicable, this section will either be displayed or suppressed. Class[es A, B and C], applicable Classes will be displayed or suppressed. ...combined \$[50] each policy year. [three (3)] individual deductibles.
2	Limitations and Exclusions/3 introduction paragraphs	61mm \$75.00	50mm \$50.00	70mm \$300.00	Para 1 Para 2	If applicable, each may either be displayed or suppressed.

2	Limitations and Exclusions	N/A	N/A	N/A	All Policy Years	As indicated in the introductory paragraph, the items within this section will fluctuate based upon the items applicable to the Classes, and depending on coverage offered.
All	Page Numbers	N/A	N/A	N/A	All Policy Years	Variable to allow for pagination as items are suppressed or displayed.

Individual Insurance Application APP-01

Page #	Section	Text/Alternate Text/Range	Rationale
1	Company Logo (upper right)	N/A	Variable to allow for the Company Logo to be displayed. We will prepare and submit all required filings at the time of any change.
1	Company address/telephone number (upper left)	N/A	If the company's address were to change, the new address will be inserted. We will prepare and submit all required filings at the time of any change.
1	Co-branding Company info/Logo (upper left)	N/A	Variable to allow for Co-branding information to be displayed. The items/information in this section will never be in larger type than the Company's name/logo, etc.
1	Marketing Name	N/A	Variable to allow for placement of product name once determined.
1	Replacement Questions	[dental] [or vision]	Applicable information/options will be displayed, or suppressed based upon coverage and/or product being offered and/or benefits available.
1	Coverage Selection Dental Plan Selection Optional Vision Plan Selection Calendar Year Maximum Selection Important Information/Effective Date	N/A N/A N/A N/A [first of the month]	Applicable information/options/entire sections will be displayed, or suppressed based upon coverage and/or product being offered and/or benefits available. Variable to allow for different issue date(s) based on coverage/ product being offered/benefits available/third party administrator limitations.
1/2	Important Notices/State required notices	N/A	Variable to allow for future state and/or nationwide changes in regulation.
2	Applicant Signature	[dental] [vision] [Service Center Address/Email address]	Applicable information/options will be displayed, or suppressed based upon coverage and/or product being offered and/or benefits available. The applicable service center address/email will be inserted.
2	Submit Application	[Online] [Fax] [Mail]	Applicable sections may be displayed or suppressed. The applicable information/options based on the selections will be displayed, or suppressed (based upon company and/or cobranding company requirements).
2	For Agent Use Only	N/A	Entire section may be displayed or suppressed.
2	For Company Use Only	N/A	Entire section may be displayed or suppressed.
ALL	Page numbers Tracking number/info/dates in lower right hand corner	N/A	Variable to allow for pagination. Section and information (based upon company and/or cobranding company tracking information) included may be displayed or suppressed.