LANDMARK DENTAL PLANS

Open Access Plans - Under Age 65 Plans

Regions	Α	В	С	D	E	F	G	Н
Single	31.58	34.63	38.05	41.86	46.04	50.61	55.55	61.26
Single+1 Family	63.01	69.09	75.92	83.51	91.86	100.97	110.84	122.23
Family	96.29	105.57	116.01	127.61	140.37	154.29	169.37	186.78

Open Access Plans - 65 and Over Plans

Regions	s A	В	С	D	E	F	G	Н
Single	34.74	38.09	41.86	46.05	50.65	55.67	61.12	67.39
Single Single+1 Family	69.31	75.99	83.51	91.86	101.05	111.07	121.92	134.45
Family	105.92	116.13	127.62	140.38	154.42	169.73	186.33	205.47

PPO Under Age 65 Plans

Regions	Α	В	С	D	E	F	G	Н
Single Single+1	28.59	31.34	34.44	37.88	41.67	45.81	50.28	55.45
Single+1	57.40	62.94	69.16	76.08	83.68	91.98	100.97	111.35
Family	87.75	96.21	105.72	116.29	127.92	140.61	154.35	170.21

PPO 65 and Over Plans

Regions	A	В	С	D	E	F	G	H
Single	31.45	34.48	37.89	41.68	45.85	50.39	55.32	61.00
Single+1 Family	63.14	69.22	76.07	83.68	92.04	101.17	111.06	122.47
Family	96.52	105.82	116.29	127.92	140.71	154.67	169.78	187.23

Optional Vision Plans

All Regions	Under Age 65	65 and Over	
Single	7.80	9.36	
Single Single+1	14.90	17.88	
Family	19.97	23.96	

Region Codes

State	Zip Codes	Region
Illinois	600-605	В
Illinois	606-608	C
Illinois	Remaining Zip Codes	A
Iowa	All Zip Codes	A
Kansas	660-662	В
Kansas	Remaining Zip Codes	A
Minnesota	All Zip Codes	В
Missouri	640-641, 644-649	В
Missouri	Remaining Zip Codes	A
Nebraska	All Zip Codes	A
North Dakota	580-581	В
North Dakota	Remaining Zip Codes	A
Wisconsin	530-532	C
Wisconsin	Remaining Zip Codes	A

Landmark Dental Alliance, Inc.

15800 32nd Avenue North, Suite 116 Plymouth, MN 55447 Phone: 888.383.2660 or 763.383.0896 www.landmark-dental.com

Premiums subject to change with 30 day notice.

EXPENSES 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.
- f. Sealants are not covered.
- 6. for oral hygiene instructions; and for:
- a. plaqué control;
- b. completion of a claim form;
- c. acid etch;
- d. broken appointments;
- e. prescription or take-home fluoride; or
- f. diagnostic photographs.
- 7. 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.
- 8. 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.
- 10. 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.
- 11. for a condition covered under any Worker's Compensation Act or 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.
- 14. for the treatment of cleft palate and anodontia.
- 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.
- for the diagnosis or treatment of TMID.
- 19. for hospital services.
- 20. 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.
- during any waiting period We require, when You voluntarily end Your insurance and re-enroll at a later date. Your waiting period is 2 years and begins on the date Your coverage first ended.
- 22. charges for infection control, sterilization and waste disposal.

VISION EXPENSES NOT COVERED

The cost of lens in excess of a standard lens will not be covered. A standard lens is any lens fitting 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 \$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;
- 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 Éligible 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 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.

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.

COORDINATION OF BENEFITS If any person under the 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. This does not apply to SD.

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 charge for the less expensive treatment.

ELIGIBILTY 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 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 Your coverage begins.

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



Underwritten by:

Security Life Ínsurance Company of America, Minnetonka, MN Administered by:

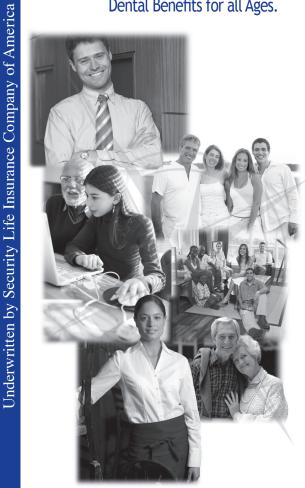
Meritain Health, Inc. Customer Service 1.800.765.4224 or 952.546.0062

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Minnetonka

LANDMARK. DENTAL ALLIANCE

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



GH 1112 S10566

DENTAL INSURANCE PLAN ENROLLMENT MAIL TO: Security Life Ins. Company of Am					FOR CON Effective		USE	ONLY
Choose your plan: ☐ PPO ☐ Open Access	Plan				Plan Code	;		
Check type of plan: ☐ Single, ☐ Single + C		amily	/ 🗖 Visio	on Option (vision is only avail	able as a rider	to the de	ental p	lan)
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Name (Last, First, Middle Initial)		 И/F		date Marital Status				
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LIST ALL YOUR ELIGIBLE DEPENDENTS	BELOW	V.				_		
Name (Last If Different, First, Middle Initial)	M/F		h Date		Middle Initial)	M/F	Birth	n Date
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Spouse						٥٥	,	,
Dependent	- 44 -	/	_ /			_ Ш Ш _	/	_/
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Dependent				Dependent				
If no, who is not?								
ACH Bank Account				Routing	Number			
VISA CARD Credit Card Number	+			Expiration Expiration	on Date			
As a convenience to me, I authorize Security I for my monthly dental and/or vision premiur appear on my monthly statement. I agree that inadvertently, the bank or credit card compan	Life Insui n. I unde t if any su iy shall b	rance (rstand uch ch e unde	Company I this will arge be d er no liab	of America to initiate entries to occur by the third business day ishonored, whether with or with tilty whatsoever even though it is the control of the cont	my bank account of each month nout cause and might result in f	ant or cre and that whether forfeiture	dit can such r intenti- of my	d account ecord will onally or insurance
I understand that this agreement will remain that it should be cancelled. I understand that my bank or my credit card company at least t	I have th	e righ	t to stop 1	payment by notification to Secur				
By my signature below, I hereby apply for covering policyholder. I hereby authorize that me This authorization remains in effect until revo	ıy premit	ams be	e charged	fe Group Dental Insurance Polic against my bank or credit card	y Form GH-111 account as indi	12 issued cated abo	to the	trusteed
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Applicant's Signature GHA-1112	Date		Agent Nar	ne	Agent ID nu	ımber		36390

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.

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 sevice 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.

PPO PLAN

Preventive & Diagnostic Services

Coverage: Two exams per calendar year

Two Prophylaxis (cleaning) per calendar year, Space Maintainers

Preferred Provider

1st year Pays 100%
2nd year Pays 100%
3rd year** Pays 100%

\$50 lifetime deductible

Non-Preferred Provider

1st year Pays 100%
2nd year Pays 100%
3rd year** Pays 100%
\$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
1st year Pays 60%
2nd year Pays 90%
3rd year* Pays 90%
\$50 annual deductible*

Non-Preferred Provider
1st year Pays 50%
2nd year Pays 80%
3rd year** Pays 80%

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 60% 2nd year Pays 50% 3rd vear** Pavs 60% 3rd year** Pays 50% \$50 annual deductible*

Orthodontic Services

Coverage: For children under age 19

Preferred Provider
1st year Pays 10%
2nd year Pays 25%
3rd year** Pays 50%

Non-Preferred Provider
1st year Pays 10%
2nd year Pays 25%
3rd year Pays 50%

For preferred provider (PP) and non-preferred provider (NPP) 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

OPEN ACCESS PLAN

Preventive & Diagnostic Services

Coverage: Two exams per calendar year

Two Prophylaxis (cleaning) per calendar year, Space Maintainers

1st year Pays 100% 2nd year Pays 100% 3rd year** Pays 100% \$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

1st year Pays 40% 2nd year Pays 80% 3rd year** Pays 80% \$50 annual deductible*

Major Services

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

1st year Pays 25% 2nd year Pays 50% 3rd year** Pays 50% \$50 annual deductible*

Orthodontic Services

Coverage: For children under age 19

1st year Pays 10% 2nd year Pays 25% 3rd year** Pays 50%

We will pay the usual and customary charge for dental procedures and services after any required deductible amount, 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

OPTIONAL VISION BENEFITS RIDER

Coverage for: • Exams • Frames • Lenses • Contact Lenses Services Offered: Lifetime-Per Person Deductible of \$50.00 on Lenses and Frames

Examination \$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 member.
Frames (once every 24 months) \$65.00
Lenses (once every 12 months)
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

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.