

SERFF Tracking Number: CLTR-126251763 State: Arkansas
 Filing Company: United of Omaha Life Insurance Company State Tracking Number: 43101
 Company Tracking Number: 700CI-DEN-EZ09
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
 Product Name: Group Dental Insurance
 Project Name/Number: United Group Dental/7000CI-DEN-EZ 09

Filing at a Glance

Company: United of Omaha Life Insurance Company

Product Name: Group Dental Insurance SERFF Tr Num: CLTR-126251763 State: Arkansas
 TOI: H10G Group Health - Dental SERFF Status: Closed-Approved- State Tr Num: 43101
 Closed

Sub-TOI: H10G.000 Health - Dental Co Tr Num: 700CI-DEN-EZ09 State Status: Approved-Closed
 Filing Type: Form Reviewer(s): Rosalind Minor
 Authors: Frank Cripps, Stephanie Disposition Date: 08/13/2009
 Young, Susan Kalmus
 Date Submitted: 08/03/2009 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: United Group Dental
 Project Number: 7000CI-DEN-EZ 09
 Requested Filing Mode: Review & Approval
 Explanation for Combination/Other:
 Submission Type: New Submission
 Overall Rate Impact:
 Filing Status Changed: 08/13/2009

Status of Filing in Domicile: Authorized
 Date Approved in Domicile: 07/29/2009
 Domicile Status Comments:
 Market Type: Group
 Group Market Size: Small and Large
 Group Market Type: Employer, Association
 Explanation for Other Group Market Type:
 State Status Changed: 08/13/2009
 Created By: Frank Cripps
 Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Frank Cripps

Filing Description:

On behalf of United of Omaha Life Insurance Company, Coulter and Associates is hereby submitting the attached group dental coverage forms for your review and approval for use in your state. A copy of the Company's filing authorization is enclosed.

The Group Policy (Form Number 7000GM-U-EZ 2001) was approved in Arkansas on 6/18/2001. The Certificate of Insurance is designed to provide dental insurance benefits to the employees/members of eligible employer or association groups and their dependents. Benefits include reimbursement of the covered expenses incurred for services listed in the Schedule under Covered Services, subject to any deductible, insurance percentage (coinsurance),

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co-pay and maximum annual benefit. In addition, some procedures may have a waiting period, age limits and/or frequency limits as described in the Dental Benefits Schedule.

The Company understands that before it can issue a policy to an association, it will need to submit that association to the Department for review and approval.

Each member/employee to be covered will be issued a Certificate of Insurance.

The Premium Rider Form #105GR-EZ will be attached to the group policy and to each certificate issued under that policy. The Group Insurance Application Form #10634 GA-EZ 04 will be used by the prospective policyholder to apply for a policy.

These are new forms and do not supersede any forms on file with the Department of Insurance.

Please do not hesitate to contact me should you have any questions or require any additional information.

Company and Contact

Filing Contact Information

Frank Cripps, Consultant frank@coulter-and-associates.com
 379 Princeton-Hightstown Rd 609-443-7540 [Phone]
 Cranbury, NJ 08512 609-443-4103 [FAX]

Filing Company Information

(This filing was made by a third party - coulterandassociatesinc)

United of Omaha Life Insurance Company	CoCode: 69868	State of Domicile: Nebraska
Mutual of Omaha Plaza	Group Code: 261	Company Type: life and health
Omaha, NE 68175	Group Name:	State ID Number:
(609) 443-7540 ext. [Phone]	FEIN Number: 47-0322111	

Filing Fees

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

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United of Omaha Life Insurance Company	\$50.00	08/03/2009	29586604

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/13/2009	08/13/2009

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	08/10/2009	08/10/2009	Frank Cripps	08/11/2009	08/11/2009

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Disposition

Disposition Date: 08/13/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Cover Letter and Authorization	Approved-Closed	Yes
Form (revised)	Eligibility	Approved-Closed	Yes
Form	Eligibility		Yes
Form	Payment of Claims	Approved-Closed	Yes
Form	Standard Provisions	Approved-Closed	Yes
Form	Coordination of Benefits	Approved-Closed	Yes
Form	Subrogation and/or Reimbursement Rights	Approved-Closed	Yes
Form	Cobra Continuation	Approved-Closed	Yes
Form (revised)	Definitions	Approved-Closed	Yes
Form	Definitions		Yes
Form	Schedule	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Premium Rider	Approved-Closed	Yes
Form	Certificate of Insurance Face Page	Approved-Closed	Yes
Form (revised)	Consumer Information Notice	Approved-Closed	Yes
Form	Consumer Information Notice		Yes

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 08/10/2009
Submitted Date 08/10/2009

Respond By Date
Dear Frank Cripps,

This will acknowledge receipt of the captioned filing.

Objection 1

- Eligibility, 7017GP-DEN-EZ 09 (Form)

Comment:

Insurance must continue for handicapped dependents as outlined under ACA 23-86-108(4) and Bulletin 14-81.

Objection 2

- Consumer Information Notice, 8964GI-EZ AR 05-03 (Form)

Comment:

Please change the address and phone numbers of our Department to read:

1200 West Third Street
Little Rock, AR 72201-1904

Phone: (800)852-5494 or (501)371-2640

Please feel free to contact me if you have questions.

Sincerely,
Rosalind Minor

Response Letter

Response Letter Status Submitted to State
Response Letter Date 08/11/2009
Submitted Date 08/11/2009

Dear Rosalind Minor,

Comments:

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Response 1

Comments: We have modified the variable information in the 7th paragraph of When Insurance Begins (page 5) to comply with ACA 23-86-108(4) in form 7017GP-DEN-EZ 09. We have also modified the 2nd paragraph, item f) in the definition of Dependent in form 7001GD-DEN-EZ 09 to comply with this code section.

Related Objection 1

Applies To:
 - Eligibility, 7017GP-DEN-EZ 09 (Form)

Comment:

Insurance must continue for handicapped dependents as outlined under ACA 23-86-108(4) and Bulletin 14-81.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Eligibility	7017GP-DEN-EZ 09		Certificate Amendment, Insert Page, Endorsement or Rider	Initial		40.300	7017GP-DEN-EZ 09 Eligibility for use in AR.pdf
Previous Version							
Eligibility	7017GP-DEN-EZ 09		Certificate Amendment, Insert Page, Endorsement or Rider	Initial		40.300	7017GP-DEN-EZ 09 Eligibility.pdf
Definitions	7001GD-DEN-EZ 09		Certificate Amendment, Insert Page, Endorsement or Rider	Initial		45.200	7001GD-DEN-EZ 09 Definitions

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for use in
AR.pdf

Previous Version

Definitions	7001GD-DEN-EZ 09	Certificate Amendment, Initial Insert Page, Endorsement or Rider	45.200	7001GD-DEN-EZ 09 Definitions .pdf
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No Rate/Rule Schedule items changed.

Response 2

Comments: We have corrected the address and phone number of the Department in form 8964GI-EZ AR 05-03 as you have directed.

Related Objection 1

Applies To:
 - Consumer Information Notice, 8964GI-EZ AR 05-03 (Form)
 Comment:

Please change the address and phone numbers of our Department to read:

1200 West Third Street
 Little Rock, AR 72201-1904

Phone: (800)852-5494 or (501)371-2640

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Consumer Information Notice	8964GI-EZ AR 05-		Other	Initial		0.000	AR Consumer

<i>SERFF Tracking Number:</i>	<i>CLTR-126251763</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>United of Omaha Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>43101</i>
<i>Company Tracking Number:</i>	<i>700CI-DEN-EZ09</i>		
<i>TOI:</i>	<i>H10G Group Health - Dental</i>	<i>Sub-TOI:</i>	<i>H10G.000 Health - Dental</i>
<i>Product Name:</i>	<i>Group Dental Insurance</i>		
<i>Project Name/Number:</i>	<i>United Group Dental/7000CI-DEN-EZ 09</i>		
	03		

Information Notice (company supplied).pdf

Previous Version

<i>Consumer Information Notice</i>	<i>8964GI-EZ AR 05-03</i>	<i>Other</i>	<i>Initial</i>	<i>0.000</i>	Consumer Information Notice.pdf
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No Rate/Rule Schedule items changed.

We trust you will find this response to be acceptable.

Sincerely,
 Frank Cripps, Stephanie Young, Susan Kalmus

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Form Schedule

Lead Form Number: 700CI-DEN-EZ 09

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 08/13/2009	7017GP- DEN-EZ 09	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Eligibility	Initial		40.300	7017GP- DEN-EZ 09 Eligibility for use in AR.pdf
Approved- Closed 08/13/2009	7023PC- DEN-EZ 09	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Payment of Claims	Initial		40.400	7023PC- DEN-EZ 09 Payment of Claims.pdf
Approved- Closed 08/13/2009	7024SP- DEN-EZ 09	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Standard Provisions	Initial		52.500	7024SP-DEN- EZ 09 Standard Provisions.pdf
Approved- Closed 08/13/2009	485GI- DENC OB- EZ 09	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Coordination of Benefits	Initial		54.000	485GI- DENC OB-EZ 09 Coordination of Benefits.pdf
Approved- Closed 08/13/2009	3316GI- DEN-EZ 09	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Subrogation and/or Reimbursement Rights	Initial		45.700	3316GI-DEN- EZ 09 Subrogation Rights.pdf
Approved-	8495GI-	Certificate	Cobra Continuation	Initial		46.000	8495GI-DEN-

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Company Tracking Number:	700CI-DEN-EZ09		
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Product Name:	Group Dental Insurance		
Project Name/Number:	United Group Dental/7000CI-DEN-EZ 09		
Closed	DEN-EZ 09 Amendmen		EZ 09
08/13/2009	t, Insert		COBRA
	Page,		Continuation.
	Endorseme		pdf
	nt or Rider		
Approved-	7001GD- Certificate	Definitions	Initial
Closed	DEN-EZ 09 Amendmen		45.200
08/13/2009	t, Insert		7001GD-
	Page,		DEN-EZ 09
	Endorseme		Definitions for
	nt or Rider		use in AR.pdf
Approved-	7000GS-U- Certificate	Schedule	Initial
Closed	EZ DEN 09 Amendmen		40.700
08/13/2009	t, Insert		7000GS-U-EZ
	Page,		DEN 09
	Endorseme		Benefits
	nt or Rider		Schedule -
			United.pdf
Approved-	10634GA- Application/	Application	Initial
Closed	EZ 04 Enrollment		40.500
08/13/2009	Form		10634GA-EZ
			04 Group
			Application.pdf
Approved-	105GR-EZ Policy/Cont	Premium Rider	Initial
Closed	ract/Fratern		0.000
08/13/2009	al		105GR-EZ
	Certificate:		Premium
	Amendmen		rider.pdf
	t, Insert		
	Page,		
	Endorseme		
	nt or Rider		
Approved-	7000CI- Certificate	Certificate of	Initial
Closed	DEN-EZ 09	Insurance Face Page	0.000
08/13/2009			7000CI-DEN-
			EZ 09
			CERTIFICAT
			E OF
			INSURANCE
			Face Page-
			United.pdf
Approved-	8964GI-EZ Other	Consumer	Initial
			0.000
			AR Consumer

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Closed AR 05-03 Information Notice
08/13/2009

Information
Notice
(company
supplied).pdf

ELIGIBILITY

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of this Policy.

Definitions

[Actively Eligible or Active Eligibility] means a[n] [Member] is:

- a) in good standing with the [Policyholder][or][V] and eligible for insurance according to the [Policyholder][or][V]'s rules of eligibility; and
- b) eligible for insurance under this Policy in accordance with the terms and conditions of this Eligibility section.

If the [Policyholder][or][V]'s rules of eligibility for insurance conflict with any of the terms and conditions of this Eligibility section, the terms and conditions of this Eligibility section shall control. Any changes to the [Policyholder][or][V]'s rules of eligibility after the Policy Effective Date will not be effective for purposes of becoming or remaining eligible for insurance under the Policy unless such changes have been approved by Our authorized representative in Our home office.]

[Actively Working or Active Work] means a[n Employee] is performing the normal duties of his or her regular job for the [Policyholder][or][V] on a regular and continuous basis [30] or more hours each [week] and is receiving compensation from the [Policyholder][or][V] for work performed for the [Policyholder][or][V] at:

- a) the [Policyholder's][or][V's] usual place of business;
- b) an alternative work site at the direction of the [Policyholder][or][V], or
- c) a location to which one must travel to perform the job.

A[n Employee] will be considered actively working on any day that is a regular paid holiday or day of vacation, or regular or scheduled non-working day, provided the [Employee] was actively working on the last preceding regular work day.]

[Attained Age] means the age of the Insured Person as of the Policy Anniversary following the Insured Person's birthday. For example, if an Insured Person's [70th] birthday is on [March 1, 2009] and the Policy Anniversary is [January 1], the Insured Person will reach the attained age of [70] on [January 1, 2010].]

[Eligibility Waiting Period] means a continuous period of Active [Work] that a[n Employee] must satisfy before becoming eligible for insurance as described in the When a[n Employee] Becomes Eligible for Insurance (Eligibility Waiting Period) provision.]

[[Employee]] means:

- a) a citizen or permanent resident of the United States [or Canada] who is Actively Working; or
- b) a person who is authorized to work in the United States pursuant to the Immigration and Nationality Act and related rules and regulations who is Actively Working.

An employee does not include a person:

- a) working outside the United States [or Canada] for a period in excess of 12 consecutive months unless written approval has been received from Our authorized representative in Our home office;
- b) [working on a seasonal or temporary basis][;][or]
- c) [performing services for the [Policyholder][or][V] [as an independent contractor, including persons reporting income on a 1099 form,] [or] [subject to the terms of a leasing agreement between the[Policyholder][or][V] and a leasing organization][.]]

[Hospital] means an accredited facility licensed by the proper authority of the area in which it is located to provide care and treatment for the condition causing confinement. A hospital does not include a facility or institution or part of a facility or institution which is licensed or used principally as a clinic, convalescent home, rest home, nursing home or home for the aged, halfway house or board and care facilities.]

[Incapacitated] means that a Dependent child is:

- a) continuously incapable of self-sustaining employment by reason of mental retardation, developmental disability, mental illness or physical handicap; and
- b) primarily dependent upon You for financial support and maintenance on a continuous basis.]

[Life Event] means:

- a) a change in legal marital status;
- b) a change in the number of Your Dependents; or
- c) a significant cost or coverage change under of any other plan under which You [or Your Dependents] are covered;] or
- d) [V].

[Member] means:

- a) a citizen or permanent resident of the United States [or Canada] who is Actively Eligible or,
- b) a person who is authorized to work in the United States pursuant to the Immigration and Nationality Act and related rules and regulations who is Actively Eligible.

A member does not include a person who resides outside the United States [or Canada] for a period in excess of 12 consecutive months unless written approval has been received from Our authorized representative in Our home office.]

[Retiree] means a former [Employee] of the [Policyholder][or][V] who is a citizen or permanent resident of the United States [or Canada] and:

- a) [has attained Social Security Normal Retirement Age;]
- b) [is at least age [V];]
- c) [has completed [V] consecutive years of full time[, or part time] [employment] with the [Policyholder][or][V] immediately prior to retirement;]
- d) [participates in a pension plan maintained or sponsored by the [Policyholder][or][V];][and]
- e) [whose age plus years of active full time[, or part time][employment] with the [Policyholder][or][V] equal at least [V]][and;]
- f) [V].]

[**Schedule** means the section of the Certificate identified as the [“Schedule”].]

[**Social Security Normal Retirement Age** means Your normal retirement age under the United States Social Security Act. The Social Security Normal Retirement Age table is available online at www.ssa.gov/OACT/ProgData/nra.html or any other online web-site address which replaces this address.]

[**Student** means Your Dependent child:

- a) who qualifies as Your “dependent” as defined in the United States Internal Revenue Code; and
- b) who attends an accredited high school, trade school, college, university or other institution of learning and is enrolled full-time [or part-time]as indicated by evidence acceptable to Us.]

When a[n Employee] Becomes Eligible for Insurance (Eligibility Waiting Period)

[A[n Employee] who is Actively [Working] on [MM/DD/YYYY] becomes eligible for insurance under this Policy on [MM/DD/YYYY].]

[A[n Employee] who has completed an Eligibility Waiting Period of [30] [days] of continuous Active [Work] on or before [MM/DD/YYYY] becomes eligible for insurance under this Policy on [MM/DD/YYYY].]

[A[n Employee] who [is hired] after [MM/DD/YYYY] becomes eligible for insurance under this Policy on the day the [Employee] begins Active [Work].]

[A[n Employee] who [is hired] after [MM/DD/YYYY] becomes eligible for insurance under this Policy on the day following completion of an Eligibility Waiting Period of [30] [days] of continuous Active [Work].]

[A[n Employee] who is not eligible for insurance under this Policy on [MM/DD/YYYY], or a[n Employee] who [is hired] after [MM/DD/YYYY], becomes eligible for insurance under this Policy on the day following completion of an Eligibility Waiting Period of [30] [days] of continuous Active [Work].]

[A[n Employee] who is not eligible for insurance under this Policy on [MM/DD/YYYY] becomes eligible on the day following completion of an Eligibility Waiting Period of [30] [days]. A[n Employee] who [is hired] after [MM/DD/YYYY] becomes eligible on the day following completion of an Eligibility Waiting Period of [30] [days].]

[If a[n employee] is hired as a part-time[or temporary] [employee] and subsequently changes to a full-time [Employee], any period of time spent as a part-time[or temporary] [employee] will be used to satisfy the Eligibility Waiting Period.]

[V.]

[When a Retiree Becomes Eligible for Insurance [(Eligibility Waiting Period)]

A Retiree who was covered under a Prior Plan will be eligible for insurance under this Policy on [MM/DD/YYYY].

[A Retiree who was covered under a Prior Plan immediately prior to retirement and retires on or after [MM/DD/YYYY] becomes eligible for insurance under this Policy on the [first day of the month which [coincides with or] follows the] day of retirement.]

[A Retiree who retired prior to [MM/DD/YYYY] is not eligible for insurance under this Policy.]

[Additional Coverage Requirement

A[n] [Employee] must elect [V] insurance maintained or sponsored by the [Policyholder][or][V] [and issued by Us] in order to be eligible for insurance under this Policy. If the [Employee] does not elect [V] insurance maintained or sponsored by the [Policyholder][or][V], the [Employee] may not elect insurance under this Policy. If the [Employee]’s [V] insurance maintained or sponsored by the [Policyholder][or][V] ends, insurance under this Policy shall also end.]

[When a Dependent Becomes Eligible

A Dependent becomes eligible for insurance under this Policy on the later of:

- a) the day You become eligible for insurance under this Policy; or
- b) the day You acquire the Dependent, provided You elect insurance for yourself under this Policy.

[If both You and Your Spouse are eligible for insurance under this Policy as [Employees] of the [Policyholder][or][V], neither You nor Your Spouse may elect insurance as a Dependent of the other person.]

[If both You and Your Spouse are eligible for insurance under this Policy as [Employees] of the [Policyholder][or][V], either You or Your Spouse, but not both, may elect insurance for Your Dependent child(ren) under this Policy.]

[In order to insure an eligible Dependent child, You must insure all of Your eligible Dependent child(ren). You must also elect the same amount of insurance for each eligible Dependent child.]

When Insurance Begins

An eligible [Employee] must request insurance for the [Employee][and any Dependents] by properly enrolling through an enrollment process acceptable to Us. Enrollment information must be submitted to the [Policyholder][or][V] within [31] days following the day the [Employee][or Dependent(s)] becomes eligible.

[We must receive a Retiree’s request for insurance within [31] days following the day the Retiree becomes eligible in order for the Retiree to be insured under this Policy.]

[A Dependent child is considered eligible for insurance at birth and may become insured at any time through the child's third birthday without being subject to terms of the Late Entrant Enrollment Period provision.]

A[n Employee] will become insured on [the first day of the month which coincides with or follows] the latest of the day:

- a) the [Employee] begins Active [Work]; or
- b) the [Employee's] enrollment information is properly completed and signed by the [Employee].

[If the [Employee] is not Actively [Working] on the day insurance would otherwise begin, insurance will begin on [the first day of the month which [coincides with or] follows] the day the [Employee] returns to Active [Work].]

[An eligible Dependent will become insured on the latest of the day:

- a) the [Employee] becomes insured;
- b) the [Employee] acquires the eligible Dependent; or
- c) the Dependent's enrollment information is properly completed and signed by the [Employee].

[Insurance for a Dependent child who became Incapacitated prior to reaching the age of 19, or age 25 if a Student, will begin in accordance with the When Insurance Begins provision, provided the child otherwise meets the definition of Dependent.]

[The First Enrollment Period

A[n Employee] may elect insurance for the [Employee] [and any Dependents] during the First Enrollment Period. The First Enrollment Period is the [31 day period] following the day the [Employee][or the Dependent] becomes eligible for insurance under this Policy.]

[Subsequent Enrollment Periods

A[n Employee] may elect, drop, increase, decrease or change insurance during a Subsequent Enrollment Period. A Subsequent Enrollment Period is any period up to [31] consecutive calendar days as designated by the [Policyholder][or][V] and agreed to in writing by Our authorized representative in Our home office.]

[Late Entrant Enrollment Period

If a[n Employee] does not elect insurance during the [Employee's][or Dependent's] First Enrollment Period, the [Employee] [or Dependent] will not be able to become insured until the first Subsequent Enrollment Period which occurs at least [24] months after the First Enrollment Period.]

[When Election Changes Are Permitted

The [Policyholder][or][V] has chosen to provide these insurance benefits under a Section 125 cafeteria plan. A cafeteria plan permits You to elect to pay Your share of the benefit cost with pre-tax dollars and permits You to change Your election only when specific Life Events occur (other than during an enrollment period designated by the [Policyholder][or][V] and agreed to in writing by Our authorized representative in Our home office). You may make an election change by submitting a written request to the [Policyholder][or][V] within [31] days from the date of a Life Event.

Life Events are described in the [Policyholder][or][V]'s cafeteria plan. Contact the [Policyholder][or][V] for information regarding the election changes that are permissible under the [Policyholder][or][V]'s cafeteria plan. If Your election change does not meet Section 125 cafeteria plan requirements, You may only make an election change as described in the Subsequent Enrollment Periods provision.]

[Within [31] days of a Life Event, You must submit to the [Policyholder][or][V] any request to change insurance through an enrollment process acceptable to Us. [If Your request is submitted more than [31] days after the date of a Life Event, You may not enroll until the next Subsequent Enrollment Period.]

[Reinstatement of Insurance]

You may be eligible to reinstate insurance that has ended [for Yourself and Your eligible Dependents] in accordance with this provision. You must submit a request to reinstate insurance to the [Policyholder][or][V] through a reinstatement request process acceptable to Us within [31] days of Your return to Active [Work].

Reinstated insurance will take effect on [the later of] [the first day of the month which [coincides with or] follows] the day the reinstatement request is completed and signed. If You are not Actively [Working] on the day the reinstated insurance would otherwise take effect, insurance will become effective on [the first day of the month which [coincides with or] follows]the day You return to Active [Work].

The following reinstatement option[s] [are][is] available:

[[Non-Payment of Premium] [or] [Voluntary Termination of Coverage]

[If insurance ended due to [non-payment of premium] [or] [voluntary termination of coverage], insurance may be reinstated during the first Subsequent Enrollment Period which occurs at least [24] months after the date on which insurance ended.]

[Involuntary Reduction in Hours]

If insurance ended because the [Employee] was no longer Actively Working due to an involuntary reduction of hours worked, insurance may be reinstated without satisfying another Eligibility Waiting Period if the [Employee] returns to Active Work and there was no break in employment with the [Policyholder][or][V] after the date insurance ended.]

[Rehired] [Employee] Due to [Layoff] [or] [Termination]

If insurance ended because the [Employee] was no longer Actively [Working] due to [layoff] [or] [termination of [employment] with the [Policyholder][or][V]], insurance may be reinstated without satisfying another Eligibility Waiting Period if the [Employee] is [rehired] and returns to Active [Work] within [90] [days] from the date [employment] ended.

[Rehired][Employee] Due to Leave of Absence

If insurance ended due to an approved leave of absence, including military leave, insurance may be reinstated within [1] [year] from the date [employment] ended, without satisfying another Eligibility Waiting Period upon return to Active [Work].

When Insurance Ends

Insurance will end for You[and Your Dependents][on the earliest of the day][on the last day of the month in which the earliest of the following events occurs]:

- a) this Policy terminates;
- b) You are no longer eligible for insurance under this Policy;
- c) [insurance ends in accordance with the Additional Coverage Requirement provision;]
- d) [You attain age [65];]
- e) [You return to employment with the [Policyholder][or][V][;]]
- f) any applicable premium is due and unpaid; or
- g) You begin active duty in the Armed Forces, National Guard or Reserves of any state or country (except for temporary active duty of [31] days or less).

[In addition to the items above, insurance for a Dependent will end [on the earliest of the day] [on the last day of the month in which the earliest of the following events occurs]:

- a) the Dependent is no longer eligible for insurance under this Policy; or
- b) the Dependent begins active duty in the Armed Forces, National Guard or Reserves of any state or country (except for temporary active duty of [31] days or less).]

[Exceptions to When Insurance Ends

If You cease to be [Actively [Working]][eligible for insurance], You[and/or Your Dependents] may be eligible to continue or obtain insurance under [the V provision.] [one of the following provisions:]

- a) [Continuation of Insurance for Approved Layoff, Leave of Absence or Paid Severance]
- b) [COBRA Continuation]
- c) [V]

[Continuation of Insurance for Approved [Layoff][,] [Leave of Absence] [or] [Paid Severance]

In the event of a conflict between this provision and any other provision of this Policy, this provision shall control.

You may be able to continue insurance[for Yourself and Your Dependent(s)] for up to [12] [weeks] from the day You cease to be Actively Working in the event of:

- a) [a temporary involuntary layoff][; or]
- b) [a personal leave of absence approved by the [Policyholder][or][V] due to[:]
 1. an Injury or Sickness; or
 2. any other personal reason].

In addition, the federal Family Medical Leave Act (FMLA) and Uniformed Services Employment and Reemployment Rights Act (USERRA) and any amendments thereto, as well as certain state laws, allow continuation of insurance in certain instances for leaves of absence, layoff or termination. Contact the [Policyholder][or][V] for additional information regarding any other continuation options that may be available.

[You may also be able to continue insurance from the day You cease to be Actively Working if You are entitled to and receive paid severance from the [Policyholder][or][V].]

Any insurance continued under this provision will be subject to the following conditions:

- a) insurance may not be continued beyond the earliest of:
 1. [1-365] [day][week][month][year][s]; [or]
 2. the time period allowed by FMLA, USERRA or applicable state law that allows for continuation;
 3. [the time period during which You receive paid severance;]
- b) [the amount of insurance may not be increased while insurance is continued under this provision;]
- c) We must receive notification acceptable to Us of the approved [absence] [or] [severance] from the [Policyholder][or][V] within [31] days from the date You cease Active [Work]; and
- d) We must continue to receive premium payment when due (premiums must be paid by You or on Your behalf).

Insurance under this provision will end on [the last day of the month which [coincides with or] follows] the earliest of the day:

- a) the time period in (a) in the preceding paragraph has been satisfied;
- b) [Your temporary involuntary layoff becomes permanent, if insurance is continued under this provision due to Your temporary involuntary layoff;]
- c) You return to Active [Work];
- d) this Policy terminates;
- e) any applicable premium is due and unpaid;
- f) You obtain a similar type of coverage under another group [or individual worksite] plan; or
- g) You begin employment with an employer other than the [Policyholder][or][V].

See the Options for Payment of Premium for Continued Insurance provision for premium payment options.]

Options for Payment of Premium for Continued Insurance

When insurance is continued, We must receive premium payment when due (premiums must be paid by You or on Your behalf) for insurance to remain effective. This can occur in one of the following ways:

- a) the [Policyholder][or][V] may pay the premiums; [or]
- b) You may pay premium to the [Policyholder][or][V] who will then submit premium to Us; or
- c) You may pay premium directly to Us].

[Contact the [Policyholder][or][V] to determine which option is available to You.]

[Contact the [Policyholder][or][V] to determine whether option (a) or (b) is available to You. If neither option is available, You should contact the Policyholder for information regarding the process for submitting premium directly to Us.]

Payment of premium does not guarantee eligibility for coverage.]

PAYMENT OF CLAIMS

Claim Forms

Before benefits are paid, We must be given written proof of loss as described in this section.

[If a Participating Provider is used, You do not need to submit a claim form to Us]

[If a Non-Participating Provider is used,] You must submit a claim form to Us. You may use a standard claim form supplied by Your Provider. The completed claim form and other information needed to prove loss should be sent to the following address:

[P.O. Box 6560]
[Sherwood, AR 72124]

Proof of Loss

You or Your Provider have 90 days from the date of service to furnish Us with completed claim forms and other information needed to prove loss. Failure to furnish such proof within this time period shall not invalidate nor reduce any claim if:

- a) it was not reasonably possible to give proof within that 90-day period; and
- b) proof is furnished as soon as reasonably possible, but not later than one year after the date of service, unless You are not legally capable.

We may occasionally require an Insured Person to be examined by a Provider of Our choice to assist in determining whether benefits are payable. We will pay for these examinations. We will not require more than a reasonable number of such examinations.

Time of Payment of Claims

[Benefits will be paid after We receive acceptable written proof of loss in accordance with the Claims Payment provision in this section. Benefits will be paid only if We determine that the claimant is entitled to benefits under the terms of the Policy. We may require supporting information which may include, but which is not limited to, the following:

- a) clinical records;
- b) charts;
- c) x-rays;
- d) oral photographs; and
- e) other diagnostic aids.

[If services are received from a Participating Provider, benefits will be paid to that Provider.]

[If services are received from a Non-Participating Provider, benefits will be paid to You][,][.] [unless You [or Your Dependent] have assigned benefits to that Provider.]

[Benefits will be paid to You[.][,][unless You [or Your Dependent] have assigned benefits to that Provider.]

Benefits not paid to the Provider shall be paid to You except that benefits unpaid at Your death may be paid, at Our option, to:

- a) any relative who We determine is entitled to the benefits; or
- b) Your estate.

Any payment made in good faith will fully discharge Us to the extent of the payment.]

Refund to Us for Overpayment of Benefits

If We pay benefits for Expenses incurred by You [and/or Your Dependent], and it is found that We paid more benefits than We should have paid under the Policy, We will have the right to a refund from You.

The amount of the refund is the difference between:

- a) the amount of benefits paid by Us for those Expenses; and
- b) the amount of benefits which should have been paid by Us for those Expenses.

However, at Our option, We may recover the excess amount by reducing or offsetting any future benefits payable for Expenses incurred by You [and Your Dependent(s)] by the amount of the overpayment.

Authority to Interpret Policy

[By purchasing the Policy, the Policyholder grants Us the discretion and the final authority to construe and interpret the Policy. This means that We have the authority to decide all questions of eligibility and all questions regarding the amount and payment of any Policy benefits within the terms of the Policy as interpreted by Us. Benefits under the Policy will be paid only if We decide, in Our discretion, that a person is entitled to them. In making any decision, We may rely on the accuracy and completeness of any information furnished by the Policyholder, an Insured Person or any other third party. Our interpretation of the Policy as to the amount of benefits and eligibility shall be binding and conclusive on all persons.

The Policyholder further grants Us the authority to delegate to third parties, including, without limitation, [Mutual of Omaha Insurance Company and] any third party administrator with whom We have contracted to provide claims administration and other administrative services ("TPA"), the discretionary authority granted in the Policy. The Policyholder expressly grants any such third party the full discretionary authority granted to Us under this Policy.

The Insured Person has the right to request a review of Our decision. If, after exercising the Policy's review procedures, the Insured Person's claim for benefits is denied or ignored, in whole or in part, the Insured Person may file suit and a court will review the Insured Person's eligibility or entitlement to benefits under the Policy.

The Policyholder, as Plan sponsor, agrees that the Policyholder retains full responsibility for the legal and tax status of its benefits program and releases Us from all responsibility

for the reporting and the employment-based design of the program and from all other responsibilities not accepted in writing by one of Our officers.]

[Policy benefits will be paid only if We determine, in Our discretion, that the claimant is entitled to benefits under the terms of the Policy (see the Authority to Interpret Policy provision in the ERISA Summary Plan Description information included with the Certificate).]

STANDARD PROVISIONS

Insurance Contract

The insurance contract consists of:

- (a) the Policy; and
- (b) the Policyholder's application attached to the Policy.

Changes in the Insurance Contract

The insurance contract may be changed (including reducing or terminating benefits or increasing premium costs) any time We and the Policyholder both agree to a change. No one else has the authority to change the insurance contract. A change in the insurance contract:

- a) does not require the consent of any Insured Person or beneficiary; and
- b) must be:
 - (1) in writing;
 - (2) made a part of the Policy; and
 - (3) signed by one of Our officers.

A change may affect any class of Insured Persons, including retirees if retiree coverage is included in the Policy.

Applications

Statements in an application are treated as representations, not as warranties.

Legal Actions

No legal action can be brought until at least sixty (60) days after We have been given written proof of loss. No legal action can be brought more than three (3) years after the date written proof of loss is required.

Assignment

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

Delegation

We may delegate some of Our obligations and responsibilities under the Policy to a third party designated by Us, including, without limitation, the TPA.

COORDINATION OF BENEFITS (COB)

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

Definitions

Claimant means the Insured Person for whom a claim under the Policy is made.

Claim Period means part or all of a Policy Year during which the Claimant is insured under the Policy.

Covered Expense means any charge which meets all of the following requirements:

- a) it is a charge for an item of Medically Necessary Expense;
- b) it is an Expense which the Claimant must pay; and
- c) it is an Expense, including deductibles, coinsurance and copayments, which is covered at least in part by any plan during a Claim Period.

However, any Expense, which is not payable by the Primary Plan because of the Claimant's failure to comply with cost containment requirements will not be considered a Covered Expense by this plan if this plan is the Secondary Plan.

If a plan provides benefits in the form of a service rather than cash payments, the reasonable cash value of the service during the Claim Period will also be considered a Covered Expense.

Plan means the Policy and any of the following coverages, including coverage which is declared to be excess to all other coverages, which provide benefit payments or services to an Insured Person for hospital, medical, surgical, dental, prescription drug or vision care:

- a) Group, blanket or franchise insurance (except student accident insurance);
- b) Group Blue Cross and/or Blue Shield coverage and prepayment coverage on a group basis, including HMOs (Health Maintenance Organizations);
- c) Coverage under a labor-management trustee plan, a union welfare plan, an employer organization plan or an employee benefits plan;
- d) Coverage under government programs, other than Medicare or Medicaid, and any other coverage required or provided by law;[
- e) Group or individual automobile "no fault" coverage or traditional automobile "fault" coverage;]
- f) Other arrangements of insured or self-insured group coverage.

Primary Plan means the Plan that pays benefits prior to payment of benefits by a Secondary Plan in accordance with the terms of this Coordination of Benefits provision.

Secondary Plan means the Plan that pays benefits after benefits have been paid by the Primary Plan in accordance with the terms of this Coordination of Benefits provision.

Coordination of Benefits (COB)

If the Claimant is covered by another Plan or Plans, the benefits under this Policy and the other plan(s) will be coordinated. This means one plan pays its full benefits first, then the other Plan(s) pay(s).

The Primary Plan pays the benefits that would be payable under its terms in the absence of this provision.

The Secondary Plan will limit the benefits it pays so that the sum of its benefits and all other benefits paid by the Primary Plan will not exceed [the greater of:]

- a) 100% of total Covered Expenses[; or]
- b) [or the amount of benefits it would have paid had it been the Primary Plan].

[This COB provision will not apply to a claim when the Covered Expense incurred during a Claim Period is \$50 or less; but if:

- a) additional Covered Expense is incurred during such Claim Period; and
- b) the total Covered Expense exceeds \$50;

then this COB provision will apply to the total amount of the claim.]

The Order of Benefit Determination provision below explains the order in which Plans must pay benefits.

Order of Benefit Determination

When another Plan **does not** have rules coordinating its benefits with those of this Policy, or if it has coordination of benefits rules which differ from the rules described in this Coordination of Benefits provision, that other plan must determine benefits first.

When another Plan **does** have rules coordinating its benefits with those of this Policy, and those rules are similar to the rules described in this Coordination of Benefits section, the first of the following rules which applies shall govern:

- a) If a Plan covers the Claimant as an employee, retiree, member, subscriber, or nondependent, then that Plan will pay its benefits first; except when:
 - (1) one Plan covers the Claimant as a laid-off or retired employee (or a dependent of such person); and
 - (2) the other Plan includes this Coordination of Benefits rule for laid-off or retired employees (or is issued in a state which requires this Coordination Of Benefits rule by law);

then the Plan which covers the Claimant as other than a laid-off or retired employee (or a dependent of such person) will pay first. If the other Plan does not have this Coordination of Benefits rule regarding laid off or retired employee rule, and if, as a result the Plans do not agree on the order of benefits, this rule will not apply.

- b) If the Claimant is a dependent child whose parents:
- 1) are not divorced or separated; or
 - 2) are divorced or separated, but the court decree states the parents will share joint custody without requiring one parent to be responsible for coverage;

then the Plan of the parent whose birthday anniversary is earlier in the calendar year will pay first; except:

- 1) If both parents' birthdays are on the same day, the rules in subsection (d) below will apply.
 - 2) If another Plan does not include this Coordination of Benefits rule based on the parents' birthdays, but instead has a rule based on the gender of the parent, then that Plan's Coordination of Benefits rule will determine the order of benefits.
- c) If the Claimant is a dependent child whose parents are divorced or separated (except when sharing joint custody), then the following rules apply:
- 1) A Plan which covers a child as a dependent of a parent who by court decree must provide dental coverage will pay first; provided that Plan has actual knowledge of the court decree.
 - 2) When there is no court decree which requires a parent to provide dental coverage to a dependent child, or when the Plan covering the parent has no knowledge of the court decree, the following rules will apply:
 - (i) When the parent who has custody of the child **has not** remarried, that parent's Plan will pay first.
 - (ii) When the parent who has custody of the child **has** remarried, then benefits will be determined by that parent's Plan first, by the stepparent's Plan second, and by the Plan of the parent without custody third.
- d) If none of the above rules applies, the Plan which has covered the Claimant for the longer period of time will pay its benefits first.

Where part of a Plan coordinates benefits and a part does not, each part will be treated like a separate Plan.

Right To Collect and Release Needed Information

In order to receive benefits, the Claimant must give Us any information which is needed to coordinate benefits. With the Claimant's consent, We may release to or collect from any person or organization any needed information about the Claimant.

Plan Reimbursement for Third Party Payment

If benefits, which this Policy should have paid, are instead paid by another Plan, we will reimburse the [Employee]. Amounts reimbursed shall be considered to be benefits paid under this Policy and shall be treated in the same manner as other benefits under this Policy in accordance with the terms of this Policy.

Right of Recovery

If this Policy pays more for a Covered Expense than is required by this COB provision, the excess payment may be recovered from:

- (a) the Claimant; or
- any person to whom the payment was made.

SUBROGATION AND/OR REIMBURSEMENT RIGHTS

This section applies if You [or Your Dependent] suffer[s] a loss otherwise payable under the Policy that is the result of an act or omission of a Third Party.

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

Definitions

Reimbursement Rights means Our right to be reimbursed if:

- (1) We pay benefits for You [or Your Dependent] because of an injury or sickness caused by a Third Party's act or omission; and
- (2) You, Your Dependent [or Your Dependent's] legal representative recovers an amount from the Third Party, the Third Party's insurer, an uninsured motorist insurer or anyone else by reason of the Third Party's act or omission. This recovery may be the result of a lawsuit, a settlement or some other act. We are entitled to be paid out of any recovery, up to the amount of benefits We pay.

Subrogation Rights means Our right to enforce Our recovery of any benefits paid for You and/or Your Dependent because of an injury or sickness caused by a Third Party's act or omission. We are entitled to be paid out of any recovery, up to the amount of benefits We pay.

Third Party means another person or organization.

Reimbursement Rights and Subrogation Rights

If You [or Your Dependent] has an injury or sickness caused by a Third Party's act or omission:

- (1) We will pay benefits subject to Our Reimbursement Rights and Subrogation Rights and on condition that You [or Your Dependent] (or the legal representative of You [or Your Dependent]):
 - a) will not take any action which would prejudice Our Reimbursement Rights or Subrogation Rights; and
 - b) will cooperate in doing what is reasonably necessary to assist Us in enforcing Our Reimbursement Rights or Subrogation Rights.
- (2) Our Reimbursement Rights or Subrogation Rights will not be limited or reduced because:

- a) the recovery does not fully compensate You [or Your Dependent] for all losses sustained or alleged; or
 - b) the recovery is not described as being related to medical or dental costs or loss of income.
- (3) We may enforce Our Reimbursement Rights or Subrogation Rights by filing a lien with the Third Party, the Third Party's insurer or another insurer, a court having jurisdiction in this matter or any other appropriate party.
- (4) The amount of Our reimbursement will not be reduced by legal fees or court costs incurred in seeking the recovery, unless We agree otherwise in writing.
- (5) We may elect to charge any reimbursement due Us under this section against any future benefit payments for You [or Your Dependents] under the Policy. This will not reduce Our right to be paid out of any recovery up to the amount of benefits not yet reimbursed.

[COBRA CONTINUATION

The COBRA Continuation provision applies only if the Policyholder employed 20 or more employees on at least 50 percent of its business days during the preceding calendar year.

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

Definitions

Dental Insurance as used in this section generally means the dental insurance You had under this Policy on the day before the qualifying event. Dental insurance is subject to change as a result of open enrollments or plan modifications.

Plan Administrator means the person or entity designated as the plan administrator for the Policyholder's group dental plan.

Qualified Beneficiary means any individual who, on the day before the qualifying event, is an Insured Person under the Policy. Qualified Beneficiary also includes a child who is born or is placed for adoption with You during the period of continued coverage.

Continuation of Dental Insurance

1. **For You and Your Dependents.** You and/or any insured Dependent who is a Qualified Beneficiary may elect to continue Dental Insurance for as long as 18 months from the day Your coverage ends because of these qualifying events:
 - a) Your employment terminates (other than due to gross misconduct); or
 - b) You no longer satisfy the requirements for hours worked.

[If an Insured Person is determined, in accordance with Title II or XVI of the Social Security Act, to have been disabled at any time during the first 60 days of continued coverage, the reference to 18 months in the preceding sentence is deemed a reference to 29 months. Notice of such determination must be given to the Plan Administrator before the first 18 months of continued coverage ends and within 60 days of the date of the determination. Refer to item 3 of this provision.]

During the period You continue coverage:

- a) any new eligible Dependents You acquire may be added in accordance with the When a Dependent Becomes Eligible provision; and
- b) any eligible Dependents You declined to insure before Your continued Dental Insurance began may be added during any open enrollment period provided by the Policy provided any additional premium is paid. However, such Dependents, other than a Qualified Beneficiary, who are added after the qualifying event will not be entitled to continue coverage as Qualified Beneficiaries after an event occurs as shown in item 2 below.

2. **For Your Dependents Only.** Your insured Spouse who is a Qualified Beneficiary and/or each of Your insured Dependent children who is a Qualified Beneficiary may elect to continue Dental Insurance for as long as 36 months from the day coverage ends because of these qualifying events:
- a) You die;
 - b) You become entitled to Medicare benefits;
 - c) You and Your Spouse are legally separated;
 - d) Your marriage is ended by divorce; or
 - e) a child is no longer an eligible Dependent.

If Your Dependent is already continuing coverage under item 1 above when an event shown in this item 2 occurs, that second event will not entitle Your Dependent to continue coverage beyond 36 months under item 1 above and this item 2 combined.

If Your Dependent becomes entitled to continue Dental Insurance under both item 1 above and this item 2 on the same day, the periods of continued coverage will run concurrently and will not exceed 36 months.

3. **Notice Requirements.** Your employer is required by law to notify the Plan Administrator within 30 days after Your termination of employment, reduction in hours, death or entitlement to Medicare. You must notify the Plan Administrator within 60 days after the day You are legally separated or divorced, or Your child ceases to be an eligible Dependent.

If an Insured Person is determined, in accordance with Title II or XVI of the Social Security Act, to have been disabled at any time during the first 60 days of continued coverage, that person must:

- a) notify the Plan Administrator within 60 days of the date of the determination and before the first 18 months of continued coverage ends; and
- b) notify the Plan Administrator within 30 days of the date of any final determination that he or she is no longer disabled. Then, continued coverage ends the first day of the month that begins more than 30 days after the date of such final determination.

Within 14 days after receiving notice of a qualifying event, the Plan Administrator will send You or Your Dependent written notice of the continuation right. The Plan Administrator must receive Your or Your Dependent's written request to continue Dental Insurance within 60 days after the day:

- a) Dental Insurance ends; or
- b) the Insured Person is sent notice of the continuation right; whichever is later.

4. **Payment of Premium.** To continue coverage, You or Your Dependent must pay the required premium, including any retroactive premium. The initial premium must be paid to the Plan Administrator within 45 days after the day continued coverage is

elected. The Plan Administrator will inform You or Your Dependent of procedures to pay subsequent monthly premiums.

5. **End of Continuation.** An Insured Person's continued Dental Insurance will end at midnight on the earliest of:
 - a) the day Your employer ceases to provide any group dental plan to any employee;
 - b) the day premium is due and unpaid;
 - c) the day the Insured Person is covered under any other group dental plan as an employee or otherwise; however, this does not apply when the Insured Person is covered under a similar group plan which contains any preexisting condition limitations which apply to that person. Then, he or she may continue coverage under the Policy until the earlier of:
 - (1) the day the preexisting conditions limitation under the new group plan no longer applies; or
 - (2) the day continued coverage would otherwise end;
 - d) 18 months (or 29 months or 36 months as provided above) from the day Your coverage ends under the Policy;
 - e) the day an Insured Person again becomes covered under the Policy;
 - f) the day an Insured Person is entitled to benefits under Medicare;
 - g) the day the Policy terminates.

6. **Other Continuation Provisions.** In the event Dental Insurance is continued under any other continuation provisions of the Policy, the periods of continued coverage will run concurrently. If another continuation provision provides a shorter continuation period for which premium is paid in whole or in part by Your employer, then the premium You are required to pay may increase for the remainder of the 18-month, 29-month, or 36-month period provided above.]

DEFINITIONS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

Certificate means this Certificate of Insurance form, including the Schedule and any Riders.

Cosmetic or Reconstructive Procedure means any treatment or procedure performed or supply provided primarily to:

- (a) improve physical appearance or to change or restore bodily form without materially correcting a bodily malfunction, condition or disease; or
- (b) prevent or treat a mental or nervous disorder through a change in bodily form.

Covered Service means a dental treatment, procedure or supply that is:

- (a) Medically Necessary;
- (b) described in the Schedule as a treatment, procedure or supply for which benefits are payable;
- (c) performed by a Provider; and
- (d) assigned a procedure code, which We determine to be generally accepted by the dental insurance industry.

[Dental Charges Database (DCD)] means a commercially available charge information database selected by Us that provides historical information about the charges of Providers by procedure code and geographic categories, all as determined and adjusted by the database supplier. The Dental Charges Database will be updated by Us as information becomes available from the database supplier, up to twice each year. We may also modify the database in Our discretion to reflect Our experience. We have the right, in Our discretion, to substitute or replace the selected database with a database or databases of comparable purpose, with or without notice.]

Dental Hygienist or Denturist means a person who is:

- (a) licensed to perform specified dental procedures under the law of the jurisdiction in which the dental procedure is performed; and
- (b) operating within the scope of his or her license.

Dentist means a person who is:

- (a) licensed to practice dentistry under the law of the jurisdiction in which the dental procedure is performed; and
- (b) operating within the scope of his or her license.

[Dependent] means a citizen, permanent resident or lawful resident of the United States [or Canada] who, as indicated by evidence acceptable to Us, is:

- a) [Your Spouse;]
- b) [Your natural born or legally adopted child;]
- c) [Your stepchild [or child of Your domestic partner] living in Your home; or]

- d) [any other child who lives with You in a regular parent/child relationship and who qualifies as Your “dependent” as defined in the United States Internal Revenue Code.]

A Dependent does not include:

- a) [anyone insured under this Policy as [an Employee] [a Member];]
- b) anyone who is a member of the Armed Forces, National Guard or Reserves of any state or county on active duty (except for temporary duty of [31][0-120] days or less for training);
- c) [Your divorced or legally separated Spouse;]
- d) [Your Spouse [age[70][60-80]or older] [after You reach the [Attained Age][age] of[70][60-80];]
- e) [a child less than 14 days old;]
- f) [a child who has reached the age of 19, or the age of 25 if a Student, unless the child is Incapacitated;]
- g) [Your married child(ren);]
- h) [Your child if the child has been legally adopted by another person;] or
- i) [a child:
 - 1. temporarily living in Your home;
 - 2. placed in Your home by a social service agency which retains control over the child; or
 - 3. who has a natural parent in a position to exercise parental responsibility and control.]]

Expense means the charge incurred for a dental treatment, procedure or supply. Expense is considered incurred on the date a treatment or procedure is performed or a supply is furnished. Expense does not include any charge which is in excess of the charge that the Provider agreed to accept as payment in full.

Experimental or Investigational Device, Treatment or Procedure means a device, treatment or procedure which We determine:

- a) is not in general use in the practice of dentistry;
- b) is under continued scientific testing or ongoing clinical trials;
- c) does not have a measurable benefit for a dental injury, condition or disease; or
- d) has not been proven to be safe and effective.

In making this determination, We may rely on outside sources, including, but not limited to, dental consultants, dental journals, or governmental regulations.

[**Insured Person** means You and/or Your Dependents who are insured under the Policy.]

Medically Necessary means a dental treatment, procedure or supply which We and/or a qualified party or entity selected by Us determines is:

- a) provided for the prevention, diagnosis, or direct treatment of a dental injury, condition or disease;
- b) appropriate and consistent with the symptoms and findings or diagnosis and treatment of the Insured Person’s dental injury, condition or disease; and

- c) provided in accordance with generally accepted professional standards of dental practice.

The fact that the Insured Person's Provider orders, prescribes or renders treatments, procedures or supplies does not automatically mean such treatments, procedures or supplies are Medically Necessary.

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

[**Network** means the network of Providers who, through contract with Us or a party or parties that have contracted with Us, have agreed to provide Covered Services to Insured Persons.]

[**Non-Participating Provider** means a Provider who does not participate in the Network on the day a treatment or procedure is performed or a supply is furnished.]

[**Non-Participating Provider Allowance** means a charge by a Non-Participating Provider for a Covered Service, which is no higher than the [90th] percentile identified on the Dental Charges Database (DCD). When there is, in Our determination, minimal data available from the DCD for a Covered Service, We will determine the Non-Participating Provider Allowance by calculating the unit cost for the applicable service category using the DCD, and multiplying that by the relative value of the Covered Service based upon a commercially available relative value scale selected by Us. In the event of an unusually complex Covered Service, a Covered Service that is a new procedure or a Covered Service that otherwise does not have a relative value that is in Our determination applicable, We will assign one. In no event will the Non-Participating Provider Allowance charge exceed the amount billed by the Provider or the amount for which the Insured Person is responsible. The term " Non-Participating Provider Allowance " may not reflect the actual charges of the Provider, and does not take into account the Provider's training, experience or category of licensure. Non-Participating Providers may charge You the difference between what they charge and the Non-Participating Provider Allowance.]

Our, We, Us means [United of Omaha Life Insurance Company][Mutual of Omaha Insurance Company].

[**Participating Provider** means a Provider who participates in the Network on the day a treatment or procedure is performed or a supply is furnished. Participating Providers have agreed to accept a predetermined allowance as payment in full for Covered Services. Any applicable deductibles, coinsurance amounts, or charges for services not covered by the Plan can be charged and collected from You.]

Policy means the group dental insurance policy, including this Certificate which is part of the policy, issued to the Policyholder by Us.

Policy Anniversary means [Month Day] of each Policy Year.

Policy Effective Date means [Month Day, Year].

Policy Year means the period commencing on the Policy Effective Date and ending on the next succeeding Policy Anniversary and, thereafter, each yearly period commencing on the Policy Anniversary.

Policyholder means[ABC Company].

Prior Plan means an insured or self-funded dental plan maintained or sponsored by the Policyholder, which was in effect immediately prior to the Policy Effective Date.

Provider means a Dentist, Denturist, or Dental Hygienist.

Rider means a document that is added to and made a part of the Policy. A Rider amends, limits, restricts, or otherwise changes the provisions of this Policy.

[**Schedule** means the section of the Certificate identified as the “Schedule”.]

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

[**Spouse** means the person to whom You are legally married, or Your domestic partner, or civil union partner or equivalent, as recognized and allowed by federal law, or by state law in Your state of residence.]

[A Spouse may include Your same sex [or opposite sex] domestic partner if:

- a) You submit a written declaration of domestic partnership signed by You and Your partner in a form acceptable to Us;[or]
- b) You submit evidence acceptable to Us that all applicable requirements of the state, city and/or county in which You reside regarding the establishment of a domestic partnership have been met[; or]
- c) [V].]

[**Temporomandibular Disorders (TMD)** means any misalignment, dysfunction or other disorder of the jaw joint (or of the complex of muscles, nerves and tissues related to that joint). It includes temporomandibular joint dysfunction, arthritis or arthrosis, other craniomandibular joint disorders, and myofacial or orofacial pain syndrome. It does not include a fracture or dislocation which results from an injury, any misalignment, dysfunction or other disorder of the jaw joint (or of the complex of muscles, nerves and tissues related to that joint).]

TPA means the third party administrator designated by Us to whom We have delegated claims administration and other administrative services.

You, Your[, Insured Person] means an [Employee] [Member] insured under the Policy.

UNITED *of* OMAHA LIFE INSURANCE COMPANY

Home Office: Mutual of Omaha Plaza
Omaha, Nebraska 68175

SCHEDULE

This Schedule describes some of the terms and conditions of the Policy including, but not limited to, the deductible(s), maximum amounts of benefits payable under the Policy, exclusions and limitations. For a complete description of the terms and conditions of the Policy, refer to the appropriate section of the Certificate.

A person is not necessarily entitled to insurance under the Policy because he or she received this Schedule. A person is only entitled to insurance if he or she is eligible in accordance with the terms of the Certificate.

[Benefits and Deductibles under the Policy may vary depending upon whether or not Covered Services are received from a Participating Provider or a Non-Participating Provider. All Participating Providers and Non-Participating Providers are independent contractors; they are not Our employees or agents. We do not supervise, control or guarantee the outcome or results of any services or supplies furnished by any Participating Provider or Non-Participating Provider. An Insured Person's relationship with a Participating Provider or a Non-Participating Provider is that of provider and patient. The Participating Provider or Non-Participating Provider is solely responsible for the services and supplies provided to an Insured Person.]

POLICY INFORMATION

[Policyholder:	[Group Name]]
[Policy Effective Date:	[MM/DD/YY]]
[Policy Anniversary	[MM/DD]]
[Policy Number:	[Group Policy Number: [XXXX]]
[Policy Year	[MM/DD through [MM/DD] [February 28 or 29].] [January 1 through December 31 of the same year.]
[Classifications:	[As defined by the Policyholder – insert class descriptions here]]

Capitalized terms used in this Schedule have the meanings assigned to them in this Schedule or in other sections of the Policy.

DEFINITIONS

[Adjusted Annual Maximum Benefit] means an amount equal to the sum of:

- a) the amount of the Policy Year Maximum Benefit; plus
- b) the amount of Rollover Benefits which have been added to the Policy Year Maximum Benefit.]

[Benefit][Late Entrant] Waiting Period means the applicable period of time shown as the “[Benefit][Late Entrant] Waiting Period” in the General Provisions section of this Schedule. This is the period of time during which an Insured Person must be insured under the Policy before certain benefits are payable.]

[Deductible] means the applicable amount shown as the “Deductible” in the General Provisions section of this Schedule. The deductible is the amount of out-of-pocket Expense which must be incurred for Covered Services before benefits are payable.]

Include this definition of Maximum Allowance (MA) for PPO type plans.

[Maximum Allowance (MA)] means the maximum payment allowed by Us for a Covered Service. As it applies to a Participating Provider, the MA shall be equal to the amount the Participating Provider has contractually agreed to accept as payment in full for a Covered Service. As it applies to a Non-Participating Provider, the MA shall be an amount equal to the lowest of:

- a) the Non-Participating Provider’s actual charge; or
- b) the Maximum Allowance payable to a Participating Provider for such Covered Service.]

Include this definition of Maximum Allowance (MA) for Indemnity type plans.

[Maximum Allowance (MA)] means the maximum payment allowed by Us for a Covered Service. The MA shall be an amount equal to the lower of:

- a) the Provider’s actual charge; or
- b) the Dental Charges Database allowance.]

[Orthodontia Maximum Benefit- Dependent [only] [and Adult]] means the total orthodontia benefits payable for Covered Services incurred while insured under the Policy. Benefits for Expenses exceeding the orthodontia maximum benefit are not payable.

Percentage Payable means the percentage of the Maximum Allowance payable by Us for Covered Services after satisfaction of any applicable Deductibles [and Benefit Waiting Periods].

Policy Year Maximum Benefit means the amount shown as the “Policy Year Maximum Benefit” in the General Provisions section of this Schedule.

[Rollover Benefit] means an amount equal to **V** % of the Rollover Claims Amount. The Rollover Benefit for any Policy Year may not exceed **V** % of the Policy Year Maximum Benefit.]

[Rollover Claims Amount] means an amount equal to \$ **V**.]

[**Tooth Whitening (Bleaching) Maximum Benefit** means the amount shown as the “Tooth Whitening (Bleaching) Maximum Benefit” in the General Provisions section of this Schedule.]

GENERAL PROVISIONS

[[Benefit][Late Entrant] Waiting Period

You [and each of Your Dependents] must complete the following [Benefit][Late Entrant] Waiting Period(s) before any benefits are payable under the Policy:

[Benefit][Late Entrant] Waiting Period:

[Type A Covered Services	None]
[Type B Covered Services	[None] [3] [6] [12] [18] [24] [months]]
[Type C Covered Services	[None] [3] [6] [12] [18] [24] [months]]
[Orthodontia Covered Services	[None] [6] [12] [24] [months]]

[If an Insured Person was covered by a Prior Plan, any period of time immediately prior to the Policy Effective Date during which the Insured Person was covered by such Prior Plan shall be applied toward satisfaction of any Benefit Waiting Period under the Policy.]]

[Deductible

The following Deductible(s) must be satisfied [each Policy Year] [once while insured under the Policy] before any benefits are payable under the Policy. Expenses for treatments, procedures or supplies that are not Covered Services, [or Expenses for treatments, procedures or supplies incurred during the applicable Benefit Waiting Period,] may not be used to satisfy the Deductible.]

[Type(s) V (A, B, C)] Covered Services Deductible: [Participating Provider] [Non-Participating Provider]

[Each Insured Person:	V (\$0-\$200)	[\$V] (\$0-\$200)]
[Family :	\$V] (\$0-\$300)	[\$V] (\$0-\$300)]

[If an Insured Person was covered by a Prior Plan, any Deductible satisfied by the Insured Person under such Prior Plan during the current Policy Year shall be applied toward satisfaction of any Deductible under the Policy for the same Policy Year.]

[Expenses for Covered Services will satisfy the Deductible for both Participating and Non-Participating Providers.]

Percentage Payable

If an Insured Person incurs Expenses for a Covered Service described in this Schedule [after completion of any applicable Benefit Waiting Periods], We will pay benefits in an amount equal to the applicable percentage of the Maximum Allowance shown in this Percentage Payable provision, not to exceed the amount of the Expense incurred, after satisfaction of any applicable Deductible. Benefits will not exceed any applicable maximum benefit limitation described in this Schedule. Our obligation to pay benefits for Covered Services is subject to all terms and conditions of the Policy, including, without limitation, the exclusions and limitations as shown in this Schedule.

	[Participating Provider]	[Non-Participating Provider]
[Type A Covered Services.....	V% (0%-100%)	[V%] (0%-100%)
[Type B Covered Services.....	V% (0%-100%)	[V%] (0%-100%)
[Type C Covered Services	V% (0%-100%)	[V%] (0%-100%)
[Orthodontia Covered Services.....	V% (0%-100%)	[V%] (0%-100%)

The Insured Person is responsible for all Deductibles and other Expenses for which benefits are not payable under the Policy. [Non-Participating Providers may bill the Insured Person for the balance of any charge over the Maximum Allowance.]

[Policy Year Maximum Benefit

The Policy Year Maximum Benefit will apply for each Insured Person each Policy Year. The Policy Year Maximum Benefit is the total amount of benefits payable for Type [A, B or C] Covered Services incurred by an Insured Person during a Policy Year. After We have paid benefits equal to the Policy Year Maximum Benefit, no additional benefits are payable for Covered Services incurred during such Policy Year.]

	[Participating Provider]	[Non-Participating Provider]
[Policy Year Maximum Benefit:	\$V (\$500-\$2500)	[\$V] (\$500-\$2500)]

[Expenses for Covered Services will satisfy the Deductible for both Participating and Non-Participating Providers.]

[Rollover Benefit

If the amount of benefits paid under the Policy for Covered Services incurred by an Insured Person during any Policy Year is less than the Rollover Claims Amount and all of the other conditions described in this Rollover Benefits provision are met, the Insured Person's Policy Year Maximum Benefit for the succeeding Policy Year shall be increased by a Rollover Benefit, resulting in an Adjusted Annual Maximum Benefit for such Insured Person. In no event shall the Adjusted Annual Maximum Benefit exceed an amount equal to two times the Policy Year Maximum Benefit.

[The Rollover Benefit provision only applies to Policy Year Maximums and cannot be used toward [Orthodontic], [TMD,] or [Tooth Whitening] services.]

Include on all plans. Only include [for Participating Providers] only on PPO type plans.

[The Policy Year Maximum Benefit[for Participating Providers] will be used to calculate the Rollover Benefit.]

An Insured Person shall only be entitled to a Rollover Benefit during a Policy Year if the Insured Person:

- a) received at least one routine dental examination and cleaning during such Policy Year; and
- b) has satisfied all applicable Benefit Waiting Periods.

If an Insured Person's coverage under the Policy ends for any reason, including, without limitation, termination of the Policy, the Insured Person will lose any Rollover Benefits that have not been paid for Covered Services incurred during the Policy Year in which coverage ended.]

[Orthodontia Maximum Benefit

The Orthodontia Maximum Benefit is the total amount of orthodontia benefits payable for Covered Services incurred by an Insured Person while insured under the Policy. The Orthodontia Maximum Benefit will apply for each Insured Person once while insured under the Policy.]

[Orthodontia Maximum Benefit: [Participating Provider] [Non-Participating Provider]
\$V (\$500-\$2500) [\$V] (\$500-\$2500)]

[The amount of benefits payable under the Policy for orthodontia services and/or supplies will be reduced by the amount of Expenses for orthodontia services and/or supplies incurred while covered under a Prior Plan.]

[Expenses for Covered Services will satisfy the Deductible for both Participating and Non-Participating Providers.]

[Tooth Whitening (Bleaching) Maximum Benefit

The Tooth Whitening (Bleaching) Maximum Benefit is the total amount of tooth whitening or bleaching benefits payable for Covered Services incurred by an Insured Person while insured under the Policy. The Tooth Whitening (Bleaching) Maximum Benefit will apply for each Insured Person once while insured under the Policy.]

[Tooth Whitening (Bleaching) Maximum Benefit.....\$V (\$750-\$1000)]

[Work in Progress

Benefits will be provided for dentures, bridgework, and cast restorations for which the final impression is taken prior to the date an Insured Person's insurance ends if final placement of the denture, bridgework, or cast restoration occurs within 31 days after the Insured Person's insurance ends.]

COVERED SERVICES

Benefits are payable under the Policy for Covered Services described in this section, subject to all terms and conditions of the Policy.

*(Type A services table to be used if “Preventive Benefit” provision is included.)
Benefits for Type A services do not apply to the Policy Year Maximum Benefit.*

TYPE A COVERED SERVICES	BENEFIT
[Examination/Evaluations	V (2) (1-4) service(s) in V [a (12) (6-12) month period][1 Policy Year].]
[Bitewing X-rays	V (4) (2-8) x-rays in V [a (12) (6-12) month period][1 Policy Year].]
[Full Mouth Series or Panoramic X-rays	1 service in V [a (36) (12-60) month period][(3) (1-5) Policy Year(s)].]
[Periapical or Occlusal X-rays	No limit on number of services.]
[Fluoride Treatment	V (2) (1-4) service(s) in V [a (12) (6-12) month period][1 Policy Year] for Dependent children up to age V (19) (14-21)].
[Cleaning (Prophylaxis)	V (2) (1-4) service(s) in V [a (12) (6-12) month period][1 Policy Year]. Up to two additional cleanings in V [a (12) (6-12) month period] [1 Policy Year] for any Insured Person when Medically Necessary due to pregnancy, heart disease, or diabetes.]
[Sealants	1 service per occlusal surface of first and second permanent molars without existing fillings in V [a (36) (12-60) month period] [(3) (1-5) Policy Year(s)] for Dependent children up to age V (19) (14-21)].
[Space Maintainers, including re- cementation	Benefits are payable for Dependent children up to age V (19) (14-21)].

](Type A services table to be used if no “Preventive Benefit” provision is included.)

TYPE A COVERED SERVICES	BENEFIT
[Examination/Evaluations	V (2) (1-4) service(s) in V [a (12) (6-12) month period][1 Policy Year].]
[Bitewing X-rays	V (4) (2-8) x-rays in V [a (12) (6-12) month period][1 Policy Year].]
[Full Mouth Series or Panoramic X-rays	1 service in V [a (36) (12-60) month period][(3) (1-5) Policy Year(s)].]
[Periapical or Occlusal X-rays	No limit on number of services.]
[Fluoride Treatment	V (2) (1-4) service(s) in V [a (12) (6-12) month period][1 Policy Year] for Dependent children up to age V (19) (14-21)].
[Cleaning (Prophylaxis)	V (2) (1-4) service(s) in V [a (12) (6-12) month period][1 Policy Year]. Up to two additional cleanings in V [a (12) (6-12) month period] [1 Policy Year] for any Insured Person when Medically Necessary due to pregnancy, heart disease, or diabetes.]
[Sealants	1 service per occlusal surface of first and second permanent molars without existing fillings in V [a (36) (12-60) month period] [(3) (1-5) Policy Year(s)] for Dependent children up to age V (19) (14-21)].
[Space Maintainers, including re- cementation	Benefits are payable for Dependent children up to age V (19) (14-21)].
[Emergency (palliative) treatment	Benefits are payable for treatment of minor dental pain.]
[Periodontal Maintenance following active periodontal treatment	V (2) (1-4) service(s) in V [a (12) (6-12) month period][1 Policy Year] in addition to routine cleaning(s).]
[Brush Biopsy / Cancer Screen	V (2) (1-4) service(s) in V [a (12) (6-12) month period][1 Policy Year].]
[Bruxism Appliance	1 appliance in any V [(36) (12-60) month period][(3) (3-5) Policy Years].]

(Move “Harmful Habit” to Ortho Table if Plan includes Ortho, otherwise keep with this table.)

[Harmful Habit Appliance	Benefits are payable for Dependent children up to age V 19 (14-21)].
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TYPE B COVERED SERVICES	BENEFIT
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[Examination/Evaluations	V (2) (1-4) service(s) in V [a (12) (6-12) month period][1 Policy Year].]
[Bitewing X-rays	V (4) (2-8) x-rays in V [a (12) (6-12) month period][1 Policy Year].]
[Full Mouth Series or Panoramic X-rays	1 service in V [a (36) (12-60) month period][(3) (1-5) Policy Year(s)].]
[Periapical or Occlusal X-rays	No limit on number of services.]
[Fluoride Treatment	V (2) (1-4) service(s) in V [a (12) (6-12) month period][1 Policy Year] for Dependent children up to age V (19) (14-21)].
[Cleaning (Prophylaxis)	V (2) (1-4) service(s) in V [a (12) (6-12) month period][1 Policy Year]. Up to two additional cleanings in V [a (12) (6-12) month period] [1 Policy Year] for any Insured Person when Medically Necessary due to pregnancy, heart disease, or diabetes.]
[Sealants	1 service per occlusal surface of first and second permanent molars without existing fillings in V [a (36) (12-60) month period] [(3) (1-5) Policy Year(s)] for Dependent children up to age V (19) (14-21).]
[Space Maintainers, including re- cementation	Benefits are payable for Dependent children up to age V (19) (14-21).]
[Emergency (palliative) treatment	Benefits are payable for treatment of minor dental pain.]
[Periodontal Maintenance following active periodontal treatment	V (2) (1-4) service(s) in V [a (12) (6-12) month period][1 Policy Year] in addition to routine cleaning(s).]
[Brush Biopsy / Cancer Screen	V (2) (1-4) service(s) in V [a (12) (6-12) month period][1 Policy Year].]
[Bruxism Appliance	1 appliance in any V [(36) (12-60) month period][(3) (3-5) Policy Years].]
<i>(Move "Harmful Habit" to Ortho Table if Plan includes Ortho, otherwise keep with this table.)</i>	
[Harmful Habit Appliance	Benefits are payable for Dependent children up to age V (19) (14-21).]
<i>(If Posterior Composites are selected include bracketed language.)</i>	
[Fillings	[Benefits are payable for amalgam (silver) and composite/resin (white) fillings.] Composite fillings on molars are limited to the amount otherwise payable for an amalgam filling.] Replacement of fillings allowed once in V [a (12) (6-36) month period][(1) (1-3) Policy Year].]
[Stainless Steel Crowns	[Benefits are payable 1 per tooth per lifetime up to age V (19) (14-21).]
[Extractions	Benefits are payable for simple extractions of erupted teeth.]
[Oral surgery	Benefits are payable for oral surgery, including x-rays, pre- and post-operative care, and surgical extractions, except TMD surgery.]
[General anesthesia or intravenous (I.V.) sedation	Benefits are payable for these services when rendered in conjunction with oral surgery.]
[Endodontics	Benefits are payable for services including, but not limited to, pulpal therapy and root canal therapy. Retreatment of a root canal is payable once in a lifetime and only after 12 months have passed since the original root canal was completed.]
[Periodontics	Benefits are payable for services, including but not limited to, scaling and root planing, and surgical treatment of gum and supporting bone disease. Services are limited to one service per area of the mouth in a V [(24) (24-36) month period].]
[Full or partial removable dentures	Benefits are payable for final dentures.]
[Replacement of removable dentures	Benefits are payable if: <ul style="list-style-type: none"> • the existing denture is more than V [(60) (60-84) months][(5) (5-7) Policy Years] old; or • significant structural changes occurred within the mouth due to extractions or other oral surgery.]
[Repair of, or addition of teeth to removable dentures	Benefits are payable if the service is performed more than six months after initial denture placement. Benefits are payable once in any (36) (36-60) month period.]
[Adjustments – full or partial dentures	Benefits are payable if the service is performed more than six months since initial insertion of the denture. Payable once in (12) (12-36) months thereafter.]
Tissue conditioning, rebasing or relining of removable dentures	Benefits are payable if the service is performed more than six months after any previous adjustment, tissue conditioning, rebasing or relining. Payable once in (36) (24 -36) months thereafter.]

[Bridgework (fixed dentures)]	Benefits are payable for the replacement of lost, extracted, or congenitally missing teeth. Benefits are payable for Insured Persons age (16) (14-19) and older.]
[Replacement of bridgework]	Benefits are payable if: <ul style="list-style-type: none"> the existing bridgework is more than V [(60) (60-84) months][(5) (5-7) Policy Years] old; or significant structural changes occurred within the mouth due to extractions or other oral surgery.]
[Repair and re-cementation of bridgework]	Benefits are payable if the service is performed more than six months after initial bridge placement. Payable once in (12) (12-36) months thereafter.]

(If Porcelain crowns are selected remove bracketed language.)

[Crowns, inlays, onlays, and labial veneers]	[Benefits for veneered molar crowns are equal to the amount otherwise payable for cast metal crowns.] Benefits are payable for damage due to decay or tooth fracture, but only if the tooth cannot be restored with standard filling material.] Benefits are payable for Insured Persons age (16) (14-19) and older.]
[Replacement of crowns, inlays, onlays, and labial veneers]	Benefits are payable if the existing crown, inlay or onlay is more than V [(60) (60-84) months][(5) (5-7) Policy Years] old.]
[Repair and re-cementation of cast crowns, inlays, onlays, and labial veneers.]	Benefits are payable if the service is performed more than six months after initial restoration placement. Payable once in (12) (12-36) months thereafter.]
[Endosteal Implants]	Once per tooth per lifetime.]

(Include only if "Tooth Whitening (Bleaching)" is selected.)

[Tooth Whitening (Bleaching)]	Once in any V [(24) (12-36) month period][(2) (1-3) Policy Year(s)].]
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TYPE C COVERED SERVICES	BENEFIT
[Emergency (palliative) treatment]	Benefits are payable for treatment of minor dental pain.]
[Periodontal Maintenance following active periodontal treatment]	V (2) (1-4) service(s) in a V [(12) (6-12) month period][1 Policy Year] in addition to routine cleanings.]
[Bruxism Appliance]	1 appliance in any V [(36) (12-60) month period][(3) (3-5) Policy Years].]

(If Posterior Composites are selected include bracketed language.)

[Fillings]	[Benefits are payable for amalgam (silver) and composite/resin (white) fillings.] Composite fillings on molars are limited to the amount otherwise payable for an amalgam filling. Replacement of fillings allowed once in V [a (12) (6-36) month period][(1) (1-3) Policy Year(s)].]
[Stainless Steel Crowns]	[Benefits are payable 1 per tooth per lifetime up to age V (19) (14-21).]
[Extractions]	Benefits are payable for simple extractions of erupted teeth.]
[Oral surgery]	Benefits are payable for oral surgery, including x-rays, pre- and post-operative care, and surgical extractions, except TMD surgery.]
[General anesthesia or intravenous (I.V.) sedation]	Benefits are payable for these services when rendered in conjunction with oral surgery.]
[Endodontics]	Benefits are payable for services including, but not limited to, pulpal therapy and root canal therapy. Retreatment of a root canal is payable once in a lifetime and only after 12 months have passed since the original root canal was completed.]
[Periodontics]	Benefits are payable for services, including but not limited to, scaling and root planing, and surgical treatment of gum and supporting bone disease. Services are limited to one service per area of the mouth in a V (24) (24-36) month period.]
[Full or partial removable dentures]	Benefits are payable for final dentures.]
[Replacement of removable dentures]	Benefits are payable if: <ul style="list-style-type: none"> the existing denture is more than V [(60) (60-84) months][(5) (5-7) Policy Years] old;

	<p>or</p> <ul style="list-style-type: none"> significant structural changes occurred within the mouth due to extractions or other oral surgery.]
[Repair of, or addition of teeth to removable dentures	Benefits are payable if the service is performed more than six months after initial denture placement. Benefits are payable once in any (36) (36-60) month period.]
[Adjustments – full or partial dentures	Benefits are payable if the service is performed more than six months since initial insertion of the denture. Payable once in (12) (12-36) months thereafter.]
Tissue conditioning, rebasing or relining of removable dentures	Benefits are payable if the service is performed more than six months after any previous adjustment, tissue conditioning, rebasing or relining. Payable once in (36) (24 -36) months thereafter.]
[Bridgework (fixed dentures)	Benefits are payable for the replacement of lost, extracted, or congenitally missing teeth. Benefits are payable for Insured Persons age (16) (14-19) and older.]
[Replacement of bridgework	Benefits are payable if: <ul style="list-style-type: none"> the existing bridgework is more than V [(60) (60-84) months][[(5) (5-7) Policy Years] old; or significant structural changes occurred within the mouth due to extractions or other oral surgery.]
[Repair and re-cementation of bridgework	Benefits are payable if the service is performed more than six months after initial bridge placement. Payable once in (12) (12-36) months thereafter.]

(If Porcelain crowns are selected remove bracketed language.)

[Crowns, inlays, onlays, and labial veneers	[Benefits for veneered molar crowns are equal to the amount otherwise payable for cast metal crowns.] Benefits are payable for damage due to decay or tooth fracture, but only if the tooth cannot be restored with standard filling material.] Benefits are payable for Insured Persons age (16) (14-19) and older.]
[Replacement of crowns, inlays, onlays, and labial veneers	Benefits are payable if the existing crown, inlay or onlay is more than V [(60) (60-84) months][[(5) (5-7) Policy Years] old.]
[Repair and re-cementation of cast crowns, inlays, onlays, and labial veneers.	Benefits are payable if the service is performed more than six months after initial restoration placement. Payable once in (12) (12-36) months thereafter.]
[Endosteal Implants	Once per tooth per lifetime.]
[TMD Services	Benefits are payable for services including, but not limited to, x-rays, cast restorations, and appliances.]

(Include only if "Tooth Whitening (Bleaching) is selected.)

[Tooth Whitening (Bleaching)	Once in any V [(24) (12-36) month period][[(2) (2-3) Policy Years].]
------------------------------	--

ORTHODONTIC COVERED SERVICES	BENEFIT
[Dependent Child [and adult] orthodontic services <i>(Remove "and adult" if services for children only.)</i>	Benefits are payable for orthodontic services including, but not limited to, x-rays, and appliances. Orthodontic treatment is deemed to have begun at the time of banding and/or when other orthodontic appliances are initially placed in connection with a current course of treatment.]

]

GENERAL EXCLUSIONS

We will not pay benefits for any Expense:

- a) for any treatment, procedure or supply which is not identified as a Covered Service in this Schedule;
- b) for any treatment, procedure or supply which is considered an Experimental or Investigational Device, Treatment or Procedure;
- c) for any treatment, procedure or supply which is not considered Medically Necessary or which is provided for patient convenience or to relieve anxiety;
- d) for a treatment, procedure or supply for which benefits are payable under any other group health or dental plan maintained or sponsored by the Policyholder;
- e) related to tests and laboratory exams, bacteriologic studies, caries susceptibility tests, pulp vitality tests, oral pathology laboratory, oral hygiene instruction, education or training, histopathologic examinations, diagnostic casts and photographs, the diagnosis or treatment of congenital malformations, magnetic resonance imaging and gnathological procedures, services, supplies or procedures related to orthognathic surgery, osteoplasties, osteotomies, LeFort procedures, maxillofacial prosthetics, vestibuloplasties, stomatoplasties, and any procedures related to the diagnosis or treatment of jaw fractures;
- f) [related to the diagnosis or treatment of Temporomandibular Disorders (TMD) and functional/myofunctional therapy except to the extent as may be required by applicable state law, or unless otherwise listed as a Covered Service in this Schedule;] *←(Delete if there are TMD benefits.)*
- g) [related to orthodontic treatment, including diagnostic procedures;] *←(Delete if there are ortho benefits.)*
- h) related to Cosmetic or Reconstructive Procedures;
- i) for procedures, restorations, devices, appliances or dentures to change vertical dimension, to alter occlusion or to replace tooth structure lost through attrition, erosion or abrasion including occlusal adjustment or equilibration;
- j) related to the replacement of lost dentures or the replacement of lost or broken appliances;
- k) for athletic mouth guards, [bruxism appliances] [or any appliance to correct harmful habits] or any procedure related to such appliance[, except as specifically covered as an orthodontic or TMD procedure]; *←(Check Schedule and delete bracketed items if covered.)*
- l) for precision attachments, connector bars, coping materials, overdentures, unilateral partial dentures and stress breakers;

- m) for drugs and medications whether or not they require a written prescription, or for analgesics or euphoric drugs;
- n) for cast restorations, full or partial dentures and fixed bridgework for, which final impressions were taken before the date insurance began or after insurance ends;
- o) for treatment, procedures, or supplies which We determine are customarily performed in association with a more comprehensive dental procedure, including, but not limited to, local anesthesia, pulp capping (direct or indirect), insulating/cementing bases, periodontal splinting (permanent or provisional), temporary crowns, bridges, and dentures; or any minor associated gingival involvement when performed in conjunction with a cast restoration or fixed bridgework;
- p) for duplication of treatments, procedures or supplies, including, but not limited to, when an Insured Person transfers from the care of one Provider to the care of another Provider;
- q) which arise out of or in the course of employment for any employer or for which the Insured Person is paid benefits under any workers' compensation or occupational disease law, or receives any settlement from a worker's compensation carrier;
- r) for treatments, procedures or supplies for which the Insured Person is not liable for payment, or which are provided or paid for by a state or federal government or its agencies;
- s) which results, whether the Insured Person is sane or insane, from an intentionally self-inflicted injury or sickness;
- t) resulting from the Insured Person's participation in a riot or in the commission of a felony;
- u) which results from an act of declared or undeclared war or armed aggression;
- v) which is incurred while the Insured Person is on active duty or training in the Armed Forces, National Guard or Reserves of any state or country and for which any governmental body or its agencies are liable.

MUTUAL OF OMAHA INSURANCE COMPANY []
 UNITED OF OMAHA LIFE INSURANCE COMPANY []
 Mutual of Omaha Plaza
 Omaha, NE 68175



Mutual of Omaha
 Home Office Use Only
 Policy Number(s): _____

Group Insurance Application

Applicant (Full Legal Name) _____ (the Policyholder)

Address _____ City _____ State _____ Zip _____

Requested Effective Date: _____, subject to our acceptance of this application and payment of premium on or before such date.

Coverage(s) being applied for:	GROUP (Contributory and Non-Contributory)	VOLUNTARY (100% Employee Paid)
<input type="checkbox"/> Life	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> AD&D	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Short Term Disability	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Long Term Disability	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Dental	<input type="checkbox"/>	<input type="checkbox"/>

Active at work requirement: An employee must meet an Active at Work requirement to become insured. Will all proposed insureds meet the Active at Work requirement? Yes No If "No," please provide the name of the individual, date of birth, date of disability or confinement and nature of disability or confinement on a separate page.

Certain states have enacted legislation that requires insurers to provide specific coverage for people residing in their states. Do you have employees residing in or working in other states? Yes No
 If "Yes," which states: _____

Financial Risk (If "Yes," to any part, please explain below)

1. Has the applicant ever filed for bankruptcy? Yes No
 2. Does the applicant anticipate ceasing or materially reducing active business operations? Yes No
- Explanation: _____

Application is made on the basis of the proposal, any available experience data and the information contained in this application.

The applicant signing below agrees to accept the terms and provisions of the Master Policy for the coverages applied for above. Insurance will become effective on the requested effective date shown above, unless we send written notice of a different effective date. If this application is not approved by an officer at the Home Office of the underwriting company, no insurance is in effect at any time and any advance payment received will be returned.

This application is submitted with the following advance payment \$ _____

Fraud Notice

[Arkansas] Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Florida Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Louisiana Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maryland Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Ohio Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Tennessee It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Virginia Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

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

For Applicant:

**Name of Broker, agent and/or insurance agency
soliciting this coverage:**

By _____
(Signature)

(Title)

(Date)

PREMIUM RIDER

This rider is made a part of Group Policy GUDS-XXXX,PH Name

This rider is effective MMDAYYEAR.

The premiums for the policy will be as follows:

CLASSIFICATION(S)

All Eligible Employees

DENTAL PREMIUMS

1.

RATE GUARANTEE DATE

MMDAYYEAR

Notwithstanding anything to the contrary in the GRACE PERIOD provision in the Policy, the Policyholder and the Company agree as follows:

If, in addition to this Policy, the Policyholder has any other insurance policy ("Insurance Policy") or Administrative Services Agreement or other type of service agreement ("Service Agreement") with the Company or any affiliate of the Company, and an administration fee or other payment described in a Service Agreement ("Fee") is not paid in full by the required due date or premium is not paid in full during the grace period for this Policy or an Insurance Policy, the total amount of premium and Fees paid for this Policy and each Insurance Policy and Service Agreement during the month in which the premium or Fee is not paid in full ("the Delinquent Month") will be allocated to this Policy and each Insurance Policy and Service Agreement on a pro-rata basis.

The amount of premium and Fees allocated to this Policy and each Insurance Policy and Service Agreement will be determined by multiplying (a) the amount of premium due for this Policy and each Insurance Policy during the Delinquent Month and the amount of Fees due for each Service Agreement during the Delinquent Month by (b) the percentage equal to (i) the total amount of premium and Fees paid for this Policy and each Insurance Policy and Service Agreement during the Delinquent Month divided by (ii) the total amount of premium and Fees due for this Policy and each Insurance Policy and Service Agreement during the Delinquent Month.

The Policyholder and the Company acknowledge and agree that the method of allocating premium and Fees described in this provision will result in (a) the full amount of premium not being paid during the grace period for this Policy and each Insurance Policy, and (b) the full amount of Fees not being paid by the required due date for each Service Agreement. Accordingly, notwithstanding anything to the contrary in this Policy or any Insurance Policy or Service Agreement, the following will occur:

1. This Policy and any other Insurance Policy will automatically terminate on the date described in this Policy and such other Insurance Policy for non-payment of premium; and

2. Any Service Agreement will automatically terminate at the end of the Delinquent Month.

Dated:

UNITED OF OMAHA LIFE INSURANCE COMPANY

Chairman of the Board and Chief Executive Officer

CERTIFICATE OF INSURANCE

UNITED OF OMAHA LIFE INSURANCE COMPANY

Home Office: Mutual of Omaha Plaza
Omaha, Nebraska 68175

United of Omaha Life Insurance Company certifies that Group Policy Number [GUDS-XXXX] (Policy) has been issued to [ABC EMPLOYER][ABC ASSOCIATION] (Policyholder).

Insurance is provided for certain[Employees][Members][and their Dependent(s)]as described herein.

The benefits described in this Certificate are subject to the terms and conditions of the Policy.

Benefits are effective only if you[and your Dependent(s)] are eligible for insurance, become insured and remain insured as described in this Certificate.

[This Certificate replaces any certificate of insurance previously issued under the Policy.]

UNITED OF OMAHA LIFE INSURANCE COMPANY



Chairman of the Board and Chief Executive Officer



Corporate Secretary

NOTICE

If we at United of Omaha fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Services Divisions
1200 West Third Street
Little Rock, Arkansas 72201-1904
Phone: (800) 852-5494 or (501) 371-2640

SERFF Tracking Number: CLTR-126251763 State: Arkansas
 Filing Company: United of Omaha Life Insurance Company State Tracking Number: 43101
 Company Tracking Number: 700CI-DEN-EZ09
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
 Product Name: Group Dental Insurance
 Project Name/Number: United Group Dental/7000CI-DEN-EZ 09

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	08/13/2009
Comments:		
Attachments:		
Signed Rule & Regulation 19 Compliance.pdf		
United Mutual Readability Cert (2).pdf		
AR Guaranty Association Notice.pdf		
AR Consumer Information Notice (company supplied).pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	08/13/2009
Comments:		
Application to be used attached under the Form Schedule page.		

	Item Status:	Status Date:
Satisfied - Item: Cover Letter and Authorization	Approved-Closed	08/13/2009
Comments:		
Attachments:		
20090803 AR Filing Letter.pdf		
Letter of Authority- United.pdf		

TO: Commissioner of Insurance
Arkansas Insurance Department

RE: United of Omaha Life Insurance Company
Group Dental Forms 7000CI-DEN-EZ 09, et al

RULE AND REGULATION 19 CERTIFICATION

This is to certify that the referenced policy form complies with the provisions of Rule and Regulation 19 as well as all applicable requirements of the Arkansas Insurance Department.

Signed for UNITED OF OMAHA LIFE INSURANCE COMPANY by:

7/29/09
Date

Signature


Marty Traynor, Vice President Voluntary Benefits
Typed Name and Title

READABILITY CERTIFICATION

This is to certify that the form(s) below has (have) been subject to the Flesch Reading Ease Test.

A. Option Selected

1. Policy and its related forms are scored for the Flesch reading ease test as one unit and the combined score is _____.
2. Policy and riders are scored separately for the Flesch reading ease test. Scores for the policy and each form are indicated below:

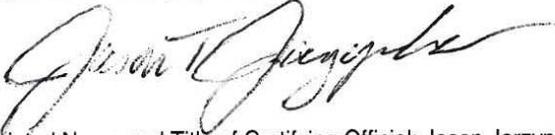
<u>Form</u>	<u>Form Number</u>	<u>Flesch</u>
Schedule	7000GS-U-EZ DEN 09	40.7
Definitions	7001GD-DEN-EZ 09	45.2
COBRA Provisions	8495GI-DEN-EZ 09	46.0
Claims Provisions	7023PC-DEN-EZ 09	40.4
COB Provisions	485GI-DENCOB-EZ 09	54.0
Standard Provisions	7024SP-DEN-EZ 09	52.5
Subrogation	3316GI-DEN-EZ 09	45.7
Eligibility	7017GP-DEN-EZ 09	40.3
Group Application	10634GA-EZ 04	40.5

B. Test Option Selected

1. Test was applied to entire form(s).
2. Test was applied on sample basis. Form(s) contain(s) more than 10,000 words. Copy of forms enclosed indicating word samples tested.

Company Name: United Mutual of Omaha America Insurance Company

Signature of Certifying Official:



Printed Name and Title of Certifying Official: Jason Jarzynka, Vice President & Actuary

Certifying Official's Address: Mutual of Omaha Plaza, Omaha, NE 68175

Date Signed: July 1, 2009

**LIMITATIONS AND EXCLUSIONS UNDER THE
ARKANSAS LIFE AND DISABILITY INSURANCE
GUARANTY ASSOCIATION ACT**

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association (“Guaranty Association”). The purpose of this Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers’ care in selecting insurance companies that are well-managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association (“Guaranty Association”) may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in the state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is **NOT** provided for Your policy or contract or any portion of it that is not guaranteed by the insurer or for which You have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide You with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce You to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act (“Act”). Below is a brief summary of the Act’s coverages, exclusions and limits. This summary does not cover all provisions of the Act, nor does it in any way change anyone’s rights or obligations under the Act or the rights or obligations of the Guaranty Association.

(*)

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract, or policy, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are **NOT** protected by the Guaranty Association if:

- (a) they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- (b) the insurer was not authorized to do business in this state;
- (c) their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does **NOT** provide coverage for:

- (a) any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- (b) any policy of reinsurance (unless an assumption certificate was issued);
- (c) interest rate yields that exceed an average rate;
- (d) dividends; and voting rights and experience rating credits;
- (e) credits given in connection with the administration of a policy by a group contractholder;
- (f) employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- (g) unallocated annuity contracts (which give rights to group contractholders, not individuals);
- (h) unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
- (i) portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- (j) portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- (k) obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;

- (l) contractual agreements establishing the member insurers obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a non-affiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover. The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1,000,000 limit with respect to any contractholder for unallocated annuity benefits, irrespective of the number of contracts held by the contractholder.

These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

NOTICE

If we at United of Omaha fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Services Divisions
1200 West Third Street
Little Rock, Arkansas 72201-1904
Phone: (800) 852-5494 or (501) 371-2640



Frank D. Cripps, Senior Consultant
Contracts and Compliance

379 Princeton-Hightstown Rd.
Cranbury, NJ 08512
Phone: 609-443-7540
Fax: 609-443-4103
frank@coulter-and-associates.com

August 3, 2009

Arkansas Insurance Department

RE: United of Omaha Life Insurance Company • NAIC #69868 • FEIN 47-0322111
Group Dental Coverage Forms Filing
Please See Attached Forms Listing
Filing Authorization Letter
Statement of Variables
Readability Certification
Rule and Regulation 19 Certification

Dear Sir or Madam:

On behalf of United of Omaha Life Insurance Company, Coulter and Associates is hereby submitting the referenced group dental coverage forms for your review and approval for use in your state. A copy of the Company's filing authorization is enclosed.

The Group Policy (Form Number 7000GM-U-EZ 2001) was approved in Arkansas on 6/18/2001. The Certificate of Insurance is designed to provide dental insurance benefits to the employees/members of eligible employer or association groups and their dependents. Benefits include reimbursement of the covered expenses incurred for services listed in the Schedule under Covered Services, subject to any deductible, insurance percentage (coinsurance), co-pay and maximum annual benefit. In addition, some procedures may have a waiting period, age limits and/or frequency limits as described in the Dental Benefits Schedule.

The Company understands that before it can issue a policy to an association, it will need to submit that association to the Department for review and approval.

Each member/employee to be covered will be issued a Certificate of Insurance.

The Premium Rider Form #105GR-EZ will be attached to the group policy and to each certificate issued under that policy. The Group Insurance Application Form #10634 GA-EZ 04 will be used by the prospective policyholder to apply for a policy.

These are new forms and do not supersede any forms on file with the Department of Insurance.

Please do not hesitate to contact me should you have any questions or require any additional information.

Sincerely,

A handwritten signature in black ink that reads 'Frank D. Cripps'.

Frank D. Cripps
Consultant

Arkansas Forms Listing

Description	Module #
CERTIFICATE:	
Certificate Face page	7000CI-DEN-EZ 09
Eligibility	7017GP-DEN-EZ 09
Payment of Claims	7023PC-DEN-EZ 09
Standard Provisions	7024SP-DEN-EZ 09
Coordination of Benefits	485GI-DENCOB-EZ 09
Subrogation and/or Reimbursement Rights	3316GI-DEN-EZ 09
Cobra Continuation	8495GI-DEN-EZ 09
Definitions	7001GD-DEN-EZ 09
Miscellaneous:	
Schedule	7000GS-U-EZ DEN 09
Application	10634 GA-EZ 04
Premium Rider	105GR-EZ
Consumer Information Notice	8964GI-EZ AR 05-03
For Information:	
Guaranty Association Notice	9763GI-EZ AR 04

MUTUAL of OMAHA INSURANCE COMPANY
Mutual of Omaha Plaza
Omaha, NE 68175
402 351 2840 fax 402 351 6666
Scott.Ault@mutualofomaha.com

SCOTT AULT
Senior Vice President
Group Insurance Division
Group Benefit Services



Date: July 1, 2009
To: State Insurance Departments
From: United of Omaha Life Insurance Company
Re: Filing Authority for Coulter & Associates, Inc.

I, Scott Ault, have authorized Coulter and Associates, to make state filings and to correspond to insurance departments on our behalf.

A handwritten signature in black ink, appearing to read "Scott Ault", with a long horizontal line extending to the right.

T. Scott Ault
Senior Vice President
Group Insurance Division

SERFF Tracking Number: CLTR-126251763 State: Arkansas
 Filing Company: United of Omaha Life Insurance Company State Tracking Number: 43101
 Company Tracking Number: 700CI-DEN-EZ09
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
 Product Name: Group Dental Insurance
 Project Name/Number: United Group Dental/7000CI-DEN-EZ 09

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
08/03/2009	Form	Definitions	08/11/2009	7001GD-DEN-EZ 09 Definitions.pdf (Superseded)
08/03/2009	Form	Consumer Information Notice	08/11/2009	Consumer Information Notice.pdf (Superseded)
08/03/2009	Form	Eligibility	08/11/2009	7017GP-DEN-EZ 09 Eligibility.pdf (Superseded)

DEFINITIONS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

Certificate means this Certificate of Insurance form, including the Schedule and any Riders.

Cosmetic or Reconstructive Procedure means any treatment or procedure performed or supply provided primarily to:

- (a) improve physical appearance or to change or restore bodily form without materially correcting a bodily malfunction, condition or disease; or
- (b) prevent or treat a mental or nervous disorder through a change in bodily form.

Covered Service means a dental treatment, procedure or supply that is:

- (a) Medically Necessary;
- (b) described in the Schedule as a treatment, procedure or supply for which benefits are payable;
- (c) performed by a Provider; and
- (d) assigned a procedure code, which We determine to be generally accepted by the dental insurance industry.

[Dental Charges Database (DCD)] means a commercially available charge information database selected by Us that provides historical information about the charges of Providers by procedure code and geographic categories, all as determined and adjusted by the database supplier. The Dental Charges Database will be updated by Us as information becomes available from the database supplier, up to twice each year. We may also modify the database in Our discretion to reflect Our experience. We have the right, in Our discretion, to substitute or replace the selected database with a database or databases of comparable purpose, with or without notice.]

Dental Hygienist or Denturist means a person who is:

- (a) licensed to perform specified dental procedures under the law of the jurisdiction in which the dental procedure is performed; and
- (b) operating within the scope of his or her license.

Dentist means a person who is:

- (a) licensed to practice dentistry under the law of the jurisdiction in which the dental procedure is performed; and
- (b) operating within the scope of his or her license.

[Dependent] means a citizen, permanent resident or lawful resident of the United States [or Canada] who, as indicated by evidence acceptable to Us, is:

- a) [Your Spouse;]
- b) [Your natural born or legally adopted child;]
- c) [Your stepchild [or child of Your domestic partner] living in Your home; or]

- d) [any other child who lives with You in a regular parent/child relationship and who qualifies as Your “dependent” as defined in the United States Internal Revenue Code.]

A Dependent does not include:

- a) [anyone insured under this Policy as [an Employee] [a Member];]
- b) anyone who is a member of the Armed Forces, National Guard or Reserves of any state or county on active duty (except for temporary duty of [31][0-120] days or less for training);
- c) [Your divorced or legally separated Spouse;]
- d) [Your Spouse [age[70][60-80]or older] [after You reach the [Attained Age][age] of[70][60-80];]
- e) [a child less than 14 days old;]
- f) [a child who has reached the [Attained Age][age] of [21][14-30][or the [Attained Age][age] of [25][14-30] if a Student, unless the child is Incapacitated;]
- g) [Your married child(ren);]
- h) [Your child if the child has been legally adopted by another person;] or
- i) [a child:
 - 1. temporarily living in Your home;
 - 2. placed in Your home by a social service agency which retains control over the child; or
 - 3. who has a natural parent in a position to exercise parental responsibility and control.]]

Expense means the charge incurred for a dental treatment, procedure or supply. Expense is considered incurred on the date a treatment or procedure is performed or a supply is furnished. Expense does not include any charge which is in excess of the charge that the Provider agreed to accept as payment in full.

Experimental or Investigational Device, Treatment or Procedure means a device, treatment or procedure which We determine:

- a) is not in general use in the practice of dentistry;
- b) is under continued scientific testing or ongoing clinical trials;
- c) does not have a measurable benefit for a dental injury, condition or disease; or
- d) has not been proven to be safe and effective.

In making this determination, We may rely on outside sources, including, but not limited to, dental consultants, dental journals, or governmental regulations.

[Insured Person means You and/or Your Dependents who are insured under the Policy.]

Medically Necessary means a dental treatment, procedure or supply which We and/or a qualified party or entity selected by Us determines is:

- a) provided for the prevention, diagnosis, or direct treatment of a dental injury, condition or disease;
- b) appropriate and consistent with the symptoms and findings or diagnosis and treatment of the Insured Person’s dental injury, condition or disease; and

- c) provided in accordance with generally accepted professional standards of dental practice.

The fact that the Insured Person's Provider orders, prescribes or renders treatments, procedures or supplies does not automatically mean such treatments, procedures or supplies are Medically Necessary.

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

[**Network** means the network of Providers who, through contract with Us or a party or parties that have contracted with Us, have agreed to provide Covered Services to Insured Persons.]

[**Non-Participating Provider** means a Provider who does not participate in the Network on the day a treatment or procedure is performed or a supply is furnished.]

[**Non-Participating Provider Allowance** means a charge by a Non-Participating Provider for a Covered Service, which is no higher than the [90th] percentile identified on the Dental Charges Database (DCD). When there is, in Our determination, minimal data available from the DCD for a Covered Service, We will determine the Non-Participating Provider Allowance by calculating the unit cost for the applicable service category using the DCD, and multiplying that by the relative value of the Covered Service based upon a commercially available relative value scale selected by Us. In the event of an unusually complex Covered Service, a Covered Service that is a new procedure or a Covered Service that otherwise does not have a relative value that is in Our determination applicable, We will assign one. In no event will the Non-Participating Provider Allowance charge exceed the amount billed by the Provider or the amount for which the Insured Person is responsible. The term " Non-Participating Provider Allowance " may not reflect the actual charges of the Provider, and does not take into account the Provider's training, experience or category of licensure. Non-Participating Providers may charge You the difference between what they charge and the Non-Participating Provider Allowance.]

Our, We, Us means [United of Omaha Life Insurance Company][Mutual of Omaha Insurance Company].

[**Participating Provider** means a Provider who participates in the Network on the day a treatment or procedure is performed or a supply is furnished. Participating Providers have agreed to accept a predetermined allowance as payment in full for Covered Services. Any applicable deductibles, coinsurance amounts, or charges for services not covered by the Plan can be charged and collected from You.]

Policy means the group dental insurance policy, including this Certificate which is part of the policy, issued to the Policyholder by Us.

Policy Anniversary means [Month Day] of each Policy Year.

Policy Effective Date means [Month Day, Year].

Policy Year means the period commencing on the Policy Effective Date and ending on the next succeeding Policy Anniversary and, thereafter, each yearly period commencing on the Policy Anniversary.

Policyholder means[ABC Company].

Prior Plan means an insured or self-funded dental plan maintained or sponsored by the Policyholder, which was in effect immediately prior to the Policy Effective Date.

Provider means a Dentist, Denturist, or Dental Hygienist.

Rider means a document that is added to and made a part of the Policy. A Rider amends, limits, restricts, or otherwise changes the provisions of this Policy.

[**Schedule** means the section of the Certificate identified as the “Schedule”.]

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

[**Spouse** means the person to whom You are legally married, or Your domestic partner, or civil union partner or equivalent, as recognized and allowed by federal law, or by state law in Your state of residence.]

[A Spouse may include Your same sex [or opposite sex] domestic partner if:

- a) You submit a written declaration of domestic partnership signed by You and Your partner in a form acceptable to Us;[or]
- b) You submit evidence acceptable to Us that all applicable requirements of the state, city and/or county in which You reside regarding the establishment of a domestic partnership have been met[; or]
- c) [V].]

[**Temporomandibular Disorders (TMD)** means any misalignment, dysfunction or other disorder of the jaw joint (or of the complex of muscles, nerves and tissues related to that joint). It includes temporomandibular joint dysfunction, arthritis or arthrosis, other craniomandibular joint disorders, and myofacial or orofacial pain syndrome. It does not include a fracture or dislocation which results from an injury, any misalignment, dysfunction or other disorder of the jaw joint (or of the complex of muscles, nerves and tissues related to that joint).]

TPA means the third party administrator designated by Us to whom We have delegated claims administration and other administrative services.

You, Your[, Insured Person] means an [Employee] [Member] insured under the Policy.

NOTICE

If we at United of Omaha Life Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
400 University Tower Building
Little Rock, Arkansas 72204
Telephone: (501) 686-2945

ELIGIBILITY

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of this Policy.

Definitions

[Actively Eligible or Active Eligibility] means a[n] [Member] is:

- a) in good standing with the [Policyholder][or][V] and eligible for insurance according to the [Policyholder][or][V]'s rules of eligibility; and
- b) eligible for insurance under this Policy in accordance with the terms and conditions of this Eligibility section.

If the [Policyholder][or][V]'s rules of eligibility for insurance conflict with any of the terms and conditions of this Eligibility section, the terms and conditions of this Eligibility section shall control. Any changes to the [Policyholder][or][V]'s rules of eligibility after the Policy Effective Date will not be effective for purposes of becoming or remaining eligible for insurance under the Policy unless such changes have been approved by Our authorized representative in Our home office.]

[Actively Working or Active Work] means a[n Employee] is performing the normal duties of his or her regular job for the [Policyholder][or][V] on a regular and continuous basis [30] or more hours each [week] and is receiving compensation from the [Policyholder][or][V] for work performed for the [Policyholder][or][V] at:

- a) the [Policyholder's][or][V's] usual place of business;
- b) an alternative work site at the direction of the [Policyholder][or][V], or
- c) a location to which one must travel to perform the job.

A[n Employee] will be considered actively working on any day that is a regular paid holiday or day of vacation, or regular or scheduled non-working day, provided the [Employee] was actively working on the last preceding regular work day.]

[Attained Age] means the age of the Insured Person as of the Policy Anniversary following the Insured Person's birthday. For example, if an Insured Person's [70th] birthday is on [March 1, 2009] and the Policy Anniversary is [January 1], the Insured Person will reach the attained age of [70] on [January 1, 2010].]

[Eligibility Waiting Period] means a continuous period of Active [Work] that a[n Employee] must satisfy before becoming eligible for insurance as described in the When a[n Employee] Becomes Eligible for Insurance (Eligibility Waiting Period) provision.]

[[Employee]] means:

- a) a citizen or permanent resident of the United States [or Canada] who is Actively Working; or
- b) a person who is authorized to work in the United States pursuant to the Immigration and Nationality Act and related rules and regulations who is Actively Working.

An employee does not include a person:

- a) working outside the United States [or Canada] for a period in excess of 12 consecutive months unless written approval has been received from Our authorized representative in Our home office;
- b) [working on a seasonal or temporary basis][;][or]
- c) [performing services for the [Policyholder][or][V] [as an independent contractor, including persons reporting income on a 1099 form,] [or] [subject to the terms of a leasing agreement between the[Policyholder][or][V] and a leasing organization][.]]

[Hospital] means an accredited facility licensed by the proper authority of the area in which it is located to provide care and treatment for the condition causing confinement. A hospital does not include a facility or institution or part of a facility or institution which is licensed or used principally as a clinic, convalescent home, rest home, nursing home or home for the aged, halfway house or board and care facilities.]

[Incapacitated] means that a Dependent child is:

- a) continuously incapable of self-sustaining employment by reason of mental retardation, developmental disability, mental illness or physical handicap; and
- b) primarily dependent upon You for financial support and maintenance on a continuous basis.]

[Life Event] means:

- a) a change in legal marital status;
- b) a change in the number of Your Dependents; or
- c) a significant cost or coverage change under of any other plan under which You [or Your Dependents] are covered;] or
- d) [V].

[Member] means:

- a) a citizen or permanent resident of the United States [or Canada] who is Actively Eligible or,
- b) a person who is authorized to work in the United States pursuant to the Immigration and Nationality Act and related rules and regulations who is Actively Eligible.

A member does not include a person who resides outside the United States [or Canada] for a period in excess of 12 consecutive months unless written approval has been received from Our authorized representative in Our home office.]

[Retiree] means a former [Employee] of the [Policyholder][or][V] who is a citizen or permanent resident of the United States [or Canada] and:

- a) [has attained Social Security Normal Retirement Age;]
- b) [is at least age [V];]
- c) [has completed [V] consecutive years of full time[, or part time] [employment] with the [Policyholder][or][V] immediately prior to retirement;]
- d) [participates in a pension plan maintained or sponsored by the [Policyholder][or][V];][and]
- e) [whose age plus years of active full time[, or part time][employment] with the [Policyholder][or][V] equal at least [V]][and;]
- f) [V].]

[**Schedule** means the section of the Certificate identified as the [“Schedule”].]

[**Social Security Normal Retirement Age** means Your normal retirement age under the United States Social Security Act. The Social Security Normal Retirement Age table is available online at www.ssa.gov/OACT/ProgData/nra.html or any other online web-site address which replaces this address.]

[**Student** means Your Dependent child:

- a) who qualifies as Your “dependent” as defined in the United States Internal Revenue Code; and
- b) who attends an accredited high school, trade school, college, university or other institution of learning and is enrolled full-time [or part-time]as indicated by evidence acceptable to Us.]

When a[n Employee] Becomes Eligible for Insurance (Eligibility Waiting Period)

[A[n Employee] who is Actively [Working] on [MM/DD/YYYY] becomes eligible for insurance under this Policy on [MM/DD/YYYY].]

[A[n Employee] who has completed an Eligibility Waiting Period of [30] [days] of continuous Active [Work] on or before [MM/DD/YYYY] becomes eligible for insurance under this Policy on [MM/DD/YYYY].]

[A[n Employee] who [is hired] after [MM/DD/YYYY] becomes eligible for insurance under this Policy on the day the [Employee] begins Active [Work].]

[A[n Employee] who [is hired] after [MM/DD/YYYY] becomes eligible for insurance under this Policy on the day following completion of an Eligibility Waiting Period of [30] [days] of continuous Active [Work].]

[A[n Employee] who is not eligible for insurance under this Policy on [MM/DD/YYYY], or a[n Employee] who [is hired] after [MM/DD/YYYY], becomes eligible for insurance under this Policy on the day following completion of an Eligibility Waiting Period of [30] [days] of continuous Active [Work].]

[A[n Employee] who is not eligible for insurance under this Policy on [MM/DD/YYYY] becomes eligible on the day following completion of an Eligibility Waiting Period of [30] [days]. A[n Employee] who [is hired] after [MM/DD/YYYY] becomes eligible on the day following completion of an Eligibility Waiting Period of [30] [days].]

[If a[n employee] is hired as a part-time[or temporary] [employee] and subsequently changes to a full-time [Employee], any period of time spent as a part-time[or temporary] [employee] will be used to satisfy the Eligibility Waiting Period.]

[V.]

[When a Retiree Becomes Eligible for Insurance [(Eligibility Waiting Period)]

A Retiree who was covered under a Prior Plan will be eligible for insurance under this Policy on [MM/DD/YYYY].

[A Retiree who was covered under a Prior Plan immediately prior to retirement and retires on or after [MM/DD/YYYY] becomes eligible for insurance under this Policy on the [first day of the month which [coincides with or] follows the] day of retirement.]

[A Retiree who retired prior to [MM/DD/YYYY] is not eligible for insurance under this Policy.]

[Additional Coverage Requirement

A[n] [Employee] must elect [V] insurance maintained or sponsored by the [Policyholder][or][V] [and issued by Us] in order to be eligible for insurance under this Policy. If the [Employee] does not elect [V] insurance maintained or sponsored by the [Policyholder][or][V], the [Employee] may not elect insurance under this Policy. If the [Employee]’s [V] insurance maintained or sponsored by the [Policyholder][or][V] ends, insurance under this Policy shall also end.]

[When a Dependent Becomes Eligible

A Dependent becomes eligible for insurance under this Policy on the later of:

- a) the day You become eligible for insurance under this Policy; or
- b) the day You acquire the Dependent, provided You elect insurance for yourself under this Policy.

[If both You and Your Spouse are eligible for insurance under this Policy as [Employees] of the [Policyholder][or][V], neither You nor Your Spouse may elect insurance as a Dependent of the other person.]

[If both You and Your Spouse are eligible for insurance under this Policy as [Employees] of the [Policyholder][or][V], either You or Your Spouse, but not both, may elect insurance for Your Dependent child(ren) under this Policy.]

[In order to insure an eligible Dependent child, You must insure all of Your eligible Dependent child(ren). You must also elect the same amount of insurance for each eligible Dependent child.]

When Insurance Begins

An eligible [Employee] must request insurance for the [Employee][and any Dependents] by properly enrolling through an enrollment process acceptable to Us. Enrollment information must be submitted to the [Policyholder][or][V] within [31] days following the day the [Employee][or Dependent(s)] becomes eligible.

[We must receive a Retiree’s request for insurance within [31] days following the day the Retiree becomes eligible in order for the Retiree to be insured under this Policy.]

[A Dependent child is considered eligible for insurance at birth and may become insured at any time through the child's third birthday without being subject to terms of the Late Entrant Enrollment Period provision.]

A[n Employee] will become insured on [the first day of the month which coincides with or follows] the latest of the day:

- a) the [Employee] begins Active [Work]; or
- b) the [Employee's] enrollment information is properly completed and signed by the [Employee].

[If the [Employee] is not Actively [Working] on the day insurance would otherwise begin, insurance will begin on [the first day of the month which [coincides with or] follows] the day the [Employee] returns to Active [Work].]

[An eligible Dependent will become insured on the latest of the day:

- a) the [Employee] becomes insured;
- b) the [Employee] acquires the eligible Dependent; or
- c) the Dependent's enrollment information is properly completed and signed by the [Employee].

[Insurance for a Dependent child who became Incapacitated prior to reaching the age of [21,][or age [25] if a Student], will begin in accordance with the When Insurance Begins provision, provided the child otherwise meets the definition of Dependent.]

[The First Enrollment Period

A[n Employee] may elect insurance for the [Employee] [and any Dependents] during the First Enrollment Period. The First Enrollment Period is the [31 day period] following the day the [Employee][or the Dependent] becomes eligible for insurance under this Policy.]

[Subsequent Enrollment Periods

A[n Employee] may elect, drop, increase, decrease or change insurance during a Subsequent Enrollment Period. A Subsequent Enrollment Period is any period up to [31] consecutive calendar days as designated by the [Policyholder][or][V] and agreed to in writing by Our authorized representative in Our home office.]

[Late Entrant Enrollment Period

If a[n Employee] does not elect insurance during the [Employee's][or Dependent's] First Enrollment Period, the [Employee] [or Dependent] will not be able to become insured until the first Subsequent Enrollment Period which occurs at least [24] months after the First Enrollment Period.]

[When Election Changes Are Permitted

The [Policyholder][or][V] has chosen to provide these insurance benefits under a Section 125 cafeteria plan. A cafeteria plan permits You to elect to pay Your share of the benefit cost with pre-tax dollars and permits You to change Your election only when specific Life Events occur (other than during an enrollment period designated by the [Policyholder][or][V] and agreed to in writing by Our authorized representative in Our home office). You may make an election change by submitting a written request to the [Policyholder][or][V] within [31] days from the date of a Life Event.

Life Events are described in the [Policyholder][or][V]'s cafeteria plan. Contact the [Policyholder][or][V] for information regarding the election changes that are permissible under the [Policyholder][or][V]'s cafeteria plan. If Your election change does not meet Section 125 cafeteria plan requirements, You may only make an election change as described in the Subsequent Enrollment Periods provision.]

[Within [31] days of a Life Event, You must submit to the [Policyholder][or][V] any request to change insurance through an enrollment process acceptable to Us. [If Your request is submitted more than [31] days after the date of a Life Event, You may not enroll until the next Subsequent Enrollment Period.]

[Reinstatement of Insurance]

You may be eligible to reinstate insurance that has ended [for Yourself and Your eligible Dependents] in accordance with this provision. You must submit a request to reinstate insurance to the [Policyholder][or][V] through a reinstatement request process acceptable to Us within [31] days of Your return to Active [Work].

Reinstated insurance will take effect on [the later of] [the first day of the month which [coincides with or] follows] the day the reinstatement request is completed and signed. If You are not Actively [Working] on the day the reinstated insurance would otherwise take effect, insurance will become effective on [the first day of the month which [coincides with or] follows]the day You return to Active [Work].

The following reinstatement option[s] [are][is] available:

[[Non-Payment of Premium] [or] [Voluntary Termination of Coverage]

[If insurance ended due to [non-payment of premium] [or] [voluntary termination of coverage], insurance may be reinstated during the first Subsequent Enrollment Period which occurs at least [24] months after the date on which insurance ended.]

[Involuntary Reduction in Hours]

If insurance ended because the [Employee] was no longer Actively Working due to an involuntary reduction of hours worked, insurance may be reinstated without satisfying another Eligibility Waiting Period if the [Employee] returns to Active Work and there was no break in employment with the [Policyholder][or][V] after the date insurance ended.]

[Rehired] [Employee] Due to [Layoff] [or] [Termination]

If insurance ended because the [Employee] was no longer Actively [Working] due to [layoff] [or] [termination of [employment] with the [Policyholder][or][V]], insurance may be reinstated without satisfying another Eligibility Waiting Period if the [Employee] is [rehired] and returns to Active [Work] within [90] [days] from the date [employment] ended.

[Rehired][Employee] Due to Leave of Absence

If insurance ended due to an approved leave of absence, including military leave, insurance may be reinstated within [1] [year] from the date [employment] ended, without satisfying another Eligibility Waiting Period upon return to Active [Work].

When Insurance Ends

Insurance will end for You[and Your Dependents][on the earliest of the day][on the last day of the month in which the earliest of the following events occurs]:

- a) this Policy terminates;
- b) You are no longer eligible for insurance under this Policy;
- c) [insurance ends in accordance with the Additional Coverage Requirement provision;]
- d) [You attain age [65];]
- e) [You return to employment with the [Policyholder][or][V][;]]
- f) any applicable premium is due and unpaid; or
- g) You begin active duty in the Armed Forces, National Guard or Reserves of any state or country (except for temporary active duty of [31] days or less).

[In addition to the items above, insurance for a Dependent will end [on the earliest of the day] [on the last day of the month in which the earliest of the following events occurs]:

- a) the Dependent is no longer eligible for insurance under this Policy; or
- b) the Dependent begins active duty in the Armed Forces, National Guard or Reserves of any state or country (except for temporary active duty of [31] days or less).]

[Exceptions to When Insurance Ends

If You cease to be [Actively [Working]][eligible for insurance], You[and/or Your Dependents] may be eligible to continue or obtain insurance under [the V provision.] [one of the following provisions:]

- a) [Continuation of Insurance for Approved Layoff, Leave of Absence or Paid Severance]
- b) [COBRA Continuation]
- c) [V]

[Continuation of Insurance for Approved [Layoff][,] [Leave of Absence] [or] [Paid Severance]

In the event of a conflict between this provision and any other provision of this Policy, this provision shall control.

You may be able to continue insurance[for Yourself and Your Dependent(s)] for up to [12] [weeks] from the day You cease to be Actively Working in the event of:

- a) [a temporary involuntary layoff][; or]
- b) [a personal leave of absence approved by the [Policyholder][or][V] due to[:]
 1. an Injury or Sickness; or
 2. any other personal reason].

In addition, the federal Family Medical Leave Act (FMLA) and Uniformed Services Employment and Reemployment Rights Act (USERRA) and any amendments thereto, as well as certain state laws, allow continuation of insurance in certain instances for leaves of absence, layoff or termination. Contact the [Policyholder][or][V] for additional information regarding any other continuation options that may be available.

[You may also be able to continue insurance from the day You cease to be Actively Working if You are entitled to and receive paid severance from the [Policyholder][or][V].]

Any insurance continued under this provision will be subject to the following conditions:

- a) insurance may not be continued beyond the earliest of:
 1. [1-365] [day][week][month][year][s]; [or]
 2. the time period allowed by FMLA, USERRA or applicable state law that allows for continuation;
 3. [the time period during which You receive paid severance;]
- b) [the amount of insurance may not be increased while insurance is continued under this provision;]
- c) We must receive notification acceptable to Us of the approved [absence] [or] [severance] from the [Policyholder][or][V] within [31] days from the date You cease Active [Work]; and
- d) We must continue to receive premium payment when due (premiums must be paid by You or on Your behalf).

Insurance under this provision will end on [the last day of the month which [coincides with or] follows] the earliest of the day:

- a) the time period in (a) in the preceding paragraph has been satisfied;
- b) [Your temporary involuntary layoff becomes permanent, if insurance is continued under this provision due to Your temporary involuntary layoff;]
- c) You return to Active [Work];
- d) this Policy terminates;
- e) any applicable premium is due and unpaid;
- f) You obtain a similar type of coverage under another group [or individual worksite] plan; or
- g) You begin employment with an employer other than the [Policyholder][or][V].

See the Options for Payment of Premium for Continued Insurance provision for premium payment options.]

Options for Payment of Premium for Continued Insurance

When insurance is continued, We must receive premium payment when due (premiums must be paid by You or on Your behalf) for insurance to remain effective. This can occur in one of the following ways:

- a) the [Policyholder][or][V] may pay the premiums; [or]
- b) You may pay premium to the [Policyholder][or][V] who will then submit premium to Us; or
- c) You may pay premium directly to Us].

[Contact the [Policyholder][or][V] to determine which option is available to You.]

[Contact the [Policyholder][or][V] to determine whether option (a) or (b) is available to You. If neither option is available, You should contact the Policyholder for information regarding the process for submitting premium directly to Us.]

Payment of premium does not guarantee eligibility for coverage.]