**LANDMARK DENTAL PLANS**

**Open Access Plans - Under Age 65 Plans**

<table>
<thead>
<tr>
<th>Regions</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>31.58</td>
<td>34.63</td>
<td>38.05</td>
<td>41.89</td>
<td>46.04</td>
<td>50.01</td>
<td>55.55</td>
<td>61.26</td>
</tr>
<tr>
<td>Single+1</td>
<td>63.01</td>
<td>69.98</td>
<td>75.82</td>
<td>83.51</td>
<td>91.80</td>
<td>100.97</td>
<td>110.84</td>
<td>122.23</td>
</tr>
<tr>
<td>Family</td>
<td>96.29</td>
<td>103.57</td>
<td>110.60</td>
<td>127.61</td>
<td>140.37</td>
<td>154.29</td>
<td>169.37</td>
<td>186.78</td>
</tr>
</tbody>
</table>

**Open Access Plans - 65 and Over Plans**

<table>
<thead>
<tr>
<th>Regions</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>34.74</td>
<td>38.09</td>
<td>41.86</td>
<td>46.05</td>
<td>50.55</td>
<td>56.67</td>
<td>61.12</td>
<td>67.39</td>
</tr>
<tr>
<td>Single+1</td>
<td>69.31</td>
<td>75.99</td>
<td>83.51</td>
<td>91.80</td>
<td>101.15</td>
<td>110.97</td>
<td>121.92</td>
<td>134.45</td>
</tr>
<tr>
<td>Family</td>
<td>95.92</td>
<td>111.13</td>
<td>127.62</td>
<td>140.38</td>
<td>154.29</td>
<td>169.73</td>
<td>186.33</td>
<td>205.47</td>
</tr>
</tbody>
</table>

**PPO Under Age 65 Plans**

<table>
<thead>
<tr>
<th>Regions</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>28.59</td>
<td>31.34</td>
<td>34.44</td>
<td>37.88</td>
<td>41.47</td>
<td>45.81</td>
<td>50.28</td>
<td>55.45</td>
</tr>
<tr>
<td>Single+1</td>
<td>57.40</td>
<td>62.84</td>
<td>69.16</td>
<td>76.80</td>
<td>83.68</td>
<td>91.98</td>
<td>100.97</td>
<td>111.35</td>
</tr>
<tr>
<td>Family</td>
<td>87.75</td>
<td>96.26</td>
<td>103.81</td>
<td>113.28</td>
<td>127.92</td>
<td>140.12</td>
<td>154.35</td>
<td>170.21</td>
</tr>
</tbody>
</table>

**PPO 65 and Over Plans**

<table>
<thead>
<tr>
<th>Regions</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>31.45</td>
<td>34.48</td>
<td>37.89</td>
<td>41.65</td>
<td>45.63</td>
<td>50.39</td>
<td>55.32</td>
<td>61.00</td>
</tr>
<tr>
<td>Single+1</td>
<td>63.43</td>
<td>69.22</td>
<td>76.06</td>
<td>83.68</td>
<td>92.04</td>
<td>101.17</td>
<td>111.07</td>
<td>121.92</td>
</tr>
<tr>
<td>Family</td>
<td>96.52</td>
<td>103.57</td>
<td>110.60</td>
<td>127.61</td>
<td>140.37</td>
<td>154.29</td>
<td>169.73</td>
<td>187.23</td>
</tr>
</tbody>
</table>

**Optional Vision Plans**

- Optional Vision Plans for all regions a, b, c, d, e, f, g, h
- Optional Vision Plans for PPO Under age 65 Plans
- Optional Vision Plans for PPO 65 and Over Plans

**Expense Not Covered**

- 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. 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 sealants that are not covered.
  7. for oral hygiene instructions, and for:
     a. plaque control;
     b. completion of a clean form;
     c. acid; or
     d. broken appointments;
     e. prescription or take-home fluoride; or
     f. diagnostic photographs.
  8. 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.
  9. for procedures that are begun but not completed.
  10. for services and treatment provided without charge or for which there would otherwise be no change in the absence of insurance.
  11. for a continual coverage under any Worker’s Compensation Act of 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.
  15. for services or supplies payable under any medical expense plan.
  16. for orthodontia, unless included by rider.
  17. prior to the date the Insured is covered under the Policy.
  18. for the diagnosis or treatment of TMD.
  19. for hospital services.
  20. for any unmarried child age 19 years of age or older unless he is dependent, upon You for support, while a full-time student.
  21. for services and treatment provided without charge or for which there would otherwise be no change in the absence of insurance.
  22. for services and treatment other than those covered.

**VSIon ExPenses nOt COVered**

- The cost of lenses in excess of a standard lens will not be covered. A standard lens is any lens having a frame with an eye size less than 61 mm.
- 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 with a retail value of $47.00.
- 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:
  1. any procedure, service or supply applied as a covered medical expense under any group insurance plan, whether benefits are payable as to all or only part of such charges;
  2. special procedures, such as orthotics, vision training and subnormal vision aids;
  3. plans or prescription sunglasses or other special purpose vision aids;
  4. medical or surgical treatment of the eye, including hospital expenses;
  5. replacement of lost or broken lenses and/or frames;
  6. duplicate glasses or lenses or frames;
  7. services of material not listed as an Eligible Expense.

**IMPORTANT INFORMATION (continued)**

**MAXIMUM CALENDAR YEAR LIMIT**

The maximum limit payable for all Eligible Expenses in any calendar year is shown in the Coverage Schedule. The Maximum Calendar Year Limit, if any, will apply to each person covered under the Policy.

**PRETREATMENT REVIEW**

If the Course of Treatment will exceed the amounts 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 treatment planned 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 provide professionally satisfactory results. If You do not request a prior review we will pay for the least expensive medical treatment of the trade actually used.

**MISSING TOOTH**

When covered under your plan, benefits are provided for placement of dentures, fixed bridges/prosthesis, 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 18 consecutive months.

**COORDINATION OF BENEFITS**

If any person under the Policy (referred to as “this Plan”) is also covered under one or more other plans, the benefits under this Plan will be coordinated with benefits payable under all other plans. This does not apply to SD.

**ALTERNATE BENEFIT**

1. We determine that a less expensive alternate procedure, service or Course of Treatments 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 charge for the less expensive treatment.

**ELIGIBILITY**

Individuals, age 6 years or older, plus their eligible dependents (spouse and unmarried children from birth to age 19, 10 years to age 23 if child is a full-time student) is subject to State requirements.

**TERMINATION OF COVERAGE**

Coverage terminates on the earliest of the following dates:

(a) the last day of the month in which You cease to be eligible for coverage;

(b) the last day of the month in which Your Dependent is no longer a dependent as defined, (c) subject to the Grace Period, the last day of the month for which a premium has not been paid by You or on your behalf; or (d) the date the Master Policy ends.

**EFFECTIVE DATE**

You and Your Dependents are covered on the first of the month following the day in which the application is received and accepted in the Service Center Office, or the date You first acquire a Dependent, if the date is after coverage begins.

**REASONABLE AND CUSTOMARY**

Reasonable and customary means the usual, customary and regular charges for the area where such expenses are incurred.

**LANDMARK DENTAL PLANS**

13800 32nd Avenue North, Suite 116
Plymouth, Minnesota 55447
Phone: 888.383.2660 or 763.383.0896
www.landmark-dental.com

**Personal Plans, now with Vision Providing a Full Spectrum of Dental Benefits for all Ages.**

**GHN112 S10566**

**Designed and Marketed by:**

13800 32nd Avenue North, Suite 116
Plymouth, Minnesota 55447
Phone: 888.383.2660 or 763.383.0896
www.landmark-dental.com

**Copyright © 2010 All Rights Reserved. Landmark Dental Alliance, Inc.**

**12/20/2010**
DENTAL INSURANCE PLAN ENROLLMENT FORM

MAIL TO: Security Life Ins. Company of America PO Box 27810 Minneapolis, MN 55427-0810

Choose your plan: □ PPO □ Open Access Plan

Check type of plan: □ Single, □ Single + One, □ Family □ Vision Option (vision is only available as a rider to the dental plan)

Name (Last, First, Middle Initial) M/F Birth Date Marital Status

FOR COMPANY USE ONLY

Effective date	Plan Code

Expiration Date

3. All dependent children over age 18, are full-time students. Yes □ No □

If not, who is not?

If you are not sure of your marital status, please check □ Single, □ Married, □ Widowed, □ Divorced.

Address

City, State, Zip

Phone

LIST ALL YOUR ELIGIBLE DEPENDENTS BELOW

Name (Last If Different, First, Middle Initial) M/F Birth Date Address

Type

Spouse

Dependent

Dependent

Please note: If additional dependent information is necessary please attach a separate sheet of paper.

1. Does Spouse have a dental plan? Yes □ No □

With whom?

If answer is ‘Yes’, are dependents enrolled under spouses plan? Yes □ No □

If no, who is not?

If not, who is not?

Billing Mode: Monthly Premium $ □

ACH Bank Account

Routing Number

Master Card Credit Card Number

Expiration Date

As a convenience to me, I authorize Security Life Insurance Company of America to initiate entries to my bank account or credit card account for my monthly dental and/or vision premium. I understand this will occur by the third business day of each month and that such record will appear on my monthly statement. I agree that any such charge is nondischargeable, whether or without cause and whether intentionally or inadvertently, the bank or credit card company shall be under no liability whatsoever even though it might result in forfeiture of my insurance.

I understand that this agreement will remain in effect until Security Life Insurance Company of America has received written notice from me that it should be cancelled. I understand that I have the right to stop payment by notification to Security Life Insurance Company of America, my bank or my credit card company at least ten days prior to the next scheduled payment.

By my signature below, I hereby apply for coverage under Security Life Group Dental Insurance Policy Form GH-1112 issued to the trusted group policyholder. I hereby authorize that my premiums be charged against my bank or credit card account as indicated above.

This authorization remains in effect until revoked by me in writing.

Applicant’s Signature GHA-1112

Date

Agent Name

Agent ID number

IMPOMANT 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.

IMPORTANT INFORMATION

ELIGIBLE EXPENSES

We will pay for Eligible Expenses You incur for Yourself or on behalf of Your insured Dependent. Expenses must be incurred while the Policy is in force and the person is covered by the Policy. The description of Eligible Expenses is shown in the Coverage Schedule. To be an Eligible Expense, the dental service or procedure must be performed by a Dentist, a Physician or a Dental Hygienist.

EXPENSES INCURRED

An Eligible Expense is considered incurred on the following dates: For full and partial dentures - the date the final impression is taken; for fixed bridges, crowns, inlays and onlays - the date the teeth are first prepared; for root canal therapy - on the date the pulp chamber is opened; for periodontal surgery - on the date surgery is performed, for all other services - the date the service is performed.

DEDUCTIBLE AMOUNT

The calendar year Deductible, if any, is shown in the Coverage Schedule. The Deductible is an amount of charges You must incur for Yourself or on behalf of Your insured Dependent before We start paying benefits.

OPTIONAL VISION BENEFITS RIDER

Coverages for: • Exams • Frames • Lenses • Contact Lenses

Services Offered: Lifetime-Per Person Deductible of $50.00 on Lenses and Frames

Examinations $50.00 (once every calendar year with $10 copay)

A routine, complete eye examination, refraction, and prescription for eyeglasses. Contact lens examinations require additional fees. If indicated, your doctor may recommend additional procedures, which are the responsibility of the members: Frames (once every 24 months) $65.00 Lenses (once every 12 months) $40.00 Single $40.00 Bifocal $60.00 Trifocal $70.00 No line bifocal or progressive power OR Lenticular $100.00 Contact Lenses (in lieu of lenses and frames) $100.00

OPEN ACCESS PLAN

Preventive & Diagnostic Services

Coverage: Two exams per calendar year

Two Prophylaxis (cleaning) per calendar year, Space Maintainers

Preferred Provider: Non-Preferred Provider

1st year Pays 100% 1st year Pays 100%

2nd year Pays 50% 2nd year Pays 50%

3rd year Pays 50% 3rd year Pays 50%

$50 lifetime deductible

Basic Restorative Services

Coverage: Bitewing x-rays, two per calendar year

One fluoride treatment per calendar year for dependents to age 16

Simple extractions/ Fillings

Full mouth or panoramic x-rays once every 3 years

Preferred Provider: Non-Preferred Provider

1st year Pays 0% 1st year Pays 0%

2nd year Pays 25% 2nd year Pays 25%

3rd year** Pays 50% 3rd year** Pays 50%

$50 annual deductible*

Major Services

Coverage: Oral Surgery • Bridges • Crowns • Periodontics • Endodontic

Preferred Provider: Non-Preferred Provider

1st year Pays 20% 1st year Pays 10%

2nd year Pays 50% 2nd year Pays 25%

3rd year** Pays 50% 3rd year** Pays 25%

$50 annual deductible*

Orthodontic Services

Coverage: For children under age 19

Preferred Provider: Non-Preferred Provider

1st year Pays 100% 1st year Pays 100%

2nd year Pays 25% 2nd year Pays 25%

3rd year Pays 50% 3rd year Pays 50%

For preferred provider (PP) and non-preferred provider (NP) services, We will pay based on the contracted fee amount negotiated with the preferred provider organization, after any required deductible amount or waiting period as shown below.

$50 lifetime preventive deductible

$50 annual deductible basic & major services (3 per family)

$1000 annual maximum for Preventive, Basic & Major services combined per person.

$500 annual/$1000 lifetime maximum for ortho services for dependent children. **and every year thereafter

Landmark Lets You Choose

With Landmark, you have the choice of using providers from a nationwide network of preferred dentists, or using your own dental provider, who may already be part of our network. To find a network provider in your area go to www.landmark-dental.com or call 1-800-392-3112.