Secure Dental
Dental Insurance

Everyone Deserves
A Healthy Smile
Secure Dental Plan

Benefits

**Preventive Dental Care**

- Initial & Periodic oral examinations²
- Intraoral x-rays, with/without bitewings
  
  *Limit one series every thirty-six months (36) per Insured*
- Bitewing x-rays
  
  *Limit one set every twelve (12) months per Insured*
- Prophylaxis (cleaning of the teeth) with/without oral examination²
- Periodontal Prophylaxis (deep scaling & cleaning)
  
  *Two (2) during a consecutive twelve (12) month period per Insured*
- Topical fluoride for Insureds under fourteen (14) years of age
  
  *One (1) treatment every twelve months per Insured*
- Topical sealant - posterior tooth for Insureds under fourteen (14) years of age³
- Space maintainers (fixed/lateral) for missing primary teeth

**Basic Dental Care**

- General anesthesia, when Dentally Necessary & in connection w/Oral Surgery
- Amalgam, silicate cement, acrylic or plastic fillings
- Topical sealant - posterior tooth of Insureds under fourteen (14) years of age³
- Simple tooth Extractions
- Temporary treatment to relieve dental pain
- Non-routine x-rays
- Full mouth or panoramic x-rays
- Oral Surgery

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¹Benefits are subject to the Calendar Year Deductible and Calendar Year Maximum specified above per Covered Insured
²Two (2) during a consecutive twelve (12) month period per Insured
³One (1) treatment per tooth every consecutive thirty-six (36) months per Insured

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**Premium Plan**

**Deductibles** $50 per person, $150 per family¹,⁶

**Additional Orthodontic Deductible** $150 per person¹,⁷

<table>
<thead>
<tr>
<th>Coinsurance</th>
<th>Preventive Care</th>
<th>Basic Care</th>
<th>Major Care</th>
<th>Orthodontic Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPO (In-Network)</td>
<td>100%²</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

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**Saver Plus Plan**

**Deductibles** $50 per person, $150 per family¹,⁶

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**Calendar Year Maximum Per Insured** $1,000

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**Saver Plan**

**Deductibles** $50 per person, $150 per family¹,⁶

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**Calendar Year Maximum Per Insured** $500

¹Family limit of 3 per person Deductibles
²Not subject to benefit waiting period
³Subject to network fee schedule
⁴Subject to 6 month benefit waiting period
⁵Subject to a 12 month benefit waiting period
⁶Separate $50 Deductible For Non-Participating Dentist per Insured
⁷Separate $150 Deductible for Non-Participating Orthodontist 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
- Apioectomy
  *If performed with a root canal, this service will be considered a separate service*
- Gingivectomy or ginvoplasty, per quadrant
- Osseous surgery, per quadrant
  *If more than one (1) periodontal surgery service is performed per quadrant, only the most inclusive surgical service performed will be considered a Covered Dental Expense*
- 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 recementing of a bridge*
- Implants

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**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

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1If performed in connection with Orthodontic Treatment Plan
2Actual savings may vary depending on your geographic location and the Participating Dentist you select
**Termination & Renewability**

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

A Covered Insured’s coverage ends on the earlier of: the date We are required by the order of an appropriate regulatory authority to non-renew or cancel the Policy or Dental Insurance Policy; the date We cease offering and renewing the same form of coverage as this Policy in Your state in which case You will be given a minimum of thirty (30) days prior written notice mailed to Your last known address; Orthodontic Benefits for an Insured if the total amount of any Orthodontic payments made by Us are equal to the Lifetime Maximum Orthodontic Benefit for such Insured; the premium due date in the month following the date the Policy is terminated by the Policyholder; the due date of any unpaid premium, subject to the grace period; the date You terminate coverage by notifying Us in writing of the date You desire coverage to terminate and specify the Covered Insured whose coverage is to terminate; the date We receive due proof that fraud or intentional misrepresentation of material fact existed in applying for the Policy or in filing a claim for Benefits under the Policy, subject to the TIME LIMIT ON CERTAIN DEFENSES provision of this Policy; with respect to Your Spouse who is covered under the Policy, the premium due date in the month following the effective date of Your divorce decree, annulment or court approved separation; the premium due date in the month following the earlier of: (a) the date the Covered Insured attains age sixty-five (65) or (b) the date the Covered Insured becomes eligible or qualified for Benefits under Medicare or any other government insurance plan (except Medicaid); or with respect to Your child(ren) who is covered under the Policy, the premium due date in the month following such Covered Insured’s 19th birthday (24th if a Full-Time Student). Coverage will not end if such child is dependent on You for support and is incapable of self-support because of a mental or physical incapacity. Such coverage will continue as long as the Policy stays in force and the child remains dependent. Proof of such handicap or disability must be furnished to Us within 31 days prior to the child reaching the limiting age, and thereafter upon Our request, but not more frequently than annually after the two (2) year period following the child’s attainment of the limiting age.

**Pre-Treatment Estimate of Benefits**

An Insured may find the amount payable by the Policy 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 Policy 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.
LIMITATIONS
In addition to any other provisions of the Policy, 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.

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

• Any expenses for treatments, care, procedures, services or supplies which are not Covered Dental Expenses or Covered Orthodontic Expense incurred by a Covered Insured, and which are not specifically enumerated in the COVERED DENTAL EXPENSE or COVERED ORTHODONTIC EXPENSE section of the Policy;
• Treatments, care, procedures, services or supplies received before the Policy Issue Date;
• Covered Dental Expense or Covered Orthodontic Expense received after the Policy terminates, regardless of when the condition originated, except as specified in the TERMINATION OF COVERAGE section of the Policy;
• Covered Dental Expenses that exceed the amount of the Calendar Year Maximum Dental Benefit Per Insured;
• Covered Orthodontic Expenses that exceed the amount of the Calendar Year Maximum Orthodontic Benefit per Insured;
• Prescription Drugs;
• Any treatments, care, procedures, services or supplies which are not specifically enumerated in the COVERED DENTAL EXPENSES or COVERED ORTHODONTIC EXPENSE sections of the Policy and any optional coverage rider attached to the Policy;
• 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;
• Any claim, bill, or other demand or request for payment for health care services that the appropriate regulatory board determines were Provided as a result of a prohibited referral;
• 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 i) an Insured must pay for such services; or ii) We must reimburse the agency 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;
• 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 Corps 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;
• Services Provided by You or a Dentist who is a member of an Insured's Family;
• Any dental condition excluded by name or specific description by either the Policy or any riders, endorsements, or amendments attached to the Policy;
• 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 Policy or when initial preparations were started prior to the Issue Date as shown on the Policy Schedule;

• Restorative services for one (1) or more natural teeth missing on the Issue Date as shown on the Policy Schedule of the Policy 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 Policy;

• Treatment of cleft palate, except for a newborn child covered under the Policy from birth, andontia or mandibular prognathicism;

• 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;

• Orthodontic diagnosis or treatment, except as provided in the COVERED ORTHODONTIC EXPENSE provision;

• 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;

• Implants, including any appliances and/or Crowns and the surgical insertion or removal of Implants;

• 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.