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Prospective Dental Client  
Nationwide Dental Program

Dear Dental Client:

Enclosed is information on dental insurance through Guardian Life Insurance Company. Liberty Insurance Group, Inc. administers this dental plan which is specifically designed to meet the needs of individuals and small companies.

**Split Value Plan** is a PPO dental plan which allows you to receive care from any dentist. If you use a PPO dentist, routine exams, bitewing x-rays, and cleanings are covered at 100%. Other services including fillings, periodontics, endodontics, crowns and bridgework are covered at reasonable coinsurance levels after a \$50 plan year (June - May) deductible. Please refer to the enclosed comparison for more detailed information.

**Quarterly premiums (3 months) for the Split Value Plan are as follows:**

Direct Invoice: Single Coverage:\$134.00 Husband & Wife Coverage:\$263.00 Family Coverage:\$329.00  
Credit Card: Single Coverage:\$138.00 Husband & Wife Coverage:\$271.00 Family Coverage:\$339.00

**Monthly Automatic Withdrawal premium for the Split Value Plan are as follows:**

Single Coverage:\$44.00 Husband & Wife Coverage:\$87.00 Family Coverage:\$109.00

The quarterly premium quoted above includes a \$5 administrative fee per invoice. Credit card payments include an additional 3% convenience fee. Monthly automatic withdrawal premium includes a \$1 per month per invoice fee.

**Out of Network Claims Payment:** In plain language this means that if you use a non PPO provider, Guardian pays the dentist the same discounted fee as a PPO provider in the same zip code. The non PPO provider may then send the patient a bill for the difference between their fee and the amount that Guardian allows. This is known as balance billing.

**DentalGuard Preferred PPO:** You receive better benefits and a lower cost per service (both covered and non covered) if you use a dentist within the PPO network. By their contract, a PPO provider cannot balance bill.

**Using a PPO dentist saves you an average of 22%! For a list of PPO providers, contact us or visit [www.GuardianLife.com](http://www.GuardianLife.com).**

**Vision Access** is included with either dental plan at no additional cost. It offers discounts on most vision services when you use a VSP provider. See enclosed flyer for more information.

**To apply please return:** A completed enrollment application, payment method form, and either a check for one quarter's premium or automatic withdrawal/credit card authorization. Checks are payable to Liberty Insurance Group. All required forms and payment must be received in Liberty's office by the last business day of the month prior to your requested effective date.

The above quoted rates and benefits are subject to change June 1, 2010. **This is not temporary dental coverage.** The expectation is that you keep coverage for at least one year. If you have any questions regarding benefits or application, please call me personally.

Sincerely,  
*Dusan Jovanovic*  
Dusan Jovanovic

**Guardian Benefit Summary Comparison**  
**Liberty Insurance Group**

	<b>Split Value Plan LP</b>	<i>In-PPO Network</i>	<i>Out-of- Network</i>
<b>Diagnostic &amp; Preventive</b>	Dental Exams (every 6 months) Dental X-Rays – Bitewings (every 12 months) Cleanings (every 6 months) Emergency Oral Exams Fluoride Treatments Tooth Sealants	100% 100% 100% 100% 100% 100%	80% 80% 80% 80% 80% 80%
<b>Basic Services</b>	Fillings Dental X-Rays – Full Mouth (every 5 years) Endodontics – Anterior & Bicuspid Periodontics – Non-Surgical Please Note: Maintenance Procedures (every 3 months); Combined Cleanings & Perio Maintenance – 4 in 12 months Anesthesia (when medically necessary) Repair & Maintenance of Crowns, Bridges, Dentures  <b>Deductible Applies to This Category</b>	80% 80% 80% 80%  80% 80%	80% 80% 80% 80%  80% 80%
<b>Major Services</b>	Crowns, Bridges, Dentures Endodontics – Molar Periodontics – Surgical Oral Surgery Dental Implants  <b>Deductible Applies to This Category</b>	50% 50% 50% 50%  Not Covered, but eligible for discount	50% 50% 50% 50%  Not Covered
<b>Orthodontics</b>	Limited to Dependent Children Age 18 and Under	50% to \$1000 Lifetime Benefit	50% to \$1000 Lifetime Benefit
<b>Miscellaneous</b>	Deductible (plan year) Office Visit Copayment Annual Benefit Maximum Maximum Rollover Benefit	\$50 x3/family None \$1,000 Included – See back for details	\$75 x3/family None \$1,000 Included – See back for details
<b>Claims Payment</b>	Claims Payment Basis	Negotiated Fee Schedule	Limited to PPO Fee Schedule**
<b>Network</b>	Dental Network	DentalGuard Preferred	
<b>Rates*</b>	Single Family	\$43.00 \$108.00	

\* Rates are valid from 6/1/09 through 5/31/10.

\*\* Charges will be paid for only up to the maximum fee level established with our contracted PPO network dentists; any amount that is charged over the fee schedule is the responsibility of the patient.

Dependent age limits are age 20, or 26 if a full-time student.

## Summary of Split Value Plan Limitations & Exclusions

Coverage is limited to charges that are necessary to prevent, diagnose or treat dental disease, defect or injury.

This plan does not pay for:

- ◆ Any restoration procedure, appliance or dental prosthesis used solely to: a) alter vertical dimension; b) restore or maintain occlusion, except to the extent that this plan covers orthodontic treatment; c) splint or stabilize teeth for periodontal reasons; or d) treat a condition caused by abrasion or attrition.
- ◆ Cosmetic or experimental treatments, unless specifically listed in the certificate of coverage as a covered cosmetic service.
- ◆ Replacing a lost, stolen or missing appliance or prosthetic device; or making a spare appliance or device.
- ◆ Treatment needed due to: a) an on-the-job or job-related injury; or b) a condition for which benefits are payable by Workers' Compensation or similar laws.
- ◆ Treatment for which no charge is made.
- ◆ Replacing an appliance or prosthetic device with a like appliance or device, unless: a) it is at least ten years old and can't be made usable; or b) it is damaged while in the covered person's mouth in an injury suffered while insured, and can't be fixed.
- ◆ The replacement of extracted or missing third molars/wisdom teeth.
- ◆ Treatment of congenital or developmental malformations, or the replacement of congenitally missing teeth.
- ◆ Evaluations and consultations for non-covered services; detailed and extensive oral evaluations.
- ◆ Any procedure performed in conjunction with, as part of or related to a non-covered procedure.
- ◆ Any procedure not specifically listed in the certificate of coverage as a covered benefit.
- ◆ Posterior composite resins are not covered.

## Summary of the Maximum Plan Rollover Provision

With Maximum Rollover, Guardian will roll over a portion of your unused annual maximum into your personal Maximum Rollover Account (MRA). The MRA can be used in future years, if you reach the plan's annual maximum.

Even better, if you use the services of DentalGuard PPO providers exclusively during the benefit year (June 1 – May 31), Guardian will increase the amount credited to your MRA.

To qualify, you must submit a claim for covered services (including preventive care) and not exceed the paid claims threshold during the benefit period. You and your insured dependents maintain separate MRAs based on your own personal claim activity. Each MRA may not exceed the MRA limit. You will receive an annual MRA statement detailing your account and those of your dependents.

<u>Plan Annual Maximum</u>	<u>Threshold</u>	<u>Max Rollover Amount</u>	<u>In-Network Only Maximum Rollover Amount</u>	<u>Maximum Rollover Account Limit</u>
\$1,000	\$500	\$250	\$350	\$1,000

If you enroll in this plan in March, April or May, your maximum rollover benefit will begin the following June.

## Use a PPO Provider Whenever Possible

If you use a provider within the DentalGuard Preferred PPO you will receive a discount and pay less for your services. The average discount is 22%! To find a preferred provider, visit the website at [www.GuardianLife.com](http://www.GuardianLife.com) (Resources: Provider Online Search; Find a Dentist; Select a Plan = PPO. Enter zip code; Choose a Network = DentalGuard Preferred.)

This brochure is a summary outline only and is not intended to serve a legal interpretation of benefits. Reasonable effort has been made to have this brochure present a characteristic overview of the plan. However, this brochure does not amend, supplement, or replace the contract, and all statements are subject to the benefits, limitations, and exclusions of the contract.

# Benefit Summary

for Vision has been prepared for the members of:

## Liberty Insurance Group

### Vision Access \*

An eligible person can receive discounts on vision care services or supplies from a vision provider that is under contract with Vision Service Plan's (VSP's) Preferred Provider Organization (PPO) network. The eligible person must pay the entire discounted fee directly to the VSP network doctor.

Discounts are not available from providers who are not members of VSP's network.

#### **DISCOUNTS:**

- **Eye Exams** – 20% off of the VSP doctor's usual charge.
- **Frames, Standard Lenses and Lens Options** – 20% off the VSP doctor's usual charge, when a complete pair of prescription glasses is purchased.
- **Contact Lens Professional Services** – 15% off the VSP doctor's usual charge for professional services. The lenses are not discounted.
- **Laser Surgery** -- an average of 15% off the laser surgeon's usual charge.

No ID cards are required, but the patient must notify the VSP network doctor that they have Guardian VSP Access Plan coverage at the time of service to receive their discount.

Discounts are only available from the VSP network doctor that provided the eye exam to the patient within the last 12 months.

#### **NOTES:**

- There is no charge for Discount Vision Access.
- To find a VSP network doctor, visit [www.vsp.com](http://www.vsp.com) or call 1-800-877-7195.
- A person must be enrolled for dental coverage in order to be eligible for Discount Vision Access.
- When a person is no longer enrolled for dental coverage, access to the network discounts ends.

\* This is not insurance. The eligible person must pay the entire discounted fee directly to the VSP network doctor.

**This handout is for illustrative purposes.**



**GUARDIAN\***

The Guardian Life Insurance Company of America, New York, NY

2004-4598

# DENTAL ENROLLMENT FORM



PLEASE RETAIN A PHOTOCOPY OF YOUR APPLICATION FOR YOUR RECORDS AND SUBMIT THIS FORM TO LIBERTY INSURANCE GROUP

PLANHOLDER NAME (COMPANY NAME) <b>LIBERTY/SBIT TRUST</b>		GROUP PLAN NO <b>378450</b>	REFERENCE #
PLANHOLDER STREET ADDRESS <b>17100 W. Bluemound Road, Suite 202</b>		CITY <b>Brookfield</b>	STATE <b>WI</b>
		ZIP <b>53005</b>	SOC. SEC. NO.
NAME (LAST, FIRST, MI)		SEX	BIRTHDATE
STREET ADDRESS	CITY	STATE	ZIP
E-MAIL ADDRESS		FAX NUMBER	HOME TELEPHONE NUMBER
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> LEGALLY SEPARATED <input type="checkbox"/> DIVORCED		WORK TELEPHONE NUMBER	
		CELL PHONE NUMBER	

**Please provide the following information for each dependent if they are applying for coverage:**

NAME (LAST, FIRST, MIDDLE INITIAL)	GENDER	SOCIAL SECURITY #	BIRTHDATE	FT STUDENT
SPOUSE	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			
CHILD	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			<input type="checkbox"/> YES <input type="checkbox"/> NO
CHILD	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			<input type="checkbox"/> YES <input type="checkbox"/> NO
CHILD	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			<input type="checkbox"/> YES <input type="checkbox"/> NO
CHILD	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			<input type="checkbox"/> YES <input type="checkbox"/> NO
CHILD	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			<input type="checkbox"/> YES <input type="checkbox"/> NO

<b>COVERAGE ELECTION</b>	
<b>FAMILY STATUS</b>	<b>PLAN CHOICE</b>
Single <input type="checkbox"/>	Split Value Plan <input checked="" type="checkbox"/>
Family <input type="checkbox"/>	
Husband & Wife <input type="checkbox"/> (2 Single Plans)	

I hereby request coverage for the Group insurance and/or coverage for which I am or may become eligible; I understand that, in order to be accepted for coverage, my signed and completed application must be received by Guardian at least one business day before my requested effective date for coverage. Effective dates can only be the first of each month. I understand that my choice indicated above is for a minimum of twelve (12) months. I authorize any provider, insurer, and/or HMO or other organization to release the necessary information regarding my dental history, treatment or benefits to Guardian or its subsidiary or authorized agent, for the purpose of plan administration.

SIGNATURE:	DATE:	EFF DATE:
		/ 1 / 20

AGENT: D usan Jovanovic

Liberty Insurance Group, Inc.  
17100 W. Bluemound Road, Suite 202  
Brookfield, WI 53005  
Phone: 262-785-1221 Fax: 262-821-0508 e-mail: dental@hsawi.com

## WHAT DO I NEED TO APPLY FOR DENTAL COVERAGE?

- |   |  |   |
|---|--|---|
| <p><b>Direct Invoice</b><br/>Enrollment form<br/>Payment method form<br/>Check for one quarter of premium<br/>Mail only</p> | <p><b>Auto Withdrawal</b><br/>Enrollment form<br/>Complete authorization on payment method form<br/>Void check<br/>Send no premium, premium will be drafted<br/>Mail, fax, or e-mail</p> | <p><b>Credit Card</b><br/>Enrollment form<br/>Complete authorization on payment method form<br/>Send no premium, premium will be charged<br/>Mail, fax, or e-mail</p> |
|---|--|---|

Billing Options Liberty Insurance Group  
Guardian Dental Program Payment Method (select one)

Name: \_\_\_\_\_

**Direct Invoice – Must submit quarterly premium with initial application**

- Send quarterly invoice to home address on application. (\$5 admin fee per invoice)
- Send semi-annual invoice (\$5 fee per invoice)       Send annual invoice (\$5 fee per invoice)
- Send direct invoice to this address (\$5 admin fee per invoice)

\_\_\_\_\_  
Name                                  Address                                  City                                  State                                  Zip

**Monthly Automatic Bank Draft**

- Monthly Automatic Bank Draft (\$1 admin fee per month per invoice)  
Initial premium drafted 4<sup>th</sup> – 6<sup>th</sup> of month you are effective. Premium will be also be drafted on the 20<sup>th</sup> of the month you are effective to pay for your second month of coverage. Thereafter premium will be drafted on the 20<sup>th</sup> of month prior to the month you are paying for. Please attach "void" check.

I authorize Liberty Insurance Group, Inc. to initiate premium deductions from the account indicated below and my financial institution to debit the same account. I understand that this authorization is in effect until I notify Liberty Insurance Group, Inc. in writing that I no longer desire this service. My notification must afford Liberty Insurance Group and my financial institution reasonable opportunity to act on it.

Checking Account       Savings Account

Transit Number: \_\_\_\_\_ Account Number: \_\_\_\_\_

\_\_\_\_\_  
Signature                                  Date

**Credit Card – Premium will be charged to your credit card**

\$5 admin fee plus 3% service fee per invoice

- Initial Premium Only – (charged prior to effective date)  
Direct invoice thereafter (see above).
- Recurring Quarterly  
(charged on the 20th prior to due date)
- Recurring Semi-Annual (charged on the 20th prior to due date)       Recurring Annual (charged on the 20th prior to due date)

Select One:       Visa       MasterCard       Discover

\_\_\_\_\_  
Credit Card Number

\_\_\_\_ / \_\_\_\_      Amount: \$ \_\_\_\_\_  
Expiration Date

I authorize Liberty Insurance Group, Inc. to bill my credit/debit card account indicated above for payment of dental insurance premium.

\_\_\_\_\_  
Signature                                  Date