

SERFF Tracking Number: NWLC-127369487 State: Arkansas
Filing Company: Nationwide Life Insurance Company State Tracking Number: 49555
Company Tracking Number: NSHDTL 2700 MAC AR
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
Product Name: Dental - MAC Amendment
Project Name/Number: /

Filing at a Glance

Company: Nationwide Life Insurance Company

Product Name: Dental - MAC Amendment

TOI: H10G Group Health - Dental

Sub-TOI: H10G.000 Health - Dental

Filing Type: Form

SERFF Tr Num: NWLC-127369487 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 49555

Co Tr Num: NSHDTL 2700 MAC State Status: Approved-Closed
AR

Author: LaToyia Brooks

Date Submitted: 08/15/2011

Reviewer(s): Rosalind Minor

Disposition Date: 08/15/2011

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: Resubmission

Group Market Size: Small and Large

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 01/28/2010

Domicile Status Comments:

Market Type: Group

Previous Filing Number: 44449

Group Market Type: Employer, Association,
Discretionary

Overall Rate Impact:

Filing Status Changed: 08/15/2011

State Status Changed: 08/15/2011

Deemer Date:

Created By: LaToyia Brooks

Submitted By: LaToyia Brooks

Corresponding Filing Tracking Number:

Filing Description:

Nationwide is filing Amendment, NSHDTL 2700 MAC AR to amend the Certificate and Schedule of Benefits. The Amendment amends the below Certificate and Schedule of Benefits. This form replaces the previously approved form that was filed and approved on 01/04/2010.

NSHDTL 2500 approved by the Department of Insurance on 03/13/2009.

NSHDTL 2500 SCHED approved by the Department of Insurance on 03/13/2009.

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Company and Contact

Filing Contact Information

Latoyia Brooks, Sr. Compliance Analyst brookl10@nationwide.com
 1 Nationwide Plaza 614-677-3871 [Phone]
 Columbus, OH 43215

Filing Company Information

Nationwide Life Insurance Company CoCode: 66869 State of Domicile: Ohio
 5525 Parkcenter Circle Group Code: 140 Company Type:
 Dublin, OH 43017 Group Name: State ID Number:
 (614) 854-3375 ext. [Phone] FEIN Number: 31-4156830

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? Yes
 Fee Explanation: Ohio's domicile = \$50.00 per filing.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Nationwide Life Insurance Company	\$50.00	08/15/2011	50622046

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/15/2011	08/15/2011

SERFF Tracking Number: *NWLC-127369487* *State:* *Arkansas*
Filing Company: *Nationwide Life Insurance Company* *State Tracking Number:* *49555*
Company Tracking Number: *NSHDTL 2700 MAC AR*
TOI: *H10G Group Health - Dental* *Sub-TOI:* *H10G.000 Health - Dental*
Product Name: *Dental - MAC Amendment*
Project Name/Number: /

Disposition

Disposition Date: 08/15/2011

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	Certification of Compliance	Approved-Closed	Yes
Form	MAC Amendment	Approved-Closed	Yes

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Form Schedule

Lead Form Number: NSHDTL 2700 MAC AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 08/15/2011	NSHDTL 2700-MAC AR	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	MAC Amendment	Initial		58.500	NSHDTL 2700 MAC AR_Amendm ent_.pdf

AMENDMENT
NATIONWIDE LIFE INSURANCE COMPANY
Columbus, Ohio

To be attached to and made part of Your Certificate of Coverage and the Schedule of Benefits

The effective date of this Amendment is the effective date of the Policy.

The Certificate and Schedule of Benefits are amended as described below. All other terms remain unchanged.

This Amendment replaces the language in the following Sections:

Schedule of Benefits

Orthodontia Services:

1. We will determine the lesser of the Maximum Reimbursement as shown in the Schedule of Covered Procedures and the Provider's actual dental charge. We will then multiply that amount by the Percentage of Covered Expenses shown in the Schedule of Benefits.

Certificate

All time references are changed to 12:01 a.m.

GENERAL DEFINITIONS –

Leave of Absence and Participating Provider Maximum Allowable Charge definitions are hereby replaced with the following:

[Leave of Absence: An arrangement where You and the Policyholder agree that You will not be Actively at Work for a specific period of time and You are expected to be Actively at Work at the end of that period. Refer to When Your Coverage Begins and Ends to determine how long Your Coverage can be continued during a Leave of Absence.]

[Participating Provider Maximum Allowable Charge (MAC): The MAC is used if a Provider who is a Participating Provider performs a Covered Procedure. This is the amount that the Provider has agreed with Us to accept as payment in full for a dental Service. [The MAC will also be used for Non-Participating Providers. You may be responsible for the difference between the MAC and the actual dental charge from a Non-Participating Provider.]

WHEN COVERAGE BEGINS AND ENDS –

Change in Family Status is amended as follows:

[Change in Family Status: Eligible Persons may enroll or change their Coverage if a change in family status occurs, provided an Enrollment Form is received within [30, 31, 45, 60, 90] days of the event. A change in family status means any of the following:

1. Marriage [or lawful domestic partnership];
2. Divorce or legal separation;
3. Birth, adoption, or Placement for Adoption of a Child;
4. Death of a Spouse or Child;
5. A court or administrative order requiring the Eligible Person to provide Coverage for his or her Child;
6. Other changes as permitted by the Policyholder and Us.]

Section titled When will Coverage begin for your Dependents? The final sentence is replaced with:

If Your Dependent is enrolled as a result of a court or administrative order, Coverage for such child shall take effect on the [first of the month following the] [date of enrollment][date of the order][as defined by policyholder], [if We are notified in accordance with Our enrollment guidelines] [and] [once the required Premium, if any, has been paid]

When will Benefits and/or rates change? Is amended to read:

Change in Eligible Class [or Location]: The amount [or cost] of Your Benefit [and/or Benefits for Your Covered Dependents] may change if You become insured under a different Eligible Class [or You move.]

[The change][If the change would increase the amount of insurance, the increase] takes effect on the [first day of the Policy month [in which You are Actively at Work] following the] [latest of the] date[the change occurs]:

COVERAGE PROVISIONS -

How are Covered Expenses determined?

The Covered Expense is based on the Maximum Reimbursement for Your plan as shown in the Schedule of Covered Procedures section of the Schedule of Benefits.

CLAIM PROVISIONS

When will the Claim be paid [or denied]? After receiving written Proof of Loss and Premium payment, We will pay [or deny] all Benefits then due for dental Claims directly to [You][or][Your Provider]. We will pay [or deny] all Claims or any portion of any Claims within 30 if the claim was submitted electronically, or within 45 days if the claim was submitted by other means, or as required by Your state, after receipt of the Claim. If a Claim or a portion of a Claim is contested by Us, You shall be notified in writing, that the Claim is contested or denied, within 30 days after receipt of the Claim by Us. The notice that a Claim is contested shall identify the contested portion of the Claim and the reasons for contesting the Claim. Upon receipt of the additional information requested from You, We shall pay or deny the contested Claim or portion of the contested Claim, within 30 days. [We shall not pay or deny any Claim later than 30 days after receiving the Claim.] We will, upon request, provide to You an estimate of the amount We will pay for a particular dental Service.

All payments made to or by Us will be made in United States dollars.

GENERAL PROVISIONS –

Misrepresentation

List corrected to include 3. We give You or Your representative a copy of the written instrument that contains Your misrepresentation.

NATIONWIDE LIFE INSURANCE COMPANY



President

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Supporting Document Schedules

	Item Status:	Status Date:
<p>Satisfied - Item: Flesch Certification</p> <p>Comments: Find the Flesch Certification attached here.</p> <p>Attachment: Read Cert.pdf</p>	Approved-Closed	08/15/2011
<p>Bypassed - Item: Application</p> <p>Bypass Reason: This requirement is not applicable.</p> <p>Comments:</p>	Approved-Closed	08/15/2011
<p>Satisfied - Item: Certification of Compliance</p> <p>Comments: Find the Certification of Compliance attached here.</p> <p>Attachment: Certification of Compliance.pdf</p>	Approved-Closed	08/15/2011

CERTIFICATION OF COMPLIANCE WITH
INSURANCE POLICY SIMPLIFICATION REQUIREMENTS

Name and Address of Insurer:

Nationwide Life Insurance Company
Special Risks Underwriting
One Nationwide Plaza
Columbus, OH 43215
Mail Code: MR-05-10

Policy/Certificate Form Number(s):

NSHDTL 2700 MAC AR

I certify that, to the best of my knowledge and belief, the policy/certificate forms are in compliance with the Flesch reading ease score and the other requirements set forth in the Insurance Policy Language Simplification Act of the State of Arkansas.

A handwritten signature in black ink, appearing to read "Tom DeNoma". The signature is fluid and cursive, with a large initial "T" and "D".

Tom DeNoma
Associate Vice President

Date: August 15, 2011

CERTIFICATION OF COMPLIANCE

Name and Address of Insurer:

**Nationwide Life Insurance Company
Special Risks Underwriting
One Nationwide Plaza
Columbus, OH 43215
Mail Code: MR-05-10**

Policy/Certificate Form Number(s):

NSHDTL 2700 MAC AR

I certify that, to the best of my knowledge and belief, the policy/certificate forms are in compliance with Arkansas Rule/Regulation 19, Arkansas Rule/Regulation 49 and the Consumer Information Notice as outlined in ACA 23-79-138.

A handwritten signature in black ink, appearing to read "Tom DeNoma". The signature is fluid and cursive, with a large loop at the beginning.

Tom DeNoma
Associate Vice President

Date: August 15, 2011