

SERFF Tracking Number: CSLI-126151694 State: Arkansas
Filing Company: Citizens Security Life Insurance Company State Tracking Number: 42397
Company Tracking Number:
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
Product Name: Group Dental - Associations & Labor Unions
Project Name/Number: Group Dental - ASSC & LBUN/

Filing at a Glance

Company: Citizens Security Life Insurance Company

Product Name: Group Dental - Associations & Labor Unions SERFF Tr Num: CSLI-126151694 State: ArkansasLH

Labor Unions

TOI: H10G Group Health - Dental

SERFF Status: Closed

State Tr Num: 42397

Sub-TOI: H10G.000 Health - Dental

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form

Co Status:

Reviewer(s): Rosalind Minor

Author: Rickie Bolduc

Disposition Date: 05/19/2009

Date Submitted: 05/14/2009

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Group Dental - ASSC & LBUN

Status of Filing in Domicile: Pending

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type: Association, Other

Filing Status Changed: 05/19/2009

Explanation for Other Group Market Type:

LABOR UNIONS

Deemer Date:

State Status Changed: 05/19/2009

Corresponding Filing Tracking Number:

Filing Description:

Enclosed please find our group dental product for your review and approval. These are new policy forms and will not replace any existing forms.

Our group products are marketed by brokers and independent agents. This dental product will be a companion product to our group life and group vision products which are being filed concurrently with this filing, but under separate SERFF

SERFF Tracking Number: CSLI-126151694 State: Arkansas
Filing Company: Citizens Security Life Insurance Company State Tracking Number: 42397
Company Tracking Number:
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
Product Name: Group Dental - Associations & Labor Unions
Project Name/Number: Group Dental - ASSC & LBUN/

number.

These forms will be marketed to Associations and Labor Unions on a voluntary basis.

The applications that will be used with this dental product are form # ASLU APP GLA 01 09 AR and form # ASLU ENR GLA 01 09 AR, which are being filed with the group life product.

A Statement of Variability is attached to the Master Policy and Certificate.

Company and Contact

Filing Contact Information

Rickie Bolduc, Actarial Associate
PO Box 436149
Louisville, KY 40253-6149
rbolduc@cslico.com
(502) 244-2431 [Phone]
(502) 244-2439[FAX]

Filing Company Information

Citizens Security Life Insurance Company
12910 Shelbyville Road, Suite 300
CoCode: 61921
Group Code: 1310
State of Domicile: Kentucky
Company Type: Life and Accident and Health

PO Box 436149
Louisville, KY 40253-6149
(502) 244-2420 ext. [Phone]
Group Name: Citizens Financial Group
State ID Number:
FEIN Number: 61-0648389

Filing Fees

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

SERFF Tracking Number: *CSLI-126151694* *State:* *Arkansas*
Filing Company: *Citizens Security Life Insurance Company* *State Tracking Number:* *42397*
Company Tracking Number:
TOI: *H10G Group Health - Dental* *Sub-TOI:* *H10G.000 Health - Dental*
Product Name: *Group Dental - Associations & Labor Unions*
Project Name/Number: *Group Dental - ASSC & LBUN/*

CHECK NUMBER	CHECK AMOUNT	CHECK DATE
026180	\$50.00	05/13/2009

SERFF Tracking Number: CSLI-126151694 State: Arkansas
Filing Company: Citizens Security Life Insurance Company State Tracking Number: 42397
Company Tracking Number:
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
Product Name: Group Dental - Associations & Labor Unions
Project Name/Number: Group Dental - ASSC & LBUN/

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/19/2009	05/19/2009

SERFF Tracking Number: *CSLI-126151694* *State:* *Arkansas*
Filing Company: *Citizens Security Life Insurance Company* *State Tracking Number:* *42397*
Company Tracking Number:
TOI: *H10G Group Health - Dental* *Sub-TOI:* *H10G.000 Health - Dental*
Product Name: *Group Dental - Associations & Labor Unions*
Project Name/Number: *Group Dental - ASSC & LBUN/*

Disposition

Disposition Date: 05/19/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: CSLI-126151694 State: Arkansas
 Filing Company: Citizens Security Life Insurance Company State Tracking Number: 42397
 Company Tracking Number:
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
 Product Name: Group Dental - Associations & Labor Unions
 Project Name/Number: Group Dental - ASSC & LBUN/

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	COVER LETTER	Approved-Closed	Yes
Supporting Document	ACTUARIAL MEMO	Approved-Closed	Yes
Supporting Document	STATEMENTS OF VARIABILITY	Approved-Closed	Yes
Form	GROUP DENTAL MASTER POLICY	Approved-Closed	Yes
Form	GROUP DENTAL CERTIFICATE	Approved-Closed	Yes

SERFF Tracking Number: CSLI-126151694 State: Arkansas
 Filing Company: Citizens Security Life Insurance Company State Tracking Number: 42397
 Company Tracking Number:
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
 Product Name: Group Dental - Associations & Labor Unions
 Project Name/Number: Group Dental - ASSC & LBUN/

Form Schedule

Lead Form Number: ASLU MAST GPA 01 09 AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	ASLU MAST GPA 01 09 AR	Policy/Contract/Fraternal Certificate	GROUP DENTAL MASTER POLICY	Initial		46	Form ASLU MAST GPA 01 09.pdf
Approved-Closed	ASLU CERT GPA 01 09 AR	Certificate	GROUP DENTAL CERTIFICATE	Initial		54	Form ASLU CERT GPA 01 09.pdf

Citizens Security Life Insurance Company

The Marketplace, Suite 300
12910 Shelbyville Road
Louisville, Kentucky 40243

GROUP DENTAL INSURANCE MASTER POLICY

POLICYHOLDER: [Group Name]
POLICY NUMBER: [Group Number]
POLICY EFFECTIVE DATE: [January 1, 2007]
POLICY ANNIVERSARY: [January 1st]
POLICY ANNIVERSARY DATE: [January 1, 2008]
PREMIUM DUE DATE: [1st to the 15th of each month]
INITIAL TERM: [12 to 36 months]
POLICY DELIVERED IN: Arkansas and governed by the laws of that State

In consideration of:

- (a) the application of the Policyholder, a copy of which is attached to and made a part of this Policy; and
- (b) the payment of the first premium.

The Company agrees to pay the benefits of this Policy subject to all of its terms and the terms as shown in the Certificate herein attached and made a part of this Master Policy. This policy is a legal contract between the Policyholder and the Company.

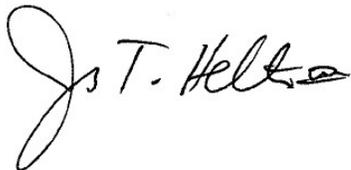
Citizens Security Life Insurance Company (Hereinafter called: We, Our, or Us) as of its Policy Effective Date executes this Policy. This Policy will take effect at 12:01 AM at the Policyholder's principal address shown on the application on the Policy Effective Date.

The insurance under this Policy does not exclude coverage for a health condition based solely on the fact that the health condition is work-related, unless the claimant is eligible for benefits under any workers' compensation act or similar law.

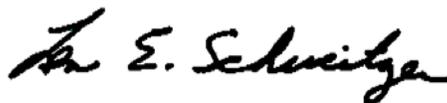
This Policy may be continued in force by payment of premium at the rates We establish until the insurance ends as provided.

READ YOUR POLICY CAREFULLY. Within 10 days from receipt of this policy, the Policyholder may return it for any reason. If returned, this policy is void. Any premium or policy fee paid on this policy will be refunded within 10 days from receipt of this policy by the Home Office. The policy may be returned to the Company or to the agent who sold this policy.

We have signed on behalf of Citizens Security Life Insurance Company.



James T. Helton, III
Executive Vice President



Len E. Schweitzer
Corporate Secretary

TABLE OF CONTENTS

Section 1.....	GENERAL PROVISIONS
Section 2.....	PREMIUM PROVISIONS
Section 3.....	CLAIM PROVISIONS
Section 4.....	TERMINATION OF INSURANCE

ANY ENDORSEMENTS OR RIDERS FOLLOW PAGE 5.

SECTION 1

GENERAL PROVISIONS

ENTIRE CONTRACT - CHANGES

The entire contract consists of;

1. this Policy;
2. the Certificate;
3. any Riders, Endorsements and Amendments, if any, adding or changing the provisions of the Policy or Certificate;
4. the Application of the Policyholder; and
5. the Enrollment Form of the Certificate Holder.

A copy of the Policyholder's Application is attached to this Policy on the date it is signed. All statements made in the Application and Enrollment Forms, in the absence of fraud, are representations and not warranties. No statement made by an Insured Person under this Policy will be used to void insurance or deny a claim unless a copy of the statement is or has been given to that Insured Person.

INDIVIDUAL CERTIFICATE

We will make a certificate available to each Insured Person under this Policy. Certificates will state the insurance protection to which He is entitled and to whom the benefits are payable.

CONFORMITY WITH STATE LAWS

The insurance laws of some states require that certain Policy provisions comply with the law of the state for all permanent residents of the state. Any Policy provision herein which does not conform with such law is hereby modified to the minimum extent necessary to satisfy legal requirements. However, any such provision is modified only for an Insured Person who is a permanent resident of the state at the time Covered Expenses are actually incurred as defined herein.

MISSTATEMENTS

If any relevant fact as to an Insured Person to whom this insurance relates is found to have been misstated, the true facts will be used to determine whether His/Her insurance is in force under the Policy and in what amount. If the error has an effect on the Premium, an adjustment of the Premium due will be made.

NON-PARTICIPATING

This Policy is non-participating. This means that it does not share in Our surplus earnings.

ASSIGNMENT

No assignment of this Policy is binding upon Us unless We agree to it in writing and not until it is filed with Us.

INCONTESTABILITY

This Policy will be incontestable, except for non-payment of premium, after it has been in force for two years.

CLERICAL ERROR

Any clerical error by Us in keeping relevant records, or a delay in making any entry, will not void any insurance otherwise validly in force or continue insurance otherwise validly terminated. When a clerical error or delay is found, Premiums and benefits will be adjusted based on the true facts and the provisions of the Policy.

CHANGES IN POLICY

The terms of this Policy can be changed only by written agreement between the Policyholder and Us. Agreement for Us can only be made by the President, Secretary or Vice President. Any changes will be made without the consent of, or notice to, any Insured Person. No agent has authority to make this Policy or to change, alter or amend any of its terms or provisions in any way.

POLICYHOLDER REQUIRED INFORMATION

Certain facts are needed to administer the Policy. We have the right to decide which facts We need. The Policyholder is required to comply with any reasonable request for information which We deem necessary to administer the Policy. We have the right to inspect any records of the Policyholder that have a bearing on the insurance or Premium under the Policy.

LEGAL ACTION

No legal action may be brought against Us to recover Policy benefits until at least 60 days after the required written Notice of Loss is submitted to Us. No such action may be brought more than 3 years after the time written Proof of Loss is required by the Policy to be given.

SECTION 2 PREMIUM PROVISIONS

PAYMENT OF PREMIUMS

The Premiums due under this Policy are payable in advance directly to Us. The first Premium is due on the Effective Date of this Policy. Premiums after the first are due on the Premium Due Date shown on the cover page of this Policy.

The payment of any Premium will not maintain the insurance in force beyond the day next following the Premium Due Date, except as provided under the GRACE PERIOD provision.

PREMIUM CALCULATION

The total Premium owed to Us under this Policy is obtained by multiplying the number of Insureds in each class by the applicable Premium rates in effect for all Insured Persons covered under this Policy and then summing the results.

PREMIUM ADJUSTMENTS

When additional or increased insurance begins or ends and the change is due to a change in the terms of this Policy, any adjustment in the premium will be made as of the date the change is effective. Otherwise, any adjustment in premium will be made on the Premium Due Date which occurs on or next follows the date of change (or the first day of the calendar month which occurs on or next follows the date of change if premiums are payable other than monthly).

CHANGES IN PREMIUM RATES

We have the right to change the Premium rates on any Premium Due Date after the Initial Term. After the Initial Term, We will not increase the Premium rates more than once in any 12 month period. We will notify the Policyholder in writing at least 31 days in advance of any increase.

PREMIUM RATE GUARANTEES

Any Premium rate guarantees are subject to the following provisions:

1. The benefits outlined in the Certificate as well as the eligibility remain unchanged.
2. There are no additions or deletions of subsidiaries or affiliates.
3. The census or geographic distribution does not change by more than 25%.

GRACE PERIOD

A Grace Period of 31 days (without interest charge) is granted for the payment of any Premium Due Date after the first. This Policy will continue in effect during this period unless the Policyholder has given written notice to Us that the insurance under this Policy is to be ended on the first day before the Grace Period would otherwise start. If the Premium is not paid by the end of the Grace Period all insurance under this Policy will end on the last day of the Grace Period, and the Policyholder will owe Us all Premiums then due and unpaid including the Premium for the Grace Period.

SECTION 3 CLAIM PROVISIONS

NOTICE OF CLAIM – PROOF OF LOSS

Written Notice of Claim (Proof of Loss) must be provided within ninety (90) days from the date of loss. We will not deny or reduce any claim filed after 90 days from the date of loss if:

1. It was not reasonably possible to file the claim within that 90-day period.
2. The claim is filed as soon as it is reasonably possible.

In any event, Proof of Loss must be provided to Us within one (1) year after it is due, unless You are legally incapable of doing so.

CLAIM FORMS

When We receive Notice of Claim that does not contain all necessary information or is not on an appropriate claim form, forms for filing Proof of Loss will be sent to the claimant along with a request for the missing information. If these forms are not provided within fifteen (15) days, the claimant will meet the Proof of Loss Requirements if We are given written proof of the nature and extent of the loss.

TIME PAYMENT OF CLAIMS

All benefits under the Policy will be paid within 30 days of receipt of Notice of Claim-Proof of Loss. If the claim is denied or contestable, we will notify the Insured within 30 days from the date that the claim is received by Us.

**SECTION 4
TERMINATION OF INSURANCE****EFFECTIVE DATE OF TERMINATION OF POLICY**

If the Policy is terminated by the Policyholder, coverage under the Policy will terminate on:

1. The later of the last day of the month next following or coinciding with the date stated in the written notice of termination from the Policyholder; or
2. The end of the month next following or coinciding with the date We receive the written notice of termination.

In either event, Premium is due and payable through the date on which coverage under the Policy terminates. If the premium is not paid, the policy will terminate as of the last day for which premium was paid.

INSURER'S RIGHT TO TERMINATE POLICY

We have the right to terminate coverage under the Policy on any Premium due date on or after the Initial Term of the Policy. We will give the Policyholder at least 31 days advance written notice of such termination. Insurance will end as provided above without the consent of, or notice to, any Insured Person.

Citizens Security Life Insurance Company

The Marketplace, Suite 300
12910 Shelbyville Road
Louisville, Kentucky 40243

CERTIFICATE OF INSURANCE FOR GROUP DENTAL INSURANCE

About Your Insurance – This Certificate explains the dental insurance coverage under this Policy issued to the Policyholder, which is underwritten by Citizens Security Life Insurance Company (Hereinafter called: We, Our, or Us). The Policy provides benefits for the Insured Person (Hereinafter called: You or Your). Read it closely to become familiar with Your plan.

Terms important to understanding the Certificate are defined in the Definitions section or in separate Certificate Provisions sections.

Important Notice – Benefits are payable only for listed Covered Procedures that were both started and completed while the patient is insured under the Policy, and after any applicable Waiting Periods have been served.

The Policy under which the Certificate is issued may at any time be amended or canceled, as stated in its provisions. Such an action may be taken without the consent of or notice to any Insured Person who claims rights or benefits under the Policy.

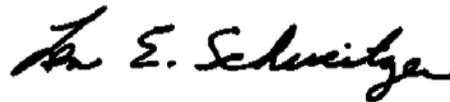
The Policy provides the benefits described in the Certificate for Insured Persons. This Certificate with any attached Riders, Endorsements, Amendments as well as the Application and Enrollment Form make up the Certificate of Insurance. It replaces any prior Certificates of Insurance issued under the Policy.

This Certificate is delivered in and governed by the laws of ARKANSAS.

We have signed on behalf of Citizens Security Life Insurance Company.



James T. Helton, III
Executive Vice President



Len E. Schweitzer
Corporate Secretary

TABLE OF CONTENTS

PAGES

PART I SCHEDULE OF BENEFITS

SCHEDULE OF BENEFITS	3
----------------------------	---

PART II GENERAL INSURANCE PROVISIONS

A. DEFINITIONS	5
B. ELIGIBILITY PROVISIONS	7
C. ENROLLMENT PROVISIONS.....	7
D. EFFECTIVE DATE PROVISIONS.....	8
E. TERMINATION PROVISIONS	8
F. PREMIUM PROVISIONS	9
G. CLAIM PROVISIONS	9
H. COORDINATION OF BENEFITS	10

PART III DENTAL INSURANCE COVERAGE PROVISIONS

A. DEDUCTIBLE	11
B. PERCENTAGE OF COVERED EXPENSE	11
C. PLAN YEAR BENEFIT MAXIMUM.....	11
D. WAITING PERIOD.....	11
E. BENEFITS PAYABLE FOR COVERED EXPENSES.....	12
F. DATE STARTED	12
G. DATE COMPLETED.....	12
H. PRE-ESTIMATION OF BENEFITS	12
I. ALTERNATE BENEFITS.....	13
J. LIMITATIONS AND EXCLUSIONS	13
K. UNBUNDLING	14
L. REVIEW OF CLAIM.....	14
M. TAKEOVER OF EXISTING COVERAGE.....	14

PART IV SCHEDULE OF COVERED PROCEDURES.....	16
--	-----------

PART I - SCHEDULE OF BENEFITS

Policyholder: [Group Name]

Policyholder Effective Date: [January 1, 2007]

Policy Number: [123456]

[Initial Term: [12 – 36 Months]]

[Eligible Classes: [All Eligible Members who are enrolled and part of a business, professional or trade group and their eligible dependents after completing the Eligibility Period]]

Eligibility Period: [0 To 360 Days from the first day of becoming a member of the Group]

[Mode of Premium Payment: [MONTHLY to ANNUAL]]

[Method of Premium Payment: [Remitted by Policyholder to Us] [and/or] [Remitted by Insured person To Us]

[Premium Due Date: [1st -15th of every month]]

[Premium Amount: [\$0-9,999.]]

Plan Year: Your plan Year is a [Calendar Year or Policy Year]

Deductible: In-Network: [\$50 Individual Deductible. Maximum Individual Deductible per Family: 3, unlimited] [Applies to Classes A,B,C]
 Out-of-Network: [\$50 Individual Deductible. Maximum Individual Deductible per Family: 3, unlimited] [Applies to Classes A,B,C]

Co-Pay: See Schedule of Covered Procedures

Waiting Periods: See Schedule of Covered Procedures

[Plan Year Benefit Maximum:

In-Network:			
<u>Year 1</u>	<u>Year 2</u>	<u>Year 3 & Forward</u>	
[\$0-9,999]	[\$0-9,999]	[\$0-9,999]	
Out-of- Network:			
<u>Year 1</u>	<u>Year 2</u>	<u>Year 3 & Forward</u>	
[\$0-9,999]	[\$0-9,999]	[\$0-9,999]]

Takeover Benefits: [Takeover Benefits Apply, or Do Not Apply]

[Orthodontic Benefits: [Orthodontic Benefits Apply to Insured Dependent Children Only, or Apply to All Insured Persons]]

[Cosmetic Benefits: [Cosmetic Benefits Apply to Insured Members Only, or Apply to All Insured Persons]]

[Maximum Roll Forward Benefits: [Roll Forward Benefits Apply to Insured Members Only, or Apply to All Insured Persons]]

Percentages of Covered Expenses:

Plan Year 1:

	In-Network	Out-of-Network	Subject to Plan Year Max Benefit	Maximum Lifetime Benefit
[Class A]	[0-100%]	[0-100%]	[Yes]	[None]
[Class B]	[0-100%]	[0-100%]	[Yes]	[None]
[Class C]	[0-100%]	[0-100%]	[Yes]	[None]
[Class D]	[0-100%]	[0-100%]	[No]	[\$0-9,999]
[Class E]	[0-100%]	[0-100%]	[No]	[\$0-9,999]

Plan Year 2:

	In-Network	Out-of-Network	Subject to Plan Year Max Benefit	Maximum Lifetime Benefit
[Class A]	[0-100%]	[0-100%]	[Yes]	[None]
[Class B]	[0-100%]	[0-100%]	[Yes]	[None]
[Class C]	[0-100%]	[0-100%]	[Yes]	[None]
[Class D]	[0-100%]	[0-100%]	[No]	[\$0-9,999]
[Class E]	[0-100%]	[0-100%]	[No]	[\$0-9,999]

Plan Year 3 and later:

	In-Network	Out-of-Network	Subject to Plan Year Max Benefit	Maximum Lifetime Benefit
[Class A]	[0-100%]	[0-100%]	[Yes]	[None]
[Class B]	[0-100%]	[0-100%]	[Yes]	[None]
[Class C]	[0-100%]	[0-100%]	[Yes]	[None]
[Class D]	[0-100%]	[0-100%]	[Yes]	[\$0-9,999]
[Class E]	[0-100%]	[0-100%]	[Yes]	[\$0-9,999]

Plan Type:

[Indemnity: No participating provider network]
 or
 [Participating Provider Program: In and Out-of-Network Benefits]
 or
 [Scheduled Plan]

PART II - GENERAL INSURANCE PROVISIONS

A. DEFINITIONS

We, Us, Our, Insurer means the Citizens Security Life Insurance Company.

He, Him and His refers to the male or female gender.

You, Your means an Insured Person.

Calendar Year, which is shown in the Schedule of Benefits, for the first year is the period of time that begins on the Effective Date and ends on December 31st. For subsequent years, it is the period of time that begins on January 1st and ends December 31st.

Covered Dental Injury means an injury to a Sound Natural Tooth sustained while insured under the Policy which is caused solely by a sudden violent act or accident which could not be predicted in advance or avoided.

Covered Expense means the lesser of: (1) the actual dental charge or (2) the Maximum Reimbursement for a Covered Procedure.

Covered Procedure means the procedures listed in the Schedule of Covered Procedures. The procedure must be: (1) for necessary dental treatments to an Insured Person while His coverage under this Policy is in force and (2) for treatment, which in Our opinion has a reasonably favorable prognosis for the patient. The procedure must be performed by a:

- a. licensed Dentist who is acting within the scope of his or her license; or,
- b. licensed Dental Hygienist acting under the supervision and direction of a Dentist.

[Co-Pay Amount is a flat dollar amount that an insured Person is required to pay a Participating Provider for a Covered Procedure. This amount may vary by Covered Procedure. It is deducted from the Covered Expense before any insurance benefit is determined.]

Dental Hygienist means someone who is licensed to practice dental hygiene and is acting under supervision and direction of a Dentist, if required, and within the scope of His license.

Dentist means a practitioner who is trained to practice Dentistry and is operating within the scope of His license.

Effective Date is the date on which insurance coverage begins under this Policy.

Eligible Class is a group of people who are eligible for coverage under this Policy. See the Schedule of Benefits for a list of Eligible Classes. Each person of the Eligible Class will qualify for insurance on the date He completes the required Eligibility Period.

Eligible Dependent means someone who is residing in the United States and who is:

- a. Your legally married spouse or lawful domestic partner.
- b. Your unmarried natural children, legally adopted children, step children, foster children or grandchildren who are under the age of 25, provided their legal residence is the same as Yours and they are dependent upon You for more than 50% of their support and maintenance. If their legal address is different from Yours, they are considered to be a Dependent if so ordered by a court decree or if they are listed as Dependents on Your most recent Federal tax return.
- c. Your natural children, legally adopted children, stepchildren, foster children or grandchildren who are 19 years old or older, but less than 25 years of age, but only if they:
 - 1) are not married; and,
 - 2) are dependent upon You for more than 50% of their support and maintenance, and are listed as Dependents on Your most recent Federal tax return; and,
 - 3) are primarily dependent upon You for support and maintenance; and are incapable of sustaining employment by reason of mental retardation, mental illness or disorder, or physical handicap.

Eligible Member means a person who belongs to an Eligible Class.

Eligible Period is the period of time that an Eligible Member must wait before He is eligible for coverage. This period, if any, is specified in the Policyholder's Application and shown in the Schedule of Benefits.

Family Members are a unit consisting of You and each of Your Insured Dependents.

Functioning Natural Tooth means a Natural Tooth which is performing its normal role in the mastication (i.e., chewing) process in the Insured Person's upper or lower arch and which is opposed in the Person's other arch by another Natural Tooth or prosthetic (i.e., artificial) replacement. Third Molars are not considered Functioning Natural Teeth for purposes of the Policy/Certificate.

Group means the Policyholder to which the Policy is issued.

In-Network Benefits means dental benefits provided under this Certificate for Covered Procedures that are provided by a Participating Provider.

Initial Insured Person is a person who is insured under this Policy on the Policy Effective Date.

Insured Dependent means an Eligible Dependent of an Insured Member for whom insurance under this Policy has become effective.

Insured Member means a person who is an Eligible Member of an Eligible Class, who has qualified for insurance by completing the Eligibility Period, and for whom insurance under the Policy has become effective.

Insured Person means an Insured Member and Insured Dependents.

Legal Action means no legal action may be brought against Us to recover Policy benefits until at least 60 days after the required written Notice of Loss is submitted to Us. No such action may be brought more than 3 years after the time written Proof of Loss is required by the Policy to be given.

Maximum Reimbursement means the amount used to determine the Covered Expense. There are three types of Maximum Reimbursements based on the plan that is issued:

- a. **Maximum Allowable Charge (CMAC):** The CMAC may be used if a Dentist who is a Non-Participating Provider performs a Covered Procedure. The amount of the CMAC is equal to the lesser of: (a) the actual dental charge; or (b) the "customary charge" for the dental Service. We determine the "customary charge" from within the range of charges made for the same Service by other providers of similar training or experience in that general geographic area.
- b. **Participating Provider Maximum Allowable Charge (MAC):** The MAC may be used if a Dentist who is a Participating Provider performs a Covered Procedure. This is the amount that the Dentist has agreed with Us to accept as payment in full for a dental Service.
- c. **Scheduled Allowable Fee (SAF):** Some plans may use a fee schedule to determine the amount payable for a Covered Procedure. This is the maximum charge that We allow for each Covered Procedure, regardless of the fee charged by the Dentist.

Natural Tooth means any tooth or part of a tooth that is organic and formed by the natural development of the body (i.e., not manufactured). Organic portions of a tooth include the clinical crown, enamel, dentin, cementum, root, and the enclosed pulp (nerve).

Non-Participating Provider means a Dentist who is not a Participating Provider. These Dentists have not entered into an agreement with us to limit their charges.

Out-of-Network Benefits means dental benefits provided under this Certificate for Covered Procedures that are not provided by a Participating Provider.

Participating Provider means a Dentist who has been selected by Us for inclusion in the Participating Provider Program. These Participating Providers agree to accept Our Participating Provider Maximum Allowed Charges as payment in full for Services rendered. When dental care is given by Participating Providers, the Insured Person will generally incur less out-of-pocket cost for Services rendered.

Participating Provider Program means Our program to offer an Insured Person the opportunity to receive dental care from Dentists who are designated by Us as Participating Providers.

Participating Provider Program Directory is a list that is periodically updated and consists of selected Dentists who:

- a. are located in Your area; and
- b. have been selected by Us to be Participating Providers and part of the Participating Provider Program.

Plan Year means the period of time shown in the Schedule of Benefits as "Calendar Year" or "Policy Year".

Policy is the entire contract. It consists of:

- a. the Policy; and,
- b. the Policyholder's Application; and,
- c. any Riders, Endorsements and Amendments; and,
- d. the Certificate of Insurance; and,
- e. the Enrollment Form, if any.

Policyholder means entity to which the Policy is issued.

Policy Anniversary means the month and day as shown on the Policy as the Policy Anniversary.

Policy Year, which is shown in the Schedule of Benefits, for the first year is the period of time that begins on the Effective Date and ends on the day before the next following Policy Anniversary. For subsequent years, it is the period of time that begins on the first and each subsequent Policy Anniversary and ends on the day before the next Policy Anniversary.

Premium is the amount of money paid each month to purchase the insurance benefits provided by the Policy.

Service means a procedure or supply which is performed by a Dentist or Dental Hygienist in connection with the dental care of an Insured Person. It is required and appropriate for treatment of the Insured Person's dental condition according to broadly accepted standards of dental care as determined by Us or Our dental consultants.

Sound Natural Tooth means a Natural Tooth which is fully restored to function, does not have any decay, is not more susceptible to injury than a virgin tooth, and is without periodontal disease.

Takeover Benefits (Continuation of Coverage) means that all Eligible members and their dependents that were insured by the Policyholder's prior dental insurer on the last day of coverage will receive:

1. Credit toward any waiting periods that is equivalent to the length of time they were insured; and
2. Credit for any deductible amount that was satisfied within the same plan year.

Benefit maximums will be limited to the maximums stated in the Schedule of Benefits of this policy less any amounts paid by the prior dental insurer within the same plan year.

Treatment Plan means the Dentist's report of recommended treatment on a form satisfactory to Us which:

- a. itemizes the dental Services; and,
- b. lists the charges for each itemized Service; and
- c. is accompanied by supporting pre-operative X-rays and any other appropriate diagnostic materials required by Us

B. ELIGIBILITY PROVISIONS

To be eligible for coverage under the Policy, an individual must:

- a. be a person of an Eligible Class of the Policyholder, as defined in the Schedule of Benefits; and
- b. satisfy the Eligibility Period, if any.

The Eligible Member's Eligible Dependents are also eligible for coverage, provided that You are insured under this Policy and that Dependent coverage is provided under the Policy.

Dual Eligibility Status: If both an Eligible Member and his spouse or lawful Domestic Partner are in an Eligible Class of the Policyholder, each may enroll individually or as a Dependent of the other, but not as both. Any Eligible Dependent child may also only be enrolled by one parent. If the spouse or lawful Domestic Partner carrying dependent coverage ceases to be eligible, Dependent coverage automatically becomes effective under the other spouse's or lawful Domestic Partner's coverage; or enrollment will default to the Policyholder's rules.

C. ENROLLMENT PROVISIONS

The term "Enrollment" means written or electronic application for coverage on an Enrollment Form furnished or approved by Us. Coverage will not become effective until the Eligible Members have enrolled themselves and their Eligible Dependents, and paid the required Premium, if any.

Initial Enrollment: Eligible Members should enroll themselves and their Eligible Dependents within 31 days of the Eligibility Period.

Change in Family Status: Members may enroll or change their coverage if a change in family status occurs, provided written application to enroll is made within 90 days of the event. A change in family status means any of the following:

- a. Marriage or lawful domestic partnership; and,
- b. Divorce or legal separation; and,
- c. Birth or adoption of a child; and,
- d. Death of a spouse or lawful domestic partner or child; and
- e. Other changes as permitted by Us.

D. EFFECTIVE DATE PROVISIONS

Eligible Members and Eligible Dependents

To become insured, You must first complete and sign an Enrollment Form which is acceptable to Us and pay the required Premium. You will become insured under the Policy at 12:01 AM at the main office of the Policyholder on Your first day of coverage.

Additional Dependents

If You acquire Additional Dependents and have Dependent coverage, You must complete, sign and submit to Us a new Enrollment Form for all Your Dependents, including newborn children. The Effective Date of the newly acquired Dependents will be governed by the same rules as described above under the heading "Eligible Members and Eligible Dependents". However, newborn children will be covered for the first 90 days following their birth. To continue coverage beyond that 90-day period, You must notify Us in writing of the Child's date of birth at any time during the 90-day period.

E. TERMINATION PROVISIONS

Insured Members

All of Your insurance under the Policy will terminate at 11:59 PM at the main office of the Policyholder on the earliest of the following dates:

- a. the date the Policy terminates;
- b. the last day of the month in which You cease to be an Eligible Member;
- c. the date You die; and
- d. on any Premium Due Date, when full payment for insurance is not made within 31 days following the Premium Due Date.

If an event that is described above occurs, written notice must be provided to Us at Our Home Office within 31 days.

Insured Dependents

Your Dependent's insurance under the Policy will terminate at 11:59 PM at the main office of the Policyholder on the earliest of the following dates:

- a. the date the Policy terminates;
- b. the last day of the month in which You cease to be an Eligible Member;
- c. the date the Insured Dependent ceases to be an Eligible Dependent;
- d. the date You die;
- e. the date the Insured Dependent dies;
- f. on any Premium Due Date, when full payment for insurance is not made within 31 days following the Premium Due Date; and
- g. the date We receive your request to terminate Dependent coverage subject to any limitation imposed by the Policyholder.

If an event that is described above occurs, written notice must be provided to Us at Our Home Office within 31 days.

Notice Required When Your Coverage Terminates

We must be informed promptly when Your coverage terminates for any reason. Failure to provide timely notice will not continue Your insurance past the time it would have otherwise ended as provided above.

In the event Premiums have been paid to Us on Your behalf after Your coverage should have terminated, We will refund the Premium for the period for which Premiums were paid in error up to a maximum of three Policy months or to the last

Policy Anniversary, whichever is less. If We are not notified that Your coverage is terminated and We pay any benefits for Your Covered Expenses incurred after the date Your coverage terminated, the full amount of those benefits will be considered an overpayment which must be repaid to Us.

Insurer's Right to Terminate Policy

We have the right to terminate coverage under the Policy on any Premium Due Date on or after the Initial Term of the Policy. We will give the Policyholder at least 31 days advance written notice of such termination.

F. PREMIUM PROVISIONS

Premium Payments

Continuance of coverage will be contingent upon payment of the premiums to Us at our Home Office. The first Premium is due on or before the effective date of your coverage; subsequent premiums are due on the premium Due Date specified in the Policy and each month thereafter.

Premium Due Dates

The first Premium is due on the Policy Effective Date. Premiums after the first are due on the Premium Due Date or within the grace period.

Grace Period

A grace period of 31 days is granted for the payment of each Premium Due Date after the first. The coverage stays in force if the Premium is paid during this grace period, unless We are given written notice that the insurance is to be ended before the Grace Period.

Right to Change Premiums

We have the right to change the Premium rates on any Premium Due Date on or after the Initial Term of the Policy. After the Initial Term, we will not increase the Premium rates more than once in a 12 month period. We will give the Policyholder written notice at least 31 days in advance of any change. All changes in rates are subject to terms outlined in the Policy.

G. CLAIM PROVISIONS

Notice Of Claim – Proof Of Loss

Written Notice of Claim must be provided within ninety (90) days from the date of loss to file written Proof of Loss. We will not deny or reduce any claim filed after 90 days from the date of loss if:

- a. It was not reasonably possible to file the claim within that 90-day period.
- b. The claim is filed as soon as it is reasonably possible.

In any event, Proof of Loss must be given to Us within one (1) year after it is due, unless You are legally incapable of doing so.

Claim Forms

You may use standard American Dental Association (ADA) approved claim forms supplied by Your Dentist or You may request forms from Us. The Claim Form must identify the treatment performed in terms of the ADA Uniform Code on Dental Procedures and Nomenclature or by narrative description. We reserve the right to request x-rays, narratives and other diagnostic information, as we see fit, to determine benefits.

When We receive notice of claim that does not contain all necessary information or is not on an appropriate Claim Form, forms for filing Proof of Loss will be sent to the claimant along with a request for the missing information. If these forms are not sent within fifteen (15) days, the claimant will meet the Proof of Loss requirements if We are given written proof of the nature and extent of the loss.

Time Payment Of Claims: After receiving written Proof of Loss and Premium payment, We will pay all benefits then due for dental claims. We will pay all claims or any portion of any claims within 30 days, or as required by Your state, after receipt of the claim. If a claim or a portion of a claim is contested by Us, the Insured Person shall be notified in writing, that the claim is contested or denied, within 30 days after receipt of the claim by us. The notice that a claim is contested shall identify the contested portion of the claim and the reasons for contesting the claim. Upon receipt of the additional information requested from the Insured Person, We shall pay or deny the contested claim or portion of the contested claim, within 60 days. We shall not pay or deny any claim later than 120 days after receiving the claim. We will, upon request, provide to the Insured Person an estimate of the amount We will pay for a particular dental Service.

Recovery Of Overpayments

We reserve the right to deduct from any benefits properly payable under this Policy the amount of any payment that has been made:

- a. in error; or
- b. pursuant to a misstatement contained in a proof of loss; or
- c. pursuant to fraud or misrepresentation made to obtain coverage under this Policy within two (2) years after the date such coverage commences; or
- d. with respect to an ineligible person; or
- e. pursuant to a claim for which benefits are recoverable under any Policy or act of law providing coverage for occupational injury or disease to the extent that such benefits are recovered.

Such deduction may be against any future claim for benefits under the Policy made by an Insured Person, if claim payments previously were made with respect to an Insured Person.

H. COORDINATION OF BENEFITS

This provision applies when an Insured Person has dental coverage under more than one Plan, as defined below. The benefits payable between the Plans will be coordinated.

A. DEFINITIONS RELATED TO COB

1. **Allowable Expense:** An expense that is considered a covered charge, at least in part, by one or more of the Plans. When a Plan provides benefits by services, reasonable cash value of each service will be treated as both an Allowable Expense and a benefit paid.
2. **Coordination of Benefits:** Taking other Plans into account when We pay benefits.
3. **Plan:** Any plan, including this one that provides benefits or services for dental expenses on a group basis. "Plan" includes group and blanket insurance and self-insured and prepaid plans. It includes government plans, and plans required or provided by statute (except Medicaid). "Plan" shall be treated separately for that part of a plan that reserves the right to coordinate with benefits or services of other plans and that part which does not.
4. **Primary Plan:** The Plan that, according to the rules for the Order of Benefit Determination, pays benefits before all other Plans.
5. **Year:** The Calendar Year, or any part of it, during which a person claiming benefits is covered under this Plan.
6. **Benefit Reserve:** means the savings recorded by a plan for claims paid for a covered person as a secondary plan rather than as a primary plan.
7. **Claim Determination Period:** means a period of at least twelve (12) consecutive months, over which allowable expenses shall be compared with total benefits payable in the absence of coordination of benefits, to determine whether over-insurance exists and how much each plan will pay or provide.

B. BENEFIT COORDINATION

Benefits will be adjusted so that the total payment under all Plans is no more than 100 percent of the Insured's Allowable Expense. In no event will total benefits paid exceed the total payable in the absence of COB.

If an Insured's benefits paid under this Plan are reduced due to COB, each benefit will be reduced proportionately. Only the amount of any benefit actually paid will be charged against any applicable Plan Year Benefit Maximum.

C. THE ORDER OF BENEFIT DETERMINATION

1. When this is the Primary Plan, We will pay benefits as if there were no other Plans.
2. When a person is covered by a Plan without a COB provision, the Plan without the provision will be the Primary Plan.
3. When a person is covered by more than one Plan with a COB provision, the order of benefit payment is as follows:
 - a. **Non-Dependent/Dependent.** A Plan that covers a person other than as a Dependent will pay before a Plan that covers that person as a Dependent.
 - b. **Dependent Child/Parents Not Separated or Divorced.** For a Dependent child, the Plan of the parent whose birthday occurs first in the Calendar Year will pay benefits first. If both parents have the same birthday, the Plan that has covered the Dependent child for the longer period will pay first.

- c. **Dependent Child/Separated or Divorced Parents.** If two or more Plans cover a person as a Dependent of separated or divorced parents, benefits for the child are determined in the following order:
 - i. The Plan of the parent who has responsibility for providing insurance as determined by a court order;
 - ii. The Plan of the parent with custody of the child;
 - iii. The Plan of the spouse of the parent with custody; and
 - iv. The Plan of the parent without custody of the child.
- d. **Dependent Child/Joint Custody:** If the joint custody court decree does not specifically state which parent is responsible for the child's medical expenses, the rules as shown for Dependent Child/Parents Not Separated or Divorced shall apply.
- e. **Longer/Shorter Length of Coverage.** When an order of payment is not established by the above, the Plan that has covered the person for the longer period of time will pay first.

D. Right to Receive and Release Needed Information

We may release to, or obtain from, any other insurance company, organization or person information necessary for COB. This will not require the consent of, or notice to You or any claimant. You are required to give Us information necessary for COB.

E. Right to Make Payments To Another Plan

COB may result in payments made by another Plan that should have been made by Us. We have the right to pay such other Plan all amounts it paid which would otherwise have been paid by Us. Amounts so paid will be treated as benefits paid under this Plan. We will be discharged from liability to the extent of such payments.

F. Right to Recovery

COB may result in overpayments by Us. We have the right to recover any excess amounts paid from any person, insurance company or other organization to whom, or for whom, payments were made.

PART III - DENTAL INSURANCE COVERAGE PROVISIONS

A. DEDUCTIBLE

The Deductible is the amount of Covered Expense which must be paid in full by You each Plan Year (or lifetime, when applicable) for each covered Family Member (or to the maximum per family limit, when applicable) who incurs a Covered Procedure before any benefits are payable. The Deductible is applied chronologically according to the dates on which the Covered Procedures on a claim were completed. The amount of the Deductible is shown in the Deductible section of the Schedule of Benefits.

B. PERCENTAGE OF COVERED EXPENSE

The Percentage of Covered Expense is the percentage of the Covered Expense that we will pay for a Covered Procedure. The percentage applicable to an Insured Person may vary by Covered Procedure and the length of time the Insured Person has been continuously covered for dental insurance. The Percentage of Covered Expense for a Covered Procedure is shown in the Schedule of Benefits.

C. PLAN YEAR BENEFIT MAXIMUM

The Plan Year Benefit Maximum is the maximum benefit payable by the Policy for all Covered Procedures completed in a Plan Year. This maximum will apply even if an Insured Person's coverage is interrupted or if an Insured Person has been covered both as an Insured Member and as an Insured Dependent during a Plan Year. The Plan Year Benefit Maximum is listed in the Schedule of Benefits.

D. WAITING PERIOD

The Waiting Period is the period of time starting on an Insured Person's Effective Date before benefits for certain Services become payable. If a Covered Procedure is started before the Waiting Period for that procedure ends, that procedure is not covered under the Policy. If an Insured Person's coverage under the Policy ends and then the Person later becomes insured again, that Insured Person's Effective Date is the most recent Effective Date unless stated otherwise in the Policy. The Waiting Periods for Covered Procedures are listed in the Schedule of Covered Procedures.

E. BENEFITS PAYABLE FOR COVERED EXPENSES

Upon receipt of Proof of Loss that an Insured Person has incurred a Covered Procedure, We will determine if benefits are payable.

Before we determine benefits, the Insured Person must satisfy any Waiting Periods and the Deductible, if applicable. We then pay the Percentage of Covered Expense, less any Co-Pay Amount subject to the Plan Year Benefit Maximum. Additionally, the benefit payable is subject to the following:

- a. The Covered Procedure must start and be completed while the Insured Person's coverage is in force, except as provided in the "Takeover of Existing Coverage" section of this Certificate.
- b. Each Covered Procedure may be subject to specific Frequency Limitations, as shown on the Schedule of Covered Procedures.
- c. Other limitations and exclusions that may affect coverage are shown in the "Limitations and Exclusions" section of this Certificate.

An Insured Person may choose a Dentist of his choice, and may choose the Services of a Dentist who is either a Participating Provider or a Non-Participating Provider. Benefits under this Certificate are determined and payable in either case. If a Participating Provider is chosen, the Insured Person will generally incur less out-of-pocket cost unless the Policyholder has selected an In-Network Only plan.

F. DATE STARTED

For benefit determination purposes, the following will define the date on which certain Covered Procedures will be deemed started;

- a. for Full Dentures or Partial Dentures, on the date the first impression is taken;
- b. for Fixed Partial Dentures (including Maryland Bridges), Crowns, Inlays, Onlays and other laboratory prepared restorations, on the date the teeth are first drilled down to receive the restoration;
- c. for Root Canal Therapy, on the date the pulp chamber is first opened;
- d. for Periodontal Surgery, on the date the surgery is actually performed; and
- e. for All Other treatment, on the date the Service is performed.

Note: If Orthodontia Services are covered, see the Schedule of Covered Procedures for Start Dates.

G. DATE COMPLETED

For benefit determination purposes, the following will define the date on which certain Covered Procedures will be deemed completed:

- a. for Root Canal Therapy, on the date the canals are permanently filled;
- b. for Fixed Partial Dentures (including Maryland Bridges), Crowns, Inlays, Onlays, and other laboratory prepared restorations, on the date the restoration is permanently cemented in place;
- c. for Dentures and Partial Dentures, on the date that the final completed appliance is first inserted in the mouth (However, no denture or partial denture will be considered completed unless and until it is accepted by the patient.); and
- d. for all other treatment, on the date the procedure is started.

Note: If Orthodontia Services are covered, see the Schedule of Covered Procedures for Completion Dates.

H. PRE-ESTIMATION OF BENEFITS

Whenever the charge for any treatment is expected to exceed \$500, We suggest that the Treatment Plan be submitted to Us by the Dentist for review before treatment begins. The Treatment Plan should be accompanied by supporting pre-operative X-rays and any other appropriate diagnostic materials that We or Our dental consultants request.

We will notify the Insured Persons attending Dentist of the estimated benefits payable based upon the Treatment Plan. In determining the amount of benefits payable, consideration will be given to alternate procedures that may accomplish a professionally satisfactory result. We will pay a benefit toward the cost of the more expensive procedure or material, but payment will be limited to the Benefits Payable for Covered Expenses for the least costly Service. We will not pay the excess amount.

I. ALTERNATE BENEFITS

There is often more than one Service that can be used to treat a dental problem or disease. In determining the benefits payable on a claim, different materials and methods of treatment will be considered. The amount payable will be limited to the Covered Expense for the least costly Service, which meets broadly accepted standards of dental care as determined by Us. The Insured Person and His Dentist may decide on a more costly procedure or material than We have determined to be satisfactory for the treatment of the condition. We will pay a benefit toward the cost of the more expensive procedure or material, but payment will be limited to the Benefits Payable for Covered Expenses for the least costly Service. We will not pay the excess amount.

J. LIMITATIONS AND EXCLUSIONS

No benefits are payable under the Policy for the Services listed below. In addition, the Services listed below will not be recognized toward the satisfaction of any Deductible:

- a. Any Services which are not included in the Schedule of Covered Procedures;
- b. any Service started or appliance installed before the Effective Date or after the Termination Date;
- c. any Service, which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least 3 years, as determined by Us;
- d. any procedure We determine is not necessary, does not offer a favorable prognosis, does not have uniform professional endorsement or is experimental in nature;
- e. crowns, inlays, onlays, cast restorations, or other laboratory prepared restorations on teeth, which may be satisfactorily restored with an amalgam or composite resin filling;
- f. any treatment which is elective or primarily cosmetic in nature and not generally recognized as a generally accepted dental practice by the American Dental Association, as well as any replacement of prior cosmetic restorations unless such procedure is listed in the Schedule of Covered Procedures;
- g. appliances, Services or procedures relating to: (1) the change or maintenance of vertical dimension; (2) restoration of occlusion (unless otherwise noted in the Schedule of Covered Procedures—only for occlusal guards); (3) splinting; (4) correction of attrition, abrasion, erosion or abfraction; (5) bite registration or (6) bite analysis;
- h. replacement of bridges unless the bridge is older than the age allowed in the Schedule of Covered Procedures and cannot be made serviceable;
- i. replacement of full or partial dentures unless the prosthetic appliance is older than the age allowed in the Schedule of Covered Procedures and cannot be made serviceable;
- j. replacement of crowns, inlays or onlays unless the prior restoration is older than the age allowed in the Schedule of Covered Procedures and cannot be made serviceable;
- k. for Orthodontic treatment unless otherwise listed as a Covered Procedure in the Schedule of Covered Procedures;
- l. Services provided for any type of temporomandibular joint (TMJ) dysfunctions, muscular, skeletal deficiencies involving TMJ or related structures, myofascial pain unless such procedure is listed as a Covered Procedure in the Schedule of Covered Procedures;
- m. charges for implants of any type, and all related procedures, removal of implants, precision or semi-precision attachments, denture duplication, overdentures and any associated surgery, or other customized Services or attachments unless such procedures are listed as Covered Procedures in the Schedule of Covered Procedures;
- n. Athletic mouth guards; myofunctional therapy; treatment for malignancies, cysts and neoplasms; failure to keep scheduled appointments; charges for completion of claim forms, infection control; precision or semi-precision attachments; denture duplication; oral hygiene instruction; separate charges for acid etch; charges for travel time; transportation costs; professional advice; treatment of jaw fractures; orthognathic surgery; exams required by a third party other than Us, personal supplies (e.g., water pik, toothbrush, floss holder, etc.); or replacement of lost or stolen appliances;
- o. prescription drugs, premedication, pharmaceuticals, or analgesia;
- p. dental disease, defect or injury caused by a declared or undeclared war or taking part in an insurrection or riot; the commission or attempted commission of a crime; an intentionally self-inflicted injury or attempted suicide while sane or insane;
- q. dental treatment not approved by the American Dental Association or which is clearly experimental in nature;
- r. any charge for a Service for which benefits are available under Worker's Compensation or an Occupational Disease Act or Law, even if the Insured Person did not purchase the coverage that is available to Him;
- s. any charge for a Service performed outside of the United States other than for emergency treatment. Benefits for emergency treatment performed outside of the United States are limited to a maximum of \$100 per year;
- t. Services performed by a Dentist who is member of the Insured Person's family. Insured Person's family is limited to a spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents;
- u. The initial placement of a removable full denture or a removable partial denture unless it includes the replacement of a Functioning Natural Tooth extracted while the Person is insured under the Policy;

- v. The initial placement of a fixed partial denture including a Maryland Bridge, unless it includes the replacement of a Functioning Natural Tooth extracted while the Person is insured under the Policy, provided that tooth was not an abutment to an existing partial denture. Frequency Limitations for replacement of Dentures and bridges are stated in the Schedule of Covered Procedures. Benefits are payable only for the replacement of those teeth which were extracted while the Person was insured under the Policy;
- w. The replacement or removal of teeth beyond the normal complement of 32;
- x. The replacement of an existing removable partial denture with a fixed partial denture unless upgrading to a fixed partial denture is essential to the correction of the Insured Person's dental condition;
- y. Local anesthetic as a separate fee;
- z. Any Treatment Plan which involves full-mouth reconstruction by the removal and reestablishment of occlusal contacts of 10 or more teeth with restorations, crowns, onlays, inlays, fixed partial dentures, dentures, or any combination of these Services; and,
- aa. Services with respect to congenital (hereditary) or developmental (before birth) malformations, except during the thirty-one (31) day period immediately following the birth of a child to a member who is insured hereunder, including but not limited to: cleft palate, maxillary and mandibular (upper and lower) malformations, enamel hypoplasia (lack of development), fluorosis, and anodontia.

K. UNBUNDLING

When certain complicated dental Services are performed and other less extensive Services are performed at the same time, they will be considered component parts of the primary Service. For benefit purposes under the Policy, these less extensive Services are considered to be integral components of the primary Service. Even if the Dentist bills separately for the primary Service and each of its component parts, the total benefit payable for all related charges will be limited to the Benefits Payable for Covered Expenses for the primary Service.

L. REVIEW OF CLAIM

If We send You a written statement denying Your claim in whole or in part or termination of Your plan, You or Your authorized representative or the provider acting on Your behalf may submit a written appeal to Us within 60 days after receipt of the statement of denial of benefits or plan termination. We will review, make a determination and notify You of Our decision regarding Your appeal within 30 days of receipt of the appeal.

M. TAKEOVER OF EXISTING COVERAGE

The following provisions are applicable if this dental plan is replacing an existing group dental plan in force (referred to as "Prior Plan") at the time of application. These are called "Takeover Benefits." The Schedule of Benefits shows if Takeover Benefits apply.

Waiting Period Credit:

When We immediately take over an entire dental group from another insurance company, those Insured Persons on the Prior Plan on the day immediately prior to the takeover Effective Date will receive Waiting Period credit if they are eligible for coverage on the Policy Effective Date of Our plan. The Waiting Period credit does not apply to a new Insured Person, Eligible Dependent add-ons, Late Entrants, or Re-enrollees.

Deductible Credits:

- a. For Calendar Year Plans: Deductible credits will be granted for the amount of Deductible satisfied under the Prior Plan during the current Calendar Year.
- b. For Policy Year Plans: The Deductible will begin anew on the policy's takeover Effective Date, which marks the start of a new Policy Year.

Plan Year Benefit Maximum:

- a. For Calendar Year plans: All paid benefits applied to the Plan Year Benefit Maximum under the Prior Plan will also be applied to Plan Year Benefit Maximum under this Certificate during the current Calendar Year.
- b. For Policy Year plans: The Plan Year Benefit Maximum will begin anew on the policy's takeover Effective Date, which marks the start of a new Policy Year.

If You had Orthodontic coverage for Your covered Dependent children under the Prior Plan and You have Orthodontic coverage under this Certificate, We will not pay benefits for Orthodontic expenses unless:

- a. You submit proof that the Maximum Lifetime Benefit for Orthodontic Services for this Certificate was not exceeded under the Prior Plan;
- b. Orthodontic treatment was started and bands or appliances were inserted while insured under the Prior Plan; and
- c. Orthodontic treatment is continued for Your Insured Dependent under this Certificate.

Lifetime Maximum:

If You submit the required proof, the Maximum Lifetime Benefit for Orthodontic treatment will be the lesser of this Certificate's Maximum Lifetime Benefit for Orthodontic Services or the Prior Plan's Orthodontic Maximum Lifetime Benefit. The Orthodontic Maximum Lifetime Benefit payable under this Certificate will be reduced by the amount paid or payable under the Prior Plan.

Verification:

The Policyholder's Application must be accompanied by a current month's billing from the current dental carrier, a copy of an in-force Certificate, as well as proof of the Effective Date for each Insured Person, if insured under the Prior Plan.

Prior Carrier's Responsibility:

The prior carrier is responsible for costs for procedures begun prior to the Effective Date of this coverage.

Prior Extractions:

If: (1) treatment is dentally necessary due to an extraction which occurred before the Effective Date of this coverage while an Insured Person was covered under the Prior Plan; and (2) treatment would have been covered under the Policyholder's Prior Plan; We will apply the expenses to this plan as long as they are Covered Procedures under both this Certificate and the Prior Plan.

Coverage for Treatment in Progress:

If an Insured Person was covered under the Prior Plan on the day before this Certificate replaced the Prior Plan, the Insured Person may be eligible for benefits for treatment already in progress on the Effective Date of this Certificate. However, the expenses must be Covered Procedures under both this Certificate and the Prior Plan. This is subject to the following:

Extension of Benefits under Prior Plan. We will not pay benefits for treatment if:

- (a) the Prior Plan has an Extension of Benefits provision;
- (b) the treatment expenses were incurred under the Prior Plan; and
- (c) the treatment was completed during the extension of benefits.

We will consider only the percentage of treatment completed beyond the extension period to determine any benefits payable under this Certificate.

PART IV - SCHEDULE OF COVERED PROCEDURES

The following is a complete list of Covered Procedures, their assigned Procedure Class, Waiting Period, and applicable Frequency Limitations. We will not pay benefits for expenses incurred for any Procedure not listed in this Schedule of Covered Procedures.

Procedure Class	Type of Maximum Reimbursement
[A Preventive/Diagnostic] [B Basic] [C Major] [D Orthodontia] [E Other]	[In-Network] [MAC - Participating Provider Maximum Allowable Charge] [CMAC - Customary Maximum Allowable Charge] [Co-Pay - Co-Pay Amount]
	[Out-of-Network] [MAC - Participating Provider Maximum Allowable Charge] [CMAC - Customary Maximum Allowable Charge] [SAF - Scheduled Allowable Fee]

Frequency Limitations

- | | |
|--|--|
| [(a) Maximum of 1 procedure per 6 months]
[(b) Maximum of 1 procedure per 36 months]
[(c) Maximum of 12 films per 36 months]
[(d) Limited to Dependent Children under age 19]
[(e) Maximum of 1 procedure per 12 months]
[(f) Limited to Dependent Children under age 14]
[(g) Limited to Dependent Children under age 12]
[(h) Maximum of 1 procedure per 24 months]
[(j) Applications made to permanent molar teeth only]
[(k) Maximum of 2 procedures per arch per 24 months]
[(l) Maximum of 1 per 5 year period per tooth]
[(m) Maximum of 1 each quadrant per 12 months]
[(n) Maximum of 1 each quadrant per 24 months]
[(o) Maximum of 1 each tooth per 24 months]
[(p) Subject to a yearly and a lifetime maximum]
[(q) Maximum of 1 each quadrant per 36 months] | [(r) Replacement of existing only if in place for 12 months (insured under age 19)]
[(s) Replace existing only if in place for 36 months (insured over age 19)]
[(t) Benefits will be based on the benefit for the corresponding non- cosmetic restoration.]
[(u) Maximum 1 time per tooth]
[(v) Maximum of 1 per lifetime]
[(w) Only in conjunction with listed complex oral surgery procedures and subject to review.]
[(x) Limited to Dependent Children under age 16]
[(y) Maximum of 1 per 24 months for age 17+]
[(z) Maximum of 1 per 12 months for age 16 & under]
[(aa) Limited to those age 25+]
[(bb) 6 months must have passed since initial placement]
[(cc) Maximum of 1 per 7 year period]
[(dd) Maximum of 1 per 10 year period]
[(ee) Maximum of 1 per 3 year period]
[(ff) Maximum of 1 per 4 year period]
[(gg) Maximum of 1 per 5 year period]
[(hh) Limited to premature loss of primary tooth under age 14] |
|--|--|

Covered Procedures	Procedure Class	Waiting Period [Months]	Limitation	[SAF] [or] [Co-Pay]
Diagnostic and Preventative				
[Comprehensive Oral Exam or]	[A]	[(0-24)]	[(a)]	[\$0- \$999]
[Periodic Oral Exam]	[A]	[(0-24)]	[(a)]	[\$0- \$999]
[Problem Focused Exam]	[A]	[(0-24)]	[(e)]	[\$0- \$999]
[Emergency Palliative Treatment]	[A]	[(0-24)]	[(e)]	[\$0- \$999]
[Single Film]	[A]	[(0-24)]	[]	[\$0- \$999]
[Additional Films]	[A]	[(0-24)]	[]	[\$0- \$999]
[Intra-Oral Occlusal Film]	[A]	[(0-24)]	[]	[\$0- \$999]
[Panoramic Film,]	[A]	[(0-24)]	[(h)]	[\$0- \$999]
[Full Mouth X-Ray]	[A]	[(0-24)]	[(h)]	[\$0- \$999]
[Bitewing – Single Film, or]	[A]	[(0-24)]	[(y) (z)]	[\$0- \$999]
[Bitewing – Two Films, or]	[A]	[(0-24)]	[(y) (z)]	[\$0- \$999]
[Bitewing – Four Films]	[A]	[(0-24)]	[(y) (z)]	[\$0- \$999]
[Prophylaxis]	[A]	[(0-24)]	[(a)]	[\$0- \$999]
[Topical Application of Fluoride]	[A]	[(0-24)]	[(e) (x)]	[\$0- \$999]
[Sealant]	[A]	[(0-24)]	[(b) (x) (j)]	[\$0- \$999]
[Space Maintainer – Fixed Unilateral]	[A]	[(0-24)]	[(x) (o)]	[\$0- \$999]
[Space Maintainer – Fixed Bilateral]	[A]	[(0-24)]	[(x) (o)]	[\$0- \$999]
[Space Maintainer – Removable Unilateral]	[A]	[(0-24)]	[(x) (o)]	[\$0- \$999]
[Space Maintainer – Removable Bilateral]	[A]	[(0-24)]	[(x) (o)]	[\$0- \$999]
FILLINGS				
[One Surface Amalgam]	[B]	[(0-24)]	[(r) (s)]	[\$0- \$999]
[Two Surface Amalgam]	[B]	[(0-24)]	[(r) (s)]	[\$0- \$999]
[Three Surface Amalgam]	[B]	[(0-24)]	[(r) (s)]	[\$0- \$999]
[Four + Surface Amalgam]	[B]	[(0-24)]	[(r) (s)]	[\$0- \$999]
[One Surface Resin – [Anterior]]	[B]	[(0-24)]	[(r) (s)]	[\$0- \$999]
[Two Surface Resin – [Anterior]]	[B]	[(0-24)]	[(r) (s)]	[\$0- \$999]
[Three Surface Resin – [Anterior]]	[B]	[(0-24)]	[(r) (s)]	[\$0- \$999]
[Four + Surface or Incisal Resin – [Anterior]]	[B]	[(0-24)]	[(r) (s)]	[\$0- \$999]
[Sedative Fillings]	[B]	[(0-24)]	[(o)]	[\$0- \$999]

ORAL SURGERY				
[Extraction, erupted tooth or exposed root]	[C]	[(0-24)]	[]	[\$0- \$999]
[Coronal Remnants]	[C]	[(0-24)]	[]	[\$0- \$999]
[Surgical Extraction]	[C]	[(0-24)]	[]	[\$0- \$999]
[Impacted (soft tissue)]	[C]	[(0-24)]	[]	[\$0- \$999]
[Impacted (partial bony)]	[C]	[(0-24)]	[]	[\$0- \$999]
[Impacted (complete bony)]	[C]	[(0-24)]	[]	[\$0- \$999]
[Alveolectomy (with extraction) – per quadrant]	[C]	[(0-24)]	[]	[\$0- \$999]
[Alveolectomy (without extraction) – per quadrant]	[C]	[(0-24)]	[]	[\$0- \$999]
[Incision and Drainage of Abscess – Intraoral]	[C]	[(0-24)]	[]	[\$0- \$999]
[General Anesthesia/Intravenous Sedation]	[C]	[(0-24)]	[(w)]	[\$0- \$999]
CROWN AND BRIDGE REPAIR				
[Inlay Recementation]	[C]	[(0-24)]	[(bb)]	[\$0- \$999]
[Crown Recementation]	[C]	[(0-24)]	[(bb)]	[\$0- \$999]
[Bridge Repair]	[C]	[(0-24)]	[(bb)]	[\$0- \$999]
[Crown Repair]	[C]	[(0-24)]	[(bb)]	[\$0- \$999]
[Bridge Recementation]	[C]	[(0-24)]	[(bb)]	[\$0- \$999]
DENTURE REPAIR				
[Repair Denture Base]	[C]	[(0-24)]	[(e) (bb)]	[\$0- \$999]
[Repair Teeth – per tooth]	[C]	[(0-24)]	[(e) (bb)]	[\$0- \$999]
[Repair Partial Base]	[C]	[(0-24)]	[(e) (bb)]	[\$0- \$999]
[Repair Partial Framework]	[C]	[(0-24)]	[(e) (bb)]	[\$0- \$999]
[Repair Broken Clasp]	[C]	[(0-24)]	[(e) (bb)]	[\$0- \$999]
[Add Tooth to Existing Partial Denture]	[C]	[(0-24)]	[(e) (bb)]	[\$0- \$999]
[Add Clasp to Existing Partial Denture]	[C]	[(0-24)]	[(e) (bb)]	[\$0- \$999]
[Replace Teeth – per tooth]	[C]	[(0-24)]	[(e) (bb)]	[\$0- \$999]
[Reline Upper Denture]	[C]	[(0-24)]	[(h) (bb)]	[\$0- \$999]
[Reline Lower Partial Denture]	[C]	[(0-24)]	[(h) (bb)]	[\$0- \$999]
[Reline Upper Denture (Lab)]	[C]	[(0-24)]	[(h) (bb)]	[\$0- \$999]
[Reline Lower Denture (Lab)]	[C]	[(0-24)]	[(h) (bb)]	[\$0- \$999]
[Reline Upper Partial Denture (Lab)]	[C]	[(0-24)]	[(h) (bb)]	[\$0- \$999]
[Reline Lower Partial Denture (Lab)]	[C]	[(0-24)]	[(h) (bb)]	[\$0- \$999]
[Rebase Complete Denture – Upper]	[C]	[(0-24)]	[(h) (bb)]	[\$0- \$999]
[Rebase Complete Denture – Lower]	[C]	[(0-24)]	[(h) (bb)]	[\$0- \$999]
[Rebase Partial Denture – Lower]	[C]	[(0-24)]	[(h) (bb)]	[\$0- \$999]
[Tissue Conditioning – Upper]	[C]	[(0-24)]	[(k) (bb)]	[\$0- \$999]
[Tissue Conditioning – Lower]	[C]	[(0-24)]	[(k) (bb)]	[\$0- \$999]

PERIODONTICS (Non-surgical)				
[Scaling and Root Planing–per quadrant]	[C]	[(0-24)]	[(n)]	[\$0- \$999]
[Periodontal Debridement (full mouth)]	[C]	[(0-24)]	[(v)]	[\$0- \$999]
[Periodontal Maintenance Procedure]	[C]	[(0-24)]	[(a)]	[\$0- \$999]
ENDODONTICS				
[Vital Pulpotomy – primary teeth only]	[C]	[(0-24)]	[(f)]	[\$0- \$999]
[Root Canal – Bicuspid]	[C]	[(0-24)] [(iv)]	[]	[\$0- \$999]
[Root Canal – Molar]	[C]	[(0-24)]	[]	[\$0- \$999]
[Apicoectomy – Anterior]	[C]	[(0-24)]	[(u)]	[\$0- \$999]
[Apicoectomy – Molar]	[C]	[(0-24)]	[(u)]	[\$0- \$999]
[Retrograde Filling]	[C]	[(0-24)]	[(u)]	[\$0- \$999]
[Root Amputation]	[C]	[(0-24)]	[(u)]	[\$0- \$999]
PERIODONTICS (Surgical)				
[Gingivectomy – per quadrant]	[C]	[(0-24)]	[(n)]	[\$0- \$999]
[Gingivectomy – per tooth]	[C]	[(0-24)]	[(o)]	[\$0- \$999]
[Gingival Curettage – Surgical per quadrant, or]	[C]	[(0-24)]	[(n)]	[\$0- \$999]
[Osseous Surgery – per quadrant]	[C]	[(0-24)]	[(n)]	[\$0- \$999]
[Soft Tissue Grafts]	[C]	[(0-24)]	[(n)]	[\$0- \$999]
[Gingival Flap Surgery]	[C]	[(0-24)]	[(n)]	[\$0- \$99]
CROWN				
[Crown Resin – resin with high noble metal]	[C]	[(0-24)]	[(l) (t)]	[\$0- \$999]
[Crown Resin – resin with noble metal]	[C]	[(0-24)]	[(l) (t)]	[\$0- \$999]
[Crown Resin – resin with predominately base metal]	[C]	[(0-24)]	[(l) (t)]	[\$0- \$999]
[Crown – porcelain/ceramic substrate]	[C]	[(0-24)]	[(l) (t)]	[\$0- \$999]
[Crown - porcelain fused to high noble metal]	[C]	[(0-24)]	[(l) (t)]	[\$0- \$999]
[Crown – porcelain fused to noble metal]	[C]	[(0-24)]	[(l) (t)]	[\$0- \$999]
[Crown –porcelain fused to predominantly base metal]	[C]	[(0-24)]	[(l) (t)]	[\$0- \$999]
[Crown – full cast high noble metal]	[C]	[(0-24)]	[(l) (t)]	[\$0- \$999]
[Crown – ¾ cast high noble metal]	[C]	[(0-24)]	[(l) (t)]	[\$0- \$999]
[Crown – full cast noble metal]	[C]	[(0-24)]	[(l) (t)]	[\$0- \$999]
[Crown – full cast predominantly base metal]	[C]	[(0-24)]	[(l)]	[\$0- \$999]
[Crown Prefabricated Stainless Steel]	[C]	[(0-24)]	[(l)]	[\$0- \$999]
[Cast Post and Core – In Addition to Crown]	[C]	[(0-24)]	[(l)]	[\$0- \$999]
[Prefabricated Post and Core – In Addition to Crown]	[C]	[(0-24)]	[(l)]	[\$0- \$999]

BRIDGE				
[Pontic Cast High Noble Metal]	[C]	[(0-24)]	[(l) (t)]	[\$0- \$999]
[Pontic Cast Noble Metal]	[C]	[(0-24)]	[(l) (t)]	[\$0- \$999]
[Pontic Cast Predominantly Base Metal]	[C]	[(0-24)]	[(l)]	[\$0- \$999]
[Pontic Porcelain Fused to High Noble Metal]	[C]	[(0-24)]	[(l) (t)]	[\$0- \$999]
[Pontic Porcelain Fused to Noble Metal]	[C]	[(0-24)]	[(l) (t)]	[\$0- \$999]
[Pontic Porcelain Fused to Predominantly Base Metal]	[C]	[(0-24)]	[(l) (t)]	[\$0- \$999]
[Pontic Resin with High Noble Metal]	[C]	[(0-24)]	[(l)]	[\$0- \$999]
[Pontic Resin with Noble Metal]	[C]	[(0-24)]	[(l)]	[\$0- \$999]
[Pontic Resin with Predominantly Base Metal]	[C]	[(0-24)]	[(l)]	[\$0- \$999]
[Crown Resin with High Noble Metal]	[C]	[(0-24)]	[(l) (t)]	[\$0- \$999]
[Crown Resin with Noble Metal]	[C]	[(0-24)]	[(l) (t)]	[\$0- \$999]
[Crown Resin with Predominantly Base Metal]	[C]	[(0-24)]	[(l) (t)]	[\$0- \$999]
[Crown Porcelain / Ceramic; Porcelain Fused to High Noble Metal]	[C]	[(0-24)]	[(l) (t)]	[\$0- \$999]
[Crown Porcelain Fused to Noble / High Noble Metal]	[C] [C]	[(0-24)] [(0-24)]	[(l) (t)] [(l) (t)]	[\$0- \$999] [\$0- \$999]
[Crown Porcelain Fused to Predominantly Base Metal]				
[Crown Porcelain Fused to Noble Metal; Full Cast High Noble Metal]	[C]	[(0-24)]	[(l)]	[\$0- \$999]
[Crown ¾ Cast High Noble Metal]	[C]	[(0-24)]	[(l)]	[\$0- \$999]
[Crown Full Cast Noble Metal]	[C]	[(0-24)]	[(l)]	[\$0- \$999]
[Crown Full Cast Predominantly Base Metal]	[C]	[(0-24)]	[(l)]	[\$0- \$999]
[Prefabricated Post and Core in Addition to Fixed Partial Denture Retainer]	[C]	[(0-24)]	[(l)]	[\$0- \$999]
[Core Buildup for Retainer,(including any pins)]	[C]	[(0-24)]	[(l)]	[\$0- \$999]
[Core Build-up (including any pins)]	[C]	[(0-24)]	[(l)]	[\$0- \$999]
[Inlay]	[C]	[(0-24)]	[(l)]	[\$0- \$999]
[Onlay]	[C]	[(0-24)]	[(l)]	[\$0- \$999]
[Veneers – excluding cosmetic restorative only]	[C]	[(0-24)]	[(l)]	[\$0- \$999]

MISCELLANEOUS				
[Occlusal Guard]	[E]	[(0-24)]	[]	[\$0- \$999]

DENTURES				
[Complete Upper Denture]	[C]	[(0-24)]	[(l)]	[\$0- \$999]
[Complete Lower Denture]	[C]	[(0-24)]	[(l)]	[\$0- \$999]
[Immediate Upper Denture]	[C]	[(0-24)]	[(l)]	[\$0- \$999]
[Immediate Lower Denture]	[C]	[(0-24)]	[(l)]	[\$0- \$999]
[Upper Partial – Resin Base]	[C]	[(0-24)]	[(l)]	[\$0- \$999]
[Lower Partial – Resin Base]	[C]	[(0-24)]	[(l)]	[\$0- \$999]
[Prefabricated Post and Core in Addition to Fixed Partial Denture Retainer]	[C]	[(0-24)]	[(l)]	[\$0- \$999]
[Core Build-up for Retainer, (including any pins)]	[C]	[(0-24)]	[(l)]	[\$0- \$999]
[Core Build-up (including any pins)]	[C]	[(0-24)]	[(l)]	[\$0- \$999]
[Inlay]	[C]	[(0-24)]	[(l)]	[\$0- \$999]
[Onlay]	[C]	[(0-24)]	[(l)]	[\$0- \$999]
[Veneers – excluding cosmetic; restorative only]	[C]	[(0-24)]	[(l)]	[\$0- \$999]
[Upper Partial – Cast Metal Base]	[C]	[(0-24)]	[(l)]	[\$0- \$999]
[Lower Partial – Cast Metal Base]	[C]	[(0-24)]	[(l)]	[\$0- \$999]
[Removable Unilateral Partial Denture]	[C]	[(0-24)]	[(l)]	[\$0- \$999]
[Denture Adjustment – Upper]	[C]	[(0-24)]	[(a) (bb)]	[\$0- \$999]
[Denture Adjustment – Lower]	[C]	[(0-24)]	[(a) (bb)]	[\$0- \$999]
[Partial Adjustment – Upper]	[C]	[(0-24)]	[(a) (bb)]	[\$0- \$999]
[Partial Adjustment – Lower]	[C]	[(0-24)]	[(a) (bb)]	[\$0- \$99]
OTHER				
[Implants]	[E]	[(0-24)]	[(p)]	[\$0- \$999]
[Cosmetic]	[E]	[(0-24)]	[(p) (u)]	[\$0- \$999]
[TMJ]	[E]	[(0-24)]	[(p)]	[\$0- \$999]
ORTHODONTIA [*]				
[Initial Orthodontic Examination]	[D]	[(0-24)]	[(d) (p)]	[\$0- \$999]
[Initial Placement of Braces or Appliances]	[D]	[(0-24)]	[(d) (p)]	[\$0- \$999]
[Continuing Treatment for Braces or Appliances]	[D]	[(0-24)]	[(d) (p)]	[\$0- \$999]

[* Orthodontia Services:

If covered, We will pay benefits for the Orthodontic Services listed above when the date started for the Orthodontic Service occurs while the person is insured under this Certificate. No payment will be made for Orthodontic treatment if the appliances or bands are inserted prior to becoming insured except as provided in the Takeover of Existing Coverage provision. We consider Orthodontic treatment to be started on the date the bands or appliances are inserted. Any other Orthodontic treatment that can be completed on the same day it is rendered is considered to be started and completed on the date the Orthodontic treatment is rendered.

We will pay the Percentage of Covered Expenses shown in the Schedule of Benefits.. The Maximum Lifetime Benefit payable to each Insured Person under this Policy, for Orthodontic Services is shown in the Schedule of Benefits. Those Insured Persons who are eligible for Orthodontia coverage are also shown in the Schedule of Benefits. The Maximum Lifetime Benefit will apply even if coverage is interrupted.

We will make a payment for covered Orthodontic Services related to the initial Orthodontic treatment which consists of diagnosis, evaluation, pre-care and insertion of bands or appliances. After the payment for the initial Orthodontic treatment, benefits for covered Orthodontic Services will be paid in equal monthly installments over the course of the remaining Orthodontic treatment. The benefit payment schedule for the initial Orthodontic treatment and monthly installments will be determined as follows:

We will determine the lesser of the MAC and the Orthodontist's fee and multiply that amount by the Percentage of Covered Expenses shown in the Schedule.

The lesser of the amount from number 1 or the Maximum Lifetime Benefit for Orthodontic Services shown in the Schedule of Benefits will be the maximum benefit payable. An initial amount of 25% of the Maximum Lifetime Benefit payable will be paid for the initial Orthodontic treatment. This amount will be payable as of the date appliances or bands are inserted.

3. The remaining 75% of the Maximum Lifetime Benefit payable will be divided by the number of quarters that Orthodontic treatment will continue to determine the amount which will be payable for each subsequent quarter of Orthodontic treatment. The subsequent monthly payments will be made only if Your Dependent remains insured under this Certificate and provides proof to Us that Orthodontic treatment continues. If Orthodontic treatment continues after the Maximum Lifetime Benefit payable has been paid, no further benefits will be paid.]

SERFF Tracking Number: *CSLI-126151694* *State:* *Arkansas*
Filing Company: *Citizens Security Life Insurance Company* *State Tracking Number:* *42397*
Company Tracking Number:
TOI: *H10G Group Health - Dental* *Sub-TOI:* *H10G.000 Health - Dental*
Product Name: *Group Dental - Associations & Labor Unions*
Project Name/Number: *Group Dental - ASSC & LBUN/*

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: CSLI-126151694 State: Arkansas
 Filing Company: Citizens Security Life Insurance Company State Tracking Number: 42397
 Company Tracking Number:
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
 Product Name: Group Dental - Associations & Labor Unions
 Project Name/Number: Group Dental - ASSC & LBUN/

Supporting Document Schedules

Satisfied -Name: Flesch Certification **Review Status:** Approved-Closed 05/19/2009
Comments:
Attachment:
 Readability Cert.pdf

Satisfied -Name: Application **Review Status:** Approved-Closed 05/19/2009
Comments:
 FOR INFORMATIONAL PURPOSES ONLY; APPLICATIONS BEING FILED UNDER SERFF # CSLI-126151657.
Attachments:
 Form ASLU APP GLA 01 09.pdf
 Form ASLU ENR GLA 01 09.pdf

Satisfied -Name: COVER LETTER **Review Status:** Approved-Closed 05/19/2009
Comments:
Attachment:
 Cover Ltr.pdf

Satisfied -Name: ACTUARIAL MEMO **Review Status:** Approved-Closed 05/19/2009
Comments:
Attachment:
 actuarial memo.pdf

Satisfied -Name: STATEMENTS OF VARIABILITY **Review Status:** Approved-Closed 05/19/2009
Comments:
Attachments:
 ASLU MAST GPA 01 09 St. of Variability.pdf
 ASLU CERT GPA 01 09 St. of Variability.pdf

Citizens Security Life Insurance Company
12910 Shelbyville Road, Suite 300
Louisville, KY 40243

Readability Certification

I, James Helton, Executive Vice President, Group Products, Citizens Security Life Insurance Company, hereby certify that the following forms have a Flesch Scale readability score of:

ASLU MAST GPA 01 09 AR; Group Dental Master Policy – 46.2
ASLU CERT GPA 01 09 AR; Group Dental Certificate – 53.6

I also certify, to the best of my knowledge and belief, the form is in compliance with the statutes and regulations for simplified and readability policy forms of the state for which it is being filed.

Signed for: Citizens Security Life Insurance Company

Date: May 5, 2009

By: 

Title: Executive Vice President,
Group Products

GROUP INSURANCE MASTER APPLICATION

POLICYHOLDER INFORMATION			
Policyholder Name:		Federal Tax ID:	
Address:			
City:	State:	Zip Code:	Phone #:
Group Contact:	Email Address:		Fax #:
Nature of the Group:			
COVERAGE REQUESTED (PLEASE CHECK ALL THAT APPLY)			
<i>Application must be accompanied by a copy of the Proposal Rate Page for the selected coverage(s).</i>			
<input type="checkbox"/> Dental	<input type="checkbox"/> Dependent Spouse.	<input type="checkbox"/> Dependent Child.	
<input type="checkbox"/> Vision	<input type="checkbox"/> Dependent Spouse.	<input type="checkbox"/> Dependent Child.	
<input type="checkbox"/> Life	<input type="checkbox"/> Dependent Family (Spouse and Child(ren))		
<input type="checkbox"/> Accidental Death and Dismemberment (<i>Member ONLY</i>)			
PLAN INFORMATION			
Plan Effective Date (Requested):		Eligibility Period Waived For Initial Enrollment (Y/N)?	
Total Number of Members:		Total Number of Members Enrolled:	
Eligibility Period for New Members:		First of the Month Following:	Other:
I Agree to Accept Electronic Delivery of the Policy and Certificates. <input type="checkbox"/> Yes <input type="checkbox"/> No			
AUTHORIZATION			
<p>I hereby authorize CITIZENS SECURITY LIFE INSURANCE to issue a Group Policy(ies) and Certificates for coverage as listed above. The effective date of coverage shall be as listed above; provided that final data submitted is satisfactory for the issuance of the policy(ies) requested. I also agree to administer the program(s) for the Members and to make premium payments, if appropriate.</p> <p><i>Any person who knowingly and with intent to defraud any insurance company, or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.</i></p>			
Authorized Signature:		Title:	Date:
Agent's Signature:			Date:
Agent's Printed Name:		Agent No:	

GROUP ENROLLMENT APPLICATION

Citizens Security Life Insurance Company
P.O.Box 436149, Louisville, KY 40253-6149

New Enrollment **Change**

Part I – To be Completed by Policyholder (Please Print)				
Group No.	Group Name.	Date of Group Membership:		
Part II – Coverage Election (eligibility for Dependent Insurance requires Member Coverage)				
VOLUNTARY LIFE	DENTAL	VISION		
Member: <input type="checkbox"/> Yes. <input type="checkbox"/> No. Coverage Amount \$ _____.	Member: <input type="checkbox"/> Yes. <input type="checkbox"/> No.	Member: <input type="checkbox"/> Yes. <input type="checkbox"/> No.		
Dependent Family (spouse & children): <input type="checkbox"/> Yes. <input type="checkbox"/> No.	Dependent Spouse: <input type="checkbox"/> Yes. <input type="checkbox"/> No.	Dependent Spouse: <input type="checkbox"/> Yes. <input type="checkbox"/> No.		
Spouse Coverage Amount \$ _____.	Dependent Child(ren): <input type="checkbox"/> Yes. <input type="checkbox"/> No.	Dependent Child(ren): <input type="checkbox"/> Yes. <input type="checkbox"/> No.		
Child(ren) Coverage Amount \$ _____.				
Part III – To be Completed by Member (Please Print)				
Member Name. (Last, First, MI).		Date of Birth.	Age.	<input type="checkbox"/> Male. <input type="checkbox"/> Married. <input type="checkbox"/> Female. <input type="checkbox"/> Single.
Street Address.	City.	State.	Zip Code.	Social Security Number.
List all Eligible Dependents to be insured under this application (Please Print)				
Name of Dependent.	Relationship.	Sex.	Date of Birth.	Social Security Number.
Beneficiary Information for Member’s Coverage (Member is the beneficiary of proceeds on Spouse and Child(ren) insurance)				
Primary. (First, Middle, Last).	Soc Sec No.	Date of Birth.	Allocation %	Relationship.
Contingent. (First, Middle, Last).	Soc Sec No.	Date of Birth.	Allocation %	Relationship.

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

I hereby request to be insured for benefits to which I may be entitled under the Group Policy (ies) issued to the Policyholder listed above. For the coverage I have declined, I understand that if I choose to enroll at a later date, my cost may be higher, Evidence of Insurability may be required or coverage may be denied.

I hereby declare that all answers above are true and complete to the best of my knowledge and belief.

Signature of Member. _____ Date. _____

Signature of Spouse. _____ Date. _____

Signature of Dependent(s) (Age 19 & older). _____ Date. _____



May 13, 2009

Arkansas Department of Insurance
Health Division, Forms and Rates
1200 West 3rd Street
Little Rock, AR 72201-1904

Re: Citizens Security Life Insurance Company - **New Submission**
NAIC#-61921 FEIN# 61-0648389
Form # ASLU MAST GPA 01 09 AR; Group Dental Master Policy
ASLU CERT GPA 01 09 AR; Group Dental Certificate

Dear Sir/Madam:

Enclosed please find our group dental product for your review and approval. These are new policy forms and will not replace any existing forms.

Our group products are marketed by brokers and independent agents. This dental product will be a companion product to our group life and group vision products which are being filed concurrently with this filing, but under separate SERFF number.

These forms will be marketed to Associations and Labor Unions on a voluntary basis.

The applications that will be used with this dental product are form # ASLU APP GLA 01 09 AR and form # ASLU ENR GLA 01 09 AR, which are being filed with the group life product.

A Statement of Variability is attached to the Master Policy and Certificate.

If you should have any questions concerning this filing, please contact me at (800) 843-7752 or e-mail rbolduc@cslico.com. Your prompt attention to this filing is greatly appreciated.

Sincerely,

A handwritten signature in black ink that reads 'Rickie Ellen Bolduc'.

Mrs. Rickie Ellen Bolduc, FLMI, AIRC, ACS
Actuarial Associate

Citizens Security Life Insurance Company

Group Dental Policy

Actuarial Memorandum

Form Number: ASLU MAST GPA 01 09 AR & ASLU CERT GPA 01 09 AR

Scope and Purpose of Filing

The purpose of this actuarial memorandum is to describe the benefits and assumptions for the attached Group Dental Insurance Policy, and to certify that this form is in compliance with applicable laws and regulations. This memorandum is not intended to be used for any other purpose.

Description of Benefits

This form is designed to provide Dental Insurance benefits to association members and their dependents. Benefits include reimbursement of expenses incurred for Covered Dental Procedures, subject to any Annual Deductible, Coinsurance, and Annual Plan Maximum per person. In addition, certain Covered Dental Procedures may have frequency limits, age limits, or waiting periods as described in the Schedule of Covered Procedures and Policy Schedule of Benefits.

There is no limit to the Insured Person's choice of provider.

Renewability Clause

This is an Annually Renewable policy form.

Marketing Method

This form will be distributed to members of associations and their dependents, through independent agents and brokers.

Underwriting

All coverage under this policy form will be guaranteed issue.

Issue Age Range

This Form can be issued to all ages.

Rating Factors

This Form has no discrete rating classes, but certain factors are considered in pricing. These factors include plan design (coinsurance, deductibles, maximum, etc); demographics (age, sex, area, industry, etc); and other risk factors (group size, participation percentage, rate guarantees, etc). The result of these various rating factors produces a unique rate for each group.

Morbidity

The morbidity assumptions are based on the Company's experience under Group Dental Policy forms.

Claim Liability and Reserves

An incurred but not reported claim reserve will be held for this form. This reserve will be estimated based on the previous 12 months claims lag data (claims by incurral month and by paid month).

Contingency and Risk Margins

This form includes a contingency and risk margin as a percentage of premium, which is sufficient to meet the Company's Return on Investment target with respect to the required Risk-Based Capital.

Actuarial Certification

I, James T. Helton III, am a Fellow of the Society of Actuaries, and a Member of the American Academy of Actuaries. I certify that to the best of my knowledge and judgment this filing is in compliance with the applicable laws of the state for which it is being filed, the premiums are neither excessive nor inadequate, and the benefits provided are reasonable in relation to the premiums.



James T. Helton III, FSA, MAAA
Executive Vice President - Group

5/4/2009

Date

CITIZENS SECURITY LIFE INSURANCE COMPANY
STATEMENT OF VARIABILITY
Citizens Security Dental Insurance Master Policy
Form ASLU MAST GPA 01 09 AR

I. Front Page

- a. Policyholder name will change with each policy issued.
- b. Group Policy Number will change with each group issued.
- c. Policy Effective Date will be given a date of issue ranging from the 1st through the 15th of the month.
- d. Policy Anniversary will reflect the month of the year and day of the month of the policy's anniversary date.
- e. Policy Anniversary Date will reflect the first policy anniversary date following the issue of the group policy.
- f. Premium Due Date will reflect the day of the month premiums are due--1st to the 15th.
- g. Initial Term is the period of time that the policy will remain in force before it will be renewed.

CITIZENS SECURITY LIFE INSURANCE COMPANY
STATEMENT OF VARIABILITY
Citizens Security's Certificate of Insurance for Group Dental Insurance
Form ASLU CERT GPA 01 09 AR

Schedule of Benefits – Page 3

- a. Policyholder: is the name of the company the holds the master policy.
- b. Policyholder Effective Date: is the issue date of the master policy.
- c. Policy Number: is the policy number of the master policy.
- d. Initial Term: Is the period of time that the master policy will remain in force before it will be renewed.
- e. Eligible Classes: we will reflect the various classes of members that are eligible for benefits under the master policy.
- f. Eligibility Period: we will reflect the number of days after the active date of membership that a member becomes eligible for insurance benefits.
- g. Mode of premium payment: we will show the frequency which premium payments are to be paid.
- h. Method of Premium Payment: We will describe how the premiums are to be paid to Us.
- i. Premium Due Date: we will show the day of the month and the months that a premium is due.
- j. Premium Amount: will reflect the amount of the premium that is due on each of the premium due dates.
- k. Plan Year: will reflect whether the policy is on a calendar year or a plan year basis.
- l. Deductible: we will show the amount of any deductible, the maximum number of deductibles per year, and to what classes of benefits the deductible applies. We will show the forging information for in-network and out-of-networks.
- m. Plan Year Benefit Maximum: we will reflect the maximum plan year benefits for each plan year if there are variances. We will show both in-network and out-of-network benefits.
- n. Takeover Benefits: we will indicate whether the takeover provisions apply or do not apply.
- o. Orthodontic Benefits: we will indicate whether the orthodontic benefits apply or do not apply.
- p. Cosmetic Benefits: we will indicate whether the cosmetic benefits apply or do not apply.
- q. Maximum Roll Forward Benefits: we will indicate whether the maximum roll forward benefits apply or do not apply.
- r. Percentage of Covered Expenses: we will reflect by plan year, the percent of customary charge for in-network as well as for out-of-network providers. We will show whether the benefit is subject to a plan year limitation and we will show if the benefit has a lifetime maximum. If there are different benefits for different plan years, we will show each plan year.
- s. Plan type: we will reflect if the policy is a indemnity plan, a participating provider program or a scheduled plan.

Definitions - Page 5

If the plan issued to the policyholder provides for a co-payment, we will include the definition of "Co-pay Amount".

Schedule of Covered Procedures – Pages 16 through 22

We will reflect several aspects of a scheduled plan. The covered procedure will be listed with a procedure class designation, a waiting period of 0 to 24 months, a limitation code if applicable and the scheduled allowable fee. If the plan issued was a co-pay plan as opposed to a scheduled fee plan, we will show the Co-pay Amount as opposed to the Scheduled Allowable Fee in the last column.