

Voluntary Dental PPO

Good news about dental benefits for employees of **Madison Lutheran Home**

Dental Plan Choice

Our company understands that today's employees demand choice. That's why we offer a voluntary dental program that allows you to choose between a basic and deluxe plan.

The Hi-Lo Choice provides you with the freedom to choose a dental plan that best fits your individual needs. Compare the cost and benefits of each plan, then determine which plan will work best for you and your family.

Plan Features:

- Freedom to choose any dentist, including specialists
- PPO options available¹
- 24-month rate guarantee

How the Plan Works

This dental plan provides a variety of benefits and allows you and your family to use any dentist or specialist you choose. Benefits are paid after any applicable deductible has been met, up to the annual maximum. Claim payments may be made to you or your dentist, whichever you prefer.

You may find a DHA provider by visiting the Assurant Employee Benefits web site at www.assurantemployeebenefits.com – Select “For Members” – “Find a dentist” – “DHA - Premier”. Or call customer service at 800.442.7742.

The Choice Is Yours

Freedom Basic provides coverage for some of the more common dental procedures. Freedom Preferred also offers valuable protection, and provides increased benefits over the Freedom Basic plan.

IMPORTANT:

Coverage for eligible employees will begin September 1, 2010. You must sign up by the Initial Enrollment Deadline, or forfeit the opportunity until the next plan anniversary date.

¹*This dental program offers a PPO (Preferred Provider Organization) through Dental Health Alliance (DHA[®]) that provides a variety of cost saving features. Although you may visit any dentist you choose, you will receive maximum savings if you visit a DHA[®] provider. The allowable amount for non-participating dentists is based on the usual and customary. Patients are responsible for fees in excess of usual and customary.*

Plan frequencies, limitations and waiting periods apply.

Assurant Employee Benefits is the brand name used for insurance products underwritten and issued by Union Security Insurance Company.

Savings You Can See

Monthly Payroll Deduction

Employee	\$20.94
Employee + 1 Dependent	\$41.58
Employee + 2 or more Dependents	\$81.89

Freedom Basic-PPO

Yearly Benefit Maximum:

Per Person, Per Policy Year	\$1,000
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Coinsurance Percentage Per Person:

Type I Dental Services	100%
Type II Dental Services	80%

Deductible:

Per Person, Per Policy Year	\$50
Waived for Type I Services	Yes

Type I Preventive Dental Services, Including:

- ◆ Oral Evaluations – once in any 6-month period
- ◆ Routine Dental Cleanings – once in any 6-month period (frequency combined with periodontal maintenance)
- ◆ Fluoride Treatment – once in any 12-month period
Only for children under age 14
- ◆ Genetic Test for Susceptibility to Oral Diseases
- ◆ Sealants – No more than once per tooth per person, only for permanent molar teeth.
Only for children under age 16
- ◆ Space Maintainer
Only for children under age 16
- ◆ Bitewing X-Rays – once in any 12-month period

Type II Basic Dental Services, Including:

- ◆ X-Rays:
 - ◆ Panoramic or complete series – once in any 60-month period
 - ◆ Other X-Rays (See Certificate of Insurance)
- ◆ New Fillings, including posterior composites
- ◆ Replacement Fillings – once in any 24-month period per Filling
- ◆ Simple Extractions, Removal of Exposed Roots, Incision and Drainage
- ◆ Certain Lab Tests, Pain Treatment, Therapeutic Drug Injections
- ◆ Minor Gum Disease Treatment: (Minor Periodontics)
- ◆ Provisional Splinting, Occlusal Adjustments – once in any 12-month period
- ◆ Scaling and Root Planing – once in any 24-month period per area
- ◆ Localized Delivery of Antimicrobial Agents
- ◆ Periodontal Maintenance – once in any 3 consecutive months (frequency combined with routine dental cleanings)

Other Policy Provisions

Benefit Adjustments

Benefits will be coordinated with any other dental coverage. Under the Alternative Treatment provision, benefits will be payable for the most economical services or supplies meeting broadly accepted standards of dental care. If the cost of a

proposed Dental Treatment Plan exceeds \$300, it should be submitted for an estimate of benefits payable.

Eligibility

Full-time employee, spouse and dependent children less than age 26.

Late Entrants

If you elect coverage more than 31 days after your Eligibility Date, your Effective Date will be delayed to the next plan Anniversary Date.

This is a brief description only. It is not a Certificate of Coverage. Please see the Group Policy, which alone determines all rights, benefits, and applicable Limitations and Exclusions. We and the policyholder have the option to cancel the group policy.

Savings You Can See

Monthly Payroll Deduction

Employee	\$32.45
Employee + 1 Dependent	\$62.07
Employee + 2 or more Dependents	\$104.32

Freedom Preferred-PPO

Yearly Benefit Maximum:

Per Person, Per Policy Year	\$1,000
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Coinsurance Percentage Per Person:

Type I Dental Services	100%
Type II Dental Services	80%
Type III Dental Services	50%

Deductible:

Per Person, Per Policy Year	\$50
Waived for Type I Services	Yes

Type I Preventive Dental Services, Including:

- ◆ Oral Evaluations – once in any 6-month period
- ◆ Routine Dental Cleanings – once in any 6-month period (frequency combined with periodontal maintenance)
- ◆ Fluoride Treatment – once in any 12-month period
Only for children under age 14
- ◆ Genetic Test for Susceptibility to Oral Diseases
- ◆ Sealants – No more than once per tooth per person, only for permanent molar teeth
Only for children under age 16
- ◆ Space Maintainer
Only for children under age 16
- ◆ Bitewing X-Rays – once in any 12-month period

Type II Basic Dental Services, Including:

- ◆ X-Rays:
 - ◆ Panoramic or complete series – once in any 60-month period
 - ◆ Other X-Rays (See Certificate of Insurance)
- ◆ New Fillings, including posterior composites
- ◆ Replacement Fillings – once in any 24-month period per Filling
- ◆ Simple Extractions, Removal of Exposed Roots, Incision and Drainage
- ◆ Certain Lab Tests, Pain Treatment, Therapeutic Drug Injections

Type III Major Dental Services, Including:

- ◆ Endodontics (includes root canal therapy)
- ◆ Endodontic retreatment (covered after 24 months have passed from initial treatment)
- ◆ Complex Oral Surgery; General Anesthesia and IV Sedation when medically required for such Surgery
- ◆ Biopsy (including brush biopsy)
- ◆ Minor Gum Disease Treatment: (Minor Periodontics)
 - ◆ Provisional Splinting, Occlusal Adjustments – once in any 12-month period
 - ◆ Scaling and Root Planing – once in any 24-month period
 - ◆ Localized Delivery of Antimicrobial Agents
 - ◆ Periodontal Maintenance – once in any 3 consecutive months (frequency combined with routine dental cleanings)
- ◆ Major Gum Disease Treatment: (Major Periodontics)

- ◆ Gingivectomy, Osseous Surgery, other major periodontic procedures – once in any 36-month period per area
- ◆ Initial Placement, Replacement and Maintenance of Inlays, Onlays, Crowns, Fixed Partial Dentures (Bridges), and Partial and Complete Dentures

Waiting Periods for Certain Services

	From Your Effective Date
<i>Repairs, Re-Cementing of Fixed Partial (Bridges), Inlays, Onlays, or Crowns</i>	None
<i>Accidental Non-Chewing Injury</i>	None
<i>All Services under Endodontics (Includes root canal therapy)</i>	6 months
<i>Stainless Steel/Plastic Crowns Only for children under age 16</i>	6 months
<i>Relines, Rebases, Denture Adjustment</i>	6 months
<i>Complex Oral Surgery</i>	12 months
<i>All Services under Minor and Major Periodontics</i>	12 months
<i>Crown/Inlays/Onlays/Labial Veneers</i>	12 months
<i>Dentures (Partial or Complete)</i>	12 months
<i>Fixed Partial Dentures (Bridges)/Diagnostic Casts</i>	12 months

Other Policy Provisions

Benefit Adjustments

Benefits will be coordinated with any other dental coverage. Under the Alternative Treatment provision, benefits will be payable for the most economical services or supplies meeting broadly accepted standards of dental care. If the cost of a proposed Dental Treatment Plan exceeds \$300, it should be submitted for an estimate of benefits payable.

Eligibility

Full-time employee, spouse and dependent children less than age 26.

Late Entrants

If you elect coverage more than 31 days after your Eligibility Date, your Effective Date will be delayed to the next plan Anniversary Date.

This is a brief description only. It is not a Certificate of Coverage. Please see the Group Policy, which alone determines all rights, benefits, and applicable Limitations and Exclusions. We and the policyholder have the option to cancel the group policy.

Limitations & Exclusions

Benefits are not payable for:

Treatment which is not dentally necessary, does not have uniform professional endorsement or is experimental or investigational in nature; treatment of the temporomandibular joint; treatment related to changing or maintaining vertical dimension, altering or restoring occlusion, bite registration or bite analysis; treatment which does not have a reasonably favorable prognosis; treatment provided primarily for cosmetic purposes; replacement of natural teeth missing on the effective date of insurance; orthodontic treatment, unless such insurance is provided under the list of covered dental services.

Treatment not included in the list of covered dental services; treatment started before the date insurance begins; treatment started before any applicable waiting period has been served; treatment completed after insurance ends; athletic mouthguards; replacement of lost or stolen appliances; myofunctional therapy; infection control; oral hygiene instruction; broken appointments; completion of claim forms; exams required by a third party; travel time; transportation costs; professional advice given on the phone.

Treatment received due to war, riot, assault or felony; treatment for a work-related injury; treatment of an intentionally self-inflicted injury; treatment performed outside of the United States, other than emergency dental treatment; treatment provided by the person's employer or a member of the person's immediate family; treatment for which a charge would not have been made in the absence of insurance; treatment for which the insured does not have to pay; treatment that has not been both delivered to and accepted by the insured.

FRAUD STATEMENTS

Please read the following before completing the attached form. To avoid unnecessary delays, be sure all parts of the Application are completed according to the instructions, and **DO NOT SEPARATE** the pages.

- ☞ **If you live in the states of Arkansas, Louisiana, or Rhode Island, the following statement applies to you:**
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.
- ☞ **If you live in the state of California, the following statement applies to you:**
For your protection California law requires the following to appear on the form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
- ☞ **If you live in the state of Colorado, the following statement applies to you:**
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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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.
- ☞ **If you live in the District of Columbia, the following statement applies to you:**
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.
- ☞ **If you live in the state of Florida, the following statement applies to you:**
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.
- ☞ **If you live in the state of Kentucky, the following statement applies to you:**
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
- ☞ **If you live in the state of Maryland, the following statement applies to you:**
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.
- ☞ **If you live in the state of New Hampshire, the following statement applies to you:**
Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.
- ☞ **If you live in the state of Oregon, the following statement applies to you:**
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 may be guilty of insurance fraud.
- ☞ **If you live in the state of Virginia, the following statement applies to you:**
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 may have violated state law.
- ☞ **If you live in a state other than mentioned above, the following statement applies to you:**
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.

Group Insurance Enrollment Card



<p>Check one – Employer Use</p> <p><input type="checkbox"/> Initial Employee:</p> <p style="padding-left: 20px;"><input type="checkbox"/> Transfer from Prior Dental</p> <p style="padding-left: 20px;"><input type="checkbox"/> Non-Transfer</p> <p><input type="checkbox"/> New Employee</p> <p><input type="checkbox"/> Change</p> <p><input type="checkbox"/> Open Enrollment</p>
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(Please print clearly.)

Employer Madison Lutheran Home	Effective Date 09/01/2010	Location/Division
Employee First Name _____ MI _____	Last Name _____	
Address _____	City _____	State _____ Zip _____
Social Security No. _____	Birthdate _____	Date of Hire _____
	Phone _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F

DENTAL COVERAGE

- I APPLY FOR:** **Freedom Basic** (Lo Plan)
- Freedom Preferred** (Hi Plan)
- Employee only
- Employee and eligible dependents

- I DECLINE COVERAGE FOR:**
- Employee
- Spouse
- Child(ren)

Do you have eligible dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," complete below to enroll them.	Relation	Sex	Birthdate			For children age 19 or older, indicate if a full-time student.	
			Mo	Day	Year	Yes	No
Spouse							
Child(ren)							

- List additional Children on reverse side and check box.
- If the address of any child is different than the employee's address, please show that **child's name and address** below.

 - If requesting coverage for a dependent child other than a son or daughter, please forward legal custody papers.

To the best of my knowledge and belief, each of the statements and answers supplied in this form is complete and true, and they constitute the sole basis for, and are the inducement for, the issuance of any insurance.

I hereby apply as indicated herein for the insurance for which I am not now insured and for which I am or may become eligible under the terms of Union Security Insurance Company's group policy or policies (including any future amendments) applying to, or requested to apply to, the employer named above. If such insurance becomes effective, I authorize deductions from my earnings of my contributions required from time to time toward the cost of such insurance. I represent that I am an active full-time employee of that employer. When necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

Date _____ Signature _____