

SERFF Tracking Number: HUMA-126372325 State: Arkansas  
Filing Company: Humana Dental Insurance Company State Tracking Number: 44894  
Company Tracking Number: AR-CBIC TO HDIC MERGER  
TOI: H20G Group Health - Vision Sub-TOI: H20G.000 Health - Vision  
Product Name: AR-CBIC to HDIC Merger  
Project Name/Number: AR-CBIC to HDIC Merger/AR- CBIC to HDIC Merger

## Filing at a Glance

Company: Humana Dental Insurance Company

Product Name: AR-CBIC to HDIC Merger

TOI: H20G Group Health - Vision

Sub-TOI: H20G.000 Health - Vision

Filing Type: Form

Implementation Date Requested:

State Filing Description:

SERFF Tr Num: HUMA-126372325 State: Arkansas

SERFF Status: Closed-Approved-  
Closed State Tr Num: 44894

Co Tr Num: AR-CBIC TO HDIC  
MERGER State Status: Approved-Closed

Reviewer(s): Rosalind Minor  
Authors: Erin Hermsen, Paula  
Konop, Tina Huettl, Christi Conrad

Date Submitted: 02/16/2010

Disposition Date: 02/17/2010

Disposition Status: Approved-  
Closed

Implementation Date:

Implementation Date:

## General Information

Project Name: AR-CBIC to HDIC Merger

Project Number: AR- CBIC to HDIC Merger

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 02/17/2010

Deemer Date:

Submitted By: Christi Conrad

Filing Description:

Dear Sir/Madam:

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments: N/A

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Employer

Explanation for Other Group Market Type:

State Status Changed: 02/17/2010

Created By: Christi Conrad

Corresponding Filing Tracking Number:

We respectfully submit for your approval the attached forms. These forms were originally approved by your department on April 24, 2002 under CompBenefits Insurance Company. We are pursuing approval of these forms for use by HumanaDental Insurance Company.

It is our intention to market these plans to employer groups, large and small, in the state of Arkansas under

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HumanaDental Insurance Company.

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

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 5083, or via SERFF.

Sincerely,  
HUMANADENTAL INSURANCE COMPANY

Erin J. Hermsen  
Specialty Benefits Compliance Consultant

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	

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## Filing Fees

Fee Required?	Yes
Fee Amount:	\$300.00
Retaliatory?	No
Fee Explanation:	\$50 per form. 6 forms x \$50= \$300.00

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Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Humana Dental Insurance Company	\$300.00	02/16/2010	34232879

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/17/2010	02/17/2010

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## **Disposition**

Disposition Date: 02/17/2010

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	Actuarial memo	Approved-Closed	No
Form	Group Vision Policy	Approved-Closed	Yes
Form	Group Vision Certificate	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	Safety Glasses Rider	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	Domestic Partner Rider	Approved-Closed	Yes
Rate	Rate Manual	Approved-Closed	No
Rate	Rate Exhibits	Approved-Closed	No
Rate	Rate Exhibit 10	Approved-Closed	No

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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 02/17/2010	VGRP- POLICY.00 2 12/09	Policy/Cont ract/Fratern al Certificate	Group Vision Policy	Initial			01 GN HD VCP Policy 12-09.pdf
Approved- Closed 02/17/2010	VGRP- CERT.002 AR 12/09	Certificate	Group Vision Certificate	Initial			02 AR HD VCP GrpCert 12-09.pdf
Approved- Closed 02/17/2010	VIS-SCH 12/09	Schedule Pages	Schedule of Benefits	Initial			03 GN HD VCP Schedule 12- 09.pdf
Approved- Closed 02/17/2010	SFGL-RDR 12/09	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Safety Glasses Rider	Initial			04 GN HD VCP SafetyGlasse s 12-09.pdf
Approved- Closed 02/17/2010	VIS-SCH- VALU 12/09	Schedule Pages	Schedule of Benefits	Initial			05 GN HD VCP Sch Value 12- 09.pdf
Approved- Closed 02/17/2010	DOMPART 0900	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Domestic Partner Rider	Initial			06 GN HD VCP Domestic Partner Rider.pdf

**HUMANADENTAL INSURANCE COMPANY**

[100 Mansell Court East

Roswell, GA 30076

(800) 865-3676]

**Group Vision Insurance Policy**

POLICYHOLDER: [ABC Corp. ]  
POLICY NUMBER: [123456 ]  
POLICY EFFECTIVE DATE: [October 1, 2000 ]  
CONTRACT PERIOD: [October 1 - September 30 ]  
STATE OF DELIVERY: [STATE ]

**Read Your Policy Carefully**

This Policy is a legal contract between the Policyholder and [HumanaDental](#) Insurance Company (hereinafter referred to as "[HumanaDental](#)"). The consideration for this contract is the group application and the payment of premiums as provided hereinafter.

**Agreement**

This Policy is the entire contract with the Policyholder and [HumanaDental](#). This Policy shall be effective for an initial term of [twelve months] from the Policy Effective Date and continuing thereafter for periods of [twelve months] each until terminated by either party upon [30 days] written notice prior to the anniversary date or as otherwise specified in the Policy. Only authorized officers may make changes for [HumanaDental](#). Such changes must be in writing and attached to this Policy. [HumanaDental](#) reserves the right to amend the Policy from time to time. [HumanaDental](#) will pay, with respect to each Insured, the insurance benefit provided in this Policy. Payment is subject to the conditions, limitations and exceptions of this Policy. Eligibility requirements to be insured under this Policy are stated in the section entitled Becoming Insured. This Policy is governed by the laws of the state shown above.

**Certificates**

[HumanaDental](#) will furnish a Certificate for each Insured person which will contain the benefits provided by this Policy.

**Incorporation Provision**

The provisions of the attached Certificate and all rider(s) issued to amend this Policy after the effective dates are made a part of this Policy. This Policy was signed by the Policyholder on the Group Application form. We sign here on behalf of [HumanaDental](#).

Gerald L. Ganoni  
President

**HUMANADENTAL INSURANCE COMPANY**

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[100 Mansell Court East

Roswell, GA 30076

(800) 865-3676]

**CERTIFICATE  
OF  
GROUP VISION INSURANCE**

This Certificate outlines the features of the Group Vision Insurance Policy issued to the Policyholder by **HumanaDental** Insurance Company (hereinafter referred to as “**HumanaDental**”). Read it carefully to become familiar with Your coverage. In this Certificate, the masculine pronouns include both masculine and feminine gender unless the context indicates otherwise. Your coverage may be terminated or amended in whole or in part under the terms and provisions of the Policy.

If you should have any questions, or to obtain coverage information or assistance in resolving complaints, please call [(800) 865-3676].

Signed for **HumanaDental** Insurance Company

[  
]  
[Gerald L. Ganoni}  
[President]

## SECTION I- DEFINITIONS

**Copayment-** means the amount an Insured is required to pay when a covered service is rendered or covered Materials are purchased.

**Dependent-** means any of the following persons:

1. Your spouse;
2. Your unmarried child;
  - a) from birth to age [19-32] and dependent upon You for support;
  - b) [19-32] years of age but under [25-32] years of age, if a full-time student dependent upon You for support; or
  - c) at least [19] years of age and:
    - i. primarily dependent upon You for support because of mental or physical handicap;
    - ii. was incapacitated and insured under Policy on his 19<sup>th</sup> birthday; and
    - iii. continues to be incapacitated beyond his 19<sup>th</sup> birthday.

A "full-time student" means a student enrolled for at least 12 semester hours for credit in an accredited college. For a trade school, enrollment must be in a course requiring attendance of 20 or more hours weekly for 6 or more months. A child also includes adopted children, as well as stepchildren or foster children living with the Subscriber in a parent-child relationship

**Group-** means the aggregate of individuals eligible to be covered under the Policy. Group also refers to the subgroup participating under the Policy for the benefit of its group members.

**Insured-** means You and Your Dependent(s) covered under the Policy.

**Materials-** means lenses, frame and contact lenses covered under the Policy.

**Non-VisionCare Plan Network Provider-** means any provider who is NOT under agreement with the VisionCare Plan Network.

**Policy-** means the Policy issued to the Policyholder.

**Policyholder** – means the Group to whom the Policy has been issued.

**Schedule of Benefits** - means the listing of benefits showing what is paid.

“You” and “Your” means the Certificateholder.

**VisionCare Plan Network-** means jointly and severally the VisionCare Plan Network Providers under agreement with Us to provide certain vision services to individuals at contracted rates and terms.

**VisionCare Plan Network Provider-** means a provider under agreement with VisionCare Plan Network.

“We”, “Our”, “Us”, and "Plan" means [HumanaDental Insurance Company](#).

## SECTION II-BECOMING INSURED

Your Coverage Begins- You and Your Dependents are covered at 12:01 a.m. on the later of:

1. [The first of the month following the date first eligible for coverage];
2. The date We accept Your enrollment, if You are not enrolled within 30 days of becoming eligible;
3. The date You first acquire a new Dependent;
4. The date We accept a Dependent’s enrollment, if he is not enrolled within 30 days of becoming eligible.

**Newborn Child-** A child born to You or Your Dependent spouse is covered from the moment of birth for 90 days. If you choose to insure Your newborn, You must enroll the child within 90 days from the date of birth and pay the additional premium, if any, or coverage for that child will terminate at the end of the 90-day period.

**Adopted Child-** A child placed with You for adoption will be covered from the earlier of: 1) the date of birth if a petition for adoption is filed within 60 days of the birth of such child; 2) the date you gain custody of the child under a temporary court order that grants You conservatorship of the child; or 3) the date the child is placed with You for adoption; and additional premium, if any, is paid.

**Your Coverage Ends-** Coverage for You and/or Your Dependent will end at 12:01 a.m. on the earlier of:

1. On the date the Policyholder tells Us that You and/or Your Dependent cease to be eligible for coverage;
2. [The last day of the month] [The date] in which Your Dependent is no longer a Dependent as defined;
3. Subject to the Grace Period provision, the last day of the month for which a premium has been paid; or
4. The date coverage ends for any class or Group to which You belong; or
5. The date the Policy ends.

If Your coverage ends it will not prejudice any existing claim. If service is being rendered at the time coverage ends for an Insured, We will continue to reimburse for such service to completion, but in no event beyond a 3-month period following the date coverage ended.

### **SECTION III-PROCEDURES FOR USING BENEFITS**

**Provider Choice** - The Insured may elect to receive services and Materials from either a VisionCare Plan Network Provider or a Non-VisionCare Plan Network Provider of his or her choice. [Additionally, the Insured may choose between either the Benefit Form Method or the Dash Method each time prior to services being received.]

#### **[Benefit Form Method]**

[Prior to obtaining vision care, an Insured [may][must] request a Benefit Form. Benefit Forms may be obtained by: (i) calling the Member Services department at [1-800-865-3676]; (ii) contacting Our Website at <http://www.visioncare.com>; or (iii) by completing the form entitled "Request for Vision Care" supplied by Us and faxing it toll free to [1-800-421-0100] or mailing it to Us at [P.O. Box 30349, Tampa, FL 33630-3349]. Upon determination that the Insured is eligible, a Benefit Form will be sent to the Insured together with a list of VisionCare Plan Network Providers for the Insured's area. **CAUTION: Do not make an appointment for services until the Benefit Form is received.**

The Insured then selects a provider from the list of VisionCare Plan Network Providers delivered with the Benefit Form and makes an appointment for services directly with the provider's office. It is important to give the VisionCare Plan Network Provider the Benefit Form at the time of the first visit. If the Insured does not obtain the Benefit Form in advance, but visits the VisionCare Plan Network provider as a private patient, the provider is not obligated to accept Our fees as full payment for services and may elect to charge the Insured his usual and customary fees. **CAUTION: Services must begin prior to the expiration date noted on the Benefit Form.**

Upon completion of the initial examination, the VisionCare Plan Network Provider will require that the Insured sign the Benefit Form. At this time, the Insured is required to pay the VisionCare Plan Network Provider the Copayment, if any, and the costs and fees associated with services or materials NOT covered by the Policy. The VisionCare Plan Network Provider will process the Benefit Form and submit it to Us.

In the event the Insured receives a prescription for corrective eyewear from the examining VisionCare Plan Network Provider, he may obtain Materials from that provider or another VisionCare Plan Network Provider. ]

#### **[Dash Method]**

[Just before scheduling an appointment for vision care, the Insured must choose a VisionCare Plan Network Provider from the list of the network providers in the Insured's area. The Insured must call to schedule an appointment and give the VisionCare Plan Network Provider his/her name, the patient's name, ID number, Group number and the name of the Group. After scheduling the appointment, the VisionCare Plan Network Provider's office verifies the Insured's eligibility and benefits before performing the exam. Upon completion of the exam, the VisionCare Plan Network Provider has the Insured sign a claim Form. The VisionCare Plan Network Provider

submits the form directly to the Plan for payment according to the VisionCare Plan Network Provider's agreement with the Plan. The Insured is responsible for any applicable Copayment and any extra costs for services and materials not covered by the Plan.]

**Using a Non-VisionCare Plan Network Provider** - When an Insured elects to obtain services or purchase Materials from a Non-VisionCare Plan Network Provider, payment of benefits are based upon the VisionCare Plan Network allowance after deduction of the Copayment. The allowance and Copayment are shown in the Schedule of Benefits. The Insured may pay the Non-VisionCare Plan Network Provider in full for any service and/or Materials at the time the service is rendered or the Materials are provided and then submit to Us an itemized statement of charges. The Insured is responsible for payment of the Copayment, the costs and fees associated with covered services or Materials in excess of the allowance as shown in the Schedule of Benefits, and any services or materials NOT covered by the Policy.

## **SECTION IV-LIMITATIONS AND EXCLUSIONS**

**Limitations-** In no event will coverage exceed the lesser of:

1. The actual cost of covered services or Materials;
2. The limits of the Policy, shown in the Schedule of Benefits; or
3. The allowance as shown in the Schedule of Benefits.

Materials covered by the Policy that are lost or broken will only be replaced at normal intervals as provided for in the Schedule of Benefits.

We will pay only for the basic cost for lenses and frames covered by the Policy. The Insured is responsible for extras selected, including but not limited to:

1. Blended lenses;
2. Progressive multifocal lenses;
3. Photochromatic lenses; tinted lenses, sunglasses, prescription and plano;
4. Coating of lens or lenses;
5. Laminating of lens or lenses;
6. Groove, Drill or Notch, and Roll and Polish;  
unless otherwise specifically listed as a covered benefit in the Schedule of Benefits.

**Exclusions-** We will not cover:

1. Orthopic or vision training and any associated supplemental testing;
2. Two pair of glasses, in lieu of bifocals, trifocals or progressives;
3. Medical or surgical treatment of the eyes;
4. Any services and/or materials required by an Employer as a condition of employment;
5. Any injury or illness covered under any Workers' Compensation or similar law;
6. Sub-normal vision aids, aniseikonic lenses or non-prescription lenses;
7. Charges incurred after: (a) the Policy ends; or (b) the Insured's coverage under the Policy ends, except as stated in the Policy;
8. Experimental or non-conventional treatment or device;
9. Contact lenses, except as specifically covered by the Policy;
10. Hi Index, aspheric and non-aspheric styles;
11. Oversized 61 and above lens or lenses;
12. Cosmetic items, unless otherwise specifically listed as a covered benefit in the Schedule of Benefits.

## **SECTION V-COORDINATION WITH OTHER BENEFITS**

## 1. APPLICABILITY.

This Coordination With Other Benefits provision applies to This Plan when You or Your covered dependents have vision care coverage under more than one Plan. For the purposes of this section only, "Plan" and "This Plan" are defined below. If this provision applies, the Order of Benefit Determination Rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan: (a) will not be reduced when, under the Order of Benefit Determination Rules, This Plan determines its benefits before another Plan; but (b) may be reduced when, under the Order of Benefit Determination Rules, another Plan determines its benefits first. The above reduction is described in Section 4, Effect on the Benefits of This Plan.

## 2. DEFINITIONS.

A "Plan" is any group insurance or group type insurance, whether insured or uninsured, which provides benefits for, or because of, vision care or treatment. This also includes 1) group or group-type coverage through HMOs and other prepayment, group practice and individual practice plans; and 2) group coverage under labor-management trusteed plans, union welfare plans, employer organization plans, employee benefit organization plans or self insured employee benefit plans. It does not include school accident type coverages, coverage under any governmental plan required or provided by law, or any state plan under Medicaid. Each contract or other arrangement for coverage is a separate Plan. Also, if an arrangement has two parts and coordination applies only to one of the two, each of the parts is a separate Plan.

"This Plan" means this Policy.

"Primary Plan"/"Secondary Plan". The Order of Benefit Determination Rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person. When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits. When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits. When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

"Allowable Expenses" means the allowed amount as shown in the Schedule of Benefits.

"Claim Determination Period" means a benefit year. However it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this provision or a similar provision takes effect.

## 3. ORDER OF BENEFIT DETERMINATION RULES.

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

- (a) The benefits of the Plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary, Medicare is secondary to the Plan covering the person as a dependent and primary to the Plan covering the person as other than a dependent, then the benefits of the Plan covering the person as a dependent are determined before those of the Plan covering that person as other than a dependent. Except in the case of legal separation or divorce (further described below), when This Plan and another Plan cover the same child as a dependent of different persons, called "parents":
  - (1) the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but
  - (2) if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time. However, if the other Plan does not have the rule described immediately above, and if, as a result, the Plans do not agree on the Order of Benefits, the rule in the other Plan will determine the order of benefits.
- (b) If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order: (1) first, the Plan of the parent with custody of the child; (2) then, the Plan of the spouse of the parent with custody of the child; and (3) finally, the Plan of the parent not having custody of the child. However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has

actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

- (c) The benefits of a Plan which covers a person as an employee who is neither laid off, retired or continuing coverage under a right of continuation (or as a dependent of the person) are determined before those of a Plan which covers that person as a laid off, retired or continuing coverage (or as a dependent of that person). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the Order of Benefits, this rule is ignored.
- (d) If none of the above rules determines the Order of Benefits, the benefits of the Plan which covered an employee, member, or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

#### 4. EFFECT ON THE BENEFITS OF THIS PLAN.

This section applies when, in accordance with Section 3. Order of Benefit Determination Rules, This Plan is a Secondary Plan to one or more other Plans. In the event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the Other Plans".

The benefits of This Plan will be reduced when the sum of: (a) the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this provision; and (b) the benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this provision, whether or not claim is made; exceeds those Allowable in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the Other Plans do not total more than those Allowable Expenses. When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

#### 5. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

Certain facts are needed to apply these rules. [HumanaDental](#) has the right to decide which facts are needed. [HumanaDental](#) may get needed facts from, or give them to, any other organization or person. [HumanaDental](#) need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give [HumanaDental](#) any facts deemed necessary to pay the claim.

#### 6. FACILITY OF PAYMENT.

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, [HumanaDental](#) may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. [HumanaDental](#) will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case, "payment made" means reasonable cash value of the benefits provided in the form of services.

#### 7. ERRORS RELATED TO YOUR COVERAGE.

The Plan has the right to correct benefit payments made in error. Providers and/or You have the responsibility to return any overpayments to the Plan. The Plan has the responsibility to make additional payment if any underpayments have been made.

### **SECTION VI-PREMIUMS**

**Premium Payments** - All premiums are payable in advance for coverage under the Policy on the first day of each calendar month in accordance with the premium rate schedules of [HumanaDental](#) in effect for each premium due date.

**Grace Periods** - A grace period of [31] days is allowed for payment of each premium due after the first premium, during such grace period the Policy shall continue in force, unless the Group has given the Plan written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the Policy. If any premium is not paid prior to the end of the grace period, the coverage to which the premium applies will lapse at the end of the grace period. We will charge a pro-rata premium for the time coverage under the Policy remained in force for any Group during such grace period.

**Change in Premiums** - Premiums are payable to [HumanaDental](#) or Our authorized agent. Premiums may be increased for a Policy period on the anniversary date of the Policy. Notice of the maximum amount of a premium increase will be mailed to the Policyholder not less than [60] days prior to the anniversary of the Policy period.

**Reinstatement** - If any renewal premium is not paid within the time granted the Policyholder for payment, a subsequent acceptance of premium by [HumanaDental](#) or by any agent authorized by [HumanaDental](#) to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, that if [HumanaDental](#) or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by [HumanaDental](#), or lacking approval, upon the forty-fifth day following the date of such conditional receipt unless [HumanaDental](#) has previously notified the Policyholder in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after such date. In all other respects, the Policyholder and [HumanaDental](#) shall have the same rights thereunder as they had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

**Termination** - This Policy may be terminated if [HumanaDental](#) elects to discontinue offering this type of group insurance coverage by this form of Policy or if [HumanaDental](#) elects to discontinue all types of coverage, in accordance with applicable state and federal laws. You will receive at least one hundred-eighty (180) days advance notice prior to such discontinuance. Unless otherwise permitted under state law, except for nonpayment of the required premium or the failure to meet continued underwriting standards, [HumanaDental](#) will not terminate this Policy prior to the first anniversary date of the Effective Date of the Policy as specified herein. Termination by [HumanaDental](#) will be without prejudice to any expenses originating prior to the effective date of termination.

This section does not apply to a termination for nonpayment of premium by the Policyholder. In the event that the Policyholder fails in a timely manner to pay premiums, the Policy will terminate on the last date for which premium was paid.

## **SECTION VII-CLAIMS**

**Notice of Claim** - Written notice of claim must be given to Us within 60-days after the occurrence or commencement of loss covered by the Policy, or as soon thereafter as reasonably possible. Notice given by or on behalf of You or Your beneficiary to Us at [P.O. Box 30349, Tampa, FL 33630-3349], or to Our authorized agent, with information sufficient to identify the Insured, shall be deemed notice to Us.

**Claim Forms-** You can get the forms You need for claiming benefits by calling Us at [(800) 865-3676] or writing Us at [P.O. Box 30349, Tampa, FL 33630-3349]. If the forms are not sent to You before the expiration of 15 days after the giving of notice, You shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made.

**Time of Payment of Claims** - Indemnities payable under this Policy for any loss, other than loss for which the Policy provides any periodic payment, will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which the Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

**Proof of Loss** – Written proof of loss must be furnished to Us at [P.O. Box 30349, Tampa, FL 33630-3349] in the case of claim for loss for which the Policy provides any periodic payment contingent upon continuing loss within 90-days after the termination period for which We are liable and, in the case of claim for any other loss, within 90-days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon

as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

**Questions or Concerns** – If We at HumanaDental Insurance Company fail to provide You with reasonable and adequate service, You should feel free to contact:

Arkansas Insurance Department  
1200 West Third Street  
Little Rock, AR 72201  
(501) 371-2640 or (800) 852-5494

**Legal Action** - No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

### **SECTION VIII- NOTICE OF CONTINUATION OF GROUP HEALTH COVERAGE RIGHTS (COBRA) FOR GROUPS SIZE 20 OR MORE**

If Your insurance terminates in accordance with the other terms of this Policy, it will be reinstated as of the date of termination if You elect to continue the insurance in force as described in this section. You may elect to continue insurance if You are currently insured under this Policy, and if such insurance is terminating due to any of the following Qualifying Events:

1. Termination of Your employment (for reasons other than gross misconduct);
2. Reduction of work hours including lay-off;
3. Death of the Certificateholder;
4. Divorce or legal separation;
5. A child ceases to be a dependent as defined in this Policy;
6. The Policyholder files for a Chapter 11 bankruptcy petition, and as a result to this You suffer a loss of coverage under Your retiree coverage.

The maximum continuation of coverage period with respect to a reason described above is: (1) 18 months with respect to 1 or 2 above. However, if You are disabled as determined under Title II or XVI of the Social Security Act at the time of the Qualifying Event or any time during the first 60 days of continuation coverage, then You and any other non-disabled eligible individuals will be eligible for an additional 11 months; (2) 36 months with respect to 3, 4 or 5 above; (3) With respect to 6 above, lifetime coverage for You, whereas Your Dependents will be covered until the earlier of: (a) Your death; or (b) death of the Dependent. If, while insurance is being continued, further qualifying events occur which would entitle You to again elect continuation, the total period of continuation may not exceed 36 months from the date the initial continuation commenced, other than the coverage due to bankruptcy filing as described above.

It is Your responsibility to notify the [Policyholder] of the occurrence of a Qualifying Event other than termination of employment or reduction in work hours. You must notify the [Policyholder] within 60 days.

It is the responsibility of the [Policyholder] to provide You with written notice of Your right to continue coverage under this Section. Such notice will also contain the amount of monthly premium You must pay to continue coverage and the time and manner in which such payments must be made.

To continue coverage under this Policy You must notify the [Policyholder] of Your election within 60 days of the latest of: (1) the date of Qualifying Event; (2) the date of the loss of coverage; or (3) The date the [Policyholder] sends notice of the right to continue coverage.

Payment for the cost of insurance for the period preceding the election must be made to the [Policyholder] within 45 days after the date of such election. Subsequent payments are to be made to the [Policyholder] in the manner described by the [Policyholder] in the notice. [The Policyholder will remit the payments to [HumanaDental](#).]

Continuation of insurance will terminate at the earliest of the following dates: (1) The end of the maximum continuation of coverage period; (2) The last day of the period of coverage for which premiums have been paid, if

You fail to make a premium payment when due; (3) Your becoming covered under another group vision care plan as employee, spouse or dependent child; however, coverage will continue for a pre-existing condition for which treatment has already commenced and which is excluded or limited by the other group vision plan; (4) Discontinuance of this vision care benefit provision; or (5) The date Your employer ceases to provide any group vision plan.

## **SECTION IX-GENERAL PROVISIONS**

**Representations and Warranties** - All statements made by any Insured or the Group are deemed representations and not warranties. No statement made by any person insured may be used in any contest unless a copy of the instrument containing the statement is or has been furnished to You, or in the event of Your death or incapacity, Your beneficiary or personal representative.

**Worker's Compensation Act** - The coverage under the Policy is not in lieu of and does not affect any requirement for coverage by any Worker's Compensation Act, or other similar legislation.

**Conformity with State Statutes** - Any provision of the Policy which, on its effective date, is in conflict with the statutes of the state in which the Insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

**Time Limit on Certain Defenses** - After the Policy has been in force for a period of two (2) years during the lifetime of the Insured, excluding any period during which the Insured is disabled, it shall become incontestable as to the statements contained in the application.

**Notice of Independent Contractor Relationship** – The Plan assumes responsibility of fulfilling the terms of this Certificate. VisionCare Plan Network Providers are independent contractors, and the Plan cannot be held responsible for any damages incurred as a result of tort, negligence, breach of contract, or malpractice by a VisionCare Plan Network Provider for any damage which results from any defective or dangerous condition in or about any facility which services are rendered or materials are provided hereunder.

**HUMANADENTAL INSURANCE COMPANY**  
**[100 Mansell Court East, Suite 400 Roswell, GA 30076]**

**SCHEDULE OF BENEFITS**

**Vision Examinations** - Each Insured is eligible for a comprehensive eye examination which shall include: 1) personal and family medical and ocular history; 2) visual acuity (unaided or acuity with present correction); 3) external exam; 4) pupillary exam; 5) visual field testing (confrontation); 6) internal exam (direct or indirect ophthalmoscopy recording cup disc ratio, blood vessel status and any abnormalities; 7) biomicroscopy (i.e. cover test); 8) tonometry; 9) refraction (with recorded visual acuity); 10) extra ocular muscle balance assessment; 11) diagnosis and treatment plan. We will cover such service once [in any [12] month period].

**Materials** - Where the vision examination shows new lenses or frames or both are necessary for proper visual health, such Materials will be covered, together with certain services as necessary. Services include, but are not limited to: (1) prescribing and ordering proper lenses; (2) assisting with selection of frames; (3) verifying accuracy of finished lenses; (4) proper fitting and adjustments.

**Lenses** - One pair of prescription lenses once [in any [12] month period]. [Benefit is only available after Insured has been covered under the Plan for [12 consecutive] months.]

[The following lens options are covered [after the applicable additional Copayment]. The VisionCare Plan Network Provider will show the Insured the lens options that the Plan covers. [Benefit is only available after Insured has been covered under the Plan for [12 consecutive] months.]:

[Level I progressive lenses: [\$10 Copayment]]  
[Level II progressive lenses: [\$10 Copayment]]  
[Level III progressive lenses: [\$10 Copayment]]  
[Level IV progressive lenses: [\$10 Copayment]]  
[Tinted lenses: [type] [\$10 Copayment]]  
[Coatings: [type] [\$10 Copayment]]  
[Photochromatic: [type] [\$10 Copayment]]  
[Non-Aspheric Styles: [type] [\$10 Copayment]]  
[Aspheric Styles: [ type] [ \$10 Copayment]]  
[Polarized Styles: [ type] [ \$10 Copayment]]  
[Other Lens Styles: [type] [ \$10 Copayment]]

**Frames** - One new frame once [in any [24] month period]. The VisionCare Plan Network Provider will show the Insured the frames that the Plan covers in full. VisionCare Plan Providers can also order any currently provided frame that an Insured may find elsewhere. If an Insured selects a frame that costs more than the amount the Plan covers, the Insured is responsible for the difference in cost. [Benefit is only available after Insured has been covered under the Plan for [12 consecutive] months.]

**Contact lenses when necessary** – One pair of contact lenses under the following circumstances and only if prior authorization from the Plan is obtained: 1) following cataract surgery without intraocular lens; 2) correction of extreme visual acuity problems not correctable with glasses; 3) Anisometropia greater than 5.00 diopters and asthenopia or diplopia, with spectacles; 4) Keratoconus; or 5) monocular aphakia and/or binocular aphakia where the doctor certifies contact lenses are medically necessary for safety and rehabilitation to a productive life. Replacement will not be more often than once [in any [12] month period] and only if prior authorization is obtained from the Plan. [The Copayment is waived].

**[Contact lenses when elective -** We will cover the combined cost of an annual vision exam, contact lens evaluation exam, fitting costs and contact lenses up to a maximum of [\$120.00]. [Payment will be IN LIEU OF ALL OTHER BENEFITS.] Replacement will not be more often than once [in any [12] month period]. [The Copayment is waived.]

**[Contact lenses when elective -** Benefits include: [[1]) the cost of an annual vision examination [and any fitting costs[and [one] follow-up visit[s]]]. Such benefit is [subject to] [not subject to] the Copayment;] [ [(2)] the cost of contact lenses available from a selection provided by a VisionCare Plan Network Provider [subject to] [not subject to] the Copayment]; [[and][or] [3]) the cost of contact lenses [and any fitting cost [and follow-up visit]]up to a maximum of [\$105.00] [subject to] [not subject to] the Copayment.] [This benefit is in lieu of all other benefits and not available when benefits for eyeglasses are received [except for the costs of fitting [and follow-up visit] for contact lenses].] Replacement will not be more often than once [in any [12] month period].]

**[Low Vision –** An Insured who has severe visual problems that are not correctable with regular lenses as diagnosed by a Ophthalmologist or Optometrist is entitled to Low Vision services subject to prior approval by the Plan.

Low Vision is a condition where the usual frame is not adequate to support the larger or thicker lenses need for correction and, therefore, a special apparatus must be built to support the lenses on the patient’s head. Low Vision benefits include ophthalmic materials or other aids prescribed by the Ophthalmologist or Optometrist and pre-approved by the Plan.

- A. Supplementary Testing – Benefits for supplementary testing include a complete Low Vision analysis and diagnosis including a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.
- B. Supplemental Care – Subsequent Low Vision therapy as necessary and appropriate.
- C. Copayment – When the Insured receives pre-approved Low Vision services and materials from a VisionCare Plan Network Provider, the Insured is only responsible for a Copayment of [25%] of the VisionCare Plan Network Provider’s contracted fee.

If the Insured chooses to receive pre-approved Low Vision services and materials from a Non-VisionCare Plan Network Provider, reimbursement will be based upon an amount not to exceed the contracted fee (after deduction of the Copayment) the Plan would have paid a VisionCare Plan Network Provider for the same services and materials. The Insured is responsible for Copayment and any difference between the Non-VisionCare Plan Network Provider’s billed charges and the reimbursement amount.

- D. Benefit Maximum – The maximum benefit for all Low Vision services and materials combined is [\$1,000] ([excluding] [including] Copayment) every [2 years].]

**Co-Payment -** An Insured's Co-payment is:

- 1. Vision Examination {for covered persons age {6} and younger} [\$0-15]
- 2. [Materials [\$15]]  
[Lenses [\$10]]  
[Frames [\$15]]

**Allowance** – Vision benefits received from Non-VisionCare Plan Network Providers will be reimbursed according to the following schedule [after deduction of the applicable Co-payment].

Vision Examination	[\$35]
Single Vision Lens	[\$25]
Bifocal Lens	[\$40]
Trifocal Lens	[\$60]
Lenticular Lens	[\$100]
Contact Lenses when elective	[\$105]
Contact Lenses when necessary	[\$210]
Frame	[\$40]
[Lens style option	[\$100]]

**WHEN COVERED SERVICES ARE OBTAINED FROM A VISIONCARE PLAN NETWORK PROVIDER, THE INSURED IS ONLY RESPONSIBLE FOR THE CO-PAYMENT AMOUNT LISTED ABOVE.**

**WHEN SERVICES ARE OBTAINED FROM A NON-VISIONCARE PLAN NETWORK PROVIDER, PAYMENT OF BENEFITS ARE BASED UPON THE VISIONCARE PLAN ALLOWANCE [AFTER DEDUCTION OF THE CO-PAYMENT LISTED ABOVE].**

## **SAFETY GLASSES RIDER**

This rider is made part of the Certificate to which it is attached. It is subject to all provisions, definitions, conditions, exclusions and limitations of the Certificate which do not conflict with this rider. If any conflicts occur, the provisions of this rider will apply.

This rider takes effect [on the date Your coverage begins] [after You have been covered under the Certificate for [12 consecutive] months] and will continue in force until the Certificate to which it is attached terminates or otherwise terminated by the Policyholder.

**Safety Glasses** – If You require safety eyewear due the nature of Your work, You are eligible for safety glasses as specified herein. Dependents are not eligible for safety eyewear. Materials must be certified as safe for a work environment by meeting the necessary test requirements as set forth by ANSI (American National Standards Institute).

- A. LENSES – The lenses for safety glasses must meet the following conditions:
1. be no less than 3mm at the thinnest point;
  2. be impact tested with a one-inch steel ball dropped from a height of 50 inches; and
  3. be engraved by the manufacturer that it is a safety lens.

Replacement will not be more often than once [in any [24] month period].

- B. FRAMES – The frames for safety glasses must meet the following conditions:
1. have a Z-87 stamp on the front and temples; and
  2. be constructed, so that, if impacted from the front, the lens will not come out the back of the frame.

Replacement will not be more often than once [in any [24] month period].

- C. COPAYMENT – When You receive Your safety glasses from a VisionCare Plan Network Provider, You are only responsible for the applicable copayment. The VisionCare Plan Network Provider will show You the frames the Plan covers in full after the copayment. If you select a frame that costs more than the amount the Plan covers, You will be responsible for the difference in cost in addition to the copayment.

Frame	[\$30] copayment
Lenses	[\$10] copayment

- D. ALLOWANCE – When You receive Your safety glasses from a Non-VisionCare Plan Network Provider, payment of benefits are based upon the allowance [after deduction of the applicable copayment]. You are responsible for [your copayment and] any charges in excess of the allowance.

Frame	[\$40] allowance
Lenses	[\$20] allowance

## SCHEDULE OF BENEFITS

**Vision Examinations** - Each Insured is eligible for a complete analysis of the eyes and related structures to determine vision problems and other abnormalities, which shall include: 1) personal and family history; 2) visual acuity (unaided or acuity with present correction); 3) external exam; 4) pupillary exam; 5) visual field testing (confrontation); 6) internal exam (direct or indirect ophthalmoscopy recording cup disc ratio, blood vessel status and any abnormalities; 7) biomicroscopy (binocular or monocular); 8) tonometry; 9) refraction (with recorded visual acuity); 10) extra ocular muscle balance assessment; 11) diagnosis and treatment plan. We will cover such service once [in any [12] month period] when provided by a VisionCare Plan Network Provider. [An Insured's Co-payment is [\$10] for a Vision Examination.]

**[Materials** – Lenses and frames are available through the VisionCare Plan Network Provider at a [20%] discount from the retail price.]

**[Lenses** - Lenses are covered through the VisionCare Plan Network Provider subject to the following Copayments paid by the Insured:

Single Vision	[\$35]
Bifocal	[\$55]
Trifocal	[\$90]
Lenticular	[\$90]]

**[Frames** – The Insured may choose from a selection of eyewear offered through the Vision Care Plan Network Provider with a [\$25] Copayment. Other frames are available at a [20%] discount from the retail price.]

**[Complete Eyewear** - Includes lenses and frames, from a selection offered through the Vision Care Plan Network Provider with a [\$49] Copayment. Eyewear outside of the selection is available with a [20%] discount from the retail price.]

**[Contact Lenses** are available from the VisionCare Plan Network Provider [with a [10%] discount from the retail price].]

**[\*Lens options are available through the VisionCare Plan Network Provider at the following discounted prices:**

[Level I progressive lenses: ~~[\$49]~~

[Level II progressive lenses: ~~[\$59]~~

[Level III progressive lenses: ~~[\$78]~~

[Level IV progressive lenses: ~~[\$98]~~

[Tinted lenses: [type] [\$15 ]]

[Coatings: [type] [\$15]]

[Photochromatic: [type] [\$50]]

[Non-Aspheric Styles: [type] [\$50]]

[Aspheric Styles: [ type] [ \$50]]

[Polarized Styles: [ type] [ \$75]]

[Other Lens Styles: [type] [ \$45]]

Deleted: items

Deleted: [brand names]

Deleted: [brand names]

Deleted: [brand names]

Deleted: [brand names]

\*Prices for lens options are in addition to the [cost][Copayment] for standard lenses.]

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# DOMESTIC PARTNER RIDER

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**HumanaDental Insurance Company**  
**[100 Mansell Court East, Suite 400 Roswell, GA 30076]**

The Certificate issued by the Company to the Policyholder is hereby amended, effective upon receipt of this Rider, as follows:

The terms and conditions of that certain Certificate are hereby confirmed in their entirety with the exception that to the extent the terms and conditions of this Rider are in conflict with the terms and conditions of the Certificate, the terms of this Rider shall govern.

**Domestic Partners**

A Domestic Partner of the certificateholder is an eligible Dependent if:

- 1) The Domestic Partner has lived with the certificateholder at the same regular residence and been each other's sole Domestic Partner continuously for a minimum of six ( 6) months and intends to continue such indefinitely;
- 2) Is not legally married to anyone else;
- 3) Is 18 years of age or older;
- 4) Is not related to the certificateholder; and
- 5) Is financially interdependent with certificateholder.

[The domestic partner may be the [same] [or] [opposite] sex as the certificateholder.]

It is agreed and acknowledged that this Rider shall be effective upon receipt by certificateholder.

Signed for [HumanaDental](#) Insurance Company :

Gerald L. Ganoni  
President

SERFF Tracking Number: HUMA-126372325 State: Arkansas  
 Filing Company: Humana Dental Insurance Company State Tracking Number: 44894  
 Company Tracking Number: AR-CBIC TO HDIC MERGER  
 TOI: H20G Group Health - Vision Sub-TOI: H20G.000 Health - Vision  
 Product Name: AR-CBIC to HDIC Merger  
 Project Name/Number: AR-CBIC to HDIC Merger/AR- CBIC to HDIC Merger

## Supporting Document Schedules

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Flesch Certification	Approved-Closed	02/17/2010
<b>Comments:</b>			
<b>Attachment:</b>			
AR Flesch Score Certification.pdf			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	Application	Approved-Closed	02/17/2010
<b>Bypass Reason:</b>	The application will be submitted under separate cover. We do not intend to use these forms until that application is approved.		
<b>Comments:</b>			

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

**CERTIFICATION of READABILITY**  
Arkansas Rule and Regulation 19

<b>Form number</b>	<b>Description</b>
VGRP-POLICY.002 12/09	Group Vision Policy
VGRP-CERT.002 AR 12/09	Group Vision Certificate
VIS-SCH 12/09	Schedule of Benefits
SFGL-RDR 12/09	Safety Glasses Rider
VIS-SCH-VALU 12/09	Schedule of Benefits
DOMPART 0900	Domestic Partner Rider

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;



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Gerald L. Ganoni, President

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2/16/2010

Individual responsible for this filing:  
Christi Conrad  
Humana Insurance Company  
1100 Employers Boulevard  
Green Bay, WI 54344  
Telephone: 1-800-558-4444, Ext 3765  
Email: cconrad@humana.com