SECURITYLIFE
INSURANCE COMPANY OF AMERICA

PrimeStar Advantage

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** 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%

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

Waiting Period ..... None – coverage begins day one

BASIC SERVICES

Includes fillings, x-rays† and simple extractions

	Day 1	After Year 1	After Year 2+
Policy Pays	35%	50%	65%

Calendar Year Deductible .. $50/year*

MAJOR SERVICES

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

	Day 1	After Year 1	After Year 2+
Policy Pays	10%	25%	50%

Calendar Year Deductible .. $50/year*

†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 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 costs will be based on what the provider charges.

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.
- Preventive root canal therapy.
- Overdentures or precision attachments.
- Full mouth debridement.
- Codes that are by report.
- 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.

PRIMESTAR ADVANTAGE IS NOT AVAILABLE IN: AK, MA, NJ, NY, NC, 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.

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 Rates

Follow the steps below to find your **PrimeStar Advantage** 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
Georgia	300-303, 308-309	3
	All Others	2
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
New Mexico	All	2
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	$18.02	$19.94	$21.87	$24.03	$26.43	$29.08	$31.96
Applicant + One	$36.05	$39.89	$43.73	$48.06	$52.87	$58.15	$63.92
Applicant + Family	$57.68	$63.83	$69.98	$76.90	$84.59	$93.05	$102.28

$2,000 Maximum Benefit Amount

Area:	1	2	3	4	5	6	7
Applicant	$22.04	$24.39	$26.74	$29.38	$32.32	$35.55	$39.08
Applicant + One	$44.07	$48.77	$53.47	$58.76	$64.64	$71.10	$78.15
Applicant + Family	$70.52	$78.04	$85.56	$94.02	$103.42	$113.76	$125.05

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.