Policyholder: PERSON COUNTY GOVERNMENT

Group number: 768979

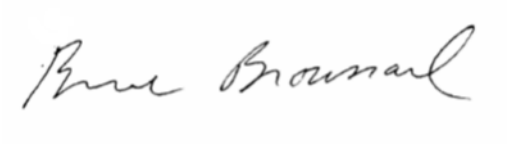
Dental Plan
Certificate of Insurance
Humana Insurance Company

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

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

Important cancellation information: Please read the "terminating coverage" provision. The page number is in the Table of Contents.
READ YOUR CERTIFICATION CAREFULLY
NOTICE
Insured may be subject to a waiting period for certain covered services

Humana



Bruce Broussard
President

READ YOUR CERTIFICATE CAREFULLY

NOTICE OF THE INSURER'S RIGHT TO REFUSE RENEWAL OF THIS POLICY

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CERTIFICATE. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from the company.

We have the right to refuse renewal of this policy. We will notify your employer of the termination of coverage under the policy not later than 45 days prior to the termination date. Termination will not prejudice a claim existing on the termination date.

ENTIRE CONTRACT: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or waive any of its provisions.

Table of Contents

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**.

Claims

Alternate services

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

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

Pretreatment plan

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

1. A list of *services* to be performed using the American Dental Association nomenclature and codes;

2. *Your dentist's* written description of the proposed treatment;

3. Supporting pretreatment X-rays showing *your* dental needs;

4. Itemized cost of the proposed treatment; and

5. Any other appropriate diagnostic materials that *we* may request.

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

An estimate for *services* is not necessary for *emergency* care.

Process and timing

An estimate for *services* is valid for 90 days after the date *we* notify *you* and *your dentist* of the *benefits* payable for the proposed *treatment plan* (subject to *your* eligibility of coverage). If treatment will not begin for more than 90 days after the date *we* notify *you* and *your dentist, we* recommend that *you* submit a new *treatment plan*.

Claims

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.*

Notice of Claim
Written notice of a claim must be given within 20 days after the occurrence of any loss covered by the policy, or as soon thereafter as it reasonable possible.

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 within 15 days.

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 within 180 days after the date of care was provided. *We* would like to receive this information within 180 days of filing the claim; however, the claim will not be reduced or denied if it was not reasonably possible to meet the 180-day guideline. Failure to furnish such proof within the time required, shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided the claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time submittal of the claim or proof of loss is otherwise required.

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

1. A complete dental chart showing:
    - Extractions;
    - Missing teeth;
    - Fillings;
    - Prosthesis;
    - Periodontal pocket depths;
    - Dates of previously performed work.
2. An itemized bill for all dental work.
3. The following exhibits:
    - X-rays;
    - Study models;

- Laboratory and/or reports;
- Patient records.

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

5. Information about other insurance coverage.

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

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

Paying claims

We determine if *benefits* are available and pay promptly any amount due under this policy in the timeframe required by state law or by *dentist* contract. *We* will provide notice of a favorable or adverse benefit determination within a reasonable time appropriate to the circumstances but no later than 30 days after the plan receives the claim. *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.

Either *you* or the *dentist* must complete and submit to *us* all claim information for proof of loss within 180 days after the date of care was provided. *We* would like to receive this information within 180 days of filing the claim; however, the claim will not be reduced or denied if it was not reasonably possible to meet the 180-day guideline. Failure to furnish such proof within the time required, shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided the claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time submittal of the claim or proof of loss is otherwise required.

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 on the application by not telling *us* the facts or withhold information necessary for *us* to administer this certificate. *We* may take action if fraud has

been determined to have occurred within the first two years of issue or reinstatement of this *policy*. Misleading information on the application can not be acted upon after that time period.

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* 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 it's determined that the *member* provided information in error. *We* will adjust premium or claim payment based on this new information.

Any person with the intent to injure, defraud, or deceive is guilty of a crime (Class H felony) which "MAY" subject the person to criminal and civil penalties.

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 proof of loss is made.

Physical Examinations and Autopsy

We at our own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Coordinating benefits with another insurer

Benefits subject to this provision

Benefits described in this certificate are coordinated with *benefits you* receive from other plans. This prevents duplication of coverage and resulting increases in the cost of dental coverage. For purposes of this section, the following definitions apply:

1. **Plan**—A plan covers medical or dental expenses and provides *benefits* or *services* by:

   - Group, franchise or blanket insurance coverage;
   - Group-based hospital service pre-payment plan, medical service pre-payment plan, group practice or other pre-payment coverage;
   - Coverage under labor-management, employer plans, trustee plans, union welfare plans, employee benefit organization plan; and
   - *Medicare* or other governmental benefits, as permitted by law.

   Plan does not include:

   - Individual or family insurance;
   - Blanket student accident insurance provided by or through an educational institution;
   - School accident-type coverage;
   - State plans under Medicaid;
   - Blanket, or franchise individual plans;
   - Automobile or homeowner coverage; or
   - Any plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.

2. **Allowable expense**—A necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid. Total benefits paid must be equal to 100 percent of necessary medical expenses covered by both plans.

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

Effect on benefits

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

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

Order of benefit determination

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

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

2. For a child covered under both parents' plans, the plan covering the parent whose birthday (month and day) occurs first in the calendar year pays before the plan covering the other parent. If the birth dates of both parents are the same, the plan that has covered the parent for the longer period of time will be the primary plan.

3. In the case of *dependent* children covered under the plans of divorced or separated parents, the following rules apply:

   - The plan of a parent who has custody will pay benefits first.
   - The plan of a stepparent who has custody will pay benefits next.
   - The plan of a parent who does not have custody will pay benefits next.
   - The plan of a stepparent who does not have custody will pay benefits next.

   A court decree may give one parent financial responsibility for the medical or dental expenses of the *dependent* children. In this case the rules stated above will not apply if they conflict with the court decree. Instead, the plan of the parent with financial responsibility will pay benefits first.

4. If a person is laid off or retired, or is a *dependent* of someone who was laid off or retired, that plan becomes the secondary plan to the plan of an active *employee*.

If rules 1-4 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.

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.

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.

Late applicant does not apply to new born children, foster children or adopted children. The enrollment period is also waived for a dependent child enrolled pursuant to a court or administrative order requiring the employee to provide coverage for a child pursuant to such order.

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
  - Upon placement in the foster home OR placement for adoption with the *employee;* or
  - Date an employee is required by the court to provide coverage for a child due to a court or administrative order.
- 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;

- The date of birth of the *employee's* natural-born child;

- Upon placement in the foster home OR placement for adoption with the *employee*; or

- The date specified in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) for a child, or a valid court or administrative order for a spouse, which requires the *employee* to provide coverage for a child or spouse as specified in such orders.

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

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

Employee enrollment

The *employee* must enroll as agreed by the *policyholder* and *us*.

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

Dependent enrollment

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

A *dependent* enrolled more than 31 days after the *dependent's eligibility date* or the *special enrollment date* will be a *late applicant.* The 31 day enrollment period is waived for a dependent child enrolled pursuant to a court or administrative order requiring the employee to provide coverage for a child pursuant to such order.

Newborn Children, Adopted Children and Foster Children

An *employee* who already has *dependent* child coverage in force prior to the newborn's date of birth is not required to complete an enrollment form for the newborn child. The newborn is covered under the Policy from the moment of birth for 30 days. If coverage is to continue, the *employees* must notify *us* within the 30 day period and pay the additional premium, if any. Adopted children and foster children will be treated the same as newborn infants and eligible for coverage on the same basis upon placement in the foster home or placement for adoption. Prior notification for newborn, adopted and foster children is not required unless additional premiums are due. If additional premiums are due, the foster child or adopted child will be covered if enrolled within 30 days after the placement in the foster home or placement for adoption.

Coverage for newborn, adopted and foster children shall consist of coverage for sickness or illness when related to dental procedures, including the necessary care or treatment of medically diagnosed congenital

defects or anomalies, including, but not limited to, all necessary treatment and care needed by individuals born with cleft lip or cleft palate.

Special Enrollment

Loss of other coverage

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

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

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

Dependent special enrollment period

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

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

Eligibility

Effective date

Employee effective date

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

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

Employee delayed effective date

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

Dependent effective date

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

- If *we* receive enrollment on, prior to, or within 31 days of the *dependent's eligibility date* that *dependent* is covered on the date he or she is eligible.

- If *we* receive enrollment on, prior to, or within 31 days of the *dependent's special enrollment date*, that *dependent's* coverage is effective on the *special enrollment date*.

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

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

Benefit changes

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

Incontestability: After *you* have been insured for two years from the date of issue or reinstatement no misstatements made by the applicant in the application shall be used to void the policy or deny a claim for loss incurred or disability commencing after the expiration of the two-year period.

Retired employee coverage

Retired employee eligibility date

Retired *employees* are an eligible class of *employees* if requested on the Employer Group Application and if approved by *us*. An *employee* who retires while insured under this *policy* is considered eligible for retired *employee* dental coverage on the date of retirement if the eligibility requirements stated in the Employer Group Application are satisfied.

Eligibility

Retired employee enrollment

Notification of the *employee's* retirement must be submitted to *us* by the *employer* within 31 days of the date of retirement. If *we* receive the notification more than 31 days after the date of retirement, *you* will be considered a *late applicant*.

Retired employee effective date

The *effective date* of coverage for an eligible retired *employee* is the date of retirement for an *employee* who retires after the date *we* approve the *employer's* request for a retiree classification, provided *we* receive notice of the retirement within 31 days. If *we* receive notice more than 31 days after retirement, the *effective date* of coverage will be the date *we* specify.

Retired employee benefit changes

Additional or increased insurance or a decrease in insurance will become effective on the approved date of change.

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. A grace period of thirty-one days will be allowed to the Policyholder for the payment of each required premium due after the first premium. The Policy will remain in force during the grace period, subject to the right of the insured to cancel in accordance with the cancellation provision hereof. The Policyholder will be required to pay premium for the grace period;

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.

If an *insured* is required by a court or administrative order to provide benefits for a *dependent*, and the *insured* is eligible for benefits under this plan, *we* may not terminate coverage for the *dependent* unless written evidence that:

- The court or administrative order is no longer in effect; or
- The *dependent* is or will be enrolled in comparable dental benefits, which coverage will take effect no later than the effective date of termination.

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.

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.

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.

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. *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.

Allowable expense means a health care service or expense, including deductibles and copayments, that is covered at least in part by any of the *plans* covering the person. 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*:

- If a person is covered by two or more *plans* that compute their benefits payments on the basis of usual and customary fees, any amount in excess of the highest usual and customary fees for a specific benefit is not an *allowable expense*.

- If a person is covered by two or more *plans* that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the fees is not an *allowable expense*.

- If a person covered by one *plan* that calculates it benefits or services on the basis of usual and customary fees and another *plan* that provides its benefits or services on the basis of negotiated fees, the *primary plan's* payment arrangement shall be the *allowable expense* for all *plans*.

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. Unmarried child, natural blood related child, stepchild, foster child or legally adopted child whose age is less than the limiting age. A child also includes adopted children, a child placed with You by administrative or court order, as well as stepchildren or foster children. An adoptive child is considered a dependent upon placement in the foster home, or placement for adoption with the *employee*. A foster child is a minor i) over whom a guardian has been appointed by the clerk of superior court by any county in North Carolina; or ii) the primary or sole custody of whom has been assigned by order of a court of competent jurisdiction.

The limiting age for each *dependent* child is:

1. 26 years; or

2. 26 years if the child is a regular full-time student at an accredited secondary school, college or university. A *dependent* continues to be eligible for coverage for up to four months after the close of a school term only if enrolled as a full-time student for the next school term. Also, a *dependent* child's coverage will remain in force during a medically necessary leave of absence until the earlier of one year after the first day of the medically necessary leave of absence; or the date coverage would otherwise terminate under the plan.

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. Dependent on the covered *employee* for support and maintenance.

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.

Definitions

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: A non-seasonal person who works on a full-time basis, with a normal work week of 30 or more hours and who is otherwise eligible for coverage, but does not include a person who works on a part-time, temporary, or substitute basis.

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

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

Expense incurred date: The date on which:

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

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

Group - means the aggregate of individuals eligible to be covered under the Policy. Group also refers to the subgroup participating under the Policy for the benefit of its group members.

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*.

In-network covered services: covered dental care services that are received according to the rules of this plan from providers employed by, under contract with, or approved in advance by *us*; and means *emergency* dental care services regardless of the status or affiliation of the provider of such services.

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.*

Out-of-network covered services: non-*emergency*, medically necessary covered health care services that are not received according to the rules of the dental benefit plan, including services from affiliated providers that are received without the approval of *us*.

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

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

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

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

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

Reimbursement limit is the maximum 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 usual and customary charges for similar *services* to a national database adjusted to the geographical area where the *services* or procedures were performed;
5. At *our* choice the fee determined by using a national Relative Value Scale. Relative Value Scale means a methodology that values procedures and *services* relative to each other that includes, but is not limited to, a scale in terms of difficulty, work, risk, as well as the material and outside costs of providing the *service*, as adjusted to the geographic area where the *services* or procedures were performed;
6. In the case of *services* rendered by providers with whom *we* have agreements, the fee or maximum allowable charge that *we* have negotiated with that provider;
7. 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;*
8. The fee based on the provider's costs for providing the same or similar *services* as reported by the provider in the most recent, publicly available Medicare cost report submitted annually to the Centers for Medicare and Medicaid Services; or
9. 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*.

Service area: means the geographic area designated by *us*, or as otherwise agreed upon between the *policyholder* and *us* and approved by the North Carolina Department of Insurance of the state in which

the *policy* is issued. The *service area* is the geographic area where the network provider services are available to *you*.

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

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

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

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

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

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

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

We, us and our: Humana Insurance Company.

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

You and your: Any *covered person*.

Humana

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

Insured by Humana Insurance Company

Policyholder: PERSON COUNTY GOVERNMENT
Group Number: 768979
Coverage Effective Date: 07/01/2016

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:
$750 per *year* per *covered person* for Preventive, 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. The Individual Extended Maximum Benefit does not apply to, and no additional benefits are available for Orthodontic services.

Individual deductible:
$25 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 $75.

Orthodontic lifetime maximum benefit
$1,500 per *covered person*.

Preventive Services:
Benefits are paid at 100%.

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

Basic Services:
Benefits are paid at 80% after the *deductible*.

- Fillings (amalgam and composite restorations)
- Non-surgical extractions
- Non-surgical residual root removal
- 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 50% 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

Orthodontic Services:
Benefits are paid at 50%.

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

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 and Orthodontic *services* MAY be subject to a 12-month waiting period before they are eligible for coverage. This 12-month waiting period can be decreased by the amount of time 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.

Orthodontic Services:

Groups with fewer than 10 dental lives with no prior orthodontia coverage--orthodontia coverage is effective 24 months after the effective date of coverage.

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

Groups with fewer than 10 dental lives-orthodontic coverage is effective 24 months after the effective date of the covered *dependent* added after the effective date of the group's Policy.

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

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 three years. Periodontal and comprehensive exams not in conjunction with each other.

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

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

4. Adjunctive test to aid in oral cancer screening for *covered persons* age 40 and older– one per *year*.

5. Intra-oral complete series X-rays, or panoramic X-ray - once every five *years* for *covered persons* 12 years of age or older. If the total cost of periapical and bitewing x-rays exceeds the cost of a complete series of x-rays, the plan will consider these as a complete series.

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 14 and younger. *Service* is payable once per *year.*

9. Sealants – application provided to *covered persons* age 14 *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 14 and younger for the installation of the initial appliance. Separate adjustment expenses will not be covered.

Basic services

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

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

3. Gold foil restorations on molar and bicuspid teeth are considered an alternate service and will be payable as a comparable amalgam filling. *You* will be responsible for the remaining *expense incurred*. Limited to a maximum of one per tooth every two years.

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

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

6. Treatment for the initial *palliative* care of pain and/or injury. *Services* include *palliative* procedures for treatment to the teeth and supporting structures. *We* will consider the *service* as a separate *benefit* only if no other *service* is provided during the same visit.

7. 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.

Simple Oral surgery services

1. Extractions - coronal remnants of a primary tooth.
2. Extraction - erupted tooth or exposed root.

Complex Oral surgery services

1. Surgical extractions.

2. Bone Smoothing.

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

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

5. Surgical access of an unerupted tooth.

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

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

8. Bone, cartilage, or synthetic grafts.

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

Periodontic services

1. Periodontal 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.*

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

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

4. 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/Prosthodontic 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 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. *We* will not cover replacement of congenitally missing teeth.

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*.

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.

Congenital defects or anomalies

Coverage for newborn, adopted and foster children will include coverage for covered dental procedures related to congenital anomalies and defects.

Covered services will be payable the same as similar *services* under the policy.

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. Services or supplies for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Worker's Compensation Act only to the extent such services or supplies are the liability of the employee, employer or worker's compensation insurance carrier according to a final adjudication under the North Carolina Worker's Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Worker's Compensation Act.

2. *Services*:

    - That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;

    - Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or

    - Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with *sickness* or *bodily injury*.

3. Any loss contributed to, with the exception of loss incurred from an act of terrorism, or cause by:

    - War or any act of war, whether declared or not;

    - Insurrection; or

    - Any conflict involving armed forces of any 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 to correct a congenital defect or 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* 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.

Supplemental Dental Expense Benefit

Humana Insurance Company
Orthodontic Services

This Supplemental Dental Expense Benefit is part of the certificate. The benefits outlined will be effective the latter of:

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

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

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

Covered services for orthodontia treatment

Covered services for orthodontic treatment include those that are:

1. For the treatment of--and appliances for--tooth guidance, interception and correction; and
2. Related to covered orthodontic treatment including:

- X-rays;
- Exams;
- Space regainers; and/or
- Study models.

How benefits will be paid if treatment begins <u>after</u> you are eligible for orthodontic benefits with us.

In order to have the full orthodontic treatment be considered for *benefits* under this plan, bands and appliances must be inserted after:

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

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

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

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

Supplemental Dental Expense Benefit

How benefits will be paid if treatment was started <u>before</u> you were eligible for orthodontic benefits with us.

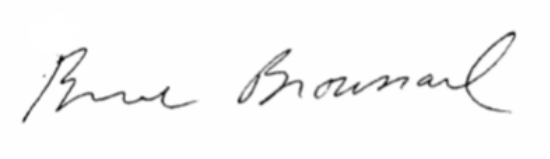
Services for orthodontic treatment received prior to *your* effective date, or prior to exhaustion of the orthodontic waiting period, are not *covered services*.

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

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

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

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



Bruce Broussard
President

Open Enrollment Rider

Humana Insurance Company
Change in Plan Rider:
Coverage for Open Enrollment

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

Open enrollment period

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

To enroll for coverage

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

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

The eligibility date of coverage is amended as follows:

Employee Coverage:

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;

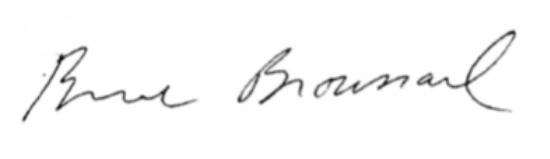
3. Of birth of the *employee's* natural-born child;

4. On the date a child is placed in the *employee's* home for adoption or foster care by the *employee*. *Covered services* are payable for adopted children or foster children on the same terms and conditions as natural-born children;

5. The date as specified in a court or administrative order, including a Qualified Medical Child Support Order, which requires *you* to provide dependent child coverage; or

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

NOTICE OF PROHIBITIONS

Under North Carolina General Statute Section 58-50-40, no person, employer, principal, agent, trustee, or third party administrator, who is responsible for the payment of group health or life insurance or group health plan premiums, shall:

1. Cause the Cancellation or Nonrenewal of group health or life insurance, hospital, medical, or dental service corporation plan, multiple employer welfare arrangement, or group health plan coverages and the consequential loss of the coverages of the persons insured, by willfully failing to pay those premiums in accordance with the terms of the insurance or plan contract, and

2. Willfully fail to deliver, at least 45 days before the termination of those coverages, to all persons covered by the group policy a written notice of the person's intention to stop payment of premiums. This written notice must also contain a notice to all persons covered by the group policy of their rights to health insurance conversion policies under Article 53 of Chapter 58 of the General Statutes and their rights to purchase individual policies under the Federal Health Insurance Portability and Accountability Act and under Article 68 of Chapter 58 of the General Statutes.

Violation of this law is a felony. Any person violating this law is also subject to a court order requiring the person to compensate persons insured for expenses or losses incurred as a result of the termination of insurance.

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE NORTH CAROLINA 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 North Carolina Life and Health Insurance Guaranty Association. The purpose of this association 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 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 these 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 North Carolina Life and Health Insurance Guaranty Association may or 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 North Carolina. You should not rely on coverage by the North Carolina 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 a 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.

The North Carolina Life and Health Insurance Guaranty Association
Post Office Box 10218
Raleigh, North Carolina 27605-0218

North Carolina Department of Insurance, Consumer Division
1201 Mailing Service Center
Raleigh, North Carolina 27699-1201

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. *On the back of this page* 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.

COVERAGE

Generally, individuals will be protected by the life and health insurance guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this association if:

- 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 the state);
- The insurer was not authorized to do business in this state;
- Their policy was issued by 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, or by an insurance exchange.

The association also does not provide coverage for:

- 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;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed the average rate specified in the law;
- Dividends;
- Experience or other credits given in connection with the administration of a policy for by a group contractholder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.
- A policy or contract commonly known as Medicare Part C or Part D or any regulations issued pursuant thereto.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out:

1. The guaranty association cannot pay out more than the insurance company would owe under the policy or contract.

2. Except as provided in (3) (4) and (5) below, the guaranty association will pay a maximum of $300,000 per individual, per insolvency, no matter the number of policies or types of policies issued by the insolvent company.

3. The guaranty association will pay a maximum of $500,000 with respect to basic hospital, medical and surgical insurance and major medical insurance.

4. The guaranty association will pay a maximum of $1,000,000 with respect to the payee of a structured settlement annuity.

5. The guaranty association will pay a maximum of $5,000,000 to any one unallocated annuity contract holder.

Humana Insurance Company

READ YOUR CERTIFICATE CAREFULLY

NOTICE OF THE INSURER'S RIGHT TO REFUSE RENEWAL OF THIS POLICY

We have the right to refuse renewal of this policy. We will notify your employer of the termination of coverage under the policy not later than 45 days prior to the termination date. Termination will not prejudice a claim existing on the termination date.

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:

Claim 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**

Claim procedures

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

Discretionary authority

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

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

Claim procedures

Definitions

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

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

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

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

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

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

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

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

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

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

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

Submitting a claim

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

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

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

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

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

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

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

Procedural defects

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

Authorized representatives

A covered person may designate an authorized representative to act on his or her behalf in pursuing a benefit claim 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 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 allother qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events or a second qualifying event during the initial period of coverage may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of

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

Second qualifying event extension of 18-month period of

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

If You Have Questions

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

Keep your plan informed of address changes

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

Plan contact information:

Humana
Billing/Enrollment Department
101 E Main Street
Louisville, KY 40201
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.