

SERFF Tracking Number: USLH-127625830 State: Arkansas
Filing Company: United Security Life and Health Insurance State Tracking Number: 49847
Company
Company Tracking Number: DVH-11POL-AR
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: Dental Plus, Vision and Hearing Expense Policy
Project Name/Number: Dental Plus, Vision and Hearing Expense Policy/

Filing at a Glance

Company: United Security Life and Health Insurance Company

Product Name: Dental Plus, Vision and Hearing SERFF Tr Num: USLH-127625830 State: Arkansas
Expense Policy

TOI: H21 Health - Other

SERFF Status: Closed-Approved- State Tr Num: 49847
Closed

Sub-TOI: H21.000 Health - Other

Co Tr Num: DVH-11POL-AR

State Status: Approved-Closed

Filing Type: Form

Author: Jaime Gettemans

Reviewer(s): Rosalind Minor

Date Submitted: 09/21/2011

Disposition Date: 10/04/2011

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Dental Plus, Vision and Hearing Expense Policy

Status of Filing in Domicile: Pending

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type: Individual

Overall Rate Impact:

Filing Status Changed: 10/04/2011

State Status Changed: 10/04/2011

Deemer Date:

Created By: Jaime Gettemans

Submitted By: Jaime Gettemans

Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

Please see the attached Cover Letter under the "Supporting Documents" tab for a detailed filing description.

Company and Contact

Filing Contact Information

Jaime Gettemans,

jaimegettemans@jandpholdings.com

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6640 S. Cicero Avenue 708-552-2417 [Phone]
 Bedford Park, IL 60638

Filing Company Information

United Security Life and Health Insurance CoCode: 81108 State of Domicile: Illinois
 Company
 6640 S. Cicero Group Code: Company Type:
 Bedford Park, IL 60638 Group Name: State ID Number:
 (708) 475-6000 ext. [Phone] FEIN Number: 36-3692140

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: Regulation 57
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United Security Life and Health Insurance Company	\$50.00	09/21/2011	51961417

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/04/2011	10/04/2011

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	10/03/2011	10/03/2011	Jaime Gettemans	10/04/2011	10/04/2011

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Disposition

Disposition Date: 10/04/2011

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

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	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	Brochure	Approved-Closed	Yes
Form (revised)	Dental Plus, Vision and Hearing Expense Policy	Approved-Closed	Yes
Form	Dental Plus, Vision and Hearing Expense Replaced Policy		Yes
Rate	Rates for Dental Plus, Vision and Hearing Expense Policy	Approved-Closed	Yes

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Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 10/03/2011

Submitted Date 10/03/2011

Respond By Date

Dear Jaime Gettemans,

This will acknowledge receipt of the captioned filing.

Objection 1

- Dental Plus, Vision and Hearing Expense Policy, DVH-11POL-AR (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-85-131(b) and Bulletin 14-81.

Objection 2

- Dental Plus, Vision and Hearing Expense Policy, DVH-11POL-AR (Form)

Comment:

The Time Payment of Claims provision is not in compliance with Rule and Regulation 43, Section 12 (a) which states that...."A Health Carrier shall pay or deny a clean claim within 30 days after receipt by the Health Carrier if the claim was submitted electronically, or within 45 days after receipt if the claim was submitted by other means....".

Also under (c) the penalty is 12% per annum times the number of days in the delinquent payment period, divided by 365.

Objection 3

- Dental Plus, Vision and Hearing Expense Policy, DVH-11POL-AR (Form)

Comment:

There needs to be a provision for the refund of unearned premium in the event of death of the insured as outlined under ACA 23-85-134.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional

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information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,
Rosalind Minor

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Response Letter

Response Letter Status Submitted to State
 Response Letter Date 10/04/2011
 Submitted Date 10/04/2011

Dear Rosalind Minor,

Comments:

I hope this correspondence finds you well.

Response 1

Comments: Pursuant to your above objection, please note that we removed the 31 day requirement from the Covered Dependent definition; specifically under the bullet point regarding handicapped dependents.

Related Objection 1

Applies To:

- Dental Plus, Vision and Hearing Expense Policy, DVH-11POL-AR (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-85-131(b) 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
Dental Plus, Vision and Hearing Expense Policy	DVH-11POL-AR		Policy/Contract/Fraternal Certificate	Initial			DVH-11POL-AR (10.4.11).

SERFF Tracking Number: USLH-127625830 State: Arkansas
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 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: Dental Plus, Vision and Hearing Expense Policy
 Project Name/Number: Dental Plus, Vision and Hearing Expense Policy/

pdf

Previous Version

Dental Plus, Vision and DVH- Hearing Expense Policy11POL- AR	Policy/Contract/Fraternal Initial Certificate	DVH- 11POL- AR.pdf
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No Rate/Rule Schedule items changed.

Response 2

Comments: Pursuant to your above objection, please note that I revised the "Time Payment of Claims" provision to include the correct wording on the time limit for payment of clean claims and also the interest rate calculation.

Related Objection 1

Applies To:

- Dental Plus, Vision and Hearing Expense Policy, DVH-11POL-AR (Form)

Comment:

The Time Payment of Claims provision is not in compliance with Rule and Regulation 43, Section 12 (a) which states that...."A Health Carrier shall pay or deny a clean claim within 30 days after receipt by the Health Carrier if the claim was submitted electronically, or within 45 days after receipt if the claim was submitted by other means....".

Also under (c) the penalty is 12% per annum times the number of days in the delinquent payment period, divided by 365.

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
Dental Plus, Vision and DVH-			Policy/Contract/Fraternal Initial				DVH-

SERFF Tracking Number: USLH-127625830 State: Arkansas
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 Company
 Company Tracking Number: DVH-11POL-AR
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: Dental Plus, Vision and Hearing Expense Policy
 Project Name/Number: Dental Plus, Vision and Hearing Expense Policy/
 Hearing Expense Policy11POL- Certificate 11POL-
 AR AR
 (10.4.11).
 pdf

Previous Version

Dental Plus, Vision and DVH- Policy/Contract/Fraternal Initial DVH-
 Hearing Expense Policy11POL- Certificate 11POL-
 AR AR.pdf

No Rate/Rule Schedule items changed.

Response 3

Comments: Pursuant to your above objection, please note that I added a "Refund of Unearned Premium" provision under the "Other Important Provisions" section.

Related Objection 1

Applies To:

- Dental Plus, Vision and Hearing Expense Policy, DVH-11POL-AR (Form)

Comment:

There needs to be a provision for the refund of unearned premium in the event of death of the insured as outlined under ACA 23-85-134.

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
Dental Plus, Vision and DVH- Hearing Expense Policy11POL- AR			Policy/Contract/Fraternal Certificate	Initial			DVH- 11POL- AR (10.4.11).

SERFF Tracking Number: USLH-127625830 State: Arkansas
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Product Name: Dental Plus, Vision and Hearing Expense Policy
Project Name/Number: Dental Plus, Vision and Hearing Expense Policy/

pdf

Previous Version

Dental Plus, Vision and DVH- Policy/Contract/Fraternal Initial
Hearing Expense Policy11POL- Certificate
AR

DVH-
11POL-
AR.pdf

No Rate/Rule Schedule items changed.

I hope that these changes sufficiently address all open issues with this filing.

I look forward to your approval!

Sincerely,

Jaime Gettemans

Sincerely,
Jaime Gettemans

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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 10/04/2011	DVH-11POL-AR	Policy/Contract	Dental Plus, Vision and Hearing Expense Policy Certificate	Initial			DVH-11POL-AR (10.4.11).pdf

UNITED SECURITY LIFE AND HEALTH INSURANCE COMPANY
[6640 South Cicero Avenue, Bedford Park, IL 60638]

DENTAL PLUS, VISION AND HEARING EXPENSE POLICY

CAUTION: The issuance of this Policy is based upon Your responses to the questions on Your application. A copy of Your application is attached to the Policy. If Your answers are incorrect or untrue, We may have the right to deny benefits or rescind Your Policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of Your answers are incorrect, contact Us at the address shown above.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.

This Policy is a legal contract between You and Us. **READ YOUR POLICY CAREFULLY.** Also, read the copy of Your application and the Policy Schedule. If there is any error or omission, tell Us. We will make any needed change.

The first premium You, the Insured, paid before the Policy Effective Date (and the copy of Your attached application), puts this Policy in force as of the Policy Effective Date. That date is shown in the Schedule. The Schedule is attached and is a part of this Policy.

Insuring Clause: We agree to provide the benefits set out in this Policy for any insured loss. This agreement is subject to all of the provisions of the Policy. A “loss” is an expense You incur for care or services this Policy covers and that You receive after the Policy Effective Date and while the Policy is in force.

PLEASE READ – 10 DAY RIGHT TO RETURN

Please read Your Policy. If You are not satisfied, send it back to Us, or to the Producer who sold it to You, within 10 days after You receive it. We will return your money. That will mean Your Policy was never in force.

GUARANTEED RENEWABLE
SUBJECT TO OUR LIMITED RIGHT TO CHANGE PREMIUMS

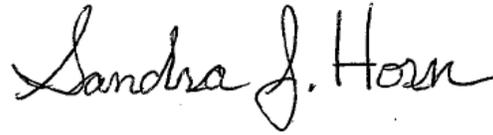
We guarantee to renew Your Policy up to age 75 as long as the premium is paid within the allowable time. We do have the right to change Your premium as stated below.

Premium Change: We can change Your premium only if We do the same to all policies of this form issued to persons of Your class. “Class” means the factors of age, gender, underwriting class and geographic area of Your state of residence that determined Your premium rate when coverage was issued. If We make a change, it will not be based on any physical impairment You might have or any claims You have incurred under this Policy. If it is necessary to change the premium for Your Policy, We will notify You in advance of the change of premium.

Our President and Secretary sign this Policy in our behalf.



Secretary



President

Countersigned By:

Licensed Resident Producer

SCHEDULE OF BENEFITS

Plan: Dental Plus, Vision and Hearing Expense Policy
Certificate Holder: [John Doe]
Birthdate: [XX/XX/XXXX]
Gender: [Male]
Family Coverage: [Y, N]
Certificate Number: [000000000000]
Policy Effective Date: [XX/XX/XXXX]
Policy Renewal Date: [XX/XX/XXXX]
Payment Option: [Monthly/Quarterly/Semi-Annually/Annually]

<u>Deductible Per Policy Year:</u>	
Individual	[\$50]
<u>Maximum Benefit Per Covered Person For all Three Benefits:</u>	
Dental, Vision and Hearing Services per Policy Year	[\$1,200]
<u>Coinsurance:</u>	
Preventive Dental Services	[90%/10%]
Basic Dental Services	[70%/30%]
Major Dental Services	[50%/50%]
<u>Maximum Benefit for Preventive Dental Services Per Visit:</u>	[\$75.00]
<u>Maximum Benefit for Vision Services Per Policy Year:</u>	
Vision Benefits	[\$150]
<u>Coinsurance:</u>	
Hearing Examinations	[70%/30%]
Hearing Aids	[70%/30%]
<u>Waiting Period:</u>	
Preventive Dental Services	[30 Day Waiting Period]
Basic Dental Services	[6 Month Waiting Period]
Major Dental Services	[12 Month Waiting Period]
Vision Services	[3 Month Waiting Period]
Hearing Aids	[12 Month Waiting Period]

NOTICE TO BUYER: This Policy may not cover all costs incurred by You during the period of coverage. You are advised to carefully review all Policy limitations.

**LIMITED BENEFIT INSURANCE POLICY
FOR DENTAL PLUS, VISION AND HEARING EXPENSES**

ALPHABETICAL GUIDE TO YOUR POLICY

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Other Important Provisions.....	13-14
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BENEFITS

After the Policy Year Deductible as shown in the Schedule of Benefits is satisfied, the Policy pays the following percentages of actual charges, not to exceed Reasonable and Customary Charges for Covered Expenses up to the Policy Year Maximum Benefit:

Covered Expenses, subject to the Exceptions and Limitations, are:

Dental Services:

Dental services, performed by a licensed Dentist, as outlined below.

Preventive Dental Services

1. Waiting Period as shown in the Schedule of Benefits.
2. Routine oral examination: Initial or periodic, limited to twice per Policy Year.
3. Prophylaxis: Scaling and cleaning of teeth, limited to twice per Policy Year.
4. Dental x-rays as follows:
 - a. Supplementary bite-wing x-rays, limited to twice per Policy Year.
 - b. Panorex and full mouth series, limited to one (1) of each every thirty-six (36) months.
 - c. Other dental x-rays necessary for the diagnosis of a specific condition requiring treatment.
5. Topical application of fluoride for Covered Dependents through the age of eighteen (18), limited to two (2) treatments per Policy Year.
6. Topical application of sealant to permanent posterior teeth (molars in upper or lower jaw).
7. The amount We will pay for this benefit is shown in the Schedule of Benefits. This benefit is subject to Deductible and Coinsurance.

Basic Dental Services

1. Waiting Period as shown in the Schedule of Benefits.
2. Sedative fillings, covered as a separate procedure only if no other service (except x-rays) is rendered during the visit.
3. Restorations (fillings) to restore teeth to normal function, using amalgam, silicate, acrylic, synthetic, and composite filling materials to restore teeth broken down by decay or injury.

4. Pin retention when part of the restoration instead of gold or crown retention.
5. Periodontics as follows:
 - a. Gingivectomy/gingivoplasty, gingival curettage, gingival flap procedure or mucogingival surgery.
 - b. Scaling and root planing.
 - c. Pedicle and free soft tissue grafts, and vestibuloplasty.
 - d. Occlusal adjustment.
 - e. Excision of pericoronal gingiva.
 - f. Periodontal prophylaxis.
 - g. Osseous surgery.
6. Endodontics as follows:
 - a. Direct pulp capping.
 - b. Pulpotomy.
 - c. Root canal therapy.
 - d. Apicoectomy.
 - e. Hemisection.
 - f. Retrograde fillings.
7. Oral surgery, including customary postoperative treatment furnished in connection with oral surgery, as follows:
 - a. Simple extraction of one (1) or more teeth.
 - b. Surgical extraction of erupted teeth and of soft tissue, partially bony, and completely bony impacted teeth.
 - c. Extraction of tooth root.
 - d. Incision and drainage of a tumor or a cyst.
 - e. Alveolectomy, alveoloplasty, and frenectomy.
 - f. Exostosis or hyperplastic tissue and excision of oral tissue for biopsy.
 - g. Re-implantation or transplantation of a natural tooth.
 - h. General anesthesia, only when provided in conjunction with a surgical procedure.
8. Space maintainers, fixed appliance (not made of precious metals), designed to preserve the space between teeth caused by the premature loss of a primary tooth (also called a baby tooth) including all adjustments within six (6) months of installation, limited to dependent children through the age of eighteen (18). This does not include space maintainers used in orthodontics to create a space between teeth.
9. Therapeutic injections of antibiotics administered by a dentist.
10. Repairs to full or partial dentures.

11. Relining of present dentures, but only if they were installed more than six (6) months earlier and if they have not been relined during the past twelve (12) months, once in any thirty-six (36) consecutive month period.
12. Rebasing of present dentures, but only if they were installed more than six (6) months earlier, not more than once in any thirty-six (36) consecutive month period.
13. Denture adjustment, only if done more than six (6) months after the initial insertion of the denture.
14. Repair or recementing of crowns, inlays, onlays or bridgework.
15. The amount We will pay for this benefit is shown in the Schedule of Benefits. This benefit is subject to Deductible and Coinsurance.

Major Dental Services

1. Waiting Period as shown in the Schedule of Benefits.
2. Post and core on permanent teeth only.
3. Gold Inlays and Onlays: Covered only when the tooth cannot be restored by basic restorations, and then only if at least five (5) consecutive years have elapsed since the last placement. Restorations on teeth which are anterior to the first bicuspid are not covered.
4. Porcelain Restorations: Covered only when the tooth cannot be restored by basic restorations, and then only if at least five (5) consecutive years have elapsed since the last placement. Restorations on teeth which are posterior to the first bicuspid are not covered.
5. Crowns: Covered only when the tooth cannot be restored by basic restorations, and then only if at least five (5) consecutive years have elapsed since the last placement. Crowns used to treat Temporomandibular Joint (TMJ) and Craniomandibular Joint (CMJ) Dysfunction will not be covered.
6. Initial installation of fixed bridge (including abutments) to replace one (1) or more natural teeth which were extracted while covered under this Plan.
7. Removable bridge, partial or complete dentures to replace one (1) or more natural teeth which were extracted while covered under this Plan.
8. Replacement of an existing partial or full removable denture or fixed bridge, or the addition of teeth to existing bridgework to replace extracted natural teeth.
9. The amount we will pay for this benefit is shown in the Schedule of Benefits. This benefit is subject to Deductible and Coinsurance.

Vision:

Visits to a Physician for a basic eye examination or eye refraction, including the cost of eyeglasses or contact lenses prescribed by the Physician, up to a maximum benefit as shown in the Schedule of Benefits in any one Policy Year. The Waiting Period is as shown in Schedule of Benefits. This benefit is subject to Deductible.

Hearing:

Hearing examinations performed by a Physician, or Audiologist, the purchase of hearing aid as prescribed as Medically Necessary by a Physician or Audiologist, including the cost of the hearing aid and any necessary repairs. There is no waiting period for hearing exams. There will be a 12 month waiting period as shown in the Schedule of Benefits for the purchase of a hearing aid. The amount We will pay for this benefit is shown in the Schedule of Benefits. This benefit is subject to Deductible and Coinsurance.

EXCEPTIONS AND LIMITATIONS

We will NOT pay benefits for the following items and/or services during the first 30 days following the Policy Effective Date:

1. Preventive Dental Services.

We will NOT pay benefits for the following items and/or services during the first 3 months following the Policy Effective Date:

1. Vision Services.

We will NOT pay benefits for the following items and/or services during the first six months following the Policy Effective Date:

1. Basic Dental Services.

We will NOT pay benefits for the following items and/or services during the first Policy Year:

1. Major Dental Services; or
2. Hearing aids.

We will NOT pay benefits for:

1. any loss resulting from war, declared or undeclared;
2. any intentionally self-inflicted Injury;
3. any loss to which a contributing cause was Your commission of or attempt to commit a felony or Your being engaged in an illegal occupation;
4. any expense for which payment is provided under Medicare;
5. any services that are not recommended by a Physician, as defined by this Policy;
6. any Experimental or Investigational procedure or treatment;
7. orthodontic treatment;
8. any expenses incurred for the diagnosis or treatment of Temporomandibular Joint (TMJ) and Craniomandibular Joint (CMJ) Dysfunction;
9. expenses incurred for surgical procedures (other than outpatient dental surgery) performed on an inpatient or outpatient basis (including any surgical procedure performed in the treatment of cataracts);
10. charges for radial keratotomy (RK), automated lamellar keratoplasty (ALK), conductive keratoplasty (CK) or other cosmetic procedures;
11. prescription drugs;
12. charges in excess of Reasonable and Customary Charges;
13. treatment or diagnosis received while outside the territorial limits of the United States;
14. services for which You are not liable or for which no charge normally is made in the absence of insurance; and
15. loss that occurs while this Policy is not in force.

POLICY YEAR DEDUCTIBLE AND MAXIMUM BENEFIT

There is a Policy Year Deductible which is shown in the Schedule of Benefits. After the Policy Year Deductible has been met, benefits are limited to the Policy Year Maximum Benefit shown in the Schedule.

DEFINITIONS

Audiologist: A person duly licensed and legally entitled to practice audiology at the time and in the state or jurisdiction in which services are performed, other than a member of the insured person's Immediate Family.

Coinsurance: Coinsurance is the dollar amount or percentage of Covered Charges that are paid by Us after any Co-payment and Deductible are satisfied. Coinsurance applies separately to each Covered Person. You are responsible for paying any Coinsurance balance that is not paid by Us.

Coinsurance only applies if it is shown in the Schedule of Benefits. The Schedule of Benefits will identify what any applicable Coinsurance percentage or amount is along with the Covered Charges to which they apply.

Covered Dependent: The Certificate Holder's lawful spouse; or child who is 18 or less and either a natural child, a child legally adopted or placed for adoption, or a stepchild.

- If an unmarried Child is age 25 or less, the child will be considered a Covered Dependent if You submit proof that the child meets the standards for a full-time student (12 credit hours) at an accredited educational institution, the student will be considered a Covered Dependent until the student is no longer a full-time student, graduates, attains age 25, or marries, whichever occurs first.
- An unmarried child of the Certificate Holder who is Totally Disabled will be considered a Covered Dependent. The child must depend upon the Certificate Holder for financial support or upon other care providers for lifetime care and supervision. As used here, "dependent upon other care providers" means requiring residential services licensed or certified by the State of Issue. Proof of support must be given to Us after We notify You of this option. Additional proof may be requested annually.
- If children only are covered, siblings of the Certificate Holder will be considered Covered Dependents if they meet the above requirements.

Covered Expenses: Expenses for necessary medical and dental services or supplies prescribed by a Physician. They may not be more than the Reasonable and Customary Charges for such services or supplies. Covered Expenses for services or supplies will be deemed to be incurred on the date or dates such services are received by You. Covered Expenses must be incurred while this Policy is in force.

Dentist: A Physician duly licensed and legally entitled to practice dentistry at the time and in the state or jurisdiction in which services are performed, other than a member of the insured person's Immediate Family.

Experimental or Investigational: The use of treatment (drugs, devices or procedures) for a specific condition when all of the following are true:

1. the safety and effectiveness of a device is not proven; that is, pre-market approval has not been granted (devices only);
2. benefits to at least one-third of subjects are not documented in controlled clinical trials published in peer-reviewed English language medical journals; and
3. the treatment is not generally accepted medical practice as determined by review of peer-reviewed English language medical literature or authoritative medical journals or publications.

Immediate Family: Your spouse, parent, child, brother or sister or any person living with You.

Injury: Accidental Bodily Injury that results in loss, independent of sickness or bodily infirmity. See the Exceptions and Limitations Section for Injuries not covered by this Policy.

Medically Necessary: A service or care:

1. required for the treatment or management of a medical symptom or condition;
2. which is the most efficient and economical care or service which can be safely provided in keeping with current medical practices;
3. not administered solely for the convenience of an insured person or any provider; and
4. which is prescribed by a Physician.

Medicare: The “Health Insurance for the Aged Act,” Title XVII of the Social Security Amendments of 1965, as then constituted or later amended.

Ophthalmologist: A Physician duly licensed and legally entitled to practice ophthalmology at the time and in the state or jurisdiction in which services are performed, other than a member of the insured person’s Immediate Family.

Optometrist: A Physician duly licensed and legally entitled to practice optometry at the time and in the state or jurisdiction in which services are performed, other than a member of the insured person’s Immediate Family.

Physician: A licensed practitioner of the healing arts acting within the scope of his/her license, other than a member of the insured person’s Immediate Family. Physician includes a licensed Dentist, Optometrist, Ophthalmologist, or Audiologist.

Policy Effective Date: The date on which this Policy first became effective. That date is shown in the Schedule of Benefits.

Policy Renewal Date: The month and day Your Policy’s premium is due. The frequency of the Policy Renewal Date can vary depending on the premium payment option You selected. This is shown in the Schedule of Benefits.

Policy Year: The year beginning on the Policy Effective Date and on each following anniversary of the Policy Effective Date.

Policy Year Deductible: The dollar amount for which You are responsible during each Policy Year. The amount of the Policy Year Deductible is shown in the Schedule of Benefits.

Policy Year Maximum Benefit: The maximum benefit We will pay during any Policy Year. This amount is shown in the Schedule of Benefits.

Producer: A person required to be licensed under the laws of the state to sell, solicit or negotiate insurance.

Reasonable and Customary Charges: The charges for services or supplies from a Health Care Practitioner, facility or supplier at the prevailing health care charges for the geographical area in which the services were performed. This data is updated on a periodic basis.

Schedule: Is attached to and is part of this Policy.

We, Us or Our: United Security Life and Health Insurance Company.

You or Your: The Insured named in the Schedule of Benefits.

TERMINATION

Your Policy will terminate on the earliest of:

1. the Policy Renewal Date following the date We receive Your written or verbal request to cancel the Policy, unless You request a later termination date (the grace period will not apply);
2. the Policy Renewal Date if sufficient premium has not been paid before the end of the grace period;
3. Your Policy Renewal Date following Your 75th birthday; or
4. the date of Your death. In the event of Your death, We will promptly return the unearned portion of any premium paid beyond the date of death.

Except in the case of Your death, if the termination date occurs within a period for which We have accepted a premium, or if We accept a premium after such date, this Policy will continue in effect until the end of the period for which premiums have been accepted. This does not apply where the acceptance of premium was a result of a misstatement of age by You. In that case, the Misstatement of Age Provision controls.

HOW TO FILE A CLAIM

Claim Forms: When We receive the notice of claim, We will send the Claimant Statement and Authorization forms for filing proofs of loss. If We do not send these forms to the claimant within 15 days, the claimant will meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the "Proof of Loss" provision.

Notice of Claim: Written notice of claim for loss must be given to Us within 30 days after the date that loss occurred or began. If notice cannot be given within 30 days, it must be given as soon as reasonably possible. The notice can be given to Us at Our Home Office or to Our agent. Notice should include Your name, the claimant's name, and Your certificate number.

Proof of Loss: Written proof of loss must be furnished to Us at Our Home Office within 90 days after the date of that loss. If it is not reasonably possible to give written proof in that 90-day period, We will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any case, the proof required must be given no later than 365 days from the date of service, except in the absence of legal capacity.

PAYMENT OF CLAIMS

Claim Review and Appeal Procedure: In the event of any claim denial with which You do not agree, You have the right to submit a written request to Us at our Home Office asking for a review of the denial of benefits. This written request must be submitted to the Company within 180 days of the date You originally received the decision that initially prompted Your appeal. That request may include documents from Your Physician or care provider that support Your basis for the requested review. Within 30 days after We receive that written request, We will notify You or Your representative of the results of the review

Payment of Claims: Benefits will be paid directly to You. Benefits unpaid at Your death will be paid to Your beneficiary or Your estate.

If any benefit is payable to Your estate, to a minor or to any person not able to give a valid release, We may pay up to \$1,200.00 to any relative of Yours by blood or connection by marriage, or any beneficiary that We find entitled to the payment. Any payment made in good faith will fully discharge Us to the extent of the payment.

Timely Payment of Claims: All benefits payable under the Policy will be paid within 30 days following receipt of written proof of loss from the insured if the claim is submitted electronically, or within 45 days following receipt of written proof of loss from the insured if the claim is submitted by other means. We shall pay a penalty to the insured for the period beginning on the 61st day after receipt of the clean claim and ending on the clean claim payment date (the delinquent payment period). The penalty will be calculated as follows: the amount of the clean claim payment times 12% per annum times the number of days in the delinquent payment period, divided by 365. Interest that amounts to less than one dollar will not be paid.

OTHER IMPORTANT PROVISIONS

Change of Beneficiary Assignment: Only You have the right to change the beneficiary. This right is Yours unless You make a beneficiary designation that may be changed. Consent of the beneficiary is not required to make a change in this Policy. Also, such consent is not required to surrender this Policy or to assign the benefits.

Conformity With State Statutes: Any provision of the Policy which, on its effective date, is in conflict with the laws of the state in which it is delivered is amended to conform to the minimum requirements of such laws.

Entire Contract Changes: This Policy, with any attachments (and the copy of Your application), is the entire contract of insurance. No Producer may make contracts, determine insurability or change the application or Policy in any way. Only an Executive Officer of the Company can approve a change. That change must be shown in the Policy.

Grace Period: Your premium must be paid on or before the date it is due or during the 31-day grace period that follows. Your Policy stays in force during Your grace period.

Illegal Occupation: We will not be liable for any loss caused by Your commission of or attempt to commit a felony. Nor will We be liable for any loss caused by Your being engaged in an illegal occupation.

Legal Action: You cannot bring a legal action to recover under Your Policy for at least 60 days after You have given Us written proof of loss. You cannot start such an action more than three years after the date written proof of loss is required.

Misstatement of Age: If Your age has been misstated, a premium adjustment will be made so that We receive the premiums that would have been due at the correct age.

Other Insurance With Us: You may have only one Policy like this one with Us at any one time. If You have more than one Policy, the one You, Your beneficiary or Your estate selects will remain in force. We will return all premiums paid for all other such policies.

Physical Examinations: We, at our expense, can have You examined as often as reasonably needed while a claim is pending.

Refund of Unearned Premium: Unearned premiums should be paid in lump sum on a date no later than thirty (30) days after the proof of the insured's death has been furnished to the insurer.

Reinstatement: Your Policy will lapse if You do not pay Your premium before the end of the grace period. If We later accept a premium and do not require an application for reinstatement, that payment will put this Policy back in force. If We require an application for reinstatement and, as may be needed, issue a conditional receipt, this Policy will be put back in force when We approve it. If We fail to notify You of disapproval within 45 days of the date of application (or the date of the conditional receipt, where that is required), Your Policy will be put back in force on that 45th day.

In all other respects, You and We will have the same rights under this Policy that We had before it lapsed, unless there are special conditions that apply to the reinstatements. If there are, they will be endorsed on or attached to the Policy. The premium We accept to reinstate this Policy will be used for a period for which premiums had not been paid. We must receive all back premiums for the Policy to be reinstated.

Term of Coverage: Your coverage starts on the Policy Effective Date at 12:01 a.m. standard time where You live. It ends at 12:01 a.m. on the same standard time on the first Policy Renewal Date. Each time You renew Your Policy, the new term begins when the old term ends.

Time Limit on Certain Defenses: For a Policy that has been in force for less than six months, We may rescind the Policy or deny an otherwise valid claim upon a showing of misrepresentation that is material to the acceptance of coverage.

For a Policy that has been in force for at least six months, but less than two years, We may rescind the Policy or deny an otherwise valid claim upon a showing misrepresentation that:

1. is material to the acceptance for coverage; and
2. pertains to the condition for which benefits are sought.

After a Policy has been in force for two years, it is not contestable upon grounds of misrepresentation alone. The Policy may be contested only upon a showing that You knowingly and intentionally misrepresented relevant facts relating to Your health.

SERFF Tracking Number: USLH-127625830 State: Arkansas
 Filing Company: United Security Life and Health Insurance State Tracking Number: 49847
 Company
 Company Tracking Number: DVH-11POL-AR
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: Dental Plus, Vision and Hearing Expense Policy
 Project Name/Number: Dental Plus, Vision and Hearing Expense Policy/

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved-Closed 10/04/2011	Rates for Dental Plus, Vision and Hearing Expense Policy	DVH-11POL-AR	New		Rates (DVH-11POL-AR).pdf

United Security Life & Health Insurance Company

Dental, Vision & Hearing "Combo" Product

EXHIBIT I - Issue Age Premium Rates - Automatic Bank Draft

Monthly *

Issue Age	Individual	Multi Adults	Issue Age	Individual	Multi Adults
0-17**	\$25.21	na	41	\$38.78	\$34.90
18	\$33.09	\$29.78	42	\$38.78	\$34.90
19	\$33.09	\$29.78	43	\$38.78	\$34.90
20	\$33.09	\$29.78	44	\$38.78	\$34.90
21	\$33.09	\$29.78	45	\$38.78	\$34.90
22	\$33.09	\$29.78	46	\$38.78	\$34.90
23	\$33.09	\$29.78	47	\$38.78	\$34.90
24	\$33.09	\$29.78	48	\$38.78	\$34.90
25	\$33.09	\$29.78	49	\$38.78	\$34.90
26	\$33.09	\$29.78	50	\$38.78	\$34.90
27	\$33.09	\$29.78	51	\$41.87	\$37.68
28	\$33.09	\$29.78	52	\$41.87	\$37.68
29	\$33.09	\$29.78	53	\$41.87	\$37.68
30	\$33.09	\$29.78	54	\$41.87	\$37.68
31	\$36.63	\$32.97	55	\$41.87	\$37.68
32	\$36.63	\$32.97	56	\$41.87	\$37.68
33	\$36.63	\$32.97	57	\$41.87	\$37.68
34	\$36.63	\$32.97	58	\$41.87	\$37.68
35	\$36.63	\$32.97	59	\$41.87	\$37.68
36	\$36.63	\$32.97	60	\$41.87	\$37.68
37	\$36.63	\$32.97	61	\$47.04	\$42.34
38	\$36.63	\$32.97	62	\$47.04	\$42.34
39	\$36.63	\$32.97	63	\$47.04	\$42.34
40	\$36.63	\$32.97	64	\$47.04	\$42.34

- * PAC: No Additional Billing Fee
Direct: Monthly \$1 Fee
15% Discount when Purchased with Major Medical

- ** Additive for multiple children under age 18

United Security Life & Health Insurance Company

Dental, Vision & Hearing "Combo" Product

EXHIBIT I - Issue Age Premium Rates - Automatic Bank Draft

Quarterly *

Issue Age	Individual	Multi Adults	Issue Age	Individual	Multi Adults
0-17**	\$75.63	na	41	\$116.34	\$104.70
18	\$99.27	\$89.34	42	\$116.34	\$104.70
19	\$99.27	\$89.34	43	\$116.34	\$104.70
20	\$99.27	\$89.34	44	\$116.34	\$104.70
21	\$99.27	\$89.34	45	\$116.34	\$104.70
22	\$99.27	\$89.34	46	\$116.34	\$104.70
23	\$99.27	\$89.34	47	\$116.34	\$104.70
24	\$99.27	\$89.34	48	\$116.34	\$104.70
25	\$99.27	\$89.34	49	\$116.34	\$104.70
26	\$99.27	\$89.34	50	\$116.34	\$104.70
27	\$99.27	\$89.34	51	\$125.61	\$113.04
28	\$99.27	\$89.34	52	\$125.61	\$113.04
29	\$99.27	\$89.34	53	\$125.61	\$113.04
30	\$99.27	\$89.34	54	\$125.61	\$113.04
31	\$109.89	\$98.91	55	\$125.61	\$113.04
32	\$109.89	\$98.91	56	\$125.61	\$113.04
33	\$109.89	\$98.91	57	\$125.61	\$113.04
34	\$109.89	\$98.91	58	\$125.61	\$113.04
35	\$109.89	\$98.91	59	\$125.61	\$113.04
36	\$109.89	\$98.91	60	\$125.61	\$113.04
37	\$109.89	\$98.91	61	\$141.12	\$127.02
38	\$109.89	\$98.91	62	\$141.12	\$127.02
39	\$109.89	\$98.91	63	\$141.12	\$127.02
40	\$109.89	\$98.91	64	\$141.12	\$127.02

- * PAC: No Additional Billing Fee
Direct: \$2 Fee Every 3 Months
15% Discount when Purchased with Major Medical

- ** Additive for multiple children under age 18

United Security Life & Health Insurance Company

Dental, Vision & Hearing "Combo" Product

EXHIBIT I - Issue Age Premium Rates - Automatic Bank Draft

Semi-Annual *

Issue Age	Individual	Multi Adults	Issue Age	Individual	Multi Adults
0-17**	\$151.26	na	41	\$232.68	\$209.40
18	\$198.54	\$178.68	42	\$232.68	\$209.40
19	\$198.54	\$178.68	43	\$232.68	\$209.40
20	\$198.54	\$178.68	44	\$232.68	\$209.40
21	\$198.54	\$178.68	45	\$232.68	\$209.40
22	\$198.54	\$178.68	46	\$232.68	\$209.40
23	\$198.54	\$178.68	47	\$232.68	\$209.40
24	\$198.54	\$178.68	48	\$232.68	\$209.40
25	\$198.54	\$178.68	49	\$232.68	\$209.40
26	\$198.54	\$178.68	50	\$232.68	\$209.40
27	\$198.54	\$178.68	51	\$251.22	\$226.08
28	\$198.54	\$178.68	52	\$251.22	\$226.08
29	\$198.54	\$178.68	53	\$251.22	\$226.08
30	\$198.54	\$178.68	54	\$251.22	\$226.08
31	\$219.78	\$197.82	55	\$251.22	\$226.08
32	\$219.78	\$197.82	56	\$251.22	\$226.08
33	\$219.78	\$197.82	57	\$251.22	\$226.08
34	\$219.78	\$197.82	58	\$251.22	\$226.08
35	\$219.78	\$197.82	59	\$251.22	\$226.08
36	\$219.78	\$197.82	60	\$251.22	\$226.08
37	\$219.78	\$197.82	61	\$282.24	\$254.04
38	\$219.78	\$197.82	62	\$282.24	\$254.04
39	\$219.78	\$197.82	63	\$282.24	\$254.04
40	\$219.78	\$197.82	64	\$282.24	\$254.04

* PAC: No Additional Billing Fee
 Direct: \$3 Fee Every 6 Months
 15% Discount when Purchased with Major Medical

** Additive for multiple children under age 18

United Security Life & Health Insurance Company

Dental, Vision & Hearing "Combo" Product

EXHIBIT I - Issue Age Premium Rates - Automatic Bank Draft

Annual*

Issue Age	Individual	Multi Adults	Issue Age	Individual	Multi Adults
0-17**	\$302.52	na	41	\$465.36	\$418.80
18	\$397.08	\$357.36	42	\$465.36	\$418.80
19	\$397.08	\$357.36	43	\$465.36	\$418.80
20	\$397.08	\$357.36	44	\$465.36	\$418.80
21	\$397.08	\$357.36	45	\$465.36	\$418.80
22	\$397.08	\$357.36	46	\$465.36	\$418.80
23	\$397.08	\$357.36	47	\$465.36	\$418.80
24	\$397.08	\$357.36	48	\$465.36	\$418.80
25	\$397.08	\$357.36	49	\$465.36	\$418.80
26	\$397.08	\$357.36	50	\$465.36	\$418.80
27	\$397.08	\$357.36	51	\$502.44	\$452.16
28	\$397.08	\$357.36	52	\$502.44	\$452.16
29	\$397.08	\$357.36	53	\$502.44	\$452.16
30	\$397.08	\$357.36	54	\$502.44	\$452.16
31	\$439.56	\$395.64	55	\$502.44	\$452.16
32	\$439.56	\$395.64	56	\$502.44	\$452.16
33	\$439.56	\$395.64	57	\$502.44	\$452.16
34	\$439.56	\$395.64	58	\$502.44	\$452.16
35	\$439.56	\$395.64	59	\$502.44	\$452.16
36	\$439.56	\$395.64	60	\$502.44	\$452.16
37	\$439.56	\$395.64	61	\$564.48	\$508.08
38	\$439.56	\$395.64	62	\$564.48	\$508.08
39	\$439.56	\$395.64	63	\$564.48	\$508.08
40	\$439.56	\$395.64	64	\$564.48	\$508.08

* No Additional Fees
15% Discount when Purchased with Major Medical

** Additive for multiple children under age 18

SERFF Tracking Number: USLH-127625830 State: Arkansas
 Filing Company: United Security Life and Health Insurance State Tracking Number: 49847
 Company
 Company Tracking Number: DVH-11POL-AR
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: Dental Plus, Vision and Hearing Expense Policy
 Project Name/Number: Dental Plus, Vision and Hearing Expense Policy/

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	10/04/2011
Comments: Please find attached the Flesch Certification for this filing.		
Attachment: 9.21.11 - Flesch Certification (DVH-11POL-AR).pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	10/04/2011
Comments: Please find attached the Application for this filing.		
Attachment: DENTALPLUS-APP-08.2011.pdf		

	Item Status:	Status Date:
Satisfied - Item: Health - Actuarial Justification	Approved-Closed	10/04/2011
Comments: Please find attached the Actuarial Memorandum for this filing.		
Attachment: Actuarial Memorandum (DVH-11POL-AR).pdf		

	Item Status:	Status Date:
Satisfied - Item: Outline of Coverage	Approved-Closed	10/04/2011
Comments: Please find attached the Outline of Coverage for this filing.		
Attachment: Dental Plus, Vision and Hearing OOC _DENTALPLUS-11OUTLINE-AR.pdf		

SERFF Tracking Number: USLH-127625830 State: Arkansas
 Filing Company: United Security Life and Health Insurance State Tracking Number: 49847
 Company
 Company Tracking Number: DVH-11POL-AR
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: Dental Plus, Vision and Hearing Expense Policy
 Project Name/Number: Dental Plus, Vision and Hearing Expense Policy/

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	10/04/2011
Bypass Reason:	Does not apply.		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter	Approved-Closed	10/04/2011
Comments:	Please find attached the Cover Letter for this filing that contains a detailed filing description.		
Attachment:	9.21.11 - Cover Letter (Dental Plus Product) - AR.pdf		

		Item Status:	Status Date:
Satisfied - Item:	Brochure	Approved-Closed	10/04/2011
Comments:	Please find attached the Brochure for this Product.		
Attachment:	DENTALPLUS-BRO-08.2011.pdf		



UNITED SECURITY

LIFE AND HEALTH INSURANCE COMPANY

6640 S. Cicero Avenue, Bedford Park, Illinois 60638
(708) 475-6100 (800) 875-4422 Fax: (708) 475-6120

FLESCH CERTIFICATION

This is to certify that the attached Dental Plus, Vision and Hearing Expense Policy (DVH-11POL-AR) received a Flesch Reading Ease Score of 49.2. This form complies with the requirements of A.C.A. 23-80-206.

Robert G. Dial
Vice President & Secretary

9/21/2011

Date

Application for Dental Plus Insurance

PLEASE TYPE OR PRINT



Add Accident Hospital Indemnity Plan: Yes No

Premium Amount: \$ _____ /

A. PERSONS TO BE INSURED

	Last	Name First	MI	Sex	Birthdate (MM/DD/YY)	Age
Proposed Insured						
Spouse						
Dependent Child						
Dependent Child						
Dependent Child						

Attach a separate sheet, signed and dated, if additional space is needed.

B. PERSONAL INFORMATION FOR PROPOSED INSURED

Residence Street Address _____ City _____ State _____ Zip _____

Day Time Phone Number _____ / _____ Cell Number _____ Best Time to Call _____ Email Address _____

Billing Address (if different than above)

Street _____ City _____ State _____ Zip _____ Phone Number _____

Occupation

Primary Insured - Employer Name _____

Spouse - Employer Name _____

Duties _____

Duties _____

C. OTHER COVERAGE IN FORCE

Is the Proposed Insured covered by, or has application been made for any type of dental insurance? Yes No

If "Yes", complete the section below.

Insurance Company Name	Policy Number	Phone Number (Include Area Code)	Effective Date (MM/DD/YY)

D. MEDICAL INFORMATION

	Primary		Spouse		Dependnt.	
	Yes	No	Yes	No	Yes	No
1. (a) Do you currently wear dentures?.....	<input type="checkbox"/>					
(b) Have you been advised to have any dental work which has not been completed?.....	<input type="checkbox"/>					
2. (a) Do you currently wear eyeglasses or contact lenses?.....	<input type="checkbox"/>					
(b) Have you received advice or treatment within the past nine months for correction of a vision problem?.....	<input type="checkbox"/>					
3. (a) Do you currently wear a hearing aid?.....	<input type="checkbox"/>					
(b) Have you been treated for hearing loss within the past nine months?.....	<input type="checkbox"/>					
(c) Has a physician recommended the purchase of a hearing aid to correct a hearing deficiency?.....	<input type="checkbox"/>					

Provide details for any "Yes" answers for questions 1-3.

Primary: _____

Spouse: _____

Dependents: _____

**UNITED SECURITY LIFE AND HEALTH INSURANCE COMPANY
[BEDFORD PARK, ILLINOIS]
DENTAL PLUS, VISION AND HEARING BENEFITS
OUTLINE OF COVERAGE --- POLICY FORM DVH-11POL-AR**

- 1) *READ YOUR POLICY CAREFULLY* – This outline provides a very brief description 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 Your insurance company. It is, therefore, important that You **READ YOUR POLICY CAREFULLY!**
- 2.) *DENTAL, VISION AND HEARING COVERAGE* – Policies of this category are designed to provide to persons insured coverage for which benefits are provided and mean bodily injury caused by an accident which occurs while this Policy is in force. The injury must be the direct cause of loss, independent of disease or bodily infirmity.
- 3) *DESCRIPTION OF THE POLICY:*
 - (a) This Policy provides Dental, Vision and Hearing Benefits as specified in the Schedule of Benefits.

SCHEDULE OF BENEFITS

<u>Deductible Per Policy Year:</u>	
Individual	[\$50]
<u>Maximum Benefit Per Covered Person For all Three Benefits:</u>	
Dental, Vision and Hearing Services per Policy Year	[\$1,200]
<u>Coinsurance:</u>	
Preventive Dental Services	[90%/10%]
Basic Dental Services	[70%/30%]
Major Dental Services	[50%/50%]
<u>Maximum Benefit for Preventive Dental Services Per Visit:</u>	[\$75.00]

<u>Maximum Benefit for Vision Services Per Policy Year:</u>	
Vision Benefits	[\$150]
<u>Coinsurance:</u>	
Hearing Examinations	[70%/30%]
Hearing Aids	[70%/30%]
<u>Waiting Period:</u>	
Preventive Dental Services	[30 Day Waiting Period]
Basic Dental Services	[6 Month Waiting Period]
Major Dental Services	[12 Month Waiting Period]
Vision Services	[3 Month Waiting Period]
Hearing Aids	[12 Month Waiting Period]

4.) *DESCRIPTION OF EXCEPTIONS AND LIMITATIONS:*

We will NOT pay benefits for the following items and/or services during the first 30 days following the Policy Effective Date:

1. Preventive Dental Services.

We will NOT pay benefits for the following items and/or services during the first six months following the Policy Effective Date:

1. Basic Dental Services.

We will NOT pay benefits for the following items and/or services during the first Policy Year:

1. Major Dental Services; or
2. Hearing aids.

We will NOT pay benefits for:

1. any loss resulting from war, declared or undeclared;
2. any intentionally self-inflicted Injury;
3. any loss to which a contributing cause was Your commission of or attempt to commit a felony or Your being engaged in an illegal occupation;
4. any expense for which payment is provided under Medicare;
5. any services that are not recommended by a Physician, as defined by this Policy;
6. any Experimental or Investigational procedure or treatment;
7. orthodontic treatment;

8. any expenses incurred for the diagnosis or treatment of Temporomandibular Joint (TMJ) and Craniomandibular Joint (CMJ) Dysfunction;
9. expenses incurred for surgical procedures (other than outpatient dental surgery) performed on an inpatient or outpatient basis (including any surgical procedure performed in the treatment of cataracts);
10. charges for radial keratotomy (RK), automated lamellar keratoplasty (ALK), conductive keratoplasty (CK) or other cosmetic procedures;
11. prescription drugs;
12. charges in excess of Reasonable and Customary Charges;
13. treatment or diagnosis received while outside the territorial limits of the United States;
14. services for which You are not liable or for which no charge normally is made in the absence of insurance; and
15. loss that occurs while this Policy is not in force.

- 5.) *GUARANTEED RENEWABLE TO AGE 75 – SUBJECT TO CHANGE IN PREMIUM BY CLASS:*
You may continue the coverage on each Insured Person provided by this Policy, until the Policy Anniversary on or following the Insured Person's 75th birthday, subject to the Policy's Termination and Insured Child provisions, by paying all premiums when they are due. We will not add any restrictive riders or endorsements while this Policy is in force. We reserve the right to change the premium charged for this Policy. Any change in premium will be made on a class basis only, as We determine, and will be based on the Insured Person's Age on the Date of Issue. No change in premium will become effective until 45 days after We deliver to You, or mail to Your last known address, a written notice of premium change.

September 21, 2011

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201

Re: **UNITED SECURITY LIFE AND HEALTH INSURANCE COMPANY**

FEIN #:	36-3692140 /	NAIC #:	81108
DVH-11POL-AR /	DENTALPLUS-APP-08.2011 /	Dental Plus, Vision and Hearing Expense Policy Application for Dental Plus Insurance	
<u>Supporting Documents</u>			
DENTALPLUS-BRO-08.2011 /		Dental Plus, Vision and Hearing Insurance Brochure	
DENTALPLUS-11OUTLINE-AR/ Rates (DVH-11POL-AR) /		Dental Plus, Vision and Hearing Outline of Coverage Rates for Dental Plus, Vision and Hearing Expense Policy	
Actuarial Memorandum /		Actuarial Memorandum for Dental Plus, Vision and Hearing Expense Policy	

Dear To Whom It May Concern:

I hope this correspondence finds you well. Please find enclosed the form referenced above for your review and approval. These are new forms and do not replace any forms previously filed and approved by your Department.

Dental Plus, Vision and Hearing Expense Policy is being filed for approval as an Individual Policy. This new form, **DVH-11POL-AR** will be effective for all business going forward from the approval date of the Arkansas Insurance Department. The Application for Dental Plus Insurance, **DENTALPLUS-APP-08.2011**, is also being filed along with this Policy for approval. The Dental Plus, Vision and Hearing Insurance Brochure, **DENTALPLUS-BRO-08.2011** is being filed as well for Informational Purposes Only. These forms are new and will be used with the Dental Plus, Vision and Hearing Expense Policy.

Along with those forms, we have filed an Outline of Coverage, Rates and an Actuarial Memorandum for this Policy for Informational Purposes Only.

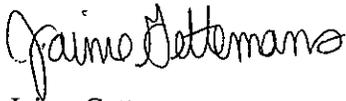
The referenced forms will provide benefits to those individuals who need to have access to Dental Plus, Vision and Hearing Insurance.

Quality Products from Caring Professionals

Page Two
September 21, 2011

Please direct any questions, correspondence or approval to my attention concerning this filing. I look forward to your approval of these forms. You can contact me directly at 708-552-2417 or via email at jaimemgettemans@priscorp.net.

Sincerely,

A handwritten signature in black ink that reads "Jaime Gettemans". The signature is written in a cursive style with a large initial "J" and a long, sweeping underline.

Jaime Gettemans
Compliance Department

Exclusions & Limitations

We will NOT pay benefits for Preventive Dental during the first 30 days following the Policy Effective Date.

We will NOT pay benefits for Vision services during the first three months following the Policy Effective Date.

We will NOT pay benefits for the following items and/or services during the first six months following the Policy Effective Date:

1. Basic Dental Services; or

We will NOT pay benefits for the following items and/or services during the first Policy Year:

1. Major Dental Services; or
2. Hearing aids.

We will NOT pay benefits for:

1. Any loss resulting from war, declared or undeclared;
2. Any intentionally self-inflicted Injury;
3. Any loss to which a contributing cause was your commission of or attempt to commit a felony or your being engaged in an illegal occupation;
4. Any expense for which payment is provided under Medicare;
5. Any services that are not recommended by a Physician, as defined by this Policy;
6. Any Experimental or Investigational procedure or treatment;
7. Orthodontic treatment;
8. Any expenses incurred for the diagnosis or treatment of Temporomandibular Joint (TMJ) and Craniomandibular Joint (CMJ) Dysfunction;
9. Expenses incurred for surgical procedures (other than outpatient dental surgery) performed on an inpatient or outpatient basis (including any surgical procedure performed in the treatment of cataracts);
10. Charges for radial keratotomy (RK), automated lamellar keratoplasty (ALK), conductive keratoplasty (CK) or other cosmetic procedures;
11. Prescription drugs;
12. Charges in excess of Reasonable and Customary Charges;
13. Treatment or diagnosis received while outside the territorial limits of the United States;
14. Services for which you are not liable or for which no charge normally is made in the absence of insurance; and
15. Loss that occurs while this Policy is not in force.

This brochure is intended to provide a general description of the policy benefits. Policy provisions and benefits may vary from state to state. Please see the policy for details. For costs and further details of the coverage, including exclusions, any restrictions or limitations and the terms under which the policy may be continued in force, see your agent or write to the Company.

ABOUT UNITED SECURITY LIFE AND HEALTH

USL&H is a regional insurance carrier that offers cancer, disability income, health and life insurance products to individuals and families. Founded in 1973, USL&H is licensed to sell its products in Arizona, Arkansas, Illinois, Indiana, Missouri and Nebraska through a network of independent insurance agents. Visit us online at www.unitedsecuritylandh.com.



Dental  *Plus*
Vision Hearing

U S **UNITED SECURITY**
L H LIFE AND HEALTH INSURANCE COMPANY

Why is Dental Plus coverage important to you and your family?

It's a proven fact that good preventative care of your entire body leads to greater quality of life. Ensuring that your teeth, vision and hearing are working at its optimal health is no exception. That is why **United Security Life and Health** developed **Dental Plus**.

Dental Plus is designed to provide you with a simple, affordable way to protect these important assets by helping you pay for their coverage. With **Dental Plus**, regular check-ups and good preventative care are possible.

There are absolutely No Network Restrictions; you can visit any dentist, optometrist, ophthalmologist or audiologist you want! **Anyone ages 18-64 is eligible, as well as dependents.**

Plan Benefits

United Security Life and Health's Dental Plus is a **Guaranteed Issue** plan for applicants aged 18 through 64, meaning your acceptance in this program is guaranteed. **Dental Plus** is also **Guaranteed Renewable**, so as long as you pay your premiums on time, you'll be able to renew your policy up to age 75.



We have also worked with our Pharmacy Benefit Manager, CareMark, to provide you with a **Free Discount Card** that will earn you **discounts and/or lower out-of-pocket expenses on many prescription drugs**. Although this is not a Prescription Co-Pay Drug Card, it will allow you to spend less money on medicine so you can deposit more money in your bank account.

Plus, Save Up To 25%

Save 10% with our multi-adult discount and **Save 15%** if purchased with a health plan.

You Can't Ignore the Facts:



Glaucoma is the second leading cause of blindness. Early diagnosis and treatment limit glaucoma-related vision.

Your teeth, gums, and surrounding tissue have plenty to say about your overall health.



Flossing and heart disease are interrelated. You can reduce your risk of heart disease by taking proper care of your teeth.



The Dental Plus Yearly Deductible is only \$50!



Once you pay the affordable \$50 Policy Year Deductible, the **Dental Plus** combo plan will pay for the following covered expenses:

- 90% Preventive Dental Services***
- 70% Basic Dental & Hearing Services***
- 50% Major Dental Services***



\$75/person

Every Preventive Dental Visit

\$150/year

Per Person Vision Benefit

Applicants receive a \$1,200 Policy Year Maximum

Monthly Rates*

For as little as **\$33/month**

Billing Fees

Annual - \$0 Monthly - \$3
Semi-Annual - \$6 PAC/Credit Card - \$1
Quarterly - \$5 List (monthly) - \$5

*Premiums are subject to change.
Premium rates shown above were filed in your state on 7/1/2011.

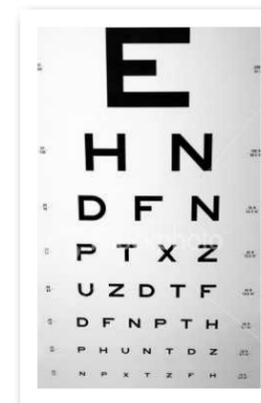
AGE	INDIVIDUAL	MULTI-ADULTS
18-30	\$33.09	\$29.78
31-40	\$36.63	\$32.97
41-50	\$38.78	\$34.90
51-60	\$41.87	\$37.68
61-64	\$47.04	\$42.34
Child*	\$25.21	N/A

*Additive for multiple children

United Security Life and Health's Dental Plus is issued individually and premiums are determined according to the age of the applicant.

After you receive the policy, the **10-Day Right to Examine** feature affords you the option to return the policy to us or your insurance agent if you are dissatisfied. We will refund any premiums you have paid and void the policy.

*It is important that you note the following **Waiting Periods** that apply before we start providing you coverage: Preventive Dental Services* - 30 days, Vision Services - 3 months, Basic Dental Services* - 6 months, Major Dental Services* - 12 months, Hearing Aids* - 12 months.



Buy from a company you can trust.

Great coverage. Great service.

SERFF Tracking Number: USLH-127625830 State: Arkansas
 Filing Company: United Security Life and Health Insurance State Tracking Number: 49847
 Company
 Company Tracking Number: DVH-11POL-AR
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: Dental Plus, Vision and Hearing Expense Policy
 Project Name/Number: Dental Plus, Vision and Hearing Expense Policy/

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)
09/21/2011	Form	Dental Plus, Vision and Hearing Expense Policy	10/04/2011	DVH-11POL-AR.pdf (Superseded)

UNITED SECURITY LIFE AND HEALTH INSURANCE COMPANY
[6640 South Cicero Avenue, Bedford Park, IL 60638]

DENTAL PLUS, VISION AND HEARING EXPENSE POLICY

CAUTION: The issuance of this Policy is based upon Your responses to the questions on Your application. A copy of Your application is attached to the Policy. If Your answers are incorrect or untrue, We may have the right to deny benefits or rescind Your Policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of Your answers are incorrect, contact Us at the address shown above.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.

This Policy is a legal contract between You and Us. **READ YOUR POLICY CAREFULLY.** Also, read the copy of Your application and the Policy Schedule. If there is any error or omission, tell Us. We will make any needed change.

The first premium You, the Insured, paid before the Policy Effective Date (and the copy of Your attached application), puts this Policy in force as of the Policy Effective Date. That date is shown in the Schedule. The Schedule is attached and is a part of this Policy.

Insuring Clause: We agree to provide the benefits set out in this Policy for any insured loss. This agreement is subject to all of the provisions of the Policy. A “loss” is an expense You incur for care or services this Policy covers and that You receive after the Policy Effective Date and while the Policy is in force.

PLEASE READ – 10 DAY RIGHT TO RETURN

Please read Your Policy. If You are not satisfied, send it back to Us, or to the Producer who sold it to You, within 10 days after You receive it. We will return your money. That will mean Your Policy was never in force.

GUARANTEED RENEWABLE
SUBJECT TO OUR LIMITED RIGHT TO CHANGE PREMIUMS

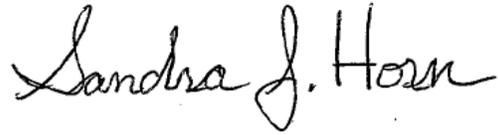
We guarantee to renew Your Policy up to age 75 as long as the premium is paid within the allowable time. We do have the right to change Your premium as stated below.

Premium Change: We can change Your premium only if We do the same to all policies of this form issued to persons of Your class. “Class” means the factors of age, gender, underwriting class and geographic area of Your state of residence that determined Your premium rate when coverage was issued. If We make a change, it will not be based on any physical impairment You might have or any claims You have incurred under this Policy. If it is necessary to change the premium for Your Policy, We will notify You in advance of the change of premium.

Our President and Secretary sign this Policy in our behalf.



Secretary



President

Countersigned By:

Licensed Resident Producer

SCHEDULE OF BENEFITS

Plan: Dental Plus, Vision and Hearing Expense Policy
Certificate Holder: [John Doe]
Birthdate: [XX/XX/XXXX]
Gender: [Male]
Family Coverage: [Y, N]
Certificate Number: [000000000000]
Policy Effective Date: [XX/XX/XXXX]
Policy Renewal Date: [XX/XX/XXXX]
Payment Option: [Monthly/Quarterly/Semi-Annually/Annually]

<u>Deductible Per Policy Year:</u>	
Individual	[\$50]
<u>Maximum Benefit Per Covered Person For all Three Benefits:</u>	
Dental, Vision and Hearing Services per Policy Year	[\$1,200]
<u>Coinsurance:</u>	
Preventive Dental Services	[90%/10%]
Basic Dental Services	[70%/30%]
Major Dental Services	[50%/50%]
<u>Maximum Benefit for Preventive Dental Services Per Visit:</u>	[\$75.00]

<u>Maximum Benefit for Vision Services Per Policy Year:</u>	
Vision Benefits	[\$150]
<u>Coinsurance:</u>	
Hearing Examinations	[70%/30%]
Hearing Aids	[70%/30%]
<u>Waiting Period:</u>	
Preventive Dental Services	[30 Day Waiting Period]
Basic Dental Services	[6 Month Waiting Period]
Major Dental Services	[12 Month Waiting Period]
Vision Services	[3 Month Waiting Period]
Hearing Aids	[12 Month Waiting Period]

NOTICE TO BUYER: This Policy may not cover all costs incurred by You during the period of coverage. You are advised to carefully review all Policy limitations.

**LIMITED BENEFIT INSURANCE POLICY
FOR DENTAL PLUS, VISION AND HEARING EXPENSES**

ALPHABETICAL GUIDE TO YOUR POLICY

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BENEFITS

After the Policy Year Deductible as shown in the Schedule of Benefits is satisfied, the Policy pays the following percentages of actual charges, not to exceed Reasonable and Customary Charges for Covered Expenses up to the Policy Year Maximum Benefit:

Covered Expenses, subject to the Exceptions and Limitations, are:

Dental Services:

Dental services, performed by a licensed Dentist, as outlined below.

Preventive Dental Services

1. Waiting Period as shown in the Schedule of Benefits.
2. Routine oral examination: Initial or periodic, limited to twice per Policy Year.
3. Prophylaxis: Scaling and cleaning of teeth, limited to twice per Policy Year.
4. Dental x-rays as follows:
 - a. Supplementary bite-wing x-rays, limited to twice per Policy Year.
 - b. Panorex and full mouth series, limited to one (1) of each every thirty-six (36) months.
 - c. Other dental x-rays necessary for the diagnosis of a specific condition requiring treatment.
5. Topical application of fluoride for Covered Dependents through the age of eighteen (18), limited to two (2) treatments per Policy Year.
6. Topical application of sealant to permanent posterior teeth (molars in upper or lower jaw).
7. The amount We will pay for this benefit is shown in the Schedule of Benefits. This benefit is subject to Deductible and Coinsurance.

Basic Dental Services

1. Waiting Period as shown in the Schedule of Benefits.
2. Sedative fillings, covered as a separate procedure only if no other service (except x-rays) is rendered during the visit.
3. Restorations (fillings) to restore teeth to normal function, using amalgam, silicate, acrylic, synthetic, and composite filling materials to restore teeth broken down by decay or injury.

4. Pin retention when part of the restoration instead of gold or crown retention.
5. Periodontics as follows:
 - a. Gingivectomy/gingivoplasty, gingival curettage, gingival flap procedure or mucogingival surgery.
 - b. Scaling and root planing.
 - c. Pedicle and free soft tissue grafts, and vestibuloplasty.
 - d. Occlusal adjustment.
 - e. Excision of pericoronal gingiva.
 - f. Periodontal prophylaxis.
 - g. Osseous surgery.
6. Endodontics as follows:
 - a. Direct pulp capping.
 - b. Pulpotomy.
 - c. Root canal therapy.
 - d. Apicoectomy.
 - e. Hemisection.
 - f. Retrograde fillings.
7. Oral surgery, including customary postoperative treatment furnished in connection with oral surgery, as follows:
 - a. Simple extraction of one (1) or more teeth.
 - b. Surgical extraction of erupted teeth and of soft tissue, partially bony, and completely bony impacted teeth.
 - c. Extraction of tooth root.
 - d. Incision and drainage of a tumor or a cyst.
 - e. Alveolectomy, alveoloplasty, and frenectomy.
 - f. Exostosis or hyperplastic tissue and excision of oral tissue for biopsy.
 - g. Re-implantation or transplantation of a natural tooth.
 - h. General anesthesia, only when provided in conjunction with a surgical procedure.
8. Space maintainers, fixed appliance (not made of precious metals), designed to preserve the space between teeth caused by the premature loss of a primary tooth (also called a baby tooth) including all adjustments within six (6) months of installation, limited to dependent children through the age of eighteen (18). This does not include space maintainers used in orthodontics to create a space between teeth.
9. Therapeutic injections of antibiotics administered by a dentist.
10. Repairs to full or partial dentures.

11. Relining of present dentures, but only if they were installed more than six (6) months earlier and if they have not been relined during the past twelve (12) months, once in any thirty-six (36) consecutive month period.
12. Rebasing of present dentures, but only if they were installed more than six (6) months earlier, not more than once in any thirty-six (36) consecutive month period.
13. Denture adjustment, only if done more than six (6) months after the initial insertion of the denture.
14. Repair or recementing of crowns, inlays, onlays or bridgework.
15. The amount We will pay for this benefit is shown in the Schedule of Benefits. This benefit is subject to Deductible and Coinsurance.

Major Dental Services

1. Waiting Period as shown in the Schedule of Benefits.
2. Post and core on permanent teeth only.
3. Gold Inlays and Onlays: Covered only when the tooth cannot be restored by basic restorations, and then only if at least five (5) consecutive years have elapsed since the last placement. Restorations on teeth which are anterior to the first bicuspid are not covered.
4. Porcelain Restorations: Covered only when the tooth cannot be restored by basic restorations, and then only if at least five (5) consecutive years have elapsed since the last placement. Restorations on teeth which are posterior to the first bicuspid are not covered.
5. Crowns: Covered only when the tooth cannot be restored by basic restorations, and then only if at least five (5) consecutive years have elapsed since the last placement. Crowns used to treat Temporomandibular Joint (TMJ) and Craniomandibular Joint (CMJ) Dysfunction will not be covered.
6. Initial installation of fixed bridge (including abutments) to replace one (1) or more natural teeth which were extracted while covered under this Plan.
7. Removable bridge, partial or complete dentures to replace one (1) or more natural teeth which were extracted while covered under this Plan.
8. Replacement of an existing partial or full removable denture or fixed bridge, or the addition of teeth to existing bridgework to replace extracted natural teeth.
9. The amount we will pay for this benefit is shown in the Schedule of Benefits. This benefit is subject to Deductible and Coinsurance.

Vision:

Visits to a Physician for a basic eye examination or eye refraction, including the cost of eyeglasses or contact lenses prescribed by the Physician, up to a maximum benefit as shown in the Schedule of Benefits in any one Policy Year. The Waiting Period is as shown in Schedule of Benefits. This benefit is subject to Deductible.

Hearing:

Hearing examinations performed by a Physician, or Audiologist, the purchase of hearing aid as prescribed as Medically Necessary by a Physician or Audiologist, including the cost of the hearing aid and any necessary repairs. There is no waiting period for hearing exams. There will be a 12 month waiting period as shown in the Schedule of Benefits for the purchase of a hearing aid. The amount We will pay for this benefit is shown in the Schedule of Benefits. This benefit is subject to Deductible and Coinsurance.

EXCEPTIONS AND LIMITATIONS

We will NOT pay benefits for the following items and/or services during the first 30 days following the Policy Effective Date:

1. Preventive Dental Services.

We will NOT pay benefits for the following items and/or services during the first 3 months following the Policy Effective Date:

1. Vision Services.

We will NOT pay benefits for the following items and/or services during the first six months following the Policy Effective Date:

1. Basic Dental Services.

We will NOT pay benefits for the following items and/or services during the first Policy Year:

1. Major Dental Services; or
2. Hearing aids.

We will NOT pay benefits for:

1. any loss resulting from war, declared or undeclared;
2. any intentionally self-inflicted Injury;
3. any loss to which a contributing cause was Your commission of or attempt to commit a felony or Your being engaged in an illegal occupation;
4. any expense for which payment is provided under Medicare;
5. any services that are not recommended by a Physician, as defined by this Policy;
6. any Experimental or Investigational procedure or treatment;
7. orthodontic treatment;
8. any expenses incurred for the diagnosis or treatment of Temporomandibular Joint (TMJ) and Craniomandibular Joint (CMJ) Dysfunction;
9. expenses incurred for surgical procedures (other than outpatient dental surgery) performed on an inpatient or outpatient basis (including any surgical procedure performed in the treatment of cataracts);
10. charges for radial keratotomy (RK), automated lamellar keratoplasty (ALK), conductive keratoplasty (CK) or other cosmetic procedures;
11. prescription drugs;
12. charges in excess of Reasonable and Customary Charges;
13. treatment or diagnosis received while outside the territorial limits of the United States;
14. services for which You are not liable or for which no charge normally is made in the absence of insurance; and
15. loss that occurs while this Policy is not in force.

POLICY YEAR DEDUCTIBLE AND MAXIMUM BENEFIT

There is a Policy Year Deductible which is shown in the Schedule of Benefits. After the Policy Year Deductible has been met, benefits are limited to the Policy Year Maximum Benefit shown in the Schedule.

DEFINITIONS

Audiologist: A person duly licensed and legally entitled to practice audiology at the time and in the state or jurisdiction in which services are performed, other than a member of the insured person's Immediate Family.

Coinsurance: Coinsurance is the dollar amount or percentage of Covered Charges that are paid by Us after any Co-payment and Deductible are satisfied. Coinsurance applies separately to each Covered Person. You are responsible for paying any Coinsurance balance that is not paid by Us.

Coinsurance only applies if it is shown in the Schedule of Benefits. The Schedule of Benefits will identify what any applicable Coinsurance percentage or amount is along with the Covered Charges to which they apply.

Covered Dependent: The Certificate Holder's lawful spouse; or child who is 18 or less and either a natural child, a child legally adopted or placed for adoption, or a stepchild.

- If an unmarried Child is age 25 or less, the child will be considered a Covered Dependent if You submit proof that the child meets the standards for a full-time student (12 credit hours) at an accredited educational institution, the student will be considered a Covered Dependent until the student is no longer a full-time student, graduates, attains age 25, or marries, whichever occurs first.
- An unmarried child of the Certificate Holder who is Totally Disabled will be considered a Covered Dependent. The child must depend upon the Certificate Holder for financial support or upon other care providers for lifetime care and supervision. As used here, "dependent upon other care providers" means requiring residential services licensed or certified by the State of Issue. Proof of support must be given to Us no later than 31 days after We notify You of this option. Additional proof may be requested annually.
- If children only are covered, siblings of the Certificate Holder will be considered Covered Dependents if they meet the above requirements.

Covered Expenses: Expenses for necessary medical and dental services or supplies prescribed by a Physician. They may not be more than the Reasonable and Customary Charges for such services or supplies. Covered Expenses for services or supplies will be deemed to be incurred on the date or dates such services are received by You. Covered Expenses must be incurred while this Policy is in force.

Dentist: A Physician duly licensed and legally entitled to practice dentistry at the time and in the state or jurisdiction in which services are performed, other than a member of the insured person's Immediate Family.

Experimental or Investigational: The use of treatment (drugs, devices or procedures) for a specific condition when all of the following are true:

1. the safety and effectiveness of a device is not proven; that is, pre-market approval has not been granted (devices only);
2. benefits to at least one-third of subjects are not documented in controlled clinical trials published in peer-reviewed English language medical journals; and
3. the treatment is not generally accepted medical practice as determined by review of peer-reviewed English language medical literature or authoritative medical journals or publications.

Immediate Family: Your spouse, parent, child, brother or sister or any person living with You.

Injury: Accidental Bodily Injury that results in loss, independent of sickness or bodily infirmity. See the Exceptions and Limitations Section for Injuries not covered by this Policy.

Medically Necessary: A service or care:

1. required for the treatment or management of a medical symptom or condition;
2. which is the most efficient and economical care or service which can be safely provided in keeping with current medical practices;
3. not administered solely for the convenience of an insured person or any provider; and
4. which is prescribed by a Physician.

Medicare: The “Health Insurance for the Aged Act,” Title XVII of the Social Security Amendments of 1965, as then constituted or later amended.

Ophthalmologist: A Physician duly licensed and legally entitled to practice ophthalmology at the time and in the state or jurisdiction in which services are performed, other than a member of the insured person’s Immediate Family.

Optometrist: A Physician duly licensed and legally entitled to practice optometry at the time and in the state or jurisdiction in which services are performed, other than a member of the insured person’s Immediate Family.

Physician: A licensed practitioner of the healing arts acting within the scope of his/her license, other than a member of the insured person’s Immediate Family. Physician includes a licensed Dentist, Optometrist, Ophthalmologist, or Audiologist.

Policy Effective Date: The date on which this Policy first became effective. That date is shown in the Schedule of Benefits.

Policy Renewal Date: The month and day Your Policy’s premium is due. The frequency of the Policy Renewal Date can vary depending on the premium payment option You selected. This is shown in the Schedule of Benefits.

Policy Year: The year beginning on the Policy Effective Date and on each following anniversary of the Policy Effective Date.

Policy Year Deductible: The dollar amount for which You are responsible during each Policy Year. The amount of the Policy Year Deductible is shown in the Schedule of Benefits.

Policy Year Maximum Benefit: The maximum benefit We will pay during any Policy Year. This amount is shown in the Schedule of Benefits.

Producer: A person required to be licensed under the laws of the state to sell, solicit or negotiate insurance.

Reasonable and Customary Charges: The charges for services or supplies from a Health Care Practitioner, facility or supplier at the prevailing health care charges for the geographical area in which the services were performed. This data is updated on a periodic basis.

Schedule: Is attached to and is part of this Policy.

We, Us or Our: United Security Life and Health Insurance Company.

You or Your: The Insured named in the Schedule of Benefits.

TERMINATION

Your Policy will terminate on the earliest of:

1. the Policy Renewal Date following the date We receive Your written or verbal request to cancel the Policy, unless You request a later termination date (the grace period will not apply);
2. the Policy Renewal Date if sufficient premium has not been paid before the end of the grace period;
3. Your Policy Renewal Date following Your 75th birthday; or
4. the date of Your death. In the event of Your death, We will promptly return the unearned portion of any premium paid beyond the date of death.

Except in the case of Your death, if the termination date occurs within a period for which We have accepted a premium, or if We accept a premium after such date, this Policy will continue in effect until the end of the period for which premiums have been accepted. This does not apply where the acceptance of premium was a result of a misstatement of age by You. In that case, the Misstatement of Age Provision controls.

HOW TO FILE A CLAIM

Notice of Claim: Written notice of claim for loss must be given to Us within 30 days after the date that loss occurred or began. If notice cannot be given within 30 days, it must be given as soon as reasonably possible. The notice can be given to Us at Our Home Office or to Our agent. Notice should include Your name, the claimant's name, and Your certificate number.

Claim Forms: When We receive the notice of claim, We will send the Claimant Statement and Authorization forms for filing proofs of loss. If We do not send these forms to the claimant within 15 days, the claimant will meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the "Proof of Loss" provision.

Proof of Loss: Written proof of loss must be furnished to Us at Our Home Office within 90 days after the date of that loss. If it is not reasonably possible to give written proof in that 90-day period, We will not reduce or deny the claim for this reason if the proof is filed as soon as

reasonably possible. In any case, the proof required must be given no later than 365 days from the date of service, except in the absence of legal capacity.

PAYMENT OF CLAIMS

Timely Payment of Claims: All benefits payable under the Policy will be paid within 45 days (except in Illinois whereas all benefits payable under the Policy will be paid within 30 days) following receipt of written proof of loss from the insured. If such payment is not made within this time period, We will pay an interest rate of 9% or the specific state of issue interest rate on such payment. Interest that amounts to less than one dollar will not be paid.

Payment of Claims: Benefits will be paid directly to You. Benefits unpaid at Your death will be paid to Your beneficiary or Your estate.

If any benefit is payable to Your estate, to a minor or to any person not able to give a valid release, We may pay up to \$1,200.00 to any relative of Yours by blood or connection by marriage, or any beneficiary that We find entitled to the payment. Any payment made in good faith will fully discharge Us to the extent of the payment.

Claim Review and Appeal Procedure: In the event of any claim denial with which You do not agree, You have the right to submit a written request to Us at our Home Office asking for a review of the denial of benefits. This written request must be submitted to the Company within 180 days of the date You originally received the decision that initially prompted Your appeal. That request may include documents from Your Physician or care provider that support Your basis for the requested review. Within 30 days after We receive that written request, We will notify You or Your representative of the results of the review

OTHER IMPORTANT PROVISIONS

Entire Contract Changes: This Policy, with any attachments (and the copy of Your application), is the entire contract of insurance. No Producer may make contracts, determine insurability or change the application or Policy in any way. Only an Executive Officer of the Company can approve a change. That change must be shown in the Policy.

Time Limit on Certain Defenses: For a Policy that has been in force for less than six months, We may rescind the Policy or deny an otherwise valid claim upon a showing of misrepresentation that is material to the acceptance of coverage.

For a Policy that has been in force for at least six months, but less than two years, We may rescind the Policy or deny an otherwise valid claim upon a showing misrepresentation that:

1. is material to the acceptance for coverage; and
2. pertains to the condition for which benefits are sought.

After a Policy has been in force for two years, it is not contestable upon grounds of misrepresentation alone. The Policy may be contested only upon a showing that You knowingly and intentionally misrepresented relevant facts relating to Your health.

Grace Period: Your premium must be paid on or before the date it is due or during the 31-day grace period that follows. Your Policy stays in force during Your grace period.

Reinstatement: Your Policy will lapse if You do not pay Your premium before the end of the grace period. If We later accept a premium and do not require an application for reinstatement, that payment will put this Policy back in force. If We require an application for reinstatement and, as may be needed, issue a conditional receipt, this Policy will be put back in force when We approve it. If We fail to notify You of disapproval within 45 days of the date of application (or the date of the conditional receipt, where that is required), Your Policy will be put back in force on that 45th day.

In all other respects, You and We will have the same rights under this Policy that We had before it lapsed, unless there are special conditions that apply to the reinstatements. If there are, they will be endorsed on or attached to the Policy. The premium We accept to reinstate this Policy will be used for a period for which premiums had not been paid. We must receive all back premiums for the Policy to be reinstated.

Physical Examinations: We, at our expense, can have You examined as often as reasonably needed while a claim is pending.

Misstatement of Age: If Your age has been misstated, a premium adjustment will be made so that We receive the premiums that would have been due at the correct age.

Illegal Occupation: We will not be liable for any loss caused by Your commission of or attempt to commit a felony. Nor will We be liable for any loss caused by Your being engaged in an illegal occupation.

Legal Action: You cannot bring a legal action to recover under Your Policy for at least 60 days after You have given Us written proof of loss. You cannot start such an action more than three years after the date written proof of loss is required.

Change of Beneficiary Assignment: Only You have the right to change the beneficiary. This right is Yours unless You make a beneficiary designation that may be changed. Consent of the beneficiary is not required to make a change in this Policy. Also, such consent is not required to surrender this Policy or to assign the benefits.

Other Insurance With Us: You may have only one Policy like this one with Us at any one time. If You have more than one Policy, the one You, Your beneficiary or Your estate selects will remain in force. We will return all premiums paid for all other such policies.

Term of Coverage: Your coverage starts on the Policy Effective Date at 12:01 a.m. standard time where You live. It ends at 12:01 a.m. on the same standard time on the first Policy Renewal Date. Each time You renew Your Policy, the new term begins when the old term ends.

Conformity With State Statutes: Any provision of the Policy which, on its effective date, is in conflict with the laws of the state in which it is delivered is amended to conform to the minimum requirements of such laws.