# OPTIONAL DENTAL & VISION SUMMARY

| PERSONAL DENTAL PLANS | | |
|---|---|---|
| **Dental Benefits** | **Choice Plan Pays** | **Plus Plan Pays** |
| **Class A - Preventive:** Initial & Periodic Exams (2 per year); Cleanings (2 per year); Fluoride treatments (to age 16); Space Maintainers | | |
| Waiting Period<br>Co-Insurance | None<br>100% | None<br>100% |
| **Class B - Basic:** X-rays; Fillings; Simple Extractions | | |
| Waiting Period*<br>Co-Insurance | None*<br>80% | None*<br>50% |
| **Class C - Major:** Oral Surgery; Endodontics; Periodontics; Crowns, Bridges, Dentures | | |
| Waiting Period*<br>Co-Insurance | None*<br>50% | None*<br>50% |
| Calendar Year Deductible - $50<br>Calendar Year Maximum for Classes A, B and C combined | $1,000 | $1,000 |
| Class A, B & C Deductible is combined for each calendar year. A maximum of three (3) individual deductibles per family shall apply. | | |
| **Optional Vision Benefits Rider (Not a Stand-alone Benefit)** | **Choice Plan Pays** | **Plus Plan Pays** |
| **Class A - Vision Exams - 1 per year** | | |
| Benefit Year One and Each Benefit Year<br>Thereafter Waiting Period | 85%<br>None* | 85%<br>None* |
| **Class B - Lenses and Frame - 1 pair every 2 years** | | |
| Benefit Year One and Each Benefit Year<br>Thereafter Waiting Period | 50%<br>None* | 50%<br>None* |
| **Class C - Contact Lenses - 1 pair every 2 years (in lieu of frames and lenses)** | | |
| Benefit Year One and Each Benefit Year<br>Thereafter Waiting Period | 50%<br>None* | 50%<br>None* |
| Calendar Year Deductible | $50/Year | $50/Year |
| Calendar Year Maximum for Classes A, B and C | $150 | $150 |

*This plan does include a 6 month waiting period for Basic Services and an 18 month waiting period for Major Services (as identified in the Certificate). A 15 month waiting period also applies to the Optional Vision Rider for Class B and Class C Services." Waiting periods will apply to any individuals who enroll for coverage after their initial 31 days of eligibility. The dental plan provides benefits for covered dental services rendered by any licensed dentist, physician or dental hygienist. The vision plan provides benefits for covered vision services rendered by an optometrist, ophthalmologist or optician. If you obtain services from a provider participating in the PPOUSA-CONNECTION Dental Network, your out-of-pocket expenses maybe lower. To locate a PPO USA-CONNECTION Dental Network provider in your area visit www.ppousa.com or call (877)277-6872. When you obtain services from a Network provider, this plan reimburses based on the network agreement in place with that provider. When you obtain services from a non-network provider, this plan reimburses based upon the Reasonable and Customary fees for the geographic area where the expenses are incurred. PPO USA is a subsidiary of Government Employees Hospital Association (GEHA), the third-largest national health plan providing health insurance to employees and retirees of the federal government. Through PPOUSA, organizations outside the federal government can now take advantage of GEHA's successful cost-containment networks and services through the CONNECTION Dental network.

**QUESTIONS? PLEASE CONTACT AmWINS CUSTOMER CARE AT 1-866-847-5820**
**Underwritten by: Security Life Insurance Company of America, Minnetonka, MN**

# IMPORTANT INFORMATION ABOUT YOUR DENTAL PLAN

**ELIGIBLE EXPENSES**

We will pay for Eligible Expenses you incur for yourself or on behalf of Your insured Dependent. Expenses must be incurred while the Policy is in force and the person is covered by the Policy. The description of Eligible Expenses is shown in the Coverage Schedule. To be an Eligible Expense, the dental service or procedure must be performed by a Dentist, a Physician or a Dental Hygienist.

**EXPENSES INCURRED**

An Eligible Expense is considered incurred on the following dates: For full and partial dentures - the date the final impression is taken; for fixed bridges, crowns, inlays and onlays - the date the teeth are first prepared; for root canal therapy - on the date the pulp chamber is opened; for periodontal surgery - on the date surgery is performed; for all other services - the date the service is performed.

**DEDUCTIBLE AMOUNT**

The calendar year Deductible, if any, is shown in 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.

**MAXIMUM CALENDAR YEAR LIMIT**

The maximum limit payable for all Eligible Expenses in any calendar year is shown in the Coverage Schedule. The Maximum Calendar Year Limit, if any, will apply to each person covered under the Policy.

**PRETREATMENT REVIEW**

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

**COORDINATION OF BENEFITS**

If any person under the Policy (referred to as "this Plan") is also covered under one or more other plans, the benefit under this Plan will be coordinated with benefits payable under all other plans. **ALTERNATE BENEFIT**

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

**ELIGIBILITY**

Individuals, 18 years of age or older, plus their eligible dependents (spouse and unmarried children from birth to age 19; extended to age 23 if child is a full-time student). This is subject to State requirements.

**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; (d) or the date the Master Policy ends.

**EFFECTIVE DATE**

You and Your Dependents are covered on the later of: the date We accept Your enrollment and determine an effective date; or the date You first acquire a Dependent, if the date is after Your coverage begins.

**REASONABLE AND CUSTOMARY**

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

**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 sealants;
- 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;
- That are applied toward satisfaction of a Deductible, if any;
- 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;
- Prior to the date the Insured is covered under the Policy;
- For the diagnosis or treatment of Temporomandibular Joint dysfunction (TMJD);
- For hospital services;
- For any unmarried child age 19 years of age and over unless he is dependent upon You for support, while a full-time student. A full-time student is one who is enrolled for 12 semester hours for credit in an accredited junior college, college or university. Any exception for a full-time student will end at age 23;
- During any waiting period We require, when You voluntarily end Your insurance and re-enroll at a later date, Your waiting period is 2 years and begins on the date Your coverage first ended.
- Charges for infection control, sterilization, and waste disposal.

**VISION EXPENSES NOT COVERED**

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 $75.00 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:

1. 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;
2. Special procedures, such as orthoptics, vision training and subnormal vision aids;
3. Plano or prescription sunglasses or other special purpose vision aids;
4. Medical or surgical treatment of the eyes, including hospital expenses;
5. Replacement of lost or broken lenses and/or frames;
6. Duplicate glasses or lenses or frames; and
7. Services or material not listed as an Eligible Expense.

***Notice: This brochure provides a brief description of some important features of your Plan. It is not the Insurance Contract, nor does it represent the Insurance Contract. A full explanation of benefits, exceptions and limitations is contained in the Certificate of Insurance under Group Dental Policy GH-1112-38870 issued to the Voluntary Group Trust. This Dental Plan may not be available in all states. No agent has the authority to change any benefits, to bind coverage with Security Life Insurance Company of America, or to promise a certain effective date.***

**IMPORTANT FRAUD NOTICES**

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.

**STATE SPECIFIC NOTICES**

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

**Colorado** - It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder 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.

**District of Columbia** - WARNING: 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, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Kentucky** - Any person who knowingly and with intent to defraud any insurer or other person files an application for insurance 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.

# MONTHLY DENTAL/VISION COST SUMMARY

## Monthly Rate Table

| Plan Type | Coverage Type | area 1 | area 2 | area 3 | area 4 | area 5 | area 6 | area 7 | area 8 |
|---|---|---|---|---|---|---|---|---|---|
| Choice Plan | Applicant Only | **$36.94** | $40.63 | **$44.33** | $49.13 | **$53.93** | $59.10 | **$65.01** | $71.66 |
| | Applicant & Spouse | **$73.87** | $81.26 | **$88.64** | $98.25 | **$107.85** | $118.19 | **$130.01** | $143.31 |
| Plus Plan | Applicant Only | **$30.71** | $33.78 | **$36.85** | $40.84 | **$44.84** | $49.14 | **$54.05** | $59.58 |
| | Applicant & Spouse | **$61.42** | $67.56 | **$73.70** | $81.69 | **$89.67** | $98.27 | **$108.10** | $119.15 |
| Optional vision Coverage | Applicant Only | **$7.00** | $7.00 | **$7.00** | $7.00 | **$7.00** | $7.00 | **$7.00** | $7.00 |
| | Applicant & Spouse | **$13.00** | $13.00 | **$13.00** | $13.00 | **$13.00** | $13.00 | **$13.00** | $13.00 |

## Zip Code Chart

| State | Zip/Area |
|---|---|
| **Alabama** | |
| 350-355 | 3 |
| 359 | 3 |
| All Other | 1 |
| **Alaska** | |
| 995-996 | 8 |
| All Other | 6 |
| **Arizona** | |
| 856-857 | 2 |
| 864 | 2 |
| All Other | 1 |
| **Arkansas** | |
| All Areas | 1 |
| **California** | |
| 900-905 | 7 |
| 906-914 | 6 |
| 915-916 | 8 |
| 917-918 | 4 |
| 919-927 | 6 |
| 930-934 | 6 |
| 939 | 6 |
| 943-948 | 4 |
| 949, 961 | 6 |
| 956-958 | 3 |
| 959 | 4 |
| All Other | 5 |
| **Colorado** | |
| 803 | 4 |
| 808-810 | 4 |
| All Other | 1 |
| **Delaware** | |
| All Areas | 2 |
| **Dist. Columbia** | |
| All Areas | 6 |
| **Georgia** | |
| 300-303 | 2 |
| All Other | 1 |
| **Hawaii** | |
| All Areas | 3 |
| **Idaho** | |
| All Areas | 1 |
| **Illinois** | |
| 600-605 | 2 |
| 606-608 | 3 |
| All Other | 1 |
| **Indiana** | |
| 463-464 | 2 |
| 473 | 3 |
| All Other | 1 |
| **Iowa** | |
| All Areas | 1 |
| **Kansas** | |
| 660-662 | 2 |
| All Other | 1 |
| **Kentucky** | |
| All Areas | 1 |
| **Louisiana** | |
| 707-711 | 2 |
| 712 | 3 |
| All Other | 1 |
| **Michigan** | |
| 480-483 | 2 |
| 490-491 | 2 |
| 488-489 | 3 |
| All Other | 1 |
| **Minnesota** | |
| 553-558 | 2 |
| 564, 566 | 2 |
| All Other | 1 |
| **Mississippi** | |
| 390-392 | 2 |
| All Other | 1 |
| **Missouri** | |
| 640-641 | 2 |
| 644-649 | 2 |
| All Other | 1 |
| **Montana** | |
| 590-591 | 1 |
| 599 | 2 |
| All Other | 3 |
| **Nebraska** | |
| All Areas | 1 |
| Nevada | |
| 890-891 | 2 |
| 894-895 | 6 |
| 898 | 6 |
| All Other | 4 |
| **New Mexico** | |
| 881 | 2 |
| 882 | 5 |
| All Other | 1 |
| **North Carolina** | |
| 277 | 2 |
| 286 | 3 |
| 287-289 | 2 |
| All Other | 1 |
| **N. Dakota** | |
| 580-581 | 2 |
| All Other | 1 |
| **Ohio** | |
| All Areas | 1 |
| **Oklahoma** | |
| 740-743 | 2 |
| All Other | 1 |
| **Oregon** | |
| 977 | 3 |
| 978 | 1 |
| All Other | 2 |
| **Pennsylvania** | |
| 170-178 | 2 |
| 182-187 | 2 |
| 190-192 | 3 |
| All Other | 1 |
| **S. Carolina** | |
| All Areas | 1 |
| **Tennessee** | |
| 373-374 | 2 |
| All Other | 1 |
| **Texas** | |
| 751-753 | 3 |
| 754 | 4 |
| 756-757 | 1 |
| 776-777 | 1 |
| All Other | 2 |
| **Utah** | |
| All Areas | 1 |
| **Washington** | |
| 982-984 | 4 |
| 990-992 | 3 |
| 993 | 6 |
| All Other | 5 |
| **W. Virginia** | |
| 255-257 | 4 |
| 262-265 | 3 |
| All Other | 2 |
| **Wisconsin** | |
| All Areas | 1 |
| **Wyoming** | |
| All Areas | 1 |

## Monthly Rate Table for CT, MA, ME, MD, NH, NJ,RI

| Plan Type | Coverage Type | area 1 | area 2 | area 3 | area 4 | area 5 | area 6 | area 7 | area 8 |
|---|---|---|---|---|---|---|---|---|---|
| Choice Plan | Applicant Only | **$38.60** | $42.46 | **$46.32** | $51.34 | **$56.36** | $61.76 | **$67.94** | $74.88 |
| | Applicant + Spouse | **$77.19** | $84.91 | **$92.63** | $102.66 | **$112.70** | $123.50 | **$135.85** | $149.75 |
| Plus Plan | Applicant Only | **$32.37** | $35.61 | **$38.84** | $43.05 | **$47.26** | $51.79 | **$56.97** | $62.80 |
| | Applicant + Spouse | **$64.74** | $71.21 | **$77.69** | $86.10 | **$94.52** | $103.58 | **$113.94** | $125.60 |
| Optional vision Coverage | Applicant | **$7.00** | $7.00 | **$7.00** | $7.00 | **$7.00** | $7.00 | **$7.00** | $7.00 |
| | Applicant + Spouse | **$13.00** | $13.00 | **$13.00** | $13.00 | **$13.00** | $13.00 | **$13.00** | $13.00 |

| Zip Code Chart | | |
|---|---|---|
| **State** | **Zip** | **area** |
| **CT** | | **5** |
| **MA** | | **5** |
| **ME** | | **1** |
| **MD** | **206-207** | **2** |
| | **209-211** | **2** |
| | **217** | **3** |
| | **all others** | **4** |
| **NH** | | **1** |
| **NJ** | | **4** |
| **RI** | | **3** |

***Calculating Your Rate***: Locate the first 3 digits of your zip code on the Zip Code Area Chart to the left. Use the corresponding area number to determine the applicable monthly premium in the Monthly Rate Table based upon your plan selection and coverage type.

| | Applicant Only | Applicant & Spouse | Total Monthly Rate |
|---|---|---|---|
| **Choice Plan:** | | | |
| **Plus Plan:** | | | |
| **Optional vision Coverage** | | | |