DENTAL Insurance
for employer groups with 2+ lives

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

- Freedom to use any Dentist – Network Options Available for Additional Savings†
- Credit for prior coverage available*
- No waiting periods for most services
- Dental rate discount for 50% voluntary participation
- Rate discount for combined dental and vision package

Class A - Preventive	Plan I	Plan II	Plan III
Initial & Periodic Exams (2 per year), Cleanings (2 per year), Fluoride Treatments (to age 16)			
Benefit Year One	100%	80%	80%
Benefit Year Two	100%	80%	100%
Benefit Year Three and Each Benefit Year Thereafter	100%	80%	100%
Deductible—Lifetime per Insured	$50	$50	$50
Waiting Period	None	None	None
Class B - Basic	**Plan I**	**Plan II**	**Plan III**
X-rays, Fillings, Simple Extractions, Sealants (to age 16)			
Benefit Year One	50%	50%	50%
Benefit Year Two	60%	50%	80%
Benefit Year Three and Each Benefit Year Thereafter	80%	50%	80%
Deductible—Each Calendar Year per Insured**	$50/Year	$50/Year	$75/Year
Waiting Period	None	None	None
Class C - Major	**Plan I**	**Plan II**	**Plan III**
Oral Surgery, Endodontics, Periodontics, Crowns, Bridges, Dentures			
Benefit Year One	30%	25%	Not Available
Benefit Year Two	50%	50%	Not Available
Benefit Year Three and Each Benefit Year Thereafter	50%	50%	Not Available
Deductible—Each Calendar Year per Insured**	$50/Year	$50/Year	–
Waiting Period	None	None	–
Class D - Orthodontics	**Plan I**	**Plan II**	**Plan III**
Straightening of Teeth (for children under age 19)			
Benefit Year One	0%	Not Available	Not Available
Benefit Year Two	50%	Not Available	Not Available
Benefit Year Three and Each Benefit Year Thereafter	50%	Not Available	Not Available
Deductible	None	–	–
Waiting Period	12 Months	–	–
Calendar Year Maximums	**Plan I**	**Plan II**	**Plan III**
Calendar Year Maximum for Classes A, B and C Combined	$1,500	$1,000	$1,000
Calendar Year Maximum for Class C – Major Services	$750	$500	N/A
Calendar Year Maximum for Class D	$500	–	–
Lifetime Maximum Per Child for Class D	$1,000	–	–

†**Maximum Care Network:** With over 140,000 dental locations nationwide, the Maximum Care Network can help you save up to 50% on routine and major dental procedures, in addition to helping you manage your annual maximums. Search providers at careington.com/co/maxcare. This option is not available in ID, NJ, NY, VT or WA. Security Life will be held harmless in the event that the provider network does not have the appropriate state licensure or that the provider does not honor the network's discount.

***Credit for prior coverage:** If this plan is replacing an existing group dental plan (with comparable coverage) those employees (and their dependents) who were covered under the preceding plan will receive credit for the time covered towards this plan's waiting periods. Credit will be calculated based on the number of months each employee was covered under the prior plan. New employees (and dependents) joining the plan will be subject to the waiting periods. **A copy of the group's prior plan and last billing statement showing those covered (and their prior plan effective date) must be provided with the group application to ensure proper credit is given.**

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

To learn more visit SecurityLife.com/GemStar or call 800.328.4667.

DENTAL EXPENSES NOT COVERED

- for overdentures and associated procedures;
- for charges in excess of those considered Reasonable and Customary;
- for cosmetic procedures;
- for the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function;
- for implants and for replacement of lost or stolen appliances, replacement of retainers, athletic mouthguards, precision or semi-precision attachments, denture duplication;
- for oral hygiene instructions; and for: plaque control, completion of a claim form acid etch, broken appointments, prescription or take-home fluoride, or diagnostic photographs;
- for services not completed by the end of the month in which coverage ends unless continuation of coverage has been requested and accepted by Us;
- for procedures that are begun, but not completed;
- for services and treatment provided without charge, or for which there would be no charge in the absence of insurance;
- for services in connection with war or any act of war, whether declared or undeclared, or condition contracted or accident occurring while on full-time active duty in the armed forces of any country or combination of countries;
- for a condition covered under any Worker's Compensation Act or similar law;
- for services that are generally considered by the dental profession as experimental or investigational;
- for the treatment of cleft palate and anodontia;
- for services or supplies payable under any medical expense plan;
- for orthodontia, unless included within Coverage Schedule;
- for services rendered prior to the date the Insured is covered under the Policy;
- for the diagnosis or treatment of Temporomandibular Joint Dysfunction (TMJD);
- for hospital services;
- if You voluntarily end Your insurance You will not be eligible to re-enroll for a period of 2 years after the date Your coverage first ended;
- charges for infection control, sterilization, and waste disposal.

UNDERWRITING GUIDELINES

ELIGIBLE EMPLOYEES

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

ELIGIBLE DEPENDENT

Eligible dependent is any of the following persons:

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

EMPLOYER RESTRICTIONS

This plan is only available to employers that have been in business more than one year.

Most Firms will qualify for this plan; however, coverage is not available to:

- Groups funded by the government or any government agency
- Groups that are home based
- Groups that are seasonal in nature
- Groups with more than 90% family content

This list of ineligible Firms is representative only and not all-inclusive. Please see rate card for additional information.

GENERAL INFORMATION

PREMIUMS, RENEWABILITY

Applicable Dental Premium Rates are guaranteed for each Employer Group for 12 months from date of issue. Thereafter, rates are subject to change in accordance with the Master Policy. Coverage is renewable as long as eligibility criteria are satisfied and premiums are paid when due.

TERMINATION OF COVERAGE

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

COORDINATION OF BENEFITS

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

PARTICIPATION DISCOUNT

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

EFFECTIVE DATE

When a firm joins the Trust, the insurance for its current employees will be effective on the date approved by the insurance company. Future new employees will become insured on the first of the month following the completion of the probationary period selected by the employer. A completed enrollment form must be received within 31 days of new employee eligibility. An employee who does not enroll when initially eligible is considered a "late entrant." A late entrant is eligible to enroll in the program as a "new employee" on the Plan's Anniversary Date or immediately if a qualifying event occurs.

REASONABLE AND CUSTOMARY

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

PLAN I NOT AVAILABLE IN SOUTH DAKOTA

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

This is only a summary of benefits and is subject to individual state regulations. This product may not be available in all states. For complete information, please see the Certificate of Insurance.

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For more information contact:

ASSURANT Health®

GEMSTAR MONTHLY PREMIUM RATES
For Effective Dates January 1, 2012 through June 1, 2012

Groups of over 100 eligible employees must be submitted to the home office for review.
Increase all rates 20% for schools and governmental bodies.

Group Dental Base Rates*			Area 1	Area 2	Area 3
Voluntary	Plan 1	Employee Only	$ 21.80	$ 23.80	$ 26.30
		Employee+Spouse	$ 44.00	$ 48.30	$ 53.10
		Employee+ Child(ren)	$ 52.10	$ 57.10	$ 62.60
		Employee + Family	$ 78.90	$ 86.50	$ 95.00
	Plan 2	Employee Only	$ 16.90	$ 18.50	$ 20.30
		Employee+Spouse	$ 34.10	$ 37.30	$ 40.90
		Employee+ Child(ren)	$ 35.20	$ 38.60	$ 42.40
		Employee + Family	$ 56.00	$ 61.40	$ 67.50
	Plan 3	Employee Only	$ 12.60	$ 13.80	$ 15.20
		Employee+Spouse	$ 25.50	$ 27.90	$ 30.70
		Employee+ Child(ren)	$ 26.40	$ 28.90	$ 31.70
		Employee + Family	$ 41.90	$ 46.00	$ 50.60
Employer Paid	Plan 1	Employee Only	$ 18.90	$ 20.70	$ 22.80
		Employee+Spouse	$ 38.40	$ 42.00	$ 46.20
		Employee+ Child(ren)	$ 45.20	$ 49.60	$ 54.40
		Employee + Family	$ 68.60	$ 75.30	$ 82.60
	Plan 2	Employee Only	$ 14.60	$ 16.00	$ 17.60
		Employee+Spouse	$ 29.60	$ 32.40	$ 35.70
		Employee+ Child(ren)	$ 30.60	$ 33.60	$ 37.00
		Employee + Family	$ 48.60	$ 53.50	$ 58.70
	Plan 3	Employee Only	$ 11.00	$ 12.10	$ 13.10
		Employee+Spouse	$ 22.10	$ 24.30	$ 26.60
		Employee+ Child(ren)	$ 22.90	$ 25.10	$ 27.60
		Employee + Family	$ 36.50	$ 40.00	$ 43.80

Group Vision Base Rates*			
Voluntary	Plan 1	Employee Only	$ 6.20
		Employee+Spouse	$ 11.50
		Employee+ Child(ren)	$ 9.90
		Employee + Family	$ 16.30
	Plan 2	Employee Only	$ 7.50
		Employee+Spouse	$ 14.10
		Employee+ Child(ren)	$ 12.20
		Employee + Family	$ 20.10
	Plan 3	Employee Only	$ 4.70
		Employee+Spouse	$ 8.60
		Employee+ Child(ren)	$ 7.40
		Employee + Family	$ 12.00
Employer Paid	Plan 1	Employee Only	$ 5.40
		Employee+Spouse	$ 10.00
		Employee+ Child(ren)	$ 8.60
		Employee + Family	$ 14.00
	Plan 2	Employee Only	$ 6.60
		Employee+Spouse	$ 12.20
		Employee+ Child(ren)	$ 10.50
		Employee + Family	$ 17.30
	Plan 3	Employee Only	$ 4.10
		Employee+Spouse	$ 7.50
		Employee+ Child(ren)	$ 6.50
		Employee + Family	$ 10.40

DENTAL ZIP CODE AREA CHART	
Pennsylvania	
Zip	Area
170-178,182-187	2
190-192	3
All Others	1

*****If the group is electing both dental and vision coverage, the base rates may be reduced by 5%. In order to qualify for this discount at least 2 employees must elect dental coverage and at least 2 employees must elect vision coverage.***

Determine your monthly dental premium	*Dental Base Rates	**Discount for electing both dental and vision ☐ Yes ☐ No	Add for Waiting Period Credit? ☐ Yes ☐ No	Discount for 50% Participation? (Voluntary Only) ☐ Yes ☐ No	Dental Monthly Premium Total	# of Employees	Dental Subtotal
Employee Only	$	X.95	X1.14	X.90	$		$
Employee + Spouse	$	X.95	X1.14	X.90	$		$
Employee +Child(ren)	$	X.95	X1.14	X.90	$		$
Employee + Family	$	X.95	X1.14	X.90	$		$
					Initial Dental Premium Due		$

Determine your monthly vision premium	*Vision Base Rates	**Discount for electing both dental and vision ☐ Yes ☐ No	Vision Monthly Premium Total	# of Employees	Vision Subtotal
Employee Only	$	X.95			$
Employee + Spouse	$	X.95			$
Employee +Child(ren)	$	X.95			$
Employee + Family	$	X.95			$
			Initial Vision Premium Due		$

Initial Remittance
Dental $
Vision $
Total Due $
Payable to Security Life Insurance Co of America