

# What is The Competitor Smile Dental?

Competitor Smile Dental offers you access to high quality, affordable dental coverage for your entire family. Coverage is provided for preventive, basic and major dental services.

## How are benefits covered?

Competitor Smile Dental pays benefits for each covered person in the following manner:

**First, you meet the \$50.00 Calendar Year Deductible per person.** (Maximum of three individual deductibles per family.)

**Then Competitor Smile Dental pays a percentage** of covered expenses based on the Reasonable and Customary (R&C) fees for those Covered Expenses. You can select your own dentist.

SERVICES	BRONZE	SILVER	GOLD
<b>Preventive:</b> Exams, Cleaning, Fluoride Treatments			
Year One	100%	100%	100%
Year Two	100%	100%	100%
Third Year and After	100%	100%	100%
Waiting Period	None	None	None
<b>Basic:</b> X-rays, Fillings, Extractions and Oral Surgery			
Year One	20%	20%	20%
Year Two	40%	40%	40%
Third Year and After	60%	60%	60%
Waiting Period	None	None	None
<b>Major:</b> Crowns, Bridges, Dentures and Root Canals			
Year One	No Coverage	10%	10%
Year Two		25%	25%
Third Year and After		50%	50%
Waiting Period		None	None
Calendar Year Maximum (Per Person)	<b>\$750</b>	<b>\$1,000</b>	<b>\$1,500</b>

## What is an Eligible Expense?

Expenses must be incurred while the Policy is in force and the person is covered by the Policy. To be an Eligible Expense, the dental services must be performed by: • A licensed Dentist acting within the scope of his license; • A licensed Physician performing dental services within the scope of his license; or • A licensed dental hygienist acting under the supervision and direction of a Dentist.

## When is an Eligible Expense considered incurred?

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

## Who is the Administrator?

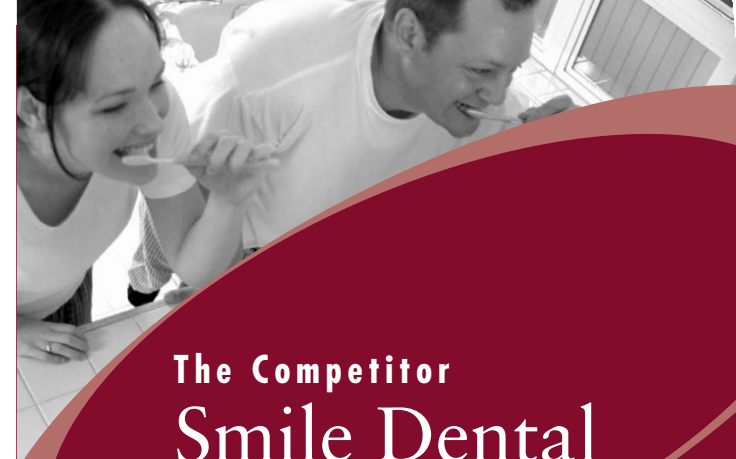
Health Plan Administrators, Inc. (HPA) is a fully licensed, full service Third Party Administrator servicing business worldwide. HPA provides state of the art industry leading insurance services.

1-800-277-3323

[www.hpainsurance.com](http://www.hpainsurance.com)

This brochure provides a brief description of the benefits, exclusions and other provisions of the policy or certificate Form Master Policy #GH-1112-38090 issued to the Voluntary Group Trust. For a complete listing, see the policy or certificate. Benefits may vary in different states. This dental insurance plan may not be available in all states.

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# The Competitor Smile Dental Insurance Plan

## THE IDEAL SOLUTION FOR

- Individuals and families
- Business owners and employees

## NEW & IMPROVED FEATURES

- Choice of \$750, \$1,000 or \$1,500 calendar year maximum per insured person
- Eligible for ages 18 years through 64 and older
- Freedom to choose any dentist
- No waiting periods
- 12 month rate guarantee
- Benefits for preventive, basic and major services



**Health Plan Administrators**  
Independence Holding Group

Underwritten by: Security Life Insurance Company of America  
Minnetonka, Minnesota

Administered by: Health Plan Administrators, Inc.

Marketed by:

## What services are covered?

### Preventive Services

**Routine oral examinations** of mouth and teeth:

2 per calendar year

**Prophylaxis** (cleaning, scaling and polishing teeth),

2 per calendar year

**Topical fluoride**, 1 per calendar year to age 16

**Space maintainers** (non-orthodontic)

### Basic Services

**Diagnostic X-rays** (full or panoramic), 1 in any

3 year period

**Bitewing X-rays:** 2 per calendar year

**Simple extraction** of one or more teeth

**Pin retention** of fillings

**Fillings** (restorations) using amalgam, silicate, acrylic, synthetic porcelain and composite filling materials

**Antibiotic injections** administered by a Dentist

**Oral surgery** and postoperative care for removal of one or more teeth, extraction of tooth root, alveolectomy, alveoplasty, frenectomy, excision for biopsy, reimplantation or transplantation of a natural tooth, excision of a tumor or cyst and incision and drainage of an abscess or cyst

**General anesthesia** and analgesic, including intravenous sedation for oral surgery

### Major Services

**Endodontic treatment** of diseases of the tooth, pulp, root and related tissue

**Periodontic services**

**Study models**, 1 in a 3 year period

**Crown build-up** for non-vital teeth

**Recementing and restoration of inlays**, onlays and crowns

**Recementing bridges**

**Repairs to full or partial dentures** or bridges, one every 2 years

**Prosthetic services** (dentures or bridgework)

## What is a Reasonable and Customary Fee?

This plan reimburses you for covered dental expenses based upon “Reasonable and Customary” fees. Reasonable and Customary fees are charges that do not exceed the general level of charges being made by other providers of dental services in the geographic area where the charge is incurred.

## Who is eligible for this coverage?

This plan is offered to individuals and their spouse ages 18 through 64 and their eligible dependents (unmarried children from birth to age 19 or 23 if a full-time student — this is subject to state requirements.) Coverage may also be obtained by individuals and their spouse ages 65 and older.

## When does my coverage start?

Coverage starts on the effective date. The effective date issued will begin on the 1st of the month (at 12:00 a.m.), following HPA, Inc.’s receipt of the completed Enrollment Form and payment of the first month of premium.

## What are my payment options?

You can pay in monthly installments by check, credit card, or auto bank withdrawal. We accept MasterCard, Visa or Discover credit cards. A list bill option is available. Please call HPA at 1-800-277-3323 for information and a list bill application form.

## What services are not covered?

These services are not covered by Competitor Smile Dental:

- Overdentures and associated procedures
- Replacement of full and partial dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function
- Replacement of lost or stolen appliances, orthodontic retainers, athletic mouth guards, precision or semi-precision attachments, denture duplication, or for sealants
- Hygiene instructions, plaque control, acid etch, broken appointments, prescription or take-home fluoride or diagnostic photographs
- Services not completed by the end of the month in which coverage terminates
- Orthodontic services

*This is not a complete listing of exclusions. For a complete listing see the policy or certificate.*

## What is an Alternate Benefit?

An alternate benefit will apply: (1) If we determine that a less expensive alternative 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.



## Vision Plus Discounts

This add-on discount benefit from HPA lets you save up to 75% on vision services, up to 50% on hearing services and vitamins and nutritional supplements. Also save on teeth whitening.

*\*The Vision Plus Discount is not affiliated with Security Life Insurance Company of America, nor is it a part of the dental insurance plan and it's optional.*

# Dental Enrollment Form for Security Life Insurance Company of America

## A. TELL US ABOUT YOURSELF

Applicant Full Name \_\_\_\_\_  
 Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_  
 Telephone (\_\_\_\_) \_\_\_\_-\_\_\_\_  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## B. WILL DEPENDENTS ALSO BE COVERED?

**Persons to be covered:**  Myself Only  Myself and Spouse  
 Myself and Children  Myself and Family

Spouse's Name \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_  
 Child's Name \_\_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_  
 Date of Birth \_\_\_\_\_  
 Child's Name \_\_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_  
 Date of Birth \_\_\_\_\_  
 Child's Name \_\_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_  
 Date of Birth \_\_\_\_\_

Does your spouse have a dental plan? .....  Yes  No

With whom? \_\_\_\_\_

Are your dependents enrolled under your spouse's plan? .....  Yes  No

Do you claim a tax exemption for all eligible dependents listed? .....  Yes  No

Are all dependent children listed over age 18 full-time students? .....  Yes  No

## C. CHOOSE YOUR DESIRED COVERAGE

**Effective date:**  1st Month: \_\_\_\_\_  
**Select a plan:**  Gold \$1,500  Silver \$1,000  Bronze \$750

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## D. SELECT YOUR PAYMENT OPTIONS

**Total rate** (from calculate your rates section) \$ \_\_\_\_\_

### Select your payment method:

Check or money order. Enclose initial payment to Security Life Insurance Company of America, with application. (Minimum of 2 months paid with enrollment)

Credit Card:  VISA  Mastercard  Discover  
 Account # \_\_\_\_\_ Expiration \_\_\_\_\_

Automatic bank withdrawal. Enclose initial payment and a voided check with application.  
 I request that (bank name) \_\_\_\_\_  
 (address) \_\_\_\_\_  
 pay and charge my account debits drawn from my account by Health Plan Administrators, Inc., to its order.

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 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 \_\_\_\_\_

## E. SIGN YOUR APPLICATION

By my signature below, I hereby apply for dental coverage under Master Policy Series #GH-1112-38090 issued to the Voluntary Group Trust.

I also certify that I have read the applicable Fraud Notice on the reverse side of this enrollment form. California Law prohibits an HIV Test from being required or used by Health insurance companies as a condition of obtaining health insurance coverage.

Applicant's signature \_\_\_\_\_ Date \_\_\_\_\_

## AGENT USE ONLY

Are you currently appointed with Security Life Insurance Company of America?  Yes  No

Agent Name Mooney Insurance Agency

HPA # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

GA Name Black, Gould & Associates

MGA Name #591800000

# Calculate Your Rates

1. Based on the plan desired and people to be insured. Enter your monthly rate. \$ \_\_\_\_\_

2. Locate your state and zip code prefix. Enter the factor. \_\_\_\_\_

3. Multiply the rate by the factor. x \$ \_\_\_\_\_

4. Add the Vision Plus Discount Fee + 5.00  
 (Optional)

5. Add the monthly administration fee + \$ 5.00

**Subtotal** \$ \_\_\_\_\_

6. Multiply by number of months  
 [ \_\_\_\_ (months) x \$ \_\_\_\_ (subtotal) = ] + \$ \_\_\_\_\_

7. Add the ONE-TIME enrollment fee + \$ 20.00

**Total Due** \$ \_\_\_\_\_

## COMPETITOR SMILE DENTAL RATE CHART EFF. OCT. 1, 2008 RATES VALID THROUGH AUG. 1, 2009

	BRONZE	SILVER	GOLD
<b>Adult Rates to Age 65</b>	<u>\$750</u>	<u>\$1,000</u>	<u>\$1500</u>
Single	16.14	26.74	29.41
Single & Spouse	30.65	50.81	55.89
Single & Children	33.49	55.49	61.04
Family	47.59	78.88	86.77
<b>Senior Rates 65 &amp; Older</b>			
Single	20.98	34.77	38.24
Single & Spouse	39.85	66.06	72.65

### Make checks payable to:

Security Life Insurance Company of America

### Mail application to:

HPA, Inc., P.O. Box 15250, Rockford, IL 61132-5250

Save time and postage when paying by credit card,  
 fax your completed application to: 1-815-633-0277

**COMPETITOR SMILE DENTAL  
ZIP CODE & AREA RATE FACTOR CHART**

<b>Alabama</b>	<b>Kansas</b>	<b>Oklahoma</b>
350-355, 359..... 1.00	660-662..... 0.91	740-743..... 0.91
All Areas..... 0.83	All Other..... 0.83	All Other..... 0.83
<b>Alaska</b>	<b>Kentucky</b>	<b>Oregon</b>
995-996..... 1.61	All Areas..... 0.83	977..... 1.00
All Areas..... 1.33	<b>Louisiana</b>	978..... 0.83
<b>Arizona</b>	707-711..... 0.91	All Areas..... 0.91
856-857, 864..... 0.91	712..... 1.00	<b>Pennsylvania</b>
All Other..... 0.83	All Other..... 0.83	170-178, 182-187..... 0.91
<b>Arkansas</b>	<b>Maryland *</b>	190-192..... 1.00
All Areas..... 0.83	<b>Michigan</b>	All Other..... 0.83
<b>California</b>	480-483, 490-491..... 0.91	<b>South Carolina</b>
900-905..... 1.46	488-489..... 1.00	All Areas..... 0.83
906-914..... 1.33	All Other..... 0.83	<b>South Dakota *</b>
915-916..... 1.61	<b>Minnesota</b>	<b>Tennessee</b>
917-918..... 1.10	553-558, 564, 566..... 0.91	373-374..... 0.91
919-927, 930-934..... 1.33	All Other..... 0.83	All Other..... 0.83
939..... 1.33	<b>Mississippi</b>	<b>Texas</b>
943-948..... 1.10	390-392..... 0.91	751-753..... 1.00
956-958..... 1.00	All Other..... 0.83	754..... 1.10
949-961..... 1.33	<b>Missouri</b>	756-757, 776-777..... 0.83
959..... 1.10	640-641, 644-649..... 0.91	All Other..... 0.91
All Other..... 1.21	All Other..... 0.83	<b>Utah</b>
<b>Colorado</b>	<b>Montana</b>	All Areas..... 0.83
803, 808-810..... 1.10	590-591..... 0.83	<b>Virginia</b>
All Other..... 0.83	599..... 0.91	201, 220-221..... 1.21
<b>Delaware</b>	All Other..... 1.00	222-223..... 1.33
All Areas..... 0.91	<b>Nebraska</b>	224-225, 230-232..... 0.83
<b>Dist Columbia</b>	All Areas..... 0.83	228-229, 240-244..... 0.91
All Areas..... 1.33	<b>Nevada</b>	233-237..... 1.21
<b>Georgia</b>	890-891..... 0.91	All Other..... 1.10
300-303..... 0.91	894-895-898..... 1.33	<b>Washington</b>
All Other..... 0.83	All Other..... 1.10	982-984..... 1.10
<b>Hawaii</b>	<b>New Mexico</b>	990-992..... 1.00
All Areas..... 1.00	881..... 0.91	993..... 1.33
<b>Idaho</b>	882..... 1.21	All Other..... 1.21
All Areas..... 0.83	All Other..... 0.83	<b>West Virginia</b>
<b>Illinois</b>	<b>North Carolina</b>	255-257..... 1.10
600-605..... 0.91	277..... 0.91	262-265..... 1.00
606-608..... 1.00	286..... 1.00	All Other..... 0.91
All Other..... 0.83	287-289..... 0.91	<b>Wisconsin</b>
<b>Indiana</b>	All Other..... 0.83	All Areas..... 0.83
463-464..... 0.91	<b>North Dakota</b>	<b>Wyoming</b>
473..... 1.00	580-581..... 0.91	All Areas..... 0.83
All Other..... 0.83	All Other..... 0.83	
<b>Iowa</b>	<b>Ohio</b>	
All Areas..... 0.83	All Areas..... 0.83	

\*Indicated states use a state specific application

Quote online at [www.hpainsurance.com](http://www.hpainsurance.com) or call 800-277-3323 x3

SLICA rev 10/08

## Fraud Warning Statements

**NAIC** 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

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 policy holder 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 insurance company 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.

### 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.

### New Mexico

Any person who knowingly presents a false or fraudulent claim for payment of 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 false or deceptive statements 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 thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

### 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.

### 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.