Group Dental Insurance
Coverage for 3 Lives or More

Coverage Underwritten and Issued by:

LIBERTY UNION
LIFE ASSURANCE COMPANY

APPEAL DENTAL PLAN

The Appeal Dental Plan is a fully insured dental plan for groups with 3 or more employees. Appeal is underwritten by Liberty Union Life Assurance Company. Liberty Union Life is an insurance company domiciled in Southeastern Michigan and specializing in group and dental coverage.

Key features of the Appeal Dental Plan include; required benefit pre-determination for all services costing more than $250 and a published schedule of maximum payments. Appeal is a stand alone dental plan and does not require the group to purchase any other insurance.

I. Plan Underwriting

A. Group size - 3 or more employees
B. **Participation**
    1. If employer pays 100 percent of premium, then 100 percent participation is required.
    2. If employer pays less than 100 percent of premium, then 75 percent participation is required.
C. Coverage begins the first day of the month following the employer determined waiting period.
D. There is a twelve (12) month waiting period on all major and orthodontic benefits unless documentation of prior group coverage is submitted.
E. Premium rates are guaranteed for twelve (12) months.
F. Plans and rates can be quoted from the rate card.

II. Group Sales Submission

Once a group has decided to purchase the Appeal Dental Plan, the following procedures must be followed by the group for policy issuance.

A. Complete and sign the Participation Agreement.
B. Complete and sign Enrollment Forms for all covered employees.
C. Check made payable to Liberty Union Life Assurance Company for first month's premium.
D. Complete and sign Waiver Forms where appropriate.
E. Latest month's billing statement from previous dental insurer.
F. Copy of benefit certificate from the previous dental insurer.

III. Group Coverage Issuance

Group acceptance and coverage issuance will be determined by Liberty Union Life. The issuance process and group notification of coverage will generally be completed within ten (10) days.

IV. Plan Operation

Liberty Union Life will coordinate all Appeal marketing, issue group coverage, receive and process all employee/group status changes and bill all groups monthly.

Mid-America Associates, Inc. will administer all group plan benefits, process claims and verify benefits. Mid-America's Service Number is (248) 585-7900.

PARTICIPATION AGREEMENT

Appeal Dental Plan

EMPLOYER GROUP INFORMATION

The Employer, in consideration of the Participation Agreement that the insurance coverage, for which this is an application reflects the following:	Plan Anniversary Date:	Requested Coverage Effective Date	
FIRM NAME (Legal Name)	Tax ID#		
Address	City	State	Zip
CORRESPONDENT CONTACT NAME	CORRESPONDENT TITLE	CORRESPONDENT PHONE	
Business is a: _____Sole Partnership _____Partnership _____Corporation	Nature of Business	Total Number of Employees	Number of Full-Time(30 or more weekly) Employees:
New employees are covered on the first of the month following - 30 days	60 days	90 days	Other
Indicate the percent of insured's premium costs which the employer will pay for employee's _____% and dependents _____%.		Name of Worker's Compensation Carrier	
Has the employer had Group Dental Insurance Coverage for the past 12 months? _____Yes _____No If yes, attach a copy of the most recent premium billing statement		Carrier Name	Policy #

EMPLOYER GROUP COVERAGE REQUEST

The Employer requests group dental insurance plan (please indicate appropriate): Plan ( )

Deductible Level ( ) Copayment Level ( ) Orthodontia Rider $1,000 ( )

Maximum Level ( ) Orthodontia Rider $1,500 ( )

The following Appeal Dental Plan monthly premium rates are issued for a group coverage effective date of _____

Employee Coverage Categories	Number of Employees	Rate	Premium
Employee Only	_____	_____	_____
Employee & Spouse	_____	_____	_____
Employee & Child	_____	_____	_____
Employee & Family	_____	_____	_____
Monthly Billing Fee			$15.00
		TOTAL MONTHLY PREMIUM	_____

APPEAL EXCLUSIONS AND LIMITATIONS

Covered Dental Charges do not include and no benefits are payable for:

1. Services incurred as a result of any injury or illness covered under Workers' Compensation or similar entitlements or public programs, or as a result of war, riots or self infliction.

2. Services covered under a medial health plan to include surgery in connection with accidental injuries to the head and jaws, and treatment of tumors or growths or treatment for malformations or congenital defects.

3. Services not actually performed including charges for completion of insurance forms or missed appointments or services for which the necessity of performance cannot be proven to the satisfaction of the insurer.

4. Services, treatments, appliances or restorations for:
   - TMJ dysfunction
   - Alteration of vertical dimension or occlusion
   - Splinting or replacing tooth structure due to attrition or abrasion
   - Implantalogy of any type including grafts of any type
   - Preventive programs including sealants, oral hygiene instruction, myofuction therapy
   - Crowns whose sole purpose is as abutments of fixed bridgework

5. Services or treatments which are:
   - Primarily cosmetic in nature
   - Experimental
   - Specialized or customizing techniques including attachments
   - Duplicate or replacement (lost or stolen) or temporary appliances

6. Veneers on crowns or pontics placed posterior to the second bicuspid.

7. Prophylaxes and/or Oral Exam more than once every six months.

8. Full mouth x-rays more often than once per three year period. Bitewing x-rays more often than one set per one year period.

9. Analgesia or nitrous oxide and general anesthesia or IV sedation.

10. Treatment incurred prior to the effective date of coverage or after termination date of policy. Incurred dates are defined as date of final placement for crowns, bridges, dentures and the like or with respect to other procedures when service is completed.

11. Perioscaling and root planing limited to full mouth or four quadrant equivalent per 24 month period.

12. Services or treatment incurred during the first 12 months following the effective date of dental coverage of this policy by any uncovered member (employee or dependent) who (a) elects to enroll for dental coverage more than 31 days following original eligibility date or (b) enrolled for dental coverage after previous voluntary termination while eligible for dental coverage; except for Class I service.

APPEAL PLAN FEATURES

SCHEDULE OF MAXIMUM COVERED CHARGES:

APPEAL Dental Plans include a published schedule of maximum payment allowances for covered services so both the insured member and the dentist know, in advance, what charges will be allowed.

FREEDOM OF DENTIST SELECTION:

APPEAL Dental Plan insured members may receive full covered services from any dentist they choose, select a dentist for each member of the family, and self-refer to specialists just by making the appointment. The choice is theirs.

REDUCE OUT OF POCKET EXPENSES:

APPEAL Dental Plan insured members reduce their balance billing out-of-pocket expenses when they receive care from any of the over thousands of participating dentists. All participating dentists are contracted with the PPO Dental network to accept the plan's Schedule of Maximum Covered Charges. To receive care from a PPO participating dentist, members select a dentist from the Dentist Directory and schedule an appointment.

GENERAL INFORMATION

WHAT FIRMS ARE ELIGIBLE?

Any firm with three or more employees engaged in one of the following industries: Construction; Manufacturing; Government; Wholesale and Retail Trade; Transportation; Commerce and Services; is eligible for participation under this program.

The prospect must be:

A. A stable business organization with low employee turnover.
B. A firm with definite employer-employee relationship.
C. A firm having the facilities and authority to handle administrative functions connected with the plan.

WHICH EMPLOYEES AND DEPENDENTS ARE ELIGIBLE?

Eligible dependents are an employee's spouse and unmarried children under 19 years of age (also those 19 to 25 years of age if they are full-time day students attending an accredited educational institute). In the event an employee or dependent was not added within 31 days when first eligible, no benefits except Class I services will be paid during the first 12 months following the date any such employee or dependent is added.

PARTICIPATION REQUIREMENTS

Employees and Dependents

Dental Insurance is available to a firm only if:

a. The firm pays the entire employee cost so the 100% eligible employee participation is maintained, or
b. Such plan is provided to the employees of a firm only as a compulsory part of their medical-dental plan so that only those employees enrolling for the "plan" receive the full package of benefits (one segment will not be provided any employee without the other segment). In this event, the employee segment can be contributory, but 75% participation will be required for employees.
c. Firms that fall below these requirements or fall below three insured employees will be given 90 days to bring participation up to the required levels. If not done, this dental plan will end at that time.

WHEN DOES COVERAGE BECOME EFFECTIVE?

Coverage for full-time employees of new firms begins on the date the participation has been accepted. The Insurance Company reserves the right to decline acceptance of any firm. Coverage for new employees of participating firms begins on the date they have completed the waiting period stipulated by the firm on their master application. Each employee will receive a certificate of insurance outlining the benefits and provisions of the policy. Full-time employee means those working 30 or more hours weekly.

WHEN DOES INSURANCE TERMINATE?

A participating firm's coverage ceases on the earlier of (a) termination of the policy (the Company may non-renew the plan subject to 60 days of written notice); (b) due date of premium unpaid within the grace period; (c) due date next following notification by the firm of cancellation; or (d) the date the participating firm no longer meets the participation requirements. An employee's insurance ceases on the earlier of (a) termination of the participating firm's coverage, as outlined above; (b) the date of the termination of active employment with the firm; (c) cessation of premium payments for such person.

HOW ARE PREMIUMS PAYABLE?

The premium billing you will receive will show each insured's name and premium. Adjustments will be reflected on the next statement. Premiums are due only on the first day of the month.

A 30-day grace period is allowed for premium payment. Upon termination of the plan, all unpaid premiums for insurance up to the date of termination, including any part of the grace period during which the insurance was in force, is due and payable by the participant.

REPLACEMENT OF EXISTING PLAN

If the firm has had a group dental insurance program in effect which is being replaced by Appeal, the Company, in applying any deductibles or waiting period in the Appeal plan, will give credit for the satisfaction (or partial satisfaction) of the waiting periods and deductible amounts satisfied with the immediate preceding insurance underwriters, but only if:

1. Such previous dental insurance was shown by the firm on their application foe dental insurance with us, and
2. A copy of the previous carrier's last dental premium statement with effective date of coverage was included with such application, and
3. A copy of the pervious carrier's dental program (brochure, certificate, or policy) was included with such application. In the event of a dental expense incurred after the effective date of our plan for which our benefits payable would be affected by recognition of such previous carrier's program, the firm will furnish proof of such satisfaction with the previous carrier sufficient to permit verification of the benefit determination.

COORDINATION OF BENEFIT

This plan includes a coordination of benefits provision. If any family member is eligible to receive benefits under another group or franchise plan, employee welfare or benefits plan, or through any governmental program, benefits under this plan will be coordinated with the benefits from any other plan so that up to 100% of the "allowable expenses" incurred during a calendar year will be paid jointly by the plans. An "allowable expense" is any reasonable, necessary and customary item of expense covered in part or full under any one of the plans involved.

HOW ARE CLAIMS HANDLED?

Administration of the plan has been designed to keep paperwork to a minimum. Upon installation of the plan, you will receive a supply of a form approved by the American Dental Association which is used by the employee's dentist. The benefits may be assigned by the employee to be paid directly to the dentist.

EXTENDED BENEFITS

If insurance ends other than for payment of the maximum benefit, before completing selected major dental treatment which began while insured, insurance for only the incomplete treatment will be extended until the first date insurance begins under another group dental policy which pays benefits for the treatment in process, or if not replaced, 3 months from the date coverage terminated.

APPEAL DENTAL
BENEFITS IN BRIEF

PLAN	A	B	C	D
CALENDAR YEAR MAX.	**$1,500**	**$1,500**	**$1,000**	**$1,000**
Deductible				
Preventive	-0-	-0-	-0-	-0-
Other	$25	$25	$50	$25
Family	3X	3X	3X	3X
Coinsurance				
Preventive	100%	100%	100%	100%
Routine	100%	80%	80%	50%
Major (1 Yr. Wait)	100%	50%	50%	50%

ORTHODONTIA COVERAGE

Quotation of orthodontia coverage requires the addition of added monthly premium. The additional monthly premium cost is to be added to the Employee & Child and the Employee & Family rates only.

OPTIONS

* Orthodontia with a lifetime maximum of $1,000
* Orthodontia with a lifetime maximum of $1,500

APPEAL DENTAL
COVERED DENTAL SERVICES

CLASS I — Preventive Procedures

1. Oral Prophylaxis (once per six month period).
2. Topical applications of fluoride for children up to age 17.
3. Space maintainers to replace primary teeth prematurely lost.
4. Bitewing X-rays limited to one set per one year period.
5. Full mouth X-ray series including bitewing (or Panoramic X-ray) limited to once per three year period.
6. Oral Exams (once per six month period).

CLASS II — Routine Procedures:

1. Other X-rays as necessary not covered in Class I.
2. Restorations, fillings (amalgam, composites, etc.) other than gold or cast restorations, to restore diseased teeth.
3. Emergency Treatment, palliative.
4. Oral Surgery, as follows: Extraction of teeth, alveolectomies, frenectomies, removal of tori, root recovery.
5. Endodontic Treatment, root canal treatment.
6. Periodontal Treatment.
7. Adjustments and repairs to full and partial dentures and fixed bridgework.
8. Relines and rebases - not more often than once every 3 years.

CLASS III — Major Procedures

(Beginning after 12 consecutive months of coverage under the employer's dental plan.)

1. Jackets, Full Cast or Veneer Crowns, and all gold and cast restorations. These restorations will be authorized only when the tooth, because of extreme caries or fracture, cannot be restored with amalgam, composite or other restorative material.
2. Initial Fixed Bridgework and full or partial dentures for the replacement of permanent teeth:
   a. which were extracted on or after the effective date of this insurance.
   b. if the teeth were missing prior to the effective date of the Covered Person's coverage under this Policy, dental benefits are not payable unless an additional tooth or teeth are extracted while the Covered Person is covered under this Policy and such tooth/teeth are included in the appliance.
3. Replacement of fixed bridgework or full or partial dentures if the appliance is at least 5 years old and cannot be made serviceable and the treatment commences after the insurance has been in effect for the insured person at least 2 years.

CLASS IV — Orthodontia

(Beginning after 12 consecutive months of coverage under the employer's dental plan.)

Appliances and treatment for dependent children under age 19 when such treatment begins one year after a dependent's effective date of dental insurance.

**All Appeal Dental plans utilize the DenteMax Network. 02/22/2000

EMPLOYER UNDERSTANDS AND AGREES AS FOLLOWS:

(1) Insurance will be effective only upon approval by Liberty Union Life Assurance Company.
(2) No agent has power on behalf of the Insurance company to make or modify a contract.
(3) All eligible persons have been given an equal opportunity to enroll, and future persons will be given the same opportunity to enroll when first eligible.
(4) Employer will furnish promptly, when it is requested, any information required to establish the eligibility of any person.
(5) Rates may be changed each year, based on those insured as of the date rates are recalculated, and upon the current table of rates.
(6) A 31-day grace period is allowed for premium payment. Upon termination of the plan, all unpaid premiums for insurance up to the date of termination, including any part of the grace period during which the insurance was in force, is due and payable.
(7) The undersigned Employer understands and agrees that the Plan, Plan Administrator, and Liberty Union do not assume the employer's responsibilities for compliance with the Consolidated Omnibus Budget Reconciliation Act of 1985.

I hereby certify that the preceding information is complete and accurate to the best of my knowledge. I also understand that the underwriting of these applications has been predicated based upon the answers to the questions contained herein and where there have been material misrepresentations of facts, it may result in the denial of claims payment, coverage can be retroactively rescinded and in such event the sole liability of the insurer will be a refund of premiums paid.

_____ Dated this _____ Day of _____ 20 _____
(Applicant's Signature) (Title)

I hereby confirm and understand the underwriting of the individual applications taken in this case has been predicated based upon the answers to the questions in said applications and where there has been misrepresentation of facts, coverage can be rescinded. To the best of my knowledge, there have been no material misrepresentations. I have reviewed the requested coverage for correctness and it complies with the coverage the employer desires.

_____ Dated this _____ Day of _____ 20 _____
(Writing Agent's Signature)

_____ Dated this _____ Day of _____ 20 _____
(General Agent's Signature)