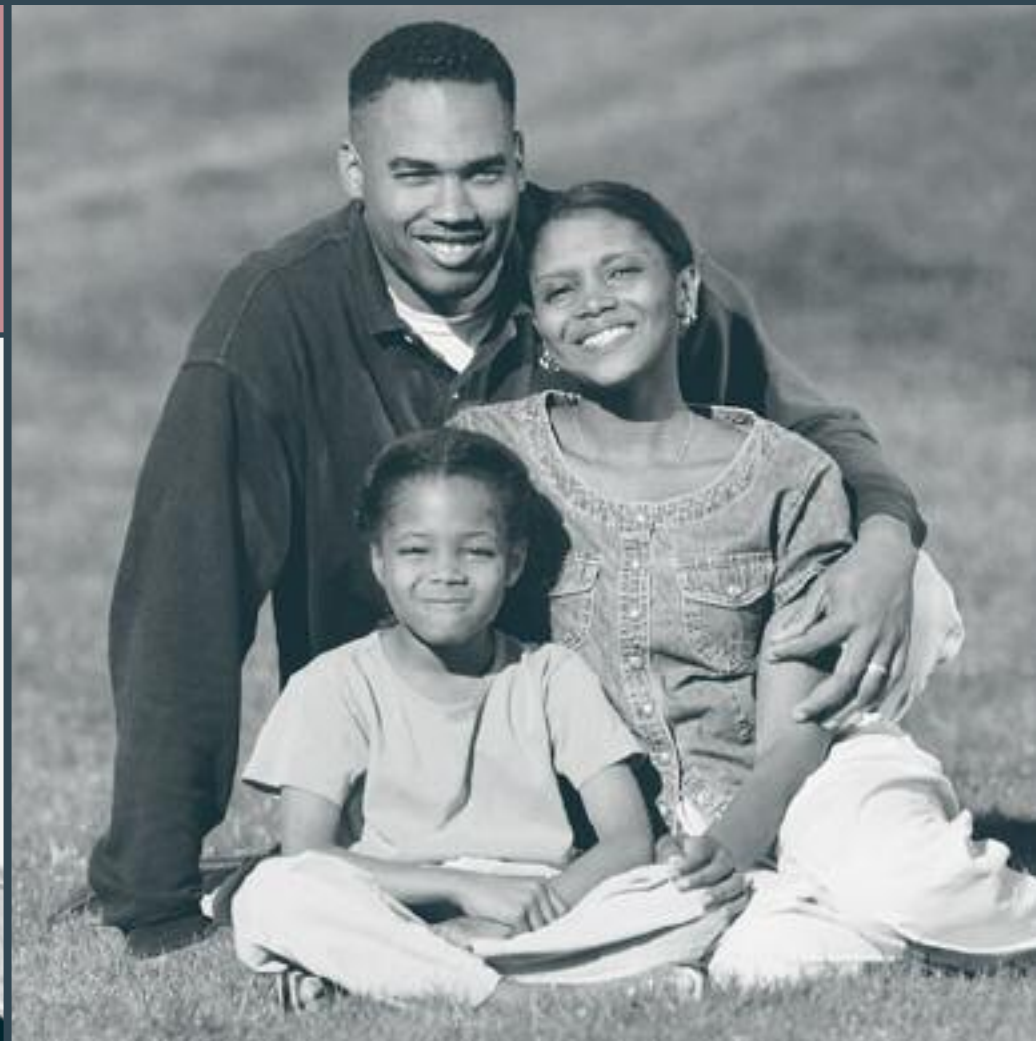


Dental

Providing confidence and security



Midwest Security
INSURANCE COMPANIES



A UnitedHealth Group Company

Midwest Security Insurance Companies

Corporate Value Statement

Midwest Security is an innovative, action-oriented company committed to a “Customer First” service ethic. We value employees who show dedication to excellence in customer service and who treat customers, both internal and external, with respect and courtesy. We expect the highest standards of honesty and integrity of our employees. We consider hard work, efficiency, productivity and the desire for continuous learning and self-improvement to be normal and reasonable expectations of ourselves as employees, and a necessity for survival in today’s competitive marketplace. Our company believes in the power of an open mind and a positive attitude, and the importance of teamwork, cooperation and consensus. Above all, we believe that success is achievable only through the daily application of these values. We are committed to continuous improvement in customer service and business processes, and we believe that continued success and growth depend upon a personal dedication to that goal on the part of each employee.



Mission Statement

Midwest Security is committed to being the premier regional provider of managed care benefit plans and administrative services in the small- to medium-sized employer marketplace.

For Groups With Five or More Employees

Dental coverage is for groups with five or more employees with Midwest Security health and life coverage. The plan is also available on a stand-alone basis for groups with 10 or more employees. Optional orthodontic coverage is available to groups with 16 or more covered employees who have had previous orthodontic coverage.

The deductible applies to Basic and Major services and is per calendar year, with a maximum of three full deductibles per family.

| | GOLD | SILVER | BRONZE |
|------------------------|---|--|-----------------------------|
| Deductible Options | \$25 • \$50 • \$100 | | |
| Annual Maximum Benefit | \$1,000 \$1,500 \$2,000 | \$1,000 \$1,500 \$2,000 | \$500 \$1,000 \$1,500 |
| I. Preventive Services | 100% | 80% | 80% |
| II. Basic Services | 80% | 80% | 50% |
| III. Major Services | 50% | 50% | 50% |
| IV. Optional | Orthodontic \$1,500 or \$2,000 lifetime maximum | 50% to \$1,500 or \$2,000 lifetime maximum | 50% to NA |

Covered Expenses

Coverage I - Preventive Services

- Routine examination, bitewing X-rays and teeth cleaning (two within twelve months).
- Full mouth X-rays (once in any 36 month intervals).
- Topical fluoride applications for dependents under age 19 (two within twelve months).
- Sealants applied to permanent molars for dependents under age 19 (no more than once every three years).

Coverage II - Basic Services

- Emergency treatment to relieve pain.
- Extractions and other oral surgery, including preoperative and postoperative care.
- Restorations of diseased or broken teeth with amalgam, silicate, acrylic, synthetic porcelain or composite.
- Periodontics procedures necessary for the treatment of diseases of the gums and bone supporting the teeth that are not covered by a health insurance policy.
- Space maintainers for dependents under age 14.
- Injections of antibiotic drugs by the attending dentist.

Coverage III - Major Services

- Installation of crowns, inlays, onlays, or gold fillings.
- Endodontics, including root canal treatment/fillings.
- Replacement of crowns, inlays, onlays, or gold fillings (not within five years of installation unless additional tooth surface is involved).
- Initial installation of dentures or bridges (not to replace teeth lost prior to the covered person's effective date).
- Replacement of existing dentures or bridges, but not within five years of the date of initial installation, and only if the existing denture or bridge cannot be made serviceable.
- Addition of teeth to existing dentures or bridges, but not to replace teeth lost prior to the covered person's effective date of coverage, unless 24 months have expired after the effective date.
- Replacement of an immediate denture installed while the covered person is insured if it cannot be made permanent and replacement is made within 12 months of installation.
- Repair, re-lining or adjustment of dentures or bridges, but not within six months of installation and not more than once in any 36-month period.

Covered Expenses (continued)

Coverage IV - Optional Orthodontic

- Orthodontic appliances and treatment, interceptive and corrective, for all eligible dependents under age 19.
- Related services for orthodontic purposes, such as exams, X-rays, extractions, space maintainers, and study models, shall be paid at the orthodontic copayment percentage.

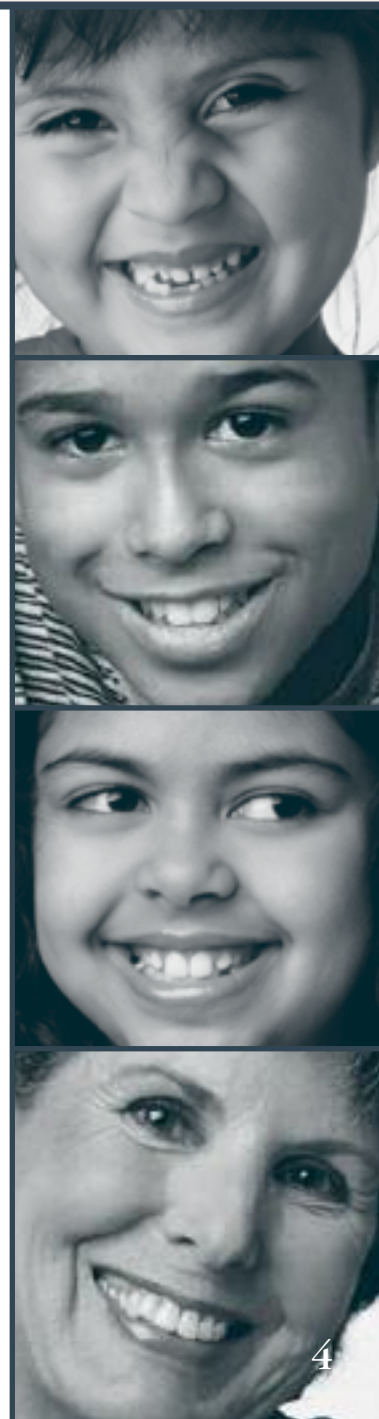
Waiting Periods For All States

| Waiting Period | Coverage I Preventive Services | Coverage II Basic Services | Coverage III Major Services | Coverage IV Optional Orthodontic |
|------------------------------|--------------------------------------|----------------------------------|-----------------------------------|--|
| New Group Initial Enrollment | Covered | Covered | Covered | Covered |
| Timely Add-ons | Covered | Covered | *Covered after 12 months | *Covered after 12 months |
| Late Applicants | Covered | Covered after 12 months | Covered after 18 months | Covered after 24 months |

Optional orthodontic coverage is available to groups with 16 or more covered employees who have had previous orthodontic coverage.

*A Timely Add-on is an employee who applies for coverage within 31 days of the eligibility date or within 31 days of one of the following qualifying events: birth, adoption, marriage, involuntary loss of other coverage, or dependent returning to full-time student status. The Coverage III & Coverage IV 12-month waiting period will be waived for Timely Add-ons if the employee had prior coverage (continuous prior dental coverage with not more than a 63-day lapse).

A Late Applicant is an employee applying for coverage more than 31 days after the date they became eligible for coverage and who is not experiencing a qualifying event associated with a Timely Add-on, as described above. Late applicants will always be subject to the applicable waiting periods.



Expenses Not Covered

- Benefits/services for injuries or conditions compensable under Worker's Compensation or Employer's Liability Laws, available from any Federal or State Government agency, municipality, county, or other political subdivision or community agency.
- Benefits/services determined to be partially or wholly cosmetic in nature, as specified in the Certificate, unless such service is necessary as a result of an accidental bodily injury sustained while the insured is covered under the Certificate.
- Benefits/services for porcelain, veneer or gold foil crowns for teeth posterior to the second bicuspid, except for the maxillary first molar. The plan will pay the applicable percentage of the fee for a cast metal crown.
- Prescription drugs and premedications; infection control programs; sterilization; preventive control programs; fees for educational programs such as training in plaque control or oral hygiene, or for dietary instruction.
- Charges for failure to keep a scheduled visit with the dentist; charges for completion of forms.
- Charges for treatment of or services related to any jaw joint problem, including Temporomandibular Joint Dysfunction (TMJ), Craniomandibular Disorder or other conditions of the joint linking the jaw bone and skull.
- Appliances or restorations for increasing vertical dimension, for restoring occlusion, for replacing tooth structure lost by attrition, for correcting congenital or developmental malformations, for aesthetic purposes, for implantology techniques, or for splints unless necessary as a result of accidental injury.
- Treatment the insurer deems experimental in nature.
- Services provided before the effective date of coverage, after coverage ends or during any waiting periods.
- Services covered under a group medical plan or Medicare.
- Unnecessary care/treatment, including duplicate dentures.
- Caries susceptibility testing, lab tests, anaerobic cultures and sensitivity testing.
- Charges for implants, including any attached crown or prosthetic device; precision/semi-precision attachments; overdentures and any associated endodontic treatment; and other customized attachments.
- Charges for a temporary bridge/denture that, when combined with the charges for the permanent bridge/denture, exceed the reasonable charge for the permanent bridge/denture.
- Charges for denture or bridgework adjustments provided to a participant within six months of the placement of the denture or bridgework.
- Benefits for treatment received from someone other than a dentist, except the scaling or cleaning of teeth and topical application of fluoride when performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of the dentist, in accordance with generally accepted dental standards.
- Claims not submitted within 12 months of the date of service.
- Treatment rendered outside the U.S. and Canada.
- Replacement of lost or stolen dental appliances, bridge work or dentures.
- Orthodontic services and related charges, such as but not limited to: exams, X-rays, extractions, and study models which are rendered solely for orthodontic purposes, unless orthodontics is included as a covered benefit in the "Services Covered by the Plan" section.
- Any service that is not specifically provided under this plan or is excluded by the rules/regulations of the plan.
- Fees that the insured is not legally required to pay to the extent that such limitation is allowable under the applicable government regulation.
- Expenses that are the result of a self-inflicted bodily injury, regardless of mental condition, or participating in a riot or act of war, or the commission of a felony.
- Charges for pulp vitality tests, study models or porcelain attachments.
- Charges in excess of usual, customary, and reasonable and maximum allowable fees for the cost of standard dental procedures.
- Routine chest X-rays and medical exams prior to oral surgery.
- Charges for orthognathic surgery.
- Services provided by a person who ordinarily resides in the insured's home or who is a family member.
- Charges for athletic mouthguards.
- Hospital, surgical or treatment facility charges or charges for services of an anesthesiologist.
- General anesthesia, unless administered by a dentist in conjunction with covered surgical procedures. Patient management or apprehension does not constitute medical necessity.

Plan Provisions

Deductible/coinsurance credit

When this group plan replaces an employee's existing group dental plan, there will be a credit for partial or full satisfaction of the calendar year deductible. No credit is allowed for coinsurance. This does not apply to employees who join the plan after the group's effective date.

Predetermination

Predetermination helps keep the cost of dental coverage down and informs plan members and their dentists of the amount of coverage paid on a dental bill.

Expenses expected to be in excess of \$300 must be submitted to Midwest Security's claim department for predetermination of benefits. Midwest Security will advise the plan member and dentist as to what portion of the expenses will be covered under the policy. The predetermination of expenses is valid for 180 days from the date the treatment is authorized.

If we do not agree, based on the predetermination review, or if the procedures to be performed and the estimated charges are not submitted in advance, we will determine the amount of expenses that will be accepted as covered dental expenses. We will consider the usual, customary, and reasonable charges for the services performed and alternate procedures, services, or courses of treatment based on the professionally endorsed standards of dental care. It is suggested that plan members don't begin any extensive treatment until they and their dentist receive notification of the services covered and benefits available.

Usual, customary, and reasonable/ maximum allowable fee

Professional charges are covered on a usual, customary, and reasonable basis as determined by the Company and shall mean payment of the usual fee charged by the provider for services rendered, but not to exceed the lesser amount of the following:

- 1 The fee most frequently charged by such provider of service for a comparable service or a service of comparable gravity, severity, and magnitude.
- 2 The fee most frequently charged by the providers of a like service with similar training and experience for the performance of a comparable service or a service of comparable gravity, severity, and magnitude, in the locality where the service was performed.
- 3 The Maximum Allowable Fee, which is the fee determined by comparing similar services or procedures to a national database adjusted to the locality where the services or procedures were performed.

Extension of benefits

If services for root canals and crowns began before the termination date and are completed within 31 days following the termination of the employer's dental plan, policy benefits are payable. If prosthetic devices, dentures and bridges were ordered and fitted before the termination date and completed within 60 days after the termination date, policy benefits are payable.

Coordination of benefits

A plan member will be fully reimbursed for allowable expenses under the various plans to the extent that the plan member's combined benefits equal 100% of the total allowable dental expenses. Benefits will be coordinated according to the provisions of the Certificate. Plan benefits are coordinated with Medicare if the member, spouse, or dependents are eligible for Medicare benefits, even if application for such benefits has not been made.

Primary coverage responsibility for dependent children abides by the birthdate rule. When both husband and wife have family coverage, the parent with the first birthday month and day in a calendar year has primary coverage responsibility.

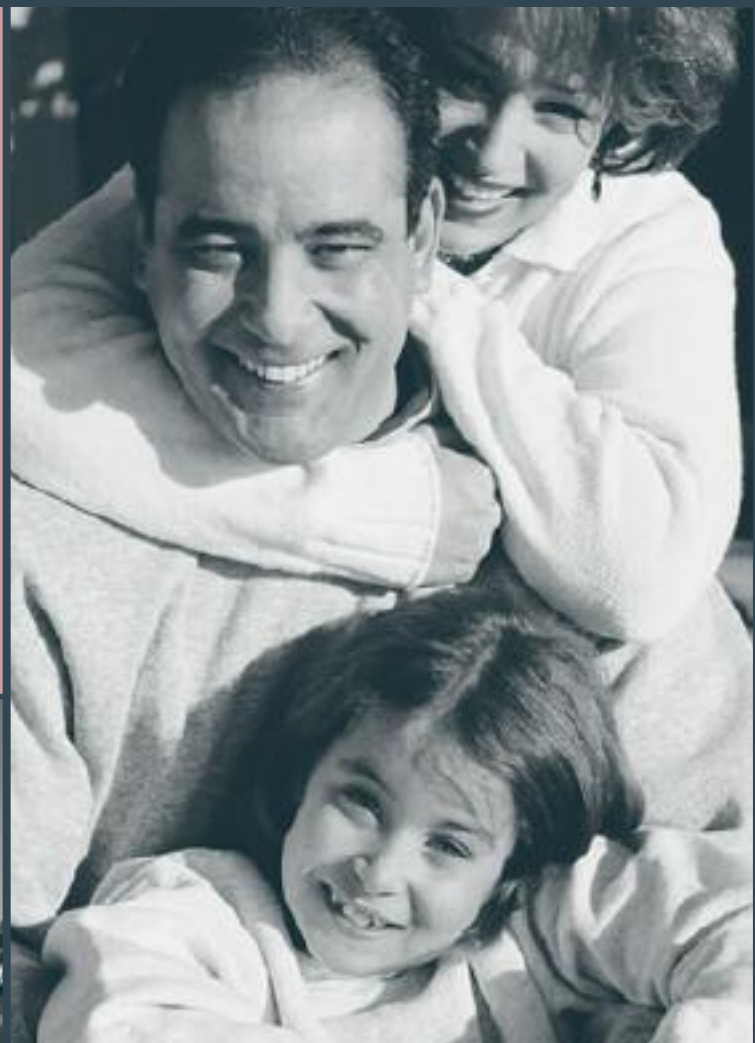
Eligibility

Eligible group size for dental is two or more lives with supporting Midwest Security life and medical coverage. Groups of 10 and over are not required to have life and medical coverage with Midwest Security to obtain dental coverage.

For groups size two to nine, we require 100% participation. For groups with 10 or more employees, 75% participation is required. Late enrollees of any size group that apply for coverage more than 31 days after the plan is effective will be subject to an 18-month waiting period on Coverage III Benefits and a 12-month waiting period on Coverage II Benefits. Timely add-ons applying for coverage who are not late enrollees may be subject to a 12-month waiting period for Coverage III benefits. See the Waiting Periods For All States section in this Dental brochure for details.

Orthodontic coverage is optional by employer and is available to groups of 16 or more covered employees if the group previously had orthodontic coverage. Timely add-ons applying for coverage who are not late enrollees may be subject to a 12-month waiting period for orthodontic benefits after their effective date. See the Waiting Periods for All States section in this Dental brochure for details.

The benefits outlined in this brochure are intended to reflect the coverages provided in the Master Policy. A more detailed explanation of coverage is provided in the Certificate. Dental is underwritten by Midwest Security Life Insurance Company.



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