Employer: ISSG

Group Number: 535841

Dental Plan
Certificate of Insurance

HumanaDental Insurance Company

This certificate outlines the insurance provided by the group policy. It is not an insurance policy in its entirety. 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 Missouri laws. This certificate replaces any certificate previously issued under the provisions of the group policy.

Gerald L. Ganoni
President

HUMANA®
Specialty Benefits

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NOTICE:

This Notice is to advise you that should any questions arise regarding policy terms and premium payments, claims processing and claims payment, you may contact us directly at our principal place of business. We will try to resolve your concern at that time.

HumanaDental Insurance Company
1100 Employers Boulevard
Green Bay, WI 54344
1-800-233-4013

To file a written complaint, please submit all pertinent information to us at:

HumanaDental Correspondence Office
P.O. Box 14611
Lexington, KY 40512-4611

Benefits

Policyholder (Employer): ISSG
Group Number: 535841
Coverage Effective Date: 03/01/2014

Summary of your benefits

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

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

Dental benefits

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

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

Individual deductible:
$50 per *calendar year* per *member* for Basic and Major Services when *services* are provided by a PPO *dentist*.

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

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

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

Benefits

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

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

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

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

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

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

Waiting periods

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

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

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

Preventive Services:
No waiting periods apply to Preventive Services.

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

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

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

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

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

Your plan benefits

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

Preventive services

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

2. Periodontal evaluations - two per *calendar year*.

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

4. Intra-oral complete series X-rays (at least 14 films, including bitewings), or panoramic film X-rays – once every five years. If the total cost of periapical and bitewing x-rays exceeds the cost of a complete series of x-rays, the plan will consider these as a complete series.

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

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

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

8. Sealants – application provided to *dependents* age 14 and younger to the occlusal surface of permanent molars that are free of decay and restorations. *Service* is payable once per tooth per lifetime**.**

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

Basic services

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

2. Composite restorations (fillings) limited to one per tooth in a two year period. on anterior teeth – Composite restorations on molar and bicuspid teeth are considered an alternate *service* and will be payable as a comparable amalgam filling. *You* will be responsible for the remaining *expense incurred*. Multiple restorations on one surface are considered one restoration.

3. Pin retention in addition to an amalgam or composite restoration – this is not covered as a separate *covered expense* when done in conjunction with a core build-up.

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

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

6. Space maintainers for retaining space when a primary tooth is prematurely lost. *Services* are payable only for *dependents* age 14 and younger for the installation of the initial appliance. Separate adjustment expenses will not be covered.

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

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

9. Full or partial denture repair.

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

Oral surgery services

1. Extractions.

2. Bone Smoothing;

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

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

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

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

7. *We* will not cover any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.

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

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

Periodontic services

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

2. Periodontal surgery, available at a maximum of once per quadrant in a three-year period. If more than one surgical *service* is performed on the same day, we will consider only the most inclusive *service* performed as a *covered service*.

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

4. Periodontal maintenance (following periodontal therapy) – procedure available twice per *calendar year*.

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

Endodontic services

1. Root canal therapy, including root canal treatments and root canal fillings – procedure available to permanent teeth only, once per tooth in a two-year period. Any X-ray, test, laboratory, exam or follow-up care is considered integral to root canal therapy.

2. Apicoectomy - procedure available for permanent teeth only.

3. Vital pulpotomy – procedure available for deciduous (baby) teeth only.

Major/Prosthodontic services

1. Repairs of bridges; full or partial dentures, and crowns.

2. Denture adjustments – procedure available only for adjustments done by a *dentist* other than the one providing the denture, or adjustments performed more than six months after initial installation.

3. Initial placement of laboratory-fabricated restorations when the tooth, as a result of extensive decay or traumatic injury, cannot be restored with a direct placement filling material. *Covered services* include inlays, onlays, crowns, veneers, core build-ups and posts. These *services* are covered only on permanent teeth.

4. Initial placement of bridges, and full and partial dentures only if the functioning tooth (excluding third molars or teeth not fully in occlusion with an opposing tooth or prosthesis) was extracted while *you* are covered under this plan. *Covered expense* includes fixed bridges, removable partial dentures and full dentures. *Services* include all adjustments and relines within six months after installation and are payable only for treatment on permanent teeth. *We* will not cover replacement of congenitally missing teeth.

5. Replacement of bridges, partials, dentures, inlays, onlays, crowns or other laboratory-fabricated restorations. The existing major restoration or prosthesis can be replaced only if:

    - It has been at least five years since the prior insertion and is not, and can not be made, serviceable;

- It is damaged beyond repair as a result of an *accidental injury* (non-chewing injury) while in the oral cavity; or
- Extraction of functioning teeth, excluding third molars or teeth not fully in occlusion with an opposing tooth or prosthesis, necessitates the replacement of the prosthesis.

These *services* are covered only on permanent teeth.

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

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

8. *We* will not cover the replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.

Integral service

The following *services* are considered integral to the dental *service*. A separate fee for these *services* is not considered a *covered expense.*

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

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

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

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

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 incurred* while *you* qualify for any worker's compensation or occupational disease act or law, whether or not *you* applied for coverage.

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 while *you* are confined in a hospital or institution owned or operated by the United States Government or any of its agencies for any service-connected *sickness* or *bodily injury*, unless *you* are legally required to pay in the absence of insurance.

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

4. Any expense arising from the completion of forms.

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

6. Any *service we* consider *cosmetic dentistry* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. *We* consider the following *cosmetic dentistry* procedures:
   - Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
   - Any *service* to correct congenital malformation;
   - Any *service* performed primarily to improve appearance; or
   - Characterizations and personalization of prosthetic devices.

7. Charges for:
   - Any type of implant and all related services, including crowns or the prosthetic device attached to it.
   - Precision or semi-precision attachments.
   - Overdentures and any endodontic treatment associated with overdentures.
   - Other customized attachments.

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

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

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

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

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

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

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

15. Orthodontic *service*s unless specified in *your* **Summary of your benefits**.

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

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

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

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

20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, temporary dental *services*, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*

21. Repair and replacement of orthodontic appliances.

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

How your plan works

General benefit payments

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

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

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

Deductibles

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

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

Coinsurance

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

Waiting periods

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

Benefit maximums

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

Alternate services

If two or more *services* are considered to be acceptable to correct the same dental condition, the *benefits* payable will be based on the *covered expenses* for the least expensive *service* which will produce a professionally satisfactory result as determined by *us*.

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*.

If a *service* is determined to be eligible, and *you* have received a written estimate from *us* indicating this, *we* will not retrospectively deny eligibility for that *service* for reasons of *medical necessity* or experimental treatment, unless the estimate was based on material misrepresentation or admission about the patient’s condition included in the dental *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. Upon receipt of notice of claim, *we* will send *you* the forms for filing proof of loss. If the forms are not sent to *you* within 15 days, *you* will have met the proof of loss requirement by sending *us* a written statement of the nature and extent of the loss within the time limit stated below.

Submitting claim information and proof of loss

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

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

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

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

Claims

Paying claims

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

Extension of benefits

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

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

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

Reasons for denying a claim

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

1. **Not a covered benefit:** The *service* is not a *covered service* under the 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.

Legal actions

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

Facility of payment

Payments made under any other plan which, according to these provisions, should have been made by *us*, will be adjusted by *us*. To do this, *we* reserve the sole right to pay the organization (s) which made such payments the amount (s) *we* determine to be warranted. Any amount (s) so paid are regarded as *benefits* paid under this policy. *We* will be fully discharged from liability under this policy to the extent of any payment so made.

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;
   - Governmental programs or programs mandated by state statute, or sponsored or provided by an educational institution, if it is not otherwise excluded from the calculation of benefits under this policy, and
   - No-fault automobile coverage.

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

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

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

Effect on benefits

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

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

Order of benefit determination

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

1. The plan that covers the person as an *employee* submitting the claim, except when that person is also a Medicare beneficiary. Medicare is:
   - Secondary to the plan covering the person as a dependent; and
   - Primary to the plan covering the person as a retired employee.

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. If the specific terms of the court decree state that parents shall have joint custody, without stating that one of the parents is responsible for the health care expenses of the child, then the benefits are determined as explained under #2 and #3 above.

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 right of continuation, mandated by federal law (e.g. COBRA) or state law, and is also covered under another plan, the benefits of the plan which covers the person as an employee or that person's dependent will be determined first, before the benefits of a plan which provides coverage under the continuation provision.

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.

Coordinating benefits with Medicare

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

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

Claims

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.

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.

Grievance procedures

We make every effort to resolve customer dissatisfaction issues at an informal level. *Our* customer service representatives are available to assist *you* with any issue relating to *your* dental coverage or any aspect of *your* plan. *We* can be reached at:

HumanaDental Insurance Company
1100 Employers Boulevard
Green Bay, WI 54344
1-800-558-4444.

Definitions

The following terms are defined as they apply to this Grievance process

Adverse determination: a determination made by *us* or *our* designated utilization review organization, that a proposed or delivered *service* has been reviewed and, based on the information provided, does not meet *your* plan requirements for *dental necessity*, *medical necessity*, appropriate or efficient and the payment for the requested *service* is either denied, reduced or terminated.

Grievance: any complaint submitted in writing, by *you* or a representative or provider on *your* behalf regarding:

1. Availability, delivery or quality of *services*, including a complaint regarding an adverse determination;
2. Claims payment, handling or reimbursement for services; or
3. Any issues related to *our* contractual relationship with *you*.

This correspondence should be submitted to:

HumanaDental Correspondence Office
P.O. Box 14611
Lexington, KY 40512-4611

Grievance review

You may wish to file a formal grievance. Formal grievances should be submitted as soon as possible following the occurrence.

First level

We will acknowledge the receipt of a formal grievance within 10 working days. *You* will be notified in writing of a final decision within 20 working days of receipt of the grievance. If the investigation cannot be completed within 20 working days, *you* will be notified in writing on or before the twentieth working day of the reasons for which additional time is needed. The investigation will be completed within 30 working days thereafter.

Within five working days of the investigation being completed, a person not involved in the grievance or the review will decide upon the appropriate resolution, and *you* will be notified in writing of the grievance resolution and the right to appeal to the Grievance Review Panel. *Our* written notice will clearly explain the resolution of the grievance and the right to request a second level of review.

Within 15 working days of the investigation being completed, *we* will notify the person who filed the grievance on *your* behalf of *our* resolution.

Second level -Grievance review panel

If *you* are not satisfied with the resolution of the formal grievance at the first level, *you* may appeal to the Grievance Review Panel by submitting a written request for review. The Grievance Review Panel will consist of:

1. Other enrollees;

2. *Our* staff providers or other providers not involved in the circumstances giving rise to the grievance or in any subsequent investigation or determination of the grievance; and

3. Where the grievance involves an adverse determination, a majority of providers that are appropriate clinical peers in the same or similar specialty as would typically manage the case being reviewed that were not involved in the circumstances giving rise to the grievance or in any subsequent investigation or determination of the grievance.

The Grievance Review Panel request will be acknowledged within 10 working days of receipt. *You* will be given the opportunity to appear before the Grievance Review Panel to present *your* position.

The Grievance Review Panel will:

1. Review the initial determination and any additional evidence *you* submitted.

2. Notify *you* in writing of a final decision within 20 working days of receipt of the grievance. If the investigation cannot be completed within 20 working days, *you* will be notified in writing on or before the twentieth working day of the reasons for which additional time is needed. The investigation will be completed within 30 working days thereafter.

   Within five working days of the investigation being completed, a person not involved in the grievance or the review will decide upon the appropriate resolution and *you* will be notified in writing of the grievance resolution and the right to appeal to the Missouri Department of Insurance.

3. Notify the person who filed the grievance on *your* behalf of *our* resolution within 15 working days of the investigation being completed.

Expedited review

An expedited review may be requested when review time frames would seriously jeopardize *your* life, health or ability to regain maximum function. *We* will accept requests for an expedited review, in writing or orally. If criteria are met for an expedited review, *we* will notify *you* verbally of the resolution within 72 hours. Written resolution will be sent within three working days.

If *you* are dissatisfied with the final decision or process, *you* have the right to appeal to the Missouri Department of Insurance during any phase of the grievance process. *We* will cooperate with *you* and the Department through this process.

Department of Insurance

You have the right to contact the Director of Insurance for assistance **at any time** at:

Missouri Department of Insurance
Room 530, Truman Building,
301 W High St.,
Jefferson City, Missouri 65101; or

P.O. Box 690,
Jefferson City, Missouri 65102.
Telephone Number: (Toll-Free) 1-800-726-7390.

Eligibility

When you are eligible for coverage

Employee coverage

Eligibility date: The *employee* is eligible for coverage when:

1. Eligibility requirements listed in the **Employer Group Application** (see *your employer* for details) are satisfied; and
2. *Employee* is in *active status.*

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

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

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

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

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

Incontestability: After *you* have been insured for two years, *we* cannot contest the validity of coverage except for nonpayment of premium. Statements *you* make cannot be contested unless they are in writing with *your* signature. A copy of the form must then be given to *you*.

Dependent coverage

Eligibility date: If an *employee* is covered, the *employee's dependent* is eligible for coverage:

1. On the date the *employee* is eligible for coverage;
2. On the date of the *employee's* marriage (spouse and/or stepchildren);
3. On the date of birth of the *employee's* natural-born child; or
4. On the date of placement, for the purpose of adoption by the *employee*, if petition for adoption is filed within 30 days of placement. Placement means in the physical custody of the adoptive parent;
5. On the date of birth, if a petition for adoption is filed within 30 days of the birth of such child; or
6. On the date specified in the court or administrative order, which requires the *employee* to provide coverage for a child or spouse as specified in such order, if *you* are eligible for *dependent* coverage.

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

Eligibility

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

Newborn enrollment: We must receive notification of birth and payment of any additional premium, if required, within 31 days after the date of birth in order to have coverage continue beyond the 31 day period after the date of birth. *Employees* who have dependent coverage in force PRIOR to the newborn's date of birth are not required to complete an enrollment form. If *you* need an enrollment form, it is available from the *employer* or from *us*. If *you* contact *us*, *we* will provide *you* all forms and instructions to enroll the newborn child and allow *you* an additional 10 days from the date the forms are provided in which to enroll the newborn child.

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

1. If *we* receive the enrollment form before the *dependent's* eligibility date, the *dependent* is covered on the date he or she is eligible.

2. If *we* receive the enrollment form within 31 days after the *dependent's* eligibility date:
   - The *dependent* is covered on the date *we* receive the completed enrollment form; or
   - The *dependent* is covered on the date he or she is eligible if the *employee* already had *dependent* coverage in force.

3. In the case of an adopted child, if *we* receive the enrollment form on, prior to or within 31 days of the eligibility date, coverage is effective on:
   - The date of birth, if petition for adoption is filed within 31 days of the birth of such child; or

   - The date of placement, if petition for adoption is filed within 31 days of the placement of such child. Coverage will continue unless placement is disrupted prior to legal adoption and the child is removed from placement.

4. The date *we* specify if *we* receive the completed enrollment forms more than 31 days after the *dependent's* eligibility date.

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

Dependent delayed effective date: A *dependent's* effective date of coverage will be delayed if the *dependent* is homebound due to *bodily injury* or *sickness*, or is confined to a hospital or mental health center. The *dependent's* coverage will be effective one day after discharge from confinement. A physician must certify the discharge. This does not apply to newborn eligibility or coverage.

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

Retired employee coverage

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

Eligibility

Effective date: Retired *employees* must enroll for coverage on forms *we* furnish. The effective date of coverage for an eligible retired *employee* is the latter of:

1. The date retired *employees* are eligible for coverage under this policy;
2. The actual retirement date for *employees* who retire after that date; or
3. The date *we* specify if *we* receive the enrollment forms more than 31 days after the retired *employee's* eligibility date.

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

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

Terminating coverage

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

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

Special provisions for active status

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

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

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

Continuation for specific circumstances

If *you* belong to a COBRA eligible group (*employers* with 20 or more e*mployees*), continuation may be available to the following *members*:

1. Surviving spouses;
2. Divorced or legally separated spouses; and
3. Eligible *dependents*

Any *member*, whose coverage would otherwise terminate because of the dissolution of marriage or legal separation, or death of the e*mployee*, may continue coverage under this policy if y*ou*, the legally separated, divorced or surviving spouse are 55 years of age or older at the time of the expiration of coverage provided by the federal Consolidated Omnibus Reconciliation Act (COBRA).

Within 60 days of legal separation or the dissolution of marriage, or prior to the expiration of a thirty-six month COBRA continuation period covering a legally separated or divorced spouse who has elected and maintained such COBRA coverage, y*ou* must give written notice of the legal separation or dissolution of marriage to the e*mployer*. The notice shall include the mailing address of the legally separated or divorced spouse.

Within 30 days of the death of the e*mployee*, or prior to the expiration of a thirty-six month COBRA continuation period covering the surviving spouse, *you* must give the *employer* written notice of death and the mailing address of the surviving spouse.

Eligibility

Within 14 days of receipt of notice of the dissolution of marriage, legal separation, or death of the *employee*, a form for election to continue coverage will be sent to the legally separated, divorced or surviving spouse. A statement of the amount of periodic premiums for the continuation of coverage and method and place of payment will be included.

The monthly premium for the continuation will not be greater than 125% of the total of the following:
1. The amount *you* would be charged if *you* were a current group *member*; and
2. The amount *your employer* would contribute toward the premium, if *you* were a current group *member*.

You must pay the first premium for the continuation of coverage under this provision within 45 days of the date following election.

You must return the election form by mail within 60 days after the date the notice to elect continuation is mailed to *you*. Failure of the legally separated, divorced, or surviving spouse to exercise the election within such 60-day period will terminate the right to continuation of benefits under this provision.

Your right to continuation of coverage under this provision will terminate on the earliest of the following:
1. The end of the period for which *you* fail to make timely payment of premium;

2. The date *your employer's* group policy is terminated and NOT replaced; (If the group policy is replaced, coverage may continue under the new group policy as if the original policy had not terminated.)

3. The date *you* become insured under any other group health plan;

4. The date *you* remarry and become insured under any other group health plan; or

5. The date *you* become 65 years of age.

Replacement provisions

Applicability: This provision applies only if:

1. *You* are eligible for dental coverage on *your employer's* effective date under this 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 this 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.

Teeth extracted prior to effective date: *We* will not pay for a prosthetic device to replace any teeth lost before *you* became insured under this plan unless the device also replaces one or more natural teeth lost or extracted after *you* became insured 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 the Company's other rights or responsibilities.

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.

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

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

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.

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

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

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

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

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

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

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

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

Definitions

Dependent: A covered *employee's*:

1. Lawful spouse; and

2. Unmarried, natural blood related child, stepchild or legally adopted child whose age is less than the limiting age. Adopted child includes a child who is placed in the home of the insured for the purpose of adoption. Coverage continues unless the placement is disrupted prior to legal adoption and the child is removed from placement. Placement means in the physical custody of the adoptive parent. Coverage shall include any *covered services* treating medical conditions existing prior to the date of placement. Each child must qualify as a dependent as defined by the United States Internal Revenue Code.

The limiting age for each *dependent* child is 26 years.

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

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

1. Mentally or physically disabled;
2. Incapable of self-sustaining employment;
3. Chiefly dependent on the covered *employee* for support and maintenance; and
4. Unmarried.

You need to provide *us* with satisfactory proof that the above conditions continually exist after the *dependent* reaches the limiting age. *We* may not request proof more often than annually after two years from the date the first proof was furnished. If *we* do not receive satisfactory proof, the child's coverage ends on the date proof is due.

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

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

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

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

Expense incurred date: The date on which:

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

Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

1. The fee most often charged in the geographical area where the *service* was performed;
2. The fee most often charged by the provider;
3. The fee that is recognized as reasonable by a prudent person;
4. The fee determined by comparing charges for similar *services* to a national database adjusted to the geographical area where the *services* or procedures were performed;

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

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

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

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

Total disability/totally disabled: An *employee* or employed covered spouse who, during the first 12 months of a disability, is prevented by *bodily injury* or *sickness* from performing the material and substantial duties of his or her respective job or occupation.

After 12 months, *total disability/totally disabled* means the person is prevented by *bodily injury* or *sickness* from performing the material and substantial duties of any occupation that he/she is 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: The insurance company as shown on the cover page of this certificate.

Year means the period of time which begins on any January 1st and ends on the following December 31st. When *you* first become covered by the *policy*, the first *year* begins for *you* on the effective date of *your* insurance and ends on the following December 31st.

You and your: Any covered *employee* and/or *dependent(s).*

PPO provisions

What is a preferred provider organization (PPO)?

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

Reasons to use a PPO provider

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

You have the freedom to choose the *dentist* of *your* choice. However, *you* will receive *maximum benefits* by seeing a PPO Network *dentist*. If *you* visit a non-participating PPO *dentist*, *you* may be billed for any *expense incurred* that exceeds *our reimbursement limits*.

How to select a provider

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

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

Gerald L. Ganoni
President

HUMANA®

Specialty Benefits

HumanaDental.com
Toll Free 800-233-4013
1100 Employers Blvd
Green Bay WI 54344

Insured by HumanaDental Insurance Company
In Kentucky, insured by The Dental Concern, Inc.

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Missouri Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policy-holders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and in some cases, to keep coverage in force. The valuable extra protection provided by theses insurers through the guaranty association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The Missouri Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Missouri. You should not rely on coverage by the Missouri Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy. Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as variable contract sold by prospectus. Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy. YOU MAY CONTACT EITHER THE ASSOCIATION OR THE MISSOURI DEPARTMENT OF INSURANCE AT THE FOLLOWING ADDRESSES SHOULD YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE.

The Missouri Life and Health Insurance Guaranty Association
520 Dix Road, Suite D
Jefferson City, MO 65109

OR

Missouri Department of Insurance
P.O. Box 690
Jefferson City, MO 65102-0690

The state law that provides for this safety-net coverage is called the Missouri Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

Generally, persons will be covered if they live in this state, and hold a life or health insurance contract or annuity, or a certificate under a group policy or contract. However, not all individuals with a right to recover under life or health insurance polices or annuities are protected by the Act. A person is not protected when:

1. The person is eligible for protection under the laws of another state;

2. The person purchased the insurance from a company that was not authorized to do business in this state;

3. The policy is issued by an organization which is not a member insurer of the association; or

4. The person does not live in this state, except under limited circumstances. Additionally, the Association may not provide coverage for the entire amount a person expects to receive from the policy. The Association does not provide coverage for any portion of the policy where the person has assumed the risk, for any policy of reinsurance (unless an assumption certificate was issued), for interest rates that exceed a specified average rate, for employer's plans that are self-funded, for parts of plans that provide dividends or credits in connection with the administration of policy, or for unallocated annuity contracts (which generally issued to pension plan trustees). The Act also limits the amount the Association is obligated to pay persons on various policies. The Association does not pay more than the amount of the contractual obligation of the insurance company. The Association does not have to pay more than three hundred thousand dollars ($300,000) in death benefits for any one life regardless of the number of policies that insure that life. The Association does not have to pay amounts over one hundred thousand ($100,000) in cash surrender or withdrawal benefits on one life regardless of the number of policies insuring that individual. For health insurance benefits, the Association is not obligated to pay over one hundred thousand ($100,000) including net cash surrender and withdrawal benefits. On an annuity contract, the Association is not liable for over one hundred thousand ($100,000) in present value. Finally, the Association is never obligated to pay more than a total of three hundred thousand dollars ($300,000) for any one insured for any combination of insurance benefits.

Notices

The following pages contain important information about Humana's claims procedures and certain federal laws. There may be differences between the Certificate of Insurance and this Notice packet. There may also be differences between this notice packet and state law. The Plan participant is eligible for the rights more beneficial to the participant.

This section includes notices about:

Claims and Appeal Procedures

Federal Legislation

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

Privacy and Confidentiality Statement

CLAIMS AND APPEALS PROCEDURES

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

DISCRETIONARY AUTHORITY

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

1) Interpret plan provisions.

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

3) Resolve factual questions relating to coverage and benefits.

CLAIMS PROCEDURES

Definitions

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

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

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

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

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

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

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

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

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

Submitting a Claim

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

A claim must be filed in writing and delivered by mail, postage prepaid, by FAX or e-mail. A request for pre-authorization may be filed by telephone. The claim or request for pre-authorization must be submitted to Humana or to Humana's designee at the address indicated in the covered person's benefit plan document or identification card. Claims will 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 or appeal. The authorization must be in writing and authorize disclosure of health information.

If a document is not sufficient to constitute designation of an authorized representative, as determined by Humana, the plan will not consider a designation to have been made. An assignment of benefits does not constitute designation of an authorized representative.

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

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

Claims Decisions

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

Pre-service Claims

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

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

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

Urgent-care Claims (expedited review)

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

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

If a claim does not provide sufficient information to determine whether, or to what extent, services are covered under the plan, Humana will notify the Claimant as soon as possible, but not more than 24 hours after receiving the Urgent-care Claim. The notice will describe the specific information necessary to complete the claim. The Claimant will have a reasonable amount of time, taking into account the covered person's circumstances, to provide the necessary information – but not less than 48 hours.

Humana will provide notice of the plan's Urgent-care Claim determination as soon as possible but no more than 48 hours after the earlier of:

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

Concurrent-care Decisions

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

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

Post-service Claims

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

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

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

Initial Denial Notices

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

A claims denial notice will convey the specific reason for the *adverse determination* and the specific plan provisions upon which the determination is based. The notice will also include a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary. The notice will disclose if any internal plan rule, protocol or similar criterion was relied upon to deny the claim. A copy of the rule, protocol or similar criterion will be provided to Claimants, free of charge, upon request.

The notice will describe the plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

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

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

APPEALS OF ADVERSE DETERMINATIONS

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

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

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

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

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

Time Periods for Decisions on Appeal

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

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

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

Procedures for determining the qualified status of medical child support orders are available at no cost upon request from the plan administrator.

CONTINUATION OF COVERAGE FOR FULL-TIME STUDENTS DURING MEDICAL LEAVE OF ABSENCE

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

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

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

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

Introduction

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

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

What is COBRA Continuation Coverage?

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

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

- Your hours of employment are reduced, or

- Your employment ends for any reason other than gross misconduct.

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

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

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

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

When is COBRA Coverage Available

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

You Must Give Notice of Some Qualifying Events

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

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. Once the Plan Administrator offers COBRA continuation coverage, the qualified beneficiaries must elect such coverage within 60 days.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage last for up to a total of 36 months. When the qualifying event is the end of employment, or reduction in the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee last until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which the employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally last for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

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

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

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

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator. For more information about your rights under ERISA, including COBRA, or other laws affecting your group 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 the EBSA website at www.dol.gov/ebsa. (address and phone numbers of Regional and District EBSA Office are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

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

IMPORTANT NOTICE FOR INDIVIDUALS ENTITLED TO MEDICARE TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982 (TEFRA) OPTIONS

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

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

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

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

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

Category 1 Medicare eligibles are:

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

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

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

Calculation and Payment of Benefits

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

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

FAMILY AND MEDICAL LEAVE ACT (FMLA)

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

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

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

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

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

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

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

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

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

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

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

YOUR RIGHTS UNDER ERISA

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

Information About the Plan and Benefits

Plan participants may:

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

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

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

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

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

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

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

Enforce Your Rights
Under ERISA, there are steps participants may take to enforce the above rights. For instance, if a participant requests a copy of plan documents does not receive them within 30 days, the participant may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the

materials and pay you up to $ 110 a day until the participant receives the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If a claim for benefits is denied or disregarded, in whole or in part, the participant may file suit in a state or Federal court. In addition, if the participant disagrees with the plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, the participant may file suit in Federal court. If plan fiduciaries misuse the plan's money, or if participants are discriminated against for asserting their rights, they may seek assistance from the U.S. Department of Labor, or may file suit in a Federal court.

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

Assistance with Questions

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

PRIVACY AND CONFIDENTIALITY STATEMENT

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

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

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

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

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

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

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

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

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