NEW YORK

Spirit DENTAL

75% Participation and Voluntary Group Dental Insurance Plan

TRIPLE OPTION, INDEMNITY OR PREVENTIVE

Underwritten by:

SECURITYHEALTH
INSURANCE COMPANY OF AMERICA, NEW YORK, INC.

388 Broadway | Schenectady, NY 12305

Marketed by:

DIRECT BENEFITS INC.

Choose Your Own Dentist

No Waiting Periods

3 Cleanings Per Year

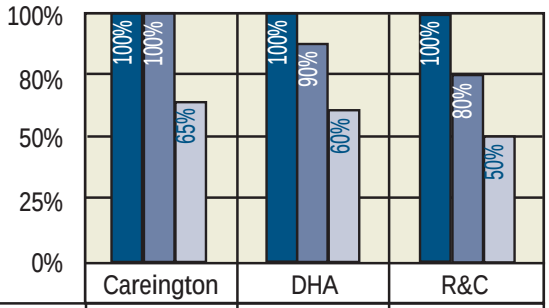
For Employers 2-149

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

S11567 (rev. 06/2015)

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:
SECURITYHEALTH
INSURANCE COMPANY OF AMERICA, NEW YORK, INC.
388 Broadway
Schenectady, NY 12305

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

Dental Network:
Careington Care PPO
www.careington.com

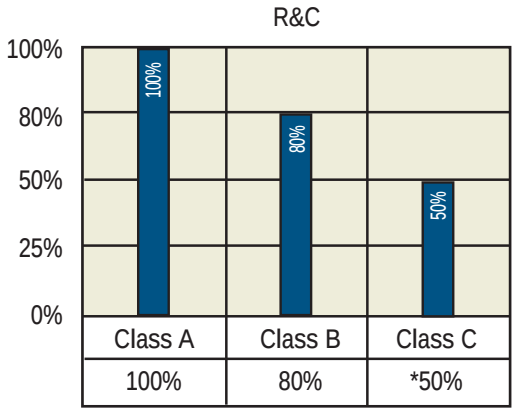
Plan Coordinator: Direct Benefits, Inc. 325 Cedar Street, Suite 800, St. Paul, MN 55101
651.649.3503 • 800.620.5010 • www.directbenefits.com

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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Schenectady, NY 12305

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Plan Coordinator:
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NOTICE: This provides a very brief description of some of the important features of your insurance policy. It is not the insurance policy and does not represent it. A full explanation of benefits, exceptions and limitations is contained in the Certificate of Insurance under Group Dental Policy Form GH-2300. Premium rates may change upon renewal. This policy is renewable at the option of the Company. This product is subject to individual state regulations.

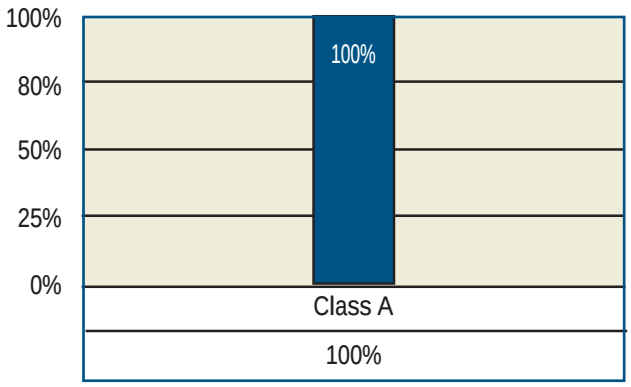
Spirit DENTAL

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 the Employer's Liability or Occupational Disease Law; for the treatment of cleft palate and anodontia; 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	$34.61	$37.94	$41.70	$45.86	$50.46	$55.46	$60.88	$67.13
Employee + 1	$64.73	$70.97	$77.99	$85.79	$94.36	$103.72	$113.86	$125.56
Family	$105.43	$115.58	$127.02	$139.73	$153.70	$168.94	$185.45	$204.50

5 - 9 LIVES

	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8
Employee Only	$29.20	$32.00	$35.17	$38.69	$42.55	$46.78	$51.35	$56.63
Employee + 1	$54.60	$59.86	$65.78	$72.36	$79.60	$87.48	$96.04	$105.90
Family	$88.92	$97.50	$107.14	$117.85	$129.64	$142.49	$156.42	$172.49

10 - 149 LIVES

	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8
Employee Only	$27.80	$30.48	$33.49	$36.84	$40.52	$44.54	$48.90	$53.93
Employee + 1	$52.00	$57.01	$62.64	$68.92	$75.80	$83.32	$91.46	$100.86
Family	$84.68	$92.86	$102.04	$112.24	$123.47	$135.71	$148.97	$164.28

Rates effective 04/01/2014 - 03/31/2016

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	$1.13	$11.68	$19.36
5-9 lives	$1.13	$11.68	$19.36
10-149 lives	$1.13	$11.68	$19.36

NEW YORK ZIP CODE AREA CHART

100-102	8	111-114	5	129	2
103-104	5	115-116	6	133-143	2
106	7	117-119	5	147	1
109	5	125	4	All Other	3
110	6	127	4		

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	$36.33	$39.84	$43.78	$48.15	$52.98	$58.23	$63.92	$70.49
Employee + 1	$56.64	$62.10	$68.23	$75.06	$82.57	$90.76	$99.63	$109.87
Family	$110.70	$121.36	$133.37	$146.71	$161.38	$177.39	$194.73	$214.72

5 - 9 LIVES

	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8
Employee Only	$30.65	$33.60	$36.92	$40.62	$44.69	$49.12	$53.92	$59.45
Employee + 1	$57.32	$62.86	$69.07	$75.97	$83.57	$91.86	$100.84	$111.19
Family	$93.37	$102.37	$112.50	$123.74	$136.12	$149.62	$164.24	$181.12

10 - 149 LIVES

	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8
Employee Only	$29.20	$32.00	$35.17	$38.69	$42.55	$46.78	$51.35	$56.63
Employee + 1	$54.60	$59.86	$65.78	$72.36	$79.60	$87.48	$96.04	$105.90
Family	$88.92	$97.50	$107.14	$117.85	$129.64	$142.49	$156.42	$172.49

Rates effective 04/01/2014 - 03/31/2016

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	$1.13	$11.68	$19.36
5-9 lives	$1.13	$11.68	$19.36
10-149 lives	$1.13	$11.68	$19.36

NEW YORK ZIP CODE AREA CHART

100-102	8	111-114	5	129	2
103-104	5	115-116	6	133-143	2
106	7	117-119	5	147	1
109	5	125	4	All Other	3
110	6	127	4		

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	$12.58	$13.79	$15.16	$16.67	$18.34	$20.16	$22.13	$24.40
Employee + 1	$23.80	$26.10	$28.68	$31.55	$34.70	$38.14	$41.87	$46.17
Family	$38.98	$42.74	$46.97	$51.66	$56.83	$62.47	$68.57	$75.62

$0 DEDUCTIBLE

	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8
Employee Only	$14.46	$15.86	$17.42	$19.17	$21.08	$23.17	$25.44	$28.05
Employee + 1	$27.38	$30.02	$32.99	$36.29	$39.92	$43.87	$48.16	$53.11
Family	$44.83	$49.15	$54.01	$59.41	$65.35	$71.84	$78.86	$86.96

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	$14.46	$15.86	$17.42	$19.17	$21.08	$23.17	$25.44	$28.05
Employee + 1	$27.38	$30.02	$32.99	$36.29	$39.92	$43.87	$48.16	$53.11
Family	$44.83	$49.15	$54.01	$59.41	$65.35	$71.84	$78.86	$86.96

$0 DEDUCTIBLE

	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8
Employee Only	$16.63	$18.23	$20.04	$22.04	$24.24	$26.65	$29.26	$32.26
Employee + 1	$31.48	$34.52	$37.93	$41.73	$45.90	$50.46	$55.39	$61.08
Family	$51.55	$56.52	$62.11	$68.32	$75.16	$82.61	$90.68	$100.01

Rates effective 04/01/2014 - 03/31/2016

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.

NEW YORK ZIP CODE AREA CHART

100-102	8	111-114	5	129	2
103-104	5	115-116	6	133-143	2
106	7	117-119	5	147	1
109	5	125	4	All Other	3
110	6	127	4		

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.*

CAREINGTON PREFERRED PROVIDER (PPO) NOT AVAILABLE IN THE FOLLOWING COUNTIES: Chenango, Essex, Franklin, Hamilton, Livingston, Tioga and Yates.

Underwritten by:
SECURITYHEALTH
INSURANCE COMPANY OF AMERICA, NEW YORK, INC.
388 Broadway
Schenectady, NY 12305

Marketed by:
DIRECT BENEFITS INC.

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

SECURITYHEALTH

INSURANCE COMPANY OF AMERICA, NEW YORK, INC.

At Security Health, we understand that a healthy smile is essential to your overall health. We also understand the importance of being the easiest company to do business with. Your health and satisfaction is part of the commitment we make to our customers..

WHO WE ARE

Security Health is a privately-owned company that provides ancillary insurance products.

WHAT WE DO

We continually monitor our operations to ensure we're providing service that surpasses your expectations. The following are a few key metrics we use to assess our service:

- 95% of calls are resolved in the initial conversation
- 90% of claims processed in less than 10 days
- New business applications processed within 2 days

We are extremely proud of our service and encourage your feedback.

OWNERSHIP
Privately-owned

EMPLOYEES
100+

Proud Partner of:

DIRECT BENEFITS INC

Spirit DENTAL & VISION

EMPLOYER ELECTION FORM

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

If accepted, the undersigned Employer agrees: (a) To make such benefits available to all present employees and all employees becoming eligible in the future; and (b) To make payroll deductions as required for the plan as are applicable to the employees. The undersigned Employer further agrees that only those full-time employees who meet the eligibility requirements (as defined under Eligibility within the brochure) are to be included, and that participation requirements must be met before the benefit plan can be made effective. The employer agrees that not less than two (2) non-related employees of the employer's eligible employees must be enrolled in the Dental and/or Vision Plan to prevent cancellation of coverage. This plan does not require any contribution from the employer. If all or part of the premium is derived from funds contributed by the insured employees, then not less than 50% of eligible employees or, if less, fifty (50) or more of such employees must be insured.

The undersigned Employer requests that benefits be made available to all employees subject to the following conditions:

a) No coverage for any employees shall take effect until this Agreement and the employee's individual Enrollment Cards are accepted by the Company and the initial premium paid; and
b) Employer agrees to remit regularly, in advance, the required premium payments to the Administrator. The undersigned Employer is the Plan Administrator as defined in ERISA, as amended.

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

EMPLOYER INFORMATION

Name of Employer_____ Send Correspondence to_____
Address _____ City_____ State_____ Zip Code_____
Phone Number ( )_____ Fax ( )_____
Nature of Business _____ [ ] Corporation [ ] Partnership [ ] Sole Proprietorship [ ] Other
Subsidiaries and Affiliates Included [ ] Yes [ ] No
Name and Address of Subsidiaries & Affiliates whose employees are to be covered: _____
_____

Effective Date Requested:
_____ (limited to 1st or 15th of the month)

INITIAL PROBATIONARY PERIOD
(a) For current employees - NONE
(b) For future employees: _____ DAYS/MONTHS

New hires to be effective on the first of the Month following probationary period.

DENTAL ADOPTION AND PARTICIPATION AGREEMENT

[ ] 75% PARTICIPATION [ ] EMPLOYER VOLUNTARY
[ ] TRIPLE OPTION [ ] INDEMNITY [ ] PREVENTIVE
[ ] 2-4 Employees [ ] 5-9 Employees [ ] 10-149 Employees

Coverage Options*:
[ ] Employer Voluntary (premium x 1.05)
[ ] Increase Calendar Year Maximum to $1500 (premium x 1.10)
[ ] Increase Calendar Year Maximum to $2000 (premium x 1.15)
[ ] Increase Calendar Year Maximum to $3000 (premium x 1.25)
[ ] Increase Calendar Year Maximum to $5000 (premium x 1.50)
[ ] $50 Calendar Year Deductible (premium x 1.05)
[ ] $25 Calendar Year Deductible (premium x 1.15)
[ ] $0 Calendar Year Deductible (premium X 1.25) *Triple Option / Indemnity*
[ ] $0 Calendar Year Deductible (premium X 1.15) *Preventive Only*
[ ] Endodontics/Periodontics covered under Class B (premium x 1.15) *Triple Option / Indemnity*
[ ] Posterior Composite Fillings covered under Basic Fillings (premium x 1.04) *Triple Option / Indemnity*
[ ] With Orthodontia (premium – see rates) *Triple Option / Indemnity*
[ ] Grading Up Benefit (premium x 1.25) *Triple Option / Indemnity*
[ ] 100% family-related (premium x 1.15)

* Premiums must be adjusted accordingly

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

The undersigned Employer hereby requests to insure eligible persons under Group Dental Policy GH-2300 insured by Security Health Insurance Company of America, New York, Inc. and hereby accepts and agrees to be bound by the terms and conditions as now in effect or hereafter may be modified.

Authorized Signature _____
Date _____ E-Mail _____

CAREINGTON PREFERRED PROVIDER (PPO) NOT AVAILABLE IN THE FOLLOWING COUNTIES: Chenango, Essex, Franklin, Hamilton, Livingston, Tioga and Yates.

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.

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

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

Spirit Dental Enrollment Card

Return completed form to your employer

☐ Indemnity - Dental
☐ Triple Option - Dental
☐ Preventive - Dental

Employer Information (TO BE COMPLETED BY THE EMPLOYER)

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

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

Employee Information (PLEASE PRINT CLEARLY)

Coverage Election: ☐ Dental Only ☐ Decline Coverage
I apply for coverage on: ☐ Employee Only ☐ Employee +1 ☐ Employee and Family (DENTAL)

Last Name	First Name	Initial	SS#
Address	Telephone Number		
City		State	Zip

LIST ALL YOUR ELIGIBLE DEPENDENTS BELOW

Last Name (If Different)	First Name	Initial	Sex M/F	Age	Birth Date M/D/Y
Spouse					
Dependent					
Dependent					
Dependent					
Dependent					

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

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

Group Dental Coverage is provided under the Group Dental Insurance Policy GH-2300 issued to the Group Policyholder, insured by Security Health Insurance Company of America, New York, Inc.

CAREINGTON PREFERRED PROVIDER (PPO) NOT AVAILABLE IN THE FOLLOWING COUNTIES: Chenango, Essex, Franklin, Hamilton, Livingston, Tioga and Yates.

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

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.

_____ _____
Employee Signature Date

Underwritten and Administered by:
Security Health Insurance Company of America, New York, Inc.
388 Broadway | Schenectady, NY 12305
800.233.0307 | SecurityLife.com

Distributed by:
Direct Benefits, Inc.
325 Cedar Street, Suite 800 | Saint Paul, MN 55101
800.620.5010 | SpiritDental.com

SECURITYHEALTH
INSURANCE COMPANY OF AMERICA, NEW YORK, INC.

Payment Authorization Form

Group Name:

Monthly Premium: Dental $_____ + Vision $_____ = Total Monthly Premium $_____

Method of Payment (select one)

CHECKING ACCOUNT (ACH)

☐ **Monthly Bank Account Debit**
Submit a voided check

_____
Financial Institution Name

_____
Bank Account Number

_____
Routing Number

CREDIT CARD

☐ **Monthly Credit Card**

Please select your card type below and provide your credit card account information:

☐ Visa ☐ MasterCard ☐ Discover

_____
Credit Card Number

_____
Name on Card

_____
Expiration Date

Authorization Agreement

I authorize Security Health to initiate electronic debits to the account listed above for payment of my insurance premium. I certify that I am an authorized user on the above listed account. I acknowledge that debits to my account for premium due will occur on a regular recurring basis based on the payment frequency indicated above until such time as coverage terminates or until I notify Security Health to terminate these transactions.

I understand that it may take up to two weeks to process a request to discontinue recurring payments. In order to make changes to this authorization (such as change in bank account, method of payment, or termination of payment) I must provide Security Health at least two weeks' notice in advance of the next scheduled payment date.

Based upon my authorization Security Health will debit my account for any current and outstanding due premiums on or within three business days following my premium due date. Premiums are due on the day of the month in which my policy was effective. For initial payments I acknowledge that Security Health may debit my account upon acceptance and approval of my application.

If any authorized payment is returned or dishonored by my bank, I acknowledge that I am responsible for any fees my bank may charge. I understand also that I may incur a return payment fee of $25 charged by Security Health if the return is due to insufficient funds. I acknowledge that such a fee, if charged, may be automatically debited from my authorized account on the next payment date. I am responsible for remitting payment within the policy grace period. If payment is not received by Security Health within the defined grace period I acknowledge that my coverage may be cancelled in accordance with the terms of the insurance contract.

I acknowledge that the origination of these electronic transactions (ACH and Card) must comply with applicable provisions of US Law.

Signature of Authorized Representative _____ **Date** _____

Print Name of Authorized Representative _____ **Date** _____

New Business Checklist

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

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

CREDIT FOR PRIOR TIME (CPT)

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

- ☐ Copy of Prior Carrier's certificate, booklet or schedule of benefits
- ☐ Copy of Prior Carrier's most recent billing statement

POLICY DOCUMENTS AND ID CARD DELIVERY ACKNOWLEDGEMENT

Please confirm Employer understands the policy documents and all Employee ID cards will be generated electronically and emailed to the Employer's email address provided on the Employer Group application:

- ☐ Electronic fulfillment acknowledged

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

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

Submission Date:

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