Filing at a Glance

Company: Ameritas Life Insurance Corp.

Product Name: Simply Dental
TOI: H10G Group Health - Dental
Sub-TOI: H10G.000 Health - Dental
Filing Type: Form

SERFF Tr Num: AMFA-125769109
SERFF Status: Closed
Co Tr Num: SIMPLY DENTAL
Co Status:
Author: Janis Landon
Date Submitted: 08/13/2008

State: ArkansasLH
State Tr Num: 39943
State Status: FEES PAID
Reviewer(s): Rosalind Minor
Disposition Date: 08/18/2008
Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Simply Dental
Project Number: Simply Dental
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 08/18/2008
State Status Changed: 08/15/2008
Corresponding Filing Tracking Number:

Status of Filing in Domicile: Disapproved
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Small and Large
Group Market Type: Trust

Deemer Date:

Filing Description:

RE: Ameritas Life Insurance Corp.

NAIC No.: 943-61301

FEIN No.: 47-0098400

Form Nos: 9040 DR-Trust Ed. 01-08 – Schedule of Benefits (Outline of Coverage)

9219 DR-Trust AR Ed. 01-08 – Dental Expense Benefits

9232 DR-Trust Ed. 01-08 – Table of Dental Procedures

9260 DR-Trust Ed. 01-08 – Orthodontic Expense Benefits

11264 6048 GEN 7/08 – Employer's Request for Group Insurance

Dear Sir/Madam:

The above insert pages will be issued with previously approved group certificate of coverage form 9021 Trust Rev. 03-08. The insert pages have been approved (2007) by your Department for use with our tailored product, but we'd like to be able to issue them on a trust basis, as well. The only difference between what was already approved and what we're submitting now is the form number; we've added the word Trust to it.

Application

The employer's application form No. 11264 6048 GEN 7/08 will be used to subscribe to the trust and to elect plan options. This form has previously been approved by your state under form No. 11264 6048 GEN 8/07. The only revisions made are the addition of the Sensible Dental Plans option in the Schedule of Benefits section and the date within the form number.

These forms will be available upon approval by your Department.

The certificates provide group dental coverage with an option to add orthodontia and/or eye care coverage depending upon the plan selected by the employer unit. Benefits are fully insured. The purpose of this filing is to obtain approval of the above insert pages for use with the policy form and certificate when the policyholder has elected a group dental product that determines the reimbursement of covered expenses on a dollar reimbursement basis.

The trusts are multiple-employer trusts that are marketed by appointed agents and brokers of Ameritas Life Insurance Corp. to employer-employee groups who meet the requirements as defined within the trust agreement.

These forms are in final print. The items shown in brackets represent variable material. These items would vary based on the specific policy/certificate plan as selected by the policyholder. An Optional and Variables statement is also included for your reference.

If your state requires the filing of group rates, the associated rate filing has also been submitted.

Each form, when scored with the policy, achieves a 50 on the Flesch Readability Scale.

Nothing in this filing includes any provisions contrary to standard industry practice.

Thank you for your review of this filing. If you need anything additional, please feel free to contact me at 800-745-1112, ext. 87997, FAX 402-467-7956 or email jlandon@ameritas.com.

Sincerely,
Janis Landon
Contract Analyst

Company and Contact

Filing Contact Information

Janis Landon, Contract Analyst	jlandon@ameritas.com
5900 O Street	(800) 745-1112 [Phone]
Lincoln, NE 68501-1889	(402) 467-7956[FAX]

Filing Company Information

Ameritas Life Insurance Corp.	CoCode: 61301	State of Domicile: Nebraska
5900 O Street	Group Code: 943	Company Type:
P O Box 81889		
Lincoln, NE 68501-1889	Group Name:	State ID Number:
(800) 756-1112 ext. [Phone]	FEIN Number: 47-0098400	

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

SERFF Tracking Number:	*AMFA-125769109*	*State:*	*Arkansas*
Filing Company:	*Ameritas Life Insurance Corp.*	*State Tracking Number:*	*39943*
Company Tracking Number:	*SIMPLY DENTAL*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Simply Dental*		
Project Name/Number:	*Simply Dental/Simply Dental*		

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Ameritas Life Insurance Corp.	$100.00	08/13/2008	21919370

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/18/2008	08/18/2008

Amendments

Item	Schedule	Created By	Created On	Date Submitted
Optionals and Variables	Supporting Document	Janis Landon	08/13/2008	08/13/2008

Disposition

Disposition Date: 08/18/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMFA-125769109*	*State:*	*Arkansas*
Filing Company:	*Ameritas Life Insurance Corp.*	*State Tracking Number:*	*39943*
Company Tracking Number:	*SIMPLY DENTAL*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Simply Dental*		
Project Name/Number:	*Simply Dental/Simply Dental*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Optionals and Variables	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	Dental Expense Benefits	Approved-Closed	Yes
Form	Table of Dental Procedures	Approved-Closed	Yes
Form	Orthodontic Expense Benefits	Approved-Closed	Yes
Form	Employer's Request for Group Insurance	Approved-Closed	Yes

Amendment Letter

Amendment Date:

Submitted Date: 08/13/2008

Comments:

Attached is the Optionals and Variables

Changed Items:

Supporting Document Schedule Item Changes:

User Added -Name: Optionals and Variables

Comment:

Opts-Var-DR-Trust.pdf

Form Schedule

Lead Form Number: 9040 DR-Trust Ed. 01-08

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	9040 DR-Trust Ed. 01-08	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Schedule of Benefits	Initial		50	9040 DR-Trust Ed. 01-08.pdf
Approved-Closed	9219 DR-Trust AR Ed. 01-08	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Dental Expense Benefits	Initial		50	9219 DR-Trust AR.pdf
Approved-Closed	9232 DR-Trust Ed. 01-08	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Table of Dental Procedures	Initial		50	9232 DR-Trust - all procedures.pdf
Approved-Closed	9260 DR-Trust Ed. 01-08	Policy/Contract/Fraternal Certificate: Amendmen	Orthodontic Expense Benefits	Initial		50	9260 DR-Trust.pdf

			t, Insert Page, Endorsement or Rider				
Approved-Closed	11264 6048 GEN 7/08	Application/ Enrollment Form	Employer's Request for Group Insurance	Initial		50	6048_AM_PearlFillableAppGen_8-12-08.pdf

SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE

The Insurance for each Insured and each Insured Dependent will be based on the Insured's class shown in this Schedule of Benefits.

Benefit Class	Class Description
Class 1	All Eligible Employees

DENTAL EXPENSE BENEFITS

[When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.]

First Level:	The Plan pays [0 - 100]% of the first $[25-250] of Covered Expenses.
[Second Level:]	You pay the next $[25 - 100] of Covered Expenses. (You will not be reimbursed for this $[25 - 100] of Covered Expenses.)
[Third Level:]	The Plan will then pay [0 - 100]% of the next $[100 - 1,500] of Covered Expenses.
[Fourth Level:]	The Plan will then pay [0 - 100]% of the next $[100 - 1,500] of Covered Expenses.
[Fifth Level:]	The Plan will then pay [0 - 100]% of the remaining $[100 - 1,500] of Covered Expenses up to the Maximum Amount.

Maximum Amount:

Maximum Amount per Benefit Period	$[500 - 2,500]

[ORTHODONTIC EXPENSE BENEFITS

The Plan pays [25% - 50%] of covered Orthodontic Expenses.

Orthodontic Maximum Amount:

Maximum Amount once per Lifetime	$[500 - 2,500]]

DENTAL EXPENSE BENEFITS

We will determine dental expense benefits according to the terms of the group policy for dental expenses incurred by an Insured. An Insured person has the freedom of choice to receive treatment from any Provider.

[PARTICIPATING AND NON-PARTICIPATING PROVIDERS. The Insured person may select a Participating Provider or a Non-Participating Provider. A Participating Provider agrees to provide services at a discounted fee to our Insureds. A Non-Participating Provider is any other Provider.]

BENEFIT PERIOD. Benefit Period refers to the period shown in the Table of Dental Procedures.

MAXIMUM AMOUNT. The Maximum Amount shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured.

COVERED EXPENSES. Covered Expenses include:

1. only those expenses for dental procedures performed by a Provider; and
2. [only those expenses for dental procedures listed and outlined on the Table of Dental Procedures.]
   or
2. [any dental procedure as defined by the Current Dental Terminology © American Dental Association.]

Covered Expenses are subject to "Limitations" [and the Table of Dental Procedures.]

DETERMINING BENEFITS. Benefits payable for Covered Expenses will be [equal to] [limited to the lesser of]:

1. the actual charge of the Provider;
2. [the usual and customary ("U&C") as determined by us, [if services are provided by a Non Participating Provider;]]
3. [the Maximum Allowable Charge ("MAC") as determined by us; [if services are provided by a Participating Provider]]
4. [the Maximum Procedure Allowance (“MPA”) as determined by us, [if services are provided by a Non-Participating Provider.]]

and will be paid in accordance with the reimbursement schedule defined on the Schedule of Benefits. This reimbursement schedule may include multiple levels of reimbursable and non-reimbursable covered expenses subject to a Maximum Amount, also shown on the Schedule of Benefits.

[Usual and Customary (“U&C”) describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. From the array of charges ranked by amount, your Policyholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by your provider and is not indicative of the appropriateness of the provider’s fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage purchased by your Policyholder.]

[MAC - The Maximum Allowable Charge is derived from the array of provider charges within a particular ZIP code area. These allowances are the charges accepted by general dentists who are Participating Providers. The MAC is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.]

[MPA - The Maximum Procedure Allowance is derived from the array of submitted provider charges within a ZIP code area. These allowances are an option for policyholders who want to offer their insured members affordable yet comprehensive coverage. The MPA is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.]

COVERAGE FOR GENERAL ANESTHESIA. Notwithstanding the limitations relating to Covered Expenses for general anesthesia (Procedure codes 9220-9242) as shown on the Table of Dental Procedures, general anesthesia administered in connection with dental procedures performed in a hospital or ambulatory surgical facility will be considered a Covered Expense if the Provider certifies that, because of the Covered Person's age, condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the dental procedures and the Covered Person is:

1. a child under the age of 7 who is determined by two (2) dentists licensed under the Arkansas Dental Practice Act to require, without delay, necessary dental treatment for a significantly complex dental condition;

2. a person with a diagnosed serious mental or physical condition; or

3. a person with a significant behavioral problem as determined by the Covered Person's physician who is licensed under the Arkansas Medical Practices Act.

All other terms and conditions of the policy will apply to these services.

[ALTERNATIVE PROCEDURES. If two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care, the amount of the Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. Instead, this provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate alternative procedure is available. Accordingly, you may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

We may request pre-operative dental x-ray films, periodontal charting and/or additional diagnostic data to determine the plan allowance for the procedures submitted. We strongly encourage pre-treatment estimates so you understand your benefits before any treatment begins. Ask your provider to submit a claim form for this purpose.]

[EXPENSES INCURRED. An expense is incurred at the time the impression is made for an appliance or change to an appliance. An expense is incurred at the time the tooth or teeth are prepared for a dental prosthesis or prosthetic crown. For root canal therapy, an expense is incurred at the time the pulp chamber is opened. All other expenses are incurred at the time the service is rendered or a supply furnished.]

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. [in the first [6, 12, 15, 18, 24] months that a person is insured if the person is a Late Entrant, except for a maximum of [$100 - $250] in the first Benefit Period.]

2. [for initial placement of any dental prosthesis or prosthetic crown unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such prosthetic crown, appliance, or fixed partial denture must include the replacement of the extracted tooth or teeth.]

3. [for appliances, restorations, or procedures to:

    a. alter vertical dimension;
    b. restore or maintain occlusion; or
    c. splint or replace tooth structure lost as a result of abrasion or attrition.]

4. for any procedure begun after the insured person's insurance under this contract terminates; [or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.]

5. to replace lost or stolen appliances.

6. for any treatment which is for cosmetic purposes.

7. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)

8. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260 DR).

9. [for which the Insured person is entitled to benefits under any workmen's compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.]

10. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.

11. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

12. because of war or any act of war, declared or not.

[TABLE OF DENTAL PROCEDURES

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.

COVERED EXPENSES

The following are typical dental expenses covered by the Plan:

- Oral Exams
- Dental Prophylaxis (excluding periodontal cleanings)
- Fluoride Treatments (excludes take-home applications)
- Dental X-Rays
- Sealants
- Fillings
- Regular Extractions (erupted and visible) Other extractions should be filed under the Health Plan.
- Root Canal
- Crowns, Bridges, Dentures
- Implants]

[TABLE OF DENTAL PROCEDURES

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY FOR YOUR PROCEDURE FREQUENCIES AND PROVISIONS.

The attached is a list of dental procedures for which benefits are payable under this section; and is based upon the Current Dental Terminology © American Dental Association. **No benefits are payable for a procedure that is not listed.**

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.
- Covered Procedures are subject to all plan provisions, procedure and frequency limitations, and/or consultant review.
- Reference to "traumatic injury" under this plan is defined as injury caused by external forces (ie. outside the mouth) and specifically excludes injury caused by internal forces such as bruxism (grinding of teeth).
- [Benefits for replacement dental prosthesis or prosthetic crown will be based on the prior placement date.] Frequencies which reference Benefit Period will be measured forward within the limits defined as the Benefit Period. All other frequencies will be measured forward from the last covered date of service.
- X-ray films, periodontal charting and supporting diagnostic data may be requested for our review.
- We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive by our insured.
- A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.]

COVERED EXPENSES
PREVENTIVE PROCEDURES
PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary
PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

ROUTINE ORAL EVALUATION

D0120 Periodic oral evaluation - established patient.
D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver.
D0150 Comprehensive oral evaluation - new or established patient.
D0180 Comprehensive periodontal evaluation - new or established patient.

COMPREHENSIVE EVALUATION: D0150, D0180

- Coverage is limited to 1 of each of these procedures per 1 provider.
- In addition, D0150, D0180 coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0120, D0145, also contribute(s) to this limitation.
- If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ROUTINE EVALUATION: D0120, D0145

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0150, D0180, also contribute(s) to this limitation.
- Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.

COMPLETE SERIES OR PANORAMIC FILM

D0210 Intraoral - complete series (including bitewings).
D0330 Panoramic film.

COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330

- Coverage is limited to 1 of any of these procedures per 3 year(s).

OTHER XRAYS

D0220 Intraoral - periapical first film.
D0230 Intraoral - periapical each additional film.
D0240 Intraoral - occlusal film.
D0250 Extraoral - first film.
D0260 Extraoral - each additional film.

PERIAPICAL FILMS: D0220, D0230

- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

BITEWING FILMS

D0270 Bitewing - single film.
D0272 Bitewings - two films.
D0273 Bitewings - three films.
D0274 Bitewings - four films.
D0277 Vertical bitewings - 7 to 8 films.

BITEWING FILMS: D0270, D0272, D0273, D0274

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0277, also contribute(s) to this limitation.
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWING FILM: D0277

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

PROPHYLAXIS (CLEANING) AND FLUORIDE

D1110 Prophylaxis - adult.
D1120 Prophylaxis - child.
D1203 Topical application of fluoride (prophylaxis not included) - child.
D1204 Topical application of fluoride (prophylaxis not included) - adult.

D1206 Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.

FLUORIDE: D1203, D1204, D1206

- Coverage is limited to 1 of any of these procedures per 1 benefit period.
- Benefits are considered for persons age 18 and under.

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D4910, also contribute(s) to this limitation.
- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

SEALANT

D1351 Sealant - per tooth.

SEALANT: D1351

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- Benefits are considered for persons age 16 and under.
- Benefits are considered on permanent molars only.
- Coverage is allowed on the occlusal surface only.

SPACE MAINTAINERS

D1510 Space maintainer - fixed - unilateral.
D1515 Space maintainer - fixed - bilateral.
D1520 Space maintainer - removable - unilateral.
D1525 Space maintainer - removable - bilateral.
D1550 Re-cementation of space maintainer.
D1555 Removal of fixed space maintainer.

SPACE MAINTAINER: D1510, D1515, D1520, D1525

- Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date.

APPLIANCE THERAPY

D8210 Removable appliance therapy.
D8220 Fixed appliance therapy.

APPLIANCE THERAPY: D8210, D8220

- Coverage is limited to the correction of thumb-sucking.

COVERED EXPENSES
NON-PREVENTIVE
PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary
PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

LIMITED ORAL EVALUATION

D0140 Limited oral evaluation - problem focused.
D0170 Re-evaluation - limited, problem focused (established patient; not post-operative visit).

LIMITED ORAL EVALUATION: D0140, D0170

- Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

SEALANT

D1351 Sealant - per tooth.

SEALANT: D1351

- Coverage is limited to 1 of any of these procedures per 1 lifetime.
- Benefits are considered for persons age 13 and under.
- Benefits are considered on permanent molars only.
- Coverage is allowed on the occlusal surface only.

AMALGAM RESTORATIONS (FILLINGS)

D2140 Amalgam - one surface, primary or permanent.
D2150 Amalgam - two surfaces, primary or permanent.
D2160 Amalgam - three surfaces, primary or permanent.
D2161 Amalgam - four or more surfaces, primary or permanent.

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D9911, also contribute(s) to this limitation.
- Three or more surface procedures will be considered as the corresponding two surface procedure.

RESIN RESTORATIONS (FILLINGS)

D2330 Resin-based composite - one surface, anterior.
D2331 Resin-based composite - two surfaces, anterior.
D2332 Resin-based composite - three surfaces, anterior.
D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior).
D2391 Resin-based composite - one surface, posterior.
D2392 Resin-based composite - two surfaces, posterior.
D2393 Resin-based composite - three surfaces, posterior.
D2394 Resin-based composite - four or more surfaces, posterior.

COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Three or more surface procedures will be considered as the corresponding two surface procedure.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.]

[TABLE OF DENTAL PROCEDURES

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.

COVERED EXPENSES - PREVENTIVE PROCEDURES

The following are typical dental expenses covered by the Plan:

- Oral Exams
- Dental Prophylaxis (excluding periodontal cleanings)
- Fluoride Treatments (excludes take-home applications)
- Dental X-Rays
- Sealants]

ORTHODONTIC EXPENSE BENEFITS

We will determine orthodontic expense benefits according to the terms of the group policy for orthodontic expenses incurred by an Insured.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted. The result is will be paid in accordance with the payment schedule as outlined on the Schedule of Benefits. This includes any Covered Expense not reimbursed, Maximum Amount, and will be reduced by the percentage outlined in the schedule, if applicable.

MAXIMUM AMOUNT. The Maximum Amount shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured.

COVERED EXPENSES. Covered Expenses refer to the [usual and customary] [actual] charges made by a provider for necessary orthodontic treatment rendered while the person is insured under this section. Expenses are limited to the Maximum Amount shown in the Schedule of Benefits and Limitations.

[Usual and Customary ("U&C") describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. From the array of charges ranked by amount, your Policyholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by your provider and is not indicative of the appropriateness of the provider's fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage purchased by your Policyholder.]

ORTHODONTIC TREATMENT. Orthodontic Treatment refers to the movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

[Optional language – the following paragraphs are included when the orthodontic benefit is based on a treatment program – the type of benefit option is selected by the policyholder]

[TREATMENT PROGRAM. Treatment Program ("Program") will be paid in installments. The first payment (downpayment) is payable on the date your treatment begins and will be [25-50] percent of the estimated total Program or the lesser of $[500 - 2,000]. A Program will start when the active appliances are inserted. A Program will end when the services are done.

The balance of the estimated total treatment charge is prorated and paid on a [monthly, quarterly] basis during the anticipated duration of the Program.]

[EXPENSES INCURRED. Benefits will be payable when a Covered Expense is incurred:

a. at the end of every [month, quarter] of a Program for an Insured who pursues a Program, but not beyond the date the Program ends; or

b. at the time the service is rendered for an Insured who incurs Covered Expenses but does not pursue a Program.

The Covered Expenses for a Program are based on the estimated cost of the Insured's Program. They are pro-rated by [month, quarter] over the estimated length of the Program.]

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

[1. [for a Program begun on or after the Insured's [17, 18, 19] birthday.]

[2.] [for a program begun before the Insured became covered under this section.]
[2.] [for a Program begun before the Insured became covered under this section, unless the Insured was covered for Orthodontic Expense Benefits under the prior carrier on [mo/dy/yr] and are both:

a. insured under this policy; and
b. currently undergoing a Treatment Program on [mo/dy/yr].]

[3. [in the first [6, 12, 15, 18, 24] months that a person is insured if the person is a Late Entrant, except for a maximum of [$100-$250] in the first Benefit Period.]

[4.] [in any quarter of a Program if the Insured was not covered under this section for the entire quarter.]
[4.] [before the Insured has been insured under this section for at least [12, 18, 24] consecutive months unless the Insured is covered on [mo/dy/yr].

5. if the Insured's insurance under this section terminates.

6. for which the Insured is entitled to benefits under any workmen’s compensation or similar law, or for charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

7. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.

8. for services not required for necessary care and treatment or not within the generally accepted parameters of care.

9. because of war or any act of war, declared or not.

10. To replace lost or stolen appliances.

[Variable language – the following paragraphs are included when the orthodontic benefit is based on a submitted claim basis (bill driven) only – the type of benefit option is selected by the policyholder]

[EXPENSES INCURRED. Benefits will be payable when a Covered Expense is incurred:

a. treatment begins, banding etc. and;

b. claim is received by us.]

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

[1. [for a Program begun on or after the Insured's [17, 18, 19] birthday.]

[2.] [for a program begun before the Insured became covered under this section.]
[2.] [for a Program begun before the Insured became covered under this section, unless the Insured was covered for Orthodontic Expense Benefits under the prior carrier on [mo/dy/yr] and are both:

a. insured under this policy; and
b. currently undergoing a Treatment Program on [mo/dy/yr].]

[3. [in the first [6, 12, 15, 18, 24] months that a person is insured if the person is a Late Entrant, except for a maximum of [$100-$250] in the first Benefit Period.]

4. if the Insured's insurance under this section terminates.

5. for which the Insured is entitled to benefits under any workmen's compensation or similar law, or for charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

6. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.

7. for services not required for necessary care and treatment or not within the generally accepted parameters of care.

8. because of war or any act of war, declared or not.

9. To replace lost or stolen appliances.

AMERITAS PEARL PLANS®
Employer's Request for Group Insurance

HealthPlan Services AMERITAS LIFE INSURANCE CORP.

Dental coverages fully insured by Ameritas Life Insurance Corp., Lincoln, NE

SECTION 1: EMPLOYER INFORMATION

❑ Corporation ❑ Partnership ❑ Proprietorship ❑ Other

1. Employer's legal business name _____

2. Street Address _____
Street City County State Zip Code

3. Mailing Address (if different) _____
Street City County State Zip Code

Attention _____ Title _____

4. Phone number ( ) _____ Fax number ( ) _____

Email address _____

5. Nature of Business _____ SIC Code _____

6. Name and address of any subsidiary or affiliate to be included _____

7. Prior group dental insurance? ❑ Yes ❑ No Carrier _____ Account No. _____

8. Plan currently in force? ❑ Yes ❑ No Effective Date _____ Date of Termination _____

9. Prior coverage with HealthPlan Services? ❑ Yes ❑ No Account No. _____

10. Mail Administrative kit and policy certificates to ❑ Employer ❑ Agent/Broker

11. Tax ID number _____

SCHEDULE OF BENEFITS

Available for groups of 3 to 99 employees. Groups of 2 are eligible if coverage is tied to a HealthPlan Services medical plan.

❑ INCENTIVE PLAN

For groups of 5-9 lives with takeover or groups with 10-99 lives

❑ **Periodontics/Endodontics**
- ❑ Basic
- ❑ Major

❑ MANAGED CARE PPO PLANS

Dental Rewards® included
(may not be available in your state)

- ❑ Plan 1
- ❑ Plan 2
- ❑ Plan 3

❑ **Benefit year maximum** (Plan 1 & 3)
- ❑ $1,000 benefit year maximum
- ❑ $1,500 benefit year maximum

❑ **Periodontics/Endodontics** (Plan 1 & 3)
- ❑ Basic
- ❑ Major

❑ STEP UP PLAN

❑ **U&C Plan**
OR
❑ **Maximum Allowable Charge**
(pre-determined fee schedule)

❑ **Deductible**
- ❑ $25 per quarter (not available in Connecticut)
- ❑ $50 annual

For groups of 5-9 lives with takeover or groups with 10-99 lives

❑ **Periodontics/Endodontics**
- ❑ Basic
- ❑ Major

❑ **Benefit year maximum**
- ❑ $1,000 benefit year maximum
- ❑ $1,500 benefit year maximum

❑ DUAL CHOICE PLAN

Select one Standard AND one Enhanced:
- ❑ Standard Plan 1 ❑ Enhanced Plan 1
- ❑ Standard Plan 2 ❑ Enhanced Plan 2

Select one Annual Max for Enhanced Plan:
- ❑ $1,500
- ❑ $2,000

Select one Plan Allowance for Enhanced Plan:
- ❑ Maximum Allowable Charge
- ❑ 75th U&C
- ❑ 90th U&C

❑ SIMPLY DENTAL PLANS

Dental Rewards included

- ❑ **EASY PLAN**
- ❑ **EASY+ PLAN**
- ❑ **EDGE PLAN**

❑ **U&C Plan** ❑ **80th** OR ❑ **90th**
OR
❑ **Maximum Allowable Charge**
(pre-determined fee schedule)

❑ **Benefit year maximum**
- ❑ $750 benefit year maximum
- ❑ $1,000 benefit year maximum
- ❑ $1,500 benefit year maximum

TAKEOVER COVERAGE OPTION	❑ **Elect**
VOLUNTARY	❑ **Elect**
TIED TO MEDICAL	❑ **Elect**
DENTAL REWARDS	❑ **Elect**
VISION EXAM (not available on Simply Dental or PPO Plan 2)	❑ **Elect**
ORTHODONTICS	❑ **Elect**

SECTION 2: COVERAGE INFORMATION

Requested effective date: Month_____ Day_____ Year_____

Effective Date Agreement

In the event of a delay of approval, I request:

If no prior coverage

❑ Original requested date

❑ Date HealthPlan Services Underwriting approves application

If prior coverage in force

❑ Original requested date

❑ A later date coinciding with termination of prior carrier

If not completed, the original requested effective date option is automatically selected. The option selected cannot be changed. Later effective dates are subject to any appropriate new business plan and rate changes made by the Trust. Subject to written approval of the employer's participation by the Trust Administrator, insurance will be effective as of the requested date. Employees hired after the effective date of insurance will be insured in accordance with Section 2 of this Employer's Request.

Service Waiting Period before employee becomes eligible:
(If Dental is written in conjunction with a HealthPlan Services Medical plan, the Medical plan's service waiting period will apply.)

1) For employees at work on the effective date: None

2) For employees hired after the effective date:

Check one: ❑ 0 ❑ 30 ❑ 60 ❑ 90 days

The eligibility date is the first of the month following completion of the service waiting period.

Employees have 31 days from their eligibility date to sign and forward an enrollment card. If an employee does not enroll within 31 days of the date he or she becomes eligible, his or her maximum benefit, and the maximum benefit for his or her insured dependents, will be limited to cleaning, exam, and fluoride for the first 12 months of coverage.

Premiums, including an initial deposit equal to the first full month's premium, are payable monthly in advance. The employer contribution must be at least 25% of the total cost of Dental Insurance, or the full cost of the employee coverage.

SECTION 3: EMPLOYEE INFORMATION

Total number of employees (including active Partners, Proprietors, and Corporate Officers) _____

Number of eligible employees _____

Number of ineligible employees _____

Part-time _____ Seasonal _____ Other _____

Total number of employees enrolling:

❑ Employee Only _____

❑ Employee plus one Dependent _____

❑ Employee plus two or more Dependents _____

I understand that participation requirements must be met at all times. ❑ Yes

A signed copy of this form received by electronic transmission will be deemed to be an original.

SECTION 4

This Employer's Request is a Counterpart to an Indenture of Trust. The Trustee and Insurance Policyholder is First Union Bank. The Trust Administrator is HealthPlan Services, Inc. The Insurer is Ameritas Life Insurance Corp. I, the undersigned employer, wish to become a participating employer in the HealthPlan Services Trust applicable to my industry classification, pursuant to Article IV, Section 1 of the Trust Indenture, and to apply for insurance coverage under the Master Policy(ies) issued to the Trustee. I am acquainted with the rules of eligibility and understand that the effective date of the insurance for which I am applying shall be subject to the written approval of the Trust Administrator, acting on behalf of the Insurer. I understand that the benefits provided shall be subject to the terms of the group insurance policy(ies) issued to the Trustee, as amended from time to time, and that these group insurance policies may be terminated by the Insurer following due notice to the Trustee. I agree to remit to the Trustee regularly in advance the required monthly premium contributions for insurance benefits, and I understand that failure to pay billed premiums will result in automatic termination of insurance coverage. I agree to offer the insurance to all present and future new employees who work for remuneration on a full-time basis. I also agree to maintain the participation requirements of the plan with respect to eligible employees and their eligible dependents in order to procure and continue the requested insurance and agree that any insurance issued as a result of this request may be cancelled as of any monthly premium due date if such participation requirements are not maintained. I hereby represent that I have read and understand the Insurance Plan, including all exclusions and limitations of coverage, as described in Form #15332 9/06, Insert Form #15332UW 9/06 and Form 15991 7/05.

AGREEMENTS

The Applicant understands that he/she, and not HealthPlan Services, Ameritas nor the Trustees, is the Plan Administrator and Fiduciary as defined in the Employee Retirement Income Security Act of 1974, as amended.

The Applicant represents that he/she has read the statements and answers to the above questions and that they are complete and true to the best of his/her knowledge and belief.

If this application is accepted by Ameritas, group insurance at the current Company's rates and under the terms applied for shall take effect as of the date shown in section 1 of this Employer's Request. If this application is not accepted, any premium advanced shall be refunded. Ameritas reserves the right to reject any case which, in its opinion, does not conform to sound underwriting criteria. No insurance is in force until written acceptance is received.

STATEMENTS

In several states, we are required to advise you of the following: Any person who knowingly and with intent to defraud provides false, incomplete or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, is guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim (see state specific statements).

The policy provides dental and eye care benefits only. Review your policy carefully.

Signed at (City)_____ (State)_____ on (Month)_____ (Day)_____ (Year)_____

Dated at (City)_____ (State)_____ on (Month)_____ (Day)_____ (Year)_____

Employer's Legal Business Name_____

Employer's Signature_____ **Title**_____

Note for California Residents: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage. For group policies issued, amended, delivered or renewed in California, dependent coverage includes individuals who are registered domestic partners and their dependents.

Note for Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Note for Florida Residents: 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 of the third degree.

Note for Kansas, Nebraska, Oregon, Vermont and Virginia Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Note for Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Note for New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Note for New Mexico Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Note for Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

A signed copy of this form received by electronic transmission will be deemed to be an original.

PLEASE PRINT

Writing Agent/Broker:

Name_____ Check one: ❑ Social Security # ❑ Tax ID #_____

Phone number ( )_____ Fax number (include area code)_____
(Important: may assist in case issue)

Email address_____

Service Fees Payable to:

Name_____ Check one: ❑ Social Security # ❑ Tax ID #_____

Address _____
City State Zip Code

Phone number (include area code)_____

General Agent's Fax Number (include area code)_____
(Important: may assist in case issue)

❑ Copy of my Ameritas Life Insurance Corp. license

❑ Not licensed with Ameritas

FOR GENERAL AGENT'S USE

Agent's/Broker's Statement:

To the best of my knowledge all statements in the Employer's Request for Group Insurance and Group Insurance Enrollment Cards are complete and true. I represent the applicant for the insurance, not the Insurance Company.

If I am not already appointed with Ameritas Life Insurance Corp. I understand and agree that before I present this product to any client, I must apply to and be appointed with Ameritas. My client has been advised by me not to terminate any existing coverage until receiving notice that the coverage being applied for is accepted. I agree that I have no right to bind this coverage, alter terms of the Insurance Contract or Employer's Request for Group Insurance, or adjust any claim for benefits under the insurance contract.

_____
Agent's/Broker's Signature Date

_____
Agent's/Broker's Name (Print) License Number

A signed copy of this form received by electronic transmission will be deemed to be an original.

Rate Information

Rate data does NOT apply to filing.

Supporting Document Schedules

Satisfied -Name: Certification/Notice

Review Status: Approved-Closed 08/18/2008

Comments:

Attachments:

ar-readability-certification-alic.pdf
ar-regulation 19-certification-alic.pdf
ar-complaint-alic.pdf

Bypassed -Name: Application

Review Status: Approved-Closed 08/18/2008

Bypass Reason: policy is filed for approval

Comments:

Satisfied -Name: Optionals and Variables

Review Status: Approved-Closed 08/18/2008

Comments:

Attachment:

Opts-Var-DR-Trust.pdf

STATE OF ARKANSAS

CERTIFICATE OF READABILITY

INSURER: Ameritas Life Insurance Corp.

This is to certify that the attached form(s) has achieved a Flesch Reading Ease Score of:

FORM NO:	FLESCH SCORE:	FORM NAME:
9040 DR-Trust Ed. 01-08	50, with policy/cert	Schedule of Benefits
9219 DR-Trust AR Ed. 01-08	50, with policy/cert	Dental Expense Benefits
9232 DR-Trust Ed. 01-08	50, with policy/cert	Table of Dental Procedures
9260 DR-Trust Ed. 01-08	50, with policy/cert	Orthodontic Expense Benefits

complies with the requirements of Ark. Stat. Ann. Sections 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

SIGNATURE: Robert G. Lange

Digitally signed by Robert G. Lange
DN: cn=Robert G. Lange, o, ou, email=blange@ameritas.com, c=US
Date: 2008.08.13 10:52:14 -05'00'

TYPED NAME: Robert G. Lange

TITLE: Vice President, General Counsel and Assistant Secretary

DATE: 8/13/2008

STATE OF ARKANSAS

REGULATION 19

INSURER: Ameritas Life Insurance Corp.

This is to certify that the attached form(s) are in compliance with Rule and Regulation 19:

Form Number:	**Form Name:**
9040 DR-Trust Ed. 01-08	Schedule of Benefits
9219 DR-Trust AR Ed. 01-08	Dental Expense Benefits
9232 DR-Trust Ed. 01-08	Table of Dental Procedures
9260 DR-Trust Ed. 01-08	Orthodontice Expense Benefits

SIGNATURE: Robert G. Lange Digitally signed by Robert G. Lange DN: cn=Robert G. Lange, o, ou, email=blange@ameritas.com, c=US Date: 2008.08.13 10:51:13 -05'00'

TYPED NAME: Robert G. Lange

TITLE: Vice President, General Counsel and Assistant Secretary

DATE: 8/13/2008

IMPORTANT INFORMATION TO POLICYHOLDERS

In the event you need to contact someone about this policy for any reason, please contact your agent. If you have additional questions, you may contact the insurance company issuing this policy at the following address and telephone number:

Ameritas Life Insurance Corp.
P.O. Box 81889
Lincoln, NE 68501-1889
1-800-366-5933

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Arkansas Insurance Department at:

Consumer Services Division
Arkansas Insurance Department
1200 W. Third Street
Little Rock, AR 72201-1904
1-800-852-5494

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Department of Insurance, have your policy number available.

OPTIONALS AND VARIABLES
Dollar Reimbursement Product Option
Insert Pages:
9040 DR-Trust Ed. 01-08, 9219 DR-Trust Ed. 01-08,
9232 DR-Trust Ed. 01-08, 9260 DR-Trust Ed. 01-08

No change will be made to any policy or certificate in violation of state statutes.

General Discussion

The above insert pages will be issued with previously approved certificate of coverage form 9021-Trust Rev. 03-08. The certificates provide group dental coverage with an option to add orthodontia and/or eye care coverage depending upon the plan selected by the employer unit.

The purpose of this filing is to obtain approval of the above insert pages for use with the policy form and certificate when the policyholder has elected a group dental product that determines the reimbursement of covered expenses on a dollar reimbursement basis.

The following items per insert page have been bracketed to allow for variable provisions.

Schedule of Benefits Insert Page - 9040 DR-Trust Ed. 01-08

When the policyholder has not chosen a PPO (Participating Provider) option, all references to participating and non-participating providers are deleted.

The policyholder will elect a plan design that may consist of multiple levels of reimbursement of covered dental expense benefits. Within each level, the policyholder will elect the percentage of reimbursement for each tier of covered expenses. The percentage amounts will range from 0 – 100% in 10% increments, the dollar amounts will range from $25 - $1500.

The Maximum Amount per benefit period will range from $500 - $2500 in $100 increments.

Orthodontic Expense Benefits – the policyholder will elect from a range of 25% - 50% of covered orthodontic expense benefits with a maximum lifetime benefit of $500 - $2500 in $100 increments. Orthodontic expense benefits may also be combined within the dental expense benefit levels.

Dental Expense Benefits - 9219 DR-Trust Ed. 01-08

PARTICIPATING PROVIDER (PPO) OPTION. When the policyholder has not chosen a PPO (or Participating Provider) option, all references to participating and non-participating providers are deleted.

COVERED EXPENSES. Covered expenses may be limited to a defined procedure list or for any valid dental procedure code defined by the Current Dental Terminology © American Dental Association. The covered dental expenses for various plan options are listed on the Table of Dental Procedures (9232 DR Ed. 01-08).

DETERMINING BENEFITS. The basis on which we will reimburse for covered dental expenses is a plan design feature that is selected by the policyholder. Benefits will either be equal to the actual charge of the provider or benefits will be limited to the lesser of: (1) the actual charge of the provider; (2) the usual and customary ("U&C") as determined by us {if services are provided by a non-participating provider, i.e., a PPO plan}; (3) Maximum Allowable Charge ("MAC") if services are provided by a participating provider; and/or (4) Maximum Procedure Allowance.

The applicable definitions of Usual and Customary, Maximum Allowable Charge and/or Maximum Procedure Allowance will print only if those claim allowances are used as the basis for determining benefits.

ALTERNATIVE PROCEDURES. This paragraph will only be included if the plan design selected by the policyholder is a closed procedure list (see discussion of Table of Dental Procedures – 9232 DR Ed. 01-08).

EXPENSES INCURRED. This paragraph may be excluded if the plan design selected by the policyholder reimburses for only preventive dental expenses.

LIMITATIONS.

Late Entrant limitation
This limitation will be used if the policyholder elects a plan design that limits benefits for a late entrant. If there is a late entrant provision, then the elimination period will vary as shown (6, 12, 15, 18, 24 months) however, there will be a minimum benefit payable in the first Benefit Period which ranges from $100 - $250.

No Prior Extraction Coverage
This plan limitation will only be used if selected by the policyholder and if covered expenses include crowns, appliances and/or prosthetics, however if the policy is issued in a takeover, this limitation would be modified as shown to reflect prior coverage.

Limitations for appliances, restoration, or procedures
The 90-day extension of coverage for certain procedures could be modified if required by the policyholder or deleted if prosthetic dental appliances are not a covered expense under the plan.

Work related injuries
Any limitations on work-incurred injury and sickness would be deleted if requested by the policyholder to provide occupational (24 hour) coverage.

Table of Dental Procedures – 9232 DR-Trust Ed. 01-08

Depending upon the plan design selected by the policyholder, there are 3 versions of the Table of Dental Procedures that would be incorporated within the policy and certificate. The three versions are provided in this filing for reference.

Preventive Procedures Open List Option – this plan design would reimburse for any valid American Dental Association ("ADA") procedure code which falls under the ADA definition of preventive procedures such as exams, prophylaxis (cleanings), fluoride treatments, x-rays and sealants.

Preventive, Basic and Major Open List Option – this plan design would reimburse for any valid ADA procedure code which falls under the ADA definition of preventive, basic and major type procedures, such as exams, cleanings, x-rays, fillings, extractions, root canals, crowns, bridges and dentures and implants.

Closed Procedure List Option – this plan design would reimburse for only those procedure codes listed within the list. The ADA procedure code numbers and definitions should be considered variable to allow for changes by the ADA.

Orthodontic Expense Benefits – 9260 DR-Trust Ed. 01-08

When orthodontic expense benefits are included in a policyholder's plan design, the policyholder has the option of selecting the reimbursement on a Treatment Program basis or on a submitted claim (bill driven) basis. The policyholder may also elect to reimburse based on the provider's actual charge or the Usual and Customary charge based on the zip code area of the provider.

- Treatment Program provision

  If the policyholder has elected to reimburse on a treatment program basis, then reimbursement will be paid in installments with the first payment payable on the date treatment begins. The payment is limited to a percentage [25% - 50%] subject to a maximum amount – the installments can be paid on a monthly or quarterly basis.

- Submitted Claim (bill driven) provision

  If the policyholder has elected to reimburse on a submitted claim basis, then the eligible reimbursement will be paid when treatment begins and as we receive claims for payment.

- Limitations

  Limitation No. 1 is deleted when we offer "adult" ortho. If coverage is available for only those insureds under a specified age, the age can range between 17, 18 or 19.

  Limitation No. 3 - *Late Entrant limitation* - This limitation will be used if the policyholder elects a plan design that limits benefits for a late entrant. If there is a late entrant provision, then the elimination period will vary as shown (6, 12, 15, 18, 24 months) however, there will be a maximum benefit payable in the first Benefit Period which ranges from $100 - $250.

  Limitation Nos. 2 & 4 - If the policy is issued in a takeover, limitations #2 and #4 would be modified as shown to reflect prior coverage.