

# Securian Dental

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## **Dental Benefit Plan Summary**

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Voluntary – Plan 2

Maine

Securian Dental Plans are underwritten by Securian Life Insurance Company and administered by DeCare Dental Health International, LLC.

Notice to Buyer: This Certificate provides dental benefits only.



## **DENTAL BENEFIT PLAN SUMMARY**

This is a Summary of your Group Dental Program (**PROGRAM**) prepared for Employers (**GROUP**) for Covered Persons with:

Voluntary Plan 2

This Program has been established and is maintained and administered in accordance with the provisions of your Dental Plan Number issued by Securian Life Insurance Company (**PLAN**). This Plan is underwritten by Securian Life Insurance Company and administered by DeCare Dental Health International, LLC.

### **IMPORTANT**

**This booklet is subject to the provisions of the Group Account Agreement and you cannot modify this agreement in any way; nor shall you accrue any rights because of any statement in or omission from this booklet.**

#### **SECURIAN DENTAL PLANS**

Administered by:

DeCare Dental Health International, LLC

3560 Delta Dental Drive

Minneapolis, Minnesota 55122-3166

(866)201-1818

**SECURIAN LIFE INSURANCE COMPANY**

**NOTICE OF INFORMATION PRACTICES RELATED TO SECURIAN DENTAL PLANS**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Securian Life Insurance Company understands that information about you and your health is personal, and we are committed to protecting your dental information. Individually identifiable information about your past, present or future health or condition, the provision of dental care to you, or payment for such dental care is considered "Protected Health Information" ("PHI").

**Our Permitted Uses and Disclosures of Your Protected Health Information**

We use and disclose PHI about you for treatment, payment, and health care operations.

**Treatment:** We may disclose PHI to your dentist(s) for treatment purposes. For example, your dentist may wish to provide a dental service to you but first seek information as to whether the service has been previously provided.

**Payment:** We disclose your PHI in order to fulfill our duty to provide your coverage, determine *SECURIAN LIFE INSURANCE COMPANY NOTICE OF INFORMATION PRACTICES RELATED TO* your benefits and make payment for services provided to you. For example, we use your PHI in order to process your claims.

**Health Care Operations:** We disclose your PHI as a part of certain operations, such as quality improvement. For example, we may use your PHI to evaluate the quality of dental services that were performed.

We may be asked by the sponsor of your dental plan to provide your PHI to the sponsor. If we are asked to do so, we intend to honor such requests unless we are prohibited by law from doing so.

We may use or disclose your PHI without your authorization for several other reasons. Subject to certain requirements, we may give out PHI without your authorization for public health purposes, auditing purposes, research studies and emergencies. We provide PHI when otherwise required by law, such as for law enforcement in specific circumstances, or for judicial or administrative proceedings. In any other situation, we will ask for your written authorization before using or disclosing your PHI. If you choose to sign an authorization to allow disclosure of your PHI, you can later revoke that authorization to stop any future uses and disclosures (other than for treatment, payment and health care operations).

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and send the new notice to you. We reserve the right to make the revised or changed notice effective for dental information we already have about you as well as any information we receive in the future. You can also request a paper copy of our notice at any time by contacting the address below, or view it on our website at [www.securiandental.com](http://www.securiandental.com).

**Individual Rights**

In most cases, you have the right to view or get a copy of your PHI. You also have the right to receive a list of instances where we have disclosed your PHI without your written authorization for reasons other than treatment, payment or health care operations. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

You may request in writing that we not use or disclose your PHI for treatment, payment and health care operations except when specifically authorized by you, when required by law, or in emergency circumstances. Although we are unable to take back any disclosures we have already made with your permission or pursuant to this notice, we will consider your request but are not legally required to accept it. You also have the right to receive confidential communications of PHI by alternative means or at alternative locations, if you clearly state that disclosure of all or part of your PHI could endanger you.

**Complaints**

If you are concerned that we have violated your privacy rights, or you disagree with a decision we have made about access to your records, you may contact Customer Service at the address listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. Customer Service can provide you with the appropriate address upon request. You will not be penalized for making a complaint.

**Our Legal Duty**

We are required by law to protect the privacy of your information, provide this notice about our information practices and follow the information practices that are described in this notice.

If you wish to inspect your records, receive a listing of disclosures, or correct or add to the information in your record, or if you have any questions, complaints or concerns, please contact:

Securian Life Insurance Company  
Alfrieda Baldwin – Station 21-3746  
400 Robert Street North  
St. Paul, MN 55101-2098

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## **DESCRIPTION OF COVERED PROCEDURES**

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### **Pretreatment Estimate** (Estimate of Benefits)

**It is recommended that a pretreatment estimate be submitted to the plan prior to treatment if your dental treatment involves major restorative, periodontic or prosthetic care (see Description of Coverages), to estimate the amount of payment. The Pretreatment Estimate is a valuable tool for both the dentist and you. Submitting a Pretreatment Estimate allows the dentist and you to know what benefits are available to you before beginning treatment. The Pretreatment Estimate will outline your responsibility to the dentist with regard to co-payments, deductibles and non-covered services. This will allow the dentist and you to make any necessary financial arrangements before treatment begins. This process does not prior authorize the treatment nor determine its dental or medical necessity. The estimated plan payment is based on your current eligibility and contract benefits in effect at the time of the completed service. Submission of other claims or changes in eligibility or the contract may alter final payment. This is not a guarantee of benefits.**

After the examination, your dentist will establish the dental treatment to be performed. If the dental treatment necessary involves major restorative, periodontic or prosthetic care, a dentist should submit a claim form to the Plan outlining the proposed treatment. The Plan will determine if the proposed treatment is covered by the Program and estimate the amount of payment.

A statement will be sent to you and your dentist estimating the amount of the Plan's payment obligation and the amount that you will owe. These estimates will be subject to your continuing eligibility in the Plan and the Contract remaining in effect. If claims for other completed dental services are received and processed prior to the completion date of the proposed treatment, this may reduce the Plan's estimated payment for the proposed treatment and increase your obligation to the dentist.

You will be responsible for payment of any deductibles and coinsurance amounts or any dental treatment that is not considered a covered service under the Plan.

### **Benefits**

The Program covers the following dental procedures when they are performed by a licensed dentist and/or a licensed denturist and when necessary and customary as determined by the standards of generally accepted dental practice. The benefits under this Program shall be provided whether the dental procedures are performed by a duly licensed physician, a duly licensed dentist or a duly licensed denturist, if otherwise covered under this Program, provided that such dental procedures can be lawfully performed within the scope of a duly licensed dentist or a duly licensed denturist.

As a condition precedent to the approval of claim payments, the Plan shall be entitled to request and receive, to such extent as may be lawful, from any attending or examining dentist, or from hospitals in which a dentist's care is provided, such information and records relating to a Covered Person as may be required to pay claims. Also, the Plan may require that a Covered Person be examined by a dental consultant retained by the Plan in or near the Covered Person's place of residence. The Plan shall hold such information and records confidential.

**TO AVOID ANY MISUNDERSTANDING OF BENEFIT PAYMENT AMOUNTS, ASK YOUR DENTIST ABOUT HIS OR HER NETWORK PARTICIPATION STATUS WITHIN YOUR NETWORK PRIOR TO RECEIVING DENTAL CARE.**

Securian Life Insurance Company does not determine whether a service submitted for payment or benefit under this Plan is a dental procedure that is dentally necessary to treat a specific condition or restore dentition for an individual. Securian evaluates dental procedures submitted to determine if the procedure is a covered benefit under your dental plan. Your dental Plan includes a preset schedule of dental services that are eligible for benefit by the Plan. Other dental services may be recommended or prescribed by your dentist that are dentally necessary, offer you an enhanced cosmetic appearance, or are more frequent than covered by the Plan. While these services may be prescribed by your dentist and are dentally necessary for you, they may not be a dental service that is benefited by this Plan or they may be a service where the Plan provides a payment allowance for a service that is considered to be optional treatment. If the Plan gives you a payment allowance for optional treatment that is covered by the plan, you may apply this Plan payment to the service prescribed by your dentist which you elected to receive. Services that are not covered by the Plan or exceed the frequency of Plan benefits do not imply that the service is or is not dentally necessary to treat your specific dental condition. You are responsible for dental services that are not covered or benefited by the Plan. Determination of services necessary to meet your individual dental needs is between you and your dentist.

ONLY those services listed are covered. Deductibles and maximums are listed under the Summary of Dental Benefits. Services covered are subject to the limitations within the Benefits, Exclusions and Limitations sections described below. For estimates of covered services, please see the "Pretreatment Estimate" section of this booklet.

#### **PREVENTIVE CARE (Diagnostic & Preventive Services)**

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**Oral Evaluations** - Any type of evaluation (checkup or exam) is covered 2 times per 12-month period.

NOTE: Comprehensive oral evaluations will be benefited 1 time per dental office, subject to the 2 times per 12-month period limitation. Any additional comprehensive oral evaluations performed by the same dental office will be benefited as a periodic oral evaluation and will be subject to the 2 times per 12-month period limitation.

#### **Radiographs (X-rays)**

- **Bitewings**- Covered at 1 series of bitewings per 12-month period
- **Full Mouth (Complete Series) or Panoramic** – Covered 1 time per 36-month period.
- **Periapical(s)** – 4 single X-rays are covered per 12-month period.
- **Occlusal** – Covered at 2 series per 24-month period.

#### **Dental Cleaning**

- **Prophylaxis or Periodontal Maintenance** – Any combination of these procedures is covered 2 times per 12-month period.

Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

NOTE: A prophylaxis performed on a Covered Person under the age of 14 will be benefited as a child prophylaxis. A prophylaxis performed on a Covered Person age 14 or older will be benefited as an adult prophylaxis.

Periodontal Maintenance is a procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

**Fluoride Treatment** (Topical application of fluoride) - Covered 2 times per 12-month period for dependent children through the age of 18.

**Space Maintainers** - Covered once per lifetime on eligible dependent children through the age of 17 for extracted primary posterior (back) teeth.

**Sealants** - Covered for permanent first and second molars of eligible dependent children through the age of 15.

## **BASIC SERVICES**

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**Emergency Treatment** - Emergency (palliative) treatment for the temporary relief of pain or infection.

### **Restorations**

- **Amalgam (silver) Restorations** – Treatment to restore decayed or fractured permanent or primary teeth.
- **Composite (white) Resin Restorations**
  - **Anterior (front) Teeth** - Treatment to restore decayed or fractured permanent or primary anterior (front) teeth.
  - **Posterior (back) Teeth** - Treatment to restore decayed or fractured permanent or primary posterior (back) teeth. Benefits shall be limited to the same surfaces and allowances for amalgam (silver filling). The patient must pay the difference in cost between the Dentist's usual fees for the covered benefit and optional treatment, plus any deductible and/or coinsurance for the covered benefit.

LIMITATION: Coverage for amalgam or composite restorations shall be limited to only 1 service per tooth surface per 24-month period.

### **Other Basic Services**

- **Restorative cast post and core build-up, including pins and posts.** See benefit coverage description under Complex or Major Restorative Services.
- **Pre-fabricated or Stainless Steel Crown.** Covered once per 24-month period for eligible dependent children through the age of 15.

### **Adjunctive General Services**

- **General Anesthesia on a child under the age of 6, exceptional medical circumstances or a developmental disability** – administration of general anesthesia in a dentist's office on a covered person who: (a) Is a child under the age of 6 (b) Is a person who has exceptional medical circumstances or a developmental disability which place the person at serious risk.
- **General Anesthesia, Intravenous Conscious Sedation and IV Sedation** – Covered when performed in conjunction with a complex surgical service.

LIMITATION: General anesthesia, intravenous conscious sedation and IV sedation will not be covered when performed with non-surgical dental care.

EXCLUSIONS – Coverage is NOT provided for:

1. Analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care.
2. Case presentation.
3. Athletic mouth guard, enamel microabrasion, and odontoplasty.
4. Services or supplies that have the primary purpose of improving the appearance of the teeth. This includes, but is not limited to whitening agents, tooth bonding and veneers.
5. Base or liner used under a restoration.
6. Sedative Fillings
7. Oral Hygiene Instructions

**BASIC ENDODONTIC SERVICES (NERVE OR PULP TREATMENT)**

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**Endodontic Therapy on Primary Teeth**

- **Pulpal Therapy**
- **Therapeutic Pulpotomy**

**Endodontic Therapy on Permanent Teeth**

- **Root Canal Therapy**
- **Apicoectomy**
- **Root Amputation on posterior (back) teeth**

**Complex or other Endodontic Services**

- **Apexification**
- **Retrograde filling**
- **Hemisection, includes root removal**

LIMITATION: All of the above procedures are covered 1 time per tooth per lifetime.

LIMITATION: Retreatment of endodontic procedures are covered 1 time per tooth per lifetime and shall be benefited only after 6 months following the completion of the original endodontic procedure.

EXCLUSIONS - Coverage is NOT provided for:

1. Removal of pulpal debridement, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
2. Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.

3. Intentional reimplantation.

### **PERIODONTICS (GUM & BONE TREATMENT )**

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**Basic Non Surgical Periodontal Care** – Treatment for diseases for the gingival (gums) and bone supporting the teeth.

- **Periodontal scaling & root planning** – covered once per 24-month period
- **Full mouth debridement** – covered once per lifetime

**Complex Surgical Periodontal Care** – Surgical treatment for diseases for the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services under this plan and are covered once per 36-month period.

- **Gingivectomy/gingivoplasty**
- **Gingival curettage**
- **Gingival flap**
- **Apically positioned flap**
- **Osseous Surgery**
- **Bone replacement graft**
- **Pedicle soft tissue graft**
- **Free soft tissue graft**
- **Subepithelial connective tissue graft**
- **Distal/proximal wedge**

### **EXCLUSIONS – Coverage is NOT provided for:**

1. The controlled release of therapeutic agents or biologic materials used to aid in soft tissue and osseous tissue regeneration.
2. Temporary procedures or interim stabilization of teeth.
3. Analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care.
4. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening are not a covered benefit.
5. Bacteriologic tests for determination of periodontal disease or pathologic agents.

### **ORAL SURGERY (TOOTH, TISSUE, OR BONE REMOVAL)**

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#### **Basic Extractions**

- Removal of Coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth
- Extraction of erupted tooth or exposed root

### **Complex Surgical Extractions**

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

### **Other Complex Surgical Procedures**

- Oroantral fistula closure
- Tooth reimplantation – accidentally evulsed or displaced tooth
- Surgical exposure of impacted or unerupted tooth to aid eruption
- Biopsy of oral tissue
- Transseptal fiberotomy
- Alveoloplasty
- Vestibuloplasty
- Excision of lesion or tumor
- Removal of nonodontogenic or odontogenic cyst or tumor
- Removal of exostosis
- Partial ostectomy
- Incision & drainage of abscess
- Frenulectomy (frenectomy or frenotomy)

LIMITATIONS: The above Oral Surgery procedures are covered once per tooth per lifetime.

EXCLUSIONS - Coverage is NOT provided for:

1. Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.
2. Any artificial material implanted or grafted into or onto bone or soft tissue, including implant procedures and associated fixtures, or surgical removal of implants.
3. Surgical repositioning of teeth.
4. Inpatient or outpatient hospital expenses.
5. Cytology sample collection – Collection of oral cytology sample via scraping of the oral mucosa.
6. Analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care.
7. Congenital (hereditary) or developmental (following birth) malformations or cosmetic surgery or dentistry for purely cosmetic reasons including but not limited to: cleft palate, maxillary and mandibular (upper and lower jaw) malformations, enamel hypoplasia (lack of development) fluorosis (at type of discoloration of the teeth) and andontia (congenitally missing teeth).

### **COMPLEX OR MAJOR RESTORATIVE SERVICES**

Services performed to restore lost tooth structure as a result of decay or fracture

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**Inlays –** Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

LIMITATION: If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the

Dentist's usual fees for the covered benefit and optional treatment, plus any coinsurance for the covered benefit.

- **Onlays and/or Permanent Crowns** - Covered 1 time per 5 year period per tooth.
- **Implant Crowns** – See Prosthetic Services.
- **Crown Repair** – Covered 1 time per 12-month period per tooth.
- **Restorative cast post and core build-up** – covered once per 5 year period

EXCLUSIONS – Coverage is NOT provided for:

1. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
2. Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
3. Base or liner used under a restoration.
4. Temporary or interim crown.
5. Gold foil restorations.
6. Canal prep & fitting of preformed dowel & post
7. Occlusal procedures, including occlusal guard and adjustments.

**PROSTHETIC SERVICES (DENTURES, PARTIALS, AND BRIDGES)**

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**Reline and Rebase** – Covered 1 per 36-month period;

- when the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge).

**Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s)** – Covered 1 per 12-month period:

- when the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge).

**Denture Adjustments** – Covered 1 time per 12-month period:

- when the denture is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the denture.

**Partial and Bridge Adjustments** – Covered 1 time per 12-month period:

- when the partial or bridge is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the partial or bridge.

**Removable Prosthetic Services (Dentures and Partials) – Covered 1 time per 5-year period;**

- for covered persons age 16 or older;
- for the replacement of extracted (removed) permanent teeth;
- if 5 years have elapsed since the last benefited removable prosthetic appliance (denture or partial) and the existing appliance needs replacement because it cannot be repaired or adjusted.

**Fixed Prosthetic Services (Bridge) – Covered 1 time per 5 year period;**

- for covered persons age 16 or older;
- for the replacement of extracted (removed) permanent teeth;
- if none of the individual units of the bridge has been benefited previously as a crown or cast restoration in the last 5 years;
- if 5 years have elapsed since the last benefited removable prosthetic appliance (bridge) and the existing appliance needs replacement because it cannot be repaired or adjusted.

**Implant Supported Fixed and Removable Prosthetic (Crowns, Bridges, Partials and Dentures) – A restoration that is retained, supported and stabilized by an implant. Implants and related services are NOT covered.**

LIMITATION: This procedure receives an optional treatment benefit equal to the least expensive professionally acceptable treatment. The additional fee is the patient's responsibility. For example: A single crown to restore one open space will be given the benefit of a Fixed Partial Denture Pontic (one unit). The optional benefit is subject to all contract limitations on the benefited service.

EXCLUSIONS – Coverage is NOT provided for:

1. The replacement of an existing partial denture with a bridge.
2. Initial installation of full or partial dentures or fixed bridgework to replace a tooth (teeth) which was extracted prior to becoming a Covered Person under this Plan.
3. Coverage for congenitally missing teeth
4. Interim removable or fixed prosthetic appliances (dentures, partials or bridges)
5. Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges)
6. Additional, elective or enhanced prosthodontic procedures including but not limited to connector bar(s), stress breakers, and precision attachments.
7. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
8. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
9. Services or supplies that have the primary purpose of improving the appearance of your teeth.
10. Placement or removal of sedative filling, base or liner used under a restoration.
11. Restorative cast post and core build-up, including pins and posts.

12. Any artificial material implanted or grafted into or onto bone or soft tissue, including implant procedures and associated fixtures, or surgical removal of implants.
13. Coverage shall be limited to the least expensive professionally acceptable treatment.

### **Exclusions**

Coverage is NOT provided for:

- a) Dental services which a Covered Person would be entitled to receive for a nominal charge or without charge if this Contract were not in force under any Worker's Compensation Law, Federal Medicare program, or Federal Veteran's Administration program. However, if a Covered Person receives a bill or direct charge for dental services under any governmental program, then this exclusion shall not apply. Benefits under this Contract will not be reduced or denied because dental services are rendered to a subscriber or dependent who is eligible for or receiving Medical Assistance.
- b) Dental services or health care services not specifically covered under the Group Dental Plan Contract (including any hospital charges).
- c) New, experimental or investigational dental techniques or services may be denied until there is, to the satisfaction of the Plan, an established scientific basis for recommendation.
- d) Dental services performed for cosmetic purposes. NOTE: Dental services are subject to post-payment review of dental records. If services are found to be cosmetic, we reserve the right to collect any payment and the member is responsible for the full charge.
- e) Dental services completed prior to the date the Covered Person became eligible for coverage.
- f) Services of anesthesiologists.
- g) Anesthesia Services, except by a Dentist or by an employee of the Dentist when the service is performed in his or her office and by a dentist or an employee of the dentist who is certified in their profession to provide anesthesia services.
- h) Analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care. NOTE: Intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.
- i) Dental services performed other than by a licensed dentist, licensed physician, his or her employees.
- j) Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- k) Artificial material implanted or grafted into or onto bone or soft tissue, including implant services and associated fixtures, or surgical removal of implants.
- l) Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- m) Orthodontic treatment services, unless specified in this Dental Benefit Plan Summary as a covered dental service benefit.
- n) Case presentations.
- o) Incomplete services.
- p) Athletic mouth guards, enamel microabrasion and odontoplasty.
- q) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the plan.

- r) Cytology sample collection.
- s) Separate services billed when they are an inherent component of a Dental Service where the benefit is reimbursed at an Allowed Amount.
- t) Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges).
- u) Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- v) Temporary procedures or interim stabilization.
- w) Base or liner used under a restoration.
- x) Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.
- y) Congenital (hereditary) or developmental (following birth) malformations or cosmetic surgery or dentistry for purely cosmetic reasons including but not limited to: cleft palate, maxillary and mandibular (upper and lower jaw) malformations, enamel hypoplasia (lack of development) fluorosis (at type of discoloration of the teeth) and andontia (congenitally missing teeth).
- z) Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening are not a covered benefit.
- aa) Sedative Fillings.
- bb) Oral Hygiene Instructions.
- cc) Gold foil restorations.
- dd) Canal prep & fitting of preformed dowel & post
- ee) Occlusal procedures, including occlusal guard and adjustments.

### **Limitations**

- a) Optional Treatment Plans: in all cases in which there are alternative treatment plans carrying different costs, the decision as to which course of treatment to be followed shall be solely that of the Covered Person and the dentist; however, the benefits payable hereunder will be made only for the applicable percentage of the least costly, commonly performed course of treatment, with the balance of the treatment cost remaining the payment responsibility of the Covered Person.

For other dental procedure exclusions and limitations, refer to the Description of Coverages in this Dental Benefit Plan Summary.

### **Post Payment Review**

Dental services are evaluated after treatment is rendered for accuracy of payment, benefit coverage and potential fraud or abuse as defined in the Health Insurance Portability and Accountability Act of 1996 – Public Law 102-191. Any payments for dental services completed solely for cosmetic purposes or payments for services not performed as billed are subject to recovery.

### **Optional Treatment Plans**

In all cases in which there are alternative treatment plans carrying different costs, the decision as to which course of treatment to be followed shall be solely that of the Covered Person and the dentist; however, the benefits payable hereunder will be made only for the applicable percentage of the least costly, commonly performed course of treatment, with the balance of the treatment cost remaining the payment responsibility of the Covered Person.

## **ELIGIBILITY**

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Covered Persons under this Program are:

### **Employees**

- a) All eligible employees who have met the eligibility requirements as established by the Group and stated within this Dental Benefit Plan Summary under Effective Dates of Coverage.
- b) Employees on Family and Medical Leave as mandated by the Federal FMLA.

### **Dependents**

A) Spouse, meaning:

1. Married;
2. Legally separated;
3. Domestic partners; NOTE: Check with your Group Administrator to determine whether or not you have domestic partner coverage available to you under this Plan.

B) Unmarried dependent children to the age of 25, including:

1. Natural-born and legally adopted children (including children placed with you for legal adoption. NOTE: A child's placement for adoption terminates upon the termination of the legal obligation of total or partial support.
2. Stepchildren who reside with you.
3. Grandchildren who are financially dependent on you and reside with you.
4. Other children who live with you and are claimed as exemptions on your Federal income tax return.
5. Children who are required to be covered by reason of a Qualified Medical Child Support Order. You can obtain, without charge, a copy of procedures governing Qualified Medical Child Support Orders ("QMCSOs") from the Plan.
6. Children who become handicapped prior to reaching the Plan's limiting age if:
  - they are primarily dependent upon you; and
  - are incapable of self-sustaining employment because of physical handicap, mental retardation, mental illness or mental disorders;

NOTE: If both you and your spouse are employees of the employer, you may be covered as either an employee or as a dependent, but not both. Your eligible dependent children may be covered under either parent's coverage, but not both.

### **Effective Dates of Coverage**

Eligible Employee:

You are covered under this program on the date your company begins participation in the program, or if you are a new employee of the Group, on the date following your company's probationary period.

## Eligible Dependents:

Your eligible dependents, as defined, are covered under this Program:

- a) On the date you first become eligible for coverage, if dependent coverage is provided or elected.
- b) On the date you first acquire eligible dependents, or add dependent coverage subject to the open enrollment requirements of the Group, if any.
- c) On the date a new dependent is acquired if you are already carrying dependent coverage.  
LIMITATION: Dependents of an eligible employee who are in active military service are not eligible for coverage under the Program.

Children may be added to the Program at the time the eligible employee originally becomes effective or may be added anytime up to 30 days following the child's 3<sup>rd</sup> birthday. If a child is born or adopted after the employee's original effective date, such child may be added anytime between birth (or date of adoption) and 30 days following the child's 3<sup>rd</sup> birthday. In the event that the child is not added by 30 days following their 3<sup>rd</sup> birthday, that child may be added only if there is a Family Status Change or at the next Open Enrollment period, if any.

The eligibility of all Covered Persons, for the purposes of receiving benefits under the Program, shall, at all times, be contingent upon the applicable monthly payment having been made for such Covered Person by the Group on a current basis.

Your contribution towards the cost of the coverage under the Plan will be determined by the Employer each year and communicated to you prior to the effective date of any changes in the cost of the coverage.

## Open Enrollment

Contact your Group Administrator for information regarding the Open Enrollment options offered by your Employer.

## Late Enrollees

If an Eligible Employee fails to enroll for employee and/or dependent coverage within thirty-one (31) days of the eligibility date or later terminates coverage, the employee and/or dependents will be considered Late Enrollees. Late Enrollees may only apply to enroll during the annual Open Enrollment period. Late enrollees shall be provided coverage, if any, only to the extent elected by the Employer.

## Family Status Change

Your benefit elections are intended to remain the same for the entire Coverage Year. During the Coverage Year, you will be allowed to change your benefits only if you experience an eligible Family Status Change which includes:

- Change in legal marital status such as marriage or divorce.
- Change in number of dependents in the event of birth, adoption, or death.
- Change in your or your spouse's employment – either starting or losing a job.
- Change in your or your spouse's work schedule, such as going from full-time to part-time or part-time to full-time, or beginning or ending an unpaid leave of absence.
- Change in dependent status, such as if a child reaches maximum age under the Plan.
- Change in residence or work location so you are no longer eligible for your current dental plan.
- Loss of other coverage.

Due to federal regulations, the changes you make to your benefits must be consistent with the Family Status Change event that you experience. For example, if you have a baby, it is consistent to add your newborn to your current dental coverage but it not consistent to drop your dental coverage altogether.

If you experience one of the eligible Family Status Changes during the year, you have 31 days from the event to change your elections. If you do not change your benefits within 31 days of the event, you will not be allowed to make changes until the next Open Enrollment period. You may obtain a Family Status Change Form by contacting your Employer. All changes are effective the date of the change.

**Termination of Coverage**

Your coverage and that of your eligible dependents ceases on the earliest of the following dates:

- a) The end of the month in which (1) you cease to be eligible; (2) your dependent is no longer eligible as a dependent under the Program.
- b) On the date the Program is terminated.
- c) On the date the Group terminates the Program by failure to pay the required Group Subscriber payments, except as a result of inadvertent error.

For extended eligibility, see Continuation of Coverage.

The Group or Plan Sponsor reserves the right to terminate the Plan, in whole or in part, at any time (subject to applicable collective bargaining agreements). Termination of the Plan will result in loss of benefits for all covered persons. If the Plan is terminated, the rights of the Plan Participants are limited to covered expenses incurred before termination.

**Continuation of Coverage (COBRA)**

Dental benefits may be continued should any of the following events occur, provided that at the time of occurrence this Program remains in effect and you or your spouse or your dependent child is a Covered Person under this Program:

<b>QUALIFYING EVENT</b>	<b>WHO MAY CONTINUE</b>	<b>MAXIMUM CONTINUATION PERIOD</b>
Employment ends, retirement, leave of absence, lay-off, or employee becomes ineligible (except gross misconduct dismissal)	Employee and dependents	Earliest of: 1. 18 months, or 2. Enrollment in other group coverage, or 3. Date coverage would otherwise terminate.
Divorce, marriage dissolution, or legal separation	Former Spouse and any dependent children who lose coverage	Earliest of: 1. 36 months, or 2. Enrollment date in other group coverage, or 3. Date coverage would otherwise terminate.
Death of Employee	Surviving spouse and dependent children	Earliest of: 1. 36 months, or 2. Enrollment date in other group coverage, or 3. Date coverage would have otherwise terminated under the contract had the employee lived.

Dependent child loses eligibility	Dependent child	Earliest of: 1. 36 months, or 2. Enrollment date in other group coverage, or 3. Date coverage would otherwise terminate.
Dependents lose eligibility due to Employee's entitlement to Medicare	Spouse and dependents	Earliest of: 1. 36 months, or 2. Enrollment date in other group coverage, or 3. Date coverage would otherwise terminate.
Employee's total disability	Employee and dependents	Earliest of: 1. 29 months, or 2. Date total disability ends, or 3. Date coverage would otherwise terminate.
Retirees of employer filing Chapter 11 bankruptcy (includes substantial reduction in coverage within 1 year of filing)	Retiree and dependents	Earliest of: 1. Enrollment date in other group coverage, or 2. Death of retiree or dependent electing COBRA.
Surviving Dependents of retiree on lifetime continuation due to the bankruptcy of the employer	Surviving Spouse and dependents	Earliest of: 1. 36 months following retiree's death, or 2. Enrollment date in other group coverage.

You or your eligible dependents have 60 days from the date you lose coverage, due to one of the events described above, to inform the Group that you wish to continue coverage.

#### 1. Choosing Continuation

If you lose coverage, your employer must notify you of the option to continue coverage within 14 days after employment ends. If coverage for your dependent ends because of divorce, legal separation, or any other change in dependent status, you or your covered dependents must notify your employer within 60 days.

You or your covered dependents must choose to continue coverage by notifying the employer in writing. You or your covered dependents have 60 days to choose to continue, starting with the date of the notice of continuation or the date coverage ended, whichever is later. Failure to choose continuation within the required time period will make you or your covered dependents ineligible to choose continuation at a later date. You or your covered dependents have 45 days from the date of choosing continuation to pay the first continuation charges. After this initial grace period, you or your covered dependents must pay charges monthly in advance to maintain coverage in force.

Charges for continuation are the group rate plus a two percent administration fee. If you or your covered dependents are totally disabled, charges for continuation are the group rate plus a two percent administration fee for the first 18 months. For months 19 through 29, a charge of the group rate plus a 50 percent administration fee may be charged.

## 2. Second qualifying event

If a second qualifying event occurs during continuation, a dependent qualified beneficiary may be entitled to election rights of their own and an extended continuation period. This rule only applies when the initial qualifying event for continuation is the employee's termination of employment, retirement, leave of absence, layoff, or reduction of hours.

When a second qualifying event occurs such as the death of the former covered employee, the dependent must notify the employer of the second event within 30 days after it occurs in order to continue coverage. In no event will the first and second period of continuation extend beyond the earlier of the date coverage would otherwise terminate or 36 months.

A qualified beneficiary is any individual covered under the dental plan the day before the qualified event as well as a child who is born or placed for adoption with the covered employee during the period of continuation coverage.

## 3. Terminating Continuation of Coverage – COBRA

Continuation of Coverage – COBRA for you and your eligible dependents, if selected, shall terminate on the last day of the month in which any of the following events first occur:

- a) The expiration of the specified period of time for which Continuation of Coverage – COBRA can be maintained; as mandated by applicable State or Federal law;
- b) This Program is terminated by the Group Subscriber;
- c) The Group Subscriber's or Covered Person's failure to make the payment for the Covered Person's Continuation of Coverage;

Questions regarding Continuation of Coverage – COBRA should be directed to your employer. Your employer will explain the regulations, qualifications and procedures required when you continue coverage.

## **PLAN PAYMENTS**

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### **Participating Dentist Network**

A participating DeCare Dental Encompass network dentist is a dentist who has signed a participating agreement with DeCare Dental Networks, LLC., which provides the network that is being used by Securian Life Insurance Company. The dentist has agreed to accept DeCare Dental Networks, LLC. DeCare Dental Encompass network's allowable charge as payment in full for covered dental care. You will be responsible for any applicable deductible and coinsurance amounts listed in the Summary of Dental Benefits section. A network dentist will not bill more than DeCare Dental Networks, LLC.'s allowable charge. A participating DeCare Dental Encompass network dentist will usually file the claim directly with Securian.

Listings of participating providers are available to Subscribers as a separate document and are furnished by the Group without charge. Names of Participating Dentists can be obtained, upon request, by calling Securian, from directory listings furnished to the Group, from the Plan's internet website at [www.securiandental.com](http://www.securiandental.com) or by contacting your provider.

## **Covered Fees**

Under this Program, YOU ARE FREE TO GO TO THE DENTIST OF YOUR CHOICE. You may have additional out-of-pocket costs if your dentist is not a participating dentist of the plan. This payment difference could result in some financial liability to you. The amount is dependent on the nonparticipating dentist's usual fees in relation to the Table of Allowances determined by DeCare Dental Networks, LLC.

TO AVOID ANY MISUNDERSTANDING OF BENEFIT PAYMENT AMOUNTS, ASK YOUR DENTIST ABOUT HIS OR HER NETWORK PARTICIPATION STATUS PRIOR TO RECEIVING DENTAL CARE.

## **Claim Payments**

**Payments are made by the Plan only when the covered dental procedures have been completed. The Plan may require additional information from you or your provider before a claim can be considered complete and ready for processing. In order to properly process a claim, the Plan may be required to add an administrative policy line to the claim. Duplicate claims previously processed will be denied.**

Participating DeCare Dental Encompass Network Dentists:

Claim payments are based on the actual charge, the amount accepted by the dentist as payment in full or the Schedule of Allowances, whichever is less. Claim payments are sent directly to your Dentist unless it was noted on the claim that payment had previously been made by you. You will be responsible for any non-covered services, as well as applicable deductible and coinsurance amounts listed in the Summary of Dental Benefits section.

Nonparticipating Dentists:

Claim payments are based on the treating dentist's submitted charge or the Schedule of Allowances established solely by DeCare Dental Networks, LLC., whichever is less. Claim payments are sent directly to your Dentist unless it was noted on the claim that payment had previously been made by you.

## **Coordination of Benefits (COB)**

If you or your dependents are eligible for dental benefits under this Program and under another dental program, benefits will be coordinated so that no more than 100% of the "Allowable Charges" is paid jointly by the programs. "Allowable Charges", as defined above, are determined prior to calculating all percentages, deductibles and benefit maximums.

The Coordination of Benefits provision determines which program has the primary responsibility for providing the first payment on a claim. In establishing the order, the program covering the patient as an employee has the primary responsibility for providing benefits before the program covering the patient as a dependent. If the patient is a dependent child, the program with the parent whose month and day of birth falls earlier in the calendar year has the primary payment responsibility. If both parents should have the same birth date, the program in effect the longest has the primary payment responsibility. If the other program does not have a Coordination of Benefits provision, that program most generally has the primary payment responsibility.

NOTE: When Coordination of Benefits applies for dependent children, provide your dentist with the birth dates of both parents.

## **Claim and Appeal Procedures**

### Initial Claim Determinations

All claims should be submitted within 90 days from the date of service, but no later than 12 months. Your claim will not be invalidated or reduced, however, if you can prove that you could not reasonably give notice within that time and that you did give notice as soon as it was reasonably possible to do so. An initial benefit determination on your claim will be made within 30 days after receipt of your claim. You will receive written notification of this benefit determination. The 30-day period may be extended for an additional 15 days if the claim determination is delayed for reasons beyond our control. In that case, we will notify you prior to the expiration of the initial 30-day period of the circumstances requiring an extension and the date by which we expect to render a decision. If the extension is necessary to obtain additional information from you, the notice will describe the specific information we need, and you will have 45 days from the receipt of the notice to provide the information. Without complete information, your claim will be denied.

To submit a claim you may use the American Dental Association Universal Claim Form, Securian Life Insurance Company's claim form or your bill along with the subscriber and patient's name, subscriber's identification number and group number. The bill must include the patient's name, patient's date of birth, date of service, procedure code, charge and dentist's signature. Securian's forms are available on our website or from Customer Service. If you are not provided a claim form within 15 days after notifying Securian of any claim you shall be deemed to have complied with the requirements of this Certificate as to proof of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

No action at law or in equity shall be brought to recover on the policy prior to the expiration of 60 days after proof of loss has been filed and no such action shall be brought at all, unless brought within 2 years from the expiration of the time within which proof of loss is required.

### Appeals

In the event that we deny a claim in whole or in part, you have a right to a full and fair review. Your request to review a claim must be in writing and submitted within 180 days from the claim denial. We will make a benefit determination within 60 days following receipt of your appeal.

Your appeal must include your name, your identification number, group number, claim number, and dentist's name as shown on the Explanation of Benefits. Send your appeal to:

Attention: Appeals Unit  
PO Box 551  
Minneapolis, MN 55440-0551

You may submit written comments, documents, or other information in support of your appeal. You will also be provided, upon request and free of charge, reasonable access to and copies of all relevant records used in making the decision. The review will take into account all information regarding the denied or reduced claim (whether or not presented or available at the initial determination) and the initial determination will not be given any weight.

The review will be conducted by someone different from the original decision-makers and without deference to any prior decision. Because all benefit determinations are based on a preset schedule of dental services eligible under your plan, claims are not reviewed to determine dental necessity or appropriateness. In all cases where professional judgment is required to determine if a procedure is covered under your plan's schedule of benefits, we will consult with a dental professional who has appropriate training and experience. In such a case, this professional will not be the same individual whose advice was obtained in connection with the initial adverse benefit determination (nor a subordinate

of any such individual). In addition, we will identify any dental professional whose advice was obtained on our behalf, without regard to whether the advice was relied upon in making the benefit determination. If, after review, we continue to deny the claim, you will be notified in writing.

#### Authorized Representative

You may authorize another person to represent you and with whom you want us to communicate regarding specific claims or an appeal. However, no authorization is required for your treating dentist to make a claim or appeal on your behalf. The authorization form must be in writing, signed by you, and include all the information required in our Authorized Representative form. This form is available by calling Customer Service. You can revoke the authorized representative at any time, and you can authorize only one person as your representative at a time.

## **GENERAL INFORMATION**

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### **Dental Plan Issuer Involvement**

Securian Life Insurance Company is the dental plan issuer involved with the Plan. Its address is stated on the back cover of this booklet. The benefits under the Plan are guaranteed by Securian Life Insurance Company under the Contract.

### **Privacy Notice**

Securian Life Insurance Company will not disclose non-public personal financial or dental information concerning persons covered under our dental benefit plans to non-affiliated third parties except as permitted by law or required to adjudicate claims submitted for dental services provided to persons covered under our dental benefit plans.

### **Using Your Dental Program**

Dentists who participate with Securian under this Program are independent contractors. The relationship between you and the participating dentist you select to provide your dental services is strictly that of provider and patient. Securian cannot and does not make any representations as to the quality of treatment outcomes of individual dentists, nor recommends that a particular dentist be consulted for professional care.

All claims should be submitted within 12 months of the date of service.

Most dentists will provide and file the claim form on your behalf. If you need a claim form to file ask your dentist for an ADA Universal claim form, or check Securian's web-site.

The dental office may file the claim form with the Plan; however, you may be required to assist in completing the patient information portion on the form (Items 1 through 14).

During your first dental appointment, it is very important to advise your dentist of the following information:

- \* YOUR SECURIAN GROUP NUMBER
- \* YOUR EMPLOYER (GROUP NAME)
- \* YOUR IDENTIFICATION NUMBER (your dependents must use **YOUR** identification number)
- \* YOUR BIRTHDAY AND THE BIRTH DATES OF YOUR SPOUSE AND DEPENDENT CHILDREN

## **Cancellation and Renewal**

The Program may be canceled by the Plan only on an anniversary date of the Group Dental Plan Contract, or at any time the Group fails to make the required payments, if membership in your Group falls below the minimum number of Subscribers we require or the Group fails to meet the terms of the Contract. Subscription charges for the Contract are generally paid through payroll deductions or paid by the Group who acts as your remitting agent. The subscription charges must be paid when due or your coverage will end. Coverage will automatically be reinstated if we receive the correct charges within thirty days (30) of the due date (the grace period). Notice of termination will be made to you 10 days prior to cancellation. It is entirely our choice whether to allow reinstatement once the grace period has ended.

Upon cancellation of the Program, Covered Persons of the Group have no right to continue coverage under the Program or convert to an individual dental coverage contract.

# **SECURIAN LIFE INSURANCE COMPANY**

**FOR CLAIMS AND ELIGIBILITY**  
Securian Life Insurance Company  
P.O. Box 231  
Minneapolis, MN 55440  
1-800-234-9009

**CORPORATE ADMINISTRATIVE MAILING ADDRESS**  
Securian Life Insurance Company  
P.O. Box 231  
Minneapolis, MN 55440  
1-800-234-9009

## **SUMMARY OF DENTAL BENEFITS**

**Group No. 41220**

After you have satisfied the deductible, if any, your dental program pays the following percentages of the treatment cost, up to a maximum fee for each completed Dental Service. The maximum fee payable by Securian for each Dental Procedure is determined by Securian.

Diagnostic and Preventive Services .....	100%
Basic Services* .....	80%
Endodontics* .....	80%
Periodontics* .....	80%
Oral Surgery* .....	80%
Major Restorative Services** .....	50%
Prosthetic Repairs and Adjustments** .....	50%
Prosthetics** .....	50%

\*6 month waiting period must be satisfied before benefits can be received

\*\*12 month waiting period must be satisfied before benefits can be received

### **Benefit Maximums:**

The Program pays up to a maximum of \$1,000.00 for each Covered Person per Coverage Year subject to the coverage percentages identified above. Benefit Maximums may not be carried over to future coverage years.

### **Deductible**

There is a \$50 deductible per Covered Person each Coverage Year not to exceed three (3) times that amount (\$150) per Family Unit.

The deductible does not apply to Diagnostic and Preventive services.

### **Coverage Year**

A Coverage Year is a 12-month period in which deductibles and benefit maximums apply. Your Coverage Year is JANUARY through DECEMBER.