

SERFF Tracking Number:	UHLC-125884962	State:	Arkansas
Filing Company:	United HealthCare Insurance Company	State Tracking Number:	40753
Company Tracking Number:	DPOLCOC.SR.08.AR		
TOI:	H10G Group Health - Dental	Sub-TOI:	H10G.000 Health - Dental
Product Name:	SR-Dental UHIC		
Project Name/Number:	/		

## Filing at a Glance

Company: United HealthCare Insurance Company

Product Name: SR-Dental UHIC

TOI: H10G Group Health - Dental

Sub-TOI: H10G.000 Health - Dental

Filing Type: Form

SERFF Tr Num: UHLC-125884962

SERFF Status: Closed

Co Tr Num: DPOLCOC.SR.08.AR

Co Status:

Authors: Jayne Jackowski, Lynn

Kaisershot

Date Submitted: 11/03/2008

State: ArkansasLH

State Tr Num: 40753

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Disposition Date: 11/06/2008

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name:

Project Number:

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 11/06/2008

State Status Changed: 11/06/2008

Corresponding Filing Tracking Number:

Filing Description:

Dental blanket group policy marketed to colleges and universities.

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Large

Group Market Type: Blanket

Deemer Date:

## Company and Contact

### Filing Contact Information

Jayne Jackowski, Senior Specialty Product

Jayne.Jackowski@eams.com

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**Analyst**

3100 AMS Blvd. (920) 661-2234 [Phone]  
Green Bay, WI 54313 (920) 661-9861[FAX]

**Filing Company Information**

United HealthCare Insurance Company CoCode: 79413 State of Domicile: Connecticut  
450 Columbus Boulevard Group Code: 707 Company Type: Health  
PO Box 150450  
Hartford, CT 06115-0450 Group Name: State ID Number:  
(215) 653-8046 ext. [Phone] FEIN Number: 36-2739571  
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## Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United HealthCare Insurance Company	\$50.00	11/03/2008	23668073

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/06/2008	11/06/2008

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	11/03/2008	11/03/2008	Jayne Jackowski	11/04/2008	11/04/2008

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Newborn and Adopted	Note To Reviewer	Jayne Jackowski	11/03/2008	11/03/2008
Newborn & Adopted Children	Note To Filer	Rosalind Minor	11/04/2008	

*SERFF Tracking Number:* UHLC-125884962      *State:* Arkansas  
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## **Disposition**

Disposition Date: 11/06/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: UHLC-125884962 State: Arkansas  
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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>Supporting Document</b>	Cover Letter	Approved-Closed	Yes
<b>Form</b>	Group Insurance Policy	Approved-Closed	Yes
<b>Form</b>	Schedule of Covered Dental Services	Approved-Closed	Yes
<b>Form</b>	Policyholder Application	Approved-Closed	Yes

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## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 11/03/2008  
Submitted Date 11/03/2008  
Respond By Date

Dear Jayne Jackowski,

This will acknowledge receipt of the captioned filing.

### Objection 1

- Group Insurance Policy (Form)

Comment: Coverage for newborn infants must be for at least 90 days as outlined under ACA 23-79-129. Also, please refer to the 60-day period for minors for whom the insured has filed a petition to adopt. Refer to ACA 23-79-137.

Please feel free to contact me if you have questions.

Sincerely,  
Rosalind Minor

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 11/04/2008  
Submitted Date 11/04/2008

Dear Rosalind Minor,

### Comments:

### Response 1

Comments: This coverage is in section 4.5 Change in Family Status. Is it in the wrong section, or is the text insufficient?

### Related Objection 1

Applies To:

- Group Insurance Policy (Form)

Comment:

Coverage for newborn infants must be for at least 90 days as outlined under ACA 23-79-129. Also, please refer to the 60-day period for minors for whom the insured has filed a petition to adopt. Refer to ACA 23-79-137.

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**Changed Items:**

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,  
Jayne Jackowski, Lynn Kaisershot

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**Note To Reviewer**

**Created By:**

Jayne Jackowski on 11/03/2008 03:33 PM

**Subject:**

Newborn and Adopted

**Comments:**

Is the language in section 4.3 Change in Family Status not sufficient or should it be located elsewhere?

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**Note To Filer**

**Created By:**

Rosalind Minor on 11/04/2008 08:38 AM

**Subject:**

Newborn & Adopted Children

**Comments:**

The newborn law states that the insurer may require that the insured give notice to his insurer of any newborn children within 90 days of the birth or before the next premium due date, whichever is later. The insureds need to know that they have 90 days to notify the insured.

The language for minors that the insured has filed a petition to adopt, must follow the language under ACA 23-79-137 (b).

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## Form Schedule

**Lead Form Number:** DPOLCOC.SR.08.AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	DPOLCOC.SR.08.AR	Policy/Cont ract/Fratern al Certificate	Group Insurance	Initial			DPOLCOC.SR.08.AR.pdf
Approved-Closed	DSCH.SR.08	Schedule Pages	Schedule of Covered Dental Services	Initial			Schedule DSCHSR08.pdf
Approved-Closed	DV-SR-APP (01/2008)	Application/ Enrollment Form	Policyholder Application	Initial			UHIC Combined Dental & Vision APP Final.pdf

# Dental Policy

## United HealthCare Insurance Company

[450 Columbus Boulevard

Hartford, Connecticut 06115-0450

[1-800-357-1371]]

This Policy ("Policy") is entered into by and between United HealthCare Insurance Company ("Company"), and the "Policyholder," as described in Exhibit 1.

Upon receipt of the Policyholder's application and payment of the required Policy Charges, this Policy is deemed executed. The Company agrees with the Policyholder to provide Coverage for Dental Services set forth herein, subject to the terms, conditions, exclusions, and limitations of this Policy. The Policyholder's application is made a part of this Policy.

This Policy replaces and supersedes any previous agreements relating to the Coverage of Dental Services between the Policyholder and the Company. The terms and conditions of this Policy will in turn be superseded by those of any subsequent agreements relating to the Coverage of Dental Services between the Policyholder and the Company.

This Policy will become effective at 12:01 a.m. at the Policyholder's address on the date specified in Exhibit 1, and will be continued in force by the timely payment of the required Policy Charges when due, subject to termination of this Policy as provided herein. When the Policy is terminated, as provided for in Article 5, this Policy and all Coverage under this Policy will end at 12:00 midnight on the date of termination.

This Policy is delivered in and governed by the laws of the [State of \_\_\_\_\_].

**NON-RENEWABLE ONE YEAR TERM INSURANCE-THIS POLICY WILL NOT BE RENEWED.**

Issued By:

United HealthCare Insurance Company

[Signature of authorized company officer]

[Title of authorized company officer]

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# Article 1: Definitions

**Amendment** - any attached description of additional or alternative provisions to the Policy. Amendments are effective only when signed by an officer of the Company. Amendments are subject to all conditions, limitations and exclusions of the Policy except for those which are specifically amended.

**Congenital Anomaly** - a physical developmental defect that is present at birth and identified within the first twelve months from birth.

**Copayment** - the charge a Covered Person is required to pay for certain Dental Services payable under the Policy. A Copayment is a percentage of Eligible Expenses. A Covered Person is responsible for the payment of any Copayment for Network Benefits directly to the provider of the Dental Service at the time of service or when billed by the provider.

**Coverage or Covered** - the entitlement by a Covered Person to reimbursement for expenses incurred for Dental Services covered under the Policy, subject to the terms, conditions, limitations and exclusions of the Policy. Dental Services must be provided: (1.) when the Policy is in effect; and (2.) prior to the date that any of the individual termination conditions as stated in *Article 5: Policy Termination* occur; and (3.) only when the recipient is a Covered Person and meets all eligibility requirements specified in the Policy.

*<sup>1</sup>Remove if Dependent coverage not provided.*

**Covered Person** – {<sup>1</sup>either} the Subscriber {<sup>1</sup>or an Enrolled Dependent}, while Coverage of such person under the Policy is in effect.

*Include if Deductible applies. <sup>1</sup>Select if deductible on a "Plan Year", or "calendar year". <sup>2</sup>Include for Network/Non-Network plans.*

**{Deductible** – the amount a Covered Person must pay for Dental Services in a {<sup>1</sup>Plan Year} {<sup>1</sup>calendar year} before the Company will begin paying for Network or Non-Network Benefits in that {<sup>1</sup>Plan Year} {<sup>1</sup>calendar year}.

**Dental Service or Dental Procedures** - dental care or treatment provided by a Dentist to a Covered Person while the Policy is in effect, provided such care or treatment is recognized by the Company as a generally accepted form of care or treatment according to prevailing standards of dental practice.

**Dentist** - any dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render Dental Services, perform dental surgery or administer anesthetics for dental surgery.

*Remove if Dependent coverage is not provided. <sup>1</sup>Include if Domestic Partner coverage is provided. <sup>2</sup>Modify age as appropriate. <sup>3</sup>Remove if group does not use Full-time Student criteria or modify as applicable to the groups full-time Student criteria. <sup>4</sup>Include if extended coverage requires Full-time Student status (when the definition of Full-time Student is included in Section 1.)*

**{Dependent** - (1.) the Subscriber's legal spouse. {<sup>1</sup>All references to the spouse of a Subscriber shall include a Domestic Partner.} or (2.) an unmarried dependent child of the Subscriber or the Subscriber's spouse (including a natural child, stepchild, a legally adopted child, a child placed for adoption, or a child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse). To be eligible for coverage under the Policy, a Dependent must reside within the United States. The definition of Dependent is subject to the following conditions and limitations:

A. The term Dependent will not include any unmarried dependent child [<sup>2</sup>19] years of age or older, except as stated in {<sup>3</sup>the next paragraph, or as stated in } *Section 3: Termination of Coverage, sub-section 3.2: Extended Coverage for Handicapped Children.*

[<sup>4</sup>B. The term Dependent will include an unmarried dependent child who is [<sup>2</sup>19] years of age or older, but less than [<sup>2</sup>23] years of age [<sup>5</sup>as defined under Full-Time Student], if evidence satisfactory to the Company of the following conditions is furnished upon request:

1. the child is not regularly employed on a full-time basis; and

2. the child is a Full-time Student; and
3. the child is primarily dependent upon the Subscriber for support and maintenance.]

The Subscriber agrees to reimburse the Company for any Dental Services provided to the child at a time when the child did not satisfy these conditions.

[The term Dependent also includes a child for whom dental care coverage is required through a Qualified Medical Child Support Order or other court or administrative order. The Policyholder is responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.]

The term Dependent does not include anyone who is also enrolled as a Subscriber, nor can anyone be a Dependent of more than one Subscriber.]

*Include if plan provides coverage for domestic partners. <sup>1</sup>Select if the domestic partner is person of the "opposite sex", "same sex" or "opposite or same sex".*

{**Domestic Partner** – a person of the [<sup>1</sup>opposite sex] [<sup>1</sup>same sex] [<sup>1</sup>opposite or same sex] with whom the Subscriber has established a Domestic Partnership. In no event, will a person's legal spouse be considered a Domestic Partner.}

*Include if plan provides coverage for domestic partners. <sup>1</sup>Select if the domestic partner is person of the "opposite sex", "same sex" or "opposite or same sex". <sup>2</sup>Modify requirements as applicable.*

{**Domestic Partnership** – a relationship between the Subscriber and one other person of the [<sup>1</sup>opposite sex] [<sup>1</sup>same sex] [<sup>1</sup>opposite or same sex]. The following requirements apply to both persons:

- [<sup>2</sup>They share the same permanent residence and the common necessities of life;
- They are not related by blood or a degree of closeness which would prohibit marriage in the law of state in which they reside;
- Each is at least 18 years of age;
- Each is mentally competent to consent to contract;
- Neither is currently married to, or Domestic Partner of, another person under either a statutory or common law;
- They are financially interdependent and have furnished at least two of the following documents evidencing such financial interdependence:
  - have a single dedicated relationship of at least 6 months duration;
  - joint ownership of residence;
  - at least two of the following:
    - ◆ joint ownership of an automobile;
    - ◆ joint checking, bank or investment account;
    - ◆ joint credit account;
    - ◆ lease for a residence identifying both partners as tenants;
    - ◆ a will and/or life insurance policies which designates the other as primary beneficiary.
- The Subscriber and Domestic Partner must jointly sign an affidavit of Domestic Partnership.}]

*<sup>1</sup>Select "contracted fee" or "Usual and Customary".*

**Eligible Expenses** – Eligible Expenses for Covered Dental Services, incurred while the Policy is in effect, are determined as stated below:

- A. For Network Benefits, when Covered Dental Services are received from Network Dentists, Eligible Expenses are the Company's contracted fee(s) for Covered Dental Services with that provider.

- B. For Non-Network Benefits, when Covered Dental Services are received from Non-Network Dentists, Eligible Expenses are the [<sup>1</sup>Company's contracted fee(s) for Covered Dental Services with a Network Dentist in the same geographic area] [<sup>1</sup>Usual and Customary fees as defined below].

In the event that a provider routinely waives Copayments and/or the Deductible, Dental Services for which the Copayments and/or the Deductible are waived are not considered to be Eligible Expenses.

**Eligible Person** - a student registered at the institution of the Policyholder who meets the eligibility requirements specified in the Policyholder's application.

**Emergency** - a dental condition or symptom resulting from dental disease which arises suddenly and, in the judgment of a reasonable person, requires immediate care and treatment, and such treatment is sought or received within 24 hours of onset.

*Remove if Dependent coverage not provided*

{**Enrolled Dependent** - a Dependent who is properly enrolled for Coverage under the Policy.}

**Experimental, Investigational or Unproven Services** - medical, dental, surgical, diagnostic, or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Company makes a determination regarding coverage in a particular case, is determined to be:

- A. Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or
- B. Subject to review and approval by any institutional review board for the proposed use; or
- C. The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
- D. Not demonstrated through prevailing peer-reviewed professional literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

**Foreign Services** - are defined as services provided outside the U.S. and U.S. Territories.

<sup>1</sup>Select the time period a person ceases to be a Full-time Student. <sup>2</sup>Select "month" or "year". <sup>3</sup>Select the time period Full-time Student designation will end. <sup>4</sup>Select "month" or "year".

**[Full-time Student** - a person who is enrolled in and attending, full-time, a recognized course of study or training at:

- A. An accredited high school;
- B. An accredited college or university; or
- C. A licensed vocational school, technical school, beautician school, automotive school or similar training school.

Full-time Student status is determined in accordance with the standards set forth by the educational institution. A person ceases to be a Full-time Student [<sup>1</sup>at the end of the calendar [<sup>2</sup>month][<sup>2</sup>year] during which ][<sup>1</sup>on the date] the person graduates or otherwise ceases to be enrolled and in attendance at the institution on a full-time basis.

A person continues to be a Full-time Student during periods of regular vacation established by the institution. If the person does not continue as a Full-time Student immediately following the period of vacation, the Full-time Student designation will end on [<sup>3</sup>the last day of the calendar [<sup>4</sup>month][<sup>4</sup>year]][<sup>2</sup>the date] in which the person was enrolled and in attendance at the institution on a full-time basis.]

<sup>1</sup>Remove if Dependents coverage not provided

**Initial Eligibility Period** - the initial period of time, determined by the Company and the Policyholder, during which Eligible Persons may enroll themselves {<sup>1</sup>and Dependents} under the Policy.

<sup>1</sup>Select "Plan Year" or "calendar year". <sup>2</sup>Change section reference as necessary.

**[Maximum Benefit** – the maximum amount paid for Covered Dental Services during a {<sup>1</sup>Plan Year} {<sup>1</sup>calendar year} for a Covered Person under the Policy or any Policy, issued by the Company to the Policyholder, that replaces the Policy. The Maximum Benefit is stated in [<sup>2</sup>Section 10]: Covered Dental Services.]

**Necessary** - Dental Services and supplies which are determined by the Company through case-by-case assessments of care based on accepted dental practices to be appropriate; and

- A. necessary to meet the basic dental needs of the Covered Person; and
- B. rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service; and
- C. consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by the Company; and
- D. consistent with the diagnosis of the condition; and
- E. required for reasons other than the convenience of the Covered Person or his or her Dentist; and
- F. demonstrated through prevailing peer-reviewed dental literature to be either:
  - 1. safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
  - 2. safe with promising efficacy
    - a. for treating a life threatening dental disease or condition; and
    - b. in a clinically controlled research setting; and
    - c. using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dentist has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this *Policy*. The definition of Necessary used in this *Policy* relates only to Coverage and differs from the way in which a Dentist engaged in the practice of dentistry may define necessary.

**[Network** - a group of Dentists who are subject to a participation agreement in effect with the Company, directly or through another entity, to provide Dental Services to Covered Persons. The participation status of providers will change from time to time.]

**[Network Benefits** - benefits available for Covered Dental Services when provided by a Dentist who is a Network Dentist.]

**[Non-Network Benefits** - coverage available for Dental Services obtained from Non-Network Dentists.]

**Physician** - any Doctor of Medicine, M.D., or Doctor of Osteopathy, D.O., who is duly licensed and qualified under the law of jurisdiction in which treatment is received.

*Include if you use a Plan Year. Remove if calendar year is used.*

**{Plan Year** - The period of time, usually beginning with the Policy's effective date of any year and terminating on the Termination Date of the succeeding year, when accumulators for Deductibles and plan maximums are calculated.}

**Policy** - the group Policy, the application of the Policyholder, Amendments and Riders which constitute the agreement regarding the benefits, exclusions and other conditions between the Company and the Policyholder.

<sup>1</sup>*Remove if Dependent coverage not provided.*

**Policy Charge** - the sum of the Premiums for all Subscribers {<sup>1</sup>and Enrolled Dependents} Covered under the Policy.

**Policyholder** - the educational institution or other defined or otherwise legally constituted group to whom the Policy is issued.

<sup>1</sup>*Remove if Dependent coverage not provided.*

**Premium** - the periodic fee required for each Subscriber {<sup>1</sup>and each Enrolled Dependent} in accordance with the terms of the Policy.

**Procedure in Progress** - all treatment for Covered Dental Services that results from a recommendation and an exam by a Dentist. A treatment procedure will be considered to start on the date it is initiated and will end when the treatment is completed.

**Rider** - any attached description of Dental Services Covered under the Policy. Dental Services provided by a Rider may be subject to payment of additional Premiums and additional Copayments. Riders are effective only when signed by an officer of the Company and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended.

<sup>1</sup>*Remove if Dependent coverage is not provided.*

**Subscriber** - an Eligible Person who is properly enrolled for Coverage under the Policy. The Subscriber is the person {<sup>1</sup>(who is not a Dependent)} on whose behalf the Policy is issued to the Policyholder.

**[Usual and Customary** - Usual and Customary fees are calculated by the Company based on available data resources of competitive fees in that geographic area.

Usual and Customary fees must not exceed the fees that the provider would charge any similarly situated payor for the same services. In the event that a provider routinely waives Copayments and/or the Deductible for benefits, Dental Services for which the Copayments and/or the Deductible are waived are not considered to be Usual and Customary.

Usual and Customary fees are determined solely in accordance with the Company's reimbursement policy guidelines. The Company's reimbursement policy guidelines are developed by the Company, in its discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (publication of the American Dental Association);
- As reported by generally recognized professionals or publications;
- As utilized for Medicare;
- As determined by medical or dental staff and outside medical or dental consultants;
- Pursuant to other appropriate source or determination accepted by the Company.]

## Article 2: Dental Services

<sup>1</sup>*Remove reference to dependents if dependent coverage not provided*

Subscribers {<sup>1</sup>and their Enrolled Dependents} are entitled to Coverage for Dental Services subject to the terms, conditions, limitations and exclusions set forth in the Policy and *Schedule of Covered Dental Services*, included in this Policy. The Policy and *Schedule(s) of Covered Dental Services* describe the

Covered Dental Services including any optional Riders and Amendments, required Copayments, and the terms, conditions, limitations and exclusions related to Coverage.

## Article 3: Premium Rates and Policy Charge

### 3.1 Premiums

The Policyholder agrees to remit the premium for each Covered Person to the Company or its authorized agent within 20 days after the receipt of the premium. The Company will have the right to examine all of the Policyholder's books and records relating to this policy at any time up to the later of 1)two years after the termination of the policy and 2)the date of final adjustment and settlement of all claims under this policy.

### 3.2 Payment of Premium

All premiums are payable in advance for each policy term in accordance with the Company's premium rates. The full premium must be paid even if the premium is received after the policy Effective Date. There is no pro-rata or reduced premium payment for late enrollees. There will be no refunds to students who cancel coverage under the policy, unless the Covered Person enters the armed forces.

Premium adjustments involving return of unearned premiums to the Policyholder will be limited to a period of 12 months immediately preceding the date of receipt by the Company of evidence that adjustments should be made. Premiums are payable to the Company, [P.O. Box 809026, Dallas, Texas 75380-9025.]

<sup>1</sup>The number of grace period days can be changed to allow more days. <sup>2</sup>Select 'retroactive to last paid date', 'on the date' or 'on the last day of the calendar month'.

### 3.3 Grace Period

A Grace Period of [<sup>1</sup>14] days will be granted for the payment of any Premium, during which time Coverage under the Policy will continue in force. In no event will the Grace Period extend beyond the date the Policy terminates.

Coverage under this Policy will automatically terminate {<sup>2</sup>retroactive to the last paid date of Coverage if} {<sup>2</sup>on the date} {<sup>2</sup>on the last day of the calendar month} the Grace Period expires and any Premium remains unpaid.

## Article 4: Enrollment and Eligibility

<sup>1</sup>Remove references to dependents if dependent coverage not provided

### 4.1 Initial Eligibility Period

Eligible Persons {<sup>1</sup>and their Dependents} may enroll for Coverage under the Policy during the Initial Eligibility Period. The Initial Eligibility Period is the period of time agreed to by the Policyholder and the Company.

### 4.2 Eligibility Conditions

The eligibility conditions stated in the application are in addition to these.

Each person who belongs to one of the Classes of Persons to be Insured as set forth in the application is eligible to be insured under the Policy. {[The Eligible Person must actively attend classes for at least the first [31] days after the date for which coverage is purchased. [Home study,] [correspondence,] [Internet,] [and] [television (TV)] courses do not fulfill the eligibility requirements that the Eligible Person actively attend classes.]} The Company maintains its right to investigate [eligibility or] student status and attendance records to verify that the Policy eligibility requirements have been met. If and when the Company discovers that the Policy eligibility requirements have not been met, its only obligation is refund of premium.

<sup>1</sup>Remove if Dependent coverage not provided

### **4.3 Coverage for a Newly Eligible Person**

Coverage for a newly Eligible Person <sup>1</sup>and any Dependents} will take effect on the date agreed to by the Policyholder and the Company. Coverage is effective only if the Company receives any required Premium and a properly completed enrollment form within 31 days of the date the person first becomes eligible.

*Remove if Dependent coverage not provided*

### **{4.4 Coverage for a Newly Eligible Dependent.**

Coverage for a new Dependent acquired by reason of birth, legal adoption, legal guardianship, placement for adoption, court or administrative order, or marriage will take effect on the date of the event. Coverage is effective only if the Company receives any required Premium and is notified of the event within 31 days.}

*Remove if Dependent coverage not provided.*

### **{4.5 Change in Family Status**

You may make Coverage changes during the year for any Dependent whose status as a Dependent is affected by a marriage, divorce, legal separation, annulment, birth, legal guardianship, placement for adoption or adoption, as required by federal law. In cases of marriage, you must submit the required contribution of coverage and a properly completed enrollment form within 31 days of the marriage. <sup>1</sup>Otherwise, you will need to wait until the next annual Open Enrollment Period.}

All dental insurance benefits applicable for children, including the Necessary care or treatment of medically diagnosed congenital defects or birth abnormalities, will apply with respect to Your newborn child from the moment of birth. You must submit the required contribution of coverage and a properly completed enrollment form within 90 days of birth.

All dental insurance benefits applicable for children, including the Necessary care or treatment of medically diagnosed congenital defects or birth abnormalities, will apply with respect to adopted children from the moment of placement for adoption if petition for adoption and application for coverage are filed within 60 days of placement or from the moment of birth if petition for adoption and application for coverage are filed within 60 days of birth. }

<sup>1</sup>Remove references to dependents if dependent coverage not provided

### **{4.6} Effective Date of Coverage**

Coverage for properly enrolled Eligible Persons <sup>1</sup>and their Dependents} will begin on the date stated in Exhibit 1.

## **Article 5: Policy Termination**

### **5.1 Conditions for Termination of This Entire Policy**

This Policy and all Coverage under this Policy will automatically terminate on the earliest of the dates specified below:

<sup>1</sup>Select the applicable termination date option.

- A. At the Company's option, <sup>1</sup>on the date} <sup>1</sup>on the last day of the calendar month} <sup>1</sup>retroactive to the last paid date of Coverage}, if the Grace Period expires and any Policy Charge remains unpaid.
- B. On the date specified by the Company in written notice to the Policyholder that this Policy will be terminated because the Policyholder provided the Company with false information material to the execution of this Policy or to the provision of Coverage under this Policy. The Company has the right to rescind this Policy back to the effective date.

## 5.2 Conditions for Termination of a Covered Person's Coverage Under the Policy

A Covered Person's Coverage, including coverage for Dental Services rendered after the date of termination for dental conditions arising prior to the date of termination, will automatically terminate on the earliest of the dates specified below.

<sup>2</sup>Remove if Dependent coverage is not provided.

- [A.] The date the Company receives written notice from the Policyholder instructing the Company to terminate Coverage of the Subscriber [<sup>2</sup>or any Covered Person] or the date requested in such notice, if later.]

When any of the following apply, the Company will provide written notice of termination to the Subscriber.

<sup>1</sup>Remove if Dependent coverage is not provided.

- [B.] The date specified by the Company that all Coverage will terminate due to fraud or misrepresentation or because the Subscriber knowingly provided the Company with false material information, including, but not limited to, false, material information relating to residence<sup>[1]</sup>, information relating to another person's eligibility for Coverage or status as a Dependent<sup>[1]</sup>. The Company has the right to rescind Coverage back to the effective date.
- [[C.] The date specified by the Company that all Coverage will terminate because the Subscriber permitted the use of his or her ID card by any unauthorized person or used another person's card.]
- [[D.] The date specified by the Company that Coverage will terminate due to material violation of the terms of the Policy.]

<sup>1</sup>Select if Premium, Copayment or both apply.

- [E.] The date specified by the Company that Coverage will terminate because the Covered Person failed to pay a required [<sup>1</sup>Premium] [<sup>1</sup>and/or] [<sup>1</sup>Copayment].

Remove entire Section 3.2 if Dependents coverage is not provided.

## {5.3 Extended Coverage for Handicapped Dependent Children

Coverage of an unmarried Enrolled Dependent who is incapable of self-support because of mental retardation or physical handicap will be continued beyond the age listed under the definition of Dependent provided that:

- A. the Enrolled Dependent becomes incapacitated prior to attainment of the limiting age; and
- B. the Enrolled Dependent is chiefly dependent upon the Subscriber for support and maintenance; and
- C. proof of such incapacity and dependence is furnished to the Company; and
- D. payment of any required Premium for the Enrolled Dependent is continued.

Coverage will be continued so long as the Enrolled Dependent continues to be so incapacitated and dependent, unless otherwise terminated in accordance with the terms of the Policy. Before granting this extension, the Company may reasonably require that the Enrolled Dependent be examined at the Company's expense by a Physician designated by the Company. At reasonable intervals, the Company may require satisfactory proof of the Enrolled Dependent's continued incapacity and dependency, including medical examinations at the Company's expense. Such proof will not be required more often than once a year. Failure to provide such satisfactory proof will result in the termination of the Enrolled Dependent's Coverage under the Policy.}

Include Section 3.3 when Extended Coverage applies. <sup>1</sup>Modify number of days as needed.

## {[5.4] Extended Coverage

A [<sup>1</sup>30 day] temporary extension of Coverage, only for the services shown below when given in connection with a Procedure in Progress, will be granted to a Covered Person on the date the person's

Coverage is terminated if termination is not voluntary. Benefits will be extended until the earlier of: (a.) the end of the [<sup>1</sup>30 day] period; or (b.) the date the Covered Person becomes covered under a succeeding policy or contract providing coverage or services for similar dental procedures.

Benefits will be Covered for: (a.) a Procedure in Progress or Dental Procedure that was recommended in writing and began, in connection with a specific dental disease of a Covered Person while the Policy was in effect, by the attending Dentist; (b.) an appliance, or modification to an appliance, for which the impression was taken prior to the termination of Coverage; or (c.) a crown, bridge or gold restoration, for which the tooth was prepared prior to the termination of Coverage.}

### **{5.5} Payment and Reimbursement Upon Termination**

Upon any termination of this Policy, the Policyholder will be and will remain liable to the Company for the payment of any and all Premiums which are unpaid at the time of termination, including a pro rata fee for any period this Policy was in force during the Grace Period, if any, preceding the termination.

## **Article 6: General Provisions**

### **6.1 Entire Policy**

The Policy, including the *Schedule of Covered Dental Services*, the application of the Policyholder, Amendments and Riders will constitute the entire Policy between parties. All statements made by the Policyholder or by a Subscriber will, in the absence of fraud, be deemed representations and not warranties.

<sup>1</sup>*Modify number of days if longer notice period is needed.*

### **6.2 Amendments and Alterations**

Amendments to the Policy are effective upon [<sup>1</sup>31] days written notice to the Policyholder. Riders are effective on the date specified by the Company. No change will be made to this Policy unless made by an Amendment or a Rider which is signed by an executive officer of the Company. No agent has authority to change this Policy or to waive any of its provisions.

### **6.3 Relationship Between Parties**

The relationships between the Company and providers and relationships between the Company and Policyholders, are solely contractual relationships between independent contractors. Providers and Policyholders are not agents or employees of the Company, nor is the Company or any employee of the Company an agent or employee of providers or Policyholders.

The relationship between a provider and any Covered Person is that of provider and patient. The provider is solely responsible for the services provided by it to any Covered Person. The Policyholder is solely responsible for enrollment and Coverage classification changes (including termination of a Covered Person's Coverage through the Company) and for the timely payment of the Policy Charge.

### **6.4 Records**

The Policyholder will furnish the Company with all information and proofs which the Company may reasonably require with regard to any matters pertaining to this Policy. The Company may at any reasonable time inspect all documents furnished to the Policyholder by an individual in connection with the Coverage and any other records pertinent to the Coverage under this Policy.

<sup>1</sup>*Remove reference to dependent if dependent coverage is not provided.*

By accepting Benefits under this Policy, each Covered Person authorizes and directs any person or institution that has provided services to them, to furnish the Company or it's designees any and all information and records or copies of records relating to the services provided to the Covered Person. The Company has the right to request this information at any reasonable time. This applies to all Covered

Persons<sup>1</sup>, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form].

The Company agrees that such information and records will be considered confidential. The Company has the right to release any and all records concerning dental services which are necessary to implement and administer the terms of this Policy, for appropriate medical review or quality assessment, or as we are required by law or regulation.

During and after the term of the Policy, the Company and its related entities may use and transfer the information gathered under the Policy for research and analytic purposes.

## **6.5 Administrative Services**

The services necessary to administer this Policy and the Coverage provided under it will be provided in accordance with the Company's or its designee's standard administrative procedures. If the Policyholder requests that such administrative services be provided in a manner other than in accordance with these standard procedures, including requests for non-standard reports, the Policyholder will pay for such services or reports at the Company's or its designee's then-current charges for such services or reports.

### **[6.6] Examination of Covered Persons**

In the event of a question or dispute concerning Coverage for Dental Services, the Company may reasonably require that a Covered Person be examined at the Company's expense by a Dentist acceptable to the Company.

<sup>1</sup>Modify number of days if needed.

### **[6.7] Clerical Error**

Clerical error will not deprive any individual of Coverage under this Policy or create a right to benefits. Failure to report the termination of Coverage will not continue such Coverage beyond the date it is scheduled to terminate according to the terms of this Policy. Upon discovery of a clerical error, any necessary appropriate adjustment in Premiums will be made. However, no such adjustment in Premiums or Coverage will be granted by the Company to the Policyholder for more than [<sup>1</sup>60] days of Coverage prior to the date the Company received notification of such clerical error.

### **[6.8] Workers' Compensation Not Affected**

The Coverage provided under this Policy does not substitute for and does not affect any requirements for coverage by workers' compensation insurance.

### **[6.9] Conformity with Statutes**

Any provision of this Policy which, on its effective date, is in conflict with the requirements of applicable state or federal statutes or regulations is hereby amended to conform to the minimum requirements of such statutes and regulations.

### **[6.10] Waiver/Estoppel**

Nothing in the Policy or *Schedule of Covered Dental Services* is considered to be waived by any party unless the party claiming the waiver receives the waiver in writing. A waiver of one provision does not constitute a waiver of any other. A failure of either party to enforce at any time any of the provisions of the Policy or *Schedule of Covered Dental Services*, or to exercise any option which is herein provided, will in no way be construed to be a waiver of such provision of the Policy or *Schedule of Covered Dental Services*.

### **[6.11] Headings**

The headings, titles and any table of contents contained in the Policy or *Schedule of Covered Dental Services* are for reference purposes only and will not in any way affect the meaning or interpretation of the Policy or *Schedule of Covered Dental Services*.

## **[6.12] Unenforceable Provisions**

If any provision of the Policy or *Schedule of Covered Dental Services* is held to be illegal or unenforceable by a court of competent jurisdiction, the remaining provisions will remain in effect and the illegal or unenforceable provision will be modified so as to conform to the original intent of the Policy or *Schedule of Covered Dental Services* to the greatest extent legally permissible.

<sup>1</sup>*Remove reference to dependents if no dependent coverage is provided*

## **[6.13] Notice**

Written notice given by the Company to an authorized representative of the Policyholder is deemed notice to all affected Subscribers {<sup>1</sup>and their Enrolled Dependents} in the administration of this Policy, including termination of this Policy. The Policyholder is responsible for giving notice to Covered Persons.

Any notice sent to the Company under this Policy and any notice sent to the Policyholder will be addressed as described in Exhibit 1.

# **[Article 7: Coordination of Benefits**

## **7.1 Coordination of Benefits Applicability**

This coordination of benefits (COB) provision applies when a person has health or dental coverage under more than one Coverage Plan. "Coverage Plan" is defined below.

The order of benefit determination rules below determine which Coverage Plan will pay as the primary Coverage Plan. The primary Coverage Plan that pays first pays without regard to the possibility that another Coverage Plan may cover some expenses. A secondary Coverage Plan pays after the primary Coverage Plan and may reduce the benefits it pays so that payments from all group Coverage Plans do not exceed 100% of the total allowable expense.

## **7.2 Definitions**

For purposes of this Section, Coordination of Benefits, terms are defined as follows:

A. A "Coverage Plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Coverage Plan and there is no COB among those separate contracts.

1. "Plan" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); medical benefits under group or individual automobile contracts; and Medicare or other governmental benefits, as permitted by law.
2. "Plan" does not include: individual or family insurance; closed panel or other individual coverage (except for group-type coverage); school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.

Each contract for coverage under (1.) or (2.) is a separate Coverage Plan. If a Coverage Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Coverage Plan.

B. The order of benefit determination rules determine whether this Coverage Plan is a "primary Coverage Plan" or "secondary Coverage Plan" when compared to another Coverage Plan covering the person.

When this Coverage Plan is primary, its benefits are determined before those of any other Coverage Plan and without considering any other Coverage Plan's benefits. When this Coverage Plan is secondary, its benefits are determined after those of another Coverage Plan and may be reduced because of the primary Coverage Plan's benefits.

- C. "Allowable expense" means a health care service or expense, including deductibles and copayments, that is covered at least in part by any of the Coverage Plans covering the person. When a Coverage Plan provides benefits in the form of services, (for example a dental HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the Coverage Plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:
1. If a person is covered by 2 or more Coverage Plans that compute their benefit payments on the basis of Usual and Customary fees, any amount in excess of the highest of the Usual and Customary fees for a specific benefit is not an allowable expense.
  2. If a person is covered by 2 or more Coverage Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.
  3. If a person is covered by one Coverage Plan that calculates its benefits or services on the basis of Usual and Customary fees and another Coverage Plan that provides its benefits or services on the basis of negotiated fees, the primary Coverage Plan's payment arrangements will be the allowable expense for all Coverage Plans.

*The definition of Allowable Expense may be amended to remove this restriction.*

- {4. The amount a benefit is reduced by the primary Coverage Plan because a covered person does not comply with the Coverage Plan provisions. Examples of these provisions are second surgical opinions and preferred provider arrangements.}
- D. "Claim determination period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under this Coverage Plan, or before the date this COB provision or a similar provision takes effect.
- E. "Closed panel Coverage Plan" is a Coverage Plan that provides health or dental benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Coverage Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
- F. "Custodial parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

### **7.3 Order of Benefit Determination Rules**

When two or more Coverage Plans pay benefits, the rules for determining the order of payment are as follows:

- A. The primary Coverage Plan pays or provides its benefits as if the secondary Coverage Plan or Coverage Plans did not exist.
- B. A Coverage Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage will be excess to any other parts of the Coverage Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Coverage Plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel Coverage Plan to provide out-of-network benefits.
- C. A Coverage Plan may consider the benefits paid or provided by another Coverage Plan in determining its benefits only when it is secondary to that other Coverage Plan.
- D. The first of the following rules that describes which Coverage Plan pays its benefits before another Coverage Plan is the rule to use.

1. Non-Dependent or Dependent. The Coverage Plan that covers the person other than as a dependent, for example as an student, member, Subscriber or retiree is primary and the Coverage Plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Coverage Plan covering the person as a dependent; and primary to the Coverage Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Coverage Plans is reversed so that the Coverage Plan covering the person as an student, member, Subscriber or retiree is secondary and the other Coverage Plan is primary.
2. Child Covered Under More Than One Plan. The order of benefits when a child is covered by more than one Coverage Plan is:
  - a. The primary Coverage Plan is the Coverage Plan of the parent whose birthday is earlier in the year if:
    - 1.) The parents are married;
    - 2.) The parents are not separated (whether or not they ever have been married); or
    - 3.) A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If both parents have the same birthday, the Coverage Plan that covered either of the parents longer is primary.

- b. If the specific terms of a court decree state that one of the parents is responsible for the child's health or dental care expenses or health or dental care coverage and the Coverage Plan of that parent has actual knowledge of those terms, that Coverage Plan is primary. This rule applies to claim determination periods or Coverage Plan years commencing after the Coverage Plan is given notice of the court decree.
- c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
  - 1.) The Coverage Plan of the custodial parent;
  - 2.) The Coverage Plan of the spouse of the custodial parent;
  - 3.) The Coverage Plan of the noncustodial parent; and then
  - 4.) The Coverage Plan of the spouse of the noncustodial parent.
- [3.] Continuation coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Coverage Plan, the Coverage Plan covering the person as an student, member, Subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored.
- [4.] Longer or shorter length of coverage. The Coverage Plan that covered the person as an student, member, Subscriber or retiree longer is primary.

*Include if double coverage is elected by the Policyholder.*

- {5. If a husband or wife is covered under this Coverage Plan as a Subscriber and as a Covered Dependent, the dependent benefits will be coordinated as if they were provided under another Coverage Plan, this means the person's Subscriber benefit will pay first.}
- [6.] If the preceding rules do not determine the primary Coverage Plan, the allowable expenses will be shared equally between the Coverage Plans meeting the definition of Coverage Plan under this provision. In addition, this Coverage Plan will not pay more than it would have paid had it been primary.

## 7.4 Effect on the Benefits of This Coverage Plan

- A. When this Coverage Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Coverage Plans during a claim determination period are not more than 100 percent of total allowable expenses.

### *Include for COB to Allowable*

{When this Coverage Plan is the secondary carrier, this Coverage Plan will only pay up to the allowable amount but never more than what this Coverage Plan would have paid as primary.}

### *Include for COB Non-Duplication.*

{When this Coverage Plan is the secondary carrier, this Coverage Plan will only pay the difference between what this Coverage Plan would have paid as primary minus what the other carrier paid.}

### *Include for COB Come Out Whole. <sup>1</sup>Remove if not applicable. <sup>2</sup>Select calendar year or Plan Year.*

{When this Coverage Plan is the secondary carrier, this Coverage Plan will pay up to the claimed amount but never more than what this Coverage Plan would have paid as primary.} {<sup>1</sup>The difference between what this Coverage Plan would have paid as primary and what is paid after coordination goes into a savings bank. This money will apply to any amounts between what is paid by both carriers but never greater than the claimed amount. Savings can be used on a current claim or banked for any other claim adjudicated during the [<sup>2</sup>calendar year][<sup>2</sup>Plan Year].}}

- B. If a covered person is enrolled in two or more closed panel Coverage Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel Coverage Plan, COB will not apply between that Coverage Plan and other closed panel Coverage Plans.
- C. This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the primary Coverage Plan.

Medicare benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

- The person is not enrolled for Medicare. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.
- The person is enrolled in a *Medicare Advantage* (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare benefits are determined as if the services were covered under Medicare Parts A and B.
- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in a Veterans Administration facility or other facility of the federal government. Medicare benefits are determined as if the services were provided by a non-governmental facility and covered under Medicare.
- The person is enrolled under a plan with a Medicare Medical Savings Account. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

## 7.5 Right to Receive and Release Needed Information

Certain facts about health or dental care coverage and services are needed to apply these COB rules and to determine benefits payable under this Coverage Plan and other Coverage Plans. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Coverage Plan and other Coverage Plans covering the person claiming benefits. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Coverage Plan must give the Company any facts it needs to apply those rules and determine benefit payable. If the Covered Person does not provide the Company

the information it needs to apply these rules and determine the benefits payable, their claim for benefits will be denied.

## 7.6 Payments Made

A payment made under another Coverage Plan may include an amount that should have been paid under this Coverage Plan. If it does, the Company may pay that amount to the organization that made the payment. That amount will then be treated as though it was a benefit paid under this Coverage Plan. The Company 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.

## 7.7 Right of Recovery

If the amount of the payments made by the Company is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it had paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.]

# [Article 8: Subrogation and Refund of Expenses

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. The Company will be subrogated to and will succeed to all rights of recovery, under any legal theory of any type, for the reasonable value of services and benefits provided by the Company to a Covered Person from: (i.) third parties, including any person alleged to have caused the Covered Person to suffer injuries or damages; (ii.) the Covered Person's employer; or (iii.) any person or entity obligated to provide benefits or payments to the Covered Person, including benefits or payments for underinsured or uninsured motorist protection (these third parties and persons or entities are collectively referred to as "Third Parties"). The Covered Person must agree to assign to the Company all rights of recovery against Third Parties, to the extent of the reasonable value of services and benefits provided by the Company, plus reasonable costs of collection.

The Covered Person must cooperate with the Company in protecting the Company's legal rights to subrogation and reimbursement, and acknowledge that the Company's rights will be considered as the first priority claim against Third Parties, to be paid before any other claims by the Covered Person are paid. The Covered Person will do nothing to prejudice the Company's rights under this provision, either before or after the need for services or benefits under the Policy. The Company may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including filing suit in the Covered Person's name. For the reasonable value of services provided under the Policy, the Company may collect, at its option, amounts from the proceeds of any settlement (whether before or after any determination of liability) or judgment that may be recovered by the Covered Person or their legal representative, regardless of whether or not the Covered Person has been fully compensated. The Covered Person will hold in trust any proceeds of settlement or judgment for the benefit of the Company under these subrogation provisions and the Company will be entitled to recover reasonable attorney fees from the Covered Person incurred in collecting proceeds held by the Covered Person. The Covered Person will not accept any settlement that does not fully compensate or reimburse the Company without the written approval of the Company. The Covered Person must agree to execute and deliver such documents (including a written confirmation of assignment, and consents to release dental records), and provide such help (including responding to requests for information about any accident or injuries and making court appearances) as may be reasonably requested by the Company.]

*Include if plan provides for refunds for overpayments*

{**Refund of Overpayments.** If the Company pays benefits for expenses incurred on account of a Covered Person, that Covered Person or any other person or organization that was paid must make a refund to the Company if:

- A. All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person,
- B. All or some of the payment made by the Company exceeded the benefits under the Policy,
- C. All or some of the payment was made in error.

The refund equals the amount the Company paid in excess of the amount it should have paid under the Policy.

If the refund is due from another person or organization, the Covered Person agrees to help the Company get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Company may reduce the amount of any future benefits that are payable under the Policy. The Company may also reduce future benefits under any other group benefits plan administered by the Company for the Policyholder. The reductions will equal the amount of the required refund. The Company may have other rights in addition to the right to reduce future benefits.}

*Include if applicable.*

**{Reimbursement of Benefits Paid.** If the Company pays benefits for expenses incurred on account of a Covered Person, the Subscriber or any other person or organization that was paid must make a refund to the Company if all or some of the expenses were recovered from or paid by a source other than the Policy as a result of claims against a third party for negligence, wrongful acts or omissions. The refund equals the amount of the recovery or payment, up to the amount the Company paid.

If the refund is due from another person or organization, the Covered Person agrees to help the Company get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Company may reduce the amount of any future benefits that are payable under the Policy. The Company may also reduce future benefits under any other group benefits plan administered by the Company for the Policyholder. The reduction will equal the amount of the required refund. The Company may have other rights in addition to the right to reduce future benefits.}

## **[Article 9]: Procedures for Obtaining Benefits**

### **[9.1] Dental Services**

<sup>1</sup>*Include if Non-Network Emergency is covered as Network.*

<sup>2</sup>*Select deductible, and copayment as applicable to the plan.*

Adjust section references as needed.

#### **[Network Benefits**

Dental Services must be provided by a Network Dentist in order to be considered Network Benefits.

{<sup>1</sup>When Dental Services are received from a Non-Network Provider as a result of an Emergency, the Copayment will be the Network Copayment.}

Enrolling for Coverage under the Policy does not guarantee Dental Services by a particular Network Dentist on the list of providers. The list of Network Dentists is subject to change. When a provider on the list no longer has a contract with the Company, the Covered Person must choose among remaining Network Dentists. The Covered Person is responsible for verifying the participation status of the Dentist, or other provider prior to receiving such Dental Services. The Covered Person must show their ID card every time they request Dental Services.

If a Covered Person fails to verify participation status or to show their ID card, and the failure results in non-compliance with required Company procedures, Coverage of Network Benefits may be denied.

Coverage for Dental Services is subject to payment of the Premium required for Coverage under the Policy<sup>[2,]</sup> {<sup>2</sup>satisfaction of the Deductible,} {<sup>2</sup>payment of the Copayment specified for any service} and payment of the percentage of Eligible Expenses shown in the Schedule of Covered Dental Services and [Article 10]: Covered Dental Services.]

<sup>1</sup>Remove if deductible not applicable. <sup>2</sup>Select contracted or U&C fees as appropriate. Adjust section references as necessary.

### **[Non-Network Benefits**

Non-Network Benefits apply when a Covered Person obtains Dental Services from Non-Network Dentists.

Non-Network Dentists may request that the Covered Person pays all charges when services are rendered. A Covered Person must file a claim with the Company for reimbursement of Eligible Expenses.

The Company reimburses a Non-Network Dentist for a covered Dental Service up to an amount equal to the {<sup>2</sup>contracted} {<sup>2</sup>Usual and Customary} fee for the same covered Dental Service received from a similarly situated Network Dentist.]

### **[Network Dentists**

The Company has arranged with certain dental care providers to participate in a Network. These Network Dentists have agreed to discount their charges for Covered services and supplies.

If Network Dentists are used, the amount of Covered expenses for which a Covered Person is responsible will generally be less than the amount owed if Non-Network Dentists had been used. The Copayment level (the percentage of Covered expenses for which a Covered Person is responsible) remains the same whether or not Network Dentists are used. However, because the total charges for Covered expenses may be less when Network Dentists are used, the portion that the Covered Person owes will generally be less.

Covered Persons are issued an identification card (ID card) showing they are eligible for Network discounts. A Covered Person must show this ID card every time Dental Services are given. This is how the provider knows that the patient is Covered under a Network plan. Otherwise, the person could be billed for the provider's normal charge.

<sup>1</sup>Change reference to customer service as needed

A Directory of Network Dentists will be made available. A Covered Person can also call [<sup>1</sup>customer service] to determine which providers participate in the Network. The telephone number for [<sup>1</sup>customer services] is on the ID card.

Network Dentists are responsible for submitting a request for payment directly to the Company, however, a Covered Person is responsible for any Copayment at the time of service. If a Network Dentist bills a Covered Person, [<sup>1</sup>customer services] should be called. A Covered Person does not need to submit claims for Network Dentist services or supplies.]

*Include when pre-treatment estimate applies. <sup>1</sup>Adjust amount as needed. <sup>2</sup>Leave bracketed text in unless determined to remove.*

### **{[9.2] Pre-Treatment Estimate**

If the charge for a Dental Service is expected to exceed [<sup>1</sup>\$500] or if a dental exam reveals the need for fixed bridgework, the Covered Person may notify the Company of such treatment before treatment begins and receive a Pre-Treatment Estimate. If a Covered Person desires a Pre-Treatment Estimate, the Covered Person or their Dentist should send a notice to the Company, via claim form, within 20 days of the exam. {<sup>2</sup>If requested the Dentist must provide the Company with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.}

The Company will determine if the proposed treatment is Covered under the Policy and estimate the amount of payment. The estimate of benefits payable will be sent to the Dentist and will be subject to all terms, conditions and provisions of the Policy. {Clinical situations that can be effectively treated by a less

costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.}

<sup>1</sup>Use bracketed sentence if day limit applies. <sup>2</sup>Modify number of days the estimate is valid as needed. <sup>3</sup>Modify number of days when treatment must be received as needed.

Pre-Treatment Estimate of benefits is not an agreement to pay for expenses. This procedure lets the Covered Person know in advance approximately what portion of the expenses will be considered for payment. {<sup>1</sup>The pre-treatment estimate is valid for [<sup>2</sup>90] days from the date the Company provides it to the Dentist. If the Covered Person will not receive the services within the [<sup>3</sup>90] days, the Covered Person or the Dentist must request another pre-treatment estimate from the Company. }

## [Article 10]: Covered Dental Services

Dental Services described in this Section and in the *Schedule of Covered Dental Services* are Covered when such services are:

- A. Necessary;
- B. Provided by or under the direction of a Dentist;
- C. Clinical situations that can be effectively treated by a less costly, dental appropriate alternative procedure will be assigned a benefit based on the least costly procedure; and
- D. Not excluded as described in [Section 11]: *General Exclusions*.

<sup>1</sup>Include when Deductible, Maximum Benefits or Copayments apply. <sup>2</sup>Include when deductible applies. <sup>3</sup>Include when Deductible applies. <sup>4</sup>Include when Maximum Benefit applies. <sup>5</sup>Include when Copayment applies. Adjust commas and the word "and" as applicable.

[<sup>1</sup>Covered Dental Services are subject to [<sup>2</sup>satisfaction of the] [<sup>3</sup>Deductible] [,] [and] [<sup>4</sup>Maximum Benefits] [<sup>5</sup>and payment of any Copayments] as described below and in the *Schedule of Covered Dental Services*.]

<sup>1</sup>Include if applicable to the plan.

This Section and the *Schedule of Covered Dental Services*: (1) describe the Covered Dental Services and any applicable limitations to those services; (2) outline [<sup>1</sup>the Copayments that the Covered Person is required to pay] for each Covered Dental Service; and (3) describe the [<sup>1</sup>Deductible] [<sup>1</sup>and] [<sup>1</sup>any Maximum Benefits] that may apply.

### [Network Benefits:

When Network Copayments are charged as a percentage of Eligible Expenses, the amount the Covered Person pays for Dental Services from Network providers is determined as a percentage of the negotiated contract fee between the Company and the provider rather than a percentage of the provider's billed charge. The Company's negotiated rate with the provider is ordinarily lower than the provider's billed charge.

A Network provider cannot charge a Covered Person or the Company for any service or supply that is not Necessary as determined by the Company. If a Covered Person agrees to receive a service or supply that is not Necessary the Network provider may charge the Covered Person. However, these charges will not be considered Covered Dental Services and will not be payable by the Company.]

### [Non-Network Benefits:

<sup>1</sup>Include when copayment is charged as a percentage of "Eligible Expenses" and determined as a percentage of the negotiated contract fee.

<sup>2</sup>Include if copayment is charged as a percentage of "Usual and Customary fees."

When Copayments are charged as a percentage of [<sup>1</sup>Eligible Expenses, the amount the Covered Person pays for Dental Services from Non-Network providers is determined as a percentage of the negotiated contract rates of Network providers] [<sup>2</sup>Usual and Customary fees, the amount the Covered Person pays for Dental Services from Non-Network providers is determined as a percentage of the Usual and

Customary fee] plus the amount by which the Non-Network provider's billed charge exceeds the [1contracted] [2Usual and Customary] fee.]

*1Remove if not applicable. 2Remove if not applicable.*

**[Copayment** is shown as a percentage of Eligible Expenses [1after the Deductible is satisfied]. [2 the Covered Person must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.]]

*Include when Deductible applies. 1Insert the deductible amount. 2Deductible can apply separately for network and non-network. 3Select if the Deductible is per "Plan Year", or "calendar year". 4Include when family maximum applies.*

### **{Deductible}**

**{Deductible** is [1\$0 - \$3,000] per Covered Person {2for Network Benefits} {2and [1\$0-\$3,000] per Covered Person for} {2Non-Network Benefits} per {3Plan Year} {3calendar year}{.}[4, not to exceed [1\$0 - \$3000]{2for Network Benefits {2and [1\$0-\$3,000] for} {2Non-Network Benefits} for all Covered Persons in a family].}

*Include if deductible applies to all services except Diagnostic and/or Preventive. 1Select Diagnostic, Preventive or both.*

{The Deductible does not apply to: [1DIAGNOSTIC SERVICES] [1and/or] [1PREVENTIVE SERVICES.]

*1Insert the Maximum Benefit amount. 2Select if Maximum Benefit is per "Covered Person" or "family". 3Maximum Benefit can apply separately for network and/or non-network. 4Select if the Maximum Benefit is per "Plan Year" or "calendar year". 5Include when family maximum applies.*

### **[Maximum Benefit**

**Maximum Benefit** is [1\$500 - \$5,000] per [2Covered Person][2family] {3for Network Benefits} {3and [1\$500-\$5,000] per [2Covered Person][2family] for} {3Non-Network Benefits} per {4Plan Year}{4calendar year}{.}[5, not to exceed [1\$1,500 - \$15,000] {3for Network Benefits} {3and [1\$1,500-\$15,000] for} {3Non-Network Benefits} for all Covered Persons in a family].]

*Include if applicable when there are separate Network and Non-Network Maximum Benefits. 1Insert the Maximum Benefit amount. 2Select if Maximum Benefit is per "Covered Person" or "family". 3Select if the Maximum Benefit is per "Plan Year" or "calendar year".*

{The sum of all Network and Non-Network Benefits will not exceed a Maximum Benefit of [1\$500 - \$5,000] per [2Covered Person][2family] per {3Plan Year} {3calendar year}.}

Maximum Benefit applies to all Covered Dental Services.

*Include if applicable. 1Modify as applicable to the plan. 2Include if applicable to the plan.*

{[1Any required [2Copayment,] [2Deductible,] [2or] [2Maximum Benefit] is waived for a Covered Person in their 2nd or 3rd trimester of pregnancy for the following Covered Dental Services:] [prophylaxis, scaling and root planing,] periodontal maintenance,] [full mouth debridement].}

## **[[Section 10.1] CREDIT FOR PRIOR COVERAGE**

*Include if "no loss, no gain" language applies. 1Select "Eligible Person" or "family".*

{If an [1Eligible Person][1family] becomes Covered under this Policy due to a mid year plan change they will need to submit evidence of both their prior carrier deductible [and maximum benefits paid] in order to receive credit under this Policy.}

# [Article 11]: General Exclusions

## 11.1 Exclusions

Except as may be specifically provided in the *Schedule of Covered Dental Services* or through a Rider to the Policy, the following are not Covered:

- A. Dental Services that are not Necessary.
- B. Hospitalization or other facility charges.
- C. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
- [D. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.]
- [E.] Any Dental Procedure not directly associated with dental disease.
- [F.] Any Dental Procedure not performed in a dental setting.
- [G.] Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
- [[H.] Placement of dental implants, implant-supported abutments and prostheses.]
- [I.] Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
- [J.] Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
- [[K.] Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.]
- [[L.] Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.]
- [[M.] Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.]
- [[N.] Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.]
- [O.] Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
- [P.] Expenses for Dental Procedures begun prior to the Covered Person becoming covered under the Policy.
- [[Q.] Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.]

[[R.] Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.]

[[S.] Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).]

<sup>1</sup>*Modify number of months as applicable.*

[[T.] Replacement of crowns, bridges, and fixed or removable prosthetic appliances inserted prior to plan Coverage unless the patient has been Covered under the school's dental policy for [<sup>1</sup>36] continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this [<sup>1</sup>36 month] period, the plan is responsible only for the procedures associated with the addition. ]

<sup>1</sup>*Modify number of months as applicable.*

[[U.] Replacement of missing natural teeth lost prior to the onset of plan Coverage until the patient has been Covered under the school's dental policy for [<sup>1</sup>36] continuous months.]

<sup>1</sup>*Modify ADA code if necessary.*

[[V.] Occlusal guards used as safety items or to affect performance primarily in sports-related activities.]

[[W.] Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.]

[X.] Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.

[Y.] Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.

[Z.] Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

[[AA.] Orthodontic Services.]

[[BB.] In the event that a Non-Network Dentist routinely waives Copayments and/or the Deductible for a particular Dental Service, the Dental Service for which the Copayments and/or Deductible are waived is reduced by the amount waived by the Non-Network provider.

<sup>1</sup>*Remove if Foreign Services are not covered even in an Emergency.*

[CC.] Foreign Services are not Covered [<sup>1</sup>unless required as an Emergency].

[DD.] Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

[EE.] Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.

## **[Article 12]: Complaint Procedures**

<sup>1</sup>*Change reference to customer service department and customer service as needed.* <sup>2</sup>*Modify reference to the "Office of the Commissioner of Insurance" as applicable.*

### **12.1 Complaint Resolution**

If a Covered Person has a concern or question regarding the provision of Dental Services or benefits under the Policy, they should contact the Company's [<sup>1</sup>customer service department] at the telephone number shown on their ID card. [<sup>1</sup>Customer service] representatives are available to take calls during

regular business hours, Monday through Friday. At other times, the Covered Person may leave a message on voicemail. A [<sup>1</sup>customer service] representative will return their call. If a Covered Person would rather send their concern to the Company in writing at this point, the Company's authorized representative can provide them with the appropriate address.

If the [<sup>1</sup>customer service] representative cannot resolve the issue to the Covered Person's satisfaction over the phone, they can provide the Covered Person with the appropriate address to submit a written complaint. We will notify the Covered Person of our decision regarding their complaint within 30 days of receiving it.

If the Covered Person disagrees with our decision after having submitted a written complaint, they can ask us in writing to formally reconsider their complaint. If the complaint relates to a claim for payment, the request should include:

- The patient's name and the identification number from the ID card
- The date(s) of service(s)
- The provider's name
- The reason the Covered Person believes the claim should be paid
- Any new information to support the Covered Person's request for claim payment

We will notify the Covered Person of our decision regarding our reconsideration of their complaint within 60 days of receiving it. If the Covered Person is not satisfied with our decision, they have the right to take their complaint to the [<sup>2</sup>Office of the Commissioner of Insurance].

*Include if plan provides for complaint hearings. <sup>1</sup>Delete if a hearing does not need to be requested. <sup>2</sup>If <sup>1</sup> is removed capitalized "We". <sup>3</sup>Modify reference to the "Office of the Commissioner of Insurance" as applicable.*

## **{12.2 Complaint Hearing**

{<sup>1</sup>If the Covered Person requests a hearing, }[<sup>2</sup>we] will appoint a committee to resolve or recommend the resolution of their complaint. If the Covered Person's complaint is related to clinical matters, the Company may consult with, or seek the participation of, medical and/or dental experts as part of the complaint resolution process.

The committee will advise the Covered Person of the date and place of the complaint hearing. The hearing will be held within 60 days following receipt of the Covered Person's request by the Company, at which time the committee will review testimony, explanation or other information that it decides is necessary for a fair review of the complaint.

We will send the Covered Person written notification of the committee's decision within 30 days of the conclusion of the hearing. If the Covered Person is not satisfied with our decision, they have the right to take their complaint to the [<sup>3</sup>Office of the Commissioner of Insurance].}

*Include if exception for emergency situations apply. <sup>1</sup>Modify reference to the Office of the Commissioner of Insurance as applicable.*

## **{{12.3} Exceptions for Emergency Situations**

The Covered Person's complaint requires immediate actions when their Dentist judges that a delay in treatment would significantly increase the risk to their health. In these urgent situations:

- The appeal does not need to be submitted in writing. The Covered Person or their Dentist should call us as soon as possible.
- We will notify the Covered Person of the decision by the end of the next business day after their complaint is received, unless more information is needed.

- If we need more information from the Covered Person's Dentist to make a decision, we will notify the Covered Person of the decision by the end of the next business day following receipt of the required information.

The complaint process for urgent situations does not apply to prescheduled treatments or procedures that we do not consider urgent situations.

If the Covered Person is not satisfied with our decision, they have the right to take their complaint to the [1Office of the Commissioner of Insurance].}

# Exhibit 1 to Dental Policy

1. **Parties.** The parties to this Policy are United HealthCare Insurance Company ("Company") and [\_\_\_\_\_] ("Policyholder").
2. **Effective Date.** The effective date of this Policy is [\_\_\_\_\_].

*Delete if Minimum Participation Requirement does not apply. <sup>1</sup>Select if participation requirement is the number or percentage of eligible persons and insert amount.*

- {3. **Minimum Participation Requirement.** The minimum participation requirement is [<sup>1</sup>2-101][<sup>1</sup>75% of] Eligible Persons enrolled for Coverage under the Policy.}

- [4]. **Notice.**

Any notice sent to the Company under this Policy will be addressed to:

United Healthcare Insurance Company

[450 Columbus Blvd.

Hartford, CT 06115-0450]

Any notice sent to Policyholder under this Policy will be addressed to:

[\_\_\_\_\_]

(Policyholder)

\_\_\_\_\_

(ADDRESS)

\_\_\_\_\_]

(CITY, STATE, ZIP)

[\_\_\_\_ Policyholder Number]

# Exhibit 2 to Dental Policy

## Policy Contents

All of the Dental Services and provisions in the *Schedule(s) of Covered Dental Services*, Amendments and Riders, issued for the Policyholder are included and made part of this Policy.

<sup>1</sup>*Include when documents are listed. Modify headings as needed.*

{<sup>1</sup>

[DOCUMENTS	DOCUMENT NUMBER	EFFECTIVE DATE]
------------	-----------------	-----------------

}

# SCHEDULE OF COVERED DENTAL SERVICES

<sup>1</sup>Include if the Copayment applies after the Deductible is satisfied. <sup>2</sup>Include if applicable when Copayment is shown as a percentage of Eligible Expenses. Delete the categories and Benefit Descriptions and Limitations that are not applicable.

[BENEFIT DESCRIPTION & LIMITATION]	[NETWORK] [COPAYMENT] is shown as a percentage of Eligible Expenses [ <sup>1</sup> after applicable Deductible is satisfied].]	[NON-NETWORK] [COPAYMENT] is shown as a percentage of Eligible Expenses [ <sup>1</sup> after applicable Deductible is satisfied].] [ <sup>2</sup> The Covered Person must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.]
<b>[DIAGNOSTIC SERVICES]</b>		
[Bacteriologic Cultures] [Limited to [1] [time] per [consecutive] [12 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Viral Cultures] [Limited to [1] [time] per [consecutive] [12 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Intraoral Bitewing Radiographs] [Limited to [1] series of films per [consecutive] [12 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Panorex Radiographs] [Limited to [1] [time] per [consecutive] [60 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Oral/Facial Photographic Images] [Limited to [1] [time] [set of images] per [consecutive] [60 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Diagnostic Casts] [Limited to [1] [time] per [consecutive] [24 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Extraoral Radiographs]	[0% - 100%]	[0% - 100%]

<b>[BENEFIT DESCRIPTION &amp; LIMITATION]</b>	<b>[NETWORK] [COPAYMENT]</b> is shown as a percentage of Eligible Expenses [ <sup>1</sup> after applicable Deductible is satisfied].]	<b>[NON-NETWORK] [COPAYMENT]</b> is shown as a percentage of Eligible Expenses [ <sup>1</sup> after applicable Deductible is satisfied].] [ <sup>2</sup> The Covered Person must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.]
[Limited to [1] [film] per [consecutive] [12 months] [calendar year] [Plan Year].]		
[Intraoral - Complete Series (including bitewings)]  [Limited to [1] [time] per [consecutive] [60 months] [calendar year] [Plan Year].] [Vertical bitewings can not be billed in conjunction with a complete series.]	[0% - 100%]	[0% - 100%]
[Intraoral Periapical Radiographs]  [Limited to [1] per [consecutive] [12 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Pulp Vitality Tests]  [Limited to [1] [charge] per visit, regardless of how many teeth are tested.]	[0% - 100%]	[0% - 100%]
[Intraoral Occlusal Film]  [Limited to [1] [film] per [consecutive] [12 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Periodic Oral Evaluation]  [Limited to [1] [time] per [consecutive] [12 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Comprehensive Oral Evaluation]  [Limited to [1] [time] per [consecutive] [36 months] [calendar year] [Plan Year] for established patients.] [Not Covered if done in conjunction with other exams.]	[0% - 100%]	[0% - 100%]
[Limited or Detailed Oral	[0% - 100%]	[0% - 100%]

[BENEFIT DESCRIPTION & LIMITATION]	[NETWORK] [COPAYMENT] is shown as a percentage of Eligible Expenses [ <sup>1</sup> after applicable Deductible is satisfied].]	[NON-NETWORK] [COPAYMENT] is shown as a percentage of Eligible Expenses [ <sup>1</sup> after applicable Deductible is satisfied].] [ <sup>2</sup> The Covered Person must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.]
Evaluation] [Limited to [1] [time] per [consecutive] [12 months] [calendar year] [Plan Year.]] [Only [1] exam is Covered per date of service.]		
[Comprehensive Periodontal Evaluation - new or established patient] [Limited to [1] [time] per [consecutive] [36 months] [calendar year] [Plan Year.] [Not Covered if done in conjunction with other exams.]	[0% - 100%]	[0% - 100%]
[Genetic Test for Susceptibility to Oral Diseases] [Limited to [1] [time] per [consecutive] [12 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Adjunctive Pre-Diagnostic Test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures] [Limited to [1] [time] per [consecutive] [12 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Decalcification Procedure] [Limited to [1] [time] per [consecutive] [12 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Tissue Staining] [Limited to [1] [time] per [consecutive] [12 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]

<b>[BENEFIT DESCRIPTION &amp; LIMITATION]</b>	<b>[NETWORK] [COPAYMENT]</b> is shown as a percentage of Eligible Expenses [ <sup>1</sup> after applicable Deductible is satisfied].]	<b>[NON-NETWORK] [COPAYMENT]</b> is shown as a percentage of Eligible Expenses [ <sup>1</sup> after applicable Deductible is satisfied].] [ <sup>2</sup> The Covered Person must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.]
[Electron Microscopy - Diagnostic]  [Limited to [1] [time] per [consecutive] [12 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Immunofluorescence]  [Limited to [1] [time] per [consecutive] [12 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Pathology Consultations]  [Limited to [1] [time] per [consecutive] [12 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Other Oral Pathology Procedures, by report]  [Limited to [1] [time] per [consecutive] [12 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Tissue In-Situ Hybridization, including interpretation]  [Limited to [1] [time] per [consecutive] [12 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
<b>[PREVENTIVE SERVICES]</b>		
[Dental Prophylaxis]  [Limited to [1] [time] per [consecutive] [12 months] [calendar year] [Plan Year].] [Is not Covered in addition to periodontal maintenance.]	[0% - 100%]	[0% - 100%]
[Fluoride Treatments - child]  [Limited to Covered Persons under the age of [12] years, and limited to [1] [time] per [consecutive] [12 months]	[0% - 100%]	[0% - 100%]

<b>[BENEFIT DESCRIPTION &amp; LIMITATION]</b>	<b>[NETWORK] [COPAYMENT]</b> is shown as a percentage of Eligible Expenses [ <sup>1</sup> after applicable Deductible is satisfied].]	<b>[NON-NETWORK] [COPAYMENT]</b> is shown as a percentage of Eligible Expenses [ <sup>1</sup> after applicable Deductible is satisfied].] [ <sup>2</sup> The Covered Person must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.]
[calendar year] [Plan Year].]		
[Sealants] [Limited to Covered Persons under the age of [12] years and [once per first or second permanent molar] every [consecutive] [60 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Space Maintainers] [Limited to Covered Persons under the age of [12] years, once per [consecutive] [60 months] [calendar year] [Plan Year] [lifetime].] [Benefit includes all adjustments within [6] months of installation.]	[0% - 100%]	[0% - 100%]
[Re-Cement Space Maintainers] [Limited to [1] per [consecutive] [12 months] [calendar year] [Plan Year] [lifetime] after initial insertion.]	[0% - 100%]	[0% - 100%]
<b>[MINOR RESTORATIVE SERVICES]</b>		
[Amalgam Restorations] [Multiple restorations on one surface will be treated as a single filling.] [Limited to [1] [time] per [consecutive] [60 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Composite Resin Restorations - Anterior] [Multiple restorations on one surface will be treated as a single filling.] [Limited to [1] [time] per [consecutive] [60 months]	[0% - 100%]	[0% - 100%]

<b>[BENEFIT DESCRIPTION &amp; LIMITATION]</b>	<b>[NETWORK] [COPAYMENT]</b> is shown as a percentage of Eligible Expenses [ <sup>1</sup> after applicable Deductible is satisfied].]	<b>[NON-NETWORK] [COPAYMENT]</b> is shown as a percentage of Eligible Expenses [ <sup>1</sup> after applicable Deductible is satisfied].] [ <sup>2</sup> The Covered Person must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.]
[calendar year] [Plan Year].]		
[Composite Resin Restorations - Posterior]  [Multiple restorations on one surface will be treated as a single filling.]  [Limited to [1] [time] per [consecutive] [60 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Gold Foil Restorations]  [Multiple restorations on one surface will be treated as a single filling] [Covered on posterior teeth only]  [Limited to [1] [time] per [consecutive] [60 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
<b>[ENDODONTICS]</b>		
[Apexification]  [Limited to [1] [time] per tooth per lifetime.]	[0% - 100%]	[0% - 100%]
[Apicoectomy and Retrograde Filling]  [Limited to [1] [time] per tooth per lifetime.]	[0% - 100%]	[0% - 100%]
[Hemisection]  [Limited to [1] [time] per tooth per lifetime.]	[0% - 100%]	[0% - 100%]
[Root Canal Therapy]  [Limited to [1] [time] per tooth per lifetime.] [Dentist cannot charge retreatment codes on tooth treated for the first [12 months].]	[0% - 100%]	[0% - 100%]

<b>[BENEFIT DESCRIPTION &amp; LIMITATION]</b>	<b>[NETWORK] [COPAYMENT]</b> is shown as a percentage of Eligible Expenses [ <sup>1</sup> after applicable Deductible is satisfied].]	<b>[NON-NETWORK] [COPAYMENT]</b> is shown as a percentage of Eligible Expenses [ <sup>1</sup> after applicable Deductible is satisfied].] [ <sup>2</sup> The Covered Person must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.]
[Retreatment of Previous Root Canal Therapy]  [Dentist who performed the original root canal should not be reimbursed for the retreatment for the first [12 months].]	[0% - 100%]	[0% - 100%]
[Root Resection/Amputation]  [Limited to [1] [time] per tooth per lifetime.]	[0% - 100%]	[0% - 100%]
[Therapeutic Pulpotomy]  [Limited to [1] [time] per primary or secondary tooth per lifetime.]	[0% - 100%]	[0% - 100%]
[Pulpal Therapy (resorbable filling) - Anterior or Posterior, Primary Tooth (excluding final restoration)]  [Limited to [1] per tooth per lifetime.] [Covered for anterior or posterior teeth only.]	[0% - 100%]	[0% - 100%]
[Pulp Caps - Direct/Indirect – excluding final restoration]  [Not Covered if utilized solely as a liner or base underneath a restoration.]	[0% - 100%]	[0% - 100%]
[Pulpal Debridement, Primary and Permanent Teeth]  [Not Covered if done by same dentist performing definitive root canal therapy.]	[0% - 100%]	[0% - 100%]
<b>[PERIODONTICS]</b>		
[Crown Lengthening]  [Limited [1] per quadrant or site per [consecutive] [60 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]

<b>[BENEFIT DESCRIPTION &amp; LIMITATION]</b>	<b>[NETWORK] [COPAYMENT]</b> is shown as a percentage of Eligible Expenses [ <sup>1</sup> after applicable Deductible is satisfied].]	<b>[NON-NETWORK] [COPAYMENT]</b> is shown as a percentage of Eligible Expenses [ <sup>1</sup> after applicable Deductible is satisfied].] [ <sup>2</sup> The Covered Person must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.]
[Gingivectomy/Gingivoplasty] [Limited [1] per quadrant or site per [consecutive] [60 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Gingival Flap Procedure] [Limited [1] per quadrant or site per [consecutive] [60 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Osseous Graft] [Limited [1] per quadrant or site per [consecutive] [60 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Osseous Surgery] [Limited [1] per quadrant or site per [consecutive] [60 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Guided Tissue Regeneration] [Limited [1] per quadrant or site per [consecutive] [60 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Soft Tissue Surgery] [Limited [1] per quadrant or site per [consecutive] [60 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Periodontal Maintenance] [Is Covered in combination with [dental prophylaxis] but not on same date of service, benefit is not to exceed in combination with [dental prophylaxis] [2] per [consecutive] [12 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Full Mouth Debridement] [Limited to once per [consecutive] [60 months]	[0% - 100%]	[0% - 100%]

[BENEFIT DESCRIPTION & LIMITATION]	[NETWORK] [COPAYMENT] is shown as a percentage of Eligible Expenses [ <sup>1</sup> after applicable Deductible is satisfied].]	[NON-NETWORK] [COPAYMENT] is shown as a percentage of Eligible Expenses [ <sup>1</sup> after applicable Deductible is satisfied].] [ <sup>2</sup> The Covered Person must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.]
[calendar year] [Plan Year].]		
[Provisional Splinting] [Cannot be used to restore vertical dimension or as part of full mouth rehabilitation, should not include use of laboratory based crowns and/or fixed partial dentures (bridges).] [Covered for single tooth extractions.] [Exclusion of laboratory based crowns or bridges for the purposes of provisional splinting.]	[0% - 100%]	[0% - 100%]
[Scaling and Root Planing] [Limited to [1] [time] per quadrant per [consecutive] [24 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Localized Delivery of Antimicrobial Agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report] [Limited to [1] per quadrant per site for refractory pockets by report.]	[0% - 100%]	[0% - 100%]
<b>[ORAL SURGERY]</b>		
[Alveoplasty] [Not Covered for single tooth extractions; bone recontouring should be included in the extraction fee.]	[0% - 100%]	[0% - 100%]
[Biopsy] [Limited to [1] biopsy per site per visit.] [Not Covered if done in conjunction with another biopsy procedure.]	[0% - 100%]	[0% - 100%]

<b>[BENEFIT DESCRIPTION &amp; LIMITATION]</b>	<b>[NETWORK] [COPAYMENT]</b> is shown as a percentage of Eligible Expenses [ <sup>1</sup> after applicable Deductible is satisfied].]	<b>[NON-NETWORK] [COPAYMENT]</b> is shown as a percentage of Eligible Expenses [ <sup>1</sup> after applicable Deductible is satisfied].] [ <sup>2</sup> The Covered Person must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.]
[Frenectomy/Frenulopasty] [Limited to [1] per site per [consecutive] [60 months] [calendar year] [Plan Year].] [Frenectomy and frenuloplasty cannot be billed on same date of service.]	[0% - 100%]	[0% - 100%]
[Surgical Incision] [Limited to [1] per site per visit.]	[0% - 100%]	[0% - 100%]
[Removal of a Benign Cyst/Lesions] [Limited to [1] per site per visit.]	[0% - 100%]	[0% - 100%]
[Removal of Torus] [Limited to [1] per site per visit.]	[0% - 100%]	[0% - 100%]
[Root Removal, Surgical] [Limited to [1] [time] per tooth per lifetime.]	[0% - 100%]	[0% - 100%]
[Simple Extractions] [Limited to [1] [time] per tooth per lifetime.]	[0% - 100%]	[0% - 100%]
[Surgical Extraction of Erupted Teeth or Roots] [Limited to [1] [time] per tooth per lifetime.]	[0% - 100%]	[0% - 100%]
[Surgical Extraction of Impacted Teeth] [Limited to [1] [time] per tooth per lifetime.]	[0% - 100%]	[0% - 100%]
[Surgical Access, Surgical Exposure, or Immobilization of Unerupted Teeth] [Limited to [1] per site per lifetime.]	[0% - 100%]	[0% - 100%]

<b>[BENEFIT DESCRIPTION &amp; LIMITATION]</b>	<b>[NETWORK] [COPAYMENT]</b> is shown as a percentage of Eligible Expenses [ <sup>1</sup> after applicable Deductible is satisfied].]	<b>[NON-NETWORK] [COPAYMENT]</b> is shown as a percentage of Eligible Expenses [ <sup>1</sup> after applicable Deductible is satisfied].] [ <sup>2</sup> The Covered Person must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.]
[Primary Closure of a Sinus Perforation]  [Limited to [1] per tooth per lifetime.]	[0% - 100%]	[0% - 100%]
[Placement of Device to Facilitate Eruption of Impacted Tooth]  [Limited to [1] [time] per tooth per lifetime.]	[0% - 100%]	[0% - 100%]
[Transseptal Fiberotomy/Supra Crestal Fiberotomy, by report]  [Limited to [1] [time] per tooth per lifetime.]	[0% - 100%]	[0% - 100%]
[Vestibuloplasty]  [Limited to [1] [time] per site per [consecutive] [60 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Bone Replacement Graft for Ridge Preservation - per site]  [Limited to [1] per site per lifetime.] [Not Covered if done in conjunction with other bone graft replacement procedures.]	[0% - 100%]	[0% - 100%]
[Excision of Hyperplastic Tissue or Pericoronal Gingiva]  [Limited to [1] per site per [consecutive] [60 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Appliance Removal (not by dentist who placed appliance) includes removal of arch bar]  [Limited to once per appliance per lifetime.]	[0% - 100%]	[0% - 100%]
[Tooth Reimplantation and/or Transplantation Services]  [Limited to [1] per site per	[0% - 100%]	[0% - 100%]

<b>[BENEFIT DESCRIPTION &amp; LIMITATION]</b>	<b>[NETWORK] [COPAYMENT]</b> is shown as a percentage of Eligible Expenses [ <sup>1</sup> after applicable Deductible is satisfied].]	<b>[NON-NETWORK] [COPAYMENT]</b> is shown as a percentage of Eligible Expenses [ <sup>1</sup> after applicable Deductible is satisfied].] [ <sup>2</sup> The Covered Person must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.]
lifetime.]		
[Oroantral Fistula Closure] [Limited to [1] per site per visit.]	[0% - 100%]	[0% - 100%]
<b>[ADJUNCTIVE SERVICES]</b>		
[Analgesia] [Covered when Necessary in conjunction with Covered Dental Services.] [If required for patients under [6] years of age or patients with behavioral problems or physical disabilities or if it is [medically] [clinically] Necessary.] [Covered for patients over age of [6] if it is [medically] [clinically] Necessary.]	[0% - 100%]	[0% - 100%]
[Desensitizing Medicament] [Limited to [1] [time] per tooth per [12 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[General Anesthesia] [Covered when Necessary in conjunction with Covered Dental Services.] [If required for patients under [6] years of age or patients with behavioral problems or physical disabilities or if it is [medically] [clinically] Necessary.] [Covered for patients over age of [6] if it is [medically] [clinically] Necessary.]	[0% - 100%]	[0% - 100%]
[Local Anesthesia] [Not Covered in conjunction with operative or surgical procedure.] [Limited to [1] [charge] per visit. [Limited to [1] [charge] per [consecutive] [60 months]	[0% - 100%]	[0% - 100%]

[BENEFIT DESCRIPTION & LIMITATION]	[NETWORK] [COPAYMENT] is shown as a percentage of Eligible Expenses [ <sup>1</sup> after applicable Deductible is satisfied].]	[NON-NETWORK] [COPAYMENT] is shown as a percentage of Eligible Expenses [ <sup>1</sup> after applicable Deductible is satisfied].] [ <sup>2</sup> The Covered Person must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.]
[calendar year] [Plan Year].		
[Intravenous Sedation and Analgesia]  [Covered when Necessary in conjunction with Covered Dental Services.]  [If required for patients under [6] years of age or patients with behavioral problems or physical disabilities or if it is [medically] [clinically] Necessary.] [Covered for patients over age of [6] if it is [medically] [clinically] Necessary.]	[0% - 100%]	[0% - 100%]
[Therapeutic Drug Injection, by report/Other Drugs and/or Medicaments, by report]  [Limited to [1] per visit per [consecutive] [12 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Occlusal Adjustment]  [Limited to [1] [time] per [consecutive] [12 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Occlusal Guards]  [Limited to [1] guard every [consecutive] [60 months] [calendar year] [Plan Year] and only if prescribed to control habitual grinding.]	[0% - 100%]	[0% - 100%]
[Occlusal Guard Reline and Repair]  [Limited to relining and repair performed more than [6] months after the initial insertion.] [Limited to [1] [time] per [consecutive] [12 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]

<b>[BENEFIT DESCRIPTION &amp; LIMITATION]</b>	<b>[NETWORK] [COPAYMENT]</b> is shown as a percentage of Eligible Expenses [ <sup>1</sup> after applicable Deductible is satisfied].]	<b>[NON-NETWORK] [COPAYMENT]</b> is shown as a percentage of Eligible Expenses [ <sup>1</sup> after applicable Deductible is satisfied].] [ <sup>2</sup> The Covered Person must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.]
[Occlusion Analysis - Mounted Case]  [Limited to [1] [time] per [consecutive] [60 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Palliative Treatment]  [Covered as a separate benefit only if no other services, other than the exam and radiographs, were done on the same tooth during the visit.]	[0% - 100%]	[0% - 100%]
[Consultation (diagnostic service provided by dentists or physician other than practitioner providing treatment.)]  [Not Covered if done with exams or professional visit.]	[0% - 100%]	[0% - 100%]
<b>[MAJOR RESTORATIVE SERVICES]</b>		
[Replacement of [complete] [dentures], [fixed] [or] [removable] [partial] [dentures], [crowns], [inlays] [or] [onlays] previously submitted for payment under the plan is limited to [1] [time] per [consecutive] [120 months] [calendar year] [Plan Year] from initial or supplemental placement.]		
[Coping]  [Limited to [1] per tooth per [consecutive] [120 months] [calendar year] [Plan Year].] [Not Covered if done at the same time as a crown on same tooth.]	[0% - 100%]	[0% - 100%]
[Crowns – Retainers/Abutments]  [Limited to [1] [time] per tooth per [consecutive] [120 months] [calendar year] [Plan Year].] [Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.]	[0% - 100%]	[0% - 100%]
[Crowns - Restorations]	[0% - 100%]	[0% - 100%]

<b>[BENEFIT DESCRIPTION &amp; LIMITATION]</b>	<b>[NETWORK] [COPAYMENT]</b> is shown as a percentage of Eligible Expenses [ <sup>1</sup> after applicable Deductible is satisfied].]	<b>[NON-NETWORK] [COPAYMENT]</b> is shown as a percentage of Eligible Expenses [ <sup>1</sup> after applicable Deductible is satisfied].] [ <sup>2</sup> The Covered Person must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.]
[Limited to [1] [time] per tooth per [consecutive] [120 months] [calendar year] [Plan Year].] [Covered only when a filling cannot restore the tooth.] [Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.]		
[Temporary Crowns - Restorations] [Limited to [1] [time] per tooth per [consecutive] [120 months] [calendar year] [Plan Year].] [Covered only when a filling cannot restore the tooth.] [Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.]	[0% - 100%]	[0% - 100%]
[Inlays/Onlays – Retainers/Abutments] [Limited to [1] [time] per tooth per [consecutive] [120 months] [calendar year] [Plan Year].] [Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.]	[0% - 100%]	[0% - 100%]
[Inlays/Onlays - Restorations] [Limited to [1] [time] per tooth per [consecutive] [120 months] [calendar year] [Plan Year].] [Covered only when a filling cannot restore the tooth.] [Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.]	[0% - 100%]	[0% - 100%]

[BENEFIT DESCRIPTION & LIMITATION]	[NETWORK] [COPAYMENT] is shown as a percentage of Eligible Expenses [ <sup>1</sup> after applicable Deductible is satisfied].]	[NON-NETWORK] [COPAYMENT] is shown as a percentage of Eligible Expenses [ <sup>1</sup> after applicable Deductible is satisfied].] [ <sup>2</sup> The Covered Person must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.]
[Pontics ] [Limited to [1] [time] per tooth per [consecutive] [120 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Retainer-Cast Metal for Resin Bonded Fixed Prosthesis] [Limited to [1] [time] per [consecutive] [120 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Pin Retention] [Limited to [2] [pins] per tooth; not Covered in addition to cast restoration.]	[0% - 100%]	[0% - 100%]
[Post and Cores] [Covered only for teeth that have had root canal therapy.]	[0% - 100%]	[0% - 100%]
[Re-Cement Inlays/Onlays, Crowns, Bridges and Post and Core] [Limited to [1] per [consecutive] [12 months] [calendar year] [Plan Year].] [Limited to those performed more than [12 months] after the initial insertion.]	[0% - 100%]	[0% - 100%]
[Sedative Filling] [Covered as a separate benefit only if no other service, other than x-rays and exam, were performed on the same tooth during the visit.]	[0% - 100%]	[0% - 100%]
[Stainless Steel Crowns] [Limited to [1] [time] per tooth per [consecutive] [120 months] [calendar year] [Plan Year].] [Covered only when a filling cannot restore the tooth.]	[0% - 100%]	[0% - 100%]

<b>[BENEFIT DESCRIPTION &amp; LIMITATION]</b>	<b>[NETWORK] [COPAYMENT]</b> is shown as a percentage of Eligible Expenses [ <sup>1</sup> after applicable Deductible is satisfied].]	<b>[NON-NETWORK] [COPAYMENT]</b> is shown as a percentage of Eligible Expenses [ <sup>1</sup> after applicable Deductible is satisfied].] [ <sup>2</sup> The Covered Person must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.]
[Prefabricated esthetic coated stainless steel crown - primary tooth, are limited to primary anterior teeth.]		
<b>[FIXED PROSTHETICS]</b>		
[Replacement of [complete dentures], [fixed or removable partial dentures,] [crowns,] [inlays] [or] [onlays] previously submitted for payment under the plan is limited to [1] [time] per [consecutive] [120 months] [calendar year] [Plan Year] from initial or supplemental placement.]		
[Fixed Partial Dentures (Bridges)]  [Limited to [1] [time] per tooth per [consecutive] [120 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
<b>[REMOVABLE PROSTHETICS]</b>		
[Replacement of [complete dentures], [fixed or removable partial dentures,] [crowns,] [inlays] [or] [onlays] previously submitted for payment under the plan is limited to [1] [time] per [consecutive] [120 months] [calendar year] [Plan Year] from initial or supplemental placement.]		
[Full Dentures]  [Limited to [1] per [consecutive] [120 months] [calendar year] [Plan Year].] [No additional allowances for precision or semi-precision attachments.]	[0% - 100%]	[0% - 100%]
[Partial Dentures]  [Limited to [1] per [consecutive] [120 months] [calendar year] [Plan Year].] [No additional allowances for precision or semi-precision attachments.]	[0% - 100%]	[0% - 100%]
[Relining and Rebasing Dentures]  [Limited to relining/rebasing performed more than [12 months] after the initial insertion.] [Limited to [1] [time] per [consecutive] [36 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]

<b>[BENEFIT DESCRIPTION &amp; LIMITATION]</b>	<b>[NETWORK] [COPAYMENT]</b> is shown as a percentage of Eligible Expenses [ <sup>1</sup> after applicable Deductible is satisfied].]	<b>[NON-NETWORK] [COPAYMENT]</b> is shown as a percentage of Eligible Expenses [ <sup>1</sup> after applicable Deductible is satisfied].] [ <sup>2</sup> The Covered Person must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.]
[Tissue Conditioning - Maxillary or Mandibular]  [Limited to [1] [time] per [consecutive] [12 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns]  [Limited to repairs or adjustments performed more than [12 months] after the initial insertion.] [Limited to [1] per [consecutive] [24 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]

# Policyholder Application

Dental Coverage and  
Vision Care Insurance  
Provided by United HealthCare Insurance Company

[ UnitedHealthcare Dental® ]

SPECTERA®

A UnitedHealth Group Company

Requested Effective Dates of Coverage:     /     /  
Termination Date:     /     /

## GENERAL INFORMATION

School's Full Legal Name:

Street Address:

City:

State:

Zip Code:

Contact Name:

Phone Number:

Fax Number:

E-Mail Address of Contact:

Billing Address (If Different):

## DENTAL PLAN CLASSES OF PERSONS TO BE INSURED

Did the school have dental coverage for the past consecutive [12] months?  Yes  No  
If yes, name of prior dental carrier and dates of coverage:

Dental Plan Selected:

### Rates and Contributions

	Tier Structure	[Rates]	[Premium Periods]	[Number of Enrolled Students]	
[Single Tier]	[Student]				
[Two Tier]	[Student]				
	[Family]				
[Three Tier]	[Student]				
	[Student + One]				
	[Family]				
[Four Tier]	[Student]				
	[Student + One]				
	[Student + Children]				
	[Family]				

Amount of Binder Check:  
\*\*\* This check must accompany the Policyholder Application

## VISION PLAN CLASSES OF PERSONS TO BE INSURED

### Premiums and Contributions

	Tier Structure	[Rates]	[Premium Periods]	[Number of Enrolled Students]	
	[Student Only]				
	[Student + One]				
	[Student + Spouse]				
	[Student + Children]				
	[Student + Family]				
	[Composite]				

Total Estimated [Monthly] Premium \$

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 represent that, to the best of my knowledge, the information I have provided in this Application is accurate and truthful. I understand that the Company will rely on the information I provide in determining eligibility for coverage, setting premium rates, and other purposes, and that any misrepresentation or fraudulent statement may result in rescission of the group policy, termination of coverage, increase in premiums, or other consequences as permitted by law.

I agree that the Company shall be entitled to rely on the most current information in its possession regarding eligibility of students 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 students or their dependents, including the addition of newly eligible students or dependents.

I understand that the Policies or Summary Plan Descriptions, and other documents, notices and communications regarding the coverage indicated on this Application may be transmitted electronically to me and to the school's students.

FRAUD WARNING NOTICE(S): {(Please review the notice that applies in your state.)}

{For applicants in {Arkansas} {and} {West Virginia}:

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

{For applicants in Colorado:

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado division of insurance within the Department of Regulatory Agencies.}

{For applicants in District of Columbia:

WARNING: It is a crime to provide false or misleading information to an insurer for purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the application.}

{For applicants in Hawaii:

For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.}

{For applicants in Kentucky:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.}

{For applicants in Louisiana:

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

{For applicants in New Jersey:

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.}

{For applicants in New Mexico:

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.}

{For applicants in Ohio:

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.}

{For applicants in Oklahoma:

Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.}

{For applicants in Oregon:

Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.}

{For applicants in the state of Pennsylvania:

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.}

{For applicants in all other states:

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.}

{For applicants in Florida:

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.}

**POLICYHOLDER SIGNATURE** (form must be signed)

Policyholder's Authorized Person's Name:	Title:
Policyholder's Authorized Person's Signature:	Date:

**AGENT/BROKER INFORMATION**

Agent/Broker Name:	Agency:	
Agent/Broker Signature:	Date:	
Street Address:		
City:	State:	Zip Code:
Phone Number:	Fax Number:	Email Address:
Commissions Payable To:	Agent/Broker Number:	

*[UnitedHealthcare Dental] and [Spectera] vision insurance products are underwritten or provided by: United HealthCare Insurance Company, Hartford, Connecticut.*

*SERFF Tracking Number:* UHLC-125884962      *State:* Arkansas  
*Filing Company:* United HealthCare Insurance Company      *State Tracking Number:* 40753  
*Company Tracking Number:* DPOLCOC.SR.08.AR  
*TOI:* H10G Group Health - Dental      *Sub-TOI:* H10G.000 Health - Dental  
*Product Name:* SR-Dental UHIC  
*Project Name/Number:* /

## **Rate Information**

Rate data does NOT apply to filing.

SERFF Tracking Number: UHLC-125884962 State: Arkansas  
Filing Company: United HealthCare Insurance Company State Tracking Number: 40753  
Company Tracking Number: DPOLCOC.SR.08.AR  
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental  
Product Name: SR-Dental UHIC  
Project Name/Number: /

## Supporting Document Schedules

<b>Satisfied -Name:</b> Certification/Notice	<b>Review Status:</b> Approved-Closed	11/06/2008
<b>Comments:</b>		
<b>Attachments:</b> AR07I_NTC_GUARASSOC_AM_CS.doc readability.pdf		
<b>Satisfied -Name:</b> Application	<b>Review Status:</b> Approved-Closed	11/06/2008
<b>Comments:</b> LOCATED IN FORM SCHEDULE		
<b>Attachment:</b> UHIC Combined Dental & Vision APP Final.pdf		
<b>Satisfied -Name:</b> Cover Letter	<b>Review Status:</b> Approved-Closed	11/06/2008
<b>Comments:</b>		
<b>Attachment:</b> arletter.pdf		

*SERFF Tracking Number:* UHLC-125884962                      *State:* Arkansas  
*Filing Company:* United HealthCare Insurance Company                      *State Tracking Number:* 40753  
*Company Tracking Number:* DPOLCOC.SR.08.AR  
*TOI:* H10G Group Health - Dental                      *Sub-TOI:* H10G.000 Health - Dental  
*Product Name:* SR-Dental UHIC  
*Project Name/Number:* /

Attachment "AR07I\_NTC\_GUARASSOC\_AM\_CS.doc" is not a PDF document and cannot be reproduced here.

**CERTIFICATION OF COMPLIANCE  
FOR  
READABILITY**

<u>Form Number(s)</u>	<u>Flesch Readability Score</u>
DPOLCOC.SR.08.AR	51.7
DSCH.SR.08	N/A
DV-SR-APP (01/2008)	N/A

I hereby certify on behalf of **United HealthCare Insurance Company** that the above Flesch Scale Analysis Readability Score is accurate, based on the computer program used to calculate the scores, and comply with the readability requirements in your state.

Signature   
Print Name Jayne Jackowski  
Title Compliance Analyst  
Date November 3, 2008

# Policyholder Application

Dental Coverage and  
Vision Care Insurance  
Provided by United HealthCare Insurance Company

[ UnitedHealthcare Dental® ]

SPECTERA®

A UnitedHealth Group Company

Requested Effective Dates of Coverage:     /     /  
Termination Date:     /     /

## GENERAL INFORMATION

School's Full Legal Name:

Street Address:

City:

State:

Zip Code:

Contact Name:

Phone Number:

Fax Number:

E-Mail Address of Contact:

Billing Address (If Different):

## DENTAL PLAN CLASSES OF PERSONS TO BE INSURED

Did the school have dental coverage for the past consecutive [12] months?  Yes  No  
If yes, name of prior dental carrier and dates of coverage:

Dental Plan Selected:

### Rates and Contributions

	Tier Structure	[Rates]	[Premium Periods]	[Number of Enrolled Students]	
[Single Tier]	[Student]				
[Two Tier]	[Student]				
	[Family]				
[Three Tier]	[Student]				
	[Student + One]				
	[Family]				
[Four Tier]	[Student]				
	[Student + One]				
	[Student + Children]				
	[Family]				

Amount of Binder Check:  
\*\*\* This check must accompany the Policyholder Application

## VISION PLAN CLASSES OF PERSONS TO BE INSURED

### Premiums and Contributions

	Tier Structure	[Rates]	[Premium Periods]	[Number of Enrolled Students]	
	[Student Only]				
	[Student + One]				
	[Student + Spouse]				
	[Student + Children]				
	[Student + Family]				
	[Composite]				

Total Estimated [Monthly] Premium \$

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 represent that, to the best of my knowledge, the information I have provided in this Application is accurate and truthful. I understand that the Company will rely on the information I provide in determining eligibility for coverage, setting premium rates, and other purposes, and that any misrepresentation or fraudulent statement may result in rescission of the group policy, termination of coverage, increase in premiums, or other consequences as permitted by law.

I agree that the Company shall be entitled to rely on the most current information in its possession regarding eligibility of students 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 students or their dependents, including the addition of newly eligible students or dependents.

I understand that the Policies or Summary Plan Descriptions, and other documents, notices and communications regarding the coverage indicated on this Application may be transmitted electronically to me and to the school's students.

FRAUD WARNING NOTICE(S): {(Please review the notice that applies in your state.)}

{For applicants in {Arkansas} {and} {West Virginia}:

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**POLICYHOLDER SIGNATURE** (form must be signed)

Policyholder's Authorized Person's Name:	Title:
Policyholder's Authorized Person's Signature:	Date:

**AGENT/BROKER INFORMATION**

Agent/Broker Name:	Agency:	
Agent/Broker Signature:	Date:	
Street Address:		
City:	State:	Zip Code:
Phone Number:	Fax Number:	Email Address:
Commissions Payable To:	Agent/Broker Number:	

*[UnitedHealthcare Dental] and [Spectera] vision insurance products are underwritten or provided by: United HealthCare Insurance Company, Hartford, Connecticut.*

November 3, 2008

Filing Sent Via SERFF

Arkansas Department of Insurance  
1200 West Third Street  
3<sup>rd</sup> and Cross  
Little Rock, AR 72201-1904

Subject: Blanket Group Dental Policy                      DPOLCOC.SR.08.AR  
Schedule of Covered Dental Services              DSCH.SR.08  
Policyholder Application-Dental Coverage  
and Vision Insurance                                      DV-SR-APP (01/2008)

Filing For: Group Dental  
United HealthCare Insurance Company  
NAIC Number: 79413  
FEIN Number: 36-2739571

We respectfully submit these forms for your formal approval. These are new forms and are not intended to replace any forms previously filed with the Department.

The forms will be used to provide Blanket Group Accident and Health Dental coverage to college students in your state. The school will be the policyholder.

These materials represent final printed format (with the exception of variable text and corresponding instructions. Please see the following paragraphs for explanation.). Once approved, these forms will be used to support the issuance of our portfolio of group dental products offered in your state.

***Explanation of Variable Text***

Each form is made up of:

- **Nonvariable Text** that always appears in an issued document.
- **Variable Text** that may or may not appear in an issued document depending on the specific product and plan design selected by the Enrolling Group. Items bracketed in the forms with straight brackets [ ] indicate these items are variable in their content without change in the subject. Changes made to variable text will meet the requirements of your state. Items bracketed with wavy brackets { } indicate these sections are variable by omission. Letters and numbers (excluding form numbers) may be varied. Colons, semicolons, semicolons followed by the word "or" and semicolons followed by the words "and/or" may be omitted. If omitted, a period will be substituted, if necessary. Articles such as "a" and "an" may be substituted as grammatically necessary. Whenever text is bracketed, we have included text that explains the logic of the variable; brackets do not appear in the document issued to a member.

- **Instruction text** provides the logic for when text is included or removed. Please note that instruction text appears only in the filing copy and will not appear in the document issued to a member.

If you have any questions or concerns, please contact me at 1-800-232-5432 extension 12234. My mailing address is United HealthCare Insurance Company, PO Box 19032, Green Bay, Wisconsin 54307-9032. My email address is Jayne\_S\_Jackowski@uhc.com.

Sincerely,

A handwritten signature in cursive script that reads "Jayne Jackowski". The signature is written in black ink and is positioned to the right of the word "Sincerely,".

Jayne Jackowski, FLMI, AIRC  
Compliance Analyst