

SERFF Tracking Number: CSLI-126599403 State: Arkansas
 Filing Company: Citizens Security Life Insurance Company State Tracking Number: 45508
 Company Tracking Number:
 TOI: H10I Individual Health - Dental Sub-TOI: H10I.000 Health - Dental
 Product Name: Individual NH Dental - Revised
 Project Name/Number: Revised NH Dental Policy/

Filing at a Glance

Company: Citizens Security Life Insurance Company

Product Name: Individual NH Dental - Revised SERFF Tr Num: CSLI-126599403 State: Arkansas
 TOI: H10I Individual Health - Dental SERFF Status: Closed-Approved- State Tr Num: 45508
 Closed

Sub-TOI: H10I.000 Health - Dental Co Tr Num: State Status: Approved-Closed
 Filing Type: Form/Rate Reviewer(s): Rosalind Minor
 Author: Rickie Bolduc Disposition Date: 04/27/2010
 Date Submitted: 04/26/2010 Disposition Status: Approved-Closed
 Implementation Date: Implementation Date:

Implementation Date Requested: On Approval
 State Filing Description:

General Information

Project Name: Revised NH Dental Policy
 Project Number:
 Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Not Filed
 Date Approved in Domicile:
 Domicile Status Comments: We do not plan to file the Revised policy in our state of domicile, Kentucky, at this time.
 Market Type: Individual
 Group Market Size:
 Group Market Type:
 Explanation for Other Group Market Type:
 State Status Changed: 04/27/2010
 Created By: Rickie Bolduc
 Corresponding Filing Tracking Number:

Explanation for Combination/Other:
 Submission Type: New Submission
 Overall Rate Impact:
 Filing Status Changed: 04/27/2010

Deemer Date:
 Submitted By: Rickie Bolduc
 Filing Description:

Enclosed please find an Individual Dental Insurance Policy and Outline of Coverage for your review and approval. These are new forms. The forms are identical to previously approved forms (PA 01 10 AR and AG 01 10 AR; tracking number SERFF #CSLI-126461188 and AR DOI # 44621; approved 01/25/2010) except we have added additional benefits and the premium has increased slightly.

This form is designed to provide Dental Insurance benefits to individual insureds who reside in living care facilities. Benefits include payment of expenses for services incurred for covered dental procedures, subject to any applicable co-

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 payment amounts.

We have added the following benefits: a) Oral Hygiene Instruction and Supplies and
 b) Denture Cleaning/Engraving.

Other forms that will be used in conjunction with these are:

- 1) Application, form # AP 01 10 AR, approved 01/25/2010;
- 2) Quality Assurance Program, form #CCA1 PA 01 10 AR; approved 01/25/2010;
- 3) Participating Dentist Agreement, form #CCA2 PA 01 10 AR; approved 01/25/2010.

Finally, enclosed is the Actuarial Memorandum containing the premium rate.

Company and Contact

Filing Contact Information

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

Filing Company Information

Citizens Security Life Insurance Company	CoCode: 61921	State of Domicile: Kentucky
12910 Shelbyville Road, Suite 300	Group Code: 1310	Company Type: Life and Accident and Health
PO Box 436149	Group Name: Citizens Financial Group	State ID Number:
Louisville, KY 40253-6149	FEIN Number: 61-0648389	
(502) 244-2420 ext. [Phone]		

Filing Fees

Fee Required?	Yes
Fee Amount:	\$150.00
Retaliatory?	No
Fee Explanation:	Policy \$50.00 Outline \$50.00 Actuarial Justification/Rate \$50.00

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Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Citizens Security Life Insurance Company	\$150.00	04/26/2010	35946143

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/27/2010	04/27/2010

SERFF Tracking Number: *CSLI-126599403* *State:* *Arkansas*
Filing Company: *Citizens Security Life Insurance Company* *State Tracking Number:* *45508*
Company Tracking Number:
TOI: *H101 Individual Health - Dental* *Sub-TOI:* *H101.000 Health - Dental*
Product Name: *Individual NH Dental - Revised*
Project Name/Number: *Revised NH Dental Policy/*

Disposition

Disposition Date: 04/27/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form	Individual Dental Policy	Approved-Closed	Yes
Form	Outline of Coverage	Approved-Closed	Yes

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Form Schedule

Lead Form Number: PA 03 10 AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 04/27/2010	PA 03 10 AR	Policy/Cont ract/Fratern al Certificate	Individual Dental	Initial		45.000	Form PA 03 10 AR.pdf
Approved-Closed 04/27/2010	AG 03 10 AR	Outline of Coverage	Outline of Coverage	Initial		40.000	Form AG 03 10 AR.pdf

Citizens Security Life Insurance Company

12910 Shelbyville Road, Suite 300, Louisville, KY 40243
Toll Free Telephone No: 1-800-843-7752

DENTAL INSURANCE POLICY

The Named Insured as shown in the Policy Schedule of Benefits will be referred to as "You", "Your" or "Yours". Citizens Security Life Insurance Company will be referred to as "We", "Our" or "Us".

IMPORTANT

This is a dental only policy. It does not pay benefits for loss from any other cause. The policy is a legal contract between You and Us.

CONSIDERATION

This policy is issued in consideration of the statements made in Your application and the payment of the premium shown in the Policy Schedule of Benefits. A copy of Your application is attached and is part of this policy. The following paragraphs set forth the insurance benefits, limitations and exclusions, definitions of terms, and other provisions.

YOUR RIGHT TO EXAMINE THIS POLICY – FREE LOOK

It is important to Us that You are satisfied with this policy and that it meets Your insurance goals. If You are not satisfied, You may return it within 30 days after You receive it. You will receive a full refund of all premiums paid, and Your policy will be void from its effective date. If You return the policy, please send it to Citizens Security Life Insurance Company at 12910 Shelbyville Road, Suite 300, Louisville, KY 40243 and note in writing: "This policy is returned for cancellation and refund of premium."

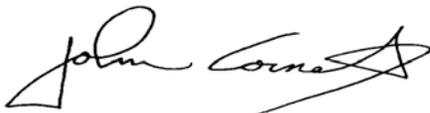
IMPORTANT NOTICE

Please read Your application attached to this policy. This policy is issued on the basis that the information shown on the application is correct and complete to the best of Your knowledge and belief. Carefully check the application. Write to Us within 30 days of the date You receive this policy if any information shown on it is not correct or complete. Incorrect information can result in the denial of a claim or termination of the policy. No duly licensed agent may change this policy or waive any of its provisions.

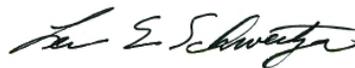
THIS POLICY IS OPTIONALLY RENEWABLE SUBJECT TO OUR RIGHT TO CHANGE PREMIUM RATES UPON ANY RENEWAL DATE.

We agree that this policy will never be restricted by the addition of any rider without Your consent. We may change the established premium rate effective on any renewal date. If the established premium rate changes, We will notify You in writing at Your last known address at least 30 days before the change becomes effective.

READ YOUR POLICY CAREFULLY. The Outline of Coverage provides only a brief description of some of the important features of your policy. The Outline of Coverage is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of You and Us. **IT IS THEREFORE IMPORTANT THAT YOU READ YOUR POLICY.**



President



Secretary

THIS IS A LIMITED POLICY---READ IT CAREFULLY
DENTAL INSURANCE POLICY
OPTIONALLY RENEWABLE
PREMIUMS ARE SUBJECT TO CHANGE ON ANY RENEWAL DATE

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POLICY SCHEDULE OF BENEFITS

Named Insured: [\[John Doe\]](#)
Mode of Payment: [\[Monthly\]](#)
Policy Premiums: [\[\\$90.00\]](#)

Policy Number: [\[XXXXXXXXX\]](#)
Policy Effective Date: [\[XX/XX/20XX\]](#)

Part 1
DEFINITIONS

- A. DENTAL HYGIENIST:** a legally qualified person, other than a member of Your Immediate Family, who is licensed by the state to treat the type of condition for which a claim is made.
- B. DENTIST:** a legally qualified person, other than a member of Your Immediate Family, who is licensed by the state to treat the type of condition for which a claim is made.
- C. PARTICIPATING PROVIDER:** a Dentist or other dental professional who has entered into a Participating Provider Agreement with Us to provide Covered Dental Procedures to an Insured.
- D. NON-PARTICIPATING PROVIDER:** a Dentist or other dental professional who has not entered into a Participating Provider Agreement with Us to provide Covered Dental Procedures to an Insured.
- E. CO-PAYMENT:** the portion of a provider's charge for services that the insured must pay directly to the provider in order to receive dental services.
- F. INSURED:** a resident of a Living Care Facility who is insured under this policy as specified in the Policy Schedule of Benefits.
- G. IMMEDIATE FAMILY:** anyone related to You in the following manner: spouse; brother or sister (includes stepbrother and stepsister); children (includes stepchildren); parents (includes stepparents); grandchildren; brother-in-law; sister-in-law; son-in-law; or daughter-in-law. Immediate Family members are not Insureds under this policy.
- H. COVERED DENTAL PROCEDURE:** any procedure listed in the Schedule of Covered Procedures.
- I. SCHEDULE OF COVERED PROCEDURES:** a listing of all Covered Dental Procedures and the corresponding required co-payments.
- J. FUNCTIONING NATURAL TOOTH:** means a tooth which is performing its normal role in the chewing process in the covered person's upper or lower arch and which is opposed in the person's other arch by another tooth or prosthetic (i.e. artificial) replacement. Third molars are not considered Functioning Natural Teeth for purposes of this policy.
- K. LIVING CARE FACILITY:** means an extended care facility, skilled nursing facility, rest home, convalescent home, convalescent hospital, home for the aged, or similar institution agreeing to permit dental services to be provided on its premises by a Provider.

Part 2
PREMIUMS AND RENEWABILITY

- A. PREMIUM DUE DATE:** The initial premium is due and payable on the Policy Effective Date, as shown in the Policy Schedule of Benefits. Subsequent premiums are due and payable on the first day of each renewal term.
- B. CHANGES IN PREMIUM RATES:** We have the right to change the premium rate on the following dates:
 - a. On any renewal date; or
 - b. The effective date of any change in benefits under the policy; or
 - c. On the effective date of any law or regulation that affects Our liability under the policy.

We will give you at least 30 days written notice prior to any change in premium rates.

- C. GRACE PERIOD:** Unless We have delivered to You, or have mailed to Your last address as shown by Our records, at least ninety (90) days prior to the premium due date a written notice of Our intention not to renew this policy beyond the period for which the premium has been accepted, a grace period of 31 days will be granted for the payment of each premium due after the initial premium. The policy shall continue in force during the grace period.
- D. FAILURE TO PAY PREMIUM WHEN DUE:** If a premium is not paid within the Grace Period, this Policy will terminate at the end of the last day for which Premium has been received.

- E. RETURN OF UNEARNED PREMIUM:** Upon cancellation of this policy, We will promptly return to you the unearned portion of any premium paid beyond the month in which the cancellation is effective. In the event of your death, We will refund any unearned premium to Your estate or assignee.
- F. RENEWABILITY:** We reserve the right to refuse renewal of this policy. Subject to the right to terminate the policy upon nonpayment of premium when due, such right to refuse renewal may not be exercised so as to take effect before the renewal date occurring on each policy anniversary (or in the case of lapse and reinstatement, at the renewal date occurring on each anniversary of the last reinstatement). Any refusal of renewal shall be without prejudice to any claim originating while the policy was in force.
- G. TERMINATION:** Coverage under this policy will end on the earliest of the following dates:
- The last day of the month in which You cease to be a resident of a Living Care Facility;
 - The last day of the last month for which a required premium is paid;
 - The premium due date following the expiration of the 90 day notice to You of Our intent to terminate; or
 - The premium due date following the expiration of Your 90 day notice to Us of Your intent to terminate.

Part 3 **BENEFITS**

- A. COVERED SERVICES:** This policy provides covered services for all procedures listed in the Schedule of Covered Procedures to the Insured specified in the Policy Schedule of Benefits.
- B. CO-PAYMENTS AND FREQUENCY LIMITS:** Covered services may be subject to co-payments or frequency limits as specified in the Schedule of Covered Procedures.
- C. OTHER COVERAGE:** If an Insured has other dental coverage in addition to this policy, under no circumstances shall total benefits for services exceed 100% of the provider's normal charge for such services.
- D. PARTICIPATING PROVIDERS:** All dental services covered under this policy may be provided by Participating Providers. Participating Providers will provide covered services at the Living Care Facility where You reside.
- E. NON-PARTICIPATING PROVIDERS:** All dental services covered under this policy may be provided by Non-Participating Providers at the Benefit levels listed in the Schedule of Covered Procedures.
- F. DETERMINATION OF SERVICES:** All professional services to be performed shall be determined by the Dentist or Dental Professional and the Insured.
- G. ACTS OF PROVIDERS:** The Dentist or Dental Professional furnishing services to You are independent contractors. We are not liable for the negligence, wrongful acts, or omissions by You or any other person, Provider, Living Care Facility, or Living Care Facility employee receiving or providing covered services.

Part 4 **CLAIM PROVISIONS**

- A. NOTICE OF CLAIM:** Notice of claim must be given to Us within sixty (60) days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of You or the beneficiary to Citizens Security Life Insurance Company, 12910 Shelbyville Road, Suite 300, Louisville, KY 40243, or to any authorized agent of Ours, with information sufficient to identify You, shall be deemed notice to Us. Notice of claim should include the name of the covered person and the policy number.
- B. CLAIM FORMS:** Upon Our receipt of a notice of claim, We will furnish to the claimant such forms as are usually furnished by Us for filing proofs of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

- C. PROOF OF LOSS:** Proof of loss must be furnished to Us in case of claim for loss for which this policy provides payment within ninety (90) days after the termination of the period for which We are liable, and in case of claim for any other loss within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.
- D. TIME OF PAYMENT OF CLAIMS:** Benefits payable under this policy will be paid within thirty (30) days of receipt of due written proof of the loss, or within three (3) business days of receipt of due proof of loss for claims submitted electronically.
- E. PAYMENT OF CLAIMS:** All benefits will be payable to You unless assigned by You or by operation of law. Any accrued benefits unpaid at Your death will be paid to Your estate or assignee.
- F. CLAIMS REVIEW PROCEDURE:** If a claim is denied in whole or in part, You or your authorized representative or a provider acting on your behalf, may request a review of the claim. The request must be in writing and must be made within sixty (60) days after the claim was denied. Send the request to Us. The request should contain any facts You consider important to the review. We will review the claims decision and send a response in writing within thirty (30) days. If the denial of benefits is confirmed, You will be told the reasons for the decision.

Part 5
LIMITATIONS AND EXCLUSIONS

- A.** This policy does not cover losses caused by or resulting from:
 1. Any procedure or service not shown on the Schedule of Covered Procedures.
 2. Services or supplies We consider being experimental or investigative.
 3. Services received before Your effective date.
 4. Services received after Your coverage terminates.
 5. Services performed by other than a licensed Dentist or Dental Hygienist.
 6. Services that are not recommended by a Dentist or Dental Hygienist
 7. Services that are not required for the preservation or restoration of oral health.
 8. Services received while outside the territorial limits of the United States.
 9. Any service that the Dentist or Dental Hygienist determines is not suitable to be rendered due to the patient's physical health, mental disability, or emotional instability.
 10. Services performed by a Dentist or Dental Hygienist who is a member of the covered person's Immediate Family.
 11. Implants (materials implanted into or on the bone or soft tissue) or the removal of implants.
 12. Any services performed for cosmetic purposes.
 13. Any charge for a service required as a result of disease or injury that is due to war or an act of war (whether declared or undeclared); taking part in an insurrection or riot; the commission or attempted commission of a felony; an intentionally self-inflicted injury or attempted suicide while sane or insane.
 14. Orthodontic treatment, unless the Policy Schedule of Benefits lists Type 4-Orthodontic Expenses as a Covered Dental Procedure.
 15. Temporomandibular Joint (TMJ) dysfunctions, unless mandated by law in the state of residency.
- B.** See the Schedule of Covered Dental Procedures for all other specific frequency limits.

Part 6
MISCELLANEOUS PROVISIONS

- A. ENTIRE CONTRACT; CHANGES:** This policy, together with the application, endorsements, benefit agreements and attached papers, if any, is the entire contract of insurance. No change in the policy is valid until approved in writing by Our president or secretary. This approval must be noted on or attached hereto. No duly licensed agent may change this policy or waive any of its provisions.
- B. TIME LIMIT ON CERTAIN DEFENSES:** After two (2) years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for the policy shall be used to void the policy or to deny a claim for loss incurred commencing after the expiration of the two (2) year period.

- C. TERM:** The term of this policy begins at noon, standard time, at the place where You reside on the effective date shown in the Policy Schedule of Benefits. It ends at noon, the same standard time, on the first renewal date. Each renewal term ends at noon, the same standard time, on the next following renewal date. Renewal dates are determined by the mode of payment. The mode of payment for the original term of the policy is shown in the Policy Schedule of Benefits. An annual premium will maintain the policy in force for 12 months, semiannual for six months, quarterly for three months and monthly for one month.
- D. REINSTATEMENT:** If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by Us or by any agent duly authorized by Us to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy: provided, however, that if We or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated policy shall cover only loss resulting from accidental injury of a Covered Dental Procedure as may be incurred after the date of reinstatement as may begin more than ten (10) days after such date. In all other respects You and We shall have the same rights thereunder as each had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement.
- E. LEGAL ACTIONS:** No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.
- F. CONFORMITY WITH STATE AND FEDERAL STATUTES:** Any provision of this policy that on its effective date is in conflict with the statutes of the state in which the insured resides on such date or with any federal statutes is hereby amended to conform to the minimum requirements of such statutes.
- G. PHYSICAL EXAMINATIONS OR AUTOPSY:** We can have the Insured medically examined, at Our expense, while a claim is pending, as often as We deem reasonably necessary to determine the validity of a claim. We can also have an autopsy performed unless prohibited by law.

SCHEDULE OF COVERED PROCEDURES

SUBJECT TO THE APPLICABLE CO-PAYMENTS AND FREQUENCY LIMITS, AND THE LIMITATIONS AND EXCLUSIONS SECTION OF THIS POLICY, WE WILL PROVIDE THE FOLLOWING BENEFITS FOR A COVERED DENTAL PROCEDURE THAT OCCURS WHILE COVERAGE IS IN FORCE.

The following is a complete list of Covered Dental Procedures, with applicable co-payments and frequency limits. We will not provide coverage for procedures not listed in this Schedule of Covered Procedures, consistent with standards currently approved and published by the American Dental Association.

Frequency Limits

- | | |
|-----|--|
| (a) | Maximum of 2 procedures per 12 months |
| (b) | Maximum of 1 per 12 months |
| (c) | Maximum of 6 procedures per 12 months |
| (d) | Maximum of 1 procedure per 36 months |
| (e) | Maximum of 1 procedure per tooth surface per 24 months |
| (g) | Once per 3 years |
| (h) | Not available until coverage in-force for 6 months |

Preventive Services		Limits	Co-Payment	Benefit
d0120	Periodic Oral Examination	(a)	\$0	\$23
d0140	Limited Oral Evaluation - Problem Focused	(a)	\$0	\$36
d0150	Comp Oral Evaluation - New/Established Patient	(a)	\$0	\$38
d0170	Re-Evaluation - Limited Problem Focused	(a)	\$0	\$20
d0270	Bitewing - Single Film	(b)	\$0	\$13
d0272	Bitewings - Two Films	(b)	\$0	\$20
d0273	Bitewings - Three Films	(b)	\$0	\$25
d0274	Bitewings - Four Films	(b)	\$0	\$31
d0210	Intraoral - Complete Series	(d)	\$0	\$53
d0220	Intraoral – Periapical 1 Film	(d)	\$0	\$13
d0230	Intraoral – Periapical Ea Add Film	(d)	\$0	\$11
d0240	Intraoral - Occlusal Film	(d)	\$0	\$18
d0330	Panoramic Film	(d)	\$0	\$43
d1110	Prophylaxis – Adult	(a)	\$0	\$45
d1206	Topical Application Of Fluoride - Adult	(b)	\$0	\$25
d1330	Oral Hygiene Instruction and Supplies	(c)	\$0	\$35

Basic Services		Limits	Co-Payment	Benefit
d2140	Amalgam-One Surface Primary Or Permanent	(e)	\$0	\$52
d2150	Amalgam-Two Surfaces Primary Or Permanent	(e)	\$0	\$63
d2160	Amalgam-Three Surfaces Primary Or Permanent	(e)	\$0	\$77
d2161	Amalgam-Four/More Surfaces Primary/Permanent	(e)	\$0	\$90
d2330	Resin-Based Composite - One Surface Anterior	(e)	\$0	\$59
d2331	Resin-Based Composite - Two Surfaces Anterior	(e)	\$0	\$72
d2332	Resin-Based Composite - Three Surfaces Anterior	(e)	\$0	\$88
d2335	Resin Compos - 4/More Surfaces/Invlv Incisal Ang	(e)	\$0	\$103
d2390	Resin-Based Composite Crown Anterior	(e)	\$0	\$114
d2391	Resin Based Composite - One Surface - Posterior	(e)	\$0	\$65
d2392	Resin Based Composite - Two Surfaces - Posterior	(e)	\$0	\$84
d2393	Resin Based Composite - Three Surfaces - Posterior	(e)	\$0	\$103
d2394	Resin Compos - Four/More Surfaces - Posterior	(e)	\$0	\$116
d3110	Pulp Cap – Direct	(g)	\$0	\$27
d3120	Pulp Cap – Indirect	(g)	\$0	\$24

Major Services		Limits	Co-Payment	Benefit
d2910	Recement Inlay	(b)	\$0	\$40
d2920	Recement Crown	(b)	\$0	\$38
d2931	Prefabrication Stainless Steel Crown	(b)	\$0	\$114
d2932	Prefabricated Resin Crown	(b)	\$0	\$112
d2940	Sedative Filling	(b)	\$0	\$40
d4341	Periodontal Scaling & Root Planing 4/>>Cont/Bound Teeth Quad	(g)	\$0	\$98
d4342	Periodontal Scaling & Root Planing 1-3 Teeth-Quad	(g)	\$0	\$61
d4355	Full Mouth Debridment Enable Comp Evaluation & Dx	(g)	\$0	\$61
d4910	Periodontal Maintenance	(b)	\$0	\$56
d5110	Complete Denture - Maxillary	(g) (h)	\$0	\$531
d5120	Complete Denture - Mandibular	(g) (h)	\$0	\$514
d5130	Immediate Denture - Maxillary	(g) (h)	\$0	\$567
d5140	Immediate Denture - Mandibular	(g) (h)	\$0	\$552
d5211	Maxillary Partial Denture - Resin Base	(g) (h)	\$0	\$383
d5212	Mandibular Partial Denture - Resin Base	(g) (h)	\$0	\$421
d5213	Max Part Denture-Cast Metal Framework w/Resin Base	(g) (h)	\$0	\$598
d5214	Mand Part Denture- Cast Metal Framework w/Resin Base	(g) (h)	\$0	\$600
d5281	Remove Unlit Part Denture - 1 Piece Cast Metal	(g) (h)	\$0	\$466
d5410	Adjust Complete Denture - Maxillary	(b)	\$0	\$40
d5411	Adjust Complete Denture - Mandibular	(b)	\$0	\$40
d5421	Adjust Partial Denture - Maxillary	(b)	\$0	\$40
d5422	Adjust Partial Denture - Mandibular	(b)	\$0	\$40
d5510	Repair Broken Complete Denture Base	(b)	\$0	\$66
d5520	Replace Missing/Broken Teeth - Complete Denture	(b)	\$0	\$56
d5610	Repair Resin Denture Base	(b)	\$0	\$80
d5620	Repair Cast Framework	(b)	\$0	\$80
d5630	Repair Or Replace Broken Clasp	(b)	\$0	\$80
d5640	Replace Broken Teeth - Per Tooth	(b)	\$0	\$60
d5650	Add Tooth To Existing Partial Denture	(b)	\$0	\$71
d5660	Add Clasp To Existing Partial Denture	(b)	\$0	\$80
d5710	Rebase Complete Maxillary Denture	(b)	\$0	\$222
d5711	Dyn Adj Ankle Ext/Flex Devc Incl Soft Intf Matl	(b)	\$0	\$212
d5720	Rebase Maxillary Partial Denture	(b)	\$0	\$209
d5721	Rebase Mandibular Partial Denture	(b)	\$0	\$209
d5730	Reline Complete Maxillary Denture	(b)	\$0	\$123
d5731	Reline Complete Mandibular Denture	(b)	\$0	\$123
d5740	Reline Maxillary Partial Denture	(b)	\$0	\$113
d5741	Reline Mandibular Partial Denture	(b)	\$0	\$113
d5750	Reline Complete Maxillary Denture	(b)	\$0	\$166
d5751	Reline Complete Mandibular Denture	(b)	\$0	\$166
d5760	Reline Maxillary Partial Denture	(b)	\$0	\$163
d5761	Reline Mandibular Partial Denture	(b)	\$0	\$163
d5899	Denture Cleaning/Engraving	(c)	\$0	\$50
d6930	Recement Fixed Partial Denture	(b)	\$0	\$54
d7111	Coronal Remnants - Deciduous Tooth	(b)	\$0	\$44
d7140	Extraction Erupted Tooth Or Exposed Root	(b)	\$0	\$57
d7210	Surg Removal of Erupted Tooth Rqr Elev Flap & Remove Bone	(b)	\$0	\$106
d7220	Removal Of Impacted Tooth - Soft Tissue	(b)	\$0	\$129
d7230	Removal Of Impacted Tooth - Partially Bony	(b)	\$0	\$165
d7240	Removal Of Impacted Tooth - Completely Bony	(b)	\$0	\$193
d7241	Remove Imp Tooth – Complete Bony w/Unusual Surg Comps	(b)	\$0	\$227
d7250	Surgical Removal of Residual Tooth Roots	(b)	\$0	\$111
d7310	Alveolplsty Conjunc w/Xtracs	(b)	\$0	\$97
d7320	Alveolplsty Not Conjunc w/Xtracs	(b)	\$0	\$490
d7510	I&D Abscess - Intraoral Soft Tissue	(b)	\$0	\$87
d9110	Palliative Treatment Dental Pain – Minor Procedure	(a)	\$0	\$40

DENTAL INSURANCE POLICY- Form PA 03 10 AR

OUTLINE OF COVERAGE

READ YOUR POLICY CAREFULLY— This outline of coverage provides a very brief description of some of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and Citizens Security Life Insurance Company. **IT IS THEREFORE IMPORTANT THAT YOU READ YOUR POLICY CAREFULLY!**

Dental Expense Coverage ONLY—This policy only provides coverage for certain dental procedures as listed in the Schedule of Covered Procedures in the policy. Some dental procedures are limited by an annual plan maximum, waiting period, limitations and exclusions. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses due to sickness.

RENEWABILITY OF POLICY

THIS POLICY IS OPTIONALLY RENEWABLE SUBJECT
TO OUR RIGHT TO CHANGE PREMIUM RATES UPON ANY RENEWAL DATE.

We reserve the right to refuse renewal of this policy. Subject to the right to terminate the policy upon nonpayment of premium when due, such right to refuse renewal may not be exercised so as to take effect before the renewal date occurring on each policy anniversary (or in the case of lapse and reinstatement, at the renewal date occurring on each anniversary of the last reinstatement). Any refusal of renewal shall be without prejudice to any claim originating while the policy was in force.

LIMITATIONS AND EXCLUSIONS

- A.** This policy does not cover losses caused by or resulting from:
1. Any procedure or service not shown on the Schedule of Covered Procedures.
 2. Services or supplies We consider being experimental or investigative.
 3. Services received before Your effective date.
 4. Services received after Your coverage terminates.
 5. Services performed by other than a licensed Dentist or Dental Hygienist.
 6. Services that are not recommended by a Dentist or Dental Hygienist
 7. Services that are not required for the preservation or restoration of oral health.
 8. Services received while outside the territorial limits of the United States.
 9. Any service that the Dentist or Dental Hygienist determines is not suitable to be rendered due to the patient's physical health, mental disability, or emotional instability.
 10. Services performed by a Dentist or Dental Hygienist who is a member of the covered person's Immediate Family.
 11. Implants (materials implanted into or on the bone or soft tissue) or the removal of implants.
 12. Any services performed for cosmetic purposes.
 13. Any charge for a service required as a result of disease or injury that is due to war or an act of war (whether declared or undeclared); taking part in an insurrection or riot; the commission or attempted commission of a felony; an intentionally self-inflicted injury or attempted suicide while sane or insane.
 14. Orthodontic treatment, unless the Policy Schedule of Benefits lists Type 4-Orthodontic Expenses as a Covered Dental Procedure.
 15. Temporomandibular Joint (TMJ) dysfunctions, unless mandated by law in the state of residency.

BENEFITS

The following is a complete list of Covered Dental Procedures with applicable frequency limits. There are **NO** co-payments for procedures listed below. We will not provide coverage for procedures not listed in this Schedule of Covered Procedures, consistent with standards currently approved and published by the American Dental Association.

THIS IS NOT A MEDICARE SUPPLEMENT POLICY

Schedule of Covered Procedures

Frequency Limits

- (a) Maximum of 2 procedures per 12 months
- (b) Maximum of 1 per 12 months
- (c) Maximum of 6 procedures per 12 months
- (d) Maximum of 1 procedure per 36 months
- (e) Maximum of 1 procedure per tooth surface per 24 months
- (g) Once per 3 years
- (h) Not available until coverage in-force for 6 months

Preventive Services		Limits	Co-Payment	Benefit
d0120	Periodic Oral Examination	(a)	\$0	\$23
d0140	Limited Oral Evaluation - Problem Focused	(a)	\$0	\$36
d0150	Comp Oral Evaluation - New/Established Patient	(a)	\$0	\$38
d0170	Re-Evaluation - Limited Problem Focused	(a)	\$0	\$20
d0270	Bitewing - Single Film	(b)	\$0	\$13
d0272	Bitewings - Two Films	(b)	\$0	\$20
d0273	Bitewings - Three Films	(b)	\$0	\$25
d0274	Bitewings - Four Films	(b)	\$0	\$31
d0210	Intraoral - Complete Series	(d)	\$0	\$53
d0220	Intraoral – Periapical 1 Film	(d)	\$0	\$13
d0230	Intraoral – Periapical Ea Add Film	(d)	\$0	\$11
d0240	Intraoral - Occlusal Film	(d)	\$0	\$18
d0330	Panoramic Film	(d)	\$0	\$43
d1110	Prophylaxis – Adult	(a)	\$0	\$45
d1206	Topical Application Of Fluoride - Adult	(b)	\$0	\$25
d1330	Oral Hygiene Instruction and Supplies	(c)	\$0	\$35

Basic Services		Limits	Co-Payment	Benefit
d2140	Amalgam-One Surface Primary Or Permanent	(e)	\$0	\$52
d2150	Amalgam-Two Surfaces Primary Or Permanent	(e)	\$0	\$63
d2160	Amalgam-Three Surfaces Primary Or Permanent	(e)	\$0	\$77
d2161	Amalgam-Four/More Surfaces Primary/Permanent	(e)	\$0	\$90
d2330	Resin-Based Composite - One Surface Anterior	(e)	\$0	\$59
d2331	Resin-Based Composite - Two Surfaces Anterior	(e)	\$0	\$72
d2332	Resin-Based Composite - Three Surfaces Anterior	(e)	\$0	\$88
d2335	Resin Compos - 4/More Surfaces/Invlv Incisal Ang	(e)	\$0	\$103
d2390	Resin-Based Composite Crown Anterior	(e)	\$0	\$114
d2391	Resin Based Composite - One Surface - Posterior	(e)	\$0	\$65
d2392	Resin Based Composite - Two Surfaces - Posterior	(e)	\$0	\$84
d2393	Resin Based Composite - Three Surfaces - Posterior	(e)	\$0	\$103
d2394	Resin Compos - Four/More Surfaces - Posterior	(e)	\$0	\$116
d3110	Pulp Cap – Direct	(g)	\$0	\$27
d3120	Pulp Cap – Indirect	(g)	\$0	\$24

Major Services		Limits	Co-Payment	Benefit
d2910	Recement Inlay	(b)	\$0	\$40
d2920	Recement Crown	(b)	\$0	\$38
d2931	Prefabrication Stainless Steel Crown	(b)	\$0	\$114
d2932	Prefabricated Resin Crown	(b)	\$0	\$112
d2940	Sedative Filling	(b)	\$0	\$40
d4341	Periodontal Scaling & Root Planing 4/>Cont/Bound Teeth Quad	(g)	\$0	\$98
d4342	Periodontal Scaling & Root Planing 1-3 Teeth-Quad	(g)	\$0	\$61
d4355	Full Mouth Debridment Enable Comp Evaluation & Dx	(g)	\$0	\$61
d4910	Periodontal Maintenance	(b)	\$0	\$56
d5110	Complete Denture - Maxillary	(g) (h)	\$0	\$531
d5120	Complete Denture - Mandibular	(g) (h)	\$0	\$514
d5130	Immediate Denture - Maxillary	(g) (h)	\$0	\$567
d5140	Immediate Denture - Mandibular	(g) (h)	\$0	\$552
d5211	Maxillary Partial Denture - Resin Base	(g) (h)	\$0	\$383
d5212	Mandibular Partial Denture - Resin Base	(g) (h)	\$0	\$421
d5213	Max Part Denture-Cast Metal Framework w/Resin Base	(g) (h)	\$0	\$598
d5214	Mand Part Denture- Cast Metal Framework w/Resin Base	(g) (h)	\$0	\$600
d5281	Remove Unlit Part Denture - 1 Piece Cast Metal	(g) (h)	\$0	\$466
d5410	Adjust Complete Denture - Maxillary	(b)	\$0	\$40
d5411	Adjust Complete Denture - Mandibular	(b)	\$0	\$40
d5421	Adjust Partial Denture - Maxillary	(b)	\$0	\$40
d5422	Adjust Partial Denture - Mandibular	(b)	\$0	\$40
d5510	Repair Broken Complete Denture Base	(b)	\$0	\$66
d5520	Replace Missing/Broken Teeth - Complete Denture	(b)	\$0	\$56
d5610	Repair Resin Denture Base	(b)	\$0	\$80
d5620	Repair Cast Framework	(b)	\$0	\$80
d5630	Repair Or Replace Broken Clasp	(b)	\$0	\$80
d5640	Replace Broken Teeth - Per Tooth	(b)	\$0	\$60
d5650	Add Tooth To Existing Partial Denture	(b)	\$0	\$71
d5660	Add Clasp To Existing Partial Denture	(b)	\$0	\$80
d5710	Rebase Complete Maxillary Denture	(b)	\$0	\$222
d5711	Dyn Adj Ankle Ext/Flex Devc Incl Soft Intf Matl	(b)	\$0	\$212
d5720	Rebase Maxillary Partial Denture	(b)	\$0	\$209
d5721	Rebase Mandibular Partial Denture	(b)	\$0	\$209
d5730	Reline Complete Maxillary Denture	(b)	\$0	\$123
d5731	Reline Complete Mandibular Denture	(b)	\$0	\$123
d5740	Reline Maxillary Partial Denture	(b)	\$0	\$113
d5741	Reline Mandibular Partial Denture	(b)	\$0	\$113
d5750	Reline Complete Maxillary Denture	(b)	\$0	\$166
d5751	Reline Complete Mandibular Denture	(b)	\$0	\$166
d5760	Reline Maxillary Partial Denture	(b)	\$0	\$163
d5761	Reline Mandibular Partial Denture	(b)	\$0	\$163
d5899	Denture Cleaning/Engraving	(c)	\$0	\$50
d6930	Recement Fixed Partial Denture	(b)	\$0	\$54
d7111	Coronal Remnants - Deciduous Tooth	(b)	\$0	\$44
d7140	Extraction Erupted Tooth Or Exposed Root	(b)	\$0	\$57
d7210	Surg Removal of Erupted Tooth Rqr Elev Flap & Remove Bone	(b)	\$0	\$106
d7220	Removal Of Impacted Tooth - Soft Tissue	(b)	\$0	\$129
d7230	Removal Of Impacted Tooth - Partially Bony	(b)	\$0	\$165
d7240	Removal Of Impacted Tooth - Completely Bony	(b)	\$0	\$193
d7241	Remove Imp Tooth – Complete Bony w/Unusual Surg Comps	(b)	\$0	\$227
d7250	Surgical Removal of Residual Tooth Roots	(b)	\$0	\$111
d7310	Alveolplsty Conjunc w/Xtracs	(b)	\$0	\$97
d7320	Alveolplsty Not Conjunc w/Xtracs	(b)	\$0	\$490
d7510	I&D Abscess - Intraoral Soft Tissue	(b)	\$0	\$87
d9110	Palliative Treatment Dental Pain – Minor Procedure	(a)	\$0	\$40

SERFF Tracking Number: CSLI-126599403 State: Arkansas
 Filing Company: Citizens Security Life Insurance Company State Tracking Number: 45508
 Company Tracking Number:
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
 Product Name: Individual NH Dental - Revised
 Project Name/Number: Revised NH Dental Policy/

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	04/27/2010
Comments:		
Attachment: Readability Cert.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	04/27/2010
Comments: Application approved 01/25/2010; SERFF #CSLI-126461188; AR DOI #44621.		
Attachment: Form AP 01 10 AR.pdf		

	Item Status:	Status Date:
Bypassed - Item: Outline of Coverage	Approved-Closed	04/27/2010
Bypass Reason: Outline of Coverage is being filed for approval; see Form Schedule Tab.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Cover Letter	Approved-Closed	04/27/2010
Comments: Please review cover letter for details of filing.		
Attachment: Cover Letter.pdf		

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

Readability Certification

I, James Helton, Executive Vice President, Citizens Security Life Insurance Company, hereby certify the following Flesch Scale readability scores.

Form PA 03 10 AR – 45
AG 03 10 AR - 40

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

Signed for: Citizens Security Life Insurance Company

Date: April 22, 2010



By: _____

Title: Executive Vice President

Citizens Security Life Insurance Company

12910 Shelbyville Rd, Ste 300

Louisville, KY 40243

**LIVING CARE FACILITY RESIDENT
APPLICATION FOR INSURANCE**

800-843-7752

APPLICATION TYPE		FOR COMPANY USE ONLY	
<input type="checkbox"/> New Applicant. <input type="checkbox"/> Change.		Billing#.	Acct#.
COVERAGE REQUESTED	MONTHLY PREMIUM	Effective Date.	
<input type="checkbox"/> Dental.	\$ _____	Dental Plan.	
<input type="checkbox"/> Vision.	\$ _____	Vision Plan.	
		PID.	

APPLICANT INFORMATION			
Last Name.	First Name.	M.I.	Social Security #:
Sex. <input type="checkbox"/> Male. <input type="checkbox"/> Female.	Date of Birth: (mm/dd/yyyy). / /		Medicaid #: (if applicable).

LEGAL REPRESENTATIVE (IF OTHER THAN THE APPLICANT IS SIGNING THIS APPLICATION)			
Last Name.	First Name.	M.I.	
Address.	City.	State.	Zip Code.
Phone #: ()	E-mail.		

FACILITY WHERE APPLICANT RESIDES	
Name.	
Address.	

AUTHORIZATION	
<p>Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.</p> <p>I understand that coverage will not be effective until this application and the applicable premium has been received and accepted and the policy has been issued by the Company.</p> <p>This application or a copy is also my request and authorization for necessary diagnostic and preventive treatment as well as any necessary repair or adjustment of prosthodontics.</p>	
Applicant/Legal Representative Signature.	Date.
Agent Name/Number.	Agent Signature. Date.



April 26, 2010

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

Re: Citizens Security Life Insurance Company - **New Submission**
NAIC # 61921 FEIN # 61-0648389
Form Number: PA 03 10 AR; Individual Dental Insurance Policy
AG 03 10 AR; Outline of Coverage
Actuarial Memorandum/Rates

Dear Sir/Madam:

Enclosed please find an Individual Dental Insurance Policy and Outline of Coverage for your review and approval. These are new forms. The forms are identical to previously approved forms (PA 01 10 AR and AG 01 10 AR; tracking number SERFF #CSLI-126461188 and AR DOI # 44621; approved 01/25/2010) except we have added additional benefits and the premium has increased slightly.

This form is designed to provide Dental Insurance benefits to individual insureds who reside in living care facilities. Benefits include payment of expenses for services incurred for covered dental procedures, subject to any applicable co-payment amounts.

We have added the following benefits: a) Oral Hygiene Instruction and Supplies and b) Denture Cleaning/Engraving.

Other forms that will be used in conjunction with these are:

- 1) Application, form # AP 01 10 AR, approved 01/25/2010;
- 2) Quality Assurance Program, form #CCA1 PA 01 10 AR; approved 01/25/2010;
- 3) Participating Dentist Agreement, form #CCA2 PA 01 10 AR; approved 01/25/2010.

Finally, enclosed is the Actuarial Memorandum containing the premium rate.

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

Sincerely,

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

Mrs. Rickie Ellen Bolduc, FLMI, AIRC, ACS
Actuarial Associate
Citizens Security Life Insurance Company