Spirit DENTAL

75% Participation and Voluntary Group Dental Insurance Plan

TRIPLE OPTION, INDEMNITY OR PREVENTIVE

Underwritten by:

SECURITYLIFE
INSURANCE COMPANY OF AMERICA

10901 Red Circle Drive
Minnetonka, MN 55343

Marketed by:

DIRECT BENEFITS INC.

Choose Your Own Dentist

No Waiting Periods

3 Cleanings Per Year

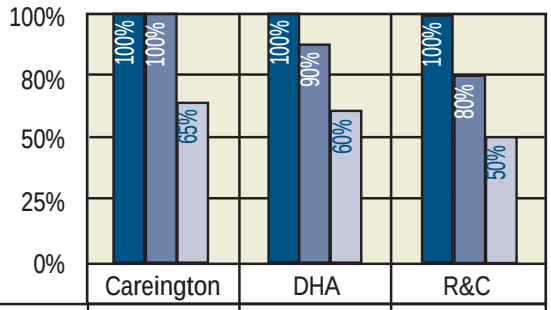
For Employers 2-149

$1,000, $1,500, $2,000, $3,000 OR $5,000 ANNUAL MAXIMUMS

S11565 (rev. 03/2016)

Spirit DENTAL

Triple Option 75% Participation and Voluntary



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

Covered Services

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

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

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

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

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

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

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

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

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

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

Optional $1,500, $2,000, $3,000 or $5,000 Maximum Benefit - You may choose to increase the calendar year maximum benefit for this plan to $1,500, $2,000, $3,000 or $5,000. There is a 10% increase to the base rate for $1,500, 15% for $2,000, 25% for $3,000 and 50% for $5,000.

Optional Grading Up Benefit - Groups without prior dental insurance coverage may choose to increase to third year benefits on Class C Major Services upon initial purchase of the plan. There is a 25% increase in the base rate for this option.

Optional Orthodontic Services are available for an additional premium. Orthodontic care for the proper alignment of teeth is provided to children and adults. Coverage is 10% reimbursement for the first year, 25% reimbursement for the second year and 50% reimbursement for the third year, with a calendar year maximum of $750 and a lifetime maximum of $1,500 per person.

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

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

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

Optional Endo/Perio to Class B - You may choose to have Endodontics and Periodontics covered under Class B services for a 15% rate increase.

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

Participation Requirements - Not less than two unrelated employees (75% of the employers eligible employees - the greater number after waivers) must be enrolled in the plan. For the Voluntary plan, not less than two unrelated employees. 100% family-related employees may apply for a 15% rate increase.

No Employer Contribution Required

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

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

Dental Network:
Careington Care PPO
www.careington.com

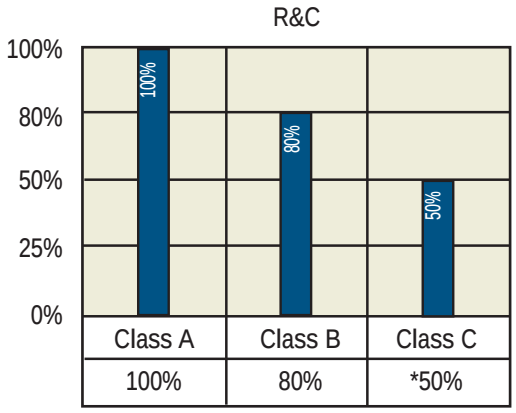
Plan Coordinator: Direct Benefits, Inc. 325 Cedar Street, Suite 800, St. Paul, MN 55101
651.649.3503 • 800.620.5010 • www.directbenefits.com

Indemnity 75% Participation and Voluntary Group Dental Plan

Covered Services

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

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



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

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

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

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

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

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

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

Optional $1,500, $2,000, $3,000 or $5,000 Maximum Benefit - You may choose to increase the calendar year maximum benefit for this plan to $1,500, $2,000, $3,000 or $5,000. There is a 10% increase to the base rate for $1,500, 15% for $2,000, 25% for $3,000 and 50% for $5,000.

Optional Grading Up Benefit - Groups without prior dental insurance coverage may choose to increase to third year benefits on Class C Major Services upon initial purchase of the plan. There is a 25% increase in the base rate for this option.

Optional Orthodontic Services are available for an additional premium. Orthodontic care for the proper alignment of teeth is provided to children and adults. Coverage is 10% reimbursement for the first year, 25% reimbursement for the second year and 50% reimbursement for the third year, with a calendar year maximum of $750 and a lifetime maximum of $1,500 per person.

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

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

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

Optional Endo/Perio to Class B - You may choose to have Endodontics and Periodontics covered under Class B services for a 15% rate increase.

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

Participation Requirements - Not less than two unrelated employees (75% of the employers eligible employees - the greater number after waivers) must be enrolled in the plan. For the Voluntary plan, not less than two unrelated employees. 100% family-related employees may apply for a 15% rate increase.

No Employer Contribution Required

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NOTICE: This provides a very brief description of some of the important features of the insurance policy. It is not the insurance policy and does not represent it. A full explanation of benefits, exceptions and limitations is contained in the Certificate of Insurance under Group Dental Policy Form GH-1112 (and any state specific). Group Vision Policy Form GH-1157 (and any state specific) for all states except IL, IA and MN. IL, IA and MN use Group Vision Policy Form GH-1154 (and any state specific). Premium rates may change upon renewal. This policy is renewable at the option of the Company. This product may not be available in all states and is subject to individual state regulations.

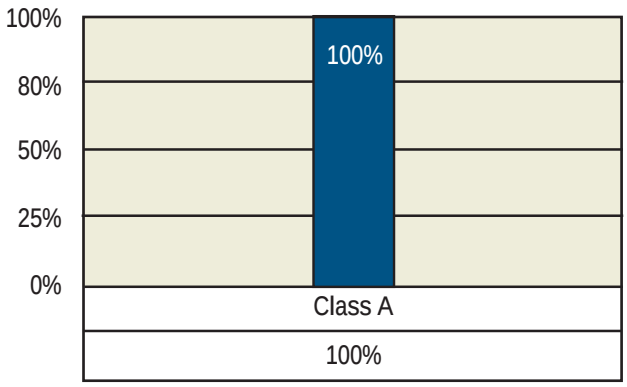
Spirit DENTAL

Preventive Group Dental Plan

Covered Services

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

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



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

Participation Requirements - Not less than two unrelated employees (75% of the employers eligible employees - the greater number after waivers) must be enrolled in the 75% plan. For the Voluntary plan, not less than two employees must enroll. 100% family-related employees may apply for a 15% rate increase.

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

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

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

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GENERAL INFORMATION

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

DEDUCTIBLE AMOUNT: The lifetime and calendar year Deductible, if any, is shown in the Coverage Schedule. The Deductible is an amount of charges You must incur for Yourself or on behalf of Your insured Dependent before We start paying benefits.

CALENDAR YEAR MAXIMUM: The maximum limit payable for all Eligible Expenses in any calendar year is shown in the Coverage Schedule. The Maximum Calendar year Limit, if any, will apply to each person covered under the Policy.

PRETREATMENT REVIEW: If the Course of Treatment will exceed $300, We will request prior review. We must be given the dentist's treatment plan consisting of a description of the planned treatment with estimated charges and diagnostic x-rays. We will determine Eligible Expenses and state how much We will pay for the treatment. Our determination may suggest an alternate, less expensive Course of Treatment if it will produce professionally satisfactory results. If You do not request a pretreatment review, We will pay for the least expensive method of treatment regardless of the method actually used.

COORDINATION OF BENEFITS: This Plan will be coordinated with any other group, blanket or franchise plan under which an individual will receive benefits. This helps keep the cost of the Plan reasonable.

TERMINATION OF COVERAGE: Coverage terminates on the earliest of the following dates: the last day of the month in which You cease to be eligible for coverage; the last day of the month in which Your dependent is no longer a dependent, as defined; subject to the Grace Period, the last day of the month for which a premium has been paid by You or on your behalf; or the date the policy ends.

EFFECTIVE DATE: Plan effective dates are always the First of the month. Enrollment cards received by Direct Benefits after the First of the month will become effective on the First of the following month. Incomplete enrollment cards or failure to submit the required initial premium amount may cause an initial delay in Issuance of insurance. Do not cancel any other Insurance or assume you are insured under the Plan until you receive written confirmation from Direct Benefits.

PLAN INFORMATION

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

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

EXPENSES NOT COVERED: No benefits will be paid for expenses incurred: for overdentures and associated procedures for charges in excess of those considered reasonable and customary or charges in excess of the Network Provider fee schedule; for cosmetic procedures; for the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function; for replacement of lost or stolen appliances, replacement of retainers, athletic mouthguards, precision or semi-precision attachments, denture duplication; for oral hygiene instructions and for plaque control, completion of a claim form, acid etch, broken appointments, prescription or take-home fluoride, or diagnostic photographs; for services not completed by the end of the month in which coverage ends unless continuation of coverage has been requested and accepted by Us; for procedures that are begun, but not completed; for services and treatment provided without charge or for which there would be no charge in the absence of insurance; for services in connection with war or any act of war, whether declared or undeclared, or condition contracted or accident occurring while on full-time active duty in the armed forces of any country or combination of countries; for a condition covered under any Worker's Compensation Act or similar law; that are applied toward satisfaction of a Deductible, if any; that are generally considered by the dental profession as experimental or investigational; for the treatment of cleft palate and anodontia; for services or supplies payable under any medical expense plan; for orthodontia, unless included within Coverage Schedule; prior to the date the Insured is covered under the Policy; for the diagnosis or treatment of Temporomandibular Joint Dysfunction (TMJD); for hospital services; if you voluntarily end your insurance You will not be eligible to re-enroll for a period of 2 years after the date Your covered first ended; charges for infection control, sterilization and waste disposal.

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

MISSING TOOTH: When covered under your plan, benefits are provided for placement of dentures, fixed bridgework, implants or the addition of teeth to existing dentures only when the service includes replacement of a natural tooth extracted or lost while covered under this plan. This limitation ends after the individual receiving care has been covered under this plan for 36 consecutive months.

TRIPLE OPTION

75% PARTICIPATION GROUP DENTAL PLAN

2 - 4 LIVES

	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8
Employee Only	28.84	31.62	34.75	38.22	42.05	46.22	50.73	55.94
Employee + 1	53.94	59.14	64.99	71.49	78.63	86.43	94.88	104.63
Family	87.86	96.32	105.85	116.44	128.08	140.78	154.54	170.42

5 - 9 LIVES

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

10 - 149 LIVES

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

Rates effective 04/01/2014 - 09/30/2016

PLAN OPTIONS

$1,500 MAX BENEFIT
Multiply rates by 1.10

$2,000 MAX BENEFIT
Multiply rates by 1.15

$3,000 MAX BENEFIT
Multiply rates by 1.25

$5,000 MAX BENEFIT
Multiply rates by 1.50

ENDO/PERIO TO CLASS B
Multiply rates by 1.15

AND/OR VOLUNTARY
Multiply rates by 1.05

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

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

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

OPTIONAL GRADING UP BENEFIT
Multiply rates by 1.25

POSTERIOR COMPOSITE FILLINGS COVERED UNDER BASIC FILLINGS
Multiply rates by 1.04

OPTIONAL 100% FAMILY-RELATED EMPLOYEES
Multiply rates by 1.15

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

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

Orthodontia can be added to any of the above plans by adding these premiums to the selected rate above. Orthodontia is covered at 10% for the first year, 25% for the second year and 50% reimbursement for the third year, with a calendar year maximum of $750 and a lifetime maximum of $1,500 per person.

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

AREA (STATE) DEFINITIONS

Alabama
350-355, 359 — 3
All Other — 1

Arizona
856-857, 864 — 2
All Other — 1

Arkansas
All Areas — 1

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

Connecticut
All Areas — 5

Delaware
All Areas — 2

Dist Columbia
All Areas — 6

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

Georgia
300-303 — 2
All Other — 1

Hawaii
All Areas — 3

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

Indiana
463-464 — 2
473 — 3
All Other — 1

Iowa
All Areas — 1

Kansas
660-662 — 2
All Other — 1

Kentucky
All Areas — 1

Louisiana
707-711 — 2
712 — 3
All Other — 1

Maine
039-041 — 4
044, 046, 048 — 3
All Other — 2

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

Massachusetts
All Areas — 5

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

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

Mississippi
390-392 — 2
All Other — 1

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

Nebraska
All Areas — 1

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

New Mexico
881 — 2
882 — 5
All Other — 1

North Dakota
580-581 — 3
All Other — 2

Ohio
All Areas — 1

Oklahoma
740-743 — 2
All Other — 1

Oregon
977 — 3
978 — 1
All Other — 2

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

South Carolina
All Areas — 1

South Dakota
All Areas — 2

Tennessee
373-374 — 2
All Other — 1

Texas
751-753 — 3
754 — 4
756-757, 776-777 — 1
All Other — 2

Utah
All Areas — 1

Vermont
All Areas — 1

Virginia
201, 220-221 — 5
222-223 — 6
224-225, 230-232 — 1
228-229, 240-244 — 2
233-237 — 5
All Other — 4

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

Wisconsin
All Areas — 2

Wyoming
All Areas — 1

INDEMNITY - CHOOSE ANY DENTIST

75% PARTICIPATION GROUP DENTAL PLAN

2 - 4 LIVES

	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8
Employee Only	30.28	33.20	36.48	40.13	44.15	48.53	53.27	58.74
Employee + 1	56.64	62.10	68.23	75.06	82.57	90.76	99.63	109.87
Family	92.25	101.14	111.14	122.26	134.48	147.83	162.27	178.94

5 - 9 LIVES

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

10 - 149 LIVES

	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8
Employee Only	24.33	26.67	29.31	32.24	35.46	38.98	42.79	47.19
Employee + 1	45.50	49.88	54.82	60.30	66.33	72.90	80.03	88.25
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Rates effective 04/01/2014 - 09/30/2016

PLAN OPTIONS

$1,500 MAX BENEFIT
Multiply rates by 1.10

$2,000 MAX BENEFIT
Multiply rates by 1.15

$3,000 MAX BENEFIT
Multiply rates by 1.25

$5,000 MAX BENEFIT
Multiply rates by 1.50

ENDO/PERIO TO CLASS B
Multiply rates by 1.15

AND/OR VOLUNTARY
Multiply rates by 1.05

OPTIONAL $50/$150

CALENDAR YEAR DEDUCTIBLE
Multiply rates by 1.05

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

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

OPTIONAL GRADING UP BENEFIT
Multiply rates by 1.25

POSTERIOR COMPOSITE FILLINGS COVERED UNDER BASIC FILLINGS
Multiply rates by 1.04

OPTIONAL 100% FAMILY-RELATED EMPLOYEES
Multiply rates by 1.15

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

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

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5-9 lives	$0.89	$9.20	$15.26
10-149 lives	$0.84	$ 8.71	$14.46

AREA (STATE) DEFINITIONS

Alabama
350-355, 359 3
All Other 1

Alaska
995-996 8
All Other 6

Arizona
856-857, 864 2
All Other 1

Arkansas
All Areas 1

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

Connecticut
All Areas 5

Delaware
All Areas 2

Dist Columbia
All Areas 6

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

Georgia
300-303 2
All Other 1

Hawaii
All Areas 3

Idaho
All Areas 1

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

Indiana
463-464 2
473 3
All Other 1

Iowa
All Areas 1

Kansas
660-662 2
All Other 1

Kentucky
All Areas 1

Louisiana
707-711 2
712 3
All Other 1

Maine
039-041 4
044, 046, 048 3
All Other 2

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

Massachusetts
All Areas 5

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

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

Mississippi
390-392 2
All Other 1

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

Montana
590-591 1
599 2
All Other 3

Nebraska
All Areas 1

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

New Jersey
All Areas 4

New Mexico
881 2
882 5
All Other 1

North Carolina
277 2
286 3
287-289 2
All Other 1

North Dakota
580-581 3
All Other 2

Ohio
All Areas 1

Oklahoma
740-743 2
All Other 1

Oregon
977 3
978 1
All Other 2

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

Rhode Island
All Areas 3

South Carolina
All Areas 1

South Dakota
All Areas 2

Tennessee
373-374 2
All Other 1

Texas
751-753 3
754 4
756-757, 776-777 1
All Other 2

Utah
All Areas 1

Vermont
All Areas 1

Virginia
201, 220-221 5
222-223 6
224-225, 230-232 1
228-229, 240-244 2
233-237 5
All Other 4

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

Wisconsin
All Areas 2

Wyoming
All Areas 1

PREVENTIVE

75% PARTICIPATION GROUP DENTAL PLAN

$50 LIFETIME DEDUCTIBLE

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

$0 DEDUCTIBLE

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

PREVENTIVE

VOLUNTARY GROUP DENTAL PLAN

$50 LIFETIME DEDUCTIBLE

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

$0 DEDUCTIBLE

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

Rates effective 04/01/2014 - 09/30/2016

PLAN OPTIONS

OPTIONAL 100% FAMILY-RELATED EMPLOYEES Multiply rates by 1.15

OPTIONAL $0/$0 CALENDAR YEAR DEDUCTIBLE Multiply rates by 1.15

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

AREA (STATE) DEFINITIONS

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

Why Should You Choose a PPO Dental Plan?

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

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

PPO Savings* Example

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

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

- Network Fee: $685.00
- Reasonable & Customary Fee: $750.00
- Dentist's Usual Fee: $985.00

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

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

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

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

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