

MINNESOTA

# A Dental Insurance Plan For You & Your Family



**TRIPLE OPTION**

Distributed by:



*Plan Coordinator:*

*Direct Benefits, Inc.  
325 Cedar Street, Suite 800  
Saint Paul, MN 55101  
651.649.3503 • 800.620.5010  
www.spiritdental.com*

Policy GH-1112-37740-1  
Form S11096 (Rev 07-11)



No Waiting Periods

Choose Your  
Own Dentist

Three Cleanings  
Per Year

\$1200 or \$2000  
Annual Maximums

Optional Vision Coverage

Free Prescription  
Drug Card

Fully Insured by  
Security Life Insurance  
Company of America

This Dental Insurance Plan helps you cover the costs of dental care. Covered dental services include exams, cleanings, fillings and extractions, as well as crowns, bridges and dentures.

This policy pays you for covered dental expenses based upon a percentage of the Reasonable and Customary (R&C) fees for those covered expenses after the \$50 lifetime deductible has been satisfied on Preventive Services and the \$50 combined calendar year deductible has been satisfied on Basic and Major Services. These percentages are: 100% for Preventive Services, 70% for Basic and 10% for Major Services in the 1st year. In the 2nd year of coverage, Basic Services increase to 80% and 50% for Major. In the 3rd year, Basic Services increase to 90%.

Spirit Dental allows you to select your own dentist, and it is affordable for you and your family.

- \* Deductibles are to a maximum of 3 Individual deductibles per family.
- \* \$50 Preventive Lifetime deductible per person.
- \* \$50 combined Basic/Major calendar year deductible per person to a maximum of 3 individual deductibles per family per calendar year.
- \* \$1200 calendar year maximum benefit per person.
- \* \$2000 calendar year maximum option for 10%.

**REASONABLE AND CUSTOMARY** - means the usual, customary and regular charges for the area where such expenses are incurred.

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## PLAN INFORMATION

**ELIGIBLE EXPENSES:** Expenses must be incurred while the Policy is in force and the person is covered by the Policy. To become an Eligible Expense, the dental services must be performed by: a licensed Physician performing dental services within the scope of his license; or a licensed dental hygienist acting under the supervision and direction of a Dentist.

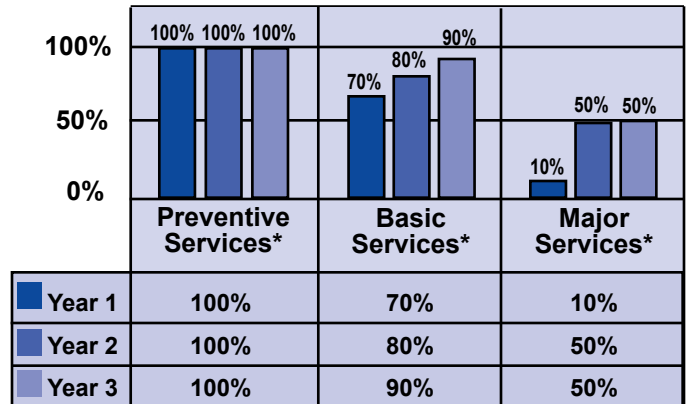
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**DENTAL EXPENSES NOT COVERED:** No benefits will be paid for expenses incurred: for overdentures and associated procedures; for charges in excess of those considered reasonable and customary; for cosmetic procedures; for the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function; for replacement of lost or stolen appliances, replacement of retainers, athletic mouthguards, precision or semi-precision attachments, denture duplication; 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; 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.

**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.

**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.

## Covered Services



### PREVENTIVE\*

- two exams per calendar year
- three cleanings per calendar year

### BASIC \*

- Space maintainers
- one series of bitewing x-rays per year
- Sealants (children to age 16)
- one topical fluoride per year to age 16

### MAJOR \*

- Simple extractions
- Implants (endosteal only), up to the allowance for the lowest cost covered traditional procedure
- One diagnostic x-ray, full or panoramic in any 3 year period
- Oral surgery
- Endodontic treatment
- Periodontic services
- Restoration services; inlays, onlays and crowns
- Prosthetic services; bridges and dentures
- Basic fillings

## GENERAL 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.

**DEDUCTIBLE AMOUNT:** The Deductible is shown in the Coverage Schedule. The Deductible is an amount of covered dental charges incurred by an insured person for which no benefits will be paid.

**CALENDAR YEAR MAXIMUM:** The maximum amount payable for all Eligible Dental Expenses in any calendar year as shown in the Coverage Schedule. The Calendar Year Maximum will apply to each insured person.

**PRETREATMENT REVIEW:** If the Course of Treatment will exceed \$300, 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:** This Plan will be coordinated with any other group, blanket or franchise plan under which an individual will receive benefits. This helps keep the cost of the Plan reasonable.

**TERMINATION OF COVERAGE:** Coverage terminates on the earliest of the following dates: the last day of the month in which You cease to be eligible for coverage; the last day of the month in which Your dependent is no longer a dependent, as defined; subject to the Grace Period, the last day of the month for which a premium has been paid by You or on your behalf; or the date the policy ends.

**EFFECTIVE DATE:** Plan effective dates are always the First of the month. Enrollment cards received by Direct Benefits after the First of the month will become effective on the First of the following month. Incomplete enrollment cards or failure to submit the required initial premium amount may cause an initial delay in Issuance of insurance. Do not cancel any other Insurance or assume You are insured under the Plan until You receive written confirmation from Direct Benefits.



Insured By:

**SECURITYLIFE**  
INSURANCE COMPANY OF AMERICA

10901 Red Circle Drive  
Minnetonka, MN 55343-9137

This Dental Insurance Plan helps you cover the costs of dental care. Covered dental services include exams, cleanings, fillings and extractions, as well as crowns, bridges and dentures.

This policy pays you for covered dental expenses for DHA or Premier PPO Provider or Non PPO providers (Out-of-Network) based on the contracted fee amount negotiated with DHA/Premier organization after the \$50 lifetime deductible has been satisfied on Preventive Services and the \$50 combined calendar year deductible has been satisfied on Basic and Major Services. These percentages are: 100% for Preventive Services, 40% for Basic and 20% for Major in the 1st year. In the 2nd year of coverage, Basic Services increase to 80% and 50% for Major. In the 3rd year, Basic Services increase to 90% and Major Services increase to 60%.

Spirit Dental allows you to select your own DHA-Premier dentist, and it is affordable for you and your family.

- \* Deductibles are to a maximum of 3 Individual deductibles per family.
- \* \$50 Preventive Lifetime deductible per person.
- \* \$50 combined Basic/Major calendar year deductible per person to a maximum of 3 individual deductibles per family per calendar year.
- \* \$1200 calendar year maximum benefit per person.
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**To look up DHA-Premier PPO providers, please visit [www.premier-dental.com](http://www.premier-dental.com).**

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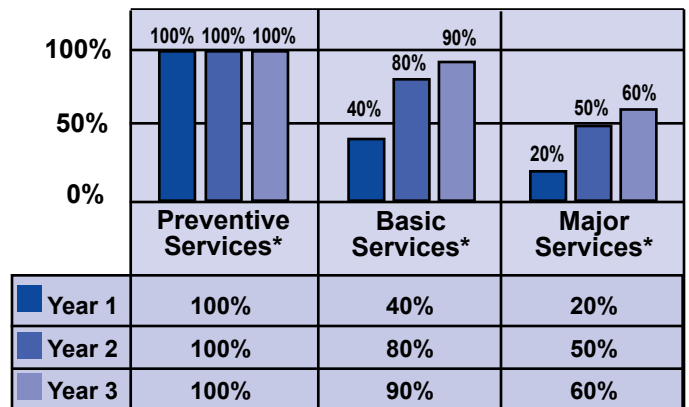
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Dental Network:



[www.premier-dental.com](http://www.premier-dental.com)



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This Dental Insurance Plan helps you cover the costs of dental care. Covered dental services include exams, cleanings, fillings and extractions, as well as crowns, bridges and dentures.

This policy pays you for covered dental expenses for Careington (Maximum Care) PPO Provider or Non PPO providers (Out-of-Network) based on the contracted fee amount negotiated with Careington (Maximum Care) organization after the \$50 lifetime deductible has been satisfied on Preventive Services and the \$50 combined calendar year deductible has been satisfied on Basic and Major Services. These percentages are: 100% for Preventive Services, 40% for Basic, 20% for Major and 10% for Ortho Services in the 1st year. In the 2nd year of coverage, Basic Services increase to 80%, 50% for Major and 25% for Ortho Services. In the 3rd year, Basic Services increases to 90%, Major Services increase to 60% and Ortho Services increase to 50%.

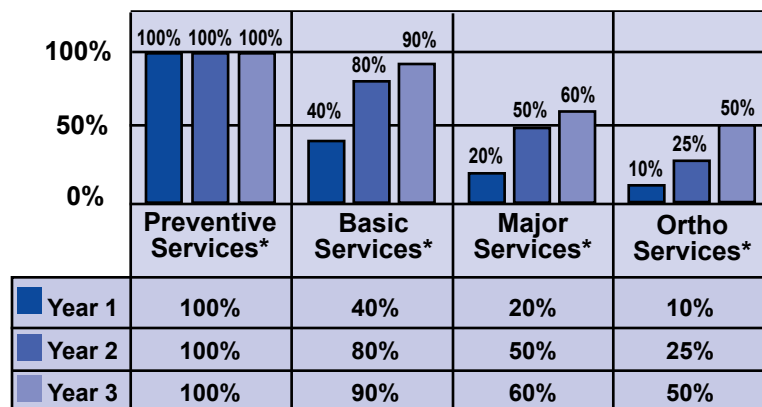
Spirit Dental allows you to select your own Careington (Maximum Care) dentist, and it is affordable for you and your family.

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**To look up Careington (Maximum Care) providers, please visit <http://www.careington.com/co/slica/>**

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### ORTHODONTIA\*

- Orthodontic care for the proper alignment of teeth is provided only to dependent children who are under 19 when treatment is received
- Coverage is 10% 1st year, 25% 2nd year and 50% 3rd year with a \$1200 lifetime maximum per child

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# Why Should You Choose a PPO Dental Plan?

In addition to paying lower monthly premium rates, Preferred Provider Organizations (PPOs), such as Careington (Maximum Care) and DHA-Premier (available with the Spirit Dental Plans) help reduce your out-of-pocket costs. PPO (“In-network”) dentists have agreed to accept a set contracted amount for each service rendered as the basis for payment under the Spirit Dental Plan. This amount is typically significantly less than the amount which could be charged by an out-of-network dentist. These PPO dentists are prohibited (by contract with the PPO) from charging you the difference between their typical fee and the amount negotiated with the PPO network.

Dentists not participating in the network are not subject to the negotiated amounts and are permitted to charge any fee for services they provide. This may lead to greater out-of-pocket costs for you and your family members. The sample comparison chart below will give you an idea of how you can save money by selecting one of Spirit Dental’s PPO plans and visiting an in-network dentist for services. It compares the charges between visiting in-network and out-of-network dentists.

## PPO Savings\* Example

This hypothetical example\*\* shows how receiving services from a PPO (in-network) dentist can save you money.

**Your Dentist says you need a Crown, a Type C service –**

- PPO Fee: \$685.00
- R&C Fee: \$750.00
- Dentist’s Usual Fee: \$985.00

IN-NETWORK When you receive care from a participating PPO dentist		OUT-OF-NETWORK When you receive care from a non-participating dentist	
Dentist’s Usual Fee is:	\$985.00	Dentist’s Usual Fee is:	\$985.00
The PPO Reduced Fee is:	\$685.00	R&C Fee is:	\$750.00
<b>Your Plan Pays:</b>		<b>Your Plan Pays:</b>	
50% x \$685 PPO Fee	- \$342.50	50% x \$750 R&C or PPO Fee	- \$375.00
Your Out-of-Pocket Cost:	\$342.50	Your Out-of-Pocket Cost:	\$610.00

**In this example, you save \$267.50 (\$610.00 minus \$342.50)...  
by using a participating PPO dentist.**

\* Savings from enrolling in the Careington (Maximum Care) or DHA-Premier PPO plans depend on various factors, including how often participants visit the dentist and the cost for services rendered.

\*\* Please note: These examples assume that your annual deductible has been met.



# Spirit Vision

## Optional Vision Insurance



Spirit Vision's vision plan is available through the EyeMed Vision Care Network. EyeMed is a leading vision benefits company, offering the following features:

- Savings on eye care and eyewear
- Quality standards for care and materials
- Access to thousands of providers nationwide, including the nation's top optical retail brands



LENSCRAFTERS™ PEARLE VISION

- Unlimited discounts on additional purchases
- Value-added features like discounts on laser vision correction and replacement contact lenses by mail

### Eye Examinations

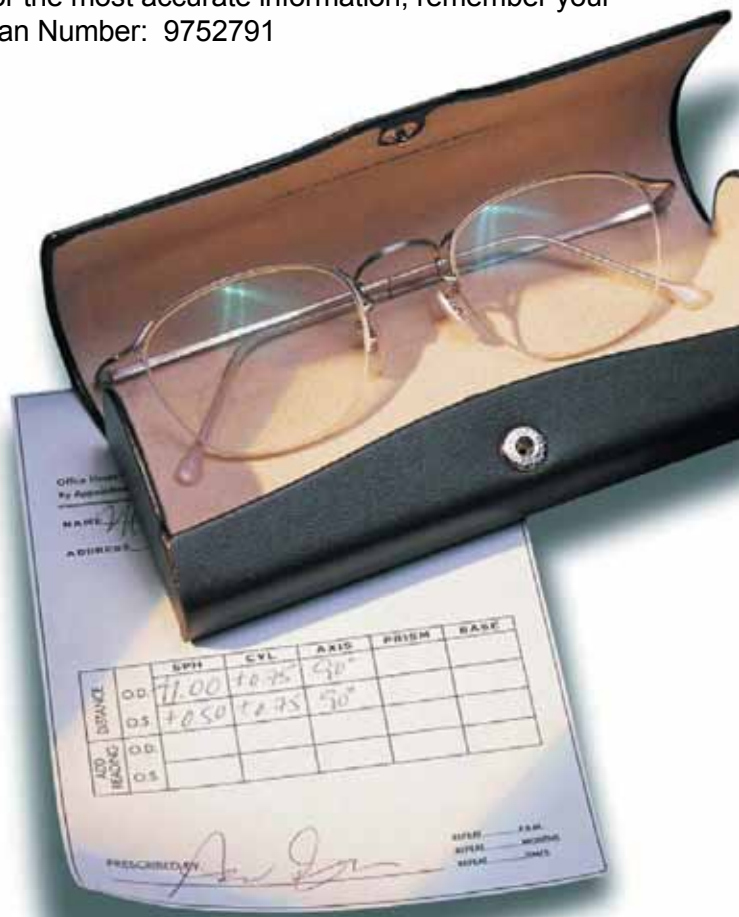
Comprehensive eye exams do more than check patients' vision. Eye doctors can detect a variety of serious conditions, including diabetes, high blood pressure and glaucoma. Early detection and treatment can minimize the effect of these conditions on long-term health. Spirit Vision Insurance covers annual eye exams for maximum health benefits.

*This product may not be available in all states.*

### Using The Plan

Using the plan is as easy as 1-2-3...

- Members locate a provider by going to [www.eyemedvisioncare.com](http://www.eyemedvisioncare.com). They can register to use the secure member site once enrolled, or choose Access from the locator drop-down box.
- Members identify themselves as EyeMed members through Spirit Vision and present the plan ID card and member ID number.
- The provider will do the rest! There are no claim or authorization forms necessary for in-network benefits.
- For the most accurate information, remember your Plan Number: 9752791



## In-Network Benefits

### EYE EXAMINATIONS

\$10 copay (once every 12 months)

Eye examinations include dilation as determined by the doctor.

### EXAM OPTIONS

Contact lens wearers will pay up to \$55 for standard contact lens exam, including fit and follow-up, or receive 10% off retail price for premium contact lens exam, fit and follow-up.

### EYEGLASS LENSES

\$20 copay (once every 24 months)

Plans cover standard plastic single vision, bifocal or trifocal lenses of any size or power. Lens options are available at additional cost.

### FRAMES

\$0 copay (once every 24 months)

Plans include a \$100 retail allowance that can be applied toward the purchase of any frame available at the provider location. The member will also receive a 20% discount off the balance if selecting a frame that costs more than \$100.

### CONTACT LENSES

(Instead of lenses and frame)

\$20 copay (once every 24 months)

Plans include a \$100 retail allowance that can be applied toward the purchase of conventional or disposable contact lenses. If the member chooses conventional contact lenses with a retail price over \$100, he or she will receive 15% off the balance. Medically necessary contact lenses are paid in full after the copay.

Replacement contact lenses can be ordered online and conveniently delivered to members' homes through [www.eyemedcontacts.com](http://www.eyemedcontacts.com).

### ADDITIONAL DISCOUNTS

Spirit Vision members will also receive unlimited additional discounts on purchases made at participating provider locations, including:

- 40% off additional complete pairs of eyeglasses
- 15% off additional purchases of conventional contact lenses
- 20% off non-covered items like cleaning cloths or nonprescription sunglasses

### Monthly Premium

#### Under age 65 Age 65 & over

Insured only	\$7.81	\$8.98
Insured & 1 (child or spouse)	\$13.17	\$15.14
Insured & 2 or more	\$18.83	\$21.65

**Note:** Visit any provider. Vision is available only as a rider to the Spirit Dental plan (not stand-alone). The vision rider is optional to purchase, but cannot be terminated separately from dental.

### Other Discounts

Coatings and lens treatments can be added for the costs below:

Lens Option	Member cost
Polycarbonate lenses	\$40
Scratch-Resistant coating	\$15
Solid or gradient tint	\$15
Ultraviolet coating	\$15
Anti-Reflective coating	\$45
Standard progressive (add-on to bifocal)	\$65
Lens options not listed	20% off retail price

These additional discounts are not part of the insurance plan.

## Out-of-Network Benefits

Members receive the richest benefits when using a participating EyeMed provider. However, the plan includes an out-of-network benefit for services and materials obtained through non-network providers.

### REIMBURSEMENT LEVELS

- Eye Examination - Up to \$25
- Frames - Up to \$40
- Single Vision Lenses - Up to \$20
- Bifocal Lenses - Up to \$30
- Trifocal Lenses - Up to \$40
- Contact Lenses - Up to \$60

### USING OUT-OF-NETWORK BENEFITS

Members must file claims for out-of-network benefits. Members can obtain an out-of-network claim form from EyeMed's Web site, [www.eyemedvisioncare.com](http://www.eyemedvisioncare.com), or by calling **866-723-0513**. Members will pay for all services and materials in full, then submit the completed claim form with receipts for reimbursement.

### LIMITATIONS - In no event will payment exceed the lesser of:

1. the actual cost of covered Services or Materials; or
2. the limits of the Policy, shown in this Schedule.

### EXCLUSIONS - We will not cover:

1. Orthoptic or vision training and any associated supplemental testing.
2. Plano lenses.
3. Lens Coatings
4. Two pair of glasses, in lieu of bifocals or trifocals.
5. Medical or surgical treatment of the eyes.
6. Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.
7. Any injury or illness when covered under any Workers' Compensation or similar law, or which is work-related.
8. Customization of bifocal lenses to a progressive or no-line lens.
9. Photo-chromatic lenses
10. Sub-normal vision aids or non-prescription lenses.
11. Services rendered or Materials purchased outside the U.S. or Canada, unless:
  - a) the Insured resides in the U.S. or Canada; and
  - b) the charges are incurred while on a business or pleasure trip.
12. Charges in excess of the Usual and Customary charge for the Service or Materials.
13. Charges incurred after:
  - a) the Policy ends; or
  - b) the Insured's coverage under the Policy ends, except as stated in the Policy.
14. Experimental or non-conventional treatment or device.
15. Spectacle lens treatments or "add-ons", except solid tints (#1 & #2), and oversize lenses.
16. High Index lenses of any material type.
17. Lost or broken Materials, except when replaced at normal intervals when Services are available.

# Indemnity – Choose Your Own Dentist

**Send completed form to:** *Direct Benefits, Inc., 325 Cedar St., Suite 800, St. Paul, MN 55101*  
*phone 651-649-3503 • fax 651-649-3502 • info@directbenefits.com*

**Premium rates illustrated are guaranteed for initial twelve months and may change annually thereafter.**

Area	Applicant Only		Applicant + 1		Applicant + Family	
	Under Age 65 / Age 65 and over		Under Age 65 / Age 65 and over		Under Age 65 / Age 65 and over	
1	31.07	33.32	63.38	68.90	90.81	98.99
2	34.06	36.53	69.98	75.54	100.41	108.53
3	37.43	40.14	77.40	83.01	111.20	119.27
4	41.17	44.16	85.65	91.32	123.20	131.19
5	45.29	48.57	94.72	100.45	136.40	144.31
6	49.78	53.39	104.62	110.41	150.80	158.63
7	54.65	58.61	115.34	121.20	166.40	174.13
8	60.26	64.63	127.72	133.65	184.40	192.02

*Rates effective 02/01/11- 01/01/12*

Premiums are determined by area. To determine your monthly premium rate, refer to the Area/State charts on this page. You may choose an optional \$2,000 Benefit plan for a 10% increase to the base rate.

Rate	=	_____
	+	_____
[ ] Optional \$2,000 benefit (rate x .10)	=	_____
[ ] Optional Vision	=	_____
[ ] Optional Credit for Prior Time (CPT) (rate x .35)	=	_____
Monthly Total	=	_____
Application Fee (\$20 if enrolled at www.spiritdental.com)	+ \$35.00	
Total Remittance	=	\$ _____

Payment options include Visa/Mastercard or checking/savings account bankdraft.

### AGENT INFORMATION *(For agent use only)*

Producer Name \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_  
 SSN/TIN \_\_\_\_\_  
 EMail Address \_\_\_\_\_  
 Insurance License # \_\_\_\_\_  
 Agent Number (if applicable) \_\_\_\_\_  
 Are you currently appointed with  
 Security Life Insurance Company? [ ] YES [ ] NO  
 License Attached? [ ] YES [ ] NO  
 PRODUCER NAME \_\_\_\_\_  
 PRODUCER SIGNATURE \_\_\_\_\_  
 DATE \_\_\_\_\_  
 GENERAL AGENT \_\_\_\_\_

### AREA (STATE) DEFINITIONS *(If no state listed, dental insurance plan is not available.)*

<b>Alabama</b>	3	<b>Colorado</b>	4	<b>Kansas</b>	2	<b>Montana</b>	1	<b>Ohio</b>	1	<b>Utah</b>	1
350-355, 359		803, 808-810		660-662		590-591		All Areas		All Areas	
All Other	1	All Other	1	All Other	1	599	2	<b>Oklahoma</b>		<b>Virginia</b>	
<b>Alaska</b>	8	<b>Delaware</b>	2	<b>Kentucky</b>	1	All Other	3	740-743	2	201, 220-221	5
995-996		All Areas		All Areas		<b>Nebraska</b>		All Other	1	222-223	6
All Other	6	<b>Dist Columbia</b>	6	<b>Louisiana</b>	2	All Areas	1	<b>Oregon</b>		224-225, 230-232	1
<b>Arizona</b>	2	All Areas		707-711	2	<b>Nevada</b>		977	3	228-229, 240-244	2
856-857, 864		<b>Georgia</b>	2	712	3	890-891	2	978	1	233-237	5
All Other	1	300-303	2	All Other	1	894-895, 898	6	All Other	2	All Other	4
<b>Arkansas</b>	1	All Other	1	<b>Massachusetts</b>	5	All Other	4	<b>Pennsylvania</b>		<b>Washington</b>	
All Areas		<b>Hawaii</b>	3	All Areas		<b>New Jersey</b>	4	170-178, 182-187	2	982-984	4
<b>California</b>	7	All Areas		<b>Michigan</b>	2	All Areas		190-192	3	990-992	3
900-905		<b>Idaho</b>	1	480-483, 490-491	2	<b>New Mexico</b>		All Other	1	993	6
906-914	6	All Areas	1	488-489	3	881	2	<b>Rhode Island</b>		All Other	5
915-916	8	<b>Illinois</b>	2	All Other	1	882	5	029	3	<b>West Virginia</b>	
917-918	4	600-605	3	<b>Minnesota</b>	2	All Other	1	All Other	2	255-257	4
919-927, 930-934	6	606-608	3	553-558, 564, 566	2	<b>North Carolina</b>		<b>South Carolina</b>		262-265	3
939	6	All Other	1	All Other	1	277	2	All Areas	1	All Other	2
943-948	4	<b>Indiana</b>	2	<b>Mississippi</b>	2	286	3	<b>Tennessee</b>		<b>Wisconsin</b>	
956-958	3	463-464	2	390-392	2	287-289	2	373-374	2	All Areas	1
949, 961	6	473	3	All Other	1	All Other	1	All Other	1	<b>Wyoming</b>	
959	4	All Other	1	<b>Missouri</b>		<b>North Dakota</b>		<b>Texas</b>		All Areas	1
All Other	5	<b>Iowa</b>	1	640-641, 644-649	2	580-581	2	751-753	3		
		All Areas		All Other	1	All Other	1	754	4		
								756-757, 776-777	1		
								All Other	2		

# DHA-Premier PPO Network Dentists

**Send completed form to:** *Direct Benefits, Inc., 325 Cedar St., Suite 800, St. Paul, MN 55101*  
*phone 651-649-3503 • fax 651-649-3502 • info@directbenefits.com*

**Premium rates illustrated are guaranteed for initial twelve months and may change annually thereafter.**

Area	Applicant Only		Applicant + 1		Applicant + Family	
	Under Age 65 / Age 65 and over		Under Age 65 / Age 65 and over		Under Age 65 / Age 65 and over	
1	28.13	30.18	54.22	59.15	76.52	83.80
2	30.84	33.08	59.97	64.85	84.80	91.86
3	33.89	36.35	66.44	71.26	94.13	100.96
4	37.28	39.99	73.63	78.39	104.49	111.05
5	41.02	43.99	81.55	86.23	115.88	122.16
6	45.08	48.35	90.18	94.78	128.33	134.27
7	49.49	53.07	99.53	104.05	141.79	147.40
8	54.57	58.53	110.32	114.74	157.33	162.54

*Rates effective 02/01/11 - 01/01/12*

Premiums are determined by area. To determine your monthly premium rate, refer to the Area/State charts on this page. You may choose an optional \$2,000 Benefit plan for a 10% increase to the base rate.

Rate	=	_____
	+	_____
[ ] Optional \$2,000 benefit (rate x .10)	=	_____
[ ] Optional Vision	=	_____
[ ] Optional Credit for Prior Time (CPT) (rate x .35)	=	_____
Monthly Total	=	_____
Application Fee	+ \$35.00	
(\$20 if enrolled at www.spiritdental.com)		
Total Remittance	=	\$ _____

Payment options include Visa/Mastercard or checking/savings account bankdraft.

### AGENT INFORMATION (For agent use only)

Producer Name \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_  
 SSN/TIN \_\_\_\_\_  
 EMail Address \_\_\_\_\_  
 Insurance License # \_\_\_\_\_  
 Agent Number (if applicable) \_\_\_\_\_  
 Are you currently appointed with  
 Security Life Insurance Company? [ ] YES [ ] NO  
 License Attached? [ ] YES [ ] NO  
 PRODUCER NAME \_\_\_\_\_  
 PRODUCER SIGNATURE \_\_\_\_\_  
 DATE \_\_\_\_\_  
 GENERAL AGENT \_\_\_\_\_

### AREA (STATE) DEFINITIONS (if no state listed, dental insurance plan is not available.)

<b>Alabama</b> 350-355, 359 All Other	3 1	<b>Colorado</b> 803, 808-810 All Other	4 1	<b>Kentucky</b> All Areas <b>Louisiana</b> 707-711	1 2	<b>Montana</b> 590-591 599 All Other	1 2 3	<b>North Dakota</b> 580-581 All Other	2 1	<b>Tennessee</b> 373-374 All Other	2 1
<b>Arizona</b> 856-857, 864 All Other	2 1	<b>Delaware</b> All Areas <b>Dist Columbia</b> All Areas	2 6	<b>Massachusetts</b> All Areas <b>Michigan</b> 480-483, 490-491	5 2	<b>Nebraska</b> All Areas <b>Nevada</b> 890-891 894-895, 898 All Other	1 2 6 4	<b>Ohio</b> All Areas <b>Oklahoma</b> 740-743 All Other	1 2 1	<b>Texas</b> 751-753 754 756-757, 776-777	3 4 1
<b>Arkansas</b> All Areas	1	<b>Georgia</b> 300-303 All Other	2 1	<b>Minnesota</b> All Areas <b>Mississippi</b> 390-392 All Other	5 2 1	<b>New Mexico</b> All Other <b>North Carolina</b> 881 882 All Other	2 6 1	<b>Oregon</b> 977 978 All Other	3 1 2	<b>Utah</b> All Areas <b>West Virginia</b> 255-257	1 4
<b>California</b> 900-905 906-914 915-916 917-918 919-927, 930-934 939 943-948 956-958 949, 961 959 All Other	7 6 8 4 6 6 4 3 6 4 5	<b>Hawaii</b> All Areas <b>Indiana</b> 463-464 473 All Other <b>Iowa</b> All Areas <b>Kansas</b> 660-662 All Other	3 2 3 1 1 2 1 2 1 1 2	<b>Missouri</b> All Areas <b>Mississippi</b> 390-392 All Other <b>Missouri</b> 640-641, 644-649 All Other	2 2 1 2 1 2 1	<b>North Carolina</b> 277 286 287-289 All Other	2 3 2 1	<b>Pennsylvania</b> 170-178, 182-187 190-192 All Other <b>Rhode Island</b> 029 All Other <b>South Carolina</b> All Areas	2 3 3 1 3 2 1	<b>Wisconsin</b> All Areas <b>Wyoming</b> All Areas	1 1 2

# Careington (Maximum Care) PPO Network Dentists

Send completed form to: *Direct Benefits, Inc., 325 Cedar St., Suite 800, St. Paul, MN 55101*  
*phone 651-649-3503 • fax 651-649-3502 • info@directbenefits.com*

**Premium rates illustrated are guaranteed for initial twelve months and may change annually thereafter.**

Area	Applicant Only		Applicant + 1		Applicant + Family	
	Under Age 65 / Age 65 and over		Under Age 65 / Age 65 and over		Under Age 65 / Age 65 and over	
1	22.41	24.49	49.41	44.94	80.63	72.55
2	24.57	26.85	53.36	49.27	87.01	79.55
3	27.00	29.51	57.81	54.14	94.17	87.41
4	29.70	32.46	62.74	59.55	102.14	96.16
5	32.68	35.71	68.18	65.51	110.90	105.77
6	35.92	39.25	74.11	72.01	120.46	116.26
7	39.43	43.09	80.53	79.05	130.81	127.62
8	43.48	47.51	87.94	87.17	142.76	140.74

Rates effective 09/01/11 - 01/01/12

Premiums are determined by area. To determine your monthly premium rate, refer to the Area/State charts on this page. You may choose an optional \$2,000 Benefit plan for a 10% increase to the base rate.

Rate	=	_____
	+	_____
[ ] Optional \$2,000 benefit (rate x .10)	=	_____
[ ] Optional Vision	=	_____
[ ] Optional Credit for Prior Time (CPT) (rate x .35)	=	_____
Monthly Total	=	_____
Application Fee	+ \$35.00	
(\$20 if enrolled at www.spiritdental.com)		
Total Remittance	=	\$ _____

Payment options include Visa/Mastercard or checking/savings account bankdraft.

## AGENT INFORMATION (For agent use only)

Producer Name \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_  
 SSN/TIN \_\_\_\_\_  
 EMail Address \_\_\_\_\_  
 Insurance License # \_\_\_\_\_  
 Agent Number (if applicable) \_\_\_\_\_  
 Are you currently appointed with  
 Security Life Insurance Company? [ ] YES [ ] NO  
 License Attached? [ ] YES [ ] NO  
 PRODUCER NAME \_\_\_\_\_  
 PRODUCER SIGNATURE \_\_\_\_\_  
 DATE \_\_\_\_\_  
 GENERAL AGENT \_\_\_\_\_

## AREA (STATE) DEFINITIONS (if no state listed, dental insurance plan is not available.)

<b>Alabama</b> 350-355, 359 All Other	3 1	<b>Colorado</b> 803, 808-810 All Other	4 1	<b>Kentucky</b> All Areas <b>Louisiana</b> 707-711	1 2	<b>Montana</b> 590-591 599 All Other	1 2 3	<b>North Dakota</b> 580-581 All Other	2 1	<b>Tennessee</b> 373-374 All Other	2 1
<b>Arizona</b> 856-857, 864 All Other	2 1	<b>Delaware</b> All Areas <b>Dist Columbia</b> All Areas	2 6	712 All Other	3 1	<b>Nebraska</b> All Areas	1	<b>Ohio</b> All Areas	1	<b>Texas</b> 751-753 754	3 4
<b>Arkansas</b> All Areas	1	<b>Georgia</b> 300-303 All Other	2 1	<b>Massachusetts</b> All Areas <b>Michigan</b> 480-483, 490-491	5 2	<b>Nevada</b> 890-891 894-895, 898 All Other	2 6 4	<b>Oklahoma</b> 740-743 All Other	2 1	<b>Utah</b> 756-757, 776-777 All Other	1 2
<b>California</b> 900-905 906-914 915-916 917-918 919-927, 930-934 939 943-948 956-958 949, 961 959 All Other	7 6 8 4 6 6 4 3 6 4 5	<b>Hawaii</b> All Areas <b>Indiana</b> 463-464 473 All Other <b>Iowa</b> All Areas <b>Kansas</b> 660-662 All Other	1 3 2 3 1 1 2 1 2 1	<b>Minnesota</b> 553-558, 564, 566 All Other <b>Mississippi</b> 390-392 All Other <b>Missouri</b> 640-641, 644-649 All Other	2 1 1 2 1 2 1	<b>New Mexico</b> 881 882 All Other <b>North Carolina</b> 277 286 287-289 All Other	2 6 4 2 3 2 1	<b>Oregon</b> 977 978 All Other <b>Pennsylvania</b> 170-178, 182-187 190-192 All Other <b>Rhode Island</b> 029 All Other <b>South Carolina</b> All Areas	1 3 2 2 3 2 1	<b>West Virginia</b> 255-257 262-265 All Other <b>Wisconsin</b> All Areas <b>Wyoming</b> All Areas	4 3 2 1 1



Please send completed form to: **Direct Benefits, Inc.**  
**325 Cedar Street, Suite 800**  
**Saint Paul, MN 55101**  
**phone: 651.649.3503 • fax: 651-649-3502**  
**info@directbenefits.com**

**DENTAL APPLICATION** Insured By Security Life Insurance Company of America - Minnetonka, Minnesota

		/ /	M [ ]	
		Mo Day Yr	F [ ]	
Email Address	Last Name	First	Initial	Birthdate
Home Address		Marital Status		Sex
		[ ] Married [ ] Single		Effective Date
City, State, Zip		Telephone:		
Billing Address (if different than the above)				

LIST DEPENDENTS TO BE COVERED (list spouse first)			Sex	Birthdate				Sex	Birthdate
Last Name (if different)	First Name	Initial	M F	Mo. Day Yr	Last Name (if different)	First Name	Initial	M F	Mo. Day Yr
2.	Spouse				5.				
3.	Child				6.				
4.					7.				

Does Spouse have a dental plan? Yes [ ] No [ ]  
 With whom? \_\_\_\_\_  
 If answer is "Yes", are dependents enrolled under spouse's plan? Yes [ ] No [ ]

I am enrolling for coverage on:  
 Myself Only     Myself + 1     Myself + Family  
 Coverage Elections:  
 \$1,200 Annual Maximum     Indemnity  
 \$2,000 Annual Maximum     DHA-Premier PPO  
 Credit for Prior Time (CPT)     Careington (Maximum Care)  
 Vision Option

BY MY SIGNATURE, I HEREBY APPLY FOR COVERAGE UNDER GROUP DENTAL INSURANCE POLICY FORM GH-1112 ISSUED TO THE VOLUNTARY GROUP TRUST INSURED BY SECURITY LIFE INSURANCE COMPANY OF AMERICA.

California Law prohibits an HIV Test from being required or used by health insurance companies as a condition of obtaining health insurance coverage & for other regulators. I also certify I have read the applicable Fraud Notice on the reverse side of this form.

Applicant's Signature \_\_\_\_\_ Agent Name (if applicable) \_\_\_\_\_ Date \_\_\_\_\_  
 GHA-1112

**PAYMENT OPTIONS – \$35 enrollment fee (\$20 if enrolled at [www.spiritdental.com](http://www.spiritdental.com))**  
 **Monthly Bank** If choosing to pay monthly Bank, you must complete and sign the Authorization Agreement form and submit it along with one months premium payable to Security Life Insurance Company of America/SLICA and your completed Dental Application.  
 **Monthly Credit Card** If choosing to pay by credit card, you must complete and sign the Authorization Agreement form below.

**AUTHORIZATION AGREEMENT:**  
 I hereby authorize Security Life Insurance Company of America/Meritain Health to initiate debit entries to my banking or credit card account. This authorization shall remain in full force until company has received advance written notification from me to terminate. I agree that if any such charge be dishonored, whether with or without cause and whether intentionally or inadvertently, the bank or credit card company shall be under no liability whatsoever even though it might result in forfeiture of my insurance. I understand that I have the right to stop payment by notification to Security Life Insurance Company of America, my bank or my credit card company at least ten business days prior to the next scheduled payment.

Name of Financial Institution \_\_\_\_\_  
 or  Checking Account (include voided check)    Account Number: \_\_\_\_\_  
 Savings Account (include deposit slip)    Account Number: \_\_\_\_\_  
 Visa     Master Card    Card # \_\_\_\_\_    Expiration Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name: \_\_\_\_\_  
 Signature: \_\_\_\_\_    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**

#### **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 insurance company 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.

#### **New Jersey**

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

#### **New Mexico**

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 civil fines and criminal penalties.

#### **Ohio**

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

#### **Pennsylvania**

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.

#### **Tennessee/Virginia**

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

### **TAKEOVER CREDIT BENEFITS**

*If you were previously covered under a group dental plan you may be eligible for credit for the time you were covered under that plan. The length of time you were covered under your prior plan will be applied to the graded benefit features of this plan which means you will enter the plan at a higher level of benefit for coverage categories that grade up over time. To enjoy this feature you must provide an evidence of coverage letter from your prior carrier. This letter must include a termination date of the prior plan that is no more than 30 days prior to the date we receive your application for coverage under the Spirit Dental plan. Takeover benefits are available for a 35% rate increase to the base rate.*



## Spirit Dental & Vision Prescription Discount Program

The Spirit Dental & Vision Prescription Discount Card is an easy way to help you and your family with all of your prescription drug needs. Participants and their family can obtain average savings of up to 65% on drug prices through our nationwide network of over 59,000 pharmacies, including major chains and community pharmacies. Your actual savings may vary depending on the medication and the pharmacy you use. Go to: [www.my-rxcard.com/sdv.html](http://www.my-rxcard.com/sdv.html) .

### To Use at Participating Pharmacies:

- Take your prescription to a participating pharmacy. All brand name and generic drugs are allowed.
- One card automatically covers all family members at no cost.
- Show your Prescription Discount Card to your pharmacist every time you fill your prescription.  
Use your Prescription Discount Card for any prescriptions that are not covered by your insurance or excluded from Medicare Part D.
- Pay the discounted portion of the drug price. Discounts are given at the time of your purchase. There is no need to submit your receipts. You will receive instant savings or the pharmacy's lowest price when you present your Prescription Discount Card.

### To Enroll in the Mail Order Pharmacy:

- Call Customer Service at 1-888-479-2000, press prompt #5.
- One of our Representatives will be happy to enroll you in our convenient mail order program.
- We guarantee quality assurance using our 7-point test on every prescription before mailing.
- Standard shipping is free.

### OUTLOOK Vision Discount Benefit

To find a provider, go to [www.outlookvision.com](http://www.outlookvision.com) or call 800-342-7188, then simply present your card at a participating provider to receive your discount. Ask about hearing aid discounts from Beltone Hearing.

### American Diabetes Wholesale

American Diabetes Wholesale offers affordable, brand name diabetic supplies directly to the consumer at up to 60% below retail prices - especially for people who are uninsured, underinsured or have to pay out of pocket. We stock *thousands* of affordable diabetes testing supplies and diabetes products from quality brands. Most orders ship directly to you within 24 hours. For cash orders, we provide easy and secure ordering on our website 24 hours a day, or by phone Monday - Friday 9:00 a.m. to 6:00 p.m. EST. Go to [www.my-rxcard.com/sdv.html](http://www.my-rxcard.com/sdv.html) and click on the American Diabetes Wholesale link to purchase online.

### Lab & Imaging Discount Benefit

Save 50% or more on Lab & Imaging tests. Go to <http://myrx.prepaidlab.com/?lcode=007> & <http://myrx.prepaidimaging.com/?lcode=007> .

**REMOVE YOUR PRESCRIPTION CARD  
and KEEP IT IN YOUR WALLET  
CUT ALONG PERFORATION TO REMOVE CARD**

\* This program is not insurance and is not affiliated with Security Life Insurance Company.



**Prescription Discount Card**

**Group #: SDVOL** *Pharmacist Help Desk: 888-886-5822*

**Member ID:** Enter cardholder's 10-digit phone # and then add 2-digit person code. 01=member 02=spouse 03=dependent etc.  
Example: xxxxxxxxxx enter as xxxxxxxxxx01

**Processor: NetCard Systems BIN # 008878**

 <a href="http://www.wellcard.com">www.wellcard.com</a>	<b>Lab &amp; Imaging</b> <a href="http://myrx.prepaidlab.com/?lcode=007">myrx.prepaidlab.com/?lcode=007</a> <a href="http://myrx.prepaidimaging.com/?lcode=007">myrx.prepaidimaging.com/?lcode=007</a>
 <a href="http://my-rxcard.com/sdv.html">my-rxcard.com/sdv.html</a>	 <a href="http://www.outlookvision.com">www.outlookvision.com</a>

***This is not Insurance.***

**Why are we partnering to offer a hearing benefit plan?**

Unlike some other health issues, the impact of hearing loss is not only felt by the individual. Family, friends, co-workers and employers are all affected. An estimated 31.5 million Americans suffer from some degree of hearing loss--yet only 1 in 5 actually choose to seek help.

**Why does hearing loss go untreated?**

Many factors account for the high rate of untreated hearing loss, however three of the main barriers are:

**Denial** - People do not want to admit they have a problem or feel they can cope adequately.

**Stigma** - Individuals see wearing a hearing instrument as a sign to others that they are getting old.

**Cost** - Because of lack of coverage by many insurance plans, hearing instrument purchases are largely an out-of-pocket expense. For some individuals, this cost is prohibitive.

**What is The Hearing Stores of Minnesota Hearing Benefit Plan?**

The Hearing Stores of Minnesota Hearing Benefit Plan is a no-cost solution to make hearing affordable for new and existing patients of Spirit Dental and Vision as well as their immediate family members.

**How can The Hearing Stores of Minnesota Hearing Benefit Plan help?**

The Hearing Stores of Minnesota Hearing is committed to improving your quality of life and giving you back moments you may be missing. We take lifestyle, hearing loss and other factors into consideration before making an appropriate recommendation to each patient. The Hearing Benefit Plan offers lower cost, quality hearing healthcare, unrivaled technology, innovative products and a no-obligation, 60 day, risk free guarantee to Successful Hearing.

**Give The Hearing Stores of Minnesota an hour and we will change your life!**

**What are some of the benefits of The Hearing Stores of Minnesota Hearing Benefit Plan?**

Members and their immediate family members on this plan will receive:

- Free Hearing Screening and product demonstration
- A No-Obligation, 60 day, risk free guarantee to Successful Hearing
- 20% Off the Retail Purchase Price of Premium Listening Instruments
- 15% Off the Retail Purchase Price of Plus Listening Instruments
- 10% Off the Retail Purchase Price of Basic Listening Instrument
- OR a 25% Trade-In Allowance (of previous price you paid for any brand) Toward the Retail Purchase of New Digital hearing instruments
- Free Lifetime Follow-up Care and Visits
- Buy One Card Any Size Batteries and Receive the Second Card Free  
\*\*\*No other Discounts Apply



[www.thehearingstores.com](http://www.thehearingstores.com)



**The Experience**

The Hearing Stores of Minnesota Experience provides exceptional value and friendly, comfortable and effective service to help you deal with your individual hearing loss.

We offer a free comprehensive hearing evaluation, the success of which is based upon your honest response to various sound frequencies and intensities. We will determine any hearing loss and explain the results of your audiogram to you in detail, using easy-to-understand terms.

We recommend technology and products that allow you to perform the daily activities you most enjoy, keeping in mind the situations you encounter daily.

We can then fit you with the appropriate hearing instruments to enhance your lifestyle and budget. The Hearing Stores of Minnesota will also give you a 60 day, risk free period that allows you to acclimate to your hearing instruments and to ensure they are the right model and style for you. If at any point during these 60 days you are not 100% satisfied with your decision, we will try something different or refund your money, in full.

**Announcing A Very Special, No-Obligation Plan**

Spirit Dental and Vision is partnering with The Hearing Stores of Minnesota to offer a no-obligation, hearing benefit plan to Spirit Dental and Vision patients and their families.

This hearing plan comes at no additional cost to Spirit Dental and Vision patients but provides excellent hearing benefits, at a great discount and with a no-risk, 60 day guarantee on all hearing instruments.

Call The Hearing Stores of Minnesota at any of our four locations. Give us an hour and we will change your life!

**1-877-427-HEAR (4327)**

**Richfield 612-455-8422**

**Minnetonka 952-746-3011**

**Burnsville 952-898-1006**

**Roseville 651-633-4642**



**Hearing Benefit Plan Member**

Name: \_\_\_\_\_

**1-877-427-HEAR (4327)**

**Richfield 612-455-8422 • Minnetonka 952-746-3011  
Burnsville 952-898-1006 • Roseville 651-633-4642**

**Members and Family Receive:**

- Greatly reduced prices on most hearing instruments
- A Free Hearing Screening and product Demonstration
- A No-Obligation, 60 day, risk free guarantee
- Year Round discounts of 10 – 20% on all accessories
- 25% Trade-In Allowance (of the previous price you paid for any brand) toward the retail purchase of Hearing instruments
- Free Lifetime Follow-Up Care and Visits
- Buy 1 Get 1 Free Batteries (any size card)

\*\*\*No other Discounts Apply

\* This program is not insurance and is not affiliated with Security Life Insurance Company.

*To expedite processing please confirm that the following is submitted.*

- Completed Application
- Signed Application
- Premium payment (payable to Security Life Insurance Company of America/SLICA) along with the \$35 one-time application fee (\$20 if enrolled at [www.spiritdental.com](http://www.spiritdental.com))
- Completed and Signed Agent Information section when applicable
- Certificate of creditable coverage if requesting Takeover Benefits

After all of the information listed above is completed and signed send all original forms to:

**Direct Benefits, Inc.**  
**325 Cedar Street, Suite 800**  
**Saint Paul, MN 55101**  
**651-649-3503 • 800-620-5010**  
**fax: 651-649-3502**  
**[info@directbenefits.com](mailto:info@directbenefits.com)**

**Submission Date:**

New Applications should be postmarked no later than the end of the month to be effective by the first of the following month.

*All Spirit One-Life Dental plans come with our **10-day Customer Satisfaction Guarantee**.*

*You have 10 days after your plan becomes effective to cancel your plan if you are not satisfied for any reason. Any premium paid (minus the enrollment fee) will be fully refunded provided no covered services have been rendered.*

*If services have been provided, you may still cancel your policy, however, the premium paid will not be eligible for reimbursement.*