Policyholder: State of Florida
Group number: CD9006

Group Dental Plan
Certificate of Insurance
Humana 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*.

NOTICE
This Certificate provides coverage for limited dental services.
Please review the Summary of Your Benefits section of this certificate carefully.

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 866-879-3630.

Humana.

Bruce Broussard
President

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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 the *policy*.

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

1. *We* will determine the total *covered expense.*

2. *We* will review the *covered expense* against any *maximum benefits* that may apply.

3. *We* will determine if *you* have met *your deductible*. If *you* have not, *we* will subtract any amount required to fulfill the *deductible*.

4. *We* will make payment for the remaining eligible *covered expense* to *you* or *your dentist,* based on *your coinsurance* for that *covered service*.

Deductibles

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

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

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**.

Claims

Alternate services

If two or more *service*s 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.

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, y*ou* or y*our 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. The following exhibits:

   - X-rays;
   - Patient records.

2. Authorizations to release any additional dental information or records.

3. Information about other insurance coverage.

4. Any information *we* need to determine *benefits.*

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

Paying claims
Once *we* receive all the necessary information, *we* will determine if *benefits* are available, and if they are, *we* will pay any amount due under this *policy* within 45 days of receipt of the claim. If *we* cannot process *your* claim due to lack of information, *we* will notify *you*, or whoever is claiming payment under the *policy* if it is not *you*, of the information needed within 45 days of receipt of claim. Once *we* have received the necessary information, *we* will process *your* claim within 60 days of receipt of information. *We* may pay all or a portion of any *benefit* provided for *covered expenses* to the provider unless *you* or the *covered person* has notified *us* in writing by the time the claim form is submitted.

Loss-of-life benefits are payable in accordance with the beneficiary designation in effect at the time of payment. If there is no loss-of-life benefits in effect, the benefits will be paid to the *employee's* estate. Any other benefits unpaid at death may be paid, at the *employee's* option, to either the *employee's* beneficiary or estate.

Extension of Benefits
Your coverage may be extended in the event *you* are *totally disabled* when *your* coverage under the *policy* ends as follows:

- the course of treatment or dental procedures were recommended in writing and commenced, in connection with a specific accident or illness incurred while the *policy* was in effect, by *your* attending physician or *dentist* while *you* were covered under the *policy*;

- the dental procedures were procedures for other than routine examinations, prophylaxis, X rays, sealants, or orthodontic services; and

- the dental procedures were performed within 90 days after *your* coverage ceased under the *policy* and the termination of coverage did not occur as a result of *your*, or, in the case of a *dependent* child, the child's parent's, voluntary termination of coverage.

The extension of benefits terminates upon the earlier of:
- the end of the 90-day period as specified above; or
- the date the patient becomes covered under the succeeding policy or contract providing coverage or services for similar dental procedures. However, if coverage or services for the dental procedures are excluded by the succeeding policy or contract through the use of an elimination period, the patient is not covered by the succeeding policy or contract and the extension of benefits does not terminate.

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.

   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.

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

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

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 the *policy*.

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

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

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

Effect on benefits

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

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

Order of benefit determination

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

1. The plan that covers the person as an *employee* submitting the claim, 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, employee 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.

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 enrolled in Medicare benefits, *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.

2. Providing *us* with a copy of any legal notices arising from *your* injury and its treatment.

3. Assisting *our* enforcement of recovery rights and doing nothing to prejudice *our* recovery rights.

4. Refraining from designating all (or any disproportionate part) of any recovery as exclusively for "pain and suffering."

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

Worker's 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.

Eligibility

Definitions

The following terms are used in this section:

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

Special enrollment date means:

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

Eligibility and enrollment date

Employee eligibility date

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

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

Dependent eligibility date

Each *dependent* is eligible for coverage on:

- The date the *employee* is eligible for coverage, if he or she has *dependents* who may be covered on that date;
- The date of the *employee's* marriage for any *dependents* (spouse or child) acquired on that date;

- The date of birth of the *employee's* natural-born child;
- On the date of placement of a child for the purpose of adoption by the *employee*; however, in the case of a newborn child, coverage begins at the moment of birth if a written agreement to adopt such child has been entered into by the *employee* prior to the birth of the child, whether or not the agreement is enforceable;
- The date a foster child is placed in the *employee's* home;
- 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
- The date specified in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) for a child, or a valid court or administrative order for a spouse, which requires the *employee* to provide coverage for a child or spouse as specified in such orders.

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

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

Employee enrollment

The *employee* must enroll as agreed by the *policyholder* and *us*. No eligible *employee* will be refused enrollment or charged a different premium than other *group employees* based on health status-related factors. *We* will administer this provision in a non-discriminatory manner.

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

Dependent enrollment

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

No eligible *employee* will be refused enrollment or charged a different premium than other *group employees* based on health status-related factors. *We* will administer this provision in a non-discriminatory manner.

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

Newborn dependent enrollment

An *employee* who already has *dependent* child coverage in force prior to the newborn's date of birth is not required to complete an enrollment form for the newborn child. However, the *employee* must timely notify *us* of the birth to make sure *we* have accurate records to administer benefits.

An *employee* who does not have *dependent* child coverage must enroll the newborn *dependent*, as agreed by the *policyholder* and *us*, within 30 days after the date of birth. If timely notice is not given, *we* may charge an additional premium from the date of birth. If notice is given within 60 days of the birth of the child, *we* may not deny coverage for a child due to the *employees* failure to timely notify *us* of the birth of the child.

Special Enrollment

Loss of other coverage

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

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

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

Dependent special enrollment period

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

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

Effective date

Employee effective date

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

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

Employee delayed effective date

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

Dependent effective date

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

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

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

Newborn dependent effective date

Coverage for a newborn child will be provided from the moment of birth and subject to "Newborn dependent enrollment" provision.

Foster Child effective date

Coverage for a foster child or a child otherwise placed in the *employee's* 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.

Benefit changes

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

Incontestability: After two years from the effective date of the *policy*, no misstatement made by the *policyholder*, except a fraudulent misstatement made in the application may be used to void the *policy*.

After *you* are insured without interruption for two years, *we* cannot contest the validity of *your* coverage except for:

- Nonpayment of premium; or
- Any fraudulent misrepresentation made by *you*.

At any time, *we* may assert defenses based upon provisions in the *policy* which relate to *your* eligibility for coverage under the *policy*.

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. The date the *policy* terminates;
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. The date *you* no longer are eligible for coverage as outlined in the **Employer Group Application**;
6. The date *You* terminate employment with the *employer*;
7. For a *dependent*, the date the *employee's* insurance terminates;
8. For a *dependent,* the end of the month 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.

Eligibility

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.

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.

Replacement provisions

Applicability: This provision applies only if:

1. *You* are eligible for dental coverage on *your employer's* effective date under the *policy*; and
2. *You* were covered on the final day of coverage on *your employer's* previous group dental plan (Prior Plan).

Delayed effective date: *We* will waive the Delayed Effective Date provision if it applies to *you* when *you* would otherwise be eligible for dental coverage on *your employer's* effective date under the *policy*. Dental coverage is provided to *you* until the earlier of the following dates:

1. 90 days after *your employer's* effective date under this plan.
2. The date *your* dental coverage would otherwise terminate according to the **Terminating coverage** section in the certificate.

If *you* satisfy the Delayed Effective Date provision before either of these dates, *your* dental coverage will continue uninterrupted.

Deductible amount: Any *expense incurred* while *you* were covered under the Prior Plan may be used to satisfy *your deductible* amount under this dental plan. These expenses must qualify as *covered expenses* that would have been applied to the *deductible* amount for the calendar year that this dental plan becomes effective.

Prior plan extension of benefits: Any *benefits* that *you* are entitled to receive during an extension period under *your* Prior Plan are not considered payable *benefits* under this plan.

Modification of policy

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

Disclosures

Discount/access disclosure

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

Who has responsibility for these discounts?

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

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

Disclosures

Shared Savings Program

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

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

However, *you* may inquire in advance to determine if a *dentist* participates in the Shared Savings Program by calling 866-879-3630. *Dentist* arrangements in the Shared Savings Program change constantly. *We* cannot guarantee that a *dentist* who is in the Shared Savings Program at the time of *your* inquiry will still be in the program at the time treatment is received. Discounts depend on availability on a claim by claim basis. Therefore, availability and discount amounts cannot be guaranteed.

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

Definitions

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

Active status: The *employee* performs all of his or her duties on a regular full-time basis for the required number of hours per week shown on the employer's group application 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.

Clinical review: The determination of *benefit* eligibility based on the review of clinical documentation by a licensed *dentist*.

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

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

Covered person: the *employee* and/or dependent who are covered under the *policy*.

Covered service: A dental *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 emergency means a sudden, serious dental condition caused by an accident or dental disease that, if not treated immediately, would result in serious harm to the dental health of the *covered person*.

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

Dependent: means a covered *member's*:

- Legally recognized spouse;
- Natural born child, step-child, foster child, legally adopted child, or child placed for adoption, whose age is less than the limiting age;

- Child whose age is less than the limiting age and for whom the *member* has received a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) to provide coverage, if the *member* is eligible for family coverage until:

  - Such QMCSO or NMSN is no longer in effect; or
  - The child is enrolled for comparable health coverage, which is effective no later than the termination of the child's coverage under the *policy*.

- Child in court-ordered temporary or other custody, whose age is less than the limiting age;

- Newborn child of a covered *dependent* 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 earliest;

The limiting age means the end of the calendar year the *dependent* child attains age 26.

Each *dependent* child is covered to the limiting age, regardless if the child is:

- Married;
- A tax dependent;
- A student;
- Employed;
- Residing or working outside of the network area;
- Residing with or receiving financial support from *you*; or
- Eligible for other coverage through employment.

A covered *dependent* child, who attains the limiting age while insured under the *policy*, remains eligible if the covered *dependent* child is:

- Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
- Chiefly dependent upon the *member* or spouse for support and maintenance.

In order for the covered *dependent* child to remain eligible as specified above, *we* must receive notification within 31 days prior to the covered *dependent* child attaining the limiting age.

You must furnish satisfactory proof to *us*, upon *our* request that the conditions as defined in the bulleted items above, continuously exist on and after the date the limiting age is reached. After two years from the date the first proof was furnished, *we* may not request such proof more often than annually. If satisfactory proof is not submitted to *us*, the child's coverage will not continue beyond the last date of eligibility.

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

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

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

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

Definitions

Expense incurred date: The date on which 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*.

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

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

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

Policy: The group policy issued to the *policyholder*.

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

Definitions

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

1. In the case of *services* rendered by providers with whom *we* have agreements, the fee or maximum allowable charge that *we* have negotiated with that provider;
2. The fee or maximum allowable charge that *we* negotiated with one or more participating providers in the geographic area for the same or similar *services;*

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

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

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

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

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

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

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

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

We, us and our: Humana Insurance Company or its subsequent designee.

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 person*.

Humana.

Humana.com
Toll Free 866-879-3630
1100 Employers Blvd
Green Bay WI 54344

Insured by Humana Insurance Company

Policyholder: State of Florida
Group number: CD9006
Coverage Effective Date: 01/01/2023

Summary of Your Benefits

This summary provides an overview of plan *benefits*. Refer to the **Your plan benefits** provision for detailed descriptions, including additional limitations or exclusions. Paid *benefits* are based on the *reimbursement limit.*

Dental benefits

Individual maximum benefit:
$1,000 per *year* per *covered person* for Preventive and Basic Services when *services* are provided by a PPO *dentist*.

$1,000 per *year* per *covered person* for Preventive and Basic Services when *services* are provided by a Non-PPO *dentist.*

Individual deductible:

Employee
$50 per *year* per *covered person* for Basic Services when *services* are provided by a PPO *dentist*.

$50 per *year* per *covered person* for Basic Services when *services* are provided by a Non-PPO *dentist*.

Maximum family deductible:

Employee and spouse
Covered expenses applied to the plan *deductible* of each *covered person* are combined to a *year* maximum of $100 when *services* are provided by a PPO *dentist*.

Covered expenses applied to the plan *deductible* of each *covered person* are combined to a *year* maximum of $100 when *services* are provided by a Non-PPO *dentist*.

Employee and child/children
Covered expenses applied to the plan *deductible* of each *covered person* are combined to a *year* maximum of $100 when *services* are provided by a PPO *dentist*.

Covered expenses applied to the plan *deductible* of each *covered person* are combined to a *year* maximum of $100 when *services* are provided by a Non-PPO *dentist*.

Employee and family
Covered expenses applied to the plan *deductible* of each *covered person* are combined to a *year* maximum of $150 when *services* are provided by a PPO *dentist*.

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

Preventive Services:
Preferred Provider Benefits: Benefits are paid at 100%.
Non-Preferred Provider Benefits: Benefits are paid at 80%.

- Routine teeth cleaning (prophylaxis)
- Topical fluoride treatment
- Sealants
- X-rays
- Oral examinations
- Space maintainers

Basic Services:
Preferred Provider Benefits: Benefits are paid at 80% after the *deductible*.
Non-Preferred Provider Benefits: Benefits are paid at 50% after the *deductible*.

- Fillings (amalgam and composite restorations)
- Non-surgical extractions
- Non-surgical residual root removal
- Oral Surgery
- Non-cast prefabricated stainless steel crowns
- Emergency exam and palliative care for pain relief
- Partial and denture repairs
- Denture relines or rebases
- Periodontics (gum disease)
- Endondontics (root canals)

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 exam – two per *year;*
   - Limited or problem focused exam– one per *year;*
   - Comprehensive exam – one every two years. Periodontal and comprehensive exams not in conjunction with each other.

2. Periodontal evaluations – one every two *years*.

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

4. Intra-oral complete series X-rays, or panoramic X-ray - once every five *years* for *covered persons* 12 years of age or older. 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 – two films per *year* for *covered persons* under age 10 and four films per *year* for *covered persons* age 10 and older.

6. Other x-rays, including intra-oral periapical and occlusal and extra-oral x-rays. Limited to x-rays necessary to diagnose a specific treatment.

7. Topical application of fluoride or fluoride varnish – provided to *covered persons* age 16 and younger. *Service* is payable once per *year.*

8. Sealants – application provided to *covered persons* age 16 *years* 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. Space maintainers for retaining space when a primary tooth is prematurely lost. *Services* are payable only for *covered persons* age 15 and younger for the installation of the initial appliance. Separate adjustment expenses will not be covered.

Basic services

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

2. Composite restorations (fillings) on anterior teeth - limited to one per tooth per surface in a two *year* period. 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. Gold foil 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*. Limited to a maximum of one per tooth every two years.

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

5. Non-cast pre-fabricated crowns on primary teeth that cannot be adequately restored with amalgam or composite restorations.

6. 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* is provided during the same visit.

7. Denture relines or rebases – once in a three year period after 6 months from installation.

8. Repairs of full or partial dentures.

Oral surgery services

1. Extractions - coronal remnants of a primary tooth.

2. Extraction - erupted tooth or exposed root.

3. Surgical extractions.

4. Bone Smoothing.

5. Trim or Remove over growth or non vital tissue or bone.

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

7. Surgical access of an unerupted tooth.

8. Mobilization of erupted or malpositioned tooth to aid eruption; or, surgical reposition of teeth.

9. Excision or removal of benign oral cysts or tumors.

10. Bone, cartilage, or synthetic grafts.

11. General anesthesia when based on review of clinical documentation provided and administered by a *dentist* in conjunction with a covered oral surgical procedure.

Periodontic services

1. Periodontal maintenance (following periodontal therapy) – procedure available two times per *year* for *covered persons* with periodontal history.

2. Periodontal scaling and root planing, available at a maximum of once per quadrant in a three year period. *Benefits* payable for a maximum of two quadrants on the same date of service. Additional quadrants are allowed after seven days or as allowed based on *clinical review*.

3. Scaling in presence of generalized moderate or severe gingival inflammation available based on *clinical review* a maximum of once a year. This service will reduce the number of routine cleanings available (under #3 in Preventive Services) so the total number of cleanings does not exceed two in a year per person.

4. Periodontal surgery, available at a maximum of once per quadrant in a three-year period.

5. Occlusal adjustments when performed in conjunction with periodontal surgery – available at a maximum of once per quadrant in a three year period.

Endodontic services

1. Root canal therapy, including root canal treatments and root canal fillings for permanent teeth - limited to one per tooth per lifetime.

2. Root canal retreatment, including root canal treatments and root canal fillings - limited to one per tooth per lifetime.

3. Apicoectomy - procedure available for permanent teeth only.

4. Partial pulpotomy for apexogenesis – procedure available for permanent teeth only.

5. Vital pulpotomy – procedure available for primary teeth.

6. Apexification/recalcification.

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. Additional charges related to materials or equipment used in the delivery of dental care;

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.

Additional benefits for newborns

If the *employee's* has dependent coverage, a child born to the *employee's* 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 expenses 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, excluding terrorism;

   - 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* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. *We* consider the following *cosmetic* procedures to include, but are not limited to:

   - Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.

   - Any *service* to correct congenital malformation;

   - Any *service* performed primarily to improve appearance;

   - Characterizations and personalization of prosthetic devices; or

   - Any procedure to change the spacing and/or shape of the teeth.

8. 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.

9. Any *service* not specifically listed in **Your plan benefits**.

10. Any *service* that:

    - Is not eligible for benefits based upon *clinical review*;
    - Does not offer a favorable prognosis;
    - Does not have uniform professional acceptance; or
    - Is deemed to be experimental or investigational in nature.

11. 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**).

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

13. Charges exceeding the *reimbursement limit* for the *service*.

14. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.

15. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, 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.*

16. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.

17. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

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* website and is updated daily. If *you* do not have Internet access, *dentist* lists are available by calling *us*. *Our* telephone number and Website 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

Open Enrollment Rider

Change in Plan Rider:
Coverage for Open Enrollment

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

Open enrollment period

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

To enroll for coverage

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

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

The eligibility date of coverage is amended as follows:

Employee Coverage:

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

1. The eligibility requirements stated in the Employer Group Application, or as otherwise agreed to by *us* and the *policyholder*, are satisfied;

2. The *employee* is in an *active status,* or;

3. The employer's annual anniversary date.

Open Enrollment Rider

Dependent coverage

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

1. The *employee* is eligible for coverage, if he or she has *dependents* who may be covered on that date;

2. Of the *employee's* marriage for any *dependents* (spouse or child) acquired on that date;

3. Of birth of the *employee's* natural-born child;

4. Of placement of the child for the purpose of adoption by the *employee.* 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. Specified in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) for a child, or a valid court or administrative order for a spouse, which requires the *employee* to provide coverage for a child or spouse as specified in such orders; or

7. Of the *employer's* annual anniversary date.

Please check the Summary of Your Benefits for waiting periods that may apply to *you.*

To obtain more information about *your* coverage, please feel free to contact our Customer Service Department at:

Humana Insurance Company
1100 Employers Blvd
Green Bay, WI 54344
866-879-3630

Bruce Broussard
President

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.

Notices

The following pages contain important information about 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. You are eligible for the rights more beneficial to you, unless preempted by state or federal law.

This section includes notices about:

Claims 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**
- **Family and Medical Leave Act (FMLA)**
- **Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)**
- **Your Rights under ERISA**

Discrimination Notice

Claim 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.

Claim 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 be 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, an internal appeal or an external review. The designation must be in writing and must be made by the covered person on Humana's Appointment of Representation (AOR) Form or on a form approved in advance by Humana. An assignment of benefits does not constitute designation of an authorized representative.

Humana's AOR Form must be submitted to Humana at the time or prior to the date an authorized representative commences a course of action on behalf of the covered person. At the same time, the authorized representative should also provide notice of commencement of the action on behalf of the covered person to the covered person, which Humana may verify 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. 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 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:

Urgent-care Claims	As soon as possible but no later than 72 hours after Humana receives the appeal request.
Pre-service Claims	Within a reasonable period but no later than 30 days after Humana receives the appeal request.
Post-service Claims	Within a reasonable period but no later than 60 days after Humana receives the appeal request.
Concurrent-care Decisions	Within the time periods specified above depending on the type of claim involved.

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:

- provides for support of a covered employee's child;
- provides for health care coverage for that child;
- is made under state domestic relations law (including a community property law);
- relates to benefits under the group health plan; and
- 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 § 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 getting this notice because you recently gained coverage under a group health and/or dental plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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 you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called 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, 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 too lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you too lose your coverage under the Plan because of the following qualifying events:

- 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 the following events:

- 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."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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. The employer must notify the Plan Administrator of the following qualifying events:

- the end of employment or reduction of hours of employment;
- death of the employee;
- commencement of a proceeding in bankruptcy with respect to the employer; or
- the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all 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.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events or a second qualifying event during the initial period of coverage may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also 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 Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum 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 COBRA continuation coverage.

Second qualifying event extension of 18-month period of

- ***continuation coverage*** **-** If your family experiences another qualifying event during the 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 the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying 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 contact or contacts identified below. For more information about your rights under ERISA, including COBRA, or other laws affecting your group heath 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 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

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information:

Humana
Billing/Enrollment Department
101 E Main Street
Louisville, KY 40201
866-879-3630

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

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

If elected, continuation coverage under USERRA will continue until the earlier of:

- 24 months beginning the first day of absence from employment due to service in the uniformed services; or

- 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 the Employment Rights Income Security Act of 1974 (ERISA)

Under 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:

- Examine, free of charge, all documents governing the plan. These documents are available in the plan administrator's office.
- 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.
- 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 and 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;
- 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;

- For questions about ERISA rights, 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;

- Call the publications hotline of the Employee Benefits Security Administration to obtain publications about ERISA rights.

Important!

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618,
  Lexington, KY 40512-4618
  If you need help filing a grievance, call the number on your ID card or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their complaint portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. Call the number on your ID card (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Language assistance services, free of charge, are available to you. Call the number on your ID card (TTY: 711)

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call the number on your ID card **(TTY: 711)**... ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que figura en su tarjeta de identificación **(TTY: 711)**... 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電會員卡上的電話號碼 **(TTY: 711)**... CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số điện thoại ghi trên thẻ ID của quý vị **(TTY: 711)**... 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . ID 카드에 적혀 있는 번호로 전화해 주십시오 **(TTY: 711)**... PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tawagan ang numero na nasa iyong ID card **(TTY: 711)**... ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Наберите номер, указанный на вашей карточке-удостоверении **(телетайп: 711)**... ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele nimewo ki sou kat idantite manm ou **(TTY: 711)**... ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le numéro figurant sur votre carte de membre **(ATS: 711)**...UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Proszę zadzwonić pod numer podany na karcie identyfikacyjnej **(TTY: 711)**... ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para o número presente em seu cartão de identificação **(TTY: 711)**... ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero che appare sulla tessera identificativa **(TTY: 711)**... ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Wählen Sie die Nummer, die sich auf Ihrer Versicherungskarte befindet **(TTY: 711)**... 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。お手持ちの ID カードに記載されている電話番号までご連絡ください **(TTY: 711)**...

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با شماره تلفن روی کارت شناسایی تان تماس بگیرید **(TTY: 711)**...

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, námboo ninaaltsoos yézhí, bee nééé ho'dólzin bikáá'ígíí bee hólne' **(TTY: 711)**...

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم الهاتف الموجود على بطاقة الهوية الخاصة بك **(TTY: 711)**.

"WARNING:
LIMITED BENEFITS WILL BE PAID WHEN NONPARTICIPATING PROVIDERS ARE USED.

You should be aware that when you elect to utilize the services of a nonparticipating provider for a covered nonemergency service, benefit payments to the provider are not based upon the amount the provider charges. The basis of the payment will be determined according to your policy's out-of-network reimbursement benefit. Nonparticipating providers may bill insureds for any difference in the amount. YOU MAY BE REQUIRED TO PAY MORE THAN THE COINSURANCE OR COPAYMENT AMOUNT. Participating providers have agreed to accept discounted payments for services with no additional billing to you other than allowance, copayment, and deductible amounts. You may obtain further information about the providers who have contracted with your insurance plan by consulting your insurer's website or contacting your insurer or agent directly."

To obtain more information about *your* coverage and to provide assistance in resolving complaints, please feel free to contact our Customer Service Department at:

Humana Insurance Company
1100 Employers Blvd
Green Bay, WI 54344
866-879-3630

Bruce Broussard
President