



# Dental Insurance Protection for You and Your Family

No Enrollment Fee

\$1500 Annual Benefit Option

100% Preventive Coverage Option

Choice of Multiple Plan Designs

Initial 12 month Rate Guarantee

Includes Coverage for Seniors

No Waiting Periods for Most Services

Freedom to Use Dentist of Your Choice



  
**Prime Star**<sup>®</sup>  
Personal Dental Plans

Underwritten by Security Life Insurance Company of America

# Plan Features

## 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 - the date the pulp chamber is opened; for periodontal surgery - 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 eligible charges You must incur for Yourself or on behalf of Your insured Dependent before We can begin paying benefits.

## MAXIMUM CALENDAR YEAR

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 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.

## COORDINATION OF BENEFITS

If any person under this Policy (referred to as "this Plan") is also covered under one or more other plans, the benefit under this Plan will be coordinated with benefits payable under all other plans.

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

## ELIGIBILITY

Individuals, 18 years of age or older, plus their eligible dependents (spouse and unmarried children from birth to age 19; extended to age 23 if child is a full-time student). This 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 been paid by you or on your behalf; (d) or the date the Master Policy ends.

## EFFECTIVE DATE

You and Your Dependents are covered on the later of: the date We accept Your enrollment and determine an effective date; or the date You first acquire a Dependent, if the date is after our coverage begins.

## REASONABLE AND CUSTOMARY

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



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-1112-38060 issued to the Voluntary Group Trust. Benefits may vary in different states. PrimeStar 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.

## Three Ways to Enroll

### Online:

For your convenience, you may enroll for coverage using our on-line enrollment system. Visit our website [www.starsdental.com/quote](http://www.starsdental.com/quote) and follow step by step instructions. To complete the enrollment your agent must provide you with their on-line 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 attached enrollment form and fax it to our administrative team. (See full instructions on the enrollment form).

### Mail:

Complete the attached enrollment form and mail to our office.

Underwritten by:  
Security Life Insurance Company of America  
10901 Red Circle Drive  
Minnetonka MN 55343  
866-847-1120

Visit our website dedicated to the service of this product.  
[www.starsdental.com](http://www.starsdental.com)



# PrimeStar<sup>®</sup> Personal Dental Plans

Dental Benefits	Premier Plan	Select Plan	Secure Plan
<b>Class A - Preventive</b> Initial & Periodic Exams (2 per year), Cleanings (2 per year), Fluoride Treatments Benefit Year One Benefit Year Two Benefit Year Three and Each Benefit Year Thereafter <b>Deductible - Lifetime per Insured</b> <b>Waiting Period</b>	100% 100% 100% \$50 None	75% 85% 100% \$50 None	80% 80% 80% \$75 None
<b>Class B - Basic</b> X-rays, Fillings, Simple Extractions, Sealants (to age 16) Benefit Year One Benefit Year Two Benefit Year Three and Each Benefit Year Thereafter <b>Deductible - Each Calendar Year Per Insured*</b> <b>Waiting Period</b>	35% 50% 65% \$50/year None	25% 35% 50% \$50/year None	25% 35% 50% \$75/year None
<b>Class C - Major</b> Oral Surgery, Endodontics, Periodontics, Crowns, Bridges, Dentures Benefit Year One Benefit Year Two Benefit Year Three and Each Benefit Year Thereafter <b>Deductible - Each Calendar Year Per Insured*</b> <b>Waiting Period</b>	10% 25% 50% \$50/year None	10% 25% 50% \$50/year None	10% 25% 50% \$75/year None
<b>Class D - Orthodontics</b> Straightening of Teeth (for children under age 19) Benefit Year One Benefit Year Two Benefit Year Three and Each Benefit Year Thereafter <b>Deductible</b> <b>Waiting Period</b>	0% 0% 50% None 24 Months	Not Available Not Available Not Available	Not Available Not Available Not Available
<b>Calendar Year Maximum for Classes A, B and C Combined</b> <b>Calendar Year Maximum for Class C - Major Services</b> <b>Calendar Year Maximum for Class D</b> <b>Lifetime Maximum Per Child for Class D</b>	\$1,000 \$500 \$500 \$1,000	\$1,000 \$500 - -	\$750 \$350 - -
* Class B & C Deductible is combined for each calendar year. A maximum of three (3) individual deductibles per family shall apply.			
<b>*OPTIONAL CALENDAR YEAR MAXIMUM INCREASE</b> <b>Calendar Year Maximum for Class C Major Services</b>	*\$1,500 *\$750	*\$1,500 *\$750	N/A N/A
<b>Optional Vision Benefits Rider (Not a Stand Alone Benefit)</b>	<b>Premier Plan</b>	<b>Select Plan</b>	<b>Secure Plan</b>
<b>Class A - Vision Exams - 1 per year</b> Benefit Year One and Each Benefit Year Thereafter <b>No Waiting Period</b>	85%	85%	85%
<b>Class B - Lenses and Frames - 1 pair every 2 years</b> Benefit Year One and Each Benefit Year Thereafter <b>15 Month Waiting Period</b>	50%	50%	50%
<b>Class C - Contact Lenses - 1 pair every 2 years ( in lieu of frames and lenses)</b> Benefit Year One and Each Benefit Year Thereafter <b>15 Month Waiting Period</b>	50%	50%	50%
<b>Calendar Year Deductible</b> <b>Calendar Year Maximum for Classes A, B and C</b>	\$50/year \$150	\$50/year \$150	\$50/year \$150

\*As an optional feature of Premier and Select Plans, you may increase your Calendar Year Maximum benefit, per individual to \$1,500 for an additional monthly fee. If you elect this feature, your Calendar Year Maximum for Major Services (as a portion of the \$1,500) will also be increased to \$750 per individual. This feature is not available for the Secure Plan. You must indicate your election of this feature on the enrollment form.

The above 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 above percentages for covered dental expenses based upon the Reasonable and Customary (R&C) fees for those covered expenses.

**QUESTIONS? PLEASE CONTACT YOUR AGENT**



## 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.

**Arkansas/Louisiana** - 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 policyholder 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** - 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.

**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.

## DENTAL EXPENSES NOT COVERED

- for overdentures and associated procedures;
- for charges in excess of those considered Reasonable and Customary;
- for cosmetic procedures;
- for the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function;
- for implants and for replacement of lost or stolen appliances, replacement of retainers, athletic mouthguards, precision or semi-precision attachments, denture duplication;
- for oral hygiene instructions; and for: plaque control, completion of a claim form, acid etch, broken appointments, prescription or take-home fluoride, or diagnostic photographs;
- 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;
- for procedures that are begun, but not completed;
- for services and treatment provided without charge, or for which there would be no charge in the absence of insurance;
- 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;
- for a condition covered under any Worker's Compensation Act or similar law;
- that are generally considered by the dental profession as experimental or investigational;
- for the treatment of cleft palate and anodontia;
- for services or supplies payable under any medical expense plan;
- for orthodontia, unless included within Coverage Schedule;
- prior to the date the Insured is covered under the Policy;
- for the diagnosis or treatment of Temporomandibular Joint (TMJ) Dysfunction;
- for hospital services;
- 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;
- 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;
- charges for infection control, sterilization, and waste disposal.

## VISION EXPENSES NOT COVERED

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:

1. 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;
2. special procedures, such as orthoptics, vision training and subnormal vision aids;
3. plano or prescription sunglasses or other special purpose vision aids;
4. medical or surgical treatment of the eyes including hospital expenses.
5. replacement of lost or broken lenses and/or frames;
6. duplicate glasses or lenses or frames; and
7. services or material not listed as an Eligible Expense.



**Security Life Insurance Company of America, Minnetonka, MN  
PRIMESTAR PERSONAL APPLICATION - 3 ENROLLMENT OPTIONS**

**ONLINE** - Visit [www.StarsDental.com/quote](http://www.StarsDental.com/quote)  
and follow the step by step Instructions  
Agent Authorization Number (Required for  
Online purchases) (AAN) \_\_\_\_\_

**FAX** - the application to 952-945-3409  
(You must choose Credit Card or  
ACH payment options)

**MAIL** - the application along with initial payment to:  
PrimeStar Personal Dental  
10901 Red Circle Drive, Suite 400  
Minnetonka, MN 55343

**Plan Selection:**  Premier  Select  Secure  Vision Option  Senior (65 or older)  Optional \$1,500 Calendar Yr Maximum Increase (Premier or Select Plans only)

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

**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	Marital Status Married <input type="checkbox"/> Single <input type="checkbox"/>			
Billing Address (If Different)		City	Zip				

**LIST ALL YOUR ELIGIBLE DEPENDENTS BELOW**

Last Name (If Different)	First Name	Initial	Sex M/F	Age	Birth Date M/D/Y
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? \_\_\_\_\_

**CALCULATE YOUR RATES:**

1. Locate the first three digits of your zip code on the **Zip Code Area Chart** found on the reverse side of this application. Using the corresponding area number, determine the applicable monthly premium, found on the **Rate Chart** on the reverse side of this application, based upon your eligibility age, plan selection and coverage type.

2. Select your mode of payment

**Monthly - Bank Account Debit (ACH)** (Checking or Savings) Complete Authorization Agreement below and submit two (2) months premium

**Checking Acct.** - Attach voided check - DO NOT SUBMIT DEPOSIT SLIP.

**Savings Acct.** - Attach savings deposit slip with account number including the bank routing number.

**Monthly Credit Card**

Complete Authorization Agreement below.

Visa  Master Card

Card # \_\_\_\_\_

Expiration Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Quarterly Direct Bill** - submit three (3) months premium

**Semi-Annual Bill** - submit six (6) months premium

Monthly Rate (found on the Premium Rate Table)	Vision Add-on (found on the Premium Rate Table)	Optional \$1,500 Calendar Yr Max Add-on Additional Premium \$6.00	Sub Total:	Multiply by 2,3 or 6 depending upon mode of payment selected above	One time enrollment Fee	Total Remittance
\$	\$	\$	\$	X	None	\$

**For Initial payment, make check payable to Security Life Insurance Company of America**

**AUTHORIZATION AGREEMENT: (When paying by ACH or Credit Card please complete the section below)**

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 if any such charge be dishonored, whether with 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 business days prior to the next scheduled payment.

NAME \_\_\_\_\_ DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_

**FOR AGENT USE ONLY - Please Print Clearly**

Producer Name		Producer Phone #			<b>FOR COMPANY USE ONLY</b>	
Street Address		City	St	Zip		
Producer Email		Producer SS#/TIN#			Effective Date: ____/____/____	
Appointed with Security Life? <input type="checkbox"/> Yes <input type="checkbox"/> No		Producer Signature			Plan Code: _____ SLIC	

**IMPORTANT INFORMATION** - The effective date is the first of the month following the day in which the application is received in the Service Center Office. 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-1112-38060-02 issued to the Voluntary Group Trust. I also certify I have read the applicable Fraud Notice contained within the brochure.**

**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 \_\_\_\_\_

