

<i>SERFF Tracking Number:</i>	<i>BLHI-125895472</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>BEST Life and Health Insurance Company</i>	<i>State Tracking Number:</i>	<i>41027</i>
<i>Company Tracking Number:</i>	<i>BL-EGD-POL-1008</i>		
<i>TOI:</i>	<i>H10G Group Health - Dental</i>	<i>Sub-TOI:</i>	<i>H10G.000 Health - Dental</i>
<i>Product Name:</i>	<i>Group Indemnity Dental</i>		
<i>Project Name/Number:</i>	<i>/</i>		

## Filing at a Glance

Company: BEST Life and Health Insurance Company

Product Name: Group Indemnity Dental	SERFF Tr Num: BLHI-125895472	State: ArkansasLH
TOI: H10G Group Health - Dental	SERFF Status: Closed	State Tr Num: 41027
Sub-TOI: H10G.000 Health - Dental	Co Tr Num: BL-EGD-POL-1008	State Status: Withdrawn
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: Tammy O'Connor	Disposition Date: 01/15/2009
	Date Submitted: 12/05/2008	Disposition Status: Withdrawn
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

## General Information

Project Name:	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments: Filed and pending approval.
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 01/15/2009	
State Status Changed: 01/15/2009	Deemer Date:
Corresponding Filing Tracking Number:	
Filing Description:	

Group dental plan offering Class I through Class IV dental benefits to eligible employees, and their eligible dependents, of participating employers. Children's Good Vision benefit may also be offered.

## Company and Contact

### Filing Contact Information

Tammy O'Connor, Director, Regulatory      toconnor@bestlife.com

SERFF Tracking Number: BLHI-125895472 State: Arkansas  
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TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental  
Product Name: Group Indemnity Dental  
Project Name/Number: /

**Compliance**

2505 McCabe Way (800) 433-0088 [Phone]  
Irvine, CA 92623

**Filing Company Information**

BEST Life and Health Insurance Company	CoCode: 90638	State of Domicile: Texas
2505 McCabe Way	Group Code:	Company Type:
Irvine, CA 92623	Group Name:	State ID Number:
(800) 433-0088 ext. [Phone]	FEIN Number: 95-6042390	

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SERFF Tracking Number: *BLHI-125895472* State: *Arkansas*  
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## **Filing Fees**

Fee Required? No  
Retaliatory? No  
Fee Explanation:  
Per Company: No

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Withdrawn	Rosalind Minor	01/15/2009	01/15/2009

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending	Rosalind Minor	12/11/2008	12/11/2008			
Industry Response						
Pending	Rosalind Minor	12/11/2008	12/11/2008			
Industry Response						

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Request to Withdraw	Note To Reviewer	Tammy O'Connor	01/14/2009	01/14/2009

*SERFF Tracking Number:* BLHI-125895472      *State:* Arkansas  
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*Project Name/Number:* /

## **Disposition**

Disposition Date: 01/15/2009

Implementation Date:

Status: Withdrawn

Comment: As requested in your Note to Reviewer on 1/14/09, this submission is being withdrawn.

Rate data does NOT apply to filing.

SERFF Tracking Number: BLHI-125895472 State: Arkansas  
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<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Certification/Notice	Withdrawn	Yes
<b>Supporting Document</b>	Application	Withdrawn	Yes
<b>Form</b>	Indemnity Policy	Withdrawn	Yes
<b>Form</b>	Indemnity Certificate of Insurance	Withdrawn	Yes
<b>Form</b>	PPO Policy	Withdrawn	Yes
<b>Form</b>	PPO Certificate of Insurance	Withdrawn	Yes
<b>Form</b>	Indemnity Plan Group Employer Application form	Withdrawn	Yes
<b>Form</b>	PPO Plan Group Employer Application Form	Withdrawn	Yes
<b>Form</b>	Dental Only Employee Enrollment Form	Withdrawn	Yes
<b>Form</b>	Dental and Vision Employee Enrollment Form	Withdrawn	Yes

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Product Name: Group Indemnity Dental  
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## Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 12/11/2008

Submitted Date 12/11/2008

Respond By Date

Dear Tammy O'Connor,

This will acknowledge receipt of the captioned filing.

### Objection 1

- Indemnity Certificate of Insurance (Form)
- PPO Certificate of Insurance (Form)

Comment: It is requested that you add additional language to the face page of the certificate that reads: Any Certificates issued in Arkansas will be governed by the State of Arkansas.

### Objection 2

- Indemnity Certificate of Insurance (Form)
- PPO Certificate of Insurance (Form)

Comment: With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking Number: BLHI-125895472 State: Arkansas  
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Product Name: Group Indemnity Dental  
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## Objection Letter

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Objection Letter Date 12/11/2008

Submitted Date 12/11/2008

Respond By Date

Dear Tammy O'Connor,

This will acknowledge receipt of the captioned filing.

### Objection 1

- Indemnity Certificate of Insurance (Form)
- PPO Certificate of Insurance (Form)

Comment: Coverage for newborn infants must be for at least 90 days as outlined under ACA 23-79-129. Also, please refer to the 60-day period for minors for whom the insured has filed a petition to adopt under ACA 23-79-137.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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**Note To Reviewer**

**Created By:**

Tammy O'Connor on 01/14/2009 04:31 PM

**Subject:**

Request to Withdraw

**Comments:**

Good afternoon.

On behalf of BEST Life and Health Insurance Company, I respectfully request to withdraw this filing. I thank you for your time and consideration.

Respectfully,

Tammy O'Connor  
Director, Regulatory Compliance  
1-800-433-0088, ext. 214

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## Form Schedule

**Lead Form Number:** BL-EGD-POL-1008

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Withdrawn	BL-GD-ID-POL-1208	Policy/Cont ract/Fratern al Certificate	Indemnity Policy	Initial			Stan-Sig-Merit Indemnity Plan Policy.pdf
Withdrawn	BL-GD-ID-CERT-1208	Certificate	Indemnity Certificate of Insurance	Initial			Stan-Sig-Merit Indemnity Plan Certificate.pdf
Withdrawn	BL-GD-PPO-POL-1208	Policy/Cont ract/Fratern al Certificate	PPO Policy	Initial			Stan-Sig-Merit PPO Plan Master Policy.pdf
Withdrawn	BL-GD-PPO-CERT-1208	Certificate	PPO Certificate of Insurance	Initial			Stan-Sig-Merit PPO Certificate.pdf
Withdrawn	BL-GD-IDP-EAPP-1208	Application/ Enrollment Form	Indemnity Plan Group Employer Application form	Initial			Stan-Sig IDP Employer Application0708.pdf
Withdrawn	BL-GD-PPO-EAPP-1208	Application/ Enrollment Form	PPO Plan Group Employer Application Form	Initial			Stan-Sig-PPODentalGroupEApp0608.pdf
Withdrawn	BL-GD-DEN-EE-1208	Application/ Enrollment Form	Dental Only Employee Enrollment Form	Initial			Dental Only Employee Enrollment Form.pdf
Withdrawn	BL-GD-DV-EE-1208	Application/ Enrollment Form	Dental and Vision Employee Enrollment Form	Initial			Dental Vision Employee Enrollment

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*Project Name/Number:* /

Form.pdf



**BEST Life and Health Insurance Company**

2505 McCabe Way  
Irvine, California 92614

A STOCK COMPANY  
(Herein called the Company)

**BEST Life and Health Insurance Company, We, Our or Us**, in consideration of the application of the Subscribing Employer and the payment of premiums as due, agrees, subject to the terms and conditions of this Group Policy, to insure Eligible Employees of Subscribing Employers to the Group Policyholder and their eligible Dependents under this Group Policy..

**GOVERNING JURISDICTION: State of Utah.** The Group Policy is issued in the State of Utah. Its terms are governed by and shall be construed in accordance with the laws of the Governing Jurisdiction.

This Group Policy becomes effective at 12:01 a.m., Standard Time at the office of the Group Policyholder on the Group Policy Effective Date in the State of Delivery specified above. Subject to the terms and conditions of this Group Policy, it can be renewed until the First Renewal Date by timely payment of the required premium by the Group Policyholder. Unless terminated in accordance with the applicable provision of this Group Policy, it can be renewed after such time from month to month, subject to the terms and conditions of this Group Policy, by timely payment of the required premium.

This Group Policy may be modified by mutual agreement between the Group Policyholder and Us.

The provisions on the following pages and the terms in the Certificate are part of this Group Policy. A copy of the Certificate is attached to, and made a part of this Group Policy.

Signed for **BEST Life and Health Insurance Company** by its President at [2505 McCabe Way, Irvine, California 92614.]

[  ]  
President

**Group Indemnity Dental Policy**  
Non-Participating

**Group Policyholder:** The Trustee of the Beneficial Employees Security Trust of Utah

**Group Policy Effective Date:** [XX-XX-XXXX]

**Group Policy Number:** [XXX]

**State of Delivery:** [Utah]

**Premiums Due On:** [1<sup>st</sup> of each month]

**First Renewal Date:** [XX-XX-XXXX]

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## GENERAL PROVISIONS

**CLERICAL ERROR:** Clerical error by the Group Policyholder shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated.

**Third Party Responsibility:** If an Insured is injured or becomes ill through the act or omission of another person, to the extent that the Insured recovers medical expenses for the same Injury or Illness from a third party or its insurer, We will be entitled to a repayment of such benefits paid under the Policy due to the same Injury or Illness. We may file a lien for such repayment. Upon request, the Insured must complete and return the required forms to Us.

The repayment agreement will be binding upon the Insured, or the legal representative of a minor or incompetent, whether:

- (1) the payment received from the third party, or its insurer, is the result of:
  - legal judgment;
  - an arbitration award;
  - a compromise settlement;
  - any other arrangements; or
- (2) the third party or its insurer had admitted liability for the payment; or
- (3) the medical expenses are itemized in the third party payment.

**Entire Contract:** The Policy (including the employer enrollment application and/or participation agreements and any applications of Insureds) is the entire contract between the Holder and Us. We will consider any statement made by the Insured or the Holder, in the absence of fraud, as a representation and not a warranty.

**Right to Contest:** After the Policy has been in force for [2] years, We will not use any statements made in the application of the Holder to void the Policy. After the Insured has been covered under the Policy for [2] consecutive years, We will not use any statement made in an individual application to defend a claim.

**Notice of Claim:** You must give Us written notice within 20 days after a claim starts or as soon as reasonably possible. The notice is to be sent to Best Life and Health at, [2505 McCabe Way, Irvine, California 92614] or given it to Our agent.

**Claim Forms:** When We receive Your notice of claim, We will send You forms for filing Your claim. If these forms are not given to You within [15] days, You can meet Our requirements by giving Us a written statement. This statement should include the nature and extent of the claim and be sent to Us within the time stated in the Proof of Loss provision.

**Proof of Loss:** You must give Us acceptable written proof of loss within 90 days of Your claim. If it was not possible for You to give proof within the 90 days, We will not deny Your claim for this reason if You send the proof as soon as You can. In any event, You must send Us the proof no later than one year from the time specified, unless You are legally incapacitated.

**Time of Payment of Claims:** Payments for a covered claim will be made to You as they accrue, subject to written proof of loss. Any balance remaining unpaid when Our liability ends will be made immediately upon receipt of written proof of loss.

**Time Limit on Certain Defenses:** After this Group Policy has been in force for [2] years, We will not use any statements made in the application of the Group Policyholder to void the Group Policy. After coverage for a Subscribing Employer has been in force for [2] years, We will not use any statements in the Subscribing Employer's application in a contest of coverage under this Group Policy. After an Insured Person has been covered under this Group Policy for [2] years, We will not use any statement made in the Insured Person's enrollment form to defend a claim.

**Payment of Claims:** All payments will be made to You, Your Dentist, or Your Ophthalmologist or Optometrist.

**Legal Actions:** You may not bring legal action against Us before [60] days, or after [3] years, from the date written proof of loss is required to be given.

**Misstatement of Age:** If the age of any individual covered under the Policy has been misstated, there shall be an adjustment of premium for the Policy so that there shall be paid to Us the premium for the coverage of such individual at his or her correct age, and the amount of the insurance coverage shall not be affected.

**Non-Participation:** This Policy is a non-participating Policy and as such neither the Policyholder nor this Policy participates in the profits or surplus earnings of the Company.

**Worker's Compensation:** The Policy is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

**Conformity with State Statutes:** Any provisions of the Policy which are in conflict with the statutes of the state in which the Policy was issued or delivered will be changed to conform to such laws.

**Waiver of Rights:** If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date, nor will it affect Our right to enforce any other provision of the Policy.

**Inspection of Group Policy:** The Group Policy is in the possession of the Policyholder. It may be inspected at any time during business hours at the office of the Policyholder.

**Duty to Cooperate:** As a condition precedent to the payment of benefits hereunder, You are required to cooperate with Us by providing all information reasonably required to accurately process Your claim... Any failure by You to provide necessary information may result in a denial of benefits for Your claim.

## **PREMIUM PROVISIONS**

**PREMIUM PAYMENTS:** Renewal premiums are payable to Us. The payment of any premium shall not continue this Group Policy in force beyond the next premium due date, except as provided in the Grace Period Provision.

**CHANGES IN PREMIUM:** We may change the amount of the required premium due from the Group Policyholder by giving the Group Policyholder at least [60] days advance written notice. [During the first [12] [24] months, We will not change the amount of the required premium.

**GRACE PERIOD:** This Group Policy has a [31] day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following [31] days. During the Grace Period, this Group Policy will remain in force. If the required premium is not paid by the end of this Grace Period, this Group Policy will lapse as of the premium due date.

### **TERMINATION OF THIS GROUP POLICY**

We may terminate this Group Policy at any time following the first renewal date by giving the Group Policyholder written notice at least [60] days in advance. The Group Policyholder may also terminate this Group Policy by giving Us written notice at least [60] days before the intended termination date. This Group Policy will also terminate if the required premium is not paid by the Group Policyholder as provided in the Grace Period provision.

**BEST Life and Health Insurance Company**

[2505 McCabe Way  
Irvine, California 92614]

A STOCK COMPANY  
(Herein called the Company)

**BEST Life and Health Insurance Company** will insure You, the Insured, and Your covered Dependents if dependent insurance is elected as shown on the Statement of Coverage Sticker, affixed below.

**GOVERNING JURISDICTION: State of Utah.** The Group Policy is issued in the State of Utah. Its terms are governed by and shall be construed in accordance with the laws of the Governing Jurisdiction.

**PLAN EFFECTIVE DATE:** This Certificate is a condensed version of the Group Policy issued to the Policyholder named on the Schedule of Benefits. The Group Policy alone is the basis by which payments are made. This Certificate supersedes and replaces any which may have been issued to You previously.

Signed for **BEST Life and Health Insurance Company** by its President at [2505 McCabe Way, Irvine, California 92614].

[ ]

President

**GROUP DENTAL CERTIFICATE  
NON-PARTICIPATING**

**THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR PARTICIPATING EMPLOYER TO DETERMINE WHETHER YOUR PARTICIPATING EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.**

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**PART 1 - SCHEDULE OF DENTAL BENEFITS**

This Certificate of Group Coverage is validated by the attachment of a “Statement of Your Coverage Sticker” affixed to the Schedule of Benefits.

The policy is issued by **BEST Life and Health Insurance** to:  
**THE TRUSTEE OF THE BENEFICIAL EMPLOYEES SECURITY TRUST OF UTAH**

**SCHEDULE OF DENTAL BENEFITS**

On this Preferred Provider Dental Plan dental services rendered by a Network Provider are based upon the Fee Schedule of the Preferred Provider Network You have selected. Services rendered by a Non-network Provider are payable on a [Usual, Reasonable and Customary] [Maximum Allowable Charge] basis, subject to the Deductible and the Maximum Benefit Limits shown in this Schedule of Benefits. Please refer to the [Usual, Reasonable and Customary] [Maximum Allowable Charge] definitions in the “Definition” of this Certificate.

<b>Benefits Description</b>	<b>Benefits</b>
<b>Calendar Year Maximum (per enrollee)</b>	[\$2,500 - \$500]
<b>[Maximum Rollover Amount]</b>	[\$0 - \$5,000]
<b>Individual Yearly Deductible</b>	[ \$100 - \$0]
<b>Family Yearly Deductible</b>	[ \$300 - \$0]
<b>Class I: Preventive Care Services</b> [Routine oral exam, cleanings, fluoride treatment for children, x-rays, sealants]	[100% - 50%] [No or After] deductible
<b>Class II: Basic Services</b> [Fillings (amalgam, porcelain & plastic), general anesthesia, emergency palliative treatment, space maintainers for children, pathology, posterior composites[,simple and surgical extractions] [, oral surgery] [, endodontics] [, and periodontics] ]  [There is a [6-12] -month waiting period for Basic Services]	[100% - 50%] After deductible [[6,12, 18 or 24]-month wait*]
<b>Class III: Major Services</b> [Crowns & gold fillings, inlays, onlays and pontics, fixed bridges, complete and partial dentures[,complex oral surgery][, implants] [,oral surgery] [,endodontics] [, and periodontics]]	[100% - 0%] After deductible [[6, 12, 18 or 24]-month wait*]
<b>[Class IV: Orthodontics]</b> [For eligible dependent children through age 20 only] [For eligible dependent children and adults]	[60% - 50%] [\$2,500 - \$1,000 Lifetime Maximum] [[6. 12, 18 or 24]-month wait*]
<b>[Children's Good Vision Benefit]</b> For dependent children through age 20 only]	[Covers 50% of eligible expenses for a vision exam once every 12 months] [[6. 12, 18 or 24]-month wait*]
[*Unless the requirements for the Major Dentistry Waiting Period Waiver have been met, Major Dental and Orthodontic Procedures and the Children’s Good Vision Benefit are not eligible covered expenses for any Insured	

during the [6, 12, 18 or 24]-month period immediately following their effective date. Please see Major Dentistry Waiting Period Waiver Provision.]

**[Special Dental Accident Benefit]**

Covers injury to sound, natural teeth up to [\$1,000 or \$500] per accident

### **Major Dentistry Waiting Period Waiver**

The [6, 12, 18 or 24]-month waiting period for Basic Services and/or Major Dental Procedures (Class III) is waived if "Yes" is indicated after "Waiting Period Waived on Major Dentistry" on the Statement of Coverage sticker.

This Waiver only applies if the Participating Employer is replacing comparable existing dental coverage that was in force for at least [12] consecutive months immediately prior to the Effective Date of this Plan's coverage and the Employee has been covered: (a) under the prior dental plan for a period of [12] consecutive months; (b) [12] months between the Employee's prior Employer's dental plan and this plan; or (c) [12] months under this dental plan, whichever occurs first.

The Waiver of this waiting period does NOT apply to: (a) the Employee's eligible dependents who were not covered for a period of at least [12] consecutive months between the employer's prior dental plan and this dental plan, or [12] months under this dental plan, whichever occurs first, or (b) the Employee's eligible dependents whose effective date of coverage under this plan is later than the Employees' effective date of coverage.

Waiver of the waiting period shall not be construed to alter any provisions of the Major Dental Procedures.

## **DENTAL PLAN EXCLUSIONS AND LIMITATIONS**

### **Limitations**

#### **Covered Dental Benefit Expenses**

We will pay for the following dental services and supplies furnished by a doctor of medical dentistry or a doctor of dental surgery. Expenses must be [Usual, Reasonable and Customary] [Maximum Allowable Charge] and incurred while You or Your Dependent are covered under the policy. If more than one treatment plan exists for a dental procedure, covered dental expenses will be based on the least expensive procedure that will produce a result that meets professionally recognized standards. Payments are subject to the Individual Calendar Year Deductible, Percentage Payable and Maximum Benefit Limits shown in the Schedule of Dental Benefits and the Dental Limitations and Exclusions.

#### **Maximum Benefit Limits**

The total amount of Benefits payable under the policy for any person will not exceed the Maximum Benefit Limits of the Preferred Provider Plan.

#### **CLASS I - Preventive Dental Procedures:**

- (1) [routine oral examination and diagnosis not more often than once every [6] months per individual;
- (2) x-rays not more often than once every [6 or 12] months per individual ([panoramic or] full mouth x-rays are limited to once in a [3-year or 5-year] period);
- (3) prophylaxis not more often than once every six months per individual;
- (4) one annual topical fluoride treatment through age [15];
- (5) sealants for Your dependent child under age [15], limited to treatment of permanent molars once in any [36]-month period.]

**CLASS II - Basic Dental Procedures:**

- (1) [pathology;
- (2) all fillings other than lab fabricated restorations (composite fillings limited to permanent anterior and posterior teeth) [(same surface fillings limited to once every [2] years)];
- (3) space maintainers for Your dependent child under age [17];
- (4) emergency palliative treatment;
- (5) simple extraction;
- (6) surgical extraction, including impaction:
  - (a) ]erupted;
  - (b) soft tissue impaction;
  - (c) partial bony impaction;
  - (d) complete bony impaction;]
- (7) general anesthesia - paid as a separate procedure only when required for complex oral surgical procedures, as determined by us, for which Benefits are payable.;
- (8) periodontics (tissues and gums);
- (9) periodontal maintenance (limited to once every [3] months per individual following active periodontal treatment);
- (10) periodontal scaling and root planing (limited to once every [36 month] [and to [2] quadrants per visit]);
- (11) endodontics (pulp capping and root canal); and
- (12) oral surgery:
  - (a) root recovery (surgical removal of residual root);
  - (b) removal of a dentigerous or odontogenic cyst;
  - (c) incision and drainage of an abscess;
  - (d) surgical exposure of impacted tooth to aid eruption;
  - (e) removal of exostosis;
  - (f) frenulectomy;
  - (g) oral antral fistula closure.]
  - (h) [simple extraction;
  - (i) surgical extraction, including impaction:
    - i. erupted;
    - ii. soft tissue impaction;
    - iii. partial bony impaction;
    - iv. complete bony impaction;]

**CLASS III - Major Dental Procedures:**

- (1) [inlays, onlays, crowns and other lab fabricated restorations [(if the tooth can be restored with less expensive materials, covered expenses will be based on those materials)];
- (2) porcelain, porcelain fused to metal, or full gold crowns are limited to patients over the age of [14] and on permanent teeth;
- (3) full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within [12] months after the extraction and while this coverage is in force;
- (4) replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
  - (a) accidental injury requiring oral surgical treatment, or
  - (b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is

done within [12] months of the injury or surgical treatment.

- (4) replacement of a full denture or bridgework if the replacement is made more than [five or seven] years after the date of installation;
- (5) repair or relining of dentures and bridgework;
- (6) implants (limited to once in a lifetime per site, and for patients over the age of [16]):
  - (a) the surgical placement of endosteal implant body including healing cap, where the bone and soft tissues are sound and healthy;
  - (b) implant supported prosthetics;
  - (c) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);
  - (d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;
- (7) periodontics (tissues and gums);
- (8) periodontal maintenance (limited to once every [3] months per individual following active periodontal treatment);
- (9) periodontal scaling and root planing (limited to once every [36] months);
- (10) endodontics (pulp capping and root canal); and
- (11) oral surgery:
  - (a) root recovery (surgical removal of residual root);
  - (b) removal of a dentigerous or odontogenic cyst;
  - (c) incision and drainage of an abscess;
  - (d) surgical exposure of impacted tooth to aid eruption;
  - (e) removal of exostosis;
  - (f) frenulectomy;
  - (g) oral antral fistula closure.]
  - (h) [simple extraction;
  - (i) surgical extraction, including impaction:
    - (i) erupted;
    - (ii) soft tissue impaction;
    - (iii) partial bony impaction;
    - (iv) complete bony impaction;]

### **Exclusions**

No payments will be made for and covered dental expenses do not include:

- (1) [treatment by someone other than a dentist or physician, except where performed by a duly qualified technician under the direction of a dentist or physician;
- (2) expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
- (3) an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
- (4) [pulp capping, if in conjunction with the installation of inlays, onlays or crowns;]
- (5) replacement of a lost or stolen or discarded prosthetic device;
- (6) dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;

- (7) the replacement of any prosthesis (a crown, [implant,] fixed bridge or denture) if such prosthesis was installed less than [five or seven] years before, unless:
  - (a) such replacement is made necessary by the initial extraction of an adjoining functional natural tooth;
  - (b) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non-chewing injury while covered;
- (8) the initial installation of a prosthetic device (a[n implant,] fixed bridge or denture), including crowns and inlays which form abutments, to replace teeth missing before You were covered under the policy, except when it also replaces a tooth that is extracted while covered unless such installation commences after You have remained continuously covered under this plan for at least [3] years immediately prior to the date such installation commences;
- (9) expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are covered under the plan.
- (10) expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
- (11) charges in excess of [Usual, Reasonable and Customary] [Maximum Allowable] charges;
- (12) services and supplies not reasonably necessary;
- (13) charges for service provided for temporomandibular joint dysfunction (TMJ);
- (14) services and supplies covered under any Worker's Compensation Act or similar law;
- (15) services and supplies performed outside of the United States of America;
- (16) expenses incurred for congenital or developmental malformations;
- (17) [expenses incurred for dental implants and related procedures, including but not limited to endosteal and subperiosteal;]
- (18) [implants, implant services and implant supported prosthetics are not covered for patients under the age of sixteen;]
- (19) [expenses incurred for the maintenance of dental implants;]
- (20) any services or supplies for correction or alteration of occlusion, or any occlusal adjustments;
- (21) charges for prescribed drugs, pre-medication or analgesia;
- (22) expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
- (23) expenses incurred for night guards or any other appliances for the correction of harmful habits;
- (24) expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, Your lawful spouse, child, parent, step-parent, grandparent, brother, sister or in-law;
- (25) expenses incurred due to treatment rendered by Your employer;
- (26) expenses not otherwise specifically listed as a Covered Expense;
- (27) expenses for services for which You would not legally have to pay if there were no insurance;
- (28) for services not completed on or before the date of termination unless the services are covered under the Extension of Dental Benefits;
- (29) expenses that are applied toward satisfaction of a Deductible, if any;
- (30) for procedures that are begun, but not completed;
- (31) adjustment, repairs or relines of prostheses for a period of six months from initial placement if the prostheses were paid for under this plan;
- (32) if an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
- (33) if multiple endodontic treatments are necessary on the same tooth within a period of one year, the allowance will be made for only one procedure;
- (34) the extraction of immature erupting third molars and non-pathologic, asymptomatic third molar extractions;

- (35) temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
- (36) expenses for gross debridement allowed one time at the beginning of the periodontal treatment plan prior to pocket depth charting;
- (37) surgical procedures incidental to orthodontic treatment, including but not limited to, extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate;
- (38) any amounts in excess of the maximum amount stated in the "Schedule of Dental Benefits" section of this Plan;
- (39) application of chemotherapeutic agents; and
- (40) ridge augmentation, ridge preservation, bone graft and guided tissue regeneration in extraction sites;
- (41) charges in excess of the Preferred Provider Fee Schedule.]

## **PART 2 - OPTIONAL ORTHODONTIC BENEFITS AND SPECIAL CHILDREN'S GOOD VISION BENEFIT**

These benefits will apply to you only if this coverage was selected and is shown on your enrollment card or if Your Certificate contains a validation sticker indicating that this coverage was selected.

### **[ORTHODONTIC BENEFITS**

Orthodontia Type Treatments and Orthodontic Procedures are limited to Your Dependent Children through age [20]. A [12, 18 or 24]-Month Waiting Period applies to this Plan and is not a covered expense during the [12]-Month Period immediately following the effective date of coverage. The Maximum Benefit limit that will be paid while an Insured is covered under this Plan is shown in PART 1 - Schedule of Benefits.

Individual calendar year deductibles do not apply to Orthodontic procedures and Benefits are payable on a Usual, Reasonable and Customary Basis, subject to the Maximum Benefit Limits shown on the Schedule of Benefits in PART 1.

The Orthodontic Benefit will cease once braces are removed.]

### **[SPECIAL CHILDREN'S GOOD VISION BENEFIT**

The Good Vision Benefit is limited to an Employee's Dependent Children through age 20. This Benefit is not a covered expense during the [12, 18 or 24]-Month Period immediately following Your Dependent Child's effective date of coverage.

For Good Vision Benefits we will pay for a vision exam once every [12] months for dependent children. This Benefit includes one annual case history, refraction and checking of eye wear against prescription if required.

We will pay for the following vision examination services furnished by a licensed ophthalmologist or optometrist. These services will include one annual case history, refraction and checking of eye wear against prescription if required. Individual calendar year deductibles do not apply. Expenses must be Usual, Reasonable and Customary and incurred while Your Dependent is covered under the Policy. Payments are subject to the Individual Calendar Year Deductible, Percentage Payable and Maximum Benefit Limits shown in the Schedule of Dental Benefits and the Dental Limitations and Exclusions.]

## [SUPPLEMENTAL DENTAL ACCIDENT BENEFIT

### **Advance Notice of Dental Treatment**

Unless the charges are less than \$[300], or for emergency treatment, the Insured's dentist must submit written advance notice and x-rays before treatment begins for our approval for eligible expenses and allowances. Please see **Advance Notice of Treatment** in PART 6 of this certificate for a complete description of this requirement.

We will pay a Supplemental Accident Benefit if You or Your covered Dependent incur covered dental expenses as a result of an accidental injury to natural teeth while this coverage is in effect. The term "functional natural teeth" means a tooth that is natural, whole, vital and free of disease or major repair.

The Benefit payable will be [100]% of the Usual, Reasonable and Customary expenses, up to a maximum of [\$1,000 or \$500] per accident. The Benefit is not subject to any Individual or Family Deductibles or any waiting periods.]

### **[Supplemental Accident Limitations and Exclusions**

The Supplemental Accident Benefit does not cover:

- (1) an accidental injury occurring before You or Your Dependent are covered;
- (2) any expenses incurred after the [12]-month period immediately following the accidental injury;
- (3) the portion of an expense paid under another part of the Policy, or paid under any other Group Policy; or
- (4) an expense incurred as a result of sickness.]

## **PART 3 - DEFINITIONS**

**Allowable Expense:** Means any Usual, Reasonable and Customary item of expense, at least a portion of which is covered under at least one of the Plans covering the person for whom claim is made. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an allowable expense and a benefit paid.

**Claim Determination Period:** Means a Calendar Year.

**Eligible Dependent:** Means:

- (1) Your lawful spouse, and
- (2) Your or Your spouse's child or children, including a natural child, step-child, foster child, lawfully adopted child or child in the process of being adopted, from the date of placement, or any child for whom You have been granted legal custody, provided they are:
  - (a) unmarried; and
  - (b) for residents of Utah, through age 25; or
  - (c) for residents of Texas, through age 24; or
  - (d) for residents of other states, through age 20, extended through age 25 if a full-time student at an educational institution.
- (3) A child named in a Qualified Medical Child Support Order will be considered a dependent.

**"Eligible Dependent"** also means a dependent child, who upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within [31] days after the termination age, the child will continue to qualify as a dependent under this plan, provided You and the dependent child continue to be insured under this plan, and the child continues to be handicapped and dependent upon You for support. This shall not apply to a dependent child who is beyond the termination age on the date You become eligible for dependent insurance under this Policy.

**Eligible Employee:** Means:

- (1) A full-time permanent employee who is:
  - (a) permanently employed, working at least 30 hours per week and paid a salary, wages, or earnings from which federal and state tax and Social Security deductions are made; and
  - (b) not covered by a collective bargaining agreement which requires Your Participating Employer to make contributions; or
- (2) A partner or proprietor actively engaged in the business on a full-time basis.

**"Eligible Employee"** does not mean an independent contractor, commission salesperson, consultant or a person who is in any manner self-employed.

**Expenses Incurred:** An Eligible Expense is considered incurred on the following dates:

- (1) For dentures - the date the final impression is taken.
- (2) For fixed bridges, implants crowns, inlays and onlays - the date the teeth are first seated (permanently placed).
- (3) For root canal therapy - the date the pulp chamber is opened.
- (4) For periodontal surgery - the date surgery is performed.
- (5) For all other services - the date the service is performed.

**Family Calendar Year Deductible:** Satisfaction of [3] Individual Calendar Year Deductibles.

**Grace Period:** A Grace Period of thirty-one [(31)] days from the due date will be allowed for payment of each premium after the first. This coverage will remain in effect during the Grace Period; provided the premium is paid before the end of the Grace Period.

**Insured:** Means an eligible employee or any of the Employee's eligible covered Dependents who are insured under the Group Policy.

**[Maximum Allowable Charge:** Means the fee shown in the Preferred Provider Fee Schedule for dental services and supplies generally furnished for cases of comparable severity and nature. For vision services and Non-Preferred Provider dental services, Maximum Allowable Charge means the plan will pay a reasonable fee based on a fee level which is in the same range of fees customarily charged for the services or supplies in the geographic area concerned.]

**[Maximum Rollover:** Means the maximum amount of the unused portion of the previous years annual maximum that you may roll over to the current years annual maximum.

**Month:** Means a period of time beginning and ending with the same date each calendar month. If a succeeding calendar month has no such date, the last day of that month will be used.

**Participating Employer:** Means an employer who is a subscriber to the Group Policy.

**Plan:** Means any Plan providing benefits or services for or by reason of dental or vision care or treatment, which benefits or services are provided in: (1) group, blanket or franchise insurance coverage; (2) group practice and other group prepayment coverage; (3) group service Plans; (4) any coverage under labor management trustee Plans, union welfare Plans, Employer organization Plans or Employee benefit organization Plans; and (5) any coverage under governmental programs, and any coverage required or provided by any statute. The term "Plan" shall not include any plan of individual coverage or school or church accident type coverages.

The term "Plan" shall be construed separately with respect to each Policy, contract or other arrangement for benefits or services and separately with respect to that portion of such Policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

**Subscriber:** Means a participating employer who meets all the eligibility, participation and enrollment requirements established under the Group Policy.

**[Usual, Reasonable and Customary:** Means the fee shown in the Preferred Provider Fee Schedule for dental services and supplies generally furnished for cases of comparable severity and nature. For vision services and Non-Preferred Provider dental services, Usual, Reasonable and Customary means the plan will pay a reasonable fee based on (a) what is usually and customarily accepted as payment for dental and vision services and supplies generally furnished for cases of comparable severity and nature within the geographic area in which the services or supplies are furnished; and (b) a fee level which is in the same range of fees customarily charged for the services or supplies in the geographic area concerned.]

**We, Our or Us:** Means BEST Life and Health Insurance Company.

**You or Your:** Means the Insured.

#### **PART 4 - PROVISIONS FOR COVERAGE**

##### **EFFECTIVE DATE**

**Employee:** If You fill out and sign an enrollment card furnished by Us, Your insurance will take effect on the later of:

- (1) the date Your employer becomes a Participating Employer, if Your enrollment card is received by Us within [31] days of that date; or
- (2) the first day of the next calendar month following the date You complete one calendar month of active full-time employment for a Participating Employer. Your enrollment card must be received by Us within [31] days after You satisfy the waiting period.

[If Your enrollment card is received by Us more than [31] days after You become eligible, You will be considered a LATE ENTRANT. A "late entrant" shall only be eligible for CLASS I - Preventive Dental Procedures during the first [12] months of continuous coverage.

During the second [12] months of continuous coverage, a "late entrant" shall only be eligible for CLASS I -

Preventive Dental Procedures and for [50]% of the Benefits for CLASS II - Basic Dental Procedures. During this second [12] months of continuous coverage, the "late entrant" Benefits shall not exceed a maximum of \$[500].

The "late entrant" Benefits are subject to the Individual Calendar Year Deductible and Percentage Payable shown in the Schedule of Benefits of this Certificate, except as stated for Basic Dental Procedures above.]

If You are not working full-time on the date Your coverage would otherwise take effect, You will not be covered until You return to active full-time employment.

**Dependent:** Your Dependent's insurance will take effect on the later of:

- (1) the date Your insurance is effective, if the enrollment card is received by Us within [31] days of that date; or
- (2) the first day of the next calendar month following the date You enroll in writing for dependent insurance. Such enrollment must be within [31] days of the Dependent first becoming eligible.

If We receive Your Dependent enrollment card more than [31] days after a Dependent becomes eligible, Your Dependent will be considered a LATE ENTRANT. A "late entrant" shall only be eligible for CLASS I - Preventive Dental Procedures during the first [12] months of continuous coverage.

During the second [12] months of continuous coverage, a "late entrant" shall only be eligible for CLASS I - Preventive Dental Procedures and for [50]% of the Benefits for CLASS II - Basic Dental Procedures. During this second [12] months of continuous coverage, the "late entrant" Benefits shall not exceed a maximum of \$[500].

The "late entrant" Benefits are subject to the Individual Calendar Year Deductible and Percentage Payable shown in the Schedule of Benefits of this Certificate, except as stated for Basic Dental Procedures above.

If a Dependent, other than a newborn dependent, is confined in a medical facility on the date his or her insurance would otherwise take effect, that Dependent will not be covered until the confinement ends.

Your dependent insurance will continue as long as Your Dependents remain eligible, contributions are made, and Your insurance remains in effect.

## **TERMINATION OF INSURANCE**

**Employee:** Except as provided in the Extension of Dental Benefits, Your insurance will stop on the earliest of the following dates:

- (1) [the last day of the month in which You cease active employment, unless You are on leave of absence, temporary layoff or total disability. In that case, Your employer may continue Your insurance by paying the required premium, but not beyond the following limits:
  - (a) approved leave of absence, [3] months;
  - (b) temporary layoff, the end of the month following the month, in which Your layoff started;
  - (c) total disability, [3] months; or
- (2) the last day of the month in which You cease to be in a class of employees eligible for insurance;

- (3) the date Your employer ceases to be a Participating Employer;
- (4) the day before the due date of any premium that remains unpaid at the end of the grace period;
- (5) the date the policy terminates; or
- (6) the date the number of insured employees of a Participating Employer falls below [3.]

**Dependent:** Except as provided in the Extension of Dental Benefits, Your dependent's insurance will stop on the earliest of the following dates:

- (1) [the date Your insurance terminates;
- (2) the date You fail to make a contribution for dependent insurance;
- (3) the date You cease to be in a class eligible for dependent insurance; or
- (4) the last day of the month in which a dependent ceases to meet the definition of "Dependent."]

If a dependent child, upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within [31] days after the termination age, We will continue coverage as long as Your coverage continues and the child continues to be handicapped and dependent upon You for support.

## **PART 5 - PROVISIONS DESCRIBING BENEFITS**

### **ADVANCE NOTICE OF DENTAL TREATMENT**

It is recommended that You or Your Dependent submit Advance Notice of Dental Treatment satisfactory to Us before treatment commences in order to obtain predetermination of covered dental expenses. If dental services are performed without such predetermination, We reserve the right to deny any claim submitted with respect to such services; provided however, that predetermination is not required for:

- (1) dental services for which the amount of covered dental charges is less than \$[500] during any course of treatment ("course of treatment" means one treatment or one of a planned series of treatments resulting from dental examination);
- (2) emergency treatment; or
- (3) oral examination and prophylaxis.

### **DEDUCTIBLES**

**[Individual Calendar Year Deductible:** The Plan Deductible shown in the Schedule of Dental Benefits will apply separately to each Insured during each Calendar Year. To satisfy the Deductible, You or Your covered Dependent must accumulate eligible expenses equal to the deductible amount.]

**[Family Calendar Year Deductible:** The Family Calendar Year Deductible is satisfied when [each of [3, 2] covered members of Your family satisfy the Individual Calendar Year Deductible] [the combined costs of services provided by covered members of Your family is equal to the Family Calendar Year Deductible amount.]

**[Deductible Carry-Over:** Although a new deductible will apply each calendar year, eligible expenses incurred during the last [3] months of a calendar year, which are applied toward satisfaction of that Calendar Year's Deductible, will also be applied toward satisfaction of the deductible for the next calendar year, provided no other eligible dental procedure expenses were incurred during the current calendar year.]

**Percentage Payable:** After the deductible is satisfied, We will pay Benefits for eligible expenses at the

percentage shown in the Schedule of Dental Benefits.

**[Maximum Rollover:** BEST Life will roll over a portion of Your unused annual maximum to the following years Annual Maximum]

#### **ALTERNATIVE PROCEDURES**

If more than one treatment plan exists for a dental procedure, covered dental expenses will be based on the least expensive procedure that will produce a result that meets professionally recognized standards. If you and your dentist decide that you want the more expensive treatment, you may be responsible for any charges that are greater than the covered expense for the less expensive treatment.

#### **EXTENSION OF DENTAL BENEFITS**

**Extension of Dental Benefits:** We will continue to pay dental Benefits for [30] days following the date Your coverage or Your Dependent's coverage terminates if:

- (1) the expenses incurred would have been eligible for payment had coverage remained in effect; and
- (2) the impression for a prosthetic device or modification had been taken before termination and delivered and installed within [30] days following the termination of coverage; or
- (3) in the treatment of root canal therapy, Your pulp chamber was opened before termination.

#### **PART 6 - COORDINATION OF BENEFITS**

**Benefits Subject to this Provision:** All of the benefits provided under the Policy are subject to this provision.

#### **Effect on Benefits:**

- (1) This provision shall apply in determining the benefits as to a person covered under this Plan for any Claim Determination Period if, for the Allowable Expenses incurred as to such person during such period, the sum of:
  - (a) the benefits that would be payable under this Plan in the absence of this provision; and
  - (b) the benefits that would be payable under all other Plans in the absence therein of provisions of similar purpose to this provision would exceed such Allowable Expenses.
- (2) As to any Claim Determination Period with respect to which this provision is applicable, the benefits that would be payable under this Plan in the absence of this provision for the Allowable Expenses incurred as to such person during such Claim Determination Period shall be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such Allowable Expenses under all other plans, except as provided in the next paragraph, shall not exceed the total of such Allowable Expenses. Benefits payable under another Plan include the benefits that would have been payable had claim been duly made therefore.
- (3) If:
  - (a) another Plan which is involved in paragraph (2) and which contains a provision coordinating its benefits with those of this Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined, and
  - (b) the rules set forth in paragraph (4) would require this Plan to determine its benefits before such other Plan, and then the benefits of such other Plan will be ignored for the purposes of determining the benefits under this Plan.
- (4) For the purposes of paragraph (3), the rules establishing the order of benefit determination are:
  - (a) The benefits of a Plan which covers the person on whose expenses claim is based other than as a Dependent shall be determined before the benefits of a Plan which covers such person

- as a Dependent.
- (b) The benefits of a Plan which covers the person on whose expenses claim is based as a Dependent of the parent whose birthday comes earliest in the year, regardless of the year of birth, shall be determined before the benefits of a Plan which covers such person as a Dependent of the other parent except that in the case of a person for whom claim is made as a dependent child:
    - 1. when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Plan which covers the child as Dependent of the parent with custody of the child will be determined before the benefits of a Plan which covers the child as a Dependent of the parent without custody;
    - 2. when the parents are divorced and the parent with custody of the child has remarried, the benefits of a Plan which covers the child as a Dependent of the parent with custody shall be determined before the benefits of a Plan which covers that child as a Dependent of the stepparent, and the benefits of a Plan which covers the child as a Dependent of the stepparent will be determined before the benefits of the parent without custody. Notwithstanding 1. and 2. above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefits of a Plan which covers the child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan which covers the child as a dependent child.
  - (c) When rules (a) and (b) do not establish an order of benefit determination, the benefits of a Plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a Plan which has covered such person the shorter period of time.
- (5) When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during any Claim Determination Period, each benefit that would be payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of this Plan.
  - (6) No Plan pays more than it would without the Coordination of Benefits provision.

**Right to Receive and Release Necessary Information:** For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provisions of similar purpose of any other Plan, We may, with the consent of any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which We deem to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to Us such information as may be necessary to implement this provision.

**Facility of Payment:** Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other Plans, We shall have the right, exercisable alone and in Our sole discretion, to pay over to any organizations making such other payments any amounts We shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, We shall be fully discharged from liability under this Plan.

**Right to Recovery:** Whenever payments have been made by Us with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, We shall have the right to recover such payments, to the extent of such excess, from among one or more of the following: any persons to or for or with respect to whom such

payments are made, any other insurers, service Plans or any other organizations.

## **PART 7 - GENERAL PROVISIONS**

**Third Party Responsibility:** If an Insured is injured or becomes ill through the act or omission of another person, to the extent that the Insured recovers medical expenses for the same Injury or Illness from a third party or its insurer, We will be entitled to a repayment of such benefits paid under the Policy due to the same Injury or Illness. We may file a lien for such repayment. Upon request, the Insured must complete and return the required forms to Us.

The repayment agreement will be binding upon the Insured, or the legal representative of a minor or incompetent, whether:

- (1) the payment received from the third party, or its insurer, is the result of:
  - legal judgment;
  - an arbitration award;
  - a compromise settlement;
  - any other arrangements; or
- (2) the third party or its insurer had admitted liability for the payment; or
- (3) the medical expenses are itemized in the third party payment.

**Entire Contract:** The Policy (including the employer enrollment application and/or participation agreements and any applications of Insureds) is the entire contract between the Policyholder and Us. We will consider any statement made by the Insured or the Policyholder, in the absence of fraud, as a representation and not a warranty.

**Right to Contest:** After the Policy has been in force for [ 2] years, We will not use any statements made in the application of the Policyholder to void the Policy. After the Insured has been covered under the Policy for [2] consecutive years, We will not use any statement made in an individual application to defend a claim.

**Notice of Claim:** You must give Us written notice within [20] days after a claim starts or as soon as reasonably possible. The notice is to be sent to BEST Life and Health at [2505 McCabe Way, Irvine, California 92614] or given it to Our agent.

**Claim Forms:** When We receive Your notice of claim, We will send You forms for filing Your claim. If these forms are not given to You within [15] days, You can meet Our requirements by giving Us a written statement. This statement should include the nature and extent of the claim and be sent to Us within the time stated in the Proof of Loss provision.

**Proof of Loss:** You must give Us acceptable written proof of loss within [90] days of Your claim. If it was not possible for You to give proof within the [90] days, We will not deny Your claim for this reason if You send the proof as soon as You can. In any event, You must send Us the proof no later than [one] year from the time specified, unless You are legally incapacitated.

**Time of Payment of Claims:** Payments for a covered claim will be made to You as they accrue, subject to written proof of loss. Any balance remaining unpaid when Our liability ends will be made immediately upon receipt of written proof of loss.

**Payment of Claims:** All payments will be made to You, Your Dentist, [or Your Ophthalmologist or Optometrist].

**Legal Actions:** You may not bring legal action against Us before [60] days, or after [3] years, from the date written proof of loss is required to be given.

**Misstatement of Age:** If the age of any individual covered under the Policy has been misstated, there shall be an adjustment of premium for the Policy so that there shall be paid to Us the premium for the coverage of such individual at his or her correct age, and the amount of the insurance coverage shall not be affected.

**Worker's Compensation:** The Policy is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

**Conformity with State Statutes:** Any provisions of the Policy which are in conflict with the statutes of the state in which the Policy was issued or delivered will be changed to conform to such laws.

**Waiver of Rights:** If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date, nor will it affect Our right to enforce any other provision of the Policy.

**Inspection of Group Policy:** The Group Policy is in the possession of the Policyholder. It may be inspected at any time during business hours at the office of the Policyholder.

**Duty to Cooperate:** As a condition precedent to the payment of benefits hereunder, You are required to cooperate with Us by providing all information reasonably required to accurately process Your claim... Any failure by You to provide necessary information may result in a denial of benefits for Your claim.

#### **PART 8 - SUMMARY PLAN DESCRIPTION SUPPLEMENT**

The following information is required by the Employee Retirement Income Security Act of 1974 (ERISA), and together with the rest of Your Certificate, it forms the Summary Plan Description.

- (1) **EMPLOYER AND NAME OF PLAN:** The plan is known as the Beneficial Employees Security Trust and is maintained by Beneficial Employees Security Trust, [P.O. Box 3100, Newport Beach, California 92658-902]7.
- (2) **PLAN IDENTIFICATION NUMBER:** [501].
- (3) **TYPE OF ADMINISTRATION AND TYPE OF WELFARE PLAN:** The plan is administered by the Administrative Representative, named herein. Benefits are insured and provided in accordance with the provisions of the Group Dental Insurance Policy issued by BEST Life and Health Insurance Company at [2505 McCabe Way, Irvine, California 92614].
- (4) **ADMINISTRATIVE REPRESENTATIVE:** The Plan is administered by BEST Life and Health Insurance Company located at [2505 McCabe Way, Irvine, California 92614]. BEST Life's telephone number is [(800) 433-0088].
- (5) **AGENT FOR SERVICE:** The person designated for service of legal process is the General Counsel of BEST Life and Health Insurance Company at the above address.
- (6) **TRUSTEE OF THE PLAN:** The Trustee of the plan is Wells Fargo Bank, N.A. The Trustee's mailing address is [180 South Main Street, 2<sup>nd</sup> Floor, Salt Lake City, Utah 84101].
- (7) **SOURCE OF PLAN CONTRIBUTION:** The contributions necessary to finance the plan are made by the employer and employees.
- (8) **DATE OF END OF THE PLAN'S FISCAL YEAR:** The fiscal year for this plan ends each year on

December 31.

- (9) **CONTINUATION OF DENTAL COVERAGE:** Federal Law (Public Law 99-272) requires Continuation of dental coverage for employers with 20 or more employees. Subject to the 20 employee requirement, You and Your Dependents who are covered under the group dental plan have the right to continue Your group dental coverage if it would terminate for the following specified reasons:
- (a) Termination of employment for any reason, except gross misconduct.
  - (b) Loss of dental plan eligibility due to reduced employment hours.
  - (c) Your employer files for a Chapter 11 reorganization;
  - (d) Your death.
  - (e) Your divorce.
- (10) Your legal separation if You no longer make contributions for spouse coverage.
- (11) A dependent child ceases to be a Dependent (i.e., reaches the maximum age, or becomes married, or is no longer a dependent for income tax purposes).
- (12) A Dependent's loss of eligibility because You become entitled to Medicare Benefits.
- (13) If You or Your Dependent would lose coverage due to one of the reasons in (e), (f), (g) or (h) on the previous page, You or Your Dependent must notify Us so We can give appropriate notice of Continuation rights and the terms which apply to the Continuation. Try to give this notification within 30 days of the event so there can be continuity of coverage.
- (14) If You or Your Dependent elect the continued coverage and make the proper premium payment, the coverage would be continued until the earliest of:
- (a) the due date to pay any required premium (if premium is not paid by that date).
  - (b) the date the continued person becomes covered under another group dental plan or entitled to Medicare Benefits.
  - (c) the date the employer's group dental plan terminates. (If coverage is replaced, the Continuation is continued under the succeeding plan.)
  - (d) a date which is:
    - 1. 18 months from the date coverage would have terminated because Your employment was terminated or eligibility was lost due to reduction in hours. However, if You are determined to have been disabled for Social Security purposes, You can continue coverage for 29 months from the date coverage terminated provided that notice of such determination of disability is given within 60 days and before the end of the 18-month continuation period.
    - 2. 36 months from the date coverage would have terminated, if coverage is continued for any other reason.
- (15) The law permits Us to charge any person electing Continuation of coverage 102% of the cost of coverage to the plan except if the person extends Continuation of coverage to 29 months because of entitlement to Social Security disability Benefits, the law permits Us to charge 150% of the plan's cost for months 19 through 29. Full details of the Continuation will be sent to You or Your Dependents when We have been notified of one of the Continuation events.
- (16) **CLAIM PROCEDURES:** (a) Claim forms may be obtained from the Personnel Department of the employer; and (b) Please see Your insurance Certificate for the requirements of the Group Insurance Policy as to notice of a claim to BEST Life and Health Insurance Company.
- (17) **CLAIMS DENIAL PROCEDURE:** Any denial of a claim for Benefits will be explained in writing and the explanation will include (a) the specific reason for the denial, (b) reference to the plan provision upon which the denial was based, (c) a description of any additional information You might be required to provide and an explanation of why it is needed, and (d) an explanation of the plan's claim review procedure.

- (18) You, Your beneficiary, or a duly-authorized representative may appeal any denial of a claim for Benefits by filing a written request for a review to BEST Life and Health Insurance Company. In connection with such a request, documents pertinent to the administration of the plan may be reviewed, and issues outlining the basis of the appeal may be submitted. You may have representation throughout the review procedure.
- (19) A request for a review must be filed within [180] days after receipt of the written notice of denial of a claim. A decision will be rendered by BEST Life and Health Insurance Company no later than [60] days after receipt of a request for review. If there are special circumstances, the decision shall be rendered as soon as possible, but no later than [15] days after receipt of the request for review. The decision, after Our review, shall be in writing and shall include specific reasons for the decision. This decision shall also include specific references to the pertinent policy provisions on which the decision was based.

#### **PART 9 - STATEMENT OF ERISA RIGHTS**

As a participant in the Plan You are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974. ERISA provides that all Plan participants shall be entitled to:

- (1) Examine, without charge, at the Administrative Representative's office and at other locations, such as work sites and union halls, all Plan documents including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
- (2) Obtain copies of all Plan documents and other Plan information upon written request to the Administrative Representative. The Administrative Representative may make a reasonable charge for the copies.
- (3) Receive a summary of the Plan's annual financial report. The Administrative Representative is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for the Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee Benefit Plan. The people who operate Your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Plan participants and beneficiaries.

No one, including Your employer, Your union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare Benefit or exercising Your rights under ERISA.

If Your claim for a welfare Benefit is denied in whole or in part You must receive a written explanation of the reason for the denial.

You have the right to have the Plan review and reconsider Your claim.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request materials from the Plan and do not receive them within 30 days, You may file suit in a federal court. In such a case, the court may require the Administrative Representative to provide the materials and pay You up to \$100 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrative Representative. If You have a claim for Benefits which are denied or ignored, in whole or in part, You may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if You are discriminated against for

asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a federal court. The court will decide who should pay court costs and legal fees. If You are successful, the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

If You have questions about Your Plan, You should contact the Administrative Representative. If You have any questions about this statement or about Your rights under ERISA, You should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

**Underwritten by BEST Life and Health Insurance Company**

**BEST Life and Health Insurance Company**

2505 McCabe Way  
Irvine, California 92614

A STOCK COMPANY  
(Herein called the Company)

**BEST Life and Health Insurance Company, We, Our or Us**, in consideration of the application of the Subscribing Employer and the payment of premiums as due, agrees, subject to the terms and conditions of this Group Policy, to insure Eligible Employees of Subscribing Employers to the Group Policyholder and their eligible Dependents under this Group Policy..

**GOVERNING JURISDICTION: State of Utah.** The Group Policy is issued in the State of Utah. Its terms are governed by and shall be construed in accordance with the laws of the Governing Jurisdiction.

This Group Policy becomes effective at 12:01 a.m., Standard Time at the office of the Group Policyholder on the Group Policy Effective Date in the State of Delivery specified above. Subject to the terms and conditions of this Group Policy, it can be renewed until the First Renewal Date by timely payment of the required premium by the Group Policyholder. Unless terminated in accordance with the applicable provision of this Group Policy, it can be renewed after such time from month to month, subject to the terms and conditions of this Group Policy, by timely payment of the required premium.

This Group Policy may be modified by mutual agreement between the Group Policyholder and Us.

The provisions on the following pages and the terms in the Certificate are part of this Group Policy. A copy of the Certificate is attached to, and made a part of this Group Policy.

Signed for **BEST Life and Health Insurance Company** by its President at [2505 McCabe Way, Irvine, California 92614.]

[  ]  
President

**Group PPO Dental Policy**  
Non-Participating

**Group Policyholder:** The Trustee of the Beneficial Employees Security Trust of Utah

**Group Policy Effective Date:** [XX-XX-XXXX]

**Group Policy Number:** [XXX]

**State of Delivery:** [Utah]

**Premiums Due On:** [1<sup>st</sup> of each month]

**First Renewal Date:** [XX-XX-XXXX]

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## GENERAL PROVISIONS

**CLERICAL ERROR:** Clerical error by the Group Policyholder shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated.

**Third Party Responsibility:** If an Insured is injured or becomes ill through the act or omission of another person, to the extent that the Insured recovers medical expenses for the same Injury or Illness from a third party or its insurer, We will be entitled to a repayment of such benefits paid under the Policy due to the same Injury or Illness. We may file a lien for such repayment. Upon request, the Insured must complete and return the required forms to Us.

The repayment agreement will be binding upon the Insured, or the legal representative of a minor or incompetent, whether:

- (1) the payment received from the third party, or its insurer, is the result of:
  - legal judgment;
  - an arbitration award;
  - a compromise settlement;
  - any other arrangements; or
- (2) the third party or its insurer had admitted liability for the payment; or
- (3) the medical expenses are itemized in the third party payment.

**Entire Contract:** The Policy (including the employer enrollment application and/or participation agreements and any applications of Insureds) is the entire contract between the Holder and Us. We will consider any statement made by the Insured or the Holder, in the absence of fraud, as a representation and not a warranty.

**Right to Contest:** After the Policy has been in force for [2] years, We will not use any statements made in the application of the Holder to void the Policy. After the Insured has been covered under the Policy for [2] consecutive years, We will not use any statement made in an individual application to defend a claim.

**Notice of Claim:** You must give Us written notice within 20 days after a claim starts or as soon as reasonably possible. The notice is to be sent to Best Life and Health at, [2505 McCabe Way, Irvine, California 92614] or given it to Our agent.

**Claim Forms:** When We receive Your notice of claim, We will send You forms for filing Your claim. If these forms are not given to You within [15] days, You can meet Our requirements by giving Us a written statement. This statement should include the nature and extent of the claim and be sent to Us within the time stated in the Proof of Loss provision.

**Proof of Loss:** You must give Us acceptable written proof of loss within 90 days of Your claim. If it was not possible for You to give proof within the 90 days, We will not deny Your claim for this reason if You send the proof as soon as You can. In any event, You must send Us the proof no later than one year from the time specified, unless You are legally incapacitated.

**Time of Payment of Claims:** Payments for a covered claim will be made to You as they accrue, subject to written proof of loss. Any balance remaining unpaid when Our liability ends will be made immediately upon receipt of written proof of loss.

**Time Limit on Certain Defenses:** After this Group Policy has been in force for [2] years, We will not use any statements made in the application of the Group Policyholder to void the Group Policy. After coverage for a Subscribing Employer has been in force for [2] years, We will not use any statements in the Subscribing Employer's application in a contest of coverage under this Group Policy. After an Insured Person has been covered under this Group Policy for [2] years, We will not use any statement made in the Insured Person's enrollment form to defend a claim.

**Payment of Claims:** All payments will be made to You, Your Dentist, or Your Ophthalmologist or Optometrist.

**Legal Actions:** You may not bring legal action against Us before [60] days, or after [3] years, from the date written proof of loss is required to be given.

**Misstatement of Age:** If the age of any individual covered under the Policy has been misstated, there shall be an adjustment of premium for the Policy so that there shall be paid to Us the premium for the coverage of such individual at his or her correct age, and the amount of the insurance coverage shall not be affected.

**Non-Participation:** This Policy is a non-participating Policy and as such neither the Policyholder nor this Policy participates in the profits or surplus earnings of the Company.

**Worker's Compensation:** The Policy is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

**Conformity with State Statutes:** Any provisions of the Policy which are in conflict with the statutes of the state in which the Policy was issued or delivered will be changed to conform to such laws.

**Waiver of Rights:** If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date, nor will it affect Our right to enforce any other provision of the Policy.

**Inspection of Group Policy:** The Group Policy is in the possession of the Policyholder. It may be inspected at any time during business hours at the office of the Policyholder.

**Duty to Cooperate:** As a condition precedent to the payment of benefits hereunder, You are required to cooperate with Us by providing all information reasonably required to accurately process Your claim... Any failure by You to provide necessary information may result in a denial of benefits for Your claim.

## PREMIUM PROVISIONS

**PREMIUM PAYMENTS:** Renewal premiums are payable to Us. The payment of any premium shall not continue this Group Policy in force beyond the next premium due date, except as provided in the Grace Period Provision.

**CHANGES IN PREMIUM:** We may change the amount of the required premium due from the Group Policyholder by giving the Group Policyholder at least [60] days advance written notice. [During the first [12] [24] months, We will not change the amount of the required premium.

**GRACE PERIOD:** This Group Policy has a [31] day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following [31] days. During the Grace Period, this Group Policy will remain in force. If the required premium is not paid by the end of this Grace Period, this Group Policy will lapse as of the premium due date.

#### **TERMINATION OF THIS GROUP POLICY**

We may terminate this Group Policy at any time following the first renewal date by giving the Group Policyholder written notice at least [60] days in advance. The Group Policyholder may also terminate this Group Policy by giving Us written notice at least [60] days before the intended termination date. This Group Policy will also terminate if the required premium is not paid by the Group Policyholder as provided in the Grace Period provision.

**BEST Life and Health Insurance Company**

[2505 McCabe Way  
Irvine, California 92614]

A STOCK COMPANY  
(Herein called the Company)

**BEST Life and Health Insurance Company** will insure You, the Insured, and Your covered Dependents if dependent insurance is elected as shown on the Statement of Coverage Sticker, affixed below.

**GOVERNING JURISDICTION: State of Utah.** The Group Policy is issued in the State of Utah. Its terms are governed by and shall be construed in accordance with the laws of the Governing Jurisdiction.

**PLAN EFFECTIVE DATE:** This Certificate is a condensed version of the Group Policy issued to the Policyholder named on the Schedule of Benefits. The Group Policy alone is the basis by which payments are made. This Certificate supersedes and replaces any which may have been issued to You previously.

Signed for **BEST Life and Health Insurance Company** by its President at [2505 McCabe Way, Irvine, California 92614].

[ \_\_\_\_\_ ]  
President

**GROUP PPO DENTAL CERTIFICATE  
NON-PARTICIPATING**

**THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR PARTICIPATING EMPLOYER TO DETERMINE WHETHER YOUR PARTICIPATING EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.**

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**PART 1 - SCHEDULE OF DENTAL BENEFITS**

This Certificate of Group Coverage is validated by the attachment of a “Statement of Your Coverage Sticker” affixed to the Schedule of Benefits.

The policy is issued by **BEST Life and Health Insurance** to:  
**THE TRUSTEE OF THE BENEFICIAL EMPLOYEES SECURITY TRUST OF UTAH**

**SCHEDULE OF DENTAL BENEFITS**

On this Preferred Provider Dental Plan dental services rendered by a Network Provider are based upon the Fee Schedule of the Preferred Provider Network You have selected. Services rendered by a Non-network Provider are payable on a [Usual, Reasonable and Customary] [Maximum Allowable Charge] basis, subject to the Deductible and the Maximum Benefit Limits shown in this Schedule of Benefits. Please refer to the [Usual, Reasonable and Customary] [Maximum Allowable Charge] definitions in the “Definition” of this Certificate.

<b>Benefits Description</b>	<b>Network</b>	<b>Non-Network</b>
<b>Calendar Year Maximum (per enrollee)</b>	[\$2,500 - \$500]	[\$2,500 - \$500]
<b>Individual Yearly Deductible</b>	[\$100 - \$0]	[\$100 - \$0]
<b>Family Yearly Deductible</b>	[\$300 - \$0]	[\$300 - \$0]
<b>Class I: Preventive Care Services</b> Routine oral exam, cleanings, fluoride treatment for children, x-rays, sealants	[100% - 50%] [No or After] deductible	[100% - 50%] [No or After] deductible
<b>Class II: Basic Services</b> Fillings (amalgam, porcelain & plastic), general anesthesia, emergency palliative treatment, space maintainers for children, pathology, posterior composites[,simple and surgical extractions] [, oral surgery] [, endodontics] [, and periodontics]	[100% - 50%] After deductible	[100% - 50%] After deductible
<b>Class III: Major Services</b> Crowns & gold fillings, inlays, onlays and pontics, fixed bridges, complete and partial dentures[,complex oral surgery][, implants] [,oral surgery] [,endodontics] [, and periodontics]	[100% - 0%] After deductible [[12, 18 or 24]-month wait*]	[100% - 0%] After deductible [[12, 18 or 24]-month wait*]
<b>[Class IV: Orthodontics]</b> [For eligible dependent children through age 20 only] [For eligible dependent children and adults]	[60% - 50%] [\$2,500 - \$1,000 Lifetime Maximum] [[12, 18 or 24]-month wait*]	
<b>[Children's Good Vision Benefit]</b> For dependent children through age 20 only]	[Covers 50% of eligible expenses for a vision exam once every 12 months] [[12, 18 or 24]-month wait*]	
[*Unless the requirements for the Major Dentistry Waiting Period Waiver have been met, Major Dental and Orthodontic Procedures and the Children’s Good Vision Benefit are not eligible covered expenses for any Insured during the [12, 18 or 24]-month period immediately following their effective date. Please see Major Dentistry Waiting Period Waiver Provision.]		
<b>Special Dental Accident Benefit</b>	Covers injury to sound, natural teeth up to [\$1,000 or \$500] per accident	

### **Major Dentistry Waiting Period Waiver**

The [6, 12, 18 or 24]-month waiting period for Basic Services and/or Major Dental Procedures (Class III) is waived if “Yes” is indicated after “Waiting Period Waived on Major Dentistry” on the Statement of Coverage sticker.

This Waiver only applies if the Participating Employer is replacing comparable existing dental coverage that was in force for at least [12] consecutive months immediately prior to the Effective Date of this Plan’s coverage and the Employee has been covered: (a) under the prior dental plan for a period of [12] consecutive months; (b) [12] months between the Employee’s prior Employer’s dental plan and this plan; or (c) [12] months under this dental plan, whichever occurs first.

The Waiver of this waiting period does NOT apply to: (a) the Employee’s eligible dependents who were not covered for a period of at least [12] consecutive months between the employer’s prior dental plan and this dental plan, or [12] months under this dental plan, whichever occurs first, or (b) the Employee’s eligible dependents whose effective date of coverage under this plan is later than the Employees’ effective date of coverage.

Waiver of the waiting period shall not be construed to alter any provisions of the Major Dental Procedures.

## **DENTAL PLAN EXCLUSIONS AND LIMITATIONS**

### **Limitations**

#### **Covered Dental Benefit Expenses**

We will pay for the following dental services and supplies furnished by a doctor of medical dentistry or a doctor of dental surgery. Expenses must be [Usual, Reasonable and Customary] [Maximum Allowable Charge] and incurred while You or Your Dependent are covered under the policy. If more than one treatment plan exists for a dental procedure, covered dental expenses will be based on the least expensive procedure that will produce a result that meets professionally recognized standards. Payments are subject to the Individual Calendar Year Deductible, Percentage Payable and Maximum Benefit Limits shown in the Schedule of Dental Benefits and the Dental Limitations and Exclusions.

#### **Maximum Benefit Limits**

The total amount of Benefits payable under the policy for any person will not exceed the Maximum Benefit Limits of the Preferred Provider Plan.

#### **CLASS I - Preventive Dental Procedures:**

- (1) [routine oral examination and diagnosis not more often than once every [6] months per individual;
- (2) x-rays not more often than once every [6 or 12] months per individual ([panoramic or] full mouth x-rays are limited to once in a [3-year or 5-year] period);
- (3) prophylaxis not more often than once every six months per individual;
- (4) one annual topical fluoride treatment through age [15];
- (5) sealants for Your dependent child under age [15], limited to treatment of permanent molars once in any [36]-month period.]

**CLASS II - Basic Dental Procedures:**

- (1) [pathology;
- (2) all fillings other than lab fabricated restorations (composite fillings limited to permanent anterior and posterior teeth) [(same surface fillings limited to once every [2] years)];
- (3) space maintainers for Your dependent child under age [17];
- (4) emergency palliative treatment;
- (5) simple extraction;
- (6) surgical extraction, including impaction:
  - (a) ]erupted;
  - (b) soft tissue impaction;
  - (c) partial bony impaction;
  - (d) complete bony impaction;]
- (7) general anesthesia - paid as a separate procedure only when required for complex oral surgical procedures, as determined by us, for which Benefits are payable.;
- (8) periodontics (tissues and gums);
- (9) periodontal maintenance (limited to once every [3] months per individual following active periodontal treatment);
- (10) periodontal scaling and root planing (limited to once every [36 month] [and to [2] quadrants per visit]);
- (11) endodontics (pulp capping and root canal); and
- (12) oral surgery:
  - (a) root recovery (surgical removal of residual root);
  - (b) removal of a dentigerous or odontogenic cyst;
  - (c) incision and drainage of an abscess;
  - (d) surgical exposure of impacted tooth to aid eruption;
  - (e) removal of exostosis;
  - (f) frenulectomy;
  - (g) oral antral fistula closure.]
  - (h) [simple extraction;
  - (i) surgical extraction, including impaction:
    - i. erupted;
    - ii. soft tissue impaction;
    - iii. partial bony impaction;
    - iv. complete bony impaction;]

**CLASS III - Major Dental Procedures:**

- (1) [inlays, onlays, crowns and other lab fabricated restorations [(if the tooth can be restored with less expensive materials, covered expenses will be based on those materials)];
- (2) porcelain, porcelain fused to metal, or full gold crowns are limited to patients over the age of [14] and on permanent teeth;
- (3) full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within [12] months after the extraction and while this coverage is in force;
- (4) replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
  - (a) accidental injury requiring oral surgical treatment, or
  - (b) oral surgical treatment involving the repositioning of muscle attachments, or the removal

- of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within [12] months of the injury or surgical treatment.
- (4) replacement of a full denture or bridgework if the replacement is made more than [five or seven] years after the date of installation;
  - (5) repair or relines of dentures and bridgework;
  - (6) implants (limited to once in a lifetime per site, and for patients over the age of [16]):
    - (a) the surgical placement of endosteal implant body including healing cap, where the bone and soft tissues are sound and healthy;
    - (b) implant supported prosthetics;
    - (c) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);
    - (d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;
  - (7) periodontics (tissues and gums);
  - (8) periodontal maintenance (limited to once every [3] months per individual following active periodontal treatment);
  - (9) periodontal scaling and root planing (limited to once every [36] months);
  - (10) endodontics (pulp capping and root canal); and
  - (11) oral surgery:
    - (a) root recovery (surgical removal of residual root);
    - (b) removal of a dentigerous or odontogenic cyst;
    - (c) incision and drainage of an abscess;
    - (d) surgical exposure of impacted tooth to aid eruption;
    - (e) removal of exostosis;
    - (f) frenulectomy;
    - (g) oral antral fistula closure.]
    - (h) [simple extraction;
    - (i) surgical extraction, including impaction:
      - (i) erupted;
      - (ii) soft tissue impaction;
      - (iii) partial bony impaction;
      - (iv) complete bony impaction;]

### **Exclusions**

No payments will be made for and covered dental expenses do not include:

- (1) [treatment by someone other than a dentist or physician, except where performed by a duly qualified technician under the direction of a dentist or physician;
- (2) expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
- (3) an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
- (4) [pulp capping, if in conjunction with the installation of inlays, onlays or crowns;]
- (5) replacement of a lost or stolen or discarded prosthetic device;
- (6) dental services and supplies which are given primarily for cosmetic reasons including alteration

- or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
- (7) the replacement of any prosthesis (a crown, [implant,] fixed bridge or denture) if such prosthesis was installed less than [five or seven] years before, unless:
    - (a) such replacement is made necessary by the initial extraction of an adjoining functional natural tooth;
    - (b) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non-chewing injury while covered;
  - (8) the initial installation of a prosthetic device (a[n implant,] fixed bridge or denture), including crowns and inlays which form abutments, to replace teeth missing before You were covered under the policy, except when it also replaces a tooth that is extracted while covered unless such installation commences after You have remained continuously covered under this plan for at least [3] years immediately prior to the date such installation commences;
  - (9) expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are covered under the plan.
  - (10) expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
  - (11) charges in excess of [Usual, Reasonable and Customary] [Maximum Allowable] charges;
  - (12) services and supplies not reasonably necessary;
  - (13) charges for service provided for temporomandibular joint dysfunction (TMJ);
  - (14) services and supplies covered under any Worker's Compensation Act or similar law;
  - (15) services and supplies performed outside of the United States of America;
  - (16) expenses incurred for congenital or developmental malformations;
  - (17) [expenses incurred for dental implants and related procedures, including but not limited to endosteal and subperiosteal;]
  - (18) [implants, implant services and implant supported prosthetics are not covered for patients under the age of sixteen;]
  - (19) [expenses incurred for the maintenance of dental implants;]
  - (20) any services or supplies for correction or alteration of occlusion, or any occlusal adjustments;
  - (21) charges for prescribed drugs, pre-medication or analgesia;
  - (22) expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
  - (23) expenses incurred for night guards or any other appliances for the correction of harmful habits;
  - (24) expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, Your lawful spouse, child, parent, step-parent, grandparent, brother, sister or in-law;
  - (25) expenses incurred due to treatment rendered by Your employer;
  - (26) expenses not otherwise specifically listed as a Covered Expense;
  - (27) expenses for services for which You would not legally have to pay if there were no insurance;
  - (28) for services not completed on or before the date of termination unless the services are covered under the Extension of Dental Benefits;
  - (29) expenses that are applied toward satisfaction of a Deductible, if any;
  - (30) for procedures that are begun, but not completed;
  - (31) adjustment, repairs or relines of prostheses for a period of six months from initial placement if the prostheses were paid for under this plan;
  - (32) if an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
  - (33) if multiple endodontic treatments are necessary on the same tooth within a period of one year,

- the allowance will be made for only one procedure;
- (34) the extraction of immature erupting third molars and non-pathologic, asymptomatic third molar extractions;
  - (35) temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
  - (36) expenses for gross debridement allowed one time at the beginning of the periodontal treatment plan prior to pocket depth charting;
  - (37) surgical procedures incidental to orthodontic treatment, including but not limited to, extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate;
  - (38) any amounts in excess of the maximum amount stated in the "Schedule of Dental Benefits" section of this Plan;
  - (39) application of chemotherapeutic agents; and
  - (40) ridge augmentation, ridge preservation, bone graft and guided tissue regeneration in extraction sites;
  - (41) charges in excess of the Preferred Provider Fee Schedule.]

## **PART 2 - OPTIONAL ORTHODONTIC BENEFITS AND SPECIAL CHILDREN'S GOOD VISION BENEFIT**

These benefits will apply to you only if this coverage was selected and is shown on your enrollment card or if Your Certificate contains a validation sticker indicating that this coverage was selected.

### **[ORTHODONTIC BENEFITS**

Orthodontia Type Treatments and Orthodontic Procedures are limited to Your Dependent Children through age [20]. A [12, 18 or 24]-Month Waiting Period applies to this Plan and is not a covered expense during the [12]-Month Period immediately following the effective date of coverage. The Maximum Benefit limit that will be paid while an Insured is covered under this Plan is shown in PART 1 - Schedule of Benefits.

Individual calendar year deductibles do not apply to Orthodontic procedures and Benefits are payable on a Usual, Reasonable and Customary Basis, subject to the Maximum Benefit Limits shown on the Schedule of Benefits in PART 1.

The Orthodontic Benefit will cease once braces are removed.]

### **[SPECIAL CHILDREN'S GOOD VISION BENEFIT**

The Good Vision Benefit is limited to an Employee's Dependent Children through age 20. This Benefit is not a covered expense during the [12, 18 or 24]-Month Period immediately following Your Dependent Child's effective date of coverage.

For Good Vision Benefits we will pay for a vision exam once every [12] months for dependent children. This Benefit includes one annual case history, refraction and checking of eye wear against prescription if required.

We will pay for the following vision examination services furnished by a licensed ophthalmologist or optometrist. These services will include one annual case history, refraction and checking of eye wear against prescription if required. Individual calendar year deductibles do not apply. Expenses must be Usual, Reasonable and Customary and incurred while Your Dependent is covered under the Policy.

Payments are subject to the Individual Calendar Year Deductible, Percentage Payable and Maximum Benefit Limits shown in the Schedule of Dental Benefits and the Dental Limitations and Exclusions.]

### [SUPPLEMENTAL DENTAL ACCIDENT BENEFIT

#### **Advance Notice of Dental Treatment**

Unless the charges are less than \$[300], or for emergency treatment, the Insured's dentist must submit written advance notice and x-rays before treatment begins for our approval for eligible expenses and allowances. Please see **Advance Notice of Treatment** in PART 6 of this certificate for a complete description of this requirement.

We will pay a Supplemental Accident Benefit if You or Your covered Dependent incur covered dental expenses as a result of an accidental injury to natural teeth while this coverage is in effect. The term "functional natural teeth" means a tooth that is natural, whole, vital and free of disease or major repair.

The Benefit payable will be [100]% of the Usual, Reasonable and Customary expenses, up to a maximum of [\$1,000 or \$500] per accident. The Benefit is not subject to any Individual or Family Deductibles or any waiting periods.]

#### **[Supplemental Accident Limitations and Exclusions**

The Supplemental Accident Benefit does not cover:

- (1) an accidental injury occurring before You or Your Dependent are covered;
- (2) any expenses incurred after the [12]-month period immediately following the accidental injury;
- (3) the portion of an expense paid under another part of the Policy, or paid under any other Group Policy; or
- (4) an expense incurred as a result of sickness.]

### **PART 3 - DEFINITIONS**

**Allowable Expense:** Means any Usual, Reasonable and Customary item of expense, at least a portion of which is covered under at least one of the Plans covering the person for whom claim is made. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an allowable expense and a benefit paid.

**Claim Determination Period:** Means a Calendar Year.

**Eligible Dependent:** Means:

- (1) Your lawful spouse, and
- (2) Your or Your spouse's child or children, including a natural child, step-child, foster child, lawfully adopted child or child in the process of being adopted, from the date of placement, or any child for whom You have been granted legal custody, provided they are:
  - (a) unmarried; and
  - (b) for residents of Utah, through age 25; or

- (c) for residents of Texas, through age 24; or
- (d) for residents of other states, through age 20, extended through age 25 if a full-time student at an educational institution.

(3) A child named in a Qualified Medical Child Support Order will be considered a dependent.

**“Eligible Dependent”** also means a dependent child, who upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within [31] days after the termination age, the child will continue to qualify as a dependent under this plan, provided You and the dependent child continue to be insured under this plan, and the child continues to be handicapped and dependent upon You for support. This shall not apply to a dependent child who is beyond the termination age on the date You become eligible for dependent insurance under this Policy.

**Eligible Employee:** Means:

- (1) A full-time permanent employee who is:
  - (a) permanently employed, working at least 30 hours per week and paid a salary, wages, or earnings from which federal and state tax and Social Security deductions are made; and
  - (b) not covered by a collective bargaining agreement which requires Your Participating Employer to make contributions; or
- (2) A partner or proprietor actively engaged in the business on a full-time basis.

**"Eligible Employee"** does not mean an independent contractor, commission salesperson, consultant or a person who is in any manner self-employed.

**Expenses Incurred:** An Eligible Expense is considered incurred on the following dates:

- (1) For dentures - the date the final impression is taken.
- (2) For fixed bridges, implants crowns, inlays and onlays - the date the teeth are first seated (permanently placed).
- (3) For root canal therapy - the date the pulp chamber is opened.
- (4) For periodontal surgery - the date surgery is performed.
- (5) For all other services - the date the service is performed.

**Family Calendar Year Deductible:** Satisfaction of [3] Individual Calendar Year Deductibles.

**Grace Period:** A Grace Period of thirty-one [(31)] days from the due date will be allowed for payment of each premium after the first. This coverage will remain in effect during the Grace Period; provided the premium is paid before the end of the Grace Period.

**Insured:** Means an eligible employee or any of the Employee's eligible covered Dependents who are insured under the Group Policy.

**[Maximum Allowable Charge:** Means the fee shown in the Preferred Provider Fee Schedule for dental services and supplies generally furnished for cases of comparable severity and nature. For vision services and Non-Preferred Provider dental services, Maximum Allowable Charge means the plan will pay a reasonable fee based on a fee level which is in the same range of fees customarily charged for the services or supplies in the geographic area concerned.]

**[Maximum Rollover:** Means the maximum amount of the unused portion of the previous years annual maximum that you may roll over to the current years annual maximum.

**Month:** Means a period of time beginning and ending with the same date each calendar month. If a succeeding calendar month has no such date, the last day of that month will be used.

**Participating Employer:** Means an employer who is a subscriber to the Group Policy.

**Plan:** Means any Plan providing benefits or services for or by reason of dental or vision care or treatment, which benefits or services are provided in: (1) group, blanket or franchise insurance coverage; (2) group practice and other group prepayment coverage; (3) group service Plans; (4) any coverage under labor management trustee Plans, union welfare Plans, Employer organization Plans or Employee benefit organization Plans; and (5) any coverage under governmental programs, and any coverage required or provided by any statute. The term "Plan" shall not include any plan of individual coverage or school or church accident type coverages.

The term "Plan" shall be construed separately with respect to each Policy, contract or other arrangement for benefits or services and separately with respect to that portion of such Policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

**Subscriber:** Means a participating employer who meets all the eligibility, participation and enrollment requirements established under the Group Policy.

**[Usual, Reasonable and Customary:** Means the fee shown in the Preferred Provider Fee Schedule for dental services and supplies generally furnished for cases of comparable severity and nature. For vision services and Non-Preferred Provider dental services, Usual, Reasonable and Customary means the plan will pay a reasonable fee based on (a) what is usually and customarily accepted as payment for dental and vision services and supplies generally furnished for cases of comparable severity and nature within the geographic area in which the services or supplies are furnished; and (b) a fee level which is in the same range of fees customarily charged for the services or supplies in the geographic area concerned.]

**We, Our or Us:** Means BEST Life and Health Insurance Company.

**You or Your:** Means the Insured.

#### **PART 4 - PROVISIONS FOR COVERAGE**

##### **EFFECTIVE DATE**

**Employee:** If You fill out and sign an enrollment card furnished by Us, Your insurance will take effect on the later of:

- (1) the date Your employer becomes a Participating Employer, if Your enrollment card is received by Us within [31] days of that date; or
- (2) the first day of the next calendar month following the date You complete one calendar month of active full-time employment for a Participating Employer. Your enrollment card must be received by Us within [31] days after You satisfy the waiting period.

[If Your enrollment card is received by Us more than [31] days after You become eligible, You will be considered a LATE ENTRANT. A "late entrant" shall only be eligible for CLASS I - Preventive Dental Procedures during the first [12] months of continuous coverage.

During the second [12] months of continuous coverage, a "late entrant" shall only be eligible for CLASS I - Preventive Dental Procedures and for [50]% of the Benefits for CLASS II - Basic Dental Procedures. During this second [12] months of continuous coverage, the "late entrant" Benefits shall not exceed a maximum of \$[500].

The "late entrant" Benefits are subject to the Individual Calendar Year Deductible and Percentage Payable shown in the Schedule of Benefits of this Certificate, except as stated for Basic Dental Procedures above.]

If You are not working full-time on the date Your coverage would otherwise take effect, You will not be covered until You return to active full-time employment.

**Dependent:** Your Dependent's insurance will take effect on the later of:

- (1) the date Your insurance is effective, if the enrollment card is received by Us within [31] days of that date; or
- (2) the first day of the next calendar month following the date You enroll in writing for dependent insurance. Such enrollment must be within [31] days of the Dependent first becoming eligible.

If We receive Your Dependent enrollment card more than [31] days after a Dependent becomes eligible, Your Dependent will be considered a LATE ENTRANT. A "late entrant" shall only be eligible for CLASS I - Preventive Dental Procedures during the first [12] months of continuous coverage.

During the second [12] months of continuous coverage, a "late entrant" shall only be eligible for CLASS I - Preventive Dental Procedures and for [50]% of the Benefits for CLASS II - Basic Dental Procedures. During this second [12] months of continuous coverage, the "late entrant" Benefits shall not exceed a maximum of \$[500].

The "late entrant" Benefits are subject to the Individual Calendar Year Deductible and Percentage Payable shown in the Schedule of Benefits of this Certificate, except as stated for Basic Dental Procedures above.

If a Dependent, other than a newborn dependent, is confined in a medical facility on the date his or her insurance would otherwise take effect, that Dependent will not be covered until the confinement ends.

Your dependent insurance will continue as long as Your Dependents remain eligible, contributions are made, and Your insurance remains in effect.

## **TERMINATION OF INSURANCE**

**Employee:** Except as provided in the Extension of Dental Benefits, Your insurance will stop on the earliest of the following dates:

- (1) [the last day of the month in which You cease active employment, unless You are on leave of absence, temporary layoff or total disability. In that case, Your employer may continue Your insurance by paying the required premium, but not beyond the following limits:
  - (a) approved leave of absence, [3] months;
  - (b) temporary layoff, the end of the month following the month, in which Your layoff started;
  - (c) total disability, [3] months; or
- (2) the last day of the month in which You cease to be in a class of employees eligible for insurance;
- (3) the date Your employer ceases to be a Participating Employer;
- (4) the day before the due date of any premium that remains unpaid at the end of the grace period;
- (5) the date the policy terminates; or
- (6) the date the number of insured employees of a Participating Employer falls below [3.]

**Dependent:** Except as provided in the Extension of Dental Benefits, Your dependent's insurance will stop on the earliest of the following dates:

- (1) [the date Your insurance terminates;
- (2) the date You fail to make a contribution for dependent insurance;
- (3) the date You cease to be in a class eligible for dependent insurance; or
- (4) the last day of the month in which a dependent ceases to meet the definition of "Dependent."]

If a dependent child, upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within [31] days after the termination age, We will continue coverage as long as Your coverage continues and the child continues to be handicapped and dependent upon You for support.

## **PART 5 - PROVISIONS DESCRIBING BENEFITS**

### **ADVANCE NOTICE OF DENTAL TREATMENT**

It is recommended that You or Your Dependent submit Advance Notice of Dental Treatment satisfactory to Us before treatment commences in order to obtain predetermination of covered dental expenses. If dental services are performed without such predetermination, We reserve the right to deny any claim submitted with respect to such services; provided however, that predetermination is not required for:

- (1) dental services for which the amount of covered dental charges is less than \$[500] during any course of treatment ("course of treatment" means one treatment or one of a planned series of treatments resulting from dental examination);
- (2) emergency treatment; or
- (3) oral examination and prophylaxis.

### **DEDUCTIBLES**

**[Individual Calendar Year Deductible:** The Plan Deductible shown in the Schedule of Dental Benefits will apply separately to each Insured during each Calendar Year. To satisfy the Deductible, You or Your covered Dependent must accumulate eligible expenses equal to the deductible amount.]

**[Family Calendar Year Deductible:** The Family Calendar Year Deductible is satisfied when [each of [3, 2] covered members of Your family satisfy the Individual Calendar Year Deductible] [the combined costs of services provided by covered members of Your family is equal to the Family Calendar Year Deductible amount.]

**[Deductible Carry-Over:** Although a new deductible will apply each calendar year, eligible expenses incurred during the last [3] months of a calendar year, which are applied toward satisfaction of that Calendar Year's Deductible, will also be applied toward satisfaction of the deductible for the next calendar year, provided no other eligible dental procedure expenses were incurred during the current calendar year.]

**Percentage Payable:** After the deductible is satisfied, We will pay Benefits for eligible expenses at the percentage shown in the Schedule of Dental Benefits.

**Maximum Benefit Limits:** The total amount of Benefits payable under the policy for any person will not exceed the Maximum Benefit Limits of the Preferred Provider Plan.

**[Maximum Rollover:** BEST Life will roll over a portion of Your unused annual maximum to the following years Annual Maximum]

#### **ALTERNATIVE PROCEDURES**

If more than one treatment plan exists for a dental procedure, covered dental expenses will be based on the least expensive procedure that will produce a result that meets professionally recognized standards. If you and your dentist decide that you want the more expensive treatment, you may be responsible for any charges that are greater than the covered expense for the less expensive treatment.

#### **EXTENSION OF DENTAL BENEFITS**

**Extension of Dental Benefits:** We will continue to pay dental Benefits for [30] days following the date Your coverage or Your Dependent's coverage terminates if:

- (1) the expenses incurred would have been eligible for payment had coverage remained in effect; and
- (2) the impression for a prosthetic device or modification had been taken before termination and delivered and installed within [30] days following the termination of coverage; or
- (3) in the treatment of root canal therapy, Your pulp chamber was opened before termination.

#### **PART 6 - COORDINATION OF BENEFITS**

**Benefits Subject to this Provision:** All of the benefits provided under the Policy are subject to this provision.

#### **Effect on Benefits:**

- (1) This provision shall apply in determining the benefits as to a person covered under this Plan for any Claim Determination Period if, for the Allowable Expenses incurred as to such person during such period, the sum of:
  - (a) the benefits that would be payable under this Plan in the absence of this provision; and
  - (b) the benefits that would be payable under all other Plans in the absence therein of provisions of similar purpose to this provision would exceed such Allowable Expenses.
- (2) As to any Claim Determination Period with respect to which this provision is applicable, the benefits that would be payable under this Plan in the absence of this provision for the Allowable Expenses incurred as to such person during such Claim Determination Period shall be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such Allowable Expenses under all other plans, except as provided in the next paragraph, shall not

exceed the total of such Allowable Expenses. Benefits payable under another Plan include the benefits that would have been payable had claim been duly made therefore.

- (3) If:
- (a) another Plan which is involved in paragraph (2) and which contains a provision coordinating its benefits with those of this Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined, and
  - (b) the rules set forth in paragraph (4) would require this Plan to determine its benefits before such other Plan, and then the benefits of such other Plan will be ignored for the purposes of determining the benefits under this Plan.
- (4) For the purposes of paragraph (3), the rules establishing the order of benefit determination are:
- (a) The benefits of a Plan which covers the person on whose expenses claim is based other than as a Dependent shall be determined before the benefits of a Plan which covers such person as a Dependent.
  - (b) The benefits of a Plan which covers the person on whose expenses claim is based as a Dependent of the parent whose birthday comes earliest in the year, regardless of the year of birth, shall be determined before the benefits of a Plan which covers such person as a Dependent of the other parent except that in the case of a person for whom claim is made as a dependent child:
    - 1. when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Plan which covers the child as Dependent of the parent with custody of the child will be determined before the benefits of a Plan which covers the child as a Dependent of the parent without custody;
    - 2. when the parents are divorced and the parent with custody of the child has remarried, the benefits of a Plan which covers the child as a Dependent of the parent with custody shall be determined before the benefits of a Plan which covers that child as a Dependent of the stepparent, and the benefits of a Plan which covers the child as a Dependent of the stepparent will be determined before the benefits of the parent without custody. Notwithstanding 1. and 2. above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefits of a Plan which covers the child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan which covers the child as a dependent child.
  - (c) When rules (a) and (b) do not establish an order of benefit determination, the benefits of a Plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a Plan which has covered such person the shorter period of time.
- (5) When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during any Claim Determination Period, each benefit that would be payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of this Plan.
- (6) No Plan pays more than it would without the Coordination of Benefits provision.

**Right to Receive and Release Necessary Information:** For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provisions of similar purpose of any other Plan, We may, with the consent of any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which We deem to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to Us such

information as may be necessary to implement this provision.

**Facility of Payment:** Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other Plans, We shall have the right, exercisable alone and in Our sole discretion, to pay over to any organizations making such other payments any amounts We shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, We shall be fully discharged from liability under this Plan.

**Right to Recovery:** Whenever payments have been made by Us with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, We shall have the right to recover such payments, to the extent of such excess, from among one or more of the following: any persons to or for or with respect to whom such payments are made, any other insurers, service Plans or any other organizations.

## **PART 7 - GENERAL PROVISIONS**

**Third Party Responsibility:** If an Insured is injured or becomes ill through the act or omission of another person, to the extent that the Insured recovers medical expenses for the same Injury or Illness from a third party or its insurer, We will be entitled to a repayment of such benefits paid under the Policy due to the same Injury or Illness. We may file a lien for such repayment. Upon request, the Insured must complete and return the required forms to Us.

The repayment agreement will be binding upon the Insured, or the legal representative of a minor or incompetent, whether:

- (1) the payment received from the third party, or its insurer, is the result of:
  - legal judgment;
  - an arbitration award;
  - a compromise settlement;
  - any other arrangements; or
- (2) the third party or its insurer had admitted liability for the payment; or
- (3) the medical expenses are itemized in the third party payment.

**Entire Contract:** The Policy (including the employer enrollment application and/or participation agreements and any applications of Insureds) is the entire contract between the Policyholder and Us. We will consider any statement made by the Insured or the Policyholder, in the absence of fraud, as a representation and not a warranty.

**Right to Contest:** After the Policy has been in force for [ 2] years, We will not use any statements made in the application of the Policyholder to void the Policy. After the Insured has been covered under the Policy for [2] consecutive years, We will not use any statement made in an individual application to defend a claim.

**Notice of Claim:** You must give Us written notice within [20] days after a claim starts or as soon as reasonably possible. The notice is to be sent to BEST Life and Health at [2505 McCabe Way, Irvine, California 92614] or given it to Our agent.

**Claim Forms:** When We receive Your notice of claim, We will send You forms for filing Your claim. If these forms are not given to You within [15] days, You can meet Our requirements by giving Us a written statement. This statement should include the nature and extent of the claim and be sent to Us within the time stated in the Proof of Loss provision.

**Proof of Loss:** You must give Us acceptable written proof of loss within [90] days of Your claim. If it was not possible for You to give proof within the [90] days, We will not deny Your claim for this reason if You send the proof as soon as You can. In any event, You must send Us the proof no later than [one] year from the time specified, unless You are legally incapacitated.

**Time of Payment of Claims:** Payments for a covered claim will be made to You as they accrue, subject to written proof of loss. Any balance remaining unpaid when Our liability ends will be made immediately upon receipt of written proof of loss.

**Payment of Claims:** All payments will be made to You, Your Dentist, [or Your Ophthalmologist or Optometrist].

**Legal Actions:** You may not bring legal action against Us before [60] days, or after [3] years, from the date written proof of loss is required to be given.

**Misstatement of Age:** If the age of any individual covered under the Policy has been misstated, there shall be an adjustment of premium for the Policy so that there shall be paid to Us the premium for the coverage of such individual at his or her correct age, and the amount of the insurance coverage shall not be affected.

**Worker's Compensation:** The Policy is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

**Conformity with State Statutes:** Any provisions of the Policy which are in conflict with the statutes of the state in which the Policy was issued or delivered will be changed to conform to such laws.

**Waiver of Rights:** If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date, nor will it affect Our right to enforce any other provision of the Policy.

**Inspection of Group Policy:** The Group Policy is in the possession of the Policyholder. It may be inspected at any time during business hours at the office of the Policyholder.

**Duty to Cooperate:** As a condition precedent to the payment of benefits hereunder, You are required to cooperate with Us by providing all information reasonably required to accurately process Your claim... Any failure by You to provide necessary information may result in a denial of benefits for Your claim.

## **PART 8 - SUMMARY PLAN DESCRIPTION SUPPLEMENT**

The following information is required by the Employee Retirement Income Security Act of 1974 (ERISA), and together with the rest of Your Certificate, it forms the Summary Plan Description.

- (1) **EMPLOYER AND NAME OF PLAN:** The plan is known as the Beneficial Employees Security Trust and is maintained by Beneficial Employees Security Trust, [P.O. Box 3100, Newport Beach, California 92658-902]7.

- (2) **PLAN IDENTIFICATION NUMBER:** [501].
- (3) **TYPE OF ADMINISTRATION AND TYPE OF WELFARE PLAN:** The plan is administered by the Administrative Representative, named herein. Benefits are insured and provided in accordance with the provisions of the Group Dental Insurance Policy issued by BEST Life and Health Insurance Company at [2505 McCabe Way, Irvine, California 92614].
- (4) **ADMINISTRATIVE REPRESENTATIVE:** The Plan is administered by BEST Life and Health Insurance Company located at [2505 McCabe Way, Irvine, California 92614]. BEST Life's telephone number is [(800) 433-0088].
- (5) **AGENT FOR SERVICE:** The person designated for service of legal process is the General Counsel of BEST Life and Health Insurance Company at the above address.
- (6) **TRUSTEE OF THE PLAN:** The Trustee of the plan is Wells Fargo Bank, N.A. The Trustee's mailing address is [180 South Main Street, 2<sup>nd</sup> Floor, Salt Lake City, Utah 84101].
- (7) **SOURCE OF PLAN CONTRIBUTION:** The contributions necessary to finance the plan are made by the employer and employees.
- (8) **DATE OF END OF THE PLAN'S FISCAL YEAR:** The fiscal year for this plan ends each year on December 31.
- (9) **CONTINUATION OF DENTAL COVERAGE:** Federal Law (Public Law 99-272) requires Continuation of dental coverage for employers with 20 or more employees. Subject to the 20 employee requirement, You and Your Dependents who are covered under the group dental plan have the right to continue Your group dental coverage if it would terminate for the following specified reasons:
  - (a) Termination of employment for any reason, except gross misconduct.
  - (b) Loss of dental plan eligibility due to reduced employment hours.
  - (c) Your employer files for a Chapter 11 reorganization;
  - (d) Your death.
  - (e) Your divorce.
- (10) Your legal separation if You no longer make contributions for spouse coverage.
- (11) A dependent child ceases to be a Dependent (i.e., reaches the maximum age, or becomes married, or is no longer a dependent for income tax purposes).
- (12) A Dependent's loss of eligibility because You become entitled to Medicare Benefits.
- (13) If You or Your Dependent would lose coverage due to one of the reasons in (e), (f), (g) or (h) on the previous page, You or Your Dependent must notify Us so We can give appropriate notice of Continuation rights and the terms which apply to the Continuation. Try to give this notification within 30 days of the event so there can be continuity of coverage.
- (14) If You or Your Dependent elect the continued coverage and make the proper premium payment, the coverage would be continued until the earliest of:
  - (a) the due date to pay any required premium (if premium is not paid by that date).
  - (b) the date the continued person becomes covered under another group dental plan or entitled to Medicare Benefits.
  - (c) the date the employer's group dental plan terminates. (If coverage is replaced, the Continuation is continued under the succeeding plan.)
  - (d) a date which is:
    - 1. 18 months from the date coverage would have terminated because Your employment was terminated or eligibility was lost due to reduction in hours. However, if You are determined to have been disabled for Social Security purposes, You can continue coverage for 29 months from the date coverage terminated provided that notice of such determination of disability is given within

60 days and before the end of the 18-month continuation period.

2. 36 months from the date coverage would have terminated, if coverage is continued for any other reason.
- (15) The law permits Us to charge any person electing Continuation of coverage 102% of the cost of coverage to the plan except if the person extends Continuation of coverage to 29 months because of entitlement to Social Security disability Benefits, the law permits Us to charge 150% of the plan's cost for months 19 through 29. Full details of the Continuation will be sent to You or Your Dependents when We have been notified of one of the Continuation events.
- (16) **CLAIM PROCEDURES:** (a) Claim forms may be obtained from the Personnel Department of the employer; and (b) Please see Your insurance Certificate for the requirements of the Group Insurance Policy as to notice of a claim to BEST Life and Health Insurance Company.
- (17) **CLAIMS DENIAL PROCEDURE:** Any denial of a claim for Benefits will be explained in writing and the explanation will include (a) the specific reason for the denial, (b) reference to the plan provision upon which the denial was based, (c) a description of any additional information You might be required to provide and an explanation of why it is needed, and (d) an explanation of the plan's claim review procedure.
- (18) You, Your beneficiary, or a duly-authorized representative may appeal any denial of a claim for Benefits by filing a written request for a review to BEST Life and Health Insurance Company. In connection with such a request, documents pertinent to the administration of the plan may be reviewed, and issues outlining the basis of the appeal may be submitted. You may have representation throughout the review procedure.
- (19) A request for a review must be filed within [180] days after receipt of the written notice of denial of a claim. A decision will be rendered by BEST Life and Health Insurance Company no later than [60] days after receipt of a request for review. If there are special circumstances, the decision shall be rendered as soon as possible, but no later than [15] days after receipt of the request for review. The decision, after Our review, shall be in writing and shall include specific reasons for the decision. This decision shall also include specific references to the pertinent policy provisions on which the decision was based.

## **PART 9 - STATEMENT OF ERISA RIGHTS**

As a participant in the Plan You are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974. ERISA provides that all Plan participants shall be entitled to:

- (1) Examine, without charge, at the Administrative Representative's office and at other locations, such as work sites and union halls, all Plan documents including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
- (2) Obtain copies of all Plan documents and other Plan information upon written request to the Administrative Representative. The Administrative Representative may make a reasonable charge for the copies.
- (3) Receive a summary of the Plan's annual financial report. The Administrative Representative is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for the Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee Benefit Plan. The people who operate Your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Plan participants and beneficiaries.

No one, including Your employer, Your union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare Benefit or exercising Your rights under ERISA.

If Your claim for a welfare Benefit is denied in whole or in part You must receive a written explanation of the reason for the denial.

You have the right to have the Plan review and reconsider Your claim.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request materials from the Plan and do not receive them within 30 days, You may file suit in a federal court. In such a case, the court may require the Administrative Representative to provide the materials and pay You up to \$100 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrative Representative. If You have a claim for Benefits which are denied or ignored, in whole or in part, You may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a federal court. The court will decide who should pay court costs and legal fees. If You are successful, the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

If You have questions about Your Plan, You should contact the Administrative Representative. If You have any questions about this statement or about Your rights under ERISA, You should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

**Underwritten by BEST Life and Health Insurance Company**



# BEST [Standard or Signature] Indemnity Dental Plans Group Employer Application

Requested Effective Date:  1<sup>st</sup> or  15<sup>th</sup> of the month \_\_\_\_\_, 20\_\_\_\_  
 Vision

Dental  Life  Stand Alone

STANDARD INDEMNITY PLAN TYPE	High Plan	Mid Plan	Basic Plan
<i>Choose Calendar Year Maximum</i>	<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$1,000	<input type="checkbox"/> \$2,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$1,200 <input type="checkbox"/> \$1,000	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$750 <input type="checkbox"/> \$500
<i>Choose Deductible</i>	<input type="checkbox"/> \$0 <input type="checkbox"/> \$25 <input type="checkbox"/> \$50 <input type="checkbox"/> \$75 <input type="checkbox"/> \$100	<input type="checkbox"/> \$0 <input type="checkbox"/> \$25 <input type="checkbox"/> \$50 <input type="checkbox"/> \$75 <input type="checkbox"/> \$100	<input type="checkbox"/> \$0 <input type="checkbox"/> \$25 <input type="checkbox"/> \$50 <input type="checkbox"/> \$75 <input type="checkbox"/> \$100
<i>Coinsurance</i>	100/90/60	100/80/50	80/80/50
<i>Perio Option</i>	<input type="checkbox"/> Class II <input type="checkbox"/> Class III	<input type="checkbox"/> Class II <input type="checkbox"/> Class III	<input type="checkbox"/> Class II <input type="checkbox"/> Class III
<i>Endo Option</i>	<input type="checkbox"/> Class II <input type="checkbox"/> Class III	<input type="checkbox"/> Class II <input type="checkbox"/> Class III	<input type="checkbox"/> Class II <input type="checkbox"/> Class III
<i>Choose Orthodontia Option</i>	<input type="checkbox"/> Adult & Child \$1,000 <input type="checkbox"/> Child Only \$1,000 <input type="checkbox"/> Child Only \$1,500	<input type="checkbox"/> Adult & Child \$1,000 <input type="checkbox"/> Child Only \$1,000 <input type="checkbox"/> Child Only \$1,500	<input type="checkbox"/> Child Only \$1,000 <input type="checkbox"/> Child Only \$1,500
<i>Voluntary Option*</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Two-Year Initial Rate Guarantee Option*</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Dual Option (check plans selected)*</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Reimbursement Level</i>	<input type="checkbox"/> 80 <sup>th</sup> percentile <input type="checkbox"/> 90 <sup>th</sup> percentile	<input type="checkbox"/> 80 <sup>th</sup> percentile <input type="checkbox"/> 90 <sup>th</sup> percentile	<input type="checkbox"/> 80 <sup>th</sup> percentile <input type="checkbox"/> 90 <sup>th</sup> percentile

\* Certain requirements apply.

### VISION PLAN TYPE

Plan Choice	Voluntary Option*	Deductible Choice	Lenses/Contacts Choice
<input type="checkbox"/> Plan A (12/12/12/12) <input type="checkbox"/> Plan B (12/12/24/12) <input type="checkbox"/> Plan C (12/12/24/24) <input type="checkbox"/> Plan D (12/24/24/24)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> \$0 <input type="checkbox"/> \$10 <input type="checkbox"/> \$25	<input type="checkbox"/> Lenses, Frames AND Contacts <input type="checkbox"/> Lenses, Frames OR Contacts

SIGNATURE INDEMNITY PLAN TYPE	Plan Option #1	Plan Option #2 (For Dual Option Use Only)
<i>Choose Calendar Year Maximum</i>	<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$750 <input type="checkbox"/> \$500	<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$750 <input type="checkbox"/> \$500
<i>Choose Deductible</i>	<input type="checkbox"/> \$0 <input type="checkbox"/> \$25 <input type="checkbox"/> \$50 <input type="checkbox"/> \$75 <input type="checkbox"/> \$100	<input type="checkbox"/> \$0 <input type="checkbox"/> \$25 <input type="checkbox"/> \$50 <input type="checkbox"/> \$75 <input type="checkbox"/> \$100
<i>Class I: Preventive Care Coinsurance</i>	<input type="checkbox"/> 100% <input type="checkbox"/> 90% <input type="checkbox"/> 80%	<input type="checkbox"/> 100% <input type="checkbox"/> 90% <input type="checkbox"/> 80%
<i>Class II: Basic Services Coinsurance</i>	<input type="checkbox"/> 90% <input type="checkbox"/> 80% <input type="checkbox"/> 70%	<input type="checkbox"/> 90% <input type="checkbox"/> 80% <input type="checkbox"/> 70%
<i>Class III: Major Services Coinsurance</i>	<input type="checkbox"/> 60% <input type="checkbox"/> 50% <input type="checkbox"/> 0%	<input type="checkbox"/> 60% <input type="checkbox"/> 50% <input type="checkbox"/> 0%
<i>Oral Surgery Option</i>	<input type="checkbox"/> Class II <input type="checkbox"/> Class III	<input type="checkbox"/> Class II <input type="checkbox"/> Class III
<i>Perio Option</i>	<input type="checkbox"/> Class II <input type="checkbox"/> Class III	<input type="checkbox"/> Class II <input type="checkbox"/> Class III
<i>Endo Option</i>	<input type="checkbox"/> Class II <input type="checkbox"/> Class III	<input type="checkbox"/> Class II <input type="checkbox"/> Class III
<i>Choose Orthodontia Option</i>	<input type="checkbox"/> Adult & Child <input type="checkbox"/> Child Only Lifetime Maximum: <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$1,000	<input type="checkbox"/> Adult & Child <input type="checkbox"/> Child Only Lifetime Maximum: <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$1,000
<i>Voluntary Option*</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Two-Year Initial Rate Guarantee Option*</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Dual Option (check plans selected)*</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Reimbursement Level</i>	<input type="checkbox"/> 80 <sup>th</sup> percentile <input type="checkbox"/> 90 <sup>th</sup> percentile	<input type="checkbox"/> 80 <sup>th</sup> percentile <input type="checkbox"/> 90 <sup>th</sup> percentile

\* Certain requirements apply.

**VISION PLAN TYPE**

Plan Choice		Voluntary Option*	Deductible Choice	Lenses/Contacts Choice
<input type="checkbox"/> Plan A (12/12/12/12)	<input type="checkbox"/> Plan B (12/12/24/12)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> \$0 <input type="checkbox"/> \$10 <input type="checkbox"/> \$25	<input type="checkbox"/> Lenses, Frames <b>AND</b> Contacts
<input type="checkbox"/> Plan C (12/12/24/24)	<input type="checkbox"/> Plan D (12/24/24/24)			<input type="checkbox"/> Lenses, Frames <b>OR</b> Contacts

Please answer the following questions:

- Yes  No Does the employer now have or has the employer had a comparable group dental plan in force during the past twelve (12) consecutive months?  
 [12-month wait on Class III and Class IV services is waived for employees who have had 12 consecutive months of comparable coverage under a prior plan and who are in a group with proof of continuous coverage and comparable prior group coverage.]  
 [For employer-sponsored: no waiting periods.  
 For voluntary: 12-month wait on Class III and Class IV services is waived for all employees in a group with 10-24 employees enrolling and 50% participation with proof of comparable prior group coverage; if 50% participation is not met, waiver will only apply to employees who have proof of 12 consecutive months of coverage under a prior plan (proof of comparable and continuous prior group coverage must be provided); all employees in a California group with 10+ employees enrolling; all employees in a group with 25+ employees enrolling.]  
 A copy of your most recent dental bill listing the covered employees and their effective dates must accompany this application.
- Yes  No Are all full-time employees enrolling in the group dental plan?
- Yes  No Are any employees enrolling in the policy currently receiving extended benefits under COBRA? If yes, please list names:  
 \_\_\_\_\_  
 \_\_\_\_\_
- Yes  No Waiting Period is waived for Present Employees.

5. **Waiting Period for New Employees:** First of the Month following continuous full time employment of:  
 1<sup>st</sup> of the month following date of hire  1 Full Calendar Month (standard)  2 Full Calendar Months  3 Full Calendar Months  4 Full Calendar Months  
 Employer Contribution for Employees (for employer-sponsored plans, the Employer must pay at least 50% for each employee.): \_\_\_\_\_%, For Dependent Coverage: \_\_\_\_\_%  
 Description of Classes not Eligible: \_\_\_\_\_ Number of Total Employees on Payroll: \_\_\_\_\_  
 Number of Full-Time Employees: \_\_\_\_\_

6. **PPO network requested:** Are there any employees living outside of the Firm's state of business?  Yes  No (If yes, please list names and the state they reside in below.)

I understand and agree that the insurance hereby applied for is not effective until this application and the full initial premium is delivered to, received by and approved by BEST Life and Health Insurance Company.

Employer Signature:	Print Name:	Date:
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**EMPLOYER ACKNOWLEDGEMENT & ASSOCIATION AND TRUST MEMBERSHIP APPLICATION**

Employer Name	Employer Federal Tax Number ( ) - ( ) -
Street Address	City State Zip Telephone Number Fax Number
Billing Address P.O. Box	City State Zip E-Mail
Nature of Firm's Business	SIC Code Person at Firm to Contact for Service and Administration of the Dental Plan <i>(continued on other side)</i>

Employer Name

**Fraud Warning**

Conformity with states that may require a fraud warning—The following general Fraud Notice is intended to comply with the laws of your state. If any part of such language is found in conflict, such language shall be construed as amended to the extent necessary in order to meet the minimum requirements of your state. Any person who, knowingly and with intent to defraud or deceive any insurance company, files an application containing any materially false, incomplete or misleading information is guilty of committing a fraudulent insurance act which may be crime and subject to criminal prosecution.

I certify that this is a bona fide business with a legitimate business purpose and which has a true employer-employee relationship with the individuals designated as employees. I understand that any false statements made in this application constitute the legal basis for termination or cancellation of coverage retroactive to the effective date and denial of all claims incurred.

**Termination of Coverage**—Employee coverage and dependent coverage will terminate on the earliest of the following dates: (1) the date the employee ceases to be an eligible employee or the date the dependent is no longer eligible as a dependent under the plan; (2) the date the plan is terminated; (3) the date the employer terminates the coverage by failing to pay the required premium; (4) the date the group policy is terminated; (5) the date the group no longer meets minimum participation requirements. The benefits are subject to all the conditions and limitations of the plan.

Eligible dependent coverage terminates on the earliest of the following: when the dependent no longer meets the definition of a dependent; on the first day of the month in which premiums were not paid, or when the member terminates coverage.

**FIRM ELIGIBILITY:**

A firm or employer must be an active business operation to request coverage. The business must continue on an active basis to retain eligibility for coverage. Coverage will be terminated on the effective date the business ceases active operation. I understand that if my firm drops in size to 1 employee for more than 90 consecutive days, all of my selected insurance coverage will be cancelled.

**IMPORTANT PLAN INFORMATION**

The undersigned Employer understands and agrees that by adopting one or more BEST plans, it is establishing an employee welfare benefit plan for its employees. The employer further understands and agrees that the general definition of an employee is a person who usually works at least 30 hours per week at the firm's business location with federal, state and social security tax withheld from their salary. The Employer's plan is funded through the Beneficial Employees Security Trust of Utah ("B.E.S.T.") to which the Employer subscribes. The insurance companies issue group insurance policies to the Trustee of B.E.S.T. These policies provide the coverage(s) the Employer selects.

B.E.S.T. receives the subscribing employer's payment and remits the insurance premium to the insurance carrier(s) or to affiliates filing a common federal income tax form that provide services to Employers and to B.E.S.T. One of the insurance carriers is BEST Life and Health Insurance Company ("BEST Life").

The Employer agrees and understands that by signing this Trust Membership Application, it becomes a Subscribing Employer of the Trust. A subscribing employer of the Trust agrees to be bound by all the terms and conditions of the Trust Agreement. A subscribing employer of the Trust further agrees that the Trustee shall not be liable to any participating Employers, to any person insured, or to anyone else in connection with the operation of the Group Insurance Trust Fund.

The Master Group Policy is issued to the Trustee of B.E.S.T. To participate in the plan, each subscribing employer adopts the Trust. The Master Group Policy is governed by the laws of the state of Utah. However, to the extent that such Policy and/or Certificate of Coverage is in conflict with the laws of another demonstrating statutory governing jurisdiction over an out-of-state multiple employer trust Policy, then such Policy and/or Certificate of Coverage will be amended to comply with the minimum requirements of that state.

**X** \_\_\_\_\_ / /  
 Signature of Company Officer Print Name & Title Dated

**Benefit Representative Report**

<i>(Please Print)</i>	<i>(Please Complete)</i> Special Instructions to BEST Health Plans
Name _____	1. May we contact the client if we need additional information? <input type="checkbox"/> Yes <input type="checkbox"/> No  2. Is this your first case with BEST Health Plans? <input type="checkbox"/> Yes <input type="checkbox"/> No  3. This is: <input type="checkbox"/> an existing client <input type="checkbox"/> a new client with my company  4. The 'New Client Kit' (certificate book, claim forms, etc.) should be sent to: <input type="checkbox"/> The benefit representative <input type="checkbox"/> The client  5. The underwriter assigned to my case should contact me? <input type="checkbox"/> Yes <input type="checkbox"/> No  General Agent (GA): _____
It is not necessary to complete the following information if you are currently receiving service fees from BEST Health Plans unless changes in address, etc. need to be made. Just sign and date the form below.	
Your Agency Name _____	
Address _____	
City _____ State _____ Zip _____	
Who Should Receive the Service Fees? <input type="checkbox"/> Benefit Representative <input type="checkbox"/> Company/Firm	
Social Security Number - - Federal Tax ID _____	
Date of Birth / / License No. _____ State _____	
Phone No. _____ FAX No. _____	
E-mail Address _____	
Please list any special handling needed for this client: _____	

I hereby certify that I hold a valid Life, Accident and Health license issued by the state in which this document was executed and that all of the information contained herein is correct, to the best of my knowledge, and that I know nothing unfavorable about this firm or any individual applying for insurance unless fully described in this application material. Furthermore, I certify that:

1. This firm is a bona fide business establishment and participation requirements are being met.
2. I have advised my client not to terminate any existing coverage until this coverage is approved.
3. Coverage, eligibility provisions, waiting periods and limitations have been fully explained to, and understood by, the Employer identified in this document.
4. I have no right to bind, modify or alter provisions of this program.

I understand and agree that the insurance applied for herein does not begin until this application is received and approved by BEST Life and Health Insurance Company, the insurance certificates are issued and the first premium is received and accepted.

Agent's Signature: _____	Print Name: _____	Date: _____
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# BEST [Standard or Signature] PPO Dental Plans Group Employer Application

Requested Effective Date:  1<sup>st</sup> or  15<sup>th</sup> of the month \_\_\_\_\_, 20\_\_\_\_\_

[  Dental  Life  Stand Alone Vision]

STANDARD PPO PLAN TYPE	High Plan	Mid Plan	Basic Plan
<i>Choose Calendar Year Maximum</i> In- and Out-of-Network Maximums	<input type="checkbox"/> In \$2,500 Out \$2,000 <input type="checkbox"/> In \$2,000 Out \$1,500 <input type="checkbox"/> In \$1,500 Out \$1,000 <input type="checkbox"/> In \$1,000 Out \$1,000	<input type="checkbox"/> In \$2,000 Out \$1,500 <input type="checkbox"/> In \$1,500 Out \$1,000 <input type="checkbox"/> In \$1,000 Out \$1,000	<input type="checkbox"/> In \$1,500 Out \$1,000 <input type="checkbox"/> In \$1,000 Out \$750
<i>Choose Deductible</i>	<input type="checkbox"/> \$0 <input type="checkbox"/> \$25 <input type="checkbox"/> \$50 <input type="checkbox"/> \$75 <input type="checkbox"/> \$100	<input type="checkbox"/> \$0 <input type="checkbox"/> \$25 <input type="checkbox"/> \$50 <input type="checkbox"/> \$75 <input type="checkbox"/> \$100	<input type="checkbox"/> \$0 <input type="checkbox"/> \$25 <input type="checkbox"/> \$50 <input type="checkbox"/> \$75 <input type="checkbox"/> \$100
<i>Coinsurance</i>	100/90/60 In 100/80/50 Out	100/80/50 In 80/60/50 Out	80/80/50 In 80/50/50 Out
<i>Perio Option</i>	<input type="checkbox"/> Class II <input type="checkbox"/> Class III	<input type="checkbox"/> Class II <input type="checkbox"/> Class III	<input type="checkbox"/> Class II <input type="checkbox"/> Class III
<i>Endo Option</i>	<input type="checkbox"/> Class II <input type="checkbox"/> Class III	<input type="checkbox"/> Class II <input type="checkbox"/> Class III	<input type="checkbox"/> Class II <input type="checkbox"/> Class III
<i>Choose Orthodontia Option</i>	<input type="checkbox"/> Adult & Child \$1,000 <input type="checkbox"/> Child Only \$1,000 <input type="checkbox"/> Child Only \$1,500	<input type="checkbox"/> Adult & Child \$1,000 <input type="checkbox"/> Child Only \$1,000 <input type="checkbox"/> Child Only \$1,500	<input type="checkbox"/> Child Only \$1,000 <input type="checkbox"/> Child Only \$1,500
<i>Voluntary Option*</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Two-Year Initial Rate Guarantee Option*</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Dual Option (check plans selected)*</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Reimbursement Level</i>	<input type="checkbox"/> 80 <sup>th</sup> percentile <input type="checkbox"/> 90 <sup>th</sup> percentile	<input type="checkbox"/> 80 <sup>th</sup> percentile <input type="checkbox"/> 90 <sup>th</sup> percentile	<input type="checkbox"/> 80 <sup>th</sup> percentile <input type="checkbox"/> 90 <sup>th</sup> percentile

\* Certain requirements apply.

### VISION PLAN TYPE

Plan Choice	Voluntary Option*	Deductible Choice	Lenses/Contacts Choice
<input type="checkbox"/> Plan A (12/12/12/12) <input type="checkbox"/> Plan B (12/12/24/12) <input type="checkbox"/> Plan C (12/12/24/24) <input type="checkbox"/> Plan D (12/24/24/24)]	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> \$0 <input type="checkbox"/> \$10 <input type="checkbox"/> \$25	<input type="checkbox"/> Lenses, Frames <b>AND</b> Contacts <input type="checkbox"/> Lenses, Frames <b>OR</b> Contacts

SIGNATURE PPO PLAN TYPE	Plan Option #1		Plan Option #2 (For Dual Option Use Only)	
	In-network	Out-of-network*	In-network	Out-of-network*
<i>Choose Calendar Year Maximum*</i> In- and Out-of-Network Maximums	<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$1,000	<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$500	<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$1,000	<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$500
<i>Choose Deductible</i>	<input type="checkbox"/> \$0 <input type="checkbox"/> \$25 <input type="checkbox"/> \$50 <input type="checkbox"/> \$75 <input type="checkbox"/> \$100		<input type="checkbox"/> \$0 <input type="checkbox"/> \$25 <input type="checkbox"/> \$50 <input type="checkbox"/> \$75 <input type="checkbox"/> \$100	
<i>Class I: Preventive Care Coinsurance*</i>	<input type="checkbox"/> 100% <input type="checkbox"/> 90% <input type="checkbox"/> 80%	<input type="checkbox"/> 100% <input type="checkbox"/> 90% <input type="checkbox"/> 80%	<input type="checkbox"/> 100% <input type="checkbox"/> 90% <input type="checkbox"/> 80%	<input type="checkbox"/> 100% <input type="checkbox"/> 90% <input type="checkbox"/> 80%
<i>Class II: Basic Services Coinsurance*</i>	<input type="checkbox"/> 90% <input type="checkbox"/> 80% <input type="checkbox"/> 70%	<input type="checkbox"/> 80% <input type="checkbox"/> 60% <input type="checkbox"/> 50%	<input type="checkbox"/> 90% <input type="checkbox"/> 80% <input type="checkbox"/> 70%	<input type="checkbox"/> 80% <input type="checkbox"/> 60% <input type="checkbox"/> 50%
<i>Class III: Major Services Coinsurance*</i>	<input type="checkbox"/> 60% <input type="checkbox"/> 50% <input type="checkbox"/> 0%	<input type="checkbox"/> 60% <input type="checkbox"/> 50% <input type="checkbox"/> 0%	<input type="checkbox"/> 60% <input type="checkbox"/> 50% <input type="checkbox"/> 0%	<input type="checkbox"/> 60% <input type="checkbox"/> 50% <input type="checkbox"/> 0%
<i>Oral Surgery Option</i>	<input type="checkbox"/> Class II <input type="checkbox"/> Class III		<input type="checkbox"/> Class II <input type="checkbox"/> Class III	
<i>Perio Option</i>	<input type="checkbox"/> Class II <input type="checkbox"/> Class III		<input type="checkbox"/> Class II <input type="checkbox"/> Class III	
<i>Endo Option</i>	<input type="checkbox"/> Class II <input type="checkbox"/> Class III		<input type="checkbox"/> Class II <input type="checkbox"/> Class III	
<i>Choose Orthodontia Option</i>	<input type="checkbox"/> Adult & Child <input type="checkbox"/> Child Only Lifetime Maximum: <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$1,000		<input type="checkbox"/> Adult & Child <input type="checkbox"/> Child Only Lifetime Maximum: <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$1,000	
<i>Voluntary Option*</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>Two-Year Initial Rate Guarantee Option**</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>Dual Option (check plans selected)**</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>Reimbursement Level</i>	<input type="checkbox"/> 80 <sup>th</sup> percentile <input type="checkbox"/> 90 <sup>th</sup> percentile		<input type="checkbox"/> 80 <sup>th</sup> percentile <input type="checkbox"/> 90 <sup>th</sup> percentile	

\*Out-of-network benefit options must be equal to or lower than the in-network benefit options.

\*\* Certain requirements apply.

**VISION PLAN TYPE**

Plan Choice		Voluntary Option*	Deductible Choice	Lenses/Contacts Choice
<input type="checkbox"/> Plan A (12/12/12/12)	<input type="checkbox"/> Plan B (12/12/24/12)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> \$0 <input type="checkbox"/> \$10 <input type="checkbox"/> \$25	<input type="checkbox"/> Lenses, Frames <b>AND</b> Contacts
<input type="checkbox"/> Plan C (12/12/24/24)	<input type="checkbox"/> Plan D (12/24/24/24)			<input type="checkbox"/> Lenses, Frames <b>OR</b> Contacts

Please answer the following questions:

1.  Yes  No **Does the employer now have or has the employer had a comparable group dental plan in force during the past twelve (12) consecutive months?**  
 [12-month wait on Class III and Class IV services is waived for employees who have had 12 consecutive months of comparable coverage under a prior plan and who are in a group with proof of continuous coverage and comparable prior group coverage.]  
 [For employer-sponsored: no waiting periods.  
 For voluntary: 12-month wait on Class III and Class IV services is waived for all employees in a group with 10-24 employees enrolling and 50% participation with proof of comparable prior group coverage; if 50% participation is not met, waiver will only apply to employees who have proof of 12 consecutive months of coverage under a prior plan (proof of comparable and continuous prior group coverage must be provided); all employees in a group with 25+ employees enrolling.]  
**A copy of your most recent dental bill listing the covered employees and their effective dates must accompany this application.**

2.  Yes  No **Are all full-time employees enrolling in the group dental plan?**

3.  Yes  No **Are any employees enrolling in the policy currently receiving extended benefits under COBRA?** If yes, please list names:  
 \_\_\_\_\_  
 \_\_\_\_\_

4.  Yes  No **Waiting Period is waived for Present Employees.**

5. **Waiting Period for New Employees:** First of the Month following continuous full time employment of:

1<sup>st</sup> of the month following date of hire  1 Full Calendar Month (standard)  2 Full Calendar Months  3 Full Calendar Months  4 Full Calendar Months

Employer Contribution for Employees (for employer-sponsored plans, the Employer must pay at least 50% for each employee): \_\_\_\_\_%, For Dependent Coverage: \_\_\_\_\_%.

Description of Classes not Eligible: \_\_\_\_\_ Number of Total Employees on Payroll: \_\_\_\_\_

Number of Full-Time Employees: \_\_\_\_\_

6. **PPO network requested:** Are there any employees living outside of the Firm's state of business?  Yes  No *(If yes, please list names and the state they reside in below.)*

I understand and agree that the insurance hereby applied for is not effective until this application and the full initial premium is delivered to, received by and approved by BEST Life and Health Insurance Company.

Employer Signature:	Print Name:	Date:
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**EMPLOYER ACKNOWLEDGEMENT & ASSOCIATION AND TRUST MEMBERSHIP APPLICATION**

Employer Name \_\_\_\_\_ Employer Federal Tax Number \_\_\_\_\_

( ) - ( ) -

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Billing Address P.O. Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ E-Mail \_\_\_\_\_

Nature of Firm's Business \_\_\_\_\_ SIC Code \_\_\_\_\_ Person at Firm to Contact for Service and Administration of the Dental Plan \_\_\_\_\_

*(continued on other side)*

Employer Name \_\_\_\_\_

**Fraud Warning**

Conformity with states that may require a fraud warning—The following general Fraud Notice is intended to comply with the laws of your state. If any part of such language is found in conflict, such language shall be construed as amended to the extent necessary in order to meet the minimum requirements of your state. Any person who, knowingly and with intent to defraud or deceive any insurance company, files an application containing any materially false, incomplete or misleading information is guilty of committing a fraudulent insurance act which may be crime and subject to criminal prosecution.

I certify that this is a bona fide business with a legitimate business purpose and which has a true employer-employee relationship with the individuals designated as employees. I understand that any false statements made in this application constitute the legal basis for termination or cancellation of coverage retroactive to the effective date and denial of all claims incurred.

**Termination of Coverage**—Employee coverage and dependent coverage will terminate on the earliest of the following dates: (1) the date the employee ceases to be an eligible employee or the date the dependent is no longer eligible as a dependent under the plan; (2) the date the plan is terminated; (3) the date the employer terminates the coverage by failing to pay the required premium; (4) the date the group policy is terminated; (5) the date the group no longer meets minimum participation requirements. The benefits are subject to all the conditions and limitations of the plan.

Eligible dependent coverage terminates on the earliest of the following: when the dependent no longer meets the definition of a dependent; on the first day of the month in which premiums were not paid, or when the member terminates coverage.

**FIRM ELIGIBILITY:**

A firm or employer must be an active business operation to request coverage. The business must continue on an active basis to retain eligibility for coverage. Coverage will be terminated on the effective date the business ceases active operation. I understand that if my firm drops in size to 1 employee for more than 90 consecutive days, all of my selected insurance coverage will be cancelled.

**IMPORTANT PLAN INFORMATION**

The undersigned Employer understands and agrees that by adopting one or more BEST plans, it is establishing an employee welfare benefit plan for its employees. The employer further understands and agrees that the general definition of an employee is a person who usually works at least 30 hours per week at the firm's business location with federal, state and social security tax withheld from their salary. The Employer's plan is funded through the Beneficial Employees Security Trust of Utah ("B.E.S.T.") to which the Employer subscribes. The insurance companies issue group insurance policies to the Trustee of B.E.S.T. These policies provide the coverage(s) the Employer selects.

B.E.S.T. receives the subscribing employer's payment and remits the insurance premium to the insurance carrier(s) or to affiliates filing a common federal income tax form, that provide services to Employers and to B.E.S.T. One of the insurance carriers is BEST Life and Health Insurance Company ("BEST Life").

The Employer agrees and understands that by signing this Trust Membership Application, it becomes a Subscribing Employer of the Trust. A subscribing employer of the Trust agrees to be bound by all the terms and conditions of the Trust Agreement. A subscribing employer of the Trust further agrees that the Trustee shall not be liable to any participating Employers, to any person insured, or to anyone else in connection with the operation of the Group Insurance Trust Fund.

The Master Group Policy is issued to the Trustee of B.E.S.T. To participate in the plan, each subscribing employer adopts the Trust. The Master Group Policy is governed by the laws of the state of Utah. However, to the extent that such Policy and/or Certificate of Coverage is in conflict with the laws of another demonstrating statutory governing jurisdiction over an out-of-state multiple employer trust Policy, then such Policy and/or Certificate of Coverage will be amended to comply with the minimum requirements of that state.

X

Signature of Company Officer

Print Name & Title

/ /  
Dated

**BENEFIT REPRESENTATIVE REPORT**

*(Please Print)*

Name \_\_\_\_\_

It is not necessary to complete the following information if you are currently receiving service fees from BEST Health Plans unless changes in address, etc. need to be made. Just sign and date the form below.

Your Agency Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Who Should Receive the Service Fees?  Benefit Representative  Company/Firm

Social Security Number - - Federal Tax ID \_\_\_\_\_

Date of Birth / / License No. \_\_\_\_\_ State \_\_\_\_\_

Phone No. \_\_\_\_\_ FAX No. \_\_\_\_\_

E-mail Address \_\_\_\_\_

*(Please Complete)*

**Special Instructions to BEST Health Plans**

1. May we contact the client if we need additional information?  
 Yes  No
2. Is this your first case with BEST Health Plans?  Yes  No
3. This is:  an existing client  a new client with my company
4. The 'New Client Kit' (certificate book, claim forms, etc.) should be sent to:  
 The benefit representative  The client
5. The underwriter assigned to my case should contact me?  Yes  No

General Agent (GA):

Please list any special handling needed for this client:

I hereby certify that I hold a valid Life, Accident and Health license issued by the state in which this document was executed and that all of the information contained herein is correct, to the best of my knowledge, and that I know nothing unfavorable about this firm or any individual applying for insurance unless fully described in this application material. Furthermore, I certify that:

1. This firm is a bona fide business establishment and participation requirements are being met.
2. I have advised my client not to terminate any existing coverage until this coverage is approved.
3. Coverage, eligibility provisions, waiting periods and limitations have been fully explained to, and understood by, the Employer identified in this document.
4. I have no right to bind, modify or alter provisions of this program.

I understand and agree that the insurance applied for herein does not begin until this application is received and approved by BEST Life and Health Insurance Company, the insurance certificates are issued and the first premium is received and accepted.

Agent's Signature:	Print Name:	Date:
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**Employee Request for  
BEST Life Dental**

Phone: (800) 433-0088 • e-mail: cs@bestlife.com • [www.bestlife.com](http://www.bestlife.com)

New Enrollment    Add Dependents    Name Change

**EMPLOYEE INFORMATION**

Last Name		First Name		M.I.	DOB	Age	Gender <input type="checkbox"/> M <input type="checkbox"/> F	SSN
Residence Street Address					City		State	Zip
Employed by (name of company)		Job Title		Weekly Hours	Date of F/T Hire		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced	
If changing your name, provide new name:					Do you have any eligible dependent children? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many?			
Will this replace other dental insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Carrier							<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Other	
Policy #			Effective Date			Anticipated Termination Date		

**Are you insuring your dependents?**    Yes    No

If 'Yes' complete the section below and explain any differences in last name, if applicable. If no, complete the waiver of coverage section below.

Eligible dependants include spouses and unmarried dependent children. Dependent children are covered through age 20, extended through age 25 if they are full-time students. Dependent children residing in: UT are covered through age 25; TX are covered through age 24; IN, MS and TN are covered through age 23.

**DEPENDANT INFORMATION**

Add	Dependent Name	Relationship	Check if Full-Time Student	Sex	Date of Birth
<input type="checkbox"/>		<b>Spouse</b>	<input type="checkbox"/>	<b>Male/Female</b>	
<input type="checkbox"/>			<input type="checkbox"/>	<b>Male/Female</b>	
<input type="checkbox"/>			<input type="checkbox"/>	<b>Male/Female</b>	
<input type="checkbox"/>			<input type="checkbox"/>	<b>Male/Female</b>	
<input type="checkbox"/>			<input type="checkbox"/>	<b>Male/Female</b>	

I certify that my date of birth, date of employment and other information on this form are correct and that I am working at the employer's place of business in full time employment at least 30 hours per week. I authorize my employer to make deductions from my earnings necessary to provide my contribution for this coverage and understand that my employer is performing this service for my benefit and not as an agent of the insurer. I understand that coverage is not in force until the effective date shown on the Certificate of Insurance issued to me; however, if I am absent from full-time employment on such dates as the result of an accident or sickness, I agree that coverage is not effective. I determine the coverage in force and that coverage is not in force if an application for that coverage has not been made by my employer. Additionally, if I am accepted, this request for group insurance will become part of the agreement between BEST Life and Health Insurance Company and myself. I, and any enrolled family members, agree to be bound by the arbitration clause in the BEST Life and Health Insurance *Certificate Booklet*, if any, instead of trial by a court of jury. I agree that insurance does not begin until this application is approved by BEST Life and Health Insurance Co., my insurance certificate is issued, and the first premium is paid. Conformity with states that may require a fraud warning – The following general Fraud Notice is intended to comply with the laws of Your state. If any part of such language is found in conflict, such language shall be construed as amended to the extent necessary in order to meet the minimum requirements of your state. Any person who knowingly and with intent to defraud or deceive any insurance company, files an application containing any materially false, incomplete or misleading information, is guilty of committing a fraudulent insurance act, which is a crime, and subject to criminal prosecution.

<b>Your Signature in black ink</b>	<b>Date</b>
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**WAIVER OF COVERAGE**

Complete if you or any of your eligible dependants are declining or refusing any type of offered coverage.

**I waive Dental coverage for:**         Myself and any dependants         Spouse only         Spouse and dependent child(ren)

Reason for waiving coverage (*you must provide a reason for waiving coverage*)    Other coverage    Cost

**Fraud Warning**

Conformity with states that may require a fraud warning—The following general Fraud Notice is intended to comply with the laws of your state. If any part of such language is found in conflict, such language shall be construed as amended to the extent necessary in order to meet the minimum requirements of your state. Any person who, knowingly and with intent to defraud or deceive any insurance company, files an application containing any materially false, incomplete or misleading information is guilty of committing a fraudulent insurance act which may be crime and subject to criminal prosecution.

I understand that if I desire to apply for dental insurance for myself and dependents at a later date under the Beneficial Employees Security Trust, I/we will be eligible for Class I, Preventive Procedures during the first 12 months of continuous coverage and during the second 12 months of continuous coverage, eligible for Class I, Preventive Procedures and for 50% of the benefits for Class II Basic Procedures not to exceed a maximum of \$500 during the second 12 months of continuous coverage. I understand that if I desire to apply for vision insurance for myself and dependents at a later date under the beneficial Employees Security Trust, I/we will be eligible for no more than a total of \$75 of vision benefits during the first 12 months of coverage.

<b>Your Signature in black ink</b>							<b>Date</b>				
<b>COBRA Electives</b>											
COBRA Electives: If you are currently continuing coverage under COBRA or a state continuation plan, what is the exact date of your qualifying event?											
BEST Use Only	WAIVER	COBRA EE <input type="checkbox"/> Yes <input type="checkbox"/> No	EE _____ 1 = Employee 2 = Dependent 3 = EE & Dependent		DEP. Refusal _____ R = No Coverage O = Other Coverage		SPOUSE EE <input type="checkbox"/> Yes <input type="checkbox"/> No		COB <input type="checkbox"/> Yes <input type="checkbox"/> No		DEP 19+ FTS Y H Y
Eff. DATE	ER#	COVERAGES	PREV EE/DEP	NEW CHG	WP	#EES	LATE L	NEWBORN N	APP = A DECL= D	INITIALS	

**Employee Request for  
BEST Life Dental/Vision**

Phone: (800) 433-0088 • e-mail: cs@bestlife.com • [www.bestlife.com](http://www.bestlife.com)

New Enrollment    Add Dependents    Name Change

EMPLOYEE INFORMATION							
Last Name	First Name	M.I.	DOB	Age	Gender <input type="checkbox"/> M <input type="checkbox"/> F	SSN	
Residence Street Address				City		State	Zip
Employed by (name of company)	Job Title	Weekly Hours	Date of F/T Hire		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced		
If changing your name, provide new name:				Do you have any eligible dependent children? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many?			
Will this replace other dental insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Carrier						<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Other	
Policy #		Effective Date		Anticipated Termination Date			

**Are you insuring your dependents?**    Yes    No

If 'Yes', complete the section below and explain any differences in last name, if applicable. If no, complete the waiver of coverage section, below.

Eligible dependants include spouses and unmarried dependent children. Dependent children are covered through age 20, extended through age 25 if they are full-time students. Dependent children residing in: UT are covered through age 25; TX are covered through age 24; IN, MS and TN are covered through age 23.

DEPENDANT INFORMATION					
Add	Dependent Name	Relationship	Check if Full-Time Student	Sex	Date of Birth
<input type="checkbox"/>		<b>Spouse</b>	<input type="checkbox"/>	<b>Male/Female</b>	
<input type="checkbox"/>			<input type="checkbox"/>	<b>Male/Female</b>	
<input type="checkbox"/>			<input type="checkbox"/>	<b>Male/Female</b>	
<input type="checkbox"/>			<input type="checkbox"/>	<b>Male/Female</b>	
<input type="checkbox"/>			<input type="checkbox"/>	<b>Male/Female</b>	

I certify that my date of birth, date of employment and other information on this form are correct and that I am working at the employer's place of business in full time employment at least 30 hours per week. I authorize my employer to make deductions from my earnings necessary to provide my contribution for this coverage and understand that my employer is performing this service for my benefit and not as an agent of the insurer. I understand that coverage is not in force until the effective date shown on the Certificate of Insurance issued to me; however, if I am absent from full-time employment on such dates as the result of an accident or sickness, I agree that coverage is not effective. I determine the coverage in force and that coverage is not in force if an application for that coverage has not been made by my employer. Additionally, if I am accepted, this request for group insurance will become part of the agreement between BEST Life and Health Insurance Company and myself. I, and any enrolled family members, agree to be bound by the arbitration clause in the BEST Life and Health Insurance *Certificate Booklet*, if any, instead of trial by a court of jury. I agree that insurance does not begin until this application is approved by BEST Life and Health Insurance Co., my insurance certificate is issued, and the first premium is paid. Conformity with states that may require a fraud warning – The following general Fraud Notice is intended to comply with the laws of Your state. If any part of such language is found in conflict, such language shall be construed as amended to the extent necessary in order to meet the minimum requirements of your state. Any person who knowingly and with intent to defraud or deceive any insurance company, files an application containing any materially false, incomplete or misleading information, is guilty of committing a fraudulent insurance act, which is a crime, and subject to criminal prosecution.

<b>Your Signature in black ink</b>	<b>Date</b>
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**WAIVER OF COVERAGE**

Complete if you or any of your eligible dependants are declining or refusing any type of offered coverage.

**Check all that apply:**

**I waive Dental coverage for:**       Myself and any dependants       Spouse only       Spouse and dependent child(ren)

**I waive Vision coverage for:**       Myself and any dependants       Spouse only       Spouse and dependent child(ren)

Reason for waiving coverage (*you must provide a reason for waiving coverage*)    Other coverage    Cost

**Fraud Warning**

Conformity with states that may require a fraud warning—The following general Fraud Notice is intended to comply with the laws of your state. If any part of such language is found in conflict, such language shall be construed as amended to the extent necessary in order to meet the minimum requirements of your state. Any person who, knowingly and with intent to defraud or deceive any insurance company, files an application containing any materially false, incomplete or misleading information is guilty of committing a fraudulent insurance act which may be crime and subject to criminal prosecution.

I understand that if I desire to apply for dental insurance for myself and dependents at a later date under the Beneficial Employees Security Trust, I/we will be eligible for Class I, Preventive Procedures during the first 12 months of continuous coverage and during the second 12 months of continuous coverage, eligible for Class I, Preventive Procedures and for 50% of the benefits for Class II Basic Procedures not to exceed a maximum of \$500 during the second 12 months of continuous coverage. I understand that if I desire to apply for vision insurance for myself and dependents at a later date under the beneficial Employees Security Trust, I/we will be eligible for no more than a total of \$75 of vision benefits during the first 12 months of coverage.

<b>Your Signature in black ink</b>							<b>Date</b>			
<b>COBRA Electives</b>										
COBRA Electives: If you are currently continuing coverage under COBRA or a state continuation plan, what is the exact date of your qualifying event?										
BEST Use Only	WAIVER	COBRA EE <input type="checkbox"/> Yes <input type="checkbox"/> No	EE _____ 1 = Employee 2 = Dependent 3 = EE & Dependent	DEP. Refusal _____ R = No Coverage O = Other Coverage	SPOUSE EE <input type="checkbox"/> Yes <input type="checkbox"/> No	COB <input type="checkbox"/> Yes <input type="checkbox"/> No	DEP 19+ FTS Y H Y			
Eff. DATE	ER#	COVERAGES	PREV EE/DEP	NEW CHG	WP	#EES	LATE L	NEWBORN N	APP = A DECL= D	INITIALS

SERFF Tracking Number: BLHI-125895472 State: Arkansas  
Filing Company: BEST Life and Health Insurance Company State Tracking Number: 41027  
Company Tracking Number: BL-EGD-POL-1008  
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental  
Product Name: Group Indemnity Dental  
Project Name/Number: /

## Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: BLHI-125895472 State: Arkansas  
Filing Company: BEST Life and Health Insurance Company State Tracking Number: 41027  
Company Tracking Number: BL-EGD-POL-1008  
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental  
Product Name: Group Indemnity Dental  
Project Name/Number: /

## Supporting Document Schedules

**Satisfied -Name:** Certification/Notice **Review Status:** Withdrawn 01/15/2009  
**Comments:**  
**Attachment:**  
AR Certificate of Compliance\_Group Dental.pdf

**Satisfied -Name:** Application **Review Status:** Withdrawn 01/15/2009  
**Comments:**  
Application and enrollment forms included in this filing.

**CERTIFICATE OF COMPLIANCE**

I hereby certify that BEST Life and Health Insurance Company will adhere to and comply with all Arkansas laws and regulations including Rule & Regulation 19 and Rule & Regulation 49.

BEST Life and Health will supply the Consumer Notice required by ACA 23-79-138 and Bulletin 11-88 .

A handwritten signature in black ink that reads "Tammy O'Connor". The signature is written in a cursive style with a large initial "T" and "O".

(Signature)

Tammy O'Connor, Director of Regulatory Compliance

(Name and Title)

December 5, 2008

(Date)