

Policyholder: LOUISIANA STATE UNIVERSITY
Group number: 841361

Dental Plan

Certificate of Insurance

Humana Health Benefits Plan of Louisiana

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

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

Humana.



Bruce Broussard
President

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REIMBURSEMENT LIMIT

The State of Louisiana requires that *we* provide *you* with the following notice:

Your Plan is designed to cover the Usual and Customary fee for dental work. *Your* Certificate of Insurance defines *reimbursement limit* as the lesser of:

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

This determination was derived from a national data base of prevailing health care charges system and is based on the 90th percentile. This system is a compilation of national data from actual fees submitted by physicians for uniformly coded dental services and procedures performed in a specific geographical location (zip codes). *We* have calculated the reimbursement level based upon the fees submitted by approximately 90% of the physicians within the zip code where the services or procedures were performed. This information is reviewed and/or updated every 6 months. As a result, 90% of the providers charge at, or below, the amounts *we* allow.

Information regarding dental reimbursement rates are available from your employer.

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 year before we pay any *coinsurance* (see **Summary of your benefits**).

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

Coinsurance

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

Waiting periods

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

Benefit maximums

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

Alternate services

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

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*.

How we pay claims

Identification numbers

You received an identification (ID) card showing *your* name, identification number and group number. Show this ID card to *your dentist* when *you* receive *services*.

Claim forms

We do not require a standard claim form to process *benefits*. When *we* receive a claim, *we* will notify *you* or *your dentist* if any additional information is needed.

Submitting claim information and proof of loss

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

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

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

Coordinating benefits with another insurer

This Coordination of Benefits (COB) provision applies when a *member* has health care coverage under more than one Plan. Plan is defined below.

The Order of Benefit Determination rules below determine which Plan will pay as the primary Plan. The primary Plan that pays first pays without regard to the possibility that another Plan may cover some expenses. A secondary Plan pays after the primary Plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100 percent of the total Allowable Expense.

DEFINITIONS

1. **Plan**— For this purpose a Plan is any of the following that provides *benefits* or *services* for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for *members* of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts. Plan includes:
 - A. Group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured);
 - B. Hospital indemnity benefits in excess of \$300 per day; medical care components of group long-term care contracts, such as skilled nursing care;
 - C. Medical or dental benefits under group or individual automobile contracts; and
 - D. Medicare or other governmental benefits, as permitted by law.

Plan does not include:

- A. Individual or family insurance;
 - B. Closed panel or other individual coverage (except for group-type coverage);
 - C. Amounts of hospital indemnity insurance of \$300 or less per day; school accident type coverage, benefits for nonmedical or nondental components of group long-term care policies;
 - D. Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.
2. **Allowable expense**— A *service* or expense, including *deductibles* and copayments, that is covered at least in part by any of the Plans covering the *member* which allows services or expenses that are similar to the *services* and expenses covered by this Plan. When a Plan provides *benefits* in the form of *services*, the reasonable cash value of each service will be considered 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. The following are examples of expenses or *services* that are not Allowable Expenses:
 - A. If a *member* is covered by two or more Plans that compute their *benefit* payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific *benefit* is not an Allowable Expense.

Recovery rights

Your obligation in the recovery process

We have the right to collect *our* payments made in error. *You* are obligated to cooperate and assist *us* and *our* agents to protect *our* recovery rights by:

1. Obtaining *our* consent before releasing any party from liability for payment of dental expenses.
2. Providing *us* with a copy of any legal notices arising from *your* injury and its treatment.
3. Assisting *our* enforcement of recovery rights and doing nothing to prejudice *our* recovery rights.
4. Refraining from designating all (or any disproportionate part) of any recovery as exclusively for “pain and suffering.”

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

Right of subrogation

To the extent that benefits are provided or paid under this Policy, *we* shall be subrogated to all rights of recovery which any *member* may acquire against any other party for the recovery of the amount paid under this Policy, however our Right of Subrogation is secondary to the right of the *member* to be fully compensated for his damages. The *member* agrees to deliver all necessary documents or papers, to execute and deliver all necessary instruments, to furnish information and assistance, and to take any action *we* may require to facilitate enforcement of *our* Right of Subrogation. *We* agree to pay *our* portion of the *member's* attorneys' fee or other costs associated with a claim or lawsuit to the extent that *we* recover any portion of the benefits paid under this Policy pursuant to *our* Right of Subrogation.

Right of reimbursement

To the extent *we* have paid benefits under this *policy*, *you* agree that if *you* recover from a third party, *you* will reimburse the portion of the damages recovered for the expenses incurred by *you* that were paid by *us*. *We* agree to pay *our* portion of *your* attorney's fees associated with a claim or lawsuit to the extent that *we* recover any portion of the benefits paid under this policy pursuant to *our* right of reimbursement.

Assignment of recovery rights

If *your* claim against the other insurer is denied or partially paid, *we* will process the claim according to the terms and conditions of this policy. If *we* make payment on *your* behalf, *you* agree that any right for expenses *you* have against the other insurer for expenses *we* pay will be assigned to *us*.

If *benefits* are paid under this policy and *you* recover under any automobile, homeowners, premises or similar coverage, *we* have the right to recover from *you* an amount equal to the amount *we* paid.

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;

Eligibility

Definitions

The following terms are used in this section:

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

Special enrollment date means:

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

Eligibility date

Employee eligibility date

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

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

Dependent eligibility date

Each *dependent* is eligible for coverage on:

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

Eligibility

Terminating coverage

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

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

Special provisions for active status

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

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

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

State continuation of health insurance

The following applies only to *employees* of employer groups with less than 20 covered *employees*.

Eligibility

You have the right to continue coverage for *yourself* and *your* covered *dependent* if:

- *Your* employment terminates; or
- *You* are no longer in a class eligible for coverage.

Continuation is available only if the *employee* has been continuously covered under the policy, or under any group policy providing similar benefits which it replaces, for at least 3 months immediately prior to the date of termination.

Eligibility

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.

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.

Disclosures

Discount/access disclosure

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

Who has responsibility for these discounts?

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

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

Disclosures

Shared Savings Program

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

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

However, *you* may inquire in advance to determine if a *dentist* participates in the Shared Savings Program by calling 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.

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

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

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

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

Covered person: the *employee* and/or dependent who is covered under the Policy.

Covered service: A dental *service* that is:

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

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

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

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

Dependent: A covered *employee's*:

1. Lawful spouse; and
2. Natural blood related child or stepchild;
3. Child who is placed in the home of the *employee* pursuant to an adoption placement agreement executed with a licensed adoption agency, from the date of placement;

Definitions

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

You and your: Any covered person.

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*:
 - For which *you* would not be required to pay if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with *sickness* or *bodily injury*.
3. Any loss caused or contributed by:
 - War or any act of war, whether declared or not;
 - Any act of international armed conflict; or
 - Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. *Your* failure to keep an appointment with the *dentist*.
6. Any *service* we consider *cosmetic* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. We consider the following *cosmetic* procedures to include, but are not limited to:
 - Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - Any *service* to correct congenital malformation;
 - Any *service* performed primarily to improve appearance;
 - Characterizations and personalization of prosthetic devices; or
 - Any procedure to change the spacing and/or shape of the teeth.

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;
- Any service for 3D imaging (cone beam images);
- Temporary and interim dental services;
- Additional charges related to material or equipment used in the delivery of dental care.
- Charges rendered for treatment in a clinical or dental facility sponsored or maintained by the *employer*;
- The removal of any implants unless specified in the Summary of Your Benefits section of this *certificate*.

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:
 - Is not eligible for benefits based upon *clinical review*;
 - Does not offer a favorable prognosis;
 - Does not have uniform professional acceptance; or
 - Is deemed to be experimental or investigational in nature.
15. Orthodontic *services* unless specified in *your Summary of your benefits*. Only the services specified in the orthodontic rider will be covered orthodontic benefits under this plan.
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, 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. Temporary dental *services*.
22. Repair and replacement of orthodontic appliances.
23. 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.
24. The oral surgery benefits under this plan does not include:
 - a. Any *services* for orthognathic surgery;
 - b. Any *services* for destruction of lesions by any method;
 - c. Any *services* for tooth transplantation;
 - d. Any *services* for removal of a foreign body from the oral tissue or bone;
 - e. Any *services* for reconstruction of surgical, traumatic, or congenital defects of the facial bones;
 - f. Any separate fees for pre and post-operative care.

25. General anesthesia or conscious sedation is not a *covered service* unless it is based on *clinical review* of documentation provided and administered by a *dentist* or *health care practitioner* in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for *covered services*.

General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered:

1. Pain control unless a documented allergy to local anesthetic is provided.
 2. Anxiety.
 3. Fear of pain.
 4. Pain management.
 5. Emotional inability to undergo surgery.
26. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
27. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
28. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
29. Separate fees for pre- and post-operative care and re-evaluation within 12 months are not considered *covered services* under the surgical periodontic services in this plan.
30. *We* do not cover *services* that generally are considered to be medical *services* except those specifically noted as covered in this certificate.

Excess coverage

We will not pay benefits for any *accidental injury* if other insurance will provide payments or expense coverage, other than that described in the Coordination of Benefits provision, regardless of whether the other coverage is described as primary, excess or contingent. If *your* claim against another insurer is denied or partially paid, *we* will process *your* claim according to the terms and conditions of this certificate. If *we* make a payment, *you* agree to assign to *us* any right *you* have against the other insurer for dental expenses *we* pay. Payments made by the other insurer will be credited toward any applicable *coinsurance* or *deductibles* for the year.

Humana.

Humana.com
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Green Bay WI 54344

Insured by Humana Health Benefit Plan of Louisiana

Benefits

Policyholder: LOUISIANA STATE UNIVERSITY
Group Number: 841361
Coverage Effective Date: 01-01-2021

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*.

Dental benefits

Individual maximum benefit:

\$1,000 per year per *covered person* for Basic and Major Services.

Individual extended maximum benefit: When a *covered person* has reached his or her Individual Maximum Benefit *covered expenses* for Preventive, Basic and Major *services* will be paid at 30% for the remainder of that *year*. Coverage of these *services* will be subject to all provisions of this Certificate, including but not limited to, the eligibility of the *covered person*, the *reimbursement limit*, and all limitations and exclusions.

Individual deductible:

\$50 per year per *covered person* for Basic and Major Services.

Maximum family deductible:

Covered expenses applied to the plan *deductible* of each *covered person* are combined to a *year* maximum of \$150.

Preventive Services:

Benefits are paid at 100%.

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

Benefits

Basic Services:

Benefits are paid at 45% after the *deductible*.

- Fillings (amalgam and composite restorations)
- Non-surgical extractions
- Non-surgical residual root removal
- Periodontic cleaning
- Oral Surgery
- Non-cast prefabricated crowns
- Emergency exam and palliative care for pain relief
- Harmful habits and thumb-sucking appliances
- Periodontics (gum disease)
- Endodontics (root canals)

Major Services:

Benefits are paid at 20% after the *deductible*.

- Crowns
- Inlays and onlays
- Removable or fixed bridgework
- Partial or complete dentures
- Denture relines or rebases
- Partial and denture repairs and adjustments

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*.

Any *member* who is a *late applicant*, is subject to a 12-month waiting period before he or she is eligible for coverage for any *service* except Preventive *services*.

If a *member* enrolls 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 the *member* had prior dental coverage immediately before his or her coverage with *us*.

If a member has continuous dental coverage without a break of more than 63 days between the termination of creditable coverage and his or her enrollment date under the policy, any period of time that was satisfied under the prior plan will be applied to the appropriate waiting periods under the policy, if any. The *employee* will then be eligible for benefits under the policy when the balance of the waiting period has been satisfied, whether the *member* is timely or a *late applicant*.

Please see *your* Summary of Benefits for waiting period provisions that are specific to *you*.

Preventive Services:

No waiting periods apply to Preventive *services*.

Basic Services:

No waiting periods apply to Basic *services*, unless the *member* is a *late applicant*.

If a *member* is a *late applicant*, he or she must be insured under this policy for a period of 12 continuous months before Basic *services* will be covered.

Major Services:

For Major Services, coverage is effective as follows:

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

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

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

For a *late applicant* added after the group's effective date under this policy, he or she MUST be insured under this policy for a period of 12 consecutive 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 exam – two per year;
 - Limited or problem focused exam– one per year;
 - Comprehensive exam – one every two years. Periodontal and comprehensive exams not in conjunction with each other.
2. Periodontal evaluations – one every two years.
3. Cleaning (prophylaxis), including all scaling and polishing procedures – three per year.
4. Adjunctive test to aid in oral cancer screening for *covered persons* age 18 and older– one per year.
5. Intra-oral complete series X-rays, or panoramic X-ray - once every three years for *covered persons* 12 years of age or older. If the total cost of periapical and bitewing x-rays exceeds the cost of a complete series of x-rays, the plan will consider these as a complete series.
6. Bitewing X-rays – one set of films per year for *covered persons* under age 10 and four films per year for *covered persons* age 10 and older.
7. Other x-rays, including intra-oral periapical and occlusal and extra-oral x-rays. Limited to x-rays necessary to diagnose a specific treatment.
8. Topical application of fluoride or fluoride varnish – provided to *covered persons* age 16 and younger. *Service* is payable twice per year.
9. Sealants – application provided to *covered persons* age 16 years and younger to the occlusal surface of permanent molars that are free of decay and restorations. *Service* is payable once per tooth per lifetime.
10. Space maintainers for retaining space when a primary tooth is prematurely lost. *Services* are payable only for *covered persons* age 15 and younger for the installation of the initial appliance. Separate adjustment expenses will not be covered.
11. Finger stick test for diabetes screening for *covered persons* age 18 and older when performed by a licensed dentist and limited to one per year.
12. An in-office blood glucose level test for diabetes screening using a glucose meter when performed by a licensed *dentist* for *covered persons* age 18 and older, and limited to one per year.

Benefits

Basic services

1. Amalgam restorations (fillings) – limited to one per tooth per surface in a two *year* period. Multiple restorations on one surface are considered one restoration.
2. Composite restorations (fillings) on anterior teeth - limited to one per tooth per surface in a two *year* period. Multiple restorations on one surface are considered one restoration.
3. Gold foil restorations on molar and bicuspid teeth are considered an alternate service and will be payable as a comparable amalgam filling. *You* will be responsible for the remaining *expense incurred*. Limited to a maximum of one per tooth every two years.
4. Recementing of inlays, onlays, crowns and bridges;
5. Non-cast pre-fabricated crowns on primary teeth that cannot be adequately restored with amalgam or composite restorations.
6. Treatment for the initial *palliative* care of pain and/or injury. *Services* include *palliative* procedures for treatment to the teeth and supporting structures. *We* will consider the *service* as a separate *benefit* only if no other *service* is provided during the same visit.
7. Fixed and removable appliances to inhibit thumb sucking and other harmful habits. *Services* are payable only for *covered persons* age 14 and younger for the installation of the initial appliance. Separate adjustment expenses will not be covered.

Oral surgery services

1. Extractions - coronal remnants of a primary tooth.
2. Extraction - erupted tooth or exposed root.
3. Surgical extractions.
4. Bone Smoothing.
5. Trim or Remove over growth or non vital tissue or bone.
6. Removal of tooth or root from sinus and closing opening between mouth and sinus.
7. Surgical access of an unerupted tooth.
8. Mobilization of erupted or malpositioned tooth to aid eruption; or, surgical reposition of teeth.
9. Excision or removal of benign oral cysts or tumors.
10. Bone, cartilage, or synthetic grafts.
11. General anesthesia when based on review of clinical documentation provided and administered by a *dentist* in conjunction with a covered oral surgical procedure.

Benefits

Periodontic services

1. Periodontal maintenance (following periodontal therapy) – procedure available three times per *year* for *covered persons* with periodontal history.
2. Periodontal scaling and root planing, available at a maximum of once per quadrant in a three year period. *Benefits* payable for a maximum of two quadrants on the same date of service. Additional quadrants are allowed after seven days or as allowed based on *clinical review*.
3. Scaling in presence of generalized moderate or severe gingival inflammation available based on *clinical review* a maximum of once a year. This service will reduce the number of routine cleanings available (under #3 in Preventive Services) so the total number of cleanings does not exceed two in a year per person.
4. Periodontal surgery, available at a maximum of once per quadrant in a three-year period.
5. Occlusal adjustments when performed in conjunction with periodontal surgery – available at a maximum of once per quadrant in a three year period.

Endodontic services

1. Root canal therapy, including root canal treatments and root canal fillings for permanent teeth - limited to one per tooth per lifetime.
2. Root canal retreatment, including root canal treatments and root canal fillings - limited to one per tooth per lifetime.
3. Apicoectomy - procedure available for permanent teeth only.
4. Partial pulpotomy for apexogenesis – procedure available for permanent teeth only.
5. Vital pulpotomy – procedure available for primary teeth.
6. Apexification/recalcification.

Major/Prosthetic services

1. Repairs of bridges; full or partial dentures, and crowns.
2. Denture adjustments when done by a *dentist* other than the one providing the denture, or adjustments performed by the dentist providing the denture after initial installation - only after 6 months after initial installation.
3. Initial placement of laboratory-fabricated restorations for a permanent tooth 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. Inlays are considered an alternate *service* and will be payable as a comparable amalgam filling. *We* will not cover the *expense incurred* for pin retention when done in conjunction with core build-up.
4. Initial placement of bridges, complete dentures, immediate dentures.
5. Replacement of bridges, partial dentures, complete dentures, inlays, onlays, crowns, veneers, core build ups and posts or other laboratory-fabricated restorations. *Covered services* include the replacement of the existing prosthesis if:
 - It has been at least five years since the prior insertion and is not, and cannot 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 after 6 months from installation.
7. Post and core build-up in addition to partial denture retainers with or without core build up.
8. Implant related services, subject to *clinical review*. Dental implant prosthetics including implant supported crowns, bridges, complete dentures or partial dentures. Implant supported complete or partial dentures are limited to a maximum of one every five years. All other services limited to a maximum of one every five years. Implant prosthetics noted above will be payable at the same level of benefits as the corresponding non-implant prosthetic. *You* will be responsible for the remaining *expense incurred*.

Benefits

Integral service

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

1. Local anesthetics;
2. Bases;
3. Pulp caps;
4. Additional charges related to materials or equipment used in the delivery of dental care;
5. Study models/diagnostic casts;
6. Treatment plans;
7. Occlusal (biting or grinding surfaces of molar and bicuspid teeth) adjustments;
8. Nitrous oxide;
9. Irrigation;
10. Tissue preparation associated with impression or placement of a restoration.
11. Any test, intraoperative, x-rays, laboratory, removal of existing posts, filling material, Thermafill carriers, and any other follow-up care is considered integral to root canal therapy.

Composite Rider

HUMANA HEALTH BENEFIT PLAN OF LOUISIANA

Change in Plan Rider: Coverage for Resin-based Composite Restorations

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

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

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



Bruce Broussard
President

Open Enrollment Rider

HUMANA HEALTH BENEFIT PLAN OF LOUISIANA

Change in Plan Rider: Coverage for Open Enrollment

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

Open enrollment period

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

To enroll for coverage

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

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

The eligibility date of coverage is amended as follows:

Employee Coverage:

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

1. The eligibility requirements stated in the Employer Group Application, or as otherwise agreed to by *us* and the *policyholder*, are satisfied;
2. The *employee* is in an *active status*, or;
3. The employer's annual anniversary date.

Open Enrollment Rider

Dependent coverage

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

1. The *employee* is eligible for coverage, if he or she has *dependents* who may be covered on that date;
2. Of the *employee's* marriage for any *dependents* (spouse or child) acquired on that date;
3. Of birth of the *employee's* natural-born child;
4. Of placement of the child for the purpose of adoption by the *employee*;
5. Specified in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) for a child, or a valid court or administrative order for a spouse, which requires the *employee* to provide coverage for a child or spouse as specified in such orders.
6. Of the *employer's* annual anniversary date.

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



Bruce Broussard
President

**Summary of the Louisiana Life and Health
Insurance Guaranty Association Act and
Notice Concerning Coverage
Limitations and Exclusions**

Residents of Louisiana 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 Louisiana Life and Health Insurance Guaranty Association (the LLHIGA). The purpose of LLHIGA is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this happens, the LLHIGA 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. However, the valuable extra protection provided by these insurers through the LLHIGA is limited. 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.

Disclaimer

The Louisiana Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent.

COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are significant limits and exclusions. Coverage is always conditioned upon residence in this state. Other conditions may also preclude coverage.

Insurance companies and insurance agents are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy.

You should not rely on the availability of coverage under the Louisiana Life and Health Insurance Guaranty Association when selecting an insurer.

The Louisiana Life and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

**Louisiana Life and Health
Insurance Guaranty Association
PO Drawer 44126
Baton Rouge, Louisiana 70804**

**Louisiana Department of Insurance
PO Box 94214
Baton Rouge, Louisiana 70804-9214**

The state law that provides for this safety-net coverage is called the Louisiana Life and Health Insurance Guaranty Association Act (the law). The following 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 any person's rights or obligations under the Act or the rights or obligations of the LLHIGA.

COVERAGE

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a direct non-group life, health or annuity policy or contract, a certificate under a direct group policy, or contract for a supplemental contract to any of these, or an unallocated annuity contract, issued by an insurer authorized to conduct business in Louisiana.. The beneficiaries, payees or assignees of insured persons may also be protected as well, even if they live in another state unless they are afforded coverage by the guaranty association of another state, or circumstances described under the law are applicable.

EXCLUSIONS FROM COVERAGE

A person who holds a direct non-group life, health, or annuity policy or contract, a certificate under a direct group policy or contract for a supplemental contract to any of these, or an unallocated annuity contract is not protected by the LLHIGA if:

1. They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
2. The insurer was not authorized to do business in this state;
3. Their policy was issued by a profit or non-profit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, an insurance exchange, an organization that issues charitable gift annuities as is defined in R.S. 22:952(A)(3), or any entity similar to any of these.

The LLHIGA also does not provide coverage for:

1. Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
2. Any policy of reinsurance (unless an assumption certificate was issued);
3. Interest rate or crediting rate yields, or similar factors employed in calculating changes in value, that exceed an average rate;
4. Dividends, premium refunds, or similar fees or allowances described under the law;
5. Credits given in connection with the administration of a policy by a group contract holder;
6. Employers', associations', or similar entities' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them) or uninsured;
7. Unallocated annuity contracts (which give rights to group contract holders, not individuals), except unallocated annuity contracts and defined contribution government plans under Section 403(b) of the Internal Revenue Code (26 U.S.C. §403(b));
8. An obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the policy owner or contract owner, including but not limited to, claims described under the law;
9. A policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to "Medicare Part C Coverage" or "Medicare Part D coverage" and any regulations issued pursuant to those parts;
10. Interest or other changes in value to be determined by the use of an index or other external references but which have not been credited to the policy or contract or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer, whichever is earlier.

LIMITS ON AMOUNT OF COVERAGE

The Louisiana Life and Health Insurance Guaranty Association also limits the amount the LLHIGA is obligated to pay out. The benefits for which the LLHIGA may become liable shall in no event exceed the lesser of the following:

1. The LLHIGA cannot pay more than what the insurance company would owe under a policy or contract if it were not an impaired or an insolvent insurer.
2. For any one insured life, regardless of the number of policies or contracts there are with the same company, the LLHIGA will pay a maximum of \$300,000 in life insurance death benefits, but no more than \$100,000 in net cash surrender and net cash withdrawal values for life insurance.
3. For any one insured life, regardless of the number of policies or contracts there are with the same company, the LLHIGA will pay a maximum of \$500,000 in health insurance benefits and the LLHIGA will pay a maximum of \$250,000 in present value of annuities, including net cash surrender and net cash withdrawal values.

In no event, regardless of the number of policies and contracts there were with the same company, and no matter how many different types of coverages, the LLHIGA shall not be liable to expend more than \$500,000 in the aggregate with respect to any on individual.

Notices

The following pages contain important information about certain federal laws. There may be differences between the Certificate of Insurance and this Notice packet. There may also be differences between this notice packet and state law. You are eligible for the rights more beneficial to you, unless preempted by state or federal law.

This section includes notices about:

Claims procedures

Federal legislation

Medical child support orders

Continuation of coverage for full-time students during medical leave of absence

General notice of COBRA continuation of coverage rights

Family and Medical Leave Act (FMLA)

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

Your Rights under ERISA

Discrimination Notice

Claim procedures

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

Discretionary authority

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

1. Interpret plan provisions;
2. Make decisions regarding eligibility for coverage and benefits; and
3. Resolve factual questions relating to coverage and benefits.

Claim procedures

Definitions

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

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

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

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

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

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

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

Urgent-care Claim (expedited review): A claim for covered services to which the application of the time periods for making non-urgent care determinations:

could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or

in the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the service that is the subject of the claim.

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

Submitting a claim

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

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

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

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

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

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

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

Procedural defects

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

Authorized representatives

A covered person may designate an authorized representative to act on his or her behalf in pursuing a benefit claim, an internal appeal or an external review. The designation must be in writing and must be made by the covered person on Humana's Appointment of Representation (AOR) Form or on a form approved in advance by Humana. An assignment of benefits does not constitute designation of an authorized representative.

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

In any event, a health care provider with knowledge of a covered person's medical condition acting in connection with an *urgent-care claim* will be recognized by the plan as the covered person's authorized representative.

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

Claims decisions

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

Pre-service claims

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

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

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

Urgent-care claims (expedited review)

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

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

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

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

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

Concurrent-care decisions

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

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

Post-service claims

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

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

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

Initial denial notices

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

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

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

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

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

Appeals of Adverse Determinations

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

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

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

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

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

Time periods for decisions on appeal

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

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

Appeals denial notices

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

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

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

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

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

Exhaustion of remedies

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

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

Legal actions and limitations

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

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

Medical child support orders

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

A QMCSO is a state-court order or judgment, including approval of a settlement agreement that:

- provides for support of a covered employee's child;
- provides for health care coverage for that child;
- is made under state domestic relations law (including a community property law);
- relates to benefits under the group health plan; and
- is "qualified," i.e., it meets the technical requirements of ERISA or applicable state law.

QMCSO also means a state court order or judgment enforcing state Medicaid law regarding medical child support required by the Social Security Act § 1908 (as added by Omnibus Budget Reconciliation Act of 1993).

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

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

Continuation of coverage for full-time students during medical leave of absence

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

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

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

General notice of COBRA continuation coverage rights

Introduction

You are getting this notice because you recently gained coverage under a group health and/or dental plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

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

When is COBRA coverage available?

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

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

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

How is COBRA Coverage Provided?

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

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

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of

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

Second qualifying event extension of 18-month period of

- ***continuation coverage*** - If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

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

Keep your plan informed of address changes

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

Plan contact information:

Humana
Billing/Enrollment Department
101 E Main Street
Louisville, KY 40201
1-800-872-7207

Family and Medical Leave Act (FMLA)

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

Uniformed Services Employment and Reemployment Rights Act of 1994

Continuation of benefits

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

Eligibility

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

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

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

Duration of coverage

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

- 24 months beginning the first day of absence from employment due to service in the uniformed services; or
- The day after the employee fails to apply for a return to employment as required by USERRA, after the completion of a period of service.

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

Other information

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

Your Rights Under the Employment Rights Income Security Act of 1974 (ERISA)

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

Information about the plan and benefits

Plan participants may:

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

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

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

Responsibilities of plan fiduciaries

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

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

Continue group health plan coverage

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

Claims determinations

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

Enforce your rights

Under ERISA, there are steps participants may take to enforce the above rights. For instance:

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

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

Assistance with questions

- Contact the group health plan human resources department or the plan administrator with questions about the plan;
- For questions about ERISA rights, contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or:

The Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210;

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

