

SERFF Tracking Number: GHPI-125848828 State: Arkansas  
Filing Company: Coventry Health and Life Insurance Company State Tracking Number: 40467  
Company Tracking Number: ARGDS08  
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental  
Product Name: AR-Dental Product  
Project Name/Number: /

## Filing at a Glance

Company: Coventry Health and Life Insurance Company

Product Name: AR-Dental Product

TOI: H10G Group Health - Dental

Sub-TOI: H10G.000 Health - Dental

Filing Type: Form

SERFF Tr Num: GHPI-125848828

SERFF Status: Closed

Co Tr Num: ARGDS08

Co Status:

Authors: Geneva Clark, Anita  
Carter

Date Submitted: 10/07/2008

State: ArkansasLH

State Tr Num: 40467

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Disposition Date: 10/09/2008

Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name:

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 10/09/2008

State Status Changed: 10/09/2008

Corresponding Filing Tracking Number:

Filing Description:

(314) 506-1928

acarter@cvty.com

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Employer

Deemer Date:

October 7, 2008

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Rosalind Minor

Sr. Certified Rate & Form Analyst

Arkansas Insurance Department

Life and Health Division

1200 West Third Street

Little Rock, Arkansas 72201

Re: Co Tracking #: ARGDS08

Group Dental Certificates of Coverage, Schedules of Benefits, Applications, Domestic  
Partner Amendment, Group Dental  
Master Policy

Dear Ms Minor:

I am writing on behalf of Coventry Health and Life Insurance Co. ("CHL") regarding submission of the above referenced documents outlined in the attached list.

The intended market for these documents is the employer group market. These documents are new, rather than replacement documents. These documents will be issued to employers.

In addition, please note the following:

1. Per a discussion on September 12, 2007 (for a previous filing), it is not necessary to file rates for groups.
2. A check in the amount of \$50.00 will be sent under separate cover as per our email discussion on September 25, 2008.
3. In compliance with ACA 23-79-206, a Readability Certificate is attached.
4. In compliance with Rule & Regulation 19, these documents do not discriminate on the basis of sex.
5. In compliance with Rule & Regulation 49, an Insurance Guaranty Association Notice is attached.
6. In compliance with ACA 23-79-138, the company's service office address and phone number as well as the AR Insurance Department address and phone number are listed in the Dental Certificates of Coverage.

Thank you for your assistance with this filing. If you have any comments or concerns, please contact me at (314) 506-1928.

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Sincerely,

Anita J. Carter, RN  
Manager, Regulatory Compliance

Enclosures

## Company and Contact

### Filing Contact Information

Anita Carter, Manager of Regulatory Compliance  
550 Maryville Centre Drive  
St. Louis, MO 63141-5818  
acarter@cvty.com  
(314) 506-1928 [Phone]  
(314) 506-1672[FAX]

### Filing Company Information

Coventry Health and Life Insurance Company  
6705 Rockledge Drive  
Suite 900  
Bethesda, MD 20817  
(314) 506-1700 ext. [Phone]  
CoCode: 81973  
Group Code: 1137  
Group Name:  
FEIN Number: 75-1296086  
State of Domicile: Delaware  
Company Type:  
State ID Number:  
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## Filing Fees

Fee Required? No  
Retaliatory? No  
Fee Explanation:  
Per Company: No

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/09/2008	10/09/2008

*SERFF Tracking Number:* GHPI-125848828      *State:* Arkansas  
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## **Disposition**

Disposition Date: 10/09/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Certification/Notice	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Form</b>	Dental Certificate of Coverage	Approved-Closed	Yes
<b>Form</b>	Dental Certificate of Coverage	Approved-Closed	Yes
<b>Form</b>	Schedule of Benefits	Approved-Closed	Yes
<b>Form</b>	Schedule of Benefits	Approved-Closed	Yes
<b>Form</b>	Schedule of Benefits	Approved-Closed	Yes
<b>Form</b>	Schedule of Benefits	Approved-Closed	Yes
<b>Form</b>	Group Dental Insurance Master Policy	Approved-Closed	Yes
<b>Form</b>	Domestic Partner Amendment	Approved-Closed	Yes
<b>Form</b>	Employer Application	Approved-Closed	Yes
<b>Form</b>	Dental Enrollment/Change Form	Approved-Closed	Yes

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## Form Schedule

### Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	AR_GDSIN DM08_CHL	Certificate	Dental Certificate of Coverage	Initial			AR_GDSIND M08_CHL.pdf
Approved-Closed	AR_GDS08_CHL	Certificate	Dental Certificate of Coverage	Initial			AR_GDS08_CHL.pdf
Approved-Closed	AR_GDSS OB50-08_CHL	Schedule Pages	Schedule of Benefits	Initial			AR_GDSSOB 50-08_CHL.pdf
Approved-Closed	AR_GDSS OB100-08_CHL	Schedule Pages	Schedule of Benefits	Initial			AR_GDSSOB 100-08_CHL.pdf
Approved-Closed	AR_GDSS OBINDM50-08_CHL	Schedule Pages	Schedule of Benefits	Initial			AR_GDSSOB INDM50-08_CHL.pdf
Approved-Closed	AR_GDSS OBINDM100-08_CHL	Schedule Pages	Schedule of Benefits	Initial			AR_GDSSOB INDM100-08_CHL.pdf
Approved-Closed	AR_GDSG EA08_CHL	Policy/Cont ract/Fraternal Certificate	Group Dental Insurance Master Policy Certificate	Initial			AR_GDSG EA08_CHL.pdf
Approved-Closed	AR_GDSD OMPART08_CHL	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Domestic Partner Amendment	Initial			AR_GDSD OMPART08_CHL.pdf
Approved-Closed	AR_GDSA PP08_CHL	Application/ Employer Enrollment Form	Application Enrollment	Initial			AR_GDSA PP08_CHL.pdf
Approved-Closed	AR_GDSE NROLL08_CHL	Application/ Dental Enrollment Form	Dental Enrollment/Change Form	Initial			AR_GDSE NROLL08_CHL.pdf



COVENTRY HEALTH AND LIFE INSURANCE COMPANY  
COVENTRY DENTAL

[ABC POLICYHOLDER]

# COVENTRY DENTAL

Underwritten by  
Coventry Health and Life Insurance Company  
6705 Rockledge Drive, Ste 900  
Bethesda, MD 20817

## CERTIFICATE OF COVERAGE

This Certificate of Coverage provides important information about the dental care services available to you as an Eligible Person of the Policyholder and any Covered Dependents which have enrolled in the Coventry Dental Plan ("Coventry Dental", "Dental Plan"). Because this certificate is only a summary of the Dental Plan, you must consult the Policy for the exact terms and conditions.

This certificate is part of the Group Policy. The Policy is underwritten by Coventry Health and Life Insurance Company and administered by Group Dental Service, Inc. ("GDS"). Inquiries regarding the Policy may be directed to:

Coventry Dental  
c/o Group Dental Service, Inc.  
111 Rockville Pike Ste# 950  
Rockville, MD 20850  
Attn: Member Services  
[1-866-690-4908]

### DEFINITIONS

Whenever used in this certificate:

**Affiliated Companies** means Coventry Health and Life Insurance Company's parent company is Coventry Health Care, Inc. ("Coventry"). Coventry is the parent company of several managed care companies, health maintenance organizations, insurance companies, third party administrators and network rental companies. Coventry and its subsidiaries are considered Affiliated Companies of Coventry Health and Life Insurance Company. These Affiliated Companies include, but are not limited to, Coventry Health Care of Arkansas, Group Health Plan Inc. and Group Dental Service, Inc.

**Annual Deductible** means the amount set forth in the Schedule of Benefits which each Covered Person must pay each year before benefits will be paid. [The maximum Annual Deductible per family is three (3) times the Individual Deductible as set forth in the Schedule of Benefits.]

**Annual Maximum** means the total amount of benefits that will be paid in a year as set forth in the Schedule of Benefits to the Covered Person. [Benefits for Orthodontia do not count to the Annual Maximum.]

**Benefit** means the amounts payable by us, as set forth in the Schedule of Benefits.

**Benefit Period** means the 12 month duration of benefits following the effective date of the Certificate.

**Benefit Year** means the 12 months following the effective date of the Certificate.

**Calendar Year** means January 1<sup>st</sup> through December 31<sup>st</sup>.

**Certificate; Certificate of Insurance** means the document describing Covered Services, Coinsurance, Deductibles, limitations and exclusions. The Schedule of Benefits is an integral part of the Certificate of Insurance.

**Child(ren)** includes any natural child, stepchild, and adopted child on the date the child is placed in Your custody; the date You are legally or financially responsible for the child, or the date of the filing of a petition for adoption, whichever date is earlier.

**Coinsurance** means a specified percentage of the Allowable Charge that You must pay as a condition of the receipt of certain services as provided in this Certificate of Insurance. Specific Coinsurance amounts are listed in the Schedule of Benefits. In some circumstances, the Allowable Charge will be more than the charges the Provider has billed for the Covered Services. In these cases, You will still be responsible for Coinsurance based on the Allowable Charge.

**Cosmetic Dentistry** - aesthetic improvement of the color and shape of teeth performed by a general dentist.

**Coventry Dental** means the dental product of Coventry Health and Life Insurance Company administered by Group Dental Service, Inc.

**Covered Dental Service** means a procedure listed in the attached Schedule of Benefits. If a procedure is not listed, it will not be covered under the Policy. All procedures are subject to the Exclusions and Limitations set forth in the Certificate.

**Covered Dependent** means an Eligible Dependent that is covered under this Certificate.

**Coventry Health and Life Insurance Company (the Company, We, Us, or Our)** means the insurance company licensed in Arkansas and domiciled in Delaware. The address of the administrative offices is 6705 Rockledge Drive, Suite 900, Bethesda, MD 20817. The Company is subject to regulation in Arkansas by the Arkansas Department of Insurance.

**Covered Person** means a person covered under this certificate.

**Deductible** means the amount a Covered Person and/or a Family must pay toward Covered Dental Services before Coventry Dental begins paying for services. The Schedule of Benefits lists the Deductible that applies to you.

**Effective Date** means the date your coverage begins under this Certificate.

**Eligible Child** means any unmarried Child(ren) of the Eligible Person:

- a) until the end of the calendar month in which he/she reaches [19] and who is primarily dependent on You for support and maintenance; or
- b) until the end of the calendar month in which he/she reaches [25] if a full-time student (written proof is required); or
- c) to any age if he/she continues to be both incapable of self-sustaining employment by reason of mental or physical incapacity and chiefly dependent upon the Covered Person for maintenance and support. Proof must be provided.

**Eligible Dependent** means any spouse and Eligible Child.

**Eligible Person** means a person as determined by the Policy and Policyholder and set forth in the application for insurance.

**Employee** means one who works for a Group, receives wages or salary, and who is regularly scheduled to work those hours per week and months per year as indicated in the Group Policy, thereby making that Employee eligible for Covered Services under the terms of the Plan.

**Enrollment/Change Form** means Our form which You complete before Your effective date. This form allows You to have coverage through Us.

**Experimental/Investigational** means drugs or procedures not recognized by the United States Food and Drug Administration, the United States Public Health Service, Medicare, and the Dental Director as universally accepted treatment.

**Family** means the Eligible Person, spouse and Eligible Child.

**Group** means persons or entity serving as the Policyholder.

**Group Application** means the document completed by the Employer to enroll in dental coverage.

**Group Policy** means the contractual agreement the Company enters into with the Member's employer for dental care coverage. The policy consists of the Group Policy, the Group Application and any attachments and/or amendments to the application or policy, the Enrollment/Change Forms, and Schedule of Benefits, as well as this Certificate of Insurance. The Policyholder is the Eligible Person's employer and is listed in the Group Policy.

**Lifetime Maximum** means the total amount of benefits payable by the Company for each Covered Individual. This maximum is for the length of the coverage under this Group Policy. Specific Lifetime Maximum amounts are listed in the Schedule of Benefits.

**Medically Necessary/Medical Necessity** means those Covered Services determined by Us to be:

- a. Medically appropriate, so that expected health services (such as, but not limited to, increased life expectancy, improved functional capacity, prevention of complications, relief of pain) materially exceed the expected health risks;
- b. Necessary to meet the health needs of the Covered Person, improve physiological function and required for a reason other than improving appearance;
- c. Rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service;
- d. Consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical research, professional medical specialty organizations or governmental agencies that are generally accepted as national authorities on the services, supplies, equipment or facilities for which coverage is requested;
- e. Consistent with the diagnosis of the condition at issue;
- f. Required for reasons other than the comfort or convenience of the Covered Person or his or her Provider; and
- g. Not experimental or investigational as determined by Us.

The fact that a Provider may prescribe, recommend, order, or approve a service or supply does not of itself determine Medical Necessity or make such service or supply a covered service.

**Member Service Department** means the Company's Member Service Department, which includes services for Covered Individuals. The number for the Member Service Department is located on Your ID card.

**Premiums** means the amounts stated in the Group Application which must be remitted to Coventry Dental for Covered Persons during the term of the Certificate.

**Policyholder** means the entity identified in the Policy and on the Certificate Cover.

**Preauthorization** means approval by the Company that is required for payment for certain services to be performed. Preauthorization does not guarantee payment if the Covered Individual is not covered at the time the service is provided.

**Provider** means a practitioner of dentistry duly licensed by the State Board of Dental Examiners acting within the scope of his license. Provider does not include: the Covered Person or the Covered Person's spouse; or the Covered Person or the Covered Person spouse's child, parent, brother, sister, or a person living with the Covered Person.

**Prudent Layperson** means a person who is without medical training and who draws on his or her practical experience when making a decision regarding whether emergency medical treatment is needed. A Prudent Layperson will be considered to have acted "reasonably" if other similarly situated laypersons would have believed, on the basis of observation of the medical symptoms at hand, that emergency medical treatment was necessary.

**Qualified Medical Child Support Order** ("QMCSO") means an order from a court of competent jurisdiction or a state agency stating that the Policyholder or Eligible Person is responsible for providing coverage under Coventry Dental. You should contact Your Policyholder for answers to any questions You have with respect to a QMCSO.

**“Retiree”** means a former Eligible Employee of the Group who meets the Group’s definition of retired employees to whom the Group offers Coverage under this *Certificate of Insurance*.

**Schedule of Benefits** means a schedule of covered benefits, fully discussed in this *Certificate of Insurance* and the Group Policy, which delineates the Covered Individual’s Coinsurance, Deductibles, out-of-pocket maximums, and other benefit limitations. The Schedule of Benefits is included with this *Certificate of Insurance*.

**Utilization Management Policies** means the evaluation of the appropriateness, medical need and efficiency of the proposed dental care service procedures. Such procedures include pre-authorization, pre-determination and alternate benefit provision.

**Waiting Period** means the time each Covered Person must be enrolled under the Certificate before benefits will be paid for each classification of services as set forth in the Certificate Schedule. The Waiting Period does not apply to Diagnostic I and Preventative Services.

**You/Your** means a Covered Individual covered under this *Certificate of Insurance*

## GENERAL PROVISIONS

### Eligibility and Enrollment

**New Enrollment** - The Policyholder shall determine which of its employees, associates or members are eligible to enroll in Coventry. The Policyholder shall be responsible for providing eligibility information to Coventry on a timely basis in an agreed upon format. Where the Policyholder provides eligibility information of any kind, including but not limited to electronic data, tapes or software, the data must be accurate and accessible.

If the Eligible Person has already satisfied the Policyholder’s eligibility requirements when the Policy begins and the Eligible Person’s enrollment information is supplied to us, coverage will begin on the Effective Date of the Policy, provided we receive the Premium.

If an individual joins the Group or becomes employed after the initial Effective Date of the Policy, in order to be eligible to enroll, the individual must first satisfy any eligibility requirements of the Policyholder. An Eligible Person must supply the enrollment information on themselves [and their Eligible Dependents] within 31 days of the date the Eligible Person meets these requirements. Coverage will begin on the date specified in the Policy Schedule provided Premium is paid.

[Dental procedures begun prior to the Covered Person’s effective date of coverage are excluded for [twelve (12) months] following the Covered Person’s effective date. Examples include, but not limited to the following: crowns, the procedure is started when the teeth are prepared. For root canals, the procedure is started when the tooth is opened and pulp is removed.] Procedures started prior to the Covered Person’s effective date are the liability of the Covered Person or a prior insurance carrier during the exclusion period.

**Enrollment Changes** - After initial enrollment, there are certain Life Change Events that permit a Covered Person to change their coverage or enroll Eligible Dependents. These events include:

- Marriage;
- Divorce or Legal Separation;
- Birth or Adoption of a child;
- Death of a Spouse or Child;
- Court order of placement or custody;
- Change in Student Status for a Child;
- Change in Employment Status.]

**Late Enrollment** - If an Eligible Person [or their Eligible Dependent] are not enrolled within 31 days of initial eligibility or a life change event, the Eligible Person [or their Eligible Dependent] cannot enroll until the next open enrollment period conducted by the Policyholder. [If the Covered Person is required to provide coverage for a Child pursuant to a Qualified Medical Child Support Order (“QMCSO”), the Covered Person will be permitted to enroll the Child without regard to enrollment season restrictions. If the insuring parent is enrolled but does not include the Child in the enrollment, Coventry Dental shall allow the non-insuring parent or child support enforcement agency, to apply for enrollment on behalf of the Child; and include the Child(ren) in the coverage regardless of enrollment

period restrictions. If a Child(ren) has dental insurance coverage through an insuring parent, Coventry Dental shall: provide to the non-insuring parent membership cards, claims forms and any other information necessary for the Child(ren) to obtain benefits through the dental insurance coverage; and process the claims forms and make appropriate payment to the non-insuring parent or health care provider if the non-insuring parent incurs expenses for dental care provided to the Child(ren). If an Eligible Person is required to provide coverage for a Eligible Dependent pursuant to a Qualified Medical Child Support Order (“QMCSO”), the Eligible Person will be permitted to enroll both the Eligible Person and the Eligible Dependent without regard to enrollment season restrictions. An Eligible Dependent of an Eligible Person who is not enrolled for coverage with Us may not be enrolled without the Eligible Person also enrolling.

Coventry Dental may not terminate the Child(ren) coverage unless written evidence is provided to Coventry Dental: that the Qualified Medical Child Support Order (“QMCSO”) is no longer in effect; the Child(ren) has been or will be enrolled under other reasonable dental insurance coverage that will take effect on or before the effective date of the termination; the employer has eliminated family members’ coverage for all of its employees; or the employer no longer employs the insuring parent, except that if the parent elects to exercise the provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985(COBRA), coverage shall be provided for the Child(ren) consistent with the employers plan for post-employment dental insurance coverage for dependents.]

**Voluntary Disenrollment** - If a Covered Person chooses to drop coverage at any time during the Policy year other than at open enrollment or during open enrollment, they will not be permitted to enroll themselves [or their Eligible Dependent] at a later time unless they supply proof of loss of coverage under another dental plan. The loss of coverage must be due to a valid life change event such as death, divorce or change in employment status of spouse. If the individual supplies such proof, they will be permitted to re-enroll at the next open enrollment period.

[Coventry reserves the right to assess a financial penalty on a Covered Person for voluntarily withdrawing from the dental plan during the first year of coverage. This penalty will not exceed the usual, customary and reasonable charge for services rendered reduced by the sum of the Premiums paid by or for the Covered Person and any co-payments paid by or for the Covered Person.]

**Dependent Eligibility** - To be eligible to be enrolled under this Agreement as a Dependent, an individual must:

- Be the lawful spouse of the Covered Person or be an unmarried child of the Covered Person or the Covered Person’s spouse including:
- Children up to the age of [nineteen (19)] who are either the birth children of the Covered Person or the Covered Person’s spouse or legally adopted by or placed for adoption with the Covered Person or Covered Person’s spouse irrespective of whether or not the adoption has become final, unmarried and dependent on the Covered Person for support and maintenance;
- Children under age [nineteen (19)] for whom the Covered Person or the Covered Person’s spouse is required to provide health care coverage pursuant to Qualified Medical Child Support Order and who are unmarried and dependent on the Covered Person for support and maintenance;
- Children up to the age [nineteen (19)] for whom the Covered Person or the Covered Person’s spouse is the court-appointed legal guardian and who are unmarried and dependent on the Covered Person for support and maintenance;
- Children [nineteen (19) or older] who are either the birth or adopted children of the Covered Person or the Covered Person’s spouse, are mentally or physically incapable of earning a living and who are chiefly dependent upon the Covered Person for support and maintenance, provided that: the onset of such incapacity occurred before age nineteen (19), proof of such incapacity and financial dependence is furnished to the Plan by the Covered Person upon enrollment of the person as a Dependent child or at the onset of the Dependent child’s incapacity prior to age nineteen (19) and annually thereafter after the two (2) year period following the Dependent child’s attainment of the attainment of the limiting age;
- Children [nineteen (19)] and older who become handicapped while a Full-time Student;

- Children under the age shown for dependent students in the definition of Eligible Child who are either the birth or adopted children of the Member, and are attending an accredited educational institution, defined as an educational institution which is eligible for payment of benefits under the Veterans Administration program, on a full-time basis. The Covered Person must provide documentation of such attendance to the Plan upon request. Coverage ends the last day of the month in which the Dependent attains the age shown in the definition of Eligible Child or is no longer enrolled in school on a full-time basis, whichever comes first.

Notwithstanding the above, a common law spouse qualifies as a spouse under this Agreement only if his or her spousal status is affirmed by a court of competent jurisdiction. A domestic partner qualifies as a spouse under this Agreement only by an attached Amendment.

**Notification of Change in Status** - A Covered Person must notify the Policyholder of any changes in status or the status of any Dependent within thirty-one (31) days after the date of the qualifying event. This notification must be submitted on a written Enrollment/Change Form to the Policyholder. Events qualifying as a change in status include, but are not limited to, changes in address, employment, divorce, marriage, dependency status, Medicare eligibility or coverage by another payer. The Plan should be notified within a reasonable time of the death of any Member.

**Termination of Coverage** - Covered Persons and/or Covered Dependents' coverage will end on when:

- the Covered Person loses eligibility under the Policyholder's eligibility requirements; or
- the end of the grace period, if the required premium payment is not paid by the end of the 31 day Grace Period; or
- Covered Dependent(s) cease to meet the requirements in the definition of Covered Dependent.

If coverage is terminated as described above, coverage for completion of a dental procedure requiring two or more visits on separate days will be extended for at least 90 days after the Covered Person's Termination Date in order for the procedure to be finished. The procedure must be started prior to the Covered Person's Termination Date. The procedure is considered "started" when the teeth are irrevocably altered. For example, for crowns, bridges and dentures, the procedure is started when the teeth are prepared and impressions are taken. For root canals, the procedure is started when the tooth is opened and pulp is removed.

**Continuation Coverage** - Certain employers may be required to meet certain criteria to offer continuation coverage to Covered Persons for a specified time upon termination of employment or reduction of work hours for any reason other than gross misconduct. The Policyholder will notify the Covered Person if applicable. If this requirement does apply, the Covered Person must elect to continue coverage for themselves [and for Covered Dependents] within 60 days from the qualifying or notification of rights by the Policyholder, whichever is later. The Covered Person must pay the required premium for continuation of coverage. Coventry Dental is not responsible for determining who is eligible for continuation coverage.

**Certificates of Coverage; 30 Day Right to Examine Certificate** - Coventry will provide to the Policyholder, for delivery to each Covered Person, a statement that summarizes the essential features of the coverage and that indicates to whom benefits under the policy are payable. If a Covered Person does not like the Certificate for any reason, it may be returned to us within 30 days after receipt. We will return any premium that has been paid. In that case, the Certificate will be void as if it had never been issued.

**Contestability of Coverage** - The Policy may not be contested, except for non-payment of premiums, after it has been in force for two years from the date of issue. A statement made by any person covered under the policy relating to insurability may not be used in contesting the validity of the coverage with respect to which the statement was made after the coverage has been in force before the contest for a period of two years during the person's lifetime. Absent fraud, each statement made by an applicant, Policyholder, or Covered Person is considered to be a representation and not a warranty. A statement made to effectuate the Policy may not be used to avoid the coverage or reduce the benefits under the Policy unless the statement is contained in a written instrument signed by the Policyholder or Covered Person and a copy of the statement is given to the Policyholder, Covered Person or beneficiary of the Covered Person. This provision does not preclude the assertion at any time of defenses based upon the person's ineligibility for coverage under the Policy or upon other provisions in the Policy.

**Notice of Claim** - Written notice must be given within 20 days after treatment or as soon as reasonably possible. Notice can be given to Coventry at our home office at Rockville, Maryland, or to our agent. Notice should include the Covered Person's name, address and group policy number. Coventry may not invalidate or reduce a claim if it is

shown that it was not reasonably possible to give notice within 20 days and notice was given as soon as was reasonably possible.

**Claim Forms** - Coventry will provide claim forms for filing Proof of Loss to each claimant or to the Policyholder for delivery to the claimant. If Coventry does not provide the claim forms within 15 days after Notice of Claim is received, the claimant is considered to have complied with the requirements of the policy as to Proof of Loss if the claimant submits within the time fixed in the Policy for filing proof of loss, written proof of the occurrence, character, and extent of the loss for which the claim is made.

**Proof of Loss** - Written proof, satisfactory to us, must be given to us within 90 days after the date of loss. If that is not reasonably possible, we will not deny or reduce any claim if proof is furnished as soon as reasonably possible except in the absence of legal capacity, not later than 1 year from the time proof is otherwise required.

**Time of Payment of Claims** - Benefits payable under the group policy for any loss will be paid not more than 30 days after written receipt of Proof of Loss. We reserve the right to request x-rays, narratives and other diagnostic information, as we see fit, to determine benefits.

**How To Submit Claims:** - Claims submitted to Coventry must identify the treatment rendered using the American Dental Association Uniform Code on Dental Procedures and Nomenclature or by narrative description. We reserve the right to request x-rays, narratives and other diagnostic information, as we see fit to determine benefits.

**Overpayment Recovery:** Coventry reserves the right to deduct from any benefits properly payable under this Policy the amount of any payment that has been made:

1. in error; or
2. pursuant to a misstatement contained in a proof of loss; or
3. pursuant to fraud or misrepresentation made to obtain coverage under this Policy within two (2) years after the date such coverage commences; or
4. with respect to an ineligible person; or
5. pursuant to a claim for which benefits are recoverable under any Policy or act of law providing coverage for occupational injury or disease to the extent that such benefits are recovered.

Such deduction may be against any future claim for benefits under the Policy made by a Covered Person if claim payments previously were made with respect to a Covered Person.

**Payment of Claims** - All benefits will be paid to the Covered Person unless assigned by the Covered Person to the Provider. Only one claim amount will be paid for each covered procedure. Any benefits unpaid at the time of the Covered Person's death will be paid in one lump sum to the Covered Person's estate.

**Legal Actions** - No action at law or in equity shall be brought to recover benefits under the group policy less than 60 days after written Proof of Loss has been furnished as required by the Policy. No such action shall be brought more than 3 years after the time written Proof of Loss is required to be furnished.

**Governing Law** - This Policy is governed by Arkansas law (to the extent not preempted by ERISA) and Arkansas Courts. Any provision of this policy which, as of its effective date, is in conflict with the laws of Arkansas is amended to conform to the minimum requirements of such laws.

**Complaints and Notices** - Complaints and Notices should be sent to:

Coventry Dental  
c/o Group Dental Service, Inc.  
111 Rockville Pike, Suite 950  
Rockville, MD 20850  
Attn: Member Services  
[1-866-433-6391]

#### **COORDINATION OF BENEFITS (COB)**

Coordination of Benefits (COB) will apply when a Covered Person is covered for dental benefits under more than one Plan. "Plan" is defined below under Plans Considered for COB.

If this COB provision applies, the Order of Benefit Determination Rules below should be looked at first. Those rules determine whether this Policy is a Primary Plan or a Secondary Plan. A "Primary Plan" means the Plan that pays benefits or provides services first under the rules. A "Secondary Plan" is any Plan that is not a Primary Plan. When there are more than two Plans covering the Covered Person, this Policy may be: a Primary Plan as to one or more other Plans; and a Secondary Plan as to a different Plan or Plans.

If the Policy is:

1. a Primary Plan, COB will not apply and benefits will not be reduced; or
2. a Secondary Plan, COB will apply, and benefits may be reduced so that the total payment from all Plans will not exceed 100% of total Allowable Expenses. This reduction is described under Effect on Benefits below.

### **Plans Considered for COB**

"Plan" is any of the following that provides benefits or services for or because of dental care or treatment:

1. group; blanket or franchise insurance; or other group type coverage, whether insured or uninsured;
2. union welfare plans; employer organization plans; or labor management trustee plans; or
3. coverage under a governmental plan; or coverage required or provided by law. This does not include benefits payable under any state plan under:
  - a. Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time); or
  - b. any plan when, by law, its benefits are in excess of those of any private insurance plan or other non-governmental plan.

Each contract or other arrangement for coverage under 1. through 3. is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

"Plan" will not include:

1. individual or family policies; or individual or family subscriber contracts; this includes: prepayment; service; group practice; or individual practice coverage; or
2. school accident type coverage.

### **Order Of Benefit Determination Rules**

#### **General**

When there is a basis for a claim under this Policy and another Plan, this Policy is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

1. the other Plan has rules coordinating its benefits with those of this Policy; and
2. both those rules and this Policy's COB Rules require that this Policy's benefits be determined before those of the other Plan.

#### **Rules**

This Policy determines its order of benefits using the first of the following rules which applies:

1. Non-Dependent/Dependent. The benefits of the Plan which covers the individual as an employee, Person or subscriber (that is, other than as a Dependent) are determined before those of the Plan which covers the individual as a Dependent.

2. Dependent Child/Parents not Separated or Divorced. Except as stated in Rule 3., when this Policy and another Plan cover the same child as a Dependent of different individuals, called "parents":
  - a. the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year;
  - b. but, if both parents have the same birthday, the benefits of the Plan that covered one parent longer are determined before those of the Plan that covered the other parent for a shorter period of time;
  - c. however, if the other Plan:
    - i. does not have this "birthday rule"; but
    - ii. has a rule based upon the gender of the parent; and

if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

3. Dependent Child/Parents Separated or Divorced. If two or more Plans cover a child as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
  - a. first, the Plan of the parent with custody of the child;
  - b. then, the Plan of the spouse of the parent with the custody of the child; and
  - c. finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state:

- a. that one of the parents is responsible for the health care expense of the child; and
- b. the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms,

the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any:

- a. Claim Determination Period; or
- b. Plan Year;

during which any benefits are actually paid or provided before the entity has the actual knowledge.

4. Active/Inactive Employee. The benefits of a Plan which covers the individual as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Plan which covers the individual as a laid off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this Rule 4. is ignored.
5. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, [Person] or subscriber longer are determined before those of the Plan which covered the employee, [Person] or subscriber for the shorter term.

### **Effect on Benefits**

COB applies to this Policy when, in accordance with the Order of Benefit Determination Rules, this Policy is a Secondary Plan as to one or more other Plans. In that event, the benefits of this Policy may be reduced under this COB provision. Such other Plan or Plans are referred to as "the other Plans" immediately below.

### **Reduction In This Policy's Benefits**

The benefits of this Policy will be reduced when the sum of:

1. the benefits that would be payable for the Allowable Expense under this Policy in the absence of this COB provision; and

2. the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made;

exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of this Policy will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of this Policy are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Policy.

“Allowable Expense” means an expense that is considered a covered charge, at least in part, by one or more of the Plans. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

“Claim Determination Period” means the year defined in the Schedule of Benefits. However, it does not include any part of a year during which an individual has no coverage under this Certificate, or any part of a year before the date this COB provision or a similar provision takes effect.

### **Right to Receive and Release Needed Information**

Certain facts are needed to apply these COB rules. Coventry has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or individual. Coventry need not tell, or get the consent of, any individual to do this. Each Covered Person claiming benefits under this Policy must give Coventry any facts it needs to pay the claim.

### **Facility of Payment**

A payment made under another Plan may include an amount which should have been paid under this Policy. If it does, Coventry may pay that amount to the organization which made that payment. That amount will then be treated as though it was a benefit paid under this Policy. Coventry will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means reasonable cash value of the benefits provided in the form of services.

### **Right of Recovery**

If the amount of the payments made by Coventry is more than it should have paid under this COB provision, it may recover the excess from one or more of:

1. the individuals it has paid or for whom it has paid;
2. the insurance companies; or
3. the other organizations.

The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

## **DENTAL BENEFITS**

All Benefits will be paid after the Covered Person satisfies any applicable Waiting Period and an Annual Deductible up to an Annual Maximum. All Benefits are subject to the Exclusions and Limitations set forth in the Policy.

Benefit Percentages are set forth in the Schedule of Benefits.. Benefits are calculated using a Maximum Allowable Charge. The Maximum Allowable Charge is a rate established by us based upon data provided by Ingenix. You may call customer service at the telephone number listed on your identification card to find out the Maximum Allowable Charge for a particular dental procedure code.

Covered Persons are responsible for amounts charged by the provider that exceed Benefits, and may be required to remit payment at the time of service. Billing arrangements are between the Covered Person and the Provider.

There is no dental network associated with this Dental Plan. A Covered Person may seek care from any Provider.

### **Pre-authorization**

Pre-authorization is **required** for the following procedure types:

Inlays, Onlays, Crowns

Root canals, Root canal retreatment

Periodontal Surgery

Periodontal scaling and root planning

Full dentures, partial dentures, fixed bridges

Implants

Third molar extractions

Complete occlusal adjustments

Documentation, including diagnostic quality radiographs, periodontal charting and other appropriate visual or written narrative should be sent with proposed treatment. If treatment is done without prior Pre-authorization approval, and documentation is submitted with a claim for payment, this claim may not be paid.]

### **Predetermination of Benefits**

If the charge for any treatment is expected to exceed [\$500], Coventry Dental **STRONGLY** suggests that a dental treatment plan be submitted to us by your dentist for review before treatment begins. This process is called predetermination and is separate and different from Pre-authorization. This may be helpful to estimate both the benefits available and your anticipated out of pocket expense. Predetermination is optional and not a requirement for use of benefits

The proposed services will be reviewed and a predetermination of benefits statement will be issued to the Covered Person or the Provider detailing the benefits that will be covered by Coventry Dental. The predetermination is good for 180 calendar days.

Payment will be subject to the plan benefits (e.g. Annual Maximums), limitations and exclusions in force at the time the claim is submitted. Predetermination of benefits is also subject to the Alternate Benefit Provision.

### **Alternate Benefit Provision**

Many dental problems can be resolved in more than one way. If: 1) we determine that a less expensive alternative benefit could be provided for the resolution of a dental problem; and 2) that benefit would produce the same resolution of the diagnosed problem within professionally acceptable limits, we may use the less expensive alternative benefit to determine the amount payable under the Certificate. For example: When an amalgam filling and a composite filling are both professionally acceptable methods for filling a molar, we may base our benefit on the amalgam filling which is the less expensive alternative benefit.

### **Services Performed Outside The United States of America**

Any Claim submitted for procedures performed outside the U.S.A. must: (1) be for a Covered Procedure, as defined; (2) be supplied in English; and (3) **use American Dental Association (ADA) codes** or provide a narrative of the services received. Reimbursement will be based on the Maximum Allowable Charge for the Group's zip code

## **LIMITATIONS AND EXCLUSIONS**

[A]. **[MISSING TEETH LIMITATION:** Administrator will not pay benefits for the initial placement of a full denture, partial denture, fixed bridge or implant to replace teeth extracted or missing on or before a Covered Person's effective date. The missing teeth limitation will be waived after the Covered Person has been covered under the plan for twelve (12) continuous months.]

[B.] **[WORK IN PROGRESS:** Dental procedures begun prior to the Covered Person's effective date of coverage are not covered. Examples include, but are not limited to, teeth prepared for crowns, root canal treatment in progress.]

No benefits are payable under the Policy for the procedures listed below unless such procedure or service is listed as covered in the Schedule of Covered Procedures.

All Benefits are subject to the following exclusions and limitations and frequency limits:

#### General

- (1) Coverage is limited to those services set forth in the Schedule of Covered Procedures. If a service is not listed, it is not included **and is not covered**.
- (2) Treatment to restore tooth structure lost due to attrition, erosion, abfraction or abrasion **is not covered**.
- (3) Where two or more professionally acceptable dental treatments for a dental condition exist, the Plan bases reimbursement on the least **expensive alternative treatment (LEAT)**.
- (4) Services furnished solely for cosmetic reasons **are not covered**.
- (5) [Any service or supply for which You have no financial liability or that was provided at no charge; those Dental Services for which the Member has no legal obligation to pay or for which a charge would not ordinarily be made in the absence of Coverage under the Dental Plan.
- (6) **Any services related to implants including implant removal, repair, restoration or placement.]**
- (7) Fees related to broken appointments, preparing or copying dental reports, duplication of x-rays, itemized bills or claim forms **are not covered**.
- (8) Treatment for injuries or conditions covered by Workers' Compensation or employer liability laws, and treatment provided without cost to the covered Person by any municipality, county, or other political subdivision **is not covered**. This exclusion does not apply to any treatment covered by Medicaid or Medicare.
- (9) Treatment as a result of, civil insurrection, duty as a member of the armed forces of any state or country, engaging in an act of declared or undeclared war, intentional or unintentional nuclear explosion or other release of nuclear energy, whether in peacetime or wartime **is not covered**.
- (10) Treatment of congenital or developmental malformations or the replacement of congenitally missing teeth **is not covered**.
- (11) [Examination, evaluation and treatment of temporomandibular joint (TMJ) pain dysfunction **is not covered**].
- (12) Treatment of jaw fractures or orthognathic surgery **is not covered**
- (13) Consultations and/or evaluation for non-covered services **is not covered**
- (14) Services and/or appliances that alter the vertical dimension or alter, restore or maintain the occlusion including, but not limited to full mouth rehabilitation, splinting, appliances or any other method **is not covered**.
- (15) Removal and replacement of clinically acceptable material or restorations with alternative materials, for any reason except the pathological condition of the tooth or teeth, **is not covered**.
- (16) Replacement of fixed or removable bridges or orthodontic appliances that have been lost, stolen or damaged due to patient abuse or misuse **is not covered**
- (17) Periodontal splinting of teeth by any method **is not covered**.
- (18) Analgesia, anxiolysis, inhalation of nitrous oxide or non-intravenous sedation **is not covered**.

- (19) Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature **is not covered.**
- (20) Any outpatient facility, surgicenter facility, or inpatient hospital facility and associated facility charges, services and supplies **is not covered**
- (21) House, extended care facility calls, hospital calls, office visits for observation (during regularly scheduled hours) when no other services are provided, office visits after regularly scheduled hours or case presentations **is not covered.**
- (22) Drugs obtainable with or without a prescription **are not covered.**
- (23) Fees for equipment sterilization, OSHA or other regulatory agency requirements or mandates, infection control, and medical waste disposal **is not covered**
- (24) Treatment that is not described by the most recent (current edition) of the American Dental Association (ADA) CDT (current dental terminology) book **is not covered.**
- (25) Any treatment covered under an individual or group medical plan, auto insurance, no fault auto insurance or uninsured motorist policy to the extent permitted by state statute **is not covered.**

Diagnostic & Preventive

- (26) Oral evaluation (comprehensive or periodic) and prophylaxis, including scaling and polishing is limited to [twice per year] [Once every six (6) months per year]. Comprehensive oral evaluation is limited to [once per thirty six (36) months].
- (27) Bitewing x-rays are limited to [once] every [twelve (12) months].
- (28) Full mouth x-rays (complete intraoral series) are limited to [once] every [thirty six (36) months],
- (29) When a combination of x-rays (i.e. ten or more periapical x-rays or panoramic x-ray with bitewing x-rays) is done on the same date of service where the reimbursement meets or exceeds the reimbursement for full mouth x-rays, the plan reimbursement and benefit allocation will be based on full mouth x-rays.
- (30) Prophylaxis if performed on the same date of service with periodontal treatment **is not covered.**
- (31) For Eligible [Covered Dependents] (age [14] and under) fluoride [once] every [twelve (12) months].
- (32) Sealants for Eligible [Covered Dependents] (age [14] and under) [once] per 1<sup>st</sup> and 2<sup>nd</sup> permanent molar once every [thirty six (36) months].
- (33) Space maintainers for Eligible [Covered Dependents] (age [14] and under) [once] per lifetime per space.

Restorative

- (34) Amalgams and Composites are limited to [one] restoration allowed per surface every [thirty six (36) months].
- (35) Core Build Ups are limited to [once] every [eighty-four (84) months].
- (36) Post and Cores are limited to [once] every [eighty-four (84) months].
- (37) Crowns, inlays and onlays are limited to [once] per tooth per [eighty-four (84) months] following date of final cementation.
- (38) Core build ups, post and cores, crowns, inlays or onlays treatment on teeth exhibiting poor periodontal prognosis **are not covered.**

- (39) Reimbursement for post and cores, crowns, inlays or onlays will be based on the date of final cementation.

#### Endodontics

- (40) Root canals are limited to [once] per tooth per lifetime. Re-treatment of root canal is limited to not more than [once] per tooth per lifetime and not sooner than [twenty four (24) months] after the initial root canal for the same tooth.
- (41) Reimbursement for root canal treatment will be based upon the date of the final fill.
- (42) Endodontic treatment on teeth exhibiting poor periodontal prognosis **is not covered**.
- (43) Intentional endodontic treatment on teeth for the express purpose providing for restorative treatment (i.e. crown) where there is no sign of injury or disease **is not covered**.

#### Periodontics

- (44) Periodontal surgery is limited to [**once per quadrant per thirty six (36) months**].
- (45) Crown lengthening is limited to [once] per tooth per lifetime. This procedure **is not covered** when done on the same date as a restoration on the same tooth.
- (46) Periodontal scaling and root planing is limited to [once] per quadrant every [twenty-four (24) months].
- (47) Full mouth gross debridement is limited to [once] per [thirty six (36) months].
- (48) Periodontal maintenance is limited to [two] per [twelve (12) month period] following active periodontal treatment (excluding gross debridement)
- (49) Gingivectomy/gingivoplasty or anatomical crown exposure **is not covered** when done on the same date as a restoration on the same tooth.
- (50) Bone grafting or guided tissue regeneration an extraction site or with endodontic surgical procedures **is not covered**.

#### Prosthodontics (Removable & Fixed)

- (51) Full dentures, partial dentures and fixed bridges are limited to [once] every [eighty four (84) months]. The [eighty four month] period shall be measured from the date on which the appliance was seated, whether paid for under the provisions of this Policy, under any prior dental care contract or by the Member.
- (52) Full dentures, partial dentures and fixed bridges are not covered for any person under the [age of 18].
- (53) Retreatments, Relines, Rebases, Replacements, or Repairs are **not covered** within [six (6) months] of the date of final insertion of the full or partial denture. [Benefits for denture repair will be limited to no more than half the cost of the Provider fee for a new denture.]
- (54) Relines and rebases of existing removable dentures no more than [once] per [thirty-six (36) month period].
- (55) Replacement of all teeth and acrylic on cast metal framework is limited to [once] per [thirty-six (36) month] period.
- (56) Interim complete dentures and interim partial dentures may not be replaced for a [twelve (12) month period].

(57) Reimbursement for full dentures, partial dentures and fixed bridges will be based upon the date of final insertion or cementation.

#### Oral & Maxillofacial Surgery

(58) Extractions of 3rd (wisdom teeth) molars under age 16 are **not covered**.

#### Orthodontics

(59) [Orthodontia coverage – limited to Lifetime Maximum. Orthodontics for cosmetic reasons is not covered.]

#### Adjunctive General Services

(60) Palliative treatment **is** covered as a separate benefit only if no other service other than exam and x-rays were done during the visit. Palliative treatment may only be rendered on an emergency basis for the relief of pain and cannot be billed as a separate charge if the underlying dental problem is corrected on the same date of service.

(61) General anesthesia or intravenous conscious sedation **is covered for** a maximum of one hour.

(62) Consultations performed by a General Dentist or Specialist **are not covered** if the dental procedure is performed on the same date of service by that General Dentist or Specialist. Consultation should already be included with the dental procedure.

## RESOLVING COMPLAINTS AND GRIEVANCES

### Complaints and Inquiries

**Investigation Upon Receipt of a Complaint or Inquiry by Telephone:** If You have a Complaint or Inquiry, You may submit it by telephone. When this is done, the Member Services representative will forward the issue to the Appeals Department. We will make every effort to resolve the issue within ten (10) working day. In some cases, however, it may take as long as fifteen (15) working days or more from the date of the call for resolution.

**Written Inquiries:** You may submit a written Inquiry to the Appeals Department. You will be sent an acknowledgement letter within three (3) working days of the original receipt of the Inquiry. When this is done, you will receive resolution of the Inquiry within thirty (30) calendar days.

**Written Complaints:** You may submit a Complaint in writing to the Appeals Department. You will be sent an acknowledgement letter within ten (10) working days of the original receipt of the Complaint. The investigation of the Complaint will be completed within twenty (20) working days of original receipt of the Complaint unless you receive notice from the Plan that additional time is required. Within five (5) working days after the completion of the investigation, You and Your Authorized Representative will be notified of the resolution of the Complaint.

Our address and phone number are as follows:

Coventry Dental  
c/o Group Dental Service, Inc.  
Attn: Appeals Department  
111 Rockville Pike, Suite 950  
P.O. Box 6228  
Rockville, MD 20849  
[Phone: 1-866-690-4908]

### Appeals

**Notice of Appeal:** If You wish to submit an Appeal, You should contact the Appeals Department in writing. If You prefer, You may also request information by contacting Member Services by telephone. (However, a formal Appeal must be submitted in writing within 180 days of an Adverse Benefit Determination and must include the following information:

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- Member name;
- Provider name;
- Date(s) of service;
- Member's and/or Member's Authorized Representative's mailing address;
- Clear indication of the remedy or corrective action being sought and an explanation of why the Plan should "reverse" the Adverse Benefit Determination;
- Copy of documentation to support the reversal of decision, e.g. Emergency details, date, time, symptoms and
- In cases where the Member's Authorized Representative is appealing on behalf of the member, a completed Member Designated Release of Information form, which can be obtained by calling the Member Services Department

Requesting information by telephone does not constitute filing an Appeal.

**Pre-Service Appeal Review:** A pre-service Appeal may be requested by You or Your Authorized Representative but must be submitted in writing within 180 days of an Adverse Benefit Determination.

Within thirty (30) calendar days after the receipt of the Appeal, the Plan will notify You and Your Authorized Representative in writing of the Plan's decision regarding the Appeal and of Your right to file an Appeal for a second-level review.

**Post-Service Appeal Review:** A Post-Service Appeal may be requested by You or Your Authorized Representative but must be submitted in writing within 180 days of an Adverse Benefit Determination.

Within sixty (60) calendar days after the receipt of the Appeal, the Plan will notify You and Your Authorized Representative in writing of the Plan's decision regarding the Appeal and of Your right to file an Appeal for a second-level review.

**Urgent Care Appeal Review:** An Urgent Care Appeal may be requested by You or Your Authorized Representative but must be submitted in writing within 180 days of an Adverse Benefit Determination. For Appeals satisfying the definition of an Urgent Care Appeal you may request an expedited Appeal of a Plan decision verbally or in writing. Within a reasonable period of time not to exceed seventy-two (72) hours of receiving a valid request for an Urgent Care Appeal, the Plan will verbally notify You of its decision. The Plan will then send a written confirmation of its decision within the following three (3) working days.

**External Review:** If You or Your Authorized Representative are not satisfied with the decision of the Plan and have exhausted the internal appeal process, You or Your Authorized Representative may request an external review in writing or via electronic media within sixty (60) days after receipt of the Plan's decision. The Independent Review Organization assigned will be chosen from a list compiled and maintained by the Arkansas Insurance Department.

Within five (5) business days after receipt of the request for an external review, You or Your Authorized Representative and treating Physician will be notified in writing whether the request is complete and if the request has been accepted for external review.

- If the request is not complete, the notice will include the information needed to make the request complete. The additional information must be submitted within seven (7) business days following receipt of the notice.

Within forty-five (45) calendar days after receipt of the request for an external review, the Independent Review Organization shall provide written notice of its decision to uphold, reverse, or partially uphold or reverse the Adverse Benefit Determination to You or Your Authorized Representative, treating Physician and the Plan.

- If the Independent Review Organization has overturned any portion or all of the Adverse Benefit Determination, the Plan shall immediately approve the Coverage that was the subject of the Adverse Benefit Determination.

You or Your Authorized Representative may request an expedited external review. Within seventy-two (72) hours of the request, the Independent Review Organization will make a decision to uphold or reverse the Adverse Benefit Determination and notify You or Your Authorized Representative, the treating Physician and the Plan.

- An expedited external review may not be provided for Adverse Benefit Determinations involving a Retrospective Review.

Except in the case of a request for an expedited external review, at the time of filing a request for an external review, You or Your Authorized Representative shall submit to the Independent Review Organization a filing fee of [\$25] along with the information and documentation to be used by the Independent Review Organization conducting the external review.

At any time during the external review process and upon receipt of additional information, the Plan may reconsider its Adverse Benefit Determination.

- The external review process will be terminated; and
- The Plan will immediately notify You or Your Authorized Representative, treating Dentist and the Independent Review Organization of its decision.

The following Group types – churches, city and county governments – are regulated by state law and are not subject to the Department of Labor regulations. The timeframes for these Appeals are within twenty (20) working days for both Pre and Post Service Appeals. All other timeframes are the same as cited in the preceding sections.

**Insurance Department:** The Member, Member’s Authorized Representative, or a Dentist acting on behalf of a Covered Person has the right to contact the Insurance Department at any time in this process.

Arkansas Insurance Department  
1200 West Third Street  
Little Rock, Arkansas 72201-1904  
1-800-852-5494  
Or  
1-501-371-2640



COVENTRY HEALTH AND LIFE INSURANCE COMPANY  
COVENTRY DENTAL

[ABC POLICYHOLDER]

# COVENTRY DENTAL

Underwritten by  
Coventry Health and Life Insurance Company  
6705 Rockledge Drive, Ste 900  
Bethesda, MD 20817

## CERTIFICATE OF COVERAGE

This Certificate of Coverage provides important information about the dental care services available to you as an Eligible Person of the Policyholder and any Covered Dependents which have enrolled in the Coventry Dental Plan ("Coventry Dental", "Dental Plan"). Because this certificate is only a summary of the Dental Plan, you must consult the Policy for the exact terms and conditions.

This certificate is part of the Group Policy. The Policy is underwritten by Coventry Health and Life Insurance Company and administered by Group Dental Service, Inc. ("GDS"). Inquiries regarding the Policy may be directed to:

Coventry Dental  
c/o Group Dental Service, Inc.  
111 Rockville Pike Ste# 950  
Rockville, MD 20850  
Attn: Member Services  
[1-866-690-4908]

### DEFINITIONS

Whenever used in this certificate:

**Affiliated Companies** means Coventry Health and Life Insurance Company's parent company is Coventry Health Care, Inc. ("Coventry"). Coventry is the parent company of several managed care companies, health maintenance organizations, insurance companies, third party administrators and network rental companies. Coventry and its subsidiaries are considered Affiliated Companies of Coventry Health and Life Insurance Company. These Affiliated Companies include, but are not limited to, Coventry Health Care of Arkansas, Group Health Plan Inc. and Group Dental Service, Inc.

**Annual Deductible** means the amount set forth in the Schedule of Benefits which each Covered Person must pay each year before benefits will be paid. [The maximum Annual Deductible per family is three (3) times the Individual Deductible as set forth in the Schedule of Benefits.]

**Annual Maximum** means the total amount of benefits that will be paid in a year as set forth in the Schedule of Benefits to the Covered Person. [Benefits for Orthodontia do not count to the Annual Maximum.]

**Benefit** means the amounts payable by us, as set forth in the Schedule of Benefits.

**Benefit Period** means the 12 month duration of benefits following the effective date of the Certificate.

**Benefit Year** means the 12 months following the effective date of the Certificate.

**Calendar Year** means January 1<sup>st</sup> through December 31<sup>st</sup>.

**Certificate; Certificate of Insurance** means the document describing Covered Services, Coinsurance, Deductibles, limitations and exclusions. The Schedule of Benefits is an integral part of the Certificate of Insurance.

**Child(ren)** includes any natural child, stepchild, and adopted child on the date the child is placed in Your custody; the date You are legally or financially responsible for the child, or the date of the filing of a petition for adoption, whichever date is earlier.

**Coinsurance** means a specified percentage of the Allowable Charge that You must pay as a condition of the receipt of certain services as provided in this Certificate of Insurance. Specific Coinsurance amounts are listed in the Schedule of Benefits. In some circumstances, the Allowable Charge will be more than the charges the Provider has billed for the Covered Services. In these cases, You will still be responsible for Coinsurance based on the Allowable Charge.

**Cosmetic Dentistry** - aesthetic improvement of the color and shape of teeth performed by a general dentist.

**Coventry Dental** means the dental product of Coventry Health and Life Insurance Company administered by Group Dental Service, Inc.

**Covered Dental Service** means a procedure listed in the attached Schedule of Benefits. If a procedure is not listed, it will not be covered under the Policy. All procedures are subject to the Exclusions and Limitations set forth in the Certificate.

**Covered Dependent** means an Eligible Dependent that is covered under this Certificate.

**Coventry Health and Life Insurance Company (the Company, We, Us, or Our)** means the insurance company licensed in Arkansas and domiciled in Delaware. The address of the administrative offices is 6705 Rockledge Drive, Suite 900, Bethesda, MD 20817. The Company is subject to regulation in Arkansas by the Arkansas Department of Insurance.

**Covered Person** means a person covered under this certificate.

**Deductible** means the amount a Covered Person and/or a Family must pay toward Covered Dental Services before Coventry Dental begins paying for services. The Schedule of Benefits lists the Deductible that applies to you.

**Effective Date** means the date your coverage begins under this Certificate.

**Eligible Child** means any unmarried Child(ren) of the Eligible Person:

- a) until the end of the calendar month in which he/she reaches [19] and who is primarily dependent on You for support and maintenance; or
- b) until the end of the calendar month in which he/she reaches [25] if a full-time student (written proof is required); or
- c) to any age if he/she continues to be both incapable of self-sustaining employment by reason of mental or physical incapacity and chiefly dependent upon the Covered Person for maintenance and support. Proof must be provided.

**Eligible Dependent** means any spouse and Eligible Child.

**Eligible Person** means a person as determined by the Policy and Policyholder and set forth in the application for insurance.

**Employee** means one who works for a Group, receives wages or salary, and who is regularly scheduled to work those hours per week and months per year as indicated in the Group Policy, thereby making that Employee eligible for Covered Services under the terms of the Plan.

**Enrollment/Change Form** means Our form which You complete before Your effective date. This form allows You to have coverage through Us.

**Experimental/Investigational** means drugs or procedures not recognized by the United States Food and Drug Administration, the United States Public Health Service, Medicare, and the Dental Director as universally accepted treatment.

**Family** means the Eligible Person, spouse and Eligible Child.

**Group** means persons or entity serving as the Policyholder.

**Group Application** means the document completed by the Employer to enroll in dental coverage.

**Group Policy** means the contractual agreement the Company enters into with the Member's employer for dental care coverage. The policy consists of the Group Policy, the Group Application and any attachments and/or amendments to the application or policy, the Enrollment/Change Forms, and Schedule of Benefits, as well as this Certificate of Insurance. The Policyholder is the Eligible Person's employer and is listed in the Group Policy.

**Lifetime Maximum** means the total amount of benefits payable by the Company for each Covered Individual. This maximum is for the length of the coverage under this Group Policy. Specific Lifetime Maximum amounts are listed in the Schedule of Benefits.

**Medically Necessary/Medical Necessity** means those Covered Services determined by Us to be:

- a. Medically appropriate, so that expected health services (such as, but not limited to, increased life expectancy, improved functional capacity, prevention of complications, relief of pain) materially exceed the expected health risks;
- b. Necessary to meet the health needs of the Covered Person, improve physiological function and required for a reason other than improving appearance;
- c. Rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service;
- d. Consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical research, professional medical specialty organizations or governmental agencies that are generally accepted as national authorities on the services, supplies, equipment or facilities for which coverage is requested;
- e. Consistent with the diagnosis of the condition at issue;
- f. Required for reasons other than the comfort or convenience of the Covered Person or his or her Provider; and
- g. Not experimental or investigational as determined by Us.

The fact that a Provider may prescribe, recommend, order, or approve a service or supply does not of itself determine Medical Necessity or make such service or supply a covered service.

**Member Service Department** means the Company's Member Service Department, which includes services for Covered Individuals. The number for the Member Service Department is located on Your ID card.

**Network Providers** refers to dentists that have contracted with Coventry Dental or partners of Coventry Dental to charge negotiated fees for each Covered Service.

**Non-Participating Provider** refers to providers that have directly or indirectly executed an agreement with Coventry Dental or partners of Coventry Dental to participate in its network.

**Out-of-Network refers** to the payment level for services received from a Non-Participating Provider.

**Out-of-Network Rate** means the maximum amount Covered by the Plan for approved Out-of-Network services. The Out-of-Network Rate will be determined by the Plan. You are responsible for charges that exceed the Plan's Out-of-Network Rate for Non-Participating Providers. This could result in You having to pay a significant portion of Your claims. You may call customer service at the telephone number listed on Your identification card to find out the Out-of-Network Rate for a particular dental procedure code.

**Premiums** means the amounts stated in the Group Application which must be remitted to Coventry Dental for Covered Persons during the term of the Certificate.

**Policyholder** means the entity identified in the Policy and on the Certificate Cover.

**Preauthorization** means approval by the Company that is required for payment for certain services to be performed. Preauthorization does not guarantee payment if the Covered Individual is not covered at the time the service is provided. Preauthorization does not guarantee payment at the In-Network benefit level for services rendered by Non-Participating Providers.

**Provider** means a practitioner of dentistry duly licensed by the State Board of Dental Examiners acting within the scope of his license. Provider does not include: the Covered Person or the Covered Person's spouse; or the Covered Person or the Covered Person spouse's child, parent, brother, sister, or a person living with the Covered Person.

**Prudent Layperson** means a person who is without medical training and who draws on his or her practical experience when making a decision regarding whether emergency medical treatment is needed. A Prudent Layperson will be considered to have acted "reasonably" if other similarly situated laypersons would have believed, on the basis of observation of the medical symptoms at hand, that emergency medical treatment was necessary.

**Qualified Medical Child Support Order**("QMCSO") means an order from a court of competent jurisdiction or a state agency stating that the Policyholder or Eligible Person is responsible for providing coverage under Coventry Dental. You should contact Your Policyholder for answers to any questions You have with respect to a QMCSO.

**"Retiree"** means a former Eligible Employee of the Group who meets the Group's definition of retired employees to whom the Group offers Coverage under this *Certificate of Insurance*.

**Schedule of Benefits** means a schedule of covered benefits, fully discussed in this *Certificate of Insurance* and the Group Policy, which delineates the Covered Individual's Coinsurance, Deductibles, out-of-pocket maximums, and other benefit limitations. The Schedule of Benefits is included with this *Certificate of Insurance*.

**Utilization Management Policies** means the evaluation of the appropriateness, medical need and efficiency of the proposed dental care service procedures. Such procedures include pre-authorization, pre-determination and alternate benefit provision.

**Waiting Period** means the time each Covered Person must be enrolled under the Certificate before benefits will be paid for each classification of services as set forth in the Certificate Schedule. The Waiting Period does not apply to Diagnostic I and Preventative Services.

**You/Your** means a Covered Individual covered under this *Certificate of Insurance*

## GENERAL PROVISIONS

### Eligibility and Enrollment

**New Enrollment** - The Policyholder shall determine which of its employees, associates or members are eligible to enroll in Coventry. The Policyholder shall be responsible for providing eligibility information to Coventry on a timely basis in an agreed upon format. Where the Policyholder provides eligibility information of any kind, including but not limited to electronic data, tapes or software, the data must be accurate and accessible.

If the Eligible Person has already satisfied the Policyholder's eligibility requirements when the Policy begins and the Eligible Person's enrollment information is supplied to us, coverage will begin on the Effective Date of the Policy, provided we receive the Premium.

If an individual joins the Group or becomes employed after the initial Effective Date of the Policy, in order to be eligible to enroll, the individual must first satisfy any eligibility requirements of the Policyholder. An Eligible Person must supply the enrollment information on themselves [and their Eligible Dependents] within 31 days of the date the Eligible Person meets these requirements. Coverage will begin on the date specified in the Policy Schedule provided Premium is paid.

[Dental procedures begun prior to the Covered Person's effective date of coverage are excluded for [twelve (12) months] following the Covered Person's effective date. Examples include, but not limited to the following: crowns, the procedure is started when the teeth are prepared. For root canals, the procedure is started when the tooth is opened and pulp is removed.] Procedures started prior to the Covered Person's effective date are the liability of the Covered Person or a prior insurance carrier during the exclusion period.

**Enrollment Changes** - After initial enrollment, there are certain Life Change Events that permit a Covered Person to change their coverage or enroll Eligible Dependents. These events include:

- Marriage;

- Divorce or Legal Separation;
- Birth or Adoption of a child;
- Death of a Spouse or Child;
- Court order of placement or custody;
- Change in Student Status for a Child;
- Change in Employment Status.]

**Late Enrollment** - If an Eligible Person [or their Eligible Dependent] are not enrolled within 31 days of initial eligibility or a life change event, the Eligible Person [or their Eligible Dependent] cannot enroll until the next open enrollment period conducted by the Policyholder. [If the Covered Person is required to provide coverage for a Child pursuant to a Qualified Medical Child Support Order (“QMCSO”), the Covered Person will be permitted to enroll the Child without regard to enrollment season restrictions. If the insuring parent is enrolled but does not include the Child in the enrollment, Coventry Dental shall allow the non-insuring parent or child support enforcement agency, to apply for enrollment on behalf of the Child; and include the Child(ren) in the coverage regardless of enrollment period restrictions. If a Child(ren) has dental insurance coverage through an insuring parent, Coventry Dental shall: provide to the non-insuring parent membership cards, claims forms and any other information necessary for the Child(ren) to obtain benefits through the dental insurance coverage; and process the claims forms and make appropriate payment to the non-insuring parent or health care provider if the non- insuring parent incurs expenses for dental care provided to the Child(ren). If an Eligible Person is required to provide coverage for a Eligible Dependent pursuant to a Qualified Medical Child Support Order (“QMCSO”), the Eligible Person will be permitted to enroll both the Eligible Person and the Eligible Dependent without regard to enrollment season restrictions. An Eligible Dependent of an Eligible Person who is not enrolled for coverage with Us may not be enrolled without the Eligible Person also enrolling.

Coventry Dental may not terminate the Child(ren) coverage unless written evidence is provided to Coventry Dental: that the Qualified Medical Child Support Order (“QMCSO”) is no longer in effect; the Child(ren) has been or will be enrolled under other reasonable dental insurance coverage that will take effect on or before the effective date of the termination; the employer has eliminated family members’ coverage for all of its employees; or the employer no longer employs the insuring parent, except that if the parent elects to exercise the provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985(COBRA), coverage shall be provided for the Child(ren) consistent with the employers plan for post-employment dental insurance coverage for dependents.]

**Voluntary Disenrollment** - If a Covered Person chooses to drop coverage at any time during the Policy year other than at open enrollment or during open enrollment, they will not be permitted to enroll themselves [or their Eligible Dependent] at a later time unless they supply proof of loss of coverage under another dental plan. The loss of coverage must be due to a valid life change event such as death, divorce or change in employment status of spouse. If the individual supplies such proof, they will be permitted to re-enroll at the next open enrollment period.

[Coventry reserves the right to assess a financial penalty on a Covered Person for voluntarily withdrawing from the dental plan during the first year of coverage. This penalty will not exceed the usual, customary and reasonable charge for services rendered reduced by the sum of the Premiums paid by or for the Covered Person and any co-payments paid by or for the Covered Person.]

**Dependent Eligibility** - To be eligible to be enrolled under this Agreement as a Dependent, an individual must:

- Be the lawful spouse of the Covered Person or be an unmarried child of the Covered Person or the Covered Person’s spouse including:
- Children up to the age of [nineteen (19)] who are either the birth children of the Covered Person or the Covered Person’s spouse or legally adopted by or placed for adoption with the Covered Person or Covered Person’s spouse irrespective of whether or not the adoption has become final, unmarried and dependent on the Covered Person for support and maintenance;
- Children under age [nineteen (19)] for whom the Covered Person or the Covered Person’s spouse is required to provide health care coverage pursuant to Qualified Medical Child Support Order and who are unmarried and dependent on the Covered Person for support and maintenance;
- Children up to the age[ nineteen (19)] for whom the Covered Person or the Covered Person’s spouse

is the court-appointed legal guardian and who are unmarried and dependent on the Covered Person for support and maintenance;

- Children [nineteen (19) or older] who are either the birth or adopted children of the Covered Person or the Covered Person's spouse, are mentally or physically incapable of earning a living and who are chiefly dependent upon the Covered Person for support and maintenance, provided that: the onset of such incapacity occurred before age [nineteen (19)], proof of such incapacity and financial dependence is furnished to the Plan by the Covered Person upon enrollment of the person as a Dependent child or at the onset of the Dependent child's incapacity prior to age [nineteen (19)] and annually thereafter after the two (2) year period following the Dependent child's attainment of the attainment of the limiting age;
- Children [nineteen (19) and older] who become handicapped while a Full-time Student;
- Children under the age shown for dependent students in the definition of Eligible Child who are either the birth or adopted children of the Member, and are attending an accredited educational institution, defined as an educational institution which is eligible for payment of benefits under the Veterans Administration program, on a full-time basis. The Covered Person must provide documentation of such attendance to the Plan upon request. Coverage ends the last day of the month in which the Dependent attains the age shown in the definition of Eligible Child or is no longer enrolled in school on a full-time basis, whichever comes first.

Notwithstanding the above, a common law spouse qualifies as a spouse under this Agreement only if his or her spousal status is affirmed by a court of competent jurisdiction. A domestic partner qualifies as a spouse under this Agreement only by an attached Amendment.

**Notification of Change in Status** - A Covered Person must notify the Policyholder of any changes in status or the status of any Dependent within thirty-one (31) days after the date of the qualifying event. This notification must be submitted on a written Enrollment/Change Form to the Policyholder. Events qualifying as a change in status include, but are not limited to, changes in address, employment, divorce, marriage, dependency status, Medicare eligibility or coverage by another payer. The Plan should be notified within a reasonable time of the death of any Member.

**Termination of Coverage** - Covered Persons and/or Covered Dependents' coverage will end on when:

- the Covered Person loses eligibility under the Policyholder's eligibility requirements; or
- the end of the grace period, if the required premium payment is not paid by the end of the 31 day Grace Period; or
- Covered Dependent(s) cease to meet the requirements in the definition of Covered Dependent.

If coverage is terminated as described above, coverage for completion of a dental procedure requiring two or more visits on separate days will be extended for at least 90 days after the Covered Person's Termination Date in order for the procedure to be finished. The procedure must be started prior to the Covered Person's Termination Date. The procedure is considered "started" when the teeth are irrevocably altered. For example, for crowns, bridges and dentures, the procedure is started when the teeth are prepared and impressions are taken. For root canals, the procedure is started when the tooth is opened and pulp is removed.

**Continuation Coverage** - Certain employers may be required to meet certain criteria to offer continuation coverage to Covered Persons for a specified time upon termination of employment or reduction of work hours for any reason other than gross misconduct. The Policyholder will notify the Covered Person if applicable. If this requirement does apply, the Covered Person must elect to continue coverage for themselves and for Covered Dependents within 60 days from the qualifying or notification of rights by the Policyholder, whichever is later. The Covered Person must pay the required premium for continuation of coverage. Coventry Dental is not responsible for determining who is eligible for continuation coverage.

**Certificates of Coverage; 30 Day Right to Examine Certificate** - Coventry will provide to the Policyholder, for delivery to each Covered Person, a statement that summarizes the essential features of the coverage and that indicates to whom benefits under the policy are payable. If a Covered Person does not like the Certificate for any reason, it may be returned to us within 30 days after receipt. We will return any premium that has been paid. In that case, the Certificate will be void as if it had never been issued.

**Contestability of Coverage** - The Policy may not be contested, except for non-payment of premiums, after it has been in force for two years from the date of issue. A statement made by any person covered under the policy relating to insurability may not be used in contesting the validity of the coverage with respect to which the statement was made after the coverage has been in force before the contest for a period of two years during the person's lifetime. Absent fraud, each statement made by an applicant, Policyholder, or Covered Person is considered to be a representation and not a warranty. A statement made to effectuate the Policy may not be used to avoid the coverage or reduce the benefits under the Policy unless the statement is contained in a written instrument signed by the Policyholder or Covered Person and a copy of the statement is given to the Policyholder, Covered Person or beneficiary of the Covered Person. This provision does not preclude the assertion at any time of defenses based upon the person's ineligibility for coverage under the Policy or upon other provisions in the Policy.

**Notice of Claim** - Written notice must be given within 20 days after treatment or as soon as reasonably possible. Notice can be given to Coventry at our home office at Rockville, Maryland, or to our agent. Notice should include the Covered Person's name, address and group policy number. Coventry may not invalidate or reduce a claim if it is shown that it was not reasonably possible to give notice within 20 days and notice was given as soon as was reasonably possible.

**Claim Forms** - Coventry will provide claim forms for filing Proof of Loss to each claimant or to the Policyholder for delivery to the claimant. If Coventry does not provide the claim forms within 15 days after Notice of Claim is received, the claimant is considered to have complied with the requirements of the policy as to Proof of Loss if the claimant submits within the time fixed in the Policy for filing proof of loss, written proof of the occurrence, character, and extent of the loss for which the claim is made.

**Proof of Loss** - Written proof, satisfactory to us, must be given to us within 90 days after the date of loss. If that is not reasonably possible, we will not deny or reduce any claim if proof is furnished as soon as reasonably possible except in the absence of legal capacity, not later than 1 year from the time proof is otherwise required.

**Time of Payment of Claims** - Benefits payable under the group policy for any loss will be paid not more than 30 days after written receipt of Proof of Loss. We reserve the right to request x-rays, narratives and other diagnostic information, as we see fit, to determine benefits.

**How To Submit Claims:** - Claims submitted to Coventry must identify the treatment rendered using the American Dental Association Uniform Code on Dental Procedures and Nomenclature or by narrative description. We reserve the right to request x-rays, narratives and other diagnostic information, as we see fit to determine benefits.

**Overpayment Recovery:** Coventry reserves the right to deduct from any benefits properly payable under this Policy the amount of any payment that has been made:

1. in error; or
2. pursuant to a misstatement contained in a proof of loss; or
3. pursuant to fraud or misrepresentation made to obtain coverage under this Policy within two (2) years after the date such coverage commences; or
4. with respect to an ineligible person; or
5. pursuant to a claim for which benefits are recoverable under any Policy or act of law providing coverage for occupational injury or disease to the extent that such benefits are recovered.

Such deduction may be against any future claim for benefits under the Policy made by a Covered Person if claim payments previously were made with respect to a Covered Person.

**Payment of Claims** - All benefits will be paid to the Covered Person unless assigned by the Covered Person to the Provider. Only one claim amount will be paid for each covered procedure. Any benefits unpaid at the time of the Covered Person's death will be paid in one lump sum to the Covered Person's estate.

**Legal Actions** - No action at law or in equity shall be brought to recover benefits under the group policy less than 60 days after written Proof of Loss has been furnished as required by the Policy. No such action shall be brought more than 3 years after the time written Proof of Loss is required to be furnished.

**Governing Law** - This Policy is governed by Arkansas law (to the extent not preempted by ERISA) and Arkansas Courts. Any provision of this policy which, as of its effective date, is in conflict with the laws of Arkansas is amended to conform to the minimum requirements of such laws.

**Complaints and Notices** - Complaints and Notices should be sent to:

Coventry Dental  
c/o Group Dental Service, Inc.  
111 Rockville Pike, Suite 950  
Rockville, MD 20850  
Attn: Member Services  
[1-866-433-6391]

**COORDINATION OF BENEFITS (COB)**

Coordination of Benefits (COB) will apply when a Covered Person is covered for dental benefits under more than one Plan. "Plan" is defined below under Plans Considered for COB.

If this COB provision applies, the Order of Benefit Determination Rules below should be looked at first. Those rules determine whether this Policy is a Primary Plan or a Secondary Plan. A "Primary Plan" means the Plan that pays benefits or provides services first under the rules. A "Secondary Plan" is any Plan that is not a Primary Plan. When there are more than two Plans covering the Covered Person, this Policy may be: a Primary Plan as to one or more other Plans; and a Secondary Plan as to a different Plan or Plans.

If the Policy is:

1. a Primary Plan, COB will not apply and benefits will not be reduced; or
2. a Secondary Plan, COB will apply, and benefits may be reduced so that the total payment from all Plans will not exceed 100% of total Allowable Expenses. This reduction is described under Effect on Benefits below.

**Plans Considered for COB**

"Plan" is any of the following that provides benefits or services for or because of dental care or treatment:

1. group; blanket or franchise insurance; or other group type coverage, whether insured or uninsured;
2. union welfare plans; employer organization plans; or labor management trustee plans; or
3. coverage under a governmental plan; or coverage required or provided by law. This does not include benefits payable under any state plan under:
  - a. Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time); or
  - b. any plan when, by law, its benefits are in excess of those of any private insurance plan or other non-governmental plan.

Each contract or other arrangement for coverage under 1. through 3. is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

"Plan" will not include:

1. individual or family policies; or individual or family subscriber contracts; this includes: prepayment; service; group practice; or individual practice coverage; or
2. school accident type coverage.

**Order Of Benefit Determination Rules**

General

When there is a basis for a claim under this Policy and another Plan, this Policy is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

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1. the other Plan has rules coordinating its benefits with those of this Policy; and
2. both those rules and this Policy's COB Rules require that this Policy's benefits be determined before those of the other Plan.

## Rules

This Policy determines its order of benefits using the first of the following rules which applies:

1. Non-Dependent/Dependent. The benefits of the Plan which covers the individual as an employee, Person or subscriber (that is, other than as a Dependent) are determined before those of the Plan which covers the individual as a Dependent.
2. Dependent Child/Parents not Separated or Divorced. Except as stated in Rule 3., when this Policy and another Plan cover the same child as a Dependent of different individuals, called "parents":
  - a. the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year;
  - b. but, if both parents have the same birthday, the benefits of the Plan that covered one parent longer are determined before those of the Plan that covered the other parent for a shorter period of time;
  - c. however, if the other Plan:
    - i. does not have this "birthday rule"; but
    - ii. has a rule based upon the gender of the parent; andif, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.
3. Dependent Child/Parents Separated or Divorced. If two or more Plans cover a child as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
  - a. first, the Plan of the parent with custody of the child;
  - b. then, the Plan of the spouse of the parent with the custody of the child; and
  - c. finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state:

- a. that one of the parents is responsible for the health care expense of the child; and
- b. the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms,

the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any:

- a. Claim Determination Period; or
- b. Plan Year;

during which any benefits are actually paid or provided before the entity has the actual knowledge.

4. Active/Inactive Employee. The benefits of a Plan which covers the individual as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Plan which covers the individual as a laid off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this Rule 4. is ignored.
5. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, [Person] or subscriber longer are determined before those of the Plan which covered the employee, [Person] or subscriber for the shorter term.

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COB applies to this Policy when, in accordance with the Order of Benefit Determination Rules, this Policy is a Secondary Plan as to one or more other Plans. In that event, the benefits of this Policy may be reduced under this COB provision. Such other Plan or Plans are referred to as “the other Plans” immediately below.

### **Reduction In This Policy’s Benefits**

The benefits of this Policy will be reduced when the sum of:

1. the benefits that would be payable for the Allowable Expense under this Policy in the absence of this COB provision; and
2. the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made;

exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of this Policy will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of this Policy are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Policy.

“Allowable Expense” means an expense that is considered a covered charge, at least in part, by one or more of the Plans. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

“Claim Determination Period” means the year defined in the Schedule of Benefits. However, it does not include any part of a year during which an individual has no coverage under this Certificate, or any part of a year before the date this COB provision or a similar provision takes effect.

### **Right to Receive and Release Needed Information**

Certain facts are needed to apply these COB rules. Coventry has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or individual. Coventry need not tell, or get the consent of, any individual to do this. Each Covered Person claiming benefits under this Policy must give Coventry any facts it needs to pay the claim.

### **Facility of Payment**

A payment made under another Plan may include an amount which should have been paid under this Policy. If it does, Coventry may pay that amount to the organization which made that payment. That amount will then be treated as though it was a benefit paid under this Policy. Coventry will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means reasonable cash value of the benefits provided in the form of services.

### **Right of Recovery**

If the amount of the payments made by Coventry is more than it should have paid under this COB provision, it may recover the excess from one or more of:

1. the individuals it has paid or for whom it has paid;
2. the insurance companies; or
3. the other organizations.

The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

## **DENTAL BENEFITS**

All Benefits will be paid after the Covered Person satisfies any applicable Waiting Period and an Annual Deductible up to an Annual Maximum. All Benefits are subject to the Exclusions and Limitations set forth in the Policy.

Benefit amounts will vary depending on whether the Covered Person obtains services from a Network Provider or from a Provider that is not part of the Network.

### **In-Network Benefits**

Coventry Dental will pay a percentage of the charge by the Network Provider for each covered service, up to the actual charge. The percentage, by Procedure Classification, is set forth in the Policy Schedule. For example, if Coventry Dental pays 80% for a covered service, the Covered Person pays the remaining balance of 20% of the In-Network Provider's fee for that Covered Service.

The Covered Person is responsible for paying the remaining balance of the charge (only up to the Provider's negotiated fee) and may be required to remit payment at the time of service. Billing arrangements are between the Covered Person and the Provider.

Network Providers are set forth in the Provider Directory. Covered Persons should confirm continued participation of a provider in the Network before receiving services. The Network has both general dentists and specialists to provide services.

### **Out-of-Network Benefits**

A Covered Person may obtain services from a Provider that is not part of the Network.

Benefit Percentages are set forth in the Policy Schedule by procedure classification. Benefits are calculated using an Out of Network Rate. You may receive Covered Services from Non-Participating Providers. If you seek services from a Non-Participating Provider, You are responsible for ensuring that the Non-Participating Provider complies with Our Utilization Management Policies. You must in certain situations receive Pre-Authorization from Us prior to receiving a Covered Service (check Your Schedule of Benefits or call Our Customer Service Department to determine when Covered Services require Pre-Authorization). Under the Out-of-Network Option, the Covered Services may be delivered in or out of the Service Area.

Coverage for Covered Services provided by Non-Participating Providers is limited to the Out-of-Network Rate less applicable Copayments, Coinsurance and Deductibles. The Out-of-Network Rate is a rate established by us based upon data provided by Ingenix. You may call customer service at the telephone number listed on your identification card to find out the Out-of-Network Rate for a particular dental procedure code.

If the amount You are charged for a service is equal to or less than the Out-of-Network Rate, the charges should be completely Covered by Your Out of Network Benefit, except for any Copayment, Deductible and Coinsurance payments You must make. However, if the amount You are charged is in excess of the Out-of-Network Rate for a particular service, you must pay the excess. For example, assume Your Coinsurance is 20%, the dentist's bill is \$150 and the Out-of-Network Rate is \$100. In this example, We would pay \$80, You would pay Coinsurance of \$20 plus the \$50 in actual charges that exceeds the Out-of Network Rate. Payments for charges in excess of the Out of Network Rate do not count towards your annual Out-of-Pocket Maximum.

Covered Persons are responsible for amounts charged by the provider that exceed Benefits, and may be required to remit payment at the time of service. Billing arrangements are between the Covered Person and the Provider.

If a Covered Person obtains services from a Provider that is not part of the Network, the Covered Person may be required to remit payment in full at the time services are rendered. The Covered Person or the provider can then submit a claim to Coventry Dental for Out-of-Networks Benefits under the Policy.

Providers that are not part of the Network have not negotiated their fees with Coventry Dental and will charge their usual and customary fees.

### **Pre-authorization**

Pre-authorization **is required** for the following procedure types:

Inlays, Onlays, Crowns

Root canals, Root canal retreatment

Periodontal Surgery

Periodontal scaling and root planning

Full dentures, partial dentures, fixed bridges

Implants

Third molar extractions

Complete occlusal adjustments

Documentation, including diagnostic quality radiographs, periodontal charting and other appropriate visual or written narrative should be sent with proposed treatment. If treatment is done without prior Pre-authorization approval, and documentation is submitted with a claim for payment, this claim may not be paid.]

### **Predetermination of Benefits**

If the charge for any treatment is expected to exceed [\$500], Coventry Dental **STRONGLY** suggests that a dental treatment plan be submitted to us by your dentist for review before treatment begins. This process is called predetermination and is separate and different from Pre-authorization. This may be helpful to estimate both the benefits available and your anticipated out of pocket expense. Predetermination is optional and not a requirement for use of benefits

The proposed services will be reviewed and a predetermination of benefits statement will be issued to the Covered Person or the Provider detailing the benefits that will be covered by Coventry Dental. The predetermination is good for 180 calendar days.

Payment will be subject to the plan benefits (e.g. Annual Maximums), limitations and exclusions in force at the time the claim is submitted. Predetermination of benefits is also subject to the Alternate Benefit Provision.

### **Alternate Benefit Provision**

Many dental problems can be resolved in more than one way. If: 1) we determine that a less expensive alternative benefit could be provided for the resolution of a dental problem; and 2) that benefit would produce the same resolution of the diagnosed problem within professionally acceptable limits, we may use the less expensive alternative benefit to determine the amount payable under the Certificate. For example: When an amalgam filling and a composite filling are both professionally acceptable methods for filling a molar, we may base our benefit on the amalgam filling which is the less expensive alternative benefit. This is the case whether a Participating Provider or Non-participating Provider performs the service.

### **Services Performed Outside The United States of America**

Any Claim submitted for procedures performed outside the U.S.A. must: (1) be for a Covered Procedure, as defined; (2) be supplied in English; and (3) **use American Dental Association (ADA) codes** or provide a narrative of the services received. Reimbursement will be based on the [Out of Network Rate] [Maximum Allowable Charge] for the Group's zip code

## **LIMITATIONS AND EXCLUSIONS**

- [A]. **[MISSING TEETH LIMITATION:** Administrator will not pay benefits for the initial placement of a full denture, partial denture, fixed bridge or implant to replace teeth extracted or missing on or before a Covered Person's effective date. The missing teeth limitation will be waived after the Covered Person has been covered under the plan for twelve (12) continuous months.]
- [B.] **[WORK IN PROGRESS:** Dental procedures begun prior to the Covered Person's effective date of coverage are not covered. Examples include, but are not limited to, teeth prepared for crowns, root canal treatment in progress.]

No benefits are payable under the Policy for the procedures listed below unless such procedure or service is listed as covered in the Schedule of Covered Procedures.

All Benefits are subject to the following exclusions and limitations and frequency limits:

General

- (1) Coverage is limited to those services set forth in the Schedule of Covered Procedures. If a service is not listed, it is not included **and is not covered**.
- (2) Treatment to restore tooth structure lost due to attrition, erosion, abfraction or abrasion **is not covered**.
- (3) Where two or more professionally acceptable dental treatments for a dental condition exist, the Plan bases reimbursement on the least **expensive alternative treatment (LEAT)**.
- (4) Services furnished solely for cosmetic reasons **are not covered**.
- (5) [Any service or supply for which You have no financial liability or that was provided at no charge; those Dental Services for which the Member has no legal obligation to pay or for which a charge would not ordinarily be made in the absence of Coverage under the Dental Plan.
- (6) **Any services related to implants including implant removal, repair, restoration or placement.]**
- (7) Fees related to broken appointments, preparing or copying dental reports, duplication of x-rays, itemized bills or claim forms **are not covered**.
- (8) Treatment for injuries or conditions covered by Workers' Compensation or employer liability laws, and treatment provided without cost to the covered Person by any municipality, county, or other political subdivision **is not covered**. This exclusion does not apply to any treatment covered by Medicaid or Medicare.
- (9) Treatment as a result of, civil insurrection, duty as a member of the armed forces of any state or country, engaging in an act of declared or undeclared war, intentional or unintentional nuclear explosion or other release of nuclear energy, whether in peacetime or wartime **is not covered**.
- (10) Treatment of congenital or developmental malformations or the replacement of congenitally missing teeth **is not covered**.
- (11) [Examination, evaluation and treatment of temporomandibular joint (TMJ) pain dysfunction **is not covered**].
- (12) Treatment of jaw fractures or orthognathic surgery **is not covered**
- (13) Consultations and/or evaluation for non-covered services **is not covered**
- (14) Services and/or appliances that alter the vertical dimension or alter, restore or maintain the occlusion including, but not limited to full mouth rehabilitation, splinting, appliances or any other method **is not covered**.
- (15) Removal and replacement of clinically acceptable material or restorations with alternative materials, for any reason except the pathological condition of the tooth or teeth, **is not covered**.
- (16) Replacement of fixed or removable bridges or orthodontic appliances that have been lost, stolen or damaged due to patient abuse or misuse **is not covered**
- (17) Periodontal splinting of teeth by any method **is not covered**.
- (18) Analgesia, anxiolysis, inhalation of nitrous oxide or non-intravenous sedation **is not covered**.
- (19) Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature **is not covered**.

- (20) Any outpatient facility, surgicenter facility, or inpatient hospital facility and associated facility charges, services and supplies **is not covered**
- (21) House, extended care facility calls, hospital calls, office visits for observation (during regularly scheduled hours) when no other services are provided, office visits after regularly scheduled hours or case presentations **is not covered**.
- (22) Drugs obtainable with or without a prescription **are not covered**.
- (23) Fees for equipment sterilization, OSHA or other regulatory agency requirements or mandates, infection control, and medical waste disposal **is not covered**
- (24) Treatment that is not described by the most recent (current edition) of the American Dental Association (ADA) CDT (current dental terminology) book **is not covered**.
- (25) Any treatment covered under an individual or group medical plan, auto insurance, no fault auto insurance or uninsured motorist policy to the extent permitted by state statute **is not covered**.

#### Diagnostic & Preventive

- (26) Oral evaluation (comprehensive or periodic) and prophylaxis, including scaling and polishing is limited to [twice per year] [Once every six (6) months per year]. Comprehensive oral evaluation is limited to [once per thirty six (36) months].
- (27) Bitewing x-rays are limited to [once] every [twelve (12) months].
- (28) Full mouth x-rays (complete intraoral series) are limited to [once] every [thirty six (36) months],
- (29) When a combination of x-rays (i.e. ten or more periapical x-rays or panoramic x-ray with bitewing x-rays) is done on the same date of service where the reimbursement meets or exceeds the reimbursement for full mouth x-rays, the plan reimbursement and benefit allocation will be based on full mouth x-rays.
- (30) Prophylaxis if performed on the same date of service with periodontal treatment **is not covered**.
- (31) For Eligible [Covered Dependents] (age [14] and under) fluoride [once] every [twelve (12) months].
- (32) Sealants for Eligible [Covered Dependents] (age [14] and under) [once] per 1<sup>st</sup> and 2<sup>nd</sup> permanent molar once every [thirty six (36) months].
- (33) Space maintainers for Eligible [Covered Dependents] (age [14] and under) [once] per lifetime per space.

#### Restorative

- (34) Amalgams and Composites are limited to [one] restoration allowed per surface every [thirty six (36) months].
- (35) Core Build Ups are limited to [once] every [eighty-four (84) months].
- (36) Post and Cores are limited to [once] every [eighty-four (84) months].
- (37) Crowns, inlays and onlays are limited to [once] per tooth per [eighty-four (84) months] following date of final cementation.
- (38) Core build ups, post and cores, crowns, inlays or onlays treatment on teeth exhibiting poor periodontal prognosis **are not covered**.
- (39) Reimbursement for post and cores, crowns, inlays or onlays will be based on the date of final cementation.

## Endodontics

- (40) Root canals are limited to [once] per tooth per lifetime. Re-treatment of root canal is limited to not more than [once] per tooth per lifetime and not sooner than [twenty four (24) months] after the initial root canal for the same tooth.
- (41) Reimbursement for root canal treatment will be based upon the date of the final fill.
- (42) Endodontic treatment on teeth exhibiting poor periodontal prognosis **is not covered**.
- (43) Intentional endodontic treatment on teeth for the express purpose providing for restorative treatment (i.e. crown) where there is no sign of injury or disease **is not covered**.

## Periodontics

- (44) Periodontal surgery is limited to [**once per quadrant per thirty six (36) months**].
- (45) Crown lengthening is limited to [once] per tooth per lifetime. This procedure **is not covered** when done on the same date as a restoration on the same tooth.
- (46) Periodontal scaling and root planing is limited to [once] per quadrant every [twenty-four (24) months].
- (47) Full mouth gross debridement is limited to [once] per [thirty six (36) months].
- (48) Periodontal maintenance is limited to [two] per [twelve (12) month period] following active periodontal treatment (excluding gross debridement)
- (49) Gingivectomy/gingivoplasty or anatomical crown exposure **is not covered** when done on the same date as a restoration on the same tooth.
- (50) Bone grafting or guided tissue regeneration an extraction site or with endodontic surgical procedures **is not covered**.

## Prosthodontics (Removable & Fixed)

- (51) Full dentures, partial dentures and fixed bridges are limited to [once] every [eighty four (84) months]. The [eighty four month] period shall be measured from the date on which the appliance was seated, whether paid for under the provisions of this Policy, under any prior dental care contract or by the Member.
- (52) Full dentures, partial dentures and fixed bridges are not covered for any person under the [age of 18].
- (53) Retreatments, Relines, Rebases, Replacements, or Repairs are **not covered** within [six (6) months] of the date of final insertion of the full or partial denture. [Benefits for denture repair will be limited to no more than half the cost of the Provider fee for a new denture.]
- (54) Relines and rebases of existing removable dentures no more than [once] per [thirty-six (36) month period].
- (55) Replacement of all teeth and acrylic on cast metal framework is limited to [once] per [thirty-six (36) month] period.
- (56) Interim complete dentures and interim partial dentures may not be replaced for a [twelve (12) month period].
- (57) Reimbursement for full dentures, partial dentures and fixed bridges will be based upon the date of final insertion or cementation.

## Oral & Maxillofacial Surgery

(58)Extractions of 3rd (wisdom teeth) molars under age 16 are **not covered**.

#### Orthodontics

(59)[Orthodontia coverage – limited to Lifetime Maximum. Orthodontics for cosmetic reasons is not covered.]

#### Adjunctive General Services

(60)Palliative treatment **is** covered as a separate benefit only if no other service other than exam and x-rays were done during the visit. Palliative treatment may only be rendered on an emergency basis for the relief of pain and cannot be billed as a separate charge if the underlying dental problem is corrected on the same date of service.

(61)General anesthesia or intravenous conscious sedation **is covered for** a maximum of one hour.

(62)Consultations performed by a General Dentist or Specialist **are not covered** if the dental procedure is performed on the same date of service by that General Dentist or Specialist. Consultation should already be included with the dental procedure.

### RESOLVING COMPLAINTS AND GRIEVANCES

#### Complaints and Inquiries

**Investigation Upon Receipt of a Complaint or Inquiry by Telephone:** If You have a Complaint or Inquiry, You may submit it by telephone. When this is done, the Member Services representative will forward the issue to the Appeals Department. We will make every effort to resolve the issue within ten (10) working day. In some cases, however, it may take as long as fifteen (15) working days or more from the date of the call for resolution.

**Written Inquiries:** You may submit a written Inquiry to the Appeals Department. You will be sent an acknowledgement letter within three (3) working days of the original receipt of the Inquiry. When this is done, you will receive resolution of the Inquiry within thirty (30) calendar days.

**Written Complaints:** You may submit a Complaint in writing to the Appeals Department. You will be sent an acknowledgement letter within ten (10) working days of the original receipt of the Complaint. The investigation of the Complaint will be completed within twenty (20) working days of original receipt of the Complaint unless you receive notice from the Plan that additional time is required. Within five (5) working days after the completion of the investigation, You and Your Authorized Representative will be notified of the resolution of the Complaint.

Our address and phone number are as follows:

Coventry Dental  
c/o Group Dental Service, Inc.  
Attn: Appeals Department  
111 Rockville Pike, Suite 950  
P.O. Box 6228  
Rockville, MD 20849  
[Phone: 1-866-690-4908]

#### Appeals

**Notice of Appeal:** If You wish to submit an Appeal, You should contact the Appeals Department in writing. If You prefer, You may also request information by contacting Member Services by telephone. (However, a formal Appeal must be submitted in writing within 180 days of an Adverse Benefit Determination and must include the following information:

- Member name;
- Provider name;
- Date(s) of service;

- Member's and/or Member's Authorized Representative's mailing address;
- Clear indication of the remedy or corrective action being sought and an explanation of why the Plan should "reverse" the Adverse Benefit Determination;
- Copy of documentation to support the reversal of decision, e.g. Emergency details, date, time, symptoms and
- In cases where the Member's Authorized Representative is appealing on behalf of the member, a completed Member Designated Release of Information form, which can be obtained by calling the Member Services Department

Requesting information by telephone does not constitute filing an Appeal.

**Pre-Service Appeal Review:** A pre-service Appeal may be requested by You or Your Authorized Representative but must be submitted in writing within 180 days of an Adverse Benefit Determination.

Within thirty (30) calendar days after the receipt of the Appeal, the Plan will notify You and Your Authorized Representative in writing of the Plan's decision regarding the Appeal and of Your right to file an Appeal for a second-level review.

**Post-Service Appeal Review:** A Post-Service Appeal may be requested by You or Your Authorized Representative but must be submitted in writing within 180 days of an Adverse Benefit Determination.

Within sixty (60) calendar days after the receipt of the Appeal, the Plan will notify You and Your Authorized Representative in writing of the Plan's decision regarding the Appeal and of Your right to file an Appeal for a second-level review.

**Urgent Care Appeal Review:** An Urgent Care Appeal may be requested by You or Your Authorized Representative but must be submitted in writing within 180 days of an Adverse Benefit Determination. For Appeals satisfying the definition of an Urgent Care Appeal you may request an expedited Appeal of a Plan decision verbally or in writing. Within a reasonable period of time not to exceed seventy-two (72) hours of receiving a valid request for an Urgent Care Appeal, the Plan will verbally notify You of its decision. The Plan will then send a written confirmation of its decision within the following three (3) working days.

**External Review:** If You or Your Authorized Representative are not satisfied with the decision of the Plan and have exhausted the internal appeal process, You or Your Authorized Representative may request an external review in writing or via electronic media within sixty (60) days after receipt of the Plan's decision. The Independent Review Organization assigned will be chosen from a list compiled and maintained by the Arkansas Insurance Department.

Within five (5) business days after receipt of the request for an external review, You or Your Authorized Representative and treating Physician will be notified in writing whether the request is complete and if the request has been accepted for external review.

- If the request is not complete, the notice will include the information needed to make the request complete. The additional information must be submitted within seven (7) business days following receipt of the notice.

Within forty-five (45) calendar days after receipt of the request for an external review, the Independent Review Organization shall provide written notice of its decision to uphold, reverse, or partially uphold or reverse the Adverse Benefit Determination to You or Your Authorized Representative, treating Physician and the Plan.

- If the Independent Review Organization has overturned any portion or all of the Adverse Benefit Determination, the Plan shall immediately approve the Coverage that was the subject of the Adverse Benefit Determination.

You or Your Authorized Representative may request an expedited external review. Within seventy-two (72) hours of the request, the Independent Review Organization will make a decision to uphold or reverse the Adverse Benefit Determination and notify You or Your Authorized Representative, the treating Physician and the Plan.

- An expedited external review may not be provided for Adverse Benefit Determinations involving a Retrospective Review.

Except in the case of a request for an expedited external review, at the time of filing a request for an external review,

You or Your Authorized Representative shall submit to the Independent Review Organization a filing fee of [\$25] along with the information and documentation to be used by the Independent Review Organization conducting the external review.

At any time during the external review process and upon receipt of additional information, the Plan may reconsider its Adverse Benefit Determination.

- The external review process will be terminated; and
- The Plan will immediately notify You or Your Authorized Representative, treating Dentist and the Independent Review Organization of its decision.

The following Group types – churches, city and county governments – are regulated by state law and are not subject to the Department of Labor regulations. The timeframes for these Appeals are within twenty (20) working days for both Pre and Post Service Appeals. All other timeframes are the same as cited in the preceding sections.

**Insurance Department:** The Member, Member's Authorized Representative, or a Dentist acting on behalf of a Covered Person has the right to contact the Insurance Department at any time in this process. The Department may be contacted at the number listed in the Schedule of Important Numbers.



## SCHEDULE OF BENEFITS

### Out of Network Benefits

[Out of Network Rate] [Maximum Allowable Charge]

### Annual Deductible

For each Covered Person – [\$50.00 In and Out-of-Network]. [The maximum Annual Deductible per family is three (3) times the Individual Deductible..]

### Annual Maximum

The total amount of benefits that will be paid in a [Benefit or Calendar Year] is [[\$1,000] per Covered Person for In and Out-of-Network]. [Benefits for Orthodontia do not count to the Annual Maximum.]

## [ORTHODONTIC BENEFIT

### [Orthodontic Deductible

The orthodontic deductible [\$50] applies to each [Covered Person] [Eligible Child under age [19] on the date orthodontic treatment begins.]

### [Orthodontic Maximum

The total amount of benefits that will be paid over the total course of a lifetime is [\$1000] per [Covered Person or Eligible Child under age [19] on the date orthodontic treatment begins.]

### **Orthodontia Services**

If covered, We will pay benefits for the orthodontic services listed above when the date started for the orthodontic service occurs while the person is insured under this Certificate. No payment will be made for orthodontic treatment if the appliances or bands are inserted prior to becoming insured unless the person was receiving benefits under the prior plan. Benefits will be offset by any amounts already paid under the prior plan. We consider orthodontic treatment to be started on the date the bands or appliances are inserted. Any other orthodontic treatment that can be completed on the same day it is rendered is considered to be started and completed on the date the orthodontic treatment is rendered.

We will pay the Insurance Percentage shown in the Schedule of Benefits after any required deductible for orthodontic services has been satisfied for the Certificate Year. The maximum benefit payable to each person, while insured under the policy, for orthodontic services is shown in the Schedule of Benefits. Those Insureds who are eligible for Orthodontia coverage are indicated in the Schedule of Benefits. The maximum benefit will apply even if coverage is interrupted.

### Exclusions and Limitations

Coverage for services and supplies is not provided for any of the following:

- Replacement of broken appliances;
- Re-treatment of Orthodontic cases;
- Changes in treatment necessitated by an accident;
- Maxillofacial surgery (subrogate with medical insurance);
- Miofunctional therapy (TMJ);
- Treatment of cleft palate;
- Treatment of micrognathia;
- Treatment of macroglossia;

### Payment of Benefits

Benefits will be pro-rated and paid out [over a twenty-four (24) month period or longer based on the treatment plan submitted] or [at the end of every Quarter].

Provider services started after the person's coverage terminates are not covered. Covered benefits in accordance with the Policy in effect at the time coverage terminates will continue for 60 days if the orthodontist is receiving monthly payments or until the later of 60 days after the date coverage terminates or the end of the quarter in progress, if the orthodontist is receiving payments on a quarterly basis. All other provisions of the Policy apply to the Orthodontic Benefit.]

Schedule of Covered Procedures

DESCRIPTION	In-Network Coverage Percentage	Out of Network Benefit	Waiting period
<b>Diagnostic I</b>			
Periodic Oral Evaluation	[50% - 100%]	[50% - 100%]	0
Limited Oral Evaluation-Problem Focused	[50% - 100%]	[50% - 100%]	0
Oral evaluation-Pt. under 3 yrs. old & counseling w/primary caregiver	[50% - 100%]	[50% - 100%]	0
Comprehensive Oral Evaluation	[50% - 100%]	[50% - 100%]	0
Detailed Extensive Oral Evaluation-Problem Focused-By Report	[50% - 100%]	[50% - 100%]	0
Comprehensive Periodontal Eval - New/Exist Pt	[50% - 100%]	[50% - 100%]	0
Intraoral-Complete Series Including Bitewings	[50% - 100%]	[50% - 100%]	0
Intraoral-Periapicals	[50% - 100%]	[50% - 100%]	0
Bitewings	[50% - 100%]	[50% - 100%]	0
Vertical Bitewings-7 to 8 Films	[50% - 100%]	[50% - 100%]	0
Panoramic Film	[50% - 100%]	[50% - 100%]	0
<b>Diagnostic II</b>			
Intraoral-Occlusal Film	[0% - 50%]	[0% - 50%]	[0-36 Months]
Extraoral Films	[0% - 50%]	[0% - 50%]	[0-36 Months]
Pat/Lat Skull & Facial Bone Survey Film	[0% - 50%]	[0% - 50%]	[0-36 Months]
Cephalometric Film	[0% - 50%]	[0% - 50%]	[0-36 Months]
Oral/Facial Images	[0% - 50%]	[0% - 50%]	[0-36 Months]
Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities	[0% - 50%]	[0% - 50%]	[0-36 Months]
Pulp Vitality Tests	[0% - 50%]	[0% - 50%]	[0-36 Months]
Diagnostic Casts	[0% - 50%]	[0% - 50%]	[0-36 Months]
<b>Preventive</b>			
Prophylaxis	[50% - 100%]	[50% - 100%]	0
Topical Application of Fluoride Not Including Prophylaxis-Child	[50% - 100%]	[50% - 100%]	0
Sealant-Per Tooth	[50% - 100%]	[50% - 100%]	0
Space Maintainer	[50% - 100%]	[50% - 100%]	0
<b>Restorative I</b>			
Amalgam Restorations	[0% - 50%]	[0% - 50%]	[0-36 Months]
Resin Restorations (Anterior)	[0% - 50%]	[0% - 50%]	[0-36 Months]
Composite Resin Restorations (Posterior)	[0% - 50%]	[0% - 50%]	[0-36 Months]
<b>Inlays &amp; Onlays</b>			
Inlay-Metallic	[0% - 50%]	[0% - 50%]	[0-36 Months]
Onlay-Metallic	[0% - 50%]	[0% - 50%]	[0-36 Months]
Inlay-Porcelain/Ceramic	[0% - 50%]	[0% - 50%]	[0-36 Months]
Onlay-Porcelain/Ceramic	[0% - 50%]	[0% - 50%]	[0-36 Months]
Inlay-Composite/Resin	[0% - 50%]	[0% - 50%]	[0-36 Months]
Onlay-Composite/Resin	[0% - 50%]	[0% - 50%]	[0-36 Months]
<b>Restorative II</b>			
Crown-Resin	[0% - 50%]	[0% - 50%]	[0-36 Months]
Crown-Porcelain	[0% - 50%]	[0% - 50%]	[0-36 Months]
Crown-3/4 Cast	[0% - 50%]	[0% - 50%]	[0-36 Months]
Crown-Full Cast	[0% - 50%]	[0% - 50%]	[0-36 Months]
Crown-Titanium	[0% - 50%]	[0% - 50%]	[0-36 Months]
Recement Inlay	[0% - 50%]	[0% - 50%]	[0-36 Months]
Recement Crown	[0% - 50%]	[0% - 50%]	[0-36 Months]

Schedule of Covered Procedures

Prefabricated Stainless Steel Crown	[0% - 50%]	[0% - 50%]	[0-36 Months]
Sedative Filling	[0% - 50%]	[0% - 50%]	[0-36 Months]
Core Build-Up, Including Any Pins	[0% - 50%]	[0% - 50%]	[0-36 Months]
Pin Retention/Tooth, In Addition to Restoration	[0% - 50%]	[0% - 50%]	[0-36 Months]
Post and Core In Addition to Crown	[0% - 50%]	[0% - 50%]	[0-36 Months]
<b>Endodontics</b>			
Pulp Cap (Excluding Final Restoration)	[0% - 50%]	[0% - 50%]	[0-36 Months]
Therapeutic Pulpotomy (Excluding Final Restoration)	[0% - 50%]	[0% - 50%]	[0-36 Months]
Gross Pulpal Debridement	[0% - 50%]	[0% - 50%]	[0-36 Months]
Pulpal Therapy	[0% - 50%]	[0% - 50%]	[0-36 Months]
Root Canal-Anterior (Excluding Final Restoration)	[0% - 50%]	[0% - 50%]	[0-36 Months]
Treatment of Root Canal Obstruction-Non-Surgical Access	[0% - 50%]	[0% - 50%]	[0-36 Months]
Incomplete Endodontic Therapy-Inoperable or Fractured Tooth	[0% - 50%]	[0% - 50%]	[0-36 Months]
Internal Root Repair of Perforation Defects	[0% - 50%]	[0% - 50%]	[0-36 Months]
Retreatment Previous Root Canal Therapy-Anterior **	[0% - 50%]	[0% - 50%]	[0-36 Months]
Apexification/Recalcification	[0% - 50%]	[0% - 50%]	[0-36 Months]
Apicoectomy/Periradicular Surgery	[0% - 50%]	[0% - 50%]	[0-36 Months]
Retrograde Filling-Per Root	[0% - 50%]	[0% - 50%]	[0-36 Months]
Root Amputation-Per Root	[0% - 50%]	[0% - 50%]	[0-36 Months]
Hemisection-Including Root Removal, Not Including Root Canal	[0% - 50%]	[0% - 50%]	[0-36 Months]
<b>Periodontics</b>			
Gingivectomy or Gingivoplasty	[0% - 50%]	[0% - 50%]	[0-36 Months]
Gingival Flap Proc	[0% - 50%]	[0% - 50%]	[0-36 Months]
Apically Positioned Flap	[0% - 50%]	[0% - 50%]	[0-36 Months]
Clinical Crown Lengthening-Hard Tissue	[0% - 50%]	[0% - 50%]	[0-36 Months]
Osseous Surgery (Including Flap Entry and Closure)	[0% - 50%]	[0% - 50%]	[0-36 Months]
Bone Replacement Graft	[0% - 50%]	[0% - 50%]	[0-36 Months]
Guided Tissue Regeneration-Resorbable Barrier per Site	[0% - 50%]	[0% - 50%]	[0-36 Months]
Pedicle Soft Tissue Graft Procedure	[0% - 50%]	[0% - 50%]	[0-36 Months]
Free Soft Tissue Graft Procedure (Including Donor Site Surgery)	[0% - 50%]	[0% - 50%]	[0-36 Months]
Subepithelial Connective Tissue Graft Procedures	[0% - 50%]	[0% - 50%]	[0-36 Months]
Periodontal Scaling and Root Planing	[0% - 50%]	[0% - 50%]	[0-36 Months]
Full Mouth Debridement to Enable Periodontal Evaluation and Diagnosis	[0% - 50%]	[0% - 50%]	[0-36 Months]
Periodontal Maintenance Procedures Following Active Therapy	[0% - 50%]	[0% - 50%]	[0-36 Months]
<b>Prosthodontics (removable)</b>			
Complete Denture	[0% - 50%]	[0% - 50%]	[0-36 Months]
Immediate Denture	[0% - 50%]	[0% - 50%]	[0-36 Months]
Partial Denture-Resin Base (Clasp/Rests)	[0% - 50%]	[0% - 50%]	[0-36 Months]
Partial Denture-Metal Frame with Resin Base	[0% - 50%]	[0% - 50%]	[0-36 Months]
Removable Unilateral Partial Denture-One Piece Cast Metal	[0% - 50%]	[0% - 50%]	[0-36 Months]
Adjust Complete and Partial Dentures	[0% - 50%]	[0% - 50%]	[0-36 Months]
Repair Complete and Partial Dentures	[0% - 50%]	[0% - 50%]	[0-36 Months]
Replace Missing or Broken Teeth-Complete Denture (Each Tooth)	[0% - 50%]	[0% - 50%]	[0-36 Months]
Add Tooth to Existing Partial Denture	[0% - 50%]	[0% - 50%]	[0-36 Months]
Add Clasp to Existing Partial Denture	[0% - 50%]	[0% - 50%]	[0-36 Months]
Replace All Teeth & Acrylic - Cast Metal Frame	[0% - 50%]	[0% - 50%]	[0-36 Months]
Rebase Complete and Partial Denture	[0% - 50%]	[0% - 50%]	[0-36 Months]
Relines Partial and Complete Denture	[0% - 50%]	[0% - 50%]	[0-36 Months]
Interim Complete Denture	[0% - 50%]	[0% - 50%]	[0-36 Months]
Interim Partial Denture	[0% - 50%]	[0% - 50%]	[0-36 Months]
Tissue Conditioning	[0% - 50%]	[0% - 50%]	[0-36 Months]
<b>[Prosthodontics (fixed)]</b>			
[Surgical placement of implant body]	[0% - 50%]	[0% - 50%]	[0-36 Months]
[Abutment supported porcelain/ceramic crown]	[0% - 50%]	[0% - 50%]	[0-36 Months]

Schedule of Covered Procedures

[Abutment supported porcelain fused to metal crown]	[0% - 50%]	[0% - 50%]	[0-36 Months]
[Abutment supported cast metal crown]	[0% - 50%]	[0% - 50%]	[0-36 Months]
[Abutment supported Crown Titanium ]	[0% - 50%]	[0% - 50%]	[0-36 Months]
[Implant supported porcelain/ceramic crown]	[0% - 50%]	[0% - 50%]	[0-36 Months]
[Implant supported porcelain fused to metal crown ]	[0% - 50%]	[0% - 50%]	[0-36 Months]
[Implant supported metal crown ]	[0% - 50%]	[0% - 50%]	[0-36 Months]
[Pontic-Cast ]	[0% - 50%]	[0% - 50%]	[0-36 Months]
[Pontic-Porcelain ]	[0% - 50%]	[0% - 50%]	[0-36 Months]
[Pontic-Porcelain/Ceramic]	[0% - 50%]	[0% - 50%]	[0-36 Months]
[Retainer-Fixed Prosthesis]	[0% - 50%]	[0% - 50%]	[0-36 Months]
[Crown-Porcelain/Ceramic]	[0% - 50%]	[0% - 50%]	[0-36 Months]
[Crown-Retainer-Porcelain]	[0% - 50%]	[0% - 50%]	[0-36 Months]
[Crown-Retainer 3/4 Cast]	[0% - 50%]	[0% - 50%]	[0-36 Months]
[Crown-Retainer-Full Cast]	[0% - 50%]	[0% - 50%]	[0-36 Months]
[Recement Fixed Partial Denture]	[0% - 50%]	[0% - 50%]	[0-36 Months]
[Post and Core/Addition to Bridge Retainer]	[0% - 50%]	[0% - 50%]	[0-36 Months]
[Core Buildup for Retainer, Including Any Pins]	[0% - 50%]	[0% - 50%]	[0-36 Months]
[Coping-Metal]	[0% - 50%]	[0% - 50%]	[0-36 Months]
<b>Oral Surgery</b>			
Simple Extraction	[0% - 50%]	[0% - 50%]	[0-36 Months]
Surgical Removal of Erupted Tooth	[0% - 50%]	[0% - 50%]	[0-36 Months]
Removal of Impacted Tooth-Soft Tissue	[0% - 50%]	[0% - 50%]	[0-36 Months]
Surgical Removal of Residual Tooth Roots (Cutting Procedure)	[0% - 50%]	[0% - 50%]	[0-36 Months]
Surgical Exposure of Impacted or Unerupted Tooth for Orthodontic Reasons	[0% - 50%]	[0% - 50%]	[0-36 Months]
Biopsy of Oral Tissue	[0% - 50%]	[0% - 50%]	[0-36 Months]
Brush biopsy	[0% - 50%]	[0% - 50%]	[0-36 Months]
Alveoloplasty	[0% - 50%]	[0% - 50%]	[0-36 Months]
Incision and Drainage Abscess-Intraoral Soft Tissue	[0% - 50%]	[0% - 50%]	[0-36 Months]
Frenulectomy (Frenectomy/Frenotomy) Separate Procedure	[0% - 50%]	[0% - 50%]	[0-36 Months]
Frenuloplasty	[0% - 50%]	[0% - 50%]	[0-36 Months]
Excision of Hyperplastic Tissue/Per Arch	[0% - 50%]	[0% - 50%]	[0-36 Months]
Surgical reduction of fibrous tuberosity	[0% - 50%]	[0% - 50%]	[0-36 Months]
<b>[Orthodontics]</b>			
[Limited Ortho ]	[0% - 50% LTM]	[0% - 50% LTM]	[0-36 Months]
[Interceptive Ortho ]	[0% - 50% LTM]	[0% - 50% LTM]	[0-36 Months]
[Comprehensive Orthodontic Treatment of the Adult Dentition]	[0% - 50% LTM]	[0% - 50% LTM]	[0-36 Months]
<b>Adjunctive Services</b>			
Palliative (Emergency) Treatment-Dental Pain-Minor Procedure	[0% - 50%]	[0% - 50%]	[0-36 Months]
Local Anesthesia	[0% - 50%]	[0% - 50%]	[0-36 Months]
Deep Sedation/General Anesthesia	[0% - 50%]	[0% - 50%]	[0-36 Months]
IV Conscious Sedation/Analgesia	[0% - 50%]	[0% - 50%]	[0-36 Months]
Consultation (by Other than Practitioner Providing Treatment)	[0% - 50%]	[0% - 50%]	[0-36 Months]
Occlusal Adjustment	[0% - 50%]	[0% - 50%]	[0-36 Months]



## SCHEDULE OF BENEFITS

### Out of Network Benefits

[Out of Network Rate] [Maximum Allowable Charge]

### Annual Deductible

For each Covered Person – [\$50.00 In and Out-of-Network]. [The maximum Annual Deductible per family is three (3) times the Individual Deductible..]

### Annual Maximum

The total amount of benefits that will be paid in a [Benefit or Calendar Year] is [[\$1,000] per Covered Person for In and Out-of-Network]. [Benefits for Orthodontia do not count to the Annual Maximum.]

## [ORTHODONTIC BENEFIT

### [Orthodontic Deductible

The orthodontic deductible [\$50] applies to each [Covered Person] [Eligible Child under age [19] on the date orthodontic treatment begins.]

### [Orthodontic Maximum

The total amount of benefits that will be paid over the total course of a lifetime is [\$1000] per [Covered Person or Eligible Child under age [19] on the date orthodontic treatment begins.]

### **Orthodontia Services**

If covered, We will pay benefits for the orthodontic services listed above when the date started for the orthodontic service occurs while the person is insured under this Certificate. No payment will be made for orthodontic treatment if the appliances or bands are inserted prior to becoming insured unless the person was receiving benefits under the prior plan. Benefits will be offset by any amounts already paid under the prior plan. We consider orthodontic treatment to be started on the date the bands or appliances are inserted. Any other orthodontic treatment that can be completed on the same day it is rendered is considered to be started and completed on the date the orthodontic treatment is rendered.

We will pay the Insurance Percentage shown in the Schedule of Benefits after any required deductible for orthodontic services has been satisfied for the Certificate Year. The maximum benefit payable to each person, while insured under the policy, for orthodontic services is shown in the Schedule of Benefits. Those Insureds who are eligible for Orthodontia coverage are indicated in the Schedule of Benefits. The maximum benefit will apply even if coverage is interrupted.

### Exclusions and Limitations

Coverage for services and supplies is not provided for any of the following:

- Replacement of broken appliances;
- Re-treatment of Orthodontic cases;
- Changes in treatment necessitated by an accident;
- Maxillofacial surgery (subrogate with medical insurance);
- Miofunctional therapy (TMJ);
- Treatment of cleft palate;
- Treatment of micrognathia;
- Treatment of macroglossia;

### Payment of Benefits

Benefits will be pro-rated and paid out [over a twenty-four (24) month period or longer based on the treatment plan submitted] or [at the end of every Quarter].

Provider services started after the person's coverage terminates are not covered. Covered benefits in accordance with the Policy in effect at the time coverage terminates will continue for 60 days if the orthodontist is receiving monthly payments or until the later of 60 days after the date coverage terminates or the end of the quarter in progress, if the orthodontist is receiving payments on a quarterly basis. All other provisions of the Policy apply to the Orthodontic Benefit.]

Schedule of Covered Procedures

DESCRIPTION	In-Network Coverage Percentage	Out of Network Benefit	Waiting period
<b>Diagnostic I</b>			
Periodic Oral Evaluation	[50% - 100%]	[50% - 100%]	0
Limited Oral Evaluation-Problem Focused	[50% - 100%]	[50% - 100%]	0
Oral evaluation-Pt. under 3 yrs. old & counseling w/primary caregiver	[50% - 100%]	[50% - 100%]	0
Comprehensive Oral Evaluation	[50% - 100%]	[50% - 100%]	0
Detailed Extensive Oral Evaluation-Problem Focused-By Report	[50% - 100%]	[50% - 100%]	0
Comprehensive Periodontal Eval - New/Exist Pt	[50% - 100%]	[50% - 100%]	0
Intraoral-Complete Series Including Bitewings	[50% - 100%]	[50% - 100%]	0
Intraoral-Periapicals	[50% - 100%]	[50% - 100%]	0
Bitewings	[50% - 100%]	[50% - 100%]	0
Vertical Bitewings-7 to 8 Films	[50% - 100%]	[50% - 100%]	0
Panoramic Film	[50% - 100%]	[50% - 100%]	0
<b>Diagnostic II</b>			
Intraoral-Occlusal Film	[50% - 100%]	[50% - 100%]	[0-36 Months]
Extraoral Films	[50% - 100%]	[50% - 100%]	[0-36 Months]
Pat/Lat Skull & Facial Bone Survey Film	[50% - 100%]	[50% - 100%]	[0-36 Months]
Cephalometric Film	[50% - 100%]	[50% - 100%]	[0-36 Months]
Oral/Facial Images	[50% - 100%]	[50% - 100%]	[0-36 Months]
Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities	[50% - 100%]	[50% - 100%]	[0-36 Months]
Pulp Vitality Tests	[50% - 100%]	[50% - 100%]	[0-36 Months]
Diagnostic Casts	[50% - 100%]	[50% - 100%]	[0-36 Months]
<b>Preventive</b>			
Prophylaxis	[50% - 100%]	[50% - 100%]	0
Topical Application of Fluoride Not Including Prophylaxis-Child	[50% - 100%]	[50% - 100%]	0
Sealant-Per Tooth	[50% - 100%]	[50% - 100%]	0
Space Maintainer	[50% - 100%]	[50% - 100%]	0
<b>Restorative I</b>			
Amalgam Restorations	[50% - 100%]	[50% - 100%]	[0-36 Months]
Resin Restorations (Anterior)	[50% - 100%]	[50% - 100%]	[0-36 Months]
Composite Resin Restorations (Posterior)	[50% - 100%]	[50% - 100%]	[0-36 Months]
<b>Inlays &amp; Onlays</b>			
Inlay-Metallic	[50% - 100%]	[50% - 100%]	[0-36 Months]
Onlay-Metallic	[50% - 100%]	[50% - 100%]	[0-36 Months]
Inlay-Porcelain/Ceramic	[50% - 100%]	[50% - 100%]	[0-36 Months]
Onlay-Porcelain/Ceramic	[50% - 100%]	[50% - 100%]	[0-36 Months]
Inlay-Composite/Resin	[50% - 100%]	[50% - 100%]	[0-36 Months]
Onlay-Composite/Resin	[50% - 100%]	[50% - 100%]	[0-36 Months]
<b>Restorative II</b>			
Crown-Resin	[50% - 100%]	[50% - 100%]	[0-36 Months]
Crown-Porcelain	[50% - 100%]	[50% - 100%]	[0-36 Months]
Crown-3/4 Cast	[50% - 100%]	[50% - 100%]	[0-36 Months]
Crown-Full Cast	[50% - 100%]	[50% - 100%]	[0-36 Months]
Crown-Titanium	[50% - 100%]	[50% - 100%]	[0-36 Months]
Recement Inlay	[50% - 100%]	[50% - 100%]	[0-36 Months]
Recement Crown	[50% - 100%]	[50% - 100%]	[0-36 Months]

Schedule of Covered Procedures

Prefabricated Stainless Steel Crown	[50% - 100%]	[50% - 100%]	[0-36 Months]
Sedative Filling	[50% - 100%]	[50% - 100%]	[0-36 Months]
Core Build-Up, Including Any Pins	[50% - 100%]	[50% - 100%]	[0-36 Months]
Pin Retention/Tooth, In Addition to Restoration	[50% - 100%]	[50% - 100%]	[0-36 Months]
Post and Core In Addition to Crown	[50% - 100%]	[50% - 100%]	[0-36 Months]
<b>Endodontics</b>			
Pulp Cap (Excluding Final Restoration)	[50% - 100%]	[50% - 100%]	[0-36 Months]
Therapeutic Pulpotomy (Excluding Final Restoration)	[50% - 100%]	[50% - 100%]	[0-36 Months]
Gross Pulpal Debridement	[50% - 100%]	[50% - 100%]	[0-36 Months]
Pulpal Therapy	[50% - 100%]	[50% - 100%]	[0-36 Months]
Root Canal-Anterior (Excluding Final Restoration)	[50% - 100%]	[50% - 100%]	[0-36 Months]
Treatment of Root Canal Obstruction-Non-Surgical Access	[50% - 100%]	[50% - 100%]	[0-36 Months]
Incomplete Endodontic Therapy-Inoperable or Fractured Tooth	[50% - 100%]	[50% - 100%]	[0-36 Months]
Internal Root Repair of Perforation Defects	[50% - 100%]	[50% - 100%]	[0-36 Months]
Retreatment Previous Root Canal Therapy-Anterior **	[50% - 100%]	[50% - 100%]	[0-36 Months]
Apexification/Recalcification	[50% - 100%]	[50% - 100%]	[0-36 Months]
Apicoectomy/Periradicular Surgery	[50% - 100%]	[50% - 100%]	[0-36 Months]
Retrograde Filling-Per Root	[50% - 100%]	[50% - 100%]	[0-36 Months]
Root Amputation-Per Root	[50% - 100%]	[50% - 100%]	[0-36 Months]
Hemisection-Including Root Removal, Not Including Root Canal	[50% - 100%]	[50% - 100%]	[0-36 Months]
<b>Periodontics</b>			
Gingivectomy or Gingivoplasty	[50% - 100%]	[50% - 100%]	[0-36 Months]
Gingival Flap Proc	[50% - 100%]	[50% - 100%]	[0-36 Months]
Apically Positioned Flap	[50% - 100%]	[50% - 100%]	[0-36 Months]
Clinical Crown Lengthening-Hard Tissue	[50% - 100%]	[50% - 100%]	[0-36 Months]
Osseous Surgery (Including Flap Entry and Closure)	[50% - 100%]	[50% - 100%]	[0-36 Months]
Bone Replacement Graft	[50% - 100%]	[50% - 100%]	[0-36 Months]
Guided Tissue Regeneration-Resorbable Barrier per Site	[50% - 100%]	[50% - 100%]	[0-36 Months]
Pedicle Soft Tissue Graft Procedure	[50% - 100%]	[50% - 100%]	[0-36 Months]
Free Soft Tissue Graft Procedure (Including Donor Site Surgery)	[50% - 100%]	[50% - 100%]	[0-36 Months]
Subepithelial Connective Tissue Graft Procedures	[50% - 100%]	[50% - 100%]	[0-36 Months]
Periodontal Scaling and Root Planing	[50% - 100%]	[50% - 100%]	[0-36 Months]
Full Mouth Debridement to Enable Periodontal Evaluation and Diagnosis	[50% - 100%]	[50% - 100%]	[0-36 Months]
Periodontal Maintenance Procedures Following Active Therapy	[50% - 100%]	[50% - 100%]	[0-36 Months]
<b>Prosthodontics (removable)</b>			
Complete Denture	[50% - 100%]	[50% - 100%]	[0-36 Months]
Immediate Denture	[50% - 100%]	[50% - 100%]	[0-36 Months]
Partial Denture-Resin Base (Clasp/Rests)	[50% - 100%]	[50% - 100%]	[0-36 Months]
Partial Denture-Metal Frame with Resin Base	[50% - 100%]	[50% - 100%]	[0-36 Months]
Removable Unilateral Partial Denture-One Piece Cast Metal	[50% - 100%]	[50% - 100%]	[0-36 Months]
Adjust Complete and Partial Dentures	[50% - 100%]	[50% - 100%]	[0-36 Months]
Repair Complete and Partial Dentures	[50% - 100%]	[50% - 100%]	[0-36 Months]
Replace Missing or Broken Teeth-Complete Denture (Each Tooth)	[50% - 100%]	[50% - 100%]	[0-36 Months]
Add Tooth to Existing Partial Denture	[50% - 100%]	[50% - 100%]	[0-36 Months]
Add Clasp to Existing Partial Denture	[50% - 100%]	[50% - 100%]	[0-36 Months]
Replace All Teeth & Acrylic - Cast Metal Frame	[50% - 100%]	[50% - 100%]	[0-36 Months]
Rebase Complete and Partial Denture	[50% - 100%]	[50% - 100%]	[0-36 Months]
Relines Partial and Complete Denture	[50% - 100%]	[50% - 100%]	[0-36 Months]
Interim Complete Denture	[50% - 100%]	[50% - 100%]	[0-36 Months]
Interim Partial Denture	[50% - 100%]	[50% - 100%]	[0-36 Months]
Tissue Conditioning	[50% - 100%]	[50% - 100%]	[0-36 Months]
<b>[Prosthodontics (fixed)]</b>			
[Surgical placement of implant body]	[50% - 100%]	[50% - 100%]	[0-36 Months]
[Abutment supported porcelain/ceramic crown]	[50% - 100%]	[50% - 100%]	[0-36 Months]

Schedule of Covered Procedures

[Abutment supported porcelain fused to metal crown]	[50% - 100%]	[50% - 100%]	[0-36 Months]
[Abutment supported cast metal crown]	[50% - 100%]	[50% - 100%]	[0-36 Months]
[Abutment supported Crown Titanium ]	[50% - 100%]	[50% - 100%]	[0-36 Months]
[Implant supported porcelain/ceramic crown]	[50% - 100%]	[50% - 100%]	[0-36 Months]
[Implant supported porcelain fused to metal crown ]	[50% - 100%]	[50% - 100%]	[0-36 Months]
[Implant supported metal crown ]	[50% - 100%]	[50% - 100%]	[0-36 Months]
[Pontic-Cast ]	[50% - 100%]	[50% - 100%]	[0-36 Months]
[Pontic-Porcelain ]	[50% - 100%]	[50% - 100%]	[0-36 Months]
[Pontic-Porcelain/Ceramic]	[50% - 100%]	[50% - 100%]	[0-36 Months]
[Retainer-Fixed Prosthesis]	[50% - 100%]	[50% - 100%]	[0-36 Months]
[Crown-Porcelain/Ceramic]	[50% - 100%]	[50% - 100%]	[0-36 Months]
[Crown-Retainer-Porcelain]	[50% - 100%]	[50% - 100%]	[0-36 Months]
[Crown-Retainer 3/4 Cast]	[50% - 100%]	[50% - 100%]	[0-36 Months]
[Crown-Retainer-Full Cast]	[50% - 100%]	[50% - 100%]	[0-36 Months]
[Recement Fixed Partial Denture]	[50% - 100%]	[50% - 100%]	[0-36 Months]
[Post and Core/Addition to Bridge Retainer]	[50% - 100%]	[50% - 100%]	[0-36 Months]
[Core Buildup for Retainer, Including Any Pins]	[50% - 100%]	[50% - 100%]	[0-36 Months]
[Coping-Metal]	[50% - 100%]	[50% - 100%]	[0-36 Months]
<b>Oral Surgery</b>			
Simple Extraction	[50% - 100%]	[50% - 100%]	[0-36 Months]
Surgical Removal of Erupted Tooth	[50% - 100%]	[50% - 100%]	[0-36 Months]
Removal of Impacted Tooth-Soft Tissue	[50% - 100%]	[50% - 100%]	[0-36 Months]
Surgical Removal of Residual Tooth Roots (Cutting Procedure)	[50% - 100%]	[50% - 100%]	[0-36 Months]
Surgical Exposure of Impacted or Unerupted Tooth for Orthodontic Reasons	[50% - 100%]	[50% - 100%]	[0-36 Months]
Biopsy of Oral Tissue	[50% - 100%]	[50% - 100%]	[0-36 Months]
Brush biopsy	[50% - 100%]	[50% - 100%]	[0-36 Months]
Alveoloplasty	[50% - 100%]	[50% - 100%]	[0-36 Months]
Incision and Drainage Abscess-Intraoral Soft Tissue	[50% - 100%]	[50% - 100%]	[0-36 Months]
Frenulectomy (Frenectomy/Frenotomy) Separate Procedure	[50% - 100%]	[50% - 100%]	[0-36 Months]
Frenuloplasty	[50% - 100%]	[50% - 100%]	[0-36 Months]
Excision of Hyperplastic Tissue/Per Arch	[50% - 100%]	[50% - 100%]	[0-36 Months]
Surgical reduction of fibrous tuberosity	[50% - 100%]	[50% - 100%]	[0-36 Months]
<b>[Orthodontics]</b>			
[Limited Ortho ]	[50% - 100% LTM]	[50% - 100% LTM]	[0-36 Months]
[Interceptive Ortho ]	[50% - 100% LTM]	[50% - 100% LTM]	[0-36 Months]
[Comprehensive Orthodontic Treatment of the Adult Dentition]	[50% - 100% LTM]	[50% - 100% LTM]	[0-36 Months]
<b>Adjunctive Services</b>			
Palliative (Emergency) Treatment-Dental Pain-Minor Procedure	[50% - 100%]	[50% - 100%]	[0-36 Months]
Local Anesthesia	[50% - 100%]	[50% - 100%]	[0-36 Months]
Deep Sedation/General Anesthesia	[50% - 100%]	[50% - 100%]	[0-36 Months]
IV Conscious Sedation/Analgesia	[50% - 100%]	[50% - 100%]	[0-36 Months]
Consultation (by Other than Practitioner Providing Treatment)	[50% - 100%]	[50% - 100%]	[0-36 Months]
Occlusal Adjustment	[50% - 100%]	[50% - 100%]	[0-36 Months]



## SCHEDULE OF BENEFITS

### Out of Network Benefits

Maximum Allowable Charge

### Annual Deductible

For each Covered Person – [\$50.00]. [The maximum Annual Deductible per family is three (3) times the Individual Deductible..]

### Annual Maximum

The total amount of benefits that will be paid in a [Benefit or Calendar Year] is [[\$1,000] per Covered Person]. [Benefits for Orthodontia do not count to the Annual Maximum.]

## [ORTHODONTIC BENEFIT

### [Orthodontic Deductible

The orthodontic deductible [\$50] applies to each [Covered Person] [Eligible Child under age [19] on the date orthodontic treatment begins.]

### [Orthodontic Maximum

The total amount of benefits that will be paid over the total course of a lifetime is [\$1000] per [Covered Person or Eligible Child under age [19] on the date orthodontic treatment begins.]

### **Orthodontia Services**

If covered, We will pay benefits for the orthodontic services listed above when the date started for the orthodontic service occurs while the person is insured under this Certificate. No payment will be made for orthodontic treatment if the appliances or bands are inserted prior to becoming insured unless the person was receiving benefits under the prior plan. Benefits will be offset by any amounts already paid under the prior plan. We consider orthodontic treatment to be started on the date the bands or appliances are inserted. Any other orthodontic treatment that can be completed on the same day it is rendered is considered to be started and completed on the date the orthodontic treatment is rendered.

We will pay the Insurance Percentage shown in the Schedule of Benefits after any required deductible for orthodontic services has been satisfied for the Certificate Year. The maximum benefit payable to each person, while insured under the policy, for orthodontic services is shown in the Schedule of Benefits. Those Insureds who are eligible for Orthodontia coverage are indicated in the Schedule of Benefits. The maximum benefit will apply even if coverage is interrupted.

### Exclusions and Limitations

Coverage for services and supplies is not provided for any of the following:

- Replacement of broken appliances;
- Re-treatment of Orthodontic cases;
- Changes in treatment necessitated by an accident;
- Maxillofacial surgery (subrogate with medical insurance);
- Miofunctional therapy (TMJ);
- Treatment of cleft palate;
- Treatment of micrognathia;
- Treatment of macroglossia;

### Payment of Benefits

Benefits will be pro-rated and paid out [over a twenty-four (24) month period or longer based on the treatment plan submitted] or [at the end of every Quarter].

Provider services started after the person's coverage terminates are not covered. Covered benefits in accordance with the Policy in effect at the time coverage terminates will continue for 60 days if the orthodontist is receiving monthly payments or until the later of 60 days after the date coverage terminates or the end of the quarter in progress, if the orthodontist is receiving payments on a quarterly basis. All other provisions of the Policy apply to the Orthodontic Benefit.]

Schedule of Covered Procedures

DESCRIPTION	Coverage Percentage	Waiting period
<b>Diagnostic I</b>		
Periodic Oral Evaluation	[50% - 100%]	0
Limited Oral Evaluation-Problem Focused	[50% - 100%]	0
Oral evaluation-Pt. under 3 yrs. old & counseling w/primary caregiver	[50% - 100%]	0
Comprehensive Oral Evaluation	[50% - 100%]	0
Detailed Extensive Oral Evaluation-Problem Focused-By Report	[50% - 100%]	0
Comprehensive Periodontal Eval - New/Exist Pt	[50% - 100%]	0
Intraoral-Complete Series Including Bitewings	[50% - 100%]	0
Intraoral-Periapicals	[50% - 100%]	0
Bitewings	[50% - 100%]	0
Vertical Bitewings-7 to 8 Films	[50% - 100%]	0
Panoramic Film	[50% - 100%]	0
<b>Diagnostic II</b>		
Intraoral-Occlusal Film	[0% - 50%]	[0-36 Months]
Extraoral Films	[0% - 50%]	[0-36 Months]
Pat/Lat Skull & Facial Bone Survey Film	[0% - 50%]	[0-36 Months]
Cephalometric Film	[0% - 50%]	[0-36 Months]
Oral/Facial Images	[0% - 50%]	[0-36 Months]
Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities	[0% - 50%]	[0-36 Months]
Pulp Vitality Tests	[0% - 50%]	[0-36 Months]
Diagnostic Casts	[0% - 50%]	[0-36 Months]
<b>Preventive</b>		
Prophylaxis	[50% - 100%]	0
Topical Application of Fluoride Not Including Prophylaxis-Child	[50% - 100%]	0
Sealant-Per Tooth	[50% - 100%]	0
Space Maintainer	[50% - 100%]	0
<b>Restorative I</b>		
Amalgam Restorations	[0% - 50%]	[0-36 Months]
Resin Restorations (Anterior)	[0% - 50%]	[0-36 Months]
Composite Resin Restorations (Posterior)	[0% - 50%]	[0-36 Months]
<b>Inlays &amp; Onlays</b>		
Inlay-Metallic	[0% - 50%]	[0-36 Months]
Onlay-Metallic	[0% - 50%]	[0-36 Months]
Inlay-Porcelain/Ceramic	[0% - 50%]	[0-36 Months]
Onlay-Porcelain/Ceramic	[0% - 50%]	[0-36 Months]
Inlay-Composite/Resin	[0% - 50%]	[0-36 Months]
Onlay-Composite/Resin	[0% - 50%]	[0-36 Months]
<b>[Restorative II</b>		
Crown-Resin	[0% - 50%]	[0-36 Months]
Crown-Porcelain	[0% - 50%]	[0-36 Months]
Crown-3/4 Cast	[0% - 50%]	[0-36 Months]
Crown-Full Cast	[0% - 50%]	[0-36 Months]
Crown-Titanium	[0% - 50%]	[0-36 Months]
Recement Inlay	[0% - 50%]	[0-36 Months]

Schedule of Covered Procedures

Recement Crown	[0% - 50%]	[0-36 Months]
Prefabricated Stainless Steel Crown	[0% - 50%]	[0-36 Months]
Sedative Filling	[0% - 50%]	[0-36 Months]
Core Build-Up, Including Any Pins	[0% - 50%]	[0-36 Months]
Pin Retention/Tooth, In Addition to Restoration	[0% - 50%]	[0-36 Months]
Post and Core In Addition to Crown	[0% - 50%]	[0-36 Months]
<b>Endodontics</b>		
Pulp Cap (Excluding Final Restoration)	[0% - 50%]	[0-36 Months]
Therapeutic Pulpotomy (Excluding Final Restoration)	[0% - 50%]	[0-36 Months]
Gross Pulpal Debridemen]	[0% - 50%]	[0-36 Months]
Pulpal Therapy	[0% - 50%]	[0-36 Months]
Root Canal-Anterior (Excluding Final Restoration)	[0% - 50%]	[0-36 Months]
Treatment of Root Canal Obstruction-Non-Surgical Access	[0% - 50%]	[0-36 Months]
Incomplete Endodontic Therapy-Inoperable or Fractured Tooth	[0% - 50%]	[0-36 Months]
Internal Root Repair of Perforation Defects	[0% - 50%]	[0-36 Months]
Retreatment Previous Root Canal Therapy-Anterior **	[0% - 50%]	[0-36 Months]
Apexification/Recalcification	[0% - 50%]	[0-36 Months]
Apicoectomy/Periradicular Surgery	[0% - 50%]	[0-36 Months]
Retrograde Filling-Per Root	[0% - 50%]	[0-36 Months]
Root Amputation-Per Root	[0% - 50%]	[0-36 Months]
Hemisection-Including Root Removal, Not Including Root Canal	[0% - 50%]	[0-36 Months]
<b>Periodontics</b>		
Gingivectomy or Gingivoplasty	[0% - 50%]	[0-36 Months]
Gingival Flap Proc	[0% - 50%]	[0-36 Months]
Apically Positioned Flap	[0% - 50%]	[0-36 Months]
Clinical Crown Lengthening-Hard Tissue	[0% - 50%]	[0-36 Months]
Osseous Surgery (Including Flap Entry and Closure)	[0% - 50%]	[0-36 Months]
Bone Replacement Graft	[0% - 50%]	[0-36 Months]
Guided Tissue Regeneration-Resorbable Barrier per Site]	[0% - 50%]	[0-36 Months]
Pedicle Soft Tissue Graft Procedure	[0% - 50%]	[0-36 Months]
Free Soft Tissue Graft Procedure (Including Donor Site Surgery)	[0% - 50%]	[0-36 Months]
Subepithelial Connective Tissue Graft Procedures	[0% - 50%]	[0-36 Months]
Periodontal Scaling and Root Planing	[0% - 50%]	[0-36 Months]
Full Mouth Debridement to Enable Periodontal Evaluation and Diagnosis	[0% - 50%]	[0-36 Months]
Periodontal Maintenance Procedures Following Active Therapy	[0% - 50%]	[0-36 Months]
<b>Prosthodontics (removable)</b>		
Complete Denture	[0% - 50%]	[0-36 Months]
Immediate Denture	[0% - 50%]	[0-36 Months]
Partial Denture-Resin Base (Clasp/Rests)	[0% - 50%]	[0-36 Months]
Partial Denture-Metal Frame with Resin Base	[0% - 50%]	[0-36 Months]
Removable Unilateral Partial Denture-One Piece Cast Metal	[0% - 50%]	[0-36 Months]
Adjust Complete and Partial Dentures	[0% - 50%]	[0-36 Months]
Repair Complete and Partial Dentures	[0% - 50%]	[0-36 Months]
Replace Missing or Broken Teeth-Complete Denture (Each Tooth)	[0% - 50%]	[0-36 Months]
Add Tooth to Existing Partial Denture	[0% - 50%]	[0-36 Months]
Add Clasp to Existing Partial Denture	[0% - 50%]	[0-36 Months]
Replace All Teeth & Acrylic - Cast Metal Frame	[0% - 50%]	[0-36 Months]
Rebase Complete and Partial Denture	[0% - 50%]	[0-36 Months]
Relines Partial and Complete Denture	[0% - 50%]	[0-36 Months]
Interim Complete Denture	[0% - 50%]	[0-36 Months]
Interim Partial Denture	[0% - 50%]	[0-36 Months]
Tissue Conditioning	[0% - 50%]	[0-36 Months]

Schedule of Covered Procedures

<b>[Prosthodontics (fixed)]</b>		
[Surgical placement of implant body]	[0% - 50%]	[0-36 Months]
[Abutment supported porcelain/ceramic crown]	[0% - 50%]	[0-36 Months]
[Abutment supported porcelain fused to metal crown]	[0% - 50%]	[0-36 Months]
[Abutment supported cast metal crown ]	[0% - 50%]	[0-36 Months]
[Abutment supported Crown Titanium ]	[0% - 50%]	[0-36 Months]
[Implant supported porcelain/ceramic crown]	[0% - 50%]	[0-36 Months]
[Implant supported porcelain fused to metal crown ]	[0% - 50%]	[0-36 Months]
[Implant supported metal crown ]	[0% - 50%]	[0-36 Months]
[Pontic-Cast ]	[0% - 50%]	[0-36 Months]
[Pontic-Porcelain ]	[0% - 50%]	[0-36 Months]
[Pontic-Porcelain/Ceramic]	[0% - 50%]	[0-36 Months]
[Retainer-Fixed Prosthesis]	[0% - 50%]	[0-36 Months]
[Crown-Porcelain/Ceramic]	[0% - 50%]	[0-36 Months]
[Crown-Retainer-Porcelain]	[0% - 50%]	[0-36 Months]
[Crown-Retainer 3/4 Cast]	[0% - 50%]	[0-36 Months]
[Crown-Retainer-Full Cast]	[0% - 50%]	[0-36 Months]
[Recement Fixed Partial Denture]	[0% - 50%]	[0-36 Months]
[Post and Core/Addition to Bridge Retainer]	[0% - 50%]	[0-36 Months]
[Core Buildup for Retainer, Including Any Pins]	[0% - 50%]	[0-36 Months]
[Coping-Metal]	[0% - 50%]	[0-36 Months]
<b>Oral Surgery</b>		
Simple Extraction	[0% - 50%]	[0-36 Months]
Surgical Removal of Erupted Tooth	[0% - 50%]	[0-36 Months]
Removal of Impacted Tooth-Soft Tissue	[0% - 50%]	[0-36 Months]
Surgical Removal of Residual Tooth Roots (Cutting Procedure)	[0% - 50%]	[0-36 Months]
Surgical Exposure of Impacted or Unerupted Tooth for Orthodontic Reasons	[0% - 50%]	[0-36 Months]
Biopsy of Oral Tissue	[0% - 50%]	[0-36 Months]
Brush biopsy	[0% - 50%]	[0-36 Months]
Alveoloplasty	[0% - 50%]	[0-36 Months]
Incision and Drainage Abscess-Intraoral Soft Tissue	[0% - 50%]	[0-36 Months]
Frenectomy (Frenectomy/Frenotomy) Separate Procedure	[0% - 50%]	[0-36 Months]
Frenuloplasty	[0% - 50%]	[0-36 Months]
Excision of Hyperplastic Tissue/Per Arch	[0% - 50%]	[0-36 Months]
Surgical reduction of fibrous tuberosity	[0% - 50%]	[0-36 Months]
<b>[Orthodontics]</b>		
[Limited Ortho ]	[0% - 50% LTM]	[0-36 Months]
[Interceptive Ortho ]	[0% - 50% LTM]	[0-36 Months]
[Comprehensive Orthodontic Treatment of the Adult Dentition]	[0% - 50% LTM]	[0-36 Months]
<b>Adjunctive Services</b>		
Palliative (Emergency) Treatment-Dental Pain-Minor Procedure	[0% - 50%]	[0-36 Months]
Local Anesthesia	[0% - 50%]	[0-36 Months]
Deep Sedation/General Anesthesia	[0% - 50%]	[0-36 Months]
IV Conscious Sedation/Analgesia	[0% - 50%]	[0-36 Months]
Consultation (by Other than Practitioner Providing Treatment)	[0% - 50%]	[0-36 Months]
Occlusal Adjustment	[0% - 50%]	[0-36 Months]



## SCHEDULE OF BENEFITS

### Out of Network Benefits

Maximum Allowable Charge

### Annual Deductible

For each Covered Person – [\$50.00]. [The maximum Annual Deductible per family is three (3) times the Individual Deductible..]

### Annual Maximum

The total amount of benefits that will be paid in a [Benefit or Calendar Year] is [[\$1,000] per Covered Person]. [Benefits for Orthodontia do not count to the Annual Maximum.]

### [ORTHODONTIC BENEFIT

#### [Orthodontic Deductible

The orthodontic deductible [\$50] applies to each [Covered Person] [Eligible Child under age [19] on the date orthodontic treatment begins.]

#### [Orthodontic Maximum

The total amount of benefits that will be paid over the total course of a lifetime is [\$1000] per [Covered Person or Eligible Child under age [19] on the date orthodontic treatment begins.]

### **Orthodontia Services**

If covered, We will pay benefits for the orthodontic services listed above when the date started for the orthodontic service occurs while the person is insured under this Certificate. No payment will be made for orthodontic treatment if the appliances or bands are inserted prior to becoming insured unless the person was receiving benefits under the prior plan. Benefits will be offset by any amounts already paid under the prior plan. We consider orthodontic treatment to be started on the date the bands or appliances are inserted. Any other orthodontic treatment that can be completed on the same day it is rendered is considered to be started and completed on the date the orthodontic treatment is rendered.

We will pay the Insurance Percentage shown in the Schedule of Benefits after any required deductible for orthodontic services has been satisfied for the Certificate Year. The maximum benefit payable to each person, while insured under the policy, for orthodontic services is shown in the Schedule of Benefits. Those Insureds who are eligible for Orthodontia coverage are indicated in the Schedule of Benefits. The maximum benefit will apply even if coverage is interrupted.

### Exclusions and Limitations

Coverage for services and supplies is not provided for any of the following:

- Replacement of broken appliances;
- Re-treatment of Orthodontic cases;
- Changes in treatment necessitated by an accident;
- Maxillofacial surgery (subrogate with medical insurance);
- Miofunctional therapy (TMJ);
- Treatment of cleft palate;
- Treatment of micrognathia;
- Treatment of macroglossia;

### Payment of Benefits

Benefits will be pro-rated and paid out [over a twenty-four (24) month period or longer based on the treatment plan submitted] or [at the end of every Quarter].

Provider services started after the person's coverage terminates are not covered. Covered benefits in accordance with the Policy in effect at the time coverage terminates will continue for 60 days if the orthodontist is receiving monthly payments or until the later of 60 days after the date coverage terminates or the end of the quarter in progress, if the orthodontist is receiving payments on a quarterly basis. All other provisions of the Policy apply to the Orthodontic Benefit.]

Schedule of Covered Procedures

DESCRIPTION	Coverage Percentage	Waiting period
<b>Diagnostic I</b>		
Periodic Oral Evaluation	[50% - 100%]	0
Limited Oral Evaluation-Problem Focused	[50% - 100%]	0
Oral evaluation-Pt. under 3 yrs. old & counseling w/primary caregiver	[50% - 100%]	0
Comprehensive Oral Evaluation	[50% - 100%]	0
Detailed Extensive Oral Evaluation-Problem Focused-By Report	[50% - 100%]	0
Comprehensive Periodontal Eval - New/Exist Pt	[50% - 100%]	0
Intraoral-Complete Series Including Bitewings	[50% - 100%]	0
Intraoral-Periapicals	[50% - 100%]	0
Bitewings	[50% - 100%]	0
Vertical Bitewings-7 to 8 Films	[50% - 100%]	0
Panoramic Film	[50% - 100%]	0
<b>Diagnostic II</b>		
Intraoral-Occlusal Film	[50% - 100%]	[0-36 Months]
Extraoral Films	[50% - 100%]	[0-36 Months]
Pat/Lat Skull & Facial Bone Survey Film	[50% - 100%]	[0-36 Months]
Cephalometric Film	[50% - 100%]	[0-36 Months]
Oral/Facial Images	[50% - 100%]	[0-36 Months]
Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities	[50% - 100%]	[0-36 Months]
Pulp Vitality Tests	[50% - 100%]	[0-36 Months]
Diagnostic Casts	[50% - 100%]	[0-36 Months]
<b>Preventive</b>		
Prophylaxis	[50% - 100%]	0
Topical Application of Fluoride Not Including Prophylaxis-Child	[50% - 100%]	0
Sealant-Per Tooth	[50% - 100%]	0
Space Maintainer	[50% - 100%]	0
<b>Restorative I</b>		
Amalgam Restorations	[50% - 100%]	[0-36 Months]
Resin Restorations (Anterior)	[50% - 100%]	[0-36 Months]
Composite Resin Restorations (Posterior)	[50% - 100%]	[0-36 Months]
<b>Inlays &amp; Onlays</b>		
Inlay-Metallic	[50% - 100%]	[0-36 Months]
Onlay-Metallic	[50% - 100%]	[0-36 Months]
Inlay-Porcelain/Ceramic	[50% - 100%]	[0-36 Months]
Onlay-Porcelain/Ceramic	[50% - 100%]	[0-36 Months]
Inlay-Composite/Resin	[50% - 100%]	[0-36 Months]
Onlay-Composite/Resin	[50% - 100%]	[0-36 Months]
<b>[Restorative II</b>		
Crown-Resin	[50% - 100%]	[0-36 Months]
Crown-Porcelain	[50% - 100%]	[0-36 Months]
Crown-3/4 Cast	[50% - 100%]	[0-36 Months]
Crown-Full Cast	[50% - 100%]	[0-36 Months]
Crown-Titanium	[50% - 100%]	[0-36 Months]
Recement Inlay	[50% - 100%]	[0-36 Months]

Schedule of Covered Procedures

Recement Crown	[50% - 100%]	[0-36 Months]
Prefabricated Stainless Steel Crown	[50% - 100%]	[0-36 Months]
Sedative Filling	[50% - 100%]	[0-36 Months]
Core Build-Up, Including Any Pins	[50% - 100%]	[0-36 Months]
Pin Retention/Tooth, In Addition to Restoration	[50% - 100%]	[0-36 Months]
Post and Core In Addition to Crown	[50% - 100%]	[0-36 Months]
<b>Endodontics</b>		
Pulp Cap (Excluding Final Restoration)	[50% - 100%]	[0-36 Months]
Therapeutic Pulpotomy (Excluding Final Restoration)	[50% - 100%]	[0-36 Months]
Gross Pulpal Debridemen]	[50% - 100%]	[0-36 Months]
Pulpal Therapy	[50% - 100%]	[0-36 Months]
Root Canal-Anterior (Excluding Final Restoration)	[50% - 100%]	[0-36 Months]
Treatment of Root Canal Obstruction-Non-Surgical Access	[50% - 100%]	[0-36 Months]
Incomplete Endodontic Therapy-Inoperable or Fractured Tooth	[50% - 100%]	[0-36 Months]
Internal Root Repair of Perforation Defects	[50% - 100%]	[0-36 Months]
Retreatment Previous Root Canal Therapy-Anterior **	[50% - 100%]	[0-36 Months]
Apexification/Recalcification	[50% - 100%]	[0-36 Months]
Apicoectomy/Periradicular Surgery	[50% - 100%]	[0-36 Months]
Retrograde Filling-Per Root	[50% - 100%]	[0-36 Months]
Root Amputation-Per Root	[50% - 100%]	[0-36 Months]
Hemisection-Including Root Removal, Not Including Root Canal	[50% - 100%]	[0-36 Months]
<b>Periodontics</b>		
Gingivectomy or Gingivoplasty	[50% - 100%]	[0-36 Months]
Gingival Flap Proc	[50% - 100%]	[0-36 Months]
Apically Positioned Flap	[50% - 100%]	[0-36 Months]
Clinical Crown Lengthening-Hard Tissue	[50% - 100%]	[0-36 Months]
Osseous Surgery (Including Flap Entry and Closure)	[50% - 100%]	[0-36 Months]
Bone Replacement Graft	[50% - 100%]	[0-36 Months]
Guided Tissue Regeneration-Resorbable Barrier per Site]	[50% - 100%]	[0-36 Months]
Pedicle Soft Tissue Graft Procedure	[50% - 100%]	[0-36 Months]
Free Soft Tissue Graft Procedure (Including Donor Site Surgery)	[50% - 100%]	[0-36 Months]
Subepithelial Connective Tissue Graft Procedures	[50% - 100%]	[0-36 Months]
Periodontal Scaling and Root Planing	[50% - 100%]	[0-36 Months]
Full Mouth Debridement to Enable Periodontal Evaluation and Diagnosis	[50% - 100%]	[0-36 Months]
Periodontal Maintenance Procedures Following Active Therapy	[50% - 100%]	[0-36 Months]
<b>Prosthodontics (removable)</b>		
Complete Denture	[50% - 100%]	[0-36 Months]
Immediate Denture	[50% - 100%]	[0-36 Months]
Partial Denture-Resin Base (Clasp/Rests)	[50% - 100%]	[0-36 Months]
Partial Denture-Metal Frame with Resin Base	[50% - 100%]	[0-36 Months]
Removable Unilateral Partial Denture-One Piece Cast Metal	[50% - 100%]	[0-36 Months]
Adjust Complete and Partial Dentures	[50% - 100%]	[0-36 Months]
Repair Complete and Partial Dentures	[50% - 100%]	[0-36 Months]
Replace Missing or Broken Teeth-Complete Denture (Each Tooth)	[50% - 100%]	[0-36 Months]
Add Tooth to Existing Partial Denture	[50% - 100%]	[0-36 Months]
Add Clasp to Existing Partial Denture	[50% - 100%]	[0-36 Months]
Replace All Teeth & Acrylic - Cast Metal Frame	[50% - 100%]	[0-36 Months]
Rebase Complete and Partial Denture	[50% - 100%]	[0-36 Months]
Relines Partial and Complete Denture	[50% - 100%]	[0-36 Months]
Interim Complete Denture	[50% - 100%]	[0-36 Months]
Interim Partial Denture	[50% - 100%]	[0-36 Months]
Tissue Conditioning	[50% - 100%]	[0-36 Months]

Schedule of Covered Procedures

<b>[Prosthodontics (fixed)]</b>		
[Surgical placement of implant body]	[50% - 100%]	[0-36 Months]
[Abutment supported porcelain/ceramic crown]	[50% - 100%]	[0-36 Months]
[Abutment supported porcelain fused to metal crown]	[50% - 100%]	[0-36 Months]
[Abutment supported cast metal crown ]	[50% - 100%]	[0-36 Months]
[Abutment supported Crown Titanium ]	[50% - 100%]	[0-36 Months]
[Implant supported porcelain/ceramic crown]	[50% - 100%]	[0-36 Months]
[Implant supported porcelain fused to metal crown ]	[50% - 100%]	[0-36 Months]
[Implant supported metal crown ]	[50% - 100%]	[0-36 Months]
[Pontic-Cast ]	[50% - 100%]	[0-36 Months]
[Pontic-Porcelain ]	[50% - 100%]	[0-36 Months]
[Pontic-Porcelain/Ceramic]	[50% - 100%]	[0-36 Months]
[Retainer-Fixed Prosthesis]	[50% - 100%]	[0-36 Months]
[Crown-Porcelain/Ceramic]	[50% - 100%]	[0-36 Months]
[Crown-Retainer-Porcelain]	[50% - 100%]	[0-36 Months]
[Crown-Retainer 3/4 Cast]	[50% - 100%]	[0-36 Months]
[Crown-Retainer-Full Cast]	[50% - 100%]	[0-36 Months]
[Recement Fixed Partial Denture]	[50% - 100%]	[0-36 Months]
[Post and Core/Addition to Bridge Retainer]	[50% - 100%]	[0-36 Months]
[Core Buildup for Retainer, Including Any Pins]	[50% - 100%]	[0-36 Months]
[Coping-Metal]	[50% - 100%]	[0-36 Months]
<b>Oral Surgery</b>		
Simple Extraction	[50% - 100%]	[0-36 Months]
Surgical Removal of Erupted Tooth	[50% - 100%]	[0-36 Months]
Removal of Impacted Tooth-Soft Tissue	[50% - 100%]	[0-36 Months]
Surgical Removal of Residual Tooth Roots (Cutting Procedure)	[50% - 100%]	[0-36 Months]
Surgical Exposure of Impacted or Unerupted Tooth for Orthodontic Reasons	[50% - 100%]	[0-36 Months]
Biopsy of Oral Tissue	[50% - 100%]	[0-36 Months]
Brush biopsy	[50% - 100%]	[0-36 Months]
Alveoloplasty	[50% - 100%]	[0-36 Months]
Incision and Drainage Abscess-Intraoral Soft Tissue	[50% - 100%]	[0-36 Months]
Frenectomy (Frenectomy/Frenotomy) Separate Procedure	[50% - 100%]	[0-36 Months]
Frenuloplasty	[50% - 100%]	[0-36 Months]
Excision of Hyperplastic Tissue/Per Arch	[50% - 100%]	[0-36 Months]
Surgical reduction of fibrous tuberosity	[50% - 100%]	[0-36 Months]
<b>[Orthodontics]</b>		
[Limited Ortho ]	[50% - 100% LTM]	[0-36 Months]
[Interceptive Ortho ]	[50% - 100% LTM]	[0-36 Months]
[Comprehensive Orthodontic Treatment of the Adult Dentition]	[50% - 100% LTM]	[0-36 Months]
<b>Adjunctive Services</b>		
Palliative (Emergency) Treatment-Dental Pain-Minor Procedure	[50% - 100%]	[0-36 Months]
Local Anesthesia	[50% - 100%]	[0-36 Months]
Deep Sedation/General Anesthesia	[50% - 100%]	[0-36 Months]
IV Conscious Sedation/Analgesia	[50% - 100%]	[0-36 Months]
Consultation (by Other than Practitioner Providing Treatment)	[50% - 100%]	[0-36 Months]
Occlusal Adjustment	[50% - 100%]	[0-36 Months]

# COVENTRY DENTAL PLAN

## GROUP DENTAL INSURANCE MASTER POLICY

Underwritten by: Coventry Health and Life Insurance Company  
6705 Rockledge Drive, Suite 900  
Bethesda, MD 20817

Administrator: Group Dental Service, Inc  
111 Rockville Pike, Suite 950  
P.O. Box 6228  
Rockville, MD 20849

This is a contract between **COVENTRY HEALTH AND LIFE INSURANCE COMPANY** herein referred to as "Coventry Dental," "Coventry," "We," "Us" and "Our," and the Policyholder.

In return for the application, which is attached, and payment of premiums, as it becomes due, we accept the terms of this Policy and agree to pay the benefits described in the Certificate of Coverage issued pursuant to this group Policy to all Covered Persons.

This Policy is issued to the Policyholder and will take effect on the date shown on the effective date of the Policy at 12:01 a.m. standard time at your address. This Policy may be continued in force by payment of premium at the rates We establish until the insurance ends as provided.

**The following are made part of this Policy: the provisions of the attached Certificates; all riders; all endorsements; and all amendments issued on and after the Effective Date.**

This Policy is governed by the laws of the jurisdiction shown below.

**POLICYHOLDER:** [Group Name]  
**GROUP POLICY NUMBER:** [Group Number]  
**POLICY EFFECTIVE DATE:** [January 1, 2009]  
**ANNIVERSARY DATE:** [January 1, 2010]  
**JURISDICTION:** Arkansas  
**PREMIUM DUE DATE:** [1<sup>st</sup> of every Month]  
**COVERAGE PROVIDED:** [See Incorporated Certificate of Coverage Schedule of Benefits]  
**INITIAL TERM:** [12 Months]

IN WITNESS WHEREOF, we have signed this policy at Bethesda, Maryland.

**COVENTRY HEALTH AND LIFE INSURANCE COMPANY**

By \_\_\_\_\_ Date: \_\_\_\_\_  
(Officer Signature and Title) Policy Effective Date

\_\_\_\_\_  
(Full or Corporate Name of ABC GROUP/the Policyholder)

By \_\_\_\_\_ Date: \_\_\_\_\_  
(Signature and Title)

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## **PART I: PROVISIONS SPECIFIC TO EMPLOYER GROUPS**

**Continuation Coverage** - Certain employers may be required to meet certain criteria to offer continuation coverage to Covered Persons for a specified time upon termination of employment or reduction of work hours for any reason other than gross misconduct. The Policyholder will notify the Covered person if applicable. If this requirement does apply, the Covered Person must elect to continue coverage for themselves and for Covered Dependents within 60 days from the qualifying or notification of rights by the Policyholder, whichever is later. The Covered Person must pay the required premium for continuation of coverage. Coventry Dental is not responsible for determining who is eligible for continuation coverage.

## **PART II: WHEN INSURANCE UNDER THIS POLICY ENDS**

In addition to termination for non-payment of premiums, either the Policyholder or Coventry Dental may terminate the Policy for any reason, including low participation, effective as of the renewal date, by providing a minimum of forty-five (45) days notice. Any failure by the Policyholder to pay premiums when due or within the Grace Period shall be deemed notice to us to terminate coverage at the end of the Grace Period. Coverage remains in effect during the Grace Period. Termination will not affect a claim for a covered loss which occurred while coverage was in effect. In the event of termination, the Policyholder shall provide a notice of termination to each Covered Person. Upon request, the Policyholder agrees to provide Coventry Dental with proof that such notice was given.

**Notice of Termination; Continued Payment of Premiums** - The Policyholder is responsible for paying premiums until the later of the date the notice of termination is received by Coventry Dental or the date coverage would otherwise terminate under the terms of the Contract.

Insurance will end as provided above without the consent of, or notice to, any Insured Dependent or Beneficiary.

## **PART III: PREMIUMS**

**A. PAYMENT OF PREMIUMS:** The premiums due under this Policy are payable in advance directly to Us at the Administrator's Office. The first premium is due on the Effective Date of this Policy. Premiums after the first are due on the Premium Due Date shown on the face page of this Policy.

The payment of any premium will not maintain the insurance in force beyond the day next following the Premium Due Date, except as provided under the GRACE PERIOD provision.

**B. PREMIUM ADJUSTMENTS:** When additional or increased insurance begins or insurance ends and such change is due to a change in the terms of this Policy, any adjustment in the premium will be made as of the date the change is effective. Otherwise, any adjustment in premium will be made on the Premium Due Date which occurs on or next follows the date of change (or the first day of the calendar month which occurs on or next follows the date of change if premiums are payable other than monthly).

Upon agreement between the Policyholder and Us, the mode of premium payment may be changed as of any Premium Due Date.

**C. PREMIUM CALCULATION:** The total premium for insurance coverage under this Policy is obtained by multiplying the number of Insureds in each class by the applicable premium rates then in effect and adding the results.

**D. CHANGES IN PREMIUM RATES:** We have the right to change the premium rates on any Premium Due Date after the Initial Term. After the Initial Term, We will not increase the premium rates more than once in any 12 month period. We will notify the Policyholder in writing at least forty-five days before any increase in premium rates.

Any premium rate guarantees are subject to the following provisions:

1. The plan of benefits outlined in the Certificate of Coverage and eligibility remains unchanged.
2. There are no additions or deletions of subsidiaries or affiliates.

3. The census, volume or geographic distribution does not change by 25% or more.
4. The employer contribution to premiums is not reduced.

**E. AGGREGATE PREMIUM:** The aggregate premium due on any Premium Due Date is the sum of the amounts determined in accordance with the PREMIUM CALCULATION provision.

**F. GRACE PERIOD:** A Grace Period of 31 days (without interest charge) is granted for the payment of any premium due after the first. This Policy will continue in effect during this period unless the Policyholder has given written notice to Us that the insurance under this Policy is to be ended on the first day before the Grace Period would otherwise start. If the premium is not paid by the end of the Grace Period, all insurance under this Policy will end on the last day of the Grace Period. The Policyholder will owe Us all premiums then due and unpaid including the premium for the Grace Period.

If the Policyholder gives Us written notice that insurance under this Policy is to be ended during the Grace Period, all insurance will end on the date We receive the written notice or the date specified, if later.

The Policyholder will owe Us the pro-rata premium for the time the insurance was in effect during the Grace Period.

#### **PART IV: GENERAL PROVISIONS**

**A. ENTIRE CONTRACT:** The entire contract consists of:

1. this Policy;
2. the application of the Policyholder;
3. the provisions shown in the Certificate;
4. the Insured enrollment forms;
5. premium rate attachment; and
6. riders and amendments, if any, adding or changing the provisions of the Policy or Certificate.

A copy of the Policyholder's application is attached to this Policy on the date it is signed. All statements made in the applications, in the absence of fraud, are representations and not warranties. No statement made by an Insured under this Policy will be used to void insurance or deny a claim unless a copy of the statement is or has been given to that Insured or to His Beneficiary, if any.

**B. INCONTESTABILITY:** This Policy will be incontestable, except for non-payment of premium, after it has been in force for two years.

**C. CHANGES IN POLICY:** The terms of this Policy can be changed only by written agreement between the Policyholder and Us. Agreement for Us can only be made by an authorized representative. Any changes will be made without the consent of, or notice to, any Insured or Beneficiary, if any. No agent has authority to make this Policy or to change, alter or amend any of its terms or provisions in any way.

**D. AGE MISSTATED:** If the age of any Insured under this Policy has been misstated, there will be a fair adjustment between the Policyholder and Us. As the basis for adjustment, We will recompute the premium for the true age of that person and the right amount of His insurance as provided by this Policy.

**E. CONFORMITY WITH LAW:** If any provision of this Policy is contrary to the law of the jurisdiction in which it is delivered, such provision is hereby amended to conform to that law.

**F. POLICY NON-PARTICIPATING:** This Policy is not entitled to share in the surplus earnings of Our Company.

**G. REPORTING REQUIREMENTS:** The Policyholder or its authorized agent must report to us, by the premium due date:

- 1) the names of all Covered Persons on the Policy Effective Date;
- 2) the names of all Covered Persons after the Policy Effective Date;
- 3) the names of those persons whose coverage has terminated; and

4) additional information required as agreed to by us and the Policyholder.

**H. CLERICAL ERROR:** Clerical error (whether by the Policyholder or Us) in keeping records having to do with this Policy, or delays in making entries on the records, will not void the insurance of any person if that insurance would otherwise have been in effect. Such clerical error will not extend the insurance of any person if that insurance would otherwise have ended or been reduced as provided by this Policy.

When a clerical error is found, premiums and benefits will be adjusted based on the true facts and this Policy.

**I. EXAMINATION OF RECORDS:** We shall be permitted to examine all of your records relating to this Policy. Examination may occur at any reasonable time while the Policy is in force; or it may occur at any time for two years after the expiration of the Policy; or, if later, until the final adjustment and settlement of all Policy claims.

**J. POLICYHOLDER NOT AGENT:** The Policyholder will in no event be considered Our agent for any purpose under this Policy.

**K. ASSIGNMENT:** No assignment of this Policy is binding upon Us unless We agree to it in writing and not until it is filed with Us at Our Home Office.

**L. INDIVIDUAL CERTIFICATE:** We will issue to the Policyholder for delivery to each person insured under this Policy Certificates that state the insurance protection to which He is entitled and to whom the benefits are payable. The word Certificates will include Certificate riders and Certificate supplements, if any.

**M. ADDITIONAL INSUREDS:** The following will be added to the group originally insured:

1. All new persons becoming eligible to and applying for insurance in such group or class, including new members of a family; and
2. Any persons required to be provided coverage under federal law who apply for insurance in such group or class.

**N. DELETION OF COVERED PERSONS:** - Covered Persons or Covered Dependent(s) may be deleted by written notice to Coventry Dental. [Retroactive terminations will only extend back for [60] days from the date written notice is received and will only be permitted if the Covered Person and/or Covered Dependent did not file any claims for benefits during that period.]

**O. RENEWAL NOTICE:** - At least 60 days before the expiration date of the Policy, Coventry will mail written notice of renewal to the Policyholder that includes the dates of the renewal period, the Plan rates and premium increases, and the terms of coverage under the Policy. Notice of renewal will be deemed accepted unless the Policyholder provides written notice to Coventry.

**P. LEGAL ACTIONS:** No action at law or in equity shall be brought to recover benefits under the group Policy less than sixty (60) days after written Proof of Loss has been furnished as required by the Policy. No such action shall be brought more than three (3) years after the time written Proof of Loss is required to be furnished.

## **PART V: CLAIM PROVISIONS**

**A. NOTICE OF CLAIM:** Written notice must be given within 20 days after treatment or as soon as reasonably possible. The notice must be given to the Administrator or to our agent. Notice should include the Covered Person's name, address and group policy number.

Claims should be sent to:

Coventry Dental  
c/o Group Dental Service, Inc.  
111 Rockville Pike, Suite 950  
P.O. Box 6228  
Rockville, MD 20849

**B. CLAIM FORMS:** When the Administrator receives notice of claim that does not contain all necessary information or is not on an appropriate claim form, forms for filing proof of loss will be sent to the claimant along

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Original Filed  
10/07/08  
Page 5 of 6

with a request for the missing information. If these forms are not sent within fifteen (15) days, the claimant will meet the proof of loss requirements if the Plan Administrator is given written proof of the nature and extent of the loss

**C. PROOF OF LOSS** Written proof, satisfactory to us, must be given to us within 90 days after the date of loss. If that is not reasonably possible, we will not deny or reduce any claim if proof is furnished as soon as reasonably possible except in the absence of legal capacity, not later than 1 year from the time proof is otherwise required.

**D. PAYMENT OF CLAIMS** - All benefits will be paid to the Covered Person unless assigned by the Covered Person to the Provider. Only one claim amount will be paid for each covered procedure. Any benefits unpaid at the time of the Covered Person's death will be paid in one lump sum to the Covered Person's estate. If any beneficiary is a minor or mentally incapacitated, we will pay the proper share of the insurance amount to such beneficiary's court appointed guardian.

**E. TIME PAYMENT OF CLAIMS:** Benefits payable under the group policy for any loss will be paid not more than 30 days after written receipt of Proof of Loss. We reserve the right to request x-rays, narratives and other diagnostic information, as we see fit, to determine benefits.

**Domestic Partner Amendment**  
**[Group Name]**  
**[Effective Date]-[End Date]**

This amendment is attached to and made part of the Group Certificate between [Group Name] and Coventry Health and Life Insurance Company effective [effective date].

**I. Definition Modifications**

A. The Definition Section of the Certificate is amended to include the definition of Domestic Partner as follows:

“**Domestic Partner** means a person of the same or opposite sex who is not related to the Eligible Person by blood or marriage, with whom the Eligible Person has established a long-term relationship of indefinite duration, with an exclusive commitment similar to that of marriage.”

B. In the Definition Section, the definition of “Eligible Dependent” is amended to include Domestic Partners and the Domestic Partner’s Children.

C. In the Definition Section, the definition of “Provider” is amended to include Eligible Person’s Domestic Partner and Eligible Person’s Domestic Partner’s child, parent, brother or sister.

**II. Qualifications to be a Domestic Partner**

The General Provision Section of the Certificate is amended to include the following new Subsection:

**Domestic Partners**

a. To be eligible as a Domestic Partner, all of the following requirements of the Eligible Person and Domestic Partner must be satisfied:

- They maintain the same principal residence, have been living together continually for at least six months, and intend to do so indefinitely.
- They are at least 18 years of age, and are mentally competent to consent to contract.
- Neither is currently legally married to, legally separated from, or a Domestic Partner of another person under either statutory or common law.
- They are not related by blood or a degree of closeness that would prohibit marriage under the laws of the state in which they reside.
- Neither has had a different Domestic Partner within the past six months, unless the previous domestic partnership terminated as the result of death.
- They are not engaged in the relationship solely for the purpose of obtaining benefit coverage.
- They have a close, committed, and exclusive personal relationship with each other, are jointly responsible for each other’s common welfare and financial obligations, and they intend to continue this relationship for the indefinite future.
- They are financially interdependent, meaning that they are jointly responsible for basic financial obligations of the domestic partnership. Interdependence will be demonstrated by at least three of the following:
  - Joint ownership, mortgage, or lease on place of residence
  - Joint title on motor vehicle
  - Proof of joint bank or credit card account
  - Agreement with a third party lender for joint repayment of indebtedness

- Designation of one partner as the other's beneficiary with respect to life insurance or retirement benefits
- Joint will, or reciprocal wills in which each partner designates the other as executor and/or primary beneficiary
- Durable property or health care powers of attorney by each partner in favor of the other

b. Effective Date of Coverage for Domestic Partners and their Children.

1. The coverage effective date for Domestic Partners will be determined according to the same provisions set forth for spouses in the Group Certificate.
2. Dependents of the Domestic Partner will be eligible under the same conditions as other members of the Eligible Person's family, as defined in the Group Certificate.

c. Termination of Coverage for Domestic Partners and their Children.

1. Upon dissolution of a domestic partnership, the Domestic Partner and the Domestic Partner's insured dependents will become ineligible.
  - (a) Notice of dissolution of the domestic partnership must be submitted in writing. Coventry Health and Life Insurance Company may accept the Eligible Person's request to remove the Domestic Partner and his/her dependents from the Eligible Person's Benefit Plan without confirmation from the Domestic Partner.
  - (b) The Domestic Partner and the Domestic Partner's insured dependents will be eligible for state continuation coverage and conversion coverage, in accordance with the provisions set forth in the Group Certificate.
  - (c) Coventry Health and Life Insurance Company will not provide COBRA continuation coverage to the Domestic Partner or his/her dependents.
2. Upon dissolution of a Domestic Partner relationship, an Eligible Person must wait for a period of six months before he/she may add a new Domestic Partner, except in the instance of death of the Domestic Partner.
3. The Domestic Partner and his/her dependents are subject to the same termination provisions as other dependents, as set forth in the Certificate.

COVENTRY HEALTH AND LIFE INSURANCE COMPANY

[GROUP NAME]

By:

By:

\_\_\_\_\_  
(Officer Signature)

\_\_\_\_\_  
Authorized Agent

\_\_\_\_\_  
Title

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date



## Employer Application

Group Dental Coverage

Company Name:	Date Created:	
Address:	DBA (if applicable):	
City:	State:	Zip Code:
Phone Number:	Fax Number:	
Primary Contact Name:	E-Mail Address of Contact:	

### EMPLOYER INFORMATION

Organization Type:  Corporation  Partnership  Sole Proprietor  Other: \_\_\_\_\_

Full Legal Name of Employer:  
(Include names of subsidiaries or affiliated companies)

Are any divisions billed to a different location?  Yes  No  
If yes, please provide contact name and addresses.

Employer Identification Number (Tax ID):

Has your firm ever filed for or is it in the process of filing for bankruptcy?  Yes  No

### DENTAL PLAN PARTICIPATION AND SELECTION

Dental Plan Name (Code):

Did the group have dental coverage for the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of prior dental carrier:
---	---------------------------------------

### CONTRACT INFORMATION

Coverage Begins:	Employee Eligibility:	Coverage Ends:	Dependent Age Limits:
<input type="checkbox"/> Date of Hire 1 <sup>st</sup> of the month following: <input type="checkbox"/> 0 days <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 6 Months <input type="checkbox"/> Other	<input type="checkbox"/> Min. 30 Hrs/Wk <input type="checkbox"/> Other _____	<input type="checkbox"/> End of month of termination <input type="checkbox"/> Date of termination <input type="checkbox"/> Other _____	<input type="checkbox"/> 19/25 <input type="checkbox"/> Other _____

Total number of employees on payroll: \_\_\_\_\_ Total number of full time/eligible employees (EE): \_\_\_\_\_

Number of COBRA participants in total group: \_\_\_\_\_ Number of Retirees in total group: \_\_\_\_\_

### Rates and Contributions

	Tier Structure	Rates	Number of Enrolled Employees	Employer Contribution %	Employee Contribution %
Single Tier	EE				
Two Tier	EE				
	Family				
Three Tier	EE				
	EE+ One				
	Family				
Four Tier	EE				
	EE+ One				
	EE+ Child(ren)				
	Family				

**OPTIONAL COVERAGE FOR TEMPOROMANDIBULAR JOINT DISORDER:**

Coverage for the treatment of musculoskeletal disorders affecting any bone or joint in the face, neck, or head, including temporomandibular joint disorder.

Accept  Decline  **By declining this optional coverage, the insured/member will not have coverage for temporomandibular joint disorder.**

**BILLING AND ADMINISTRATIVE CONTACT INFORMATION**

Please provide the information below if different than above for billing purposes and plan administration.

<b>BILLING CONTACT</b>		
Contact Name:	Contact Title:	
Address:	E-Mail Address:	
City:	State:	Zip Code:
Phone:	Fax:	

**AGENT/BROKER VERIFICATION**

<b>BROKER INFORMATION</b>		
Agent/Broker Name:	Tax ID#:	% Commission:
Agency Name:	Address:	
City:	State:	Zip Code:
E-Mail Address:	Phone:	Fax::

<b>GENERAL AGENT INFORMATION</b>		
Agent/Broker Name:	Tax ID#:	% Commission:
Agency Name:	Address:	
City:	State:	Zip Code:
E-Mail Address:	Phone:	Fax::

**SIGNATURE SECTION**

I understand and agree that the first month's estimated premium and fully completed enrollment information for all eligible persons requesting insurance coverage must be submitted with this application BEFORE action is taken on this application. Coverage is not in effect unless and until I receive notification of acceptance from the Company. If this application is declined, the Company will return the premium deposit submitted with the application. If my coverage is approved, premium is payable monthly in advance.

I understand and agree that failure to pay premium when due will be considered a default in premium payment, and that the Company will terminate coverage following a grace period (time extension for payment of premium) of [31] days from the date of nonpayment of premium. If the coverage is terminated by the Company for nonpayment of premium, I will still owe, and the insurance company will collect, premium, for the grace period. I understand that coverage may also be terminated for other reasons as provided in the policy.

I represent and agree that all the answers and statements in this request are full, complete and true, to the best of my knowledge and belief, and understand that the said answers and statements form the basis upon which coverage will be made effective. I understand that the material omissions or misrepresentations could result in voiding or reformation of coverage.

I agree that the Company shall be entitled to rely on the most current information in its possession regarding eligibility of employees and their dependents in providing coverage under this policy. I understand and agree that I am responsible for notifying the Company promptly of any changes in this information that may affect the eligibility of employees of their dependents, including the addition of newly eligible employees or dependents.

**ARKANSAS**

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

Authorized Officer's Name:	Title:
Authorized Officer's Signature:	Date:
Agent Name:	Date:
Agent Signature:	Date:



# Dental Enrollment / Change Form

\*Denotes required fields for enrollment. For items with \*\* please select a Reason for Enrollment OR Change.

<b>A EMPLOYER INFORMATION: To Be Completed By Employer</b>					
Company Name: _____			*Group No.: _____		
Date Employed Full Time: _____			*Effective Date of Coverage or Change _____		
<b>REASON FOR ENROLLMENT OR CHANGE</b>					
<b>ENROLL</b>		<b>TERMINATE COVERAGE</b>		<b>CHANGE</b>	
<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Group Request	<input type="checkbox"/> Terminate Subscriber	<input type="checkbox"/> Name		
<input type="checkbox"/> New Group	<input type="checkbox"/> Member Request	<input type="checkbox"/> Terminate Dependent	<input type="checkbox"/> Address/Phone		
<input type="checkbox"/> New Hire	<input type="checkbox"/> Qualifying Event (Reason)	<input type="checkbox"/> Deceased			
<input type="checkbox"/> COBRA	Date ____/____/____	<input type="checkbox"/> Termination Reason: _____			
<input type="checkbox"/> Add Dependent	**List Reason: _____				
<b>Employee Status:</b>					
<input type="checkbox"/> Active	<input type="checkbox"/> COBRA	<input type="checkbox"/> Salary	<input type="checkbox"/> Hourly	Number of hours a week _____	<input type="checkbox"/> Other _____
<b>Benefits Administrator Approval:</b>				Date: _____	
<b>B DENTAL COVERAGE ELECTION</b>					
<b>I ELECT THE FOLLOWING FOR MYSELF AND MY DEPENDENT(S):</b> <input type="checkbox"/> Dental Plan Code <sup>1</sup> _____					
<b>Type of Coverage:</b> <input type="checkbox"/> Employee <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child <input type="checkbox"/> Employee/Children <input type="checkbox"/> Employee/Spouse/Child(ren)					
<b>Member Certificates:</b> <input checked="" type="checkbox"/> Electronic <input checked="" type="checkbox"/> Paper (Coventry Dental will assume paper certificates if not completed)					
<b>C DENTAL WAIVER ( only complete if waiving coverage)</b>					
I understand that if I decide to apply for dental coverage for myself and any applicable dependents(s) at a later date, neither my dependent(s) nor I will be eligible for coverage until (1) my employer's next open enrollment period, or (2) there is a qualifying event as defined in the EOC/COI.					
<input type="checkbox"/> Waive Dental	<input type="checkbox"/> Myself	<input type="checkbox"/> Spouse	<input type="checkbox"/> Dependent(s)	Reason: <input type="checkbox"/> Other Insurance <input type="checkbox"/> Spousal Coverage	
<input type="checkbox"/> Other Reason (please explain) _____					
Employee Signature (only if you are waiving coverage) _____				Date _____	
<b>D EMPLOYEE INFORMATION</b>					
*Last Name			*First Name		MI
*Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		*Birthdate		*Social Security Number	
*Address					
*City			*State	*Zip Code	
Work Phone			Home Phone		
<b>E FAMILY MEMBERS TO BE COVERED OR DELETED</b>					
if address and phone numbers of covered dependents are different from those of policyholder, please attach that information on a separate sheet of paper.					
	FULL NAME (Last, First, MI)	SEX	RELATIONSHIP	BIRTHDATE	SOCIAL SECURITY #
<input type="checkbox"/> Enroll <input type="checkbox"/> Delete		M F	SPOUSE	/ /	- -
<input type="checkbox"/> Enroll <input type="checkbox"/> Delete		M F		/ /	- -
<input type="checkbox"/> Enroll <input type="checkbox"/> Delete		M F		/ /	- -
<input type="checkbox"/> Enroll <input type="checkbox"/> Delete		M F		/ /	- -
<b>F OTHER DENTAL COVERAGE</b>					
<b>WHEN coverage BEGINS,</b> will you or any of your family members have any other dental insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No					

<sup>1</sup> Underwritten by Coventry Health and Life Insurance Company 6705 Rockledge Drive, Ste 900 Bethesda, MD 20817

Continued on back

**G EMPLOYEE SIGNATURE**

I represent that all information supplied in this application is true and correct. I have thoroughly reviewed, understand, and accurately responded to all questions and information on this application. I hereby agree to the conditions of enrollment on the reverse side of this form.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

Acceptance of Coverage

Please make a copy for your records

**I accept the insurance provided by my employer's group insurance plan. I authorize deductions from my earnings for the required contributions toward the cost of insurance. (This authorization applies only if employee contributions are required.) I understand that by accepting insurance, I am required to remain enrolled as a covered employee and cannot make an elective change in the coverage selected until the next open enrollment period, if there is one provided for in the Master Agreement to Provide Dental Benefits.**

**Fraud Statements**

**Attention California:** For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison, and substantial civil penalties.

**Attention Colorado Residents:** An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.

**Attention Florida and Virginia Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

**Attention Maryland Residents:** It is a crime to knowingly provide, or to knowingly assist, abet, or conspire with another to provide false, incomplete, or misleading information to an insurance company with intent to injure, defraud, or deceive the company or any other person. Penalties include imprisonment, fines, and denial of insurance benefits.

**Attention Pennsylvania Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Attention Residents of Other States:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. In addition, an insurer may deny insurance benefits if false information materially related to the claim was provided by the applicant.

*SERFF Tracking Number:* GHPI-125848828      *State:* Arkansas  
*Filing Company:* Coventry Health and Life Insurance Company      *State Tracking Number:* 40467  
*Company Tracking Number:* ARGDS08  
*TOI:* H10G Group Health - Dental      *Sub-TOI:* H10G.000 Health - Dental  
*Product Name:* AR-Dental Product  
*Project Name/Number:* /

## **Rate Information**

Rate data does NOT apply to filing.

SERFF Tracking Number: GHPI-125848828 State: Arkansas  
Filing Company: Coventry Health and Life Insurance Company State Tracking Number: 40467  
Company Tracking Number: ARGDS08  
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental  
Product Name: AR-Dental Product  
Project Name/Number: /

## Supporting Document Schedules

**Satisfied -Name:** Certification/Notice **Review Status:** Approved-Closed 10/09/2008

**Comments:**

The attached cover letter includes information regarding the above regulations. The Flesch Certificate and Insurance Guaranty Association Notice is also attached. A document list is also attached.

**Attachments:**

AR Dental Initial Cover Ltr.pdf  
GDS Readability Cert.pdf  
AR\_GA08\_CHL.pdf  
AR-GDS Document List 100708.pdf

**Satisfied -Name:** Application **Review Status:** Approved-Closed 10/09/2008

**Comments:**

The Applications to be used with this product are also attached here. The applications can also be found under the Form/Schedule tab.

**Attachments:**

AR\_GDSAPP08\_CHL.pdf  
AR\_GDSENROLL08\_CHL.pdf



(314) 506-1928  
[acarter@cvty.com](mailto:acarter@cvty.com)

October 7, 2008

Rosalind Minor  
Sr. Certified Rate & Form Analyst  
Arkansas Insurance Department  
Life and Health Division  
1200 West Third Street  
Little Rock, Arkansas 72201

**Re: Co Tracking #: ARGDS08  
Group Dental Certificates of Coverage, Schedules of  
Benefits, Applications, Domestic Partner Amendment,  
Group Dental Master Policy**

Dear Ms Minor:

I am writing on behalf of Coventry Health and Life Insurance Co. ("CHL") regarding submission of the above referenced documents outlined in the attached list.

The intended market for these documents is the employer group market. These documents are new, rather than replacement documents. These documents will be issued to employers.

In addition, please note the following:

1. Per a discussion on September 12, 2007 (for a previous filing), it is not necessary to file rates for groups.
2. A check in the amount of \$50.00 will be sent under separate cover as per our email discussion on September 25, 2008.
3. In compliance with ACA 23-79-206, a Readability Certificate is attached.
4. In compliance with Rule & Regulation 19, these documents do not discriminate on the basis of sex.
5. In compliance with Rule & Regulation 49, an Insurance Guaranty Association Notice is attached.

6. In compliance with ACA 23-79-138, the company's service office address and phone number as well as the AR Insurance Department address and phone number are listed in the Dental Certificates of Coverage.

Thank you for your assistance with this filing. If you have any comments or concerns, please contact me at (314) 506-1928.

Sincerely,

A handwritten signature in black ink, appearing to read "Anita J. Carter". The signature is fluid and cursive, with a large initial "A" and "C".

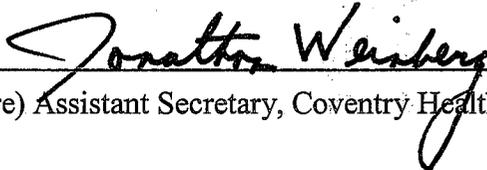
Anita J. Carter, RN  
Manager, Regulatory Compliance

Enclosures

## READABILITY CERTIFICATION

I hereby certify that the following forms comply with the Arkansas minimum Flesch reading ease test scores pursuant to A.C.A. § 23-80-206:

AR\_GDSAPP08\_CHL  
AR\_GDSENROLL08\_CHL  
AR\_GDSGEA08\_CHL  
AR\_GDSINDM08\_CHL  
AR\_GDS08\_CHL  
AR\_GDSSOBINDM50-08\_CHL  
AR\_GDSSOBINDM100-08\_CHL  
AR\_GDSSOB50-08\_CHL  
AR\_GDSSOB100-08\_CHL  
AR\_GDSDOMPART08\_CHL

  
\_\_\_\_\_  
(Signature) Assistant Secretary, Coventry Health & Life Insurance Company

Jonathan D. Weinberg  
\_\_\_\_\_  
(Print Name)

October 7, 2008  
\_\_\_\_\_  
(Date)

**LIMITATIONS AND EXCLUSIONS UNDER THE  
ARKANSAS LIFE AND HEALTH INSURANCE  
GUARANTY ASSOCIATION ACT**

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

**DISCLAIMER**

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in the state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association  
c/o The Liquidation Division  
1023 West Capitol  
Little Rock, Arkansas 72201

Arkansas Insurance Department  
1200 West Third Street  
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

(Continued on reverse side)

## COVERAGES

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

## EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

## LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

**Documents filed 10/07/08**

AR_GDSINDM08_CHL	Dental Certificate of Coverage (COC)
AR_GDS08_CHL	Dental Certificate of Coverage (COC)
AR_GDSSOB50-08_CHL	Dental Schedule of Benefits (SOB)
AR_GDSSOB100-08_CHL	Dental Schedule of Benefits (SOB)
AR_GDSSOBINDM50-08_CHL	Dental Schedule of Benefits (SOB)
AR_GDSSOBINDM100-08_CHL	Dental Schedule of Benefits (SOB)
AR_GDSGEA08_CHL	Group Dental Insurance Master Policy
AR_GDSDOMPART08_CHL	Domestic Partner Amendment
AR_GDSAPP08_CHL	Employer Application
AR_GDSENROLL08_CHL	Dental Enrollment/Change Form



## Employer Application

Group Dental Coverage

Company Name:	Date Created:	
Address:	DBA (if applicable):	
City:	State:	Zip Code:
Phone Number:	Fax Number:	
Primary Contact Name:	E-Mail Address of Contact:	

### EMPLOYER INFORMATION

Organization Type:  Corporation  Partnership  Sole Proprietor  Other: \_\_\_\_\_

Full Legal Name of Employer:  
(Include names of subsidiaries or affiliated companies)

Are any divisions billed to a different location?  Yes  No  
If yes, please provide contact name and addresses.

Employer Identification Number (Tax ID):

Has your firm ever filed for or is it in the process of filing for bankruptcy?  Yes  No

### DENTAL PLAN PARTICIPATION AND SELECTION

Dental Plan Name (Code):

Did the group have dental coverage for the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of prior dental carrier:
---	---------------------------------------

### CONTRACT INFORMATION

Coverage Begins:	Employee Eligibility:	Coverage Ends:	Dependent Age Limits:
<input type="checkbox"/> Date of Hire 1 <sup>st</sup> of the month following: <input type="checkbox"/> 0 days <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 6 Months <input type="checkbox"/> Other	<input type="checkbox"/> Min. 30 Hrs/Wk <input type="checkbox"/> Other _____	<input type="checkbox"/> End of month of termination <input type="checkbox"/> Date of termination <input type="checkbox"/> Other _____	<input type="checkbox"/> 19/25 <input type="checkbox"/> Other _____

Total number of employees on payroll: \_\_\_\_\_ Total number of full time/eligible employees (EE): \_\_\_\_\_

Number of COBRA participants in total group: \_\_\_\_\_ Number of Retirees in total group: \_\_\_\_\_

### Rates and Contributions

	Tier Structure	Rates	Number of Enrolled Employees	Employer Contribution %	Employee Contribution %
Single Tier	EE				
Two Tier	EE				
	Family				
Three Tier	EE				
	EE+ One				
	Family				
Four Tier	EE				
	EE+ One				
	EE+ Child(ren)				
	Family				

**OPTIONAL COVERAGE FOR TEMPOROMANDIBULAR JOINT DISORDER:**

Coverage for the treatment of musculoskeletal disorders affecting any bone or joint in the face, neck, or head, including temporomandibular joint disorder.

Accept  Decline  **By declining this optional coverage, the insured/member will not have coverage for temporomandibular joint disorder.**

**BILLING AND ADMINISTRATIVE CONTACT INFORMATION**

Please provide the information below if different than above for billing purposes and plan administration.

<b>BILLING CONTACT</b>		
Contact Name:	Contact Title:	
Address:	E-Mail Address:	
City:	State:	Zip Code:
Phone:	Fax:	

**AGENT/BROKER VERIFICATION**

<b>BROKER INFORMATION</b>		
Agent/Broker Name:	Tax ID#:	% Commission:
Agency Name:	Address:	
City:	State:	Zip Code:
E-Mail Address:	Phone:	Fax::

<b>GENERAL AGENT INFORMATION</b>		
Agent/Broker Name:	Tax ID#:	% Commission:
Agency Name:	Address:	
City:	State:	Zip Code:
E-Mail Address:	Phone:	Fax::

**SIGNATURE SECTION**

I understand and agree that the first month's estimated premium and fully completed enrollment information for all eligible persons requesting insurance coverage must be submitted with this application BEFORE action is taken on this application. Coverage is not in effect unless and until I receive notification of acceptance from the Company. If this application is declined, the Company will return the premium deposit submitted with the application. If my coverage is approved, premium is payable monthly in advance.

I understand and agree that failure to pay premium when due will be considered a default in premium payment, and that the Company will terminate coverage following a grace period (time extension for payment of premium) of [31] days from the date of nonpayment of premium. If the coverage is terminated by the Company for nonpayment of premium, I will still owe, and the insurance company will collect, premium, for the grace period. I understand that coverage may also be terminated for other reasons as provided in the policy.

I represent and agree that all the answers and statements in this request are full, complete and true, to the best of my knowledge and belief, and understand that the said answers and statements form the basis upon which coverage will be made effective. I understand that the material omissions or misrepresentations could result in voiding or reformation of coverage.

I agree that the Company shall be entitled to rely on the most current information in its possession regarding eligibility of employees and their dependents in providing coverage under this policy. I understand and agree that I am responsible for notifying the Company promptly of any changes in this information that may affect the eligibility of employees of their dependents, including the addition of newly eligible employees or dependents.

**ARKANSAS**

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

Authorized Officer's Name:	Title:
Authorized Officer's Signature:	Date:
Agent Name:	Date:
Agent Signature:	Date:



# Dental Enrollment / Change Form

\*Denotes required fields for enrollment. For items with \*\* please select a Reason for Enrollment OR Change.

<b>A EMPLOYER INFORMATION: To Be Completed By Employer</b>					
Company Name: _____			*Group No.: _____		
Date Employed Full Time: _____			*Effective Date of Coverage or Change _____		
<b>REASON FOR ENROLLMENT OR CHANGE</b>					
<b>ENROLL</b>		<b>TERMINATE COVERAGE</b>		<b>CHANGE</b>	
<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Group Request	<input type="checkbox"/> Terminate Subscriber	<input type="checkbox"/> Name		
<input type="checkbox"/> New Group	<input type="checkbox"/> Member Request	<input type="checkbox"/> Terminate Dependent	<input type="checkbox"/> Address/Phone		
<input type="checkbox"/> New Hire	<input type="checkbox"/> Qualifying Event (Reason)	<input type="checkbox"/> Deceased			
<input type="checkbox"/> COBRA	Date ____/____/____	<input type="checkbox"/> Termination Reason: _____			
<input type="checkbox"/> Add Dependent	**List Reason: _____				
<b>Employee Status:</b>					
<input type="checkbox"/> Active	<input type="checkbox"/> COBRA	<input type="checkbox"/> Salary	<input type="checkbox"/> Hourly	Number of hours a week _____	<input type="checkbox"/> Other _____
<b>Benefits Administrator Approval:</b>				Date: _____	
<b>B DENTAL COVERAGE ELECTION</b>					
<b>I ELECT THE FOLLOWING FOR MYSELF AND MY DEPENDENT(S):</b> <input type="checkbox"/> Dental Plan Code <sup>1</sup> _____					
<b>Type of Coverage:</b> <input type="checkbox"/> Employee <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child <input type="checkbox"/> Employee/Children <input type="checkbox"/> Employee/Spouse/Child(ren)					
<b>Member Certificates:</b> <input checked="" type="checkbox"/> Electronic <input checked="" type="checkbox"/> Paper (Coventry Dental will assume paper certificates if not completed)					
<b>C DENTAL WAIVER ( only complete if waiving coverage)</b>					
I understand that if I decide to apply for dental coverage for myself and any applicable dependents(s) at a later date, neither my dependent(s) nor I will be eligible for coverage until (1) my employer's next open enrollment period, or (2) there is a qualifying event as defined in the EOC/COI.					
<input type="checkbox"/> Waive Dental	<input type="checkbox"/> Myself	<input type="checkbox"/> Spouse	<input type="checkbox"/> Dependent(s)	Reason: <input type="checkbox"/> Other Insurance <input type="checkbox"/> Spousal Coverage	
<input type="checkbox"/> Other Reason (please explain) _____					
Employee Signature (only if you are waiving coverage) _____				Date _____	
<b>D EMPLOYEE INFORMATION</b>					
*Last Name			*First Name		MI
*Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		*Birthdate		*Social Security Number	
*Address					
*City			*State	*Zip Code	
Work Phone			Home Phone		
<b>E FAMILY MEMBERS TO BE COVERED OR DELETED</b>					
if address and phone numbers of covered dependents are different from those of policyholder, please attach that information on a separate sheet of paper.					
	FULL NAME (Last, First, MI)	SEX	RELATIONSHIP	BIRTHDATE	SOCIAL SECURITY #
<input type="checkbox"/> Enroll <input type="checkbox"/> Delete		M F	SPOUSE	/ /	- -
<input type="checkbox"/> Enroll <input type="checkbox"/> Delete		M F		/ /	- -
<input type="checkbox"/> Enroll <input type="checkbox"/> Delete		M F		/ /	- -
<input type="checkbox"/> Enroll <input type="checkbox"/> Delete		M F		/ /	- -
<b>F OTHER DENTAL COVERAGE</b>					
<b>WHEN coverage BEGINS,</b> will you or any of your family members have any other dental insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No					

<sup>1</sup> Underwritten by Coventry Health and Life Insurance Company 6705 Rockledge Drive, Ste 900 Bethesda, MD 20817

Continued on back

**G EMPLOYEE SIGNATURE**

I represent that all information supplied in this application is true and correct. I have thoroughly reviewed, understand, and accurately responded to all questions and information on this application. I hereby agree to the conditions of enrollment on the reverse side of this form.

\_\_\_\_\_  
Employee Signature\_\_\_\_\_  
Date

Acceptance of Coverage

Please make a copy for your records

I accept the insurance provided by my employer's group insurance plan. I authorize deductions from my earnings for the required contributions toward the cost of insurance. (This authorization applies only if employee contributions are required.) I understand that by accepting insurance, I am required to remain enrolled as a covered employee and cannot make an elective change in the coverage selected until the next open enrollment period, if there is one provided for in the Master Agreement to Provide Dental Benefits.

**Fraud Statements**

**Attention California:** For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison, and substantial civil penalties.

**Attention Colorado Residents:** An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.

**Attention Florida and Virginia Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

**Attention Maryland Residents:** It is a crime to knowingly provide, or to knowingly assist, abet, or conspire with another to provide false, incomplete, or misleading information to an insurance company with intent to injure, defraud, or deceive the company or any other person. Penalties include imprisonment, fines, and denial of insurance benefits.

**Attention Pennsylvania Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Attention Residents of Other States:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. In addition, an insurer may deny insurance benefits if false information materially related to the claim was provided by the applicant.