

SERFF Tracking Number: AMFA-128098139 State: Arkansas
Filing Company: Standard Insurance Company State Tracking Number:
Company Tracking Number: SIC - FILINGS
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
Product Name: SIC - BNL Filing
Project Name/Number: RSL - BNL Filing/RSL - BNL Filing

Filing at a Glance

Company: Standard Insurance Company

Product Name: SIC - BNL Filing

TOI: H10G Group Health - Dental

Sub-TOI: H10G.000 Health - Dental

Filing Type: Form

SERFF Tr Num: AMFA-128098139 State: Arkansas

SERFF Status: Closed-Approved State Tr Num:

Co Tr Num: SIC - FILINGS

State Status: FEES PAID

Reviewer(s): Donna Lambert

Authors: Janis Landon, Stephanie

Disposition Date: 02/17/2012

Mundt, Mary Chmelka

Date Submitted: 02/16/2012

Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date: 03/19/2012

State Filing Description:

General Information

Project Name: RSL - BNL Filing

Project Number: RSL - BNL Filing

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type: Employer, Association

Filing Status Changed: 02/17/2012

State Status Changed: 02/16/2012

Created By: Mary Chmelka

Corresponding Filing Tracking Number:

Filing Description:

Form Nos.: 9040 Rev. 02-12 – Schedule of Benefits

9050 Rev. 02-12 - Premiums

9070 Rev. 02-12 - Conditions For Insurance Coverage

9260 Rev. 02-12 – Orthodontic Expense Benefits

9260-Takeover Rev. 02-12 - Orthodontic Expense Benefits

9044 Rev. 02-12 – Loss of Sight Rider

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Overall Rate Impact:

Deemer Date:

Submitted By: Mary Chmelka

PLEASE NOTE: This filing is identical in content to two other filings being submitted on behalf of Reliance Standard Life Insurance Company and Ameritas Life Insurance Corp. We would appreciate the Department's consideration of consistent and similar reviews.

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Dear Sir/Madam:

Enclosed for your review and approval are the above listed insert pages, which will be issued for new group policies/certificates issued or renewed after the Department's approval date. These forms will be used with the following forms:

Form Number Type of Form

9000 Rev. 03-08 Group Master Policy
9021 Rev. 03-08 Group Certificate
9021-Trust Rev. 03-08 Group Certificate

With the exception of the 9044 Rev. 02-12 Rider, which is a new form, these insert pages will replace the following forms:

Form number Approval date SERFF number
9040 Rev. 09-11 9/27/2011 AMFA-127622669
9050 Rev. 01-12 2/1/2012 AMFA-128038365
9070 Ed. 01-05 11/8/2004 SERT65HRBV659
9260 Ed. 01-05 11/8/2004 SERT65HRBV659
9260 Takeover Ed. 01-05 11/8/2004 SERT65HRBV659

These forms have been revised to allow for additional plan designs. Red-lined copies are enclosed for ease of reference.

These forms will be marketed to any eligible group as defined by the state of issue however; the primary market will be an employer-employee group. Forms are in final print. The items shown in brackets represent variable material. These items would vary based on the specific plan(s) as selected by the policyholder. An Optional and Variables statement is also included for your reference.

If your state requires the filing of group rates, please be advised that rates associated with these forms have been submitted under separate cover.

These forms, when scored with the policy and certificate, achieve a score of 50 when scored on the Flesch reading ease test. No part of this filing contains any unusual or possibly controversial items from normal company and industry

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standards. Nothing in this filing includes any provisions contrary to standard industry practice.

Thank you for your review of this filing. If you need anything additional, please feel free to contact me at 800-745-1112, ext. 82444, FAX 402-309-2573 or email jlandon@ameritas.com.

Sincerely,

Janis Landon
 Sr. Contact Analyst

Company and Contact

Filing Contact Information

Janis Landon, Senior Contract Analyst
 475 Fallbrook Blvd.
 Lincoln, NE 68521

jlandon@ameritas.com
 800-745-1112 [Phone] 82444 [Ext]
 402-309-2573 [FAX]

Filing Company Information

Standard Insurance Company
 900 SW Fifth Avenue
 Portland, OR 97204-1235
 (800) 745-6665 ext. [Phone]

CoCode: 69019 State of Domicile: Oregon
 Group Code: 1348 Company Type:
 Group Name: State ID Number:
 FEIN Number: 93-0242990

Filing Fees

Fee Required? Yes
 Fee Amount: \$300.00
 Retaliatory? No
 Fee Explanation: 6 forms x \$50 = \$300.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Standard Insurance Company	\$300.00	02/16/2012	56423362

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	02/17/2012	02/17/2012

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Disposition

Disposition Date: 02/17/2012

Implementation Date: 03/19/2012

Status: Approved

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	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Redline Versions	Approved	Yes
Supporting Document	Optionals & Variables	Approved	Yes
Supporting Document	3rd Party Authorization	Approved	Yes
Form	Schedule of Benefits	Approved	Yes
Form	Premiums	Approved	Yes
Form	Conditions For Insurance Coverage	Approved	Yes
Form	Orthodontic Expense Benefits	Approved	Yes
Form	Orthodontic Expense Benefits	Approved	Yes
Form	Loss of Sight Rider	Approved	Yes

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Form Schedule

Lead Form Number: 9040 Rev. 02-12

Schedule Item	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved 02/17/2012	9040 Rev. 02-12	Policy/Cont Schedule of Benefits ract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Revised	Replaced Form #: 9040 Rev. 09-11 Previous Filing #: AMFA-127622669	50.000	9040 Rev. 02-12.pdf
Approved 02/17/2012	9050 Rev. 02-12	Policy/Cont Premiums ract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Revised	Replaced Form #: 9050 Rev. 01-12 Previous Filing #: AMFA-128038365	50.000	9050 Rev. 02-12.pdf
Approved 02/17/2012	9070 Rev. 02-12	Policy/Cont Conditions For ract/Fraternal Insurance Coverage Certificate: Amendment, Insert Page, Endorsement or Rider	Revised	Replaced Form #: 9070 Ed. 01-05 Previous Filing #: SERT-65HRBV659	50.000	9070 Rev. 02-12.pdf
Approved 02/17/2012	9260 Rev. 02-12	Policy/Cont Orthodontic Expense ract/Fraternal Benefits Certificate:	Revised	Replaced Form #: 9260 Ed. 01-05 Previous Filing #: SERT-65HRBV659	50.000	9260 Rev. 02-12.pdf

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Amendmen t, Insert Page, Endorseme nt or Rider	Approved 9260- 02/17/2012 Takeover Rev. 02-12	Policy/Cont Orthodontic Expense Revised ract/Fratern Benefits al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Replaced Form #: 50.000 9260-Takeover Ed. 01-05 Previous Filing #: SERT-65HRBV659	9260- takeover Rev. 02-12.pdf
Amendmen t, Insert Page, Endorseme nt or Rider	Approved 9044 Rev. 02/17/2012 02-12	Policy/Cont Loss of Sight Rider Initial ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	50.000	9044 Rev. 02- 12-sic.pdf

**SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE**

The Insurance for each Insured [and each Insured Dependent] will be based on the Insured's class shown in this Schedule of Benefits.

<u>Benefit Class</u>	<u>Class Description</u>
[Class 1	All Eligible Employees]

[DENTAL EXPENSE BENEFITS

[When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out-of-pocket costs.]

Deductible Amount:

[When a Participating Provider is used:]

[Type 1 Procedures] - [each Benefit Period]	[\$0][*]
[Type 1 Deductible does not apply after the first Benefit Period or thereafter.]	
[Type 1 Deductible is waived during the first Benefit Period.]	
[Type 2 Procedures] - [each Benefit Period]	[\$50][*]
[Type 3 Procedures] - [each Benefit Period]	[\$50][*]
[Type 4 Procedures] - [each Benefit Period]	[\$50][*]

[When a Non-Participating Provider is used:]

[Type 1 Procedures] - [each Benefit Period]	[\$0][*]
[Type 1 Deductible does not apply after the first Benefit Period or thereafter.]	
[Type 1 Deductible is waived during the first Benefit Period.]	
[Type 2 Procedures] - [each Benefit Period]	[\$50][*]
[Type 3 Procedures] - [each Benefit Period]	[\$50][*]
[Type 4 Procedures] - [each Benefit Period]	[\$50][*]

Maximum Deductible [each Benefit Period, per Quarter] [\$50]

[[Any deductible satisfied during the Benefit Period will be applied to both the Participating Provider Deductible and the Non-Participating Provider Deductible.] Once the Maximum Deductible per Benefit Period has been met, no further deductible will be required for that Benefit Period.]

[Dental expenses incurred by an individual on or after January 1, [2010], but before [May 1, 2010], will apply to the Deductible Amount if:

- a. proof is furnished to us that such dental expenses were applicable to the deductible under the Policyholder's dental insurance policy in force immediately prior to [May 1, 2010]; and
- b. such expenses would have been considered Covered Expenses under this policy had this policy been in force at the time the expenses were incurred.]

Coinsurance Percentage:	[Participating Provider]	[Non-Participating Provider]
[Type 1 Procedures]	[100%]	[90%]

SCHEDULE OF BENEFITS

(Continued)

[Type 2 Procedures]	[80%]	[70%]
[Type 3 Procedures]	[50%]	[40%]
[Type 4 Procedures]	[50%]	[50%]

[For Covered Procedures, we will pay up to the following maximum amount that corresponds to the Benefit Period in which the Covered Procedure was performed:

Maximum Amount -	1st Benefit Period	[\$1000]
	2 nd Benefit Period	[\$1250]
	3 rd Benefit Period	[\$1500]
	4 th + Benefit Period	[\$1750]

[For those persons insured on [January 1, 2009] the Maximum Amount that corresponds to the [3rd Benefit Period] applies during the first Benefit Period the person becomes insured.]]

[You and/or your dependents must be insured under the dental plan for [6] months to be eligible for Type [3] Procedures. Please refer to the DENTAL EXPENSE BENEFITS page for details regarding elimination period(s), limitations and exclusions.]]

[ORTHODONTIC EXPENSE BENEFITS

[Deductible Amount]	[\$0]
[Coinsurance Percentage]	
Step 1.	[25%]
Step 2.	[30%]
Step 3.	[35%]
Step 4.	[50%]

[For those persons insured on [January 1, 2009] Step [2] applies during the first Benefit Period the person becomes insured.

For those persons insured after [January 1, 2009] Step 1 applies during the first Benefit Period the person becomes insured.

or

Step 1 applies during the first Benefit Period the person becomes insured.]

If a plan includes Takeover benefits the first two paragraphs above will be included to allow those that qualify for Takeover to start at a higher Coinsurance Percentage. If a plan does not include Takeover benefits only the last sentence above will be included.

Step 2 will apply during the second Benefit Period, Step 3 during the third Benefit Period, and Step 4 will apply during each Benefit Period after.

If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.]

[Maximum Benefit during Lifetime]	[\$1,000]]
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[The Plan pays [25%-50%] of covered Orthodontic Expenses.]

[The Maximum Benefit shown above will be modified for:

- a. any person who was insured for an Orthodontic Expense Benefit under the prior carrier on [December 31, 2007], and
- b. on [January 1, 2008] is both:
 - i. insured under the policy, and
 - ii. currently undergoing a Treatment Program which would have been a covered Treatment Program under the prior carrier had the prior carrier's coverage remained in force.

The modification will result in a reduction of the Maximum Benefit based on:

- a. the normal benefit payable under the policy for the current Treatment Program, minus any amounts to which the person is entitled from the prior carrier for such Treatment Program.

Nothing stated above, however, will act to provide coverage or increase benefits, when the Treatment Program is subject to any limitation shown on 9260.]

[You and/or your dependents must be insured under the dental plan for [12] months to be eligible for Orthodontic Procedures. Please refer to the ORTHODONTIC EXPENSE BENEFITS page for details regarding elimination period(s), limitations and exclusions.]

[EYE CARE EXPENSE BENEFITS

[When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out-of-pocket costs.]

Deductible Amount:

[Exam- [each Benefit Period]]	[\$ 10][*]
[Contact Lens Fitting and Evaluation][each Benefit Period]	[\$0-60]
[Lenses - Other than contact lenses- [Once Per Lifetime]]	[\$ 25][*]
[Frames and Contact Lenses - [Once Per Lifetime]]	[\$ 25][*]

[Maximum Amount – [each Benefit Period] [\$200][*]

[Increasing Eye Care Maximum

For Covered Procedures, we will pay up to the following maximum amount that corresponds to the Benefit Period in which the Covered Procedure was performed:

[Maximum Amount -	1st Benefit Period	[\$0-350]
	2nd Benefit Period	[\$0-350]
	3rd Benefit Period	[\$50-400]
	4th + Benefit Period	[\$50-400]]

[Please refer to the EYE CARE EXPENSE BENEFITS page for details regarding frequency, limitations, and exclusions.]

[LASER VISION CORRECTION EXPENSE BENEFITS

[Deductible Amount - [each Benefit Period]] \$[50]
Coinsurance Percentage: [100%]

[Please refer to the LASER VISION CORRECTION BENEFIT RIDER for details regarding frequency, limitations, and exclusions.]

[HEARING CARE EXPENSE BENEFITS

Deductible Amount:

[Exams] - [each Benefit Period] [\$0]
[Hearing Aids] - [each Benefit Period] [\$0]
[Hearing Aid Maintenance] - [each Benefit Period] [\$0]
[Hearing Miscellaneous] - [each Benefit Period] [\$0]

[If an Insured incurs Covered Expenses:

- i. during the last three months of any Benefit Period; and
- ii. these expenses are applied towards the Deductible Amount for that Benefit Period,

Such Covered Expenses will also apply to the Deductible Amount for the following Benefit Period.]

Coinsurance Percentage:

[Exams] [100%*]
[Hearing Aids] [50%]
[Hearing Aid Maintenance] [100%*]
[Hearing Miscellaneous] [100%*]

*refer to 9290 SCHEDULE OF HEARING CARE SERVICES regarding the amount of benefits payable.

[[Hearing Aid] Maximum Amount [(per ear)]:

[1st 12 month Period] \$[400]
[2nd 12 month Period] \$[600]
[3rd 12 month Period] \$[800]
[4th 12 month Period or thereafter] \$[1,000]

The term "12 Month Period" means the 12 month period of time beginning with the effective date of the hearing care benefits shown above for the Insured and each Insured Dependent, if any, and thereafter each subsequent 12 month period that begins on the anniversary of the effective dates described earlier in this sentence. It is important to note that for purposes of determining the appropriate 12 Month Period, the Insured and each Insured Member, if any, may have different initial effective dates depending on when they first became covered by this Policy.

EXCEPTION: If an Insured or Insured Dependent, if any, was previously covered under this policy but had a break in continuous coverage under this policy of more than twelve consecutive months, upon resuming coverage hereunder the Insured or Insured Dependent, if any, will be considered a new insured

person for determining the applicable 12 Month Period when calculating the Covered Expense. After resuming coverage under this policy following a break in coverage of more than 12 consecutive months, the insured's initial 12 Month Period (and each subsequent 12 Month Period) will be based on the Insured's new effective date. Insureds with a break in coverage under this policy of less than 12 consecutive months will, upon resumption of their coverage under this policy, be treated as if they had continuous coverage under this policy BUT ONLY FOR PURPOSES OF THE 12 MONTH PERIOD DETERMINATION. For all other purposes, persons will not be considered insured under this policy during any period of time when their coverage is not in effect.]

[COMBINED EXPENSE BENEFITS

[*Combined [Dental And Eye Care] Deductible Amount: [each Benefit Period]] [\$50]
The deductibles listed with the () above are subject to the maximum deductible amount listed here.]*

[*Combined [Dental and Eye Care] Maximum – [each Benefit Period] [\$1,500]
The maximums listed with the () above are subject to the maximum amount listed here.]*

[Combined [Dental and Eye Care] Exam Frequencies
 Routine Exams for [Dental and Eye Care] are limited to [Twice] per [Benefit Period]

Dental Exams will include:

- [D0120 Periodic oral evaluation]
- [D0150 Comprehensive oral evaluation - new or established patient.]
- [D0180 Comprehensive periodontal evaluation – new or established patient.]

A routine eye care exam is a vision examination as defined on the Schedule of Eye Care Services.]

The above frequencies for [Dental and Eye Care] Exams are subject to the plan frequencies as defined within the [Table of Dental Procedures and the Eye Care Insurance provision].]

[DENTAL EXPENSE BENEFITS

[When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.]

- First Level: The Plan pays [0 - 100]% of the first \$[0-5,000] of Covered [Preventive, Dental and Orthodontic] Expenses [up to the Maximum Amount].
- Second Level: You pay the next \$[25 - 250] of Covered Expenses. (You will not be reimbursed for this \$[25 - 250] of Covered Expenses.)
- Third Level: The Plan will also pay [0 - 100]% of the next \$[0 - 5,000] of any Covered [Dental and Orthodontic] Expenses [subject to the Maximum Amount].
- Fourth Level: The Plan will also pay [0 - 100]% of the next \$[0 - 5,000] of any Covered [Dental and Orthodontic] Expenses [subject to the Maximum Amount].
- Fifth Level: The Plan will also pay [0 - 100]% of the remaining \$[0 - 5,000] of any Covered [Dental and Orthodontic] Expenses [subject to the Maximum Amount].

[Maximum Amount [per Benefit Period] \$[500 - 2,500, Not Applicable]]

PREMIUMS

TABLE OF MONTHLY PREMIUM RATES

[Dental Care Insurance	\$**.** per Insured Person
	\$**.** per Dependent Unit
Orthodontic Insurance	\$**.** per Insured Person
	\$**.** per Dependent Unit
Eye Care Insurance	\$**.** per Insured Person
	\$**.** per Dependent Unit]

[ASSOCIATED GROUPS]

PAYMENT OF PREMIUMS. The first premium will be due on the Policy Effective Date to cover the period from that date to the first Premium Due Date. Other premiums will be due on or before each Premium Due Date. Premiums are payable at our Home Office or at some other location to which we and the Policyholder agree.

PREMIUM DUE DATE. The Premium Due Date will be the [first] day of the month that falls on or after the Policy Effective Date. If we agree with the Policyholder to the payment of premiums on a basis other than monthly, the Premium Due Date will be fixed to match the correct basis. If there is a change in the method of payment or Premium Due Date, a pro-rata charge in the premium due will be made.

PREMIUM STATEMENTS. The premium due as of any Premium Due Date is the number of units in force on such date for each type of insurance multiplied by the rate shown in the Table of Premium Rates. A premium statement will be made as of the Premium Due Date showing the premium payable. If premiums are payable on other than a monthly basis, each statement will show any pro-rata premium charges and credits in the last premium period due to changes in the number of Insureds and in the amount of insurance for which people are insured. This is subject to the rules below.

SIMPLIFIED ACCOUNTING. The premium will start on the Premium Due Date falling on or after the date the insurance or the increase in the insurance is effective for: a) a person becoming insured; or b) an increase in the amount of insurance on any person. The premium will stop on the Premium Due Date falling on or after the date of termination of insurance or through the date of service of the last paid claim. There will be no pro-rata charges or credits for a partial month. If premiums are payable other than monthly, charges and credits will be figured as though the Premium Due Date is monthly.

We will be liable for the return of unearned premiums (premium for the period which claims were not paid) to the Policyholder only for the [3, 6, 9, 12] months before the date we receive evidence that a return is due.

ADJUSTMENT IN PREMIUM RATES. We may change the rates shown in the Table of Premium Rates by giving the Policyholder at least [30, 45, 60, 90] days advance written notice. We may change the rates at any time the Schedule of Benefits, or any other terms and conditions of the policy, are changed. We will not change the rates until the Renewal Date shown on the policy cover or more than once in any [12, 24, 36, 48] month period thereafter, unless there is a change in the Schedule of Benefits or a change in any other terms and conditions in the policy.

[Notwithstanding the above, We reserve the right to change any one or more of the rates prior to the Renewal Date or more than once in any [12, 24, 36, 48] month period thereafter upon the occurrence of any one or more of the following:

1. We determine that the average number of dependent children for each Insured with Dependent coverage exceeds 4.0; and/or
2. We determine that the number of Insureds is less than 80% of those Insureds initially enrolled under the Policy as of either (i) the Plan Effective Date, if during the period of time between the Plan Effective Date and the Renewal Date, or (ii) the most recent [12, 24, 36, 48] month anniversary of the Renewal Date; and/or
3. We are required by either the federal government or by any state or local government or by any agency thereof to pay a new or increased tax, assessment, or monetary charge of any kind (other than a new or any increase to the amount of tax we pay based upon our net operating income). Such taxes, assessments or fees would include those that are charged or assessed in connection with the operation of a health care exchange authorized by federal or state law.
- [4. We determine that more than 50% of the number of Insureds are direct relatives, unless a Quarterly Wage and Tax Report is provided that proves the relatives work for the Policyholder. A Direct Relative is any family member related by blood or marriage.]

Should either or all of the above occur and should we elect to change rates as a result, we agree to notify the Policyholder of the corresponding rate changes at least [30, 45, 60, 90] days in advance of the Premium Due Date for which the rate change shall be effective. The right to change rates as well as the timing of such changes in the above two limited situations shall at all times be subject to applicable state laws and regulations.]

RENEWAL DATE refers to the date each calendar year that the coverage issued under the group policy is considered for renewal. The Renewal Date(s) are shown on the policy cover.

CONDITIONS FOR INSURANCE COVERAGE

ELIGIBILITY

ELIGIBLE CLASS FOR MEMBERS. The members of the eligible class(es) are shown on the Schedule of Benefits. Each member of the eligible class (referred to as "Member") will qualify for such insurance on the day he or she completes the required eligibility period, if any. Members choosing to elect coverage will hereinafter be referred to as "Insured."

[If employment is the basis for membership, a member of the Eligible Class for Insurance is any full-time active employee working at least [**] hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.]

[If a husband and wife are both Members, and if either of them insures their dependent children, then the husband or wife, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.]

[ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the latest of:

1. the day he or she qualifies for coverage as a Member;
2. the day he or she first becomes a Member; or
3. the day he or she first has a dependent. For dependent children, a newborn child will be considered an eligible dependent upon reaching their [2nd] birthday. The child may be added at birth or within 31 days of the [2nd] birthday.

[A Member must be an Insured to also insure his or her dependents.]

[[If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any person who is a full-time active employee working at least [30] hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.]

[Any husband or wife who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.]

[When a member of the Eligible Class for Dependent Insurance dies and, if at the date of death, has dependents insured, the Policyholder has the option of offering the dependents of the deceased employee continued coverage. If elected by the Policyholder and the affected dependents, the name of such deceased member will continue to be listed as a member of the Eligible Class for Dependent Insurance.]

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured is [not] required to contribute to the payment of his or her insurance premiums.

[Dependent Insurance: An Insured is [not] required to contribute to the payment of insurance premiums for his or her dependents.]

CONDITIONS FOR INSURANCE (CONTINUED)

[SECTION 125. This policy is provided as part of the Employer's Section 125 Plan. Each Member has the option under the Section 125 Plan of participating or not participating in this policy.

If a Member does not elect to participate when initially eligible, the Member may elect to participate at a subsequent Election Period. This Election Period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on [mo/dy/yr]. [A Member who elects to participate during an Election Period who did not elect to participate when initially eligible will be a Late Entrant and subject to Limitation No. <1> on 9219. (There is NO "open enrollment" under this policy.)]

Members may change their election option only during an Election Period, except for a change in family status. Such events would be marriage, divorce, birth of a child, death of a spouse or child, or termination of employment of a spouse.

[OPEN ENROLLMENT. If a Member does not elect to participate when initially eligible, the Member may elect to participate at the Policyholder's next enrollment period. This enrollment period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on January 1.]

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the policy, [coverage is effective immediately.]

For persons who become Members after the Plan Effective Date of the policy, [qualification will occur on the first of the month falling on or first following the eligibility period of [two months] of continuous active employment.]

[If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.]

[ELIMINATION PERIOD. Certain covered expenses may be subject to an elimination period, please refer to the TABLE OF DENTAL PROCEDURES, DENTAL EXPENSE BENEFITS and if applicable, the ORTHODONTIC EXPENSE BENEFITS pages for details.]

EFFECTIVE DATE. [Each Member has the option of being insured [and insuring his or her Dependents.] To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums.] The Effective Date for each Member [and his or her Dependents,] will be the [** of the month falling on or next following]:

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.
2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.
- [3. the date we accept the Member and/or Dependent for insurance when the Member and/or Dependent is a Late Entrant. The Member and/or Dependent will be subject to any limitation concerning Late Entrants.]

CONDITIONS FOR INSURANCE (CONTINUED)

EXCEPTIONS. If employment is the basis for membership, a Member must be in active service on the date the insurance, or any increase in insurance, is to take effect. If not, the insurance will not take effect until the day he or she returns to active service. Active service refers to the performance in the customary manner by an employee of all the regular duties of his or her employment with his or her employer on a full-time basis at one of the employer's business establishments or at some location to which the employer's business requires the employee to travel. [If a Member is not considered to be in active service because of a temporary layoff or leave of absence the insurance will remain in effect until the earliest of the date his or her employment is formally terminated or [three] months from the date the layoff or leave of absence began.]

A Member will be in active service on any regular non-working day if he or she is not totally disabled on that day and if he or she was in active service on the regular working day before that day.

If membership is by reason other than employment, a Member must not be totally disabled on the date the insurance, or any increase in insurance, is to take effect. The insurance will not take effect until the day after he or she ceases to be totally disabled.

TERMINATION DATES

INSUREDS. The insurance for any Insured, will automatically terminate on the [** of the month falling on or next following the] **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

[DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on [the ** of the month falling on or next following] the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the ** of the month falling on or next following the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."]

CONTINUATION OF COVERAGE. If coverage ceases according to TERMINATION DATE, some or all of the insurance coverages may be continued. Contact your plan administrator for details.

ORTHODONTIC EXPENSE BENEFITS

We will determine orthodontic expense benefits according to the terms of the group policy for orthodontic expenses incurred by an Insured.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount shown in the Schedule of Benefits.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Benefit During Lifetime shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured during his or her lifetime.

COVERED EXPENSES. Covered Expenses refer to the usual and customary charges made by a provider for necessary orthodontic treatment rendered while the person is insured under this section. Expenses are limited to the Maximum Amount shown in the Schedule of Benefits and Limitations.

Usual and Customary ("U&C") describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. From the array of charges ranked by amount, your Policyholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by your provider and is not indicative of the appropriateness of the provider's fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage purchased by your Policyholder.

ORTHODONTIC TREATMENT. Orthodontic Treatment refers to the movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

TREATMENT PROGRAM. Treatment Program ("Program") means an interdependent series of orthodontic services prescribed by a provider to correct a specific dental condition. A Program will start when the active appliances are inserted. A Program will end when the services are done, or [monthly, semi-annually, annually, after eight calendar quarters] starting with the day the appliances were inserted, whichever is earlier.

EXPENSES INCURRED. Benefits will be payable when a Covered Expense is incurred:

- a. [monthly, semi-annually, annually, at the end of every quarter] of a Program for an Insured who pursues a Program, but not beyond the date the Program ends; or
- b. at the time the service is rendered for an Insured who incurs Covered Expenses but does not pursue a Program.

The Covered Expenses for a Program are based on the estimated cost of the Insured's Program. They are pro-rated by [month, quarter, six-month period, year] over the estimated length of the Program. [However, the first payment will be [25 percent, 250 dollars] of the total allowed Covered Expense.] [Consideration of the initial payment shall not exceed 25% of the total estimated charge.]]

[BENEFITS PAYABLE UPON TERMINATION. If coverage terminates during a Program quarter, the quarterly benefit payable for that quarter will be pro-rated by day for the period of time that coverage was in-force and premium was received.]

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. [for a Program [begun] on or after the Insured's [17, 18, 19] birthday.]
2. [for a Program begun before the Insured became covered under this section.]
3. [in the first [6, 12, 15, 18, 21, 24] months that a person is insured if the person is a Late Entrant.]
4. before the Insured has been insured under this section for at least [12, 18, 24] consecutive months.
5. in any quarter of a Program if the Insured was not covered under this section for the entire quarter.
6. if the Insured's insurance under this section terminates.
7. for which the Insured is entitled to benefits under any workmen's compensation or similar law, or for charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.
8. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.
9. for services not required for necessary care and treatment or not within the generally accepted parameters of care.
10. because of war or any act of war, declared or not.
11. to replace lost or stolen appliances.

ORTHODONTIC EXPENSE BENEFITS

We will determine orthodontic expense benefits according to the terms of the group policy for orthodontic expenses incurred by an Insured.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount shown in the Schedule of Benefits.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Benefit During Lifetime shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured during his or her lifetime.

COVERED EXPENSES. Covered Expenses refer to the usual and customary charges made by a provider for necessary orthodontic treatment rendered while the person is insured under this section. Expenses are limited to the Maximum Amount shown in the Schedule of Benefits and Limitations.

Usual and Customary ("U&C") describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. From the array of charges ranked by amount, your Policyholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by your provider and is not indicative of the appropriateness of the provider's fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage purchased by your Policyholder.

ORTHODONTIC TREATMENT. Orthodontic Treatment refers to the movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

TREATMENT PROGRAM. Treatment Program ("Program") means an interdependent series of orthodontic services prescribed by a provider to correct a specific dental condition. A Program will start when the active appliances are inserted. A Program will end when the services are done, or [monthly, semi-annually, annually, after eight calendar quarters] starting with the day the appliances were inserted, whichever is earlier.

EXPENSES INCURRED. Benefits will be payable when a Covered Expense is incurred:

- a. [monthly, semi-annually, annually, at the end of every quarter] of a Program for an Insured who pursues a Program, but not beyond the date the Program ends; or
- b. at the time the service is rendered for an Insured who incurs Covered Expenses but does not pursue a Program.

The Covered Expenses for a Program are based on the estimated cost of the Insured's Program. They are pro-rated by [month, quarter, six-month period, year] over the estimated length of the Program. [However, the first payment will be [25 percent, 250 dollars] of the total allowed Covered Expense.] [Consideration of the initial payment shall not exceed 25% of the total estimated charge.]]

[BENEFITS PAYABLE UPON TERMINATION. If coverage terminates during a Program quarter, the quarterly benefit payable for that quarter will be pro-rated by day for the period of time that coverage was in-force and premium was received.]

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. [for a Program [begun] on or after the Insured's [17, 18, 19] birthday.]
2. for a Program begun before the Insured became covered under this section, unless the Insured was covered for Orthodontic Expense Benefits under the prior carrier on [mo/dy/yr] and is both:
 - a. insured under this policy; and
 - b. currently undergoing a Treatment Program on [mo/dy/yr].
3. [in the first [6, 12, 15, 18, 21, 24] months that a person is insured if the person is a Late Entrant.]
4. [before the Insured has been insured under this section for at least [12, 18, 24] consecutive months unless the Insured is covered on [mo/dy/yr].
5. in any quarter of a Program if the Insured was not covered under this section for the entire quarter.
6. if the Insured's insurance under this section terminates.
7. for which the Insured is entitled to benefits under any workmen's compensation or similar law, or for charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.
8. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.
9. for services not required for necessary care and treatment or not within the generally accepted parameters of care.
10. because of war or any act of war, declared or not.
11. to replace lost or stolen appliances.

STANDARD INSURANCE COMPANY
ACCIDENTAL LOSS OF SIGHT BENEFIT RIDER

Accidental Loss of Sight Benefit will be paid according to applicable sections of the Policy and the limitations contained herein. Except as noted below, this benefit does not vary, alter, waive or extend any of the terms of the Policy and/or Certificate.

I. DEFINITIONS

Injury - Loss which results directly and independently of all other causes from accidental bodily injury which occurs while this benefit is in force as to the Insured.

Loss of Sight - Means the entire irrecoverable, irreversible and permanent loss of sight.

II. BENEFITS PAYABLE

Benefits are payable upon receipt of proof satisfactory to the Company that the Member's or Dependent's Loss of Sight:

- A. Resulted from accidental injury, directly and independently of all other causes;
- B. Occurred while the Member and/or Dependent was insured under this benefit; and
- C. Occurred within 90 days from the date of injury.

III. AMOUNT OF BENEFIT

Loss of Sight of One Eye.....	\$[2,500.00]
Loss of Sight of Both Eyes.....	\$[5,000.00]

IV. [LIMITATIONS]: Covered Expenses will not include and no benefits will be payable for expenses incurred for:

- 1. intentional self-inflicted injury, while sane or not;
- 2. bacterial infections, except those which occur with a cut or wound at the time of accident;
- 3. any kind of disease;
- 4. medical or surgical treatment (except those which occur with a cut or wound at the time of the accident);
- 5. because of war or any act of war, declared or not;
- 6. injury sustained while in any of the armed forces (land, sea or air) of any country or international authority, except while on temporary domestic National Guard or Reserve duty for less than 30 days;
- 7. racing, test or experimental flying, endurance tests, or participating in any speed or performance contest;
- 8. committing or attempting to commit a felony or misdemeanor;
- 9. injury sustained while under the influence of alcohol or illegal drugs;

ACCIDENTAL LOSS OF SIGHT BENEFIT (Continued)

10. injury sustained while the Insured is hang-gliding or parachuting, except where the Insured must make a parachute jump for self preservation;
11. participating in a riot, rebellion or insurrection; or
12. engaging in an illegal occupation.
13. for which the Insured is entitled to benefits under any workmen's compensation or similar law, or for charges for services or supplies received as a result of any condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.]

VI. TERMINATION

This benefit terminates on the earliest of:

- A. the date the Insured ceases to be a Member.
- B. the date Eye Care Insurance under the policy is terminated.
- C. the date Standard Insurance Company elects to cancel this coverage.

VII. CANCELLATION

On the first day of any month, Standard Insurance Company can elect to cancel all coverage under this benefit.

VIII. CONVERSION

Conversion of this benefit is not allowed.

This provision is effective on ***Effective Date***

Standard Insurance Company



President

SERFF Tracking Number: AMFA-128098139

State: Arkansas

Filing Company: Standard Insurance Company

State Tracking Number:

Company Tracking Number: SIC - FILINGS

TOI: H10G Group Health - Dental

Sub-TOI: H10G.000 Health - Dental

Product Name: SIC - BNL Filing

Project Name/Number: RSL - BNL Filing/RSL - BNL Filing

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: AR - readability-sic.pdf	Approved	02/17/2012

	Item Status:	Status Date:
Bypassed - Item: Application Bypass Reason: N/A Comments:	Approved	02/17/2012

	Item Status:	Status Date:
Satisfied - Item: Redline Versions Comments: Attachments: 9040 Rev. 02-12-rl.pdf 9050 Rev. 02-12-rl.pdf 9070 Rev. 02-12-rl.pdf 9260 Rev. 02-12-rl.pdf 9260-takeover Rev. 02-12-rl.pdf	Approved	02/17/2012

	Item Status:	Status Date:
Satisfied - Item: Optionals & Variables Comments: Attachment: Opt & Var 9040-9050-9070-9260-9044 Rev. 02-12.pdf	Approved	02/17/2012

	Item Status:	Status
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SERFF Tracking Number: AMFA-128098139 State: Arkansas
Filing Company: Standard Insurance Company State Tracking Number:
Company Tracking Number: SIC - FILINGS
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
Product Name: SIC - BNL Filing
Project Name/Number: RSL - BNL Filing/RSL - BNL Filing

Satisfied - Item: 3rd Party Authorization

Approved

Date:
02/17/2012

Comments:

Attachment:

SIC authorization 01-2012.pdf

STATE OF ARKANSAS
CERTIFICATE OF READABILITY

INSURER: Standard Insurance Company

This is to certify that the attached form(s) has achieved a Flesch Reading Ease Score of:

<u>FORM NO:</u>	<u>FLESCH SCORE:</u>	<u>FORM NAME:</u>
9040 Rev. 02-12	50, with policy/certificate	Schedule of Benefits
9050 Rev. 02-12	50	Premiums
9070 Rev. 02-12	50	Conditions For Insurance Coverage
9044 Rev. 02-12	50	Loss of Sight Rider
9260 Rev. 02-12	50	Orthodontic Expense Benefits
9260-Takeover Rev. 02-12	50	Orthodontic Expense Benefits

complies with the requirements of Ark. Stat. Ann. Sections 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

SIGNATURE: **Gail M. Garcia**
TYPED NAME: Gail M. Garcia
TITLE: Vice President - Group Compliance
DATE: 2/16/12

Digitally signed by Gail M. Garcia
DN: cn=Gail M. Garcia, o=Ameritas Life
Insurance Corp., ou=Group
Compliance, email=ggarcia@ameritas.
com, c=US
Date: 2009.05.12 13:04:06 -05'00'

**SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE**

The Insurance for each Insured [and each Insured Dependent] will be based on the Insured's class shown in this Schedule of Benefits.

<u>Benefit Class</u>	<u>Class Description</u>
[Class 1	All Eligible Employees]

[DENTAL EXPENSE BENEFITS

[When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out-of-pocket costs.]

Deductible Amount:

[When a Participating Provider is used:]

[Type 1 Procedures] - [each Benefit Period]	[\$0][*]
[Type 1 Deductible does not apply after the first Benefit Period or thereafter.]	
[Type 1 Deductible is waived during the first Benefit Period.]	
[Type 2 Procedures] - [each Benefit Period]	[\$50][*]
[Type 3 Procedures] - [each Benefit Period]	[\$50][*]
[Type 4 Procedures] - [each Benefit Period]	[\$50][*]

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[When a Non-Participating Provider is used:]

[Type 1 Procedures] - [each Benefit Period]	[\$0][*]
[Type 1 Deductible does not apply after the first Benefit Period or thereafter.]	
[Type 1 Deductible is waived during the first Benefit Period.]	
[Type 2 Procedures] - [each Benefit Period]	[\$50][*]
[Type 3 Procedures] - [each Benefit Period]	[\$50][*]
[Type 4 Procedures] - [each Benefit Period]	[\$50][*]

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Maximum Deductible [each Benefit Period, per Quarter] [\$50]

[[Any deductible satisfied during the Benefit Period will be applied to both the Participating Provider Deductible and the Non-Participating Provider Deductible.] Once the Maximum Deductible per Benefit Period has been met, no further deductible will be required for that Benefit Period.]

[Dental expenses incurred by an individual on or after January 1, [2010], but before [May 1, 2010], will apply to the Deductible Amount if:

- a. proof is furnished to us that such dental expenses were applicable to the deductible under the Policyholder's dental insurance policy in force immediately prior to [May 1, 2010]; and
- b. such expenses would have been considered Covered Expenses under this policy had this policy been in force at the time the expenses were incurred.]

Coinsurance Percentage:	[Participating Provider]	[Non-Participating Provider]
[Type 1 Procedures]	[100%]	[90%]

SCHEDULE OF BENEFITS

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(Continued)

[Type 2 Procedures]	[80%]	[70%]
[Type 3 Procedures]	[50%]	[40%]
[Type 4 Procedures]	[50%]	[50%]

[For Covered Procedures, we will pay up to the following maximum amount that corresponds to the Benefit Period in which the Covered Procedure was performed:

Deleted: Maximum Amount –
[Each Benefit Period]
[\$1500][*]

Maximum Amount -	1st Benefit Period	[\$1000]
	2 nd Benefit Period	[\$1250]
	3 rd Benefit Period	[\$1500]
	4 th + Benefit Period	[\$1750]

[For those persons insured on [January 1, 2009] the Maximum Amount that corresponds to the [3rd Benefit Period] applies during the first Benefit Period the person becomes insured.]

[You and/or your dependents must be insured under the dental plan for [6] months to be eligible for Type [3] Procedures. Please refer to the DENTAL EXPENSE BENEFITS page for details regarding elimination period(s), limitations and exclusions.]

[ORTHODONTIC EXPENSE BENEFITS

[Deductible Amount]	[\$0]
[Coinsurance Percentage]	
Step 1.	[25%]
Step 2.	[30%]
Step 3.	[35%]
Step 4.	[50%]

[For those persons insured on [January 1, 2009] Step [2] applies during the first Benefit Period the person becomes insured.

For those persons insured after [January 1, 2009] Step 1 applies during the first Benefit Period the person becomes insured.

or

Step 1 applies during the first Benefit Period the person becomes insured.]

If a plan includes Takeover benefits the first two paragraphs above will be included to allow those that qualify for Takeover to start at a higher Coinsurance Percentage. If a plan does not include Takeover benefits only the last sentence above will be included.

Step 2 will apply during the second Benefit Period, Step 3 during the third Benefit Period, and Step 4 will apply during each Benefit Period after.

If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.]

[Maximum Benefit during Lifetime] [\$1,000]

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[The Plan pays [25%-50%] of covered Orthodontic Expenses.]

[The Maximum Benefit shown above will be modified for:

- a. any person who was insured for an Orthodontic Expense Benefit under the prior carrier on [December 31, 2007], and
- b. on [January 1, 2008] is both:
 - i. insured under the policy, and
 - ii. currently undergoing a Treatment Program which would have been a covered Treatment Program under the prior carrier had the prior carrier's coverage remained in force.

The modification will result in a reduction of the Maximum Benefit based on:

- a. the normal benefit payable under the policy for the current Treatment Program, minus any amounts to which the person is entitled from the prior carrier for such Treatment Program.

Nothing stated above, however, will act to provide coverage or increase benefits, when the Treatment Program is subject to any limitation shown on 9260.]

[You and/or your dependents must be insured under the dental plan for [12] months to be eligible for Orthodontic Procedures. Please refer to the ORTHODONTIC EXPENSE BENEFITS page for details regarding elimination period(s), limitations and exclusions.]

[EYE CARE EXPENSE BENEFITS

[When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out-of-pocket costs.]

Deductible Amount:

[Exam- [each Benefit Period]]	[\$ 10][*]
[Contact Lens Fitting and Evaluation][each Benefit Period]	[\$0-60]
[Lenses - Other than contact lenses- [Once Per Lifetime]]	[\$ 25][*]
[Frames and Contact Lenses - [Once Per Lifetime]]	[\$ 25][*]

[Maximum Amount – [each Benefit Period] [\$200][*]

[Increasing Eye Care Maximum

For Covered Procedures, we will pay up to the following maximum amount that corresponds to the Benefit Period in which the Covered Procedure was performed:

[Maximum Amount -	1st Benefit Period	[\$0-350]
	2nd Benefit Period	[\$0-350]
	3rd Benefit Period	[\$50-400]
	4th + Benefit Period	[\$50-400]]

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[Please refer to the EYE CARE EXPENSE BENEFITS page for details regarding frequency, limitations, and exclusions.]

[LASER VISION CORRECTION EXPENSE BENEFITS

[Deductible Amount - [each Benefit Period]] \$[50]
Coinsurance Percentage: [100%]

[Please refer to the LASER VISION CORRECTION BENEFIT RIDER for details regarding frequency, limitations, and exclusions.]

[HEARING CARE EXPENSE BENEFITS

Deductible Amount:

[Exams] - [each Benefit Period] [\$0]
[Hearing Aids] - [each Benefit Period] [\$0]
[Hearing Aid Maintenance] - [each Benefit Period] [\$0]
[Hearing Miscellaneous] - [each Benefit Period] [\$0]

[If an Insured incurs Covered Expenses:

- i. during the last three months of any Benefit Period; and
- ii. these expenses are applied towards the Deductible Amount for that Benefit Period,

Such Covered Expenses will also apply to the Deductible Amount for the following Benefit Period.]

Coinsurance Percentage:

[Exams] [100%*]
[Hearing Aids] [50%]
[Hearing Aid Maintenance] [100%*]
[Hearing Miscellaneous] [100%*]

*refer to 9290 SCHEDULE OF HEARING CARE SERVICES regarding the amount of benefits payable.

[[Hearing Aid] Maximum Amount [(per ear)]:

[1st 12 month Period] \$[400]
[2nd 12 month Period] \$[600]
[3rd 12 month Period] \$[800]
[4th 12 month Period or thereafter] \$[1,000]

The term “12 Month Period” means the 12 month period of time beginning with the effective date of the hearing care benefits shown above for the Insured and each Insured Dependent, if any, and thereafter each subsequent 12 month period that begins on the anniversary of the effective dates described earlier in this sentence. It is important to note that for purposes of determining the appropriate 12 Month Period, the Insured and each Insured Member, if any, may have different initial effective dates depending on when they first became covered by this Policy.

EXCEPTION: If an Insured or Insured Dependent, if any, was previously covered under this policy but had a break in continuous coverage under this policy of more than twelve consecutive months, upon resuming coverage hereunder the Insured or Insured Dependent, if any, will be considered a new insured

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person for determining the applicable 12 Month Period when calculating the Covered Expense. After resuming coverage under this policy following a break in coverage of more than 12 consecutive months, the insured's initial 12 Month Period (and each subsequent 12 Month Period) will be based on the Insured's new effective date. Insureds with a break in coverage under this policy of less than 12 consecutive months will, upon resumption of their coverage under this policy, be treated as if they had continuous coverage under this policy BUT ONLY FOR PURPOSES OF THE 12 MONTH PERIOD DETERMINATION. For all other purposes, persons will not be considered insured under this policy during any period of time when their coverage is not in effect.]

[COMBINED EXPENSE BENEFITS

[*Combined [Dental And Eye Care] Deductible Amount: [each Benefit Period]] [\$50]
The deductibles listed with the () above are subject to the maximum deductible amount listed here.]*

[*Combined [Dental and Eye Care] Maximum – [each Benefit Period] [\$1,500]
The maximums listed with the () above are subject to the maximum amount listed here.]*

[Combined [Dental and Eye Care] Exam Frequencies
Routine Exams for [Dental and Eye Care] are limited to [Twice] per [Benefit Period]

Dental Exams will include:

[D0120 Periodic oral evaluation]

[D0150 Comprehensive oral evaluation - new or established patient.]

[D0180 Comprehensive periodontal evaluation – new or established patient.]

A routine eye care exam is a vision examination as defined on the Schedule of Eye Care Services.]

The above frequencies for [Dental and Eye Care] Exams are subject to the plan frequencies as defined within the [Table of Dental Procedures and the Eye Care Insurance provision].]

[DENTAL EXPENSE BENEFITS

[When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.]

First Level: The Plan pays [0 - 100]% of the first \$[0-5,000] of Covered [Preventive, Dental and Orthodontic] Expenses [up to the Maximum Amount].

Second Level: You pay the next \$[25 - 250] of Covered Expenses. (You will not be reimbursed for this \$[25 - 250] of Covered Expenses.)

Third Level: The Plan will also pay [0 - 100]% of the next \$[0 - 5,000] of any Covered [Dental and Orthodontic] Expenses [subject to the Maximum Amount].

Fourth Level: The Plan will also pay [0 - 100]% of the next \$[0 - 5,000] of any Covered [Dental and Orthodontic] Expenses [subject to the Maximum Amount].

Fifth Level: The Plan will also pay [0 - 100]% of the remaining \$[0 - 5,000] of any Covered [Dental and Orthodontic] Expenses [subject to the Maximum Amount].

[Maximum Amount [per Benefit Period] \$[500 - 2,500, Not Applicable]]

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PREMIUMS

TABLE OF MONTHLY PREMIUM RATES

[Dental Care Insurance	\$**.**. per Insured Person \$**.**. per Dependent Unit
Orthodontic Insurance	\$**.**. per Insured Person \$**.**. per Dependent Unit
Eye Care Insurance	\$**.**. per Insured Person \$**.**. per Dependent Unit]

[ASSOCIATED GROUPS]

PAYMENT OF PREMIUMS. The first premium will be due on the Policy Effective Date to cover the period from that date to the first Premium Due Date. Other premiums will be due on or before each Premium Due Date. Premiums are payable at our Home Office or at some other location to which we and the Policyholder agree.

PREMIUM DUE DATE. The Premium Due Date will be the [first] day of the month that falls on or after the Policy Effective Date. If we agree with the Policyholder to the payment of premiums on a basis other than monthly, the Premium Due Date will be fixed to match the correct basis. If there is a change in the method of payment or Premium Due Date, a pro-rata charge in the premium due will be made.

PREMIUM STATEMENTS. The premium due as of any Premium Due Date is the number of units in force on such date for each type of insurance multiplied by the rate shown in the Table of Premium Rates. A premium statement will be made as of the Premium Due Date showing the premium payable. If premiums are payable on other than a monthly basis, each statement will show any pro-rata premium charges and credits in the last premium period due to changes in the number of Insureds and in the amount of insurance for which people are insured. This is subject to the rules below.

SIMPLIFIED ACCOUNTING. The premium will start on the Premium Due Date falling on or after the date the insurance or the increase in the insurance is effective for: a) a person becoming insured; or b) an increase in the amount of insurance on any person. The premium will stop on the Premium Due Date falling on or after the date of termination of insurance or through the date of service of the last paid claim. There will be no pro-rata charges or credits for a partial month. If premiums are payable other than monthly, charges and credits will be figured as though the Premium Due Date is monthly.

We will be liable for the return of unearned premiums (premium for the period which claims were not paid) to the Policyholder only for the [3, 6, 9, 12] months before the date we receive evidence that a return is due.

ADJUSTMENT IN PREMIUM RATES. We may change the rates shown in the Table of Premium Rates by giving the Policyholder at least [30, 45, 60, 90] days advance written notice. We may change the rates at any time the Schedule of Benefits, or any other terms and conditions of the policy, are changed. We will not change the rates until the Renewal Date shown on the policy cover or more than once in any [12, 24, 36, 48] month period thereafter, unless there is a change in the Schedule of Benefits or a change in any other terms and conditions in the policy.

[Notwithstanding the above, We reserve the right to change any one or more of the rates prior to the Renewal Date or more than once in any [12, 24, 36, 48] month period thereafter upon the occurrence of any one or more of the following:

1. We determine that the average number of dependent children for each Insured with Dependent coverage exceeds 4.0; and/or
2. We determine that the number of Insureds is less than 80% of those Insureds initially enrolled under the Policy as of either (i) the Plan Effective Date, if during the period of time between the Plan Effective Date and the Renewal Date, or (ii) the most recent [12, 24, 36, 48] month anniversary of the Renewal Date; and/or
3. We are required by either the federal government or by any state or local government or by any agency thereof to pay a new or increased tax, assessment, or monetary charge of any kind (other than a new or any increase to the amount of tax we pay based upon our net operating income). Such taxes, assessments or fees would include those that are charged or assessed in connection with the operation of a health care exchange authorized by federal or state law.

[4. We determine that more than 50% of the number of Insureds are direct relatives, unless a Quarterly Wage and Tax Report is provided that proves the relatives work for the Policyholder. A Direct Relative is any family member related by blood or marriage.]

Deleted: ¶

Should either or all of the above occur and should we elect to change rates as a result, we agree to notify the Policyholder of the corresponding rate changes at least [30, 45, 60, 90] days in advance of the Premium Due Date for which the rate change shall be effective. The right to change rates as well as the timing of such changes in the above two limited situations shall at all times be subject to applicable state laws and regulations.]

RENEWAL DATE refers to the date each calendar year that the coverage issued under the group policy is considered for renewal. The Renewal Date(s) are shown on the policy cover.

CONDITIONS FOR INSURANCE COVERAGE
ELIGIBILITY

ELIGIBLE CLASS FOR MEMBERS. The members of the eligible class(es) are shown on the Schedule of Benefits. Each member of the eligible class (referred to as "Member") will qualify for such insurance on the day he or she completes the required eligibility period, if any. Members choosing to elect coverage will hereinafter be referred to as "Insured."

[If employment is the basis for membership, a member of the Eligible Class for Insurance is any full-time active employee working at least [**] hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.]

[If a husband and wife are both Members, and if either of them insures their dependent children, then the husband or wife, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.]

[ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the latest of:

1. the day he or she qualifies for coverage as a Member;
2. the day he or she first becomes a Member; or
3. the day he or she first has a dependent. For dependent children, a newborn child will be considered an eligible dependent upon reaching their [2nd] birthday. The child may be added at birth or within 31 days of the [2nd] birthday.

[A Member must be an Insured to also insure his or her dependents.]

[[If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any person who is a full-time active employee working at least [30] hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.]

[Any husband or wife who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.]

[When a member of the Eligible Class for Dependent Insurance dies and, if at the date of death, has dependents insured, the Policyholder has the option of offering the dependents of the deceased employee continued coverage. If elected by the Policyholder and the affected dependents, the name of such deceased member will continue to be listed as a member of the Eligible Class for Dependent Insurance.]

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured is [not] required to contribute to the payment of his or her insurance premiums.

[Dependent Insurance: An Insured is [not] required to contribute to the payment of insurance premiums for his or her dependents.]

CONDITIONS FOR INSURANCE (CONTINUED)

[SECTION 125. This policy is provided as part of the Employer's Section 125 Plan. Each Member has the option under the Section 125 Plan of participating or not participating in this policy.

If a Member does not elect to participate when initially eligible, the Member may elect to participate at a subsequent Election Period. This Election Period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on [mo/dy/yr]. [A Member who elects to participate during an Election Period who did not elect to participate when initially eligible will be a Late Entrant and subject to Limitation No. <1> on 9219. (There is NO "open enrollment" under this policy.)]

Members may change their election option only during an Election Period, except for a change in family status. Such events would be marriage, divorce, birth of a child, death of a spouse or child, or termination of employment of a spouse.

[OPEN ENROLLMENT. If a Member does not elect to participate when initially eligible, the Member may elect to participate at the Policyholder's next enrollment period. This enrollment period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on January 1.]

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the policy, [coverage is effective immediately.]

For persons who become Members after the Plan Effective Date of the policy, [qualification will occur on the first of the month falling on or first following the eligibility period of [two months] of continuous active employment.]

[If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.]

[ELIMINATION PERIOD. Certain covered expenses may be subject to an elimination period, please refer to the TABLE OF DENTAL PROCEDURES, DENTAL EXPENSE BENEFITS and if applicable, the ORTHODONTIC EXPENSE BENEFITS pages for details.]

EFFECTIVE DATE. Each Member has the option of being insured [and insuring his or her Dependents.] To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member [and his or her Dependents,] will be the [** of the month falling on or next following]:

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.
2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.
- [3. the date we accept the Member and/or Dependent for insurance when the Member and/or Dependent is a Late Entrant. The Member and/or Dependent will be subject to any limitation concerning Late Entrants.]

CONDITIONS FOR INSURANCE (CONTINUED)

EXCEPTIONS. If employment is the basis for membership, a Member must be in active service on the date the insurance, or any increase in insurance, is to take effect. If not, the insurance will not take effect until the day he or she returns to active service. Active service refers to the performance in the customary manner by an employee of all the regular duties of his or her employment with his or her employer on a full-time basis at one of the employer's business establishments or at some location to which the employer's business requires the employee to travel. [If a Member is not considered to be in active service because of a temporary layoff or leave of absence the insurance will remain in effect until the earliest of the date his or her employment is formally terminated or [three] months from the date the layoff or leave of absence began.]

Deleted: ¶

A Member will be in active service on any regular non-working day if he or she is not totally disabled on that day and if he or she was in active service on the regular working day before that day.

If membership is by reason other than employment, a Member must not be totally disabled on the date the insurance, or any increase in insurance, is to take effect. The insurance will not take effect until the day after he or she ceases to be totally disabled.

TERMINATION DATES

INSUREDS. The insurance for any Insured, will automatically terminate on the [** of the month falling on or next following the] **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

[DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on [the ** of the month falling on or next following] the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the ** of the month falling on or next following the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."]

CONTINUATION OF COVERAGE. If coverage ceases according to TERMINATION DATE, some or all of the insurance coverages may be continued. Contact your plan administrator for details.

ORTHODONTIC EXPENSE BENEFITS

We will determine orthodontic expense benefits according to the terms of the group policy for orthodontic expenses incurred by an Insured.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount shown in the Schedule of Benefits.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Benefit During Lifetime shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured during his or her lifetime.

COVERED EXPENSES. Covered Expenses refer to the usual and customary charges made by a provider for necessary orthodontic treatment rendered while the person is insured under this section. Expenses are limited to the Maximum Amount shown in the Schedule of Benefits and Limitations.

Usual and Customary ("U&C") describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. From the array of charges ranked by amount, your Policyholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by your provider and is not indicative of the appropriateness of the provider's fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage purchased by your Policyholder.

ORTHODONTIC TREATMENT. Orthodontic Treatment refers to the movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

TREATMENT PROGRAM. Treatment Program ("Program") means an interdependent series of orthodontic services prescribed by a provider to correct a specific dental condition. A Program will start when the active appliances are inserted. A Program will end when the services are done, or ~~monthly, semi-annually, annually, after eight calendar quarters~~, starting with the day the appliances were inserted, whichever is earlier.

Deleted: after eight calendar quarters

EXPENSES INCURRED. Benefits will be payable when a Covered Expense is incurred:

a. ~~monthly, semi-annually, annually, at the end of every quarter~~ of a Program for an Insured who pursues a Program, but not beyond the date the Program ends; or

Deleted: a

Deleted: at the end of every quarter (three-month period)

b. at the time the service is rendered for an Insured who incurs Covered Expenses but does not pursue a Program.

Field Code Changed

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The Covered Expenses for a Program are based on the estimated cost of the Insured's Program. They are pro-rated by ~~month, quarter, six-month period, year~~ over the estimated length of the Program. ~~However, the first payment will be [25 percent, 250 dollars] of the total allowed Covered Expense. [Consideration of the initial payment shall not exceed 25% of the total estimated charge.]~~

Deleted: quarter (three-month periods)

[BENEFITS PAYABLE UPON TERMINATION. If coverage terminates during a Program quarter, the quarterly benefit payable for that quarter will be pro-rated by day for the period of time that coverage was in-force and premium was received.]

Deleted: , up to a maximum of eight quarters. The last quarterly payment for a Program may be changed if the estimated and actual cost of the Program differ.¶

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. [for a Program [begun] on or after the Insured's [17, 18, 19] birthday.]
2. [for a Program begun before the Insured became covered under this section.]
3. [in the first [6, 12, 15, 18, 21, 24] months that a person is insured if the person is a Late Entrant.]
4. before the Insured has been insured under this section for at least [12, 18, 24] consecutive months.
5. in any quarter of a Program if the Insured was not covered under this section for the entire quarter.
6. if the Insured's insurance under this section terminates.
7. for which the Insured is entitled to benefits under any workmen's compensation or similar law, or for charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.
8. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.
9. for services not required for necessary care and treatment or not within the generally accepted parameters of care.
10. because of war or any act of war, declared or not.
11. to replace lost or stolen appliances.

ORTHODONTIC EXPENSE BENEFITS

We will determine orthodontic expense benefits according to the terms of the group policy for orthodontic expenses incurred by an Insured.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount shown in the Schedule of Benefits.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Benefit During Lifetime shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured during his or her lifetime.

COVERED EXPENSES. Covered Expenses refer to the usual and customary charges made by a provider for necessary orthodontic treatment rendered while the person is insured under this section. Expenses are limited to the Maximum Amount shown in the Schedule of Benefits and Limitations.

Usual and Customary ("U&C") describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. From the array of charges ranked by amount, your Policyholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by your provider and is not indicative of the appropriateness of the provider's fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage purchased by your Policyholder.

ORTHODONTIC TREATMENT. Orthodontic Treatment refers to the movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

TREATMENT PROGRAM. Treatment Program ("Program") means an interdependent series of orthodontic services prescribed by a provider to correct a specific dental condition. A Program will start when the active appliances are inserted. A Program will end when the services are done, or ~~monthly, semi-annually, annually, after eight calendar quarters~~, starting with the day the appliances were inserted, whichever is earlier.

Deleted: after eight calendar quarters

EXPENSES INCURRED. Benefits will be payable when a Covered Expense is incurred:

- a. ~~monthly, semi-annually, annually, at the end of every quarter~~ of a Program for an Insured who pursues a Program, but not beyond the date the Program ends; or
- b. at the time the service is rendered for an Insured who incurs Covered Expenses but does not pursue a Program.

Deleted: at the end of every quarter (three-month period)

The Covered Expenses for a Program are based on the estimated cost of the Insured's Program. They are pro-rated by ~~month, quarter, six-month period, year~~ over the estimated length of the Program. ~~[However, the first payment will be [25 percent, 250 dollars] of the total allowed Covered Expense.] [Consideration of the initial payment shall not exceed 25% of the total estimated charge.]~~

[BENEFITS PAYABLE UPON TERMINATION. If coverage terminates during a Program quarter, the quarterly benefit payable for that quarter will be pro-rated by day for the period of time that coverage was in-force and premium was received.]

Deleted: quarter (three-month periods) over the estimated length of the Program, up to a maximum of eight quarters. The last quarterly payment for a Program may be changed if the estimated and actual cost of the Program differ.¶

9260 Takeover ~~Rev. 02-12~~

Deleted: Ed. 01-05

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. [for a Program [begun] on or after the Insured's [17, 18, 19] birthday.]
2. for a Program begun before the Insured became covered under this section, unless the Insured was covered for Orthodontic Expense Benefits under the prior carrier on [mo/dy/yr] and is both:
 - a. insured under this policy; and
 - b. currently undergoing a Treatment Program on [mo/dy/yr].
3. [in the first [6, 12, 15, 18, 21, 24] months that a person is insured if the person is a Late Entrant.]
4. [before the Insured has been insured under this section for at least [12, 18, 24] consecutive months unless the Insured is covered on [mo/dy/yr].
5. in any quarter of a Program if the Insured was not covered under this section for the entire quarter.
6. if the Insured's insurance under this section terminates.
7. for which the Insured is entitled to benefits under any workmen's compensation or similar law, or for charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.
8. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.
9. for services not required for necessary care and treatment or not within the generally accepted parameters of care.
10. because of war or any act of war, declared or not.
11. to replace lost or stolen appliances.

OPTIONALS AND VARIABLES

**9040 Rev. 02-12, 9050 Rev. 02-12, 9070 Rev. 02-12, 9070-Trust Rev. 02-12,
9260 Rev. 02-12, 9260-Takeover Rev. 02-12, 9044 Rev. 02-12**

No change will be made to any policy or certificate in violation of state statutes.

General Items

- 1) We wish to reserve the right to change any addresses, telephone number, websites, and titles of company personnel should they change in the future.
- 2) If the Policyholder has elected multiple plan designs which may be offered within the same policy, e.g., different plans per classes of insureds, optional buy-up feature, etc., then the group policy will be issued with multiple Schedule of Benefits (9040), Dental Expense Benefits (9219) and Table of Dental Procedures (9232) which will reflect each plan design being offered. Each certificate will include on those pages reflecting that plan design.
- 3) If the Policyholder does not choose to cover Dependents, all Dependent provisions and references will be deleted.
- 4) References to Dental, Eye Care and/or Hearing will be added/removed if the plan design does not contain Dental, Eye Care, and/or Hearing as selected by the Policyholder.
- 5) References to Employer and Employee and the subsequent sections that pertain to an Employer/Employee relationship under the policy may be removed if issued to a policy that is not sponsored by an employer.

SCHEDULE OF BENEFITS– 9040 Rev. 02-12

The Benefit Class Description of eligible members and dependents could be modified as required by the policyholder.

The sample Schedule of Benefits pages as submitted illustrates one specific plan design. The following illustrate the variances, which are based on the plan design selected by the Policyholder. The Schedule of Benefits will reflect the plan design chosen by the Policyholder.

If a particular Benefit Type is not selected by the Policyholder or not included because of coverage philosophy that Benefit Type will be removed entirely.

BENEFIT CLASS & OPTIONS

1. References to certain benefits, (ex. orthodontia, eye care, ppo), could be deleted if not selected by the Policyholder. Benefit options such as deductibles, coinsurance percentages and maximums will reflect the plan design selected by the Policyholder.
2. All benefits, definitions, waiting periods and contributions could be broken out to provide different levels according to classes if required by the Policyholder. (ex.

Union employees, non-union employees, clerical employees, non-clerical employees).

DENTAL EXPENSE BENEFITS

When the Policyholder has not chosen a PPO (Participating Provider) option, all references to participating and non-participating providers are deleted.

DEDUCTIBLE AMOUNT

Dependent upon Policyholder selection, Deductible Amounts can range from \$0 to \$250 in increments of \$5, by frequency of services and/or Benefit Type, and can be applied per Benefit Period, Quarter, Visit, and/or Lifetime. Deductible Amounts can be combined to apply to more than one Benefit Type. For example, a \$50 per Benefit Period deductible can apply to Type 1, Type 2, Type 3, and/or Type 4 benefits.

If the Deductible Amount is different when utilizing a Participating Provider versus a Non-Participating Provider the Deductible Amount will be listed similar to the following:

Deductible Amount:

When a Participating Provider is used:	
Combined Type 1, 2 and Type 3 Procedures - each Benefit Period	\$50
When a Non-Participating Provider is used:	
Type 1 Procedures	\$0
Combined Type 2 and Type 3 Procedures - each Benefit Period	\$50

If the Policyholder elects a plan in which the deductible for Type 1 Procedures only applies in the First Benefit Period the following statement will be included.

Type 1 Deductible does not apply after the first Benefit Period or thereafter.

If the Policyholder elects a plan in which the deductible for Type 1 Procedures does not apply in the First Benefit Period the following statement will be included.

Type 1 Deductible is waived during the first Benefit Period.

The Maximum Deductible option provides a limit on the Deductible amounts that apply in a Benefit Period. For example, a \$10 per Visit Deductible when seeing a Participating Provider and a \$50 per Benefit Period Deductible when seeing a Non-Participating Provider may be limited to a total of \$50 per Benefit Period deductible when a Participating and Non-Participating Provider are seen in the same Benefit Period. The following language would be added for plans with this option:

Maximum Deductible per Benefit Period	\$50
---------------------------------------	------

Any deductible satisfied during the Benefit Period will be applied to both the Participating Provider Deductible and the Non-Participating Provider Deductible. Once the Maximum Deductible per Benefit Period has been met, no further deductible will be required for that Benefit Period.

When the policyholder has chosen to include a deductible carry-over provision, the following language will be added to the paragraph DEDUCTIBLE AMOUNT, on the Schedule of Benefits:

If an Insured incurs Covered Expenses:

- i. during the last three months of any Benefit Period; and
- ii. these expenses are applied towards the Deductible Amount for that Benefit Period,

Such Covered Expenses will also apply to the Deductible Amount for the following Benefit Period.

When the policyholder has chosen to include a maximum on the number of Deductibles required to be satisfied by a family, the following language will be added to the paragraph DEDUCTIBLE AMOUNT or added by rider:

On the date that [two] [three] [four] members of one family have satisfied their own Deductible Amounts for [the Benefit Period] [their Lifetime], no Covered Expenses incurred after that date by any other family member will be applied toward the satisfaction of any Deductible Amount for the rest of that [Benefit Period]. No Covered Expense that was incurred prior to such date that was used to satisfy any part of a Deductible Amount will be eligible for reimbursement, however.

When the policyholder has chosen to include a maximum dollar amount of deductible required to be satisfied by a family, the following language will be added to the paragraph DEDUCTIBLE AMOUNT or added by rider. This dollar amount may be per Benefit Period, Quarter, or Lifetime and ranges from \$0 - \$300 in \$5 increments.

On the date that the members of one family have satisfied the Maximum Family Deductible shown below, no covered Expenses incurred after that date by any other family member will be applied toward the satisfaction of any Deductible Amount for the rest of that [Benefit Period] [Quarter] [their Lifetime].

Maximum Family Deductible \$[150]

When the policyholder has chosen to include a maximum dollar amount of Deductible required to be satisfied by a family with different amounts when choosing a Participating versus Non-Participating Provider, the following language will be added to the paragraph DEDUCTIBLE AMOUNT or added by rider. The dollar amounts may be by Benefit Period, Quarter, or per Lifetime and range from \$0 - \$300 in \$5 increments:

On the date that the members of one family have satisfied the Maximum Family Deductible shown below, no Covered Expenses incurred after that date by any other family member will be applied toward the satisfaction of any Deductible Amount for the rest of that [Benefit Period] [Quarter] [their Lifetime].

Provider	Participating Provider	Non-Participating
Maximum Family Deductible	\$[100]	\$[150]

The paragraph regarding Deductible Takeover will be removed if the plan design selected does not include benefits for Takeover.

COINSURANCE PERCENTAGE

The Coinsurance Percentage can range between 0% to 100% in increments of 5%.

Type 1 Procedures	25% - 100%
Type 2, 3, or 4 Procedures	0% - 100%

If the Plan Allowance selected by the policyholder is on a scheduled basis or is based solely on the Actual Charge of the provider the following is included next to the Coinsurance Percentage for clarification purposes:

Coinsurance Percentage:	
Type 1 Procedures	25% - 100% [of Schedule, of Actual Charges]
Type 2 Procedures	0% - 100% [of Schedule, of Actual Charges]
Type 3 Procedures	0% - 100% [of Schedule, of Actual Charges]
Type 4 Procedures	0% - 100% [of Schedule, of Actual Charges]

If the Coinsurance Percentage is different when utilizing a Participating Provider versus a Non-Participating Provider the Coinsurance Percentage will be as listed in the example below:

Coinsurance Percentage:	Participating Provider	Non-Participating
Provider		
[Type 1 Procedures]	[25% - 100%]	[25% - 100%]
[Type 2 Procedures]	[0% - 100%]	[0% - 100%]
[Type 3 Procedures]	[0% - 100%]	[0% - 100%]
[Type 4 Procedures]	[0% - 100]	[0% - 100%]

The difference between participating and non-participating providers will not exceed state allowances.

If an Incentive Coinsurance Percentage is selected it will be as listed in the **example** below. The Incentive Coinsurance Percentage amounts will also vary from 0% - 100% in increments of 5%. It may also be separated into Participating Provider versus Non-Participating Provider amounts, similar to the above, if the Coinsurance Percentage is different when utilizing a Participating Provider versus Non-Participating Provider and determined on an Incentive basis.

Coinsurance Percentage:

Type 1 Procedures:

Step 1.	70%
Step 2.	80%
Step 3.	90%
Step 4.	100%

Type 2 Procedures:

Step 1.	50%
Step 2.	60%
Step 3.	80%
Step 4.	90%

Type 3 and Type 4 Procedures:

Step 1.	25%
Step 2.	35%

Step 3.	50%
Step 4.	60%

If an Incentive Coinsurance Percentage is selected, a descriptive paragraph outlining when the Insured moves between the Steps will be included. The Coinsurance Steps range from two steps up to four steps. The Coinsurance Percentage as listed will be adjusted to accurately reflect the number of steps included in the plan design. The dates used below are illustrative, the appropriate dates based on the policyholder's actual effective date will be used. Below are the Incentive Method descriptive paragraph options that can be selected:

1. Effective Date Incentive:

[For those persons insured on [January 1, 2009] Step [3] applies during the first Benefit Period the person becomes insured.

For those persons insured after [January 1, 2009] Step 1 applies during the first Benefit Period the person becomes insured.

or

Step 1 applies during the first Benefit Period the person becomes insured.]

If a plan includes Takeover benefits the first two paragraphs above will be included to allow those that qualify for Takeover to start at a higher Coinsurance Percentage. If a plan does not include Takeover benefits only the last sentence above will be included.

If the person visits a dentist during each Benefit Period and has a dental procedure performed, Step 2 will apply during the second Benefit Period, Step 3 during the third Benefit Period, and Step 4 will apply during each Benefit Period after.

If, during any Benefit Period, the person fails to visit a dentist or fails to have a dental procedure performed, Step 1 will automatically reapply during the following Benefit Period, and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

Exception: If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

2. Date of Hire Incentive:

A. The Coinsurance Percentage Steps for those persons insured after [January 1, 2009], will be determined as follows:

1. Step 1 applies during the first Benefit Period the person becomes insured.
2. If the person visits a dentist during each Benefit Period and has a dental procedure performed, Step 2 and 3 will apply during the second and third Benefit Period, respectively, and Step 4 will apply during each Benefit Period after.
3. If, during any Benefit Period, the person fails to visit a dentist to have a dental procedure performed, Step 1 will automatically reapply during the following Benefit Period, and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

Exception: If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

B. The Coinsurance Percentage Steps for those persons insured on [January 1, 2009], will be determined as follows:

Step 1 Those employed in [2009].

Step 2 Those employed in [2008].

Step 3 Those employed in [2007].

Step 4 Those employed prior to [2007].

1. Any such person between [January 1, 2009], and [December 31, 2009] will advance to the next higher Coinsurance Percentage Step on January 1, [2010].
2. Any person falling in #1 above who does not visit a dentist during [2010] and have a dental procedure performed, will revert to Step 1 on January 1, [2011]
3. Any person who has advanced to the next higher Coinsurance Percentage Step will advance to the next higher step if during each Benefit Period, he or she visits a dentist and has a dental procedure performed. If this is not done, however, the person will revert to Step 1 on the next following January 1 and must advance to Steps 2, 3 and 4 as if he or she were newly insured.

3. Progressive Incentive:

[For those persons insured on [January 1, 2009] Step [2] applies during the first Benefit Period the person becomes insured.

For those persons insured after [January 1, 2009] Step 1 applies during the first Benefit Period the person becomes insured.

or

Step 1 applies during the first Benefit Period the person becomes insured.]

If a plan includes Takeover benefits the first two paragraphs above will be included to allow those that qualify for Takeover to start at a higher Coinsurance Percentage. If a plan does not include Takeover benefits only the last sentence above will be included.

Step 2 will apply during the second Benefit Period, Step 3 during the third Benefit Period, and Step 4 will apply during each Benefit Period after.

If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

4. New Date of Hire Incentive:

A. The Coinsurance Percentage Steps for those persons insured after [January 1, 2009], will be determined as follows:

1. Step 1 applies during the first Benefit Period the person becomes insured.
2. If the person visits a dentist during each Benefit Period and has a dental procedure performed, Step 2 and 3 will apply during the second and third Benefit Period, respectively, and Step 4 will apply during each Benefit Period after.
3. If, during any Benefit Period, the person fails to visit a dentist to have a dental procedure performed, Step 1 will automatically reapply during the following Benefit Period, and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

Exception: If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

B. The Coinsurance Percentage Steps for those persons insured on [January 1, 2009], will be determined as follows:

Step 1 Those employed in [2009].

Step 2 Those employed in [2008].

Step 3 Those employed in [2007].

Step 4 Those employed prior to [2007].

1. Any such person between [January 1, 2009], and [December 31, 2009] who does not visit a dentist during [2009] will remain at the same Step that applied during [2009].
2. Any person who has advanced to the next higher Coinsurance Percentage Step will advance to the next higher step if during each Benefit Period, he or she visits a dentist and has a dental procedure performed. If this is not done, however, the person will revert to Step 1 on the next following January 1 and must advance to Steps 2, 3 and 4 as if he or she were newly insured.

5. Family Progressive Incentive:

[For those persons insured on [January 1, 2009] Step [3] applies during the first Benefit Period.

For those persons insured after [January 1, 2009] Step 1 applies during the first Benefit Period.

or

Step 1 applies during the first Benefit Period.]

If a plan includes Takeover benefits the first two paragraphs above will be included to allow those that qualify for Takeover to start at a higher Coinsurance Percentage. If a plan does not include Takeover benefits only the last sentence above will be included.

Step 2 will apply during the second Benefit Period.

Step 3 will apply during the third Benefit Period.

Step 4 will apply during each Benefit Period after.

If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

6. 10% Advance Incentive:

[For those persons insured on <MDY(cDivEffDate)> Step <nDenStart> applies during the first Benefit Period the person becomes insured.

For those persons insured after <MDY(cDivEffDate)> Step 1 applies during the first Benefit Period the person becomes insured.

or

Step 1 applies during the first Benefit Period the person becomes insured.]

If a plan includes Takeover benefits the first two paragraphs above will be included to allow those that qualify for Takeover to start at a higher Coinsurance Percentage. If a plan does not include Takeover benefits only the last sentence above will be included.

If the person visits a dentist during each Benefit Period and has a dental procedure performed, Step 2 will apply during the second Benefit Period, Step 3 during the third Benefit Period, and Step 4 will apply during each Benefit Period after.

If, during any Benefit Period, the person fails to visit a dentist or fails to have a dental procedure performed, the coinsurance percentage drops back one Step. The coinsurance percentage will never be less than the coinsurance percentage in Step 1.

Exception: If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

7. Date of Hire progressive Incentive:

A. The Coinsurance Percentage Steps for those persons insured after [January 1, 2009], will be determined as follows:

1. Step 1 applies during the first Benefit Period the person becomes insured.
2. If the person visits a dentist during each Benefit Period and has a dental procedure performed, Step 2 and 3 will apply during the second and third Benefit Period, respectively, and Step 4 will apply during each Benefit Period after.

3. If, during any Benefit Period, the person fails to visit a dentist to have a dental procedure performed, the person will remain at the same Step that applied during the previous Benefit Period.

Exception: If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

- B. The Coinsurance Percentage Steps for those persons insured on [January 1, 2009], will be determined as follows:

Step 1 Those employed in [2009].

Step 2 Those employed in [2008].

Step 3 Those employed in [2007].

Step 4 Those employed prior to [2007].

1. Any such person between [January 1, 2009], and [December 31, 2009] will advance to the next higher Coinsurance Percentage Step on January 1, [2010].
2. Any person falling in #1 above who does not visit a dentist during [2010] and have a dental procedure performed, will remain at the same Step that applied during the previous Benefit Period.
3. Any person who has advanced to the next higher Coinsurance Percentage Step will advance to the next higher step if during each Benefit Period, he or she visits a dentist and has a dental procedure performed. If this is not done, however, the person will remain at the same Step that applied during the previous Benefit Period.

8. Date of Hire Advance Incentive:

- A. The Coinsurance Percentage Steps for those persons insured after [January 1, 2009], will be determined as follows:

1. Step 1 applies during the first Benefit Period the person becomes insured.
2. If the person visits a dentist during each Benefit Period and has a dental procedure performed, Step 2 and 3 will apply during the second and third Benefit Period, respectively, and Step 4 will apply during each Benefit Period after.
3. If, during any Benefit Period, the person fails to visit a dentist to have a dental procedure performed, the insured person's coinsurance level will drop back one coinsurance level step.

Exception: If, during any Benefit Period, the person has a break in continuous coverage of more than twelve months, the insured person's coinsurance level will revert back one coinsurance level step for every 12 months of the break.

B. The Coinsurance Percentage Steps for those persons insured on [January 1, 2009], will be determined as follows:

- Step 1 Those employed in [2009]
- Step 2 Those employed in [2008]
- Step 3 Those employed in [2007]
- Step 4 Those employed prior to [2007]

1. Any such person insured between [January 1, 2009], and [December 31, 2009] will advance one step to the next higher Coinsurance Percentage Step on [January 1, 2010], if they have visited a dentist and had a dental procedure performed. Initial insured employees and dependents will remain at the same coinsurance level step during [2010] if they fail to visit the dentist and have one dental procedure performed.
2. For every January 1, thereafter, should any person fail to visit the dentist in any calendar year, or should he or she fail to have at least one dental procedure performed within the given year, the person will drop back one coinsurance level step, but never below the original Step 1 coinsurance level.

Exception: If, during any Benefit Period, the person has a break in continuous coverage of more than twelve months, the insured person's coinsurance level will revert back one coinsurance level step for every 12 months of the break.

MAXIMUM AMOUNT

The Maximum Amount can range between \$250 to \$10,000 or more in increments of \$50 dependent upon plan selection.

If the Maximum Amount is different when utilizing a Participating Provider versus a Non-Participating Provider the Maximum Amount will be listed as following:

When a Non-Participating Provider is used:	
Maximum Amount - Each Benefit Period	[\$1,000]
When a Participating Provider is used:	
Maximum Amount - Each Benefit Period	[\$1,250]

If the Policyholder selects a plan in which the Dental Maximum Amount increases each year the Maximum Amount will be listed as following. This may also vary to apply to just 2 Benefit Periods or up to 4 Benefit Periods as listed below.

[For Covered Procedures, we will pay up to the following maximum amount that corresponds to the Benefit Period in which the Covered Procedure was performed:

Maximum Amount -	1st Benefit Period	[\$1000]
	2nd Benefit Period	[\$1250]
	3rd Benefit Period	[\$1500]

4th + Benefit Period

[\$1750]

[For those persons insured on [January 1, 2009] the Maximum Amount that corresponds to the [3rd Benefit Period] applies during the first Benefit Period the person becomes insured.]]
The statement above will only be included if the plan includes a provision in which members who are on the plan on the plan's effective date will start at a higher level than those who later enroll on the plan. Otherwise, this statement will be removed.

If certain procedures will not count toward the Maximum Amount, a sentence such as the following will be added to the paragraph MAXIMUM AMOUNT:

In no event will expenses incurred for Type [1] Procedures count toward the Maximum Benefit.

If an Internal Maximum is selected the following text will be used. This could apply to any of the Benefit Types or may apply to procedures for Temporomandibular Joint Dysfunction. The dollar amount listed will vary based on plan selection. This Internal Maximum may apply each "Benefit Period" or "per Lifetime".

Type [3] Eligible Dental Expense Benefits may not exceed [\$500] [per Lifetime, in any Benefit Period].

ELIMINATION (WAITING) PERIODS

Elimination Periods may be included based on plan selection. If included, the Elimination Period will be one of the following 3, 6, 9, 12, 18, or 24 months. The Elimination period may also apply to different Benefit Types and/or multiple Benefit Types. For example the Elimination Period could be 6 months on Type 2 Procedures and 12 months on Type 3 Procedures. If no Elimination Period applies, the entire paragraph will be removed.

ORTHODONTIC EXPENSE BENEFITS

The Orthodontic Maximum Amount can range between \$250 to \$10,000 or more in increments of \$50 dependent upon plan selection.

The Maximum Amount for Orthodontic Expense Benefits can be applied "During Lifetime" or "each Benefit Period" or both.

The Deductible Amount can vary in \$25 increments ranging from \$0 - \$200.

The Coinsurance percentage can vary in 5% increments from 25% to 60%.

If the Policyholder selects a plan in which the Coinsurance Percentage increases over time the following will be included. It may also be separated into Participating Provider versus Non-Participating Provider amounts, if the Coinsurance Percentage is different when utilizing a Participating Provider versus Non-Participating Provider and determined on an Incentive basis.

[Coinsurance Percentage:

Step 1.	[25%]
Step 2.	[30%]
Step 3.	[35%]

Step 4.

[50%]

[For those persons insured on [January 1, 2009] Step [2] applies during the first Benefit Period the person becomes insured.

For those persons insured after [January 1, 2009] Step 1 applies during the first Benefit Period the person becomes insured.

or

Step 1 applies during the first Benefit Period the person becomes insured.]

If a plan includes Takeover benefits the first two paragraphs above will be included to allow those that qualify for Takeover to start at a higher Coinsurance Percentage. If a plan does not include Takeover benefits only the last sentence above will be included.

Step 2 will apply during the second Benefit Period, Step 3 during the third Benefit Period, and Step 4 will apply during each Benefit Period after.

If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.]

If the Deductible Amount, Coinsurance, or Maximum Amount for Orthodontic expense benefits is different when utilizing a Participating Provider versus a Non-Participating Provider these amounts will be listed similar to the following:

	Participating Provider	Non-Participating Provider
Deductible Amount - Once per lifetime	\$100	\$150
Coinsurance Percentage	60%	50%
Maximum Benefit During Lifetime	\$1,500	\$1,000

An Elimination Period for Orthodontic Expense Benefits may be included based on plan selection. If included the Elimination Period will be 12, 18, or 24 months.

If the policyholder has selected a plan with Takeover for Orthodontic Expense Benefits, the following will be listed:

The Maximum Benefit shown above will be modified for:

- a. any person who was insured for an Orthodontic Expense Benefit under the prior carrier on [January 1, 2009], and
- b. on [January 1, 2009] is both:
 - i. insured under the policy, and
 - ii. currently undergoing a Treatment Program which would have been a covered Treatment Program under the prior carrier had the prior carrier's coverage remained in force.

The modification will result in a reduction of the Maximum Benefit based on:

- a. the normal benefit payable under the policy for the current Treatment Program, minus
- b. any amounts to which the person is entitled from the prior carrier for such Treatment Program.

Nothing stated above, however, will act to provide coverage or increase benefits, when the Treatment Program is subject to any limitation shown on 9260.

Similar to the Dental Maximum Amount, if an internal maximum on Orthodontic Expense Benefits exists the following will be included:

Orthodontic Expense Benefits may not exceed \$[1,000] [in any Benefit Period, per Lifetime].

If the Policyholder has selected a plan in which the deductible for Dental and Orthodontic Expense Benefits are combined together so that the member only has to satisfy one deductible, the following will be included:

The deductible is combined for both the Dental Expense and the Orthodontic Expense Benefits.

EYE CARE EXPENSE BENEFITS

When the Policyholder has not chosen a PPO (Participating Provider) option, all references to participating and non-participating providers are deleted.

The Deductible Amount for Eye Care Expense Benefits can range from \$0 to \$25 based on plan selection. This amount can be applied "Each Benefit Period" or "Once per Lifetime". The Deductible Amount may also be applied to any and/or multiple Eye Care Benefits. For Example a \$25 Deductible on Lenses and Frames - Each Benefit Period. The deductible may also vary whether a Participating Provider or Non-Participating Providers is used.

The Maximum Amount for Eye Care Expense Benefits can range from \$50 to \$300 in \$50 increments or may be removed entirely if not included in the selected plan design.

Some services such as eye care exams, frames, or lenses may not apply to the Eye Care Maximum. If the policyholder has selected this plan than the following will be included:

[Eye Care Exams] are not subject to the Eye Care Maximum Amount.

Increasing Eye Care Maximum

If this plan is selected, the Member's eye care maximum will increase each benefit period up to the greatest amount in either the 3rd or 4th benefit period.

For Covered Procedures, we will pay up to the following maximum amount that corresponds to the Benefit Period in which the Covered Procedure was performed:

[Maximum Amount -	1st Benefit Period	[\$0-350]
	2nd Benefit Period	[\$0-350]
	3rd Benefit Period	[\$50-400]
	4th + Benefit Period	[\$50-400]]

LASER VISION CORRECTION EXPENSE BENEFITS

The Deductible Amount for Laser Vision Correction Expense Benefits can range from \$0 to \$250 based on plan selection. This amount can be applied "Each Benefit Period" or "Once per Lifetime".

The Coinsurance Percentage for Laser Vision Correction Expense Benefits can range from 50% - 100% in 5% increments. Normally it remains at 100%. Similarly to the Dental Expense Benefits Coinsurance Percentage the Percentage can be on an incentive basis starting at 50% and increasing to as much as 100% over 2 - 4 years.

If the Incentive Coinsurance option is selected by the policyholder the following will also be included:

[For those persons insured on [January 1, 2009] Step [2] applies during the first Benefit Period the person becomes insured.

For those persons insured after [January 1, 2009] Step 1 applies during the first Benefit Period the person becomes insured.

or

Step 1 applies during the first Benefit Period the person becomes insured.]

If a plan includes Takeover benefits the first two paragraphs above will be included to allow those that qualify for Takeover to start at a higher Coinsurance Percentage. If a plan does not include Takeover benefits only the last sentence above will be included.

Step 2 will apply during the second Benefit Period, Step 3 during the third Benefit Period, and Step 4 will apply during each Benefit Period after.

If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

HEARING CARE EXPENSE BENEFITS

Deductible Amounts for Hearing Expense Benefits can range between \$0 to \$250 in increments of \$5 dependent upon Policyholder selection. Deductible Amounts can be applied by Benefit Period, Quarter, Annually, per Visit, and per Lifetime. Deductible Amounts can also be combined to apply to more than one Hearing Benefit Type. For Example, a \$50 per Benefit Period deductible can apply to Hearing Exams, Hearing Aids, and Hearing Aid Maintenance. The Deductible Amount listed on the Schedule of Benefits page is indicative of one of the most popular plan designs.

When the policyholder has chosen to include a deductible carry-over provision on hearing expense benefits, the following language will be added to the paragraph DEDUCTIBLE AMOUNT, on the Schedule of Benefits:

If an Insured incurs Covered Expenses:

- i. during the last three months of any Benefit Period; and
- ii. these expenses are applied towards the Deductible Amount for that Benefit Period,

Such Covered Expenses will also apply to the Deductible Amount for the following Benefit Period.

The Coinsurance Percentage for Hearing Expense Benefits can range from 50% to 100% based on Policyholder selection and our own coverage philosophy.

The Hearing Aid Maximum Amount can apply to "both ears" or "per ear". It may increase from as little as 2 12-month periods up to 4 12-month periods. The dollar amounts can range from \$400 - \$1,500 dollars in \$50 increments.

COMBINED EXPENSE BENEFITS

The Deductible Amount for Combined Expense Benefits, if selected by the policyholder, can range from \$10 to \$250 based on plan selection. This amount can be applied "Each Benefit Period" or "Once per Lifetime".

In addition, an aggregate deductible amount may be included per lifetime. This would be a deductible amount limit that an Insured would satisfy once per lifetime then no other deductible would be required. If selected by the policyholder, the following would be included:

*Combined Dental and Eye Care Deductible Amount	\$200
Once per Lifetime	

The combined [Annual, Lifetime] deductible is subject to the Aggregate Lifetime deductible amount listed here.

The Combined Maximum Amount, if selected by the policyholder, can range from \$250 to \$10,000 or more in increments of \$50 based on plan selection.

The Combined Exam Frequencies, if selected by the policyholder, can range from 1 to 4 Exams - Each Benefit Period or a rolling period of months based on plan selection. If applicable, the rolling number of months may be 6 months or 12 months.

The procedures listed may be changed to match the procedures listed on the 9232 Table of Dental Procedures that qualify as Dental Exams.

TABLE OF MONTHLY PREMIUM RATES – 9050 Rev. 02-12

The rate table will reflect the rate structure selected by the Policyholder, which could include: Insured/Dependent Unit, Insured/Spouse/Children Only/Spouse and Children, or One Dependent/Two or More Dependents.

The policyholder may request to have the total rate for the Member and Dependent Unit combined. The example lists the Dependent Only rates. In this case the rate table will look like the following:

Dental Care Insurance	\$XX.XX	per Insured Person
	\$XX.XX	Insured Person + Spouse
	\$XX.XX	Insured Person + Children
	\$XX.XX	Insured Person + Spouse & Children

Any of the Benefit Types, Dental, Orthodontic, Eye Care, etc. may be combined together to indicate the total rate for each of the Benefit Types.

Ex. Dental and Eye Care Insurance \$XX.XX per Insured Person.

The 3 month variable could be modified to extend to a longer period, e.g., 6, 9, or 12 based on plan selection.

The 30 day advance written notice could be modified to 45, 60, 90 days, but never less than the number required by the state law.

If a policyholder has subsidiaries, multiple locations, etc. which are covered under the group policy, these subsidiaries, locations would be listed here.

Based on the case criteria and upon request of the Policyholder, the policy can be issued with an expanded rate guarantee period of 24, 36, or 48 months. This extended period is conditional upon the items listed within the provision. A 12-month guarantee period is the standard provision.

CONDITIONS FOR INSURANCE COVERAGE – 9070 Rev. 02-12 and 9070-Trust Rev. 02-12

Any reference to employer or employee will be removed if this product is issued to an association or any other non Employer-Employee group. In addition the sections referring to; a deceased employee, Section 125, satisfying an eligibility period again if eligibility terminates, and Exceptions (being actively at work) other than the last paragraph about not being totally disabled, will be removed if issued to an association or other non Employer-Employee group.

ELIGIBILITY

The definition of Active Service could be changed to whatever a policyholder requires. For example, union employees and school districts would use a different definition.

All definitions of eligible employees and dependents could be modified as required by the policyholder. Variations include: full, part-time or seasonal, active or retired, number of hours

worked per week, excluding certain classes of employees, and plans where the participation in the policyholder's medical plan is required for participation in our dental and/or eye care plan.

The paragraphs under Eligibility relating to husbands and wives working for the same employer are optional as requested by the policyholder.

When the policyholder has an existing dental HMO plan offered by another insurance company the following will be included.

Employees who are enrolled in the Prepaid Plan are not members of the Eligible Class for Personal Insurance and are excluded from the coverage under this policy.

ANNUAL ENROLLMENT SWITCH PERIOD Any employee above who has been covered by the Prepaid Plan for six (6) months or more may become a Member under this policy at any Annual Enrollment Switch period. A thirty-one (31) day Annual Enrollment Switch period will be held each [December] to be effective [January 1]. The Late Entrant penalty and the Waiting Period will be waived for such employee, enrolled in the Prepaid Plan, who becomes a Member during an Annual Enrollment Switch period if certain conditions are met.

When an individual insured has the option to elect between various plan designs, the following paragraphs may be added since the employee may have the option to move between Classes during an open enrollment period as defined by the policyholder, the policyholder may request that one of the following definitions be added to the eligibility provision to avoid adverse selection:

Annual Enrollment Switch Period

An Annual Enrollment Switch period will be held each [December] to be effective [January 1] to allow members to move from Class [1 – Exam Only] to Class [2 - Exam and Materials]. However, if a member terminates from the Class [2 plan option -Exam and Materials], they are not eligible to re-enroll within Class [2 -Exam and Materials] for [two (2)] year(s).

ANNUAL ENROLLMENT SWITCH PERIOD. An Annual Enrollment Switch Period for the eye care plans will be held each [December] to be effective [January 1] to allow members to move from one eligible eye care Class to another eligible eye care Class. However, if a member terminates from the eye care Class they have elected, they are not eligible to re-enroll within an eligible eye care Class until the next Annual Enrollment Switch Period.

In the section entitled ELIGIBLE CLASS FOR DEPENDENT INSURANCE, the reference to the 2nd birthday can also be changed to the 3rd birthday based on the policyholder's selection or our own coverage philosophy.

CONTRIBUTION REQUIREMENTS

Contribution requirements can vary by class of employee and can vary for the Member versus the Dependents. The contribution requirements will reflect what is required by the policyholder of their members.

If the policyholder ties the contribution to their medical plan the following will be included:

An Insured may or may not be required to contribute to the payment of his or her insurance premiums.

If the policyholder has chosen to not require the member to pay for premium if they are not otherwise on another dental and/or eye care plan the following will be included:

An Insured is not required to contribute to the payment of his or her insurance premiums. An insured may or may not be required to contribute to the payment of insurance premiums if he or she is both covered under this policy and also covered under another plan.

SECTION 125

If the policyholder has a Section 125 plan, then, based on the Section 125 and the plan year, one of the following paragraphs would be included:

When the policy year and the Section 125 plan year coincide:

SECTION 125. [(Dependents Only)] This policy is provided as part of the Policyholder's Section 125 Plan. Each Member has the option under the Section 125 Plan of participating or not participating in this policy.

If a Member does not elect to participate when initially eligible, the Member may elect to participate at a subsequent Election Period. This Election Period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on [date]. [A Member who elects to participate during an Election Period who did not elect to participate when initially eligible will be a Late Entrant and subject to Limitation No. [X] on [9219]. (There is NO "open enrollment" under this policy.)]

Members may change their election option only during an Election Period, except for a change in family status. Such events would be marriage, divorce, birth of a child, death of a spouse or child, or termination of employment of a spouse.

When the policy year and the Section 125 plan year do not coincide:

SECTION 125. [(Dependents Only)] This policy is provided as part of the Policyholder's Section 125 Plan. Each Member has the option under the Section 125 Plan of participating or not participating in this policy.

If a Member does not elect to participate when initially eligible, the Member may elect to participate at a subsequent Annual Election Period. The first Annual Election Period will be in [December 2009] and those who elect to participate in this program at that time will have their insurance become effective on [January 1, 2010]. Each Annual election Period thereafter will be in [June] for a [July 1] effective date. [A Member who elects to participate during an Election Period who did not elect to participate when initially eligible will be a Late Entrant and subject to Limitation No. [X] on [9219]. (There is NO "open enrollment" under this policy.)]

A Member may change their election option only during an Annual Election Period, except for a change in family status. Such events would be marriage, divorce, birth of a child, death of a spouse or child, or termination of employment of a spouse.

If the Section 125 rules only apply to Dependents then the optional "Dependents Only" listed above will be included. When the policyholder has elected to have an annual open enrollment each year or does not have a late entrant provision, the bracketed sentence about Late Entrants will be removed.

ELIGIBILITY PERIOD

Eligibility Periods can vary from no waiting period to whatever the policyholder wishes. The eligibility period will never be any longer than prescribed by state law. Eligibility Periods can vary by class of employee and vary between existing employees and newly hired employees.

The reinstatement paragraph under Eligibility Period could be modified to include a time period as required by the Policyholder or deleted, allowing for no reinstatement.

If the policyholder elects to include an annual open enrollment the following will be included. The reference to Dependents only will only be included if the annual open enrollment only applies to dependents.

OPEN ENROLLMENT. [(Dependents Only)] If a Member does not elect to participate when initially eligible, the Member may elect to participate at the Policyholder's next enrollment period. This enrollment period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on [date].

EFFECTIVE DATE

The following statement will be removed if this is a non-contributory plan.

Each Member has the option of being insured [and insuring his or her Dependents.] To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums.

The date the person becomes effective, whether premium contributions are or are not required, could be changed either on the page or by rider. Examples of changes are:

Effective "on the date".

Effective "on the first of the month"

Effective "on the fifteenth (or whatever) of the month".

Showing different effective dates for different classes of employees.

EXCEPTIONS

The section entitled EXCEPTIONS may be removed entirely if the policy is issued to a non-employer group. The section pertaining to temporary layoff or a leave of absence may be included at the Policyholder's request.

TERMINATION DATES

The termination date could be changed similarly to the effective date variables shown above.

CONTINUATION OF COVERAGE. Any state required continuation provisions will be included within this section per individual state requirements.

ORTHODONTIC EXPENSE BENEFITS – 9260 Rev. 02-12 and 9260-Takeover Rev. 02-12

The Usual and Customary paragraph can be removed entirely if a plan design to pay the actual charge of the provider is selected.

The Maximum Amount definition can be changed to allow for a definition of a Maximum that is each Benefit Period or that is both per Lifetime and per Benefit Period.

The reference to "eight calendar quarters" or "calendar quarters" in TREATMENT PROGRAM and EXPENSES INCURRED may be modified for more or fewer quarters, or to change "quarters" to "months", "semi-annual", or "annual" payments, etc.

If the Policyholder selects a plan in which the Orthodontic expenses are paid monthly upon receipt of a claim the section entitled TREATMENT PROGRAM shall be removed and the section entitled EXPENSES INCURRED shall be the following:

[EXPENSES INCURRED. Benefits will be payable when a Covered Expense is incurred at the time the service is rendered for an Insured who incurs Covered Expenses.

[The first payment will be [25 percent, 250 dollars] of the total allowed Covered Expense.]
[Consideration of the initial payment shall not exceed 25% of the total estimated charge.]

If a plan is selected that provides for an amount of Orthodontic Expenses to be covered "up front" then the following sentence will be added to the last paragraph under Expense Incurred. This could be a specified dollar amount or a percentage of the Orthodontic Maximum Amount.

However, the first payment will be [25 percent] of the total allowed Covered Expense.

Based on plan selection the following will be included in the last paragraph under Expenses Incurred:

Consideration of the initial payment shall not exceed 25% of the total estimated charge.

Any limitation or any of the sub-items could be deleted based on our coverage philosophy.

The age limitation is deleted when we offer "adult" ortho. Adult ortho would provide benefits for the Insured, Insured's spouse, and adult dependent children.

The age 17 could be changed if required by policyholder or based on our coverage philosophy. If the age is changed to 19 then the word "begun" will be removed to indicate that the ortho program will cease upon the Insured reaching their 19th birthday.

The elimination period of 12 months could be modified based on policyholder negotiations. Normally it remains at 12 months.

The Late Entrant Provision limitation can be modified similar to the options for Late Entrants listed for Dental Expense Benefits or removed entirely as required by the policyholder or based on our coverage philosophy.

Any Limitations on work-incurred injury or sickness would be deleted should we be requested by the policyholder to provide occupational (24 hour) coverage.

ACCIDENTAL LOSS OF SIGHT BENEFIT RIDER – 9044 Rev. 02-12

The dollar amounts listed may vary based on policyholder request and our coverage philosophy.

Any limitation or any of the sub-items could be deleted based on our coverage philosophy.



January 2012

TO ALL STATE INSURANCE DEPARTMENT PERSONNEL

Standard Insurance Company, Administrative Offices at 1100 SW Sixth Avenue, Portland, Oregon 97204-1093, has provided Ameritas Life Insurance Corp. with the authority to submit forms related to dental and vision insurance benefits on our behalf. Accordingly, Ameritas Life Insurance Corp. has the authority to represent us in the submission and negotiation of the approval of these forms and their accompanying rates.

In this regard, the signatures of:

Gail M. Garcia
Vice President, Group Compliance

Kelly Wieseler
Vice President, Group Actuary

Janis Landon
Senior Contract Analyst

Kate McCown
Manager, Group Compliance

Geri L. McKeown
Manager, Group Compliance

When affixed to a letter or certification of intent, will be as binding as if signed by an officer of Standard Insurance Company.

Sincerely,

A handwritten signature in black ink that reads "Alex M Terry". The signature is fluid and cursive.

Alex Terry, FSA, MAAA
Second Vice President and Associate Actuary
900 SW Fifth Avenue
Portland OR 97204-1235
971.321.8232