

SERFF Tracking Number: USHG-126178761 State: Arkansas  
Filing Company: Freedom Life Insurance Company of America State Tracking Number: 42588  
Company Tracking Number: GDENTPPO-C-AR-FLIC  
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental  
Product Name: AR Dental PPO FLIC  
Project Name/Number: /

## Filing at a Glance

Company: Freedom Life Insurance Company of America

Product Name: AR Dental PPO FLIC

TOI: H10G Group Health - Dental

Sub-TOI: H10G.000 Health - Dental

Filing Type: Form

Implementation Date Requested: On Approval

State Filing Description:

SERFF Tr Num: USHG-126178761 State: ArkansasLH

SERFF Status: Closed

State Tr Num: 42588

Co Tr Num: GDENTPPO-C-AR-FLIC

State Status: Approved-Closed

Co Status:

Reviewer(s): Rosalind Minor

Author: Shari McBride

Disposition Date: 06/15/2009

Date Submitted: 06/05/2009

Disposition Status: Approved-Closed

Implementation Date:

## General Information

Project Name:

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 06/15/2009

Deemer Date:

Filing Description:

June 5, 2009

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: Filed concurrently.

Market Type: Group

Group Market Size: Large

Group Market Type: Association

Explanation for Other Group Market Type:

State Status Changed: 06/15/2009

Corresponding Filing Tracking Number:

The Honorable Jay Bradford

Life and Health Division

Department of Insurance

1200 West 3rd Street

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Product Name: AR Dental PPO FLIC  
Project Name/Number: /  
Little Rock, AR 72201-1904

Attn: Life and Health Division

Re: Freedom Life Insurance Company of America  
FEIN # 61-1096685  
New Submission  
Association Group Dental Form  
GDENTPPO-C-AR-FLIC – Dental Expense Certificate

Dear Commissioner:

Enclosed for your review and approval is the above referenced form. The form is new and not intended to replace any forms previously approved by your Department.

Form GDENTPPO-C-AR-FLIC is a dental expense certificate providing coverage for preventive, basic and major dental care.

The group master policy form will be issued to previously approved / filed associations or those that we may file for approval in the future. The group policy will be issued in Arizona. Please be advised this dental product will be marketed along side our medical plans submitted under separate cover, and will utilize the same applications as those plans. A certificate of insurance will be issued to members of the association to evidence coverage under the group policy. These products will be marketed to individuals, by licensed agents in your state.

Please be advised that bracketed information is considered variable. All of the variables (i.e., deductibles, coinsurance percentages, etc.) that we plan to use have been included on the schedule pages within the brackets.

The appropriate fees and transmittal documents are also enclosed.

Your consideration of this filing is greatly appreciated. Should you have any questions, please contact me via email at [mcbrides@ushealthgroup.com](mailto:mcbrides@ushealthgroup.com) , telephone (800) 387-9027, ext. 422, or fax (817) 878-3310.

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Sincerely,

Shari McBride, FLMI  
 Product Analyst  
 Product Development

## Company and Contact

### Filing Contact Information

Shari McBride, Product Analyst mcbrides@ushealthgroup.com  
 801 Cherry Street, Unit 33 (800) 221-9039 [Phone]  
 Fort Worth, TX 76102 (817) 878-3422[FAX]

### Filing Company Information

Freedom Life Insurance Company of America CoCode: 62324 State of Domicile: Texas  
 3100 Burnett Plaza Group Code: 839 Company Type: Accident, Life and Health

801 Cherry Street, Unit 33  
 Fort Worth, TX 76102 Group Name: State ID Number:  
 (817) 878-3328 ext. [Phone] FEIN Number: 61-1096685  
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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? Yes  
 Fee Explanation: \$50 filing fee per form.  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
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SERFF Tracking Number: USHG-126178761 State: Arkansas  
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Freedom Life Insurance Company of America \$50.00 06/05/2009 28392494



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 Product Name: AR Dental PPO FLIC  
 Project Name/Number: /

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/15/2009	06/15/2009

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	06/09/2009	06/09/2009	Shari McBride	06/11/2009	06/11/2009

*SERFF Tracking Number:* USHG-126178761      *State:* Arkansas  
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*Product Name:* AR Dental PPO FLIC  
*Project Name/Number:* /

## **Disposition**

Disposition Date: 06/15/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	6-11-09 Tracked Changes	Approved-Closed	Yes
<b>Form</b>	Dental Certificate	Approved-Closed	Yes

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## Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 06/09/2009

Submitted Date 06/09/2009

Respond By Date

Dear Shari McBride,

This will acknowledge receipt of the captioned filing.

Objection 1

- Dental Certificate (Form)

Comment:

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

Objection 2

- Dental Certificate (Form)

Comment:

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

Objection 3

- Dental Certificate (Form)

Comment:

Under item 3 of the conversion coverage, it is stated that the insured must be covered for three (3) consecutive months immediately prior to the date coverage ceases. This is a limitation which is not part of the Conversion Law. Refer to ACA 23-86-114 (a).

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 06/11/2009  
Submitted Date 06/11/2009

Dear Rosalind Minor,

### Comments:

Thank you for your prompt review and response on the above referenced filing.

### Response 1

Comments: Please accept my apologies for this oversight. We have changed the coverage for newborns to 90 days and also for adoptees.

### Related Objection 1

Applies To:

- Dental Certificate (Form)

Comment:

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

### Changed Items:

#### Supporting Document Schedule Item Changes

Satisfied -Name: 6-11-09 Tracked Changes

Comment: The pages that have been changed are included as a tracked / underlined copy for your convenience.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

## Response 2

SERFF Tracking Number: USHG-126178761 State: Arkansas  
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Comments: We have removed the 31 day limitation and replaced it with 'as soon as reasonably possible.'

#### **Related Objection 1**

Applies To:

- Dental Certificate (Form)

Comment:

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

#### **Changed Items:**

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

#### **Response 3**

Comments: This item has been removed.

#### **Related Objection 1**

Applies To:

- Dental Certificate (Form)

Comment:

Under item 3 of the conversion coverage, it is stated that the insured must be covered for three (3) consecutive months immediately prior to the date coverage ceases. This is a limitation which is not part of the Conversion Law. Refer to ACA 23-86-114 (a).

#### **Changed Items:**

No Supporting Documents changed.

No Form Schedule items changed.

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No Rate/Rule Schedule items changed.

A tracked copy is included for your convenience in review. We appreciate your continued review.

Sincerely,  
Shari McBride

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## Form Schedule

**Lead Form Number:** GDENTPPO-C-AR-FLIC

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	GDENTPP O-C-AR- FLIC	Certificate	Dental Certificate	Initial		52	GDENTPPO- C-AR- FLIC.pdf

# FREEDOM LIFE INSURANCE COMPANY OF AMERICA

[3100 Burnett Plaza • 801 Cherry Street, Unit 33 • FORT WORTH, TEXAS 76102 • 1-800-387-9027]

(Hereinafter called: the Company, We, Our or Us)

## DENTAL EXPENSE CERTIFICATE

**THIS CERTIFICATE IS GUARANTEED RENEWABLE, SUBJECT TO THE COMPANY'S RIGHT TO DISCONTINUE OR TERMINATE THE CERTIFICATE AS PROVIDED IN THE RENEWAL CONDITIONS AND TERMINATION OF COVERAGE PROVISIONS OF THIS CERTIFICATE.**

**IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION:** Please read the copy of **Your** application for coverage, which is attached to and part of this **Certificate**, to see if any dental history or other information inquired about or contained in the application is incorrect, incomplete or missing. Contact **Us** immediately if any information contained in the application is incorrect, incomplete or missing. Any incorrect or incomplete statements or answers, as well as any missing information could cause a claim to be denied or the coverage under this Certificate to be reformed or voided.

**We**, Freedom Life Insurance Company of America, promise to pay **Covered Expenses** incurred by an **Insured** as stated in the BENEFITS provision of this **Certificate** and the **Group Policy**. **Benefits** are also subject to the definitions, exclusions, limitations, reductions, maximum benefit amounts and other provisions of this **Certificate**, as well as any riders, endorsements, or amendments attached to this **Certificate**.

**Certain phrases and words have the first letter of each word capitalized and the entire word or phrase printed in bold face type. These are generally defined phrases and words, and as such have the express meaning set forth in DEFINITIONS section of this Certificate.**

The **Group Policy** and this **Certificate** shall remain in effect until thirty (30) days after written notice of termination is given by **Us** or the **Group Policyholder**.

### YOUR 30 DAY RIGHT TO RETURN THIS CERTIFICATE

If **You** are not satisfied with this **Certificate**, **You** may return it to **Us** within thirty (30) days after **You** receive it. **You** may return it to **Us** by mail or to the agent who sold it. This **Certificate** will be voided as of the **Issue Date**, and **We** will refund any premium **We** have received prior to **Our** receipt of the returned **Certificate**.

### RENEWAL CONDITIONS

**You** may renew this **Certificate** on any renewal date, subject to the TERMINATION OF COVERAGE provision, unless **We** give **You** at least thirty-one (31) days written notice that **We** are refusing to renew. **We** may refuse to renew only if **We** do so on all **Certificates** of this form on a **Class Basis** in the state where **Your Certificate** was issued. **Our** refusal to renew can only be effective on a premium due date and the coverage under this **Certificate** will then terminate at 12:01 A.M. local time where **You** live. To renew, pay the renewal premium at the interval(s) available to **You** at the time of renewal. It must be paid on or before its due date or during the grace period. If not renewed due to non-payment of premium, this **Certificate** is no longer effective, subject to the grace period, at 11:59 P.M. local time where **You** live on the date the unpaid renewal premium is due. Renewal is also subject to the Termination of Coverage provision.

This **Certificate** is a legal contract between **You** and **Us**. **PLEASE READ YOUR CERTIFICATE CAREFULLY!**



SECRETARY



PRESIDENT

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# I. CERTIFICATE SCHEDULE

Coverage is provided under **Group Policy** form: [GDENTPPO-P-FLIC]

Issued to **Group Policyholder**: [ABC Association]

**Certificate Form**: [GDENTPPO-C-AR-FLIC]

**Primary Insured**: [xxxx xxx] Age at Issue: [xx]

**Certificate Number**: [1234567890] **Issue Date**: [xxxxxxxx]

**Other Insureds** at Issue: [xxxxxxxxxxxxxxxxxxxx]  
[xxxxxxxxxxxxxxxxxxxx]

**Initial Premium**: [\$00.00]

<u>Amount</u>	<u>Mode of Premium Payment</u>	<u>Method</u>
[\$00.00]	[Monthly, Quarterly, Semi-Annual, Annual]	[Credit Card, Check, Bank Draft]

**First Renewal Date**: [xxxxxxxx]

## COVERAGE

### YOUR CERTIFICATE COVERAGE IS AS FOLLOWS:

**Calendar Year Maximum Per Insured**: [\$1000]

**Calendar Year Deductible, Per Insured**: [\$50]

[When three (3) **Insureds** satisfy this **Calendar Year Deductible**, no additional **Calendar Year Deductible** per **Insured** will be required for the remainder of the **Calendar Year**.]

**Separate Deductible For Non-Participating Dentist** [\$100]

[A total of [three (3)] **Insureds** will be required to meet the **Separate Deductible For Non-Participating Dentist** after satisfaction of the **Calendar Year Deductible**.]

### COINSURANCE PAYMENTS SCHEDULES – PARTICIPATING DENTIST

**Company Insurance Percentage** for Preventive Dental Care: [80%]  
**Insured Coinsurance Percentage** for Preventive Dental Care: [20%]

**Company Insurance Percentage** for Basic Dental Care: [50%]  
**Insured Coinsurance Percentage** for Basic Dental Care: [50%]

**Company Insurance Percentage** for Major Dental Care: [50%]  
**Insured Coinsurance Percentage** for Major Dental Care: [50%]

### COINSURANCE PAYMENTS SCHEDULES – NON-PARTICIPATING DENTIST

**Company Insurance Percentage** for Preventive Dental Care: [60%]  
**Insured Coinsurance Percentage** for Preventive Dental Care: [40%]

**Company Insurance Percentage** for Basic Dental Care: [50%]  
**Insured Coinsurance Percentage** for Basic Dental Care: [50%]

**Company Insurance Percentage** for Major Dental Care: [50%]  
**Insured Coinsurance Percentage** for Major Dental Care: [50%]

## II. DEFINITIONS

“**Abutment**” means tooth or teeth on either side of missing teeth that are used as support for a **Fixed Bridge**.

“**Ambulatory Surgical Center**” means a state licensed public or private establishment with an organized medical staff of **Providers** with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures and continuous **Provider** services and registered professional nursing services whenever an **Insured** is in the center that does not provide services or other accommodations for the overnight stay of patients.

**Ambulatory Surgical Center** does not include a facility that primarily terminates pregnancies, a **Provider's** office maintained for the practice of medicine, or an office maintained for the practice of dentistry.

“**Apicoectomy**” means the surgical amputation or cutting off of a portion of the root of a tooth.

“**Benefits**” means only treatments, procedures, services and supplies specifically enumerated in the BENEFITS section of this **Certificate**. If a treatment, procedure, service or supply is not specifically enumerated in the BENEFITS section of this **Certificate**, then the fees charged or expenses associated with such items are not covered under this **Certificate** as a **Benefit**.

“**Bitewing X-ray**” means an x-ray showing exposed portions of the back teeth. This type of x-ray is primarily used for the detection of hidden decay between teeth.

“**Calendar Year**” means the period beginning on the **Issue Date** and ending on December 31 of that year. In subsequent years, it is the period from January 1 through December 31 of the same year.

“**Calendar Year Deductible**” means the amount of **Covered Expenses** each **Insured** must incur within a **Calendar Year** before any **Benefits** are payable under this **Certificate**. No **Benefits** are payable under this **Certificate** for any **Covered Expenses**, until after such **Calendar Year Deductible** is satisfied. The **Calendar Year Deductible** is shown on the **Certificate Schedule**.

[When [three (3)] **Insureds** satisfy this **Calendar Year Deductible**, no additional **Calendar Year Deductible** per **Insured** will be required for the remainder of the **Calendar Year**.]

The **Separate Deductible for Non-Participating Dentist** may not be used to satisfy the **Calendar Year Deductible**.

“**Calendar Year Maximum Per Insured**” means the maximum amount after satisfaction of the **Calendar Year Deductible** and subject to the applicable **Insured Coinsurance Percentage** that **We** will pay for **Covered Expenses** incurred by an **Insured** in a **Calendar Year**. The amount of the **Calendar Year Maximum Per Insured** is shown on the **Certificate Schedule**.

“**Class Basis**” means the classification by which each **Insured's** rates are determined. **Class Basis** shall be determined by zip code (first 3 digits) and county of residence, plan of coverage, sex, date of issue, and attained age. **We** will not and cannot change the rates on this **Certificate** unless rates are changed on all **Certificates** issued on the same **Class Basis**.

“**Certificate**” means the entire contract between **You** and **Us**, and consists of this written description of coverage, the **Group Policy**, together with the application of each **Insured**, which is attached hereto and by this reference incorporated herein as if set forth fully at length, as well as any riders, endorsements or amendments attached hereto.

“**Certificate Schedule**” means the schedule of **Certificate** information found on Page 3 of this **Certificate**.

“**Company Insurance Percentage**” means the portion of the **Covered Expenses We** must pay to or on behalf of an **Insured** for **Benefits** under this **Certificate**, after satisfaction by the **Insured** of the **Calendar Year Deductible**. The **Company Insurance Percentage** is shown on the **Certificate Schedule** for **Covered Expenses** for **Benefits** under this **Certificate** for (i) Preventive Dental Care, (ii) Basic Dental Care; and (iii) Major Dental Care at (i) **Participating Dentists**; and (ii) **Non-Participating Dentists**.

“**Covered Expenses**” means those services, supplies, care or treatment for which **Benefits** are hereafter provided and payable, if:

1. prescribed, performed or ordered by a **Dentist**;

2. incurred by an **Insured**;
3. **Medically Necessary**;
4. Charges for such services, supplies, care or treatment do not exceed **Usual and Customary**;
5. Charges that do not exceed the **Maximum Allowable Charge** for each applicable service, supply, care or treatment; and
6. Charges that do not exceed the **Calendar Year Maximum Per Insured**.

“**Crown**” means a dental restoration usually covering the whole exposed portion of a tooth.

“**Dentist**” means an individual who is licensed to practice dentistry or perform **Oral Surgery** in the state where the dental service is performed, and who is operating within the scope of his or her license. A physician will be considered a **Dentist** when performing any of the dental services described in the BENEFITS section of this **Certificate**.

“**Denture**” means a removable replacement for a natural tooth or teeth.

“**Endodontics**” means the treatment of diseases within the tooth, primarily **Root Canal Therapy**.

“**Extraction**” means the removal of a natural tooth or teeth.

“**Family**” means the spouse, son or daughter, brother or sister, parent, grandparent or grandchild of an **Insured**.

“**First Renewal Date**” means the first premium due date following payment of the **Initial Premium** which is shown on the **Certificate Schedule**.

“**Fixed Bridge**” means a non-removable replacement for a natural tooth or teeth.

“**Full Denture**” means a **Denture** replacing all upper teeth, all lower teeth or both.

“**Full-Time Student**” means an individual, under the age of 24, who is enrolled in at least twelve (12) credit hours per semester at any accredited college or university.

“**Gingivectomy**” means excision of diseased gum tissue so that new tissue will grow.

“**Group Policy**” means the association group insurance contract issued to the **Group Policyholder** under which this **Certificate** is issued to the **Primary Insured**.

“**Group Policyholder**” means the entity to which the group insurance contract (“**Group Policy**”) is issued.

“**Hospital**” means a place which:

1. is legally operated for the care and treatment of sick and injured persons at their expense;
2. is primarily engaged in providing medical, diagnostic and surgical facilities (either on its premises or in facilities available to it on a formal pre-arranged basis);
3. has continuous twenty-four (24) hour nursing services by or under the supervision of a registered nurse (R.N.); and
4. has a staff of one (1) or more providers available at all times.

It also means a place which may not meet the above requirements, but is accredited as a **Hospital** by the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association or the Commission on the Accreditation of Rehabilitation Facilities.

**Hospital** does not mean:

1. a convalescent home, nursing home, rest home or skilled nursing home;
2. a place primarily operated for treatment of drug addicts, alcoholics, or the aged;
3. a special unit or wing of a **Hospital** used by or for any of the above;
4. a long-term mental facility; or
5. a facility primarily providing custodial care.

“**Impacted**” or “**Impaction**” means a tooth partly or wholly buried under the gum by bone or tissue.

**“Initial Premium”** means the amount charged for coverage under this **Certificate** for **You** and all **Other Insureds** for the period of time from the **Issue Date** through the day before the **First Renewal Date**. The amount of the **Initial Premium** is shown on the **Certificate Schedule**, and is payable in advance of the **Issue Date**.

**“Injury”** means accidental **Injury** (or Injuries) to a natural tooth or teeth sustained by an **Insured** which is the direct cause of the loss independent of disease, infirmity, or any other cause, which occurs while this **Certificate** is in force.

**“Insured”** means the following:

1. the **Primary Insured** whose coverage under this **Certificate** is still in force and effect,
2. any other individuals named as **Other Insureds** on the **Certificate Schedule** whose coverage under this **Certificate** is still in force and effect, and
3. any individual who is added to this **Certificate** after the **Issue Date** by proper endorsement after proper application and payment of any additional premium whose coverage under this **Certificate** is still in force and effect.

**“Insured Coinsurance Percentage”** means the portion of the **Covered Expenses You** must pay for **Covered Expenses** for **Benefits** under this **Certificate**, after satisfaction of the applicable **Calendar Year Deductible**. The **Insured Coinsurance Percentage** is shown on the **Certificate Schedule** for **Covered Expenses** for **Benefits** under this **Certificate** for (i) Preventive Dental Care, (ii) Basic Dental Care and (iii) Major Dental Care at (i) **Participating Dentists**; and (ii) **Non-Participating Dentists**.

**“Issue Date”** means the date set forth and identified as the **Issue Date** on the **Certificate Schedule**.

**“Maximum Allowable Charge”** means the following:

1. For **Providers, Maximum Allowable Charge** is the actual expense incurred by an **Insured** for the applicable service, supplies, care, or treatment **Provided**, after any reduction, adjustment, and/or discount pursuant to any **Participating Dentist** agreements or other network agreements, negotiated rates, fee schedules or arrangements that determine or prescribe the actual amount of charges or fees that the **Provider**:
  - a) agreed to accept as payment in full for such services, supplies, care or treatment, and
  - b) ultimately charged such **Insured**, regardless of any higher amount that may have been placed on the **Provider’s** billing statement of charges.
2. For **Hospitals, Ambulatory Surgical Centers**, or treatment facilities, **Maximum Allowable Charge** is the actual amount charged by such entity for the applicable service or treatment **Provided** to an **Insured**, after any reduction, adjustment, and/or network discount pursuant to any **Participating Dentist** agreements, or other network agreements, negotiated rates, fee schedules or other arrangements that determine or prescribe the actual amount of charges or fees that such entity:
  - a) agreed to accept as payment in full for such applicable services, supplies, care, or treatment, and
  - b) ultimately charged such **Insured** for such applicable services, supplies, care, or treatment, regardless of any higher amount that may have been placed on the entity’s billing statement of charges.

However, the amount of the **Maximum Allowable Charge** under (1) and (2) above shall never exceed (i) the amount for which the applicable **Insured** has a legal liability and payment obligation for the receipt of such applicable services, supplies, care, or treatment, or (ii) the amount of **Usual and Customary Expense** for the receipt of such applicable services, supplies, care, or treatment.

**“Medical Necessity”** and **“Medically Necessary”** means any care and treatment when provided:

1. at the request or upon the approval of an **Insured’s Dentist**;
2. appropriate and necessary for the symptoms, diagnosis or treatment of such **Injury** or **Sickness**;
3. according to and within generally accepted standards for dental practice;
4. in the most cost effective setting and manner available to treat the **Insured**; and
5. not primarily for the convenience of an **Insured**, an **Insured’s Family**, a **Dentist**, or another healthcare provider.

The fact that a **Dentist** prescribed, ordered, recommended or approved a service, supply, or treatment does not in and of itself make it **Medically Necessary**, a **Covered Expense**, or a **Benefit** under this **Certificate**.

**“Mode Of Premium Payment”** means the interval of time (monthly, quarterly, semi-annual or annual) that you have selected for payment of the **Initial Premium** and subsequent premium payments. The premium payment interval selected by **You** as the **Mode Of Premium Payment** is shown on the **Certificate Schedule**. This **Mode Of Premium Payment** is subject to change at **Our** discretion.

**“Non-Participating Dentist”** means a **Dentist** that at the time **Covered Expenses** are incurred, has not entered into or has terminated a prior agreement to provide services to **Insureds** under this **Certificate**.

**“Oral Surgery”** means surgery of the oral mouth cavity, including teeth, tongue and gums.

**“Other Insureds”** means those members of **Your Family** that are listed on the **Certificate Schedule** on the **Issue Date**.

**“Partial Denture”** means a **Denture** replacing some, but not all, of the upper or lower teeth.

**“Participating Dentist”** means a **Dentist** that has entered into, and not terminated by the date the **Covered Expenses** are incurred, an agreement to provide services to Insured under this **Certificate**.

**“Periodontics”** means the treatment of diseases of the gum and tissue around the teeth.

**“Pontic”** means an artificial replacement of a missing tooth.

**“Primary Insured”** means the individual whose name is printed on the **Certificate Schedule** as the **Primary Insured** and whose coverage under this **Certificate** has not ended.

**“Prophylaxis”** means the professional cleaning and scaling of the teeth.

**“Prosthodontics”** means the artificial replacement of natural teeth, through the use of **Dentures, Fixed Bridges** and **Removable Bridges**.

**“Pulp”** means the soft tissue inside the **Crown** and roots of a tooth, composed of nerves, blood vessels and other tissue.

**“Removable Bridge”** means a **Partial Denture** normally held by clasps to the natural teeth, permitting removal if desired.

**“Root Canal Therapy”** means treatment of the **Pulp** of the tooth.

**“Separate Deductible for Non-Participating Dentist”** means, in addition to the **Calendar Year Deductible**, the amount of **Covered Expenses** an **Insured** must incur in a **Calendar Year** for services rendered by **Non-Participating Dentist** before any applicable **Benefits** are payable under this **Certificate**.

No **Benefits** are payable under this **Certificate** for services rendered by **Non-Participating Dentist** until after the **Separate Deductible For Non-Participating Dentist**, and the amount of the **Calendar Year Deductible** are satisfied and fully payable by either **You** or such **Insured**. The amount of the **Separate Deductible For Non-Participating Dentist** is shown on the **Certificate Schedule** and applies per **Calendar Year** separately to each **Insured**.

[A total of [three (3)] **Insureds** will be required to meet the **Separate Deductible For Non-Participating Dentist** after satisfaction of the **Calendar Year Deductible**.]

**“Sickness”** means illness or disease afflicting a natural tooth or teeth, which first manifests itself on or after the **Issue Date** shown on the **Certificate Schedule** and while this **Certificate** is in force.

**“Space Maintainer”** means an appliance to keep space from closing after a loss of a temporary tooth so that the permanent tooth will have room to grow.

**“Usual and Customary”** means the actual expense, but not to exceed the [seventieth (70th)] percentile, of the prevailing **Dentists’** charges for the service or treatment as determined by one (1) of the current prevailing health care charge information systems utilized in the insurance industry. For services or treatments provided by other than **Dentists, Usual and Customary** means the actual expense, but not to exceed the average charge made for similar services or supplies in

the locality where the service or supply is furnished, taking into consideration the nature and the severity of the treatment incurred by **You**.

**“Utilization Review”** means a system for prospective or concurrent review of the **Medical Necessity** and appropriateness of Dental services being **Provided** or proposed to be **Provided** to an **Insured** within this state. **Utilization Review** does not include elective requests for clarification of coverage.

**“We,” “Us,” “Our” and “Company”** means Freedom Life Insurance Company of America.

**“You,” “Your” and “Yours”** means the **Primary Insured** named on the **Certificate Schedule**.

### **III. WHEN COVERAGE BEGINS AND ENDS**

#### **A. EFFECTIVE DATE**

This **Certificate** is effective at 12:01 a.m. local time where **You** live on the **Issue Date** shown on the **Certificate Schedule**.

#### **B. CONSIDERATION**

**We** issued this **Certificate** in consideration of and in reliance on the statements in the application and the payment of the **Initial Premium**. A copy of the application is attached. Such premium payment will keep this **Certificate** in force until the **First Renewal Date**. The **First Renewal Date** and **Initial Premium** are shown on the **Certificate Schedule**.

#### **C. ELIGIBILITY AND ADDITIONS**

**Your** spouse, unmarried dependent children who are under the age of 19 (24 if a **Full-Time Student**) and grandchildren who are considered **Your** dependents for federal tax purposes and who are under age 19 (24 if a **Full-Time Student**), any children which an **Insured** is required to insure under a court order, any child whom **You** or **Your** spouse (if listed as an **Other Insured** on the **Certificate Schedule**), intends to adopt and has become a party to a suit for that purpose, and any child who is in the custody of an **Insured** under a temporary court order that grants the **Insured** conservatorship of the child, are eligible for this coverage. Any eligible dependent (other than a newborn or adoptee) will be added to this **Certificate** when **We** approve the written application for such coverage, and accept payment of any necessary premium.

Children born to (newborn) or placed for adoption with (adoptee) **You**, or **Your** spouse (if listed as an **Other Insured** on the **Certificate Schedule**) while this **Certificate** is in force will be insured from and after the moment of birth or placement. **You** must notify **Us** within thirty-one (31) days after: (1) the birth or placement; (2) such **Insured** becomes a party in a suit in which the adoption of the child by such **Insured** is sought; or (3) such **Insured** has custody of the child under a temporary court order that grants to such **Insured** conservatorship of the child. **You** must also pay any required premium within the thirty-one (31) day period.

**We** will tell **You** if additional premium is needed. If **You** do not tell **Us** of the birth or placement of any children, their coverage will end thirty-one (31) days after their date of birth or placement, suit or temporary court order.

#### **D. TERMINATION OF COVERAGE**

##### **1. TERMINATIONS SUBJECT TO RIGHT OF CONVERSION**

Subject to the Section E. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONVERSION below, an applicable **Insured’s** coverage under this **Certificate** ends on the earlier of the following:

- a. with respect to **Your** spouse who is covered under this **Certificate**, the premium due date in the month following the effective date of Your divorce decree, annulment or court approved separation;
- b. with respect to **Your** child(ren) who are covered under this **Certificate**, the premium due date in the month following such **Insured’s** 19<sup>th</sup> birthday (24<sup>th</sup> if a **Full-Time Student**).

##### **2. TERMINATIONS BY PRIMARY INSURED NOT SUBJECT TO RIGHT OF CONVERSION**

Section E. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONVERSION notwithstanding, the following described actions by either the **Primary Insured** or other applicable **Insured** will result in a termination

of each applicable **Insured's** coverage under this **Certificate** with no right of conversion, in which event the coverage ends on the earlier of the following:

- a. the due date of any unpaid **Renewal Premium**, subject to the grace period; or
- b. the date **You** terminate coverage by notifying **Us** of the date **You** desire coverage to terminate and specify the **Insured** whose coverage is to terminate.

### 3. TERMINATION OF THE CERTIFICATE NOT SUBJECT TO RIGHT OF CONVERSION

Section E. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONVERSION notwithstanding, **We** may refuse to renew and cancel coverage for all **Insureds** under this **Certificate** with no right of conversion for the following reasons:

- a. **We** are required by the order of an appropriate regulatory authority to non-renew or cancel the **Certificate** or **Group Policy**;
- b. **We** cease or discontinue offering and renewing coverage of the same form of coverage as this **Certificate** in **Your** state upon a minimum of thirty one (31) days prior written notice mailed to **Your** last known address;
- c. the date **We** receive due proof that fraud or intentional misrepresentation of material fact existed in applying for this **Certificate** or in filing a claim for **Benefits** under this **Certificate**.

As long as this **Certificate** is in force for **You**, the coverage of **Your** child who is an **Insured** will not end if he or she is dependent upon **You** for support and maintenance and incapable of self-support because of a mental handicap or physical disability. Such dependent **Insured's** coverage under this **Certificate** will continue regardless of the dependent **Insured's** age, as long as **Renewal Premium** is timely and properly paid for **You** and the dependent **Insured** and such dependent **Insured** remains dependent upon **You** and incapable of self support because of such mental handicap or physical disability. Proof of such handicap or disability must be furnished to **Us** within thirty-one (31) days prior to the dependent **Insured** reaching the limiting age, and thereafter upon **Our** request, but not more frequently than annually after the two (2) year period following the attainment of the limiting age.

Any termination of coverage or of this **Certificate** will be effective at 11:59 P.M. local time where **You** live on the date(s) specified above.

If **You** die, **Your Spouse**, if then an **Insured** under this **Certificate**, will become the **Primary Insured**. If **You** and **Your** spouse (if any) are not covered under this **Certificate**, the oldest **Insured** will become the **Primary Insured**.

**We** will not accept premium for any **Insured** whose coverage has terminated. Premiums, which are sent to **Us** and include an amount to cover the **Insured** whose coverage has terminated, will be returned. **We** will only accept the correct premium to cover those **Insureds** who are eligible for coverage. If premiums are accepted in error, **Our** liability is limited to coverage for the period of time for which premiums were accepted in error.

Except for claims involving fraud or intentional misrepresentation of material fact, any termination will be without prejudice to any **Covered Expenses** incurred by an **Insured** for **Sickness and Injury Benefits, Wellness and Screening Benefits** or **Miscellaneous Benefits** prior to the date of termination. If coverage is terminated, unearned premium will be computed pro-rata and any unearned premium will be refunded to **You**.

### E. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONVERSION

A **Certificate Of Conversion Coverage**, whereby the coverage then afforded by this **Certificate** for an applicable **Insured** will continue without a requirement of any additional evidence of the insurability of such **Insured**, is available only:

1. for **Your** spouse who is covered under this **Certificate**, if his or her coverage ceases due to divorce, annulment or court approved separation;
2. for **Your** unmarried child(ren) who is covered under this **Certificate**, if his or her coverage ceases due to his or her reaching the limiting age of 19 (24 if enrolled as a **Full-Time Student**), or
3. for each applicable **Insured**, if coverage under this **Certificate** terminates because the **Group Policyholder** has terminated coverage under the **Group Policy**, and does not replace coverage with another group policy, in which case **You** will be given thirty (30) days prior written notice of the termination, mailed to **Your** last known address. Upon termination of the **Group Policy**, **You** may apply on behalf of all **Insureds** for a **Certificate Of Conversion Coverage**. The **Certificate Of Conversion Coverage** must be applied for and the first premium received by **Us**

within thirty-one (31) days after the date that coverage under the **Group Policy** terminates. If a **Certificate Of Conversion Coverage** is issued, it will take effect on the day after coverage under the **Group Policy** terminates.

A **Certificate Of Conversion Coverage** is not available and will not be provided if:

Conversion coverage is not provided if:

1. an **Insured's** coverage under the **Group Policy** ceases because the **Group Policy** was terminated and was replaced by similar group coverage within thirty-one (31) days;
2. an **Insured's** coverage under the **Group Policy** ceases because of failure to pay the required premiums in the time allowed;
3. an **Insured** was not covered under this **Certificate** for the three (3) consecutive months immediately prior to the date coverage ceases;
4. an **Insured** is covered by similar benefits furnished by any:
  - a. dental expense plan;
  - b. dental service subscriber contract;
  - c. dental pre-payment plan; or
  - d. dental plan provided in accordance with the requirements of any state or federal law; or
5. an **Insured** is eligible to be covered by any group:
  - a. dental expense plan;
  - b. dental service subscriber contract;
  - c. dental pre-payment plan; or
  - d. dental plan provided in accordance with the requirements of any state or federal law.

In order to be eligible for a **Certificate Of Conversion Coverage**, a written election of continuation of coverage via conversion must be made by the applicable **Insured**, on a form furnished by **Us**, and the first premium must be paid, in advance, to **Us** on or before the date on which the applicable coverage under this **Certificate** for such **Insured** would otherwise terminate. The amount of first premium required from the effective date through the end of the first renewal period of the **Certificate Of Conversion Coverage** shall not be more than **Our** full group premium rate then applicable for the applicable **Insured** under the **Certificate** with the same mode of payment. Applicable **Insureds** shall not be required to pay the **Renewal Premium** for a **Certificate Of Conversion Coverage** less often than monthly.

## IV. ALTERNATE TREATMENT

An **Insured** has the right to choose his or her course of treatment and **Dentist**. However, if an **Insured** chooses treatment which is more expensive than is needed to correct the dental problem according to accepted standards of dental practice, the **Benefits** payable will be those **Usual and Customary** charges payable for the less expensive treatment which provides professionally satisfactory results at the most cost effective level.

## V. BENEFITS

After the **Calendar Year Deductible** has been met, and subject to the applicable **Insured Coinsurance Percentage** set forth in the **Certificate Schedule**, **We** will pay, to or on behalf of the **Insured**, the applicable **Company Insurance Percentage** of the remaining **Covered Expenses** incurred by an **Insured** for the following **Benefits**, up to but not exceeding the **Calendar Year Maximum Per Insured**. Coverage is limited to **Covered Expenses** incurred by an **Insured** for the following items to prevent, diagnose or treat dental disease, defect or **Injury**. Coverage under this Section of the **Certificate** will be reduced for services, supplies, care or treatment obtained from a **Non-Participating Dentist**. The difference between both the **Company Insurance Percentages** and the **Insured Coinsurance Percentages** for: (i) **Participating Dentists** and **Non-Participating Dentists** are shown in the **Certificate Schedule**.

### A. Preventive Dental Care

**Benefits** include fees and expenses charged by **Dentists** for the following items of preventive dental care and which constitute **Covered Expenses** incurred by an **Insured** :

1. Initial and Periodic oral examinations. Limited to one (1) during a consecutive six (6) month period;
2. Intraoral X-rays, with or without bitewings. Limited to one (1) series in a consecutive thirty-six (36) month period;
3. **Bitewing X-rays**. Limited to one (1) set during a consecutive twelve (12) month period;
4. **Prophylaxis** (cleaning of the teeth) with or without an oral examination. Limited to one (1) treatment during a consecutive six (6) month period;

5. Periodontal **Prophylaxis** (deep scaling and cleaning). Limited to one (1) treatment during a consecutive six (6) month period;
6. Topical application of fluoride for **Insureds** under 19 years of age. Limited to one (1) treatment during a consecutive twelve (12) month period;
7. Temporary treatment to relieve dental pain; and
8. **Space Maintainers** (fixed or lateral) for missing primary teeth.

## **B. Basic Dental Care**

**Benefits** include fees and expenses charged by **Dentists** for the following items of basic dental care, including, **Endodontics**, **Periodontics**, maintenance of **Prosthodontics** and Oral Surgery, as well as constituting **Covered Expenses** incurred by an **Insured** at least six (6) months after the **Issue Date** :

1. General anesthesia, when **Medically Necessary** and in connection with **Oral Surgery**;
2. Amalgam, silicate cement, acrylic or plastic fillings;
3. Topical application of sealant on a posterior tooth for **Insureds** under 14 years of age. Limited to one (1) treatment per tooth in a consecutive thirty-six (36) month period;
4. **Root Canal Therapy**, including treatment plan and follow-up care;
5. **Apicoectomy**. If performed with a root canal, this service will be considered a separate service;
6. **Gingivectomy** or ginivoplasty, per quadrant;
7. Osseous surgery, per quadrant. If more than one (1) periodontal surgery service is performed per quadrant, only the most inclusive surgical service performed will be considered a **Covered Expense** under this **Certificate**;
8. **Periodontic** scaling;
9. Repairs and adjustments to **Dentures**. This will not be considered a **Covered Expense** if performed within six (6) months of: **Denture** installation; adjustments to **Dentures** or **Partial Dentures**; replacement of a broken tooth or complete or **Partial Denture**; other **Denture** repairs; and recementing of a bridge;
10. Simple tooth **Extractions**; and
11. Surgical **Extractions** of an **Impacted** tooth, including full bony **Impaction**.

## **C. Major Care, Restorative and Installation of Prosthodontics**

The following major care **Benefits** are payable at the **Company Insurance Percentage** shown in the **Certificate Schedule** only if such **Covered Expenses** are incurred at least twelve (12) months after the **Issue Date** of the **Certificate**:

1. Gold inlay fillings, two or three surfaces;
2. Single **Crown** restorations;
3. **Dentures**, including fixed or removable prosthetic devices, complete **Dentures**, upper and lower;
4. **Partial Dentures**; lower, with two (2) clasps and gold lingual bar; upper with two clasps and gold palatal bar;
5. Bridge **Pontics**; and
6. **Abutment Crowns**.

## **VI. PRE-DETERMINATION OF BENEFITS**

To help assure the best dental care at the most effective cost, some of the dental procedures covered by this **Certificate** require a pre-determination of **Benefits**. If the total dental treatment being considered is expected to exceed [\$500], a written plan of treatment must be sent to **Us** by **Your Dentist** at least two (2) weeks prior to receiving such treatment. The **Dentist** must itemize all recommended services and costs and provide **Us** with supporting documentation. **We** will notify the **Dentist** of the **Benefits** payable under this **Certificate**.

If a pre-determination of **Benefits** is not submitted prior to receiving treatment, **We** reserve the right to make a determination of **Benefits** payable taking into account alternative procedures, services, or courses of treatment, based on accepted standards of dental practice. If verification of necessity of dental services cannot reasonably be made, the **Benefits** may be a lesser amount than would otherwise be payable.

## **VII. CLAIMS PROCEDURES, INVESTIGATION AND PAYMENT**

- A. **NOTICE OF CLAIM:** Written notice of claim must be provided within thirty (30) days after a **Covered Expense** is incurred or as soon thereafter as possible. The notice can be given to **Us** at **Our** address shown on Page 1, or to any one (1) of **Our** agents. Notice should include **Your** name and **Your Certificate** number.
- B. **CLAIM FORMS:** When **We** receive written notice of claim, **We** will send **You** forms for filing proof of loss. If these forms are not provided to **You** within fifteen (15) days, **You** will meet the proof of loss requirements by providing **Us** with a written statement of the nature and extent of the claim. **We** must receive this statement within the time limit stated in the proofs of loss section.
- C. **PROOFS OF LOSS:** Written proof of a **Covered Expense** must be provided to **Us** within ninety (90) days after such **Covered Expense** is incurred. If it was not reasonably possible for **You** to give **Us** proof in the time required, **We** will not reduce or deny the claim for this reason if the proof is filed as soon as possible. In any event, the proof required must be provided no later than one (1) year from the time specified unless **You** are legally unable to act.
- D. **TIME OF PAYMENT OF CLAIMS:** **We** will make payments due to or on **Your** behalf promptly upon **Our** receipt of proper proof of loss and completion of **Our** claims investigation.

Payment shall be treated as being made on the date a draft or valid instrument was placed in the United States mail to the last known address of the claimant or beneficiary in a properly addressed, postpaid envelope, or, if not so posted, on the date of delivery.

**Benefits** not paid within thirty (30) days after receipt of a proper proof of loss and completion of **Our** claims investigation will be considered overdue if the claim is not denied for valid and proper reasons within such thirty (30) day period. **We** will pay interest on accrued **Benefits** at the rate of one and one-half percent per month on the amount of the overdue claim, from the date the claim is received by **Us** (if the claim is not paid within thirty (30) days after the receipt of an acceptable proof of loss), until it is finally settled or adjudicated.

- E. **PAYMENT OF CLAIMS:** All **Benefits** will be paid to **You**, unless **You** direct otherwise in writing. Any **Benefits** unpaid at **Your** death will be paid to **Your** estate unless previously directed otherwise in writing. Any payment made in good faith will fully discharge **Us** to the extent of the payment.

## VIII. DEDUCTIBLES

### A. CALENDAR YEAR DEDUCTIBLE

No **Benefits** are payable under this **Certificate** for any **Covered Expenses** incurred by an **Insured**, until after the **Calendar Year Deductible** is satisfied and fully payable each **Calendar Year** by such **Insured**. In addition to the **Calendar Year Deductible**, the **Separate Deductible For Non-Participating Dentist** will apply to services rendered by **Non-Participating Dentist**.

The amount of the **Separate Deductible For Non-Participating Dentist** may not be used to satisfy the **Calendar Year Deductible**.

### B. SEPARATE DEDUCTIBLE FOR NON-PARTICIPATING DENTIST

No **Benefits** are payable under this **Certificate** for services rendered by **Non-Participating Dentist** until after the amount of the **Calendar Year Deductible** and the **Separate Deductible For Non-Participating Dentist** are satisfied and fully payable. The amount of the **Separate Deductible For Non-Participating Dentist** is shown on the **Certificate Schedule** and applies per **Calendar Year** separately to each **Insured**.

The amount of the **Calendar Year Deductible** may not be used to satisfy the **Separate Deductible For Non-Participating Dentist**.

### [C. FAMILY CALENDAR YEAR DEDUCTIBLE MAXIMUM

[Once a total of [three (3)] **Insureds** have met their **Calendar Year Deductibles**, no additional **Calendar Year Deductible** will be assessed by **Us** in connection with treatment and services rendered to any **Other Insured** during the remainder of such **Calendar Year**. In the event services are provided by a **Non-Participating Dentist** a total of [three (3)] **Insureds** will be required to meet the **Separate Deductible For Non-Participating Dentist** after satisfaction of the **Calendar Year Deductible**.]

## IX. EXCLUSIONS AND LIMITATIONS

**Exclusions** - This **Certificate** does not provide coverage or any payment for the following:

1. Any expenses for treatments, care, procedures, services or supplies which are not **Covered Expenses** incurred by an **Insured**, and which are not specifically enumerated in the BENEFITS section of this **Certificate**;
2. Treatment on or to the teeth or gums for cosmetic purposes, including charges for personalizations, characterizations or **Dentures**;
3. Any dental conditions for which the **Insured** has received or is entitled to receive compensation for that particular dental condition under any Worker's Compensation or Occupational Disease Law;
4. Expenses incurred for oral hygiene instructions, a plaque control program or dietary instructions;
5. Services provided by **You** or a **Dentist** who is a member of the **Insured's Family**;
6. Any loss caused by war or act of war, whether declared or undeclared;
7. Loss incurred while engaged in military, naval or air service;
8. Replacement of lost or stolen prosthetics;
9. Dental treatment provided by or paid for by the United States government or any instrumentality thereof;
10. Expenses incurred for restorative services (i.e. the initial placement of a complete or partial **Denture** or for fixed bridgework) or **Endodontic** therapy if it involves the replacement of one or more natural teeth missing on the **Issue Date** of this **Certificate** or when initial preparations were started prior to **Your Issue Date** as shown on the **Certificate Schedule**;
11. Expenses incurred for restorative services for one (1) or more natural teeth missing on the **Issue Date** as shown on the **Certificate Schedule** of the **Certificate** will be considered **Covered Expenses** if incurred five (5) years after the **Issue Date**;
12. Dental services performed in a **Hospital** and any related expenses;
13. Temporomandibular Joint Disorder or Craniomandibular Disorder diagnosis and treatment;
14. Replacement of an appliance or prosthetic device, **Crown**, cast restoration or a **Fixed Bridge** within five (5) years after the date it was last placed, whether under this plan or any prior plan under which **You** were covered. This exclusion does not apply if replacement is due to accidental dental **Injury** received while covered under this **Certificate**;
15. Expenses incurred for dental care which is not customarily performed, which is experimental in nature or which is not considered acceptable by the American Dental Association or Federal Drug Administration;
16. Treatment of cleft palate, except for a newborn child covered under this **Certificate** from birth, andontia or mandibular prognathicism;
17. General anesthesia, except as specifically provided in the BENEFITS section;
18. Placement of bone grafts or extra-oral substances in the treatment of periodontal disorders;
19. The use of unilateral, removable prosthetics;
20. Orthodontic diagnosis or treatment;
21. Charges incurred by **You** due to broken or cancelled appointments;
22. Expenses which exceed 100% of those actually incurred by the **Insured**;
23. Expenses for which an **Insured** is not legally liable to pay;
24. **Crowns** for teeth that are restorable by other means or for the purpose of periodontal splinting;
25. Services that are otherwise included by a plan of health insurance;
26. Implants, including any appliances and/or **Crowns** and the surgical insertion or removal of implants;
27. **Crowns**, fillings or appliances that are used to correct (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or for cosmetic purposes; and
28. Orthognathic surgery.
29. the amount of any professional fees or other medical expenses contained on a billing statement to an **Insured** which exceed the amount of the **Maximum Allowable Charge**;

## X. COORDINATION OF BENEFITS

**Benefits** payable under this **Certificate** will be proportionately reduced by any Other Valid Insurance Coverage **You** maintain. Other Valid Insurance Coverage, defined below, will reduce the **Benefits** payable under this **Certificate**. The amount of the reduced **Benefits** payable under this **Certificate** will be determined by applying the formula below:

The amount which would have been payable under this **Certificate** if **You** did not have any Other Valid Insurance Coverage, divided by the total like amounts under all Other Valid Insurance Coverage maintained by **You** for such loss.

When **Your Benefits** are reduced due to Other Valid Insurance Coverage, **We** will return part of the last monthly premium that **You** paid prior to the commencement of a loss covered under this **Certificate**. The proportion **We** will use to determine **Your** premium refund will be the same proportion **We** use to determine the **Benefit** reduction in the formula above.

When **Your** Other Valid Insurance Coverage is written on a provision of service basis, the "like amount" of such other coverage will mean the dollar amount which the services **You** received would have cost **You** if **You** did not have the Other Valid Insurance Coverage.

Other Valid Insurance Coverage means any other dental health insurance coverage **You** maintain under any of the following: a group health plan; individual dental health insurance coverage; a Governmental Plan or a Church Plan; any union, employer, or employee dental health benefit plan. Other valid insurance coverage does not include: Title XIX of the Social Security Act [42 U.S.C.A. Section 1396 et seq.]; a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a public health plan offered under Chapter 89 of Title 5, United States Code; a health benefit plan under section 2504(e) of Title 22, United States Code. Other Valid Insurance Coverage does not include coverage under Medicare and/or amendments thereto.

**Benefits** under this **Certificate** for any **Insured** who is eligible for or has coverage under Medicare, and/or amendments thereto, shall be limited to only the excess of **Usual and Customary** charges (as determined by Medicare) for services, supplies, care or treatment covered under this **Certificate** that are not paid by Medicare and/or its amendments, subject to all provisions, limitations, exclusions, reductions and maximum **Benefits** set forth in this **Certificate**.

## **XI. UNIFORM PROVISIONS**

**A. ENTIRE CONTRACT; CHANGES:** The entire contract between **You** and the **Company** consists of the **Group Policy**, this **Certificate**, including **Your** application which is attached hereto, and any amendments, riders or endorsements attached to this **Certificate**. All statements made by **You** will, in the absence of fraud, be deemed representations and not warranties. No statement made by an applicant for insurance will be used to contest the insurance or reduce the **Benefits**, unless contained in a written application, which is signed by the applicant. No change in the **Group Policy** or this **Certificate** will be valid unless it is noted on or attached to the **Group Policy** or this **Certificate**, signed by one of **Our** officers, and delivered to the **Primary Insured**.

No agent may:

1. change, alter or modify the **Group Policy**, this **Certificate**, or any amendments, riders or endorsements attached to this **Certificate**;
2. waive any provisions of the **Group Policy**, this **Certificate**, or any amendments, riders or endorsements attached to this **Certificate**;
3. extend the time period for payment of premiums under this **Certificate**; or
4. waive any of the **Company's** rights or requirements.

No change in the **Group Policy** or this **Certificate** will be valid unless it is:

1. noted on or attached to the **Group Policy** or this **Certificate**;
2. signed by one of **Our** officers; and
3. delivered to the **Primary Insured**, as shown on the **Certificate Schedule**.

**B. TIME LIMIT ON CERTAIN DEFENSES:**

1. After two (2) years from the **Issue Date**, only fraudulent misstatements in the application may be used to void this **Certificate** or deny any claim for a loss incurred after the two (2) year period;
2. No claim for a **Covered Expense** incurred by an **Insured** after two (2) years from the **Insured's** effective date of coverage will be reduced or denied because a medical condition, not excluded by name or specific description, existed before the effective date of coverage.

**C. GRACE PERIOD:** Unless at least thirty-one (31) days prior to a premium due date **We** have mailed to **You** written notice of **Our** intention not to renew this **Certificate**, a grace period of thirty-one (31) days is given for the payment of any premium. During the grace period, this **Certificate** will remain in force. However, **You** are still responsible for any premium for continued coverage under the grace period unless **You** cancel coverage before the due date. If **You** cancel **Your** coverage, there is no grace period.

**D. REINSTATEMENT:** If the premium is not paid before the grace period ends, later acceptance of premium by **Us** (or by an agent authorized to accept payment) without requiring an application for reinstatement will reinstate this

**Certificate** as of the date of acceptance of the late premium. If **We** or **Our** agent require an application, **You** will be given a conditional receipt for the premium. If the application is approved, this **Certificate** will be reinstated as of the approval date. Lacking such approval, this **Certificate** will be reinstated on the forty-fifth (45th) day after the date of the conditional receipt, unless **We** have previously notified **You**, in writing, of **Our** disapproval.

The reinstated **Certificate** will cover only **Covered Expenses** that result from treatment incurred after the date of reinstatement. In all other respects, **Your** rights and **Our** rights will remain the same subject to any provisions noted on or attached to the reinstated **Certificate**.

- E. MISSTATEMENT OF AGE:** If the age of an **Insured** has not been stated correctly, his or her correct age will be used to determine: i) the amount of insurance for which he or she is entitled; ii) the effective date of termination of insurance; and iii) any other rights or **Benefits** under this **Certificate** or the **Group Policy**.
- F. UNHONORED CHECK OR DRAFT:** Any premium payment made by a check or draft which is not honored at the bank upon which it is drawn shall be of no effect toward coverage under this **Certificate** unless and until valid restitution is made to **Us** within the time provided herein for making such premium payment.
- G. CONFORMITY WITH STATE STATUTES:** Any provision of this **Certificate** or the **Group Policy** which, on its effective date, is in conflict with the laws of the state in which **You** live on that date, is amended to conform to the minimum requirements of such laws.

SERFF Tracking Number: USHG-126178761 State: Arkansas  
Filing Company: Freedom Life Insurance Company of America State Tracking Number: 42588  
Company Tracking Number: GDENTPPO-C-AR-FLIC  
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental  
Product Name: AR Dental PPO FLIC  
Project Name/Number: /

## Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: USHG-126178761 State: Arkansas  
Filing Company: Freedom Life Insurance Company of America State Tracking Number: 42588  
Company Tracking Number: GDENTPPO-C-AR-FLIC  
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental  
Product Name: AR Dental PPO FLIC  
Project Name/Number: /

## Supporting Document Schedules

**Satisfied -Name:** Flesch Certification **Review Status:** Approved-Closed 06/15/2009  
**Comments:**  
**Attachment:**  
GDENTPPO-C-FLIC FLESCH.pdf

**Satisfied -Name:** Application **Review Status:** Approved-Closed 06/15/2009  
**Comments:**  
The approved applications to be used with this form is APP-FI-FLIC, et al, approved on 10/18/2006 and/or APP-09-NOARB-FLIC, approved 05/18/2009, state tracking number 42363. The 10/18/06 approval letter is attached for your convenience.  
**Attachment:**  
10-18-06 approval letters.pdf

**Satisfied -Name:** 6-11-09 Tracked Changes **Review Status:** Approved-Closed 06/15/2009  
**Comments:**  
The pages that have been changed are included as a tracked / underlined copy for your convenience.  
**Attachment:**  
GDENTPPO-C-AR-FLIC tracked.pdf

**FREEDOM LIFE INSURANCE COMPANY OF AMERICA**

[3100 Burnett Plaza 801 Cherry Street, Unit 33 Fort Worth, Texas 76102 1-800-387-9027]

**READABILITY CERTIFICATION**

I hereby certify that the forms, listed below, have been properly scored and have achieved the Flesch Score, as indicated.

<u>Form Number</u>	<u>Flesch Score</u>
GDENTPPO-C-FLIC	52

Name: Shelley Kuhleman

Signature: 

Title: Assistant Vice President, Product Development

Dated: June 5, 2009

# FREEDOM LIFE INSURANCE COMPANY OF AMERICA

3100 Burnett Plaza ♦ 801 Cherry Street, Unit 33, ♦ Fort Worth, Texas 76102 ♦ 1-800-387-9027

October 10, 2006

Ms Rosalind Minor  
Senior Certified Rate and Form Analyst  
Life and Health Division  
Department of Insurance  
1200 West 3<sup>rd</sup> Street  
Little Rock, AR 72201-1904

**RECEIVED**

OCT 24 2006

Prod. Development

**COPY**

**RECEIVED**

OCT 12 2006

LIFE AND HEALTH  
ARKANSAS INSURANCE DEPARTMENT

RE: Freedom Life Insurance Company of America  
NAIC 62324 FEIN #61-1096685  
Response To Your May 30 Letter and June 08 E:mail

Forms – Product 1

HDHP-06-C-AR-FLIC High Deductible Health Plan Certificate

Forms – Product 2

GMS-06-C-AR-FLIC Medical Surgical Expense Certificate

Form – Both Products

APP-FI-FLIC Application Family Information Page  
APP-CS-FLIC Application Coverage Selection Page  
APP-MH-FLIC Application Medical History Page  
APP-NOARBNOTE-FLIC Application Notices Page - **NEW**  
APP-AA-AR-FLIC Acknowledgements and Authorizations Page  
GRP-P-06-FLIC Group Policy  
GRP-SA-06-AR-FLIC Group Supplemental Application - **NEW**

Riders

DOC-06-OR-FLIC Optional Doctors Office Visit Co-Pay Rider  
GBMAT-06-OR-AR-FLIC Optional Maternity Rider  
MAT-06-OR-AR-FLIC Optional Maternity Rider  
WAIVER-C-OR-FLIC Waiver of Renewal Premium During First Renewal Premium  
ALDDR-06-OR-AR-FLIC Rate Guaranteed Period Upon Death or Total Disability of Primary Insured  
Optional Alcohol and Drug Dependency Rider - **NEW**  
LISH-06-OR-AR-FLIC Optional Loss or Impairment of Speech and Hearing Rider - **NEW**  
MED-06-OR-AR-FLIC Optional Mental or Emotional Disorders and Licensed Professional Counselors Rider - **NEW**  
MSD-06-OR-AR-FLIC Optional Musculoskeletal Disorder Rider – **NEW**

Forms Previously Filed Exempt

GRP-APP-FLIC

Dear Ms Minor:

Thank you for your review of these forms and your willingness to be flexible in the review procedures. For convenience I am repeating your concerns as they are numbered in you letter and will continue to use these numbers throughout our correspondence. Our responses are shown in bold type face.

**APPROVED**

OCT 18 2006

LIFE AND HEALTH  
ARKANSAS INSURANCE DEPARTMENT

**YOUR 5-30 LETTER:**

1. It is requested that you provide a Statement of Variability.
  - a. **Information shown in the Certificate forms as bracketed is variable information. The following is an explanation of the variability:**
    - i. **The brackets on page 3A are placeholders for specific insured and plan information.**
    - ii. **In the Certificate Schedule and throughout the Certificate there are brackets around numbers and amounts. All current variables are now indicated within the brackets.**
    - iii. **Text bracketed within the body of the Certificate represents plan options. The bracketed text will either appear or not appear in the Certificate, depending on the plan of benefits selected.**
  - b. **We also wish to reserve the right to add additional optional benefit information to the schedule upon approval of additional optional riders.**
2. Under the separate deductible for Non-Participating Providers, it appears that this is an addition to the calendar year single deductible. If so, please add language under the Separate Deductible that this deductible is in addition to the calendar year single deductible.

**In order to comply with Bulletin 9-85 we have eliminated this feature. See Item 3 below.**

3. It appears that the Insured Maximum Participating Provider Coinsurance and the Insured Maximum Non-Participating Provider Coinsurance is not in compliance with our Bulletin 9-85 which states in part that the Department will presume that a difference exceeding 25% in benefit levels effectively negates an insured freedom to utilize non-panel providers.

**For HDHP-06-C-AR-FLIC, the plan offerings are 100%/80%, 80%/60%, 70%/50% and 50%/50%. For GMS-06-C-AR-FLIC the plan offerings are 80%/60%, 70%/50% and 50%/50%. In addition, we have modified the forms so that the deductible for Non-Participating services is not in addition to the Calendar Year deductible. We feel these modifications bring us into compliance with Bulletin 9-85. Substitute pages have been submitted where appropriate.**

4. It is required that your company certify that all benefits payable as PPO and Non-PPO will comply with our Bulletin 9-85.

**We certify the benefits payable for PPO and Non-PPO will comply with Bulletin 9-85**

5. With respect to Childhood Preventive Care, benefit for recommended immunization services shall be exempt from any copay, coinsurance, deductible, or dollar limit provisions in the accident and health insurance policy. This exemption shall be explicitly stated in the policy. Refer to ACA 23-79-141 (f)(2)(A)

**Language has been revised to include the missing elements of the statute.**

6. Our Conversion Law, (ACA 23-86-115, does not contain a limitation that the insured is to be covered under the certificate for the three (3) consecutive months immediately prior to the date the group policy terminates. As a suggestion, you might want to separate the Continuation and Conversion language since these are two separate laws in Arkansas. Refer to ACA 23-86-114 and ACA 23-85-115.

**We have modified the provision to apply the 3-month guideline only where it is appropriate. Our company policy is to allow/encourage members who would normally be entitled to conversion to continue their existing coverage in lieu of actual conversion to a different "conversion" product. The person terminating coverage for the appropriate reasons may be**

asked to apply in the same manner as would be required for a conversion policy, we merely modify the certificate number of the member by adding a "1" as an identifier in our system and issue the certificate with the exact coverage they had before. There is no underwriting, the rates for an adult remain the same as the rate prior to continuation/conversion and if it's a child reaching the limiting age, the rate changes to the appropriate adult rate. The "continued" certificate may be retained as if it were a conversion policy, subject to the same provisions of the statute. We feel this approach is equitable and less disruptive to our insureds.

7. Benefits must be offered for Mental Illness as outlined under ACA 23-86-113. Also benefits must be offered for Alcohol/Drug Treatment as outlined under ACA 23-79-139

**Several forms for offers were inadvertently left out of this filing. I apologize. Forms GRP-SA-06-AR-FLIC, LISH-06-OR-AR-FLIC, MSD-06-OR-AR-FLIC, ALDDR-06-OR-AR-FLIC, and MED-06-OR-AR-FLIC are submitted. They are new and do not replace any previously approved forms. GRP-SA-06-AR-FLIC is the supplemental application form used to make all of the offers to the policyholder, including the offers for mental illness and alcohol/drug treatment.**

8. Application APP-FI-FLIC has a section for an Initiation Fee and Membership Dues. What are the amounts of these fees? Also, as a reminder, since these fee/dues are considered as a part of the premium and should be reported as such, they should be refunded if the policy/certificate is returned within the free look period.

**The Initiation Fee is \$35 and Membership Dues is 3 tiered: \$9.95, \$19.95 and \$29.95 depending on what level of participation with the Association is selected. These monies go to the Association. They are not considered part of the Premium.**

9. The application contains language on "Binding Arbitration." Binding Arbitration is not allowed in Arkansas. Refer to ACA 23-79-203.

**Form APP-NOARBNOTE-FLIC is the correct form that should have been submitted as part of the application. Please substitute the enclosed application for the one originally submitted.**

10. Under the Consumer Report Notice to application, it is stated...."This inquiry includes information as to your "mode of living ". Under Rule 42, Section 5 (5) it is stated that "Neither the marital status, the living arrangements, the occupation, the gender, the medical history, the beneficiary designation, nor the zip code or other territorial classification of a proposed insured may be used to establish, or aid in establishing the proposed insured's sexual orientation. Please certify that the question in the application is in compliance with Rule 42.

**The information concerning "mode of living" is used in connection with application for life products and is used in determining occupational or hobby underwriting hazards.**

**FROM YOUR JUNE 7 E:MAIL.** I will just continue the numbering.

11. Concerning the definition for "Your Renewal Premium Class." Under the definition, it is stated that your renewal premium class will be determined by the Issue Date. Why the issue date basis? How are you going to use the issue date to determine the renewal premium.

**We consider the initial and renewal insureds to be two separate and distinct classes. When insureds within an Issue Date time block (not by actual date) renew, we consider them a distinct renewal class. Once such a renewal class is established, the block is analyzed. If the block is performing inconsistently, we reserve the right to adjust rates so that one block does not support/pull down another block.**

12. Another class is determined by the underwriting risk assessment of each insured. If an individual has an illness or disease after the issue of the certificate, will the insured be rated each year on the renewal date based on current illness or disease?

**No. Renewal rating is done by renewal class block, not on an individual basis. The risk assessment is a voluntary request made by the insured. It affords us the opportunity to apply discounts based on changes in lifestyle, e.g., going from smoker to non-smoker. If the criteria are met, then the rates are adjusted. If the criteria are not met, the rates continue in the same track they would have been on without the risk assessment. Any subsequent rate changes for that individual would be those based on the renewal class for that person.**

13. Finally, another area is xiv – the number and type of other certificates of coverage issued by US covering individuals in Your current state of residence with the same or similar factors described above. Why would this be a valid basis for determining a renewal class.

**There are expense factors applied that vary from state to state and region to region. Renewal rates for a renewal block are determined depending on the insured's residence and other factors the insured has in common with others in that location.**

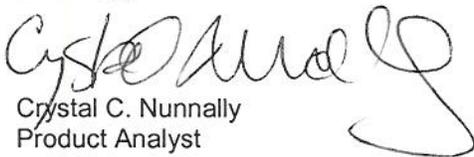
**Please be assured, none of the renewal rating is done at an individual level. Blocks are rated by applying several common factors which allow us to create diverse renewal classes.**

**Additionally there is some "clean-up". I am assigning these alphabets for purposes of our correspondence.**

- A. 10 DAY RIGHT TO RETURN has been changed to 30 days on the Certificate face pages.
- B. Language has been added to the schedule for GMS-06-C-AR-FLIC to clarify satisfaction of the deductible and coinsurance maximum percentage when participating providers are used.
- C. An exclusion for TMJ and CMD has been added for clarification. We did not feel our existing "teeth" exclusion was adequate.

Your consideration of this filing is greatly appreciated. We would appreciate receiving a stamped copy of the forms, indicating the date of acknowledgement. A postage paid envelope is enclosed for your convenience. Should you have any questions, please contact me via email [nunnallyc@ushealthgroup.com](mailto:nunnallyc@ushealthgroup.com), or by telephone at (800) 387-9027, ext. 312, or fax (817) 878-3810.

Sincerely,

  
Crystal C. Nunnally  
Product Analyst  
Product Development

Enclosures

Sent via UPS

# FREEDOM LIFE INSURANCE COMPANY OF AMERICA

3100 Burnett Plaza ♦ 801 Cherry Street, Unit 33, ♦ Fort Worth, Texas 76102 ♦ 1-800-387-9027

October 18, 2006

Ms Rosalind Minor  
Senior Certified Rate and Form Analyst  
Life and Health Division  
Department of Insurance  
1200 West 3<sup>rd</sup> Street  
Little Rock, AR 72201-1904

**RECEIVED**

OCT 24 2006

Prod. Development

RE: Freedom Life Insurance Company of America  
NAIC 62324 FEIN #61-1096685  
Response To Your October 16, 2006 Email

Forms – Product 1  
HDHP-06-C-AR-FLIC

High Deductible Health Plan Certificate

Forms – Product 2  
GMS-06-C-AR-FLIC

Medical Surgical Expense Certificate

Form – Both Products

APP-FI-FLIC  
APP-CS-AR-FLIC  
APP-MH-FLIC  
APP-NOARBNOTE-FLIC  
APP-AA-AR-FLIC  
GRP-P-06-FLIC  
GRP-SA-06-AR-FLIC

Application Family Information Page  
Application Coverage Selection Page- **NEW**  
Application Medical History Page  
Application Notices Page  
Acknowledgements and Authorizations Page  
Group Policy  
Group Supplemental Application - **REVISED**

Riders  
DOC-06-OR-FLIC  
GBMAT-06-OR-AR-FLIC  
MAT-06-OR-AR-FLIC  
WAIVER-C-OR-FLIC

Optional Doctors Office Visit Co-Pay Rider  
Optional Maternity Rider  
Optional Maternity Rider  
Waiver of Renewal Premium During First Renewal Premium  
Rate Guaranteed Period Upon Death or Total Disability of  
Primary Insured

ALDDR-06-OR-AR-FLIC  
LISH-06-OR-AR-FLIC

Optional Alcohol and Drug Dependency Rider -  
Optional Loss or Impairment of Speech and Hearing Rider -  
**WITHDRAWN**

MED-06-OR-AR-FLIC  
MSD-06-OR-AR-FLIC

Optional Mental or Emotional Disorders and Licensed  
Professional Counselors Rider -  
Optional Musculoskeletal Disorder Rider

Forms Previously Filed Exempt  
GRP-APP-FLIC

Dear Ms Minor:

Good speaking with you this morning. In response to your October 16, 2003 Email I've done the following:

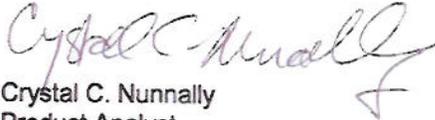
1. Removed the initiation fee and association dues information from APP-CS-AR-FLIC. I am submitting that form in substitution for APP-CS-FLIC.



2. I formerly withdraw LISH-06-OR-AR-FLIC. This form was sent in error. The benefits required by ACA §23-79-130 are already in the certificate.
3. A revised GRP-SA-06-AR-FLIC with the speech and hearing offer deleted is sent in substitution for the previously submitted form.

Your consideration of this filing is greatly appreciated. We would appreciate receiving a stamped copy of the forms, indicating the date of acknowledgement. A postage paid envelope is enclosed for your convenience. Should you have any questions, please contact me via email [nunnallyc@ushealthgroup.com](mailto:nunnallyc@ushealthgroup.com), or by telephone at (800) 387-9027, ext. 312, or fax (817) 878-3810.

Sincerely,



Crystal C. Nunnally  
Product Analyst  
Product Development

Enclosures

Sent via EMAIL

**RECEIVED**

OCT 24 2006

**Prod. Development**

the locality where the service or supply is furnished, taking into consideration the nature and the severity of the treatment incurred by **You**.

“**Utilization Review**” means a system for prospective or concurrent review of the **Medical Necessity** and appropriateness of Dental services being **Provided** or proposed to be **Provided** to an **Insured** within this state. **Utilization Review** does not include elective requests for clarification of coverage.

“**We**,” “**Us**,” “**Our**” and “**Company**” means Freedom Life Insurance Company of America.

“**You**,” “**Your**” and “**Yours**” means the **Primary Insured** named on the **Certificate Schedule**.

### **III. WHEN COVERAGE BEGINS AND ENDS**

#### **A. EFFECTIVE DATE**

This **Certificate** is effective at 12:01 a.m. local time where **You** live on the **Issue Date** shown on the **Certificate Schedule**.

#### **B. CONSIDERATION**

**We** issued this **Certificate** in consideration of and in reliance on the statements in the application and the payment of the **Initial Premium**. A copy of the application is attached. Such premium payment will keep this **Certificate** in force until the **First Renewal Date**. The **First Renewal Date** and **Initial Premium** are shown on the **Certificate Schedule**.

#### **C. ELIGIBILITY AND ADDITIONS**

**Your** spouse, unmarried dependent children who are under the age of 19 (24 if a **Full-Time Student**) and grandchildren who are considered **Your** dependents for federal tax purposes and who are under age 19 (24 if a **Full-Time Student**), any children which an **Insured** is required to insure under a court order, any child whom **You** or **Your** spouse (if listed as an **Other Insured** on the **Certificate Schedule**), intends to adopt and has become a party to a suit for that purpose, and any child who is in the custody of an **Insured** under a temporary court order that grants the **Insured** conservatorship of the child, are eligible for this coverage. Any eligible dependent (other than a newborn or adoptee) will be added to this **Certificate** when **We** approve the written application for such coverage, and accept payment of any necessary premium.

Children born to (newborn) or placed for adoption with (adoptee) **You**, or **Your** spouse (if listed as an **Other Insured** on the **Certificate Schedule**) while this **Certificate** is in force will be insured from and after the moment of birth or placement. **You** must notify **Us** within ninety (90) days after: (1) the birth or placement; (2) such **Insured** becomes a party in a suit in which the adoption of the child by such **Insured** is sought; or (3) such **Insured** has custody of the child under a temporary court order that grants to such **Insured** conservatorship of the child. **You** must also pay any required premium within the ninety (90) day period.

**We** will tell **You** if additional premium is needed. If **You** do not tell **Us** of the birth or placement of any children, their coverage will end ninety (90) days after their date of birth or placement, suit or temporary court order.

#### **D. TERMINATION OF COVERAGE**

##### **1. TERMINATIONS SUBJECT TO RIGHT OF CONVERSION**

Subject to the Section E. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONVERSION below, an applicable **Insured's** coverage under this **Certificate** ends on the earlier of the following:

- a. with respect to **Your** spouse who is covered under this **Certificate**, the premium due date in the month following the effective date of Your divorce decree, annulment or court approved separation;
- b. with respect to **Your** child(ren) who are covered under this **Certificate**, the premium due date in the month following such **Insured's** 19<sup>th</sup> birthday (24<sup>th</sup> if a **Full-Time Student**).

##### **2. TERMINATIONS BY PRIMARY INSURED NOT SUBJECT TO RIGHT OF CONVERSION**

Section E. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONVERSION notwithstanding, the following described actions by either the **Primary Insured** or other applicable **Insured** will result in a termination

of each applicable **Insured's** coverage under this **Certificate** with no right of conversion, in which event the coverage ends on the earlier of the following:

- a. the due date of any unpaid **Renewal Premium**, subject to the grace period; or
- b. the date **You** terminate coverage by notifying **Us** of the date **You** desire coverage to terminate and specify the **Insured** whose coverage is to terminate.

### 3. TERMINATION OF THE CERTIFICATE NOT SUBJECT TO RIGHT OF CONVERSION

Section E. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONVERSION notwithstanding, **We** may refuse to renew and cancel coverage for all **Insureds** under this **Certificate** with no right of conversion for the following reasons:

- a. **We** are required by the order of an appropriate regulatory authority to non-renew or cancel the **Certificate** or **Group Policy**;
- b. **We** cease or discontinue offering and renewing coverage of the same form of coverage as this **Certificate** in **Your** state upon a minimum of thirty one (31) days prior written notice mailed to **Your** last known address;
- c. the date **We** receive due proof that fraud or intentional misrepresentation of material fact existed in applying for this **Certificate** or in filing a claim for **Benefits** under this **Certificate**.

As long as this **Certificate** is in force for **You**, the coverage of **Your** child who is an **Insured** will not end if he or she is dependent upon **You** for support and maintenance and incapable of self-support because of a mental handicap or physical disability. Such dependent **Insured's** coverage under this **Certificate** will continue regardless of the dependent **Insured's** age, as long as **Renewal Premium** is timely and properly paid for **You** and the dependent **Insured** and such dependent **Insured** remains dependent upon **You** and incapable of self support because of such mental handicap or physical disability. Proof of such handicap or disability must be furnished to **Us** as soon as reasonably possible prior to the dependent **Insured** reaching the limiting age, and thereafter upon **Our** request, but not more frequently than annually after the two (2) year period following the attainment of the limiting age.

Any termination of coverage or of this **Certificate** will be effective at 11:59 P.M. local time where **You** live on the date(s) specified above.

If **You** die, **Your Spouse**, if then an **Insured** under this **Certificate**, will become the **Primary Insured**. If **You** and **Your** spouse (if any) are not covered under this **Certificate**, the oldest **Insured** will become the **Primary Insured**.

**We** will not accept premium for any **Insured** whose coverage has terminated. Premiums, which are sent to **Us** and include an amount to cover the **Insured** whose coverage has terminated, will be returned. **We** will only accept the correct premium to cover those **Insureds** who are eligible for coverage. If premiums are accepted in error, **Our** liability is limited to coverage for the period of time for which premiums were accepted in error.

Except for claims involving fraud or intentional misrepresentation of material fact, any termination will be without prejudice to any **Covered Expenses** incurred by an **Insured** for **Benefits** prior to the date of termination. If coverage is terminated, unearned premium will be computed pro-rata and any unearned premium will be refunded to **You**.

### E. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONVERSION

A **Certificate Of Conversion Coverage**, whereby the coverage then afforded by this **Certificate** for an applicable **Insured** will continue without a requirement of any additional evidence of the insurability of such **Insured**, is available only:

1. for **Your** spouse who is covered under this **Certificate**, if his or her coverage ceases due to divorce, annulment or court approved separation;
2. for **Your** unmarried child(ren) who is covered under this **Certificate**, if his or her coverage ceases due to his or her reaching the limiting age of 19 (24 if enrolled as a **Full-Time Student**), or
3. for each applicable **Insured**, if coverage under this **Certificate** terminates because the **Group Policyholder** has terminated coverage under the **Group Policy**, and does not replace coverage with another group policy, in which case **You** will be given thirty (30) days prior written notice of the termination, mailed to **Your** last known address. Upon termination of the **Group Policy**, **You** may apply on behalf of all **Insureds** for a **Certificate Of Conversion Coverage**. The **Certificate Of Conversion Coverage** must be applied for and the first premium received by **Us**

within thirty-one (31) days after the date that coverage under the **Group Policy** terminates. If a **Certificate Of Conversion Coverage** is issued, it will take effect on the day after coverage under the **Group Policy** terminates.

A **Certificate Of Conversion Coverage** is not available and will not be provided if:

Conversion coverage is not provided if:

1. an **Insured's** coverage under the **Group Policy** ceases because the **Group Policy** was terminated and was replaced by similar group coverage within thirty-one (31) days;
2. an **Insured's** coverage under the **Group Policy** ceases because of failure to pay the required premiums in the time allowed;
3. ~~an **Insured** was not covered under this **Certificate** for the three (3) consecutive months immediately prior to the date coverage ceases;~~
4. an **Insured** is covered by similar benefits furnished by any:
  - a. dental expense plan;
  - b. dental service subscriber contract;
  - c. dental pre-payment plan; or
  - d. dental plan provided in accordance with the requirements of any state or federal law; or
5. an **Insured** is eligible to be covered by any group:
  - a. dental expense plan;
  - b. dental service subscriber contract;
  - c. dental pre-payment plan; or
  - d. dental plan provided in accordance with the requirements of any state or federal law.

In order to be eligible for a **Certificate Of Conversion Coverage**, a written election of continuation of coverage via conversion must be made by the applicable **Insured**, on a form furnished by **Us**, and the first premium must be paid, in advance, to **Us** on or before the date on which the applicable coverage under this **Certificate** for such **Insured** would otherwise terminate. The amount of first premium required from the effective date through the end of the first renewal period of the **Certificate Of Conversion Coverage** shall not be more than **Our** full group premium rate then applicable for the applicable **Insured** under the **Certificate** with the same mode of payment. Applicable **Insureds** shall not be required to pay the **Renewal Premium** for a **Certificate Of Conversion Coverage** less often than monthly.

## IV. ALTERNATE TREATMENT

An **Insured** has the right to choose his or her course of treatment and **Dentist**. However, if an **Insured** chooses treatment which is more expensive than is needed to correct the dental problem according to accepted standards of dental practice, the **Benefits** payable will be those **Usual and Customary** charges payable for the less expensive treatment which provides professionally satisfactory results at the most cost effective level.

## V. BENEFITS

After the **Calendar Year Deductible** has been met, and subject to the applicable **Insured Coinsurance Percentage** set forth in the **Certificate Schedule**, **We** will pay, to or on behalf of the **Insured**, the applicable **Company Insurance Percentage** of the remaining **Covered Expenses** incurred by an **Insured** for the following **Benefits**, up to but not exceeding the **Calendar Year Maximum Per Insured**. Coverage is limited to **Covered Expenses** incurred by an **Insured** for the following items to prevent, diagnose or treat dental disease, defect or **Injury**. Coverage under this Section of the **Certificate** will be reduced for services, supplies, care or treatment obtained from a **Non-Participating Dentist**. The difference between both the **Company Insurance Percentages** and the **Insured Coinsurance Percentages** for: (i) **Participating Dentists** and **Non-Participating Dentists** are shown in the **Certificate Schedule**.

### A. Preventive Dental Care

**Benefits** include fees and expenses charged by **Dentists** for the following items of preventive dental care and which constitute **Covered Expenses** incurred by an **Insured** :

1. Initial and Periodic oral examinations. Limited to one (1) during a consecutive six (6) month period;
2. Intraoral X-rays, with or without bitewings. Limited to one (1) series in a consecutive thirty-six (36) month period;
3. **Bitewing X-rays**. Limited to one (1) set during a consecutive twelve (12) month period;
4. **Prophylaxis** (cleaning of the teeth) with or without an oral examination. Limited to one (1) treatment during a consecutive six (6) month period;