ALABAMA PHARMACY ASSOCIATION

Southland National Insurance Corporation
"Defined Care 1500 Dental Plan"

	Monthly Rate*
Member	**$20.00**
Member + One Dependent	**$35.00**
Family	**$50.00**
Benefit Maximum, per person per year	**$1,500**
Deductible, per person per year **	**$50**
Member copayments for:	
Preventive Services Oral exams, cleanings, bitewing x-rays, other x-rays, fluoride treatments, sealants.	No charge
Basic Services Fillings, simple extractions, diagnostic casts, prosthodontic repairs, palliative care, space maintainers.	See member copay schedule
Major Services Endodontics, complex oral surgery, single crowns, bridges, inlays/onlays, anesthesia, periodontics, dentures.	See member copay schedule

** This rate includes a $ service charge.*
***This deductible applies to Basic & Major Services only.*

Copayment vs. Usual Charge Comparison
Listed below are a few of the more commonly performed procedures, the member's copayment for the covered dental service and the dentist's usual charge for the service.

Procedure	ADA Code	Member Copayment	Dentist Usual Charge***
Cleaning	1110	$0	$50
Exam	120	$0	$25
X-Ray	330	$0	$63
Sealant	1351	$0	$28
Filling	2150	$31	$80
Extraction	7110	$26	$80
Perio scaling	4341	$63	$138
Root canal	3330	$378	$570
Crown	2750	$389	$650

**** 2000 Dental Practice Report survey (national median fee) and local survey. Amounts above are for illustrative purposes only. Actual amounts may vary by dentist, procedure & geographic location. The above example assumes the deductible has been met.*

Participating DentaNet Dentists - <u>Members must use a Participating DentaNet Dentist</u> to receive plan benefits. The amount Members are required to pay for covered dental services is listed in the Member's Copayment Schedule. The Member's Copayment Schedule is subject to periodic review and update to reflect changes in the participating dentist's Maximum Allowable Charge (MAC) fee schedule.

Eligibility - All APA Members, spouses and unmarried dependent children are eligible to participate. Employees of APA members & their families are also eligible.

Benefit Adjustments - Benefits will be coordinated with any other dental coverage. Under the Alternative Dental Treatment provision, benefits will be payable for the most economical procedure meeting broadly accepted standards of dental care. It is recommended that all treatment plans exceeding $300 be submitted to Southland National for an estimate of benefits payable.

Limitations and Exclusions - No benefits are payable for natural teeth missing on date of insurance; care that is not necessary, not listed under the Schedule of Dental Services in your Group Policy, not professionally endorsed; experimental or cosmetic in nature; care for which there is no legal obligation to pay, not incurred while insured; work-related; TMJ disorders, orthodontics, implants, vertical dimension, bite registration; emergency oral exam; loss due to war, riot, felony or assault.

To Enroll – Please complete the APA Member Southland National Enrollment Application.

Mail or fax the enrollment form to the address below:

Alabama Pharmacy Association
1211 Carmichael Way
Montgomery, AL 36106
Fax: 334-271-5423

This brochure is a brief description of the plan benefits and is designed to highlight features of the program only. A more complete description of benefits and exclusions is found in the Certificate of Coverage. Please see Group Policy SNIC-GDC2000-11, which alone determines all rights and benefits.

Southland Application

Southland National Group Dental Insurance Enrollment/Change Application	Please Check one (X) New Subscriber Date of Membership ________ ( ) Change ( ) Open Enrollment

Last Name / First / Initial	Soc. Sec. #	***Company Use Only***
Home Address / City / State / Zip	Phone	***Group Number***
E-mail Address / Membership Date (Mo/Day/Yr) / Birth Date (Mo/Day/Yr)	Sex ( ) Male ( ) Female	***Effective Date***
Employer/Group Name **ALABAMA PHARMACY ASSOCIATION**	Phone 800-529-7533	***Plan Code***
Employer Address / City / State / Zip Carmichael Road / Montgomery / Al	Fax	***Premium: $***

Coverage Desired: ( ) Individual Only ( ) Individual and one dependent ( ) Individual and family

List All Dependents To Be Covered

Last Name	First	Initial	Soc. Sec. #	Birth Date (Mo/Day/Yr)
1.				
2.				
3.				
4.				
5.				

Does spouse have a dental plan? ( ) Yes ( ) No. If yes, with whom? ______________________

If above answer is "Yes," are dependents enrolled under Spouse's plan? ( ) Yes ( ) No.

Are all listed dependent children under age 19 or full time students under age 23? ( ) Yes ( ) No.
If "No," who is not? ______________________

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony.

To the best of my knowledge and belief, each of the statements and answers supplied in this form is complete and true, and they constitute the sole basis for, and are the inducement for, the issuance of any insurance.

I hereby apply as indicated herein for the insurance for which I am not now insured and for which I am or may become eligible under the terms of Southland National Insurance Corporation's group policy or policies (including any future amendments) applying to, or requested to apply to, the Employer/Group named above. If such insurance becomes effective, I authorize deductions from my earnings of my contributions required from time to time toward the cost of such insurance. I represent that I am an Eligible Subscriber.

I, the agent, hereby certify by my signature below, that I have truly and accurately recorded on this application the information supplied by the Applicant.

______________________ ________
Signature of Subscriber Date

______________________ ________
Signature of Licensed Agent Agent #
Kathryne L. Brugge LinkSolutions, Inc.