

SERFF Tracking Number: BLHI-126481382 State: Arkansas  
Filing Company: BEST Life and Health Insurance Company State Tracking Number: 45248  
Company Tracking Number: BL-GD-PPO-POL 0909  
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental  
Product Name: Group Dental  
Project Name/Number: /

## Filing at a Glance

Company: BEST Life and Health Insurance Company

Product Name: Group Dental

SERFF Tr Num: BLHI-126481382 State: Arkansas

TOI: H10G Group Health - Dental

SERFF Status: Closed-Approved-  
Closed State Tr Num: 45248

Sub-TOI: H10G.000 Health - Dental

Co Tr Num: BL-GD-PPO-POL 0909 State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Author: Tammy O'Connor

Disposition Date: 04/13/2010

Date Submitted: 03/24/2010

Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name:

Status of Filing in Domicile: Pending

Project Number:

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments: Filed in State of  
Domicile on 2/1/2010. Pending approval

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type: Trust

Filing Status Changed: 04/13/2010

Explanation for Other Group Market Type:

State Status Changed: 04/13/2010

Deemer Date:

Created By: Tammy O'Connor

Submitted By: Tammy O'Connor

Corresponding Filing Tracking Number:

Filing Description:

On behalf of BEST Life and Health Insurance Company, please find enclosed the following forms for your review and approval. These forms are new and are not intended to replace any previously approved forms. Please see the attached forms list for a description of the submitted forms.

These forms are being submitted as a Multiple Employer Trust and were filed in our State of Domicile, Utah, on 2/1/2010. The forms are issued to the Trustee of the Beneficial Employees Security Trust of Utah. The trust documents for the Subscribing Employers are attached.

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These forms provide coverage for dental benefits for eligible employees and dependents of Subscribing Employers under a multiple employer trust. Coverage will be solicited by licensed agents and brokers. I am filing a PPO Plan along with an Indemnity Plan.

Please note all variable items are bracketed. However, variability will not be used if it conflicts with the minimum requirements as mandated by State and/or Federal law. In addition the included applications will not be used to solicit individual policies.

## Company and Contact

### Filing Contact Information

Tammy O'Connor, Director, Regulatory toconnor@bestlife.com  
 Compliance  
 2505 McCabe Way 800-433-0088 [Phone] 214 [Ext]  
 Irvine, CA 92623

### Filing Company Information

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

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## Filing Fees

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

SERFF Tracking Number: BLHI-126481382 State: Arkansas  
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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/13/2010	04/13/2010

### 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	04/09/2010	04/09/2010	Tammy O'Connor	04/12/2010	04/12/2010

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Filing fees and Registration of Multiple Employer Trust	Note To Reviewer	Tammy O'Connor	04/02/2010	04/02/2010
Filing fees and Registration of Multiple Employer Trust	Note To Filer	Rosalind Minor	04/01/2010	04/01/2010

SERFF Tracking Number: BLHI-126481382 State: Arkansas  
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TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental  
Product Name: Group Dental  
Project Name/Number: /

## Disposition

Disposition Date: 04/13/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: BLHI-126481382 State: Arkansas  
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 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental  
 Product Name: Group Dental  
 Project Name/Number: /

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Actuarial Memo	Approved-Closed	No
Supporting Document	Statement of Variability	Approved-Closed	Yes
Supporting Document	Approved Trust Document	Approved-Closed	Yes
Form	Group PPO Policy	Approved-Closed	Yes
Form (revised)	PPO Certificate	Approved-Closed	Yes
Form	PPO Certificate	Replaced	Yes
Form	PPO Application Form	Approved-Closed	Yes
Form	Indemnity Policy	Approved-Closed	Yes
Form (revised)	Indemnity Certificate	Approved-Closed	Yes
Form	Indemnity Certificate	Replaced	Yes
Form	Indemnity Application Form	Approved-Closed	Yes
Form	Employee Enrollment Form Dental Only	Approved-Closed	Yes
Form	Employee Enrollment Form Dental and Vision	Approved-Closed	Yes
Form	Adult Orthodontic Benefit Rider	Approved-Closed	Yes
Form	Child Orthodontic Benefit Rider	Approved-Closed	Yes
Form	Children's Good Vision Benefit Rider	Approved-Closed	Yes

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TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental  
Product Name: Group Dental  
Project Name/Number: /

## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 04/09/2010  
Submitted Date 04/09/2010

Respond By Date

Dear Tammy O'Connor,

This will acknowledge receipt of the captioned filing.

### Objection 1

- PPO Certificate, BL-GD-PPO-CERT/AR 0909 (Form)
- Indemnity Policy, BL-GD-ID-POL 0909 (Form)

Comment: On the face page of the certificate, the Governing Jurisdiction is the State of Utah. Please change to read Arkansas or amend the certificate with language that reads: any certificates issued in Arkansas will be governed by the State of Arkansas.

### Objection 2

- PPO Certificate, BL-GD-PPO-CERT/AR 0909 (Form)
- Indemnity Policy, BL-GD-ID-POL 0909 (Form)

Comment: Under the Important Notice for Arkansas Residents, the address and phone number is incorrect for our Department. Please change to read: 1200 West Third Street, Little Rock, AR 72201-1904.  
Phone numbers are: (501)371-2640 or (800)852-5494.

### Objection 3

- PPO Certificate, BL-GD-PPO-CERT/AR 0909 (Form)
- Indemnity Policy, BL-GD-ID-POL 0909 (Form)

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

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 04/12/2010  
Submitted Date 04/12/2010

SERFF Tracking Number: BLHI-126481382 State: Arkansas  
 Filing Company: BEST Life and Health Insurance Company State Tracking Number: 45248  
 Company Tracking Number: BL-GD-PPO-POL 0909  
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental  
 Product Name: Group Dental  
 Project Name/Number: /

Dear Rosalind Minor,

**Comments:**

**Response 1**

Comments: I have made the appropriate revisions.

**Related Objection 1**

Applies To:

- PPO Certificate, BL-GD-PPO-CERT/AR 0909 (Form)
- Indemnity Policy, BL-GD-ID-POL 0909 (Form)

Comment:

On the face page of the certificate, the Governing Jurisdiction is the State of Utah. Please change to read Arkansas or amend the certificate with language that reads: any certificates issued in Arkansas will be governed by the State of Arkansas.

**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
PPO Certificate	BL-GD-PPO-CERT/AR 0909		Certificate	Initial			AR_PPO Certificate.pdf
<b>Previous Version</b>							
PPO Certificate	BL-GD-PPO-CERT/AR 0909		Certificate	Initial			AR_PPO Certificate.pdf
Indemnity Certificate	BL-GD-ID-CERT/AR 0909		Certificate	Initial			AR_Indemnity Certificate.pdf

SERFF Tracking Number: BLHI-126481382 State: Arkansas  
 Filing Company: BEST Life and Health Insurance Company State Tracking Number: 45248  
 Company Tracking Number: BL-GD-PPO-POL 0909  
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental  
 Product Name: Group Dental  
 Project Name/Number: /

**Previous Version**

Indemnity Certificate	BL-GD-ID-CERT/AR 0909	Certificate	Initial	AR_Indemnity Certificate.pdf
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No Rate/Rule Schedule items changed.

**Response 2**

Comments: I have made the appropriate revisions.

**Related Objection 1**

Applies To:

- PPO Certificate, BL-GD-PPO-CERT/AR 0909 (Form)
- Indemnity Policy, BL-GD-ID-POL 0909 (Form)

Comment:

Under the Important Notice for Arkansas Residents, the address and phone number is incorrect for our Department. Please change to read: 1200 West Third Street, Little Rock, AR 72201-1904. Phone numbers are: (501)371-2640 or (800)852-5494.

**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
PPO Certificate	BL-GD-PPO-CERT/AR 0909		Certificate	Initial			AR_PPO Certificate.pdf
<b>Previous Version</b>							
PPO Certificate	BL-GD-PPO-CERT/AR		Certificate	Initial			AR_PPO Certificate.pdf

SERFF Tracking Number: BLHI-126481382 State: Arkansas  
 Filing Company: BEST Life and Health Insurance Company State Tracking Number: 45248  
 Company Tracking Number: BL-GD-PPO-POL 0909  
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental  
 Product Name: Group Dental  
 Project Name/Number: /

0909  
 Indemnity Certificate BL-GD-ID- Certificate Initial AR\_Indem  
 CERT/AR nity  
 0909 Certificate.  
 pdf

**Previous Version**

Indemnity Certificate BL-GD-ID- Certificate Initial AR\_Indem  
 CERT/AR nity  
 0909 Certificate.  
 pdf

No Rate/Rule Schedule items changed.

**Response 3**

Comments: I have made the appropriate revisions.

**Related Objection 1**

- Applies To:
- PPO Certificate, BL-GD-PPO-CERT/AR 0909 (Form)
  - Indemnity Policy, BL-GD-ID-POL 0909 (Form)

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

**Changed Items:**

No Supporting Documents changed.

**Form Schedule Item Changes**

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
PPO Certificate	BL-GD-PPO-CERT/AR 0909		Certificate	Initial			AR_PPO Certificate.pdf

SERFF Tracking Number: BLHI-126481382 State: Arkansas  
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 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental  
 Product Name: Group Dental  
 Project Name/Number: /

**Previous Version**

PPO Certificate	BL-GD- PPO- CERT/AR 0909	Certificate	Initial	AR_PPO Certificate. pdf
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Indemnity Certificate	BL-GD-ID- CERT/AR 0909	Certificate	Initial	AR_Indem nity Certificate. pdf
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**Previous Version**

Indemnity Certificate	BL-GD-ID- CERT/AR 0909	Certificate	Initial	AR_Indem nity Certificate. pdf
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No Rate/Rule Schedule items changed.

Sincerely,  
Tammy O'Connor

SERFF Tracking Number: BLHI-126481382 State: Arkansas  
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TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental  
Product Name: Group Dental  
Project Name/Number: /

**Note To Reviewer**

**Created By:**

Tammy O'Connor on 04/02/2010 01:11 PM

**Last Edited By:**

Rosalind Minor

**Submitted On:**

04/13/2010 08:41 AM

**Subject:**

Filing fees and Registration of Multiple Employer Trust

**Comments:**

Good morning, Ms. Minor. I have requested the filing fee and will overnight the check to you next week. You will have it no later than Friday morning, April 9. I am completing the form for registering our trust and anticipate sending the paperwork in on Monday, April, 5. Thank you.

Sincerely,

Tammy O'Connor

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TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental  
Product Name: Group Dental  
Project Name/Number: /

**Note To Filer**

**Created By:**

Rosalind Minor on 04/01/2010 02:09 PM

**Last Edited By:**

Rosalind Minor

**Submitted On:**

04/13/2010 08:41 AM

**Subject:**

Filing fees and Registration of Multiple Employer Trust

**Comments:**

Before review can begin on this submission, it is requested that you provide us with a filing fee. Our filing fees are listed under the General Information for Arkansas. For this submission, there are 11 forms at \$50.00 per form, for a total of \$550.00.

Also, the Multiple Employer Trust must be registered with our License Division before you market an approved product to the MET. The Registration Instruction and forms are found on the License Division website at: <http://www.insurance.arkansas.gov/License/forms.htm>. Scroll down to SELF, TRUST, MET, MEWA.

Thank you for your cooperation in this matter.

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 Product Name: Group Dental  
 Project Name/Number: /

## Form Schedule

### Lead Form Number: BL-GD-PPO-POL 0909

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 04/13/2010	BL-GD-PPO-POL 0909	Policy/Cont ract/Fratern al Certificate	Group PPO Policy	Initial			PPO Policy.pdf
Approved-Closed 04/13/2010	BL-GD-PPO-CERT/AR 0909	Certificate	PPO Certificate	Initial			AR_PPO Certificate.pdf
Approved-Closed 04/13/2010	BL-GD-PPO-APP 0909	Application/ Enrollment Form	PPO Application Form	Initial			PPODentalGroupEApp0608.pdf
Approved-Closed 04/13/2010	BL-GD-ID-POL 0909	Policy/Cont ract/Fratern al Certificate	Indemnity Policy	Initial			Indemnity Policy.pdf
Approved-Closed 04/13/2010	BL-GD-ID-CERT/AR 0909	Certificate	Indemnity Certificate	Initial			AR_Indemnity Certificate.pdf
Approved-Closed 04/13/2010	BL-GD-ID-APP 0909	Application/ Enrollment Form	Indemnity Application Form	Initial			Indemnity Employer Application 0909.pdf
Approved-Closed 04/13/2010	BL-GD-DEN-EE 0909	Application/ Enrollment Form	Employee Enrollment Form Dental Only	Initial			Dental Only Employee Enrollment Form.pdf
Approved-Closed 04/13/2010	BL-GD-DV-EE 0909	Application/ Enrollment Form	Employee Enrollment Form Dental and Vision	Initial			Dental Vision Employee Enrollment Form.pdf
Approved-	BL-GD-	Certificate	Adult Orthodontic	Initial			Adult_Ortho

SERFF Tracking Number: BLHI-126481382 State: Arkansas  
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 Company Tracking Number: BL-GD-PPO-POL 0909  
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental  
 Product Name: Group Dental  
 Project Name/Number: /

Closed	AOR 0909	Amendmen Benefit Rider			Rider.pdf
04/13/2010		t, Insert Page, Endorseme nt or Rider			
Approved- Closed	BL-GD- COR 0909	Certificate Amendmen Benefit Rider	Child Orthodontic	Initial	Child_Ortho Ride.pdf
04/13/2010		t, Insert Page, Endorseme nt or Rider			
Approved- Closed	BL-GD- CGV 0909	Certificate Amendmen Vision Benefit Rider	Children's Good	Initial	Child_GoodVi sion_Rider.pd f
04/13/2010		t, Insert Page, Endorseme nt or Rider			

**BEST Life and Health Insurance Company**

2505 McCabe Way  
Irvine, California 92614

A STOCK COMPANY  
(Herein called the Company)

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

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

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

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

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

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

[  ]  
President



Secretary

**Group PPO Dental Policy**  
Non-Participating

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

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

**Group Policy Number:** [XXX]

**State of Delivery:** [Utah]

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

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

## TABLE OF CONTENTS

General Provisions .....	[X]
Premium Provisions .....	[X]
Termination of The Group Policy.....	[X]

## GENERAL PROVISIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## PREMIUM PROVISIONS

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

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

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

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

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

**BEST Life and Health Insurance Company**

[2505 McCabe Way  
Irvine, California 92614]

A STOCK COMPANY  
(Herein called the Company)

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

**GOVERNING JURISDICTION:** The Group Policy is issued in the State of Utah. Any certificates issued in Arkansas will be governed by the State of Arkansas.

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

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

[  ]

President

[  ]

Secretary

**GROUP PPO DENTAL  
NON-PARTICIPATING**

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



## **IMPORTANT NOTICE FOR ARKANSAS RESIDENTS**

For assistance with questions regarding your policy, benefits and Claims, please contact BEST Life and Health Insurance Company at the following:

2505 McCabe Way  
Irvine, CA 92614  
1-800-433-0088

You may also contact your agent for assistance.

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

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

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Effective Date .....	[X]
Termination of Insurance.....	[X]
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Advance Notice of Dental Treatment.....	[X]
Deductibles.....	[X]
Alternate Procedures .....	[X]
Extension of Dental Benefits .....	[X]
Provision for Takeover .....	[X]
Coordination of Benefits.....	[X]
<b>PART 6 - GENERAL PROVISIONS</b> .....	[X]
<b>PART 7- SUMMARY PLAN DESCRIPTION SUPPLEMENT</b> .....	[X]
<b>PART 8- STATEMENT OF ERISA RIGHTS</b> .....	[X]

**PART 1 - SCHEDULE OF BENEFITS**

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

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

**SCHEDULE OF DENTAL BENEFITS**

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

Benefits Description	Network	Non-Network
Calendar Year Maximum (per enrollee)	[\$2,500 - \$500]	[\$2,500 - \$500]
Individual Yearly Deductible	[ \$100 - \$0]	[ \$100 - \$0]
Family Yearly Deductible	[ \$300 - \$0]	[ \$300 - \$0]
Preventive Dental Procedures Routine oral exam, cleanings, fluoride treatment for children, x-rays, sealants	[100% - 50%] [No or After] deductible	[100% - 50%] [No or After] deductible
Basic Services Fillings (amalgam, porcelain & plastic), general anesthesia, emergency palliative treatment, space maintainers for children, pathology, posterior composites	[100% - 50%] After deductible	[100% - 50%] After deductible
Major Services Crowns & gold fillings, inlays, onlays and pontics, fixed bridges, complete and partial dentures.	[100% - 0%] After deductible [[12, 18 or 24]-month wait*]	[100% - 0%] After deductible [[12, 18 or 24]-month wait*]
[Simple and Surgical Extractions]	[100% - 0%] After deductible [[12, 18 or 24]-month wait*]	[100% - 0%] After deductible [[12, 18 or 24]-month wait*]
[Oral Surgery]	[100% - 0%] After deductible [[12, 18 or 24]-month wait*]	[100% - 0%] After deductible [[12, 18 or 24]-month wait*]
[Periodontics]	[100% - 0%] After deductible [[12, 18 or 24]-month wait*]	[100% - 0%] After deductible [[12, 18 or 24]-month wait*]
[Endodontics]	[100% - 0%] After deductible [[12, 18 or 24]-month wait*]	[100% - 0%] After deductible [[12, 18 or 24]-month wait*]

[Orthodontics] [For eligible dependent children through age 18 only] [For eligible dependent children and adults]	[60% - 50%] [\$2,500 - \$1,000 Lifetime Maximum] [[12, 18 or 24]-month wait*] [\$500 - \$750 Annual Maximum]
[Children's Good Vision Benefit For dependent children through age 18 only]	[Covers 50% of eligible expenses for a vision exam once every 12 months] [[12, 18 or 24]-month wait*]
[*Unless the requirements for the Major Dentistry Waiting Period Waiver have been met, Major Dental and Orthodontic Procedures and the Children's Good Vision Benefit are not eligible covered expenses for any Insured during the [12, 18 or 24]-month period immediately following their effective date. Please see Major Dentistry Waiting Period Waiver Provision.]	
Special Dental Accident Benefit	Covers injury to sound, natural teeth up to [\$1,000 or \$500] per accident

**PLAN SELECTED:** As selected by the [Subscribing Employer] [Insured Employee] and shown on the Statement of Coverage.

#### SCHEDULE OF BENEFITS

	High Plan	Medium Plan	Basic Plan
<b>Calendar Year Maximum</b>	[\$1000 - \$3000]	[\$1000 - 2000]	[\$500-\$1000]
<b>Preventive Dental Procedures</b> [Includes dental exams, cleanings, fluoride treatments for children, x-rays]	[80% - 100%]coverage for Eligible Expenses	[80%-100%] coverage for Eligible Expenses	[50%-100%] coverage for Eligible Expenses
[Deductible]	[\$0-\$50]	[\$0-\$75]	[\$0-\$100]
[ Waiting Period]	[None]	[None]	[None]
<b>Basic Dental Procedures</b> [Includes emergency palliative treatment, fillings, (amalgam, porcelain and plastic), anesthesia, space maintainers and pathology]	[50%-100%] coverage for Eligible Expenses	[50%-100%] coverage for Eligible Expenses	[30%-80%] coverage for Eligible Expenses
[ Deductible]	[\$0-\$50per Calendar Year]; [3] family maximum	[\$0-\$75 per Calendar Year]; [3] family maximum	\$50-\$100[\$50; \$75; \$100 per Calendar Year]; [3] family maximum
[Waiting Period]	[0-12 months]	0-12 months	0-12 months

[ Periodontics/Endodontics]	[Covered; N/A]	[Covered; N/A]	N/A
[Oral Surgery]	Covered	Covered	N/A

**Major Dental Procedures**

[Includes prosthetics, crowns & gold fillings, inlays, onlays and pontics] [50%-80%] coverage for Eligible Expenses [40%-60%] coverage for Eligible Expenses [0%-50%] coverage for Eligible Expenses

[ Deductible] Basic Services Calendar Year deductible applies Basic Services Calendar Year deductible applies Basic Services Calendar Year deductible applies

[ Waiting Period ] 0-24 months 0-24 months 0-24 months

[Periodontics/Endodontics] [Covered; N/A] [Covered; N/A] [Covered]

[Oral Surgery] N/A N/A [Covered]

**[Orthodontics]**

[40%-60%] coverage for Eligible Expenses [40%-60%] coverage for Eligible Expenses [40%-60%] coverage for Eligible Expenses

[Child only] [Child with Adult] [Child only] [Child with Adult] [Child only]

Waiting Period [0-24] months [0-24] months [0-24] months

Lifetime Maximum Benefit

Child with Adult [\$1000-\$2500] [\$1000-\$2000] [\$500-\$1500]

Child only [\$1000-\$2500] [\$1000-\$2000] [\$500-\$1500]

**[Special Dental Accident Benefit]**

Covers injury to sound, natural teeth [\$1,000] maximum per accident [\$1,000] maximum per accident [\$1,000] maximum per accident]

**[Children's Good Vision Benefit]**

[50%] of Usual and Customary Expenses [50%] of Usual and Customary Expenses [50%] of Usual and Customary Expenses]



**[Major Dentistry Waiting Period Waiver**

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

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

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

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

**PART 2 - DENTAL PLAN LIMITATIONS AND EXCLUSIONS**

**Limitations**

**Covered Dental Benefit Expenses**

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

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

- (1) [routine oral examination and diagnosis not more often than once every six months per individual;
- (2) bitewing x-rays not more often than once every twelve months per individual
- (3) full mouth x-rays or panoramic films are limited to once every five years
- (4) prophylaxis not more often than once every six months per individual;

- (5) one annual topical fluoride treatment through age 15;
- (6) sealants for Your dependent child under age [14]15, limited to treatment of permanent molars once in any 36-month period.]

**CLASS II - Basic Dental Procedures include:**

- (1) [all fillings other than lab fabricated restorations (composite fillings limited to permanent anterior teeth)];
- (2) space maintainers for Your dependent child under age 17;
- (3) emergency palliative treatment;
- (4) limited oral exam not more than once every six months
- (5) oral surgery;
  - (a) simple extraction, excluding orthodontic extractions unless You are covered by a Best Life orthodontic rider.
  - (b) surgical extraction, including impaction:
    - 1. erupted
    - 2. soft tissue impaction
    - 3. partial bony impaction
    - 4. complete bony impaction
  - (c) root recovery (surgical removal of residual root)
  - (d) removal of a dentigerous or odontogenic cyst
  - (e) incision and drainage of an abscess
- (6) general anesthesia - paid as a separate procedure only when required for complex oral surgical procedures (partial and complete bony impacted extractions only), for which Benefits are payable.
- (7) periodontics (tissues and gums);
- (8) periodontal maintenance (limited to once every [3] months per individual following active periodontal treatment);
- (9) periodontal scaling and root planing (limited to once every [36 month] [and to [2] quadrants per visit]);
- (10) endodontics (pulp capping and root canal); and
- (11) oral surgery:
  - (a) root recovery (surgical removal of residual root);
  - (b) removal of a dentigerous or odontogenic cyst;

- (c) incision and drainage of an abscess;
- (d) surgical exposure of impacted tooth to aid eruption;
- (e) removal of exostosis;
- (f) frenulectomy;
- (g) oral antral fistula closure.]

**Major** under Basic Dental Procedures.

- (a) [surgical exposure of impacted tooth to aid eruption
- (b) removal of exostosis is a covered benefit only if required for the placement of fixed or removal appliance”
- (c) frenulectomy
- (d) oral antral fistula closure]

**Note:** Unless the [12]-month waiting period requirement for Major Dentistry services has been met, the services below are not covered benefits for any treatment that began during the 12-month period immediately following Your effective date of coverage.

**CLASS III - Major Dental Procedures include:**

- (1) [inlays, onlays, crowns and other lab fabricated restorations (not including veneers);  
  
Suggestion: Another suggestion would be to add language that would convert inlays and onlays to a filling when a lesser benefit is warranted.
- (2) full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within 12 months after the extraction and while this coverage is in force;
- (3) replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
  - (a) accidental injury requiring oral surgical treatment, or
  - (b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within 12 months of the injury or surgical treatment.
- (4) replacement of a full denture or bridgework if the replacement is made more than seven years after the date of installation;



- (5) repair or relines of dentures and bridgework;
- (6) periodontics (tissues and gums);
- (7) periodontal exam (not in addition to a routine oral exam);
- (8) periodontal maintenance (limited to once every four months per individual following active periodontal treatment (limited to a minimum of four months following scaling and root planing), and not in addition to a routine prophylaxis)
- (9) periodontal scaling and root planing (limited to once every 36 months and two quadrants per visit, and not in addition to a routine prophylaxis)
- (10) endodontics (root canal )
  - (a) **Dental Limitations and** soft tissues are sound and healthy;
  - (b) implant supported prosthetics;
  - (c) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);
  - (d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;
- (11) periodontics (tissues and gums);
- (12) periodontal maintenance (limited to once every [3] months per individual following active periodontal treatment);
- (13) periodontal scaling and root planing (limited to once every [36] months); [and to [2] quadrants per visit];
- (14) endodontics (pulp capping and root canal); and
- (15) [oral surgery:
  - (a) root recovery (surgical removal of residual root);
  - (b) removal of a dentigerous or odontogenic cyst;
  - (c) incision and drainage of an abscess;
  - (d) surgical exposure of impacted tooth to aid eruption;
  - (e) removal of exostosis;
  - (f) frenulectomy;
  - (g) oral antral fistula closure.]
  - (h) [simple extraction;
  - (i) surgical extraction, including impaction:
    - i. erupted;
    - ii. soft tissue impaction;
    - iii. partial bony impaction;
    - iv. complete bony impaction;]

## Exclusions

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

- (1) [expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
- (2) an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
- (3) pulp capping, if in conjunction with the installation of inlays, onlays or crowns and fillings;
- (4) replacement of a lost or stolen or discarded prosthetic device;
- (5) dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
- (6) the replacement of a crown, prosthesis, fixed bridge or denture if such crown, prosthesis, fixed bridge or denture was installed less than [5 or 7]seven years before, unless such replacement is made necessary by the initial extraction of an adjoining functional natural tooth;
- (7) the initial installation of a prosthetic device (a fixed bridge or denture), including crowns and inlays which form abutments, to replace teeth missing before You were covered under the policy, except when it also replaces a tooth that is extracted while covered unless such installation commences after You have remained continuously covered under this plan for at least three years immediately prior to the date such installation commences;
- (8) expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are covered under a BEST Life orthodontic rider.
- (9) expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
- (10) charges in excess of Usual, Reasonable and Customary charges;
- (11) services and supplies not reasonably necessary;
- (12) charges for service provided for temporomandibular joint dysfunction (TMJ);
- (13) services and supplies covered under any Worker's Compensation Act or similar law;
- (14) services and supplies performed outside of the United States of America are subject to a fixed fee schedule. Please see your schedule of benefits for description.

- (15) expenses incurred for congenital or developmental malformations;
- (16) expenses incurred for dental implants and related procedures, including but not limited to endosteal, subperiosteal, and any associated fixed or removable prosthetic device.
- (17) [implants, implant services and implant supported prosthetics are not covered for patients under the age of sixteen;] and
- (18) [expenses incurred for the maintenance of dental implants;]
- (19) any services or supplies for correction or alteration of occlusion, or any occlusal adjustments;
- (20) expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
- (21) expenses incurred for night guards or any other appliances for the correction of harmful habits;
- (22) expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, Your lawful spouse, child, parent, step-parent, grandparent, brother, sister, cousin or in-law;
- (23) expenses incurred due to treatment rendered by Your employer;
- (24) expenses not otherwise specifically listed as a Covered Expense;
- (25) expenses for services for which You would not legally have to pay if there were no insurance;
- (26) services not completed on or before the date of termination must be completed within 90-days of the termination date, unless such services are covered under the Extension of Dental Benefits. If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST LIFE shall be liable only for the amount it would have been liable for had one dentist rendered the services;
- (27) expenses that are applied toward satisfaction of a Deductible, if any;
- (28) for all procedures that are begun prior to your effective date, but not completed;
- (29) adjustment, repairs or relines of prostheses for a period of one year from initial placement if the prostheses were paid for under this plan;
- (30) if an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST LIFE shall be liable only for the amount it would have been liable for had one dentist rendered the services;



- (31) if multiple endodontic treatments are necessary on the same tooth within a period of one year, the allowance will be made for only one procedure;
- (32) the extraction of immature erupting third molars and non-pathologic, asymptomatic third molar extractions;
- (33) expenses for gross debridement allowed one time at the beginning of the periodontal treatment plan prior to pocket depth charting;
- (34) surgical procedures incidental to orthodontic treatment, including but not limited to, extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate;
- (35) any amounts in excess of the maximum amount stated in the "Schedule of Dental Benefits" section of this Plan;
- (36) Any service or procedure not commonly found within the scope of practice by a licensed dentist. Such procedures are identified within the current Common Dental Terminology (CDT Codes) published by the American Dental association. Pulp capping when completed with fillings or other lab fabricated restorations; including but not limited to inlays, onlays and crowns, preventative tests and examinations diagnostic casts and oral cancer screenings, and expenses incurred for sedative fillings, including charges for prescribed drugs, pre-medication or analgesia;  
Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
- (37) ridge augmentation, ridge preservation, bone graft and guided tissue regeneration in extraction sites and expenses incurred for dental implants and related procedures, including but not limited to endosteal and subperiosteal;];
- (38) charges in excess of the Preferred Provider Fee Schedule.
- (39) x-rays are considered an integral part of the endodontic procedure rather than a separate service and are therefore not eligible for benefits;
- (40) any combination of eight or more x-rays (including but not limited to bitewings or periapicals/intraorals) will be combined into a full mouth x-ray series.
- (41) expenses incurred for a core buildup will only be considered in conjunction with a crown.]

### PART 3 - DEFINITIONS

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

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

**Eligible Dependent:** Means:

- (1) Your lawful spouse; and
- (2) Your or Your spouse's child or children, including a natural child, step-child, foster child, lawfully adopted child or child in the process of being adopted, from the date of placement, or any child for whom You have been granted legal custody, provided they are:
  - (a) unmarried, and
  - (b) under 26 years old; and
- (3) A child named in a Qualified Medical Child Support Order will be considered a dependent.

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

**Eligible Employee:** Means:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



## PART 4 - PROVISIONS FOR COVERAGE

### EFFECTIVE DATE

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

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

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

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

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

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

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

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

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

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

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

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

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

### TERMINATION OF INSURANCE

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

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

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

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

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

### PART 5 - PROVISIONS DESCRIBING BENEFITS

#### ADVANCE NOTICE OF DENTAL TREATMENT

It is recommended that You or Your Dependent submit Advance Notice of Dental Treatment satisfactory to Us before treatment commences in order to obtain predetermination of covered dental expenses. If dental services are performed without such predetermination, We reserve the right to deny any claim

submitted with respect to such services; provided however, that predetermination is not required for:

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

## DEDUCTIBLES

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

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

[Lifetime Deductible: The Lifetime Deductible as shown in the Schedule of Dental Benefits.]

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

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

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

## ALTERNATIVE PROCEDURES

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



## EXTENSION OF DENTAL BENEFITS

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

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

## PROVISION FOR TAKEOVER

If your employer has chosen to offer Takeover, this means that we give employees credit for certain benefits if the employee had substantially similar coverage accumulated under a group dental plan without any break in that coverage.

To qualify for Takeover you must provide to BEST Life:

- Evidence that the prior carrier's coverage has been in force for at least 12 months;
- A copy of the prior carrier's most recent bill, which should include a listing of all covered employees, as well as each employee's effective date of coverage; and
- A copy of the in-force dental plan description, which may be a contract schedule of benefits, certificate, or coverage description.

In addition, any deductible amount incurred under the prior plan during the current calendar year will be used toward satisfying the new BEST Life deductible. For proper deductible credit to be given, written documentation must be submitted at time of enrollment. A benefit applied to the maximum benefit amounts under the prior plan will also be applied to the maximum benefit amounts under BEST Life.

Orthodontic treatment that began under the prior plan and continues uninterrupted under BEST Life will be considered for takeover if both plans include orthodontic coverage. Any benefits payable under BEST Life will be reduced by the amount payable under the prior plan.

There are limitations in coverage when not replacing a current group dental plan.

## COORDINATION OF BENEFITS

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

### **Effect on Benefits:**

- (1) This provision shall apply in determining the benefits as to a person covered under this Plan for any Claim Determination Period if, for the Allowable Expenses incurred as to such person during such period, the sum of:
  - (a) the benefits that would be payable under this Plan in the absence of this provision; and
  - (b) the benefits that would be payable under all other Plans in the absence therein of provisions of similar purpose to this provision would exceed such Allowable Expenses.

- (2) As to any Claim Determination Period with respect to which this provision is applicable, the benefits that would be payable under this Plan in the absence of this provision for the Allowable Expenses incurred as to such person during such Claim Determination Period shall be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such Allowable Expenses under all other plans, except as provided in the next paragraph, shall not exceed the total of such Allowable Expenses. Benefits payable under another Plan include the benefits that would have been payable had claim been duly made therefore.
- (3) If:
- (a) another Plan which is involved in paragraph (2) and which contains a provision coordinating its benefits with those of this Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined, and
  - (b) the rules set forth in paragraph (4) would require this Plan to determine its benefits before such other Plan, and then the benefits of such other Plan will be ignored for the purposes of determining the benefits under this Plan.
- (4) For the purposes of paragraph (3), the rules establishing the order of benefit determination are:
- (a) The benefits of a Plan which covers the person on whose expenses claim is based other than as a Dependent shall be determined before the benefits of a Plan which covers such person as a Dependent.
  - (b) The benefits of a Plan which covers the person on whose expenses claim is based as a Dependent of the parent whose birthday comes earliest in the year, regardless of the year of birth, shall be determined before the benefits of a Plan which covers such person as a Dependent of the other parent except that in the case of a person for whom claim is made as a dependent child:
    - 1. when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Plan which covers the child as Dependent of the parent with custody of the child will be determined before the benefits of a Plan which covers the child as a Dependent of the parent without custody;
    - 2. when the parents are divorced and the parent with custody of the child has remarried, the benefits of a Plan which covers the child as a Dependent of the parent with custody shall be determined before the benefits of a Plan which covers that child as a Dependent of the stepparent, and the benefits of a Plan which covers the child as a Dependent of the stepparent will be determined before the benefits of the parent without custody.  
Notwithstanding 1. and 2. above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefits of a Plan which covers the child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan which covers the child as a dependent child.
  - (c) When rules (a) and (b) do not establish an order of benefit determination, the benefits of a Plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a Plan which has covered such person the shorter period of time.
- (5) When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during any Claim Determination Period, each benefit that would be

payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of this Plan.

(6) No Plan pays more than it would without the Coordination of Benefits provision.

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

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

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

## PART 6 - GENERAL PROVISIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**CONTINUATION OF DENTAL COVERAGE:** Federal Law (Public Law 99-272) requires Continuation of Dental Coverage for employers with 20 or more employees. Subject to the 20 employee requirement, You and Your Dependents who are covered under the group dental plan have the right to continue Your group dental coverage if it would terminate for the following specified reasons:

- (1) Termination of employment for any reason, except gross misconduct.
- (2) Loss of dental plan eligibility due to reduced employment hours.
- (3) Your employer files for a Chapter 11 reorganization;
- (4) Your death.
- (5) Your divorce.
- (6) Your legal separation if You no longer make contributions for spouse coverage.
- (7) A dependent child ceases to be a Dependent (i.e., reaches the maximum age, or becomes married, or is no longer a dependent for income tax purposes).
- (8) A Dependent's loss of eligibility because You become entitled to Medicare Benefits.
- (9) If You or Your Dependent would lose coverage due to one of the reasons in (5), (6), (7) or (8), You or Your Dependent must notify Us so We can give appropriate notice of Continuation rights and the terms which apply to the Continuation. For continuity of coverage, please give this notification within 30 days of the event.
- (10) If You or Your Dependent elect the continued coverage and make the proper premium payment, the coverage would be continued until the earliest of:
  - (1) the due date to pay any required premium (if premium is not paid by that date).
  - (2) the date the continued person becomes covered under another group dental plan or entitled to Medicare Benefits.
  - (3) the date the employer's group dental plan terminates. (If coverage is replaced, the Continuation is continued under the succeeding plan.)
  - (4) a date which is:
    1. 18 months from the date coverage would have terminated because Your employment was terminated or eligibility was lost due to reduction in hours. However, if You are determined to have been disabled for Social Security purposes, You can continue coverage for 29 months from the date coverage terminated provided that notice of such determination of disability is given within 60 days and before the end of the 18-month continuation period.
    2. 36 months from the date coverage would have terminated, if coverage is continued for any other reason.

The law permits Us to charge any person electing Continuation of coverage 102% of the cost of coverage to the plan except if the person extends Continuation of coverage to 29 months because of entitlement to Social Security disability Benefits, the law permits Us to charge 150% of the plan's cost for months 19 through 29. Full details of the Continuation will be sent to You or Your Dependents when We have been notified of one of the Continuation events.



## PART 7 - SUMMARY PLAN DESCRIPTION SUPPLEMENT

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

- (1) **EMPLOYER AND NAME OF PLAN:** The plan is known as the Beneficial Employees Security Trust and is maintained by Beneficial Employees Security Trust, [P.O. Box 3100, Newport Beach, California 92658-902]7.
- (2) **PLAN IDENTIFICATION NUMBER:** [501].
- (3) **TYPE OF ADMINISTRATION AND TYPE OF WELFARE PLAN:** The plan is administered by the Administrative Representative, named herein. Benefits are insured and provided in accordance with the provisions of the Group Dental Insurance Policy issued by BEST Life and Health Insurance Company at [2505 McCabe Way, Irvine, California 92614].
- (4) **ADMINISTRATIVE REPRESENTATIVE:** The Plan is administered by BEST Life and Health Insurance Company located at [2505 McCabe Way, Irvine, California 92614]. BEST Life's telephone number is [(800) 433-0088].
- (5) **AGENT FOR SERVICE:** The person designated for service of legal process is the Chief Legal Counsel of BEST Life and Health Insurance Company at the above address.
- (6) **TRUSTEE OF THE PLAN:** The Trustee of the plan is Wells Fargo Bank, N.A. The Trustee's mailing address is [180 South Main Street, 2<sup>nd</sup> Floor, Salt Lake City, Utah 84101].
- (7) **SOURCE OF PLAN CONTRIBUTION:** The contributions necessary to finance the plan are made by the employer and employees.
- (8) **DATE OF END OF THE PLAN'S FISCAL YEAR:** The fiscal year for this plan ends each year on December 31.
- (9) **CLAIM PROCEDURES:** (a) Claim forms may be obtained from the Personnel Department of the employer; and (b) Please see Your insurance Certificate for the requirements of the Group Insurance Policy as to notice of a claim to BEST Life and Health Insurance Company.
- (10) **CLAIMS DENIAL PROCEDURE:** Any denial of a claim for Benefits will be explained in writing and the explanation will include (a) the specific reason for the denial, (b) reference to the plan provision upon which the denial was based, (c) a description of any additional information You might be required to provide and an explanation of why it is needed, and (d) an explanation of the plan's claim review procedure.
- (11) You, Your beneficiary, or a duly-authorized representative may appeal any denial of a claim for Benefits by filing a written request for a review to BEST Life and Health Insurance Company. In connection with such a request, documents pertinent to the administration of the plan may be reviewed, and issues outlining the basis of the appeal may be submitted. You may have representation throughout the review procedure.
- (12) A request for a review must be filed within [180] days after receipt of the written notice of denial of a claim. A decision will be rendered by BEST Life and Health Insurance Company no later than [60] days after receipt of a request for review. If there are special circumstances, the decision shall be rendered as soon as possible, but no later than [15] days after receipt of the request for review. The decision, after Our review, shall be in writing and shall include specific reasons for the decision. This decision shall also include specific references to the pertinent

(13) policy provisions on which the decision was based.

## **PART 8- STATEMENT OF ERISA RIGHTS**

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

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

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

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

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

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

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

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

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

Underwritten by BEST Life and Health Insurance Company

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

[  Dental  Life  Stand Alone Vision]

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

\* Certain requirements apply.

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

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

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

**VISION PLAN TYPE**

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

Please answer the following questions:

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

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

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

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

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

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

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

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

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

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

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

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

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

( ) - ( ) -

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

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

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

*(continued on other side)*

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

**Fraud Warning**

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

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

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

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

**FIRM ELIGIBILITY:**

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

**IMPORTANT PLAN INFORMATION**

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

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

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

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

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

**BENEFIT REPRESENTATIVE REPORT**

<p style="text-align: center;"><i>(Please Print)</i></p> <p>Name _____</p> <p>It is not necessary to complete the following information if you are currently receiving service fees from BEST Health Plans unless changes in address, etc. need to be made. Just sign and date the form below.</p> <p>Your Agency Name _____</p> <p>Address _____</p> <p>City _____ State _____ Zip _____</p> <p>Who Should Receive the Service Fees? <input type="checkbox"/> Benefit Representative <input type="checkbox"/> Company/Firm</p> <p>Social Security Number - - - Federal Tax ID _____</p> <p>Date of Birth / / License No. _____ State _____</p> <p>Phone No. _____ FAX No. _____</p> <p>E-mail Address _____</p> <p>Please list any special handling needed for this client:</p>	<p style="text-align: center;"><i>(Please Complete)</i></p> <p style="text-align: center;"><b>Special Instructions to BEST Health Plans</b></p> <p>1. May we contact the client if we need additional information?  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Is this your first case with BEST Health Plans? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. This is: <input type="checkbox"/> an existing client <input type="checkbox"/> a new client with my company</p> <p>4. The 'New Client Kit' (certificate book, claim forms, etc.) should be sent to:  <input type="checkbox"/> The benefit representative <input type="checkbox"/> The client</p> <p>5. The underwriter assigned to my case should contact me? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>General Agent (GA):</p>
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I hereby certify that I hold a valid Life, Accident and Health license issued by the state in which this document was executed and that all of the information contained herein is correct, to the best of my knowledge, and that I know nothing unfavorable about this firm or any individual applying for insurance unless fully described in this application material. Furthermore, I certify that:

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

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

Agent's Signature:	Print Name:	Date:
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**BEST Life and Health Insurance Company**

2505 McCabe Way  
Irvine, California 92614

A STOCK COMPANY  
(Herein called the Company)

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

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

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

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

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

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

[  ]  
President



**Secretary**

**Group Indemnity Dental Policy**  
Non-Participating

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

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

**Group Policy Number:** [XXX]

**State of Delivery:** [Utah]

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

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

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## GENERAL PROVISIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## PREMIUM PROVISIONS

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

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

**GRACE PERIOD:** This Group Policy has a [31] day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following [31] days.

During the Grace Period, this Group Policy will remain in force. If the required premium is not paid by the end of this Grace Period, this Group Policy will lapse as of the premium due date.

**TERMINATION OF THIS GROUP POLICY**

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

**BEST Life and Health Insurance Company**

[2505 McCabe Way  
Irvine, California 92614]

A STOCK COMPANY  
(Herein called the Company)

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

**GOVERNING JURISDICTION:** The Group Policy is issued in the State of Utah. Any certificates issued in Arkansas will be governed by the State of Arkansas.

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

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



President



Secretary

**GROUP INDEMNITY DENTAL CERTIFICATE  
NON-PARTICIPATING**

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

**IMPORTANT NOTICE FOR ARKANSAS RESIDENTS**

For assistance with questions regarding your policy, benefits and Claims, please contact BEST Life and Health Insurance Company at the following:

2505 McCabe Way  
Irvine, CA 92614  
1-800-433-0088

You may also contact your agent for assistance.

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

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

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**PART 1 - SCHEDULE OF BENEFITS**

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

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

**PLAN SELECTED:** As selected by the [Subscribing Employer] [Insured Employee] and shown on the Statement of Coverage.

**SCHEDULE OF BENEFITS**

	<b>High Plan</b>	<b>Medium Plan</b>	<b>Basic Plan</b>
<b><u>Calendar Year Maximum</u></b>	[\$1000 - \$3000]	[\$1000 - 2000]	[\$500-\$1000]
<b><u>Preventive Dental Procedures</u></b> Includes dental exams, cleanings, fluoride treatments for children, x-rays	[80% - 100%] coverage for Eligible Expenses	[80%-100%] coverage for Eligible Expenses	[50%-100%] coverage for Eligible Expenses
Deductible	[\$0-\$50]	[\$0-\$75]	[\$0-\$100]
Waiting Period	[None]	[None]	[None]
<b><u>Basic Dental Procedures</u></b> Includes emergency palliative treatment, fillings, (amalgam, porcelain and plastic), anesthesia, space maintainers and pathology	[50%-100%] coverage for Eligible Expenses	[50%-100%] coverage for Eligible Expenses	[30%-80%] coverage for Eligible Expenses
Deductible	[\$0-\$50 per Calendar Year]; [3] family maximum	[\$0-\$75 per Calendar Year]; [3] family maximum	\$50-\$100[\$50; \$75; \$100 per Calendar Year]; [3] family maximum
Waiting Period	[0-12 months]	0-12 months	0-12 months
Periodontics/Endodontics	[Covered; N/A]	[Covered; N/A]	N/A
Oral Surgery	Covered	Covered	N/A
<b><u>Major Dental Procedures</u></b> Includes prosthetics, crowns & gold fillings, inlays, onlays and pontics	[50%-80%] coverage for Eligible Expenses	[40%-60%] coverage for Eligible Expenses	[0%-50%] coverage for Eligible Expenses

Deductible	Basic Services Calendar Year deductible applies	Basic Services Calendar Year deductible applies	Basic Services Calendar Year deductible applies
Waiting Period	0-24 months	0-24 months	0-24 months
Periodontics/Endodontics	[Covered; N/A]	[Covered; N/A]	[Covered]
Oral Surgery	N/A	N/A	[Covered]
<b><u>Orthodontics</u></b>	[40%-60%] coverage for Eligible Expenses	[40%-60%] coverage for Eligible Expenses	[40%-60%] coverage for Eligible Expenses
	[Child only] [Child with Adult]	[Child only] [Child with Adult]	[Child only]
Waiting Period	[0-24] months	[0-24] months	[0-24] months
Lifetime Maximum Benefit			
Child with Adult	[\$1000-\$2500]	[\$1000-\$2000]	[\$500-\$1500]
Child only	[\$1000-\$2500]	[\$1000-\$2000]	[\$500-\$1500]
<b><u>Special Dental Accident Benefit</u></b>	[\$1,000] maximum per accident	[\$1,000] maximum per accident	[\$1,000] maximum per accident]
Covers injury to sound, natural teeth			
<b><u>Children's Good Vision Benefit</u></b>	[50%] of Usual and Customary Expenses	[50%] of Usual and Customary Expenses	[50%] of Usual and Customary Expenses]

### Major Dentistry Waiting Period Waiver

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

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

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

## PART 2 - DENTAL PLAN EXCLUSIONS AND LIMITATIONS

### Limitations

#### Covered Dental Benefit Expenses

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

#### Preventive Dental Procedures:

- (1) [routine oral examination and diagnosis not more often than once every [6] months per individual;
- (2) x-rays not more often than once every [6 or 12] months per individual ([panoramic or] full mouth x-rays are limited to once in a [3-year or 5-year] period);
- (3) prophylaxis not more often than once every six months per individual;
- (4) one annual topical fluoride treatment through age [15];
- (5) sealants for Your dependent child under age [14], limited to treatment of permanent molars once in any [36]-month period.]

#### Basic Dental Procedures:

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

- (c) incision and drainage of an abscess;
- (d) surgical exposure of impacted tooth to aid eruption;
- (e) removal of exostosis;
- (f) frenulectomy;
- (g) oral antral fistula closure.]

**Major Dental Procedures:**

- (1) [inlays, onlays, crowns and other lab fabricated restorations [(if the tooth can be restored with less expensive materials, covered expenses will be based on those materials)];
- (2) porcelain, porcelain fused to metal, or full gold crowns are limited to patients over the age of [14] and on permanent teeth;
- (3) full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within [12] months after the extraction and while this coverage is in force;
- (4) replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
  - (a) accidental injury requiring oral surgical treatment, or
  - (b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within [12] months of the injury or surgical treatment.
- (4) replacement of a full denture or bridgework if the replacement is made more than [five or seven] years after the date of installation;
- (5) repair or reline of dentures and bridgework;
- (6) implants (limited to once in a lifetime per site, and for patients over the age of [16]):
  - (a) the surgical placement of endosteal implant body including healing cap, where the bone and soft tissues are sound and healthy;
  - (b) implant supported prosthetics;
  - (c) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);
  - (d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;
- (7) periodontics (tissues and gums);
- (8) periodontal maintenance (limited to once every [3] months per individual following active periodontal treatment);
- (9) periodontal scaling and root planing (limited to once every [36] months); [and to [2] quadrants per visit]);
- (10) endodontics (pulp capping and root canal); and
- (11) [oral surgery:
  - (a) root recovery (surgical removal of residual root);
  - (b) removal of a dentigerous or odontogenic cyst;
  - (c) incision and drainage of an abscess;
  - (d) surgical exposure of impacted tooth to aid eruption;
  - (e) removal of exostosis;
  - (f) frenulectomy;
  - (g) oral antral fistula closure.]
  - (h) [simple extraction;
  - (i) surgical extraction, including impaction:
    - (i) erupted;

- (ii) soft tissue impaction;
- (iii) partial bony impaction;
- (iv) complete bony impaction;]

**Exclusions**

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

- (1) [treatment by someone other than a dentist or physician, except where performed by a duly qualified technician under the direction of a dentist or physician;
- (2) expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
- (3) an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
- (4) pulp capping, if in conjunction with the installation of inlays, onlays or crowns and fillings;
- (5) replacement of a lost or stolen or discarded prosthetic device;
- (6) dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
- (7) the replacement of any prosthesis (a crown, [implant,] fixed bridge or denture) if such prosthesis was installed less than [5 or 7] years before, unless:
  - (a) such replacement is made necessary by the initial extraction of an adjoining functional natural tooth;
  - (b) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non-chewing injury while covered;
- (8) the initial installation of a prosthetic device (a[n implant,] fixed bridge or denture), including crowns and inlays which form abutments, to replace teeth missing before You were covered under the policy, except when it also replaces a tooth that is extracted while covered unless such installation commences after You have remained continuously covered under this plan for at least [3] years immediately prior to the date such installation commences;
- (9) expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are covered under the plan.
- (10) expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
- (11) charges in excess of [Usual, Reasonable and Customary] [Maximum Allowable] charges;
- (12) services and supplies not reasonably necessary;
- (13) charges for service provided for temporomandibular joint dysfunction (TMJ);
- (14) services and supplies covered under any Worker's Compensation Act or similar law;
- (15) services and supplies performed outside of the United States of America;
- (16) expenses incurred for congenital or developmental malformations;
- (17) [expenses incurred for dental implants and related procedures, including but not limited to endosteal and subperiosteal;] or
- (18) [implants, implant services and implant supported prosthetics are not covered for patients under the age of sixteen;] and
- (19) [expenses incurred for the maintenance of dental implants;]
- (20) any services or supplies for correction or alteration of occlusion, or any occlusal adjustments;
- (21) charges for prescribed drugs, pre-medication or analgesia;

- (22) expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
- (23) expenses incurred for night guards or any other appliances for the correction of harmful habits;
- (24) expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, Your lawful spouse, child, parent, step-parent, grandparent, brother, sister or in-law;
- (25) expenses incurred due to treatment rendered by Your employer;
- (26) expenses not otherwise specifically listed as a Covered Expense;
- (27) expenses for services for which You would not legally have to pay if there were no insurance;
- (28) for services not completed on or before the date of termination unless the services are covered under the Extension of Dental Benefits;
- (29) expenses that are applied toward satisfaction of a Deductible, if any;
- (30) for all procedures that are begun prior to your effective date, but not completed;
- (31) adjustment, repairs or relines of prostheses for a period of six months from initial placement if the prostheses were paid for under this plan;
- (32) if an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
- (33) if multiple endodontic treatments are necessary on the same tooth within a period of one year, the allowance will be made for only one procedure;
- (34) the extraction of immature erupting third molars and non-pathologic, asymptomatic third molar extractions;
- (35) temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
- (36) expenses for gross debridement allowed one time at the beginning of the periodontal treatment plan prior to pocket depth charting;
- (37) surgical procedures incidental to orthodontic treatment, including but not limited to, extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate;
- (38) any amounts in excess of the maximum amount stated in the "Schedule of Dental Benefits" section of this Plan;
- (39) application of chemotherapeutic agents; and
- (40) ridge augmentation, ridge preservation, bone graft and guided tissue regeneration in extraction sites;
- (41) charges in excess of the Preferred Provider Fee Schedule.]

### **PART 3 - DEFINITIONS**

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

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

**Eligible Dependent:** Means:

- (1) Your lawful spouse; and
- (2) Your or Your spouse's child or children, including a natural child, step-child, foster child, lawfully adopted child or child in the process of being adopted, from the date of placement, or any child for whom You have been granted legal custody, provided they are:
  - (a) unmarried, and
  - (b) under 26 years old; and
- (3) A child named in a Qualified Medical Child Support Order will be considered a dependent.

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

**Eligible Employee:** Means:

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

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

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

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

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

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

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

**[Maximum Allowable Charge:** Means the fee shown in the Preferred Provider Fee Schedule for dental services and supplies generally furnished for cases of comparable severity and nature. For vision

services and Non-Preferred Provider dental services, Maximum Allowable Charge means the plan will pay a reasonable fee based on a fee level which is in the same range of fees customarily charged for the services or supplies in the geographic area concerned.]

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

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

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

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

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

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

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

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

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

## PART 4 - PROVISIONS FOR COVERAGE

### EFFECTIVE DATE

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

- (1) the date Your employer becomes a Participating Employer, if Your enrollment card is received by Us within [31] days of that date; or

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

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

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

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

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

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

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

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

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

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

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

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

## TERMINATION OF INSURANCE

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

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

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

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

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

## PART 5 - PROVISIONS DESCRIBING BENEFITS

### ADVANCE NOTICE OF DENTAL TREATMENT

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

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

### DEDUCTIBLES

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

**[Family Calendar Year Deductible:** The Family Calendar Year Deductible is satisfied when [each of [3, 2]

covered members of Your family satisfy the Individual Calendar Year Deductible] [the combined costs of services provided by covered members of Your family is equal to the Family Calendar Year Deductible amount.]

[Lifetime Deductible: The Lifetime Deductible as shown in the Schedule of Dental Benefits.]

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

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

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

#### **ALTERNATIVE PROCEDURES**

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

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

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

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

#### **COORDINATION OF BENEFITS**

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

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

- (1) This provision shall apply in determining the benefits as to a person covered under this Plan for any Claim Determination Period if, for the Allowable Expenses incurred as to such person during such period, the sum of:
  - (a) the benefits that would be payable under this Plan in the absence of this provision; and
  - (b) the benefits that would be payable under all other Plans in the absence therein of provisions of similar purpose to this provision would exceed such Allowable Expenses.
- (2) As to any Claim Determination Period with respect to which this provision is applicable, the

benefits that would be payable under this Plan in the absence of this provision for the Allowable Expenses incurred as to such person during such Claim Determination Period shall be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such Allowable Expenses under all other plans, except as provided in the next paragraph, shall not exceed the total of such Allowable Expenses. Benefits payable under another Plan include the benefits that would have been payable had claim been duly made therefore.

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

**Right to Receive and Release Necessary Information:** For the purpose of determining the applicability of

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

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

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

## PART 6 - GENERAL PROVISIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**CONTINUATION OF DENTAL COVERAGE:** Federal Law (Public Law 99-272) requires Continuation of Dental Coverage for employers with 20 or more employees. Subject to the 20 employee requirement, You and Your Dependents who are covered under the group dental plan have the right to continue

Your group dental coverage if it would terminate for the following specified reasons:

- (1) Termination of employment for any reason, except gross misconduct.
- (2) Loss of dental plan eligibility due to reduced employment hours.
- (3) Your employer files for a Chapter 11 reorganization;
- (4) Your death.
- (5) Your divorce.
- (6) Your legal separation if You no longer make contributions for spouse coverage.
- (7) A dependent child ceases to be a Dependent (i.e., reaches the maximum age, or becomes married, or is no longer a dependent for income tax purposes).
- (8) A Dependent's loss of eligibility because You become entitled to Medicare Benefits.
- (9) If You or Your Dependent would lose coverage due to one of the reasons in (5), (6), (7) or (8), You or Your Dependent must notify Us so We can give appropriate notice of Continuation rights and the terms which apply to the Continuation. For continuity of coverage, please give this notification within 30 days of the event.
- (10) If You or Your Dependent elect the continued coverage and make the proper premium payment, the coverage would be continued until the earliest of:
  - (1) the due date to pay any required premium (if premium is not paid by that date).
  - (2) the date the continued person becomes covered under another group dental plan or entitled to Medicare Benefits.
  - (3) the date the employer's group dental plan terminates. (If coverage is replaced, the Continuation is continued under the succeeding plan.)
  - (4) a date which is:
    1. 18 months from the date coverage would have terminated because Your employment was terminated or eligibility was lost due to reduction in hours. However, if You are determined to have been disabled for Social Security purposes, You can continue coverage for 29 months from the date coverage terminated provided that notice of such determination of disability is given within 60 days and before the end of the 18-month continuation period.
    2. 36 months from the date coverage would have terminated, if coverage is continued for any other reason.

The law permits Us to charge any person electing Continuation of coverage 102% of the cost of coverage to the plan except if the person extends Continuation of coverage to 29 months because of entitlement to Social Security disability Benefits, the law permits Us to charge 150% of the plan's cost for months 19 through 29. Full details of the Continuation will be sent to You or Your Dependents when We have been notified of one of the Continuation events.

#### **PART 7 - SUMMARY PLAN DESCRIPTION SUPPLEMENT**

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

- (1) **EMPLOYER AND NAME OF PLAN:** The plan is known as the Beneficial Employees Security Trust and is maintained by Beneficial Employees Security Trust, [P.O. Box 3100, Newport Beach, California 92658-902]7.
- (2) **PLAN IDENTIFICATION NUMBER:** [501].
- (3) **TYPE OF ADMINISTRATION AND TYPE OF WELFARE PLAN:** The plan is administered by the Administrative Representative, named herein. Benefits are insured and provided in accordance with

the provisions of the Group Dental Insurance Policy issued by BEST Life and Health Insurance Company at [2505 McCabe Way, Irvine, California 92614].

**(4) ADMINISTRATIVE REPRESENTATIVE:** The Plan is administered by BEST Life and Health Insurance Company located at [2505 McCabe Way, Irvine, California 92614]. BEST Life's telephone number is [(800) 433-0088].

**(5) AGENT FOR SERVICE:** The person designated for service of legal process is the General Counsel of BEST Life and Health Insurance Company at the above address.

**(6) TRUSTEE OF THE PLAN:** The Trustee of the plan is Wells Fargo Bank, N.A. The Trustee's mailing address is [180 South Main Street, 2<sup>nd</sup> Floor, Salt Lake City, Utah 84101].

**(7) SOURCE OF PLAN CONTRIBUTION:** The contributions necessary to finance the plan are made by the employer and employees.

**(8) DATE OF END OF THE PLAN'S FISCAL YEAR:** The fiscal year for this plan ends each year on December 31.

**(9) CLAIM PROCEDURES:** (a) Claim forms may be obtained from the Personnel Department of the employer; and (b) Please see Your insurance Certificate for the requirements of the Group Insurance Policy as to notice of a claim to BEST Life and Health Insurance Company.

**(10) CLAIMS DENIAL PROCEDURE:** Any denial of a claim for Benefits will be explained in writing and the explanation will include (a) the specific reason for the denial, (b) reference to the plan provision upon which the denial was based, (c) a description of any additional information You might be required to provide and an explanation of why it is needed, and (d) an explanation of the plan's claim review procedure.

You, Your beneficiary, or a duly-authorized representative may appeal any denial of a claim for Benefits by filing a written request for a review to BEST Life and Health Insurance Company. In connection with such a request, documents pertinent to the administration of the plan may be reviewed, and issues outlining the basis of the appeal may be submitted. You may have representation throughout the review procedure.

A request for a review must be filed within [180] days after receipt of the written notice of denial of a claim. A decision will be rendered by BEST Life and Health Insurance Company no later than [60] days after receipt of a request for review. If there are special circumstances, the decision shall be rendered as soon as possible, but no later than [15] days after receipt of the request for review. The decision, after Our review, shall be in writing and shall include specific reasons for the decision. This decision shall also include specific references to the pertinent policy provisions on which the decision was based.

## **PART 8 - STATEMENT OF ERISA RIGHTS**

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

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

required by law to furnish each participant with a copy of this summary financial report.

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

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

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

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

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

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

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

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

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

Dental  Life  Stand Alone

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

\* Certain requirements apply.

**VISION PLAN TYPE**

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

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

\* Certain requirements apply.

**VISION PLAN TYPE**

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

Please answer the following questions:

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

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

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

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

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

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

Employer Name

**Fraud Warning**

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

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

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

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

**FIRM ELIGIBILITY:**

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

**IMPORTANT PLAN INFORMATION**

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

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

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

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

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

**Benefit Representative Report**

*(Please Print)*

Name \_\_\_\_\_

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

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

Address \_\_\_\_\_

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

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

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

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

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

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

*(Please Complete)*

**Special Instructions to BEST Health Plans**

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

General Agent (GA):

Please list any special handling needed for this client:

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

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

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

Agent's Signature:	Print Name:	Date:
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IDP0608

**EMPLOYEE INFORMATION**

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

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

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

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

**DEPENDANT INFORMATION**

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

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

**Your Signature in black ink****Date****WAIVER OF COVERAGE**

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

**I waive Dental coverage for:**  Myself and any dependants  Spouse only  Spouse and dependent child(ren)Reason for waiving coverage (*you must provide a reason for waiving coverage*)  Other coverage  Cost**Fraud Warning**

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

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

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

DC0708

### EMPLOYEE INFORMATION

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

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

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

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

### DEPENDANT INFORMATION

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

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

**Your Signature in black ink**

**Date**

### WAIVER OF COVERAGE

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

**Check all that apply:**

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

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

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

### Fraud Warning

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

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

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

DVC0708

**BEST Life and Health Insurance Company**  
[2505 McCabe Way  
Irvine, California 92614]

A STOCK COMPANY  
(Herein called the Company)

**POLICYHOLDER: BENEFICIAL EMPLOYEES SECURITY TRUST OF UTAH**

**RIDER TO GROUP POLICY NO: [XXXXXXX]**

**RIDER EFFECTIVE DATE: [XXXXXXXXXX]**

This rider is made a part of the Group Policy and Certificate to which it is attached. It is subject to all of the provisions, limitations and exclusions of the Group Policy not inconsistent with this rider and is applicable only to Insureds who are covered under this Plan.

**ADULT ORTHODONTIC BENEFIT RIDER**

These benefits will apply to you only if this coverage was selected and is shown on Your Schedule of Benefits.

Orthodontia Type Treatments and Orthodontic Procedures, as defined in the Current Dental Terminology of the American Dental Association, are limited to You and Your Covered Dependents beginning at age 19. A [12, 18 or 24]-Month Waiting Period immediately following the effective date applies to this Plan. Orthodontia Type Treatments and Orthodontic Procedures are not covered during the [12, 18 or 24]-Month Waiting Period immediately following the effective date of this Plan.

BEST Life will pay up to [1/3] of the covered orthodontic treatment, as an initial down payment for covered services. The balance of the maximum benefit will be paid as monthly installments over the remaining treatment period, up to the limit of this rider.

[Deductibles do not apply to the Adult Orthodontic Benefit Rider.] Benefits are payable on a Usual, Reasonable and Customary Basis, subject to the Lifetime Maximum Benefit Limits shown on the Schedule of Benefits.

The Adult Orthodontic Benefit Rider will cease once braces are removed.

No other provision or condition of the Group Policy or Certificate is changed in any way by this rider, except as noted above.

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

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



President

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



Secretary

**BEST Life and Health Insurance Company**  
[2505 McCabe Way  
Irvine, California 92614]

A STOCK COMPANY  
(Herein called the Company)

**POLICYHOLDER: BENEFICIAL EMPLOYEES SECURITY TRUST OF UTAH**

**RIDER TO GROUP POLICY NO: [XXXXXXX]**

**RIDER EFFECTIVE DATE: [XXXXXXXXXX]**

This rider is made a part of the Group Policy and Certificate to which it is attached. It is subject to all of the provisions, limitations and exclusions of the Group Policy not inconsistent with this rider and is applicable only to Insureds who are covered under this Plan.

**CHILD ORTHODONTIC BENEFIT RIDER**

These benefits will apply to you only if this coverage was selected and is shown on Your Schedule of Benefits.

Orthodontia Type Treatments and Orthodontic Procedures, as defined in the Current Dental Terminology of the American Dental Association, are limited to Your Dependent Children through age [18]. A [12, 18 or 24]-Month Waiting Period immediately following the effective date applies to this Plan. Orthodontia Type Treatments and Orthodontic Procedures are not covered during the [12, 18 or 24]-Month Waiting Period immediately following the effective date of this Plan.

BEST Life will pay up to [1/3] of the covered orthodontic treatment, as an initial down payment for covered services. The balance of the maximum benefit will be paid as monthly installments over the remaining treatment period, up to the limit of this rider.

[Deductibles do not apply to the Child Orthodontic Benefit Rider.] Benefits are payable on a Usual, Reasonable and Customary Basis, subject to the Lifetime Maximum Benefit Limits shown on the Schedule of Benefits.]

The Child Orthodontic Benefit Rider will cease once braces are removed.

No other provision or condition of the Group Policy or Certificate is changed in any way by this rider, except as noted above.

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

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



President

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



Secretary

**BEST Life and Health Insurance Company**  
[2505 McCabe Way  
Irvine, California 92614]

A STOCK COMPANY  
(Herein called the Company)

**POLICYHOLDER: BENEFICIAL EMPLOYEES SECURITY TRUST OF UTAH**

**RIDER TO GROUP POLICY NO: [XXXXXXX]**

**RIDER EFFECTIVE DATE: [XXXXXXXXXX]**

This rider is made a part of the Group Policy and Certificate to which it is attached. It is subject to all of the provisions, limitations and exclusions of the Group Policy not inconsistent with this rider and is applicable only to Insureds who are covered under this Plan.

**CHILDREN'S GOOD VISION BENEFIT RIDER**

These benefits will apply to you only [if this coverage] [Children's Orthodontic Benefit Rider] was selected and is shown on your Schedule of Benefits.

The Children's Good Vision Benefit Rider is limited to an employee's dependent children through age 18. [This benefit is not a covered expense during the [12, 18 or 24]-month Waiting Period immediately following Your dependent child's effective date of coverage].

The Children's Good Vision Benefit Rider will pay for one vision examination, including one annual case history, refraction and checking of eye wear against a prescription, every [12] months. This examination must be furnished by a licensed ophthalmologist or optometrist:

[Deductibles do not apply.] Expenses must be Usual, Reasonable and Customary and incurred while Your Dependent is covered under the Policy. Payments are subject to the Orthodontic Lifetime Maximum, Percentage Payable and Maximum Benefit Limits shown in the Schedule of Dental Benefits.

No other provision or condition of the Group Policy or Certificate is changed in any way by this rider, except as noted above.

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

[

]



President

[

]



Secretary

SERFF Tracking Number: BLHI-126481382 State: Arkansas  
 Filing Company: BEST Life and Health Insurance Company State Tracking Number: 45248  
 Company Tracking Number: BL-GD-PPO-POL 0909  
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental  
 Product Name: Group Dental  
 Project Name/Number: /

## Supporting Document Schedules

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Flesch Certification	Approved-Closed	04/13/2010

**Comments:**

Please note the Consumer Information Notice is included in the Certificate on the page following the Face Page

**Attachments:**

AR\_Certification.pdf  
 FLESCH Cert\_Group Dental.pdf  
 AR\_Guaranty Notice.pdf

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Application	Approved-Closed	04/13/2010

**Comments:**

**Attachments:**

Indemnity Employer Application 0909.pdf  
 PPODentalGroupEApp0608.pdf

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Statement of Variability	Approved-Closed	04/13/2010

**Comments:**

**Attachment:**

Statement of Variability\_Group Dental.pdf

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Approved Trust Document	Approved-Closed	04/13/2010

**Comments:**

**Attachment:**

Utah Trust Document.pdf

**Certification Regarding Compliance with Arkansas Regulation 19s10B**

I, Paul Peatross, do hereby truthfully certify to the Arkansas Insurance Department that this submission including form number(s) BL-GD-PPO-POL 0909, BL-GD-PPO-CERT 0909, BL-GD-PPO-APP 0909, BL-GD-ID-POL 0909, BL-GD-ID-CERT 0909, BL-GD-ID-APP 0909, BL-GD-DEN-EE 0909, BL-GD-DV-EE 0909, BL-GD-AOR 0909, BL-GD-COR 0909 and BL-GD-CGV 0909 meet the provisions of rule 19s10B as well as all applicable requirements of Arkansas laws and regulations.

Date: March 24, 2010

A handwritten signature in black ink, appearing to read 'P. Peatross', written in a cursive style.

Sr. Vice-President and Chief Legal Counsel  
BEST Life and Health Insurance Company

## CERTIFICATE OF FLESCH COMPLIANCE

I hereby certify to the best of my knowledge and belief that the following forms have a combined FLESCH Test Score of 40.43.

### FORMS:

BL-GD-ID-POL 0909	Indemnity Policy
BL-GD-ID-CERT 0909, et al	Indemnity Certificate
BL-GD-PPO-POL 0909	PPO Policy
BL-GD-PPO-CERT 0909, et al	PPO Certificate
BL-GD-IDP-EAPP 0909	Indemnity Plan Group Employer Application Form
BL-GD-PPO-EAPP 0909	PPO Plan Group Employer Application Form
BL-GD-DEN-EE 0909	Dental Only Employee Enrollment Form
BL-GD-DV-EE 0909	Dental and Vision Employee Enrollment Form



(Signature)

Paul Peatross, Sr. Vice-President  
(Name and Title)

March 4, 2010  
(Date)

**NOTICE OF  
THE ARKANSAS LIFE AND HEALTH  
INSURANCE GUARANTY ASSOCIATION ACT**

The Arkansas Life and Health Insurance Guaranty Association Act (the "Act") provides protection, subject to certain limitations and exclusions, against loss under life and health insurance policies and annuity contracts issued by insolvent insurers licensed in this state. Some limitations and exclusions apply; some are listed below.

This notice is provided to you only to make you aware of the existence of the limited protection under the Act. It confers no rights to any policyholder or contract holder not provided under the Act. It does not change or vary any exclusion or limitation contained in the Act. Specific reference must be made to the Act to determine whether any particular policy or contract is covered, the amount of any coverage which may be available, and applicable limitations or exclusions.

Some of the limitations and exclusions are as follows:

1. The Act limits the amount the Guaranty Association is obligated to pay: The Association cannot pay more than what the insurer would owe under a policy or contract. Also, for any one insured, the Guaranty Association will pay a maximum of \$300,000 no matter how many policies or contracts you have with the same insurer even if they provide different coverages. Within this overall \$300,000 limit, the Association will pay a maximum of \$300,000 in net cash surrender values, \$300,000 in life insurance death benefits, \$300,000 in present value of annuities, and \$300,000 in disability or health insurance benefits. There is a \$1,000,000 limit with respect to any one contract holder for unallocated annuity benefits irrespective of the number of participants in the plan.
2. You are not covered:
  - a. If you are not a resident of Arkansas at the time the order of the insurer's insolvency was issued;
  - b. Your insurer was not licensed in this state; or,
  - c. Your insurer was a self-insured plan, trust or other similar entity, health maintenance organization or other entity excluded under the Act.
3. Obligations not specifically provided in the policy or contract are not covered by the Act. Examples of obligations, which are not covered by the Act, include damages or loss due to misrepresentations of policy benefits, inaccurate solicitation material, unfiled policy documents or endorsements, and extra-contractual damages, penalties and similar damages or claims.
4. Dividends or interest rate yields that do not meet specifications described in the Act are not covered under the Act.

**You should not rely upon coverage under the Act when buying a life or health insurance policy or selecting an insurer, and neither agents nor insurers should use the existence of the Guaranty Association to induce you to purchase a product from them.**

For more information relative to the Act, you may contact:

The Arkansas Life and Health Arkansas Insurance Department  
Insurance Guaranty Association 1200 West Third Street  
c/o The Liquidation Division Little Rock, AR 72201-1904  
1023 West Capitol, Suite 2  
Little Rock, AR 72201

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

Dental  Life  Stand Alone

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

\* Certain requirements apply.

**VISION PLAN TYPE**

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

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

\* Certain requirements apply.

**VISION PLAN TYPE**

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

Please answer the following questions:

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

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

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

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

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

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

Employer Name

**Fraud Warning**

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

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

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

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

**FIRM ELIGIBILITY:**

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

**IMPORTANT PLAN INFORMATION**

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

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

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

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

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

**Benefit Representative Report**

*(Please Print)*

Name \_\_\_\_\_

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

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

Address \_\_\_\_\_

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

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

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

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

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

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

*(Please Complete)*

**Special Instructions to BEST Health Plans**

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

General Agent (GA):

Please list any special handling needed for this client:

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

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

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

Agent's Signature:	Print Name:	Date:
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IDP0608

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

[  Dental  Life  Stand Alone Vision]

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

\* Certain requirements apply.

**VISION PLAN TYPE**

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

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

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

\*\* Certain requirements apply.

**VISION PLAN TYPE**

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

Please answer the following questions:

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

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

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

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

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

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

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

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

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

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

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

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

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

( ) - ( ) -

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

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

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

*(continued on other side)*

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

**Fraud Warning**

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

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

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

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

**FIRM ELIGIBILITY:**

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

**IMPORTANT PLAN INFORMATION**

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

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

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

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

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

**BENEFIT REPRESENTATIVE REPORT**

<p style="text-align: center;"><i>(Please Print)</i></p> <p>Name _____</p> <p>It is not necessary to complete the following information if you are currently receiving service fees from BEST Health Plans unless changes in address, etc. need to be made. Just sign and date the form below.</p> <p>Your Agency Name _____</p> <p>Address _____</p> <p>City _____ State _____ Zip _____</p> <p>Who Should Receive the Service Fees? <input type="checkbox"/> Benefit Representative <input type="checkbox"/> Company/Firm</p> <p>Social Security Number - - - - - Federal Tax ID _____</p> <p>Date of Birth / / License No. _____ State _____</p> <p>Phone No. _____ FAX No. _____</p> <p>E-mail Address _____</p> <p>Please list any special handling needed for this client:</p>	<p style="text-align: center;"><i>(Please Complete)</i></p> <p style="text-align: center;"><b>Special Instructions to BEST Health Plans</b></p> <p>1. May we contact the client if we need additional information?  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Is this your first case with BEST Health Plans? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. This is: <input type="checkbox"/> an existing client <input type="checkbox"/> a new client with my company</p> <p>4. The 'New Client Kit' (certificate book, claim forms, etc.) should be sent to:  <input type="checkbox"/> The benefit representative <input type="checkbox"/> The client</p> <p>5. The underwriter assigned to my case should contact me? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>General Agent (GA): _____</p>
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I hereby certify that I hold a valid Life, Accident and Health license issued by the state in which this document was executed and that all of the information contained herein is correct, to the best of my knowledge, and that I know nothing unfavorable about this firm or any individual applying for insurance unless fully described in this application material. Furthermore, I certify that:

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

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

Agent's Signature: _____	Print Name: _____	Date: _____
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## VARIABILITY STATEMENT

### BL-GD-ID-POL 0909

**Face Page** – The address of the company may change.  
The President of the company may change.

**Group Policy Effective Date** – Is specific to the client.

**Group Policy Number** - Specific to the client.

**State of Delivery** - Specific to the client.

**Premiums Due On** - Specific to the client.

**First Renewal Date** – Specific to the client.

**Right to Contest** – Is bracketed to allow for any statutory changes.

**Claim Forms** – Is bracketed to allow for any statutory changes.

**Time Limit on Certain Defenses** – Is bracketed to allow for any statutory changes.

**Legal Actions** – Is bracketed to allow for any statutory changes.

**Changes in Premium** – Is bracketed to allow for any statutory changes, as well as flexibility for the client.

**Grace Period** – Is bracketed to allow for any statutory changes.

**Termination of the Group Policy** – Is bracketed to allow for any statutory changes.

**Face Page** – The address of the company may change.  
The President of the company may change.

**Table of Contents** – Is bracketed to allow for formatting and pagination.

**Schedule of Dental Benefits** – Benefits and amounts are bracketed to allow for the flexibility of the Employer and also for any statutory changes that may be required. The ranges are included in the brackets. Optional benefits may or may not be included at the request of the Employer. Usual, Reasonable and Customary or Maximum Allowable Charge will be used depending on the network.

**Waiting Period** – This will range from 0 – 12 months.

**Exclusions and Limitations** – bracketed for flexibility with statutory changes and underwriting changes.

**Optional Benefits** – Bracketed and may or may not be included at the request of the Employer.

**Grace Period** – Is bracketed to allow for any statutory changes.

**Family Calendar Year Deductible** – Will range from 2-3 individual deductibles.

**Maximum Allowable Charge** – May or may not be included depending on the network.

**Maximum Rollover** – May or may not be offered depending on the Employer.

**Effective Date** – Bracketed timeframe will range from 0 to 12 months or 30 – 90 days.

**Termination of Insurance** – Bracketed timeframe will range from 9 to 12 months.

**Deductibles** – Bracketed to allow for customer flexibility.

**Right to Contest** – Bracketed to allow for statutory changes.

**Notice of Claim and Claim Forms** – Bracketed to allow for statutory changes.

**Proof of Loss** – Bracketed to allow for statutory changes.

**Legal Actions** – Bracketed to allow for statutory changes.

**Face Page** – The address of the company may change.  
The President of the company may change.

**Group Policy Effective Date** – Is specific to the client.

**Group Policy Number** - Specific to the client.

**State of Delivery** - Specific to the client.

**Premiums Due On** - Specific to the client.

**First Renewal Date** – Specific to the client.

**Right to Contest** – Is bracketed to allow for any statutory changes.

**Claim Forms** – Is bracketed to allow for any statutory changes.

**Time Limit on Certain Defenses** – Is bracketed to allow for any statutory changes.

**Legal Actions** – Is bracketed to allow for any statutory changes.

**Changes in Premium** – Is bracketed to allow for any statutory changes, as well as flexibility for the client.

**Grace Period** – Is bracketed to allow for any statutory changes.

**Termination of the Group Policy** – Is bracketed to allow for any statutory changes.

### BL-GD-ID-CERT 0909

### BL-GD-PPO-POL 0909

BL-GD-PPO-CERT-0909

**Face Page** – The address of the company may change.

The President of the company may change.

**Table of Contents** – Is bracketed to allow for formatting and pagination.

**Schedule of Dental Benefits** – Benefits and amounts are bracketed to allow for the flexibility of the Employer and also for any statutory changes that may be required. The ranges are included in the brackets. Optional benefits may or may not be included at the request of the Employer. Usual, Reasonable and Customary or Maximum Allowable Charge will be used depending on the network.

**Waiting Period** – This will range from 0 – 12 months.

**Exclusions and Limitations** – bracketed for flexibility with statutory changes and underwriting changes.

**Optional Benefits** – Bracketed and may or may not be included at the request of the Employer.

**Grace Period** – Is bracketed to allow for any statutory changes.

**Family Calendar Year Deductible** – Will range from 2-3 individual deductibles.

**Maximum Allowable Charge** – May or may not be included depending on the network.

**Maximum Rollover** – May or may not be offered depending on the Employer.

**Effective Date** – Bracketed timeframe will range from 0 to 12 months or 30 – 90 days.

**Termination of Insurance** – Bracketed timeframe will range from 9 to 12 months.

**Deductibles** – Bracketed to allow for customer flexibility.

**Right to Contest** – Bracketed to allow for statutory changes.

**Notice of Claim and Claim Forms** – Bracketed to allow for statutory changes.

**Proof of Loss** – Bracketed to allow for statutory changes.

**Legal Actions** – Bracketed to allow for statutory changes.

**Marketing Name** – Bracketed to allow for renaming without refilling.

**Benefits** – Bracketed to allow for flexibility in what benefits are chosen.

BL-GD-IDP-EAPP 0909

BEST OF UTAH  
AGREEMENT AND  
DECLARATION OF TRUST  
FOR THE SERVICE INDUSTRY

THIS AGREEMENT AND DECLARATION OF TRUST is made and entered into this first day of August, 1982, by and between PENSION ADMINISTRATORS, INC., a California corporation, with its principal office being located in Newport Beach, California (hereinafter referred to as "Settlor") and DONALD R. LAWRENZ, SR., with his principal office located in Newport Beach, California (hereinafter referred to as the "Managing Trustor"), and FIRST INTERSTATE BANK OF UTAH, a Utah corporation, with its office being located in Salt Lake City, Utah (hereinafter referred to as "Trustee");

WHEREAS, the Employers subscribing hereto (hereinafter referred to as "Subscribing Employers") desire to implement, through the purchase of group insurance, certain welfare plans established by them for their respective eligible Employees and the dependents of such Employees; and

WHEREAS, Settlor desires to establish this Trust in order to provide a conduit for subscribing Employers to make from time to time the periodic Payments for insurance contracts by which the benefits under the welfare plans of the respective subscribing Employers will be provided; and

WHEREAS, the Trustee and Managing Trustor have agreed to accept this Trust upon all the terms and conditions hereinafter set forth;

NOW, THEREFORE, to carry this Trust into effect, and in consideration of the premises and of the mutual covenants herein contained, it is mutually agreed as follows:

ARTICLE I

The following definitions shall govern the interpretation of this Agreement and Declaration of Trust:

1. "Subscription Agreement" shall mean the agreement signed by an Employer whereby said employer agrees to be bound by all the terms and provisions of this Trust and whereunder said employer promises to make payment on behalf of its eligible Employees and their dependents for benefits, if applicable.

2. "Subscribing Employer" shall mean any Employer who has signed a Subscription Agreement and who has been accepted as an Employer by the Managing Trustor or his designee.

3. "Employee" shall mean a person employed by a Subscribing Employer and as defined in the contract or contracts of insurance owned by the Trustee.

4. "Insurer" shall mean BEST Life Assurance Company of California with its principal offices located at 4201 Birch Street, Newport Beach, California 92660; Commercial Bankers Life Insurance Company with its principal offices located at 1401 Dove Street, Newport Beach, California 92660; and any other insurance company or companies hereafter selected pursuant to the terms of this Trust. The Insurer shall not be deemed a party to this Trust and the obligations of the Insurer shall be determined solely by the terms and conditions of the policy or policies, and any additional agreements between the Trustee and the Insurer.

5. "Agreement and Declaration of Trust", "Trust" or "Agreement" shall mean this instrument, including any amendments thereto made in conformity with the terms hereof.

6. "Fund" shall mean:

(a) as to the Trustee, only such group insurance contracts issued hereunder, and such individual insurance policies, if any, as may be, with the consent of the Trustee, either owned or held by the Trustee. Trustee is not and shall not be deemed a fiduciary, co-fiduciary, or investment manager with respect to any res, asset, chose in action, contract right, or thing of value of any kind or nature whatsoever, whether tangible or intangible, other than or in addition to the items described in the immediately preceding sentence, and particularly with respect to the items described in subparagraph (b) hereunder, and

(b) as to the Managing Trustor, the sum of all funds and things of value held by the Managing Trustor, and shall include, but not be limited to, Payments from Subscribing Employers, interest, income, or any other return thereon, insurance policies together with any premium dividends, refunds, retrospective rate credits or other sums payable to the Trustee or Managing Trustor on account of such policies, and any other property of any kind received and held by the Managing Trustor for the use and purposes declared by this Trust.

7. "Trustee" shall mean the banking association originally designated as Trustee in this Agreement and any person, persons, association or corporation hereafter selected pursuant to the terms of this Trust.

8. "Managing Trustor" shall mean the person originally designated as Managing Trustor in this Agreement and any person, persons, association or corporation hereafter selected pursuant to the terms of this Trust.

9. "Plan" shall mean any welfare program established by the BEST Employers Association, in order to provide Benefits for

eligible Employees of Employers and their dependents through contracts of insurance issued to the Trustee or to the individual employees or their dependents.

10. "Benefits" shall mean any and all Benefits provided for eligible Employees and their dependents exclusively through contracts of insurance issued to the Trustee.

11. "Payments" shall mean amounts remitted to the Managing Trustor by Subscribing Employers from the general assets of a Subscribing Employer and from contributions of eligible Employees, which are forwarded to the Managing Trustor by a Subscribing Employer for payment of premiums on insurance policies issued to the Trustee, plus amounts remitted to the Managing Trustor by a Subscribing Employer for the costs of establishing and administering this Trust.

## ARTICLE II

### ESTABLISHMENT OF TRUST

There is hereby established a trust to be hereinafter known and identified as the Beneficial Employees Security Trust of Utah. Although a single trust, such trust shall be comprised of two separate and distinct funds as described and defined in ARTICLE I subparagraph 6 hereof, and nothing herein shall be construed so as to impose upon the Trustee by inference, implication or otherwise any rights, powers, duties, responsibilities or obligations of any nature whatsoever with respect to any matter or matters except those directly relating to items as defined in subparagraph (a) of paragraph 6 of ARTICLE I hereof. The purpose of the trust shall be to provide a conduit for payment by a Subscribing Employer of premiums for insurance policies to fully fund Benefits for Subscribing Employers, their eligible Employees, and their dependents.

## ARTICLE III

### TRUSTEE

1. The Trustee shall execute this Agreement and Declaration of Trust and such execution shall constitute an acceptance of this Trust and the office of Trustee.

2. The Trustee shall continue to serve until death, incapacity, resignation or removal as herein provided:

(a) The Trustee may resign from this Trust by delivering a written notice of resignation to the Managing Trustor. The resignation shall be effective on the date specified in the notice, which shall be a date not less than ninety (90) days from the date of delivery of the notice of resignation, unless the Managing Trustor shall consent in writing to an earlier effective date.

(b) The Trustee may be removed at any time by the Managing Trustor. The Managing Trustor shall mail or deliver to the Trustee notice of his removal to be effective thirty (30) days from the giving of notice.

(c) Upon termination of the services of a Trustee for any reason whatsoever, the Trustee or his personal representative, to the extent held by the Trustee, shall transfer and deliver to the successor Trustee the Fund and all policies, books, checks, receipts, accounts and other records of any kind or character without exception relating to the Trust, and execute all instruments necessary to effect such transfer.

3. Whenever a Trustee shall die, become incapacitated, resign or be removed, a successor Trustee shall be selected by the Managing Trustor.

4. Such selection shall be evidenced by an instrument in writing and bear the written acceptance of the successor Trustee. One executed copy of such writing shall be appended to this Agreement and a copy of such writing shall be delivered to the Insurer. The Managing Trustor shall notify such other persons and institutions that may be directly affected by such succession. The successor Trustee shall serve in the place and stead of the previously selected Trustee, and so often as a new Trustee shall be so selected, the Fund and all the powers and authorities herein granted or given to the Trustee shall vest in the successor Trustee as fully and effectively as though it had been the original Trustee hereunder.

#### ARTICLE IV

##### DUTIES AND POWERS OF THE TRUSTEE

1. The Trustee shall discharge its duties with the standard of care established by law.

2. The Trustee shall have only such duties, powers and responsibilities as are specifically allocated to it under this Agreement. No other or future duties, powers or responsibilities shall be implied.

3. The Trustee shall have the following duties, powers and responsibilities:

(a) The Trustee shall, as directed by the Managing Trustor, apply for policies of insurance from insurance companies licensed to conduct insurance business in the State of Utah or other states as required. The Trustee shall be the legal owner of all policies, unless prohibited by law.

(b) The Trustee, unless prohibited by law, shall hold in safekeeping the policies of group insurance issued pursuant to this Agreement.

(c) The Trustee shall receipt and hold on file any documents pertaining to the resignation, removal or appointment of a successor Managing Trustor.

(d) The Trustee shall file any tax returns and reports required of it by law on the basis of information and records furnished to Trustee by the Managing Trustor.

(e) The Trustee shall provide any bond required under law for the faithful performance of its duties.

(f) The Trustee may retain, consult with and rely upon the advice of legal counsel.

(g) The Trustee shall receive reasonable compensation from the Fund for its services as may be agreed upon from time to time by the Managing Trustor and Trustee. The Trustee shall be reimbursed by the Managing Trustor from the fund for all proper and necessary expenses reasonably incurred. To the extent not prohibited by law this shall be deemed to include but not be limited to: legal fees, costs, and legal damages suffered in connection with any action, suit or proceedings in which it may be involved by virtue of it being or having been a Trustee hereunder, except those final judgements where the Trustee is adjudged to have committed negligence or breached any fiduciary duty.

(h) The Trustee may do all things, execute all instruments and enter into all agreements and transactions as are reasonable, desirable or necessary to execute the specific powers set forth herein.

## ARTICLE V

### MANAGING TRUSTOR

1. The Managing Trustor shall execute this Agreement and Declaration of Trust and such execution shall constitute an acceptance of the office of Managing Trustor.

2. The Managing Trustor shall continue to serve until death, resignation, incapacity or removal as herein provided:

(a) The Managing Trustor may resign from this Trust by delivering a written notice of resignation to the Trustee and to the President of BEST Employers Association. The resignation shall be effective on the date specified in the notice, which shall be a date not less than ninety (90) days from the date of delivery of the notice of resignation, unless the President of BEST Employers Association shall consent in writing to an earlier effective date.

(b) The Managing Trustor may be removed at any time by the President of BEST Employers Association. The President of BEST Employers Association shall mail or deliver to the Managing

Trustor notice of his removal to be effective thirty (30) days from the giving of notice, and shall mail a copy to the Trustee.

(c) Upon termination of the services of a Managing Trustor for any reason whatsoever, the Managing Trustor or his personal representative, to the extent held by the Managing Trustor, shall transfer and deliver as directed by the President of BEST Employers Association to the successor Managing Trustor or the President of BEST Employers Association the Fund and all books, checks, receipts, accounts and other records of any kind or character without exception relating to the Trust, and execute all instruments necessary to effect such transfer.

3. Whenever a Managing Trustor shall die, become incapacitated, resign, or be removed, a successor Managing Trustor shall be selected by the President of BEST Employers Association, or if the President shall for any reason fail or refuse to name a successor Managing Trustor, the BEA Administrative Committee shall select a successor Managing Trustor.

4. Such selection shall be evidenced by an instrument in writing and bear the written acceptance of the successor Managing Trustor. One executed copy of such writing shall be appended to this Agreement and a copy of such writing shall be delivered to the Insurer, the Trustee, and to the President of BEST Employers Association. The successor Managing Trustor shall notify such other persons and institutions that may be directly affected by such succession. The successor Managing Trustor shall serve in the place and stead of the previously acting Managing Trustor and so often as a new Managing Trustor shall be so selected all the powers and authority herein granted or given to the Managing Trustor, shall vest in the successor Managing Trustor as fully and effectively as though he had been the original Managing Trustor hereunder.

## ARTICLE VI

### DUTIES AND POWERS OF THE MANAGING TRUSTOR

1. The Managing Trustor shall discharge his duties with the standard of care established by law.

2. The Managing Trustor shall have only such duties, powers and responsibilities as are specifically allocated to him under this Agreement. No other or further duties, powers or responsibilities shall be implied.

3. The Managing Trustor shall have the following duties and responsibilities:

(a) The Managing Trustor shall arrange for the issuance of policies of insurance to provide Benefits. The Managing Trustor shall direct the Trustee as to the exercise of all rights and privileges granted to the Trustee as policyholder

and may agree with the Insurer on any alterations, modifications or amendments of such policies, all as the Managing Trustor, in his sole discretion may deem necessary or desirable.

(b) The Managing Trustor shall collect and pay premiums for all policies issued pursuant to this Trust.

(c) The Managing Trustor shall keep the policies in force by paying from the Fund to the extent that the Fund is sufficient, the premiums required under the policies and shall direct that all reports required by Insurer are furnished.

(d) The Managing Trustor shall receive Payments from each Subscribing Employer.

4. The Managing Trustor, in order to carry out the purposes of this Trust and to discharge his obligations as Managing Trustor hereunder, shall have the following powers:

(a) To receive, hold and administer Payments from Subscribing Employers which are due and payable to the Fund; to pay or provide for payment of all reasonable and necessary expenses of administering the affairs of the Fund, including but without limitation, the employment of or contracting with administrative, legal, accounting, expert and clerical personnel; the designation and use of a depository bank; the lease of premises; and the purchase of materials, supplies and equipment; all as the Managing Trustor in his sole discretion, may find necessary or appropriate to the performance of his duties and the sound and efficient administration of the Fund.

(b) To prepare and file any tax returns or reports required of the Trustee or Managing Trustor, including but not limited to the annual report of the Plans required by the Employee Retirement Income Security Act of 1974.

(c) To pay out of the Fund such sums as may be necessary for the continuance of the Trust, including costs incurred in establishing the Trust and applicable taxes imposed upon the Fund; to pay out of the fund premiums on any liability policy purchased by Managing Trustor; and to contest the validity of any tax, levy, assessment, claim or demand which may be levied or made against the Fund.

(d) To establish and accumulate such reserve funds as the Managing Trustor may deem necessary or desirable for the proper and safe administration of the Fund, and to invest and reinvest said reserves or a portion thereof in savings accounts, or in obligations of the United States Government, or in securities which are recognized under law for the investment of the Fund.

(e) To refund to Subscribing Employers such portions of Payments as are found to be in excess of amounts due from them.

(f) To originate and maintain any and all actions or legal proceedings which may be deemed necessary for the protection of the Fund or the Trustee or Managing Trustor; to compromise, settle or release claims on behalf of or against the Fund or the Trustee or Managing Trustor on such terms as the Managing Trustor, in his sole discretion, may deem advisable or desirable; to construe the provisions hereof, and any such construction adopted in good faith by the Managing Trustor shall be binding upon all of the parties hereto.

(g) To delegate such of his powers and duties as may in the opinion of the Managing Trustor be desirable.

(h) To provide for the administration of this Trust in whole or in part, jointly with, or in cooperation with, other Trusts established for similar purposes in order to reduce the expense of administration.

(i) To keep true and accurate books and accounts and records of all transactions.

(j) To apply any dividend resulting from experience rating of the policies hereunder to a reserve to be used only for reduction of future premiums due from all Subscribing Employers. The Insurer shall accept the direction of the Managing Trustor regarding the aforesaid application and shall have no responsibility in this regard.

(k) To accumulate Trust Fund surpluses from, but not limited to, investment income, interest, and premium dividends and refunds, and to use such funds pursuant to ERISA Section 404(a)(1) for the benefit of beneficiaries of the Fund.

(l) To purchase a liability policy or policies covering the Managing Trustor for his services hereunder.

(m) To establish from time to time rules for eligibility and termination of Subscribing Employers.

(n) To terminate a Subscribing Employer's participation in the Trust if it is deemed by the Managing Trustor, or the President of BEST Employers Association, that a Subscribing Employer's continued participation in the Trust is detrimental to other Subscribing Employers and/or the financial stability of the Trust Fund; or, if it is determined that any information furnished to the Trust, or the Insurer, by a Subscribing Employer is false or misleading and such misinformation has affected the rate charged said Subscribing Employer for benefits provided to him or his employees by the Trust.

5. The Managing Trustor shall provide any bond required under law for the faithful performance of his duties.

6. The Managing Trustor shall receive reasonable compensation for his services. To the extent not prohibited by law this

shall be deemed to include but not be limited to: legal fees, costs, expenses and legal damages suffered in connection with any action, suit or proceedings in which he may be involved by virtue of his being or having been a Managing Trustor hereunder, except those final judgements where the Managing Trustor is adjudged to have committed negligence or breached any fiduciary duty.

7. The Managing Trustor may do all things, execute all instruments and enter into all agreements and transactions as are reasonable, desirable or necessary to execute the specific powers set forth herein and to facilitate the foregoing duties, powers and responsibilities.

## ARTICLE VII

### EMPLOYER PAYMENTS

1. To provide Benefits for its eligible Employees and their dependents, each Subscribing Employer shall pay to the Fund such Payments as are from time to time billed to them by the Managing Trustor.

2. The failure of a Subscribing Employer to make Payments as are requested by the Managing Trustor shall constitute a violation of that Subscribing Employer's obligation thereunder. The failure of a Subscribing Employer to make Payments shall not relieve any other Subscribing Employer of its obligation to make Payments and no Subscribing Employer shall be liable for the failure of any other Subscribing Employer to make its Payments. The Managing Trustor shall have no duty on behalf of any eligible Employee or his dependents to enforce the Payments required of a Subscribing Employer. No fiduciary of this Trust shall be liable for an act or omission of a Subscribing Employer to carry out its responsibility for making its Payments.

3. From time to time the Managing Trustor and/or the President of BEST Employers Association shall establish standards for payment and delinquencies. These standards may include but are not limited to penalties for late payments and suspension and/or cancellation of coverage.

4. All Subscribing Employers shall make such reports and statements to the Managing Trustor with respect to the amount and calculation of any and all Payments, or with respect to any other matter pertinent to the establishment, maintenance and administration of the Fund, as the Managing Trustor may deem necessary and desirable. The Managing Trustor may, at reasonable times and during normal business hours, cause an audit or examination by a Certified Public Accountant or other agent of the Managing Trustor, of the books and records of a Subscribing Employer which may be pertinent in connection with said Payments and reports and insofar as same may be necessary to accomplish the purpose of this Agreement.

5. Payments to the Fund shall not constitute or be deemed to be wages. No Subscribing Employer, Trustee, Managing Trustor, Employee, or any beneficiary, nor any other person, shall have any right, title or interest in the Fund other than as specifically provided in this Trust; and no part of the Fund shall revert to the Subscribing Employers, the Trustee, Managing Trustor, any Employee or any other person. Neither an Employee, nor his beneficiary shall have the option to receive any part of the Payments to the Fund in lieu of Benefits. Neither the Fund nor any Payments to the Fund shall in any manner be liable for or subject to the debts, contracts or liabilities of the Subscribing Employers, the Trustee, Managing Trustor, or any Employee.

#### ARTICLE VIII

##### AMENDMENT, TERMINATION AND MERGER OF THE TRUST

1. The Trust may be amended by the Managing Trustor. No amendment affecting the rights, powers, or duties of the Trustee shall be effective unless and until it has been approved in writing by the Trustee. The Managing Trustor and Trustee shall execute any instrument necessary in connection therewith. The Managing Trustor shall forthwith notify the insurer and the participating current Subscribing Employers of any executed amendment.

2. This Trust shall terminate concurrently with the termination of all group policies held by the Trustee. In the event of termination, the Managing Trustor shall notify each Subscribing Employer and the Trustee. Subject to the payment of expenses for termination, the Trustee, upon direction of the Managing Trustor, shall transfer any individual policy held by the Trustee to the individual insured unless otherwise provided by law. Any balance remaining in the Fund shall be expended by the Managing Trustor for the benefit of the beneficiaries of this Trust as provided in this Agreement.

3. The parties hereto recognize that at some time or times in the future it may be in the best interest of the Fund that the Fund be merged, consolidated or joined with other trust funds, or that the Fund accept funds from other trust funds in connection with a joinder or consolidation, or inclusion in this Fund of new employers. The Managing Trustor shall have full power to investigate, evaluate and negotiate any such merger, consolidation, joinder, or similar inclusion, and to prepare and enter into agreements to consummate same.

#### ARTICLE IX

##### GENERAL PROVISIONS

1. No party dealing with the Trustee or Managing Trustor shall be obligated to see that the application of any funds or property of the Fund is proper, or to see that the terms of the Trust have been complied with or to inquire into the necessity or

(b) The BEA Administrative Committee shall serve in an advisory capacity to the Managing Trustor. Upon incapacity or resignation of the Managing Trustor, if the President of BEST Employers Association fails to appoint a successor Managing Trustor, the Administrative Committee shall select a successor Trustor by consent of a majority of its members. Upon resignation of a Managing Trustor in the absence of any action by the President of BEST Employers Association, the Administrative Committee may agree on behalf of the Trust by unanimous consent of its members to a settlement of the account of the Managing Trustor. Vacancies shall be disregarded in determining the number of members which may consent.

(c) BEA Administrative Committee shall not be liable or responsible for:

(i) Any debts, liabilities or obligations of the Trust or the Managing Trustor; or

(ii) The acts or omissions of any fiduciary (except as specifically undertaken by agreement of indemnity), or other person rendering services to the Trust Fund.

#### ARTICLE X

##### APPOINTMENT OF ADMINISTRATIVE SERVICES CONTRACTOR

1. Upon the execution of this Trust, the Managing Trustor hereby designates Beneficial Administration Company, a California corporation (hereinafter BAC), as Administrative Services Contractor, and Pension Administrators, Inc., a California corporation (hereinafter PA), as Marketing Contractor to perform such of the duties and responsibilities imposed hereunder upon the Managing Trustor for the administration and marketing of this Trust as may be mutually agreed upon by BAC, PA and the Managing Trustor pursuant to separate administrative services and marketing agreements. The Administrative Services Contractor and Marketing Contractor shall be entitled to receive a fee for their services as set forth in the administrative services and marketing agreements, and such fees shall be charged against the Fund.

2. The Administrative Services Contractor and Marketing Contractor may be removed at any time by the Managing Trustor upon giving ninety (90) days written notice to the Administrative Services Contractor or Marketing Contractor. The Administrative Services Contractor or Marketing Contractor may resign at any time upon giving ninety (90) days written notice to the Managing Trustor.

3. In the event of the resignation or removal of the Administrative Services Contractor or Marketing Contractor, the Managing Trustor may appoint a successor Administrative Services Contractor or Marketing Contractor to serve in their place.

IN WITNESS WHEREOF, this Trust has been executed as of the day and year first above written by the Managing Trustor, the Settlor by its president thereunto duly authorized, and by the Trustee by its respective officers thereunto duly authorized.

ATTEST:

PENSION ADMINISTRATORS, INC.

*R. Dana Christy*

By:

*Donald R. Lawrenz*  
Donald R. Lawrenz, Sr.  
President

ATTEST:

FIRST INTERSTATE BANK OF UTAH, N.A.

*Samuel T. Hunsman*

By:

*Edward G. Richard*  
Vice President and Trust Officer

ATTEST:

*R. Dana Christy*

By:

*Donald R. Lawrenz*  
Donald R. Lawrenz, Sr.  
Managing Trustor

AMENDMENT NO. 1

TO

BEST OF UTAH

AGREEMENT AND

DECLARATION OF TRUST

FOR THE SERVICE INDUSTRY

WHEREAS, there has heretofore been entered into an Agreement and Declaration of Trust, effective August 1, 1982, between PENSION ADMINISTRATORS, INC., a California Corporation, Settlor, and Donald R. Lawrenz, Sr., Managing Trustor, and FIRST INTERSTATE BANK OF UTAH, a Utah Corporation, Trustee; and

WHEREAS, ARTICLE VI, DUTIES AND POWERS OF THE MANAGING TRUSTOR, Paragraph 7., provides as follows:

"7. The Managing Trustor may do all things, execute all instruments and enter into all agreements and transactions as are reasonable, desirable or necessary to execute the specific powers set forth herein and to facilitate the foregoing duties, powers and responsibilities."

WHEREAS, ARTICLE VIII, AMENDMENT, TERMINATION, AND MERGER OF THE TRUSTS, Paragraph 1. and Paragraph 3. provide as follows:

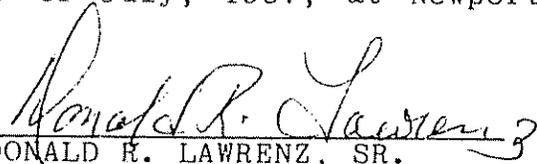
"1. The Trust may be amended by Managing Trustor. No amendment affecting the rights, powers, or duties of the Trustee shall be effective unless and until it has been approved in writing by the Trustee. The Managing Trustor and Trustee shall execute any instrument necessary in connection therewith. The Managing Trustor shall forthwith notify the insurer and the participating current Subscribing Employers of any executed amendment."

"3. The parties hereto recognize that at some time or times in the future it may be in the best interest of the Fund that the Fund be merged, consolidated or joined with other trust funds, or that the Fund accept funds from other trust funds in connection with a joinder or consolidation, or inclusion in this Fund of new

employers. The Managing Trustor shall have full power to investigate, evaluate and negotiate any such merger, consolidation, joinder, or similar inclusion, and to prepare and enter into agreements to consummate same."

NOW THEREFORE this Trust is hereby amended to delete "FOR THE SERVICE INDUSTRY" from the title of said trust and shall be merged, consolidated, and joined to form one Trust with the BEST OF UTAH.

Executed this 31 day of July, 1987, at Newport Beach, California.

  
DONALD R. LAWRENZ, SR.  
MANAGING TRUSTOR

390/UT/S/7.87



Since 1970

*Paula Krop*

**DATE:** April 11, 2000

**TO:** Steve Course  
David F. Friedly  
Stan Hassan  
Alan Koransky  
Laurie Lee  
Gary Lee Miller  
John Vanderschraaf  
Jim Voegtlin

**FROM:** Donald R. Lawrenz

After many years of service and because of my continuing heavy workload I have decided to resign as Managing Trustor of the Beneficial Employees Security Trusts of California and Utah. My resignation will be effective May 5, 2000.

Best Employers Association has met and convened and has elected a successor Managing Trustor, Laurie Lee.

Laurie has agreed to serve in this position effective May 5, 2000. Please adjust your records to indicate Laurie as the new Managing Trustor of the California and Utah Trusts.

In the future, all amendments, expenses, documents, new Trust issues et al will be directed to Laurie Lee for her signature.

Please join me in congratulating Laurie Lee on her new position.

Donald R. Lawrenz  
Managing Trustor

AMENDMENT TO THE  
BEST OF UTAH AGREEMENT AND DECLARATION OF TRUST

A. For purposes of this Amendment, Successor Managing Trustor:

Pursuant to the terms, conditions and mutual covenants of the BEST OF UTAH AGREEMENT AND DECLARATION OF TRUST, and the requirement to name a successor Managing Trustor in the event of the death, incapacitation, resignation or removal of the Managing Trustor, DONALD R. LAWRENZ, JR., has been named as the successor Managing Trustor, effective September 8, 1996

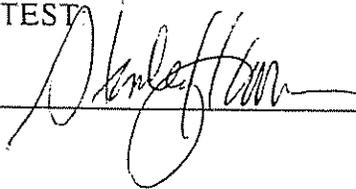
B. For purposes of this Amendment, the following words and phrases shall have the meanings as shown below:

1. PENSION ADMINISTRATORS, INC., a California corporation, with its principal office being located in Irvine, California (hereinafter referred to as "Settlor");
2. DONALD R. LAWRENZ, JR., with his principal office located in Irvine, California (hereinafter referred to as the "Managing Trustor"); and
3. WELLS FARGO BANK, with its office being located in Salt Lake City, Utah (hereinafter referred to as "Trustee")

Any other words or phrases that are used and not defined in this Amendment shall have the meanings ascribed to them in the Original BEST OF UTAH AGREEMENT AND DECLARATION OF TRUST.

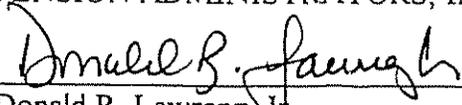
The signature of the Managing Trustor below is evidence of the notice and acceptance of his selection as successor Managing Trustor.

ATTEST

  
\_\_\_\_\_

PENSION ADMINISTRATORS, INC.

By:

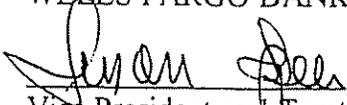
  
\_\_\_\_\_  
Donald R. Lawrenz, Jr.  
President

ATTEST

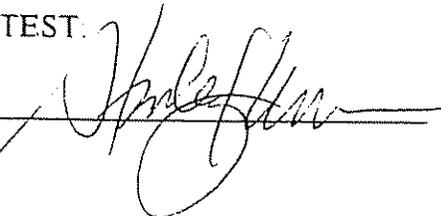
  
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WELLS FARGO BANK, N A

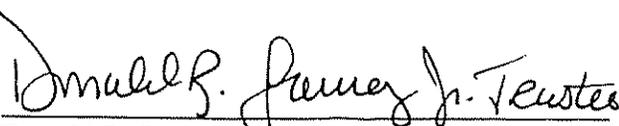
By:

  
\_\_\_\_\_  
Vice President and Trust Officer

ATTEST

  
\_\_\_\_\_

By:

  
\_\_\_\_\_  
Donald R. Lawrenz, Jr.  
Managing Trustor

SERFF Tracking Number: BLHI-126481382 State: Arkansas  
 Filing Company: BEST Life and Health Insurance Company State Tracking Number: 45248  
 Company Tracking Number: BL-GD-PPO-POL 0909  
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental  
 Product Name: Group Dental  
 Project Name/Number: /

## 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)
03/24/2010	Form	PPO Certificate	04/12/2010	AR_PPO Certificate.pdf (Superseded)
03/24/2010	Form	Indemnity Certificate	04/12/2010	AR_Indemnity Certificate.pdf (Superseded)

**BEST Life and Health Insurance Company**

[2505 McCabe Way  
Irvine, California 92614]

A STOCK COMPANY  
(Herein called the Company)

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

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

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

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

[  ]

President

[  ]

Secretary

**GROUP PPO DENTAL  
NON-PARTICIPATING**

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



**IMPORTANT NOTICE FOR ARKANSAS RESIDENTS**

For assistance with questions regarding your policy, benefits and Claims, please contact BEST Life and Health Insurance Company at the following:

2505 McCabe Way  
Irvine, CA 92614  
1-800-433-0088

You may also contact your agent for assistance.

If we at BEST Life and Health 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, AR 72204  
501-371-1811

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## PART 1 - SCHEDULE OF BENEFITS

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

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

### SCHEDULE OF DENTAL BENEFITS

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

Benefits Description	Network	Non-Network
Calendar Year Maximum (per enrollee)	[\$2,500 - \$500]	[\$2,500 - \$500]
Individual Yearly Deductible	[ \$100 - \$0]	[ \$100 - \$0]
Family Yearly Deductible	[ \$300 - \$0]	[ \$300 - \$0]
Preventive Dental Procedures Routine oral exam, cleanings, fluoride treatment for children, x- rays, sealants	[100% - 50%] [No or After] deductible	[100% - 50%] [No or After] deductible
Basic Services Fillings (amalgam, porcelain & plastic), general anesthesia, emergency palliative treatment, space maintainers for children, pathology, posterior composites	[100% - 50%] After deductible	[100% - 50%] After deductible
Major Services Crowns & gold fillings, inlays, onlays and pontics, fixed bridges, complete and partial dentures.	[100% - 0%] After deductible [[12, 18 or 24]-month wait*]	[100% - 0%] After deductible [[12, 18 or 24]-month wait*]
[Simple and Surgical Extractions]	[100% - 0%] After deductible [[12, 18 or 24]-month wait*]	[100% - 0%] After deductible [[12, 18 or 24]-month wait*]
[Oral Surgery]	[100% - 0%] After deductible [[12, 18 or 24]-month wait*]	[100% - 0%] After deductible [[12, 18 or 24]-month wait*]
[Periodontics]	[100% - 0%] After deductible [[12, 18 or 24]-month wait*]	[100% - 0%] After deductible [[12, 18 or 24]-month wait*]
[Endodontics]	[100% - 0%] After deductible [[12, 18 or 24]-month wait*]	[100% - 0%] After deductible [[12, 18 or 24]-month wait*]

[Orthodontics] [For eligible dependent children through age 18 only] [For eligible dependent children and adults]	[60% - 50%] [\$2,500 - \$1,000 Lifetime Maximum] [[12, 18 or 24]-month wait*] [\$500 - \$750 Annual Maximum]
[Children's Good Vision Benefit For dependent children through age 18 only]	[Covers 50% of eligible expenses for a vision exam once every 12 months] [[12, 18 or 24]-month wait*]
[*Unless the requirements for the Major Dentistry Waiting Period Waiver have been met, Major Dental and Orthodontic Procedures and the Children's Good Vision Benefit are not eligible covered expenses for any Insured during the [12, 18 or 24]-month period immediately following their effective date. Please see Major Dentistry Waiting Period Waiver Provision.]	
Special Dental Accident Benefit	Covers injury to sound, natural teeth up to [\$1,000 or \$500] per accident

**PLAN SELECTED:** As selected by the [Subscribing Employer] [Insured Employee] and shown on the Statement of Coverage.

#### SCHEDULE OF BENEFITS

	High Plan	Medium Plan	Basic Plan
<b><u>Calendar Year Maximum</u></b>	[\$1000 - \$3000]	[\$1000 - 2000]	[\$500-\$1000]
<b><u>Preventive Dental Procedures</u></b> [Includes dental exams, cleanings, fluoride treatments for children, x-rays]	[80% - 100%]coverage for Eligible Expenses	[80%-100%]coverage for Eligible Expenses	[50%-100%]coverage for Eligible Expenses
[Deductible]	[\$0-\$50]	[\$0-\$75]	[\$0-\$100]
[ Waiting Period]	[None]	[None]	[None]
<b><u>Basic Dental Procedures</u></b> [Includes emergency palliative treatment, fillings, (amalgam, porcelain and plastic), anesthesia, space maintainers and pathology]	[50%-100%] coverage for Eligible Expenses	[50%-100%] coverage for Eligible Expenses	[30%-80%] coverage for Eligible Expenses
[ Deductible]	[\$0-\$50per Calendar Year]; [3] family maximum	[\$0-\$75 per Calendar Year]; [3] family maximum	\$50-\$100[\$50; \$75; \$100 per Calendar Year]; [3] family maximum
[Waiting Period]	[0-12 months]	0-12 months	0-12 months

[ Periodontics/Endodontics]	[Covered; N/A]	[Covered; N/A]	N/A
[Oral Surgery]	Covered	Covered	N/A

**Major Dental Procedures**

[Includes prosthetics, crowns & gold fillings, inlays, onlays and pontics]

[50%-80%] coverage for Eligible Expenses	[40%-60%] coverage for Eligible Expenses	[0%-50%] coverage for Eligible Expenses
--	--	---

[ Deductible]	Basic Services Calendar Year deductible applies	Basic Services Calendar Year deductible applies	Basic Services Calendar Year deductible applies
---------------	---	---	---

[ Waiting Period ]	0-24 months	0-24 months	0-24 months
--------------------	-------------	-------------	-------------

[Periodontics/Endodontics]	[Covered; N/A]	[Covered; N/A]	[Covered]
----------------------------	----------------	----------------	-----------

[Oral Surgery]	N/A	N/A	[Covered]
----------------	-----	-----	-----------

**[Orthodontics]**

[40%-60%] coverage for Eligible Expenses	[40%-60%] coverage for Eligible Expenses	[40%-60%] coverage for Eligible Expenses
--	--	--

[Child only] [Child with Adult]	[Child only] [Child with Adult]	[Child only]
------------------------------------	------------------------------------	--------------

Waiting Period	[0-24] months	[0-24] months	[0-24] months
----------------	---------------	---------------	---------------

Lifetime Maximum Benefit Child with Adult	[\$1000-\$2500]	[\$1000-\$2000]	[\$500-\$1500]
Child only	[\$1000-\$2500]	[\$1000-\$2000]	[\$500-\$1500]

**[Special Dental Accident Benefit]**

Covers injury to sound, natural teeth	[\$1,000] maximum per accident	[\$1,000] maximum per accident	[\$1,000] maximum per accident]]
--	--------------------------------------	--------------------------------------	--

**[Children's Good Vision Benefit]**

[50%] of Usual and Customary Expenses	[50%] of Usual and Customary Expenses	[50%] of Usual and Customary Expenses]]
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**[Major Dentistry Waiting Period Waiver**

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

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

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

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

**PART 2 - DENTAL PLAN LIMITATIONS AND EXCLUSIONS**

**Limitations**

**Covered Dental Benefit Expenses**

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

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

- (1) [routine oral examination and diagnosis not more often than once every six months per individual;
- (2) bitewing x-rays not more often than once every twelve months per individual
- (3) full mouth x-rays or panoramic films are limited to once every five years
- (4) prophylaxis not more often than once every six months per individual;

- (5) one annual topical fluoride treatment through age 15;
- (6) sealants for Your dependent child under age [14]15, limited to treatment of permanent molars once in any 36-month period.]

**CLASS II - Basic Dental Procedures include:**

- (1) [all fillings other than lab fabricated restorations (composite fillings limited to permanent anterior teeth);
- (2) space maintainers for Your dependent child under age 17;
- (3) emergency palliative treatment;
- (4) limited oral exam not more than once every six months
- (5) oral surgery;
  - (a) simple extraction, excluding orthodontic extractions unless You are covered by a Best Life orthodontic rider.
  - (b) surgical extraction, including impaction:
    - 1. erupted
    - 2. soft tissue impaction
    - 3. partial bony impaction
    - 4. complete bony impaction
  - (c) root recovery (surgical removal of residual root)
  - (d) removal of a dentigerous or odontogenic cyst
  - (e) incision and drainage of an abscess
- (6) general anesthesia - paid as a separate procedure only when required for complex oral surgical procedures (partial and complete bony impacted extractions only), for which Benefits are payable.
- (7) periodontics (tissues and gums);
- (8) periodontal maintenance (limited to once every [3] months per individual following active periodontal treatment);
- (9) periodontal scaling and root planing (limited to once every [36 month] [and to [2] quadrants per visit]);
- (10) endodontics (pulp capping and root canal); and
- (11) oral surgery:
  - (a) root recovery (surgical removal of residual root);
  - (b) removal of a dentigerous or odontogenic cyst;

- (c) incision and drainage of an abscess;
- (d) surgical exposure of impacted tooth to aid eruption;
- (e) removal of exostosis;
- (f) frenulectomy;
- (g) oral antral fistula closure.]

**Major** under Basic Dental Procedures.

- (a) [surgical exposure of impacted tooth to aid eruption
- (b) removal of exostosis is a covered benefit only if required for the placement of fixed or removal appliance”
- (c) frenulectomy
- (d) oral antral fistula closure]

**Note:** Unless the [12]-month waiting period requirement for Major Dentistry services has been met, the services below are not covered benefits for any treatment that began during the 12-month period immediately following Your effective date of coverage.

**CLASS III - Major Dental Procedures include:**

- (1) [inlays, onlays, crowns and other lab fabricated restorations (not including veneers);  
  
Suggestion: Another suggestion would be to add language that would convert inlays and onlays to a filling when a lesser benefit is warranted.
- (2) full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within 12 months after the extraction and while this coverage is in force;
- (3) replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
  - (a) accidental injury requiring oral surgical treatment, or
  - (b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within 12 months of the injury or surgical treatment.
- (4) replacement of a full denture or bridgework if the replacement is made more than seven years after the date of installation;



- (5) repair or relines of dentures and bridgework;
- (6) periodontics (tissues and gums);
- (7) periodontal exam (not in addition to a routine oral exam);
- (8) periodontal maintenance (limited to once every four months per individual following active periodontal treatment (limited to a minimum of four months following scaling and root planing), and not in addition to a routine prophylaxis)
- (9) periodontal scaling and root planing (limited to once every 36 months and two quadrants per visit, and not in addition to a routine prophylaxis)
- (10) endodontics (root canal )
  - (a) **Dental Limitations and** soft tissues are sound and healthy;
  - (b) implant supported prosthetics;
  - (c) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);
  - (d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;
- (11) periodontics (tissues and gums);
- (12) periodontal maintenance (limited to once every [3] months per individual following active periodontal treatment);
- (13) periodontal scaling and root planing (limited to once every [36] months); [and to [2] quadrants per visit];
- (14) endodontics (pulp capping and root canal); and
- (15) [oral surgery:
  - (a) root recovery (surgical removal of residual root);
  - (b) removal of a dentigerous or odontogenic cyst;
  - (c) incision and drainage of an abscess;
  - (d) surgical exposure of impacted tooth to aid eruption;
  - (e) removal of exostosis;
  - (f) frenulectomy;
  - (g) oral antral fistula closure.]
  - (h) [simple extraction;
  - (i) surgical extraction, including impaction:
    - i. erupted;
    - ii. soft tissue impaction;
    - iii. partial bony impaction;
    - iv. complete bony impaction;]

## Exclusions

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

- (1) [expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
- (2) an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
- (3) pulp capping, if in conjunction with the installation of inlays, onlays or crowns and fillings;
- (4) replacement of a lost or stolen or discarded prosthetic device;
- (5) dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
- (6) the replacement of a crown, prosthesis, fixed bridge or denture if such crown, prosthesis, fixed bridge or denture was installed less than [5 or 7]seven years before, unless such replacement is made necessary by the initial extraction of an adjoining functional natural tooth;
- (7) the initial installation of a prosthetic device (a fixed bridge or denture), including crowns and inlays which form abutments, to replace teeth missing before You were covered under the policy, except when it also replaces a tooth that is extracted while covered unless such installation commences after You have remained continuously covered under this plan for at least three years immediately prior to the date such installation commences;
- (8) expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are covered under a BEST Life orthodontic rider.
- (9) expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
- (10) charges in excess of Usual, Reasonable and Customary charges;
- (11) services and supplies not reasonably necessary;
- (12) charges for service provided for temporomandibular joint dysfunction (TMJ);
- (13) services and supplies covered under any Worker's Compensation Act or similar law;
- (14) services and supplies performed outside of the United States of America are subject to a fixed fee schedule. Please see your schedule of benefits for description.

- (15) expenses incurred for congenital or developmental malformations;
- (16) expenses incurred for dental implants and related procedures, including but not limited to endosteal, subperiosteal, and any associated fixed or removable prosthetic device.
- (17) [implants, implant services and implant supported prosthetics are not covered for patients under the age of sixteen;] and
- (18) [expenses incurred for the maintenance of dental implants;]
- (19) any services or supplies for correction or alteration of occlusion, or any occlusal adjustments;
- (20) expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
- (21) expenses incurred for night guards or any other appliances for the correction of harmful habits;
- (22) expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, Your lawful spouse, child, parent, step-parent, grandparent, brother, sister, cousin or in-law;
- (23) expenses incurred due to treatment rendered by Your employer;
- (24) expenses not otherwise specifically listed as a Covered Expense;
- (25) expenses for services for which You would not legally have to pay if there were no insurance;
- (26) services not completed on or before the date of termination must be completed within 90-days of the termination date, unless such services are covered under the Extension of Dental Benefits. If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST LIFE shall be liable only for the amount it would have been liable for had one dentist rendered the services;
- (27) expenses that are applied toward satisfaction of a Deductible, if any;
- (28) for all procedures that are begun prior to your effective date, but not completed;
- (29) adjustment, repairs or relines of prostheses for a period of one year from initial placement if the prostheses were paid for under this plan;
- (30) if an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST LIFE shall be liable only for the amount it would have been liable for had one dentist rendered the services;



- (31) if multiple endodontic treatments are necessary on the same tooth within a period of one year, the allowance will be made for only one procedure;
- (32) the extraction of immature erupting third molars and non-pathologic, asymptomatic third molar extractions;
- (33) expenses for gross debridement allowed one time at the beginning of the periodontal treatment plan prior to pocket depth charting;
- (34) surgical procedures incidental to orthodontic treatment, including but not limited to, extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate;
- (35) any amounts in excess of the maximum amount stated in the "Schedule of Dental Benefits" section of this Plan;
- (36) Any service or procedure not commonly found within the scope of practice by a licensed dentist. Such procedures are identified within the current Common Dental Terminology (CDT Codes) published by the American Dental association. Pulp capping when completed with fillings or other lab fabricated restorations; including but not limited to inlays, onlays and crowns, preventative tests and examinations diagnostic casts and oral cancer screenings, and expenses incurred for sedative fillings, including charges for prescribed drugs, pre-medication or analgesia;  
Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
- (37) ridge augmentation, ridge preservation, bone graft and guided tissue regeneration in extraction sites and expenses incurred for dental implants and related procedures, including but not limited to endosteal and subperiosteal;];
- (38) charges in excess of the Preferred Provider Fee Schedule.
- (39) x-rays are considered an integral part of the endodontic procedure rather than a separate service and are therefore not eligible for benefits;
- (40) any combination of eight or more x-rays (including but not limited to bitewings or periapicals/intraorals) will be combined into a full mouth x-ray series.
- (41) expenses incurred for a core buildup will only be considered in conjunction with a crown.]

### PART 3 - DEFINITIONS

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

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

**Eligible Dependent:** Means:

- (1) Your lawful spouse; and
- (2) Your or Your spouse's child or children, including a natural child, step-child, foster child, lawfully adopted child or child in the process of being adopted, from the date of placement, or any child for whom You have been granted legal custody, provided they are:
  - (a) unmarried, and
  - (b) under 26 years old; and
- (3) A child named in a Qualified Medical Child Support Order will be considered a dependent.

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

**Eligible Employee:** Means:

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

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

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

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

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

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

**Insured:** Means an eligible employee or any of the Employee's eligible covered Dependents who are

insured under the Group Policy.

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

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

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

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

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

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

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

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

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

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



## PART 4 - PROVISIONS FOR COVERAGE

### EFFECTIVE DATE

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

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

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

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

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

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

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

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

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

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

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

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

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

### TERMINATION OF INSURANCE

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

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

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

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

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

### PART 5 - PROVISIONS DESCRIBING BENEFITS

#### ADVANCE NOTICE OF DENTAL TREATMENT

It is recommended that You or Your Dependent submit Advance Notice of Dental Treatment satisfactory to Us before treatment commences in order to obtain predetermination of covered dental expenses. If dental services are performed without such predetermination, We reserve the right to deny any claim

- submitted with respect to such services; provided however, that predetermination is not required for:
- (1) dental services for which the amount of covered dental charges is less than \$[500] during any course of treatment ("course of treatment" means one treatment or one of a planned series of treatments resulting from dental examination);
  - (2) emergency treatment; or
  - (3) oral examination and prophylaxis.

## DEDUCTIBLES

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

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

[Lifetime Deductible: The Lifetime Deductible as shown in the Schedule of Dental Benefits.]

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

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

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

## ALTERNATIVE PROCEDURES

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



## EXTENSION OF DENTAL BENEFITS

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

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

## PROVISION FOR TAKEOVER

If your employer has chosen to offer Takeover, this means that we give employees credit for certain benefits if the employee had substantially similar coverage accumulated under a group dental plan without any break in that coverage.

To qualify for Takeover you must provide to BEST Life:

- Evidence that the prior carrier's coverage has been in force for at least 12 months;
- A copy of the prior carrier's most recent bill, which should include a listing of all covered employees, as well as each employee's effective date of coverage; and
- A copy of the in-force dental plan description, which may be a contract schedule of benefits, certificate, or coverage description.

In addition, any deductible amount incurred under the prior plan during the current calendar year will be used toward satisfying the new BEST Life deductible. For proper deductible credit to be given, written documentation must be submitted at time of enrollment. A benefit applied to the maximum benefit amounts under the prior plan will also be applied to the maximum benefit amounts under BEST Life.

Orthodontic treatment that began under the prior plan and continues uninterrupted under BEST Life will be considered for takeover if both plans include orthodontic coverage. Any benefits payable under BEST Life will be reduced by the amount payable under the prior plan.

There are limitations in coverage when not replacing a current group dental plan.

## COORDINATION OF BENEFITS

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

### **Effect on Benefits:**

- (1) This provision shall apply in determining the benefits as to a person covered under this Plan for any Claim Determination Period if, for the Allowable Expenses incurred as to such person during such period, the sum of:
  - (a) the benefits that would be payable under this Plan in the absence of this provision; and
  - (b) the benefits that would be payable under all other Plans in the absence therein of provisions of similar purpose to this provision would exceed such Allowable Expenses.

- (2) As to any Claim Determination Period with respect to which this provision is applicable, the benefits that would be payable under this Plan in the absence of this provision for the Allowable Expenses incurred as to such person during such Claim Determination Period shall be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such Allowable Expenses under all other plans, except as provided in the next paragraph, shall not exceed the total of such Allowable Expenses. Benefits payable under another Plan include the benefits that would have been payable had claim been duly made therefore.
- (3) If:
- (a) another Plan which is involved in paragraph (2) and which contains a provision coordinating its benefits with those of this Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined, and
  - (b) the rules set forth in paragraph (4) would require this Plan to determine its benefits before such other Plan, and then the benefits of such other Plan will be ignored for the purposes of determining the benefits under this Plan.
- (4) For the purposes of paragraph (3), the rules establishing the order of benefit determination are:
- (a) The benefits of a Plan which covers the person on whose expenses claim is based other than as a Dependent shall be determined before the benefits of a Plan which covers such person as a Dependent.
  - (b) The benefits of a Plan which covers the person on whose expenses claim is based as a Dependent of the parent whose birthday comes earliest in the year, regardless of the year of birth, shall be determined before the benefits of a Plan which covers such person as a Dependent of the other parent except that in the case of a person for whom claim is made as a dependent child:
    - 1. when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Plan which covers the child as Dependent of the parent with custody of the child will be determined before the benefits of a Plan which covers the child as a Dependent of the parent without custody;
    - 2. when the parents are divorced and the parent with custody of the child has remarried, the benefits of a Plan which covers the child as a Dependent of the parent with custody shall be determined before the benefits of a Plan which covers that child as a Dependent of the stepparent, and the benefits of a Plan which covers the child as a Dependent of the stepparent will be determined before the benefits of the parent without custody. Notwithstanding 1. and 2. above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefits of a Plan which covers the child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan which covers the child as a dependent child.
  - (c) When rules (a) and (b) do not establish an order of benefit determination, the benefits of a Plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a Plan which has covered such person the shorter period of time.
- (5) When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during any Claim Determination Period, each benefit that would be

payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of this Plan.

(6) No Plan pays more than it would without the Coordination of Benefits provision.

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

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

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

## PART 6 - GENERAL PROVISIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**CONTINUATION OF DENTAL COVERAGE:** Federal Law (Public Law 99-272) requires Continuation of Dental Coverage for employers with 20 or more employees. Subject to the 20 employee requirement, You and Your Dependents who are covered under the group dental plan have the right to continue Your group dental coverage if it would terminate for the following specified reasons:

- (1) Termination of employment for any reason, except gross misconduct.
- (2) Loss of dental plan eligibility due to reduced employment hours.
- (3) Your employer files for a Chapter 11 reorganization;
- (4) Your death.
- (5) Your divorce.
- (6) Your legal separation if You no longer make contributions for spouse coverage.
- (7) A dependent child ceases to be a Dependent (i.e., reaches the maximum age, or becomes married, or is no longer a dependent for income tax purposes).
- (8) A Dependent's loss of eligibility because You become entitled to Medicare Benefits.
- (9) If You or Your Dependent would lose coverage due to one of the reasons in (5), (6), (7) or (8), You or Your Dependent must notify Us so We can give appropriate notice of Continuation rights and the terms which apply to the Continuation. For continuity of coverage, please give this notification within 30 days of the event.
- (10) If You or Your Dependent elect the continued coverage and make the proper premium payment, the coverage would be continued until the earliest of:
  - (1) the due date to pay any required premium (if premium is not paid by that date).
  - (2) the date the continued person becomes covered under another group dental plan or entitled to Medicare Benefits.
  - (3) the date the employer's group dental plan terminates. (If coverage is replaced, the Continuation is continued under the succeeding plan.)
  - (4) a date which is:
    1. 18 months from the date coverage would have terminated because Your employment was terminated or eligibility was lost due to reduction in hours. However, if You are determined to have been disabled for Social Security purposes, You can continue coverage for 29 months from the date coverage terminated provided that notice of such determination of disability is given within 60 days and before the end of the 18-month continuation period.
    2. 36 months from the date coverage would have terminated, if coverage is continued for any other reason.

The law permits Us to charge any person electing Continuation of coverage 102% of the cost of coverage to the plan except if the person extends Continuation of coverage to 29 months because of entitlement to Social Security disability Benefits, the law permits Us to charge 150% of the plan's cost for months 19 through 29. Full details of the Continuation will be sent to You or Your Dependents when We have been notified of one of the Continuation events.



## PART 7 - SUMMARY PLAN DESCRIPTION SUPPLEMENT

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

- (1) **EMPLOYER AND NAME OF PLAN:** The plan is known as the Beneficial Employees Security Trust and is maintained by Beneficial Employees Security Trust, [P.O. Box 3100, Newport Beach, California 92658-902]7.
- (2) **PLAN IDENTIFICATION NUMBER:** [501].
- (3) **TYPE OF ADMINISTRATION AND TYPE OF WELFARE PLAN:** The plan is administered by the Administrative Representative, named herein. Benefits are insured and provided in accordance with the provisions of the Group Dental Insurance Policy issued by BEST Life and Health Insurance Company at [2505 McCabe Way, Irvine, California 92614].
- (4) **ADMINISTRATIVE REPRESENTATIVE:** The Plan is administered by BEST Life and Health Insurance Company located at [2505 McCabe Way, Irvine, California 92614]. BEST Life's telephone number is [(800) 433-0088].
- (5) **AGENT FOR SERVICE:** The person designated for service of legal process is the Chief Legal Counsel of BEST Life and Health Insurance Company at the above address.
- (6) **TRUSTEE OF THE PLAN:** The Trustee of the plan is Wells Fargo Bank, N.A. The Trustee's mailing address is [180 South Main Street, 2<sup>nd</sup> Floor, Salt Lake City, Utah 84101].
- (7) **SOURCE OF PLAN CONTRIBUTION:** The contributions necessary to finance the plan are made by the employer and employees.
- (8) **DATE OF END OF THE PLAN'S FISCAL YEAR:** The fiscal year for this plan ends each year on December 31.
- (9) **CLAIM PROCEDURES:** (a) Claim forms may be obtained from the Personnel Department of the employer; and (b) Please see Your insurance Certificate for the requirements of the Group Insurance Policy as to notice of a claim to BEST Life and Health Insurance Company.
- (10) **CLAIMS DENIAL PROCEDURE:** Any denial of a claim for Benefits will be explained in writing and the explanation will include (a) the specific reason for the denial, (b) reference to the plan provision upon which the denial was based, (c) a description of any additional information You might be required to provide and an explanation of why it is needed, and (d) an explanation of the plan's claim review procedure.
- (11) You, Your beneficiary, or a duly-authorized representative may appeal any denial of a claim for Benefits by filing a written request for a review to BEST Life and Health Insurance Company. In connection with such a request, documents pertinent to the administration of the plan may be reviewed, and issues outlining the basis of the appeal may be submitted. You may have representation throughout the review procedure.
- (12) A request for a review must be filed within [180] days after receipt of the written notice of denial of a claim. A decision will be rendered by BEST Life and Health Insurance Company no later than [60] days after receipt of a request for review. If there are special circumstances, the decision shall be rendered as soon as possible, but no later than [15] days after receipt of the request for review. The decision, after Our review, shall be in writing and shall include specific reasons for the decision. This decision shall also include specific references to the pertinent

(13) policy provisions on which the decision was based.

## **PART 8- STATEMENT OF ERISA RIGHTS**

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

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

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

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

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

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

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

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

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

Underwritten by BEST Life and Health Insurance Company

**BEST Life and Health Insurance Company**

[2505 McCabe Way  
Irvine, California 92614]

A STOCK COMPANY  
(Herein called the Company)

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

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

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

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



President



Secretary

**GROUP INDEMNITY DENTAL CERTIFICATE  
NON-PARTICIPATING**

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

## **IMPORTANT NOTICE FOR ARKANSAS RESIDENTS**

For assistance with questions regarding your policy, benefits and Claims, please contact BEST Life and Health Insurance Company at the following:

2505 McCabe Way  
Irvine, CA 92614  
1-800-433-0088

You may also contact your agent for assistance.

If we at BEST Life and Health 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, AR 72204  
501-371-1811

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**PART 1 - SCHEDULE OF BENEFITS**

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

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

**PLAN SELECTED:** As selected by the [Subscribing Employer] [Insured Employee] and shown on the Statement of Coverage.

**SCHEDULE OF BENEFITS**

	<b>High Plan</b>	<b>Medium Plan</b>	<b>Basic Plan</b>
<b><u>Calendar Year Maximum</u></b>	[\$1000 - \$3000]	[\$1000 - 2000]	[\$500-\$1000]
<b><u>Preventive Dental Procedures</u></b> Includes dental exams, cleanings, fluoride treatments for children, x-rays	[80% - 100%] coverage for Eligible Expenses	[80%-100%] coverage for Eligible Expenses	[50%-100%] coverage for Eligible Expenses
Deductible	[\$0-\$50]	[\$0-\$75]	[\$0-\$100]
Waiting Period	[None]	[None]	[None]
<b><u>Basic Dental Procedures</u></b> Includes emergency palliative treatment, fillings, (amalgam, porcelain and plastic), anesthesia, space maintainers and pathology	[50%-100%] coverage for Eligible Expenses	[50%-100%] coverage for Eligible Expenses	[30%-80%] coverage for Eligible Expenses
Deductible	[\$0-\$50per Calendar Year]; [3] family maximum	[\$0-\$75 per Calendar Year]; [3] family maximum	\$50-\$100[\$50; \$75; \$100 per Calendar Year]; [3] family maximum
Waiting Period	[0-12 months]	0-12 months	0-12 months
Periodontics/Endodontics	[Covered; N/A]	[Covered; N/A]	N/A
Oral Surgery	Covered	Covered	N/A
<b><u>Major Dental Procedures</u></b> Includes prosthetics, crowns & gold fillings, inlays, onlays and pontics	[50%-80%] coverage for Eligible Expenses	[40%-60%] coverage for Eligible Expenses	[0%-50%] coverage for Eligible Expenses

Deductible	Basic Services Calendar Year deductible applies	Basic Services Calendar Year deductible applies	Basic Services Calendar Year deductible applies
Waiting Period	0-24 months	0-24 months	0-24 months
Periodontics/Endodontics	[Covered; N/A]	[Covered; N/A]	[Covered]
Oral Surgery	N/A	N/A	[Covered]
<b><u>[Orthodontics]</u></b>	[40%-60%] coverage for Eligible Expenses	[40%-60%] coverage for Eligible Expenses	[40%-60%] coverage for Eligible Expenses
	[Child only] [Child with Adult]	[Child only] [Child with Adult]	[Child only]
Waiting Period	[0-24] months	[0-24] months	[0-24] months
Lifetime Maximum Benefit			
Child with Adult	[\$1000-\$2500]	[\$1000-\$2000]	[\$500-\$1500]
Child only	[\$1000-\$2500]	[\$1000-\$2000]	[\$500-\$1500]
<b><u>[Special Dental Accident Benefit]</u></b>	[\$1,000] maximum per accident	[\$1,000] maximum per accident	[\$1,000] maximum per accident]
Covers injury to sound, natural teeth			
<b><u>[Children's Good Vision Benefit]</u></b>	[50%] of Usual and Customary Expenses	[50%] of Usual and Customary Expenses	[50%] of Usual and Customary Expenses]

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

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

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

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

## PART 2 - DENTAL PLAN EXCLUSIONS AND LIMITATIONS

### Limitations

#### Covered Dental Benefit Expenses

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

#### Preventive Dental Procedures:

- (1) [routine oral examination and diagnosis not more often than once every [6] months per individual;
- (2) x-rays not more often than once every [6 or 12] months per individual ([panoramic or] full mouth x-rays are limited to once in a [3-year or 5-year] period);
- (3) prophylaxis not more often than once every six months per individual;
- (4) one annual topical fluoride treatment through age [15];
- (5) sealants for Your dependent child under age [14], limited to treatment of permanent molars once in any [36]-month period.]

#### Basic Dental Procedures:

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

- (c) incision and drainage of an abscess;
- (d) surgical exposure of impacted tooth to aid eruption;
- (e) removal of exostosis;
- (f) frenulectomy;
- (g) oral antral fistula closure.]

**Major Dental Procedures:**

- (1) [inlays, onlays, crowns and other lab fabricated restorations [(if the tooth can be restored with less expensive materials, covered expenses will be based on those materials)];
- (2) porcelain, porcelain fused to metal, or full gold crowns are limited to patients over the age of [14] and on permanent teeth;
- (3) full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within [12] months after the extraction and while this coverage is in force;
- (4) replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
  - (a) accidental injury requiring oral surgical treatment, or
  - (b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within [12] months of the injury or surgical treatment.
- (4) replacement of a full denture or bridgework if the replacement is made more than [five or seven] years after the date of installation;
- (5) repair or reline of dentures and bridgework;
- (6) implants (limited to once in a lifetime per site, and for patients over the age of [16]):
  - (a) the surgical placement of endosteal implant body including healing cap, where the bone and soft tissues are sound and healthy;
  - (b) implant supported prosthetics;
  - (c) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);
  - (d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;
- (7) periodontics (tissues and gums);
- (8) periodontal maintenance (limited to once every [3] months per individual following active periodontal treatment);
- (9) periodontal scaling and root planing (limited to once every [36] months); [and to [2] quadrants per visit]);
- (10) endodontics (pulp capping and root canal); and
- (11) [oral surgery:
  - (a) root recovery (surgical removal of residual root);
  - (b) removal of a dentigerous or odontogenic cyst;
  - (c) incision and drainage of an abscess;
  - (d) surgical exposure of impacted tooth to aid eruption;
  - (e) removal of exostosis;
  - (f) frenulectomy;
  - (g) oral antral fistula closure.]
  - (h) [simple extraction;
  - (i) surgical extraction, including impaction:
    - (i) erupted;

- (ii) soft tissue impaction;
- (iii) partial bony impaction;
- (iv) complete bony impaction;]

## Exclusions

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

- (1) [treatment by someone other than a dentist or physician, except where performed by a duly qualified technician under the direction of a dentist or physician;
- (2) expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
- (3) an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
- (4) pulp capping, if in conjunction with the installation of inlays, onlays or crowns and fillings;
- (5) replacement of a lost or stolen or discarded prosthetic device;
- (6) dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
- (7) the replacement of any prosthesis (a crown, [implant,] fixed bridge or denture) if such prosthesis was installed less than [5 or 7] years before, unless:
  - (a) such replacement is made necessary by the initial extraction of an adjoining functional natural tooth;
  - (b) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non-chewing injury while covered;
- (8) the initial installation of a prosthetic device (a[n implant,] fixed bridge or denture), including crowns and inlays which form abutments, to replace teeth missing before You were covered under the policy, except when it also replaces a tooth that is extracted while covered unless such installation commences after You have remained continuously covered under this plan for at least [3] years immediately prior to the date such installation commences;
- (9) expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are covered under the plan.
- (10) expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
- (11) charges in excess of [Usual, Reasonable and Customary] [Maximum Allowable] charges;
- (12) services and supplies not reasonably necessary;
- (13) charges for service provided for temporomandibular joint dysfunction (TMJ);
- (14) services and supplies covered under any Worker's Compensation Act or similar law;
- (15) services and supplies performed outside of the United States of America;
- (16) expenses incurred for congenital or developmental malformations;
- (17) [expenses incurred for dental implants and related procedures, including but not limited to endosteal and subperiosteal;] or
- (18) [implants, implant services and implant supported prosthetics are not covered for patients under the age of sixteen;] and
- (19) [expenses incurred for the maintenance of dental implants;]
- (20) any services or supplies for correction or alteration of occlusion, or any occlusal adjustments;
- (21) charges for prescribed drugs, pre-medication or analgesia;

- (22) expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
- (23) expenses incurred for night guards or any other appliances for the correction of harmful habits;
- (24) expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, Your lawful spouse, child, parent, step-parent, grandparent, brother, sister or in-law;
- (25) expenses incurred due to treatment rendered by Your employer;
- (26) expenses not otherwise specifically listed as a Covered Expense;
- (27) expenses for services for which You would not legally have to pay if there were no insurance;
- (28) for services not completed on or before the date of termination unless the services are covered under the Extension of Dental Benefits;
- (29) expenses that are applied toward satisfaction of a Deductible, if any;
- (30) for all procedures that are begun prior to your effective date, but not completed;
- (31) adjustment, repairs or relines of prostheses for a period of six months from initial placement if the prostheses were paid for under this plan;
- (32) if an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
- (33) if multiple endodontic treatments are necessary on the same tooth within a period of one year, the allowance will be made for only one procedure;
- (34) the extraction of immature erupting third molars and non-pathologic, asymptomatic third molar extractions;
- (35) temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
- (36) expenses for gross debridement allowed one time at the beginning of the periodontal treatment plan prior to pocket depth charting;
- (37) surgical procedures incidental to orthodontic treatment, including but not limited to, extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate;
- (38) any amounts in excess of the maximum amount stated in the "Schedule of Dental Benefits" section of this Plan;
- (39) application of chemotherapeutic agents; and
- (40) ridge augmentation, ridge preservation, bone graft and guided tissue regeneration in extraction sites;
- (41) charges in excess of the Preferred Provider Fee Schedule.]

### PART 3 - DEFINITIONS

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

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

**Eligible Dependent:** Means:

- (1) Your lawful spouse; and
- (2) Your or Your spouse's child or children, including a natural child, step-child, foster child, lawfully adopted child or child in the process of being adopted, from the date of placement, or any child for whom You have been granted legal custody, provided they are:
  - (a) unmarried, and
  - (b) under 26 years old; and
- (3) A child named in a Qualified Medical Child Support Order will be considered a dependent.

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

**Eligible Employee:** Means:

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

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

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

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

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

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

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

**[Maximum Allowable Charge:** Means the fee shown in the Preferred Provider Fee Schedule for dental services and supplies generally furnished for cases of comparable severity and nature. For vision

services and Non-Preferred Provider dental services, Maximum Allowable Charge means the plan will pay a reasonable fee based on a fee level which is in the same range of fees customarily charged for the services or supplies in the geographic area concerned.]

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

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

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

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

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

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

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

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

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

## PART 4 - PROVISIONS FOR COVERAGE

### EFFECTIVE DATE

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

- (1) the date Your employer becomes a Participating Employer, if Your enrollment card is received by Us within [31] days of that date; or

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

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

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

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

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

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

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

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

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

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

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

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

## TERMINATION OF INSURANCE

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

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

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

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

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

## PART 5 - PROVISIONS DESCRIBING BENEFITS

### ADVANCE NOTICE OF DENTAL TREATMENT

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

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

### DEDUCTIBLES

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

**[Family Calendar Year Deductible:** The Family Calendar Year Deductible is satisfied when [each of [3, 2]

covered members of Your family satisfy the Individual Calendar Year Deductible] [the combined costs of services provided by covered members of Your family is equal to the Family Calendar Year Deductible amount.]

[Lifetime Deductible: The Lifetime Deductible as shown in the Schedule of Dental Benefits.]

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

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

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

#### **ALTERNATIVE PROCEDURES**

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

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

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

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

#### **COORDINATION OF BENEFITS**

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

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

- (1) This provision shall apply in determining the benefits as to a person covered under this Plan for any Claim Determination Period if, for the Allowable Expenses incurred as to such person during such period, the sum of:
  - (a) the benefits that would be payable under this Plan in the absence of this provision; and
  - (b) the benefits that would be payable under all other Plans in the absence therein of provisions of similar purpose to this provision would exceed such Allowable Expenses.
- (2) As to any Claim Determination Period with respect to which this provision is applicable, the

benefits that would be payable under this Plan in the absence of this provision for the Allowable Expenses incurred as to such person during such Claim Determination Period shall be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such Allowable Expenses under all other plans, except as provided in the next paragraph, shall not exceed the total of such Allowable Expenses. Benefits payable under another Plan include the benefits that would have been payable had claim been duly made therefore.

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

**Right to Receive and Release Necessary Information:** For the purpose of determining the applicability of

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

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

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

## PART 6 - GENERAL PROVISIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**CONTINUATION OF DENTAL COVERAGE:** Federal Law (Public Law 99-272) requires Continuation of Dental Coverage for employers with 20 or more employees. Subject to the 20 employee requirement, You and Your Dependents who are covered under the group dental plan have the right to continue

Your group dental coverage if it would terminate for the following specified reasons:

- (1) Termination of employment for any reason, except gross misconduct.
- (2) Loss of dental plan eligibility due to reduced employment hours.
- (3) Your employer files for a Chapter 11 reorganization;
- (4) Your death.
- (5) Your divorce.
- (6) Your legal separation if You no longer make contributions for spouse coverage.
- (7) A dependent child ceases to be a Dependent (i.e., reaches the maximum age, or becomes married, or is no longer a dependent for income tax purposes).
- (8) A Dependent's loss of eligibility because You become entitled to Medicare Benefits.
- (9) If You or Your Dependent would lose coverage due to one of the reasons in (5), (6), (7) or (8), You or Your Dependent must notify Us so We can give appropriate notice of Continuation rights and the terms which apply to the Continuation. For continuity of coverage, please give this notification within 30 days of the event.
- (10) If You or Your Dependent elect the continued coverage and make the proper premium payment, the coverage would be continued until the earliest of:
  - (1) the due date to pay any required premium (if premium is not paid by that date).
  - (2) the date the continued person becomes covered under another group dental plan or entitled to Medicare Benefits.
  - (3) the date the employer's group dental plan terminates. (If coverage is replaced, the Continuation is continued under the succeeding plan.)
  - (4) a date which is:
    1. 18 months from the date coverage would have terminated because Your employment was terminated or eligibility was lost due to reduction in hours. However, if You are determined to have been disabled for Social Security purposes, You can continue coverage for 29 months from the date coverage terminated provided that notice of such determination of disability is given within 60 days and before the end of the 18-month continuation period.
    2. 36 months from the date coverage would have terminated, if coverage is continued for any other reason.

The law permits Us to charge any person electing Continuation of coverage 102% of the cost of coverage to the plan except if the person extends Continuation of coverage to 29 months because of entitlement to Social Security disability Benefits, the law permits Us to charge 150% of the plan's cost for months 19 through 29. Full details of the Continuation will be sent to You or Your Dependents when We have been notified of one of the Continuation events.

#### **PART 7 - SUMMARY PLAN DESCRIPTION SUPPLEMENT**

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

- (1) **EMPLOYER AND NAME OF PLAN:** The plan is known as the Beneficial Employees Security Trust and is maintained by Beneficial Employees Security Trust, [P.O. Box 3100, Newport Beach, California 92658-902]7.
- (2) **PLAN IDENTIFICATION NUMBER:** [501].
- (3) **TYPE OF ADMINISTRATION AND TYPE OF WELFARE PLAN:** The plan is administered by the Administrative Representative, named herein. Benefits are insured and provided in accordance with

the provisions of the Group Dental Insurance Policy issued by BEST Life and Health Insurance Company at [2505 McCabe Way, Irvine, California 92614].

**(4) ADMINISTRATIVE REPRESENTATIVE:** The Plan is administered by BEST Life and Health Insurance Company located at [2505 McCabe Way, Irvine, California 92614]. BEST Life's telephone number is [(800) 433-0088].

**(5) AGENT FOR SERVICE:** The person designated for service of legal process is the General Counsel of BEST Life and Health Insurance Company at the above address.

**(6) TRUSTEE OF THE PLAN:** The Trustee of the plan is Wells Fargo Bank, N.A. The Trustee's mailing address is [180 South Main Street, 2<sup>nd</sup> Floor, Salt Lake City, Utah 84101].

**(7) SOURCE OF PLAN CONTRIBUTION:** The contributions necessary to finance the plan are made by the employer and employees.

**(8) DATE OF END OF THE PLAN'S FISCAL YEAR:** The fiscal year for this plan ends each year on December 31.

**(9) CLAIM PROCEDURES:** (a) Claim forms may be obtained from the Personnel Department of the employer; and (b) Please see Your insurance Certificate for the requirements of the Group Insurance Policy as to notice of a claim to BEST Life and Health Insurance Company.

**(10) CLAIMS DENIAL PROCEDURE:** Any denial of a claim for Benefits will be explained in writing and the explanation will include (a) the specific reason for the denial, (b) reference to the plan provision upon which the denial was based, (c) a description of any additional information You might be required to provide and an explanation of why it is needed, and (d) an explanation of the plan's claim review procedure.

You, Your beneficiary, or a duly-authorized representative may appeal any denial of a claim for Benefits by filing a written request for a review to BEST Life and Health Insurance Company. In connection with such a request, documents pertinent to the administration of the plan may be reviewed, and issues outlining the basis of the appeal may be submitted. You may have representation throughout the review procedure.

A request for a review must be filed within [180] days after receipt of the written notice of denial of a claim. A decision will be rendered by BEST Life and Health Insurance Company no later than [60] days after receipt of a request for review. If there are special circumstances, the decision shall be rendered as soon as possible, but no later than [15] days after receipt of the request for review. The decision, after Our review, shall be in writing and shall include specific reasons for the decision. This decision shall also include specific references to the pertinent policy provisions on which the decision was based.

## **PART 8 - STATEMENT OF ERISA RIGHTS**

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

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

required by law to furnish each participant with a copy of this summary financial report.

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

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

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

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

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

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

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

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