SECURITYLIFE
INSURANCE COMPANY OF AMERICA

# PrimeStar Advantage Plus

## Individual Dental Insurance

30 DAY CUSTOMER SATISFACTION GUARANTEE

Protecting your smile starts with that semi-annual trek to the dentist. Research shows that good dental health is essential to your overall health. Keeping your smile sparkling with **PrimeStar Advantage Plus** is as easy as 1-2-3.
**Get started today with no enrollment fees!**

## 1 Here's what's covered:

### PREVENTIVE SERVICES

Includes exams and cleanings (2 per year), fluoride treatments and sealants (under age 16)

Policy Pays ..... 100% – coverage begins day one

Lifetime Deductible ..... $50 over the life of policy

### BASIC SERVICES

Includes fillings, x-rays† and simple extractions

| Policy Pays ..... | 35% Day 1 | 65% After Year 1 | 80% After Year 2+ |
|---|---|---|---|

Calendar Year Deductible .. $50/year*

### MAJOR SERVICES

Includes oral surgery, endodontics, periodontics, crowns, bridges and dentures

Policy Pays ..... 15% day 1, then after year one 50%

Calendar Year Deductible .. $50/year*

### ORTHODONTIC SERVICES

Straightening of teeth (under age 19)

Policy Pays ..... 50%

Calendar Year Maximum ... $500/year per child

Lifetime Maximum ..... $1,000 per child

Waiting Period ..... 24 months

†Bitewing x-rays are a Preventive Service for TN.
*Basic and Major calendar year deductible is combined per person, with a maximum of 3 deductibles per family.

### DENTAL PROVIDER

PrimeStar Advantage Plus gives you the freedom to use any dentist with the advantage of utilizing a MaxCare network provider for additional savings. The MaxCare network gives you:

- Over 200,000 access points nationwide
- Discounts of 5-50% on dental services
- Network discounts available immediately
- Provider search at **Careington.com/co/SLICA**

Additionally, when you utilize a MaxCare dental provider, your out-of-pocket costs may be lower because they have agreed to a negotiated fee for services. You are responsible for any coinsurance and the required deductible. It is important to note that if you receive care from a non-MaxCare provider your out-of-pocket charges will be based on the Reasonable and Customary charge.

## 2 Your coverage options:

### MAXIMUM BENEFIT AMOUNT

I want the policy to pay a yearly maximum amount of:

- ☐ $1,000 for Preventive, Basic & Major Services combined. Major Services will not exceed $500.
- ☐ $2,000 for Preventive, Basic & Major Services combined. Major Services will not exceed $1,000.

A higher Maximum Benefit Amount will increase your premium.

## 3 Interested in **optional vision coverage**?

### EXAMS once per year

Policy Pays ..... 100%

Waiting Period ..... None – covered day 1

### LENS & FRAMES OR CONTACTS
1 pair every 2 years

Policy Pays ..... 75%

Waiting Period ..... 15 months

Calendar Year Deductible ..... $25/person

Maximum Benefit Amount .... $200/year

### VISION COVERAGE

- ☐ Yes (available at an additional cost)
- ☐ No

Proudly brought to you by:

Enroll at SecurityLife.com

what's not included...

## DENTAL LIMITATIONS & EXCLUSIONS

The following are not covered or available as an alternative benefit:

- Occlusal, athletic, or night guards.
- Full mouth debridement.
- Preventive root canal therapy.
- Codes that are by report.
- Overdentures or precision attachments.
- Items/treatments/services: not listed as an eligible expense on the Coverage Schedule; not prescribed by/performed by/under the direct supervision of a dental practitioner; not dentally necessary as determined by us; not meeting the accepted standards of dental practice; experimental in nature; that have a questionable prognosis; covered under any medical insurance policy; or performed by a member of your or your spouse's family (includes parents, step-parents, in-laws, spouse or former spouse, domestic partner, children, siblings, aunts, uncles, cousins, nieces, nephews, grandparents, and guardians).
- Services furnished primarily for cosmetic reasons, including but not limited to: specialized techniques, characterizing and personalizing prosthetic devices; making facings on prosthetic devices for any tooth in back of the second bicuspid; or replacements of restorations performed for cosmetic reasons.
- Charges for any appliance or service that is used to: change vertical dimension; restore or maintain occlusion, except to the extent that this policy covers orthodontic treatment; splint or stabilize teeth for periodontal reasons; or treat disturbances of the temporomandibular joint (TMJ).
- Charges for any service performed as a result of abrasion, attrition, bruxism, erosion or abfraction.
- Implantology and related services; implants and all related procedures, including removal of implants.
- Charges for any services that are considered to be an integral part of another service, such as pulp capping, surgical trays, or sutures.
- Ridge preservation, augmentation, bone grafts and regeneration procedures performed in edentulous sites.
- Preparation and fitting of preformed dowel or post for root canal tooth; pulp cap either directly or indirectly.
- Duplicate or temporary devices, appliances, and services except as listed as an eligible expense.
- Replacing a lost, stolen or missing appliance or prosthetic device.
- Application of chemotherapeutic agents.
- Oral hygiene, plaque control, diet instruction or infection control.
- Non-emergency services performed outside the USA, Canada & Mexico.
- Treatment which is: due to an on-the-job or job-related illness or injury; or a condition for which benefits are payable by Workers' Compensation or similar laws, whether or not benefits are claimed.
- 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: your covered employer, labor union or similar group, in its dental/medical department/clinic; a facility owned/run by any government body; or any public program, except Medicaid, paid for/sponsored by any government body.
- Treatment resulting from: your participation in a war or an act of war, declared or undeclared; your attempting to commit, or committing, an assault or felony; your unlawful participation in a riot, rebellion, or insurrection; or an intentionally self-inflicted injury while sane or insane.
- Procedures or treatment not prescribed or performed by or under the direct supervision of an orthodontia provider.

**PRIMESTAR ADVANTAGE PLUS IS NOT AVAILABLE IN: AK, GA, MA, NJ, NY, TX, VT, WA.**
**VISION COVERAGE NOT AVAILABLE IN MD.**

This provides a very brief description of some of the important features of the insurance policy. It is not the insurance policy and does not represent it. A full explanation of benefits, exceptions and limitations is contained in Individual Dental Policy Form IP1000 (and any state specific) and Vision Rider IPR1001 (and any state specific), or One Life Group Dental Policy that may be issued to the group voluntary trust, GH-1112 (and any state specific) and Vision Rider GHR-1112(Vision) (and any state specific). Premium rates may change upon renewal. This policy is renewable at the option of the insured (IP1000) or the Company (GH-1112). This product may not be available in all states and is subject to individual state regulations. **SecurityLife.com | 800.328.4667**

## VISION LIMITATIONS & EXCLUSIONS

- The cost of a lens in excess of a standard lens will not be covered. Standard lens fits in 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. Standard frame 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.
- The cost of replacement frames will not be covered, unless the existing frame is not compatible with the replacement lenses.

The following are not covered or available as an alternative benefit:

- Two pair of glasses in lieu of bifocals.
- Artistically painted contact lenses.
- Medical or surgical treatment of the eyes.
- Codes that are by report.
- Items, treatments or services: not listed as an eligible expense; not prescribed by or performed by or under the direct supervision of a vision provider; not visually necessary to restore or maintain a patient's visual acuity and health; not meeting the accepted standards of vision practice; experimental in nature; or covered under any medical insurance policy.
- Orthoptics or vision training and any associated supplemental testing.
- Plano lenses (less than a ± .50 diopter power).
- Replacement of lenses, frames/contacts furnished under this policy that are lost or broken, except at the normal intervals when services are otherwise available.
- Corneal refractive therapy or orthokeratology.
- Additional office visits for contact lens pathology.
- Contact lens modification, polishing or cleaning.
- Charges for service agreements or insurance policies.

## GENERAL INFORMATION

Eligibility: Individuals 18+, plus their eligible dependents. This is subject to individual state regulations.

Predetermination of Benefits: It is recommended that a treatment plan/course of treatment 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. 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. 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.

Alternate Benefit: If we determine that a less expensive procedure, service, or treatment plan/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.

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

The following are not covered or available as an alternative benefit:

- Telephone consultations, charges for failure to keep a scheduled appointment, x-ray copy fees, or charges for completion of a claim form.
- Ancillary charges, including but not limited to, hospital, ambulatory surgical center or similar facility; or use of provider office space.
- Charges for sterilization of equipment; disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies.

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Rates effective January 1, 2014

# PrimeStar Advantage Plus Rates

Follow the steps below to find your **PrimeStar Advantage Plus** monthly policy rate:

## 1 Find your Area by locating the first 3 digits of your zip code

| State | Zip | Area |
|---|---|---|
| Alabama | All | 1 |
| Arizona | 851, 855-856, 859, 865 | 2 |
| | All Others | 3 |
| Arkansas | All | 1 |
| California | 922-925, 932-933, 936-937, 952-953 | 5 |
| | 934, 938-939, 942, 955, 959-961 | 6 |
| | All Others | 7 |
| Colorado | 800-806, 808-809 | 5 |
| | All Others | 3 |
| Delaware | 199 | 3 |
| | All Others | 5 |
| D.C. | All | 7 |
| Florida | 330-334 | 5 |
| | 341-342 | 4 |
| | All Others | 3 |
| Hawaii | All | 5 |
| Idaho | 832-834 | 2 |
| | All Others | 3 |
| Indiana | 460-464 | 3 |
| | All Others | 2 |
| Iowa | 500-503 | 3 |
| | 511, 515, 520, 522-524, 527-528 | 2 |
| | All Others | 1 |
| Kansas | 660-662, 666, 670-672 | 2 |
| | All Others | 1 |
| Kentucky | 400-402, 410, 422 | 3 |
| | 403, 405, 411, 421, 423-424, 427 | 2 |
| | All Others | 1 |
| Louisiana | 700-701, 704 | 2 |
| | All Others | 1 |
| Maine | 039-041 | 5 |
| | 042 | 4 |
| | All Others | 3 |
| Maryland | 208-209 | 6 |
| | 213, 215-216, 218 | 4 |
| | All Others | 5 |
| Michigan | 480-483 | 5 |
| | 484-485, 488-492 | 4 |
| | All Others | 3 |
| Minnesota | 550-554 | 4 |
| | All Others | 3 |
| Mississippi | All | 1 |
| Montana | 590-591, 598 | 4 |
| | All Others | 3 |
| Nebraska | 680-681, 685 | 2 |
| | 687 | 3 |
| | All Others | 1 |
| New Hampshire | 030-031, 038 | 6 |
| | All Others | 5 |
| North Carolina | 275-277, 280-282 | 4 |
| | 283-289 | 2 |
| | All Others | 3 |
| North Dakota | 580-581, 585 | 3 |
| | All Others | 2 |
| Ohio | 430-432, 440-442 | 3 |
| | All Others | 2 |
| Oklahoma | 730-731 | 3 |
| | 740-741 | 2 |
| | All Others | 1 |
| Oregon | All | 4 |
| Pennsylvania | 150-154, 156, 160, 170-171, 175-176, 180-181 | 3 |
| | 183, 189-194 | 5 |
| | All Others | 2 |
| Rhode Island | All | 4 |
| South Carolina | All | 2 |
| South Dakota | All | 2 |
| Utah | All | 2 |
| Virginia | 201, 220-225 | 5 |
| | 226, 228-229, 240-241 | 3 |
| | 230-238 | 4 |
| | All Others | 2 |
| West Virginia | 254, 267 | 3 |
| | All Others | 1 |
| Wisconsin | 538-539, 542, 545-548 | 3 |
| | All Others | 4 |
| Wyoming | All | 2 |

**MY AREA #**

## 2 Find your dental rate by your Area and Maximum Benefit Amount

**$1,000 Maximum Benefit Amount**

| Area: | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|---|
| Applicant | $30.47 | $33.71 | $36.96 | $40.62 | $44.68 | $49.15 | $54.02 |
| Applicant + One | $62.09 | $68.72 | $75.34 | $82.79 | $91.07 | $100.18 | $110.11 |
| Applicant + Family | $105.78 | $117.06 | $128.35 | $141.04 | $155.14 | $170.66 | $187.58 |

**$2,000 Maximum Benefit Amount**

| Area: | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|---|
| Applicant | $37.34 | $41.32 | $45.30 | $49.78 | $54.76 | $60.23 | $66.21 |
| Applicant + One | $75.83 | $83.92 | $92.01 | $101.11 | $111.22 | $122.34 | $134.48 |
| Applicant + Family | $127.77 | $141.40 | $155.03 | $170.36 | $187.40 | $206.14 | $226.58 |

**DENTAL RATE**

## 3 If adding vision, find your cost below. Vision is not available in MD.

**Optional vision coverage**

| | | | | | |
|---|---|---|---|---|---|
| Applicant | $7.00 | Applicant + One | $14.00 | Applicant + Family | $20.00 |

**VISION RATE**

## 4 Add 2 & 3 together to find your total monthly cost for your policy

**Total monthly cost for my policy:**

· The monthly premium is guaranteed for the initial 12 months of coverage. After 12 months, premiums may increase.

Security Life Insurance Company of America
10901 Red Circle Drive
Minnetonka, Minnesota 55343
800.233.0307

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## PrimeStar Individual Insurance Application

### General Information

| Last Name | First Name | Middle Initial |
|---|---|---|
| | | |

| Address | Date of Birth (MM/DD/YYYY) |
|---|---|
| | |

| City | State | Zip | Marital Status ☐ Married ☐ Single |
|---|---|---|---|
| | | | |

| Telephone Number | Gender ☐ Male ☐ Female |
|---|---|
| | |

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 + One ☐ Applicant + Family
**List Dependents Below**

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

| | | | | |
|---|---|---|---|---|
| **1 Dental Plan Selection** | ☐ **Essential** *(NOT available in AK, MA, NJ, NY, NC,VT, WA)* | ☐ **Advantage** *(NOT available in AK, MA, NJ, NY, NC, VT, WA)* | ☐ **Advantage Plus** *(NOT available in AK, GA, MA, NJ, NY, TX, VT, WA)* | ☐ **Complete** *(NOT available in AK, GA, MA, NJ, NY, TX, VT, WA)* |
| **2 Maximum Benefit Amount Selection** | Comes with $500 | ☐ $1,000 ☐ $2,000* *Choose one.* | ☐ $1,000 ☐ $2,000* | ☐ $1,000 ☐ $2,000* |
| | | **A higher Maximum Benefit Amount will increase your premium amount.* | | |
| **3 Optional Vision Coverage** | ☐ Yes ☐ No *Optional vision coverage is available at an additional cost. Not available in MD, NJ, NY, WA.* | | | |

### Important Information

If you choose paper billings a fee of $6 will apply (not applicable for CO, IN, NM, PA).
**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:**

**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.

**AK, CO, LA, NJ, OH, OK, TN, VA, WV:** Any person who knowingly intends to defraud an insurance company, submits an application or files a statement of claim containing any false, incomplete, or misleading information, commits the crime of fraud, and may be subject to criminal prosecution and civil penalties. In CO, and TN, additional penalties may include imprisonment, fines, or denial of insurance benefits. In CO, an insurer or insurance agent who knowingly provides false, incomplete, or misleading information to a policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**DC:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, the insurer may deny benefits if false information materially related or a claim was provided.

**VT:** Any person who knowingly, and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information may be guilty of fraud and may be subject to criminal or civil penalties.

**KS:** 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.

**IL, PA:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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. This activity subjects such a person to criminal and civil penalties.

**TX:** Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statement may be guilty of fraud.

**Please read and check box below to receive your policy electronically**

☐ ***I consent to receiving my Policy, Outline of Coverage where applicable, and any other plan information electronically and I will electronically affirm or provide my signature below of my consent to do so. I understand I need internet access and that I can withdraw my consent at any time per the notification instructions below, I understand I can receive any of the documents in paper form if I choose. My email address is:*** _____

**Applicant Signature**

**By signing below, the applicant acknowledges the above statements and understands or agrees to the following:**

**All statements and answers given in this application are true and complete to the best of my knowledge:**

- **I may return my policy within the right-to-cancel period as described in my policy;**
- **I acknowledge receipt of the Outline of Coverage (in states where required by law);**
- **I understand the policy I am applying for provides dental and vision benefits only and is not a Medicare supplement;**
- **I acknowledge that the agent of record, if applicable, is my insurance agent for purposes of the Security Life Privacy Policy; and**
- **I understand that it is my responsibility to give notice to Security Life of changes in my e-mail address or any information above, as well as my status and my family's status that effect coverage, such as marriage, births, or death of someone covered under the policy. I will provide notice via fax 717.481.7175 or in writing to Security Life: P.O. Box 83149, Lancaster, PA 17608**

**Applicant Signature** _____ **Date** _____

**Submit Application**

*Must submit with PrimeStar Payment Authorization Form & Replacement Notice (if applicable)*

| **ONLINE** | **MAIL** | **FAX** |
|---|---|---|
| SecurityLife.com | Security Life Insurance Company of America<br>P.O. Box 83149 \| Lancaster, PA 17608 | 717.481.7175 |

**For Agent use only (if applicable)**

| | | | |
|---|---|---|---|
| Agent Name | | Phone # | |
| Street Address | City | State | Zip |
| Email | SS#/TIN#/AAN# | | |
| Appointed with Security Life? ☐ Yes ☐ No | Signature | | |

**For Company use only** **Effective Date:** **Plan Code:**

10901 Red Circle Drive | Minnetonka, MN 55343
800.233.0307 | SecurityLife.com

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INSURANCE COMPANY OF AMERICA

**PrimeStar Payment Authorization Form**

**Applicant's Full Name:**

**Monthly Premium** (from Rate Sheet):

**Method of Payment** (select one)

| CHECKING ACCOUNT (ACH) | CREDIT CARD | PAPER BILL |
|---|---|---|
| ☐ **Monthly Bank Account Debit**<br>*Submit 2 months of premium and a voided check*<br><br>☐ **Quarterly Bank Account Debit**<br>*Submit 3 months of premium and a voided check* | ☐ **Monthly Credit Card**<br><br>Please select your card type below and provide your credit card account information:<br><br>☐ Visa ☐ MasterCard ☐ Discover<br><br>_____<br>Credit Card Number<br><br>_____ _____<br>Expiration Date CVC *(on back of card)* | ☐ **Quarterly (3 months) Paper Bill**<br>*Submit 3 months of premium*<br><br>☐ **Semi-Annual (6 months) Paper Bill**<br>*Submit 6 months of premium*<br><br>Paper billing begins on your policy effective date and we will provide you with a quarterly or semi-annual invoice of charges due for the insurance policy.<br><br>*A $6 fee per bill will be applied on all future bills. (Not applicable to CO, IN, NM, PA.)* |

**Authorization Agreement**

I authorize Security Life Insurance Company of America to initiate electronic debit entries to my account chosen above for payment of my insurance premium. My account will be debited by the third business day of the month in which premium is due. I understand I will receive a notice if the amount changes. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of the US law. (Applies only to ACH and Credit Card options.)

I understand that in order to make changes to this authorization (such as a change in bank account, method of payment, or termination of payment) I need to give Security Life written notification at least 10 days prior to the next scheduled payment. I understand that the insurance plan may be cancelled by Security Life if any payment is dishonored by my bank for any reason. In the case of an NSF, I am liable for any fees my bank may charge me and may also be responsible for an NSF fee of up to $25 which may be automatically debited for each NSF.

**Your Signature** _____ **Date** _____

Security Life Insurance Company of America
10901 Red Circle Drive
Minnetonka, Minnesota 55343
800.233.0307

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**IF THIS IS A REPLACEMENT**
leave the top half of this form with the Applicant and send the signed bottom half of this form with the Application

## NOTICE TO APPLICANT REGARDING REPLACEMENT OF DENTAL INSURANCE

According to information you have furnished, you intend to lapse or otherwise terminate existing dental insurance and replace it with a policy to be issued by Security Life Insurance Company of America.

For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

Even though some of your present health conditions may be covered under the new policy, these conditions may be subject to certain waiting periods under the new policy before coverage is effective.
You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.
Do not cancel your present policy until you have actually received your new policy and are sure you want to keep it.

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## NOTICE TO APPLICANT REGARDING REPLACEMENT OF DENTAL INSURANCE

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If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.
Do not cancel your present policy until you have actually received your new policy and are sure you want to keep it.

The above "Notice to Applicant" was delivered to me on:

_____ _____
(Date) (Applicant's Signature)

REP1000-APP

Security Life Insurance Company of America
10901 Red Circle Drive
Minnetonka, Minnesota 55343
800.233.0307

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# 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.