Filing at a Glance

Company:	Reserve National Insurance Company
Product Name:	Dental Filing
State:	Arkansas
TOI:	H10G Group Health - Dental
Sub-TOI:	H10G.000 Health - Dental
Filing Type:	Form
Date Submitted:	10/11/2012
SERFF Tr Num:	FRCS-128710849
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	5777
Implementation Date Requested:	On Approval
Author(s):	Marilyn Odell
Reviewer(s):	Rosalind Minor (primary)
Disposition Date:	10/12/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: *Arkansas* **Filing Company:** *Reserve National Insurance Company*
TOI/Sub-TOI: *H10G Group Health - Dental/H10G.000 Health - Dental*
Product Name: *Dental Filing*
Project Name/Number: *RESERVE/65/65*

General Information

Project Name: RESERVE/65
Project Number: 65
Requested Filing Mode: Review & Approval

Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer
Filing Status Changed: 10/12/2012
State Status Changed: 10/12/2012
Created By: Marilyn Odell
Corresponding Filing Tracking Number:

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments: Filing was recently submitted in domicile state (OK).

Market Type: Group
Group Market Size: Small and Large
Overall Rate Impact:

Deemer Date:
Submitted By: Exselsa Cartwright

Filing Description:
We have been retained by Reserve National Insurance Company to file the enclosed forms for approval in your state.

Our fee of $250 has been sent by EFT on this same date.

The Company offers their assurance that the Guaranty Association notice required by Regulation 49 will be provided.

The captioned forms provide group dental insurance that will be issued to Employer groups in your state.

The enclosed Coverage Schedule pages are representative of those intended for use. Plan I has been included in the Forms Schedule. Plans II, III, IV and V are included in Supporting Information as well as the Statement of Variables that describes the benefit options. Information on these pages is variable, but will never be less than the applicable minimum requirements of your state's laws.

The insurance will be marketed through properly licensed representatives.

All forms are written in readable language and will be in a format that is acceptable to the Department. Printing is subject to changes in ink, paper stock, page numbering, margins, positioning, and format. Printing standards will never be less than that required by law.

To the best of our knowledge, this filing is complete and intended to comply with the insurance laws of your jurisdiction.

If you have any questions or need additional information, please call toll-free 1-800-927-2730. Thank you for your assistance.

Company and Contact

Filing Contact Information

Marilyn Odell, Compliance Specialist
1020 Central
Suite 201
Kansas City, MO 64105

marilyn.odell@firstconsulting.com
800-927-2730 [Phone] 2835 [Ext]
816-391-2755 [FAX]

State: *Arkansas* **Filing Company:** *Reserve National Insurance Company*
TOI/Sub-TOI: *H10G Group Health - Dental/H10G.000 Health - Dental*
Product Name: *Dental Filing*
Project Name/Number: *RESERVE/65/65*

Filing Company Information

(This filing was made by a third party - FC01)

Reserve National Insurance Company
601 East Britton Road
Oklahoma City, OK 73114
(405) 848-7931 ext. [Phone]

CoCode: 68462
Group Code: 215
Group Name: Unitrin, Inc
FEIN Number: 73-0661453

State of Domicile: Oklahoma
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$250.00
Retaliatory?	No
Fee Explanation:	The fee in the retailatory state is $175. The fee in your state is $50 x 5 forms = $250.00. Therefore, the fee is $250.00.
Per Company:	No

Company	Amount	Date Processed	Transaction #
Reserve National Insurance Company	$250.00	10/11/2012	63733661

State: *Arkansas* **Filing Company:** *Reserve National Insurance Company*
TOI/Sub-TOI: *H10G Group Health - Dental/H10G.000 Health - Dental*
Product Name: *Dental Filing*
Project Name/Number: *RESERVE/65/65*

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/12/2012	10/12/2012

State: *Arkansas* **Filing Company:** *Reserve National Insurance Company*
TOI/Sub-TOI: *H10G Group Health - Dental/H10G.000 Health - Dental*
Product Name: *Dental Filing*
Project Name/Number: *RESERVE/65/65*

Disposition

Disposition Date: 10/12/2012
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Statement of Variables	Approved-Closed	Yes
Supporting Document	Schedule Pages	Approved-Closed	Yes
Form	Group Dental Insurance Policy	Approved-Closed	Yes
Form	Group Insurance Certificate	Approved-Closed	Yes
Form	Coverage Schedule	Approved-Closed	Yes
Form	Group Enrollment Form (Master Application)	Approved-Closed	Yes
Form	Employee Enrollment Form	Approved-Closed	Yes

State: *Arkansas* **Filing Company:** *Reserve National Insurance Company*
TOI/Sub-TOI: *H10G Group Health - Dental/H10G.000 Health - Dental*
Product Name: *Dental Filing*
Project Name/Number: *RESERVE/65/65*

Form Schedule

Lead Form Number: GDP-12 AR

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1	Approved-Closed 10/12/2012	GDP-12 AR	POL	Group Dental Insurance Policy	Initial:	52.000	RNIC Specimen Dental Policy Revised_AR.pdf
2	Approved-Closed 10/12/2012	GDC-12 AR	CER	Group Insurance Certificate	Initial:	51.000	RNIC Dental Certificate Revised_AR.pdf
3	Approved-Closed 10/12/2012	GDS-12	SCH	Coverage Schedule	Initial:	50.000	RNIC Specimen Option I Dental Schedule.pdf
4	Approved-Closed 10/12/2012	GDP-App-12 AR	AEF	Group Enrollment Form (Master Application)	Initial:	56.000	Group Enrollment Form and Information_AR.pdf
5	Approved-Closed 10/12/2012	GDC-App-12 AR	AEF	Employee Enrollment Form	Initial:	54.000	Employee Enrollment Form_AR.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

Reserve National Insurance Company
[601 East Britton Road
Oklahoma City, OK 73114-7710
reservenational.com]

GROUP DENTAL INSURANCE POLICY
NONPARTICIPATING

Policyholder: [Name (business) of Policyholder]

Group Policy Number: [1234-56789]

Policy Effective Date: [6/1/2012]

Policy Anniversary Date: [6/1/2013]

We, Reserve National Insurance Company, will pay the benefits described in this Policy subject to its provisions.

By paying the first premium and accepting this Policy, the Policyholder agrees to be bound by the terms of this Policy.

Renewable at the Option of the Company: This policy is renewable at the option of the company. Please refer to the Policy Term and Renewability provision.

This Policy is subject to the laws of [State].

IMPORTANT INFORMATION REGARDING YOUR INSURANCE. If you need to contact someone about this insurance for any reason, please contact your agent. If no agent was involved in its sale, or if you have additional questions, then you may contact the insurance company at the above address or phone them at [1-800-654-9106]. If unable to obtain satisfaction from the company or agent, you may contact the state regulatory agency at [Arkansas Insurance Department, 1200 West Third Street, Little Rock, Arkansas 72201] or phone them at [1-800-852-5494 or 1-501-371-2640]. Please have your policy number available.

Signed for Reserve National Insurance Company.

Secretary

President

PREMIUM CALCULATIONS AND PAYMENT

Premiums are payable on a monthly basis, unless We agree to some other mode of payment. Premiums must be paid to Us at Our Home Office or to Our authorized administrator.

The payment of any premium will keep the coverage in force to the next premium due date, subject to the Grace Period provision of the Policy Provisions.

We may change the premium for the insurance provided under the Policy by giving the Policyholder a written notice at least 31 days prior to any change.

POLICY PROVISIONS

ENTIRE CONTRACT: This Policy, all amendments, endorsements, or riders, the application of the Policyholder (a copy attached to this Policy) and individual enrollment forms, if any, will constitute the entire contract between the Policyholder and Us. All statements made by the Policyholder or by the Insureds will be deemed representations and not warranties.

No agent or other individual except Our President or Secretary has the authority to make or modify this Policy or extend the time for payment of any premium. No change in this Policy will be valid unless made by endorsement or by amendment signed by the Policyholder and Our President or Secretary and attached to this Policy. Any change so made will be binding on the Insured and on any other person(s) referred to in this Policy.

GRACE PERIOD: A Grace Period of 31 days will be granted for the payment of premiums after the first premium. The coverage under this Policy will continue in force during such Grace Period, but the Insured will be liable for the premium for any period such coverage continues in force, provided written notice of termination has not previously been given Us.

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with this Policy. No such action will be brought after the expiration of three years after written proof of loss is required to be furnished.

CERTIFICATES: We will issue an individual Certificate describing the benefits under the Policy.

NONPARTICIPATION: This Policy does not share in Our surplus earnings.

ADDITIONAL INSUREDS: The Company may add additional classes of insureds to the policy from time to time in accordance with the terms of the Policy.

CONFORMITY TO LAW: Any provision of this Policy which, on its Effective Date, is in conflict with the laws of the state in which the Policy was delivered or issued for delivery, is considered amended to conform to the applicable requirements of such state.

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

POLICY TERM: This Policy continues from its Effective Date for as long as the premium is paid, subject to the Grace Period.

A. The Policyholder may terminate this Policy on any premium due date by giving Us written notice in advance of any premium due date; and

B. We may terminate this Policy on any premium due date by giving written notice to the Policyholder at least [31] days in advance of any premium due date.

CERTIFICATE PROVISIONS MADE PART OF THE POLICY

The remainder of this Policy consists of provisions shown in the Certificate as issued to the Certificateholder. The provisions described in the TABLE OF CONTENTS are part of this Policy. Riders and amendments, if any, adding or changing the provisions of the Certificate are also made part of this Policy.

[RESERVE NATIONAL]

Reserve National Insurance Company
[601 East Britton Road
Oklahoma City, OK 73114-7710
reservenational.com]

Reserve National Insurance Company (herein called We, Our or Us) certifies that the Insured(s) listed below are covered under the Policy issued to the Policyholder.

Certificate Number: [XXXXXXXXXX]

Named Insured: [John Doe]

Dependent(s): [John Doe]

YOUR GROUP INSURANCE CERTIFICATE

GENERAL INFORMATION

About Your Insurance

This Certificate explains the plan of insurance underwritten by Reserve National Insurance Company. Read it closely to become familiar with Your coverage. In the Policy and this Certificate the masculine pronouns include both masculine and feminine gender unless the context indicates otherwise.

Important Notice

Benefits are payable only for expenses incurred while Your insurance is in force. No agent has the right to change the Policy or to waive any part of it. The Policy, under which this Certificate is issued, may be amended or cancelled at any time as stated in its provisions. Such an action may be taken without the consent of or notice to any person who claims rights or benefits under the Policy. The insurance under the Policy does not take the place of nor does it affect any requirements for coverage by Worker's Compensation or a similar type of insurance.

IMPORTANT INFORMATION REGARDING YOUR INSURANCE. If you need to contact someone about this insurance for any reason, please contact your agent. If no agent was involved in its sale, or if you have additional questions, then you may contact the insurance company at the above address or phone them at [1-800-**654-9106**]. If unable to obtain satisfaction from the company or agent, you may contact the state regulatory agency at [Arkansas Insurance Department, 1200 West Third Street, Little Rock, Arkansas 72201] or phone them at [1-800-852-5494 or 1-501-371-2640]. Please have your policy number available.

Signed for Reserve National Insurance Company.

Secretary

President

CERTIFICATE OF PARTICIPATION IN A GROUP DENTAL INSURANCE POLICY PROVIDING BENEFITS FOR DENTAL EXPENSE AS PROVIDED IN THE GROUP POLICY – READ YOUR CERTIFICATE CAREFULLY

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DEFINITIONS

ADA CODE - means the American Dental Association Code assigned to a particular dental procedure.

COURSE OF TREATMENT- means all treatment and procedures performed in the oral cavity under a plan of treatment during one or more sessions that are the result of the same initial diagnosis. It also includes any complications during such treatment.

DENTAL HYGIENIST - means a person who works under the supervision of a Dentist/Physician and who is currently licensed to practice dental hygiene.

DENTIST/PHYSICIAN- means a person who is licensed to practice as a dentist or physician and who is operating within the scope of his license. It does not mean a member of an Insured's Immediate Family.

DEPENDENT - means any of the following persons:

1. Your spouse;
2. Your domestic partner;
3. Dependent children from birth to age 26.
4. Each unmarried child at least 26 years of age:
    a. who is incapable of self-sustaining employment by reason of mental retardation or physical handicap;
    b. who was incapacitated and insured under the Policy on his 26th birthday; and
    c. who continues to be incapacitated beyond his 26th birthday.

ELIGIBLE EXPENSES - means covered dental services and procedures described in this Certificate and the Coverage Schedule.

EXPERIMENTAL AND INVESTIGATIONAL - means:

1. a drug or device not lawfully marketed without U.S. Food and Drug Administration and approval is yet to be given for marketing;
2. a drug, device or medical treatment or procedure has not shown reliable evidence or is subject to on going phase I, II or III clinical trials or is under study to determine
    a. the maximum tolerated dose,
    b. its toxicity,
    c. its safety,
    d. its efficacy, or
    e. its efficacy as compared with the standard means of treatment or diagnosis; or

3. a drug, device or medical treatment or procedure that is not medically necessary. However, a drug, device or medical treatment or procedure will not be considered investigative if reliable evidence shows that its use is reasonable and necessary for the treatment of a particular patient.

INSURED - means You and Your Dependents covered under the Policy and for whom a premium is paid.

POLICY - means the Policy issued to the Policyholder.

REASONABLE AND CUSTOMARY - means the normal charge, in the absence of insurance, of the provider, but not more than the prevailing charge in the area for like services. "Like" services means one that is identical or substantially the same. "Area" means a municipality, or in the case of a large city, a subdivision in which the service is rendered or such greater area as necessary to obtain a representative cross-section of charges for like services.

WE, OUR, US - means Reserve National Insurance Company.

YOU, YOUR, YOURS - means the Named Insured.

CONDITIONS FOR INSURANCE

YOUR INSURANCE STARTS- You and Your Dependents are covered on the later of:

1. the date We accept Your enrollment and determine an effective date; or
2. the date You first acquire a Dependent, if the date is after Your coverage begins.

NEWBORN INFANT COVERAGE

A Dependent newborn child is covered from the moment of birth. If any additional premium is required, a notice of birth together with the premium must be submitted to Us. For a newborn child, You must notify Us and pay any required premium within the first 90 days after such birth for coverage to continue beyond the first 90 days after birth.

ADOPTED CHILDREN COVERAGE

A Dependent child placed with You for adoption is covered from the date of such placement without evidence of insurability. Such coverage will continue, unless the placement is disrupted prior to legal adoption and the child is removed from placement.

If any premium is required, a notice of placement for adoption together with the premium must be submitted to us. This must be done within 31 days after the date of such placement to continue coverage beyond the first 31-day period.

Any minor child under Your charge, care and control when a petition for adoption has been filed, will be covered from the date the petition is filed, if coverage is applied for within 60 days of such filing. Coverage for an adopted newborn child is from the moment of birth if applied for within 60 days after birth. Coverage ceases upon the dismissal or denial of a petition for adoption.

YOUR INSURANCE ENDS

Insurance for You and Your Dependents will end automatically on the earliest of the following dates:

1. the last day of the month in which You cease to be eligible;
2. the last day of the month in which Your Dependent is no longer a Dependent as defined;
3. subject to the Grace Period, the last day of the month for which a premium has been paid by You or on Your behalf; or
4. the date the Policy ends.

If Your coverage ends it will not prejudice any existing claim.

DENTAL INSURANCE

ELIGIBLE EXPENSES: We will pay You for Eligible Expenses You incur by or on behalf of You or any insured Dependent. Expenses must be incurred while the Policy is in force and the person is covered by the Policy. Any Deductible and Maximum Plan Year Limit is shown in the Coverage Schedule.

To be an Eligible Expense, the dental service or procedure must be performed by:

1. a Dentist;
2. a Physician; or
3. a Dental Hygienist.

EXPENSES INCURRED: An Eligible Expense is considered incurred on the following dates:

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

PRETREATMENT REVIEW: If the Course of Treatment will exceed the amount shown in the Coverage Schedule, We will require prior review. We must be given the Dentist's treatment plan consisting of a description of the planned treatment with estimated charges and diagnostic x-rays. We will determine Eligible Expenses and state how much We will pay for the treatment. Our determination may suggest an alternate less expensive Course of Treatment if it will produce professionally satisfactory results.

In the cases where the Insured is liable for costs beyond the applicable coinsurance or deductible, We may not retroactively deny payment when services are provided for dental care services that are otherwise covered, if We failed to provide pretreatment authorization as required. If pretreatment authorization is provided by Us, We may not deny payment for the authorized service except in cases where fraud or material misrepresentation has occurred.

If You do not request a pretreatment review We will pay for the least expensive method of treatment regardless of the method actually used.

ALTERNATE BENEFIT: If:

1. We determine that a less expensive alternate procedure, service or Course of Treatment can be performed in place of the proposed treatment to correct a dental condition; and

2. the alternative treatment will produce a professionally satisfactory result; then the maximum We will allow will be the charge for the less expensive treatment.

MAXIMUM CALENDAR YEAR LIMIT: The maximum limit payable for all Eligible Expenses in any calendar year is shown in the Coverage Schedule. The Maximum Calendar Year Limit, if any, will apply to each person covered under the Policy.

DEDUCTIBLE: The lifetime and calendar year Deductible, if any, are shown in the Coverage Schedule. The Deductible is an amount of charges You incur by or on behalf of You or any insured Dependent for which no benefits will be paid.

COORDINATION OF BENEFITS

If any person under the Policy (referred to as "this Plan") is also covered under one or more other plans, the benefit under this Plan will be coordinated with benefits payable under all other plans.

This coordination will apply in determining the benefits payable for any Claim Period if the sum of:

1. the benefits that would be payable under this Plan in the absence of coordination; and
2. the benefits that would be payable under all other plans without provisions for coordination in those plans would exceed such benefits.

Except as provided in the following paragraph, when Coordination of Benefits is applied to the benefits payable for any Claim Period, the benefits that would be payable for Eligible Expenses under this Plan in the absence of Coordination of Benefits will be reduced to the extent necessary so that the sum of those reduced benefits and all the benefits payable for those Eligible Expenses under all other plans will not exceed the total of those Eligible Expenses. Benefits payable under all other plans include the benefits that would have been payable had a claim been properly made for them.

The rules establishing the order of benefit determination are:

1. The benefits of a plan covering a person for whom claim is made other than as a dependent will be determined before the benefits of a plan covering such person as a dependent.
2. Except as stated in (3) below, when this Plan and another plan cover the same child as a dependent of different persons, called "parents":
    a. the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
    b. if both parents have the same birthday, the benefits of the plan covering the parent longer are determined before benefits of the plan covering the other parent for the shorter period of time. However, if the other plan does not have the rule described in a. above, but instead uses a different method, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
3. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for such child are determined in this order:
    a. first, the plan of the parent with custody of the child;
    b. then, the plan of the spouse of the parent with custody of the child; and
    c. finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of such parent has actual knowledge of those terms, the benefits of that plan are determined first. This does not apply with respect to any Claim Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

4. The benefits of a plan covering a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid-off or retired employee (or as the employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule 4. is ignored.

5. If none of the above rules determines the order of benefits, the benefits of a plan which has covered the person for whom claim is made for the longer period of time will be determined before the benefits of a plan covering the person the shorter period of time.

If We are responsible for secondary coverage for Eligible Expenses, We will not deny coverage or payment of the amount We owe as secondary payer solely on the basis of the failure of another group contract, which is responsible as the primary payer, to pay for such Eligible Expenses. This will not require Us to pay the obligations of the primary payer.

For the purposes of administering the above provisions of this Plan or any similar provisions of other plans, We may, without consent or notice to any person, release to or obtain from any other insurance company, organizations or person, any information concerning any individual which We consider necessary.

Any person claiming benefit under this Plan will furnish Us with any information necessary.

Whenever payments which should have been made under this Plan in accordance with the above provisions have been made under any other plans, We will have the right, at Our sole discretion, to pay any organizations making these payments any amount We determine to be due. Amounts paid in this manner will be considered to be benefits paid under this Plan and, to the extent of these payments, We will be fully discharged from liability under this Plan.

Whenever payments have been made by Us, for Eligible Expenses in a total amount in excess of the maximum amount of payment necessary to satisfy the intent of the above provisions, We will have the right to recover the excess from one or more of the following:

1. other insurance companies;
2. other organizations; or
3. persons to or for whom payments were made.

BENEFITS SUBJECT TO COORDINATION. All benefits provided under the Policy are subject to coordination.

DEFINITIONS. The following definitions apply only to this Coordination of Benefits section:

1. The term "plan" means coverage providing hospital, medical or dental benefits or services by:
   a. group or blanket insurance coverage, group practice or other pre-payment coverage on a group basis except school accident coverage;
   b. any coverage under labor-management trusteed plans, union welfare plans, employer organization plans or employee benefit plans.

The term "plan" will be construed separately for a policy, contract, or other arrangement for benefits or services that reserves the right to take the benefits or services of their plans into consideration in determining its benefits, or separately for that portion which does not reserve the right.

2. The term "Eligible Expense" means any necessary, reasonable and customary item of expense all or part of which is covered under one of the plans. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered to be both an Eligible Expense and a benefit paid.

3. The term "Claim Period" means a plan year or portion of a plan year for a claim on a person covered under this Plan.

GENERAL PROVISIONS

OUR RIGHT TO CONTEST: After the Policy has been in force for two years, we do not have the right to contest its various provisions except for non-payment of premiums. After coverage for the insured person has been in force for two years during the insured person's lifetime, we do not have the right to contest the insured person's coverage except for fraud or non-payment of premium.

NOTICE OF CLAIM: Written notice of claim must be given to Us within 30 days after the beginning of the loss, or as soon as reasonably possible. Notice given to Us at Our Home Office or to Our authorized administrator with information sufficient to identify the insured person will be notice to Us.

PAYMENT OF CLAIMS: If the Policy provides coverage of a claimant as a dependent of a parent who has legal responsibility for the dependent's medical care, and such parent does not have custody of the dependent, We may, upon request of the custodial parent, make the payments directly to the provider of care. Any payments so made will release Us from all further liability to the Insured to the extent of the payments made. Benefits for other losses are paid to the Insured. However, We have the right to pay all or part of the benefits due to the provider of care. This is true whether or not the Insured is alive. If the Insured has died and We do not pay accrued benefits to the provider of care, benefits will be paid to the Insured's estate.

CLAIM FORMS: When We receive written notice of claim, We will send forms for filing proof of loss. If such forms are not sent within 15 days after giving notice, the claimant will be deemed to have complied with the requirements of the Policy as to proof of loss.

PROOF OF LOSS: Written proof of loss must be furnished to Us within 90 days after the date of loss. If it is not possible to give notice within the time required We will not deny the claim for such reason, if proof is given as soon as reasonably possible.

TIME OF PAYMENT OF CLAIM: We will pay immediately, or as soon as is reasonably possible, following receipt of due written proof of loss, all benefits due under the Policy.

PHYSICAL EXAMINATION AND AUTOPSY: We have the right to examine the person whose injury or sickness is the basis of claim as often as We may reasonably require during the pendency of a claim.

REPLACEMENT: In the event the Policy immediately replaces another plan with Your same employer providing similar medical insurance and under which You and Your Dependents are insured on the date of such replacement:

1. We will not provide insurance or benefits that duplicate any payable by the prior plan under any extended benefits, continuation of benefits or like provision. When the prior plan's liability ceases under such provisions, We will extend the insurance or benefits of this Plan.
2. In the case of a deductible, co-insurance and waiting period, We will give credit for the satisfaction of the same or similar provisions under the prior plan. A deductible credit will be given for expenses actually incurred and applied against the deductible provisions of the prior plan during the same policy year as the effective date of this Plan.

Our liability as described above supersedes any provisions to the contrary described in the Policy.

RIGHT OF REFUND

(This provision will apply except where prohibited by law.)

WHEN THIS PROVISION APPLIES: An Insured may incur charges due to injuries for which benefits are paid by the Policy. The injuries may be caused by the act or omission of another person. If so, the Insured may have a claim against that other person for payment of dental charges. If recovery under the claim is made, the Insured must repay Us the recovery made from: (a) the other person; or (b) the other person's insurer. "Recovery" means monies paid to the Insured through judgment, settlement or otherwise to compensate for all losses caused by the injuries. "Net Recovery" means the Insured's recovery less attorney's fees and court costs incurred in making the recovery. "Refund" means repayment to Us for benefits paid.

AMOUNT SUBJECT TO REFUND: Only the amount recovered for charges incurred will be subject to refund. One-third of the Net Recovery will be deemed to be for such charges. However, in no case will the amount of refund exceed the amount of benefits paid for the injury under the Policy.

[RESERVE NATIONAL]

Reserve National Insurance Company
[601 East Britton Road
Oklahoma City, OK 73114-7710
reservenational.com]

COVERAGE SCHEDULE
DENTAL INSURANCE PLAN

WE WILL PAY THE REASONABLE AND CUSTOMARY CHARGE FOR DENTAL PROCEDURES AND SERVICES AFTER ANY REQUIRED DEDUCTIBLE AMOUNT, AS SHOWN BELOW.

[Class A. Preventive Services Include:

1. two routine examinations (including any initial exam) of the mouth and teeth per calendar year;
2. two prophylaxis (cleaning, scaling and polishing teeth) per calendar year;
3. one topical fluoride per calendar year, to age 16;
4. full mouth or panoramic x-rays once every 3 years;
5. series of bitewing x-rays twice each calendar year;
6. periapical x-rays as necessary;
7. space maintainers to preserve space between teeth for premature loss of a primary baby tooth. This does not include use for orthodontic treatment;
8. sealants, applicable only to first and second permanent molars for Dependent Children under age 16. Covered once per tooth in any 36 consecutive months.

Deductible, each calendar year	None
We pay, after Deductible	100% of Preventive Services, described above.

Waiting Period – None

Class B. Basic Services, Include:

1. extractions, routine removal;
2. pin retention of fillings;
3. fillings of amalgam, silicate, acrylic, synthetic porcelain and composite filling materials (restorations of mesiolingual, distolingual, mesiobuccal and distobuccal surfaces considered single surface restorations);
4. antibiotic injections administered by Dentist;
5. oral surgery, including postoperative care for:
   a. removal of teeth, including impacted teeth;
   b. extraction of tooth root;
   c. alveolectomy, alveoplasty, and frenectomy;
   d. excision of periocoronal gingiva, exostosis, or hyperplastic tissue, and excision of oral tissue for biopsy;
   e. reimplantation or transplantation of a natural tooth;
   f. excision of a tumor or cyst and incision and drainage of an abscess or cyst;
   g. general anesthesia and analgesic, including intravenous sedation, as needed for above procedures;
6. endodontic treatment of disease of the tooth, pulp, root, and related tissue, as follows:
   a. root canal therapy (not covered, if pulp chamber was opened before covered);
   b. pulpotomy;
   c. apicoectomy;
   d. retrograde filling;
7. periodontic services, limited to:
   a. two prophylaxis following surgery per calendar year;
   b. root scaling and planing, once per quadrant of mouth in any 6 month period;
   c. localized delivery of chemotherapeutic agents;

d. occlusal adjustment, performed with covered surgery;
e. gingivectomy, gingival curettage, and mucogingival;
f. osseous surgery including flap entry and closure;
g. pedical or free soft tissue grafts;
h. one appliance (night guards) in 5 year period;

Deductible, each calendar year	$50*
We pay, after Deductible	90% of Basic Services, described above.

Waiting Period - None

Class C. **Major Services Include:**

1. one study model in 3 year period;
2. crown build-up for non-vital teeth;
3. recementing inlays, onlays and crowns;
4. recementing bridges;
5. one repair of dentures or bridges in any 2 year period, limited to 20% of cost of replacement;
6. general anesthesia and analgesic, including intravenous sedation;
7. restoration services, limited to:
   a. gold or porcelain inlays, onlay, and crowns for tooth with extensive caries or fracture that is unable to be restored with an amalgam, silicate, acrylic, synthetic porcelain or composite filling material;
   b. replacement of existing inlay, onlay, or crown, only after 5 years since the restoration was initially placed or last replaced. This limitation will not apply if replacement is necessary due to the extraction of functioning natural teeth while covered;
   c. stainless steel crowns;
   d. post and core;
8. prosthetic services, limited to:
   a. initial placement of dentures or fixed bridgework (including acid etch metal bridges), when denture or bridgework includes replacement of a natural tooth extracted or lost while covered under the Policy. This limitation ends after the insured has been covered under the Policy for 36 months;
   b. replacement of dentures or fixed bridgework that cannot be repaired, only after 5 years from the date placed or last replaced;
   c. addition of teeth to existing partial denture, only if to replace natural teeth extracted or lost while covered under the Policy. This limitation ends after the insured has been covered under the Policy for 36 months;
   d. relining or rebasing of existing removable dentures, only after one year from date the denture was placed and only once in any 2 year period.

Deductible, each calendar year	$50*
We pay, after Deductible	50% of Major Services, described above.

Waiting Period – 12 Months from Effective Date

Class D. **Orthodontia Services For Insured Dependents Under 19 Years of Age Include:**

1. surgical therapy
2. appliance therapy
3. functional/myofunctional therapy

Deductible, each calendar year	None
We pay, after Deductible	50% of Orthodontia Services, as described above.

Waiting Period – 12 Months from Effective Date

MAXIMUM BENEFIT AMOUNT:

Combined per calendar year for Classes A, B and C	$1,000 per Insured
Maximum per calendar year for Class D	$ 500 per Insured
Lifetime under the policy for Class D	$1,000 per Insured

*Class B and C Deductible is a combined $50 each calendar year. A maximum of three (3) individual deductibles per family shall apply.

If Course of Treatment is to exceed $300, prior review is requested.]

[DENTAL EXPENSES NOT COVERED

The Policy, under which your certificate is issued, covers services and procedures as described in the Coverage Schedule. Your coverage, under the policy, **does not** cover any miscellaneous or separate expense not considered a covered service or procedure.

No benefits will be paid for expenses incurred:

1. for overdentures and associated procedures;
2. for charges in excess of those considered Reasonable and Customary;
3. for cosmetic procedures;
4. for the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function;
5. for implants; and for:
   a. replacement of lost or stolen appliances;
   b. replacement of retainers;
   c. athletic mouthguards;
   d. precision or semi-precision attachments; or
   e. denture duplication;
6. for oral hygiene instructions; and for:
   a. plaque control;
   b. completion of a claim form;
   c. acid etch;
   d. broken appointments;
   e. prescription or take-home fluoride; or
   f. diagnostic photographs;
7. for services not completed by the end of the month in which coverage ends;
8. for procedures that are begun, but not completed;
9. for services and treatment provided without charge, or for which there would be no charge in the absence of insurance;
10. for services in connection with war or any act of war, whether declared or undeclared, or condition contracted or accident occurring while on full-time active duty in the armed forces of any country or combination of countries;
11. for a condition covered under any Worker's Compensation Act or similar law;
12. that are generally considered by the dental profession as experimental or investigational;
13. for the treatment of cleft palate and anodontia;
14. for services or supplies payable under any medical expense plan;
15. for orthodontia, unless included as a Class D coverage;
16. prior to the date the Insured is covered under the Policy;
17. for the diagnosis or treatment of Temporomandibular Joint (TMJ) Dysfunction;
18. for hospital services;
19. if You voluntarily end Your insurance, You will not be eligible to re-enroll for a period of 2 years after the date Your coverage first ended;
20. charges for infection control, sterilization, and waste disposal.]

Reserve National Insurance Company
[601 East Britton Road
Oklahoma City, OK 73114-7710
reservenational.com]

GROUP ENROLLMENT FORM

General Information

Employer's Full Legal Name (exactly as it will appear in the Contract):

Coverage Requested [LIST DENTAL PLAN AND OPTIONS]

Business is: __ Corporation __ Partnership __ Proprietorship ☐Other _____

State of Incorporation: _____

Tax ID Number: **Years in Business:**

Nature of Business:

For groups with 2 to 9 eligible employees:
Is this a home based business? __ Yes __ No

Are 90% or more of the employees in the same family? Yes __ No __

Complete Street Address:

Street _____

City _____ State _____ Zip _____ County _____

Complete Mailing Address (if different):

Street _____

City _____ State _____ Zip _____ County _____

Contact Person: Title:

Email: **Telephone Number:** **Fax Number:**

Who should receive the initial Certificates and Administration Materials?
☐ Employer—***Email required:*** _____ ☐ Producing Agent

Type of Bill Requested: List Bill **Billing Frequency:** Monthly

Declarations

APPLICANT'S DECLARATION

1. To the best of my knowledge and belief, all the statements and answers given in this application are true and complete.
2. I understand and agree that (a) no agent may change or waive any of the provisions of this application or of any plan of insurance; (b) any change or waiver may be made only by an officer of Reserve National Insurance Company; and (c) this application will be accepted or declined partly on the basis of the statements and answers given in this application.

FRAUD STATEMENT

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

_____	_____	_____
Signature of Officer or Owner	Print Name of Officer or Owner	Date

PRODUCING AGENT'S DECLARATION

1. To the best of my/our knowledge and belief, all the statements and answers given in this application are true and complete.

2. I/we have no knowledge or information about the Applicant, its employees, the dependents of these employees, or any continued persons that is not fully stated in this application.

_____	_____	_____
Signature of Agent	Print Name of Agent	Date

Address:	Telephone #:	License #:
	Email:	

HOME OFFICE USE:

Reserve National Insurance Company
[601 East Britton Road
Oklahoma City, OK 73114-7710
reservenational.com]

EMPLOYEE ENROLLMENT FORM

The Certificate provides dental benefits only. Review your Certificate carefully.

EMPLOYER INFORMATION

Group Name: Group Number:

TYPE OF ENROLLMENT

Please check reason for completing:

☐ New Hire ☐ Late Enrollment

☐ Loss of Other Coverage:
I and/or my dependents were previously covered under another group plan.
Loss of coverage was due to: Termination Date:

☐ Termination of Spouse's Employment _____/_____/_____

☐ Divorce _____/_____/_____

☐ Term./Expiration of Coverage _____/_____/_____

☐ Other - reason: _____/_____/_____

EMPLOYEE INFORMATION

Name (last, first, middle): Address (street, city, state, zip):

Social Security Number: Class: Regular # of Hours Worked per Week: Date of Hire: Full-time:___/___/__ Part-time:___/___/___ ☐ Single ☐ Married

Date of Birth: _____/_____/_____ Gender: ☐ Male ☐ Female Occupation: Home Phone No.: ( ) -

INSURANCE COVERAGE ELECTIONS

(Verify coverage with your employer. Select coverage by checking "Yes" or Waive coverage by checking "No".)

EMPLOYEE	DEPENDENT(S)
Dental*	**Dependent Dental**
☐ Yes ☐ No	☐ Yes ☐ No

1. If waiving dental coverage, please specify reason for waiving:

2. *For Voluntary Dental Coverage Only: Were you or any other person enrolling covered under voluntary dental coverage provided by this employer? ☐ Yes ☐ No If Yes, list name(s) and effective date(s) of prior voluntary dental coverage.

3. Dental Coordination of Benefits: do you or any of your dependents have other dental coverage?
☐ Yes ☐ No
If Yes, Please specify person's name, name of carrier, and policy number of other coverage.

DEPENDENT INFORMATION – COMPLETE THIS SECTION FOR EACH DEPENDENT TO BE COVERED

	Full Name (first, middle, last)	Relationship	Date of Birth (mo., day, year)	Gender M/F	Social Security Number	Student** or Disabled
☐ Spouse						
☐ Domestic Partner						
Child						
Child						
Child						

ACKNOWLEDGMENT (SEE NOTIFICATION STATEMENTS ON PAGE 3.)

With my signature below:
1. I confirm I have read and understand the Fraud Statement printed below.
3. I understand that I must authorize deductions from my wages for my portion, if any, of the premium.
4. When this insurance becomes effective, I authorize deduction from my wages to pay my portion, if any, of the premium.
5. I hereby state the statements are true and have been completed to the best of my knowledge and belief.

Date: _____/_____/_____ Signature: _____

FRAUD STATEMENT

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

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	10/12/2012
Comments:			
Attachment(s):			
AR RDB.pdf Authorization_3-29-2012.pdf AR COC.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	10/12/2012
Comments:	Applications (enrollment forms) are attached under the Form Schedule tab.		

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variables	Approved-Closed	10/12/2012
Comments:			
Attachment(s):			
Kemper Dental Statement of Plan Variability.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Schedule Pages	Approved-Closed	10/12/2012
Comments:			
Attachment(s):			
RNIC Specimen Option II Dental Schedule Draft (accepted).pdf RNIC Specimen Option III Dental Schedule (accepted).pdf RNIC Specimen Option IV Dental Schedule.pdf RNIC Specimen Option V Dental Schedule (accepted).pdf			

STATE OF ARKANSAS

READABILITY CERTIFICATION

COMPANY NAME: Reserve National Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
GDP-12 AR	52
GDC-12 AR	51
GDS-12	50
GDP-App-12 AR	56
GDC-App-12 AR	54

Scott Snider
Senior Vice President, Corporate Counsel

October 8, 2012
Date

RESERVE NATIONAL

Reserve National Insurance Company
601 East Britton Road
Oklahoma City, OK 73114-7710
reservenational.com

Date: March 29, 2012

To: The Insurance Commissioner

Authorization

This Authorization, or a copy thereof, will authorize the consulting firm of First Consulting & Administration, Inc., Kansas City, Missouri, to represent this Company in matters related to forms and rates before the Insurance Department.

This Authorization shall be valid for a period of one year and renewable for a like period at the end of each term until terminated by the Company.

Company Name: Reserve National Insurance Company

Signature: Kyle D. Conrad

Name: Kyle D. Conrad

Title: Sr. Vice President and Assoc. Corp. Counsel

STATE OF ARKANSAS

CERTIFICATION OF COMPLIANCE

Company Name: Reserve National Insurance Company

Form Title(s): Group Dental Insurance Policy, Group Insurance Certificate, Coverage Schedule, Group Enrollment Form, Employee Enrollment Form

Form Number(s): GDP-12 AR, GDC-12 AR, GDS-12, GDP-App-12 AR, GDC-App-12 AR

I hereby certify that to the best of my knowledge and belief, the above form(s) and submission complies with Reg. 19, as well as the other laws and regulations of the State of Arkansas.

Scott Snider
Senior Vice President, Corporate Counsel

October 8, 2012
Date

Kemper Dental
P.O. Box 269010
Oklahoma City, Oklahoma 73126

Kemper Dental
Statement of Plan Variability
(Form Nos.: GDC-12, GDP-12, GDS-12)

The Kemper Dental plans contain five plan options with two categories of benefit designs: Waiting Period Plans and a Graded Benefit Plan.

The "Waiting Period Plans" consists of four plan options: Plan I, II, III, and IV. All four plans waive the waiting period for Preventive benefits and provide variable benefits by plan option for Preventive and Basic services. Plans I and II reimburse Preventive benefits at 100%, Plans III and IV reimburse at 80%; Plan I waives the 3-month waiting period on Basic and reimburses at 90%, whereas Plans II and III contain a 3-month waiting period on Basic and reimburse at 80%; Plan IV contains a 3-month waiting period on Basic and reimburses at 60%. All plan options contain a 12-month waiting period on Major benefits with a reimbursement rate of 50% under Plan I, II, and III, and a rate of 40% under Plan IV.

Plan V is a Graded Benefit Plan, and as with the "Waiting Period Plans", Preventive benefits have no waiting period and are reimbursed at 100% from the first day of coverage; in lieu of waiting periods this plan option provides a progressive increase in benefits for Basic and Major with each plan year, reaching maturity of benefits (Basic 80%, Major 50%) on benefit year 3.

All plans provide the option of Orthodontia coverage, an increase or decrease in UCR percentile for reimbursement (70%-80%-90%), an increase in calendar year maximum to $1,500 or $2,000, an option for moving Endodontic and Periodontic coverage (Plans II, III, IV, and V) from Major to Basic, and Credit for Prior Time (waiting periods removed – Plans I, II, III, and IV and optional Orthodontia coverage).

The Coverage Schedule for Plan I has been included in the Forms Schedule. Coverage Schedules for Plans II, III, IV and V are included in Supporting Information to help further clarify how the variable text may be utilized.

Variability Ranges:

Deductible:

- Calendar year deductibles range from $0 - $100.00.
- The deductible may be waived for some or all types of services (i.e. Class A).
- A separate deductible may be applied to Class A services ranging from $0 - $100.00.
- A separate lifetime deductible may be applied to all or some types of services.
- A family deductible ranges from a maximum of three individual deductibles to no maximum.

Co-insurance:

Kemper Dental
P.O. Box 269010
Oklahoma City, Oklahoma 73126

- Co-insurance amounts may vary from 0% to 100% within each benefit Class category, and may grade up in value over the length of time covered by a plan.

Waiting Periods:

- Waiting periods may vary from none to 24 months within each benefit Class category.
- Waiting periods for Class A may vary from 0, 1, 3, 6, and 12 months.
- Waiting periods for Class B may vary from 0, 3, 6, and 12 months.
- Waiting periods for Class C may vary from 0, 6, 12, 15, 18, and 24 months.
- Waiting periods for Class D may vary from 12, 18, and 24 months.

Benefit Maximums:

- Calendar year benefit maximum limits ranging from $1000 - $2000 are applied to Class A, B and C Services.
- A separate internal calendar year maximum on Class C services is sometimes requested. A maximum of $500 - $2000 could occur.
- When orthodontia (Class D) is part of a plan, calendar year maximum benefit limits range from $500 to $1000, with a lifetime maximum benefit range of $1000 to $2000.

Covered Expenses:

- Placement of specific covered expense items are variable with Class A, B and C. For example, when plans cover endodontics and periodontics, they are usually Class C services. There are instances when coverage for endodontics and/or periodontics is moved to Class B. As another example, x-rays are sometimes covered as a Class A service, but other times moved to Class B.

Expenses Not Covered:

- The Expenses Not Covered list is variable in concert with the Covered Expense section.

[RESERVE NATIONAL]

Reserve National Insurance Company
[601 East Britton Road
Oklahoma City, OK 73114-7710
reservenational.com]

COVERAGE SCHEDULE
DENTAL INSURANCE PLAN

WE WILL PAY THE REASONABLE AND CUSTOMARY CHARGE FOR DENTAL PROCEDURES AND SERVICES AFTER ANY REQUIRED DEDUCTIBLE AMOUNT, AS SHOWN BELOW.

[Class A. Preventive Services Include:

1. two routine examinations (including any initial exam) of the mouth and teeth per calendar year;
2. two prophylaxis (cleaning, scaling and polishing teeth) per calendar year;
3. one topical fluoride per calendar year, to age 16;
4. full mouth or panoramic x-rays once every 3 years;
5. series of bitewing x-rays twice each calendar year;
6. periapical x-rays as necessary;
7. space maintainers to preserve space between teeth for premature loss of a primary baby tooth. This does not include use for orthodontic treatment;
8. sealants, applicable only to first and second permanent molars for Dependent Children under age 16. Covered once per tooth in any 36 consecutive months.

Deductible, each calendar year	None
We pay, after Deductible	100% of Preventive Services, described above.

Waiting Period – None

Class B. Basic Services, Include:

1. extractions, routine removal;
2. pin retention of fillings;
3. fillings of amalgam, silicate, acrylic, synthetic porcelain and composite filling materials (restorations of mesiolingual, distolingual, mesiobuccal and distobuccal surfaces considered single surface restorations);
4. antibiotic injections administered by Dentist;
5. oral surgery, including postoperative care for:
   a. removal of teeth, including impacted teeth;
   b. extraction of tooth root;
   c. alveolectomy, alveoplasty, and frenectomy;
   d. excision of periocoronal gingiva, exostosis, or hyperplastic tissue, and excision of oral tissue for biopsy;
   e. reimplantation or transplantation of a natural tooth;
   f. excision of a tumor or cyst and incision and drainage of an abscess or cyst;
   g. general anesthesia and analgesic, including intravenous sedation, as needed for above procedures.

Deductible, each calendar year	$50*
We pay, after Deductible	80% of Basic Services, described above.

Waiting Period - 3 Months from Effective Date

Class C. **Major Services Include:**

1. endodontic treatment of disease of the tooth, pulp, root, and related tissue, as follows:
   a. root canal therapy (not covered, if pulp chamber was opened before covered);
   b. pulpotomy;
   c. apicoectomy;
   d. retrograde filling;
2. periodontic services, limited to:
   a. two prophylaxis following surgery per calendar year;
   b. root scaling and planing, once per quadrant of mouth in any 6 month period;
   c. localized delivery of chemotherapeutic agents;
   d. occlusal adjustment, performed with covered surgery;
   e. gingivectomy, gingival curettage, and mucogingival;
   f. osseous surgery including flap entry and closure;
   g. pedical or free soft tissue grafts;
   h. one appliance (night guards) in 5 year period;
3. one study model in 3 year period;
4. crown build-up for non-vital teeth;
5. recementing inlays, onlays and crowns;
6. recementing bridges;
7. one repair of dentures or bridges in any 2 year period, limited to 20% of cost of replacement;
8. general anesthesia and analgesic, including intravenous sedation;
9. restoration services, limited to:
   a. gold or porcelain inlays, onlay, and crowns for tooth with extensive caries or fracture that is unable to be restored with an amalgam, silicate, acrylic, synthetic porcelain or composite filling material;
   b. replacement of existing inlay, onlay, or crown, only after 5 years since the restoration was initially placed or last replaced. This limitation will not apply if replacement is necessary due to the extraction of functioning natural teeth while covered;
   c. stainless steel crowns;
   d. post and core;
10. prosthetic services, limited to:
    a. initial placement of dentures or fixed bridgework (including acid etch metal bridges), when denture or bridgework includes replacement of a natural tooth extracted or lost while covered under the Policy. This limitation ends after the insured has been covered under the Policy for 36 months;
    b. replacement of dentures or fixed bridgework that cannot be repaired, only after 5 years from the date placed or last replaced;
    c. addition of teeth to existing partial denture, only if to replace natural teeth extracted or lost while covered under the Policy. This limitation ends after the insured has been covered under the Policy for 36 months;
    d. relining or rebasing of existing removable dentures, only after one year from date the denture was placed and only once in any 2 year period.

Deductible, each calendar year	$50*
We pay, after Deductible	50% of Major Services, described above.

Waiting Period - 12 Months from Effective Date

Class D. **Orthodontia Services For Insured Dependents Under 19 Years of Age Include:**

1. surgical therapy
2. appliance therapy

3. functional/myofunctional therapy

Deductible, each calendar year	None
We pay, after Deductible	50% of Orthodontia Services, as described above.

Waiting Period – 12 Months from Effective Date

MAXIMUM BENEFIT AMOUNT:

Combined per calendar year for Classes A B and C	$1,000 per Insured
Maximum per calendar year for Class D	$ 500 per Insured
Lifetime under the policy for Class D	$1,000 per Insured

*Class B and C Deductible is a combined $50 each calendar year. A maximum of three (3) individual deductibles per family shall apply.

If Course of Treatment is to exceed $300, prior review is requested.]

[DENTAL EXPENSES NOT COVERED

The Policy, under which your certificate is issued, covers services and procedures as described in the Coverage Schedule. Your coverage, under the policy, **does not** cover any miscellaneous or separate expense not considered a covered service or procedure.

No benefits will be paid for expenses incurred:

1. for overdentures and associated procedures;
2. for charges in excess of those considered Reasonable and Customary;
3. for cosmetic procedures;
4. for the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function;
5. for implants; and for:
   a. replacement of lost or stolen appliances;
   b. replacement of retainers;
   c. athletic mouthguards;
   d. precision or semi-precision attachments; or
   e. denture duplication;
6. for oral hygiene instructions; and for:
   a. plaque control;
   b. completion of a claim form;
   c. acid etch;
   d. broken appointments;
   e. prescription or take-home fluoride; or
   f. diagnostic photographs;
7. for services not completed by the end of the month in which coverage ends;
8. for procedures that are begun, but not completed;
9. for services and treatment provided without charge, or for which there would be no charge in the absence of insurance;
10. for services in connection with war or any act of war, whether declared or undeclared, or condition contracted or accident occurring while on full-time active duty in the armed forces of any country or combination of countries;
11. for a condition covered under any Worker's Compensation Act or similar law;
12. that are generally considered by the dental profession as experimental or investigational;
13. for the treatment of cleft palate and anodontia;
14. for services or supplies payable under any medical expense plan;

15. for orthodontia, unless included as a Class D coverage;
16. prior to the date the Insured is covered under the Policy;
17. for the diagnosis or treatment of Temporomandibular Joint (TMJ) Dysfunction;
18. for hospital services;
19. if You voluntarily end Your insurance, You will not be eligible to re-enroll for a period of 2 years after the date Your coverage first ended;
20. charges for infection control, sterilization, and waste disposal.]

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COVERAGE SCHEDULE
DENTAL INSURANCE PLAN

WE WILL PAY THE REASONABLE AND CUSTOMARY CHARGE FOR DENTAL PROCEDURES AND SERVICES AFTER ANY REQUIRED DEDUCTIBLE AMOUNT, AS SHOWN BELOW.

[Class A. Preventive Services Include:

1. two routine examinations (including any initial exam) of the mouth and teeth per calendar year;
2. two prophylaxis (cleaning, scaling and polishing teeth) per calendar year;
3. one topical fluoride per calendar year, to age 16;
4. full mouth or panoramic x-rays once every 3 years;
5. series of bitewing x-rays twice each calendar year;
6. periapical x-rays as necessary;
7. space maintainers to preserve space between teeth for premature loss of a primary baby tooth. This does not include use for orthodontic treatment;
8. sealants, applicable only to first and second permanent molars for Dependent Children under age 16. Covered once per tooth in any 36 consecutive months.

Deductible, each calendar year	None
We pay, after Deductible	80% of Preventive Services, described above.

Waiting Period – None

Class B. Basic Services, Include:

1. extractions, routine removal;
2. pin retention of fillings;
3. fillings of amalgam, silicate, acrylic, synthetic porcelain and composite filling materials (restorations of mesiolingual, distolingual, mesiobuccal and distobuccal surfaces considered single surface restorations);
4. antibiotic injections administered by Dentist;
5. oral surgery, including postoperative care for:
   a. removal of teeth, including impacted teeth;
   b. extraction of tooth root;
   c. alveolectomy, alveoplasty, and frenectomy;
   d. excision of periocoronal gingiva, exostosis, or hyperplastic tissue, and excision of oral tissue for biopsy;
   e. reimplantation or transplantation of a natural tooth;
   f. excision of a tumor or cyst and incision and drainage of an abscess or cyst;
   g. general anesthesia and analgesic, including intravenous sedation, as needed for above procedures.

Deductible, each calendar year	$50*
We pay, after Deductible	80% of Basic Services, described above.

Waiting Period - 3 Months from Effective Date

Class C. **Major Services Include:**

1. endodontic treatment of disease of the tooth, pulp, root, and related tissue, as follows:
   a. root canal therapy (not covered, if pulp chamber was opened before covered);
   b. pulpotomy;
   c. apicoectomy;
   d. retrograde filling;
2. periodontic services, limited to:
   a. two prophylaxis following surgery per calendar year;
   b. root scaling and planing, once per quadrant of mouth in any 6 month period;
   c. localized delivery of chemotherapeutic agents;
   d. occlusal adjustment, performed with covered surgery;
   e. gingivectomy, gingival curettage, and mucogingival;
   f. osseous surgery including flap entry and closure;
   g. pedical or free soft tissue grafts;
   h. one appliance (night guards) in 5 year period;
3. one study model in 3 year period;
4. crown build-up for non-vital teeth;
5. recementing inlays, onlays and crowns;
6. recementing bridges;
7. one repair of dentures or bridges in any 2 year period, limited to 20% of cost of replacement;
8. general anesthesia and analgesic, including intravenous sedation;
9. restoration services, limited to:
   a. gold or porcelain inlays, onlay, and crowns for tooth with extensive caries or fracture that is unable to be restored with an amalgam, silicate, acrylic, synthetic porcelain or composite filling material;
   b. replacement of existing inlay, onlay, or crown, only after 5 years since the restoration was initially placed or last replaced. This limitation will not apply if replacement is necessary due to the extraction of functioning natural teeth while covered;
   c. stainless steel crowns;
   d. post and core;
10. prosthetic services, limited to:
    a. initial placement of dentures or fixed bridgework (including acid etch metal bridges), when denture or bridgework includes replacement of a natural tooth extracted or lost while covered under the Policy. This limitation ends after the insured has been covered under the Policy for 36 months;
    b. replacement of dentures or fixed bridgework that cannot be repaired, only after 5 years from the date placed or last replaced;
    c. addition of teeth to existing partial denture, only if to replace natural teeth extracted or lost while covered under the Policy. This limitation ends after the insured has been covered under the Policy for 36 months;
    d. relining or rebasing of existing removable dentures, only after one year from date the denture was placed and only once in any 2 year period.

Deductible, each calendar year	$50*
We pay, after Deductible	50% of Major Services, described above.

Waiting Period - 12 Months from Effective Date

Class D. **Orthodontia Services For Insured Dependents Under 19 Years of Age Include:**

1. surgical therapy
2. appliance therapy

3. functional/myofunctional therapy

Deductible, each calendar year	None
We pay, after Deductible	50% of Orthodontia Services, as described above.

Waiting Period – 12 Months from Effective Date

MAXIMUM BENEFIT AMOUNT:

Combined per calendar year for Classes A B and C	$1,000 per Insured
Maximum per calendar year for Class D	$ 500 per Insured
Lifetime under the policy for Class D	$1,000 per Insured

*Class B and C Deductible is a combined $50 each calendar year. A maximum of three (3) individual deductibles per family shall apply.

If Course of Treatment is to exceed $300, prior review is requested.]

[DENTAL EXPENSES NOT COVERED

The Policy, under which your certificate is issued, covers services and procedures as described in the Coverage Schedule. Your coverage, under the policy, **does not** cover any miscellaneous or separate expense not considered a covered service or procedure.

No benefits will be paid for expenses incurred:

1. for overdentures and associated procedures;
2. for charges in excess of those considered Reasonable and Customary;
3. for cosmetic procedures;
4. for the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function;
5. for implants; and for:
   a. replacement of lost or stolen appliances;
   b. replacement of retainers;
   c. athletic mouthguards;
   d. precision or semi-precision attachments; or
   e. denture duplication;
6. for oral hygiene instructions; and for:
   a. plaque control;
   b. completion of a claim form;
   c. acid etch;
   d. broken appointments;
   e. prescription or take-home fluoride; or
   f. diagnostic photographs;
7. for services not completed by the end of the month in which coverage ends;
8. for procedures that are begun, but not completed;
9. for services and treatment provided without charge, or for which there would be no charge in the absence of insurance;
10. for services in connection with war or any act of war, whether declared or undeclared, or condition contracted or accident occurring while on full-time active duty in the armed forces of any country or combination of countries;
11. for a condition covered under any Worker's Compensation Act or similar law;
12. that are generally considered by the dental profession as experimental or investigational;
13. for the treatment of cleft palate and anodontia;
14. for services or supplies payable under any medical expense plan;

15. for orthodontia, unless included as a Class D coverage;
16. prior to the date the Insured is covered under the Policy;
17. for the diagnosis or treatment of Temporomandibular Joint (TMJ) Dysfunction;
18. for hospital services;
19. if You voluntarily end Your insurance, You will not be eligible to re-enroll for a period of 2 years after the date Your coverage first ended;
20. charges for infection control, sterilization, and waste disposal.]

[RESERVE NATIONAL]

Reserve National Insurance Company
[601 East Britton Road
Oklahoma City, OK 73114-7710
reservenational.com]

COVERAGE SCHEDULE
DENTAL INSURANCE PLAN

WE WILL PAY THE REASONABLE AND CUSTOMARY CHARGE FOR DENTAL PROCEDURES AND SERVICES AFTER ANY REQUIRED DEDUCTIBLE AMOUNT, AS SHOWN BELOW.

[Class A. Preventive Services Include:

1. two routine examinations (including any initial exam) of the mouth and teeth per calendar year;
2. two prophylaxis (cleaning, scaling and polishing teeth) per calendar year;
3. one topical fluoride per calendar year, to age 16;
4. sealants, applicable only to first and second permanent molars for Dependent Children under age 16. Covered once per tooth in any 36 consecutive months.

Deductible, each calendar year	None
We pay, after Deductible	80% of Preventive Services, described above.

Waiting Period – None

Class B. Basic Services, Include:

1. full mouth or panoramic x-rays once every 3 years;
2. series of bitewing x-rays twice each calendar year;
3. periapical x-rays as necessary;
4. space maintainers to preserve space between teeth for premature loss of a primary baby tooth. This does not include use for orthodontic treatment; extractions, routine removal;
5. pin retention of fillings;
6. fillings of amalgam, silicate, acrylic, synthetic porcelain and composite filling materials (restorations of mesiolingual, distolingual, mesiobuccal and distobuccal surfaces considered single surface restorations);
7. antibiotic injections administered by Dentist;

Deductible, each calendar year	$50*
We pay, after Deductible	60% of Basic Services, described above.

Waiting Period - 3 Months from Effective Date

Class C. Major Services Include:

1. oral surgery, including postoperative care for:
   a. removal of teeth, including impacted teeth;
   b. extraction of tooth root;
   c. alveolectomy, alveoplasty, and frenectomy;
   d. excision of periocoronal gingiva, exostosis, or hyperplastic tissue, and excision of oral tissue for biopsy;
   e. reimplantation or transplantation of a natural tooth;
   f. excision of a tumor or cyst and incision and drainage of an abscess or cyst;
   g. general anesthesia and analgesic, including intravenous sedation, as needed for above procedures.

2. endodontic treatment of disease of the tooth, pulp, root, and related tissue, as follows:
   a. root canal therapy (not covered, if pulp chamber was opened before covered);
   b. pulpotomy;
   c. apicoectomy;
   d. retrograde filling;
3. periodontic services, limited to:
   a. two prophylaxis following surgery per calendar year;
   b. root scaling and planing, once per quadrant of mouth in any 6 month period;
   c. localized delivery of chemotherapeutic agents;
   d. occlusal adjustment, performed with covered surgery;
   e. gingivectomy, gingival curettage, and mucogingival;
   f. osseous surgery including flap entry and closure;
   g. pedical or free soft tissue grafts;
   h. one appliance (night guards) in 5 year period;
4. one study model in 3 year period;
5. crown build-up for non-vital teeth;
6. recementing inlays, onlays and crowns;
7. recementing bridges;
8. one repair of dentures or bridges in any 2 year period, limited to 20% of cost of replacement;
9. general anesthesia and analgesic, including intravenous sedation;
10. restoration services, limited to:
    a. gold or porcelain inlays, onlay, and crowns for tooth with extensive caries or fracture that is unable to be restored with an amalgam, silicate, acrylic, synthetic porcelain or composite filling material;
    b. replacement of existing inlay, onlay, or crown, only after 5 years since the restoration was initially placed or last replaced. This limitation will not apply if replacement is necessary due to the extraction of functioning natural teeth while covered;
    c. stainless steel crowns;
    d. post and core;
11. prosthetic services, limited to:
    a. initial placement of dentures or fixed bridgework (including acid etch metal bridges), when denture or bridgework includes replacement of a natural tooth extracted or lost while covered under the Policy. This limitation ends after the insured has been covered under the Policy for 36 months;
    b. replacement of dentures or fixed bridgework that cannot be repaired, only after 5 years from the date placed or last replaced;
    c. addition of teeth to existing partial denture, only if to replace natural teeth extracted or lost while covered under the Policy. This limitation ends after the insured has been covered under the Policy for 36 months;
    d. relining or rebasing of existing removable dentures, only after one year from date the denture was placed and only once in any 2 year period.

Deductible, each calendar year	$50*
We pay, after Deductible	40% of Major Services, described above.

Waiting Period - 12 Months from Effective Date

Class D. Orthodontia Services For Insured Dependents Under 19 Years of Age Include:

1. surgical therapy
2. appliance therapy
3. functional/myofunctional therapy

Deductible, each calendar year	None
We pay, after Deductible	50% of Orthodontia Services, as described above.

Waiting Period – 12 Months from Effective Date

MAXIMUM BENEFIT AMOUNT:

Combined per calendar year for Classes A B and C	$1,000 per Insured
Maximum per calendar year for Class D	$ 500 per Insured
Lifetime under the policy for Class D	$1,000 per Insured

*Class B and C Deductible is a combined $50 each calendar year. A maximum of three (3) individual deductibles per family shall apply.

If Course of Treatment is to exceed $300, prior review is requested.]

[DENTAL EXPENSES NOT COVERED

The Policy, under which your certificate is issued, covers services and procedures as described in the Coverage Schedule. Your coverage, under the policy, **does not** cover any miscellaneous or separate expense not considered a covered service or procedure.

No benefits will be paid for expenses incurred:

1. for overdentures and associated procedures;
2. for charges in excess of those considered Reasonable and Customary;
3. for cosmetic procedures;
4. for the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function;
5. for implants; and for:
   a. replacement of lost or stolen appliances;
   b. replacement of retainers;
   c. athletic mouthguards;
   d. precision or semi-precision attachments; or
   e. denture duplication;
6. for oral hygiene instructions; and for:
   a. plaque control;
   b. completion of a claim form;
   c. acid etch;
   d. broken appointments;
   e. prescription or take-home fluoride; or
   f. diagnostic photographs;
7. for services not completed by the end of the month in which coverage ends;
8. for procedures that are begun, but not completed;
9. for services and treatment provided without charge, or for which there would be no charge in the absence of insurance;
10. for services in connection with war or any act of war, whether declared or undeclared, or condition contracted or accident occurring while on full-time active duty in the armed forces of any country or combination of countries;
11. for a condition covered under any Worker's Compensation Act or similar law;
12. that are generally considered by the dental profession as experimental or investigational;
13. for the treatment of cleft palate and anodontia;
14. for services or supplies payable under any medical expense plan;
15. for orthodontia, unless included as a Class D coverage;
16. prior to the date the Insured is covered under the Policy;

17. for the diagnosis or treatment of Temporomandibular Joint (TMJ) Dysfunction;
18. for hospital services;
19. if You voluntarily end Your insurance, You will not be eligible to re-enroll for a period of 2 years after the date Your coverage first ended;
20. charges for infection control, sterilization, and waste disposal.]

[RESERVE NATIONAL]

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COVERAGE SCHEDULE
DENTAL INSURANCE PLAN

WE WILL PAY THE REASONABLE AND CUSTOMARY CHARGE FOR DENTAL PROCEDURES AND SERVICES AFTER ANY REQUIRED DEDUCTIBLE AMOUNT, AS SHOWN BELOW.

[Class A. Preventive Services Include:

1. two routine examinations (including any initial exam) of the mouth and teeth per calendar year;
2. two prophylaxis (cleaning, scaling and polishing teeth) per calendar year;
3. one topical fluoride per calendar year, to age 16;
4. full mouth or panoramic x-rays once every 3 years;
5. series of bitewing x-rays twice each calendar year;
6. periapical x-rays as necessary;
7. space maintainers to preserve space between teeth for premature loss of a primary baby tooth. This does not include use for orthodontic treatment;
8. sealants, applicable only to first and second permanent molars for Dependent Children under age 16. Covered once per tooth in any 36 consecutive months.

Deductible, each calendar year	None
We pay, after Deductible	100% of Preventive Services, described above.

Waiting Period – None

Class B. Basic Services, Include:

1. extractions, routine removal;
2. pin retention of fillings;
3. fillings of amalgam, silicate, acrylic, synthetic porcelain and composite filling materials (restorations of mesiolingual, distolingual, mesiobuccal and distobuccal surfaces considered single surface restorations);
4. antibiotic injections administered by Dentist;
5. oral surgery, including postoperative care for:
   a. removal of teeth, including impacted teeth;
   b. extraction of tooth root;
   c. alveolectomy, alveoplasty, and frenectomy;
   d. excision of periocoronal gingiva, exostosis, or hyperplastic tissue, and excision of oral tissue for biopsy;
   e. reimplantation or transplantation of a natural tooth;
   f. excision of a tumor or cyst and incision and drainage of an abscess or cyst;
   g. general anesthesia and analgesic, including intravenous sedation, as needed for above procedures.

Deductible, each calendar year	$50*
We pay, after Deductible:	Benefit Level Year One: 50% of Basic Services, described above; Benefit Level Year Two: 65% of Basic Services, described above;

Benefit Level Year Three and Each Thereafter, 80% of Basic Services, described above.

Waiting Period - None

Class C. **Major Services Include:**

1. endodontic treatment of disease of the tooth, pulp, root, and related tissue, as follows:
   a. root canal therapy (not covered, if pulp chamber was opened before covered);
   b. pulpotomy;
   c. apicoectomy;
   d. retrograde filling;
2. periodontic services, limited to:
   a. two prophylaxis following surgery per calendar year;
   b. root scaling and planing, once per quadrant of mouth in any 6 month period;
   c. localized delivery of chemotherapeutic agents;
   d. occlusal adjustment, performed with covered surgery;
   e. gingivectomy, gingival curettage, and mucogingival;
   f. osseous surgery including flap entry and closure;
   g. pedical or free soft tissue grafts;
   h. one appliance (night guards) in 5 year period;
3. one study model in 3 year period;
4. crown build-up for non-vital teeth;
5. recementing inlays, onlays and crowns;
6. recementing bridges;
7. one repair of dentures or bridges in any 2 year period, limited to 20% of cost of replacement;
8. general anesthesia and analgesic, including intravenous sedation;
9. restoration services, limited to:
   a. gold or porcelain inlays, onlay, and crowns for tooth with extensive caries or fracture that is unable to be restored with an amalgam, silicate, acrylic, synthetic porcelain or composite filling material;
   b. replacement of existing inlay, onlay, or crown, only after 5 years since the restoration was initially placed or last replaced. This limitation will not apply if replacement is necessary due to the extraction of functioning natural teeth while covered;
   c. stainless steel crowns;
   d. post and core;
10. prosthetic services, limited to:
    a. initial placement of dentures or fixed bridgework (including acid etch metal bridges), when denture or bridgework includes replacement of a natural tooth extracted or lost while covered under the Policy. This limitation ends after the insured has been covered under the Policy for 36 months;
    b. replacement of dentures or fixed bridgework that cannot be repaired, only after 5 years from the date placed or last replaced;
    c. addition of teeth to existing partial denture, only if to replace natural teeth extracted or lost while covered under the Policy. This limitation ends after the insured has been covered under the Policy for 36 months;
    d. relining or rebasing of existing removable dentures, only after one year from date the denture was placed and only once in any 2 year period.

Deductible, each calendar year	$50*
We pay, after Deductible:	Benefit Level Year One: 10% of Major Services, described above;

	Benefit Level Year Two: 25% of Major Services, described above; Benefit Level Year Three and Each Thereafter, 50% of Major Services, described above.

Waiting Period - None

Class D. Orthodontia Services For Insured Dependents Under 19 Years of Age Include:

1. surgical therapy
2. appliance therapy
3. functional/myofunctional therapy

Deductible, each calendar year	None
We pay, after Deductible	50% of Orthodontia Services, as described above.

Waiting Period – None

MAXIMUM BENEFIT AMOUNT:

Combined per calendar year for Classes A, B and C	$1,000 per Insured
Maximum per calendar year for Class D	$ 500 per Insured
Lifetime under the policy for Class D	$1,000 per Insured

*Class B and C Deductible is a combined $50 each calendar year. A maximum of three (3) individual deductibles per family shall apply.

If Course of Treatment is to exceed $300, prior review is requested.]

[DENTAL EXPENSES NOT COVERED

The Policy, under which your certificate is issued, covers services and procedures as described in the Coverage Schedule. Your coverage, under the policy, **does not** cover any miscellaneous or separate expense not considered a covered service or procedure.

No benefits will be paid for expenses incurred:

1. for overdentures and associated procedures;
2. for charges in excess of those considered Reasonable and Customary;
3. for cosmetic procedures;
4. for the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function;
5. for implants; and for:
   a. replacement of lost or stolen appliances;
   b. replacement of retainers;
   c. athletic mouthguards;
   d. precision or semi-precision attachments; or
   e. denture duplication;
6. for oral hygiene instructions; and for:
   a. plaque control;
   b. completion of a claim form;
   c. acid etch;
   d. broken appointments;
   e. prescription or take-home fluoride; or
   f. diagnostic photographs;
7. for services not completed by the end of the month in which coverage ends;
8. for procedures that are begun, but not completed;

9. for services and treatment provided without charge, or for which there would be no charge in the absence of insurance;
10. for services in connection with war or any act of war, whether declared or undeclared, or condition contracted or accident occurring while on full-time active duty in the armed forces of any country or combination of countries;
11. for a condition covered under any Worker's Compensation Act or similar law;
12. that are generally considered by the dental profession as experimental or investigational;
13. for the treatment of cleft palate and anodontia;
14. for services or supplies payable under any medical expense plan;
15. for orthodontia, unless included as a Class D coverage;
16. prior to the date the Insured is covered under the Policy;
17. for the diagnosis or treatment of Temporomandibular Joint (TMJ) Dysfunction;
18. for hospital services;
19. if You voluntarily end Your insurance, You will not be eligible to re-enroll for a period of 2 years after the date Your coverage first ended;
20. charges for infection control, sterilization, and waste disposal.]