

SERFF Tracking Number: HUMA-126032077 State: Arkansas
Filing Company: Humana Dental Insurance Company State Tracking Number: 41551
Company Tracking Number: AR-09-001 DEN
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
Product Name: AR-09-001 DEN
Project Name/Number: AR-09-001 DEN/AR-09-001 DEN

Filing at a Glance

Company: Humana Dental Insurance Company

Product Name: AR-09-001 DEN SERFF Tr Num: HUMA-126032077 State: ArkansasLH
TOI: H10G Group Health - Dental SERFF Status: Closed State Tr Num: 41551
Sub-TOI: H10G.000 Health - Dental Co Tr Num: AR-09-001 DEN State Status: Approved-Closed
Filing Type: Form Co Status: Reviewer(s): Rosalind Minor
Authors: Christi Conrad, Paula Disposition Date: 02/13/2009
Konop, Tina Huettl, Erin Hermsen
Date Submitted: 02/13/2009 Disposition Status: Approved-Closed
Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: AR-09-001 DEN
Project Number: AR-09-001 DEN
Requested Filing Mode: Review & Approval

Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 02/13/2009

Deemer Date:

Filing Description:

RE: GROUP DENTAL INSURANCE FORMS FILING
HUMANADENTAL INSURANCE COMPANY
NAIC #119-70580

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments: Pending approval in WI.
Market Type: Group
Group Market Size: Small and Large
Group Market Type: Employer
Explanation for Other Group Market Type:
State Status Changed: 02/13/2009
Corresponding Filing Tracking Number:

Form number Description

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GN-70146-HD 1/09 Certificate Cover
GN-70146-HD TAB 1/09 Table of Contents
GN-70146-HD SCP 1/09 Schedule of Benefits
GN-70146-HD SCI 1/09 Schedule of Benefits
GN-70146-HD BEN 1/09 Benefits
AR-70146-HD LE 1/09 Limitations and Exclusions
AR-70146-HD PAY 1/09 Pay Provision
GN-70146-HD EE 1/09 Eligibility and Effective Date Provision
GN-70146-HD TER 1/09 Termination Provision
AR-70146-HD DEF 1/09 Definitions
GN-70146-HD ORTHO 1/09 Orthodontic Rider
GN-70146-HD Implant 1/09 Implant Rider
GN-70146-HD Roll Roll Over
GN-70146-HD Open Enrollment Open Enrollment Rider
Back Cover (included for informational purposes)

Dear Sir/Madam:

We respectfully submit for your approval the attached forms. This is a new filing; the attached forms do not replace or supersede any like forms previously filed.

The forms included in this filing are intended for use with new employer group dental plans. We are using a previously approved contract as the base for these new plans, and that contract was approved in your state on 3/28/2005. For your ease of review, we have noted modifications in blue text.

To the best of our knowledge, we believe the attached forms satisfy the minimum requirements of applicable Arkansas statutes and regulations.

Fee Information Date Last Modified: 02/09/2009 02:28 PM

We bypassed EFT because the General Instructions indicate that Arkansas is retaliatory and our domicillary state of

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Wisconsin does not have a fee.

Upon approval, please notify me via SERFF. If you have any questions regarding this filing, please contact me by phone at 1-800-558-4444, extension 3765, or via SERFF.

Sincerely,
HUMANADENTAL INSURANCE COMPANY

Christi Conrad
Specialty Benefits Compliance Specialist

Company and Contact

Filing Contact Information

Christi Conrad, Specialty Benefits Compliance Specialist cconrad@humana.com
325 Reid St. (920) 337-3765 [Phone]
De Pere, WI 54115

Filing Company Information

Humana Dental Insurance Company CoCode: 70580 State of Domicile: Wisconsin
1100 Employer's Blvd Group Code: 119 Company Type:
Green Bay, WI 54344 Group Name: State ID Number:
(800) 558-4444 ext. [Phone] FEIN Number: 39-0714280

Filing Fees

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

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Humana Dental Insurance Company	\$0.00	02/13/2009	

<i>SERFF Tracking Number:</i>	<i>HUMA-126032077</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Humana Dental Insurance Company</i>	<i>State Tracking Number:</i>	<i>41551</i>
<i>Company Tracking Number:</i>	<i>AR-09-001 DEN</i>		
<i>TOI:</i>	<i>H10G Group Health - Dental</i>	<i>Sub-TOI:</i>	<i>H10G.000 Health - Dental</i>
<i>Product Name:</i>	<i>AR-09-001 DEN</i>		
<i>Project Name/Number:</i>	<i>AR-09-001 DEN/AR-09-001 DEN</i>		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/13/2009	02/13/2009

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Filing Fee	Note To Filer	Rosalind Minor	02/13/2009	

SERFF Tracking Number: HUMA-126032077 *State:* Arkansas
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Disposition

Disposition Date: 02/13/2009

Implementation Date:

Status: Approved-Closed

Comment: This submission is being approved with the understanding that the filing fee will be submitted to our Department.

Please refer to my Note to Filer.

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Back Cover	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Form	Certificate Cover	Approved-Closed	Yes
Form	Table of Contents	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	Benefits	Approved-Closed	Yes
Form	Limitations and Exclusions	Approved-Closed	Yes
Form	Pay Provision	Approved-Closed	Yes
Form	Eligibility and Effective Date Provision	Approved-Closed	Yes
Form	Termination Provision	Approved-Closed	Yes
Form	Definitions	Approved-Closed	Yes
Form	Ortho Rider	Approved-Closed	Yes
Form	Implant Rider	Approved-Closed	Yes
Form	Roll Over	Approved-Closed	Yes
Form	Open Enrollement	Approved-Closed	Yes

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Form Schedule

Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	GN-70146-HD 1/09	Certificate	Certificate Cover	Initial			_ A-HD GN CertCvr 1-09.pdf
Approved-Closed	GN-70146-HD TAB 1/09	Certificate	Table of Contents	Initial			_ B-HD GN TOC 1-09.pdf
Approved-Closed	GN-70146-HD SCI 1/09	Certificate	Schedule of Benefits	Initial			_ C1-HD GN SCH PP,TRP 1-09 v4.pdf
Approved-Closed	GN-70146-HD SCP 1/09	Certificate	Schedule of Benefits	Initial			_ C2-HD GN SCH PPO 1-09 v4.pdf
Approved-Closed	GN-70146-HD BEN 1/09	Certificate	Benefits	Initial			_ D-HD GN Benefits 1-09 v5.pdf
Approved-Closed	AR-70146-HD LE 1/09	Certificate	Limitations and Exclusions	Initial			_ E-HD AR LE 1-09.pdf
Approved-Closed	AR-70146-HD PAY 1/09	Certificate	Pay Provision	Initial			_ F-HD AR Pay 1-09.pdf
Approved-Closed	GN-70146-HD EE 1/09	Certificate	Eligibility and Effective Date Provision	Initial			_ K-HD GN EligEff 1-09 v4.pdf
Approved-Closed	GN-70146-HD TER 1/09	Certificate	Termination Provision	Initial			_ L-HD GN Term 1-09.pdf
Approved-Closed	AR-70146-HD DEF 1/09	Certificate	Definitions	Initial			_ Q-HD AR Definitions 1-09.pdf
Approved-Closed	GN-70146-HD Ortho 1/09	Certificate	Ortho Rider	Initial			_ R-HD GN OrthoRdr 1-09.pdf

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Approved- Closed	GN-70146- HD Implant 1/09	Certificate Implant Rider	Initial	_ V-HD GN Implant 1-09 v2.pdf
Approved- Closed	GN-70146- HD Roll	Certificate Roll Over	Initial	_ W-HD GN Rollover2 v4.pdf
Approved- Closed	GN-70146- HD Open Enrollment	Certificate Open Enrollement	Initial	_ U-HD GN OpenEnrolRd r 1-09.pdf

{Employer: }
{Group number: }
{Employee: }
{Certificate/ Member Number }

Dental Plan Certificate of Insurance HumanaDental Insurance Company

This certificate outlines the insurance provided by the group policy. It is not an insurance policy. It does not extend or change the coverage listed in the group policy. The insurance described in this certificate is subject to the provisions, terms, exclusions and conditions of the group policy.

We will amend this certificate to conform to the minimum requirements of {state name} laws. This certificate replaces any certificate previously issued under the provisions of the group policy.

{

NOTICE

**This Certificate provides coverage for limited dental services.
Please review [the Summary of Your Benefits section of this certificate](#) carefully.**

}



A handwritten signature in black ink, appearing to read "Gerald L. Ganoni".

{Gerald L. Ganoni}
{President}

Table of Contents

Benefits

- **{Waiting periods{###}}**
- **Summary of your benefits..... {###}**
- **Your plan benefits..... {###}**
- **Limitations and exclusions (all services) {###}**
- **How your plan works..... {###}**

Claims

- **How we pay claims..... {###}**
- **Coordinating benefits with another insurer {###}**
- **{Recovery rights{###}}**

Eligibility

- **When you are eligible for coverage {###}**
- **Terminating coverage..... {###}**
- **{Replacement provisions{###}}**

{Disclosures}{Discount/access disclosure}{###}

{Shared Savings} {Shared savings program}{###}

Definitions..... {###}

(Italicized words within text are defined in the Definitions section of this document.)

{PPO (Preferred Provider Organization) provisions{###}

{Supplemental dental expense benefit (Orthodontia){###}

{Composite rider}{###}

{Implant {prosthetic} rider}{###}

{Open enrollment rider}{###}

{Roll-over {plan}{account} rider}.....{###}

{Coverage for domestic partners}{###}

Policyholder (Employer): { VARIABLE }
Group Number: { VARIABLE }
Employee: { VARIABLE }
Employee ID: { VARIABLE }
[Type of coverage: { VARIABLE }]
Coverage Effective Date: { VARIABLE }

[Waiting Periods

This provision describes for the *employee* {and *dependents* added at the same time as the *employee*} the waiting periods that will be applied before *benefits* are available for *covered services*. {Each *member* added after the effective date of the *policyholder* may be subject to a separate waiting period.} {Each *dependent* added after the effective date of the *employee* may be subject to a separate waiting period.} {Please call *us* for the waiting period that applies to those *dependents*.}

Preventive Services:

{Insert Waiting Period Options from Statement of Variability}

{Basic Services:}

{Insert Waiting Period Options from Statement of Variability}

{Major Services}

{Insert Waiting Period Options from Statement of Variability}

{Orthodontic Services:}

{Insert Waiting Period Options from Statement of Variability}]

Summary of Your Benefits

This summary provides an overview of plan *benefits*. Refer to the **Your plan benefits** [and **Waiting periods**] provisions for detailed descriptions, including additional limitations or exclusions. {Paid *benefits* are based on the *reimbursement limit*.}

Dental benefits

Individual maximum benefit:

#{**VARIABLE**} per {*year*} {lifetime} per *member* {for} {Preventive,} {Basic,} {Major} {and} {Orthodontic} Services.

[Individual extended maximum benefit

When a *covered person* has reached his or her Individual Maximum Benefit *covered expenses* for {Preventive,} {Basic,} {Major} {Orthodontic} *services* will be paid at {30%} for the remainder of that *year*. Coverage of these *services* will be subject to all provisions of this Certificate, including but not limited to, the eligibility of the *covered person*, the *reimbursement limit*, and all limitations and exclusions. {The Individual Extended Maximum Benefit does not apply to, and no additional benefits are available for {Preventive,} {Basic,} {Major} {Orthodontic} {services,} Implants, and all related services, including implant supported prostheses.}]

{Individual deductible:

#{**VARIABLE**} per {*year*} {lifetime} per *member* for {Preventive,} {Basic,} {Major} {and} {Orthodontic} Services.}

{Maximum family deductible:

Covered expenses applied to the plan *deductible* of each covered *member* are combined to a {*year*} {lifetime} maximum of #{**VARIABLE**}.}

{Orthodontic deductible:

#{**VARIABLE**} per {*year*} {lifetime} per *member*.}

{Orthodontic lifetime maximum benefit

#{**VARIABLE**} per {*member*} {each covered *dependent child* {to} *age*} {18-30} {and under}.}

Preventive Services:

Benefits are paid at [VARIABLE] [percent] {after the *deductible*}.

- {Insert Preventive Covered Services from Statement of Variability}

{Basic Services:

Benefits are paid at [VARIABLE] [percent] {after the *deductible*.}

- {Insert Basic Covered Services from Statement of Variability } }

{Major Services:

Benefits are paid at [VARIABLE] [percent] {after the *deductible*}.

- {Insert Major Covered Services from Statement of Variability } }

{Orthodontic Services:

Benefits are paid at [VARIABLE] [percent], {after the {orthodontic} *deductible*.}

Please refer to the Orthodontic Services Rider of *your* certificate to determine who is eligible for coverage under this *benefit*. }

Policyholder (Employer): { VARIABLE }
Group Number: { VARIABLE }
Employee: { VARIABLE }
Employee ID: { VARIABLE }
[Type of coverage: { VARIABLE }]
Coverage Effective Date: { VARIABLE }

[Waiting Periods

This provision describes for the *employee* {and *dependents* added at the same time as the *employee*} the waiting periods that will be applied before *benefits* are available for *covered services*. {Each *member* added after the effective date of the *policyholder* may be subject to a separate waiting period.} {Each *dependent* added after the effective date of the *employee* may be subject to a separate waiting period.} {Please call *us* for the waiting period that applies to those *dependents*.}

Preventive Services:

{Insert Waiting Period Options from Statement of Variability}

{Basic Services:}

{Insert Waiting Period Options from Statement of Variability}

{Major Services}

{Insert Waiting Period Options from Statement of Variability}

{Orthodontic Services:}

{Insert Waiting Period Options from Statement of Variability}]

Summary of Your Benefits

This summary provides an overview of plan *benefits*. Refer to the **Your plan benefits** [and **Waiting periods**] provisions for detailed descriptions, including additional limitations or exclusions. {Paid *benefits* are based on the *reimbursement limit*.}

{Any *covered expense* that is applied to any *maximum benefit* or *deductible* will be applied equally toward the satisfaction of both the PPO Provider and corresponding Non-PPO Provider *maximum benefit* or *deductible*.}

Dental benefits

Individual maximum benefit:

#{**VARIABLE**} per {*year*} {lifetime} per *member* for Preventive, {and}{Basic} {Major} {and} {Orthodontic} Services when *services* are provided by a PPO *dentist*.

#{**VARIABLE**} per {*year*} {lifetime} per *member* for Preventive, {and}{Basic} {Major} {and} {Orthodontic} Services when *services* are provided by a Non-PPO *dentist*.

[Individual extended maximum benefit When a *covered person* has reached his or her Individual Maximum Benefit, *covered expenses* for {Preventive,} {Basic,} {Major} {Orthodontic} *services* will be paid at {30%} for the remainder of that *year*. Coverage of these *services* will be subject to all provisions of this Certificate, including but not limited to the eligibility of the *covered person*, the *reimbursement limit*, and all limitations and exclusions. {The Individual Extended Maximum Benefit does not apply to, and no additional benefits are available for {Preventive,} {Basic,} {Major} {Orthodontic} {*services*,} Implants, and all related services, including implant supported prostheses.}]

[A covered person may be eligible for a rollover of a portion of his or her unused Individual Maximum Benefit. Please see the Roll-over [plan][account][rider][amendment]for more details.]

{Individual deductible:

#{**VARIABLE**} per {*year*} {lifetime} per *member* for {Preventive,} {Basic} {Major} {and} {Orthodontic} Services when *services* are provided by a PPO *dentist*.

#{**VARIABLE**} per {*year*} {lifetime} per *member* for {Preventive,} {Basic} {Major} {and} {Orthodontic} Services when *services* are provided by a Non-PPO *dentist*.}

{Maximum family deductible:

Covered expenses applied to the plan *deductible* of each covered *member* are combined to a {*year*} {lifetime} maximum of #{**VARIABLE**} when *services* are provided by a PPO *dentist*.

Covered expenses applied to the plan *deductible* of each covered *member* are combined to a {*year*} {lifetime} maximum of #{**VARIABLE**} when *services* are provided by a Non-PPO *dentist*.}

{Orthodontic deductible:

#{**VARIABLE**} per {*year*} {lifetime} per *member*.}

{Orthodontic lifetime maximum benefit

#{**VARIABLE**} per {*member*} {each covered *dependent child* {to} *age* {18-30}{and under}} when *services* are provided by a PPO *dentist*.

Benefits

[\$**VARIABLE**] per {*member*} {each covered *dependent child* {to} age}{18-30}{and under}} when *services* are provided by a Non-PPO *dentist*.)

Preventive Services:

Preferred Provider Benefits: Benefits are paid at [VARIABLE] [percent] {after the *deductible*}.

Non-Preferred Provider Benefits: Benefits are paid at [VARIABLE] [percent] {after the *deductible*}.

- {Insert Preventive Covered Services from Statement of Variability }

{Basic Services:

Preferred Provider Benefits: Benefits are paid at [VARIABLE] [percent] {after the *deductible*}.

Non-Preferred Provider Benefits: Benefits are paid at [VARIABLE] [percent] {after the *deductible*}.

- {Insert Basic Covered Services from Statement of Variability } }

{Major Services:

Preferred Provider Benefits: Benefits are paid at [VARIABLE] [percent] {after the *deductible*}.

Non-Preferred Provider Benefits: Benefits are paid at [VARIABLE] [percent]{after the *deductible*}.

- {Insert Major Covered Services from Statement of Variability}}

{Orthodontic Services:

Preferred Provider Benefits: Benefits are paid at [VARIABLE] [percent] {after the {orthodontic} *deductible*}.

Non-Preferred Provider Benefits: Benefits are paid at [VARIABLE] [percent] {after the {orthodontic} *deductible*}.

Please refer to the Orthodontic Services Rider of *your* certificate to determine who is eligible for coverage under this *benefit*. }

Your plan benefits

We pay *benefits* on *covered expenses* as explained in the **How your plan works** section. [*Benefits* for *covered services* explained below are limited to the *maximum benefit* shown in the **Summary of your benefits.**]

Preventive services

1. Oral evaluations (periodic, limited, comprehensive and problem focused) - {two - four} per *year*.
2. Periodontal evaluations - {two - four} per *year*.
3. Cleaning (prophylaxis), including all scaling and polishing procedures – {two - four} per *year*.
4. **For members age 40 and older, oral cancer screening – {one} per *year*.**
5. Intra-oral complete series X-rays (at least 14 films, including bitewings), or panoramic X-ray – {once, twice} {every one - five years} **{per lifetime}**. If the total cost of periapical and bitewing x-rays exceeds the cost of a complete series of x-rays, the plan will consider these as a complete series.
6. Bitewing X-rays – {one, two} set{s} per *year*.
7. Other X-rays – only to diagnose specific treatment.
8. Topical fluoride treatment – {provided to {dependents} {covered person(s)} age {10-19} and younger}. {*Service* is payable once per *year*.}
9. {Sealants – application provided {to {dependents} {covered person{s}} age {10-19} and younger} to the occlusal surface of permanent molars that are free of decay and restorations. *Service* is payable {once per tooth per lifetime}.}

We will not cover preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.

Basic services

1. {Amalgam restorations (fillings) – {limit to {one} per tooth in a {one, two, three} *year* period.}Multiple restorations on one surface are considered one restoration.}
2. {Composite restorations (fillings) {limited to {one} per tooth in a {one, two, three} *year* period.}{on anterior teeth – Composite restorations on molar and bicuspid teeth are considered an alternate *service* and will be payable as a comparable amalgam filling. *You* will be responsible for the remaining *expense incurred*.} Multiple restorations on one surface are considered one restoration.}
3. {Recementing of inlays, onlays, crowns and bridges.}
4. {Repairs of {bridges}{and crowns}.}
5. {Non-cast pre-fabricated{stainless steel} crowns – *service* on primary teeth that cannot be adequately restored with amalgam or composite restorations.}
6. {Space maintainers for retaining space when a primary tooth is prematurely lost. {*Services* are payable only {for *dependents* age {10-19} and younger} for the installation of the initial appliance. Separate adjustment expenses will not be covered.}}
7. {Fixed and removable appliances to inhibit thumb sucking and other harmful habits. {*Services* are payable only {for *dependents* age {10-19} and younger} for the installation of the initial appliance. Separate adjustment expenses will not be covered.}}
8. {*Emergency* care – treatment for the initial *palliative* care of pain and/or injury. *Services* include *palliative* procedures for treatment to the teeth and supporting structures. *We* will consider the *service* as a separate *benefit* only if no other *service*, except X-rays, is provided during the same visit.}}
9. {Consultation – diagnostic *service* provided by a dentist or physician other than the practitioner providing the treatment. Coverage is limited to {one-two} consultation{s} per provider.}}
10. {Covered expenses incurred by *you* during a plan of treatment for any jaw joint problem, including temporomandibular joint disorder, craniomaxillary disorder, craniomandibular disorder, head and

neck neuromuscular disorder or other conditions of the joint linking the jaw bone and skull.}}

{{Simple}}{Routine} Oral surgery services}

1. {Extraction{s}}{- coronal remnants of a deciduous tooth}.
2. {Extraction - erupted tooth or exposed root.}

{Periodontic services

1. Periodontal scaling and root planing, available at a maximum of {once, twice} per quadrant in a {one, two, three} year period.
2. Periodontal maintenance (following periodontal therapy) – procedure available {twice, three times} per year.
3. {Periodontal surgery, available at a maximum of {once, twice} per quadrant in a {one, two, three-year} period. If more than one surgical service is performed on the same day, we will consider only the most inclusive service performed as a covered service.}
4. {Occlusal adjustments when performed in conjunction with periodontal surgery} – {available at a maximum of {once, twice} per quadrant in a {one, two, three} year period.}

Separate fees for pre and post operative care and re-evaluation within three months are not covered.

{Endodontic services

1. Root canal therapy, including root canal treatments and root canal fillings – procedure available to permanent teeth only, {once} per tooth in a {one, two, three} year period. Any X-ray, test, laboratory, exam or follow-up care is considered integral to root canal therapy.
2. {Apicoectomy - procedure available for permanent teeth only.}
3. {Partial pulpotomy for apexogenesis – procedure available for permanent teeth only.}
4. {Vital pulpotomy – procedure available for deciduous (baby) teeth only.}}

{Major/Prosthodontic services

1. {Repairs of {bridges}{;} {full or partial dentures}{,} {and crowns}.}
2. Denture adjustments – procedure available only for adjustments done by a dentist other than the one providing the denture, or adjustments performed more than six months after initial installation.
3. Initial placement of laboratory-fabricated restorations when the tooth, as a result of extensive decay or traumatic injury, cannot be restored with a direct placement filling material. Covered services include inlays, onlays, crowns, veneers, core build-ups and posts{.}{,} {implant supported crowns and abutments}{.}{These services are covered only on permanent teeth.}. {We will not cover the expense incurred for pin retention when done in conjunction with core build-up.}
4. Initial placement of bridges, and full and partial dentures {only if the functioning tooth (excluding third molars or teeth not fully in occlusion with an opposing tooth or prosthesis) was extracted while you are covered under this plan.} Covered expense includes fixed bridges, removable partial dentures and full dentures. Services include all adjustments and relines within six months after installation {and are payable only for treatment on permanent teeth}. {We will not cover replacement of congenitally missing teeth.}
5. Replacement of bridges, partials, dentures, inlays, onlays, crowns or other laboratory-fabricated restorations. The existing major restoration or prosthesis can be replaced only if:
 - It has been at least {three, four, five} years since the prior insertion and is not, and cannot be made, serviceable;
 - It is damaged beyond repair as a result of an accidental injury (non-chewing injury) while in the oral cavity; or

Benefits

- Extraction of functioning teeth, excluding third molars or teeth not fully in occlusion with an opposing tooth or prosthesis, necessitates the replacement of the prosthesis.
{These *services* are covered only on permanent teeth.}
- 6. Denture relines or rebases – {once, twice} in a {two, three, four, five} **year** period.
- 7. {Covered expenses incurred by *you* during a plan of treatment for any jaw joint problem, including temporomandibular joint disorder, craniomaxillary disorder, craniomandibular disorder, head and neck neuromuscular disorder or other conditions of the joint linking the jaw bone and skull.}

{We will not cover the replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.}

{{Complex}}{Oral surgery services}

1. {Surgical extractions.}
2. {{Bone Smoothing.}}
3. {Trim or Remove over growth or non vital tissue or bone.}
4. {Removal of tooth or root from sinus and closing opening between mouth and sinus.}}
5. {Surgical access of an erupted tooth.}
6. {Mobilization of erupted or malpositioned tooth to aid eruption; or, surgical reposition of teeth.}
7. {Excision or removal of benign oral cysts or tumors.}
8. {Bone, cartilage, or synthetic grafts.}
9. {General anesthesia when *medically necessary* and administered by a *dentist* in conjunction with a covered oral surgical procedure.}

{No benefit is payable for:}

1. {*Any services* for orthognathic surgery.}
2. {*Any services* for destruction of lesions by any method.}
3. {*Any services* for tooth transplantation.}
4. {*Any services* for removal of a foreign body from the oral tissue or bone.}
5. {*Any services* for reconstruction of surgical, traumatic, or congenital defects of the facial bones.}
6. {*Any* surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.}
7. {*Any services* generally considered to be medical services.}
8. {*Any* separate fees for pre and post operative *services*.}

Integral service

The following *services* are considered integral to the dental *service*. A separate fee for these *services* is not considered a *covered expense*.

1. {Local anesthetics;}
2. {Bases;}
3. {Pulp caps;}
4. {Temporary dental *services*;}
5. {Study models/diagnostic casts;}
6. {Treatment plans;}
7. {Occlusal (biting or grinding surfaces of molar and bicuspid teeth) adjustments;}
8. {Nitrous oxide;}
9. {Irrigation;}
10. {Tissue preparation associated with impression or placement of a restoration.}

Benefits

[We do not cover caries susceptibility testing, {lab tests}, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.]

We do not cover *services* that generally are considered to be medical *services* except those outlined in this section.

{General anesthesia is not a *covered expense* unless it is a *medical necessity* and administered by a *dentist* in conjunction with covered oral surgical procedures outlined in this section. Patient management or apprehension is not considered a *medical necessity*.}

Limitations & exclusions (all services)

In addition to the limitations and exclusions listed in **Your plan benefits** section, this policy does not provide *benefits* for the following:

1. Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law, whether or not *you* applied for coverage.
2. *Services*:
 - That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with *sickness* or *bodily injury*.
3. Any loss caused or contributed by:
 - War or any act of war, whether declared or not;
 - Any act of international armed conflict; or
 - Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. *Your* failure to keep an appointment with the *dentist*.
6. {Any *service* we consider *cosmetic dentistry* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. We consider the following *cosmetic dentistry* procedures:
 - {Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.}
 - Any *service* to correct congenital malformation;
 - Any *service* performed primarily to improve appearance; or
 - Characterizations and personalization of prosthetic devices.}
7. {Charges for:
 - {Any type of implant and all related services, including crowns or the prosthetic device attached to it.}
 - Precision or semi-precision attachments.
 - Overdentures and any endodontic treatment associated with overdentures.
 - Other customized attachments.}
8. {Any *service* related to:
 - Altering vertical dimension of teeth;
 - Restoration or maintenance of occlusion;}
 - {• Splinting teeth, including multiple abutments, or any *service* to stabilize periodontally weakened teeth;

Benefits

- Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
 - Bite registration or bite analysis. }
9. Infection control, including but not limited to sterilization techniques.
 10. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
 11. {Any hospital, surgical or treatment facility, or for *services* of an anesthesiologist or anesthesiologist. }
 12. {Prescription drugs or pre-medications, whether dispensed or prescribed. }
 13. Any *service* not specifically listed in **Your plan benefits**.
 14. Any *service* that we determine:
 - Is not a *dental necessity*;
 - Does not offer a favorable prognosis;
 - Does not have uniform professional endorsement; or
 - Is deemed to be experimental or investigational in nature.
 15. {Orthodontic *services* unless specified in *your Summary of your benefits*. }
 16. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates (unless the *service* is eligible under **Extension of benefits**).
 17. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
 18. {Charges exceeding the *reimbursement limit* for the *service*. }
 19. {Treatment resulting from any intentionally self-inflicted injury or *bodily illness*. }
 20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, temporary dental *services*, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.
 21. {Repair and replacement of orthodontic appliances. }
 22. {Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches. }
 23. {[Any non-emergent dental expenses incurred for services rendered outside of the United States.](#) }

How your plan works

General benefit payments

We pay *benefits* for *covered expenses*, as stated in the **Summary of your benefits** and **Your plan benefits** sections, and according to any riders that are part of *your* policy. Paid *benefits* are subject to the conditions, limitations, exclusions and maximums of this policy.

After you receive a *service*, we will determine if it qualifies as a *covered service*. If we determine it is a *covered service*, we will pay *benefits* as follows:

1. We will determine the total *covered expense*.
2. We will review the *covered expense* against any *maximum benefits* that may apply.
3. {We will determine if you have met your *deductible*. If you have not, we will subtract any amount required to fulfill the *deductible*. }
4. We will make payment for the remaining eligible *covered expense* to you or your *dentist*, based on your *coinsurance* for that *covered service*.

{Deductibles

The *deductible* is the amount that you are responsible to pay per {*year*} {lifetime} before we pay any *coinsurance* (see **Summary of your benefits**).

1. **Individual deductible:** You will have met the individual *deductible* when, {each year} {in a lifetime}, the total eligible *covered expenses* incurred reaches the individual *deductible* amount.
2. **Family deductible:** The total *deductible* that a family must pay in a {*year*} {lifetime}. Once met, we will waive any remaining individual *deductibles* for that {*year*} {lifetime}.

Coinsurance

The percentage of the *reimbursement limit* that we will pay. *Coinsurance* applies after the *deductible* is satisfied and up to the *maximum benefit*.

{Waiting periods

This is the time period that certain *services* are not eligible for coverage under this policy. This begins on your effective date and lasts for the time shown in the **Waiting periods** provision of [this certificate](#). }

Benefit maximums

The amount we pay for *services* are limited to a *maximum benefit*. We will not make *benefit* payments that are more than the *maximum benefit* for the *covered services* shown in the **Summary of your benefits**.

Alternate services

If two or more services are considered to be acceptable to correct the same dental condition, the *benefits* payable will be based on the *covered expenses* for the least expensive *service* which will produce a professionally satisfactory result as determined by *us*.

If *you* or *your dentist* decide on a more costly treatment than *we* determine to be satisfactory for treatment of the condition, payment will be limited to the *reimbursement limit* and will be subject to any *deductible* and *coinsurance* for the least costly treatment. *You* will be responsible for the remaining *expense incurred*.

Pretreatment plan

We suggest that if dental treatment is expected to exceed {\$300}, *you* or *your dentist* submit a dental *treatment plan* for *us* to review before *your* treatment. The dental *treatment plan* should consist of:

1. A list of *services* to be performed using the American Dental Association nomenclature and codes;
2. *Your dentist's* written description of the proposed treatment;
3. Supporting pretreatment X-rays showing *your* dental needs;
4. Itemized cost of the proposed treatment; and
5. Any other appropriate diagnostic materials that *we* may request.

An estimate for *services* is not a guarantee of what *we* will pay. It tells *you* and *your dentist* in advance about the *benefits* payable for the *covered expenses* in the *treatment plan*. *We* will notify *you* and *your dentist* of the *benefits* payable based on the submitted *treatment plan*.

An estimate for *services* is not necessary for *emergency* care.

Process and timing

An estimate for *services* is valid for {90} days after the date *we* notify *you* and *your dentist* of the *benefits* payable for the proposed *treatment plan* (subject to *your* eligibility of coverage). If treatment will not begin for more than {90} days after the date *we* notify *you* and *your dentist*, *we* recommend that *you* submit a new *treatment plan*.

Certificate information

The company issuing the Certificate is:
HumanaDental Insurance Company
1100 Employers Blvd.
Green Bay, Wi. 54344
1-800-233-4013

The insurance department can be reached at:
Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1904
1-800-852-5494

Definitions

The following terms are used in this section:

Late applicant: If you enroll or are enrolled more than {31} days after your eligibility date or *special enrollment date*, you will be considered a *late applicant* and your benefits will only cover {Preventive} {and Basic} services for the first {12} months of coverage.}{The following waiting periods will apply:

1. {{3} months for Preventive Services;}
2. {{3-12} months for Basic Services;
3. {{6-12} months for Major Services; {and}}
4. {{0-24} months for Orthodontic Services.}}

Special enrollment date means:

- The date of change in family status after the initial eligibility date as follows:
 - Date of marriage;
 - Date of divorce;
 - Date specified in a Qualified Medical Child Support Order (QMCSO);
 - Date specified in a National Medical Support Notice (NMSN);
 - Date of birth of a natural born child; or
 - Date of adoption of a child or date of placement of a child with the *employee* for the purpose of adoption; or
- The date of termination of coverage under a group dental plan or other dental insurance coverage, as specified under the "Special Enrollment" provision.}}

Eligibility date

Employee eligibility date

The *employee* is eligible for coverage on the date:

- The eligibility requirements stated in the Employer Group Application, or as otherwise agreed to by us and the *policyholder*, are satisfied[; and]
- [The *employee* is in an *active status*.]

Dependent eligibility date

Each *dependent* is eligible for coverage on:

- The date the *employee* is eligible for coverage, if he or she has *dependents* who may be covered on that date;
- The date of the *employee's* marriage for any *dependents* (spouse or child) acquired on that date;
- The date of birth of the *employee's* natural-born child;
- The date of placement of the child for the purpose of adoption by the *employee*; or
- The date specified in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) for a child, or a valid court or administrative order for a spouse, which requires the *employee* to provide coverage for a child or spouse as specified in such orders.

The *employee* may cover his or her *dependents* only if the *employee* is also covered.

A *dependent* child who enrolls for other group coverage through any employment is no longer eligible for group coverage under the policy. If a *dependent* child becomes an *employee* of the *employer*, he or she is no longer eligible as a *dependent* and must make application as an eligible *employee*.

Employee enrollment

The *employee* must enroll as agreed by the *policyholder* and *us*. [Depending on the total number of *employees* covered by the *employer's policy*, we may require any *employee* to provide evidence of health status whenever enrolling as permitted by laws, rules, or regulations.]

If the *employee* enrolls more than 31 days after the *employee's eligibility date* or more than 31 days after the *employee's special enrollment date*, the *employee* is a *late applicant*.

Dependent enrollment

Check with the *employer* immediately on how to enroll for *dependent* coverage. The *employee* must enroll for *dependent* coverage and enroll additional *dependents* as agreed by the *policyholder* and *us*.

[Depending on the total number of *employees* covered by the *employer's policy*, we may require any *dependent* to provide evidence of health status whenever enrolling as permitted by laws, rules, or regulations.]

A *dependent* enrolled more than 31 days after the *dependent's eligibility date* or the *special enrollment date* will be a *late applicant*.

Newborn dependent enrollment

An *employee* who already has *dependent* child coverage in force prior to the newborn's date of birth is not required to complete an enrollment form for the newborn child. However, the *employee* must notify *us* of the birth.

An *employee* who does not have *dependent* child coverage must enroll the newborn *dependent*, as agreed by the *policyholder* and *us*, within 31 days after the date of birth.

Newborn dependent effective date

- If we receive enrollment on, prior to, or within 2 years of the newborn's date of birth, *dependent* coverage is effective on the first of the month following receipt of the enrollment.
- If we receive enrollment between 2 years and 2 years and 31 days after the newborn's date of birth, *dependent* coverage is effective on the child's second birth date.
- If we receive enrollment more than 2 years and 31 days after the newborn's date of birth, the newborn is considered a *late applicant*.

{Special Enrollment

Loss of other coverage

If you are an employee or dependent who was previously eligible for coverage under the policy and had waived coverage, you may be eligible for *special enrollment* under the policy.

You will not be considered a late applicant, if the following applies:

- You declined enrollment under the policy at the time of initial enrollment because:
 - You were covered under a group dental plan at the time of eligibility and your coverage terminated as a result of:
 - Termination of employment or eligibility;
 - Reduction in number of hours of employment;
 - Divorce, legal separation or death of a spouse; or
 - Termination of your employer’s contribution for the coverage; or
 - You had COBRA continuation coverage under another plan at the time of eligibility and such coverage has since been exhausted; and
 - You stated, at the time of initial enrollment, that coverage under the group dental plan, or COBRA continuation was your reason for declining enrollment; and
 - You were covered under an alternate plan provided by the employer and you are replacing coverage with the policy;
- You apply for coverage within 31 days after termination of coverage under the group dental plan or COBRA.]

Dependent special enrollment period

The *dependent* Special Enrollment Period is a 31-day period from the *special enrollment date*.

If *dependent* coverage is available under the *employer's policy* or added to the *policy*, an *employee* who is a *covered person* can enroll eligible *dependents* during the Special Enrollment Period. An *employee*, who is otherwise eligible for coverage and had waived coverage under the *policy* when eligible, can enroll himself/herself and eligible *dependents* during the Special Enrollment Period. The *employee* or *dependent* enrolling within 31 days from the *special enrollment date* will not be considered a *late applicant*.

Effective date

Employee effective date

The *employee's effective date* provision is stated in the Employer Group Application. It may be the date immediately following, or the first of the month following, completion of the waiting period or the *special enrollment date*.

If the *employee* enrolls more than 31 days after his or her *eligibility date* or *special enrollment date*, he or she is a *late applicant*. [The *effective date* of coverage will be the first of the month following the receipt of the enrollment form.]

[Employee delayed effective date

Eligibility

If the *employee* is not in *active status* on the *eligibility date*, coverage will be effective the day after the *employee* returns to *active status*. The *employer* must notify *us* [in writing] [or] [by *electronic mail*] of the *employee's* return to *active status*.]

Dependent effective date

The *dependent's effective date* will be determined as follows:

- If *we* receive enrollment on, prior to, or within 31 days of the *dependent's eligibility date* that *dependent* is covered on the date he or she is eligible.
- If *we* receive enrollment on, prior to, or within 31 days of the *dependent's special enrollment date*, that *dependent's* coverage is effective on the *special enrollment date*.
- If *we* receive enrollment more than 31 days after the *dependent's eligibility date*, or the *special enrollment date*, that *dependent* is considered a *late applicant*. The *effective date* of coverage will be the first of the month following the receipt of the enrollment [form].

However, no *dependent's effective date* will be prior to the *employee's effective date* of coverage.

Benefit changes

Benefit changes will become effective on the date specified by *us*.

Incontestability: After *you* have been insured for two years, *we* cannot contest the validity of coverage except for nonpayment of premium. Statements *you* make cannot be contested unless they are in writing with *your* signature. A copy of the form must then be given to *you*.

{Retired employee coverage

Retired employee eligibility date

Retired *employees* are an eligible class of *employees* if requested on the Employer Group Application and if approved by *us*. An *employee* who retires while insured under this *policy* is considered eligible for retired *employee* dental coverage on the date of retirement if the eligibility requirements stated in the Employer Group Application are satisfied.

Retired employee enrollment

Notification of the *employee's* retirement must be submitted to *us* by the *employer* within 31 days of the date of retirement. If *we* receive the notification more than 31 days after the date of retirement, *you* will be considered a *late applicant*.

Retired employee effective date

The *effective date* of coverage for an eligible retired *employee* is the date of retirement for an *employee* who retires after the date *we* approve the *employer's* request for a retiree classification, provided *we* receive notice of the retirement within 31 days. If *we* receive notice more than 31 days after retirement, the *effective date* of coverage will be the date *we* specify.

Retired employee benefit changes

Additional or increased insurance or a decrease in insurance will become effective on the approved date of change. }

Terminating coverage

Your insurance coverage may end at any time, as stated below and in the **Employer Group Application**.

Coverage terminates on the earliest of the following events:

1. Termination date listed in the policy;
2. Failure to pay premium by the required due date;
3. The {date} {end of the month} {end of the year} the *employer* stops participating in the policy;
4. The {date} {end of the month} {end of the year} *you* enter the military fulltime;
5. {The}{date} {end of the month} {end of the year} *you* no longer are eligible for coverage as outlined in the **Employer Group Application**;
6. {The}{date} {end of the month} {end of the year} {first of the month following the date} *You* terminate employment with the *employer*;
7. For a *dependent*, the {date} {end of the month} {end of the year} {first of the month following the date} the *employee's* insurance terminates;
8. For a *dependent*, the {date} {birthday} {end of the month} {end of the year} {first of the month following the date} he/she no longer meets the definition of a *dependent*;
9. The {date} {end of the month} {end of the year} an *employee* requests that insurance be terminated for the *employee* and/or *dependents*;
10. An *employee's* retirement date unless the **Employer Group Application** provides coverage for retirees; or
11. For any *benefit* that may be deleted from the policy, the {date} {end of the month} {end of the year} it is deleted.

[Special provisions for active status

If the *employer* continues coverage under this policy, *your* coverage remains in force for no longer than:

1. {Three} consecutive months if the *employee* is temporarily laid off, in part-time status or on approved {non-medical} leave of absence; or
2. {Six} consecutive months if the *employee* is *totally disabled*.

If this coverage terminates and the *employee* returns to an *active status*, the *employee* will be considered a new *employee* and must re-enroll for insurance coverage.]

Definitions

Accidental injury: Damage to the mouth, teeth and supporting tissue due directly to an accident. It does not include damage to the teeth, appliances or prosthetic devices that results from chewing or biting food or other substances.

Active status: The *employee* performs all of his or her duties on a regular full-time basis for the required {number of hours per week shown on the employer's group application} {{40} hours per week}, {for {48} weeks per *year*}. *Active status* applies to *employees* whether they perform their duties at the *employer's* business establishment or at another location when required to travel for job purposes; on each regular paid vacation day; and any regular non-working holiday if the *employee* is not *totally disabled* on his or her effective date of coverage. An *employee* is considered in *active status* if he or she was in *active status* on his or her last regular working day.

Benefit: The amount payable in accordance with the provisions of this plan.

Bodily injury: An injury due directly to an accident.

Coinsurance: The percent of *covered expense* that is payable as *benefits* {after the *deductible* is satisfied,} up to the *maximum benefit*. The applicable *coinsurance* percentage rate is shown in the **Summary of your benefits**.

Cosmetic dentistry: *Services* provided by a *dentist* primarily for the purpose of improving appearance.

Covered expense: The *reimbursement limit* for a *covered service*.

Covered service: A *service* considered a *dental necessity*, *medical necessity* or routine Preventive *service* that is:

1. Ordered by a *dentist*;
2. For the *benefits* described, subject to any *maximum benefit*, as well as all other terms, provisions, limitations and exclusions of the policy; and
3. Incurred when a *member* is insured for that *benefit* under the policy on the *expense incurred date*.

{Deductible: The amount of *covered expenses* you must incur and pay before we pay *benefits*. }

Dental necessity: The extent of care and treatment that is the generally accepted, proven and established practice by most *dentists* with similar experience and training. Such care and treatment must use the least costly setting or procedure required by the patient's condition, and must not be provided primarily for the convenience of the patient or the *dentist*. To determine *dental necessity*, we may require preoperative dental X-rays and other pertinent information to determine if *benefits* are payable for the *service* submitted.

Dentist: An individual who is duly licensed to practice dentistry or perform oral surgery and is acting within the lawful scope of his or her license.

Dependent: A covered *employee's*:

1. Lawful spouse; and
2. Unmarried, natural blood related child, stepchild or legally adopted child whose age is less than the limiting age. Such child must receive at least 50 percent support and maintenance from the covered *employee*; and
3. Child for whom *you* have received a court or administrative order to provide coverage until:
 - A. Such court or administrative order is no longer in effect; or

Definitions

- B. The child is enrolled for comparable health coverage which is effective no later than the termination date of this plan.

Each child, other than those who qualify because of a court or administrative order, must meet all of the qualifications of a *dependent* as determined by the United States Internal Revenue Code.

The limiting age for each *dependent* child is:

1. {19} years; {or}
2. {{25} years if the child is a regular full-time student at an accredited secondary school, college or university. A *dependent* continues to be eligible for coverage for up to four months after the close of a school term only if enrolled as a full-time student for the next school term.} [Also, a *dependent* child's coverage will remain in force during a medically necessary leave of absence until the earlier of one year after the first day of the medically necessary leave of absence; or the date coverage would otherwise terminate under the plan.]

A covered *dependent* child who becomes an *employee* eligible for other group coverage no longer is eligible for coverage under this *policy*.

A covered *dependent* child who reaches the limiting age while insured under this policy remains eligible for dental expense *benefits* if:

1. Mentally or physically disabled;
2. Incapable of self-sustaining employment;
3. Dependent on the covered *employee* for at least 50 percent of support and maintenance; and
4. Unmarried.

You need to provide us with satisfactory proof that the above conditions continually exist after the *dependent* reaches the limiting age. We may not request proof more often than annually after two years from the date the first proof was furnished. If we do not receive satisfactory proof, the child's coverage ends on the date proof is due.

Emergency: A sudden, serious dental condition caused by an accident or dental disease that, if not treated immediately, would result in serious harm to the dental health of the *member*. Coverage for an *emergency* is limited to *palliative* care only.

Employee: The person who is regularly employed and paid a salary or earnings and is in *active status* at the *employer's* place of business. If the *employer* is a union, the *employee* must be in good standing and eligible for insurance according to the union's rules of eligibility.

Employer: The *policyholder* of the **Group Insurance Plan**, or any subsidiary described in the **Employer Group Application**.

Expense incurred: The amount you are charged for a *service*.

Expense incurred date: The date on which{:

1. {The teeth are prepared for fixed bridges, crowns, inlays or onlays;}
2. {The final impression is made for dentures or partials;}
3. {The pulp chamber of a tooth is opened for root canal therapy;}
4. {Periodontal surgery is performed;}
5. }The *service* is performed {for *services* not listed above.}

Family member: Anyone related to you by blood, marriage or adoption.

Definitions

Health care practitioner: Someone who is professionally licensed by the appropriate state agency to diagnose or treat a *bodily injury* or *sickness*, and who provides *services* within the scope of that license. A *health care practitioner's* services are not covered if he/she lives in *your* home or is a *family member*.

{Late applicant: An *employee* or an *employee's* eligible *dependent* who enrolls or is enrolled for dental coverage more than {31} days after his/her eligibility date. }

Maximum benefit: The maximum amount that may be payable for each *member* for *covered services*. The applicable *maximum benefit* is shown in the **Summary of your benefits**. No further *benefits* are payable after the *maximum benefit* is reached.

{Maximum family deductible: The total *deductible* applied to one family in a *year*, as defined on the **Summary of your benefits**. }

Medical necessity/ medically necessary: The extent of services required to diagnose or treat a *bodily injury* or *sickness* that is known to be safe and effective by most *health care practitioners* who are licensed to diagnose or treat that *bodily injury* or *sickness*. Such *services* must be:

1. The least costly setting procedure required by *your* condition;
2. Not provided primarily for the convenience of *you* or the *health care practitioner*;
3. Consistent with *your* symptoms or diagnosis of the *sickness* or *bodily injury* under treatment;
4. Furnished for an appropriate duration and frequency in accordance with accepted medical practices, and appropriate for *your* symptoms, diagnosis, or *sickness* or *bodily injury*; and
5. Substantiated by the records and documentation maintained by the provider of *service*.

Member: *Employees* and/or their covered *dependents*.

Palliative: Treatment used in an *emergency* to relieve, ease or alleviate the acute severity of dental pain, swelling or bleeding. *Palliative* treatment usually is performed for, but not limited to, the following acute conditions:

1. Toothache;
2. Localized infection;
3. Muscular pain; or
4. Sensitivity and irritations of the soft tissue.

Services are not considered *palliative* when used in association with any other *covered services* except X-rays and/or exams.

Policyholder: The legal entity named on the face page of the policy.

Reimbursement limit is the maximum allowable fee for a *covered service*. It is the lesser of:

1. {The fee most often charged in the geographical area where the *service* was performed;}
2. {The fee most often charged by the provider;}
3. {The fee that is recognized as reasonable by a prudent person;}
4. {The fee determined by comparing charges for similar *services* to a national database adjusted to the geographical area where the *services* or procedures were performed;}
5. {At *our* choice the fee determined by using a national Relative Value Scale. Relative Value Scale means a methodology that values procedures and *services* relative to each other that includes, but is not limited to, a scale in terms of difficulty, work, risk, as well as the material and outside costs of providing the *service*, as adjusted to the geographic area where the *services* or procedures were performed;}

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6. {In the case of *services* rendered by providers with whom *we* have agreements, the fee that *we* have negotiated with that provider;}
7. {The fee based on rates negotiated with one or more participating providers in the geographic area for the same or similar *services*;}
8. {The fee based on the provider's costs for providing the same or similar *services* as reported by the provider in the most recent, publicly available Medicare cost report submitted annually to the Centers for Medicare and Medicaid Services; or}
9. {The fee based on a percentage of the fee Medicare allows for the same or similar *services* provided in the same geographic area.}

Charges billed by a provider that exceed the *reimbursement limit* will not apply to the *member's* {*deductible* or} *coinsurance*.

Services: Procedures, surgeries, exams, consultations, advice, diagnosis, referrals, treatment, tests, supplies, drugs, devices or technologies.

Sickness: A disturbance in function or structure of *your* body causing physical signs or symptoms that, if left untreated, will result in deterioration of your health.

Total disability/totally disabled: An *employee* or employed covered spouse who, during the first {12} months of a disability, is prevented by *bodily injury* or *sickness* from performing all aspects of his or her respective job or occupation. After {12} months, *total disability/totally disabled* means the person is prevented by *bodily injury* or *sickness* from engaging in any paid job or occupation that he/she is reasonably qualified for by education, training or experience.

For any *member* who is not employed, *total disability* means a disability preventing him/her from performing the usual and customary activities of someone in good health of the same age and gender.

A *totally disabled* individual may not engage in any paid job or occupation.

Treatment plan: A written report on a form satisfactory to us and completed by the *dentist* that includes:

1. A list of the services to be performed, using the American Dental Association nomenclature and codes;
2. *Your dentist's* written description of the proposed treatment;
3. Supporting pretreatment x-rays showing *your* dental needs;
4. Itemized cost of the proposed treatment; and
5. Any other appropriate diagnostic materials as requested by *us*.

We, us and our: The insurance company as shown on the cover page of this certificate.

[*Year* means [a 365-day period that begins initially on the policy's effective date and each 365-day period thereafter beginning on the anniversary date of the policy, unless otherwise agreed to by the *policyholder* and *us*.] [the period of time which begins on any January 1st and ends on the following December 31st.] [When *you* first become covered by the *policy*, the first *year* begins for *you* on the effective date of *your* insurance [and ends on the following December 31st].]

You and your: Any covered *employee* and/or *dependent(s)*.

Supplemental Dental Expense Benefit

Orthodontic Services

This Supplemental Dental Expense Benefit is part of the certificate. The benefits outlined will be [effective the latter of:]

1. [The] effective date of *your* certificate[; or]
2. [Completion of any applicable *waiting period*].

[Please refer to the Waiting Periods provision to verify if an orthodontic *waiting period* applies to *you*.]

{*Benefits* are available only to {covered *dependent* children} {*members*} age {18} and under at the time treatment begins {, and continue, while coverage is available, to age {20}}.}

{*Benefits* are available to any covered *member*.}

We pay *benefits* based on *our reimbursement limits* and *your* orthodontic *maximum benefit*. Except as modified below, all plan terms, conditions and limitations apply.

Covered services for orthodontia treatment

Covered services for orthodontic treatment include those that are:

1. For the treatment of--and appliances for--tooth guidance, interception and correction[; and]
2. [Related to covered orthodontic treatment including:
 - X-rays;
 - [Extractions;]
 - Exams;
 - Space regainers; and/or
 - Study models].

How benefits will be paid if treatment begins after you are eligible for orthodontic benefits with us.

In order to have the full orthodontic treatment be considered for *benefits* under this plan, bands and appliances must be inserted after:

1. *Your* effective date under this plan; and
2. Exhaustion of any orthodontic *waiting period*.

If *services* are eligible under this plan at the time orthodontic appliances or bands are initially inserted, *we* will pay the lesser of:

1. 25 percent of the total *treatment plan* charge;
2. 25 percent of the total *maximum benefit* payable; or
3. The *dentist's* initial fee.

We will pay the remaining installments at the end of each quarter while *you* are covered for orthodontic benefits under this plan. If for any reason the *treatment plan* is terminated before treatment is completed, *we* will not pay further *benefits*.

Supplemental Dental Expense Benefit

How benefits will be paid if treatment was started before you were eligible for orthodontic benefits with us.

Services for orthodontic treatment received prior to your effective date[, or prior to exhaustion of the orthodontic waiting period,] are not covered services.

Benefits are available only for the portion of the treatment after:

1. *Your* effective date under this plan[; and][.]
2. [Exhaustion of any orthodontic *waiting period*.]

Benefits will be prorated to account for the portion of treatment completed prior to orthodontic eligibility.

Additionally, if *you* had orthodontic coverage under *your* prior dental plan, any benefits paid by *your* prior plan, will be applied to the Orthodontic Lifetime Maximum Benefit of this plan.



{ Gerald L. Ganoni }
{ President }

Change in Plan Rider: Coverage for Implant{s} {Crown and Abutment}

Your certificate is amended to include this plan rider. The effective date of the rider is the latter of the effective date of *your* certificate or the date this rider is added to *your* certificate. *Benefits* are subject to all policy terms, conditions and limitations.

The following Implant {Prosthetic} benefit is added to *your* certificate as follows:

{Implants will be allowed as a benefit payable under {Basic} {Major} *services* on *your* Summary of Your Benefits subject to the Individual Maximum Benefit. Services payable to the lesser of {\$1000-3000} or the Individual Maximum Benefit [The Individual Extended Maximum Benefit does not apply to, and no additional benefits are available for, Implants and all related services, including implant supported prostheses.] Implants and implant supported prostheses covered under this plan are limited to the replacement of permanent teeth extracted while insured under this plan, or for replacement of a prior prosthesis if it has been at least {five} years since the prior insertion, and is not, and cannot be made serviceable.}

Implant placement and any related procedures are not covered under the dental Plan. The prosthesis and abutment connected to the implant will be allowed as a benefit payable under {Basic} {Major} *services* on *your* Summary of Your Benefits. [The Individual Extended Maximum Benefit does not apply to, and no additional benefits are available for, Implants and all related services, including implant supported prostheses.] Implant prostheses covered under this plan are limited to the replacement of permanent teeth extracted while insured under this plan, or for replacement of a prior prosthesis if it has been at least {five} years since the prior insertion, and is not, and cannot be made serviceable.}



{Gerald L. Ganoni}

{President}

Roll-over [plan][account]

[This [rider] [amendment] is made part of the *policy* to which it is attached. [The effective date of this change is [the latter of the effective date of the *certificate*] [or] [the date this benefit is added to the *policy*].]]

Definitions

The following terms are used in this [rider] [amendment]:

[Roll-over [account][plan] means an [account][plan] that can accumulate funds as specified in the eligibility section below, that may be used on *covered expenses* that exceed the **individual maximum benefit** in the *year* or *years* after the funds are accrued.]

[Roll-over account limit means the amount of funds that are eligible to accrue in the roll-over account up to a specified amount.]

Coverage description

Eligibility for Roll-over [plan][account]

You may be eligible for a rollover of a portion of *your* unused **individual maximum benefit**.

To qualify for the *roll-over [plan][account]* benefits detailed in this [rider] [amendment] *you* must:

- {Have {at least}{one dental cleaning}{or}{one claim}{or}{services totaling up to {\$300 - 2500}}in that *year*}. {Only claims incurred on or after the start of the next *year* will count toward the accumulation of roll-over funds. }
- {Have satisfied all waiting period requirements as specified on the Summary of Your Benefits {, if any}.}

[If all of the benefits that *you* receive that *year* are for *services* provided by a PPO *dentist*, *you* may be entitled to greater roll-over funds than if any of the *services* are provided by a Non-PPO *dentist*.]

Any rollover funds *you* earn can accrue and are stored in *your roll-over [plan][account]*. If *you* reach *your individual maximum benefit* for covered [non-orthodontic] *services*, we will pay benefits up to the amount that has accumulated in *your roll-over [plan][account]*.

The amount of roll-over funds accumulated in the *roll-over [plan][account]* will not exceed the *roll-over account limit*.

[*Your* accrued roll-over funds may be lost, if *you* have a break in coverage of any length of time, for any reason.]

Using your Roll-over [plan][account]

If *you* exceed *your individual maximum benefit* in any given *year*, and *you* have money in *your* rollover account, we will continue to pay *benefits* for *covered expenses* up to the amount available in *your roll-over [plan][account]*.

Roll-over [plan][account]

Your individual maximum benefit	<i>Your</i> roll-over amount		[Roll-over account limit]
	In-network	Out-of-network	
[\$500-5000]	[\$250-1500]	[\$250-1500]	[\$500-3000]

Limitations and exclusions

- {If *your* coverage under this dental plan becomes effective in {October, November, or December} {the last 3 months of the *year*}, *you* will not be eligible to accrue *roll-over [plan][account]* funds until January 1st of the next {full} *year*.}
- {*You* may not use the roll-over funds for orthodontic *services*.}
- {Rollover funds will not be applied to *your roll-over [plan][account]* until the *year* that starts one year from the date the rollover provision first applies.}

[HumanaDental Insurance Company]

[Signature of Officer]
[Typed Name of Officer]
[Title of Officer]

Change in Plan Rider: Coverage for Open Enrollment

Your certificate is amended to include this plan rider. The effective date of the rider is the latter of the effective date of your certificate or the date this rider is added to your certificate. *Benefits* are subject to all policy terms, conditions and limitations[, including waiting periods].

Open enrollment period

The open enrollment period is the annual period during which eligible *employees* may apply for coverage for themselves and their eligible *dependents* as outlined in the **Employer Group Application** (see your employer for details).

To enroll for coverage

The *employee* must complete the enrollment/change form provided by *us*, carefully listing each person to be covered. Enrollment during the open enrollment period will be allowed if *we* receive the completed forms within the open enrollment period. Any reference to *late applicants* within the [Eligibility section of]your certificate and/or Policy is removed. *Late applicants* are not eligible for coverage, and must wait until the following open enrollment periods to apply.

When you are eligible for coverage section in your certificate is amended as follows:

The eligibility date of coverage is amended as follows:

Employee Coverage:

The *employee* is eligible for coverage on the date:

1. The eligibility requirements stated in the Employer Group Application, or as otherwise agreed to by *us* and the *policyholder*, are satisfied;
2. The *employee* is in an *active status*, or;
3. The employer's annual anniversary date.

Dependent Coverage:

Each *dependent* is eligible for coverage on the date:

1. The *employee* is eligible for coverage, if he or she has *dependents* who may be covered on that date;
2. Of the *employee's* marriage for any *dependents* (spouse or child) acquired on that date;
3. Of birth of the *employee's* natural-born child;
4. Of placement of the child for the purpose of adoption by the *employee*;
5. Specified in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) for a child, or a valid court or administrative order for a spouse, which requires the *employee* to provide coverage for a child or spouse as specified in such orders.
6. Of the *employer's* annual anniversary date.

[Please check your Schedule of Benefits for waiting periods that may apply to you.]



{ Gerald L. Ganoni }
{ President }

<i>SERFF Tracking Number:</i>	<i>HUMA-126032077</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Humana Dental Insurance Company</i>	<i>State Tracking Number:</i>	<i>41551</i>
<i>Company Tracking Number:</i>	<i>AR-09-001 DEN</i>		
<i>TOI:</i>	<i>H10G Group Health - Dental</i>	<i>Sub-TOI:</i>	<i>H10G.000 Health - Dental</i>
<i>Product Name:</i>	<i>AR-09-001 DEN</i>		
<i>Project Name/Number:</i>	<i>AR-09-001 DEN/AR-09-001 DEN</i>		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: HUMA-126032077 State: Arkansas
Filing Company: Humana Dental Insurance Company State Tracking Number: 41551
Company Tracking Number: AR-09-001 DEN
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
Product Name: AR-09-001 DEN
Project Name/Number: AR-09-001 DEN/AR-09-001 DEN

Supporting Document Schedules

Satisfied -Name: Flesch Certification	Review Status: Approved-Closed	02/13/2009
Comments:		
Attachment: Certification of Compliance HDIC 1-09.pdf		
Satisfied -Name: Application	Review Status: Approved-Closed	02/13/2009
Comments:		
Attachment: AR-Application 1-09.pdf		
Satisfied -Name: Back Cover	Review Status: Approved-Closed	02/13/2009
Comments:		
Attachment: _ Z-HD GN Backcovr 1-09.pdf		
Satisfied -Name: Statement of Variability	Review Status: Approved-Closed	02/13/2009
Comments:		
Attachment: Statement of Variability 1-09 v3.pdf		

TO: State of Arkansas
Office of the Commissioner of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

GN-70090-HD 3/08	GN-70146-HD 1/09
GN-70146-HD TAB 1/09	GN-70146-HD SCP 1/09
GN-70146-HD SCI 1/09	GN-70146-HD BEN 1/09
GN-70146-HD LE 1/09	GN-70146-HD PAY 1/09
GN-70146-HD EE 1/09	GN-70146-HD TER 1/09
GN-70146-HD DEF 1/09	GN-70146-HD ORTHO 1/09
GN-70146-HD Implant 1/09	GN-70146-HD Roll
GN-70146-HD OE 1/09	

Back Cover (included for informational purposes)
Statement of Variability

CERTIFICATION OF COMPLIANCE
Arkansas Rule and Regulation 19

I, Gerald L. Ganoni, an officer of HumanaDental Insurance Company, hereby certify that I have authority to bind and obligate the company by the filing of this form. I further certify that, to the best of my knowledge, information and belief:

- (a) The accompanying form as identified above does comply with all applicable provisions of the Arkansas Rule and Regulation 19; and
- (b) The form does meet the Flesch reading ease test for a score of 40 for all applicable policies, certificates and certificate riders unless the Commissioner of Insurance of the State of Arkansas requires a lower score;



Gerald L. Ganoni, President

2-13-2009
Date

Individual responsible for this filing:

Christi Conrad
Human Insurance Company
Green Bay, WI 54344
Telephone 1-800-558-4444, Ext.3765
E-mail: cconrad@humana.com

Application- Forms previously used with approval date

GN-70146-HD 1/09	Approved 4/11/05
GN-70146-HD TAB 1/09	Approved 4/11/05
GN-70146-HD SCP 1/09	Approved 4/11/05
GN-70146-HD SCI 1/09	Approved 4/11/05
GN-70146-HD BEN 1/09	Approved 4/3/08
GN-70146-HD LE 1/09	Approved 4/11/05
GN-70146-HD PAY 1/09	Approved 4/11/05
GN-70146-HD EE 1/09	Approved 4/11/05
GN-70146-HD TER 1/09	Approved 4/11/05
GN-70146-HD DEF 1/09	Approved 4/11/05
GN-70146-HD ORTHO 1/09	Approved 4/11/05
GN-70146-HD Implant 1/09	Approved 6/19/07
GN-70146-HD Roll	New
GN-70146-HD OE 1/09	Approved 6/19/07

HUMANA[®]
Specialty Benefits

{HumanaDental.com}
Toll Free 800-233-4013
1100 Employers Blvd
Green Bay WI 54344

Insured by HumanaDental Insurance Company
In Kentucky, insured by The Dental Concern, Inc.

Statement of Variability

- All demographic information remains variable text. This information does not impact the benefits of the product, but is merely used as a form of identification in the course of product administration.
- All numbers are variable. Numbers within a provision determined by the laws of the governing jurisdiction will be varied only within the confines of the law.
- Bracketed text within the certificate may be adjusted, or omitted.
- The Waiting Period Options (for Employee and Employer) give alternate text to appear under Waiting Periods (GN-70146-HD SCP [1/09](#) and GN-70146-HD SCI [1/09](#)), as applicable for the product design chosen.
- The Summary of Your Benefits Variable Options give alternate benefit ranges and covered service options to appear under Summary of Your Benefits (GN-70146-HD SCP [1/09](#) and GN-70146-HD SCI [1/09](#)), as applicable for the product design chosen.
- We also reserve the right to amend the attached to fix any minor typographical errors we may have neglected to find prior to submitting to your department, and to amend the language to clarify the intent within the confines of the law.

Waiting Period Options - Employee

{If *you* are a *late applicant* the following waiting periods will apply:

1. {{3} months for Preventive *services*;}
2. {{3-6} months for Basic *services*;}
3. {{6-12} months for Major *services*; {and}
4. {{0-24} months for Orthodontic *services*.} }

{If *you* are a *late applicant*, there is a {0-24}-month waiting period before *you* are eligible for coverage for all *services* except {Preventive} {and Basic}.)

{If *you* enroll timely, {Preventive} {Basic} {Major} {and} {Orthodontic} *services* **will not be subject to a waiting period.**} {*Services* may be subject to a {0-24}-month waiting period before *you* are eligible for coverage.} {**no waiting periods will apply.**} {This {0-24}-month waiting period can be decreased by the amount of time *you* had prior dental coverage immediately before *your* coverage with *us*.} {Please call *us* if *you* have any questions about the waiting periods that apply to *you*.}

{Each *member* added after the effective date of the *policyholder* is subject to a separate {0-24} month waiting period.} {,} {if there was no qualifying event}.)

{Each *dependent* added after the effective date of the *employee* is subject to a separate {0-24} month waiting period} {,} {if there was no qualifying event}.)

[If your dental coverage was continuous without a break of more than 63 days between the termination of creditable coverage and your enrollment date under the policy, any period of time that was satisfied under the prior plan will be applied to the appropriate waiting periods under the policy, if any. The *employee* will then be eligible for benefits under the policy when the balance of the waiting period has been satisfied, whether the *member* is timely or a *late applicant*.]

Preventive Services:

{There are no *waiting periods* for Preventive *services* } {, if *you* enroll timely}.)

{The *late applicant waiting period* applies to Preventive *services*.}

{If *you* are a *late applicant*, *you* must be insured under this policy for a period of {0-24} continuous months before Preventive *services* will be covered.}

Basic Services:

{There are no *waiting periods* for Basic *services* } {, if *you* enroll timely}.)

{The *late applicant waiting period* applies to Basic *services*.}

{Basic *services* {are} {are not} payable on *your* effective date of coverage.}

{*You* must be insured under this policy for a period of {0-24} continuous months before Basic *services* will be covered.}

{If *you* are a *late applicant*, *you* must be insured under this policy for a period of {0-24} continuous months before Basic *services* will be covered.}

Major Services

{There are no *waiting periods* for Major *services*} {, if *you* enroll timely}.)

{Major *services* {are} {are not} payable on *your* effective date of coverage.}

{No waiting period applies to Major *services*.}

{*You* must be insured under this policy for a period of {0-24} continuous months before Major *services* will be covered.} {Endodontic *services* are only subject to the *waiting period* if *you* are a *late applicant*.}

{If you are a *late applicant*, you must be insured under this policy for a period of {0-24} continuous months before Major *services* will be covered.}

{Orthodontic Services:}

{Orthodontic *services* {are} {are not} payable on *your* effective date of coverage.}

{No waiting periods apply to Orthodontic *services*.}

{There are no *waiting periods* for Orthodontic *services*} {, if you enroll timely} {and Orthodontic *services* are a *covered expense* under your plan.}

{You must be insured under this policy for a period of {0-24} continuous months before Orthodontic *services* will be covered.}

{If you are a *late applicant*, you must be insured under this policy for a period of {0-24} continuous months before Orthodontic *services* will be covered.}

Waiting Period Options Employer

{If a *member* is a *late applicant* the following waiting periods will apply:

5. {{3} months for Preventive *services*;}
6. {{3-6} months for Basic *services*;
7. {{6-12} months for Major *services*; {and}
8. {{0-24} months for Orthodontic *services*.} }

{If a *member* is a *late applicant*, there is a {0-24}-month waiting period before **he or she is** eligible for coverage for all *services* except {Preventive} {and Basic}.}

{If a *member* enrolls timely, {Preventive} {Basic} {Major} {and} {Orthodontic} *services*}{**will not be subject to a waiting period**} {may be subject to a {0-24}-month waiting period before **he or she is** eligible for coverage}.} {This {0-24}-month waiting period can be decreased by the amount of time the *member* had prior dental coverage immediately before **his or her** coverage with *us*.} {Please call *us* for the waiting period that applies to those *dependents*.} }

[If a member has continuous dental coverage without a break of more than 63 days between the termination of creditable coverage and his or her enrollment date under the policy, any period of time that was satisfied under the prior plan will be applied to the appropriate waiting periods under the policy, if any. The *employee* will then be eligible for benefits under the policy when the balance of the waiting period has been satisfied, whether the *member* is timely or a *late applicant*.]

{Please see *your* Summary of Benefits for waiting period provisions that are specific to *you*.}

Preventive Services:

{No waiting periods apply to Preventive *services*.}

Basic Services:

{No waiting periods apply to Basic *services* }

{If a *member* is a *late applicant*, **he or she** must be insured under this policy for a period of {0-24} continuous months before Basic *services* will be covered.}

{Each *dependent* added after the effective date of the *employee* is subject to a separate {0-24} month waiting period} {,} {if there was no qualifying event}.}

{Each *member* added after the effective date of the *policyholder* is subject to a separate {0-24} month waiting period} {,} {if there was no qualifying event}.}

Employer Waiting Periods Cont..

Major Services

{The following criteria is used to determine the waiting periods that may apply to *members* covered under this policy: }

{For Major Services, coverage is effective as follows:

If *you* had {0-24} months of continuous dental coverage immediately prior to *your* effective date with us, coverage is effective on *your* effective date.

If *you* did not have {0-24} months of continuous dental coverage immediately prior to *your* effective date with us, coverage is effective {0-24} months after *your* effective date.}

{Each *member*, including a *late applicant*, added after the group's effective date under this policy MUST be insured under this policy for a period of {0-24} consecutive months before Major *services* will be covered.}

{For Major Services, coverage is effective as follows:

Groups with fewer than {10} dental lives with no prior dental coverage, coverage is effective {0-24} months after the effective date of coverage.

Groups with fewer than {10} dental lives with prior dental coverage, coverage is effective on the effective date of coverage.

Groups with more than {10} dental lives with or without prior dental coverage, coverage is effective on the effective date of coverage.}

{Each *member*, including a *late applicant*, added after the group's effective date under this policy must be insured under this policy for a period of {0-24} continuous months before Major *services* will be covered.}

Employer Waiting Period cont.

Orthodontic Services

{Orthodontia coverage is effective as follows:

If {the *dependent* child} {*you*} had {0-24} months of continuous orthodontic benefits under the prior dental plan, and coverage did not lapse between the prior plan and {the *dependent's*} {*your*} effective date with this plan, then the effective date of orthodontic coverage is the effective date of this plan.

If {the *dependent* child} {*you*} did not have {0-24} months of continuous orthodontic benefits under the prior dental plan, or there was a lapse in coverage between the prior plan and {the *dependent's*} {*your*} effective date with this plan, {the *dependent*} {*you*} must be insured under this plan for a period of {0-24} consecutive months before services will be covered.}

{Orthodontia coverage is effective as follows:

Groups with fewer than {10} dental lives with no prior orthodontia coverage--orthodontia coverage is effective {0-24} months after the effective date of coverage.

Groups with fewer than {10} dental lives with prior dental and orthodontia coverage--orthodontia coverage is effective on the effective date of coverage.

Groups with fewer than {10} dental lives-orthodontic coverage is effective {0-24} months after the effective date of the covered *dependent* added after the effective date of *your* Policy.

Groups with more than {10} dental lives--orthodontia coverage is effective on *your* effective date of coverage.}

Summary of Your Benefits Variable Options

Individual Calendar Year, Plan Year, or Lifetime Maximum Benefit:

\$200 to unlimited

Individual Calendar Year, Plan Year, or Lifetime Deductible:

\$0 to \$1,000

Maximum Family Deductible:

\$0 to \$1,000

Orthodontic Calendar Year, Lifetime Deductible:

\$0 to \$1,000

Individual Lifetime Orthodontic Maximum Benefit:

\$50 to \$4,000

Coinsurance:

0% to 100%

[\(Any applicable state requirements for coinsurance differentials will be followed.\)](#)

The following descriptions may or may not be included, may be adjusted between categories (Preventive, Basic or Major), and/or may be updated based on ADA industry changes. Additional titles for covered services may be created as may be required to reflect the level of detail for coverage as needed.

Covered Services:

Routine prophylaxis	Non-surgical extractions	Amalgam restorations
Topical fluoride	Routine extractions	Dentures relines/rebases
Sealants	Surgical extractions	Partials & dentures repairs & adjustments
X-Rays	Surgical removal residual root	Non-cast prefabricated crowns
Bitewing X-rays	{Simple}{Complex}Oral surgery services	Partial or complete dentures
Periapical X-rays	Endodontics (root canals)	Fixed bridgework
Panoramic X-rays	Periodontics (gum disease)	Removable bridgework
Stainless steel crowns	Periodontic surgical services	Periodontic adjunctive services
Complete intra-oral X-ray series	Orthodontics	Inlays & onlays
Oral examinations	Crowns	General anesthesia
Space maintainers	Emergency care	IV sedation
Non-surgical Extractions	Fixed prosthodontics	Composite restorations
Emergency exam	Palliative care for pain relief	Removable prosthodontics
Periodontic Examinations	Periodontic Cleaning/Root Planing	Periodontic Adjunctive Services
Harmful habit & thumb sucking appliances	Non-surgical residual root removal	Fillings (amalgam and composite Restorations)
Consultations	Crown Repairs	Bridge Repairs
Pulp Capping	Injection of antibiotic drugs	Temporomandibular Joint Disorder (TMJ)

**only the late applicant waiting period will apply to this service.

