SPIRIT DENTAL

Chailland High Option Group Dental Plan

You may go to any dentist you choose! The Spirit Dental Plan reimburses you for covered dental expenses based upon a percentage of the Reasonable and Customary (R&C) fees for those services. Charges in excess of R&C fees will be the responsibility of the insured.

BENEFIT SUMMARY	COVERAGE
Class A – Preventive Services • *Routine Exams and Cleanings (2 per calendar year)* • *Fluoride treatment for children under age 16 (one per calendar year)* • *Bitewing X-rays (1 series per calendar year)*	100%
Class B – Basic Services • *Simple extractions* • *Basic fillings* • *Space Maintainers* • *Sealants (children to age 16)*	80%
Class C – Major Services • *One diagnostic X-ray, full or panoramic in any 3 year period* • *Oral Surgery* • *Endodontic treatment* • *Periodontic services* • *Crowns, inlays and onlays* • *Prosthetic services; bridges and dentures*	1st Year – 10% 2nd Year – 25% 3rd Year – 50%
Deductible	$100 Lifetime per Person Applies to Class A, B and C services, with a maximum of 3 individual deductibles per family.
Orthodontia	Calendar Year Max: $500.00 Lifetime Max: $1,000 Has the same payment schedule as Major Services
Annual Maximum Benefit	$1,500 Per person per calendar year

Monthly Premiums for Chailland High Option Plan

Level of Coverage	*Monthly Premium*		
	Area 1	*Area 2*	*Area 3*
Employee Only	$32.83	$35.95	$39.45
Employee + 1 dependent	$68.73	$74.82	$81.71
Employee + 2 or more dependents	$98.67	$107.32	$117.06

Plan Guidelines

Requires 6 months of employment with Chailland to be eligible to enroll. Rates include credit for prior time
Assumes each plan will renew annually, with all employees renewing at same time regardless of effective date.
Rates are not valid for Chailland employees working at schools, educational facilities, municipalities or state/federal government agencies
Insured by: Security Life Insurance Company of America, Minnetonka, MN
Administered by: CBSA Performax, Minneapolis, MN

SPIRIT DENTAL

Chailland Low Option Group Dental Plan

You may go to any dentist you choose! The Spirit Dental Plan reimburses you for covered dental expenses based upon a percentage of the Reasonable and Customary (R&C) fees for those services. Charges in excess of R&C fees will be the responsibility of the insured.

BENEFIT SUMMARY	COVERAGE
Class A – Preventive Services • *Routine Exams and Cleanings (2 per calendar year)* • *Fluoride treatment for children under age 16 (one per calendar year)* • *Bitewing X-rays (1 series per calendar year)*	1st Year – 60% 2nd Year – 70% 3rd Year – 80%
Class B – Basic Services • *Simple extractions* • *Basic fillings* • *Space Maintainers* • *Sealants (children to age 16)*	1st Year – 25% 2nd Year – 40% 3rd Year – 60%
Class C – Major Services • *One diagnostic X-ray, full or panoramic in any 3 year period* • *Oral Surgery* • *Endodontic treatment* • *Periodontic services* • *Crowns, inlays and onlays* • *Prosthetic services; bridges and dentures*	1st Year – 0% 2nd Year – 15% 3rd Year – 25%
Deductible	$50 Annual Deductible Applies to Class A, B and C services, with a maximum of 3 individual deductibles per family.
Orthodontia	Not Covered
Annual Maximum Benefit	$1,000 Per person per calendar year

Monthly Premiums for Chailland Low Option Plan

Level of Coverage	*Monthly Premium*		
	Area 1	*Area 2*	*Area 3*
Employee Only	$18.90	$20.72	$22.77
Employee + 1 dependent	$38.84	$42.58	$46.79
Employee + 2 or more dependents	$55.76	$61.12	$67.17

Plan Guidelines

Requires 6 months of employment with Chailland to be eligible to enroll. Rates include credit for prior time
Assumes each plan will renew annually, with all employees renewing at same time regardless of effective date.
Rates are not valid for Chailland employees working at schools, educational facilities, municipalities or state/federal government agencies
Insured by: Security Life Insurance Company of America, Minnetonka, MN
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GENERAL INFORMATION

ELIGIBILITY: Active employees plus their eligible dependents (spouse and unmarried children from birth to age 22; extended to age 26 if child is a full-time student) This is subject to State requirements.

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 charges in excess of those considered reasonable and customary; for overdentures and associated procedures; for cosmetic procedures; for the replacement of dentures, bridges, inlays, onlays, or crowns that can be repaired or restored to normal function; for implants, and for (a) the replacement of retainers, (b) the replacement of lost or stolen appliances, (c) athletic mouthguards, (d) precision or semi-precision attachments, (e) denture duplication, or for (f) 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 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 in the 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.

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.