Dental Plan
Certificate of Insurance
HumanaDental Insurance Company

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

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

This certificate contains a deductible and excess coverage provision.

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.

Bruce Broussard
President

Humana
CERTIFICATE OF ASSUMPTION

You are hereby notified that Humana Insurance Company has, effective July 1st, 2014, assumed liability for your policy or certificate with HumanaDental Insurance Company.

After this date, all references in the policy or certificate to HumanaDental Insurance Company are changed to Humana Insurance Company. Humana Insurance Company has assumed all rights and obligations under your policy contract. All policy benefits and conditions will remain the same, only the company name has changed.

All correspondence and inquiries concerning premium payments, policy changes and notices of claims should continue to be sent to the address you are currently using unless you are notified at a later date of a change of address.

Your rights as a policy or certificate holder will not be affected by the changes in insurance companies. For complaints call 800-233-4013.

THIS CERTIFICATE OF ASSUMPTION FORMS A PART OF YOUR POLICY OR CERTIFICATE ISSUED TO YOU BY HUMANADENTAL INSURANCE COMPANY AND SHOULD BE ATTACHED TO YOUR CONTRACT.

IN WITNESS WHEREOF, Humana Insurance Company has caused this Certificate of Assumption to be duly signed and issued.

Bruce Broussard  
President
Table of contents

Benefits
Summary of your benefits ........................................................................................................................................ 4
Waiting periods ....................................................................................................................................................... 6
Your plan benefits ............................................................................................................................................... 7
Limitations and exclusions (all services) ............................................................................................................... 11
How your plan works ........................................................................................................................................ 14
Claims
How we pay claims ........................................................................................................................................... 16
Coordinating benefits with another insurer ....................................................................................................... 19
Recovery rights ................................................................................................................................................... 22
Eligibility
When you are eligible for coverage .................................................................................................................... 24
Termination coverage ......................................................................................................................................... 27
Definitions ......................................................................................................................................................... 29
(Italicized words within text are defined in the Definitions section of this document.)
PPO (Preferred Provider Organization) provisions ........................................................................................... 34
Supplemental dental expense benefit (orthodontia) ......................................................................................... 35
Composite rider .................................................................................................................................................. 37
Coverage for domestic partners ....................................................................................................................... 38
Open Enrollment Rider .................................................................................................................................... 41
Benefits

Policyholder (Employer): HILLSBOROUGH COMM COLLEGE
Group Number: 540901
Coverage Effective Date: 07/01/2015

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

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

Dental benefits
Individual maximum benefit:
$1,500 per calendar year per member for Preventive, Basic and Major Services when services are provided by a PPO dentist.

$1,500 per calendar year per member for Preventive, Basic and Major Services when services are provided by a Non-PPO dentist.

Individual deductible:
$25 per calendar year per member for Basic and Major Services when services are provided by a PPO dentist.

$50 per calendar year per member for Basic and Major Services when services are provided by a Non-PPO dentist.

Maximum family deductible:
Covered expenses applied to the plan deductible of each covered member are combined to a calendar year maximum of $75 when services are provided by a PPO dentist.

Covered expenses applied to the plan deductible of each covered member are combined to a calendar year maximum of $150 when services are provided by a Non-PPO dentist.

Orthodontic lifetime maximum benefit
$1,000 per member when services are provided by a PPO dentist.

$1,000 per member when services are provided by a Non-PPO dentist.
Benefits

Preventive Services:
Preferred Provider Benefits: Benefits are paid at 100%.
Non-Preferred Provider Benefits: Benefits are paid at 100%.

1. Routine teeth cleaning (prophylaxis)
2. Topical fluoride treatment
3. Sealants
4. X-rays
5. Oral examinations

Basic Services:
Preferred Provider Benefits: Benefits are paid at 90% after the deductible.
Non-Preferred Provider Benefits: Benefits are paid at 80% after the deductible.

1. Fillings (amalgam and composite restorations)
2. Non-surgical extractions
3. Non-surgical residual root removal
4. Non-cast prefabricated crowns
5. Emergency exam and palliative care for pain relief
6. Space maintainers
7. Harmful habits and thumb-sucking appliances
8. Partial and denture repairs and adjustments
9. Oral surgery
10. Periodontics (gum disease)
11. Endodontics (root canals)

Major Services:
Preferred Provider Benefits: Benefits are paid at 60% after the deductible.
Non-Preferred Provider Benefits: Benefits are paid at 50% after the deductible.

1. Crowns
2. Inlays and onlays
3. Removable or fixed bridgework
4. Partial or complete dentures
5. Denture relines or rebases

Orthodontic Services:
Preferred Provider Benefits: Benefits are paid at 50%.
Non-Preferred Provider Benefits: Benefits are paid at 50%.

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

Waiting periods
This provision describes to the employer the waiting period criteria that will apply to members before benefits are available for covered services. Dependents added after the effective date of the employee may be subject to a separate waiting period. Please call us for the waiting period that applies to those dependents.

Members who are late applicants are subject to a 12-month waiting period before they are eligible for coverage for any service except Preventive Services.

If members enroll timely, Major and Orthodontic services may be subject to a 12-month waiting period before they are eligible for coverage. This 12-month waiting period can be decreased by the amount of time members had prior dental coverage immediately before their coverage with us.

Preventive Services:
No waiting periods apply to Preventive Services.

Basic Services:
No waiting periods apply to Basic Services, unless members are late applicants. If members are late applicants, they must be insured under this policy for a period of 12 continuous months before Basic Services will be covered.

Major Services:
For groups with fewer than 10 dental lives with no prior dental coverage, coverage is effective 12 months after the effective date of coverage.

For groups with fewer than 10 dental lives with prior dental coverage, coverage is effective on the effective date of coverage.

For groups with more than 10 dental lives with or without prior dental coverage, coverage is effective on the effective date of coverage.

All members, including late applicants, added after the group's effective date under this policy must be insured under this policy for a period of up to 12 continuous months before Major Services will be covered.

Orthodontic Services:
Groups with fewer than 10 dental lives with no prior orthodontia coverage, orthodontia coverage is effective 12 months after the effective date of coverage.

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

Groups with fewer than 10 dental lives, orthodontic coverage is effective 12 months after the effective date of the covered member added after the effective date of the group’s Policy.

Groups with more than 10 dental lives, orthodontia coverage is effective on the effective date of coverage.
Benefits

Your plan benefits

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

Preventive services

1. Oral evaluations (periodic, limited, comprehensive and problem focused) - two per calendar year.

2. Periodontal evaluations - two per calendar year.

3. Cleaning (prophylaxis), including all scaling and polishing procedures – two per calendar year.

4. Intra-oral complete series X-rays (at least 14 films, including bitewings), or panoramic film X-rays – once every 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.

5. Bitewing X-rays – one set per calendar year.

6. Other X-rays – only to diagnose specific treatment.

7. Topical fluoride treatment – provided to dependents age 14 and younger. Service is payable once per calendar year.

8. Sealants – application provided to dependents 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.

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

Basic services

1. Amalgam restorations (fillings) – limit to one per tooth in a two year period. Multiple restorations on one surface are considered one restoration.

2. Composite restorations (fillings) limited to one per tooth in a two 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. Pin retention in addition to an amalgam or composite restoration – this is not covered as a separate covered expense when done in conjunction with a core build-up.

4. Recementing of inlays, onlays, crowns and bridges.

5. Non-cast pre-fabricated crowns – service on primary teeth that cannot be adequately restored with amalgam or composite restorations.
6. Space maintainers for retaining space when a primary tooth is prematurely lost. *Services* are payable only for *dependents* age 14 and younger for the installation of the initial appliance. Separate adjustment expenses will not be covered.

7. Fixed and removable appliances to inhibit thumb sucking and other harmful habits. *Services* are payable only for *dependents* age 14 and younger for the installation of the initial appliance. Separate adjustment expenses will not be covered.

8. *Emergency* care – treatment for the initial *palliative* care of pain and/or injury. *Services* include *palliative* procedures for treatment to the teeth and supporting structures. We will consider the *service* as a separate *benefit* only if no other *service*, except X-rays, is provided during the same visit.

9. Full or partial denture repair.

10. Consultation – diagnostic service provided by a dentist or physician other than practitioner providing the treatment. Coverage is limited to one consultation per provider.

**Oral surgery services**

1. Extractions.

2. Bone Smoothing;

3. Trim or Remove over growth or non vital tissue or bone; or

4. Removal of tooth or root from sinus and closing opening between mouth and sinus.

5. General anesthesia when *medically necessary* and administered by a *dentist* in conjunction with a covered oral surgical procedure.

6. *We* will not cover any *services* for orthognathic surgery.

7. *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.

8. *We* will not cover *services* generally considered to be medical *services*.

9. Separate fees for pre and post operative services are not a *covered expense*.

**Periodontic services**

1. Periodontal scaling and root planing, available at a maximum of once per quadrant in a three-year period.

2. Periodontal surgery, available at a maximum of once per quadrant in a 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 adjustments when performed in conjunction with periodontal surgery – available at a maximum of once per quadrant in a three-year period.
4. Periodontal maintenance (following periodontal therapy) – procedure available twice per calendar year.

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

**Endodontic services**
1. Root canal therapy, including root canal treatments and root canal fillings – procedure available to permanent teeth only, once per tooth in a two-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.

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

   These *services* are covered only on permanent teeth.

6. Denture relines or rebases – once in a three-year period.

7. *We* will not cover the *expense incurred* for pin retention when done in conjunction with core build-up.

8. *We* will not cover the replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
Integral service
The following services are considered integral to the dental service. A separate fee for these services is not considered a covered expense.

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

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

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

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

Additional benefits for newborns
If the employee has dependent coverage, a child born to the employee or any of the employee’s covered dependents while this policy is in effect is covered from the moment of birth for the same benefits and under the same terms and conditions that are applicable for other children covered as dependents under the policy.

Coverage for such newborn child consists of benefits for services which are a dental necessity for the treatment of a bodily injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, or premature birth; and transportation costs, not to exceed $1,000 to and from the nearest available facility appropriately staffed and equipped to treat the newborn’s condition. The transportation must be certified by the attending physician as necessary to protect the health and safety of the newborn child, and is subject to the reimbursement limit.

Coverage for the newborn child to an employee’s covered dependent terminates 18 months after the child’s date of birth or according to the Terminating coverage provision in the certificate, whichever is earliest.

If you are an employee with single coverage currently in force, refer to the When you are eligible for coverage provision for information on addition dependent coverage.
Limitations & exclusions (all services)

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

1. Any expense arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which benefits are paid under any Workers’ Compensation or Occupational Disease Act or Law.

2. Services:
   - That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
   - Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
   - Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.

3. Any loss caused or contributed by:
   - War or any act of war, whether declared or not;
   - Any act of international armed conflict; or
   - Any conflict involving armed forces of any international authority.

4. Any expense arising from the completion of forms.

5. Your failure to keep an appointment with the dentist.

6. Any service we consider cosmetic dentistry unless it is necessary as a result of an accidental injury sustained while you are covered under this policy. We consider the following cosmetic dentistry procedures:
   - Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
   - Any service to correct congenital malformation, unless the service is for treatment of a covered newborn as allowed under the Additional benefits for newborns section of Your plan benefits;
   - Any service performed primarily to improve appearance; or
   - Characterizations and personalization of prosthetic devices.
7. Charges for:
   • Any type of implant and all related services, including crowns or the prosthetic device attached to it.
   • Precision or semi-precision attachments.
   • Overdentures and any endodontic treatment associated with overdentures.
   • Other customized attachments.

8. Any service related to:
   • Altering vertical dimension of teeth;
   • Restoration or maintenance of occlusion;
   • Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth;
   • Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
   • Bite registration or bite analysis.

9. Infection control, including but not limited to sterilization techniques.

10. Fees for treatment performed by someone other than a dentist except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards.

11. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.

12. Prescription drugs or pre-medications, whether dispensed or prescribed.

13. Any service not specifically listed in Your plan benefits.

14. Any service that we determine:
   • Is not a dental necessity;
   • Does not offer a favorable prognosis;
   • Does not have uniform professional endorsement; or
   • Is deemed to be experimental or investigational in nature.

15. Orthodontic services unless specified in your Summary of your benefits.

16. Any expense incurred before your effective date or after the date your coverage under this policy terminates (unless the service is eligible under Extension of benefits).

17. Services provided by someone who ordinarily lives in your home or who is a family member.

18. Charges exceeding the reimbursement limit for the service.

19. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, temporary dental services, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are considered an integral part of the entire dental service.


22. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
How your plan works

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

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

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

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

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

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

Waiting periods
This is the time period that certain services are not eligible for coverage under this policy. This begins on your effective date and lasts for the time shown in the Waiting periods provision.

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

Alternate services
If two or more services are acceptable to correct a dental condition, we will base the benefits payable on the covered expenses for the least expensive covered service that produces a professionally satisfactory result, as determined by us. We will pay up to the reimbursement limit for the least costly covered service and subject to any deductible, coinsurance and maximum benefit. You will be responsible for paying the excess amount.
Benefits

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

**Pretreatment plan**

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

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

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

An estimate for services is not necessary for emergency care.

**Process and timing**

An estimate for services is valid for 90 days after the date we notify you and your dentist of the benefits payable for the proposed treatment plan (subject to your eligibility of coverage). If treatment will not begin for more than 90 days after the date we notify you and your dentist, we recommend that you submit a new treatment plan.
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 this policy in the timeframe required by state law or by dentist contract. 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 covered expenses which are:
1. Recommended in writing by a health care practitioner;
2. Initiated while this coverage is in force and for a specific bodily injury or sickness incurred while this coverage is in force (see definition of expense incurred date);
3. Provided for services other than routine examination, prophylaxis, x-rays, sealants, or orthodontic services; and
4. Completed within the first 90 days following the termination date of your coverage, if such termination was other than voluntary.

Benefits for covered expenses for treatment due to such bodily injury or sickness will continue until the earliest of the following:
1. The end of the first 90 days immediately following the termination date of your coverage; or
2. The date a succeeding plan provides similar benefits for treatment due to such bodily injury or sickness.

These benefits are subject to the provisions and conditions of the policy.

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 certificate.
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. Fraud: You make an intentional misrepresentation by not telling us the facts or withhold information necessary for us to administer this certificate.

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 member 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 member provided information in error. We will adjust premium or claim payment based on this new information.
Claims

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.

4. **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 after the expiration of the applicable statute of limitations after such proof of loss is required to be given.

**Claims paid incorrectly**

If a claim was paid in error, we have the right to recover our payments. 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.
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 this 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 year. If, in any year, a person is not covered under this policy for the entire year, the claim determination period will be the portion of the year in which he or she was covered under this 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, except when that person is also a Medicare beneficiary and Medicare is secondary to the plan covering the person as a dependent of an active employee. In that case the Order of benefit determination is:
   • The benefits of the plan covering the person as an employee, member or subscriber is primary;
   • The benefits of the plan of an active employee covering the person as a dependent is secondary; and then
   • Medicare benefits.

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.

5. When the person is covered under a COBRA continuation plan (as provided under the Consolidation Omnibus Budget Reconciliation Act of 1987) and is also covered under another group plan, the benefits of the plan which covers the person as an employee or as the employee’s dependent will be determined before the benefits of a plan covering the person as a former employee or as the former employee’s dependent.

If rules 1-5 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.
**Claims**

**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 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 year deductibles*.

**Coordinating benefits with Medicare**
Coordinating benefits with Medicare will conform to federal statutes and regulations in all instances.

If you are eligible for Medicare benefits, whether enrolled or not, *your benefits* under this plan will be coordinated to the extent *benefits* are paid or would have been payable under Medicare as allowed by federal statutes and regulations. Medicare means Title XVIII, Parts A and B, of the Social Security Act, as enacted or amended.

**Right of recovery**
We reserve the right to recover *benefit* payments made for an allowable expense under this plan in the amount that exceeds the maximum amount we are required to pay under these provisions. This applies to us against:

1. Anyone for whom we made such payment.
2. Any insurance company or organization that, according to these provisions, owes *benefits* for the same allowable expense under any other plan.

**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.
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.
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.

Right of subrogation
You agree to transfer any rights to us that you have to recover any expenses paid under this policy. We will be subrogated to these recovery rights from any funds paid or payable.

We may enforce our subrogation rights by asserting a claim to any coverage to which you may be entitled. If we are precluded from exercising our subrogation rights, we may exercise our right of reimbursement.

Right of reimbursement
If we pay benefits and you later recover payment from the liable party, we have the right to recover from you the amount we paid. You must notify us in writing within 31 days of any settlement, compromise or judgment. If you waive or impair our right to reimbursement, we will suspend payment of past or future services until all outstanding lien(s) are resolved.

If you recover payments from and release any legally responsible party from future expenses relating to a sickness or bodily injury, we have a continuing right to seek reimbursement from you. This right, however, will apply only to the extent allowed by law. This reimbursement obligation exists regardless of whether a settlement, compromise or judgment designates that the recovery includes or excludes dental expenses.

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 this 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 this 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.
**Limitations to recovery rights**

Any such Right of Subrogation or Reimbursement provided to *us* under this policy shall not apply or shall be limited to the extent that the Florida Statutes or the Courts of Florida eliminate or restrict such rights.

**Workers’ compensation**

If *we* pay *benefits* but determine that the *benefits* were for the treatment of *bodily injury* or *sickness* that arose from or was sustained in the course of any occupation or employment for compensation, profit or gain, *we* have the right to recover that payment. *We* will exercise *our* right to recover against *you*.

The recovery rights will be applied even though:
1. The Workers’ Compensation benefits are in dispute or are made by means of settlement or compromise;
2. No final determination is made that *bodily injury* or *sickness* was sustained in the course of, or resulted from, *your* employment;
3. The amount of Workers’ Compensation due to medical or health care is not agreed upon or defined by *you* or the Workers’ Compensation carrier; or
4. Medical or health care benefits are specifically excluded from the Workers’ Compensation settlement or compromise.

*You* agree that, in consideration for the coverage provided by the policy, *we* will be notified of any Workers’ Compensation claim that *you* make, and *you* agree to reimburse *us* as described above.
When you are eligible for coverage

Employee coverage

Eligibility date: The employee is eligible for coverage when:
1. Eligibility requirements listed in the Employer Group Application (see your employer for details) are satisfied; and
2. Employee is in active status.

Effective date: The employee’s effective date will be calculated after we receive the completed enrollment forms we furnish. The employee’s Effective Date provision is outlined in the Employer Group Application (see your employer for details). Your effective date may be:

1. Immediately after the waiting period;
2. The first of the month after the waiting period; or
3. The date approved by us.

Employee delayed effective date: If the employee is not in active status on the effective date, coverage is effective on the day after the employee returns to active status. The employer must notify us in writing when an employee returns to active status.

Benefit changes: Additional or increased insurance coverage will be effective on the approved date of change if the employee is in active status. Otherwise, the change will be effective on the day after the employee returns to active status. A decrease in insurance coverage is effective on the approved date of change.

Late applicant: If you enroll or are enrolled more than 31 days after your eligibility date, you will be considered a late applicant and your benefits will only cover Preventive services for the first 12 months of coverage.

Incontestability: After you have been insured for two years, we cannot contest the validity of coverage except for nonpayment of premium. Absent of fraud, all statements made by you will be deemed representations and not warranties. 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.

Dependent coverage

Eligibility date: If an employee is covered, the employee’s dependent is eligible for coverage:
1. On the date the employee is eligible for coverage;
2. On the date of the employee’s marriage (spouse and/or stepchildren);
3. On the date of birth of the employee’s natural-born child; or
Eligibility

4. On the date a child under age 18 is placed in the employee’s home for the purpose of adoption by the employee. Coverage shall begin from the moment of birth, if a written agreement to adopt such child has been entered into by the employee prior to the birth of such child, whether or not the agreement is enforceable;

5. The date a child under age 18 is placed in the employee’s home as a foster child;

6. The date any child for whom the employee is the legal guardian, who is dependent on the employee for health care coverage pursuant to a valid court order, or who lives with the employee in a normal parent-child relationship and qualifies for the dependent exemption as defined in the Internal Revenue Code and Federal Tax Regulations. We have the right to request proof of the child’s dependency status at any time; or

7. The date of birth of a child born to an employee’s covered dependent.

Dependents who become employed by the employer participating in this policy must apply for coverage as an eligible employee.

**Dependent enrollment:** Check with the employer on how to enroll for dependent coverage. Late enrollment may reduce benefits. The employer must enroll for dependent coverage and enroll additional dependents on enrollment forms we furnish.

**Dependent effective date:** Each dependent’s effective date of coverage is determined as follows, subject to the Dependent delayed effective date section:

1. If we receive the enrollment form before the dependent’s eligibility date, the dependent is covered on the date he or she is eligible.
2. If we receive the enrollment form within 31 days after the dependent’s eligibility date:
   - The dependent is covered on the date we receive the completed enrollment form or, if the dependent is a newborn child, on the newborn’s date of birth; or
   - The dependent is covered on the date he or she is eligible if the employee already had dependent coverage in force.
3. The date we specify if we receive the completed enrollment forms more than 31 days after the dependent’s eligibility date.

A dependent’s effective date cannot occur before the employee’s effective date of coverage.

**Dependent delayed effective date:** 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.

**Late applicant:** With the exception of newborns and adopted children, if you enroll or are enrolled more than 31 days after your eligibility date, you will be considered a late applicant and your benefits will only cover Preventive services for the first 12 months of coverage.
Eligibility

Newborn enrollment and effective date: Employees who have dependent coverage in force PRIOR to the newborn’s date of birth are not required to complete an enrollment form. To enroll for dependent coverage, the employee must complete an enrollment form. This form is available from the employer or from us. The newborn is covered for all applicable benefits from the moment of birth. Additional premium, if any, must be paid to us within 45 days following receipt of notice of the additional premium due.

Notice of the newborn’s date of birth must be given to us, in writing, no later than 30 days after the date of birth. If timely notice is given, no additional premium will be charged for coverage of the newborn for the duration of the 30-day notice period. If timely notice is not given, we will charge the applicable premium from the date of birth. The applicable premium for the child will be charged after the initial 30-day notice period.

Foster child enrollment and effective date: Coverage for a foster child or a child otherwise placed in the employee or covered spouse’s custody by a court order, prior to the child’s eighteenth birthday, will be provided from the date of placement if, on the date of placement, the employee had dependent coverage. No coverage will be provided under this provision for the child who is not ultimately placed in the employee’s home. For a child in the employee’s custody, coverage will terminate the date the employee no longer has legal custody.

Retired employee coverage

Eligibility date: Retired employees are considered an eligible class if requested in the Employer Group Application and approved by us. Retired employees are eligible for coverage when the eligibility requirements in the Employer Group Application are satisfied.

Effective date: Retired employees must enroll for coverage on forms we furnish. The effective date of coverage for an eligible retired employee is the latter of:
1. The date retired employees are eligible for coverage under this policy;
2. The actual retirement date for employees who retire after that date; or
3. The date we specify if we receive the enrollment forms more than 31 days after the retired employee’s eligibility date.

Retired employee delayed effective date: A retired employee’s effective date of coverage will be delayed if the person is homebound due to bodily injury or sickness; or is confined to a hospital or mental health center. Coverage will be effective one day after discharge from confinement. A physician must certify the discharge. A decrease in insurance will be effective on the approved date of change.

Late applicant: If you enroll or are enrolled more than 31 days after your eligibility date, you are considered a late applicant and your benefits will only cover Preventive services for the first 12 months of coverage.
Eligibility

Terminating coverage

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

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

Special provisions for active status

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

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

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

Continuation of coverage during military leave

An employee called to active duty or state active duty is eligible for continuation if they are:

1. A member of the Florida National Guard; or
2. A Florida resident and a member of any branch of the United States military reserves.

Any employee’s dependents who have coverage under this plan immediately prior to the date of the employee’s covered absence are also eligible to elect continuation.

You or an appropriate military authority, must notify your employer of your intent to continue coverage under this section. Notification must occur prior to reporting to active duty or state active duty, unless such notice is precluded by military necessity or if such notice is impossible or unreasonable.

Coverage available under any insurance sponsored by the Department of Defense will be coordinated with benefits available under this plan, as allowed by the Department of Defense.
Eligibility

Premium payment
If continuation coverage is elected under this section, coverage will have the same premium in effect as for other *members* under this same plan, unless the *employee* requests coverage changes that might alter the premium in effect prior to such activation.

Reinstatement
*We* will reinstate coverage for the *members* who elected not to continue coverage under this plan while on active duty or state active duty:

1. After receipt of that person’s request for reinstatement upon return from active duty or state active duty; and
2. If reinstatement is requested within 30 days after returning to work with the same *employer*.

Upon reinstatement of coverage, no additional waiting period will be applied for any condition that existed at the time the *member* was called to active duty or state active duty.

Other information
*Employees* should contact their *employer* with any questions regarding coverage normally available during a military leave of absence or continuation coverage and notify the *employer* of any changes in marital status, or a change of address.
Accidental injury: Damage to the mouth, teeth and supporting tissue due directly to an accident. It does not include damage to the teeth, appliances or prosthetic devices that results from chewing or biting food or other substances.

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

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

Bodily injury: An injury due directly to an accident.

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

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

Covered expense: The reimbursement limit for a covered service.

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

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

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

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

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

**Dependent:** A covered employee’s:

1. Lawful spouse; and Natural blood related child, stepchild, foster child or legally adopted child whose age is less than the limiting age. Each child must qualify as a dependent as defined by the U.S. Internal Revenue Code; or

2. Covered dependent’s newborn child. Coverage for such child terminates 18 months after the date of birth or the date as determined by the Terminating coverage provision, whichever is earlier.

The limiting age for each dependent child is:

1. 26 years; or
2. The end of the calendar year the child reaches 26, if such child is dependent upon the employee for support and:
   - Living in the household of the employee; or
   - In regular full-time or part-time attendance at an accredited secondary school, college or university.

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

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

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

If a claim is denied, you must furnish satisfactory proof to us that the above conditions continuously existed on and after the date the limiting age was reached. We may not request proof more often than annually after two years from the date the first proof was furnished. If we do not receive satisfactory proof, the child’s coverage ends on the date proof is due.

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

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

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

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

**Expense incurred date:** The date on which:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. The fee most often charged in the geographical area where the *service* was performed;
2. The fee most often charged by the provider;
3. The fee that is recognized as reasonable by a prudent person;
4. The fee determined by comparing charges for similar *services* to a national database adjusted to the geographical area where the *services* or procedures were performed;
5. At *our* choice the fee determined by using a national Relative Value Scale. Relative Value Scale means a methodology that values procedures and *services* relative to each other that includes, but is not limited to, a scale in terms of difficulty, work, risk, as well as the material and outside costs of providing the *service*, as adjusted to the geographic area where the *services* or procedures were performed;
6. In the case of *services* rendered by providers with whom *we* have agreements, the fee that *we* have negotiated with that provider;
7. The fee based on rates negotiated with one or more participating providers in the geographic area for the same or similar *services*;
8. The fee based on a percentage of the fee Medicare allows for the same or similar *services* provided in the same geographic area.

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

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

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

**Total disability/totally disabled:** An employee or employed covered spouse who, during the first 12 months of a disability, is prevented by *bodily injury* or *sickness* from performing material and substantial duties of his or her respective job or occupation. After 12 months, *total disability/totally disabled* means the person is prevented by *bodily injury* or *sickness* from engaging in any paid job or occupation that he/she is reasonably qualified or trained.

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

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

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

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

_Year_ means the period of time which begins on any January 1st and ends on the following December 31st. When you first become covered by the _policy_, the first _year_ begins for _you_ on the effective date of _your_ insurance and ends on the following December 31st.

_You and your:_ Any covered _employee_ and/or _dependent(s)_.
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 this plan.

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 a PPO Network dentist. If you visit a non-participating PPO dentist, you may be billed for any expense incurred that exceeds our reimbursement limits.

How to select a provider

A list of participating dentists in your PPO 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 a PPO dentist, benefits will be paid at the out-of-network level.

Bruce Broussard
President
Orthodontic services
This Supplemental Dental Expense Benefit is part of the certificate. The benefits outlined will be effective the latter of:

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

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

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

Covered services for orthodontia treatment
Covered services for orthodontic treatment include those that are:

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

How benefits will be paid if treatment begins after you are eligible for orthodontic benefits with us.
In order to have the full orthodontic treatment be considered for benefits under this plan, bands and appliances must be inserted after:

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

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

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

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

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

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

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

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

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

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

Bruce Broussard  
President
Composite rider

Change in plan rider:
Coverage for Resin-based Composite Restorations

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

The following Resin-based Composite restoration benefit is added to your certificate as follows:

Resin-based Composite restorations (fillings) on molar and bicuspid teeth are covered and will be a payable filling under basic services. Multiple restorations on one surface are considered one restoration. Limited to once per tooth in a two year period.

Bruce Broussard
President
Domestic partners

Change in plan rider:

Coverage for domestic partners

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

The following definitions are added to your certificate:

**Domestic partners:** The employee and another individual of the same or opposite sex who:

1. Cohabit, have done so for the previous 24 months and intend to do so indefinitely;
2. Have an exclusive mutual commitment to be jointly responsible for each other's common welfare and share financial obligations;
3. Are not related by blood to a degree of closeness that would prohibit legal marriage in the state where they legally live;
4. Are not married to, or legally separated from, anyone else;
5. Are not in another domestic partnership;
6. Are not in this domestic partnership solely to obtain insurance coverage;
7. Are both at least age 18 and competent to consent to contract; and
8. Have filed registration of a Declaration of Domestic Partnership, or its equivalent, in the city, county or state where they live, if it offers the ability for registration. If registration of a Declaration of Domestic Partnership or its equivalent is not available in your city, county or state, we reserve the right to require an affidavit from the domestic partners attesting that the above requirements are met.

We may periodically request that you furnish satisfactory proof to us that the requirements of domestic partners continue to be met. Domestic partners are subject to all terms and provisions of the certificate including, but not limited to, all eligibility requirements and termination provisions. Your domestic partner may be identified as a spouse on identification cards or the certificate, however, your domestic partner and your domestic partner's dependent child(ren) are not eligible for COBRA or state continuation.

**Domestic partner's dependent child:** Any child:

1. Who lives with the domestic partner in a parent/child relationship;
2. Who is the domestic partner's unmarried natural blood related child, stepchild or legally adopted child;
3. Who is younger than the limiting age of a dependent child;
4. Who is primarily dependent upon the domestic partner for support;
5. Who is not covered by any other dental plan; and
6. Who is not entitled to coverage through another dental plan because of a Qualified Medical Child Support Order.
A domestic partner's dependent child(ren) are subject to all terms and provisions of the certificate including, but not limited to, all eligibility requirements and termination provisions.

**When you are eligible for coverage**

In addition to the Dependent coverage, Eligibility date section in your certificate, the following applies to domestic partners and any domestic partner's dependent child(ren):

1. For the employee's domestic partner, the eligibility date will be the earlier of:
   - The date of registration of the Declaration of Domestic Partnership; or
   - The date the employee submits to the employer or us an affidavit attesting that a domestic partnership exists and all requirements of the definition of domestic partner are met.

2. For a domestic partner's dependent child(ren):
   - The eligibility date of the employee's domestic partner for any domestic partner's dependent child(ren) acquired on that date; or
   - The date the child meets the definition of a domestic partner's dependent child.

The effective date of a domestic partner's dependent child will not be before the effective date of the employee's domestic partner.

**Terminating coverage**

In addition to the Terminating coverage provision in your certificate, the following applies to domestic partners and any domestic partner's dependent child(ren).

The employee's domestic partner and any dependent child(ren) allowed eligibility will terminate on:

1. The date one of the domestic partners dies.
2. The date one of the domestic partners marries.
3. The earliest of the following:
   - The date one domestic partner gives or sends to the other partner a written notice that he or she is terminating the domestic partnership;
   - The date the employee submits to the employer notification to terminate the domestic partnership;
Domestic partners

- The date indicated on the Notice of Termination of Domestic Partnership or its equivalent, as filed in the city, county or state where the domestic partners live if it offers the ability to terminate a domestic partnership;

- The date any of the requirements of the domestic partner definition is not met; or

- For any domestic partner's dependent child(ren), the date any of the requirements of domestic partner's dependent child(ren) definition is not met.

The coverage of any domestic partner's dependent child(ren) will terminate upon termination of the employee's domestic partner.

Bruce Broussard
President
HumanaDental Insurance Company

Change in Plan Rider:
Coverage for Open Enrollment

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

Open enrollment period

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

To enroll for coverage

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

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

The eligibility date of coverage is amended as follows:

Employee coverage:

Eligibility date: The employee is eligible for coverage when:
1. Eligibility requirements listed in the Employer Group Application (see your employer for details) are satisfied; and
2. Employee is in active status; or
3. Your Employers annual anniversary date.

Dependent coverage:

Eligibility date: If an employee is covered, the employee’s dependent is eligible for coverage:
1. On the date the employee is eligible for coverage;
2. On the date of the employee’s marriage (spouse and/or stepchildren);
3. On the date of birth of the employee’s natural-born child;
4. On the date a child under age 18 is placed in the employee’s home for the purpose of adoption by the employee. Coverage shall begin from the moment of birth, if a written agreement to adopt such child has been entered into by the employee prior to the birth of such child, whether or not the agreement is enforceable;
5. The date a child under age 18 is placed in the employee’s home as a foster child;
6. The date any child for whom the *employee* is the legal guardian, who is dependent on the *employee* for health care coverage pursuant to a valid court order, or who lives with the *employee* in a normal parent-child relationship and qualifies for the dependent exemption as defined in the Internal Revenue Code and Federal Tax Regulations. *We* have the right to request proof of the child’s dependency status at any time;
7. The date of birth of a child born to an *employee’s* covered *dependent*; or
8. The *employer’s* annual anniversary date.

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

Bruce Broussard
President
Humana

www.humanadental.com
Toll Free 800-248-4139
1100 Employers Blvd
Green Bay WI 54344

Insured by HumanaDental Insurance Company
Florida Notice:
Effective July 1, 1994, certain victims of violent crime do not have to meet the deductible or copayment provision of any insurance policy for the treatment of their crime-related injuries pursuant to the Florida Crimes Compensation Act, excluding 960.28. Eligibility under the Florida Crimes Compensation Act is determined when victims of violent crime apply for services with the Office of the Attorney General, Division of Victim Services. When victims are determined eligible, they are given written notification which references their insurance exemption. If you are eligible under the Florida Crimes Compensation Act, please forward a copy of such written notification to us to report your status.
DISCOUNT/ACCESS DISCLOSURE
From time to time, we may offer or provide access to discount programs to persons who become insureds. In addition, we may arrange for third party service providers such as optometrists, dentists, and laboratories to provide discounts on goods and services to persons who become insureds. Some of these third party service providers may make payments to us when insureds take advantage of these discount programs. These payments offset the cost to us of making these programs available and may help reduce the costs of your plan administration. Although we have arranged for third parties to offer discounts on these goods and services, these discount programs are not insured benefits under this Policy. The third party service providers are solely responsible to insureds for the provision of any such goods and/or services. We are not responsible for any such goods and/or services, nor are we liable if vendors refuse to honor such discounts. Further, we are not liable to insureds for the negligent provision of such goods and/or services by third party service providers. Discount programs may not be available to persons who "opt out" of marketing communications and where otherwise restricted by law.
The following pages contain important information about Humana’s claims procedures and certain federal laws. There may be differences between the Certificate of Insurance and this Notice packet. There may also be differences between this notice packet and state law. The Plan participant is eligible for the rights more beneficial to the participant.

This section includes notices about:

Claims and Appeal Procedures

Federal Legislation
- Medical Child Support Orders
- Continuation of Coverage for Full-time Students During Medical Leave of Absence
- General Notice Of COBRA Continuation Of Coverage Rights
- Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)
- Family And Medical Leave Act (FMLA)
- Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)
- Your Rights Under ERISA

Privacy and Confidentiality Statement
CLAIMS AND APPEALS PROCEDURES

The Employee Retirement Income Security Act of 1974 (ERISA) established minimum requirements for claims procedures. Humana complies with these standards. Covered persons in insured plans subject to ERISA should also consult their insurance benefit plan documents (e.g., the Certificate of Insurance or Evidence of Coverage). Humana complies with the requirements set forth in any such benefit plan document issued by it with respect to the plan unless doing so would prevent compliance with the requirements of the federal ERISA statute and the regulations issued thereunder. The following claims procedures are intended to comply with the ERISA claims regulation, and should be interpreted consistent with the minimum requirements of that regulation. Covered persons in plans not subject to ERISA should consult their benefit plan documents for the applicable claims and appeals procedures.

DISCRETIONARY AUTHORITY

With respect to paying claims for benefits or determining eligibility for coverage under a policy issued by Humana, Humana as administrator for claims determinations and as ERISA claims review fiduciary, shall have full and exclusive discretionary authority to:

1) Interpret plan provisions.

2) Make decisions regarding eligibility for coverage and benefits; and

3) Resolve factual questions relating to coverage and benefits.
CLAIMS PROCEDURES

Definitions

**Adverse determination:** means a decision to deny benefits for a pre-service claim or a post-service claim under a group health and/or dental plan.

**Claimant:** A covered person (or authorized representative) who files a claim.

**Concurrent-care Decision:** A decision by the plan to reduce or terminate benefits otherwise payable for a course of treatment that has been approved by the plan (other than by plan amendment or termination) or a decision with respect to a request by a Claimant to extend a course of treatment beyond the period of time or number of treatments that has been approved by the plan.

**Group health plan:** an employee welfare benefit plan to the extent the plan provides dental care to employees or their dependents directly (self insured) or through insurance (including HMO plans), reimbursement or otherwise.

**Health insurance issuer:** the offering company listed on the face page of your Certificate of Insurance or Certificate of Coverage and referred to in this document as “Humana.”

**Post-service Claim:** Any claim for a benefit under a group health plan that is not a Pre-service Claim.

**Pre-service Claim:** A request for authorization of a benefit for which the plan conditions receipt of the benefit, in whole or in part, on advance approval.

**Urgent-care Claim (expedited review):** A claim for covered services to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or in the opinion of a physician with knowledge of the covered person’s medical condition, would subject the covered person to severe pain that cannot be adequately managed without the service that is the subject of the claim.

Humana will make a determination of whether a claim is an Urgent-care Claim. However, any claim a physician, with knowledge of a covered person’s medical condition, determines is a "Urgent-care Claim" will be treated as a "claim involving urgent care."
Submitting a Claim

This section describes how a Claimant files a claim for plan benefits.

A claim must be filed in writing and delivered by mail, postage prepaid, by FAX or e-mail. A request for pre-authorization may be filed by telephone. The claim or request for pre-authorization must be submitted to Humana or to Humana’s designee at the address indicated in the covered person’s benefit plan document or identification card. Claims will not be deemed submitted for purposes of these procedures unless and until received at the correct address.

Claims submissions must be in a format acceptable to Humana and compliant with any legal requirements. Claims not submitted in accordance with the requirements of applicable federal law respecting privacy of protected health information and/or electronic claims standards will not be accepted by Humana.

Claims submissions must be timely. Claims must be filed as soon as reasonably possible after they are incurred, and in no event later than the period of time described in the benefit plan document.

Claims submissions must be complete and delivered to the designated address. At a minimum they must include:

- Name of the covered person who incurred the covered expense.
- Name and address of the provider
- Diagnosis
- Procedure or nature of the treatment
- Place of service
- Date of service
- Billed amount

A general request for an interpretation of plan provisions will not be considered a claim. Requests of this type, such as a request for an interpretation of the eligibility provisions of the plan, should be directed to the plan administrator.

Procedural Defects

If a Pre-service Claim submission is not made in accordance with the plan’s requirements, Humana will notify the Claimant of the problem and how it may be remedied within five (5) days (or within 24 hours, in the case of an Urgent-care Claim). If a Post-service Claim is not made in accordance with the plan’s requirement, it will be returned to the submitter.

Authorized Representatives

A covered person may designate an authorized representative to act on his or her behalf in pursuing a benefit claim or appeal. The authorization must be in writing and authorize disclosure of health information.
If a document is not sufficient to constitute designation of an authorized representative, as determined by Humana, the plan will not consider a designation to have been made. An assignment of benefits does not constitute designation of an authorized representative.

- Any document designating an authorized representative must be submitted to Humana in advance or at the time an authorized representative commences a course of action on behalf of the covered person. Humana may verify the designation with the covered person prior to recognizing authorized representative status.
- In any event, a health care provider with knowledge of a covered person’s medical condition acting in connection with an Urgent-care Claim will be recognized by the plan as the covered person’s authorized representative.

Covered persons should carefully consider whether to designate an authorized representative. Circumstances may arise under which an authorized representative may make decisions independent of the covered person, such as whether and how to appeal a claim denial.

Claims Decisions

After a determination on a claim is made, Humana will notify the Claimant within a reasonable time, as follows:

**Pre-service Claims**

Humana will provide notice of a favorable or adverse determination within a reasonable time appropriate to the medical circumstances but no later than 15 days after the plan receives of the claim.

This period may be extended by an additional 15 days, if Humana determines the extension is necessary due to matters beyond the control of the plan. Before the end of the initial 15-day period, Humana will notify the Claimant of the circumstances requiring the extension and the date by which Humana expects to make a decision.

If the reason for the extension is because Humana does not have enough information to decide the claim, the notice of extension will describe the required information, and the Claimant will have at least 45 days from the date the notice is received to provide the necessary information.

**Urgent-care Claims (expedited review)**

Humana will determine whether a particular claim is an Urgent-care Claim. This determination will be based on information furnished by or on behalf of a covered person. Humana will exercise its judgment when making the determination with deference to the judgment of a physician with knowledge of the covered person’s condition. Humana may require a Claimant to clarify the medical urgency and circumstances supporting the Urgent-care Claim for expedited decision-making.

Notice of a favorable or adverse determination will be made by Humana as soon as possible, taking into account the medical urgency particular to the covered person’s situation, but not later than 72 hours after receiving the Urgent-care Claim.

If a claim does not provide sufficient information to determine whether, or to what extent, services are covered under the plan, Humana will notify the Claimant as soon as possible, but not more than 24 hours after receiving the Urgent-care Claim. The notice will describe the specific information necessary to complete the claim. The Claimant will have a reasonable amount of time, taking into account the covered person’s circumstances, to provide the necessary information – but not less than 48 hours.
Humana will provide notice of the plan's Urgent-care Claim determination as soon as possible but no more than 48 hours after the earlier of:

- The plan receives the specified information; or
- The end of the period afforded the Claimant to provide the specified additional information.

**Concurrent-care Decisions**

Humana will notify a Claimant of a Concurrent-care Decision involving a reduction or termination of pre-authorized benefits sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination.

Humana will decide Urgent-care Claims involving an extension of a course of treatment as soon as possible taking into account medical circumstances. Humana will notify a Claimant of the benefit determination, whether adverse or not, within 24 hours after the plan receives the claim, provided the claim is submitted to the plan 24 hours prior to the expiration of the prescribed period of time or number of treatments.

**Post-service Claims**

Humana will provide notice of a favorable or adverse determination within a reasonable time appropriate to the medical circumstances but no later than 30 days after the plan receives the claim.

This period may be extended an additional 15 days, if Humana determines the extension is necessary due to matters beyond the plan’s control. Before the end of the initial 30-day period, Humana will notify the affected Claimant of the extension, the circumstances requiring the extension and the date by which the plan expects to make a decision.

If the reason for the extension is because Humana does not have enough information to decide the claim, the notice of extension will describe the required information, and the Claimant will have at least 45 days from the date the notice is received to provide the specified information. Humana will make a decision on the earlier of the date on which the Claimant responds or the expiration of the time allowed for submission of the requested information.

**Initial Denial Notices**

Notice of a claim denial (including a partial denial) will be provided to Claimants by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time frames noted above. With respect to adverse decisions involving Urgent-care Claims, notice may be provided to Claimants orally within the time frames noted above. If oral notice is given, written notification must be provided no later than 3 days after oral notification.

A claims denial notice will convey the specific reason for the adverse determination and the specific plan provisions upon which the determination is based. The notice will also include a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary. The notice will disclose if any internal plan rule, protocol or similar criterion was relied upon to deny the claim. A copy of the rule, protocol or similar criterion will be provided to Claimants, free of charge, upon request.
The notice will describe the plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

If an adverse determination is based on medical necessity, experimental treatment or similar exclusion or limitation, the notice will state that an explanation of the scientific or clinical basis for the determination will be provided, free of charge, upon request. The explanation will apply the terms of the plan to the covered person’s medical circumstances.

In the case of an adverse decision of an Urgent-care Claim, the notice will provide a description of the plan’s expedited review procedures

**APPEALS OF ADVERSE DETERMINATIONS**

A Claimant must appeal an adverse determination within 180 days after receiving written notice of the denial (or partial denial). An appeal may be made by a Claimant by means of written application to Humana, in person, or by mail, postage prepaid.

A Claimant, on appeal, may request an expedited appeal of an adverse Urgent-care Claim decision orally or in writing. In such case, all necessary information, including the plan's benefit determination on review, will be transmitted between the plan and the Claimant by telephone, facsimile, or other available similarly expeditious method, to the extent permitted by applicable law.

Determination of appeals of denied claims will be conducted promptly, will not defer to the initial determination and will not be made by the person who made the initial adverse claim determination or a subordinate of that person. The determination will take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim.

On appeal, a Claimant may review relevant documents and may submit issues and comments in writing. A Claimant on appeal may, upon request, discover the identity of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the adverse determination being appealed, as permitted under applicable law.

If the claims denial is based in whole, or in part, upon a medical judgment, including determinations as to whether a particular treatment, or other service is experimental, investigational, or not medically necessary or appropriate, the person deciding the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The consulting health care professional will not be the same person who decided the initial appeal or a subordinate of that person.
**Time Periods for Decisions on Appeal**

Appeals of claims denials will be decided and notice of the decision provided as follows:

<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>Time Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent-care Claims</td>
<td>As soon as possible but no later than 72 hours after Humana receives the appeal request.</td>
</tr>
<tr>
<td>Pre-service Claims</td>
<td>Within a reasonable period but no later than 30 days after Humana receives the appeal request.</td>
</tr>
<tr>
<td>Post-service Claims</td>
<td>Within a reasonable period but no later than 60 days after Humana receives the appeal request.</td>
</tr>
<tr>
<td>Concurrent-care Decisions</td>
<td>Within the time periods specified above depending on the type of claim involved.</td>
</tr>
</tbody>
</table>

**Appeals Denial Notices**

Notice of a claim denial (including a partial denial) will be provided to Claimants by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time periods noted above.

A notice that a claim appeal has been denied will include:

- The specific reason or reasons for the adverse determination.
- Reference to the specific plan provision upon which the determination is based.
- If any internal plan rule, protocol or similar criterion was relied upon to deny the claim. A copy of the rule, protocol or similar criterion will be provided to the Claimant, free of charge, upon request.
- A statement describing any voluntary appeal procedures offered by the plan and the claimant’s right to obtain the information about such procedures, and a statement about the Claimant’s right to bring an action under section 502(a) of ERISA.
- If an adverse determination is based on medical necessity, experimental treatment or similar exclusion or limitation, the notice will state that an explanation of the scientific or clinical basis for the determination will be provided, free of charge, upon request. The explanation will apply the terms of the plan to the covered person’s medical circumstances.

In the event an appealed claim is denied, the Claimant will be entitled to receive without charge reasonable access to, and copies of, any documents, records or other information that:

- Was relied upon in making the determination.
- Was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination.
- Demonstrates compliance with the administrative processes and safeguards required in making the determination.
- Constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant’s diagnosis, without regard to whether the statement was relied on in making the benefit determination.
EXHAUSTION OF REMEDIES

Upon completion of the appeals process under this section, a Claimant will have exhausted his or her administrative remedies under the plan. If Humana fails to complete a claim determination or appeal within the time limits set forth above, the claim shall be deemed to have been denied and the Claimant may proceed to the next level in the review process.

After exhaustion of remedies, a Claimant may pursue any other legal remedies available, which may include bringing civil action under ERISA section 502(a) for judicial review of the plan’s determination. Additional information may be available from the local U.S. Department of Labor Office.

LEGAL ACTIONS AND LIMITATIONS

No lawsuit may be brought with respect to plan benefits until all remedies under the plan have been exhausted.

No lawsuit with respect to plan benefits may be brought after the expiration of the applicable limitations period stated in the benefit plan document. If no limitation is stated in the benefit plan document, then no such suit may be brought after the expiration of the applicable limitations under applicable law.

MEDICAL CHILD SUPPORT ORDERS

An individual who is a child of a covered employee shall be enrolled for coverage under the group health plan in accordance with the direction of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSO).

A QMCSO is a state-court order or judgment, including approval of a settlement agreement that: (a) provides for support of a covered employee’s child; (b) provides for health care coverage for that child; (c) is made under state domestic relations law (including a community property law); (d) relates to benefits under the group health plan; and (e) is “qualified,” i.e., it meets the technical requirements of ERISA or applicable state law. QMCSO also means a state court order or judgment enforcing state Medicaid law regarding medical child support required by the Social Security Act section 1908 (as added by Omnibus Budget Reconciliation Act of 1993).

An NMSO is a notice issued by an appropriate agency of a state or local government that is similar to a QMCSO requiring coverage under the group health plan for a dependent child of a non-custodial parent who is (or will become) a covered person by a domestic relations order providing for health care coverage.

Procedures for determining the qualified status of medical child support orders are available at no cost upon request from the plan administrator.
CONTINUATION OF COVERAGE FOR FULL-TIME STUDENTS DURING MEDICAL LEAVE OF ABSENCE

A dependent child who is in regular full-time attendance at an accredited secondary school, college or university, or licensed technical school continues to be eligible for coverage for until the earlier of the following if the dependent child takes a medically necessary leave of absence:

- Up to one year after the first day of the medically necessary leave of absence; or
- The date coverage would otherwise terminate under the plan.

We may require written certification from the dependent child’s health care practitioner that the dependent child has a serious bodily injury or sickness requiring a medically necessary leave of absence.

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

Introduction

You are receiving this notice because you have recently become covered under a group health and/or dental plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health and/or dental coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health and/or dental coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan’s benefit plan document or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, the qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualified events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than gross misconduct.
If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following events happen:

- Your spouse dies;
- Your spouse’s hours of employment are reduced;
- Your spouse’s employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of any of the following qualifying events happen:

- The parent-employee dies;
- The parent-employee’s hours of employment are reduced;
- The parent-employee’s employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

**When is COBRA Coverage Available**

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or commencement of a proceeding in bankruptcy with respect to the employer, the employer must notify the Plan Administrator of the qualifying event.

**You Must Give Notice of Some Qualifying Events**

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child) you must notify the Plan Administrator within 60 days after the qualifying event occurs.

**How is COBRA Coverage Provided?**

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. Once the Plan Administrator offers COBRA continuation coverage, the qualified beneficiaries must elect such coverage within 60 days.
COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce or legal separation, or a dependent child’s losing eligibility as a dependent child, COBRA continuation coverage last for up to a total of 36 months. When the qualifying event is the end of employment, or reduction in the employee’s hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee last until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which the employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee’s hours of employment, COBRA continuation coverage generally last for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator within 60 days of such determination, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is given to the Plan within 60 days of the event. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, gets divorced or legally separated, or if the dependent child stops being eligible under the plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator. For more information about your rights under ERISA, including COBRA, or other laws affecting your group health and/or dental plans, contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (address and phone numbers of Regional and District EBSA Office are available through EBSA’s website.)

Keep Your Plan Informed of Address Changes

In order to protect your family’s rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send the Plan Administrator.
IMPORTANT NOTICE FOR INDIVIDUALS ENTITLED TO MEDICARE TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982 (TEFRA) OPTIONS

Where an employer employs more than 20 people, the Tax Equity And Fiscal Responsibility Act of 1982 (TEFRA) allows covered employees in active service who are age 65 or older and their covered spouses who are eligible for Medicare to choose one of the following options.

OPTION 1 - The benefits of their group health plan will be payable first and the benefits of Medicare will be payable second.

OPTION 2 - Medicare benefits only. The employee and his or her dependents, if any, will not be insured by the group health plan.

The employer must provide each covered employee and each covered spouse with the choice to elect one of these options at least one month before the covered employee or the insured spouse becomes age 65. All new covered employees and newly covered spouses age 65 or older must be offered these options. If Option 1 is chosen, its issue is subject to the same requirements as for an employee or dependent that is under age 65.

Under TEFRA regulations, there are two categories of persons eligible for Medicare. The calculation and payment of benefits by the group health plan differs for each category.

Category 1 Medicare eligibles are:

- Covered employees in active service who are age 65 or older who choose Option 1;
- Age 65 or older covered spouses; and
- Age 65 or older covered spouses of employees in active service who are either under age 65 or age 70 or older;

Category 2 Medicare eligibles are any other covered persons entitled to Medicare, whether or not they enrolled. This category includes, but is not limited to:

- Retired employees and their spouses; or
- Covered dependents of a covered employee, other than his or her spouse.

Calculation and Payment of Benefits

For covered persons in Category 1, benefits are payable by the policy without regard to any benefits payable by Medicare. Medicare will then determine its benefits.

For covered persons in Category 2, Medicare benefits are payable before any benefits are payable by the policy. The benefits of the policy will then be reduced by the full amount of all Medicare benefits the covered person is entitled to receive, whether or not the eligible individual is actually enrolled for Medicare Benefits.
FAMILY AND MEDICAL LEAVE ACT (FMLA)

If an employee is granted a leave of absence (Leave) by the employer as required by the Federal Family and Medical Leave Act, s/he may continue to be covered under the plan for the duration of the Leave under the same conditions as other employees who are currently employed and covered by the plan. If the employee chooses to terminate coverage during the Leave, or if coverage terminates as a result of nonpayment of any required contribution, coverage may be reinstated on the date the employee returns to work immediately following the end of the Leave. Charges incurred after the date of reinstatement will be paid as if the employee had been continuously covered.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

Continuation of Benefits
Effective October 13, 1994, federal law requires health plans offer to continue coverage for employees that are absent due to service in the uniformed services and/or dependents.

Eligibility
An employee is eligible for continuation under USERRA if he or she is absent from employment because of voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard, or commissioned corps of the Public Health Service. Duty includes absence for active duty, active duty for training, initial active duty for training, inactive duty training and for the purpose of an examination to determine fitness for duty.

An employee’s dependents that have coverage under the plan immediately prior to the date of the employee’s covered absence are eligible to elect continuation under USERRA.

If continuation of Plan coverage is elected under USERRA, the employee or dependent is responsible for payment of the applicable cost of coverage. If the employee is absent for not longer than 31 days, the cost will be the amount the employee would otherwise pay for coverage. For absences exceeding 30 days, the cost may be up to 102% of the cost of coverage under the plan. This includes the employee’s share and any portion previously paid by the employer.

Duration of Coverage
Of elected, continuation coverage under USERRA will continue until the earlier of:

1. Twenty-four months beginning the first day of absence from employment due to service in the uniformed services; or

2. The day after the employee fails to apply for a return to employment as required by USERRA, after the completion of a period of service.

Under federal law, the period coverage available under USERRA shall run concurrently with the COBRA period available to an employee and/or eligible dependent.

Other Information
Employees should contact their employer with any questions regarding coverage normally available during a military leave of absence or continuation coverage and notify the employer of any changes in marital status, or change of address.
YOUR RIGHTS UNDER ERISA

Under the Employee Retirement Income Security Act of 1974 (ERISA), all plan participants covered by ERISA are entitled to certain rights and protections, as described below. Notwithstanding anything in the group health plan or group insurance policy, following are a covered person’s minimum rights under ERISA. ERISA requirements do not apply to plans maintained by governmental agencies or churches.

Information About the Plan and Benefits

Plan participants may:

1. Examine, free of charge, all documents governing the plan. These documents are available in the plan administrator's office.
2. Obtain, at a reasonable charge, copies of documents governing the plan, including a copy of any updated summary plan description and a copy of the latest annual report for the plan (Form 5500), if any, by writing to the plan administrator.
3. Obtain, at a reasonable charge, a copy of the latest annual report (Form 5500) for the plan, if any, by writing to the plan administrator.

As a plan participant, you will receive a summary of any material changes made in the plan within 210 days after the end of the plan year in which the changes are made unless the change is a material reduction in covered services or benefits, in which case you will receive a summary of the material reduction within 60 days after the date of its adoption.

If the plan is required to file a summary annual financial report, you will receive a copy from the plan administrator.

Responsibilities of Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plan. These people, called "fiduciaries" of the plan, have a duty to act prudently and in the interest of plan participants and beneficiaries.

No one, including an employer, may discharge or otherwise discriminate against a plan participant in any way to prevent the participant from obtaining a benefit to which the participant is otherwise entitled under the plan or from exercising ERISA rights.

Continue Group Health Plan Coverage

Participants may be eligible to continue health care coverage for themselves, their spouse or dependents if there is a loss of coverage under the group health plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the COBRA notice in this document regarding the rules governing COBRA continuation coverage rights.

Claims Determinations

If a claim for a plan benefit is denied or disregarded, in whole or in part, participants have the right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial within certain time schedules.

Enforce Your Rights

Under ERISA, there are steps participants may take to enforce the above rights. For instance, if a participant requests a copy of plan documents does not receive them within 30 days, the participant may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the
materials and pay you up to $110 a day until the participant receives the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If a claim for benefits is denied or disregarded, in whole or in part, the participant may file suit in a state or Federal court. In addition, if the participant disagrees with the plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, the participant may file suit in Federal court. If plan fiduciaries misuse the plan's money, or if participants are discriminated against for asserting their rights, they may seek assistance from the U.S. Department of Labor, or may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If the participant is successful, the court may order the person sued to pay costs and fees. If the participant loses, the court may order the participant to pay the costs and fees.

**Assistance with Questions**

Contact the group health plan human resources department or the plan administrator with questions about the plan. Contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210 with questions about ERISA rights. Call the publications hotline of the Employee Benefits Security Administration to obtain publications about ERISA rights.
PRIVACY AND CONFIDENTIALITY STATEMENT

We understand the importance of keeping your personal and health information private (PHI). PHI includes both medical information and individually identifiable information, such as your name, address, telephone number or social security number. We are required by applicable federal and state law to maintain the privacy of your PHI.

Under both law and our policies, we have a responsibility to protect the privacy of your PHI. We:

- Protect your privacy by limiting who may see your PHI;
- Limit how we may use or disclose your PHI;
- Inform you of our legal duties with respect to your PHI;
- Explain our privacy policies; and
- Strictly adhere to the policies currently in effect.

We reserve the right to change our privacy practices at any time, as allowed by applicable law, rules and regulations. We reserve the right to make changes in our privacy practices for all PHI that we maintain, including information we created or received before we made the changes. When we make a significant change in our privacy practices, we will send notice to our health plan subscribers. For more information about our privacy practices, please contact us.

As a covered person, we may use and disclose you PHI, without your consent/authorization, in the following ways:

**Treatment**: we may disclose your PHI to a health care practitioner, a hospital or other entity which asks for it in order for you to receive medical treatment.

**Payment**: we may use and disclose your PHI to pay claims for covered services provided to you by health care practitioners, hospitals or other entities.

We may use and disclose your PHI to conduct other health care operations activities.

It has always been our goal to ensure the protection and integrity of your personal and health information. Therefore, we will notify you of any potential situations where your identification would be used for reasons other than treatment, payment and health plan operations.