



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 Complete 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%

Waiting Period None – coverage begins day one

BASIC SERVICES

Includes fillings, x-rays[†], oral surgery and simple extractions

Policy Pays 80%

Calendar Year Deductible .. \$50/year*

Waiting Period 6 months

MAJOR SERVICES

Includes endodontics, periodontics, crowns, bridges & dentures

Policy Pays 50%

Calendar Year Deductible .. \$50/year*

Waiting Period 15 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 Complete 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 all Services
- \$2,000 for all Services

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:

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.
- 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 COMPLETE IS NOT AVAILABLE IN: AK, GA, MA, NJ, NM, 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 $\pm .50$ 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.



PrimeStar Complete Rates

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

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

State	Zip	Area	State	Zip	Area	State	Zip	Area
Alabama	All	1	Iowa	500-503	3	New Hampshire	030-031, 038	6
Arizona	851, 855-856, 859, 865	2	Kansas	511, 515, 520, 522-524, 527-528	2	North Carolina	All Others	5
	All Others	3		All Others	1		275-277, 280-282	4
Arkansas	All	1			Kentucky		400-402, 410, 422	3
California	922-925, 932-933, 936-937, 952-953	5	403, 405, 411, 421, 423-424, 427	2		North Dakota	580-581, 585	3
	934, 938-939, 942, 955, 959-961	6		All Others			1	All Others
	All Others	7	Louisiana		700-701, 704	2	Ohio	430-432, 440-442
Colorado	800-806, 808-809	5		All Others	1	Oklahoma		730-731
	All Others	3	Maine		039-041		5	740-741
Connecticut	062-063	6		All Others	1	Oregon	All	4
	All Others	7	Maryland		208-209		6	Pennsylvania
Delaware	199	3		213, 215-216, 218	4	All Others	183, 189-194	
	All Others	5	All Others		5		Rhode Island	
D.C.	All	7		Michigan	480-483	5	South Carolina	All
Florida	330-334	5	484-485, 488-492		4	South Dakota	All	2
	341-342	4		All Others	3		Utah	All
All Others	3	Minnesota	550-554		4	Virginia		201, 220-225
Hawaii	All		5	All Others	3		226, 228-229, 240-241	3
	Idaho	832-834	2		Mississippi			All
All Others		3	Missouri	630-633, 640-641			3	All Others
Illinois	600-608	5		650-652, 656-658	2		West Virginia	
	609-611, 617-618, 620-622, 626-627	3	All Others		1	Wisconsin		538-539, 542, 545-548
	612, 615-616	2		Montana	590-591, 598		4	All Others
	All Others	1	Nebraska		680-681, 685	2	Wyoming	
Indiana	460-464	3		687	3	All Others		1
	All Others	2	All Others		1			

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	\$35.89	\$39.72	\$43.54	\$47.85	\$52.64	\$57.90	\$63.64
Applicant + One	\$71.78	\$79.43	\$87.09	\$95.70	\$105.27	\$115.80	\$127.28
Applicant + Family	\$114.84	\$127.09	\$139.34	\$153.12	\$168.43	\$185.28	\$203.65

\$2,000 Maximum Benefit Amount

Area:	1	2	3	4	5	6	7
Applicant	\$44.01	\$48.70	\$53.40	\$58.68	\$64.55	\$71.00	\$78.04
Applicant + One	\$88.02	\$97.41	\$106.80	\$117.36	\$129.10	\$142.01	\$156.09
Applicant + Family	\$140.84	\$155.86	\$170.88	\$187.78	\$206.56	\$227.21	\$249.75

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
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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.