

IMPORTANT NOTICE

Security Life Dental Insurance is marketed by licensed agents. This brochure must be completed through a licensed agent and submitted to the Company by a licensed agent.

If you are interested in purchasing a Security Life dental plan and you do not have agent representation, please contact us at (866) 847-1120.

We will connect you with a qualified individual who can help you find the dental plan that best meets your needs.

★ No Enrollment Fee

★ Optional Vision Coverage

★ Includes Coverage for All Ages

★ Freedom to Choose Any Dentist

★ Up to \$2,000 Annual Maximum

★ No Waiting Periods for Most Services

Dental Benefits

Class A - Preventive Services	Elite	Premier	Select
Initial & Periodic Exams (2 per year), Cleanings (2 per year), Fluoride Treatments (to age 16), Sealants (no age limitation)			
Benefit Year One	100%	100%	75%
Benefit Year Two	100%	100%	85%
Benefit Year Three and Each Benefit Year Thereafter	100%	100%	100%
Deductible - Lifetime per Insured	\$50	\$50	\$50
Class B - Basic Services	Elite	Premier	Select
X-rays, Fillings, Simple Extractions			
Benefit Year One	35%	35%	25%
Benefit Year Two	65%	50%	35%
Benefit Year Three and Each Benefit Year Thereafter	80%	65%	50%
Deductible - Each Calendar Year per Insured*	\$50/yr	\$50/yr	\$50/yr
Class C - Major Services	Elite	Premier	Select
Oral Surgery, Endodontics, Periodontics, Crowns, Bridges, Dentures			
Benefit Year One	15%	10%	10%
Benefit Year Two	50%	25%	25%
Benefit Year Three and Each Benefit Year Thereafter	50%	50%	50%
Deductible - Each Calendar Year per Insured*	\$50/yr	\$50/yr	\$50/yr
Class D - Orthodontic Services	Elite	Premier	Select
Straightening of Teeth (for children under age 19)	Not		Not
Benefit Year One	Available	0%	Available
Benefit Year Two	Under	0%	Under
Benefit Year Three and Each Benefit Year Thereafter	This Plan	50%	This Plan
Calendar Year Maximums			
Calendar Year Maximum for Classes A, B and C Combined	\$1,000	\$1,000	\$1,000
Calendar Year Maximum for Class C - Major Services	\$500	\$500	\$500
Calendar Year Maximum for Class D	-	\$500	-
Lifetime Maximum Per Child for Class D	-	\$1,000	-

Calendar Year Maximum Increase Option
You may increase the Calendar Year Maximum benefit, per individual, for an additional monthly fee
 Option 1 - Increase Classes A, B & C to \$1,500 with Class C Major Services limited to \$750
 Option 2 - Increase Classes A, B & C to \$2,000 with Class C Major Services limited to \$1,000

*DEDUCTIBLE Class B & C Deductible is combined for each calendar year.
 A maximum of 3 individual deductibles per family shall apply.
 WAITING PERIODS Class A, B & C None, Class D Orthodontics - 24 months

Optional Vision Benefits Rider

Class A - Vision Exams - 1 per year	Elite	Premier	Select
Benefit Year One and Each Benefit Year Thereafter	100%	85%	85%
Class B - Lenses and Frames - 1 pair every 2 years	Elite	Premier	Select
Benefit Year One and Each Benefit Year Thereafter	50%	50%	50%
Class C - Contact Lenses - 1 pair every 2 years (in lieu of frames and lenses)	Elite	Premier	Select
Benefit Year One and Each Benefit Year Thereafter	50%	50%	50%
Calendar Year Deductible	\$50/yr	\$50/yr	\$50/yr
Calendar Year Maximum for Classes A, B and C	\$200	\$150	\$150
Waiting Periods - Class A - None, Class B & C - 15 Months			

For more information contact:



Three Ways to Enroll

Online
 Enrollment is available online by visiting our website at www.starsdental.com/quote. Online enrollment requires an agent authorization number (AAN). This 8-digit number can be obtained from your agent or by calling 866-847-1120.

Fax
 For your convenience we accept enrollment by Fax. Complete the enrollment form and fax to our administrative team. (See full instructions on the enrollment form).

Mail
 Complete the enrollment form and mail to our office. (See full instructions on the enrollment form).

- Vision rider is not a standalone benefit.
- State Exceptions: Premier Plan is not available in South Dakota. Optional Vision Benefits are not available in Maryland or South Dakota.
- The plans provide for an increase in coinsurance levels based upon each Benefit Year of coverage. Benefit Year begins with each insured's effective date and continues for 12 months. Each primary insured and dependent will have their own Benefit Year beginning with their specific effective date of coverage.
- This plan reimburses at the percentages shown for covered dental expenses based upon the Reasonable and Customary (R&C) fees for those covered expenses. Reasonable and Customary means the usual, customary and regular charges for the area where such expenses are incurred.

Marketed by



IMPORTANT INFORMATION

ELIGIBILITY

Individuals, 18 years of age or older, plus their eligible dependents (spouse and/or unmarried children from birth to age 19; extended to age 23 if child is a full-time student). This is subject to individual state regulations.

PRETREATMENT REVIEW

If the Course of Treatment will exceed the amount shown in the Coverage Schedule, 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.

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 alternate treatment will produce a professionally satisfactory result; then the maximum We will allow will be the charges for the less expensive treatment.

COORDINATION OF BENEFITS

This Plan will be coordinated with any other group, blanket or franchise plan under which an Individual will receive benefits.

Dental Insurance Protection for You and Your Family

DENTAL EXCLUSIONS AND LIMITATIONS

- Charges in excess of those considered Reasonable and Customary
- Cosmetic procedures
- The replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function
- Implants and for replacement of lost or stolen appliances, replacement of retainers, athletic mouthguards, precision or semi-precision attachments, denture duplication
- 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.
- Overdentures and associated procedures
- Oral hygiene instructions, and for: plaque control, completion of a claim form, acid etch, broken appointments, prescription or take-home fluoride, or diagnostic photographs
- Services not completed by the end of the month in which coverage ends unless continuation of coverage has been requested and accepted by Us
- Procedures that are begun, but not completed
- Services and treatment provided without charge, or for which there would be no charge in the absence of insurance
- 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
- 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
- The treatment of cleft palate and anodontia
- Services or supplies payable under any medical expense plan
- Orthodontia, unless included within the Coverage Schedule
- Services rendered prior to the date the Insured is covered under the Policy
- The diagnosis or treatment of Temporomandibular Joint Dysfunction (TMJD)
- 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 and
- Charges for infection control, sterilization, and waste disposal.

VISION EXCLUSIONS AND LIMITATIONS

The cost of a lens in excess of a standard lens will not be covered. A standard lens is any lens which fits 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. A standard frame is any frame which has a retail value of \$75.00 or less. The cost of replacement frames will not be covered, unless the existing frame is not compatible with the replacement lenses.

In addition to the above, the following expenses are not covered:

- Any procedure, service or supply included as a covered medical expense under any group insurance plan, whether benefits are payable as to all or only part of such charges;
- Special procedures, such as orthoptics, vision training and subnormal vision aids;
- Plano or prescription sunglasses or other special purpose vision aid;
- Medical or surgical treatment of the eyes including hospital expenses;
- Replacement of lost or broken lenses and/or frames;
- Duplicate glasses or lenses or frames; and
- Services or materials not listed as an Eligible Expense.

This brochure provides a very brief description of some important features of your Plan. It is not the Insurance Contract nor does it represent the Contract. A full explanation of benefits, exceptions and limitations is contained in the Certificate of Insurance under Group Policy Form GH-1112. A specimen copy is available upon request.

Some provisions may vary by state. This Dental Plan may not be available in all states.

No agent has the authority to change any benefits, to bind coverage with Security Life Insurance Company of America or to promise a certain effective date.

**Security Life Insurance Company of America, Minnetonka, MN
PrimeStar Enrollment Form**

Plan Selection: Elite Premier Select
 Vision Option

I apply for coverage on: Applicant Only Applicant and Spouse
 Applicant and Child(ren) Applicant and Family

Optional Calendar Year Maximum Increase Selection \$1,500 \$2,000

APPLICANT INFORMATION (PLEASE PRINT CLEARLY)

Last Name		First Name		Initial		Birth Date / /	
Address				Telephone Number		Sex: M <input type="checkbox"/> F <input type="checkbox"/>	
City				State		Zip	
Billing Address (If Different)		City		State		Zip	
				Marital Status Married <input type="checkbox"/> Single <input type="checkbox"/>			

LIST ALL YOUR ELIGIBLE DEPENDENTS BELOW

Last Name (If Different)	First Name	Initial	Sex M/F	Age	Birth Date / /
Spouse					/ /
Dependent					/ /
Dependent					/ /
Dependent					/ /
Dependent					/ /

Does Spouse have a dental plan: Yes No With Whom? _____
 If answer is "Yes", are dependents enrolled under spouses plan? Yes No
 Do you claim a tax exemption for all eligible dependents listed above? Yes No If no, who is not? _____
 All dependent children over age 18 are full-time students. Yes No If no, who is not? _____

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.

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 insurer 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 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 hereto 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.

IMPORTANT INFORMATION

Effective Date – The effective date is the first of the month following the day in which the application is received in the Service Center Office.

Identification Card and Certificate of Insurance - Upon receipt of your completed application you will receive a copy of your Certificate of Insurance and Identification Card(s).

Do not cancel any other dental coverage you may have until you receive written confirmation from Security Life. Please allow 3-4 weeks for processing.

By my signature below, I hereby apply for coverage under Group Dental Insurance Policy GH-1112-38060 issued to the Voluntary Group Trust. I also certify I have read the applicable Fraud Notice above.

California Law prohibits an HIV Test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Applicant Signature _____ Date _____

Please refer to the reverse side for payment options and agent information

PRIMESTAR PERSONAL DENTAL - PREMIUM RATE TABLE

For effective dates April 1, 2009 through August 1, 2009

**FOR ALL STATES EXCEPT MARYLAND, NORTH CAROLINA, NORTH DAKOTA,
SOUTH DAKOTA, WASHINGTON**

(Please request separate rate sheets for the above states)

Monthly Premiums illustrated are guaranteed for the initial twelve (12) months of coverage. Thereafter, premiums are likely to increase on a semi-annual basis.

RATE CHART			Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8
UNDER AGE 65	ELITE	Applicant Only	\$ 27.00	\$ 30.00	\$ 32.00	\$ 36.00	\$ 40.00	\$ 44.00	\$ 49.00	\$ 54.00
		Applicant+Spouse	\$ 56.00	\$ 61.00	\$ 67.00	\$ 75.00	\$ 81.00	\$ 90.00	\$ 99.00	\$ 108.00
		Applicant+ Child(ren)	\$ 62.00	\$ 66.00	\$ 73.00	\$ 79.00	\$ 88.00	\$ 96.00	\$ 106.00	\$ 117.00
		Applicant + Family	\$ 95.00	\$ 103.00	\$ 113.00	\$ 124.00	\$ 138.00	\$ 150.00	\$ 166.00	\$ 183.00
	PREMIER	Applicant Only	\$ 23.00	\$ 25.00	\$ 27.00	\$ 30.00	\$ 34.00	\$ 37.00	\$ 41.00	\$ 45.00
		Applicant+Spouse	\$ 47.00	\$ 51.00	\$ 56.00	\$ 63.00	\$ 68.00	\$ 76.00	\$ 83.00	\$ 91.00
		Applicant+ Child(ren)	\$ 56.00	\$ 60.00	\$ 66.00	\$ 72.00	\$ 80.00	\$ 87.00	\$ 96.00	\$ 106.00
		Applicant + Family	\$ 84.00	\$ 91.00	\$ 100.00	\$ 110.00	\$ 122.00	\$ 133.00	\$ 147.00	\$ 162.00
	SELECT	Applicant Only	\$ 20.00	\$ 23.00	\$ 25.00	\$ 26.00	\$ 29.00	\$ 33.00	\$ 36.00	\$ 40.00
		Applicant+Spouse	\$ 41.00	\$ 46.00	\$ 49.00	\$ 56.00	\$ 60.00	\$ 66.00	\$ 72.00	\$ 80.00
		Applicant+ Child(ren)	\$ 43.00	\$ 47.00	\$ 51.00	\$ 56.00	\$ 63.00	\$ 68.00	\$ 76.00	\$ 83.00
		Applicant + Family	\$ 67.00	\$ 75.00	\$ 82.00	\$ 90.00	\$ 99.00	\$ 108.00	\$ 120.00	\$ 131.00
65 AND OVER	ELITE	Applicant Only	\$ 30.00	\$ 32.00	\$ 36.00	\$ 40.00	\$ 44.00	\$ 49.00	\$ 54.00	\$ 57.00
		Applicant+Spouse	\$ 62.00	\$ 67.00	\$ 75.00	\$ 81.00	\$ 90.00	\$ 99.00	\$ 108.00	\$ 119.00
	PREMIER	Applicant Only	\$ 25.00	\$ 27.00	\$ 30.00	\$ 34.00	\$ 37.00	\$ 41.00	\$ 45.00	\$ 48.00
		Applicant+Spouse	\$ 52.00	\$ 56.00	\$ 63.00	\$ 68.00	\$ 76.00	\$ 83.00	\$ 91.00	\$ 100.00
	SELECT	Applicant Only	\$ 22.00	\$ 25.00	\$ 26.00	\$ 29.00	\$ 33.00	\$ 36.00	\$ 40.00	\$ 44.00
		Applicant+Spouse	\$ 46.00	\$ 49.00	\$ 56.00	\$ 61.00	\$ 66.00	\$ 72.00	\$ 80.00	\$ 88.00

Optional Vision Rates for All Ages					
Elite Plan	Applicant Only	\$ 6.00	Premier & Select Plans	Applicant Only	\$ 5.00
	Applicant+Spouse	\$ 13.00		Applicant+Spouse	\$ 10.00
	Applicant+ Child(ren)	\$ 13.00		Applicant+ Child(ren)	\$ 10.00
	Applicant + Family	\$ 17.00		Applicant + Family	\$ 13.00

ZIP CODE AREA CHART													
State & Zip	Area	State & Zip	Area	State & Zip	Area	State & Zip	Area	State & Zip	Area	State & Zip	Area	State & Zip	Area
Alabama		California		Illinois		Michigan		Nebraska	1	Pennsylvania		Virginia	
350-355	3	943-948	4	600-605	2	480-483	2	Nevada		170-178	2	222-223	6
359	3	949, 961	6	606-608	3	490-491	2	890-891	2	182-187	2	224-225	1
All Others	1	956-958	3	All Others	1	488-489	3	894-895	6	190-192	3	230-232	1
Alaska		959	4	Indiana		All Others	1	898	6	All Others	1	228-229	2
995-996	8	All Others	5	463-464	2	Minnesota		All Others	4	So. Carolina	1	240-244	2
All Others	6	Colorado		473	3	553-558	2	New Mexico		Tennessee		233-237	5
Arizona		803	4	All Others	1	564, 566	2	881	2	373-374	2	All Others	4
856-857	2	808-810	4	Iowa	1	All Others	1	882	5	All Others	1	West Virginia	
864	2	All Others	1	Kansas		Mississippi		All Others	1	Texas		255-257	4
All Others	1	Delaware	2	660-662	2	390-392	2	Ohio	1	751-753	3	262-265	3
Arkansas	1	Dist Columbia	6	All Others	1	All Others	1	Oklahoma		754	4	All Others	2
California		Georgia		Kentucky	1	Missouri		740-743	2	756-757	1	Wisconsin	1
900-905	7	300-303	2	Louisiana		640-641	2	All Others	1	776-777	1	Wyoming	1
906-914	6	307, 311	2	707-711	2	644-649	2	Oregon		All Others	2		
915-916	8	All Others	1	712	3	All Others	1	977	3	Utah	1		
917-918	4	Hawaii	3	All Others	1	Montana		978	1	Virginia			
919-927	6	Idaho	1			590-591	1	All Others	2	201	5		
930-934	6					599	2			220-221	5		
939	6					All Others	3						