

SERFF Tracking Number: HUMA-126890740 State: Arkansas
Filing Company: Humana Dental Insurance Company State Tracking Number: 47212
Company Tracking Number: AR-10-006 H1 DENV2
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
Product Name: New H1 Dental Portfolio v2
Project Name/Number: New H1 Dental Portfolio v2/New H1 Dental Portfolio v2

Filing at a Glance

Company: Humana Dental Insurance Company

Product Name: New H1 Dental Portfolio v2

TOI: H10G Group Health - Dental

Sub-TOI: H10G.000 Health - Dental

Filing Type: Form

SERFF Tr Num: HUMA-126890740 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 47212

Co Tr Num: AR-10-006 H1 DENV2 State Status: Approved-Closed

Reviewer(s): Rosalind Minor
Disposition Date: 11/14/2010

Authors: Erin Hermsen, Paula
Konop, Tina Huettl, Christi Conrad

Date Submitted: 11/04/2010
Disposition Status: Approved-
Closed

Implementation Date Requested:

State Filing Description:

Implementation Date:

General Information

Project Name: New H1 Dental Portfolio v2

Project Number: New H1 Dental Portfolio v2

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 11/14/2010

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Employer

Explanation for Other Group Market Type:

State Status Changed: 11/15/2010

Created By: Christi Conrad

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Christi Conrad

Filing Description:

RE: HumanaDental Insurance Company

NAIC #: 119-70580

FEIN#: 39-0714280

Forms Included:

HUMD-ASSOC-CERT.002 6/10

HUMD-AEAR-209 10/10

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Dear Rosalind:

We are submitting the above-referenced forms for approval in Arkansas. Your department just recently approved these forms under SERFF tracking number HUMA-126688162 . The changes that were requested to be made through your disapproval were made within the Certificate, in which they should have been made on the state amendment. I am resubmitting with the changes requested on the state amendment.

If you should have any questions, please contact me via SERFF or by phone at 1-800-558-4444 ext. 3765.

Sincerely,
HUMANADENTAL INSURANCE COMPANY

Christi Conrad
Compliance Analyst

Attachments

Company and Contact

Filing Contact Information

Christi Conrad, Specialty Benefits Compliance cconrad@humana.com
Specialist
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?	Yes
Fee Amount:	\$100.00
Retaliatory?	No
Fee Explanation:	2 forms x \$50 per form= \$100.00
Per Company:	No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Humana Dental Insurance Company	\$100.00	11/04/2010	41537212

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/14/2010	11/14/2010

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Disposition

Disposition Date: 11/14/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Form	Dental Certificate	Approved-Closed	Yes
Form	Amendatory Endorsement	Approved-Closed	Yes

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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 11/14/2010	HUMD-ASSOC- CERT.002 6/10	Certificate	Dental Certificate	Initial			05 H1 HD Assoc Cert 6- 10.pdf
Approved-Closed 11/14/2010	HUMD-AEAR-209 10/10	Certificate	Amendatory Amendmen t, Insert Page, Endorseme nt or Rider	Initial			AR AEAR 209 10-10.pdf

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*.

HumanaDental Insurance Company agrees to pay *benefits* for *services* rendered to *covered persons*, subject to all the terms and provisions of the *policy*. We reserve the full and exclusive right to interpret the terms of the *policy* and to determine the *benefits* payable thereunder.

Important Notice

Please read the copy of *your* enrollment application. Carefully check for errors and report any errors in the information provided in *your* enrollment application to us in writing at [P.O. Box 30111, Tampa, FL 33630-3111]. *Your* coverage under the *policy* is issued in consideration of *your* enrollment application; [a copy of which is attached and made part of the *policy*,] and *your* payment of premiums as provided herein. [An incorrect or incomplete enrollment application may cause a *covered person's* coverage to be voided and claims to be reduced or denied].

Notice to Buyer

The *policy* provides coverage for limited dental *services*. If *you* should have any questions arise regarding *your* coverage, or if *you* need assistance in resolving a complaint, contact us at [1-800-233-4013].

Renewability

Coverage remains in effect at *your* option except as provided in the "Termination Rights" section of this *certificate*.

[



]

[Gerald L. Ganoni]
[President]

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[Section I - PPO

PPO Provisions

What is a Preferred Provider Organization (PPO)?

A Preferred Provider Organization (PPO) is a network or group of *dentists* who are contracted to furnish, at *negotiated fees*, dental *services* for *you* under the *policy*.

Reasons to use a PPO provider

1. *We* negotiate fees for dental *services*. The *negotiated fees* lower costs for *you* when *you* use *dentists* in the PPO Network.
2. *You* may receive a better *benefit* and *your* out-of-pocket expenses are lowered.
3. *You* have a wide variety of *dentists* in the PPO to help *you* with *your* dental care needs.

You have the freedom to choose the *dentist* of *your* choice. However, *you* will receive *maximum benefits* by seeing an *in-network dentist*. If *you* visit an *out-of-network dentist*, *you* may be balance billed for any *expense incurred* that exceeds *our reimbursement limit*.

How to select a provider

A list of *in-network dentists* is available on *our* Web site and is updated daily. If *you* do not have Internet access, *dentist* lists are available by calling *us*. *Our* telephone number and Web site address are listed on the back of *your* dental *identification card*.

If *you* are traveling or need *emergency* care and are unable to access care from an *in-network dentist*, *benefits* will be paid at the out-of-network level.]

Section [II] - Benefits

A. Your plan benefits

We pay *benefits* for *covered expenses* as explained in the “*your plan benefits*” section. *Benefits* for the *services* explained below are limited to the *benefit* maximum shown in the Schedule. The following *services* are considered as integral parts of the entire dental *service*. A separate fee for those *services* is not considered a *covered expense*.

- | | |
|--|--|
| 1. Local Anesthetics; | 7. <i>Treatment Plans</i> ; |
| 2. Bases; | 8. Occlusal Adjustments; |
| 3. Pulp Caps; | 9. Nitrous Oxide; |
| 4. Temporary Dental <i>Services</i> | 10. Irrigation; and |
| 5. Study Models/Diagnostic Casts; | 11. Removal of restorations, prosthesis or |
| 6. Tissue preparation associated with impression
or placement of a restoration; | appliances. |

We will not cover caries susceptibility testing, [lab tests], anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

[If a procedure is a *covered service* both hereunder and under *your* group or individual medical *policy* with Humana Insurance Company, Humana Insurance Company will be considered primary over HumanaDental Insurance Company.]

Covered [Preventive]/[Diagnostic] Services

[There is no waiting period for all services in this category.]

[There is a [0-12] month waiting period for all services in this category.]

1. Oral evaluations (periodic, limited, comprehensive and problem focused) - [two - four] per [calendar] [plan] [year].
2. Periodontal evaluations - [two] per [calendar] [plan] [year].
3. Cleaning (prophylaxis), including all scaling and polishing procedures – [two] per [calendar] [plan] [year].
4. Topical fluoride treatment – [provided to [dependents] [covered person(s)] age [14] and younger] [and] [[60] years and older]. [Service is payable once per [calendar] [plan] [year]].
5. [Sealants – application provided [to [dependents] [covered person(s)] age [14] and younger] to the occlusal surface of permanent molars that are free of decay and restorations. Service is payable [[once [per tooth] [per lifetime].]
6. We will not cover preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.

Covered [Basic]/[Restorative] Services

[There is no waiting period for all services in this category.][There is a [0-12]-month waiting period for all services in this category.]

1. [Amalgam restorations (fillings) – [limited to [one] per tooth in a [one, two, three] [calendar] [plan] [year] period.] [Multiple restorations on one surface are considered one restoration.]
2. [Composite restorations (fillings) [limited to [[two] per covered person per [calendar] [plan] [year] [one] per tooth in a [one, two, three] [calendar] [plan] [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. [Intra-oral complete series X-rays (at least 14 films, including bitewings), or panoramic film X-rays – [once, twice] every [one - five years]. 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.]
4. [Bitewing X-rays – [one, two] set[s] per [calendar] [plan] [year].]
5. [Other X-rays – only to diagnose specific treatment [[one] per [calendar] [plan] [year].]
6. [Treatment for 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.]]

Covered [Major]/[Prosthodontic] Services

[There is no waiting period for all services in this category.]

[There is a [0-12] month waiting period for all services in this category.]

[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. [Vital pulpotomy – procedure available for deciduous (baby) teeth only.]]
4. [Pulp tests - allowed only with emergency exam.]

[Periodontic services

1. Periodontal scaling and root planing, available at a maximum of [once, twice] per quadrant in a [one, two, three] [calendar] [plan] [year] period.
2. [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.]

3. [Occlusal Guards.]
4. Periodontal maintenance (following periodontal therapy) – procedure available [twice, three times] per [calendar] [plan] year.]
5. Separate fees for pre and post operative care and re-evaluation within three months are not covered.

[Prosthodontic [and other major services]]

1. [Recementing of inlays, onlays, crowns and bridges.]
2. [Non-cast [stainless steel] pre-fabricated crowns – service on primary teeth that cannot be adequately restored with amalgam or composite restorations.] [Limited to [1] per [calendar][plan] year]]
3. [Repairs of [bridges][;] [full or partial dentures][,] [and crowns].] [Limited to [1 per calendar][plan] year]].
4. [Space maintainers for retaining space when a primary tooth is prematurely lost. [Services are payable only [for dependents age [14] and younger] for the installation of the initial appliance. Separate adjustment expenses will not be covered.]]
5. [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. Limited to [1 per calendar][plan] year.]
6. [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.]]
7. [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.]]
8. [Replacement of bridges, partials, dentures, inlays, onlays, crowns or other laboratory-fabricated restorations. The existing major restoration or prosthesis can be replaced only if:
 - A. It has been at least [three, four, five] years since the prior insertion and is not, and cannot be made, serviceable;
 - B. It is damaged beyond repair as a result of an accidental injury (non-chewing injury) while in the oral cavity; or
 - C. 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.]
9. [Oral surgery services.]
 - A. [Extraction - coronal remnants of a deciduous tooth.]
 - B. [Extraction - erupted tooth or exposed root.]
 - C. [[Surgical Extractions (We will not cover the elective removal of non-pathologic impacted teeth);]
 - D. [Bone Smoothing;]
 - E. [Trim or Remove over growth or non vital tissue or bone;][or]
 - F. [Removal of tooth or root from sinus and closing opening between mouth and sinus.]]
 - G. [General anesthesia when medically necessary and administered by a dentist in conjunction with a covered oral surgical procedure.]
 - H. [We will not cover any services for orthognathic surgery.]
 - I. [We will not cover 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.]
10. [Denture relines or rebases – [once, twice] in a [two, three, four, five] [calendar] [plan][year] period.]
11. We will not cover the expense incurred for pin retention when done in conjunction with core build-up.
12. We will not cover the replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.]

B. Limitations & exclusions (all services)

In addition to the limitations and exclusions listed in ***your plan benefits*** section, the *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*:
 - A. 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;
 - B. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - C. 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:
 - A. War or any act of war, whether declared or not;
 - B. Any act of international armed conflict; or
 - C. 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 the *policy*. We consider the following *cosmetic dentistry* procedures:
 - A. [Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.]
 - B. Any *service* to correct congenital malformation;
 - C. Any *service* performed primarily to improve appearance; or
 - D. Characterizations and personalization of prosthetic devices.]
7. [Charges for:
 - A. [Any type of implant and all related *services*, including crowns or the prosthetic device attached to it.]
 - B. Precision or semi-precision attachments.
 - C. Overdentures and any endodontic treatment associated with overdentures.
 - D. Other customized attachments.]
8. [Any *service* related to:
 - A. Altering vertical dimension of teeth;
 - B. Restoration or maintenance of occlusion;]
 - [C. Splinting teeth, including multiple abutments, or any *service* to stabilize periodontally weakened teeth;
 - D. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
 - E. 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 anesthetist.]
12. [Prescription drugs or pre-medications, whether dispensed or prescribed.]
13. Any *service* not specifically listed in **your plan benefits**.
14. Any *service* shown as “Not Covered” in the Schedule.
15. [For any *service* shown as “0% Co-Insurance” in the Schedule. In this event, the *covered person* is responsible for the full *negotiated fee* amount.]
16. Any *service* that *we* determine:
 - A. Is not a *dental necessity*;
 - B. Does not offer a favorable prognosis;
 - C. Does not have uniform professional endorsement; or
 - D. Is deemed to be experimental or investigational in nature.
17. Orthodontic *services*.
18. Any *expense incurred* before *your effective date* or after the date *your* coverage under the *policy* terminates.
19. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
20. [Charges exceeding the *reimbursement limit* for the *service*.]
21. [Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.]
22. 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*.
23. [Repair and replacement of orthodontic appliances.]
24. [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.]
25. Elective removal of non-pathologic impacted teeth.

C. How your plan works

General benefit payments

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

When a *covered person* receives a *service*, *we* will determine if it qualifies as a *covered service*. Any *service* qualifying as a *covered service* must not be excluded by the terms of the *policy* or limited by a waiting period. After determining that the *service* is a *covered service*, *we* will pay *benefits* as follows:

1. [*We* will determine if the service was rendered by an *in-network* or *out-of-network dentist*. If rendered by

an *in-network dentist*, we will determine the *negotiated fee* amount. If rendered by an *out-of-network dentist*, we will determine the *reimbursement limit*. The result is the total amount of eligible *expenses incurred* related to a particular *service*.]

2. We will review the eligible *expenses incurred*, against any *policy* or *benefit* maximums which may apply to a particular *service*.
3. We will determine if the *covered person* has met **his or her deductible**. If **he or she** has not, for any *services* subject to the *deductible*, we will subtract any amount required to be paid as part of the *deductible*; and
4. We will make payment for the remaining eligible *expense incurred* to you or your servicing provider based on our *coinsurance* for that *service*.

[Deductibles

The *deductible* is the amount shown on the Schedule that the *covered person* must pay in *covered expenses* before we pay any *coinsurance*.

How do you know when you no longer have to pay toward your deductible?

1. **Individual deductible:** [Each [calendar] [plan] [year],] when the total eligible *covered expenses* a *covered person* has incurred reaches the individual *deductible* amount as shown on the Schedule, the individual *deductible* has been met for that *covered person*; or
2. **Family deductible:** [Each [calendar] [plan] [year],] once the amount of family *deductible* has been fulfilled, as described above, any *covered person* will not have to pay any further individual *deductibles* [for the rest of that same [calendar] [plan] [year].]

Coinsurance

Coinsurance is shared responsibility between the *covered person* and us. The level of *coinsurance* of *covered expenses* we will pay toward the total *expenses incurred* for *services* is shown on the Schedule.

[Waiting periods

This is the time period that certain *services* are not eligible for coverage under the *policy*. This begins on a *covered person's effective date* and lasts for the time shown in **your plan benefit** section and the Schedule.]

Benefit maximums

The amount we pay for *services* is 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 Schedule.

D. Pre-determination

How can you find out what will be covered before you receive treatment?

If dental treatment is expected to exceed [\$300], you or your dentist can submit a dental *treatment plan* to us for review prior to treatment. The dental *treatment plan* should consist of:

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.

Predetermination of *benefits* is not a guarantee of what we will pay. It tells you and your dentist in advance, *benefits* payable for the *covered expenses* named in the *treatment plan*. We will notify you and your dentist of the *benefits* payable based upon the submitted *treatment plan*.

Predetermination of *benefit* is not necessary for *emergency care*.

You may call us at [800-233-4013] or write to us at [Humana Dental Insurance Company 1100 Employers Blvd, Green Bay WI 54344] to find out what will be a *covered expense* before you receive treatment.

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 *covered service* that produces a professionally satisfactory result, as determined by us. Payment will be limited to the *reimbursement limit* for the least costly *covered service* and subject to any *deductible* and *coinsurance*. You will be responsible for paying the excess amount.

Process and timing

Subject to your eligibility of coverage under the *policy*, the predetermination of *benefits* is valid for 90 days after the date we notify you and your dentist of the *benefits* payable for the proposed *treatment plan*. If treatment is to commence more than 90 days after the date we notify you and your dentist of the *benefits* payable for the proposed *treatment plan*, a new *treatment plan* must be submitted to us.

Section [III] – Claims

A. How we pay claims

Identification numbers

You received an identification (ID) card showing your name, identification number and group number. Show this ID card to your dentist when you receive services.

Claim forms

We do not require a standard claim form to process *benefits*. When we receive a claim, we will notify you or your dentist if any additional information is needed.

Submitting claim information and proof of loss

Either you or the dentist must complete and submit to us all claim information for proof of loss. We would like to receive this information within 90 days after the *expense incurred date*; however, the claim will not be reduced or denied if it was not reasonably possible to meet the 90-day guideline. In any event, we will need written proof of loss notice within one year after the date proof of loss is requested, except if you were legally incapacitated.

Here are examples of information *we* may need (this is not a comprehensive list and only provides a few examples of the information *we* may request).

1. [A complete dental chart showing:
 - Extractions;
 - Missing teeth;
 - Fillings;
 - Prosthesis;
 - Periodontal pocket depths;
 - Dates of previously performed work;]
2. An itemized bill for all dental work.
3. The following exhibits:
 - X-rays;
 - [• Study models;]
 - [• Laboratory and/or reports;]
 - Patient records.
4. [Authorizations to release any additional dental information or records.]
5. [Information about other insurance coverage.]
6. Any information *we* need to determine *benefits*.

[If you do not provide *us* with the necessary information, *we* will deny any related claims until *you* provide it to *us*.]

Paying claims

We determine if *benefits* are available and pay promptly any amount due under the *policy* not more than 30 days after receipt of due written proof of loss. *We* may pay all or a portion of any *benefit* provided for *covered expenses* to the *dentist* unless *you* have notified *us* in writing by the time the claim form is submitted. *Our* payments are made in good faith and will fully discharge *us* of any liability to the extent of such payment.

[Extension of benefits

Benefits are payable for [root canals,] [crowns,] [inlays,] [onlays,] [veneers,] [fixed bridges,] [dentures] [and] [partials] that are:

1. Incurred while *your* coverage is in force (see definitions of *expense incurred* and *expense incurred date* in the **Definitions** section); and
2. Completed within the first [60] days after *your* coverage terminates. These *benefits* are subject to the provisions and conditions of the *policy*.

You have up to [90] days after *your* termination date to submit claims for these extended *Benefits*.]

Reasons for denying a claim

Below is a list of the most common reasons *we* cannot pay a claim. Claim payments may be limited or denied in accordance with any of the provisions contained in this *certificate*.

1. **Not a covered benefit:** The *service* is not a *covered service* under the *policy*. See Section [II] B herein.
2. **Eligibility:** *You* no longer are eligible under the **Terminating coverage** section of this *certificate*, or the *expense incurred date* was prior to *your effective date*.
3. **Policy compliance:** The *covered person* has not acted in accordance with the *policy* requirements.
4. **Fraud:** *You* make an intentional misrepresentation by not telling *us* the facts or withhold information necessary for *us* to administer *your* coverage under the *policy*.

Insurance fraud is a crime. Anyone who willingly and knowingly engages in an activity intended to defraud *us* by filing a claim or form that contains false or deceptive information may be guilty of insurance fraud.

If a *covered person* commits fraud against *us*, as determined by *us*, coverage ends automatically, without notice, on the date the fraud is committed. This termination may be retroactive. *We* also will provide information to the proper authorities and support any criminal charges that may be brought. Further, *we* reserve the right to seek civil remedies available to *us*.

We will not end coverage if, after investigating the matter, we determine that the *covered person* provided information in error. We will adjust premium or claim payment based on this new information.

If you provided correct information and we made a processing error, you will be eligible for coverage and claims payment for *covered expenses*. We will adjust your premium or claim payment based on the correct information.

5. **Duplicating provisions:** If any charge is described as covered under two or more *benefit* provisions, we will pay only under the provision allowing the greater *benefit*. This may require us to make a recalculation based on both the amounts already paid and the amounts due to be paid. We have no obligation to pay for *benefits* other than those this *certificate* provides.

Legal actions

You cannot bring a legal action to recover a claim until 60 days after the date written proof of loss is made. No action may be brought more than three years after proof of loss is made.

Claims paid incorrectly

If a claim was paid in error, we have the right to recover our payments, within 12 months from the date we paid the claim. We may correct this error by an adjustment to any amount applied to the *deductible* or *maximum benefits*.

Errors may include such actions as:

1. Claims paid for *services* that are not actually covered under the *policy*.
2. Claims payment that is more than the amount allowed under the *policy*.
3. Claims paid based on fraud or an intentional misrepresentation.

We may seek recovery of our payments made in error from anyone to, for or with respect to whom such payments were made; or any insurance companies or organizations that provide other coverage for the *covered expenses*. We will determine from whom we shall seek recovery. [For information on our process, see the **Recovery rights** provision.]

B. Coordinating benefits with another insurer

Benefits subject to this provision

Benefits described in this *certificate* are coordinated with *benefits* you receive from other plans. This prevents duplication of coverage and resulting increases in the cost of dental coverage. For purposes of this section, the following definitions apply:

1. **Plan**—A plan covers medical or dental expenses and provides *benefits* or *services* by:
 - Group, franchise or blanket insurance coverage;
 - Group-based hospital service pre-payment plan, medical service pre-payment plan, group practice or other pre-payment coverage;
 - Coverage under labor-management, employer plans, trustee plans, union welfare plans, employee *benefit* organization plan; and
 - Governmental programs or programs mandated by state statute, or sponsored or provided by an educational institution, if it is not otherwise excluded from the calculation of *benefits* under the *policy*.

This provision does not apply to any individual policies or blanket student accident insurance provided by or through an educational institution.

2. **Allowable expense**—Any eligible expense, a portion of which is covered under one of the plans covering the person for whom the claim is made. Each plan will determine what an eligible expense is based on the provisions of the plan. When a plan provides *benefits* in the form of *services* rather than cash payments, the reasonable cash value of each *service* rendered will be both an allowable expense and a *benefit* paid. An expense or *service* that is not covered by any of the plans is not an allowable expense.

3. **Claim determination period**—A [calendar year] [plan year]. If, in any [calendar year] [plan year], a person is not covered under the *policy* for the entire [calendar year] [plan year], the claim determination period will be the portion of the year in which he or she was covered under the *policy*.

Effect on benefits

One of the plans involved will pay *benefits* first. This is called the primary plan. Under the primary plan, *benefits* will be paid without regard to the other plan(s).

All other plans are called secondary plans. The secondary plan may reduce the *benefits* so that the total *benefits* paid or provided by all plans during a claim determination period are not more than 100 percent of the total allowable expense.

Order of benefit determination

To pay claims, it must be determined which plan is primary and which plan(s) is/are secondary. A plan will pay *benefits* first if it meets one of the following conditions:

1. The plan that covers the person as an *employee* submitting the claim.
2. For a child covered under both parents' plans, the plan covering the parent whose birthday (month and day) occurs first in the *calendar year* pays before the plan covering the other parent. If the birth dates of both parents are the same, the plan that has covered the parent for the longer period of time will be the primary plan.
3. In the case of *dependent* children covered under the plans of divorced or separated parents, the following rules apply:
 - The plan of a parent who has custody will pay *benefits* first.
 - The plan of a stepparent who has custody will pay *benefits* next.
 - The plan of a parent who does not have custody will pay *benefits* next.
 - The plan of a stepparent who does not have custody will pay *benefits* next.

A court decree may give one parent financial responsibility for the medical or dental expenses of the *dependent* children. In this case the rules stated above will not apply if they conflict with the court decree. Instead, the plan of the parent with financial responsibility will pay *benefits* first.

4. If a person is laid off or retired, or is a *dependent* of someone who was laid off or retired, that plan becomes the secondary plan to the plan of an active *employee*.

If rules 1-4 do not determine the primary plan, the plan covering the person for the longest time is the primary plan. If it still cannot be determined which plan is the primary plan, *we* will waive the above rules and incorporate the rules identical with those of the other plan.

Right of recovery

We will not request a refund or offset against a claim more than 12 months after *we* have paid a claim except in the case of fraud or misrepresentation by the health care provider.

Right to necessary information

We may require certain information to apply and coordinate these provisions with other plans. *We* will, without *your* consent, release to or obtain information from any insurance company, organization or person to implement this provision. *You* agree to furnish any information *we* need to apply these provisions.

[Non-duplication of Medicare benefits

We will not duplicate *benefits* for expenses that are or could have been paid by Medicare as the primary payer.

If the *covered person* is enrolled in Medicare, *we* will coordinate with Medicare being the primary payer. Before filing a claim with *us*, a claim must first be filed with Medicare. Then, a copy of the itemized bill and a copy of the Explanation of Medicare Benefits should be sent to *us*.

If the *covered person* is eligible for Medicare *benefits*, but not enrolled, *benefits* under the *policy* will be coordinated as if Medicare had been in force and primary. In all cases, coordination of *benefits* with Medicare will confirm to Federal Statutes and Regulations.

Medicare means Title XVIII, Parts A and B of the Social Security Act, as enacted or amended.]

Other coverage with us

Coverage effective as any one time under a like *policy* with *us* is limited to coverage under one *policy* elected by *you*. *We* will return all premium paid for all other coverages.

C. Excess coverage

We will not pay *benefits* for any *accidental injury* if other insurance will provide payments or expense coverage, regardless of whether the other coverage is described as primary, excess or contingent. If *your* claim against another *insurer* is denied or partially paid, *we* will process *your* claim according to the terms and conditions of the *policy* as described in this *certificate*. If *we* make a payment, *you* agree to assign to *us* any right *you* have against the other *insurer* for dental expenses *we* pay. Payments made by the other *insurer* will be credited toward any applicable *coinsurance* or [calendar] [plan] [year] *deductibles*.

D. Recovery rights

Your obligation in the recovery process

We have the right to collect *our* payments made in error. *You* are obligated to cooperate and assist *us* and *our* agents to protect *our* recovery rights by:

1. Obtaining *our* consent before releasing any party from liability for payment of dental expenses.
2. Providing *us* with a copy of any legal notices arising from *your* injury and its treatment.
3. Assisting *our* enforcement of recovery rights and doing nothing to prejudice *our* recovery rights.
4. Refraining from designating all (or any disproportionate part) of any recovery as exclusively for “pain and suffering.”

If *you* fail to cooperate, *we* will collect from *you* any payments *we* made.

We will not request a refund or offset against a claim more than 12 months after *we* have paid a claim except in the case of fraud or misrepresentation by the health care provider.

[Assignment of recovery rights

If *your* claim against the other *insurer* is denied or partially paid, *we* will process the claim according to the terms and conditions of the *policy*. If *we* make payment on *your* behalf, *you* agree that any right for expenses *you* have against the other *insurer* for expenses *we* pay will be assigned to *us*.

If *benefits* are paid under the *policy* and *you* recover under any automobile, homeowners, premises or similar coverage, *we* have the right to recover from *you* an amount equal to the amount *we* paid.]

[E. Appeal rights

How to Challenge Our Claim Decision

If a *covered person* disagrees with *our* decision on payment of a particular claim, the *covered person* can request a second review of the claim, also known as an appeal. To request this review, *you* must send *us* a letter requesting a second claim review within 60 days from the time *you* received notice of *our* claim payment decision. The *covered person* may also send any documents or information that are relevant to *our* decision of how to pay the claim.

Once *we* receive the request, *we* will make a second review of the claim and provide notice of *our* decision within 15 business days.

The *covered person* may also contact the Missouri Department of Insurance to file a grievance.

Rights You Have after a Second Claim Review and Denial

You cannot bring any legal action against *us* prior to 60 days but not more than the time allowed by the applicable statute of limitations after the date all necessary claims payment information has been received. The *covered person* also must have completed a second claim review and utilized any external appeals procedure available under state law.]

Section [IV] - Eligibility

A. When you are eligible for coverage

Primary insured coverage

Eligibility date: The *primary insured* is eligible for coverage when:

1. Eligibility requirements listed in the *Primary Insured* Application are satisfied; and
2. The *primary insured* is a member of the group *policyholder*.

Effective date: *Your effective date* will be calculated after *we* approve the completed application. *Your effective date* will be the date approved 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*.

Every time *you* change coverage, either with or without an application, the two year review timeframe starts over with regard to the new information and *benefits*.

Dependent coverage

Eligibility date: If the *primary insured* is covered, the *primary insured's dependent* is eligible for coverage:

1. On the date the *primary insured* is eligible for coverage;
2. On the date of the *primary insured's* marriage (spouse and/or stepchildren);
3. On the date of birth of the *primary insured's* natural-born child; or
4. On the date a child is placed in the *primary insured's* home for adoption by the *primary insured*.

[A *dependent child* is eligible to apply if he or she is under the age of [25-31] at the time of enrollment.]

Application: If *you* have any questions in regard to applying, for *dependent* coverage, please contact *us* at [1-800-233-4013].

Effective date: Each *dependent's effective date* of coverage is determined as follows, subject to the *Dependent Delayed Effective Date* provision:

1. If *we* receive the application before the *dependent's* eligibility date, the *dependent* is covered on the date he or she is eligible.
2. If *we* receive the application within [31] days after the *dependent's* eligibility date:
 - A. The *dependent* is covered on the date *we* receive the completed application; or
 - B. The *dependent* is covered on the date he or she is eligible if the *primary insured* already had *dependent* coverage in force.
3. The date *we* specify if *we* receive the completed application more than [31] days after the *dependent's* eligibility date.

Coverage for a newborn child born to *you* or a covered *dependent* will be effective from the moment of birth. Notification must be provided to *us* within 31 days of the newborn's date of birth. If notification is provided within 31 days, no additional premium will be charged for coverage of the newborn for the duration of the 31-day notice period. If notification is not provided within 31 days, *we* may charge an additional premium from the date of birth. *We* will not deny coverage provided the required notice is given to *us* within 60 days of the date of birth.

Coverage for a newborn child of a covered *dependent* will not extend beyond 18 months after birth.

Coverage for an adopted child will be effective from the date of birth if an agreement of adoption is entered into prior to the birth, or from the date of placement in *your* home prior to the child's 18th birthday. Notification, or completion of an application, as applicable, must be provided to *us* within 31 days of date of birth or placement. If notification is provided within 31 days, no additional premiums will be charged for coverage of the adopted or foster child for the duration of the 31-day notice period. If notification is not provided within 31 days, *we* may charge an additional premium from the date of birth or placement. *We* will not deny coverage provided the required notice is given to *us* within 60 days of the date of birth or placement.

No coverage will be provided for a child who is not ultimately placed in *your* home. For children in *your* custody, coverage will terminate the date *you* no longer have legal custody.

A *dependent's effective date* cannot occur before the *primary insured's effective date* of coverage.

[Dependent delayed effective date: For other than a newborn, a *dependent's effective date* of coverage will be delayed if the *dependent* is homebound due to *bodily injury* or *sickness*, or is confined to a hospital or mental health center. The *dependent's* coverage will be effective one day after discharge from confinement. A physician must certify the discharge.]

B. Changes to your coverage

Changes in benefits

You may call or write *us* to request additional, increased or decreased *benefits*. If the additional *benefit* *you* request are available, as determined and approved by *us*, the *benefit* will become effective on the date *we* approve the change.

Change in state of residence

If *you* move out of *your* current state of residence *you* may be eligible for new *benefits* under *your* new state of residence.

Call or write *us* at least 14 days prior to *your* move to a new state to inform *us* of *your* new address and phone number. Once received, *we* will inform *you* of any changes to *your* plan, on such topics as, new networks, *benefits* and premium. Such change will be retroactive and effective as of the date of *your* move.

Child-only coverage

The parent or legal guardian in whose name coverage is issued is considered the *primary insured*. In the case of child-only coverage, as a parent or legal guardian, *you* have contracted on behalf of *your dependent* for the *benefits* described in the *policy*. It is *your* responsibility to assure *your dependent's* compliance with any and all terms and conditions outlined in the *policy*.

To add a *dependent* child to child-only coverage, follow the procedures listed above.

Our rights to make changes to the policy

We have the right to make certain changes to the *policy*.

Changes we will make without notice to you

If a change is required by a state or federal law or government division, *we* can make the change at any time without notice to *you*.

Changes where we will notify you

We also can make changes to the *policy* on the premium due date or upon separate notice, provided *we* send *you* a written explanation of the change 31 days prior to its effect. All such changes will be made in accordance with state law. *Your* continued payment of premium will stand as proof of *your* agreement to the change.

How do you know these are our changes?

No modification or amendment to the *policy* will be valid unless approved by the President, Secretary or a Vice-President of *our* company. No agent has authority to modify the *policy*, waive any of the *policy* provisions, extend the time for premium payment or bind *us* by making any promise of representation.

C. Premium payment

Your Duty to Pay Premium

You must pay the required premium to *us* as it becomes due. Failure to do so will result in termination of coverage.

The first premium is due on the *effective date*. Subsequent premiums are due on the first day of each premium period. Premium period means monthly, quarterly, semi-annually or annually, as selected by *you*. All premiums are payable to *us* at *our* address.

Grace Period

A grace period of 31 days will be allowed for the payment of each required premium due after the first premium. If premium is not paid, *we* will terminate the insurance as of the last day through which premium was paid.

[Changes to Your Premium

We will not change the initial premium shown on the cover of this *certificate* for the first [12] consecutive months except for the following:

- *Family members* are added or deleted;
- Coverage is increased or decreased;
- A *covered person* moves to a different zip code or county; or
- Premium payment method is changed.

The premium change will be effective on the date of such change. After the first [12] consecutive months, premium may change on any premium due date for any of the reasons stated above or the following:

- A new rate table applies;
- Any *covered person's* age increases; or
- Any *covered person's* rating classification changes.

We will provide written notice at least [30-60] days prior to the *effective date* of any premium change.]

Return of Premium/Rescission

In no event, except upon termination of *your* coverage under the *policy* will the premium be returned. If *your* coverage is terminated, the amount of returned premium will be calculated pro rata.

Further, any refunds required by the state will be prorated to the termination date from the date of last premium payment.

D. Terminations

[Terminating coverage

Your insurance coverage may end at any time, as stated below. Coverage terminates on the earliest of the following events:

1. Termination date of the *policy*;
2. Failure to pay premium by the required due date;
3. The [date] [end of the month] [end of the year] *you* enter the military fulltime;
4. [The][date] [end of the month] [end of the year] *you* no longer are eligible for coverage;
5. The date a *covered person* commits fraud or intentional misrepresentation of a material fact, as determined by *us*;
6. For a *dependent*, the [date] [end of the month] [end of the year] *your* insurance terminates;
7. For a *dependent*, the [date] [end of the month] [end of the year] he/she no longer meets the definition of a *dependent*; or
8. The [date] [end of the month] [end of the year] *you* request that insurance be terminated for *you* and/or *your dependents* [given that coverage has been continuously inforce for at least 12 months from the effective date of this certificate].

[We will provide [30-60] days advance written notice of termination to *you*, [unless termination is due to nonpayment of premium]. [In that event, *we* will provide a [10]-day advance written notice.]]

Your duty to notify us

You are responsible to notify *us* of any of the events stated above which would result in termination of a *covered person*.

If *we* accept premium for any *covered person* extending beyond the date, age or event specified in this provision as a reason for termination, then coverage for the *covered person* will continue during the period for which an identifiable premium was accepted, except where such acceptance of premium was based on misstatement of age.

If *you* fail to provide timely notification of these events, the termination date and the period for which premium refund (if any) will be calculated, will be determined based on when *we* should have received the notification, as determined by *us*.

Continuation of Coverage for Surviving Dependents

If *your* coverage has been in force for at least 90 days and *you* die while *dependent* coverage is in force, the surviving *dependents* that are covered under the *policy* on the date of death may be eligible to continue coverage under the *policy*.

The surviving spouse or legal guardian of the covered *dependent* child(ren) must notify *us* in writing within 31 days of *your* death. Premium must continue to be paid in order for coverage to continue. The premium may change and will be based upon the classification of risk and age of those continuing coverage.

The surviving *dependent* spouse will become the *primary insured* if covered under the *policy* on the date of death. In the case of child-only coverage, the surviving *dependent's* parent or legal guardian will become the *primary insured* of the continued *policy*.

All conditions, limitations, exclusions and maximums hereunder will continue to apply.

Modification of policy

The *policy* may be modified at any time by agreement between *us* and the *policyholder* without the consent of any *covered person*. Modifications will not be valid unless approved by *our* president, vice president, secretary or other authorized officer. The approval must be endorsed on, or attached to, the *policy*. No agent has the authority to modify the *policy*, waive any of the *policy* provisions, extend the time for premium payment, make or alter any contract, or waive any of the Company's other rights or responsibilities.

Section [V] – General Provisions

[Assignment of benefits

Assignment of *benefits* may be made only with *our* consent. It is not binding until *we* receive and acknowledge in writing the original or copy of the assignment before payment of the *benefit*. *We* do not guarantee the legal validity or effect of such assignment.]

Conformity with state statutes

Any provisions that are in conflict with the laws of the states in which the *policy* and this coverage are issued are amended to conform to the minimum requirements of those laws.

Cost of legal representation

The cost of *our* legal representation in matters related to *our* rights under the *policy* shall be borne solely by *us*. The costs of legal representation incurred by or on behalf of a *covered person* shall be borne solely by *you* or the *covered person*, unless *we* are given timely notice of the claim and an opportunity to protect *our* own interests and *we* failed or declined to do so.

Entire contract

The rules governing *our* agreement to provide *you* with dental insurance in exchange for *your* premium payment is based on several written documents: the *policy*; riders, amendments, endorsements and *your* application and the application of the *policyholder*.

Privacy statement

We strive to ensure the privacy and confidentiality of information about *our covered persons* as it related to both personal data and health history.

Relationship with providers

We and *dentists* or other *health care practitioners* are at all times acting independently. *We* do not make any treatment decisions, nor prescribe treatment options, regardless of any coverage determinations *we* make under the *policy*.

Section [VI]- Definitions

The following are definitions of terms used in this *certificate*. Defined terms are printed in “*italic*” type wherever found in this *certificate*.

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.

[Balance bill: The amount that an *out-of-network dentist* may charge a *covered person*. Such amount charged equals the difference between the amount paid by *us* and the amount of the *out-of-network dentist* bill charge.]

Benefit: The amount payable in accordance with the provisions of the *policy*.

Bodily injury: An injury due directly to an accident.

[Calendar year: The period of time beginning January 1 and ending on December 31 of the same year. The first *calendar year* begins for a *covered person* on the date *benefits* under the *policy* first become effective for that *covered person* and ends on the following December 31.]

Certificate: This document, together with any amendments, riders or endorsements, which describe the agreement between *you* and *us*.

Coinsurance: Shared coverage. *Our coinsurance* is the percent of *covered expense* payable as *benefits*, after the *deductible* is satisfied, up to the *maximum benefit* portion as shown on the schedule.

[Copayment: A specified dollar amount, if on the Schedule, to be paid by a *covered person* to a provider toward *covered expenses* of certain *services* specified in the *policy*.]

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

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

Covered person: Anyone eligible to receive *policy benefits* as a *covered person*.

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 herein, subject to any *maximum benefit*, and all other terms, provisions, limitations and exclusions of the *policy*; and
3. Incurred when a *covered person* is insured for that *benefit* under the *policy* on the *expense incurred date*.

Deductible: The amount of *covered expense* that a *covered person* must incur and is responsible to pay before *we* pay certain *benefits*.

Dental injury: An injury to a *sound nature tooth* caused by a sudden and external force that could not be predicted in advance and could not be avoided. It does not include biting or chewing injuries.

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, as determined by *us*. 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 *health care practitioner*.

Dentist: An individual who is validly licensed to practice dentistry or provide dental *services* and is acting within the lawful scope of his or her license.

Dependent:

1. *Your* legally recognized spouse;
2. *Your* unmarried natural child, step-child, foster child or legally adopted child whose age is less than the limiting age and who is not provided coverage as a named subscriber, insured, enrollee, or *covered person* under any group or individual health benefit plan, or entitled to benefits under Title XVIII of the Social Security Act, P.L. 89097, 42 U.S.C. Section 1395, et seq.;

3. An unmarried child whose age is less than the limiting age and for whom *you* have received a court or administrative order to provide coverage and who is not provided coverage as a named subscriber, insured, enrollee, or *covered person* under any group or individual health benefit plan, or entitled to benefits under Title XVIII of the Social Security Act, P.L. 89097, 42 U.S.C. Section 1395, et seq;
4. *Your dependent* child who upon attainment of the limiting age while insured under the *policy* is and continues to be both incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the *primary insured* for support and maintenance. Proof of such incapacity and dependency must be furnished to *us* by the *primary insured* at least 31 days after the child's attainment of the limiting age. *We* may require at reasonable intervals during the 2 years following the child's attainment of the limiting age subsequent proof of the child's incapacity and dependency. After such 2-year period *we* may require subsequent proof not more than once each year.
5. A covered *dependent's* newborn child (limited to 18 months after birth).

Dependent does not mean a:

1. Grandchild, unless such child is born to a *dependent* covered under the *policy*.
2. Great grandchild; or
3. Child who has not yet attained full legal age, but how has been declared by a court to be emancipated.

The limiting age for each child to be considered a *dependent* under the *policy* is [no more than [25-31] years of age] [the *dependent's* 31st birthday][the end of the month in which the *dependent* attains the age of 31].

A covered *dependent* child who becomes eligible for other group dental coverage no longer is eligible for coverage under the *policy*.

We will not deny enrollment of a child on the grounds that: (1) the child was born out of wedlock; or (2) the child is not claimed as a *dependent* on the parent's federal income tax return; or (3) the child does not reside with the parent or in *our* service area.

Effective date: The first date all the terms and provision of the *policy* apply. It is the date that appears on the face page or schedule of this *certificate* or on the date of any amendment, rider or endorsement hereto.

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 *covered person*. Coverage for an *emergency* is limited to *palliative* care only.

Expense incurred: The *reimbursement limit* charged for *services* that are a *dental necessity* or *medically necessary* to treat the condition.

Expense incurred date: The date on which:

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

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

Geographic area: The three digit zip code in which the dental service is provided; or a greater area if necessary to obtain a representative cross-section of charges for a like dental service.

Health care practitioner: A practitioner 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 the practitioner resides in the *covered person's* home or is a *family member*.

Identification card or ID: The card each *covered person* receives that contains *our* address and telephone number.

[In-Network dentist: A *dentist* under agreement with *us* to provide certain dental *services* to *covered persons* at contracted rates and terms.]

Insurer: HumanaDental Insurance Company.

Maximum benefit: The maximum amount that may be payable for each *covered person* for *expenses incurred*. The applicable *maximum benefits* are shown on the Schedule No further *benefits* are payable once the *maximum benefits* are reached.

Medically necessary: The required extent of *service*, treatment or product that a *health care practitioner* would provide to his/her patient for the purpose of diagnosing, palliating or treating a *sickness* or *bodily injury*, or its symptoms. Such health care *service*, treatment or product must be:

1. In accordance with nationally recognized standards of medical practice and generally accepted as safe, widely used and effective for the proposed use;
2. Clinically appropriate in terms of type, frequency, intensity, toxicity, extent, setting and duration;
3. Not primarily for the convenience of *covered person* or the *health care practitioner*;
4. Clearly substantiated by the records and documentation concerning the patient's condition;
5. Performed in the most cost effective setting required by the patient's condition; and
6. Supported by the preponderance of nationally recognized peer review medical literature, if any, published in the English language as of the date of *service*.

Negotiated fee: The rate mutually agreed upon between *us* and a *dentist* in a specific instance.

[Out-of-Network dentist: A *dentist* who is NOT under agreement with *us* to provide certain dental *services* to *covered persons* at contracted rates and terms.]

Palliative: Treatment used in an *emergency* situation 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.

[Plan year: If shown on the Schedule, the period of time which begins immediately on *your effective date* and renews 12 months following the initial *effective date*. For persons enrolled other than on *your initial effective date* or a subsequent anniversary date, *benefits* begin immediately on the *covered person's effective date* and renew 12 months following the *covered person's initial effective date*.]

Policy: The document describing the *benefits* we provide as agreed to by *us* and the *policyholder*.

Policyholder: The legal entity identified as the *policyholder* on the face page of the *policy* and to whom the *policy* is issued.

Primary insured: The person to whom this *certificate* is issued.

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

1. In the case of *services* rendered by providers with whom *we* have agreements, the fee that *we* have negotiated with that provider;

2. The fee based on rates negotiated with one or more participating providers in the geographic area for the same or similar *services*;

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

Renewal: The time frame established by billing mode for premium payment.

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

Sickness: A disturbance in function or structure of the *covered person's* body which causes physical signs or symptoms that, if left untreated, will result in a deterioration of *your* health state of the structure of system(s) of the *covered person's* body.

Sound natural tooth: A tooth that:

1. Is organic and formed by the natural development of the body (not manufactured, capped, crowned or bonded);
2. Has not been extensively restored;
3. Has not become extensively decayed or involved in periodontal disease; and
4. Is not more susceptible to injury than a whole natural tooth, (for example a tooth that has not been previously broken, chipped, filled, cracked or fractured).

Treatment plan: A written report on a form satisfactory to *us*, which is completed by the *dentist*. It consists of:

1. A list of the *services* to be performed, using the American Dental Association Nomenclature and codes;
2. The *dentist's* written description of the proposed treatment;
3. Supporting pretreatment x-rays showing the *covered person's* 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 *insurer* as shown on the cover page of this *certificate*.

Year, Yearly: The *calendar year* or *plan year* as shown on the Schedule of Benefits.

You and your: The *primary insured*.

[Section [VII]–Non-Insurance Discounts

Discount/access disclosure

From time to time, *we* may offer or provide *you* with access to discount programs. In addition, *we* may arrange for third-party dental service to provide *you* with discounts on goods and *services*. Some of these third-party dental service providers may make payments to *us* when these discount programs are used. These payments offset the cost to *us* of making these programs available and may help reduce the costs of *your* plan administration.

Who has responsibility for these discounts?

Although *we* have arranged for third parties to offer discounts on these goods and *services*, these discount programs are not insured *benefits* under the *policy*. The third-party providers are solely responsible for providing the goods and/ or *services*. *We* are not responsible for any goods and/ or *services* nor are *we* liable if vendors refuse to honor such discounts. Further, *we* are not liable for the negligent provision of such goods and/ or *services* by third-party service providers.

Discount programs may not be available to people who "opt out" of marketing communications, or where otherwise restricted by law.]

[Section [VIII]–Shared Savings

We have a Shared Savings Program that may provide *you* with savings if *we* obtain discounts from *dentists*. When *we* are able to obtain these discounts, *your deductible* and *coinsurance* will be calculated at the discounted amount.

You do not need to inquire in advance about a *dentist's* status. When processing *your* claim, *we* automatically will determine if the *dentist* was participating in the program at the time treatment was provided, and *we* will calculate *your deductible* and *coinsurance* on the discounted amount. *Your* Explanation of Benefits statement will reflect any savings received.

However, *you* may inquire in advance to determine if a *dentist* participates in the Shared Savings Program by calling [1-800-233-4013]. *Dentist* arrangements in the Shared Savings Program change constantly. *We* cannot guarantee that a *dentist* who is in the Shared Savings Program at the time of *your* inquiry will still be in the program at the time treatment is received. Discounts depend on availability on a claim by claim basis. Therefore, availability and discount amounts cannot be guaranteed.

We make no representations about the *dentists* participating in the Shared Savings Program. Additionally, *we* reserve the right to modify, amend or discontinue the Shared Savings Program at any time.]



[www.humanadental.com]

[Toll Free 800-233-4013]

[1100 Employers Blvd

Green Bay WI 54344]

Insured by HumanaDental Insurance Company

HumanaDental Insurance Company

AMENDATORY ENDORSEMENT

(Arkansas Residents Only)

This Amendatory Endorsement is attached to and made a part of your contract. It changes your coverage as follows:

A. Section II – Benefits, A. Your plan benefits, the following is hereby added:

State Required Benefits:

Coverage is provided for anesthesia and hospital or ambulatory surgical facility charges for services performed in connection with dental procedures in a hospital or ambulatory surgical facility if: (1) the provider treating the *covered person* certifies that because of the *covered person's* age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures; and (2) the *covered person* is: (a) a child under 7 years of age who is determined by two *dentists* to have a significantly complex dental condition; (b) *covered person* diagnosed with a serious mental or physical condition; or (c) a *covered person* with a significant behavioral problem as determined by his or her physician. Such coverage does not apply to TMJ.

B. Section III – Claims, the following changes are hereby made:

1. **A. How we pay claims, Paying Claims**, is deleted and replaced with the following:

Clean claims will be paid or denied within 30 days after receipt of claim filed electronically or within 45 days after receipt of claim submitted by other means. *We* shall notify *you* within 30 days after receipt of the claim if *we* determine that additional information is needed to process the claim. If *we* do not pay the claim or give notice that additional information is needed in order to process the claim, *we* shall pay a penalty to *you* for the period beginning on the 61st day after receipt of the clean claim and ending on the clean claim payment date, calculated as follows: the amount of the clean claim payment times 12% per annum times the number of days in the delinquent payment period, divided by 365.

Clean Claim means a claim for payment of a *covered expense* that is submitted on a HCFA 1500, on a UB92, in a format required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), or on *our* standard claim form with all required fields completed in accordance with *our* published claim filing requirements. A Clean Claim shall not include a claim (1) for payment of expenses incurred during a period of time for which premiums are delinquent, (2) for benefits under a Medicare supplement policy if the claim is not accompanied by an explanation of Medicare benefits or the Explanation of Medicare Benefits ("EOMB") has not been otherwise received by the Health Carrier, or (3) for which the Health Carrier needs additional information in order to resolve one or more of the issues listed in Subsection 13(b) of this rule.

2. **Recovery rights**, the following is added:

If *we* exercise recoupment, *we* will give the health care provider a written or electronic statement specifying the basis for the recoupment. The statement will provide the following information: (a) the amount of the recoupment; (b) the *covered person's* name to whom the recoupment applies; (c) the *covered person's* identification number; (d) date of date of service; (e) service or services on which the recoupment is based; (f) pending claims being recouped or future claims that will be recouped; and (g) specific reasons for the recoupment.

As used in this section, recoupment means any action or attempt by *us* to recover or collect payments already made to the health care provider with respect to a claim: (a) by reducing other payments currently owed to the health care provider; (b) by withholding or setting off the amount against current or future payments to the health care provider; (c) by demanding payment back from a health care provider for a claim already paid; or (d) by any other manner that reduces or affects the future claim payments to the health care provider.

C. Section IV – Eligibility, A. When you are eligible for coverage, Dependent coverage, Effective date, is hereby deleted and replaced with the following:

Effective date: Each *dependent's* effective date of coverage is determined as follows, subject to the *Dependent Delayed Effective Date* provision:

1. If *we* receive the application before the *dependent's* eligibility date, the *dependent* is covered on the date he or she is eligible.
2. If *we* receive the application within [31] days after the *dependent's* eligibility date:
 - A. The *dependent* is covered on the date *we* receive the completed application; or

- B. The *dependent* is covered on the date he or she is eligible if the *primary insured* already had *dependent* coverage in force.
3. The date *we* specify if *we* receive the completed application more than [31] days after the *dependent's* eligibility date.

Coverage for a newborn child born to *you* or a covered *dependent* will be effective from the moment of birth and will remain in force for 90 days. Coverage for a newborn child will be the same as coverage for all other *dependents*. Notification must be provided to *us* within 90 days of the newborn's date of birth and *you* must pay the required additional premium, if any, in order to have coverage for the newborn child continue beyond such 90 days.

Coverage for a newborn child of a covered *dependent* child will not extend beyond 18 months after birth.

Coverage for an adopted child or a minor under *your* charge, care and control for whom *you* have filed a petition to adopt, is effective upon the earlier of the date of placement for the purpose of adoption, or the date of the entry of an order granting the adoptive parent custody of the child for purposes of adoption. Coverage for such child will be the same as for all other *dependents*. Coverage will continue unless the placement is disrupted prior to legal adoption and the child is removed from placement. However, *you* must notify *us* in writing within 60 days of such placement for adoption or entry of an order and pay the required additional premium, if any, in order to have coverage for the adopted child continue beyond such 60 day period. A *dependent's effective date* cannot occur before the *primary insured's effective date* of coverage.

Section VI- Definitions of Dependent #4 has been replaced with the following:

Your dependent child who upon attainment of the limiting age while insured under the *policy* is and continues to be both incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the *primary insured* for support and maintenance. Proof of such incapacity and dependency must be furnished to *us* by the *primary insured* after the child's attainment of the limiting age. After 2 years from the date the first proof was furnished, *we* may not request such proof more often than annually. If satisfactory proof is not submitted to *us*, the child's coverage will not continue beyond the last date of eligibility.

This Amendatory Endorsement is subject to all of the exceptions, definitions and conditions of the contract not inconsistent herewith. In all other respects, your contract remains the same.



[Gerald L. Ganoni]
[President]



SERFF Tracking Number: HUMA-126890740 State: Arkansas
 Filing Company: Humana Dental Insurance Company State Tracking Number: 47212
 Company Tracking Number: AR-10-006 H1 DENV2
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
 Product Name: New H1 Dental Portfolio v2
 Project Name/Number: New H1 Dental Portfolio v2/New H1 Dental Portfolio v2

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: H1 Flesch Certification 2010v2.pdf	Approved-Closed	11/14/2010

	Item Status:	Status Date:
Satisfied - Item: Application Comments: The applications used will be: GR APP AR-72002 3/2009 which was approved under tracking number ICCI-126056991 on 5/20/2009.	Approved-Closed	11/14/2010

	Item Status:	Status Date:
Satisfied - Item: Statement of Variability Comments: Attachment: GN Statement of Variability 6-10.pdf	Approved-Closed	11/14/2010

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

Forms Included:
HUMD-ASSOC-CERT.002 6/10
HUMD-AEAR-209 10/10

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

11/4/2010
Date

Individual responsible for this filing:

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

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 bracketed 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 moved or omitted.
- The Waiting Period Options give alternate text to appear under Waiting Periods, 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, 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

{If a *you* enroll timely, {Preventive} {Basic} {Major} {and} {Orthodontic} Services may be subject to a {0-12}-month waiting period before *you* are eligible for coverage. {This {0-12}-month waiting period may 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 applies to *you*.} }

{Each *dependent* added after the effective date of the *member* is subject to a separate {0-12} month waiting period.}

Preventive Services:

{There are no *waiting periods* for Preventive Services.}

{Basic Services:}

{There are no *waiting periods* for 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 {0-12} continuous months before Basic Services will be covered.}

{Major Services}

{There are no *waiting periods* for Major Services.}

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

{*You* must be insured under this policy for a period of {0-12} continuous months before Major Services will be covered.} {Endodontic services are only subject to the *waiting period* if *you* are a *late applicant*.}

{Orthodontic Services:}

{There are no *waiting periods* for Orthodontic Services.}

{Orthodontic 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 Orthodontic Services will be covered.}

Summary of Your Benefits Variable Options

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

\$1000 to \$5000

Individual Calendar Year, Plan Year, or Lifetime Deductible:

\$0 to \$250

Maximum Family Deductible:

\$0 to \$500

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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	Oral surgery	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.