

SECURITY LIFE INSURANCE COMPANY OF AMERICA

Minnetonka, Minnesota

COVERAGE SCHEDULE DENTAL INSURANCE PLAN

PREFERRED (In-Network) PROVIDER: WE WILL PAY BASED ON THE CONTRACTED FEE FOR SERVICE WITH THE PREFERRED PROVIDER ORGANIZATION FOR DENTAL PROCEDURES AND SERVICES AFTER ANY REQUIRED DEDUCTIBLE AMOUNT, AS SHOWN BELOW.

NON-PREFERRED (Out of Network) PROVIDER: WE WILL PAY BASED ON THE REASONABLE AND CUSTOMARY CHARGE FOR DENTAL PROCEDURES AND SERVICES AFTER ANY REQUIRED DEDUCTIBLE AMOUNT, AS SHOWN BELOW.

Class A. Preventive Services Include:

1. two routine (including any initial exam) examinations of mouth and teeth per calendar year;
2. two prophylaxis (cleaning, scaling and polishing teeth) per calendar year;
3. one topical fluoride per calendar year, to age 16;
4. bitewing x-rays, 1 series per calendar year; and
5. emergency palliative treatment.

Deductible 1 per Lifetime
We pay, after Deductible
Waiting Period –None

**Preferred &
Non-Preferred
Providers**

\$50
100%

Class B. Basic Services, Include:

1. one diagnostic x-rays, full or panoramic in any 3 year period;
2. periapical x-rays;
3. simple extraction of teeth;
4. pin retention of fillings;
5. fillings of amalgam, silicate, acrylic, synthetic porcelain and composite filling materials (restorations of mesiolingual, distolingual, mesiobuccal and distobuccal surfaces considered single surface restorations);
6. antibiotic injections administered by Dentist;
7. space maintainers to preserve space between teeth for premature loss of a primary baby tooth. This does not include use for orthodontic treatment;
8. endodontic treatment of disease of the tooth, pulp, root, and related tissue, as follows:
 - a. root canal therapy (not covered, if pulp chamber was opened before covered);
 - b. pulpotomy;
 - c. apicoectomy; and retrograde fillings.
9. periodontic services, limited to:
 - a. two prophylaxis following surgery per calendar year;
 - b. root scaling and planing, once per quadrant of mouth in any 6 month period;
 - c. occlusal adjustment, performed with covered surgery;
 - d. gingivectomy, gingival curettage, and mucogingival;
 - e. osseous surgery including flap entry and closure;
 - f. pedicle or free soft tissue grafts; and
 - g. one appliance (night guards) in 5-year period.

Deductible 1 per Lifetime
We pay, after Deductible
Waiting Period – None

**Preferred &
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Providers**

\$50
80%

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Class C. Major Services Include:

1. oral surgery , including postoperative care for:
 - a. removal of teeth, including impacted teeth;
 - b. extraction of tooth root,
 - c. alveolectomy, alveoplasty, and frenectomy;
 - d. excision of periocoronary gingiva, exostosis, or hyperplastic tissue, and excision of oral tissue for biopsy;
 - e. reimplantation or transplantation of a natural tooth; and
 - f. excision of a tumor or cyst and incision and drainage of an abscess or cyst;
2. one study model in 3 year period;
3. crown build-up for non-vital teeth;
4. recementing inlays, onlays and crowns;
5. recementing bridges;
6. one repair of dentures or bridges in any 2 year period, limited to 20% of cost of replacement;
7. general anesthesia and analgesic, including intravenous sedation, for oral surgery;
8. restoration services, limited to:
 - a. gold or porcelain inlays, onlay, and crowns for tooth with extensive caries or fracture that is unable to be restored with an amalgam, silicate, acrylic, synthetic porcelain, or composite filling material.
 - b. replacement of existing inlay, onlay, or crown, after 5 years of the restoration initially placed or last replaced. This limitation will not apply if replacement is necessary due to the extraction of functioning natural teeth while covered.
 - c. stainless steel crowns.
 - d. post and core.
9. prosthetic services, limited to:
 - a. initial placement of dentures or fixed bridgework (including acid etch metal bridges), when denture or bridgework includes replacement of a natural tooth extracted or lost while covered under the Policy. This limitation ends after covered under the Policy for 36 months.
 - b. replacement of dentures or fixed bridgework that cannot be repaired after 5 years from the date of placed or last replaced.
 - c. addition of teeth to existing partial denture, only if to replace natural teeth extracted or lost while covered under the Policy. This limitation will not apply after covered under the Policy for 36 months.
 - d. relining or rebasing of existing removable dentures, only after one year from date the denture was placed and only once in any 2-year period.
10. dental implant procedures, as an alternative to the lowest cost covered traditional (non-implant) dental procedure that would provide satisfactory results. The eligible amount considered for the implant procedure will be the amount the plan would have considered as eligible for the covered traditional dental procedure. Pre-Determination is required. All deductible, co-insurance and maximum limitations of the plan apply. Coverage under this provision is not provided for:
 - a. Implants for cosmetic purposes.
 - b. Implants placed for teeth extracted prior to the date covered under this plan.
 - c. Replacement implants when replacement is made prior to the end of a five (5) year period from the date of initial placement, and then coverage is provided only when the existing implant cannot be repaired and the existing implant was placed while covered under this plan.
 - d. Implants placed for removable dentures.
 - e. Mini-implants (transitional implants).
 - f. Bone augmentation procedures such as grafting.
 - g. Procedures necessitated as the result of a failed implant, except as specified in "c" above. This includes replacing a failed implant either by placement of another implant or any other traditional dental procedure(s) used to replace or correct the failed implant.
 - h. Repairs to implants that were placed while not covered by this plan.

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Deductible 1 per Lifetime
We pay, after Deductible
Waiting Period – None

**Preferred &
Non-Preferred
Providers**

\$50
50%

**Preferred &
Non-Preferred
Providers**

Maximum Benefit Amount:

Combined per calendar year for Classes A, B and C

\$2,000

If Course of Treatment is to exceed \$750, prior review is requested.

DENTAL EXPENSES NOT COVERED

The Policy, under which your certificate is issued, covers services and procedures as described in the Coverage Schedule. Your coverage, under the policy, **does not** cover any miscellaneous separate expense not considered a covered service or procedure.

No benefits will be paid for expenses incurred:

1. for overdentures and associated procedures.
2. for charges in excess of those considered reasonable and customary.
3. for cosmetic procedures.
4. for the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function.
5. replacement of lost or stolen appliances; and for:
 - a. replacement of retainers;
 - b. athletic mouthguards;
 - c. precision or semi-precision attachments;
 - d. denture duplication; or
 - f. sealants.
6. for oral hygiene instructions; and for:
 - a. plaque control;
 - b. completion of a claim form;
 - c. acid etch;
 - d. broken appointments;
 - e. prescription or take-home fluoride; or
 - f. diagnostic photographs.
7. 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.
8. for procedures that are begun, but not completed.
9. for services and treatment provided without charge or for which there would be no charge in the absence of insurance.
10. 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.
11. for a condition covered under any Worker's Compensation Act or similar law.
12. that are applied toward satisfaction of a Deductible, if any.
13. that are generally considered by the dental profession as experimental or investigational.
14. for the treatment of cleft palate and anodontia.
15. for services or supplies payable under any medical expense plan.
16. for orthodontia, unless included by rider.

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No benefits will be paid for expenses incurred (cont):

17. prior to the date the Insured is covered under the Policy.
18. for the diagnosis or treatment of Temporomandibular Joint Dysfunction (TMJD).
19. for hospital services.
20. 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.
21. 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.