ALL OTHER STATES

Spirit DENTAL

75% Participation and Voluntary Group Dental Insurance Plan

TRIPLE OPTION, INDEMNITY OR PREVENTIVE

Underwritten by:

SECURITYLIFE
INSURANCE COMPANY OF AMERICA

10901 Red Circle Drive
Minnetonka, MN 55343-9137

Marketed by:

DIRECT BENEFITS INC.

Choose Your Own Dentist

No Waiting Periods

3 Cleanings Per Year

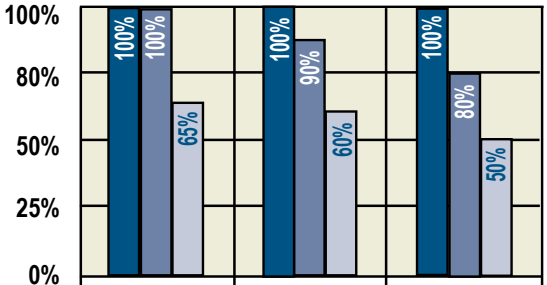
For Employers 2-149

$1,000, $1,500, $2,000 or $3,000 ANNUAL MAXIMUMS

S11496 (exp. 09/2014)

GH-1112-37740-2

Spirit DENTAL — Triple Option 75% Participation and Voluntary



	Careington	DHA	R&C
Class A	100%	100%	100%
Class B	100%	90%	80%
Class C	*65%	*60%	*50%

Covered Services

Option 1 – Careington PPO
This Plan covers dental expenses For Preferred Provider (In-Network) services based on the contracted fee amount negotiated with the preferred provider organization to a calendar year maximum of $1,000 per person. The PPO percentages are: 100% for Class A, 100% for Class B and 65% for ***Class C with an Internal Maximum on Major Services of $250 the 1st year, $500 the 2nd year and no separate limit in the 3rd year**.

Option 2 – DHA/Premier PPO
This Plan covers dental expenses For Preferred Provider (In-Network) services based on the contracted fee amount negotiated with the preferred provider organization to a calendar year maximum of $1,000 per person. The PPO percentages are: 100% for Class A, 90% for Class B and 60% for ***Class C with an Internal Maximum on Major Services of $150 the 1st year, $300 the 2nd year and no separate limit in the 3rd year**.

Option 3 – Out of Network - Indemnity (R&C)
This Plan reimburses you for covered dental expenses based upon a percentage of the Reasonable and Customary (R&C) fees for those covered expenses to a calendar year maximum of $1,000. These percentages are: 100% for Class A, 80% for Class B and 50% for ***Class C with an Internal Maximum on Major Services of $125 the 1st year, $250 the 2nd year and no separate limit in the 3rd year.**

Class A - *Preventive Services*
-- Two exams per year
-- Three cleanings per year
-- One topical fluoride per year *to age 16*
-- One set of bitewing x-rays per calendar year to age 19 and every 2 calendar years for adults

Class B - *Basic Services*
-- Basic fillings
-- Space maintainers
-- Sealants *(children to age 16)*

Class C - *Major Services*
-- One diagnostic x-ray, full or panoramic in any 5 year period
-- Oral surgery
-- Simple extractions
-- Endodontic treatment
-- Periodontic services
-- Crowns, inlays and onlays
-- Prosthetic services; bridges and dentures
-- Implants (endosteal only), up to the allowance for the lowest cost covered traditional procedure

$100 Lifetime Deductible - Applies to preventive, basic or major services per person, to a maximum of 3 Individual deductibles per family.

Credit for Prior Time (CPT) - Credit towards satisfaction of any benefit year class may be given for the length of time an employee was covered under the employer's prior dental insurance plan, provided there is no interruption in coverage between the prior plan and the replacement plan. The insured applying for CPT must have been covered for the same benefit classes under the prior plan in order to receive credit under the new plan. In other words, if the employer's prior plan did not provide Major or Orthodontic class coverage and the new plan provides both, CPT may not be given for the class not previously provided.

CPT is given individually to each person (employee, spouse or child) covered. Any new employee and/or dependents added on or subsequent to the group's effective date of this coverage, will not receive CPT.

The agent has no authority to grant CPT or to waive the waiting period provision of the Plan.

Optional $1,500, $2,000 or $3,000 Maximum Benefit - You may choose to increase the calendar maximum benefit for this plan to $1,500, $2,000 or $3,000. There is a 10% increase to the base rate for $1,500, 15% for $2,000 and 25% for $3,000.

Optional Orthodontic Services are available for an additional premium. Orthodontic care for the proper alignment of teeth is provided to children and adults. Coverage is 10% reimbursement for the first year, 25% reimbursement for the second year, and 50% reimbursement for the third year, with a lifetime maximum of $1500 per person.

Optional $50/$150 Calendar Year Deductible - You may choose to replace the $100 lifetime deductible with a $50 per person/$150 per family annual deductible that applies to Class B and C services for a 5% rate increase.

Optional $25/$75 Calendar Year Deductible - You may choose to replace the $100 lifetime deductible with a $25 per person/ $75 per family annual deductible that applies to Class B and C services for a 15% rate increase.

Optional $0/$0 Calendar Year Deductible - You may choose to replace the $100 lifetime deductible with a $0 per person/ $0 per family annual deductible that applies to Class B and C services for a 25% rate increase.

Optional Endo/Perio to Class B - You may choose to have Endodontics and Periodontics covered under Class B services for a 13% rate increase.

Optional Benefit - A group may elect to include coverage for posterior composite fillings (white fillings on back teeth) under the Basic Fillings coverage category. This benefit is available for a 4% increase.

Participation Requirements - Not less than two unrelated employees (75% of the employers eligible employees - the greater number after waivers) must be enrolled in the plan. For the Voluntary plan, not less than two unrelated employees. 100% family-related employees may apply for a 13% rate increase.

No Employer Contribution Required

Underwritten by:
SECURITYLIFE
INSURANCE COMPANY OF AMERICA
10901 Red Circle Drive
Minnetonka, MN 55343-9137

Dental Network:
DHA – PREMIER
www.premier-dental.com

Dental Network:
Careington Care PPO
www.careington.com

Plan Coordinator:
Direct Benefits, Inc.
325 Cedar Street, Suite 800, Saint Paul, MN 55101
651.649.3503 • 800.620.5010
www.directbenefits.com

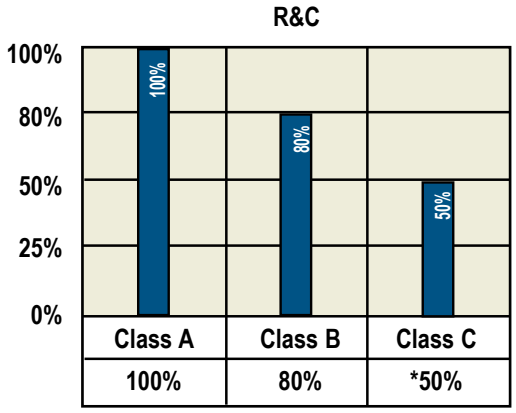
NOTICE: This provides a very brief description of some of the important features of your insurance policy. It is not the insurance policy and does not represent it. A full explanation of benefits, exceptions and limitations is contained in the Certificate of Insurance under Group Dental Policy Form GH-1112. Premium rates may change upon renewal. This policy is renewable at the option of the Company. This product may not be available in all states and is subject to individual state regulations.

Indemnity 75% Participation and Voluntary Group Dental Plan

Covered Services

This Plan reimburses you for covered dental expenses based upon a percentage of the Reasonable and Customary (R&C) fees for those covered expenses to a calendar year maximum of $1,000. These percentages are: 100% for Class A, 80% for Class B and 50% for ***Class C of the R&C rate with an Internal Maximum on Major Services of $125 the 1st year, $250 the 2nd year and no separate limit in the 3rd year.**

Spirit Dental allows you to select your own dentist and it provides affordable rates guaranteed for 12 months.



Class A - *Preventive Services*
-- Two exams per year
-- Three cleanings per year
-- One topical fluoride per year *to age 16*
-- One set of bitewing x-rays per calendar year to age 19 and every 2 calendar years for adults

Class B - *Basic Services*
-- Basic fillings
-- Space maintainers
-- Sealants *(children to age 16)*

Class C - *Major Services*
-- One diagnostic x-ray, full or panoramic in any 5 year period
-- Oral surgery
-- Simple extractions
-- Endodontic treatment
-- Periodontic services
-- Crowns, inlays and onlays
-- Prosthetic services; bridges and dentures
-- Implants (endosteal only), up to the allowance for the lowest cost covered traditional procedure

$100 lifetime deductible - Applies to preventive, basic or major services per person, to a maximum of 3 Individual deductibles per family.

Credit for Prior Time (CPT) - Credit towards satisfaction of any benefit year class may be given for the length of time an employee was covered under the employer's prior dental insurance plan, provided there is no interruption in coverage between the prior plan and the replacement plan. The insured applying for CPT must have been covered for the same benefit classes under the prior plan in order to receive credit under the new plan. In other words, if the employer's prior plan did not provide Major or Orthodontic class coverage and the new plan provides both, CPT may not be given for the class not previously provided.

CPT is given individually to each person (employee, spouse or child) covered. Any new employee and/or dependents added on or subsequent to the group's effective date of this coverage, will not receive CPT.

The agent has no authority to grant CPT or to waive the waiting period provision of the Plan.

Optional $1,500, $2,000 or $3,000 Maximum Benefit - You may choose to increase the calendar maximum benefit for this plan to $1,500, $2,000 or $3,000. There is a 10% increase to the base rate for $1,500, 15% for $2,000 and 25% for $3,000.

Optional $1,500, $2,000 or $3,000 Maximum Benefit - You may choose to increase the calendar maximum benefit for this plan to $1,500, $2,000 or $3,000. There is a 10% increase to the base rate for $1,500, 15% for $2,000 and 25% for $3,000.

Optional Orthodontic Services are available for an additional premium. Orthodontic care for the proper alignment of teeth is provided to children and adults. Coverage is 10% reimbursement for the first year, 25% reimbursement for the second year, and 50% reimbursement for the third year, with a lifetime maximum of $1500 per person.

Optional $50/$150 Calendar Year Deductible - You may choose to replace the $100 lifetime deductible for a $50/ $150 calendar year deductible per person/ family that applies to Class B and C services for a 5% rate increase.

Optional $25/$75 Calendar Year Deductible - You may choose to replace the $100 lifetime deductible with a $25 per person/ $75 per family annual deductible that applies to Class B and C services for a 15% rate increase.

Optional $0/$0 Calendar Year Deductible - You may choose to replace the $100 lifetime deductible with a $0 per person/ $0 per family annual deductible that applies to Class B and C services for a 25% rate increase.

Optional Endo/Perio to Class B - You may choose to have Endodontics and Periodontics covered under Class B services for a 13% rate increase.

Optional Benefit - A group may elect to include coverage for posterior composite fillings (white fillings on back teeth) under the Basic Fillings coverage category. This benefit is available for a 4% increase.

Participation Requirements - Not less than two unrelated employees (75% of the employers eligible employees - the greater number after waivers) must be enrolled in the plan. For the Voluntary plan, not less than two unrelated employees. 100% family-related employees may apply for a 13% rate increase.

No Employer Contribution Required

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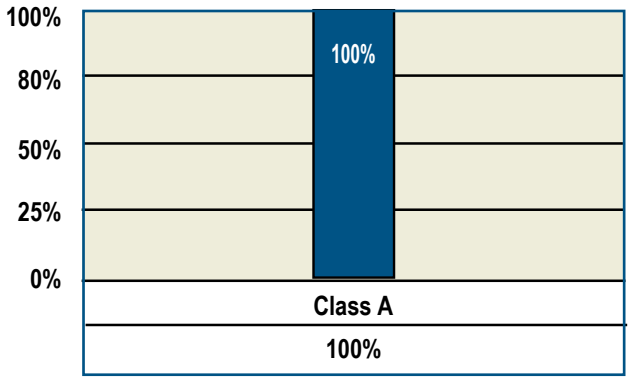
Spirit DENTAL — PREVENTIVE GROUP DENTAL PLAN

Covered Services

This Plan reimburses you for covered dental expenses based upon a percentage of the Reasonable and Customary (R&C) fees for those covered expenses to a calendar year maximum of $1000. The percentage is: 100% for Class A.

Spirit Dental allows you to select your own dentist and it provides affordable rates guaranteed for 12 months.



Class A - *Preventive Services*
- -- Two exams per year
- -- Three cleanings per year
- -- One topical fluoride per year *to age 16*
- -- One set of bitewing x-rays per calendar year to age 19 and every 2 calendar years for adults

Participation Requirements - Not less than two unrelated employees (75% of the employers eligible employees - the greater number after waivers) must be enrolled in the 75% plan. For the Voluntary plan, not less than two employees must enroll. 100% family-related employees may apply for a 10% rate increase.

$50 Lifetime Deductible - Applies to preventive services per person.

Optional $0 Calendar Year Deductible - You may choose to replace the $50 lifetime deductible for a $0 calendar year deductible per person/ family that applies to Class A services for a 15% rate increase.

The specific Preventive expenses listed above are the only covered dental services under this plan. No other dental procedures are covered under this plan.

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GENERAL INFORMATION

ELIGIBILITY: Active employees plus their eligible dependents (spouse and unmarried children from birth to age 26). This is subject to individual state regulations.

DEDUCTIBLE AMOUNT: The lifetime and 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.

CALENDAR YEAR MAXIMUM: 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 $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.

COORDINATION OF BENEFITS: This Plan 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 Plan 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; the last day of the month in which Your dependent is no longer a 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 policy ends.

EFFECTIVE DATE: Plan effective dates are always the First of the month. Enrollment cards received by Direct Benefits after the First of the month will become effective on the First of the following month. 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 Plan until you receive written confirmation from Direct Benefits.

PLAN INFORMATION

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

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 all other services - on the date the service is performed.

EXPENSES NOT COVERED: No benefits will be paid for expenses incurred: for overdentures and associated procedures for charges in excess of those considered reasonable and customary or charges in excess of the Network Provider fee schedule; for cosmetic procedures; for the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function; 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 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 included within Coverage Schedule; prior to the date the Insured is covered under the Policy; for the diagnosis or treatment of Temporomandibular Joint Dysfunction (TMJD); for 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 covered first ended; charges for infection control, sterilization and waste disposal.

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.

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.

TRIPLE OPTION

75% PARTICIPATION GROUP DENTAL PLAN

2 - 4 LIVES

	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8
Employee Only	27.73	30.40	33.41	36.75	40.43	44.44	48.78	53.79
Employee + 1	51.87	56.87	62.49	68.74	75.61	83.11	91.23	100.61
Family	84.48	92.62	101.78	111.96	123.15	135.37	148.60	163.87

5 - 9 LIVES

	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8
Employee Only	24.33	26.67	29.31	32.24	35.46	38.98	42.79	47.19
Employee + 1	45.50	49.88	54.82	60.30	66.33	72.90	80.03	88.25
Family	74.10	81.25	89.28	98.21	108.03	118.74	130.35	143.74

10 - 149 LIVES

	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8
Employee Only	23.17	25.40	27.91	30.70	33.77	37.12	40.75	44.94
Employee + 1	43.33	47.51	52.20	57.43	63.17	69.43	76.22	84.05
Family	70.57	77.38	85.03	93.53	102.89	113.09	124.14	136.90

Rates effective 11/01/2012 - 05/01/2013

PLAN OPTIONS

ORTHODONTIA RATES ($1500 lifetime maximum for adults and children)

Orthodontia can be added to any of the above plans by adding these premiums to the selected rate above. Orthodontia is covered at 10% first year, 25% second year and 50% third year with a $750 annual maximum benefit per person.

	Employee	Employee +1	Family
2-4 lives	$0.94	$9.73	$16.13
5-9 lives	$0.89	$9.20	$15.26
10-149 lives	$0.84	$ 8.71	$14.46

ENDO/PERIO TO CLASS B
Multiply rates by 1.13

AND/OR VOLUNTARY
Multiply rates by 1.05

$1,500 MAX BENEFIT
Multiply rates by 1.10

$2,000 MAX BENEFIT
Multiply rates by 1.15

$3,000 MAX BENEFIT
Multiply rates by 1.25

OPTIONAL $50/$150 CALENDAR YEAR DEDUCTIBLE
Multiply rates by 1.05

OPTIONAL $25/$75 CALENDAR YEAR DEDUCTIBLE
Multiply rates by 1.15

OPTIONAL $0/$0 CALENDAR YEAR DEDUCTIBLE
Multiply rates by 1.25

NOTE: A $15 monthly administration fee will be added to each employer group. Waived if employer is paying by ACH bankdraft or Visa/Master Card.

AREA (STATE) DEFINITIONS

Alabama
350-355, 359 3
All Other 1

Arizona
856-857, 864 2
All Other 1

Arkansas
All Areas 1

California
900-905 7
906-914 6
915-916 8
917-918 4
919-927, 930-934 6
939 6
943-948 4
956-958 3
949, 961 6
959 4
All Other 5

Colorado
803, 808-810 4
All Other 1

Delaware
All Areas 2

Dist Columbia
All Areas 6

Florida
320, 322, 326-329 1
338, 344, 347 1
330-332 5
334 4
All Other 3

Georgia
300-303 2
All Other 1

Hawaii
All Areas 3

Illinois
600-605 2
606-608 3
All Other 1

Indiana
463-464 2
473 3
All Other 1

Iowa
All Areas 1

Kansas
660-662 2
All Other 1

Kentucky
All Areas 1

Louisiana
707-711 2
712 3
All Other 1

Maryland
206-207, 209-211 2
217 3
All Other 4

Massachusetts
All Areas 5

Michigan
480-483, 490-491 2
488-489 3
All Other 1

Minnesota
553-558, 564, 566 2
All Other 1

Mississippi
390-392 2
All Other 1

Missouri
640-641, 644-649 2
All Other 1

Montana
590-591 1
599 2
All Other 3

Nebraska
All Areas 1

Nevada
890-891 2
894-895, 898 6
All Other 4

New Mexico
881 2
882 5
All Other 1

North Dakota
580-581 2
All Other 1

Ohio
All Areas 1

Oklahoma
740-743 2
All Other 1

Oregon
977 3
978 1
All Other 2

Pennsylvania
170-178, 182-187 2
190-192 3
All Other 1

Rhode Island
All Areas 3

South Carolina
All Areas 1

Tennessee
373-374 2
All Other 1

Utah
All Areas 1

West Virginia
255-257 4
262-265 3
All Other 2

Wisconsin
All Areas 1

Wyoming
All Areas 1

INDEMNITY - CHOOSE ANY DENTIST

75% PARTICIPATION GROUP DENTAL PLAN

2 - 4 LIVES

	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8
Employee Only	29.12	31.92	35.08	38.59	42.45	46.66	51.22	56.48
Employee + 1	54.46	59.71	65.61	72.17	79.39	87.27	95.80	105.64
Family	88.70	97.25	106.87	117.56	129.31	142.14	156.03	172.06

5 - 9 LIVES

	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8
Employee Only	25.54	28.00	30.77	33.85	37.24	40.93	44.93	49.54
Employee + 1	47.77	52.38	57.56	63.31	69.64	76.55	84.03	92.66
Family	77.81	85.31	93.75	103.12	113.43	124.68	136.87	150.93

10 - 149 LIVES

	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8
Employee Only	24.33	26.67	29.31	32.24	35.46	38.98	42.79	47.19
Employee + 1	45.50	49.88	54.82	60.30	66.33	72.90	80.03	88.25
Family	74.10	81.25	89.28	98.21	108.03	118.74	130.35	143.74

Rates effective 11/01/2012 - 05/01/2013

PLAN OPTIONS

ORTHODONTIA RATES ($1500 lifetime maximum for adults and children)

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	Employee	Employee +1	Family
2-4 lives	$0.94	$9.73	$16.13
5-9 lives	$0.89	$9.20	$15.26
10-149 lives	$0.84	$ 8.71	$14.46

ENDO/PERIO TO CLASS B
Multiply rates by 1.13

AND/OR VOLUNTARY
Multiply rates by 1.05

$1,500 MAX BENEFIT
Multiply rates by 1.10

$2,000 MAX BENEFIT
Multiply rates by 1.15

$3,000 MAX BENEFIT
Multiply rates by 1.25

OPTIONAL $50/$150 CALENDAR YEAR DEDUCTIBLE
Multiply rates by 1.05

OPTIONAL $25/$75 CALENDAR YEAR DEDUCTIBLE
Multiply rates by 1.15

OPTIONAL $0/$0 CALENDAR YEAR DEDUCTIBLE
Multiply rates by 1.25

NOTE: A $15 monthly administration fee will be added to each employer group. Waived if employer is paying by ACH bankdraft or Visa/Master Card.

AREA (STATE) DEFINITIONS

Alabama
350-355, 359 3
All Other 1
Alaska
995-996 8
All Other 6
Arizona
856-857, 864 2
All Other 1
Arkansas
All Areas 1
California
900-905 7
906-914 6
915-916 8
917-918 4
919-927, 930-934 6
939 6
943-948 4
956-958 3
949, 961 6
959 4
All Other 5
Colorado
803, 808-810 4
All Other

Delaware
All Areas 2
Dist Columbia
All Areas 6
Florida
320, 322, 326-329 1
338, 344, 347 1
330-332 5
334 4
All Other 3
Georgia
300-303 2
All Other 1
Hawaii
All Areas 3
Idaho
All Areas 1
Illinois
600-605 2
606-608 3
All Other 1
Indiana
463-464 2
473 3
All Other 1
Iowa
All Areas 1

Kansas
660-662 2
All Other 1
Kentucky
All Areas 1
Louisiana
707-711 2
712 3
All Other 1
Maine
039-041 4
044, 046, 048 3
All Other 2
Maryland
206-207, 209-211 2
217 3
All Other 4
Massachusetts
All Areas 5
Michigan
480-483, 490-491 2
488-489 3
All Other 1
Minnesota
553-558, 564, 566 2
All Other 1

Mississippi
390-392 2
All Other 1
Missouri
640-641, 644-649 2
All Other 1
Montana
590-591 1
599 2
All Other 3
Nebraska
All Areas 1
Nevada
890-891 2
894-895, 898 6
All Other 4
New Jersey
All Areas 4
New Mexico
881 2
882 5
All Other 1
North Carolina
277 2
286 3
287-289 2
All Other 1

North Dakota
580-581 2
All Other 1
Ohio
All Areas 1
Oklahoma
740-743 2
All Other 1
Oregon
977 3
978 1
All Other 2
Pennsylvania
170-178, 182-187 2
190-192 3
All Other 1
Rhode Island
All Areas 3
South Carolina
All Areas 1
South Dakota
All Areas 2
Tennessee
373-374 2
All Other 1

Texas
751-753 3
754 4
756-757, 776-777 1
All Other 2
Utah
All Areas 1
Vermont
All Areas 1
Virginia
201, 220-221 5
222-223 6
224-225, 230-232 1
228-229, 240-244 2
233-237 5
All Other 4
West Virginia
255-257 4
262-265 3
All Other 2
Wisconsin
All Areas 1
Wyoming
All Areas 1

PREVENTIVE — 75% PARTICIPATION GROUP DENTAL PLAN

$50 LIFETIME DEDUCTIBLE

	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8
Employee Only	$10.48	$11.49	$12.63	$13.89	$15.28	$16.80	$18.44	$20.33
Employee + 1	$19.84	$21.75	$23.90	$26.29	$28.92	$31.79	$34.89	$38.48
Family	$32.49	$35.62	$39.14	$43.05	$47.36	$52.06	$57.14	$63.02

$0 DEDUCTIBLE

	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8
Employee Only	$12.05	$13.21	$14.52	$15.97	$17.57	$19.31	$21.20	$23.38
Employee + 1	$22.82	$25.02	$27.49	$30.24	$33.26	$36.56	$40.13	$44.26
Family	$37.36	$40.96	$45.01	$49.51	$54.46	$59.86	$65.72	$72.47

PREVENTIVE — VOLUNTARY GROUP DENTAL PLAN

$50 LIFETIME DEDUCTIBLE

	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8
Employee Only	$12.05	$13.21	$14.52	$15.97	$17.57	$19.31	$21.20	$23.38
Employee + 1	$22.82	$25.02	$27.49	$30.24	$33.26	$36.56	$40.13	$44.26
Family	$37.36	$40.96	$45.01	$49.51	$54.46	$59.86	$65.72	$72.47

$0 DEDUCTIBLE

	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8
Employee Only	$13.86	$15.19	$16.70	$18.37	$20.20	$22.21	$24.38	$26.89
Employee + 1	$26.24	$28.77	$31.61	$34.77	$38.25	$42.05	$46.16	$50.90
Family	$42.96	$47.10	$51.76	$56.94	$62.63	$68.84	$75.57	$83.34

Rates effective 11/01/2012 - 05/01/2013

NOTE: A $15 monthly administration fee will be added to each employer group.
Waived if employer is paying by ACH bankdraft or Visa/Master Card.

AREA (STATE) DEFINITIONS

Alabama		**Delaware**		**Kansas**		**Mississippi**		**North Dakota**		**Texas**	
350-355, 359	3	All Areas	2	660-662	2	390-392	2	580-581	2	751-753	3
All Other	1	**Dist Columbia**		All Other	1	All Other	1	All Other	1	754	4
Alaska		All Areas	6	**Kentucky**		**Missouri**		**Ohio**		756-757, 776-777	1
995-996	8	**Florida**		All Areas	1	640-641, 644-649	2	All Areas	1	All Other	2
All Other	6	320, 322, 326-329	1	**Louisiana**		All Other	1	**Oklahoma**		**Utah**	
Arizona		338, 344, 347	1	707-711	2	**Montana**		740-743	2	All Areas	1
856-857, 864	2	330-332	5	712	3	590-591	1	All Other	1	**Vermont**	
All Other	1	334	4	All Other	1	599	2	**Oregon**		All Areas	1
Arkansas		All Other	3	**Maine**		All Other	3	977	3	**Virginia**	
All Areas	1	**Georgia**		039-041	4	**Nebraska**		978	1	201, 220-221	5
California		300-303	2	044, 046, 048	3	All Areas	1	All Other	2	222-223	6
900-905	7	All Other	1	All Other	2	**Nevada**		**Pennsylvania**		224-225, 230-232	1
906-914	6	**Hawaii**		**Maryland**		890-891	2	170-178, 182-187	2	228-229, 240-244	2
915-916	8	All Areas	3	206-207, 209-211	2	894-895, 898	6	190-192	3	233-237	5
917-918	4	**Idaho**		217	3	All Other	4	All Other	1	All Other	4
919-927, 930-934	6	All Areas	1	All Other	4	**New Jersey**		**Rhode Island**		**West Virginia**	
939	6	**Illinois**		**Massachusetts**		All Areas	4	All Areas	3	255-257	4
943-948	4	600-605	2	All Areas	5	**New Mexico**		**South Carolina**		262-265	3
956-958	3	606-608	3	**Michigan**		881	2	All Areas	1	All Other	2
949, 961	6	All Other	1	480-483, 490-491	2	882	5	**South Dakota**		**Wisconsin**	
959	4	**Indiana**		488-489	3	All Other	1	All Areas	2	All Areas	1
All Other	5	463-464	2	All Other	1	**North Carolina**		**Tennessee**		**Wyoming**	
Colorado		473	3	**Minnesota**		277	2	373-374	2	All Areas	1
803, 808-810	4	All Other	1	553-558, 564, 566	2	286	3	All Other	1		
All Other		**Iowa**		All Other	1	287-289	2				
		All Areas	1			All Other	1				

Why Should You Choose a PPO Dental Plan?

In addition to paying lower monthly premium rates, Preferred Provider Organizations (PPOs), such as Careington and DHA-Premier (available with the Spirit Dental Plans) help reduce your out-of-pocket costs. PPO ("in-network") dentists have agreed to accept a set contracted amount for each service rendered as the basis for payment under the Spirit Dental Plan. This amount is typically significantly less than the amount which could be charged by an out-of-network dentist. These PPO dentists are prohibited (by contract with the PPO) from charging you the difference between their typical fee and the amount negotiated with the PPO network.

Dentists not participating in the network are not subject to the negotiated amounts and are permitted to charge any fee for services they provide. This may lead to greater out-of-pocket costs for you and your family members. The sample comparison chart below will give you an idea of how you can save money by selecting one of Spirit Dental's PPO plans and visiting an in-network dentist for services. It compares the charges between visiting in-network and out-of-network dentists.

PPO Savings* Example

This hypothetical example** shows how receiving services from a PPO (in-network) dentist can save you money.

Your Dentist says you need a Crown, a Type C service –

- PPO Fee: $685.00
- R&C Fee: $750.00
- Dentist's Usual Fee: $985.00

IN-NETWORK When you receive care from a participating PPO dentist		**OUT-OF-NETWORK** When you receive care from a non-participating dentist	
Dentists's Usual Fee is:	$985.00	Dentist's Usual Fee is:	$985.00
The PPO Reduced Fee is:	$685.00	R&C Fee is:	$750.00
Your Plan Pays:		**Your Plan Pays:**	
50% x $685 PPO Fee	- $342.50	50% x $750 R&C or PPO Fee	- $375.00
Your Out-of-Pocket Cost:	$342.50	Your Out-of-Pocket Cost:	$610.00

In this example, you save $267.50 ($610.00 minus $342.50) by using a participating PPO dentist.

* *Savings from enrolling in the Careington or DHA-Premier PPO plans depend on various factors, including how often participants visit the dentist and the cost for services rendered.*

** *Please note: These examples assume that your annual deductible has been met.*

Underwritten by:

SECURITYLIFE
INSURANCE COMPANY OF AMERICA

10901 Red Circle Drive
Minnetonka, MN 55343-9137

Marketed by:

DIRECT BENEFITS INC.

Plan Coordinator:

Direct Benefits, Inc.
325 Cedar Street, Suite 800
Saint Paul, MN 55101
651.649.3503 • 800.620.5010
www.directbenefits.com

Spirit DENTAL & VISION

EMPLOYER ELECTION FORM

Please mail completed form to:
Direct Benefits, Inc.
325 Cedar Street - Suite 800
St Paul, MN 55101
(800) 620-5010 / (651) 649-3502 Fax

EMPLOYER INFORMATION

Legal Name of Employer_____ Send Correspondence to_____
Address_____ City_____ State_____ Zip Code_____
Phone Number ( )_____ Fax ( )_____
Nature of Business_____ Email Address for Contact Person_____
Subsidiaries and Affiliates Included [ ] Yes [ ] No
Name and Address of Subsidiaries & Affiliates whose employees are to be covered:_____
Effective Date of Employer Participation:_____
Class of Employees:
Regular full-time Employees working [ ] or more hours per week.
[ ] All Employees [ ] All regular full-time Employees
[ ] All Employees, except_____
Employees must be actively at work on Effective Date of coverage, if not, coverage will be effective on the First day of the month following return to active employment.

Employee Waiting Period:
Waiting Period (current Employees): [ ] Effective Date [ ] 1 month [ ] other_____
Waiting Period (new Employees): [ ] 1 month [ ] 2 months [ ] other_____
New Employees are covered on the first day of the month following the Waiting Period.

Premiums:
Dental Employee: $_____ Employee/One Dependent: $_____ Employee/Family: $_____
Vision Employee: $_____ Employee/One Dependent: $_____ Employee/Family: $_____

PLAN SELECTION

DENTAL ADOPTION AND PARTICIPATION AGREEMENT

[ ] 75% PARTICIPATION [ ] EMPLOYER VOLUNTARY
[ ] TRIPLE OPTION [ ] INDEMNITY [ ] PREVENTIVE

[ ] 2-4 Employees [ ] 5-9 Employees [ ] 10-149 Employees

Coverage Options*:
[ ] Employer Voluntary (premium x 1.05)
[ ] Increase Calendar Year Maximum to $1500 (premium x 1.10)
[ ] Increase Calendar Year Maximum to $2000 (premium x 1.15)
[ ] Increase Calendar Year Maximum to $3000 (premium x 1.25)
[ ] $50 Calendar Year Deductible (premium x 1.05)
[ ] $25 Calendar Year Deductible (premium x 1.15)
[ ] $0 Calendar Year Deductible (premium X 1.25) ***Triple Option / Indemnity***
[ ] $0 Calendar Year Deductible (premium X 1.15) ***Preventive Only***
[ ] Endodontics/Periodontics covered under Class B (premium x 1.13) Indemnity & PPO
[ ] Posterior Composite Fillings covered under Basic Fillings (premium x 1.04) Indemnity & Triple Option
[ ] With Orthodontia (premium – see rates) Indemnity & Triple Option

*** Premiums must be adjusted accordingly**

There are initially ____ full-time employees of which ____ are enrolled in this Plan.

The undersigned Employer hereby requests participation in the Employers' Voluntary Benefit Insurance Trust, to insure eligible persons under Group Dental Policy GH-1112-37740-2 insured by Security Life Insurance Company of America, Minnetonka, MN and hereby accepts and agrees to be bound by the terms and conditions as now in effect or hereafter may be modified.

Authorized Signature _____
Date _____ E-Mail _____

VISION APPLICATION

[ ] 75% PARTICIPATION [ ] EMPLOYER VOLUNTARY
[ ] Plan A (9791948) [ ] Plan B (9791955)
[ ] Plan C (9752783) [ ] Plan D (9791963)
[ ] Plan E (9791971) [ ] Plan F (9752791)
[ ] Plan G (9719576)

VISION PLANS NOT AVAILABLE IN NJ, VT, WA

All States other than Illinois and Iowa
It is agreed that the Policy will become effective at rates to be determined by Us, provided the application is accepted by Us. The applicant declares that to the best of its knowledge and belief that statements and answers are complete and true.

Illinois and Iowa
The Employer hereby requests participation under group Policy number Series GH-1154 issued to the Employers' Voluntary Benefit Insurance Trust, To insure eligible persons under the Policy, based upon the above statements and representations. The Employer must select the coverage and pay the required premium. Those eligible will be covered as described in this application.

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 a fine and confinement in prison.

Authorized Signature_____
Date_____ E-Mail_____

GHA-1157
GH-1154 (Illinois/Iowa)

PRODUCER'S STATEMENT – I hereby certify that all the information contained in this Employer Election Form is correct to the best of my knowledge and I know nothing unfavorable about this entity or any individual proposed for participation. I have complied with the underwriting rules and regulations and have explained in detail the coverage to the entity.

(Please Print)
Producer Name_____ SS#/TIN#_____ Appointed with Security Life? [ ] Yes [ ] No
Street Address_____ City_____ State_____ Zip_____
Phone Number_____ Email_____ Agent Signature_____

Spirit Dental/Vision Enrollment Card

Return completed form to your employer

FOR COMPANY USE ONLY
Effective Date: ____/____/____
Plan Code:_____
Group #/ Division _____
CPT: _____

Employer Information (TO BE COMPLETED BY THE EMPLOYER)

Name and Address of Employer or Organization (if applicable)	Full-Time Hire Date
	Telephone Number

Employee Information (PLEASE PRINT CLEARLY)

Coverage Election: ☐ Dental Only ☐ Vision Only ☐ Dental & Vision ☐ Decline Coverage
I apply for coverage on: ☐ Employee Only ☐ Employee +1 ☐ Employee and Family **(DENTAL)**
I apply for coverage on: ☐ Employee Only ☐ Employee +1 ☐ Employee and Family **(VISION)** *Vision Plans not available in NJ, VT, WA*

Last Name	First Name	Initial	
Address	Telephone Number		
City		State	Zip

Birth Date: / /
Sex: M [ ] F [ ]
Marital Status Married [ ] Single [ ]

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					

Please note: If additional dependent information is necessary please attach a separate sheet of paper.

1. Does Spouse have a dental plan? Yes ☐ No ☐ With whom? _____
If answer is "Yes", are dependents enrolled under spouses plan? Yes ☐ No ☐

Group Dental Coverage is provided under the Group Dental Insurance Policy GH-1112 issued to the Employers' Voluntary Benefit Insurance Trust insured by Security Life Insurance Company of America, Minnetonka, Minnesota.

Group Vision Coverage is provided under the Group Vision Policy GH-1157 or under the Group Vision Policy GH-1154 issued to the Group Policyholder (policyholder may be a trusteed group policyholder in some states) insured by Security Life Insurance Company of America, Minnetonka, Minnesota.

By my signature below, I hereby apply for the coverage or coverage's selected above. I certify that I have read the applicable Fraud Notice below. I also hereby authorize payroll deductions from my earnings for any contributions required. This Authorization remains in effect until revoked by me in writing.

California Law prohibits an HIV Test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

_____ _____
Employee Signature Date

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.

STATE SPECIFIC NOTICES

Arkansas/Louisiana - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly present 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.

Florida - Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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.

Maine - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland - Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey - Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

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 thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Tennessee/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.

MERITAIN HEALTH

Authorization to honor checks drawn or automatic debit entries made by Meritain Health 1405 Xenium Lane North, Suite 140 Minneapolis, MN 55441

Name of bank: _____

(Include branch name if applicable)

Address of bank/branch: _____

Bank routing number: _____ Account number: _____

Account type: ☐ Checking (please attach a voided check) ☐ Savings

Print name of bank depositor/account holder: _____

For the purpose of paying premiums on the policies or contracts listed below:

Policy or contract no.: _____

Name of insured: _____

Address: _____

City/State/Zip: _____

Indemnification agreement

To the bank named above:

In consideration of your participation in the arrangement authorized by your depositor in this document hereof, whereby amounts payable to this company are collected by checks drawn or automatic debit entries made by the company on the account of the depositor, Meritain Health hereby agrees:

1) Meritain Health will indemnify and hold you harmless from any liability to any person having an account with you arising out of the payment by you of any check drawn or automatic debit entry made by Meritain Health on the account of such person, or arising out of the dishonor by you, whether with or without cause or intentionally or inadvertently, of any such check drawn or automatic debit entry made by Meritain Health, whether or not such claim or liability asserted against you be based upon the forfeiture or alleged forfeiture of a policy or contract of insurance, the premium on which is sought to be collected by Meritain Health, by any such check or automatic debit entry, and
2) Meritain Health will refund to you any amount erroneously paid by you on any such check or automatic debit entry if claim for the amount of such erroneous payment is made by you within twelve months from the date of the check or automatic debit entry on which such erroneous payment was made.

If your participation in this arrangement is to be terminated, the company requests 30 days written notice to be sent to its Executive Office, 1405 Xenium Lane North, Suite 140, MN 55441.

Vice President Claims

Bank depositor/Account holder authorization

I hereby authorize Meritain Health to draw checks or make withdrawals by automatic debit each month on this account. Funds will be withdrawn on the policy or contract due date.

I agree that the presentation of such check or automatic debit to such bank shall constitute due notice of premium being due upon the said policies or contracts.

I agree that if any withdrawal for the payment of premiums is dishonored, or if the amount has been refunded to the bank upon its request, the payment shall be considered to be in default and if payment of the premium in default is not made within 31 days of the date on which such premium was due, the policy or contract shall terminate except as may otherwise be provided therein.

I agree that this arrangement may be discontinued by either of us for any reason at any time upon written notice to the other. On or after such discontinuance, premiums shall be payable as provided in the policy or contract and at the company's rate for the method of payment selected.

I hereby authorize the bank listed above to honor and charge to my account checks drawn or automatic debit entries made on my account by and payable to Meritain Health. The signatures on such checks may either be typed or printed. The bank shall have no liability for the return unpaid of any such check or automatic debit entry if the balance in my account is insufficient to pay the same upon presentation. I further agree that if any such check or automatic debit entry be dishonored, the bank shall be under no liability whatsoever, even though such dishonor results in the forfeiture of insurance. This authorization shall continue in force until revoked by me in writing.

_____ _____

(Signature of Bank Depositor/Account Holder) (Date)

[ ] Monthly Credit Card

If choosing to pay by credit card, you must complete and sign the Authorization Agreement form below.

AUTHORIZATION AGREEMENT:

I hereby authorize Meritain Health to initiate debit entries to my credit card account. This authorization shall remain in full force until company has received advance written notification from me to terminate. I agree that if any such charge be dishonored, whether with or without cause and whether intentionally or inadvertently, the credit card company and Meritain Health shall be under no liability whatsoever even though it might result in forfeiture of my insurance. I understand that I have the right to stop payment by notification to Meritain Health, at least ten business days prior to the next scheduled payment.

Name of Financial Institution _____

[ ] Visa [ ] Master Card

Card # _____

Expiration Date_____/_____/_____

Name _____

Signature: _____

Date: _____

NEW BUSINESS CHECKLIST

Please confirm that the following is submitted with all new cases.

- ☐ Completed Employer Application
- ☐ Completed Employee Enrollments
- ☐ First Month Premium (payable to Security Life Insurance Company of America) along with the $15 monthly billing fee. $15 fee is waived if buying Spirit Vision or Spirit Life or paying by ACH Bankdraft or Visa / MasterCard.
- ☐ Producer Licensing Forms (if not previously contracted)
- ☐ Online Agent-generated Proposal (www.directbenefits.com/dental/181-spirit-calculator)

CREDIT FOR PRIOR TIME (CPT)

Please confirm that all of the following documentation is provided prior to coverage on take-over cases:

- ☐ Copy of Prior Carrier's certificate, booklet or schedule of benefits (for ortho takeover only)
- ☐ Copy of Prior Carrier's most recent billing statement

After all of the information listed above is completed and signed send all original forms to:

Direct Benefits, Inc.
325 Cedar Street, Suite 800
Saint Paul, MN 55101
651.649.3503 • 800.620.5010
fax: 651-649-3502
tracey@directbenefits.com

Submission Date:

New Group Information should be postmarked no later than the end of the month to be effective by the first of the following month.