

Insured by Symetra® Life Insurance Company | 777 108th Avenue NE, Bellevue, Washington 98004

DENTAL	Class A - Preventive Services	Silver	Gold
	Initial & Periodic Exams (2/year), Cleanings (2/year), Fluoride Treatments (to age 16), Sealants (no age limitation)		
	Benefit Level	80%	100%
	Deductible per Insured	None	None
	Waiting Period	None	None
	Class B - Basic Services	Silver	Gold
	Filings, Oral Surgery, X-Rays, Simple Extractions		
	Benefit Level	80%	80%
	Deductible per Insured	\$50/Year [†]	\$50/Year [†]
	Waiting Period	9 Months	6 Months
Class C - Major Services	Silver	Gold	
Endodontics, Periodontics, Crowns, Bridges, Dentures			
Benefit Level	50%	50%	
Deductible per Insured	\$50/Year [†]	\$50/Year [†]	
Waiting Period	18 Months	15 Months	
Calendar Year Maximum Options per Insured for Classes A, B & C Combined			
	\$1,000	\$1,000	
	\$1,500	\$1,500	
	\$2,000	\$2,000	

VISION RIDER – OPTIONAL	Class A - Vision Exams (1/year)	Plan I	Plan II
	Benefit (Waiting Period: None)	100%	85%
	Class B - Lenses & Frames (1 pair/2 years)	Plan I	Plan II
	Benefit (Waiting Period: 15 Months)	50%	50%
	Class C - Contact Lenses (1 pair/2 years)	Plan I	Plan II
	<i>In lieu of frames and lenses</i>		
	Benefit (Waiting Period: 15 Months)	50%	50%
	Calendar Year Deductible	\$50/Year	\$50/Year
Calendar Year Maximum for Classes A, B & C	\$200/Year	\$150/Year	
Vision rider is not a standalone benefit.			

- No Enrollment Fees
- Optional Vision Coverage
- Includes Coverage for All Ages
- 100% Preventive Coverage
- Up to \$2,000 Annual Maximum
- Freedom to Choose Any Dentist – Optional Network Available for Addition Savings*

Two ways to enroll:

Online

Online at securitylife.com/personaldental. Online enrollment requires an agent authorization number (AAN). This eight-digit number can be obtained from your agent or by calling 866.847.1120.

Mail

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

***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, 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.

†DEDUCTIBLE: Class B & C deductible is combined for each calendar year. A maximum of 3 individual deductibles per family shall apply. This plan reimburses at the percentages shown for covered dental expenses based upon Reasonable and Customary (R&C) fees for those covered expenses. Reasonable and Customary means the usual, customary and regular charges for the area where such expenses are incurred.



ASSURANT
Health®

DENTAL EXCLUSIONS AND LIMITATIONS

- Charges in excess of those considered Reasonable and Customary
- Cosmetic procedures
- The replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function
- Implants and for replacement of lost or stolen appliances, replacement of retainers, athletic mouthguards, precision or semi-precision attachments, denture duplication
- Missing Tooth: When covered under your plan, benefits are provided for placement of dentures, fixed bridgework, implants or the addition of teeth to existing dentures only when the service includes replacement of a natural tooth extracted or lost while covered under this plan. This limitation ends after the individual receiving care has been covered under this plan for 36 consecutive months.
- Overdentures and associated procedures
- Oral hygiene instructions, and for: plaque control, completion of a claim form, acid etch, broken appointments, prescription or take-home fluoride, or diagnostic photographs
- Services not completed by the end of the month in which coverage ends unless continuation of coverage has been requested and accepted by Us
- Procedures that are begun, but not completed
- Services and treatment provided without charge, or for which there would be no charge in the absence of insurance
- Services in connection with war or any act of war, whether declared or undeclared, or condition contracted or accident occurring while on full-time active duty in the armed forces of any country or combination of countries
- A condition covered under any Worker's Compensation Act or similar law
- That are applied toward satisfaction of a Deductible, if any
- That are generally considered by the dental profession as experimental or investigational
- The treatment of cleft palate and anodontia
- Services or supplies payable under any medical expense plan
- Orthodontia, unless included within the Coverage Schedule
- Services rendered prior to the date the Insured is covered under the Policy
- The diagnosis or treatment of Temporomandibular Joint Dysfunction (TMJD)
- Hospital services
- If You voluntarily end Your insurance, You will not be eligible to re-enroll for a period of 2 years after the date Your coverage first ended
- Charges for infection control, sterilization, and waste disposal

VISION EXCLUSIONS AND LIMITATIONS

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

The cost of a frame in excess of a standard frame will not be covered. A standard frame is any frame which has a retail value of \$75 or less. The cost of replacement frames will not be covered, unless the existing frame is not compatible with the replacement lenses.

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

- Any procedure, service or supply included as a covered medical expense under any group insurance plan, whether benefits are payable as to all or only part of such charges
- Special procedures, such as orthoptics, vision training and subnormal vision aids
- Plano or prescription sunglasses or other special purpose vision aids
- Medical or surgical treatment of the eyes including hospital expenses
- Replacement of lost or broken lenses and/or frames
- Duplicate glasses or lenses or frames
- Services or materials not listed as an Eligible Expense

This brochure provides a very brief description of some important features of your Plan. It is not the Insurance Contract nor does it represent the Contract. For applicants in New Hampshire, a full explanation of benefits, exceptions and limitations is contained in the Certificate of Insurance under Group Policy Form LGC-8854 2/04. For applicants in Vermont, a full explanation of benefits, exceptions and limitations is contained in Group Policy Form 9041 1/05. A specimen copy is available upon request.

Some provisions may vary by state. This Dental Plan may not be available in all states.

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

IMPORTANT INFORMATION

ELIGIBILITY

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

PRETREATMENT REVIEW

If the Course of Treatment will exceed the amount shown in the Coverage Schedule, We will request prior review. We must be given the Dentist's treatment plan consisting of a description of the planned treatment with estimated charges and diagnostic x-rays. We will determine Eligible Expenses and state how much We will pay for the treatment. Our determination may suggest an alternate, less expensive Course of Treatment if it will produce professionally satisfactory results. If You do not request a pretreatment review, We will pay for the least expensive method of treatment regardless of the method actually used.

ALTERNATE BENEFIT

If: 1) We determine that a less expensive alternate procedure, service or Course of Treatment can be performed in place of the proposed treatment to correct a dental condition; and 2) the alternate treatment will produce a professionally satisfactory result; then the maximum We will allow will be the charges for the less expensive treatment.

COORDINATION OF BENEFITS

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

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For more information contact:

Symetra® Life Insurance Company

PrimeStar Classic Enrollment Form

Vermont

Dental Plan Selection: Gold Silver

Optional Vision Plan Selection: Plan 1 Plan 2

Calendar Year Maximum Selection: \$1,000 \$1,500 (added cost \$8.00) \$2,000 (added cost \$11.00)

I apply for coverage on: Applicant Only Applicant and Spouse Applicant and Child(ren) Applicant and Family

APPLICANT INFORMATION (PLEASE PRINT CLEARLY)

Last Name		First Name		Initial		Birth Date / /	
Address				Telephone Number		Sex: M <input type="checkbox"/> F <input type="checkbox"/>	
City				State	Zip	Marital Status Married <input type="checkbox"/> Single <input type="checkbox"/>	
Billing Address (If Different)		City		State	Zip		

LIST ALL YOUR ELIGIBLE DEPENDENTS BELOW

Last Name (If Different)	First Name	Initial	Sex M/F	Age	Birth Date
Spouse					/ /
Dependent					/ /
Dependent					/ /
Dependent					/ /
Dependent					/ /

Does Spouse have a dental plan: Yes No With Whom? _____

If answer is "Yes", are dependents enrolled under spouses plan? Yes No

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 Certificate of Insurance - Upon receipt of your completed application you will receive a copy of your Certificate of Insurance and Identification Card(s).

Do not cancel any other dental coverage you may have until you receive written confirmation from Symetra Life. Please allow 3-4 weeks for processing.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

By my signature below, I hereby apply for coverage with Symetra Life Insurance Company, 777 108th Avenue NE, Bellevue, WA, 98004 under Dental Insurance Policy Form LGC-9041 1/05. I also certify I have read the Fraud Notice above.

Applicant Signature _____ Date _____

Please refer to the reverse side for payment options and agent information

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PRIMESTAR CLASSIC DENTAL

PREMIUM RATE TABLE FOR VERMONT

For effective dates November 1, 2011 through April 1, 2012

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

RATE CHART			
UNDER AGE 65	GOLD PLAN	Applicant Only	\$ 39.00
		Applicant+Spouse	\$ 79.00
		Applicant+ Child(ren)	\$ 90.00
		Applicant + Family	\$ 138.00
	SILVER PLAN	Applicant Only	\$ 34.00
		Applicant+Spouse	\$ 74.00
		Applicant+ Child(ren)	\$ 81.00
		Applicant + Family	\$ 125.00
65 AND OVER	GOLD PLAN	Applicant Only	\$ 42.00
		Applicant+Spouse	\$ 90.00
	SILVER PLAN	Applicant Only	\$ 40.00
		Applicant+Spouse	\$ 81.00

Optional Vision Rates for All Ages		
Plan 1	Applicant Only	\$ 6.00
	Applicant+Spouse	\$ 12.00
	Applicant+ Child(ren)	\$ 12.00
	Applicant + Family	\$ 16.00
Plan 2	Applicant Only	\$ 5.00
	Applicant+Spouse	\$ 10.00
	Applicant+ Child(ren)	\$ 10.00
	Applicant + Family	\$ 12.00