

SERFF Tracking Number:	AENX-125587631	State:	Arkansas
Filing Company:	Aetna Life Insurance Company	State Tracking Number:	38564
Company Tracking Number:	AH AR0004301F01		
TOI:	H21 Health - Other	Sub-TOI:	H21.000 Health - Other
Product Name:	2008 Dental		
Project Name/Number:	2008 Dental/AH AR0004301F01		

Filing at a Glance

Company: Aetna Life Insurance Company

Product Name: 2008 Dental

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Filing Type: Form

SERFF Tr Num: AENX-125587631 State: ArkansasLH

SERFF Status: Closed

State Tr Num: 38564

Co Tr Num: AH AR0004301F01

State Status: Approved-Closed

Co Status:

Reviewer(s): Rosalind Minor

Author: SPI AetnaSPI

Disposition Date: 04/03/2008

Date Submitted: 03/31/2008

Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: 2008 Dental

Project Number: AH AR0004301F01

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 04/03/2008

State Status Changed: 04/03/2008

Corresponding Filing Tracking Number:

Filing Description:

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Employer

Deemer Date:

The purpose of this filing is to address the following changes to our dental products:

1. Add a new Calendar Year Maximum Incentive Benefit option to our traditional dental and preferred provider dental plans.

2. Add a new dental exclusion.

SERFF Tracking Number: AENX-125587631 State: Arkansas
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3. Add posterior composite services to the traditional dental and preferred provider dental plans.

Company and Contact

Filing Contact Information

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Filing Company Information

Aetna Life Insurance Company
 151 Farmington Avenue
 Hartford, CT 06156
 (860) 273-7546 ext. [Phone]

CoCode: 60054
 Group Code: 1
 Group Name: Aetna
 FEIN Number: 06-6033492

State of Domicile: Connecticut
 Company Type:
 State ID Number:

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Aetna Life Insurance Company	\$50.00	03/31/2008	19152219

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/03/2008	04/03/2008

SERFF Tracking Number: AENX-125587631 *State:* Arkansas
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Disposition

Disposition Date: 04/03/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Comprehensive PPO Dental Coverage	Approved-Closed	Yes
Form	Important Reminders	Approved-Closed	Yes
Form	Exclusions that Apply to Dental Insurance	Approved-Closed	Yes
Form	Coinsurance Incentives	Approved-Closed	Yes
Form	Coinsurance Incentives	Approved-Closed	Yes

SERFF Tracking Number: AENX-125587631 State: Arkansas
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Form Schedule

Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	GR-9N 18-007 02	Certificate	Comprehensive PPO Initial Dental Coverage	Initial		47	GR-9N 18-007 02.PDF
			t, Insert Page, Endorsement or Rider				
Approved-Closed	GR-9N 18-010 03	Certificate	Important Reminders Initial	Initial		40	GR-9N 18-010 03.PDF
			t, Insert Page, Endorsement or Rider				
Approved-Closed	GR-9N 28-025 02	Certificate	Exclusions that Apply Initial	Initial		44	GR-9N 28-025 02.PDF
			Amendments to Dental Insurance t, Insert Page, Endorsement or Rider				
Approved-Closed	GR-9N S-20-011 02	Certificate	Coinsurance Incentives	Initial		40	GR-9N S-20-011 02.PDF
			t, Insert Page, Endorsement or Rider				
Approved-Closed	GR-9N S-21-011 02	Certificate	Coinsurance Incentives	Initial		0	GR-9N S-21-011 02.PDF
			t, Insert Page, Endorsement or Rider				

[Comprehensive] [PPO] Dental Expense Coverage

[Calendar Year] Maximum Benefit [Rollover Feature]

[This plan has a [calendar year] maximum benefit. This is the most **Aetna** will pay for all covered dental expenses incurred by you [or your covered dependent] in a [calendar year]. The [calendar year] Maximum Benefit Amount applies even if there is a break in your coverage with **Aetna**.]

[The balance of your [calendar year] maximum benefit amount remaining at the end of year will be designated as the Unused Annual Amount. The Unused Annual Amount may be carried forward to the next [calendar year] and added to your new [calendar year] maximum benefit.]

[The Unused Annual Amount carried forward each year is subject to the Annual Maximum Rollover Amount. [The Unused Annual Amount cannot exceed the Annual Maximum Rollover Amount while this plan is in force.] The Annual Maximum Rollover Amount is listed on your [*Schedule of Benefits*].]

[This plan also has a Cumulative Rollover Maximum Amount. This is the maximum benefit accumulation amount allowed for multiple year rollover amounts.]

Refer to your [*Schedule of Benefits*] for the maximum amounts.

[[Calendar Year] Maximum Incentive Benefit

The [Type A] [Type B] [Type C] services [Calendar Year] Maximum Incentive Benefit which applies to your coverage for a [calendar year] will be increased to the applicable amount shown on your [*Schedule of Benefits*]; depending upon the number of immediately preceding consecutive [calendar years] in which you [were enrolled without a break in coverage] [met the following condition].

Condition: While covered, [you visited a **dental provider** for a [Type A] [Type B] [Type C] service at least once during the [calendar year]; and all [Type A] [Type B] [Type C] services shown in the List of Dental Services which were recommended by the **dental provider** were completed during that [calendar year]] [you were covered the immediately preceding [calendar year] [your coverage remained in effect without a break in coverage for [1] [2] [3] years].

If, during any [calendar year], the condition above was satisfied; the [Type A] [Type B] [Type C] services [Calendar Year] Maximum Incentive Benefit will be increased to the [Calendar Year] Maximum Incentive Benefit applicable to the next [calendar year] as shown on your [*Schedule of Benefits*].

If, during any [calendar year], the condition above was not satisfied; the [Type A] [Type B] [Type C] services [Calendar Year] Maximum Incentive Benefit may [reduce to the [Calendar Year] Maximum Incentive Benefit for the first [calendar year]] [reduce to the [Calendar Year] Maximum Incentive Benefit for the immediately preceding [calendar year]] [stay the same for the next [calendar year]].

[Contract year]: The first [contract year] for you and your covered dependents is the twelve-month period starting on the date your own Dental Expense Coverage begins. Subsequent [contract years] begin on the anniversary of that date.]

[Coinsurance Incentive Plan]

The [Type A] [Type B] [Type C] services **plan coinsurance** which applies to your coverage for a [calendar year] will be increased to the applicable percent shown on your [*Schedule of Benefits*]; depending upon the number of immediately preceding consecutive [calendar years] in which you [were enrolled without a break in coverage] [met the following conditions].

Condition: While covered, [you visited a **dental provider** for a [Type A] [Type B] [Type C] service at least once during the [calendar year]; and all [Type A] [Type B] [Type C] services shown in the List of Dental Services which were recommended by the **dental provider** were completed during that [calendar year]] [you were covered the immediately preceding [calendar year]] [your coverage remained in effect without a break in coverage for [1] [2] [3] years].

If, during any [calendar year], the condition above was satisfied; the [Type A] [Type B] [Type C] services **plan coinsurance** will be increased to **the plan coinsurance** applicable to the next [calendar year] as shown on your [*Schedule of Benefits*].

If, during any [calendar year], the condition above was not satisfied; the [Type A] [Type B] [Type C] services **plan coinsurance** may [reduce to the **plan coinsurance** for the first [calendar year]] [reduce to the **plan coinsurance** for the immediately preceding [calendar year]] [stay the same for the next [calendar year]].

[Contract year]: The first [contract year] for you and your covered dependents is the twelve-month period starting on the date your own Dental Expense Coverage begins. Subsequent [contract years] begin on the anniversary of that date.]

Important Reminder

The [copays,] [deductible,] coinsurance and maximums that apply to each type of dental care are shown in the [Summary of Benefits].

[You may receive services and supplies from [network] and [out-of-network] providers. Services and supplies given by a [network] provider are covered at the [network] level of benefits shown in the [Summary of Benefits]. Services and supplies given by an [out-of-network] provider are covered at the [out-of-network] level of benefits shown in the [Summary of Benefits].

Refer to *About the PPO Dental Coverage* for more information about covered services and supplies.]

[Type A Expenses: Diagnostic and Preventive Care**VISITS AND X-RAYS**

Office visit during regular office hours, for oral examination [(limited to 2 visits every year)]

Prophylaxis (cleaning) [(limited to 2 treatments per year)]

Adult

Child

Topical application of fluoride, [(limited to 1 course of treatment per year and to children under age [14])]

Sealants, per tooth [(limited to 1 application every [5] years for permanent bicuspids and molars only, and to children under age [14])]

Bitewing x-rays [(limited to 1 set per year)]

Entire denture series [consisting of at least 14 films], including bitewings if necessary, or panoramic film [(limited to 1 set every [5] years)]

[Vertical bitewing X-rays (limited to [1 -4] set(s) every [3-5] years)]

[Type B Expenses: Basic Restorative Care**[VISITS AND X-RAYS**

Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)

Emergency palliative treatment, per visit]

[X-RAY AND PATHOLOGY

Periapical x-rays (single films up to [13])

Intra-oral, occlusal view, maxillary or mandibular

Upper or lower jaw, extra-oral

Biopsy and histopathologic examination of oral tissue]

[Vertical bitewing X-rays (limited to [1 -4] set(s) every [3-5] years)]

[ORAL SURGERY

Extractions

Exposed root or erupted tooth

Surgical removal of erupted tooth

Impacted Teeth

Removal of tooth (soft tissue)

Odontogenic Cysts and Neoplasms

Incision and drainage of abscess

Removal of odontogenic cyst or tumor

Other Surgical Procedures

Alveoplasty, in conjunction with extractions - per quadrant

Alveoplasty, not in conjunction with extraction - per quadrant

Sialolithotomy: removal of salivary calculus

Closure of salivary fistula

Excision of hyperplastic tissue

Removal of exostosis

Transplantation of tooth or tooth bud

Closure of oral fistula of maxillary sinus

Sequestrectomy

Crown exposure to aid eruption

Removal of foreign body from soft tissue

Frenectomy

Suture of soft tissue injury]

[PERIODONTICS

Occlusal adjustment (other than with an appliance or by restoration)

Root planing and scaling, per quadrant [(limited to 4 separate quadrants every [2] years)]

Root planing and scaling – 1 to 3 teeth per quadrant [(limited to 1 per site every [2] years)]

Gingivectomy, per quadrant [(limited to 1 per quadrant every [3] years)

Gingivectomy, 1 to 3 teeth per quadrant[, (limited to 1 per site every [3] years)

Gingival flap procedure - per quadrant [(limited to 1 per quadrant every [3] years)

Gingival flap procedure – 1 to 3 teeth per quadrant [(limited to 1 per site every [3] years)

Periodontal maintenance procedures following active therapy [(limited to 2 per year)]

Localized delivery of chemotherapeutic agents]

[ENDODONTICS

Pulp cap

Pulpotomy

Apexification/recalcification

Apicoectomy

Root canal therapy, including necessary x-rays

Anterior

Bicuspid]

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[-2-]

[00000]

[RESTORATIVE DENTISTRY Excludes inlays, crowns (other than prefabricated stainless steel or resin) and bridges. (Multiple restorations in 1 surface will be considered as a single restoration.)

Amalgam restorations

Resin-based composite restorations [(other than for molars)]

Pins

Pin retention—per tooth, in addition to amalgam or resin restoration

Crowns (when tooth cannot be restored with a filling material)

Prefabricated stainless steel

Prefabricated resin crown (excluding temporary crowns)

Recementation

Inlay

Crown

Bridge]]

[Type C Expenses: Major Restorative Care

[ORAL SURGERY

Impacted Teeth

Removal of tooth (partially bony)

Removal of tooth (completely bony)]

[PERIODONTICS

Osseous surgery (including flap and closure), 1 to 3 teeth per quadrant [, (limited to 1 per quadrant, every 5 years)]

Osseous surgery (including flap and closure), per quadrant [(, limited to 1 per site, every 5 years]

Soft tissue graft procedures]

[Clinical Crown Lengthening - Hard Tissue]

[ENDODONTICS

Root canal therapy, including necessary x-rays

Molar]

[RESTORATIVE. [Inlays, onlays, labial veneers and crowns are covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge [(limited to 1 per tooth every [10] years- see *Replacement Rule*).

Inlays/Onlays-Metallic or Porcelain/Ceramic

Inlay, 1 or more surfaces

Onlay, 2 or more surfaces

Inlays/Onlays-Resin-based composite

Inlay, 1 or more surfaces

Onlay, 2 or more surfaces]

[Labial Veneers

- Laminate-chairside
- Resin laminate – laboratory
- Porcelain laminate – laboratory

Crowns

Resin

- Resin with noble metal
- Resin with base metal

Porcelain

- Porcelain with noble metal
- Porcelain with base metal

Base metal (full cast)

Noble metal (full cast)

Metallic (3/4 cast)

Post and core

[Core Build-Up]]

[PROSTHODONTICS- First installation of dentures and bridges is covered only if needed to replace teeth extracted while coverage was in force and which were not abutments to a denture or bridge less than [10] years old. (See *Tooth Missing But Not Replaced Rule.*) Replacement of existing bridges or dentures is limited to 1 every [10] years. (See *Replacement Rule.*)

Bridge Abutments (See Inlays and Crowns)

Pontics

- Base metal (full cast)
- Noble metal (full cast)
- Base metal (full cast)
- Porcelain with noble metal
- Porcelain with base metal
- Resin with noble metal
- Resin with base metal

Removable Bridge (unilateral)

One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics

Dentures and Partials (Fees for dentures and partial dentures include relines, rebases and adjustments within 6 months after installation.

Fees for relines and rebases include adjustments within 6 months after installation. Specialized techniques and characterizations are not eligible.)

Complete upper denture

Complete lower denture

Partial upper or lower, resin base (including any conventional clasps, rests and teeth)

Partial upper or lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth)]

[Stress breakers
Interim partial denture (stayplate), anterior only
Office reline
 Laboratory reline
 Special tissue conditioning, per denture
 Rebase, per denture
 Adjustment to denture more than 6 months after installation
Full and partial denture repairs
Broken dentures, no teeth involved
Repair cast framework
Replacing missing or broken teeth, each tooth
Adding teeth to existing partial denture
 Each tooth
 Each clasp
Repairs: crowns and bridges
Occlusal guard (for bruxism only)[, (limited to 1 every 5 years)]]

[IMPLANTS]

[SPACE MAINTAINERS Only when needed to preserve space resulting from premature loss of deciduous teeth. (Includes all adjustments within 6 months after installation.)

Fixed (unilateral or bilateral)
Removable (unilateral or bilateral)
Removable inhibiting appliance to correct thumbsucking
Fixed or cemented inhibiting appliance to correct thumbsucking]

[GENERAL ANESTHESIA AND INTRAVENOUS SEDATION (only when medically necessary and provided in conjunction with a covered surgical procedure)]

[ORTHODONTICS

Interceptive orthodontic treatment
Limited orthodontic treatment
Comprehensive orthodontic treatment of adolescent dentition
Comprehensive orthodontic treatment of adult dentition
Post treatment stabilization]

Exclusions That Apply to [Basic] [Limited] [DMO] [PPO] [Comprehensive] Dental Insurance

Not every dental care service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician** or **dentist**. The plan covers only those services and supplies that are included in the [*What the Plan Covers*] section. Charges made for the following are not covered. In addition, some services are specifically limited or excluded. This section describes expenses that are not covered or subject to special limitations. This includes services and supplies done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

[These dental exclusions are in addition to the exclusions listed under your medical coverage.]

[Apicoectomy (dental root resection), root canal treatment.]

Cosmetic services and supplies including plastic surgery, reconstructive surgery, cosmetic surgery; personalization or characterization of dentures or other services and supplies which improve, alter or enhance appearance, augmentation and vestibuloplasty; and other substances to protect, clean, whiten, bleach or alter the appearance of teeth, whether or not for psychological or emotional reasons[;] [except to the extent coverage is specifically provided in the [*What the Plan Covers*] section]. Facings on molar crowns and pontics will always be considered cosmetic.

[Crown, inlays and onlays, and veneers unless:

- It is treatment for decay or traumatic **injury** and teeth cannot be restored with a filling material; or
- The tooth is an abutment to a covered partial denture or fixed bridge.]

[Dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth and removal of implants.]

[Services and supplies provided by an [**out-of-network**] **provider**.]

Services and supplies provided for your personal comfort or convenience, or the convenience of any other person, including a provider.

Services and supplies provided in connection with treatment or care that is not covered under the plan.

Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.

[Dental services and supplies that are covered in whole or in part:

- Under any other part of this plan; or
- Under any other plan of group benefits provided by the policyholder.]

Dentures, crowns, inlays, onlays, bridges, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, or erosion.

[First installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth all of which were lost while the person was not covered.]

Any instruction for diet, plaque control and oral hygiene.

[General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another necessary covered service or supply

Except as covered in the [*What the Plan Covers*] section, [non-surgical] [surgical] treatment of any **jaw joint disorder**. [and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment.]

[**Orthodontic treatment** except as covered in the [*What the Plan Covers*] section].

Pontics, crowns, cast or processed restorations made with high noble metals (gold or titanium).

Prescribed drugs; pre-medication; or analgesia.

Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures.

[Replacement of teeth beyond the normal complement of 32.]

[Removal of soft bony impactions.]

[Services and supplies provided where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.]

[Surgical removal of impacted wisdom teeth when only for orthodontic reasons.]

[Topical application of fluoride.]

[Treatment by other than a **dentist**. However, the plan will cover some services provided by a licensed dental hygienist under the supervision and guidance of a **dentist**. These are:

- Scaling of teeth; and
- Cleaning of teeth.]

[Treatment of alveolectomy.]

[Treatment of periodontal disease.]

Aetna Life Insurance Company
[Limited][Comprehensive]Dental Expense Insurance
[Schedule of Benefits]

[Coinsurance Incentives] [and [Calendar Year] Maximum Incentive Benefit]

[Please refer to the listing of **covered expenses**, percentage payable, and maximums appearing below. The percentage the plan will pay varies by the type of expense.]

[Plan Coinsurance]				[[Calendar Year] Maximum Incentive Benefit]
	Type A Services	Type B Services	Type C Services	
During the first [Calendar	[70%	30%	30%	[\$250]
Year]:	70%	30%	30%	[\$250]
During the second [Calendar	70%	30%	30%	[\$250]
Year]:	70%	30%	30%	[\$250]
During the third [Calendar	70%	30%	30%	[\$250]
Year]:	70%	30%	30%	[\$250]
During the fourth and	70	30%	30%]]	[\$250]]
subsequent [Calendar Years]:	70	30%	30%]]	[\$250]]

[PLAN COINSURANCE]

Orthodontic Treatment 30%]

[[Calendar Year] Maximum Incentive Benefit]

The most the plan will pay for **covered expenses** incurred by any one covered person in a [calendar year] is called the [calendar year] incentive maximum benefit.]

[The [Calendar Year] Maximum Benefit [does] [does not] apply to the "[basic] [major] [special] [comprehensive] [medical] [dental] [vision] [hearing] [prescription drug] expense coverage" described in the Booklet-Certificate.]

[Orthodontic Lifetime Maximum Benefit]

Orthodontic Maximum Benefit \$[500]

The most the plan will pay for **covered expenses** incurred by any one covered person is called the orthodontic maximum benefit.]

[Lifetime Maximum Benefit]

Lifetime Maximum Benefit \$[1,000]

The most the plan will pay for **covered expenses** incurred by any one covered person during their lifetime is called the Lifetime Maximum Benefit.]

[The Lifetime Maximum Benefit [does] [does not] apply to the "[basic] [major] [special] [comprehensive] [medical] [dental] [vision] [hearing] [**prescription drug**] expense coverage" described in the Booklet-Certificate.]

Lifetime Maximum Benefit Automatic Yearly Restoration

At the beginning of each new benefit period, the amount up to \$100 which:

- (1) has been counted against your Lifetime Maximum Benefit; and
- (2) has not been previously restored,

will automatically be restored without action on your part. Evidence of good health will not be required. However, your insurance must be in force and restoration is not available during the "extended insurance period."]

Aetna Life Insurance Company
Comprehensive Dental Expense Insurance (PPO)
[Schedule of Benefits]

[Coinsurance Incentives] [and [Calendar Year] Maximum Incentive Benefit]

[Please refer to the listing of **covered expenses** and the percentage payable appearing below. The percentage the plan will pay varies by the type of expense.]

[Plan Coinsurance In-Network Benefits]				[[Calendar Year] Maximum Incentive Benefit]
	Type A Services	Type B Services	Type C Services	
During the first [Calendar Year]:	[70%	30%-	30%	[\$250]
During the second [Calendar Year]:	70%	30%	30%	[\$250]
During the third [Calendar Year]:	70%	30%	30%	[\$250]
During the fourth and subsequent [Calendar Years]:	70	30%	30%]	[\$250]]

[Plan Coinsurance Out-of-Network Benefits]				[[Calendar Year] Maximum Incentive Benefit]
	Type A Services	Type B Services	Type C Services	
During the first [Calendar Year]:	[70%	30%-	30%	[\$250]
During the second [Calendar Year]:	70%	30%	30%	[\$250]
During the third [Calendar Year]:	70%	30%	30%	[\$250]
During the fourth and subsequent [Calendar Years]:	70	30%	30%]	[\$250]]

[PLAN COINSURANCE]	[IN-NETWORK]	[OUT-OF-NETWORK]
Orthodontic Treatment [30%]	[30%]	[30%] [Not covered]

[[Calendar Year] Maximum Incentive Benefit]

The most the plan will pay for **covered expenses** incurred by any one covered person in a [calendar year] is called the [calendar year] incentive maximum benefit.]

[The [calendar year] maximum incentive benefit applies to in-network and out-of-network covered dental expenses combined. However, when your **covered expenses** totaling [\$250] have been applied to your maximum, the plan will no longer pay benefits for any further out-of-network dental expenses that you or your dependents incur.]

[The [calendar year] maximum incentive benefit does apply to in-network **covered expenses**. However, a [calendar year] maximum incentive benefit does not apply to out-of-network **covered expenses**.]

[The [Calendar Year] Maximum Benefit [does] [does not] apply to the "[basic] [major] [special] [comprehensive] [medical] [dental] [vision] [hearing] [**prescription drug**] expense coverage" described in the Booklet-Certificate.]

[Orthodontic Lifetime Maximum Benefit]

	[IN-NETWORK]	[OUT-OF-NETWORK]
[Orthodontic Lifetime Maximum:]		
[\$500]	[\$500]	[\$500]

[All **in-network** and **out-of-network** covered orthodontia expenses apply to the orthodontic lifetime maximum. However, when **covered expenses** totaling \$500 have been applied to this maximum, the plan will no longer pay benefits for any further out-of-network dental expenses that you or your dependents incur.]

[Dental Emergency Maximum Benefit]

	[IN-NETWORK]	[OUT-OF-NETWORK]
Dental Emergency Maximum: [\$75]	[\$75]	[\$75]
The most the plan will pay for covered expenses incurred a covered person for any one Dental Emergency is called the Dental Emergency Maximum.]		

[Lifetime Maximum Benefit]

	[IN-NETWORK]	[OUT-OF-NETWORK]
[Lifetime Maximum Benefit: \$1,000	\$1,000	\$1,000
The most the plan will pay for covered expenses incurred by any one covered person during their lifetime is called the Lifetime Maximum Benefit.]		

[The Lifetime Maximum Benefit applies to covered in-network and out-of-network expenses combined.]

[The Lifetime Maximum Benefit does not apply to covered in-network expenses. However, a Lifetime Maximum Benefit applies to covered out-of-network expenses.]

[The Lifetime Maximum Benefit [does] [does not] apply to the "[basic] [major] [special] [comprehensive] [medical] [dental] [vision] [hearing] [**prescription drug**] expense coverage" described in the Booklet-Certificate.]

[Lifetime Maximum Benefit Automatic Yearly Restoration]

At the beginning of each new benefit period, the amount up to \$100 which:

- (1) has been counted against your Lifetime Maximum Benefit; and
- (2) has not been previously restored,

will automatically be restored without action on your part. Evidence of good health will not be required. However, your insurance must be in force and restoration is not available during the "extended insurance period."

<i>SERFF Tracking Number:</i>	<i>AENX-125587631</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Aetna Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>38564</i>
<i>Company Tracking Number:</i>	<i>AH AR0004301F01</i>		
<i>TOI:</i>	<i>H21 Health - Other</i>	<i>Sub-TOI:</i>	<i>H21.000 Health - Other</i>
<i>Product Name:</i>	<i>2008 Dental</i>		
<i>Project Name/Number:</i>	<i>2008 Dental/AH AR0004301F01</i>		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: AENX-125587631
Filing Company: Aetna Life Insurance Company
Company Tracking Number: AH AR0004301F01
TOI: H21 Health - Other
Product Name: 2008 Dental
Project Name/Number: 2008 Dental/AH AR0004301F01

State: Arkansas
State Tracking Number: 38564
Sub-TOI: H21.000 Health - Other

Supporting Document Schedules

Satisfied -Name: Certification/Notice	Review Status: Approved-Closed	04/03/2008
Comments:		
Attachments:		
Coverletter GR-9N 2008 Dental Enhancements.PDF		
EOV GR-9N 18-007 02.PDF		
EOV GR-9N 18-010 03.PDF		
EOV GR-9N 28-025 02.PDF		
EOV GR-9N S-20-011 02.PDF		
EOV GR-9N S-21-011 02.PDF		
EOV GR-9N S-22-010 02.PDF		
EOV GR-9N S-30-010 02.PDF		
Attachment A.PDF		
Flesch Certification.PDF		
Bypassed -Name: Application	Review Status: Approved-Closed	04/03/2008
Bypass Reason: N/A		
Comments:		
Bypassed -Name: Health - Actuarial Justification	Review Status: Approved-Closed	04/03/2008
Bypass Reason: N/A		
Comments:		
Bypassed -Name: Outline of Coverage	Review Status: Approved-Closed	04/03/2008
Bypass Reason: N/A		
Comments:		



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March 31, 2008

Mr. Joe Musgrove
Life, A&H Division
Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

Subject: Aetna Life Insurance Company NAIC No: 60054
FEIN: 06-6033492
Group, Accident and Health Insurance Coverage
Booklet Certificate Forms: GR-9N 18-007 02; GR-9N 18-010 03; GR-9N 28-025 02;
GR-9N S-20-011 02; GR-9N S-21-011 02

Dear Mr. Musgrove:

The forms listed above are being submitted for your Department's approval on a general use basis. Attachment A describes each form being submitted and the changes that are being made to previously filed forms. The forms are in final form rather than being a draft or proof.

The purpose of this filing is to address the following changes to our dental products:

1. Add a new Calendar Year Maximum Incentive Benefit option to our traditional dental and preferred provider dental plans.
2. Add a new dental exclusion.
3. Add posterior composite services to the traditional dental and preferred provider dental plans.

Variability, as indicated by bracketed material on the forms, is required so that only the appropriate language may be reflected on the forms. A detailed Explanation of Variability has been included.

These forms, upon approval, will be used with Booklet-Certificate GR-9N and Wraparound Policy GR-29N, approved by your Department on June 23, 2006.

We have included the certification of readability as required with this filing under separate cover.

For your information, the Connecticut Department of Insurance has granted it's approval of the enclosed policy and the certificate forms for use outside the state of Connecticut on February 1, 2008.

Mr. Joe Musgrove
Arkansas Department of Insurance
Page 2

We trust that you will find everything in order, and we look forward to your response. If you have any questions regarding this submission, please do not hesitate to contact me at the address or telephone number above.

Sincerely

A handwritten signature in black ink, appearing to read "Emran Rahman". The signature is written in a cursive, flowing style.

Emran Rahman FLMI, HIA
Product & Regulatory Affairs Consultant

Aetna Life Insurance Company
Explanation of Variability
GR-9N
18-007
02

When the plan is traditional plan without s network, the heading will be Dental Expense Coverage or Comprehensive Dental Expense Coverage. When the plan is a PPO plan, the heading will be PPO Dental Expense Coverage. The term 'Coverage' may be changed to 'Plan'.

Benefit amounts are listed on the Schedule of Benefits, S-20 and S-21.

General Comments

- References to network may be changed to 'in-network' or 'preferred' and out-of-network may be changed to "non-preferred".
- 'Schedule of Benefits' may be changed to 'Summary of Benefits' or 'Summary of Coverage'.
- References to 'plan coinsurance' may be changed to 'payment percentage'.

[Calendar Year] Maximum Benefit

1. This benefit feature is optional and will be included when elected by the policyholder. The amounts of each maximum will be listed on the Schedule of Benefits with other plan maximums.

The reference to a Calendar Year Maximum may be changed to a Policy Year Maximum.

- The Calendar Year Maximum may apply to network or out-of-network expenses or both.
 - The Calendar Year Maximum may be different for network or out-of-network expenses.
2. This will only be included when the plan includes a Rollover feature.
 3. The reference to Annual Maximum Rollover Annual Amount may be omitted if not selected by the policyholder.
 4. The reference to Cumulative Rollover Maximum Amount may be omitted if not selected by the policyholder.

Aetna Life Insurance Company
Explanation of Variability
GR-9N
18-007
02

Calendar Year Maximum Incentive Benefit

5. The benefit feature is optional and will be included when elected by the policyholder.

The calendar year incentive maximum amounts are shown on the Schedule of Benefits S-20 and S-21.

6. The services may be reflected as shown or Type A, B, or C Services may be omitted in accordance with the plan of benefits selected by a particular policyholder or at Aetna's discretion. Also, the reference to Type A, Type B, and Type C Services may be omitted and replaced with Preventive, Basic or Major Services, respectively. There are two options for the calendar year maximum incentive. Upon issue only one of the options will appear.
7. Option 1: "were enrolled without a break in coverage" may be included or omitted. If included the last paragraph including the calendar year definition will also be included. All other paragraphs relating to "Condition" will be omitted.
8. Option 2: "met the following conditions" will be included if the option one is omitted. If included the following 3 paragraphs will be included.
9. Only the services provided under the policyholder's plan will be included.

If the plan calendar year maximum increases for the next calendar year, such increase may apply to all types of services included in the Policyholder's plan.

There are three options in the conditions paragraph. Upon issue only one of the options will appear.

10. If any plan calendar year maximum decreases for the next following calendar year, such decrease may apply to all types of services included in the Policyholder's plan. This item shows three options if the condition is not satisfied. Upon issue only one of the options will appear.
11. This item will be included when the Policyholders plan does not operate on a Calendar Year basis. The reference to contract year may be changed to benefit year or policy year (e.g., February 1-January 31).

Aetna Life Insurance Company
Explanation of Variability
GR-9N
18-007
02

Coinsurance Incentive Plan

12. This benefit feature is optional and will be included when elected by the policyholder.

The plan coinsurance amounts are shown on the Schedule of Benefits S-20 and S-21.

13. The services may be reflected as shown or Type A, B, or C Services may be omitted in accordance with the plan of benefits selected by a particular policyholder or at Aetna's discretion. Also, the reference to Type A, Type B, and Type C Services may be omitted and replaced with Preventive, Basic or Major Services, respectively. There are two options for the coinsurance incentive. Upon issue only one of the options will appear.

14. Option 1: "were enrolled without a break in coverage" may be included or omitted. If included the last paragraph including the calendar year definition will also be included. All other paragraphs relating to "Condition" will be omitted.

15. Option 2: "met the following conditions" will be included if the option one is omitted. If included the following 3 paragraphs will be included.

16. Only the services provided under the policyholder's plan will be included.

If the plan coinsurance increases for the next calendar year, such increase may apply to all types of services included in the Policyholder's plan.

There are three options in the conditions paragraph. Upon issue only one of the options will appear.

17. If any plan coinsurance decreases for the next following calendar year, such decrease may apply to all types of services included in the Policyholder's plan. This item shows three options if the condition is not satisfied. Upon issue only one of the options will appear.

18. This item will be included when the Policyholders plan does not operate on a Calendar Year basis. The reference to calendar year may be expressed as applying during a benefit year (e.g., February 1-January 31) instead of a calendar year.

Aetna Life Insurance Company
Explanation of Variability
GR-9N
18-010
03

General Comments

This Dental Care Schedule will be used when the policyholder elects a coinsurance plan. The services listed in the Dental Care Schedule are variable. A service may be added or omitted in accordance with the policyholder's plan of benefits. The entire list may be moved to the Summary of Benefits. The following rules apply to services listed in the schedule.

Dental terminology may be changed to reflect new terminology adopted by the American Dental Association.

Any maximum number of services in a defined period of time may be increased, or the maximum may be omitted.

Any frequency limits may be decreased, or the frequency limit may be omitted.

Any age limitation may be increased, or may be omitted.

All endodontic, periodontic and/or orals surgery services may be moved to the major restorative category (Type C Services).

All Type B Services may be omitted if the policyholder's plan does not cover basic restorative services.

All Type C Services may be omitted if the policyholder's plan does not cover major restorative services.

The section on orthodontics may be omitted if the policyholder's plan of benefits does not include coverage for orthodontia expenses.

Type A Expenses: Diagnostic and Preventative Care, Type B Expenses: Basic Restorative Care and Type C Expenses: Major Restorative Care

1. The item may be omitted. If included, any of the listed items may be omitted.
2. The frequency limit may increase (e.g. 2-6) or the entire limit phrase may be modified or omitted.
3. 1 may increase (e.g. 1-2) or the entire limit phrase may be modified or omitted.
4. Age 14 may increase (e.g. 14 – 21) or may be omitted.
5. The time period of 5 years may decrease (e.g. 2-5) or it may be omitted.
6. This item may be omitted.
7. The time period of 5 years may decrease (e.g. 1-5) or the entire limit phrase may be modified or omitted.

Aetna Life Insurance Company
Explanation of Variability
GR-9N
18-010
03

8. Periapical x-rays single film maximum may range from 13 – 25, or may be omitted. This is not variable in terms of number of films. Periapical x-rays are x-rays of a single tooth from crown to root. The standard maximum is usually 13, since 14 or more x-rays are considered a ‘full-mouth series’ or an ‘entire series’ of x-rays.
9. This item may be omitted or any of the listed items may be omitted. It may be moved to Type C Expenses: Major Restorative Care.
10. Root planing and scaling per quadrant may be decreased (e.g. 1- 4) or the entire limit phrase may be modified or omitted.
11. The timeframe may decrease (e.g. 1-2 years) or the entire limit phrase may be modified or omitted.
12. The timeframe may decrease (e.g. 1-3 years).
13. The timeframe may be decreased (e.g. 1-10 years).

Aetna Life Insurance Company
Exclusions that Apply to [Basic][Limited][DMO][PPO][Comprehensive] Dental Insurance
Explanation of Variability
GR-9N
28-025
02

Note

Throughout this section, each bracketed exclusion may be omitted, or specific services or supplies mentioned within the exclusion may be omitted if the policyholder has elected to provide coverage and the plan does not include these exclusions, or coverage is provided under the medical plan, or the exclusion is already listed in the medical exclusions section. The exclusions in this section 28-025 may be moved to the medical exclusions list when Aetna medical coverage is also purchased.

Exclusions That Apply to [Basic] [Limited] [PPO] [Comprehensive] Dental Insurance

1. Section 28-025 may be omitted if the policyholder's plan does not include dental coverage.
2. Heading: The product plan name applicable to the policyholder's coverage will print.
3. The appropriate section reference will print.
4. This paragraph will print for plans when an Aetna medical plan is purchased with the dental coverage.
5. Apicoectomy may be omitted if coverage is provided.
6. Cosmetic Services: The bracketed phrase will print when certain items of the exclusion are covered under the dental plan.
7. Crown, inlays...: This item may be omitted if coverage is provided.
8. The items listed will reflect the appropriate exclusions.
9. Services and supplies...: This item will be omitted for PPO plans and included for DMO plans.
10. This item may be omitted if coverage is provided.
11. The appropriate terms will be included to reflect the coverage selected by the policyholder.
12. Orthodontic treatment...: This item may be omitted if coverage is provided.
13. Removal of soft bony impactions. This item may be omitted if coverage is provided.
14. Surgical removal of...: This item may be omitted if coverage is provided.
15. Topical application of fluoride. This item may be omitted if coverage is provided.
16. Treatment by other than a dentist. This item may be omitted if coverage is provided.

Aetna Life Insurance Company
Exclusions that Apply to [Basic][Limited][DMO][PPO][Comprehensive] Dental Insurance
Explanation of Variability
GR-9N
28-025
02

17. Treatment of alveolectomy. This item may be omitted if coverage is provided.
18. Treatment of periodontal disease. This item may be omitted if coverage is provided.

Aetna Life Insurance Company
Comprehensive Dental Expense Insurance
Explanation of Variability
Schedule of Benefits
GR-9N
S-20-011
02

Coinsurance Incentives and Calendar Year Maximum Incentive Benefit

This page supports a coinsurance plan which provides for a higher level of plan coinsurance and/or calendar year maximum based on the insured's length of time in an Aetna Dental plan or based on the insured's utilization of their dental care benefits.

The reference to calendar year may be expressed as applying during a benefit year (e.g., February 1-January 31) instead of a calendar year.

1. All Type A, B, or C Services may be included on the Schedule or only one or two services may be included on the schedule in accordance with the plan of benefits selected by a particular policyholder or at Aetna's discretion. Also, the reference to Type A, Type B, and Type C Services may be expressed as Preventive, Basic or Major Services, respectively. This item may be omitted if the plan does not have this feature.
2. The standard plan coinsurance may vary but will not be less than the percentages shown. Type A, Type B, and Type C coinsurance percentages may increase to 100% upon policyholder option. This item may be omitted if the plan does not have this feature.
3. Calendar Year Maximum Incentive Benefit- The amount may vary but will not be less than the amount shown. This item may be omitted if the plan does not have this feature.
4. The calendar year maximum incentive benefit may be integrated with other coverages. When included this item will reflect the coverages included or excluded. This item may be omitted.
5. The Orthodontic Treatment coinsurance percentage level will range from 100% to 30%. This item may be omitted if the plan does not have this feature.
6. Orthodontic Lifetime Maximum - The amount may vary but will not be less than the amount shown. This item may be omitted if the plan does not have this feature.
7. Lifetime Maximum Benefit - The amount may vary but will not be less than the amount shown. The maximum may be combined with other health coverages in the certificate of coverage. When the plan is integrated with the policyholder's medical plan, this item will name the medical coverages that are or are not integrated with the dental maximum. This item may be omitted.
8. The lifetime maximum may be integrated with other coverages. When included this item will reflect the coverages included or excluded. This item may be omitted.
9. This item may be omitted.

Aetna Life Insurance Company
PPO – Comprehensive Dental Expense Insurance
Explanation of Variability
Schedule of Benefits
GR-9N
S-21-011
02

Coinsurance Incentives and Calendar Year Maximum Incentive Benefit

This benefit provides a higher level of plan coinsurance and calendar year maximum based on an insured's length of membership in the plan, or based on the insured's utilization of their dental care benefits.

The reference to calendar year may be changed to plan year, policy year or contract term.

The incentives may apply to network only benefits or both network and out-of-network benefits.

1. The services may be reflected as shown or Type A, B, or C Services may be omitted in accordance with the plan of benefits selected by a particular policyholder or at Aetna's discretion. Also, the reference to Type A, Type B, and Type C Services may be expressed as Preventive, Basic or Major Services, respectively. This item may be omitted if the plan does not have this feature.
2. The standard plan coinsurance may vary, but will not be less than the percentages shown. Type A, Type B, and Type C coinsurance percentages may increase to 100% upon policyholder option. This item may be omitted if the plan does not have this feature.
3. Calendar Year Maximum Incentive Benefit- The amount may vary but will not be less than the amount shown. This item may be omitted if the plan does not have this feature.
4. The calendar year maximum incentive benefit may be integrated with other coverages. When included this item will reflect the coverages included or excluded. This item may be omitted.
5. The Orthodontic Treatment coinsurance percentage level will range from 100% to 30%. This item may be omitted if the plan does not have this feature.
6. Orthodontic Lifetime Maximum- The amount may vary but will not be less than the amount shown. This item may be omitted if the plan does not have this feature.
7. This item may be omitted.
8. The maximum amount for the dental emergency benefit may be increased.
9. Lifetime Maximum Benefit- The amount may vary but will not be less than the amount shown. The maximum may be combined with other health coverages in the certificate of coverage. When the plan is integrated with the policyholder's medical plan, this item will name the medical coverages that are or are not integrated with the dental maximum. This item may be omitted.
10. The lifetime maximum may be integrated with other coverages. When included this item will reflect the coverages included or excluded. This item may be omitted.

Aetna Life Insurance Company
Explanation of Variability
Summary of Benefits
GR-9N
S-22-010
02

Primary Care Dentist Services

1. The fields in the upper right “header” are variable and illustrative. Upon issue they will be completed to reflect the name of the policyholder, the group policy number and the coverage effective date.

The following comments apply to the Dental Care Schedule applicable to Network Providers:

The list of covered services is variable to allow for inclusion or omission of covered services in accordance with the plan of benefits selected by a particular policyholder. The list of covered services may be revised to move services from one category to another, or to consolidate services into one list.

The Copay Amounts shown are the most restrictive that Aetna will include in a policyholder’s plan. The amounts shown may be decreased.

In some instances benefits will be paid for services not specifically listed on the Dental Care Schedule.

The description of the individual dental services may change to reflect changes in dental technology and/or dental practices or to reflect new terminology adopted by the American Dental Association.

The age and frequency limits may be omitted or may vary, but will not be more restrictive than the limits shown.

Any maximum number of services in a defined period of time may be increased, or the maximum may be omitted.

The section on orthodontics may be omitted if the policyholder’s plan of benefits does not include coverage for orthodontia expenses.

Aetna Life Insurance Company
Explanation of Variability
Summary of Benefits
GR-9N
S-30-010
02

Comprehensive Dental Expense Insurance

The following comments apply to the Dental Care Schedule applicable to Network Providers:

The list of covered services is variable to allow for inclusion or omission of covered services in accordance with the plan of benefits selected by a particular policyholder. The list of covered services may be revised to move services from one category to another, or to consolidate services into one list.

The Copay Amounts shown are the most restrictive that Aetna will include in a policyholder's plan. The amounts shown may be decreased.

In some instances benefits will be paid for services not specifically listed on the Dental Care Schedule.

The description of the individual dental services may change to reflect changes in dental technology and/or dental practices or to reflect new terminology adopted by the American Dental Association.

The age and frequency limits may be omitted or may vary, but will not be more restrictive than the limits shown.

Any maximum number of services in a defined period of time may be increased, or the maximum may be omitted.

Attachment A
List of Forms

Document Name	Description	Form Number	Previously Approved Form Number	Description of Change
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Booklet-Certificate Sections

Section 18 Dental Care Schedule	Comprehensive [PPO] Dental Coverage	GR-9N 18-007 02	GR-9N 18-007 01	Adds optional provisions for the Calendar Year Maximum Incentive Benefit.
Section 18 Dental Care Schedule	Important Reminders	GR-9N 18-010 03	GR-9N 18-010 02	Adds optional posterior composite service to schedule.
Section 28 Exclusions	Exclusions That Apply to Dental Insurance	GR-9N 28-025 02	GR-9N 28-025 01	Adds exclusion for replacement of teeth beyond the normal complement of 32.

Schedule of Benefits Sections

Section 20 Schedule of Dental Expense Benefits	Coinsurance Incentives	GR-9N S-20-011 02	GR-9N S-20-011 01	Adds optional provisions for the Calendar Year Maximum Incentive Benefit.
Section 21 Schedule of Dental Expense Benefits	Coinsurance Incentives	GR-9N S-21-011 02	GR-9N S-21-011 01	Adds optional provisions for the Calendar Year Maximum Incentive Benefit.



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Blue Bell, PA 19422

William I. Kramer
Vice President
Law and Regulatory Affairs
Phone: (215) 775-5659
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March 26, 2008

Mr. Joe Musgrove
Life, A&H Division
Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

Subject: **Aetna Life Insurance Company NAIC 60054**
GR-29N 01-01 et al
GR-9N-29-005 et al

Dear Mr. Musgrove:

This is to certify that the attached [Forms GR-9N 18 007-02 et al and GR-9N S-20-011 02 et al] insert pages have achieved a Combined Flesch Reading Ease Scores of 40 and comply with the requirements of Ark. Stat. Ann. Sections 66-3251 through 66-3258 cited as the Life and Disability Insurance Policy Language Simplification Act.

Sincerely,

A handwritten signature in black ink, appearing to read "William I. Kramer", with a long horizontal flourish extending to the right.

William I. Kramer
Vice President