

PrimeStar[®] Classic Personal Dental Insurance Plans

Underwritten by Security Life Insurance Company of America
10901 Red Circle Drive, Minnetonka, Minnesota 55343

- ★ No Billing Fees
- ★ Optional Vision Coverage
- ★ 100% Preventive Coverage
- ★ Freedom to Choose Any Dentist
- ★ Up to \$2,000 Annual Maximum

Dental Benefits

Class A - Preventive Services <i>Initial & Periodic Exams (2/yr.), Cleanings (2/yr.) Fluoride Treatments to age 16, Sealants (for all ages)</i>	Gold	Silver
Benefit Level.....	100%	80%
Deductible per Insured.....	None	None
Waiting Period.....	None	None

Class B - Basic Services <i>Fillings, Oral Surgery, X-Rays, Simple Extractions</i>	Gold	Silver
Benefit Level.....	80%	80%
Deductible per Insured.....	\$50/Year*	\$50/Year*
Waiting Period.....	6 Months	9 Months

Class C - Major Services <i>Endodontics, Periodontics, Crowns, Bridges, Dentures</i>	Gold	Silver
Benefit Level.....	50%	50%
Deductible per Insured.....	\$50/Year*	\$50/Year*
Waiting Period.....	15 Months	18 Months

Calendar Year Maximum Options per Insured for Classes A, B and C Combined	Gold	Silver
.....	\$1000	\$1000
.....	\$1500	\$1500
.....	\$2000	\$2000

***Deductible** - Class B & C Deductible is combined for each calendar year. A Maximum of 3 Individual deductibles per family shall apply. This plan reimburses at the percentages shown for covered dental expenses based upon 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

Choose the Plan Options that Work Best for You!

Select either the Gold or Silver Dental Plan. You may also select an optional vision benefit - Plan 1 or Plan 2 regardless of the Dental Plan you choose.

Three Ways to Enroll

Online

Enrollment is available online by visiting our website at www.starsdental.com/classic. 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).

Optional Vision Benefits Rider

Class A - Vision Exams - 1 per year	Plan 1	Plan 2
Benefit Year One and Each Benefit Year Thereafter.....	100%	85%
Class B - Lenses and Frames - 1 pair every 2 years		
Benefit Year One and Each Benefit Year Thereafter.....	50%	50%
Class C - Contact Lenses - 1 pair every 2 years (in lieu of frames and lenses)		
Benefit Year One and Each Benefit Year Thereafter.....	50%	50%
Calendar Year Deductible.....	\$50/yr	\$50/yr
Calendar Year Maximum for Classes A, B and C.....	\$200	\$150
Waiting Periods - Class A.....	None	None
Class B & C.....	15 Months	15 Months
Vision rider is not a standalone benefit.		
Optional Vision Benefits are not available in Maryland.		

For more information contact:

Northwest Marketing Resources, Inc.
PO Box 447, Olympia WA 98507
800.565.0313 - Fax 360.754.1931
www.northwestmarketingresources.com

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 aids;
- 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.

**PrimeStar Classic Enrollment Form
for
Washington**

Dental Plan Selection: Gold Silver

Optional Vision Plan Selection: Plan 1 Plan 2

Calendar Year Maximum Selection: \$1,000 \$1,500 (added cost \$8.00) \$2,000 (added cost \$11.00)

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	State	Zip	

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 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.

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.

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.

Applicant Signature _____ Date _____

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

PRIMESTAR CLASSIC PREMIUM RATE CALCULATION AND AUTHORIZATION AGREEMENT

The following sections must be completed and signed by the applicant and agent

CALCULATE YOUR RATES:

1. Locate the first three digits of your zip code on the **Zip Code Area Chart** found on the **Premium Rate Table**. Using the corresponding area number, determine the applicable monthly premium, 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

Authorization To Convert Your Check To An Electronic Funds Transfer Debit – By sending your check to us, you authorize **Security Life Insurance Company of America** to convert the check into an electronic funds transfer. Please be aware that your bank account may be debited as soon as the same day we receive your payment.

Monthly Rate (found on the Premium Rate Table)	Calendar Year Maximum Selection <input type="checkbox"/> \$1,000 No Added Cost <input type="checkbox"/> \$1,500 Added Cost \$8.00 <input type="checkbox"/> \$2,000 Added Cost \$11.00	Vision Add-on (found on the Premium Rate Table)	Sub Total:	Multiply by 2,3 or 6 depending upon mode of payment selected above	Total Remittance
\$	\$	\$	\$	X	\$

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.

Account Holder's Name _____

Date _____

Account Holder's Signature _____

FOR AGENT USE ONLY – Please Print Clearly

Producer Name Jan Smith		Producer Phone # 360-943-4500			
Street Address 522 Franklin St SE		City Olympia	St WA	Zip 98501	
Producer Email info@ghbinsurance.com			Producer SS#/TIN# 91-0639776		
Appointed with Security Life? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Producer Signature _____			

For your convenience there are three ways to enroll in the PrimeStar Classic Dental Plan.

Please choose one of the following:

ONLINE - Visit www.StarsDental.com/classic and follow the step by step Instructions Agent Authorization Number (Required for Online purchases) (AAN) _____

FAX - the application to 360-754-1931 (You must choose Credit Card or ACH payment options)

MAIL - the application along with initial payment to: Northwest Marketing Resources P.O. Box 447 Olympia, WA 98507

FOR COMPANY USE ONLY

Effective Date: ____/____/____ Plan Code: _____

PRIMESTAR CLASSIC DENTAL

**PREMIUM RATE TABLE FOR
WASHINGTON**

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

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

RATE CHART			Area 3	Area 4	Area 5	Area 6
UNDER AGE 65	GOLD PLAN	Applicant Only	\$ 32.00	\$ 35.00	\$ 38.00	\$ 43.00
		Applicant+Spouse	\$ 64.00	\$ 73.00	\$ 79.00	\$ 88.00
		Applicant+ Child(ren)	\$ 71.00	\$ 77.00	\$ 87.00	\$ 94.00
		Applicant + Family	\$ 111.00	\$ 121.00	\$ 134.00	\$ 147.00
	SILVER PLAN	Applicant Only	\$ 29.00	\$ 32.00	\$ 35.00	\$ 39.00
		Applicant+Spouse	\$ 59.00	\$ 67.00	\$ 71.00	\$ 81.00
		Applicant+ Child(ren)	\$ 65.00	\$ 71.00	\$ 79.00	\$ 86.00
		Applicant + Family	\$ 101.00	\$ 110.00	\$ 122.00	\$ 135.00
65 AND OVER	GOLD PLAN	Applicant Only	\$ 35.00	\$ 38.00	\$ 43.00	\$ 49.00
		Applicant+Spouse	\$ 73.00	\$ 79.00	\$ 88.00	\$ 96.00
	SILVER PLAN	Applicant Only	\$ 32.00	\$ 35.00	\$ 39.00	\$ 45.00
		Applicant+Spouse	\$ 67.00	\$ 71.00	\$ 81.00	\$ 88.00

Optional Vision Rates for All Ages						
Plan 1	Applicant Only	\$ 6.00		Plan 2	Applicant Only	\$ 5.00
	Applicant+Spouse	\$ 12.00			Applicant+Spouse	\$ 9.00
	Applicant+ Child(ren)	\$ 12.00			Applicant+ Child(ren)	\$ 9.00
	Applicant + Family	\$ 16.00			Applicant + Family	\$ 12.00

ZIP CODE AREA CHART	
Washington	
Zip	Area
982-984	4
990-992	3
993	6
All Others	5