



ANNUAL STATEMENT
For the Year Ended December 31, 2011
of the Condition and Affairs of the
SUPERIOR DENTAL CARE, INC.

NAIC Group Code..... ,
(Current Period) (Prior Period)

NAIC Company Code..... 96280

Employer's ID Number..... 31-1119867

Organized under the Laws of OHIO

State of Domicile or Port of Entry OHIO

Country of Domicile US

Licensed as Business Type.....DENTAL SERVICE CORPORATION

Is HMO Federally Qualified? Yes [] No [X]

Incorporated/Organized..... November 30, 1984

Commenced Business..... January 1, 1986

Statutory Home Office

6683 CENTERVILLE-BUSINESS PARKWAY..... DAYTON OH 45459
(Street and Number) (City or Town, State and Zip Code)

Main Administrative Office

6683 CENTERVILLE-BUSINESS PARKWAY..... DAYTON OH 45459
(Street and Number) (City or Town, State and Zip Code)

937-438-0283
(Area Code) (Telephone Number)

Mail Address

6683 CENTERVILLE-BUSINESS PARKWAY..... DAYTON OH 45459
(Street and Number or P. O. Box) (City or Town, State and Zip Code)

Primary Location of Books and Records

6683 CENTERVILLE-BUSINESS PARKWAY..... DAYTON OH 45459
(Street and Number) (City or Town, State and Zip Code)

937-438-0283
(Area Code) (Telephone Number)

Internet Web Site Address

www.superiordental.com

Statutory Statement Contact

WENDY GLOVER
(Name)

937-438-0283
(Area Code) (Telephone Number) (Extension)

WGLOVER@SUPERIORDENTAL.COM
(E-Mail Address)

937-291-5690
(Fax Number)

OFFICERS

Name	Title	Name	Title
1. RICHARD W PORTUNE DDS	PRESIDENT	2. DOUGLAS R HOEFLING DDS DDS	TREASURER
3. ROGER E CLARK DDS	SECRETARY	4. REBECCA J YORK	EXECUTIVE VP & CEO

OTHER

DIRECTORS OR TRUSTEES

Dennis A Burns DDS	Roger E Clark DDS	Douglas R Hoefling DDS	Richard W Portune DDS
L Don Shumaker DDS	James L Sims DDS	Rebecca J York	

State of.....Ohio...
County of...Montgomery..

The officers of this reporting entity being duly sworn, each depose and say that they are the described officers of said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement, together with related exhibits, schedules and explanations therein contained, annexed or referred to, is a full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above, and of its income and deductions therefrom for the period ended, and have been completed in accordance with the NAIC *Annual Statement Instructions and Accounting Practices and Procedures* manual except to the extent that: (1) state law may differ; or, (2) that state rules or regulations require differences in reporting not related to accounting practices and procedures, according to the best of their information, knowledge and belief, respectively. Furthermore, the scope of this attestation by the described officers also includes the related corresponding electronic filing with the NAIC, when required, that is an exact copy (except for formatting differences due to electronic filing) of the enclosed statement. The electronic filing may be requested by various regulators in lieu of or in addition to the enclosed statement.

(Signature)
RICHARD W PORTUNE DDS

1. (Printed Name)
PRESIDENT

(Title)

(Signature)
DOUGLAS R HOEFLING DDS DDS

2. (Printed Name)
TREASURER

(Title)

(Signature)
ROGER E CLARK DDS

3. (Printed Name)
SECRETARY

(Title)

Subscribed and sworn to before me

This _____ day of _____ 2012

a. Is this an original filing? Yes [X] No []

b. If no

1. State the amendment number _____

2. Date filed _____

3. Number of pages attached _____

EXHIBIT 2 - ACCIDENT AND HEALTH PREMIUMS DUE AND UNPAID

1	2	3	4	5	6	7
Name of Debtor	1 - 30 Days	31 - 60 Days	61 - 90 Days	Over 90 Days	Nonadmitted	Admitted
A&H Premiums Due and Unpaid						
Kettering Health Network.....	265,898	245,894				511,792
Montgomery County.....	121,379					121,379
Fairfield Medical Center.....	49,175	48,782				97,957
0299997. Group subscribers subtotal.....	436,452	294,676	0	0	0	731,128
0299998. Premiums due and unpaid not individually listed.....	155,600					155,600
0299999. Total group.....	592,052	294,676	0	0	0	886,728
0599999. Accident and health premiums due and unpaid (Page 2, Line 15).....	592,052	294,676	0	0	0	886,728

EXHIBIT 3 - HEALTH CARE RECEIVABLES

1	2	3	4	5	6	7
Name of Debtor	1 - 30 Days	31 - 60 Days	61 - 90 Days	Over 90 Days	Nonadmitted	Admitted

NONE

EXHIBIT 4 - CLAIMS UNPAID AND INCENTIVE POOL, WITHHOLD AND BONUS (Reported and Unreported)

Aging Analysis of Unpaid Claims						
1	2	3	4	5	6	7
Account	1 - 30 Days	31 - 60 Days	61 - 90 Days	91 - 120 Days	Over 120 Days	Total
Claims Unpaid (Reported)						
0399999. Aggregate accounts not individually listed - covered.....	724,563					724,563
0499999. Subtotals.....	724,563	0	0	0	0	724,563
0599999. Unreported claim and other claim reserves.....						838,271
0699999. Total amounts withheld.....						224,816
0799999. Total claims unpaid.....						1,787,650

EXHIBIT 5 - AMOUNTS DUE FROM PARENT, SUBSIDIARIES AND AFFILIATES

1 Name of Affiliate	2 1 - 30 Days	3 31 - 60 Days	4 61 - 90 Days	5 Over 90 Days	6 Nonadmitted	Admitted	
						7 Current	8 Non-Current
Amounts Due From Parent, Subsidiaries and Affiliates							
0299999. Receivables not individually listed.....	367,285	.....	.....	.....	.....367,285	.....	.....
0399999. Total gross amounts receivable.....	367,285	0	0	0	367,285	0	0

EXHIBIT 6 - AMOUNTS DUE TO PARENT, SUBSIDIARIES AND AFFILIATES

1	2	3	4	5
Affiliate	Description	Amount	Current	Non-Current

NONE

EXHIBIT 7 - PART 1 - SUMMARY OF TRANSACTIONS WITH PROVIDERS

Payment Method	1 Direct Medical Expense Payment	2 Column 1 as a % of Total Payment	3 Total Members Covered	4 Column 3 as a % of Total Members	5 Column 1 Expenses Paid to Affiliated Providers	6 Column 1 Expenses Paid to Non-Affiliated Providers
Capitation Payments:						
1. Medical groups.....	0	0.0	.....	.....	.....	.....
2. Intermediaries.....	0	0.0	.....	.....	.....	.....
3. All other providers.....	0	0.0	.....	.....	.....	.....
4. Total capitation payments.....	0	0.0	0	.....	.....0	0
Other Payments:						
5. Fee-for-service.....	0	0.0	XXX	XXX	.....	.....
6. Contractual fee payments.....	0	0.0	XXX	XXX	.....	.....
7. Bonus/withhold arrangements - fee-for-service.....	0	0.0	XXX	XXX	.....	.....
8. Bonus/withhold arrangements - contractual fee payments.....	31,782,375	100.0	XXX	XXX	31,782,375	.....
9. Non-contingent salaries.....	0	0.0	XXX	XXX	.....	.....
10. Aggregate cost arrangements.....	0	0.0	XXX	XXX	.....	.....
11. All other payments.....	0	0.0	XXX	XXX	.....	.....
12. Total other payments.....	31,782,375	100.0	XXX	XXX	31,782,375	0
13. Total (Line 4 plus Line 12).....	31,782,375	100.0	XXX	XXX	31,782,375	0

EXHIBIT 7 - PART 2 - SUMMARY OF TRANSACTIONS WITH INTERMEDIARIES

1 NAIC Code	2 Name of Intermediary	3 Capitation Paid	4 Average Monthly Capitation	5 Intermediary's Total Adjusted Capital	6 Intermediary's Authorized Control Level RBC
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NONE

EXHIBIT 8 - FURNITURE, EQUIPMENT AND SUPPLIES OWNED

	1	2	3	4	5	6
Description	Cost	Improvements	Accumulated Depreciation	Book Value Less Encumbrances	Assets Not Admitted	Net Admitted Assets
1. Administrative furniture and equipment.....	NONE					0
2. Medical furniture, equipment and fixtures.....						0
3. Pharmaceuticals and surgical supplies.....						0
4. Durable medical equipment.....						0
5. Other property and equipment.....						0
6. Total.....						0



EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

REPORT FOR: 1. CORPORATION.....SUPERIOR DENTAL CARE, INC. 2. DAYTON, OH

BUSINESS IN THE STATE OF GRAND TOTAL DURING THE YEAR (Location)

NAIC Group Code.....0

NAIC Company Code.....96280

	1	Comprehensive (Hospital & Medical)		4	5	6	7	8	9	10
		2	3							
	Total	Individual	Group	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefit Plan	Title XVIII Medicare	Title XIX Medicaid	Other
Total Members at end of:										
1. Prior year.....	157,144					157,144				
2. First quarter.....	163,239					163,239				
3. Second quarter.....	162,621					162,621				
4. Third quarter.....	168,379					168,379				
5. Current year.....	170,034					170,034				
6. Current year member months.....	1,986,996					1,986,996				
Total Member Ambulatory Encounters for Year:										
7. Physician.....	0									
8. Non-physician.....	0									
9. Totals.....	0	0	0	0	0	0	0	0	0	0
10. Hospital patient days incurred.....	0									
11. Number of inpatient admissions.....	0									
12. Health premiums written (b).....	39,957,422					39,957,422				
13. Life premiums direct.....	0									
14. Property/casualty premiums written.....	0									
15. Health premiums earned.....	39,957,422					39,957,422				
16. Property/casualty premiums earned.....	0									
17. Amount paid for provision of health care services.....	31,782,375					31,782,375				
18. Amount incurred for provision of health care services.....	32,406,658					32,406,658				

(a) For health business: number of persons insured under PPO managed care products.....0 and number of persons insured under indemnity only products.....0.

(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees \$.0



EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

REPORT FOR: 1. CORPORATION.....SUPERIOR DENTAL CARE, INC. 2. DAYTON, OH

BUSINESS IN THE STATE OF INDIANA DURING THE YEAR (Location)

NAIC Group Code.....0 NAIC Company Code.....96280

	1 Total	Comprehensive (Hospital & Medical)		4 Medicare Supplement	5 Vision Only	6 Dental Only	7 Federal Employees Health Benefit Plan	8 Title XVIII Medicare	9 Title XIX Medicaid	10 Other
		2 Individual	3 Group							
Total Members at end of:										
1. Prior year.....	0									
2. First quarter.....	0									
3. Second quarter.....	0									
4. Third quarter.....	0									
5. Current year.....	0									
6. Current year member months.....	0									
Total Member Ambulatory Encounters for Year:										
7. Physician.....	0									
8. Non-physician.....	0									
9. Totals.....	0	0	0	0	0	0	0	0	0	0
10. Hospital patient days incurred.....	0									
11. Number of inpatient admissions.....	0									
12. Health premiums written (b).....	0									
13. Life premiums direct.....	0									
14. Property/casualty premiums written.....	0									
15. Health premiums earned.....	0									
16. Property/casualty premiums earned.....	0									
17. Amount paid for provision of health care services.....	0									
18. Amount incurred for provision of health care services.....	0									

NONE

(a) For health business: number of persons insured under PPO managed care products.....0 and number of persons insured under indemnity only products.....0.
(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees \$.....0



EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

REPORT FOR: 1. CORPORATION.....SUPERIOR DENTAL CARE, INC. 2. DAYTON, OH

BUSINESS IN THE STATE OF KENTUCKY DURING THE YEAR (Location)

NAIC Group Code.....0 NAIC Company Code.....96280

	1 Total	Comprehensive (Hospital & Medical)		4 Medicare Supplement	5 Vision Only	6 Dental Only	7 Federal Employees Health Benefit Plan	8 Title XVIII Medicare	9 Title XIX Medicaid	10 Other
		2 Individual	3 Group							
Total Members at end of:										
1. Prior year.....	3,309					3,309				
2. First quarter.....	3,446					3,446				
3. Second quarter.....	3,303					3,303				
4. Third quarter.....	3,702					3,702				
5. Current year.....	3,356					3,356				
6. Current year member months.....	35,965					35,965				
Total Member Ambulatory Encounters for Year:										
7. Physician.....	0									
8. Non-physician.....	0									
9. Totals.....	0	0	0	0	0	0	0	0	0	0
10. Hospital patient days incurred.....	0									
11. Number of inpatient admissions.....	0									
12. Health premiums written (b).....	605,794					605,794				
13. Life premiums direct.....	0									
14. Property/casualty premiums written.....	0									
15. Health premiums earned.....	605,794					605,794				
16. Property/casualty premiums earned.....	0									
17. Amount paid for provision of health care services.....	549,792					549,792				
18. Amount incurred for provision of health care services.....	568,483					568,483				

(a) For health business: number of persons insured under PPO managed care products.....0 and number of persons insured under indemnity only products.....0.
(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees \$.....0



EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

REPORT FOR: 1. CORPORATION.....SUPERIOR DENTAL CARE, INC. 2. DAYTON, OH

BUSINESS IN THE STATE OF OHIO DURING THE YEAR (Location)

NAIC Group Code.....0 NAIC Company Code.....96280

	1 Total	Comprehensive (Hospital & Medical)		4 Medicare Supplement	5 Vision Only	6 Dental Only	7 Federal Employees Health Benefit Plan	8 Title XVIII Medicare	9 Title XIX Medicaid	10 Other
		2 Individual	3 Group							
Total Members at end of:										
1. Prior year.....	153,835					153,835				
2. First quarter.....	159,793					159,793				
3. Second quarter.....	159,318					159,318				
4. Third quarter.....	164,677					164,677				
5. Current year.....	166,678					166,678				
6. Current year member months.....	1,951,031					1,951,031				
Total Member Ambulatory Encounters for Year:										
7. Physician.....	0									
8. Non-physician.....	0									
9. Totals.....	0	0	0	0	0	0	0	0	0	0
10. Hospital patient days incurred.....	0									
11. Number of inpatient admissions.....	0									
12. Health premiums written (b).....	39,351,628					39,351,628				
13. Life premiums direct.....	0									
14. Property/casualty premiums written.....	0									
15. Health premiums earned.....	39,351,628					39,351,628				
16. Property/casualty premiums earned.....	0									
17. Amount paid for provision of health care services.....	31,232,583					31,232,583				
18. Amount incurred for provision of health care services.....	31,838,175					31,838,175				

(a) For health business: number of persons insured under PPO managed care products.....0 and number of persons insured under indemnity only products.....0.
(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees \$.....0

Sch. S-Pt. 1-Sn. 2
NONE

Sch. S-Pt. 2
NONE

Sch. S-Pt. 3-Sn. 2
NONE

Sch. S-Pt. 4
NONE

Sch. S-Pt. 5
NONE

SCHEDULE S - PART 6

Restatement of Balance Sheet to Identify Net Credit for Ceded Reinsurance

	1 As Reported (Net of Ceded)	2 Restatement Adjustments	3 Restated (Gross of Ceded)
ASSETS (Page 2, Col. 3)			
1. Cash and invested assets (Line 12).....	5,885,631		5,885,631
2. Accident and health premiums due and unpaid (Line 15).....	886,728		886,728
3. Amounts recoverable from reinsurers (Line 16.1).....			0
4. Net credit for ceded reinsurance.....	XXX		0
5. All other admitted assets (balance).....	2,982		2,982
6. Totals assets (Line 28).....	6,775,341	0	6,775,341
LIABILITIES, CAPITAL AND SURPLUS (Page 3)			
7. Claims unpaid (Line 1).....	1,787,650		1,787,650
8. Accrued medical incentive pool and bonus payments (Line 2).....			0
9. Premiums received in advance (Line 8).....	939,221		939,221
10. Funds held under reinsurance treaties with authorized and unauthorized reinsurers (Line 19).			0
11. Reinsurance in unauthorized companies (Line 20).....			0
12. All other liabilities (balance).....	324,884		324,884
13. Total liabilities (Line 24).....	3,051,755	0	3,051,755
14. Total capital and surplus (Line 33).....	3,723,586	XXX	3,723,586
15. Total liabilities, capital and surplus (Line 34).....	6,775,341	0	6,775,341
NET CREDIT FOR CEDED REINSURANCE			
16. Claims unpaid.....	0		
17. Accrued medical incentive pool.....	0		
18. Premiums received in advance.....	0		
19. Reinsurance recoverable on paid losses.....	0		
20. Other ceded reinsurance recoverables.....	0		
21. Total ceded reinsurance recoverables.....	0		
22. Premiums receivable.....	0		
23. Funds held under reinsurance treaties with authorized and unauthorized reinsurers.....	0		
24. Unauthorized reinsurance.....	0		
25. Other ceded reinsurance payables/offsets.....	0		
26. Total ceded reinsurance payables/offsets.....	0		
27. Total net credit for ceded reinsurance.....	0		

SCHEDULE T - PART 2

INTERSTATE COMPACT - EXHIBIT OF PREMIUMS WRITTEN

Allocated by States and Territories

			Direct Business Only			
			1 Life (Group and Individual)	2 Annuities (Group and Individual)	3 Disability Income (Group and Individual)	4 Long-Term Care (Group and Individual)
States, Etc.			5 Deposit-Type Contracts	6 Totals		
1.	Alabama.....	AL				0
2.	Alaska.....	AK				0
3.	Arizona.....	AZ				0
4.	Arkansas.....	AR				0
5.	California.....	CA				0
6.	Colorado.....	CO				0
7.	Connecticut.....	CT				0
8.	Delaware.....	DE				0
9.	District of Columbia.....	DC				0
10.	Florida.....	FL				0
11.	Georgia.....	GA				0
12.	Hawaii.....	HI				0
13.	Idaho.....	ID				0
14.	Illinois.....	IL				0
15.	Indiana.....	IN				0
16.	Iowa.....	IA				0
17.	Kansas.....	KS				0
18.	Kentucky.....	KY				0
19.	Louisiana.....	LA				0
20.	Maine.....	ME				0
21.	Maryland.....	MD				0
22.	Massachusetts.....	MA				0
23.	Michigan.....	MI				0
24.	Minnesota.....	MN				0
25.	Mississippi.....	MS				0
26.	Missouri.....	MO				0
27.	Montana.....	MT				0
28.	Nebraska.....	NE				0
29.	Nevada.....	NV				0
30.	New Hampshire.....	NH				0
31.	New Jersey.....	NJ				0
32.	New Mexico.....	NM				0
33.	New York.....	NY				0
34.	North Carolina.....	NC				0
35.	North Dakota.....	ND				0
36.	Ohio.....	OH				0
37.	Oklahoma.....	OK				0
38.	Oregon.....	OR				0
39.	Pennsylvania.....	PA				0
40.	Rhode Island.....	RI				0
41.	South Carolina.....	SC				0
42.	South Dakota.....	SD				0
43.	Tennessee.....	TN				0
44.	Texas.....	TX				0
45.	Utah.....	UT				0
46.	Vermont.....	VT				0
47.	Virginia.....	VA				0
48.	Washington.....	WA				0
49.	West Virginia.....	WV				0
50.	Wisconsin.....	WI				0
51.	Wyoming.....	WY				0
52.	American Samoa.....	AS				0
53.	Guam.....	GU				0
54.	Puerto Rico.....	PR				0
55.	US Virgin Islands.....	VI				0
56.	Northern Mariana Islands.....	MP				0
57.	Canada.....	CN				0
58.	Aggregate Other Alien.....	OT				0
59.	Totals.....		0	0	0	0

NONE

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Group Code	Group Name	NAIC Company Code	Federal ID Number	Federal RSSD	CIK	Name of Securities Exchange if Publicly Traded (U.S. or International)	Names of Parent, Subsidiaries or Affiliates	Domiciliary Location	Relationship to Reporting Entity	Directly Controlled by (Name of Entity/Person)	Type of Control (Ownership Board, Management Attorney-in-Fact, Influence, Other)	If Control is Ownership Provide Percentage	Ultimate Controlling Entity(ies)/Person(s)	*
Members														
.....		00000.....	20-4819498	.....	.....	.....	Superior Dental Care Alliance, Inc.....	OH.....	UDP.....	.....	Board.....	.....	.....	.....
.....		00000.....	31-1707600	.....	.....	.....	SDC Development, LLC.....	OH.....	NIA.....	Superior Dental Care Alliance, Inc.....	Ownership.....	100.00	Superior Dental Care Alliance, Inc.....	.....

SCHEDULE Y

PART 2 - SUMMARY OF INSURER'S TRANSACTIONS WITH ANY AFFILIATES

1	2	3	4	5	6	7	8	9	10	11	12	13
NAIC Company Code	Federal ID Number	Names of Insurers and Parent, Subsidiaries or Affiliates	Shareholder Dividends	Capital Contributions	Purchases, Sales or Exchanges of Loans, Securities, Real Estate, Mortgage Loans or Other Investments	Income/ (Disbursements) Incurred in Connection with Guarantees or Undertakings for the Benefit of any Affiliate(s)	Management Agreements and Service Contracts	Income/ (Disbursements) Incurred under Reinsurance Agreements	*	Any Other Material Activity Not in the Ordinary Course of the Insurer's Business	Totals	Reinsurance Recoverable/ (Payable) on Losses and/or Reserve Credit Taken/ (Liability)
Affiliated Transactions												
.....	31-1119867.....	Superior Dental Care, Inc.....	.....	.....	.....	.....	.....(4,566,788)	.....	.....	.....	.....(4,566,788)	.....
.....	20-4819498.....	Superior Dental Care Holding Company.....	.....	.....	.....	.....	.....4,566,788	.....	.....	.....	.....4,566,788	.....
9999999.	Control Totals.....	.....	.....0	0	0	0	0	0	XXX	0	0	0

SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

The following supplemental reports are required to be filed as part of your statement filing unless specifically waived by the domiciliary state. However, in the event that your domiciliary state waives the filing requirement, your response of WAIVED to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

MARCH FILING		Responses
1.	Will the Supplemental Compensation Exhibit be filed with the state of domicile by March 1?	YES
2.	Will an actuarial opinion be filed by March 1?	YES
3.	Will the confidential Risk-Based Capital Report be filed with the NAIC by March 1?	YES
4.	Will the confidential Risk-Based Capital Report be filed with the state of domicile, if required, by March 1?	YES

APRIL FILING		
5.	Will the Management's Discussion and Analysis be filed by April 1?	YES
6.	Will the Supplemental Investment Risk Interrogatories be filed by April 1?	YES
7.	Will the Accident and Health Policy Experience Exhibit be filed by April 1?	YES

JUNE FILING		
8.	Will an audited financial report be filed by June 1?	YES
9.	Will Accountants Letter of Qualifications be filed with the state of domicile and electronically with the NAIC by June 1?	YES

AUGUST FILING		
10.	Will Communication of Internal Control Related Matters Noted in Audit be filed with the state of domicile by August 1?	YES

The following supplemental reports are required to be filed as part of your statement filing. However, in the event that your company does not transact the type of business for which the special report must be filed, your response of NO to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason, enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

MARCH FILING		
11.	Will the Medicare Supplement Insurance Experience Exhibit be filed with the state of domicile and the NAIC by March 1?	NO
12.	Will the Supplemental Life data due March 1 be filed with the state of domicile and the NAIC?	NO
13.	Will the Supplemental Property/Casualty data due March 1 be filed with the state of domicile and the NAIC?	NO
14.	Will Schedule SIS (Stockholder Information Supplement) be filed with the state of domicile by March 1?	YES
15.	Will the actuarial opinion on participating and non-participating policies as required in Interrogatories 1 and 2 on Exhibit 5 to Life Supplement be filed with the state of domicile and electronically with the NAIC by March 1?	NO
16.	Will the actuarial opinion on non-guaranteed elements as required in Interrogatory 3 to Exhibit 5 to Supplement be filed with the state of domicile and electronically with the NAIC by March 1?	NO
17.	Will the Medicare Part D Coverage Supplement be filed with the state of domicile and the NAIC by March 1?	NO
18.	Will an approval from the reporting entity's state of domicile for relief related to the five-year rotation requirement for lead audit partners be filed electronically with the NAIC by March 1?	NO
19.	Will an approval from the reporting entity's state of domicile for relief related to the one-year cooling off period for independent CPA be filed electronically with the NAIC by March 1?	NO
20.	Will an approval from the reporting entity's state of domicile for relief related to the Requirements for Audit Committees be filed electronically with the NAIC by March 1?	NO

APRIL FILING		
21.	Will the Long-Term Care Experience Reporting Forms be filed with the state of domicile and the NAIC by April 1?	NO
22.	Will the Supplemental Life data due April 1 be filed with the state of domicile and the NAIC?	NO
23.	Will the Supplemental Property/Casualty Insurance Expense Exhibit due April 1 be filed with any state that requires it, and, if so, the NAIC?	NO
24.	Will the Supplemental Health Care Exhibit (Parts 1, 2 and 3) be filed with the state of domicile and the NAIC by April 1?	NO
25.	Will the regulator only (non-public) Supplemental Health Care Exhibit's Expense Allocation Report be filed with the state of domicile and the NAIC by April 1?	NO

AUGUST FILING		
26.	Will Management's Report of Internal Control Over Financial Reporting be filed with the state of domicile by August 1?	YES

SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

EXPLANATIONS:

BAR CODE:

- 1.
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* 9 6 2 8 0 2 0 1 1 3 6 0 0 0 0 0 0 *


* 9 6 2 8 0 2 0 1 1 2 0 5 0 0 0 0 0 *


* 9 6 2 8 0 2 0 1 1 2 0 7 0 0 0 0 0 *


* 9 6 2 8 0 2 0 1 1 3 7 1 0 0 0 0 0 *


* 9 6 2 8 0 2 0 1 1 3 7 0 0 0 0 0 0 *


* 9 6 2 8 0 2 0 1 1 3 6 5 0 0 0 0 0 *


* 9 6 2 8 0 2 0 1 1 2 2 4 0 0 0 0 0 *


* 9 6 2 8 0 2 0 1 1 2 2 5 0 0 0 0 0 *


* 9 6 2 8 0 2 0 1 1 2 2 6 0 0 0 0 0 *


* 9 6 2 8 0 2 0 1 1 3 0 6 0 0 0 0 0 *


* 9 6 2 8 0 2 0 1 1 2 1 1 0 0 0 0 0 *


* 9 6 2 8 0 2 0 1 1 2 1 3 0 0 0 0 0 *


* 9 6 2 8 0 2 0 1 1 2 1 6 0 0 0 0 0 *


* 9 6 2 8 0 2 0 1 1 2 1 7 0 0 0 0 0 *

**Overflow Page
NONE**

**Overflow Page
NONE**

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2011
(To Be Filed by March 1)
FOR THE STATE OF.....Indiana



NAIC Group Code.....0
Address (City, State and Zip Code).....Centerville, OH 45459
Person Completing This Exhibit.....Wendy Glover

NAIC Company Code.....96280

Title.....Chief Financial Officer.....Telephone Number.....937-438-0283

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2008				Policies Issued in 2009, 2010 & 2011					
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	11 Premiums Earned	12 Incurred Claims		13 Percent of Premiums Earned	14 Number of Covered Lives	15 Premiums Earned	16 Incurred Claims		17 Percent of Premiums Earned	18 Number of Covered Lives
											Amount	13 Percent of Premiums Earned				16 Amount	17 Percent of Premiums Earned		
NONE																			

GENERAL INTERROGATORIES

- 1. If response in Column 1 is no, give full and complete details.....
- 2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
 - 2.1 Address.....
 - 2.2 Contact person and phone number.....
- 3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
 - 3.1 Address.....
 - 3.2 Contact person and phone number.....
- 4. Explain any policies identified as policy type "O".

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT



For the Year Ended December 31, 2011
(To Be Filed by March 1)
FOR THE STATE OF.....Kentucky

NAIC Group Code.....0
Address (City, State and Zip Code).....Centerville, OH 45459
Person Completing This Exhibit.....Wendy Glover

NAIC Company Code.....96280

Title.....Chief Financial Officer.....Telephone Number.....937-438-0283

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2008			Policies Issued in 2009, 2010 & 2011				
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	11 Premiums Earned	Incurred Claims		14 Number of Covered Lives	15 Premiums Earned	Incurred Claims		18 Number of Covered Lives
											12	13 Percent of Premiums Earned			16	17 Percent of Premiums Earned	
										Amount	Percent of Premiums Earned	Amount	Percent of Premiums Earned				
NONE																	

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....
2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.

2.1 Address.....

2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).

3.1 Address.....

3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2011
(To Be Filed by March 1)
FOR THE STATE OF.....Ohio



NAIC Group Code.....0
Address (City, State and Zip Code).....Centerville, OH 45459
Person Completing This Exhibit.....Wendy Glover

NAIC Company Code.....96280

Title.....Chief Financial Officer.....Telephone Number.....937-438-0283

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2008				Policies Issued in 2009, 2010 & 2011			
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	11 Premiums Earned	Incurred Claims		14 Number of Covered Lives	15 Premiums Earned	Incurred Claims		18 Number of Covered Lives
											12 Amount	13 Percent of Premiums Earned			16 Amount	17 Percent of Premiums Earned	
NONE																	

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....
2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.

2.1 Address.....

2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).

3.1 Address.....

3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

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SCHEDULE S - PART 4

Reinsurance Ceded To Unauthorized Companies

1	2	3	4	5	6	7	8	9	Letter of Credit Issuing or Confirming Bank (a)			13	14	15	16	17
NAIC Company Code	Federal ID Number	Effective Date	Name of Reinsurer	Reserve Credit Taken	Paid and Unpaid Losses Recoverable (Debit)	Other Debits	Total (Cols. 5 + 6 + 7)	Letters of Credit	10	11	12	Trust Agreements	Funds Deposited by and Withheld from Reinsurers	Other	Miscellaneous Balances (Credit)	Sum of Cols. 9 + 13 + 14 + 15 + 16 But Not in Excess of Col. 8
									American Bankers Association (ABA) Routing Number	Letter of Credit Code	Bank Name					

NONE

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Group Code	Group Name	NAIC Company Code	Federal ID Number	Federal RSSD	CIK	Name of Securities Exchange if Publicly Traded (U.S. or International)	Names of Parent, Subsidiaries or Affiliates	Domiciliary Location	Relationship to Reporting Entity	Directly Controlled by (Name of Entity/Person)	Type of Control (Ownership Board, Management Attorney-in-Fact, Influence, Other)	If Control is Ownership Provide Percentage	Ultimate Controlling Entity(ies)/Person(s)	*
Members														
.....		00000.....	20-4819498	.....	.....	.....	Superior Dental Care Alliance, Inc.....	OH.....	UDP.....	.....	Board.....	.....	.....	.....
.....		00000.....	31-1707600	.....	.....	.....	SDC Development, LLC.....	OH.....	NIA.....	Superior Dental Care Alliance, Inc.....	Ownership.....	100.00	Superior Dental Care Alliance, Inc.....	.....