

The Competitor Smile Dental

A Dental Plan for You and Your Family

- Freedom to Choose any Dentist
- Pays Benefits Based on the Reasonable and Customary Fees*
- Automatic Acceptance
- Personal Portability
- Initial Benefits for Preventive Care
- **Included** Orthodontia Coverage
- Choose \$1,000 or \$1,500 Maximum Per Insured Person Per Year
- Direct Bill, List Bill, Automatic Bank Draft, MasterCard, Visa or Discover Card.

Choose Maximum Benefit Options of
\$1,000 or \$ 1,500 Per Insured, Per Year
Benefit Schedule Per Insured Person

Care	Deductible	Benefit	Beginning
Preventative Exams, Cleaning	\$35 Lifetime	80%	Day One
Basic** Fillings, X-Rays, Extractions, Oral Surgery	\$50 Per Year	50%	6 Months
Major** Crowns, Bridges, Root Canals, Dentures, Perio Surgery			15 Months
Orthodontia*** Straightening of Teeth	No Deductible	50%	24 Months

* Reasonable & Customary fees are charges that do not exceed the general level of charges being made by other providers of dental services in the state where the charge is incurred.

**Combined Basic and Major deductible.

***Orthodontia child coverage is Included.

Only available to insured children under age 19 and subject to a maximum benefit of \$500 per year per insured child and a \$1,000 lifetime maximum per insured child.

Please review the actual brochure or Certificate of Coverage for benefit details and for the plans exclusions and limitations. All benefits are subject to the Master Policy series GH-112-3607 issued to the Voluntary Group Trust.

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

Administered By: Health Plan Administrators, Inc.
Rockford, IL

Marketed by:

Health Plan Administrators, Inc.
15436 North Florida Ave, Ste. 105 ~ Tampa, FL 33613
Toll Free: 1-800-277-3323 ~ Fax: 1-888-329-4721
www.HPA-INC.com

COVERED EXPENSES

Deductibles, coinsurance and benefit maximums are per Covered Person.

Preventative Services (immediate coverage - no waiting period)

- Routine oral examinations of mouth and teeth, 2 per calendar year.
- Prophylaxis (cleaning, scaling and polishing teeth), 2 per calendar year.
- Topical fluoride, 1 per calendar year to age 16.
- Space maintainers (non-orthodontic).

Basic Services (subject to a 6 month waiting period)

- Diagnostic X-rays (full or panoramic), 1 in any 3 year period.
- Bitewing X-rays, 2 per calendar year.
- Simple extraction of one or more teeth.
- Pin retention of fillings.
- Fillings (restorations) using amalgam, silicate, acrylic, synthetic porcelain and composite filling materials.
- Antibiotic injections administered by a Dentist.
- Oral surgery and postoperative care for removal of one or more teeth (including impacted teeth), extraction of tooth root, alveolectomy, alveoplasty, frenectomy, excision of pericoronal gingiva, exostosis, hyperplastic tissue, excision or oral tissue for biopsy, reimplantation or transplantation of a natural tooth, excision of a tumor or cyst and incision and drainage of an abscess or cyst.

Major Services (subject to a 15 month waiting period)

- Endodontic treatment of diseases of the tooth, pulp, root, and related tissue.
- Periodontic services.
- Study models, one in 3 year period.
- Crown build-up for non-vital teeth.
- Recementing inlays, onlays and crowns.
- Recementing bridges.
- Repairs to full or partial dentures or bridges, one in any 2 year period and not more than 20% of the cost of replacement (repairs within one year of placement are not covered).
- General anesthesia and analgesic, including intravenous sedation for oral surgery.
- Restoration services (inlays; onlays; crowns).
- Prosthetic services (dentures; bridgework).

Orthodontia Services (Included and subject to a 24 month waiting period)

- Surgical therapy
- Appliance therapy
- Functional/myofunctional therapy

Orthodontia services are available only to insured children under age 19 and subject to a maximum benefit of \$500 per year per insured child and a \$1,000 lifetime maximum per insured child.

NOTICE: This brochure provides a very brief description of some important features of The Competitor Smile Dental Plan. The complete terms, provisions and conditions of coverage are described in the actual Certificate of Insurance that will be issued to you upon approval of application. All benefits are subject to the master policy series GH-1112-3607 issued to the Voluntary Group Trust.

Plan Information

The Competitor Smile Dental Plan

ELIGIBILITY AND EFFECTIVE DATE:

You and your spouse age 18 through 64 and your unmarried dependent children under age 19 (or 23 if a full time student) may apply for coverage.

The effective date issued and coverage will begin on either the 1st or the 15th (at 12:00 AM), whichever is first to follow HPA, Inc.'s receipt of the completed enrollment form and payment of the first months premium.

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

EXPENSES INCURRED: An Eligible Expense is considered incurred on the following dates: for full and partial dentures - on the date the final impression is taken. for fixed bridges, crowns, inlays and onlays - on the date the teeth are first prepared. for root canal therapy - on the date the pulp chamber is opened. for periodontal surgery - on the day surgery is performed. orthodontic services - on the date the appliance or bands are inserted or on the date a one-step orthodontic procedure is performed. for all other services - on the date the service is performed.

EXPENSES NOT COVERED: No benefits will be paid for expenses incurred: for any portion of a charge for any service in excess of the Scheduled Benefit. for any procedure not listed as a Scheduled Benefit. for overdentures and associated procedure. for cosmetic procedures for replacement of full and partial dentures. bridges, inlays, onlays or crowns that can be repaired or restored to normal function. for implants; and for (a) the replacement of lost or stolen appliances; (b) the replacement of orthodontic retainers; (c) athletic mouthguards; (d) precision or semi-precision attachments; (e) denture duplication; or for (f) sealants. for oral hygiene instructions; and for (a) plaque control; (b) the completion of claim form; (c) acid etch; (d) broken appointments; (e) prescription or take-home fluoride; or for (f) diagnostic photographs. for services not completed by the end of the month in which coverage terminates. for procedures that begun, but not completed. for those services for which there would be no charge in the absence of insurance or for any service or treatment provided without charge. For services in connection with war or any act of war, whether declared or undeclared, or condition contracted or accident occurring while on full-time active duty in the armed forces of any country or combination of countries for care or treatment of a condition for which you are entitled to or eligible for benefits under any Worker's Compensation Act or similar law. that are applied toward satisfaction of a Deductible, if any:

ALTERNATE BENEFIT: If: (1) We determine that a less expensive alternative procedure, service or Course of Treatment can be performed in place of the proposed treatment to correct a dental condition; and (2) the alternative treatment will produce a professionally satisfactory result; then the maximum we will allow will be the charge for the less expensive treatment.

Enrollment Instructions

- 1) Complete the top of the **Enrollment Form** on the next page.
- 2) Select **plan: \$1,000 or \$1,500**
- 3) Determine who you want to insure on the plan.
- 4) Answer questions on the **Enrollment Form**
- 5) Locate your resident address zip code on the state **Zip & Area Chart** below.
- 6) Match the letter listed to the right of the zip codes, to the same letter listed on the **Monthly Premium Chart**.
- 7) Find the Monthly Premium for the plan options you selected.
- 8) Enter the Monthly Premium in the **Premium Calculation Section** on the **Enrollment Form** located on the next page.
- 9) Add the one time enrollment fee of \$10.00 and the monthly administration fee of \$5.00.
- 10) **Total the premium and select a premium payment method.**

Child only coverage is not available. All dependent children under the age of 19 must be enrolled with parent.

ZIP AND AREA Chart

Monthly Premium Chart 7/1/01

ZIP AND AREA Chart				Monthly Premium Chart 7/1/01			
State	Area	Zip Codes	Letter	Competitor Smile Dental Areas \$ Coverage Options	Calendar Year Maximum		
					\$1,000	\$1,500	
Alaska	F	Missouri	A	Area A Applicant Applicant + Spouse Applicant + Child(ren) Applicant + Family	19.21	20.95	
Arizona	C	630-633, 640-641	C		37.14	41.77	
850-853, 856-857	D	Montana	C		29.79	33.52	
Arkansas	A	Nebraska	A		53.06	59.69	
720-722	B	680-681	B		Area B Applicant Applicant + Spouse Applicant + Child(ren) Applicant + Family	21.58	23.53
California	D	Nevada	C			41.72	46.93
900-904	G	890 - 891	D			33.47	37.66
913-916, 926-951	F	893, 894, 897	C	59.61		67.06	
905-912, 917-925, 952-958	E	892, 895	E	Area C Applicant Applicant + Spouse Applicant + Child(ren) Applicant + Family		23.71	25.86
Colorado	C	New Mexico	B			45.85	51.57
800-809, 815-816	D	870-875	C			36.78	41.38
Delaware	D	North Dakota	A		65.51	73.69	
Dist. of Columbia	E	Ohio	B		Area D Applicant Applicant + Spouse Applicant + Child(ren) Applicant + Family	25.84	28.19
Georgia	A	440-444	D			49.98	56.21
300-303	C	Oklahoma	B			40.09	45.10
Idaho	B	730-731, 740-748	C	71.41		80.32	
Illinois	C	Oregon	D	Area E Applicant Applicant + Spouse Applicant + Child(ren) Applicant + Family		28.21	30.77
600-606	E	Pennsylvania	B			54.56	61.37
Indiana	B	150-153, 180-181, 189-194	D			43.77	49.24
460-466	C	South Carolina	A		77.96	87.69	
Iowa	A	Tennessee	A		Area F Applicant Applicant + Spouse Applicant + Child(ren) Applicant + Family	30.35	33.11
500-502	B	370-374, 380-383	B			58.69	66.01
Kansas	B	Texas	C			47.08	52.97
660-666, 670-672	C	770-777	E	83.85		94.32	
Kentucky	B	750-753, 760-767	D	Area G Applicant Applicant + Spouse Applicant + Child(ren) Applicant + Family		33.19	36.20
Louisiana	A	Utah	A			64.19	72.20
700-701, 707-711	C	840-841	C			51.49	57.93
Michigan	C	Virginia	C		91.71	103.17	
480-483	E	220-223	E				
484-489, 493-495	D	230-238	D				
Minnesota	A	Washington	E				
550-554	D	980-984	F				
Mississippi	A	West Virginia	B				
390-392	B	Wisconsin	B				
		535, 538	A				
		Wyoming	B				

Dental Plan Enrollment

Applicant full name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Age: _____ Birthdate: _____ Male Female Phone: _____
 Social Security #: _____
 Spouse's Social Security #: _____
 Billing Address: _____
 Later Effective Date (Circle One): 1st 15th

COMPLETE THIS ITEM TO INSURE YOUR SPOUSE AND/OR CHILDREN

Full Name (First, M, Last)	Birthday	Age	M	F
Spouse				
Child 1				
Child 2				
Child 3				
Child 4				

By my signature below, I hereby apply for dental coverage under master policy series #GH-1112-3607 issued to the Voluntary Group Trust for:
 Myself Only Myself and Spouse Myself and Children Myself and Family
 Does Spouse have a dental plan? Yes No With Whom? _____
 Are dependents enrolled under spouse's plan? _____
 Do you claim a tax exemption for all eligible dependents listed above? Yes No
 All dependent children listed above over Age 18 are full time students: Yes No
 Signature of Applicant _____ Date _____

Plan Selection	Premium Calculations
<input type="checkbox"/> \$1,000 MAX <input type="checkbox"/> \$1,500 MAX	Enter Premium Here \$ _____ One Time Enrollment Fee + \$ _____ Monthly Admin. Fee + \$ _____ Total Amount Due \$ _____
Billing Method <input type="checkbox"/> Direct Monthly Bill <input type="checkbox"/> MasterCard, Visa, Discover Card <input type="checkbox"/> Automatic Bank Draft (Attach a Voided Check) <small>List Bill Available, call HPA for details and list bill form.</small>	

FOR CREDIT CARD PAYMENT, please complete the following:
 I authorize Health Plan Administrators, Inc. to bill my VISA/MC/Discover account for the monthly premium.
 VISA MC DISCOVER
 List digits of Account# _____ Exp. Date _____
 Cardholder's Signature _____ Date _____

If Automatic Check Withdrawal is selected, your monthly Security Life premium will be automatically withdrawn from your checking account. Please complete the Authorization Form below:
REQUEST FOR AUTOMATIC CHECK WITHDRAWAL
 To: _____
(Print full name of Bank or Branch where account is maintained.)

 Street Address: _____

 City & State: _____
 I request that you pay and charge my account, debits drawn on my account by Health Plan Administrators, Inc. to its own order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may at any time, end this agreement by giving 30 days advance written notice to me and to Health Plan Administrators, Inc. You are to treat such debit as if it were signed by me. If you dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.
 Signature of Premium Payer: _____
Include One Voided Check With Application

FOR AGENT USE ONLY	Agent Name <u>Assurance Benefits/Buffie Garcia</u> E-mail <u>buffie@abc-incorp.com</u> Address <u>PO Box 41454</u> Tel# <u>623-780-0077</u> City <u>Phoenix Az 85080</u> State _____ Zip _____ SS # _____ HPA Code # _____ G.A. Name _____ Phone# _____
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Make Check Payable to: Security Life Insurance Company of America
Mail Completed Enrollment Form to: HPA, Inc. - P.O. Box 15250 - Rockford, IL 61132-5250

Important Fraud Notices

Alaska 21.36.380 requires the following notice on claim forms:

"A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law."

Arkansas 23.66.503 requires the following notice on applications and claim forms or any proof of loss:

"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."

California 1871.2 requires the following notice on claim forms:

"For your protection California law requires the following to appear on this form. Any person who knowingly presents 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."

Colorado 10-1-127(7)(a) requires the following notice on the application or the policy or the claim form:

"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 12-273 requires the following notice on all applications and claim forms:

"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 Bulletin 96-1 requires the following notice on the application and claim forms:

"A person who knowingly and with intent to defraud, or deceive an insurance company files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree."

Indiana 27-2-16-3 requires the following notice on claim forms:

"A person who knowingly and with intent to defraud an insurer files a statement of claim containing false, incomplete, or misleading information commits a felony."

Kentucky 304.47-030 requires the following notice on applications:

"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."

Kentucky 304.47-030 requires the following notice on claim forms:

"Any person who knowingly and with intent to defraud any insurance company or other person files a 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."

Louisiana HB 1868, Section 1424 B requires the following notice on applications:

"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."

Maine 2186 requires the following notice on application and claim forms:

"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."

Minnesota 60A.955 requires the following notice on claim forms:

"A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime."

New Hampshire 402.82 requires the following notice on claim forms:

"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."

New Jersey 17:33A-6 requires the following notice on applications:

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

New Jersey 17:33A-6 requires the following notice on claim forms:

"Any Person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties."

New Mexico 59A-16C-8 requires the following notice on applications and claim forms:

"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."

New York 403(d) requires the following notice on applications and claim forms:

"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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

Ohio 3999.21 requires the following notice on applications and claim forms:

"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."

Oklahoma 3613.1 requires the following notice on policies and claim forms:

"WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, makes a claim for the proceeds on an insurance policy containing false, incomplete or misleading information is guilty of a felony."

Pennsylvania 40-3-901.1 NILS (40 p.s. 474.1) does not specifically state that the following notice on applications and claim forms is required, but the DOI requires it:

"Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties."

Virginia 52-40 (Related Laws) requires the following notice on applications:

"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."