

SECURITY LIFE INSURANCE COMPANY OF AMERICA

Minnetonka, Minnesota 55343-9137

COVERAGE SCHEDULE

DENTAL INSURANCE PLAN

FOR BOTH PREFERRED PROVIDER (PP) AND NON-PREFERRED PROVIDER (NPP) SERVICES, WE WILL PAY BASED ON THE CONTRACTED FEE AMOUNT NEGOTIATED WITH THE PREFERRED PROVIDER ORGANIZATION REGARDLESS OF WHETHER A PP OR NPP PROVIDER IS USED, 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; and
4. bitewing x-rays, 2 series per calendar year.
5. emergency palliative treatment

Waiting Period – None

Deductible

\$50*

We pay

100%

Class B. Basic Services, Include:

1. simple extraction of teeth;
2. pin retention of fillings;
3. fillings of amalgam, silicate, acrylic, synthetic porcelain and composite filling materials (restorations of mesiolingual, distolingual, mesiobuccal and distobuccal surfaces considered single surface restorations). Posterior composite fillings are paid at the amalgam rate;
4. antibiotic injections administered by Dentist;
5. one diagnostic x-ray, full or panoramic in any 3 year period, and;
6. intra-oral and extra-oral diagnostic x-rays.
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
 - d. 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. pedical or free soft tissue grafts; and
 - g. one appliance (night guards) in 5-year period.
10. oral surgery, including postoperative care for:
 - a. removal of teeth, including impacted teeth;
 - b. extraction of tooth root,
 - c. alveolectomy, alveoplasty, and frenectomy;

**COVERAGE SCHEDULE
DENTAL INSURANCE PLAN**

Class B. Basic Services, Include (cont.):

- d. excision of periocoronal 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.

Waiting Period – None

Deductible, each calendar year

\$50*

We pay, after Deductible

50%

Class C. Major Services Include:

- 1. one study models in 3 year period;
- 2. crown build-up for non-vital teeth;
- 3. recementing inlays, onlays and crowns;
- 4. recementing bridges;
- 5. one repair of dentures or bridges in any 2 year period, limited to 20% of cost of replacement;
- 6. general anesthesia and analgesic, including intravenous sedation, for oral surgery;
- 7. 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.
- 8. 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.
- 9. sealants, for covered dependent children up to age 16, limited to a \$50 maximum benefit per calendar year.

**COVERAGE SCHEDULE
DENTAL INSURANCE PLAN**

Waiting Period - None	
Deductible, each calendar year	\$50*
We pay, after Deductible	50%

Maximum Benefit Amount:

Combined per calendar year for Classes A, B, and C	\$1,000
--	---------

*Class A, B, and C deductible is a combined \$50 each calendar year. A maximum of three (3) individual deductibles per family shall apply.

If the course of treatment includes Basic and Major Services, and these services are expected 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 the Preferred Provider allowance.
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. for implants; and for:
 - a. replacement of lost or stolen appliances;
 - b. replacement of retainers;
 - c. athletic mouthguards;
 - d. precision or semi-precision attachments; or
 - e. denture duplication.
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.

**COVERAGE SCHEDULE
DENTAL INSURANCE PLAN**

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

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 within Coverage Schedule.
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.