Secure Dental
Dental Insurance

Everyone Deserves A Healthy Smile
# Secure Dental Plan

## Benefits & Discounts

### Preventive Dental Care
- Initial & Periodic oral examinations\(^2\)
- Intraoral X-rays, with/without bitewings
  \[_{\text{Limit one series every thirty-six months per Insured}}\]
- Bitewing X-rays
  \[_{\text{Limit one set every twelve months per Insured}}\]
- Prophylaxis (cleaning of the teeth) with/without oral examination\(^2\)
- Periodontal Prophylaxis (deep scaling & cleaning)\(^2\)
- Topical fluoride for Insureds under fourteen years of age
  \[_{1 \text{ treatment every twelve months per Insured}}\]
- Space maintainers (fixed/lateral) for missing primary teeth

### Basic Dental Care
- General anesthesia, when Dentally Necessary and in connection with Oral Surgery
- Amalgam, silicate cement, acrylic or plastic fillings
- Simple tooth Extractions
- Temporary treatment to relieve dental pain
- Non-routine X-rays
- Full mouth or panoramic x-rays
- Oral Surgery

### Premium Plan

<table>
<thead>
<tr>
<th>Deductibles</th>
<th>$50 per person, $150 per family(^{1,6})</th>
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<tr>
<td>PPO (In-Network)</td>
<td>100(^2)</td>
<td>80(^4)</td>
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</tr>
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<td>Non-PPO (Out-of-Network)</td>
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- Calendar Year Maximum Per Insured $1,500
- Orthodontic Calendar Year Maximum Per Insured $400
- Lifetime Maximum Orthodontic Benefit Per Insured $1,000

### Saver Plus Plan

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- Calendar Year Maximum Per Insured $1,000

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- Calendar Year Maximum Per Insured $500

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\(^{1}\)Benefits are subject to the Calendar Year Deductible and Calendar Year Maximum specified above per Insured

\(^{2}\)One during a consecutive six months per Insured

\(^{3}\)One treatment per tooth every consecutive thirty-six months per Insured

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\(^{1}\)Family limit of 3 per Person Deductibles

\(^{2}\)Not subject to benefit waiting period

\(^{3}\)Subject to network fee schedule

\(^{4}\)Subject to 6 month benefit waiting period

\(^{5}\)Subject to a 12 month benefit waiting period

\(^{6}\)Separate $50 Deductible For Non-Contracted Dentist per Insured

\(^{7}\)Separate $150 Deductible for Non-Contracted Orthodontic Dental Care per Insured

\(^{8}\)Separate $150 Deductible for Non-Contracted Orthodontic Dental Care per Insured
**Major Dental Care**

*(Insurance Benefits for Premium & Saver Plus Plans)*

- Onlays/Inlay fillings, two or three surfaces
- Single Crown restorations
- Dentures, including fixed or removable prosthetic devices, complete Dentures, upper & lower
- Partial Dentures - lower, with two clasps & gold lingual bar upper w/two clasps & gold palatal bar
- Bridge Pontics
- Abutment Crowns
- Root Canal Therapy, including treatment plan & follow-up care
- Apicoectomy *If performed with a root canal, this service will be considered a separate service*
- Gingivectomy or ginivoplasty, per quadrant
- Osseous surgery
- Periodontic scaling
- Surgical Extractions of an impacted tooth, including full bony impaction
- Repairs & adjustments to Dentures *This will not be considered a Covered Dental Expense if performed within six (6) months of: Denture installation; adjustments to Dentures or Partial Dentures; replacement of a broken tooth or complete or Partial Denture; other Denture repairs; and re-cementing of a bridge*
- Implants

**Orthodontic Care**

*(Insurance Benefits for Premium Plan only)*

- Periodic oral evaluation
- Comprehensive oral evaluation – new or established patient
- Re-evaluation *limited, problem focused (established patient, not post-operative visit)*
- Comprehensive periodic evaluation – new or established patient
- Intraoral – complete series (including bitewings)
- Panoramic film, including bitewings & periapicals if necessary
- Cephalometric Film
- Oral/facial images (includes intra & extraoral images)
- Diagnostic casts
- Transseptal fiberotomy, supra crestal fiberotomy, by report
- Limited Orthodontic treatment of the primary dentition
- Limited Orthodontic treatment of the transitional dentition
- Limited Orthodontic treatment of the adolescent dentition
- Limited Orthodontic treatment of the adult dentition
- Interceptive Orthodontic Treatment of the primary dentition
- Interceptive Orthodontic Treatment of the transitional dentition
- Comprehensive Orthodontic Treatment of the transitional dentition
- Comprehensive Orthodontic Treatment of the adolescent dentition
- Comprehensive Orthodontic Treatment of the adult dentition
- Removable appliance therapy
- Fixed appliance therapy
- Pre-orthodontic treatment visit
- Periodic Orthodontic treatment visit (as part of contract)
- Orthodontic retention (removal of appliances, construction & placement of retainer(s))
- Orthodontic treatment (alternative billing to a contract fee)
- Repair of Orthodontic appliance
- Replacement of lost or broken retainer (limited to replacement of broken retainer)
- Rebonding or recementing, and/or repair, as required of fixed retainers

**Dental Network Discounts**

Saver Plan and Saver Plus Plan members may take advantage of savings on the following services, when services are provided by a Contracted Dentist:

- Save up to 20% on most major dental procedures, including onlays/inlay fillings, single crown restorations, dentures, bridge pontics, root canal therapy, surgical extractions of impacted teeth, and implants.
- Save up to 20% on orthodontic care, including braces and retainers for children and adults, diagnostic casts, oral/facial images, and fixed appliance therapy.

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1. If performed in connection with Orthodontic Treatment Plan
2. Actual savings may vary depending on Your geographic location and the contracted Dentist You select
3. Discount services for Saver Plan Members
4. Discount services for Saver Plan and Saver Plus Plan Members
**Termination**

Your Certificate is guaranteed renewable to age sixty-five (65) or in the event an Insured otherwise becomes a Medicare enrollee.

An Insured’s coverage ends on the earlier of: with respect to Your Spouse who is covered under the Certificate, the premium due date in the month following the effective date of Your divorce decree, annulment or court approved separation; with respect to Your child(ren) who are covered under the Certificate, the premium due date in the month following such Insured’s twenty-fifth (25th) birthday; the due date of any unpaid Renewal Premium, subject to the grace period; the date You terminate coverage by notifying Us of the date You desire coverage to terminate and specify the Insured whose coverage is to terminate; We are required by the order of an appropriate regulatory authority to non-renew or cancel the Certificate or Group Dental Insurance Policy; We cease or discontinue offering and renewing coverage of the same form of coverage as the Certificate in Your state upon a minimum of ninety (90) days prior written notice mailed to Your last known address; the date We receive due proof that fraud or intentional misrepresentation of material fact existed in applying for the Certificate or in filing a claim for Benefits under the Certificate.

**Coordination of Benefits**

The Dental Certificate contains a Coordination of Benefits provision, which describes how Benefits will be payable. Benefits payable under the Certificate may be reduced when a Covered Insured has more than one plan, depending on whether this coverage is a primary or secondary plan. The Certificate contains a Coordination of Benefits provision which outlines the order of benefit determination rules for determining if coverage is primary or secondary.

**Pre-Treatment Estimate of Benefits**

An Insured may find the amount payable by the Certificate prior to having a Dentist begin any extensive treatment. Your Dentist may submit the treatment plan to Us prior to services being performed. We will notify You and the Dentist, in advance regarding what benefits are considered Covered Dental Expenses or Covered Orthodontic Expense and how much is payable under the Certificate and how much You will be responsible for paying.

The Pre-Treatment Estimate is not a guarantee of payment. Benefits are payable if coverage is in effect on the date Covered Dental Expenses or Covered Orthodontic Expenses are performed, subject to the definitions, exclusions, and limitations, and Benefit Waiting Periods.
PREMIUM, SAVER PLUS & SAVER PLANS LIMITATIONS

In addition to any other provisions of the Certificate, Benefits and coverage are limited as follows:

• The amount of the Calendar Year Maximum Dental Benefit Per Insured shall not exceed the sum of $500 for the Saver Plan, $1,000 for the Saver Plus Plan, and $1,500 for the Premium Plan, with an additional $400 Calendar Year Maximum Orthodontic Benefit per Insured and Lifetime Maximum Orthodontic Benefit Per Insured of $1,000 on the Premium Plan.

• No Benefits are payable under the BASIC DENTAL CARE provision unless they are incurred at least six (6) months after the Issue Date.

• No Benefits are payable under the MAJOR DENTAL CARE provision unless they are incurred at least twelve (12) months after the Issue Date.

• No Benefits are payable under the ORTHODONTIC DENTAL EXPENSES provision unless they are incurred at least twelve (12) months after the Issue Date.

PREMIUM, SAVER PLUS & SAVER PLANS NON-COVERED ITEMS

Coverage under the Certificate is limited as provided by the definitions, terms, conditions, limitations, and exclusions contained in each and every section of the Certificate. In addition, the Certificate does not provide coverage for professional and dental services provided to an Insured or any payment obligation for Us under the Certificate for any of the following, all of which are excluded from coverage:

• treatments, care, procedures, services or supplies received before the Certificate Issue Date;

• covered Dental Expenses that exceed the amount of the Calendar Year Maximum Dental Benefit Per Insured;

• Prescription Drugs;

• any professional services for which the Insured and/or any covered family member are not legally liable for payment;

• any professional services for which the Insured and/or any covered family member were once legally liable for payment, but from which liability the insured and/or family member were released;

• Dental Injury or Dental Sickness due to any act of war (whether declared or undeclared);

• services provided by any state or federal government agency, including the Veterans Administration unless, by law, an Insured must pay for such services;

• any dental conditions for which the covered Insured has received or is entitled to receive compensation for that particular dental condition under any Worker’s Compensation or Occupational Disease Law;

• expenses incurred for oral hygiene instructions, a plaque control program or dietary instructions;

• expenses incurred for dental care which is not customarily performed, which is experimental in nature or which is not considered acceptable by the American Dental Association or Federal Drug Administration;

• any professional and dental services provided an Insured in treatment of a Dental Sickness or Dental Injury caused or contributed to by such Insured’s being intoxicated or under the influence of any drug, narcotic or hallucinogens unless administered on the advice of a provider, and taken in accordance with the limits of such advice;

• intentionally self-inflicted Dental Injury, suicide or any suicide attempt while sane or insane;

• Dental Sickness or Dental Injury while serving in one of the branches of the armed forces of the United States of America;

• Dental Sickness or Dental Injury while in a foreign country and serving on active duty in the United States Army, Navy, Marine Corp or Air Force Reserves or the National Guard;

• Dental Sickness or Dental Injury while serving on active duty in the armed forces of any foreign country or any international authority;

• any dental condition excluded by name or specific description by either the Certificate or any riders, endorsements, or amendments attached to the Certificate;

• any loss to which a contributing cause was the Insured’s being engaged in an illegal occupation or illegal activity;

• participation in aviation, except as fare-paying passenger traveling on a regular scheduled commercial airline flight;

• cosmetic surgery or cosmetic dentistry, except for Dentally Necessary cosmetic surgery which is incidental to or following surgery resulting from trauma or infection to correct a normal bodily function;

• Temporomandibular Joint Disorder (TMJ) and Craniomandibular Disorder (CMD);

• treatment received outside of the United States;

• treatment on or to the teeth or gums for cosmetic purposes, including charges for personalizations, characterizations or Dentures;

• replacement of lost or stolen prosthetics;

• restorative services (i.e. the initial placement of a complete or Partial Denture or for Fixed Bridgework) or Endodontic therapy if it involves the replacement of one or more natural teeth missing on the Issue Date of the Certificate or when initial preparations were started prior to the Issue Date as shown on the Certificate Schedule;

• restorative services for one (1) or more natural teeth missing on the Issue Date as shown on the Certificate Schedule of the Certificate will be considered Covered Dental Service if incurred five (5) years after the Issue Date;

• dental services performed in a hospital and any related expenses;

• replacement of an appliance or prosthetic device, Crown, cast restoration or a Fixed Bridge within five (5) years after the date it was last placed. This exclusion does not apply if replacement is due to accidental Dental Injury received while covered under the Certificate;

• treatment of cleft palate, except for a newborn child covered under the Certificate from birth, andontia or mandibular prognathism;
Premium, Saver Plus & Saver Plans Non-Covered Items, cont’d

- general anesthesia, except as specifically provided in the COVERED DENTAL EXPENSES section;
- placement of bone grafts or extra-oral substances in the treatment of periodontal disorders;
- the use of unilateral, removable prosthetics;
- charges incurred by an Insured due to broken or cancelled appointments;
- Crowns for teeth that are restorable by other means or for the purpose of periodontal splinting;
- Crowns, fillings or appliances that are used to correct (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or for cosmetic purposes;
- orthognathic surgery; and
- expenses which exceed 100% of those actually incurred by the covered Insured.

Additional Premium Plan Non-Covered Items

- any expenses for treatments, care, procedures, services or supplies which are not Covered Dental Expenses or Covered Orthodontic Expenses incurred by a covered Insured, and which are not specifically enumerated in the COVERED DENTAL EXPENSES or COVERED ORTHODONTIC EXPENSES section of the Certificate;
- Covered Dental Expenses or Covered Orthodontic Expenses received after the Certificate terminates, regardless of when the condition originated;
- Covered Orthodontic Expenses that exceed the amount of the Calendar Year Maximum Orthodontic Benefit per Insured;
- any treatments, care, procedures, services or supplies which are not specifically enumerated in the COVERED DENTAL EXPENSES or COVERED ORTHODONTIC EXPENSES sections of the Certificate and any optional coverage rider attached to the Certificate; and
- Orthodontic diagnosis or treatment, except as provided in the COVERED ORTHODONTIC EXPENSES provision.

Additional Saver Plus & Saver Plans Non-Covered Items

- any expenses for treatments, care, procedures, services or supplies which are not Covered Dental Expenses incurred by a covered Insured, and which are not specifically enumerated in the COVERED DENTAL EXPENSES section of the Certificate;
- Covered Dental Expenses received after the Certificate terminates, regardless of when the condition originated;
- any treatments, care, procedures, services or supplies which are not specifically enumerated in the COVERED DENTAL EXPENSES sections of the Certificate and any optional coverage rider attached to the Certificate; and
- Orthodontic diagnosis or treatment.

Additional Saver Plan Non-Covered Items

- any expenses for treatments, care, procedures, services or supplies which are not Covered Dental Expenses incurred by a covered Insured, and which are not specifically enumerated in the COVERED DENTAL EXPENSES section of the Certificate;
- any treatments, care, procedures, services or supplies which are not specifically enumerated in the COVERED DENTAL EXPENSES sections of the Certificate and any optional coverage rider attached to the Certificate; and
- Orthodontic diagnosis or treatment.

ACA Individual Mandate & Shared Responsibility Payment

The individual mandate of the Affordable Care Act ("ACA") generally requires individuals to maintain “minimum essential coverage” in 2014 and beyond, or be subject to the payment of the annual shared responsibility payment, the amount of which is based, in part, upon the individual’s household income each year. The SecureDental Plan provides benefits for dental only coverage, but it is not Workers’ Compensation coverage under state law or an “essential health benefits” under the ACA and it is not considered “minimum essential coverage” plan under the ACA. Therefore, unless an Insured under the SecureDental Plan has an exemption from the ACA’s individual mandate or maintains “minimum essential coverage” under the ACA, the Insured will be subject to the ACA’s shared responsibility payment. If an individual (a) does not receive an ACA exemption annually from the federal government for the individual mandate, or (b) does not maintain “minimum essential coverage” under the ACA for 9 or more consecutive months during each year, (including coverage under one of the following types of plans (i) an employer sponsored group health plan, (ii) a grandfathered health plan, (iii) a non-grandfathered health plan for which the government has granted a waiver of the individual mandate, or (iv) an ACA essential health benefits plan), he will be subject to the ACA’s annual “shared responsibility payment”, even if covered under one of the PremierChoice Specified Disease/Sickness and Accident Plans. For additional information on the individual mandate, “shared responsibility payment”, exemptions from the mandate and other matters concerning the ACA, please visit www.healthcare.gov, the federal government’s website.
The underwriting insurance company in Your state has agreed to perform or cause to be performed certain monthly administrative services on behalf of the association including the collection of certain enrollment fees and monthly membership dues on behalf of the association and transmission to the association of monthly membership census data. The underwriting insurance company in Your state is paid a monthly fee by the association for these administrative services.