

Pearl Dependable Dental™

Platinum Dental Insurance Plan

Gold Dental Insurance Plan

Silver Dental Insurance Plan

MORE OPTIONS. ADDED BENEFITS.

Pearl's Dependable Dental Insurance Plans are valuable protection for individuals and their families. By offering you more options and added benefits, we help you cover the high costs of Preventive, Basic, Major, and in some cases, Orthodontic dental services. But the best part is, we do it at a price you can afford!

PLAN HIGHLIGHTS

- Choose your own dentist
- One \$50 deductible per insured person, per calendar year. (Deductible is waived for preventive services)
- Choice of 3 Premium Plans (Platinum, Gold, and Silver)

SERVICES PROVIDED

Preventive Dental Services include 2 exams per 12 months, cleanings, and fluoride treatment for children 16 and under. There is no waiting period for these services.

Basic Dental Services include x-rays, fillings, sealants (to age 16), and simple extractions. There is a six month waiting period for these services.

Major Dental Services include crowns, bridges, dentures, endodontics, periodontics, and oral surgery (extractions and impactions). Also, a new chemotherapeutic agent (or drug) prescribed in the treatment of periodontal services is included. There is an 18 month waiting period for these services.

Orthodontic Services includes the straightening of teeth for children under age 19. There is a 24 month waiting period for these services.

ELIGIBILITY

To be eligible for Pearl's Dependable Dental Plans, those applying for coverage must be between the ages of 18 and 64. Eligible dependents, which include your spouse and unmarried children to age 19 (23 if full-time student), may also be insured. This is subject to State requirements.

- A combined Maximum Benefit for Preventive, Basic and Major Services of **\$1,500** per insured person per calendar year.
- Major Services have a Maximum Benefit of **\$750** per insured person per calendar year.
- **100%** of Preventive Dental Services covered.
- **80%** of Basic Dental Services covered.*
- **50%** of Major Dental Services covered.*
- **50%** of Orthodontic Services covered.†

* After \$50 deductible and waiting period is met.
 † After waiting period is met. Maximum benefit \$500 per calendar year and \$1,000 lifetime per insured child.

PLATINUM PLAN MONTHLY RATES BY AREA **			
Area	Applicant Only	Applicant + 1 (Spouse or 1 Child)	Applicant + Family
1	\$ 31.10	\$ 60.93	\$ 86.43
2	34.09	66.81	94.76
3	37.46	73.41	104.13
4	41.21	80.76	114.55
5	45.33	88.83	126.00
6	49.83	97.64	138.50
7	54.70	107.18	152.03
8	60.31	118.19	167.65

- A combined Maximum Benefit for Preventive, Basic and Major Services of **\$1,250** per insured person per calendar year.
- Major Services have a Maximum Benefit of **\$750** per insured person per calendar year.
- **100%** of Preventive Dental Services covered.
- **50%** of Basic Dental Services covered.*
- **50%** of Major Dental Services covered.*
- **0%** of Orthodontic Services covered.

* After \$50 deductible and waiting period is met.

GOLD PLAN MONTHLY RATES BY AREA **			
Area	Applicant Only	Applicant + 1 (Spouse or 1 Child)	Applicant + Family
1	\$ 26.70	\$ 52.32	\$ 74.20
2	29.27	57.36	81.35
3	32.16	63.03	89.39
4	35.38	69.34	98.33
5	38.92	76.27	108.17
6	42.78	83.83	118.89
7	46.96	92.03	130.51
8	51.78	101.48	143.92

- A combined Maximum Benefit for Preventive, Basic and Major Services of **\$1,000** per insured person per calendar year.
- Major Services have a Maximum Benefit of **\$500** per insured person per calendar year.
- **80%** of Preventive Dental Services covered.
- **50%** of Basic Dental Services covered.*
- **50%** of Major Dental Services covered.*
- **0%** of Orthodontic Services covered.

* After \$50 deductible and waiting period is met.

SILVER PLAN MONTHLY RATES BY AREA **			
Area	Applicant Only	Applicant + 1 (Spouse or 1 Child)	Applicant + Family
1	\$ 22.65	\$ 44.40	\$ 62.97
2	24.84	48.68	69.04
3	27.29	53.49	75.86
4	30.02	58.84	83.45
5	33.02	64.73	91.79
6	36.30	71.15	100.90
7	39.85	78.10	110.76
8	43.94	86.12	122.14

AREA DEFINITIONS BY ZIP CODE

State ZIP ... Area	State ZIP ... Area	State ZIP ... Area	State ZIP ... Area	State ZIP ... Area	State ZIP ... Area	State ZIP ... Area	State ZIP ... Area	State ZIP ... Area
AK 995-996. 8	CA 919-927. 6	DE 2	KS (other) 1	MO 640-641 2	ND (other) 1	OR 978 1	TX (other) 2	WA 993 6
AK (other) 6	CA 930-934. 6	GA 300-303. 2	KY 1	MO 644-649 2	NE 1	OR (other) 2	UT 1	WA (other) 5
AL 350-355. 3	CA 939 6	GA (other) 1	LA 700-711 2	MO (other) 1	NM 881 2	PA 170-178 2	VA 201 5	WV 255-257 4
AL 359 3	CA 943-948. 4	HI 3	LA 712 3	MS 390-392. 2	NM 882 5	PA 182-187 2	VA 220-221 5	WV 262-265 3
AL (other) 1	CA 949 6	IA 1	LA (other) 1	MS (other) 1	NM (other) 1	PA 190-192 3	VA 222-223 6	WV (other) 2
AR 1	CA 956-958. 3	ID 1	MI 480-483 2	MT 590-591 1	NV 890-891 2	PA (other) 1	VA 224-225 1	WI 1
AZ 856-857. 2	CA 959 4	IL 600-605. 2	MI 488-489 3	MT 599 2	NV 894-895. 6	SC 1	VA 228-229 2	WY 1
AZ 864 2	CA 961 6	IL 606-608. 3	MI 490-491 2	MT (other) 3	NV 898 6	TN 373-374. 2	VA 230-232 1	
AZ (other) 1	CA (other) 5	IL (other) 1	MI (other) 1	NC 277 2	NV (other) 4	TN (other) 1	VA 233-237 5	
CA 900-905. 7	CO 803 4	IN 463-464. 2	MN 553-558 2	NC 286 3	OH 1	TX 751-753. 3	VA 240-244. 2	
CA 906-914. 6	CO 808-810. 4	IN 473 3	MN 564 2	NC 287-289. 2	OK 740-743. 2	TX 754 4	VA (other) 4	
CA 915-916. 8	CO (other) 1	IN (other) 1	MN 566 2	NC (other) 1	OK (other) 1	TX 756-757. 1	WA 982-984 4	
CA 917-918. 4	DC 6	KS 660-662. 2	MN (other) 1	ND 580-581. 2	OR 977 3	TX 776-777. 1	WA 990-992 3	

The listing of a State does not necessarily mean that Security Life is authorized to write in that State.

PROGRAM INFORMATION

Eligible Expenses: 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/her license; a licensed Physician performing dental services within the scope of his/her license; or a licensed dental hygienist acting under the supervision and direction of a dentist.

Expenses 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 date surgery is performed; for orthodontic services—on the date the appliance or bands are inserted or on the date a one-step orthodontic procedure is performed; for all other services—on the date the service is performed.

Expenses Not Covered: No benefits will be paid for expenses incurred: for any portion of a charge for any service in excess of the Scheduled Benefit; for any procedure not listed as a Scheduled Benefit; for overdentures and associated procedures; for cosmetic procedures, for the replacement of full and partial dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function; for implants; and for (a) the replacement of lost or stolen appliances; (b) the replacement of orthodontic retainers; (c) athletic mouthguards; (d) precision or semi-precision attachments; (e) denture duplication; for oral hygiene instructions; and for (a) plaque control; (b) the completion of claim form; (c) acid etch; (d) broken appointments; (e) prescription or take-home fluoride; or for (f) diagnostic photographs.

In addition, no benefits will be paid for expenses incurred: for services not completed by the end of the month in which coverage terminates; for procedures that are begun, but not completed; for those services for which there would be no charge in the absence of insurance or for any service or treatment provided without charge; 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 care or treatment of a condition for which you are entitled to or eligible for benefits under any Workers' 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; for the treatment of cleft palate and anodontia; for services or supplies payable under any medical expense plan; for orthodontia (unless specifically included); prior to the date the Insured is covered under the Policy; for the diagnosis or treatment of TMJD; 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; 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.

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.

GENERAL INFORMATION

Deductible Amount: The Deductible is shown in the Coverage Schedule. The Deductible is an amount of covered dental charges incurred by an insured person for which no benefits will be paid.

Calendar Year Maximum: The maximum amount payable for all Eligible Dental Expenses in any calendar year is shown in the Coverage Schedule. The Calendar Year Maximum will apply to each insured person.

Coordination of Benefits: This program will be coordinated with any other group, blanket or franchise plan under which an individual will receive benefits. This helps keep the cost of the program reasonable.

Termination of Coverage: Coverage terminates on the earliest of the following dates: the last day of the month in which you cease to be eligible for coverage; for dependents, the last day of the month for which they are no longer an eligible dependent as defined; subject to the Grace Period, the last day of the month for which a premium has been paid by you or on your behalf; or the date the Master Policy ends.

Pretreatment Review: If the Course of Treatment will exceed \$300, 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.

Effective Date: Effective dates are always the First of the month following receipt of the application. Incomplete enrollment cards or failure to submit the required initial premium amount may cause an initial delay in issuance of insurance. Do not cancel any other insurance or assume you are insured under the program until you receive written confirmation from Pearl Insurance.

UNDERWRITTEN BY:

Security Life

INSURANCE COMPANY OF AMERICA
Minnetonka, Minnesota 55343-9137

Notice: The Plan Effective Date is always the FIRST of the month following receipt of application. Premium rates guaranteed for the first 12 months.

Reimbursement is based on the Reasonable and Customary rates. Reasonable and Customary charges are fees that do not exceed the general level of charges being made by other providers of dental services in the area where the charge is incurred.

This brochure provides a very brief description of some important features of this Plan. It is not the Insurance Contract nor does it represent the Insurance Contract. A full explanation of benefits, exceptions and limitations is contained in the Certificate of Insurance, under Group Policy GH-1112-38080, issued to The Voluntary Group Trust. 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.

MARKETED AND ADMINISTERED BY:

PEARL
INSURANCE

Pearl & Associates, Ltd.

1200 East Glen Avenue
Peoria Heights, IL 61616

1.866.809.5175 • www.pearlins.com

We've Got More To Smile About



Pearl
Dependable
Dental™

Insurance Protection for Individuals and Families

How To Enroll In Pearl Dependable Dental™

1. Complete the Dental Insurance Enrollment Form below.
2. Complete the payment method section.
3. Return your Enrollment Form, payment method form and check (made payable to **Security Life Insurance Company of America**) to:
Pearl & Associates, Ltd. 1200 East Glen Avenue, Peoria Heights, IL 61616-5348

Security Life

INSURANCE COMPANY OF AMERICA
Minnetonka, Minnesota 55343-9137

FOR COMPANY USE ONLY

EFFECTIVE DATE _____

PLAN CODE _____

WAIVER CPT _____

GROUP # _____

DIVISION # _____

DENTAL INSURANCE ENROLLMENT FORM

ENROLL ME IN THE: PLATINUM PLAN GOLD PLAN SILVER PLAN

LAST NAME FIRST M. I.

HOME ADDRESS

CITY STATE ZIP PHONE

NAME OF PROFESSIONAL ASSOCIATION YOU BELONG TO (IF APPLICABLE)

BILL TO: (IF APPLICABLE)

CITY STATE ZIP PHONE

List below all dependents to be covered:

LAST NAME (IF DIFFERENT)	FIRST	M.I.	SEX	DATE OF BIRTH
SPOUSE:				/ /
CHILD:				/ /
CHILD:				/ /
CHILD:				/ /
CHILD:				/ /
CHILD:				/ /
CHILD:				/ /

DATE OF BIRTH / / MALE FEMALE

Marital Status: MARRIED SINGLE
 WIDOWED DIVORCED

Please bill my: RESIDENCE EMPLOYER

Applying for coverage of:

APPLICANT APPLICANT + 1 APPLICANT + FAMILY

Does spouse have a dental plan? YES NO

With whom? _____

If "Yes," are dependents enrolled under Spouse's plan? YES NO

Proof of full-time student status must be submitted for children between ages 19-23.

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. I hereby apply for coverage under the Policy Series GH-1112 issued to the Voluntary Group Trust.

APPLICANT'S SIGNATURE _____

DATE _____

PAYMENT METHOD SECTION

Electronic Funds Transfer (EFT)—Save \$14.00 per Year:

Enjoy the convenience of having your premium payment automatically withdrawn each month and the assurance that your coverage will not lapse due to a late payment. Complete the authorization agreement below. For checking account withdrawals, **include a voided blank check**. Write "VOID" across the blank check. Complete the premium calculation section for monthly EFT. Remit your check (made payable to **Security Life Insurance Company of America**) to Pearl & Associates, Ltd. for the first two monthly premiums and the one time enrollment fee. Future premiums will be deducted from your checking or savings account.

Premium calculation for monthly EFT

• Determine your monthly premium according to the Area/rate chart

\$ _____ X 2 = \$ _____

• EFT administration fee @ \$.50 per month\$ 1.00

• One time enrollment fee\$ 25.00

• Total remittance to begin EFT\$ _____

Direct Bill:

Direct billing is available on a quarterly basis. The quarterly billing dates are January, April, July and October. If your coverage effective date falls in the middle of a quarter your premium will be pro-rated. Complete the premium calculation section for quarterly direct bill. Remit your check (made payable to **Security Life Insurance Company of America**) to Pearl & Associates, Ltd. for the total remittance due.

Premium calculation for quarterly direct bill

• Determine your monthly premium according to the Area/rate chart

\$ _____ X 3 = \$ _____

• Quarterly direct bill administration fee\$ 5.00

• One time enrollment fee\$ 25.00

• Total remittance to begin quarterly direct bill\$ _____

AUTHORIZATION AGREEMENT TO DRAFT BANK ACCOUNT

Please complete the following information:

1. My Account is:

Checking (include voided check)

Savings (include deposit slip or copy of account statement)

2. Name of Bank or Institution: _____

3. Account #: _____

I hereby authorize you to electronically charge my account for premium debits to Security Life Insurance Company of America, Minnetonka, Minnesota, c/o Pearl & Associates, Ltd., Peoria Heights, Illinois. I understand my account will be charged according to my billing due date. The deduction will be made on the first of each month. I agree that this electronic payment shall be regarded the same as if a check was written by me and drawn on my account. This authorization is to remain in effect until revoked by me in writing.

I understand that the credit for payment is conditioned upon the order being honored when presented. I understand that this authorization may be terminated: (1) at the option of Pearl & Associates, Ltd. if any debt is not honored when presented for payment, or (2) upon thirty (30) days written notice given by Pearl & Associates, Ltd., the bank or me.

APPLICANT'S SIGNATURE _____

DATE _____

PRODUCER INFORMATION

NOTE:

If you have written business with Security Life Insurance Company of America/Pearl & Associates, Ltd. in this State during the calendar year, just complete your name and Tax ID and sign below. There is no need to submit a copy of your license with every case.

PRODUCER NAME

INSURANCE LICENSE #

ADDRESS

Insurance license attached:

YES NO

CITY

STATE

ZIP

Are you currently appointed with Security Life Insurance Company of America?

YES NO

()

PHONE

TAXPAYER # OR SOCIAL SECURITY #

PRODUCER SIGNATURE

Pearl & Associates, Ltd.

PEARL & ASSOCIATE, LTD. AGENT ID # (IF ASSIGNED)

GENERAL AGENT

Larry White Ins. Serv., Inc. GCA122042

FRAUD WARNING STATEMENTS

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 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 a loss or benefit or knowingly presents false information in an application 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 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.