

PLAN MANAGEMENT AGREEMENT

for

Administrative Services

between

HUMANADENTAL INSURANCE COMPANY

and

ABC COMPANY

This Plan Management Agreement for administrative services is made and entered into by and between **HumanaDental Insurance Company**, a Wisconsin corporation with administrative offices in De Pere, Wisconsin, and **ABC Company**, with principal offices in Sample City, Wisconsin.

This Agreement is effective this [variable: insert effective date].

In consideration of the mutual promises and covenants contained in this Agreement, together with all exhibits, the Client and HumanaDental Insurance Company hereby agree as follows:

ARTICLE I Definitions

- 1.1 Agreement means this Plan Management Agreement for administrative services.
- 1.2 Client means ABC Company.
- 1.3 COBRA means the Federal Consolidated Omnibus Budget Reconciliation Act of 1986, as amended.
- 1.4 Employer means the employer of a Participant.
- 1.5 Participant means an employee or former employee of an Employer who is or may become eligible to receive a benefit, or whose beneficiaries may be or become eligible to receive a benefit under the provisions of the Plan.
- 1.6 Plan means the health care plan (or plans) maintained by the Client, or portions of that plan (or plans), with respect to which administrative services are to be provided under this Agreement by the Plan Manager. The Plan is identified in Exhibit "A" of this Agreement as to proper name and as to type.

- 1.7 Plan Administrator (or Administrator) means the person named in the documents describing the Plan as responsible for the operation and administration of the Plan. If no such person is identified, then the person establishing or maintaining the Plan will be deemed to be the Plan Administrator.
- 1.8 Plan Manager means HumanaDental Insurance Company, acting in accordance with this Agreement.

ARTICLE II

Relationship Between the Parties

- 2.1 In performing its obligations under this Agreement, the Plan Manager operates within a framework of Plan management policies and practices authorized or established by the Plan Administrator, in accordance with the provisions of the Plan. In this context, the Plan Manager's normal operating procedures, practices and rules will be followed unless they are inconsistent with these Plan management policies or practices.
- 2.2 The Plan Manager does not have discretionary authority or responsibility in the administration of the Plan. The Plan Manager will not exercise discretionary authority or control respecting the disposition or management of assets of the Plan.
- 2.3 The Plan Administrator and not the Plan Manager is ultimately responsible for interpreting the provisions of the Plan and determining questions of eligibility for Plan participation.
- 2.4 Accordingly, the Plan Manager is not a trustee, sponsor, or fiduciary with respect to directing the operation of the Plan or managing any assets of the Plan.
- 2.5 The Plan Manager may act as an agent of the Client authorized to perform specific actions or conduct specified transactions only as provided in this Agreement.
- 2.6 Plan benefits shall be funded exclusively through the Plan. The Plan Manager is not responsible or accountable for providing funds to pay plan benefits under any circumstances.
- 2.7 The Plan Manager is not responsible for maintaining the Plan in compliance with any applicable laws and regulations governing or affecting the Plan.

ARTICLE III

General Duties of Client

- 3.1 The Client will identify and describe the Plan as to type (e.g. single employer) on Exhibit "A" of this Agreement. The Client warrants that the Plan is not a "multiple employer welfare arrangement", as defined in the Federal Employee Retirement Security Act of 1974, as amended ("ERISA").
- 3.2 The Client assures that sufficient funds will be available on a timely basis to honor all claims reimbursements under the Plan. Sufficient funds for making claims payments must be made available, in accordance with this Agreement, to enable services under this Agreement to continue without interruption.
- 3.3 The Client promises that all methods employed to fund the Plan shall comply with all applicable laws or regulations.

- 3.4 The Client agrees to furnish each Participant written notification of the source of funding for Plan benefits.
- 3.5 The Client promises that current copies of the documents describing the Plan will be provided to the Plan Manager along with other appropriate materials governing the administration of the Plan. These documents and materials may include employee booklets, summary descriptions, employee communications significantly affecting the Plan, and any amendments or revisions.
- 3.6 The Client promises that timely written notice will be provided to the Plan Manager of Plan management policies and practices, interpretations of the benefit provisions of the Plan, and changes in the Plan provisions.
- 3.7 The Client shall provide accurate information to the Plan Manager as to the number and names of persons covered by the Plan and any other information necessary to enable the Plan Manager to provide the services required by this Agreement. This information shall be kept current on at least a monthly basis.
- 3.8 The Client is responsible for selecting legal and/or tax counsel to provide advice to the Client about the law and the Plan. The Client acknowledges that the Plan Manager cannot provide professional tax or legal services to the Client.
- 3.9 The Client is responsible for compliance with all applicable provisions of law addressing the Client's duties respecting the Plan. This includes compliance with all legal reporting and disclosure requirements, adoption and approval of all required documents respecting the Plan. Even though the Plan Manager may be required to perform certain duties under this Agreement, such as preparing drafts of documents for approval and adoption, the Client agrees that the Plan Manager does not undertake the responsibility for legal compliance for any other person.
- 3.10 The Client must make full payment for services rendered under this Agreement when due. However, if full payment is not made when due, payment in full must be made by the end of a grace period of thirty (30) days to enable services under this Agreement to continue without interruption. The Plan Manager may provide written notice by regular U.S. mail to the Client requesting payment of the deficiency in full by the end of the thirty (30) day period.
- 3.11 The Client shall not direct the Plan Manager to act or refrain from acting in any way which would violate any applicable law or regulation. The Client shall not behave in any way which could implicate or involve the Plan Manager in a violation of these laws.
- 3.12 In the event that the general obligations of this Article III may be construed in such a manner so as to conflict with more specific provisions of this Agreement regarding a particular issue, the more specific and comprehensive provisions shall be given effect.

ARTICLE IV General Duties of Plan Manager

- 4.1 The Plan Manager shall process claims and make payments in accordance with the provisions of the Plan and related interpretations of the benefit provisions of the Plan which are made or approved by the Plan Administrator on a timely basis and confirmed in writing.

- 4.2 The Plan Manager shall be entitled to rely and act based upon documents, letters, electronic communications, or telephone communications which are confirmed in writing and provided to it by the Client or Plan Administrator. Reliance will continue until the time the Client or the Plan Administrator notifies the Plan Manager in writing of any change or amendment to those communications.
- 4.3 The Plan Manager shall provide claimants who have had a claim wholly or partially denied with a written explanation of the reason for the denial. The Plan Manager shall provide claimants with information about what steps may be taken if the claimant wishes to submit the denied claim for review. These obligations of the Plan Manager will be discharged in accordance with the provisions of the Plan or authorization by the Plan Administrator.
- 4.4 The Plan Manager shall not be responsible for any delay or lack of performance of services under this Agreement attributable to the Client's failure to provide any information as required under this Agreement.
- 4.5 The Plan Manager will perform its duties under this agreement using the same degree of ordinary care, skill, prudence, and diligence that a reasonable provider of administrative services would use in similar circumstances. This includes making a good faith effort to correct any mistake or clerical error which may occur due to actions or inaction by the Plan Manager undertaken in good faith once the error or mistake is discovered.
- 4.6 With respect to its obligations under this Agreement, the Plan Manager will maintain professional liability and errors and omissions insurance in amounts sufficient to protect against losses with respect to occurrences arising out of failure to properly perform its obligations under this Agreement.
- 4.7 In the event that the general obligations of this Article IV may be construed in such a manner so as to conflict with more specific provisions of this Agreement with respect to a particular issue, the more specific and comprehensive provisions shall be given effect.

ARTICLE V
Claims Administration

- 5.1 The Client hereby delegates to the Plan Manager authority to make determinations on behalf of the Client or Plan Administrator with respect to benefit payments under the Plan and to pay such benefits, as specified in this Article V.
- 5.2 The Plan Manager will accept claims for benefits under the Plan which are made in accordance with procedures established in the Plan documents and submitted for payment during the term of this Agreement.
- 5.3 The Plan Manager will process claims in accordance with the provisions of the Plan which are in effect and which have been communicated to the Plan Manager by the Client at the time the services are provided.
- 5.4 Claims will be processed using the Plan Manager's normal claims processing procedures, practices and rules unless they are (a) inconsistent with Plan management policies or practices authorized or established by the Plan Administrator in accordance with the provisions of the Plan, and (b) described to the Plan Manager in writing as being inconsistent.

- 5.5 The Plan Manager will promptly approve or deny claims submitted for payment in accordance with an initial determination by the Plan Manager or an appeal of a denied claim, except as provided in section 5.6.
- 5.6 However, if the Plan Administrator makes a determination to approve or deny a claim which is different than the determination made by the Plan Manager, the Plan Manager will promptly issue an approval or denial of the claim, provided the Plan Administrator's decision is first communicated to the Plan Manager in writing.
- 5.7 In the event a claim is wholly or partially denied in accordance with section 5.5, above, the Plan Manager shall provide the Participant with a written explanation of the reason for the denial, and information as to what steps may be taken if the Participant wishes to appeal the claim denial.
- However, if a claim is wholly or partially denied in accordance with section 5.6, above, the Plan Manager may decide that it will provide this explanation and information only as directed in special written instructions from the Plan Administrator which are acceptable to the Plan Manager.
- 5.8 Appeals of denied claims shall be processed in accordance with the applicable provisions of the Plan. The Client acknowledges that the Plan Administrator shall have the ultimate responsibility and authority to make final determinations with respect to claims.
- 5.9 If adequate funds are not made available for the timely payment of claims, the Plan Manager may notify Participants and payees who may be affected if the Client or Plan Administrator does not notify Participants and payees within fourteen (14) business days after written request by the Plan Manager to do so.
- 5.10 With respect to claims for which provider discounts are available ("Provider Discounts"):
- (a) The Client authorizes and directs the Plan Manager to process claims under this Agreement taking the Provider Discounts into account.
 - (b) However, the Client directs the Plan Manager that a Provider Discount will not be applied with respect to a claim if doing so would result in payment by the Plan of a greater expense than would be payable if the Provider Discount was not applied.

ARTICLE VI Reports and Records

- 6.1 The Plan Manager will provide standard reports to the Client or Plan Administrator only as mutually agreed upon by the Plan Manager and the Client.
- 6.2 The Plan Manager will keep and maintain accounts and records pertaining to its activities under this Agreement which are required by law or by mutual agreement of the parties.
- 6.3 The Plan Manager will prepare and make available records required to assist the Client or the Plan Administrator regarding audits, legal action, or regulatory review and reporting, upon reasonable request by the Client. The Client agrees to reimburse the Plan Manager for its reasonable costs of preparation, duplication, and transmission of these records.

- 6.4 Claims records may be maintained in micro-photographic or electronic media format, in accordance with the Plan Manager's internal policies, rather than original hard copy. If the Client desires that original hard copy records be maintained, the Client must notify the Plan Manager in writing no later than 45 days after the effective date of this Agreement. The Plan Manager will then ship the original documents to a location specified by the Client, and the Client agrees to pay the cost for this service.

ARTICLE VII
Additional Administrative Services

- 7.1 Upon reasonable request by the Client or the Plan Administrator, the Plan Manager will provide standard language concerning Plan benefits to assist the Plan Administrator in the preparation of the summary description of the Plan. This service will be available at the commencement of this Agreement and when language changes are made necessary by changes in Plan design or governmental requirements.
- 7.2 will vary depending on type of COBRA administration chosen:**
- 7.2 The Plan Manager will retain a COBRA Service Provider to coordinate and provide certain administrative services regarding COBRA continuation coverage provided under the Plan only as specified in Exhibit "B". The Client or the Employer shall continue to have all liability for funding of COBRA coverage benefits under the Plan. **[Ceridian option]**
- 7.2 The Plan Manager will assist the Client or the Plan Administrator in arranging to provide Utilization and/or Case Management services with respect to the Plan only as specified in Exhibit "C".
- 7.4 The Plan Manager will provide the following miscellaneous administrative services, following its normal procedures:
- (a) Production of basic Participant identification cards.
 - (b) Routine claims processing audit controls.
- 7.5 The Plan Manager will provide "Subrogation/Recovery" services (in addition to routine application of the coordination of benefits provisions of the Plan) for identifying and obtaining recovery of claims payments from all appropriate parties through operation of the subrogation or recovery provisions of the Plan.
- (a) Subrogation / Recovery services will be provided by the Plan Manager following its normal procedures, and such services may be performed by subcontractors selected by the Plan Manager (including local counsel).
 - (b) Subrogation / Recovery services include the following activities:
 - (1) Investigation of claims and obtaining additional information to determine if a person or entity may be the appropriate party for payment;
 - (2) Presentation of appropriate claims and demands for payment to parties determined to be liable;

- (3) Notification to Participants that recovery or subrogation rights will be exercised with respect to a claim;
 - (4) Filing and prosecution of legal proceedings against any appropriate party for determination of liability and collection of any payments for which such appropriate party may be liable;
 - (5) Pursuit of appropriate post judgment remedies; and
 - (6) Submittal of a quarterly report setting forth the status of the Plan Manager's Subrogation / Recovery efforts.
- (c) Subrogation / Recovery services will be provided for a period of two (2) years following termination of this Agreement, unless such termination results from a material default in the delivery of such subrogation services. Subrogation / Recovery services will be continued only in respect to claims processed under this Agreement.
 - (d) The cost to the Client for providing services under this section 7.5 is presented within section F3.1 (a) of Exhibit "F", in accordance with Article IX. However, there will be no cost to the Client for recovery of claims payments made in error by the Plan Manager exclusive of any other cause. Also in this context, the Plan Manager may not be obligated to file and prosecute legal proceedings against persons for determination of liability and collection of any payments.

7.6 The Plan Manager may retain or coordinate with service providers, experts, or professional advisors to assist the Plan Manager in providing services under this Agreement. The Client shall reimburse the Plan Manager for these services if requested by or agreed to by the Client.

7.7 The Plan Manager will arrange access to one or more networks of dental care providers which are presently available through an arrangement with the Plan Manager only as specified in Exhibit "D".

7.8 In the event the number of Participants in the Plan decreases by [variable: see below] in connection with changes such as:

- (1) Employee benefit programs or Plan design made by the Client, including changes required by applicable law or regulatory action;
- (2) The Client's corporate structure or organization; or
- (3) The level of Plan participation attributable to employee choice;

the Plan Manager will continue processing Claims for the terminated employees, which are incurred prior to the date of such change as provided in Article V of this Agreement.

Such claims will be processed as long as this Agreement is in force. The Client will be billed an additional administrative fee per employee as provided under section F3.1(b).

This section 7.9 will not apply in the event the Plan Administrator provides timely written notification to the Plan Manager directing that services described in this section are not required.

[VARIABLE: for groups with less than 400 lives: 25%] [for groups with 400 or more lives: 100 or more

employees]

ARTICLE VIII
Banking

- 8.1 The rights and obligations of the Client and the Plan Manager under this Article VIII shall be regulated through a "Banking Arrangement" substantially in the form presented in Exhibit "E".
- 8.2 The Client promises that sufficient funds will be available on a timely basis to honor all claims reimbursements under the Plan. Upon notice from the Plan Manager that additional funds are required, the Client promises that adequate funds will be immediately provided to fund claims approved.
- 8.3 The Client agrees that funds provided to honor all claims reimbursements under the Plan will be United States money, which may be transmitted by wire transfer, bank draft, or other medium agreed to by the Plan Manager and the Client.

ARTICLE IX
Costs of Administrative Services

- 9.1 The Plan Manager shall be entitled to a fee for services provided under this Agreement described on Exhibit "F" to this Agreement.
- 9.2 If payments for administrative services provided under this Agreement are not made on a timely basis, a late charge of 1.25% per month (or the maximum amount allowed by applicable law, if less) multiplied by the amount of the deficiency shall be paid by the Client no later than by the end of the next billing cycle. Payments made after the grace period allowed in the invoice or billing arrangement are not "timely".
- 9.3 The Client and the Plan Manager understand and agree that the fees for services under this Agreement may be renegotiated in the event that substantial changes to the Plan would significantly increase or decrease the obligations or costs of providing administrative services with respect to the Plan.

ARTICLE X
Contract Period

- 10.1 The effective date of this Agreement is [month / day / year] (the "Effective Date"). This Agreement shall continue for an initial period of [variable: one (1) year] from the Effective Date, unless terminated earlier as provided in Article XI, below.
- 10.2 This Agreement shall automatically renew for successive additional one-year periods unless it is terminated as provided in Article XI.

ARTICLE XI
Termination

- 11.1 This Agreement may be terminated by the Client or by the Plan Manager at the end of any contract period upon advance written notice of at least thirty (30) days.
- 11.2 The Plan Manager, in its discretion, may terminate this Agreement before the end of any contract period upon thirty (30) days written notice, if the Client fails to cure any one or more of the following deficiencies before the end of the thirty (30) day notice period:
- (a) Failure to pay all or part of the fees payable under Article IX of this Agreement when due.
 - (b) Failure to provide adequate funds to honor claims reimbursement payments on a timely basis.
 - (c) Direction is given by the Client or Plan Administrator requiring the Plan Manager to suspend claims processing or payment for more than twenty (20) days; or
- 11.3 Either party may terminate this Agreement immediately upon written notice in the event of:
- (a) The bankruptcy, insolvency or liquidation of the other party; or
 - (b) The commission by the other party of any material breach of this Agreement which is not cured, or any act of fraud, misconduct or bad faith in connection with the performance of its duties under this Agreement. However, a material breach of this Agreement may be cured within thirty (30) days after written notice from the other party.
- 11.4 The Plan Manager, in its discretion, may terminate this Agreement upon written notice in the event of repeated occurrences (two or more) of the conditions described in section 11.2 or two or more instances where services are interrupted in accordance with section 3.10.
- 11.5 All obligations of the Plan Manager under this Agreement will end on the effective date of termination of this Agreement, even though the claim for benefits was incurred or submitted for payment prior to termination of this Agreement, unless a supplemental Agreement is entered into prior to the termination date.
- 11.6 In the event of the termination of this Agreement, the Plan Manager will provide the Client or the Plan Administrator with reasonable access to records or information concerning the Plan in its possession, upon written request. The Plan Manager will within a reasonable time honor requests for copies of records and information provided they are reasonable and the Client agrees to pay for the services. The Plan Manager shall have the right to retain copies of such property and records as reasonably necessary or is otherwise required by law.
- 11.7 Upon termination of this Agreement, any monetary obligation of the Client to the Plan Manager shall become immediately due and payable.
- 11.8 Termination under any section of this Article XI shall not cause either party to waive any rights it may have to exercise any remedies available to it under any other section of this Agreement or under any applicable law.

ARTICLE XII
Confidentiality

12.1 For purposes of this Article XII:

- (a) Covered Person means an individual with respect to whom benefits may be or become payable under the provisions of the Plan.
- (b) Private Health Information means any of the following categories of information:
 - (1) Patient Records includes, but is not limited to, all dental records, dentist and provider notes and bills and claims with respect to a Covered Person.
 - (2) Patient Information includes Patient Records and all written and oral dental information received about a Covered Person.
 - (3) Individually Identifiable Health Information means any other information, including demographic information, collected from an individual that:
 - (A) Is created or received by a dentist, dental plan, employer, or dental clearinghouse; and
 - (B) Relates to the past, present, or future payment for the provision of dental care to an individual and identifies the individual, or with respect to which there is a reasonable basis to believe that the information can be used to identify the individual.

12.2 The Client and the Plan Manager acknowledge and agree that in the course of performing their respective duties under this Agreement, they may acquire or obtain access to or knowledge of Private Health Information or other personal information regarding Covered Persons. This information is at all times the property of the Plan or the Client, depending upon its nature and source, and not the Plan Manager, even if it is received by the Plan Manager. Information of this nature that is received by the Plan Manager will be deemed to be information received on behalf of the Plan. However, information that is produced incidentally through application of the computer systems employed by the Plan Manager in the course of providing services under this Agreement will not be considered property of the Plan or the Client or any Covered Person, if it is not specific to the Plan or not material to Plan administration.

12.3 The Client and the Plan Manager will safeguard Private Health Information and other personal information to ensure that the information is not improperly disclosed. The Client, the Plan Administrator, and the Plan Manager or any person appointed by or under their control, respectively, will make sure that Plan functionaries and third party service providers having access to Private Health Information and other personal information are trained in privacy policies directed at safeguarding against improper disclosure, made familiar with the confidentiality obligations set forth in this Agreement, and abide by those requirements as minimum safeguards against improper disclosure. The Client and the Plan Manager acknowledge with respect to Private Health Information, and other personal information that:

- (a) Disclosure is improper if it is not allowed by law or made for any purpose other than Plan administration or benefits delivery. Disclosure to Plan functionaries or dental care providers may be proper, if the disclosure is allowed by law and made for Plan purposes.
- (b) The Employer or Plan Sponsor may legally have access, on an as-needed basis, through the Plan Administrator to limited dental information for the purpose of determining Plan costs, contributions, Plan design, and whether Plan modifications are warranted.
- (c) Federal regulators such as the Department of Health and Human Services and the Department of Labor may legally require access to Protected Health Information in order to investigate compliance with federal legal requirements concerning confidentiality of Private Health Information.
- (d) The Plan Manager will not be responsible for determining the rights of Covered Persons to acquire access to or modify Private Health Information and other personal information concerning them (whether or not such information is at any time in the possession of the Plan Manager).
- (e) In the event that the Plan Manager is directed by the Client or Plan Administrator to disclose Private Health Information or other personal information concerning them for purposes other than Plan operation or benefits delivery, the Plan Manager will not be responsible for providing an accounting to Covered Persons of such disclosure(s) (whether or not such information is at any time in the possession of the Plan Manager).
- (f) The Plan Manager will notify the Plan Administrator of any disclosure of Private Health Information in its possession or control that is not consistent with the provisions of this Agreement of which the Plan Manager becomes aware.
- (g) The Client, the Plan Administrator, and the Plan Manager acknowledge and agree that improper disclosure of Private Health information or other personal information agreement will amount to a material breach of this Agreement. In the event of improper disclosure, the culpable party shall take reasonable steps to alleviate the effects of the improper disclosure; but if those efforts to cure are not successful, the improper disclosure will constitute grounds for immediate termination of this Agreement.

12.4 Accordingly, the Plan Manager will afford access to Private Health Information or other personal information received by it to the Plan Administrator or the Client, as permitted under this Agreement and by law. The Plan Manager will afford access to this information to other persons only as reasonably directed in writing by the Plan Administrator or the Client, with due regard for confidentiality, and the Plan Manager shall have no further obligation with respect to that information. The Plan Manager is directed to afford access to Private Health Information and other personal information to the persons listed on Exhibit "G".

12.5 The Client represents and warrants that the Plan Administrator is and shall continue to be obligated to safeguard Private Health Information in accordance with the provisions of this Agreement as minimum standards. The Client further represents and warrants that security controls, restrictive processes, and other appropriate safeguards have been put in place between the Employer and the Plan to protect Private Health Information from improper disclosure.

- 12.6 In connection with performing its obligations under this Agreement, it may become necessary for the Plan Manager to disclose to the Plan Administrator or the Client, their designees or third parties under contract with either of them ("Recipients", for purposes of this subsection) trade secret and/or proprietary information of the Plan Manager or its affiliates (referred to in this subsection collectively as "HumanaDental"). The Client and the Plan Administrator agree to safeguard and ensure the confidentiality of such trade secret and/or proprietary information, which shall include information relating to (i) the business of HumanaDental, its affiliates, their clients and representatives, (ii) third parties under contract with HumanaDental, (iii) dental service provider arrangements or contracts, (iv) dental service provider network arrangements or contracts, and (v) documentation relating to the computer systems utilized by HumanaDental.
- (a) Access to the trade secret and/or proprietary information described above will be permitted for Recipients only; it may be used by Recipients only in a manner necessary to accomplish the purposes described above with respect to Private Health Information and other personal information; and it may not be disclosed to any third parties, including their employees that do not have a need to know, without authorization by HumanaDental. Access to such records or information does not constitute a transfer of ownership, permission to appropriate, or license to use the same for any purpose not contemplated under this Agreement.
 - (b) The Client understands and agrees that the Client (or its designee) must recognize and abide by restrictions upon disclosure of information and/or systems that are imposed by contracts between HumanaDental and third parties or by law, regulation, or order of a court or regulatory agency.
- 12.7 Upon termination of this Agreement, records containing Private Health Information or other personal information in the possession of the Plan Manager will be either delivered to the Plan Administrator or destroyed when the Plan Manager's records retention obligations have been fulfilled. If such delivery or destruction is not feasible, the protections of this Agreement will continue to apply to those records and further uses and disclosures of the Private Health Information or other personal information shall be limited to those purposes that make the return or destruction of the information infeasible.
- 12.8 The Client and the Plan Manager agree that they will require other persons or entities that receive Private Health Information or other personal information regarding Covered Persons and/or trade secret or propriety information in connection with and as permitted by this Agreement to agree in writing to observe the protections described herein as minimum safeguards against improper disclosure of such information.

ARTICLE XIII
Hold Harmless

- 13.1 The Client agrees to indemnify and hold the Plan Manager harmless against any and all loss, liability, or damage (including payment of reasonable attorney's fees) which the Plan Manager may incur by reason of failure of the Client or its employees, agents or representatives to abide by the provisions of the Plans or this Agreement or to administer the Plans or assets and funds of the Plans in a prudent and proper manner; failure of the Plans or documents describing the Plan prepared or adopted by the Plan sponsor to comply with applicable laws; fraud, embezzlement, willful misconduct, or intentional disregard on the part of the Client or its employees, agents or representatives; disputes concerning

denials of benefits or benefit payments made by or at the direction of the Client or the Plan Administrator; or actions taken by the Plan Manager at the direction of the Client or the Administrator.

- 13.2 The Plan Manager agrees to indemnify and hold the Client harmless against any and all loss, liability, or damage (including payment of reasonable attorney's fees) which the Client may incur by reason of the failure of the employees, agents or representatives of the Plan Manager to abide by this Agreement, or fraud, embezzlement, willful misconduct or intentional disregard on the part of the Plan Manager or its employees, agents, or representatives. The Plan Manager will not be liable on account of actions or inaction undertaken by it in good faith and performed in accordance with the provisions of this Agreement or for the cost of benefits under the Plan which are claimed or awarded to a Participant.
- 13.3 The obligations under this Article XIII shall continue beyond the term of this Agreement as to any act or omission which occurred during the term of this Agreement.

ARTICLE XIV Taxes and Assessments

- 14.1 If a tax or other assessment, including a premium tax, with respect to the Plan (other than an income tax with respect to the fees earned by the Plan Manager) is imposed upon the Plan Manager, the Plan Manager will provide written notification to the Client together with a copy of the tax bill or assessment within ten (10) business days of receipt.
- 14.2 If the Plan Manager pays the tax or assessment, the Client shall reimburse the Plan Manager for any amounts paid plus reasonable out-of-pocket expenses immediately upon notification by the Plan Manager that the tax has been paid.

ARTICLE XV Defense of Actions

- 15.1 The Client and the Plan Manager agree to cooperate with respect to (a) the determination, settlement and defense of any and all claims for benefits undertaken by the Plan Manager pursuant to this Agreement, and (b) the settlement of and conduct of a defense against any claim for benefits which has been denied, which may include attending hearings and trials and assisting in securing the attendance of witnesses and giving of evidence.
- 15.2 The payment of legal fees arising out of any transaction or activity under this Agreement shall be the responsibility of the person incurring the expense, except as provided in Article XIII. However, legal fees incurred by the Plan Manager and attributable to a request, direction, or demand by the Client, the Plan Administrator, or Employer shall be the responsibility of the person making the request, direction or demand. Legal fees incurred by the Plan Manager and attributable to the defense of claims determinations made in accordance with this Agreement shall be the obligation of the Client.

ARTICLE XVI Miscellaneous

- 16.1 Ancillary Agreements. The Client agrees to execute or cause to be executed all ancillary agreements appropriate and necessary to enable the services described in this Agreement to be performed.
- 16.2 Entire Agreement. This Agreement (including the Exhibits and Plan documents as incorporated herein by reference) constitutes the entire agreement between the parties with respect to the Plan, and there are no agreements, representations or warranties regarding the subject matter of this Agreement between the parties other than those set forth or provided for in this Agreement (including the Exhibits and Plan documents as incorporated by reference).
- 16.3 Assignment. Neither the Plan Manager nor the Client may assign or otherwise transfer its rights and obligations under this Agreement to any other person or entity without the prior written consent of the other party. However, the functions to be performed by the Plan Manager may at any time be transferred to an affiliate of the Plan Manager. Any other attempted assignment or delegation shall render this Agreement voidable at the option of the non-assigning party.
- 16.4 Notices. All notices to the Client under this Agreement shall be personally delivered or sent by a method no less rapid than first class mail, with postage prepaid, or facsimile, to the Client at the following address:

Attn: [Management contact's name]
ABC Company
[address]
[city / state / zip]
[Telephone No.]
[FAX No.]
[Email]

All notices to the Plan Manager under this Agreement shall be personally delivered or sent by a method no less rapid than first class mail, with postage prepaid, or facsimile, to the Plan Manager at the following address:

Attn: Gerald L. Ganoni
HumanaDental Insurance Company
1100 Employers Boulevard
Green Bay, Wisconsin 54344
Telephone No. (920) 337-7602
FAX No. (920) 337-3183
Email: jganoni@humana.com

- 16.5 Severability. If any provision of this Agreement is determined to be unenforceable or invalid, such determination will not affect the validity of the other provisions contained in this Agreement. Failure to enforce any provision of this Agreement does not affect the rights of the parties to enforce such provision in another circumstance. Neither does it affect the rights of the parties to enforce any other provision of this Agreement at any time.
- 16.6 Applicable Law. This Agreement shall be governed by and construed in accordance with the internal laws of the State of Wisconsin, to the extent not preempted by federal law.
- 16.7 Amendment. This Agreement may be amended by the Client and the Plan Manager at any time by a writing duly executed by an appropriate officer of the Plan Manager and the Client.

16.8 Effect of Payment of Administration Charges. This Agreement shall be considered executed by the Plan Manager and the Client, upon signature of the respective parties. Payment of fees prior to completion and signature of this Agreement will constitute execution of a written temporary agreement, pending completion and signature of this Agreement.

IN WITNESS WHEREOF, the Client and the Plan Manager have executed this Agreement on _____, 20__.

ABC Company
Sample City, Wisconsin

(By) _____
(signature)

Name: _____

Title: _____

HUMANADENTAL INSURANCE COMPANY
De Pere, Wisconsin

(By) _____
Gerald L. Ganoni
President

EXHIBIT A

Identification of the Plan

ABC Company Employee Dental Plan
(Dental Coverage)
(Governmental Plan)

EXHIBIT B

COBRA Administration Services

DEFINITIONS

- B1.1 "COBRA" means the Federal Consolidated Omnibus Budget Reconciliation Act of 1986, as amended, which requires health care continuation coverage through amendments to the Employee Retirement Income Security Act of 1974, the Internal Revenue Code of 1986, and the Public Health Services Act of 1944.
- B1.2 "Qualified Beneficiary" means a current or former employee of an Employer who is entitled to continued coverage under the Plan through COBRA and a spouse or dependent of a current or former employee who is entitled to continued coverage under the Plan through COBRA. A Qualified Beneficiary under COBRA law also includes a child born to the current or former employee during the coverage period or a child placed for adoption with the current or former employee during the coverage period. At the time COBRA election is made, these individuals are also referred to as a "COBRA Continuee".
- B1.3 "COBRA Service Provider" means a provider of COBRA administrative services retained by the Plan Manager to provide specific COBRA administrative services as described in this Exhibit B.

DUTIES OF THE PLAN MANAGER

- B2.1 The Plan Manager will provide claims processing and other administrative services as described in this Agreement with respect to COBRA Continuees as Covered Persons under the Plan.
- B2.2 The Plan Manager will not determine questions of eligibility for COBRA continuation under the Plan.
- B2.3 The Plan Manager will retain a COBRA Service Provider who is responsible for providing all notices required by COBRA to Qualified Beneficiaries.
- B2.4 The COBRA Service Provider will notify the Plan Manager and Employer of an individual's election of COBRA continuation coverage.
- B2.5 The COBRA Service Provider will, in accordance with its regular practices, bill COBRA Continuees for the costs payable by them for COBRA continuation coverage under the Plan on a monthly basis.
- B2.6 The COBRA Service Provider will, in accordance with its regular practices, collect the amounts billed in accordance with section B2.5 on a monthly basis from COBRA Continuees. A 31-day grace period will be allowed for payment of the amount due.

The COBRA Service Provider will deposit the amounts collected under section B2.6 in a general account for COBRA payments, and remit the balance in the account to the Employer or Plan Administrator on a monthly basis less any amount which may be directed by the Employer or Plan Administrator to be offset against the costs of services due under this Agreement.

- B2.7 Where the costs of COBRA continuation coverage are billed and collected by the COBRA Service Provider, the COBRA Service Provider will furnish the Client, the Employer, or the Plan Administrator with monthly information of the aggregate COBRA continuation coverage costs billed in accordance with section B2.5 and the aggregate coverage costs collected in accordance with section B2.6.
- B2.8 The Plan Manager will record a termination date for each COBRA Continuee as designated to the Plan Manager by the Employer or Plan Administrator or COBRA Service Provider (the "Termination Date"). After the Termination Date such individual will no longer be considered to be a COBRA Continuee and a Covered Person. The Plan Manager will not provide services under this Agreement with respect to any COBRA Continuee insofar as those services may pertain to time periods occurring after the Termination Date.

DUTIES OF THE CLIENT OR EMPLOYER

- B3.1 The Client and the Employer understand and agree that the Employer is solely responsible for compliance with COBRA and for deciding all questions, including matters of clerical error, arising out of COBRA Continuees' eligibility for COBRA continuation coverage.
- B3.2 The Client and the Employer understand and agree that the Plan Manager is in no way responsible and does not assume responsibility for compliance with any obligations of the Employer under COBRA. Performance of services under this Agreement shall not be construed by the Client or Employer that the Plan Manager endorses, warrants, or represents that the COBRA continuation coverage provided by the Employer is in compliance with any legal obligation of the Employer.
- B3.3 Notification to the Plan Manager and COBRA Service Provider by the Employer, or Plan Administrator of the termination date, qualifying event and eligibility of an individual to receive COBRA continuation coverage
- B3.4 Notification to the Plan Manager and COBRA Service Provider by the Employer or Plan Administrator of the appropriate amounts due for coverage under the Plan.
- B3.5 The Client and the Employer understand and agree that the Client shall inform each affected entity (e.g. HMO) of the existence of this Agreement and, by separate written agreement or otherwise, secure each entity's acceptance of its pertinent provisions.

NOTICES

- B4.1 The Plan Manager shall be entitled to rely and act based upon documents, letters, electronic communications, or telephone communications which are confirmed in writing and provided to it by the Client or Employer. Reliance will continue until the time the Client or the Employer notifies the Plan Manager in writing of any change or amendment to those communications.

B4.2 Notices provided by the Client regarding these COBRA Administration Services to the Plan Manager shall be personally delivered or sent by a method no less rapid than first class mail, with postage prepaid, or facsimile, to the Plan Manager at the following address:

Attn: Gerald L. Ganoni
HumanaDental Insurance Company
1100 Employers Boulevard
Green Bay, Wisconsin 54344
Telephone No. (920) 337-7602
FAX No. (920) 337-3183
Email: jganoni@humana.com

EXHIBIT C

Utilization / Case Management Services

"NO SERVICES PROVIDED"

EXHIBIT D

Networks

DEFINITIONS

- D1.1 "Dental Care Provider" means any dentist or any other provider of dental care services or supplies which are Covered Services under the terms of the Plan.
- D1.2 "Network" means a network of Preferred Providers which is available to provide services with respect to Participants in connection with this Agreement.
- D1.3 "Preferred Provider" means a Dental Care Provider that is available by virtue of this Agreement to furnish services or supplies with respect to Participants under applicable utilization management or case management provisions of the Plan.
- D1.4 "Preferred Provider Services" means Covered Services provided by a Preferred Provider or for emergency care.
- D1.5 "Service Area" means the Zip Code Areas in which each Network provides dental care services in accordance with the terms of this Agreement and the Plan.
- D1.6 "Zip Code Area" means the geographical area described by any five-digit zip code established by the United States Post Office.

NETWORKS

- D2.1 The Plan Manager will engage one or more Networks to provide Covered Services under the Preferred Provider Services provisions of the Plan, within each Service Area served by the Networks. The Plan Manager will provide a listing of Network locations and Preferred Provider locations within each Service Area.

PROVIDERS

- D3.1 The Client agrees that the Plan Manager shall not be held responsible for the actions of Dental Care Providers, including providing dental care services, and that in no event shall the hold harmless and indemnity provisions of the Agreement apply against the Plan Manager with respect to any expense caused by the acts or omissions of Dental Care Providers.
- D3.2 The Plan Manager represents that provider agreements entered into by it in connection with its obligations under this Agreement comply with all of the requirements of applicable law. With respect to its obligations under this Agreement, the Plan Manager will exercise due diligence in selecting Dental Care Providers.
- D3.3 The Plan Manager acknowledges that providers of professional dental care services under contract with a Network maintained by the Plan Manager or by companies under common control with it comply with credentialing standards no less stringent than those prevailing in the industry.

EXHIBIT E

CLASSIC BANKING ARRANGEMENT

In order to facilitate the transfer of claims payment funds in connection with the Client's obligations under the Plan Management Agreement, **ABC Company**, the "Client," and **HumanaDental Insurance Company**, the "Plan Manager," agree to the following terms and conditions:

Under this method of claims payment, claims are paid by means of checks drawn against the Claims Payment Account set up by the Plan Manager.

- E1.1 The Plan Manager will inform the Client each week of the amount of the payment that must be paid from the Client's Designated Account for checks issued the previous week. The Client will be informed each Monday of the amount of the checks issued the previous week.
- E1.2 The Client will establish and maintain a Designated Account which will fund claims checks under the Plan Management Agreement.
 - (a) The Client will initiate a payment to fund the Claims Payment Account. The payment is to be effective the week of the receipt of the weekly funding request.
 - (b) The Client will pay any banking fees charged to service the Designated Account.
- E1.3 With respect to the Claims Payment Account:
 - (a) Amounts credited to the Claims Payment Account by the Client will be made from the Client's general assets or a fund established by the Client.
 - (b) The Plan Manager will pay any banking fees charged to service the Claims Payment Account.
 - (c) No interest will be paid with respect to balances in the Claims Payment Account.
 - (d) The Client will make an initial deposit to the Claims Payment Account of **\$ [variable]**. This amount represents an estimated **[variable number of days]** of claims expense activity with respect to the Plan and is considered a funding security deposit.
 - (e) **This amount is due prior to the Plan effective date.**
 - (f) The Client will maintain the dollar equivalent of **[variable number of days]** claims activity on deposit in the Claims Payment Account.
 - (g) The Client will reimburse the Plan Manager for any bank fees related to overdrafts caused by the Client in the Claims Payment Account.
- E1.4 The Plan Manager will provide a monthly financial reconciliation statement that reports Claims Payment Account activity.

E1.5 While this Plan Management Agreement is in effect, the Client and the Plan Manager may agree in writing to change this method of "banking". However, any such change shall not affect continuing obligations under the Plan Management Agreement or liability of the Client for checks authorized for payment, fees incurred as provided in this Agreement, and/or any due and agreed upon balance requirements in effect prior to the effective date of the change.

E1.6 Persons to contact at the Client's location regarding banking issues:

Primary Contact:

Name: _____

Phone Number: _____

FAX Number: _____

Email: _____

Secondary Contact:

Name: _____

Phone Number: _____

FAX Number: _____

Email: _____

E1.7. The Claims Payment Account is identified:

Bank Name: National City Bank

Bank Address: Louisville, KY

Transit Routing Number: 083000056

Name of Account: ABC Company

Account Number: [variable]

EXHIBIT F

Schedule of Fees

F1.1 The monthly fees presented in this Exhibit F are valid for the period of time beginning [variable: on the Effective Date of this Agreement] and ending on [variable: month / day / year], except as otherwise stated.

F2.1 General:

<u>Line of Coverage</u>	<u>Single</u>	<u>Family</u>	<u>-or- Composite</u>
Dental Access Fee	\$	\$	\$

F3.1 Specific:

- (a) Under §7.5 of the Agreement, the administrative fee for providing Subrogation / Recovery Services is 30% of all amounts recovered under that section. The administrative fee will be applied towards the net recovery, exclusive of any legal fees.
- (b) With respect to access to provider networks in accordance with §7.7 of this Agreement or other similar provider arrangements arranged through the Plan Manager, the Client understands that a special access fee may be payable, depending upon the network or arrangement. The Client and the Plan Manager agree that the Client will be obligated to pay any special fee under this §F3.1(b) only upon advance written notice to and written consent by the Client.
- (c) The fee payable for run-out claims processing under §7.8 of the Agreement will be based upon the enrollment levels in effect the month prior to the date of such change. Fees will be equal to three (3) months of administrative fees that are in effect for the service period during which the run-out claims processing services are provided.

F4.1 Payment:

- (a) Fees set forth in sections F2.1 are payable to the Plan Manager once per month.
- (b) Any special access fees payable under §F3.1(b) shall be paid by the Client to Plan Manager as billed.

EXHIBIT G

**Persons Authorized to Receive
Private Health Information**

Name: ?????
Title: ?????
Company: [Client/other]
Address: ?????
?????
Telephone: (???) ???-????
Fax: (???) ???-????
Email:

Name: ????
Title: ????
Company: [Client/other]
Address: ????
????
Telephone: (???) ???-????
Fax: (???) ???-????
Email:

Employer: GN MAF TRADITIONAL SAMPLE
Group Number: 123456

SAMPLE

Dental Plan
Certificate of Insurance

HumanaDental Insurance Company

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

*We will amend this certificate to conform to the minimum requirements of *** Unevaluated expression: <cState> *** laws. This certificate replaces any certificate previously issued under the provisions of the group policy.*



Gerald L. Ganoni
President

HUMANA
Specialty Benefits

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Benefits

Policyholder (Employer): ALTEST33
Group Number: 123456
Coverage Effective Date: 08/14/2007

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:

\$2,500 per *calendar year* per *member* for Preventive, Basic and Major Services.

Individual deductible:

\$25 per *calendar year* per *member* for Preventive, Basic and Major Services.

Maximum family deductible:

Covered expenses applied to the plan *deductible* of each covered *member* are combined to a *calendar year* maximum of \$75

Orthodontic lifetime maximum benefit

\$1,000 per *member*

Preventive Services:

Benefits are paid at 100% percent after the *deductible*.

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

Basic Services:

Benefits are paid at 50% percent after the *deductible*.

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

Benefits

Major Services:

Benefits are paid at 30% percent after the *deductible*.

1. Crowns
2. Inlays and onlays
3. Removable or fixed bridgework
4. Partial or complete dentures
5. Denture relines or rebases
6. Periodontics (gum disease)
7. Endodontics (root canals) only the *late applicant* waiting period will apply to this *service*

Orthodontic Services:

Benefits are paid at 50% percent

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

Benefits

Waiting periods

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

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

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

Preventive Services:

No waiting periods apply to Preventive Services.

Basic Services:

No waiting periods apply to Basic Services, unless *members* are *late applicants*.

If *members* are *late applicants*, they must be insured under this policy for a period of 12 continuous months before Basic Services will be covered.

Major Services:

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

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

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

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

Orthodontic Services:

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

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

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

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

Benefits

Your plan benefits

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

Preventive services

1. Oral evaluations (periodic, limited, comprehensive and problem focused) - two per *calendar year*.
2. Periodontal evaluations - two per *calendar year*.
3. Cleaning (prophylaxis), including all scaling and polishing procedures – two per *calendar year*.
4. Intra-oral complete series X-rays (at least 14 films, including bitewings), or panoramic film X-rays – once every five years. If the total cost of periapical and bitewing x-rays exceeds the cost of a complete series of x-rays, the plan will consider these as a complete series.
5. Bitewing X-rays –one set per *calendar year*.
6. Other X-rays – only to diagnose specific treatment.
7. Topical fluoride treatment – provided to *dependents* age 14 and younger. *Service* is payable once per *calendar year*.
8. Sealants – application provided to *dependents* age 14 and younger to the occlusal surface of permanent molars that are free of decay and restorations. *Service* is payable once per tooth per lifetime.
9. *We will not cover preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.*

Basic services

1. Amalgam restorations (fillings) – limit to one per tooth in a two year period. Multiple restorations on one surface are considered one restoration.
2. Composite restorations (fillings) limited to one per tooth in a two year period. on anterior teeth – Composite restorations on molar and bicuspid teeth are considered an alternate *service* and will be payable as a comparable amalgam filling. *You* will be responsible for the remaining *expense incurred*. Multiple restorations on one surface are considered one restoration.
3. Pin retention in addition to an amalgam or composite restoration – this is not covered as a separate *covered expense* when done in conjunction with a core build-up.

Benefits

4. Recementing of inlays, onlays, crowns and bridges.
5. Non-cast pre-fabricated crowns – *service* on primary teeth that cannot be adequately restored with amalgam or composite restorations.
6. Space maintainers for retaining space when a primary tooth is prematurely lost. *Services* are payable only for *dependents* age 14 and younger for the installation of the initial appliance. Separate adjustment expenses will not be covered.
7. Fixed and removable appliances to inhibit thumb sucking and other harmful habits. *Services* are payable only for *dependents* age 14 and younger for the installation of the initial appliance. Separate adjustment expenses will not be covered.
8. *Emergency care* – treatment for the initial *palliative* care of pain and/or injury. *Services* include *palliative* procedures for treatment to the teeth and supporting structures. We will consider the *service* as a separate *benefit* only if no other *service*, except X-rays, is provided during the same visit.
9. Full or partial denture repair.
10. Consultation – diagnostic service provided by a dentist or physician other than practitioner providing the treatment. Coverage is limited to one consultation per provider.

Oral surgery services

1. Extractions.
2. Bone Smoothing;
3. Trim or Remove over growth or non vital tissue or bone; or
4. Removal of tooth or root from sinus and closing opening between mouth and sinus.
5. General anesthesia when *medically necessary* and administered by a *dentist* in conjunction with a covered oral surgical procedure.
6. *We will not cover any services* for orthognathic surgery.
7. *We will not cover any surgical or nonsurgical treatment* for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
8. *We will not cover services* generally considered to be medical *services*.
9. Separate fees for pre and post operative services are not a *covered expense*.

Benefits

Periodontic services

1. Periodontal scaling and root planing, available at a maximum of once per quadrant in a three-year period.
2. Periodontal surgery, available at a maximum of once per quadrant in a three-year period. If more than one surgical *service* is performed on the same day, we will consider only the most inclusive *service* performed as a *covered service*.
3. Occlusal adjustments when performed in conjunction with periodontal surgery – available at a maximum of once per quadrant in a three-year period.
4. Periodontal maintenance (following periodontal therapy) – procedure available twice per *calendar year*.
5. Separate fees for pre and post operative care and re-evaluation within three months are not covered.

Endodontic services

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

Major/Prosthodontic services

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

Benefits

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

These *services* are covered only on permanent teeth.

6. Denture relines or rebases – once in a three-year period.
7. *We* will not cover the *expense incurred* for pin retention when done in conjunction with core build-up.
8. *We* will not cover the replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.

Integral service

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

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

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

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

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

Benefits

Limitations & exclusions (all services)

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

1. Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law, whether or not *you* applied for coverage.
2. *Services*:
 - That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with *sickness* or *bodily injury*.
3. Any loss caused or contributed by:
 - War or any act of war, whether declared or not;
 - Any act of international armed conflict; or
 - Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. *Your* failure to keep an appointment with the *dentist*.
6. Any *service* we consider *cosmetic dentistry* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. We consider the following *cosmetic dentistry* procedures:
 - Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - Any *service* to correct congenital malformation;
 - Any *service* performed primarily to improve appearance; or
 - Characterizations and personalization of prosthetic devices.
7. Charges for:
 - Any type of implant and all related services, including crowns or the prosthetic device attached to it.
 - Precision or semi-precision attachments.
 - Overdentures and any endodontic treatment associated with overdentures.
 - Other customized attachments.

Benefits

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 anesthesiologist.
12. Prescription drugs or pre-medications, whether dispensed or prescribed.
13. Any *service* not specifically listed in **Your plan benefits**.
14. Any *service* that we determine:
 - Is not a *dental necessity*;
 - Does not offer a favorable prognosis;
 - Does not have uniform professional endorsement; or
 - Is deemed to be experimental or investigational in nature.
15. Orthodontic *services* unless specified in *your Summary of your benefits*.
16. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates (unless the *service* is eligible under **Extension of benefits**).
17. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
18. Charges exceeding the *reimbursement limit* for the *service*.
19. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.
20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, temporary dental *services*, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.
21. Repair and replacement of orthodontic appliances.

Benefits

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

Excess coverage

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

Benefits

How your plan works

General benefit payments

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

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

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

Deductibles

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

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

Coinsurance

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

Waiting periods

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

Benefit maximums

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

Alternate services

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

Benefits

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

Pretreatment plan

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

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

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

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

Process and timing

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

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*.

Claim forms

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

Submitting claim information and proof of loss

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

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

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

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

Claims

Paying claims

We determine if *benefits* are available and pay promptly any amount due under this policy in the timeframe required by state law or by *dentist* contract. *We* may pay all or a portion of any *benefit* provided for *covered expenses* to the *dentist* unless *you* have notified *us* in writing by the time the claim form is submitted. *Our* payments are made in good faith and will fully discharge *us* of any liability to the extent of such payment.

Extension of benefits

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

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

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

Reasons for denying a claim

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

1. **Not a covered benefit:** The *service* is not a *covered service* under the certificate.
2. **Eligibility:** *You* no longer are eligible under the **Terminating coverage** section of this certificate, or the *expense incurred date* was prior to *your* effective date.
3. **Fraud:** *You* make an intentional misrepresentation by not telling *us* the facts or withhold information necessary for *us* to administer this certificate.

Insurance fraud is a crime. Anyone who willingly and knowingly engages in an activity intended to defraud *us* by filing a claim or form that contains false or deceptive information may be guilty of insurance fraud.

If a *member* commits fraud against *us*, as determined by *us*, coverage ends automatically, without notice, on the date the fraud is committed. This termination may be retroactive. *We* also will provide information to the proper authorities and support any criminal charges that may be brought. Further, *we* reserve the right to seek civil remedies available to *us*.

We will not end coverage if, after investigating the matter, *we* determine that the *member* provided information in error. *We* will adjust premium or claim payment based on this new information.

Claims

If *you* provided correct information and *we* made a processing error, *you* will be eligible for coverage and claims payment for *covered expenses*. *We* will adjust *your* premium or claim payment based on the correct information.

4. **Duplicating provisions:** If any charge is described as covered under two or more benefit provisions, *we* will pay only under the provision allowing the greater *benefit*. This may require *us* to make a recalculation based on both the amounts already paid and the amounts due to be paid. *We* have no obligation to pay for *benefits* other than those this certificate provides.

Legal actions

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

Claims paid incorrectly

If a claim was paid in error, *we* have the right to recover *our* payments. *We* may correct this error by an adjustment to any amount applied to the *deductible* or *maximum benefits*. Errors may include such actions as:

1. Claims paid for *services* that are not actually covered under the policy.
2. Claims payment that is more than the amount allowed under the policy.
3. Claims paid based on fraud or an intentional misrepresentation.

We may seek recovery of *our* payments made in error from anyone to, for or with respect to whom such payments were made; or any insurance companies or organizations that provide other coverage for the *covered expenses*. *We* will determine from whom *we* shall seek recovery. For information on *our* process, see the **Recovery rights** provision.

Claims

Coordinating benefits with another insurer

Benefits subject to this provision

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

1. **Plan**—A plan covers medical or dental expenses and provides *benefits* or *services* by:
 - Group, franchise or blanket insurance coverage;
 - Group-based hospital service pre-payment plan, medical service pre-payment plan, group practice or other pre-payment coverage;
 - Coverage under labor-management, employer plans, trustee plans, union welfare plans, employee benefit organization plan; and
 - Governmental programs or programs mandated by state statute, or sponsored or provided by an educational institution, if it is not otherwise excluded from the calculation of benefits under this policy.

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

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

Effect on benefits

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

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

Order of benefit determination

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

Claims

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 of recovery

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

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

Right to necessary information

We may require certain information to apply and coordinate these provisions with other plans. We will, without *your* consent, release to or obtain information from any insurance company, organization or person to implement this provision. *You* agree to furnish any information we need to apply these provisions.

Claims

Recovery rights

Your obligation in the recovery process

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

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

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

Right of subrogation

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

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

Right of reimbursement

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

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

Assignment of recovery rights

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

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

Claims

Worker's compensation

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

The recovery rights will be applied even though:

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

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

Eligibility

When you are eligible for coverage

Employee coverage

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

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

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

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

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

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

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

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

Dependent coverage

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

1. On the date the *employee* is eligible for coverage;
2. On the date of the *employee's* marriage (spouse and/or stepchildren);
3. On the date of birth of the *employee's* natural-born child; or
4. On the date a child is placed in the *employee's* home for adoption by the *employee*.

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

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

Eligibility

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

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

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

Dependent delayed effective date: A *dependent's* effective date of coverage will be delayed if the *dependent* is homebound due to *bodily injury* or *sickness*, or is confined to a hospital or mental health center. The *dependent's* coverage will be effective one day after discharge from confinement. A physician must certify the discharge.

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

Retired employee coverage

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

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

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

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

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

Eligibility

Terminating coverage

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

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

Special provisions for active status

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

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

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

Eligibility

Replacement provisions

Applicability: This provision applies only if:

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

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

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

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

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

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

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. These payments offset the cost to *us* of making these programs available and may help reduce the costs of *your* plan administration.

Who has responsibility for these discounts?

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

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

Shared savings

Shared savings program

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

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

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

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

Definitions

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

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

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

Bodily injury: An injury due directly to an accident.

Calendar year: January 1 through December 31.

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

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

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

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

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

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

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

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

Dependent: A covered *employee's*:

Definitions

1. Lawful spouse; and
2. Unmarried, natural blood related child, stepchild or legally adopted child whose age is less than the limiting age. Each child must qualify as a dependent as defined by the U.S. Internal Revenue Code. This child must receive at least 50 percent support and maintenance from the covered *employee*.

The limiting age for each *dependent* child is:

1. 19 years; or
2. 25 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.

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 at least 50 percent of support and maintenance; and
4. Unmarried.

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

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

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

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

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

Expense incurred date: The date on which:

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

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

Definitions

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

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

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

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

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

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

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

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

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

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

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

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

1. The fee most often charged in the geographical area where the *service* was performed;
2. The fee most often charged by the provider;
3. The fee that is recognized as reasonable by a prudent person;

Definitions

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

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

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

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

Total disability/totally disabled: An *employee* or employed covered spouse who, during the first 12 months of a disability, is prevented by *bodily injury* or *sickness* from performing 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: The insurance company as shown on the cover page of this certificate.

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

Supplemental dental expense benefit

Orthodontic services

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

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

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

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

Covered services for orthodontia treatment

Covered services for orthodontic treatment include those that are:

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

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

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

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

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

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

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

Supplemental dental expense benefit

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

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

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

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

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

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



Gerald L. Ganoni
President

HUMANA[®]

Specialty Benefits

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

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

Notices

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

This section includes notices about:

Claims and Appeal Procedures

Federal Legislation

Medical Child Support Orders

General Notice Of COBRA Continuation Of Coverage Rights

Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)

Family And Medical Leave Act (FMLA)

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

Your Rights Under ERISA

Privacy and Confidentiality Statement

CLAIMS AND APPEALS PROCEDURES

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

DISCRETIONARY AUTHORITY

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

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

CLAIMS PROCEDURES

Definitions

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

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

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

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

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

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

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

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

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

Submitting a Claim

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

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

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

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

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

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

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

Procedural Defects

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

Authorized Representatives

A covered person may designate an authorized representative to act on his or her behalf in pursuing a benefit claim or appeal. The authorization must be in writing and authorize disclosure of health information.

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

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

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

Claims Decisions

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

Pre-service Claims

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

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

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

Urgent-care Claims (expedited review)

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

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

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

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

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

Concurrent-care Decisions

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

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

Post-service Claims

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

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

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

Initial Denial Notices

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

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

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

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

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

APPEALS OF ADVERSE DETERMINATIONS

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

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

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

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

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

Time Periods for Decisions on Appeal

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

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

Appeals Denial Notices

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

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

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

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

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

EXHAUSTION OF REMEDIES

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

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

LEGAL ACTIONS AND LIMITATIONS

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

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

MEDICAL CHILD SUPPORT ORDERS

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

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

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

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

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

Introduction

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

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

What is COBRA Continuation Coverage?

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

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

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

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

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

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

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

When is COBRA Coverage Available

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

You Must Give Notice of Some Qualifying Events

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

How is COBRA Coverage Provided?

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

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

Disability Extension of 18-Month Period of Continuation Coverage

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

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

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

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

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

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

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

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

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

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

Category 1 Medicare eligibles are:

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

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

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

Calculation and Payment of Benefits

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

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

FAMILY AND MEDICAL LEAVE ACT (FMLA)

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

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

Continuation of Benefits

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

Eligibility

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

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

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

Duration of Coverage

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

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

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

Other Information

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

YOUR RIGHTS UNDER ERISA

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

Information About the Plan and Benefits

Plan participants may:

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

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

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

Responsibilities of Plan Fiduciaries

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

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

Continue Group Health Plan Coverage

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

Claims Determinations

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

Enforce Your Rights

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

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

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

Assistance with Questions

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

PRIVACY AND CONFIDENTIALITY STATEMENT

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

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

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

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

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

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

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

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

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



A DENTAL HEALTH MAINTENANCE ORGANIZATION

100 Mansell Court East, Suite 400
Roswell, GA 30076
1-800-342-5209

MEMBER HANDBOOK

AND

EVIDENCE OF COVERAGE

Mission Statement:

CompBenefits was founded to promote the cost efficient delivery of quality, preventive-oriented dental care. Our mission is to serve our members, customers, participating providers, agents, and the communities in which we are located and be recognized by the public as a quality dental benefits company .

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IMPORTANT NOTICE

To obtain information or make a complaint:
You may call Unified Life's toll-free telephone number
for information or to make a complaint at

1-800-342-5209

You may contact the Texas Department of Insurance to
obtain information on companies, coverage, rights or
complaints at

1-800-252-3439

You may write the Texas Department of Insurance at:
de Texas

P.O. Box 149104
Austin, TX 78714-9104
FAX # (512) 475-1771

PREMIUM OR CLAIM DISPUTES: Should You have
a dispute concerning Your premium or about a claim You
should contact Unified Life first.

If the dispute is not resolved by Unified Life,
you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This
notice is for information only and does not become a part
or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:
Usted puede llamar al numero de telefono gratis de
Unified Lifes para informacion o para someter
una queja al

1-800-342-5209.

Puede comunicarse con el Departamento de Seguros
de Texas para obtener informacion acerca de
companias, coberturas, derechos o quejas al

1-800-252-3439.

Puede escribir al Departamento de Seguros

P.O. Box 149104
Austin, TX 78714-9104
FAX # (512) 475-1771

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si
tiene una disputa concerniente a su prima o a un
reclamo, debe comunicarse con primero.

Si no se resuelve la disputa, puede entonces
comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA: Este aviso es
solo para proposito de informacion y no se convierte
en parte o condicion del documento adjunto.

SPECIAL COMMUNICATION NEEDS

If You have special communication needs

We want the plan to be convenient for all members, particularly those with special needs. That is why we offer many materials in both Spanish and English. If You are not comfortable speaking in English, You can still call Member Services at 1-800-342-5209. We have a number of bilingual Member Services Representatives. If You have a disability affecting Your ability to communicate or read, this Member Handbook and Evidence of Coverage is also available on audiocassette, in large type, Braille, and through the use of an interpreter.

Si usted necesita asistencia especial para comunicarse

Queremos que el plan sea conveniente para todos nuestros miembros, en especial aquellos quienes tengan requerimientos especiales. Con este fin ofrecemos muchos materiales impresos en español e inglés. Si no se siente cómodo comunicándose en inglés, puede llamar sin embargo a Servicios Para Miembros al 1-800-342-5209. Tenemos a varios representantes bilingües. Si tiene alguna invalidez que afecte sus posibilidades de comunicarse o de leer, este manual es disponible en forma de audio cassette, en letra mayúscula, en letra para desprovistos de vista y también por medio de un intérprete.

INTRODUCING THE COMPBENEFITS DHMO DENTAL PLAN

Welcome to CompBenefits, a single service dental health maintenance organization ("DHMO"). We are pleased that You have selected our coverage for Your dental needs. This Handbook and Evidence of Coverage ("Handbook") contains a description of covered benefits as well as Copayments, limitations and exclusions. There is a helpful glossary located in the appendix of this Handbook that gives definitions of dental terminology found in this Handbook. You have a responsibility to know what services are covered under your dental plan, **please read this Handbook carefully**. If You have questions about what Your dental plan covers, please refer to your Handbook and Schedule of Benefits or call Member Services at 1-800-342-5209.

HOW THE DHMO PLAN WORKS

Your dental plan is designed to help You and Your family obtain comprehensive dental care by offering inexpensive preventive care and reduced rates for many other dental treatments. You will only pay a Copayment for covered services or treatments You receive at the time services are performed, unless You make other payment arrangements with Your dentist. Copayment amounts are shown on Your Schedule of Benefits. Procedures not listed on the Schedule of Benefits that are performed by Your selected Participating Dentist are available at a discount of that provider's usual and customary fee. You should ask Your Participating Dentist for a benefit determination and cost estimate before You receive any dental treatment.

GETTING STARTED

Selecting Your Dentist

First, You must select a Participating General Dentist from a list of dentist participating in the CompBenefits network as Your primary care dentist. If You have a chronic dental condition, You may select a Participating Specialty Dentist as Your primary care dentist. (Consult Your Schedule of Benefits to know what Your Copayment will be for services provided by a Participating Specialty Dentist.) A directory of all the Participating Dentists will be provided for You at the time of enrollment. The directory is sorted by city, and lists all the dentists in the facility, the address, telephone number, languages spoken, and if the dentist is accepting new patients. Provider directories are updated quarterly and copies can be requested from Member Services. If You need assistance finding a Participating Dentist, call Member Services at 1-800-342-5209 or use the provider locator function on our Internet web site at www.CompBenefits.com. Once You have located a Participating Dentist, please contact our Member Services department with Your selection.

You may select a different Participating Dentist at any time. All You have to do is call or write Member Services to request the change. All requests for dentist changes received by the 15th of the month will become effective on the 1st of the following month. You may select a new dentist up to four times in a calendar year. Requesting a change of dentist more than twice in a thirty-day (30) period is considered excessive and may not be honored.

On rare occasions it may be necessary to assign You to another dentist. A change may be necessary in the following situations:

- if Your selected dentist decides to no longer participate in the CompBenefits network
- if the dentist is unable to effectively provide the care You need
- if efforts to establish a satisfactory relationship between You and the dentist have failed, or
- if You refuse treatment from the dentist that he or she feels is necessary.

If a change is needed, You will be asked to select another dentist from the directory. We strive to provide written notification if Your provider leaves the plan and will send You a letter indicating the change, along with a current provider list, to assist in Your selection of another dentist.

Identification Card

You will be issued an identification card upon enrollment in the Plan. The card identifies You as a CompBenefits Member. If Your card is lost or stolen, call Member Services at 1-800-342-5209 to get a new card mailed to You.

Making an appointment

When You need dental care, simply call Your Participating Dentist's office to make an appointment. When You call, make sure You have Your ID card handy, in case You are asked questions regarding Your dental plan. All non-emergency Dental Care Services shall be on a prior appointment basis during the normal office hours of the Participating Dentist. In order to receive Benefits, You must first make an appointment with a Participating Dentist and the request for an appointment must be made after the Effective Date. When making an appointment, You should inform Dental Facility that You are a Plan Member. You may request an emergency appointment (treatment of accidental, painful, or urgent conditions) within twenty-four (24) hours of calling the Dental Facility, subject to the appropriate Copayment.

Specialty Care

You may be referred by Your Participating General Dentist to a Participating Specialty Dentist (i.e. endodontist, orthodontist, oral surgeon, periodontist, prosthodontist, or pediatric dentist). Participating Specialty Dentist benefits vary by plan. Please refer to Your Schedule of Benefits for payment and benefit information.

Second Opinions

Both You and Your dentist decide on Your course of treatment. If You are not satisfied with Your Participating Dentist's treatment plan, we encourage You to get a second opinion from another Participating Dentist. The second consultation is subject to any applicable Copayments. Please refer to Your Schedule of Benefits for the exact amount.

Whether You need routine, preventive care, emergency care, or just have a dental question, You should call Your selected Participating Dentist first.

EMERGENCY CARE

The Plan covers dental emergencies 24 hours a day, seven days a week, no matter where You are. If You have a dental emergency, You are covered for palliative (emergency) treatment. Palliative treatment involves only those things necessary to control unexpected pain or more than usual bleeding, prevent complications related to an infection, or prevent the loss of a tooth from a traumatic injury. Emergency dental service is intended to relieve

pain caused by an acute condition until Your Participating Dentist can see You. **Your emergency care benefit does not include procedures that may be required, but are not necessary for the relief of pain.** For example, root canals and crowns may be necessary treatments but are not covered under emergency care benefits. If You have an emergency that involves extensive accidental or traumatic injury to Your teeth or mouth, or that affects Your ability to breath or swallow, You should contact Your medical physician.

What is considered an emergency dental service?

Emergency dental services are limited to procedures administered in a dentist's office, dental clinic, or other comparable facility; to evaluate and stabilize dental conditions of a recent onset and severity accompanied by excessive bleeding, severe pain or acute infection that would lead a prudent layperson possessing an average knowledge of dentistry to believe that immediate care is needed.

What should you do in an emergency?

In the Service Area: If You are within 75 miles of Your Participating Dentist, during normal business hours, contact Your dentist and request an emergency appointment. If Your emergency is after normal business hours, You should still try to contact Your selected dentist. The dentist's office should have a message machine or an answering service with instructions on how the dentist can be reached after hours in the event of an emergency. Follow the instructions and provide information on how the dentist can contact You. If Your dentist is not available, or if You cannot get to Your dentist in time, You may see any Participating Dentist for palliative (emergency) treatment.

If You are unable to find another Participating Dentist, please contact Member Services at 1-800-342-5209 or use the provider locator function our Internet web site at www.CompBenefits.com. If You cannot reach any Participating Dentists after hours, You may obtain palliative (emergency) treatment from any licensed dentist.

Out-of-Service Area Emergency Care: If You are more than 75 miles from the nearest available Participating Dentist, You can receive palliative (emergency) treatment from any licensed dentist. You will be reimbursed for the cost of the emergency care minus any applicable Copayments. In order to be reimbursed for the services, You must have an itemized statement and receipt showing the services paid in full from the treating dentist. We must be notified of such treatment within ninety (90) days of its receipt, or as soon as reasonably possible.

IF YOU HAVE A COMPLAINT

We are committed to offering outstanding service to Our members. If You have a concern or complaint about Your dental care or coverage, the way we manage it, or a decision we have made, we want to know. Our goal is to acknowledge and resolve complaints in a timely manner. We monitor complaints and use this feedback from Members to improve our performance.

Complaints

Our Member Services Department is available by phone Monday through Friday, 8:00 AM to 6:00 PM Eastern Standard Time to assist members in addressing any dissatisfaction with their dental plan benefits and / or participating dental office. You can call Member Services at (800) 342-5209 or submit a Complaint in writing. Written Complaints should be mailed to:

Attn: Grievance Coordinator
CompBenefits
5775 Blue Lagoon Drive, Suite 400
Miami, FL 33126-2034

If You submit a written Complaint please include Your concern, specific details, dates, and Your name and contact information. Should You have any question about submitting a written Complaint, call Member Services at (800) 342-5209. Complaints must be submitted to Us within one year of the occurrence of events upon which the

Complaint is based. Your complaint will be acknowledged in writing within five (5) business days of receipt. Written Complaints will be researched and resolved within 30 days from the date of receipt. A response letter explaining the Plan's resolution of the Complaint will be sent to You. The letter will include specific clinical reasons and/or references to Your Handbook that apply and contain a full description of the process for Appeal, including time frames.

Appeal of Complaint Resolution

If the Complaint is not resolved to your satisfaction, You have the right to Appeal the resolution of Your Complaint by appearing before a Complaint Appeal panel in the county where You normally receive dental services or at an agreed upon location, or You may address a written Appeal directly to the panel at:

Attn: Quality Improvement Coordinator
CompBenefits
2929 Briarpark, Suite 314
Houston, Texas 77042
1-800-679-7883 ext. 233

We will send You an acknowledgment letter within five (5) business days of the receipt of Your Appeal request. You will be contacted to make arrangements for a meeting or to submit Your written Appeal. We will convene the Appeal panel and address Your Appeal within thirty (30) days of Your request. The Appeal panel consists of dentists, Plan staff and Plan members who do not work for Us. They will consider all information presented and give a decision on the Appeal. Once the Appeal panel reaches a decision, You will receive a letter with specific clinical and contractual criteria used to reach the decision. Should You disagree with the decision of the appeal panel, or at anytime You are dissatisfied, You have the right to contact the **Texas Department of Insurance** in writing at the following address:

P.O. Box 149104
Austin, Texas 78714-9104
(800) 252-3439
(512) 475-1771 (facsimile)

The Plan is prohibited from retaliating against You or Your group for filing a complaint against the Plan or for appealing a Plan decision. The Plan is also prohibited from retaliating against a dentist because the dentist has on behalf of a member filed a complaint against the Plan or appealed a Plan decision. Since the Plan does not determine if the dental care services furnished or proposed to be furnished to a Member are Necessary Treatment, the right to appeal to an independent review organization ("IRO") is not applicable.

ELIGIBILITY AND COVERAGE

Who is eligible for the plan

You and Your eligible Dependents are allowed to participate in the plan if You live or work in the Service Area. In order for You and Your dependents to be eligible for and receive dental benefits, We must receive all Contributions and Enrollment Fees, if applicable, in advance. Your Participating Dentist must receive any Copayments in accordance with Your Schedule of Benefits. Additionally, the permanent legal residence of all of Your Dependents must be the same as Yours or;

1. in the Service Area with someone else having temporary or permanent conservatorship or guardianship of such Dependents, including adoptees or children who have become the subject of a suit for adoption by You, but where You still have legal responsibility for the health care of such Dependents;
2. in the Service Area under other circumstances where You are legally responsible for the health care of Your Dependents;
3. in the Service Area living with Your spouse; or
4. anywhere in the United States for a child whose coverage under a plan is required by a medical support

order.

Dependent children living outside of the Service Area must receive their care within the Service Area. They will only be covered for emergency care when outside the Service Area.

When coverage begins

Your Coverage Begins- You and Your Dependents are covered at 12:01 a.m. on the later of:

1. The first of the month following the date first eligible for coverage;
2. The date We accept Your enrollment, if You are not enrolled within 31 days of becoming eligible;
3. The date You first acquire a new Dependent;
4. The date We accept a Dependent's enrollment, if not enrolled within 31 days of becoming eligible.

Newborn Child - A child born to You or Your Dependent spouse is covered from the moment of birth for 31 days. If you choose to insure Your newborn, You must enroll the child within 31 days from the date of birth or coverage for that child will terminate at the end of the 31-day period.

Adopted Child - A child placed with You for adoption will be covered from the earlier of: 1) the date of birth if a petition for adoption is filed within 30 days of the birth of such child; 2) the date you gain custody of the child under a temporary court order that grants You conservatorship of the child; or 3) the date the child is placed with You for adoption; and additional premium, if any, is paid.

When coverage ends

Coverage for You and/or Your Dependent(s) will end at 12:01 a.m. on the earlier of:

1. One the date the Contractholder tells Us that You and/or Your Dependent cease to be eligible for coverage;
2. The date in which Your Dependent is no longer a Dependent as defined;
3. Subject to the Grace Period provision, the last day of the month for which Contributions have been paid; or
4. The date coverage ends for any class or Group to which You belong; or
5. The date the Contract ends.

If Your family status changes

Even though You only enroll in Your dental plan once a year, changes in Your personal situation can happen at any time. For instance, if You get married or have a baby, You may want to add Your spouse or child to Your coverage. If so, we need to know about the change as soon as possible. If any of these changes occur in Your family contact Your benefits administrator or Us immediately:

- You get married
- One of Your Dependent children gets married
- You or Your spouse deliver a child or adopt a child
- Your spouse or Dependent child dies
- One of Your Dependent children reaches the maximum age for coverage

If You are declining enrollment for Yourself or Your dependents (including Your spouse) because of other dental insurance coverage, You may in the future be able to enroll Yourself or Your Dependents in the plan, provided that You request enrollment within 31 days after Your coverage ends. In addition, if You have a new Dependent as a result of marriage, birth or adoption, You may be able to enroll Your Dependent, provided that You request enrollment within 31 days after the marriage, birth, or adoption.

If Your name or address changes

Member Services is responsible for updating general information. Just call Member Services at 1-800-342-5209. You may also make Your changes in writing by mailing to the following address:

CompBenefits
Attention: Member Services
100 Mansell Court East, Suite 400
Roswell, Georgia 30076

If the plan changes

If We change Benefits and/or Contributions under this plan, the Contractholder will receive forty-five (45) days written notice prior to the effective date of the change. The Contractholder will have the right to cancel this plan, without penalty, if the Contractholder does not want to continue coverage because of the change.

CANCELATION AND NON-RENEWAL

A Member's coverage may be cancelled in the case of:

1. nonpayment of amounts due under the Handbook upon 30 days advance written notice, except no written notice will be required for failure to pay Contributions;
2. fraud or intentional material misrepresentation upon 15 days advance written notice;
3. fraud in the use of services or facilities upon 15 days advance written notice;
4. failure to meet eligibility requirements other than the requirement that the Subscriber reside, live, or work in the service area, coverage may be cancelled immediately, subject to continuation of coverage and conversion privilege provisions, if applicable;
5. misconduct detrimental to safe plan operations and the delivery of services, coverage may be cancelled immediately;
6. failure of the Member and a Participating Dentist to establish a satisfactory patient-dentist relationship, if it is shown that the Plan has, in good faith, provided the Member with the opportunity to select an alternative Participating Dentist, the Member has been notified in writing at least 30 days in advance that the Plan considers the patient-dentist relationship to be unsatisfactory and specifies the changes that are necessary in order to avoid termination, and the Member has failed to make such changes, coverage may be cancelled at the end of the 30 days;
7. the Subscriber neither resides, lives, or works in the Service Area, or area for which the Plan is authorized to do business, but only if coverage is terminated uniformly without regard to any health status-related factor of Subscribers, coverage may be cancelled after 30 days written notice. Coverage for a child who is the subject of a medical support order cannot be cancelled solely because the child does not reside, live or work in the Service Area.

Cancellation of Your coverage by the Plan is without prejudice. Participating Dentists shall complete all dental procedures You may be undergoing. Your dentist will treat You until the specific treatment or procedure has been completed or for ninety (90) days, whichever is less.

CONTINUATION OF COVERAGE

If You are covered under a group plan and Your coverage under the group contract is terminated for any reason, except involuntary termination for cause, and You were continuously covered under this Plan for 3 consecutive

months prior to losing coverage, You can transfer Your dental benefits to an individual plan or You can continue Your group coverage subject to the eligibility provisions below:

1. Continuation of group coverage must be requested in writing within 31 days following the later of: (a) the date the group coverage would otherwise terminate; or (b) the date the Member is given notice of the right of continuation by either the employer or the group Contractholder.
2. A Member electing continuation must pay to the group Contractholder or employer on a monthly basis, in advance, the amount of contribution required by the Contractholder or employer, plus two percent of the group rate for the coverage being continued under the group contract, on the due date of each payment.
3. The Member's written election of continuation, together with the first contribution required to establish contributions on a monthly basis, in advance, must be given to the Contractholder or employer within 31 days following the later of: (a) the date the group coverage would otherwise terminate; or (b) the date the Member is given notice of the right of continuation by either the employer or the group Contractholder.
4. Continuation may not terminate until the earliest of: (a) six months after the date the election is made; (b) the date on which failure to make timely payments would terminate coverage; (c) the date on which the Member is covered for similar services and benefits by another dental insurance policy or dental subscriber contract or dental practice or other prepayment plan; or (d) the date on which the group coverage terminates in its entirety.

COORDINATION OF BENEFITS

At CompBenefits, we want to make sure You receive all of the benefits to which You are entitled. That is why it is important to let Your Participating Dentist and the Plan know if You or any of Your Dependents are covered by more than one dental plan. If this is so, benefits may be coordinated so that not more than 100% of eligible expense incurred is paid. Remember, the benefits You receive from this plan may be affected by the benefits You receive from any other dental plan.

GENERAL PROVISIONS

Grace Period

The contract has a thirty (30) day grace period. This provision means that if any required Contribution is not paid on or before the date it is due, it may be paid subsequently during the grace period. During the grace period, the contract will stay in force. If full payment is not received within the thirty (30) day grace period, coverage will be terminated effective the first day of the grace period. Subscriber will be liable for the cost of Dental Care Services received during the grace period.

Reinstatement

The following guidelines shall apply to requests for reinstatement:

1. The Contractholder must submit a request for reinstatement to the Plan.
2. The Contractholder must remit to the Plan all Contributions for the period between the termination date and the reinstatement date.

Upon receipt by the Plan of the appropriate Contributions, the Plan will notify Contractholder of the Effective Date of resumption of Benefits. The Contractholder is responsible for notifying Members of the reinstatement of coverage.

Dental Records

Dental records concerning services rendered to Member shall remain the property of the Participating Dentist. Member may obtain copies of their dental records for a reasonable fee directly payable to the Participating Dentist. Member agrees that his/her dental records may be reviewed by the Plan as deemed necessary in order to fulfill its

obligations under the contract and for compiling utilization and/or similar data. The Plan agrees to honor confidentiality of said data.

Limitations and Exclusions

1. No service of any dentist other than a Participating Dentist will be covered by the Plan, except emergency care as provided in this Handbook.
2. Whenever any Contributions or Copayments are delinquent, Member will not be entitled to receive Benefits, transfer Dental Facilities, or enjoy any of the other privileges of a Member in good standing.
3. The Plan does not provide coverage for the following services:
 - a) Cost of hospitalization and pharmaceuticals, drugs or medications.
 - b) Services which, in the opinion of the Participating Dentist, are not Necessary Treatment to establish and maintain Member's optimal dental health and appearance.
 - c) Any service that is not consistent with the normal and/or usual services provided by the Participating Dentist or which, in the opinion of the Participating Dentist, would endanger the health of the Member.
 - d) Any service or procedure which the Participating Dentist is unable to perform because of the general health or physical limitations of the Member.
 - e) Any dental procedure started prior to the Member's Effective Date.
 - f) Services for injuries and conditions, which are, covered under Workers' Compensation or Employers' Liability laws.
 - g) Treatment for cysts, neoplasms and malignancies.
 - h) General anesthesia.

Incontestability

In the absence of fraud, all statements made by a Subscriber are considered representations and not warranties. During the first two years, coverage can be voided for material misrepresentations contained in the written application. After two years, coverage can be voided only in the event of fraudulent misstatement contained in the written application.

Conformity with Texas Law

This Handbook shall be interpreted in accordance with the laws of the state of Texas and any action or claim, including arbitration, shall be brought within the state of Texas. Any statute, act, ordinance, rule or regulation of any governmental authority with jurisdiction over the Plan shall have the effect of amending this Handbook to conform with the minimum requirements thereof. In the event any portion of this Handbook is held to be void, it shall not affect any other provisions.

Notice of Independent Contractor Relationship

The Plan assumes responsibility of fulfilling the terms of this Handbook. Participating Dentists are independent contractors. The Plan cannot be held responsible for any damages incurred as a result of tort, negligence, breach of contract, or malpractice by a Participating Dentist, or for any damages which result from any defective or dangerous condition in or about any Dental Facility.

Claims

The Plan shall, not later than the 15th day after receipt of notice of a claim: (1) acknowledge receipt of the claim; (2) commence any investigation of the claim; and (3) request from the claimant all items, statements, and forms that the CompBenefits reasonably believes, at that time, will be required from the claimant. Additional requests may be made if during the investigation of the claim such additional requests are necessary.

CompBenefits shall notify a claimant in writing of the acceptance or rejection of the claim not later than the 15th business day after the date CompBenefits receives all items, statements, and forms, in order to secure final proof of loss.

CompBenefits shall pay the claim not later than the fifth (5th) business day after the notice has been made. If payment of the claim or part of the claim is conditioned on the performance of an act by the claimant, CompBenefits shall pay the claim not later than the fifth business day after the date the act is performed.

DEFINITIONS

Appeal is the formal process by which the Plan offers the Member a mechanism to request a secondary review of a complaint resolution.

Benefits are those Dental Care Services available to the Members as stated in their Schedule of Benefits.

Complaint is a verbal or written expression of dissatisfaction with the Plan, regarding any process. It does not include a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the Member.

Contractholder means an individual, association, employer, trust or organization to which an individual or group contract for Dental Care Services has been issued.

Contributions are those periodic payments due CompBenefits by Contractholder to receive Benefits as provided by the Handbook.

Copayment is the fee the Participating Dentist may charge Member when providing Dental Care Services.

Dental Care Services are those services to be performed by a Participating Dentist pursuant to the terms of this Handbook and the Participating Dentist's agreement with Us.

Dental Facility is the location of the Participating Dentist's office.

Dependent means any of the following persons:

1. Your spouse;
2. Your unmarried children or grandchildren;
 - a) from birth to age 25 and dependent upon You for support; or
 - b) at least 25 years of age and:
 - i. primarily dependent upon You for support because of mental or physical handicap;
 - ii. was incapacitated and covered under this Handbook and Evidence of Coverage on his or her 25th birthday; and continues to be incapacitated beyond his 25th birthday.

The term "children" also includes adopted children, stepchildren, and foster children living with You in a parent-child relationship.

Effective Date is the first day that a Member is entitled to receive Benefits designated in the Handbook.

Enrollment Fee, if applicable, is a one-time application fee for non-group contracts.

Member is a Subscriber and/or covered eligible Dependent of a Subscriber.

Necessary Treatment is that set of Dental Care Services determined by the Participating Dentist required to establish and maintain a Member's optimal dental health and appearance.

Participating General Dentist and Participating Specialty Dentist (hereinafter referred to as "Participating Dentist") are those licensed dentists selected and contracted with the Plan as independent contractors to provide Dental Care Services to Members.

Service Area means the entire state of Texas.

Subscriber is an Individual in good standing for whom the necessary Contributions and Copayments have been made in payment for Dental Care Services and to whom a Handbook evidencing coverage has been issued.

Treatment Plan is that individual proposal by the Participating Dentist outlining the recommended course of Member's Dental Care Services. The Member may request a written copy.

Usual Charges are those fees that are customarily charged for Dental Care Services by the Participating Dentist. We do not determine said charges.

You or Your means the Subscriber.

We, Us, Our or the Plan means CompBenefits.

GLOSSARY OF DENTAL TERMINOLOGY

Abscess – a localized infection due to a collection of pus in the bone or soft tissue caused by severe decay, trauma, or gum disease.

Alveolar - referring to a bone to which a tooth is attached.

Alveoplasty - surgical procedure for recontouring alveolar structures, usually in preparation for a prosthesis.

Amalgam - a silver/mercury mixture which is used for fillings.

Anterior - refers to the teeth in the forward part of the mouth - incisors and canines.

Apicoectomy - amputation of the root of the tooth.

Bitewing - an x-ray between the adjoining surfaces of adjacent teeth.

Bridge - a prosthetic replacement of one or more missing teeth on a framework that may be removed by the patient.

Cavity - lesion or hole in the tooth caused by decay.

Cement/Recement/Recementation – the application or re-application of a special type of glue to hold a crown in place or to protect the tooth's nerve.

Crown - part of the tooth that is covered with enamel; also a cover for decayed or damaged tooth made of porcelain and/or metal is called by the same name.

Curettage - scraping or cleaning the walls of a cavity or gingival pocket.

Debridement - removal of foreign matter.

Denture - an artificial substitute for natural teeth and adjacent tissues.

Denture Base - that part of a denture that makes contact with soft tissue and retains the artificial teeth.

Diagnostic Cast - plaster or stone model of teeth and adjoining tissues; also referred to as *Study Model*.

Endodontist - a dentist who specializes in root canals and treatment of diseases or injuries of the pulp and the area surrounding the root of the tooth

Extraction - removal of a tooth.

Filling - a lay term used for the restoring of lost tooth structure by using materials such as metal, plastic or cement.

Gingiva -the gums.

Gingivectomy - the excision or removal of gingiva.

Gingivoplasty - surgical procedure to reshape gingiva to create a normal, functional form.

Graft - a piece of tissue or alloplastic material placed in contact with tissue to repair a defect or supplement a deficiency.

Immediate Denture - prosthesis constructed for placement immediately after removal of remaining natural teeth.

Impacted Tooth -usually associated with a wisdom tooth, it is a tooth that is under the gum tissue.

Inlay - a dental restoration made outside the mouth to correspond to the prepared tooth, which is then cemented to the tooth.

Intraoral - inside the crown of a tooth.

Labial - pertaining to or around the lip.

Malocclusion - improper alignment of biting or chewing surfaces of upper and lower teeth.

Mandible (mandibular – adj.) - lower jaw.

Maxilla (maxillary – adj.) - upper jaw.

Occlusion - any contact between biting or chewing surfaces of upper and lower teeth.

Oral - pertaining to the mouth.

Oral Evaluation - a thorough evaluation the state of health of the mouth, teeth and gums.

Oral Surgeon - a dentist who specializes in surgical and adjunctive treatment of diseases, injuries, deformities, defects and esthetic aspects of the mouth.

Orthodontics – a specialized branch of dentistry that corrects malocclusions and restores teeth to proper alignment and function.

Osseous - bony.

Palliative - action that relieves pain but is not curative.

Panoramic -a full mouth x-ray (180 degree view) of the teeth, upper and lower jaws on one film.

Partial Denture - usually refers to the prosthetic device that replaces the missing teeth on a framework that can be removed by the patient.

Pediatric Dentist – a dentist who specializes in the treatment of children from birth through adolescence.

Periapical - the area surrounding the end of the tooth root.

Periodontist – a dentist who specializes in the treatment of diseases of the gums.

Permanent teeth – the 32 adult teeth that replace the primary or baby teeth. Also known as secondary teeth.

Pontic - the term used for the artificial tooth on a bridge.

Primary teeth- the first set of teeth; also known as deciduous teeth or baby teeth.

Prophylaxis - cleaning and polishing of the teeth to remove coronal plaque, calculus and stains.

Prosthodontist - a specialty dentist whose practice is limited to the restoration of the natural teeth and/or the replacement of missing teeth with artificial substitutes.

Pulp - the soft inner structure of the tooth, consisting of blood vessels and nerve tissue.

Pulp Cavity - the space within a tooth that contains the pulp.

Pulpotomy - the removal of the coronal portion of the pulp.

Quadrant - one of the four equal sections into which the dental arches can be divided; begins at the midline of the arch and extends distally to the last tooth; usually includes five or more teeth.

Reline - process of resurfacing the tissue side of a denture with a new base material.

Root Canal Therapy - treatment of the pulp cavity to eliminate periapical disease and to promote healing and repair of periapical tissues.

Root Planing - a procedure designed to remove microbial flora, bacterial toxins on the root surface or in the pocket, calculus and diseased cementum or dentin.

Scaling - removal of plaque, calculus and stains from teeth.

Sealant - a material which is bonded to a tooth to prevent decay.

Space Maintainer - a device used to hold or maintain the space previously held by an extracted tooth.

Veneer - a layer of tooth colored material attached to the surface by fusion, cementation, or mechanical retention.

**HUMANA
DENTAL**

**Dental Traditional
Preferred**

Administered by HumanaDental Insurance Company

MEMBER NUMBER

999999999

MEMBER NAME

DOE JOHN H

GROUP NUMBER

9999999

BENEFIT

DENTAL

COVERAGE

EMPLOYEE

EFFECTIVE DATE

01/01/01

sample

■ **Present this card to your dentist at the time services are rendered.**

■ **Waiting periods may apply.**

■ **Predetermination of benefits:**

If expense incurred in performing a dental service or one series of dental services can reasonably be expected to be \$300 or more, the Plan Supervisor recommends you or your dentist submit those charges for a predetermination of benefits. The **Dental Treatment Plan** should consist of:

- A list of the services to be performed using the American Dental Association Nomenclature and codes;
 - Your Dentist's written description of the proposed treatment;
 - Supporting preoperative x-rays, including a narrative, showing your dental needs;
 - Itemized cost of the proposed treatment; and
- Any other appropriate diagnostic materials as requested by us.

For information regarding eligibility, benefits, claims, or dentist verification, simply visit www.humanadental.com or call 1-800-626-1690 for additional customer service.

This policy provides automatic assignment of benefits to the provider. Mail itemized bills including diagnosis to:

HumanaDental
PO Box 14611
Lexington KY 40512-4611

ADA Dental Claim Form STANDARD 2007

ATTENDING DENTIST'S STATEMENT

Header information

1. Type of transaction (mark all applicable boxes)
 Statement of actual services EPSDT/Title XIX
 Request for predetermination / preauthorization

2. Predetermination/preauthorization number

Insurance company / dental benefit plan information

3. Company/plan name, address, city, state, ZIP code

Other coverage

4. Other dental or medical coverage? No (Skip 5-11) Yes (Complete 5-11)

5. Name of policyholder/subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of birth (MM/DD/YYYY) 7. Gender 8. Policyholder Subscriber ID #
 M F

9. Plan/group number 10. Patient's Relationship to Person Named in #5
 Self Spouse Dependent/Other

11. Other insurance company/plan name, address, city, state, ZIP code

Mail this form to: HumanaDental Claims Office
 PO Box 14611
1-800-233-4013 Lexington, KY 40512-4611

Policyholder / subscriber information

12. Subscriber name, address, city, state, ZIP code

13. Date of birth (MM/DD/YYYY) 14. Gender
 M F

15. Policyholder ID# 16. Plan/group number

17. Employer name

Patient information

18. Relationship to policyholder above 19. Student Status
 Self Spouse Dependent/Other FTS PTS

20. Patient name, address, city, state, ZIP code

21. Date of birth (MM/DD/YYYY) 22. Gender
 M F

23. Patient ID #/Acct #

Record of services provided

	24. Procedure date (MM/DD/YYYY)	25. Area of oral cavity	26. Tooth system	27. Tooth number(s) or letter(s)	28. Tooth surface	29. Procedure code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								

34. Place an 'X' on each missing tooth	Permanent																Primary										32. Other Fee(s)	33. Total Fee
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K		

35. Remarks

Authorizations

36. Patient signature Date
 X _____

37. Subscriber signature authorize payment Date
 X _____

Billing dentist or dental entity

48. Name, address, city, state, ZIP code

49. NPI 50. License #

51. SSN or TIN

52. Phone number

52A. Additional provider ID #

Ancillary claim/treatment information

38. Place of treatment: 39. Number of enclosures: 40. Is treatment for Orthodontics?
 Clinic Hospital X-Rays Models No Yes

41. Date appliance placed 42. Months of treatment remaining

43. Replacement of prosthesis? 44. Date Prior Placement (MM/DD/YYYY)
 No Yes

45. Treatment Resulting from: Occupational Illness Auto Other Injury

46. Date of Accident 47. Auto Accident State

Treating dentist and treatment location

53. I hereby certify that the procedures as indicated by (print name):
 X _____

54. NPI 55. Address, city, state

Please note: Pretreatment Review is not a guarantee of benefits payable.
 This estimate advises you in advance of the amount of insurance benefits payable if the described procedures are performed during a period of the patient's eligibility.



Toll Free: 800-558-4444
 1100 Employers Blvd
 Green Bay, WI 54344

DATE: 01/01/2001

EXPLANATION OF REMITTANCE

1. JANE DOE
 123 MAIN STREET
 ANYTOWN, USA 99999

2. PATIENT NAME	JOHN DOE	10. PROVIDER NAME:	SYLVESTER STEVEN E DDS
3. ACCT NUMBER:	999999999999	11. TOTAL CHARGED:	342.00
4. PATIENT ID:	999999999	12. PAID BY OTHER PLAN:	-
5. PATIENT DOB:	05/15/1977	13. PAID BY YOUR PLAN:	- 201.00
6. INSURED NAME	JANE DOE	14. YOUR PORTION:	= 83.00
7. INSURED ID:	999999999		
8. GROUP NUMBER:	9999999		
9. GROUP NAME	ABC MANUFACTURING		

15. DOCUMENT NUMBER: X99999999
 24. 25. 26. 27.

16. 17. 18. 19. 20. 21. 22. 23.

SERV. CODE	TOOTH NBR	SERVICE DESCRIPTION	SERVICE DATE	AMOUNT CHARGED	AMOUNT ALLOWED	AMOUNT NOT COVD	REMARKS See Back	AMOUNT DISCOUNTED	DE-DUCT-IBLE	% CO-INS	AMOUNT PAID
00220		SINGLE X-RAY	02/11/2000	12.00	11.00			1.00		100	11.00
00140		LIMITED EXAM	02/11/2000	30.00	20.00		94G	10.00		100	20.00
00230		ADD'L X-RAY	02/11/2000	10.00	9.00			1.00		100	9.00
01351	01	SEALANT/TOOTH	02/11/2000	25.00	23.00			2.00		100	23.00
01351	16	SEALANT/TOOTH	02/11/2000	25.00	23.00			2.00		100	23.00
02386	02	RESIN FILLING	02/11/2000	120.00	70.00	29.00	B02 945 0B5	21.00	25.00	100	45.00
02386	15	RESIN FILLING	02/11/2000	120.00	70.00	29.00	945 0B5	21.00		100	70.00
TOTALS				342.00	226.00	58.00		58.00			201.00

28.

Check Amount: Check Amount: 201.00	Check Issued To: Check Issued To: SYLVESTER STEVEN E DDS
--	--

ACCUMULATIONS TOWARD POLICY MAXIMUMS:		31.	32.
Individual Deductible Amount: <u>25.00</u>	Met To Date: <u>25.00</u>	Annual Maximum Amount: <u>1750.00</u>	Met To Date: <u>350.00</u>
29.	30.	Ortho Maximum Amount: <u>1750.00</u>	Met To Date: _____
		33.	34.

35.

If the statement on the reverse side of this form reflect a partial or full denial of the claims submitted, and you disagree or do not understand the reasons for this denial, you may appeal this decision. You have the right to:

1. Request a review of the denial,
2. Review pertinent plan documents; and
3. Submit in writing, any data, documents or comments which are relevant to our review of this denial.

"Your appeal under the Employee Retirement and Income Security Act (ERISA) must be requested and submitted in writing within sixty (60) days of receiving this statement. We will review all information and send written notification within sixty (60) days of your request. Some states provide longer periods of time for filing a complaint or grievance and require resolution of those complaints within a shorter period of time. Please consult your Certificate of Insurance or contact us by using our toll free number listed below for information regarding the requirements in your state."

Have you moved recently? Please inform us of your new address by calling our toll free number: 1-800-233-4013

Please review this statement to assure that there are no discrepancies or irregularities between this and the treatment you obtained. You may notify us by using our toll free number 1-800-233-4013. Thank you for your efforts in containing health care costs.

36.

37.

CODE DESCRIPTION

310	INSURED IS ONLY LIABLE FOR THE AMOUNT SHOWN IN THE "YOUR PORTION" FIELD.
94G	THE SUBMITTED CODE HAS BEEN SUBSTITUTED WITH THE APPROPRIATE ADA CODE.
945	RESIN RESTORATIONS ON PRE-MOLARS ARE NOT COVERED EXCEPT ON BUCCAL SURFACES. AN ALLOWANCE HAS BEEN MADE FOR AN AMALGAM RESTORATION.
802	THE DEDUCTIBLE IS NOW SATISFIED, BALANCE PAID AT THE INDICATED PERCENT.
0B5	CLAIM /SERVICE DENIED/REDUCED BECAUSE COVERAGE GUIDELINES WERE NOT MET OR WERE EXCEED.

**Detailed Explanation of EOB (Explanation of Benefits)
Providers EOB**

1. Employee's name, address, city/state and zip code
2. Patient's name
3. Account number assigned by the provider to identify the patient in their office
4. Patient ID number
5. Patient date of birth
6. Employee/plan member's name
7. Employee/plan member's social security number
8. Employee's group number
9. Employee's group name
10. Provider's name
11. Total amount the provider charged for the claim
12. Amount paid by another insurance plan (coordination of benefits)
13. Amount paid by HumanaDental
14. Amount the employee/plan member is responsible to pay
15. Internal number assigned by HumanaDental to identify the claim
16. ADA procedure code the provider performed
17. Tooth number on which the service was performed
18. Description of the ADA procedure code
19. Date of service
20. Amount charged per service
21. Eligible amount per service
22. Amount not covered
23. Reason for an amount not covered or an explanation of how the service was processed
24. Negotiated discount given for the service performed
25. Amount applied to the deductible
26. Percentage the service was paid/coinsurance level
27. Total benefit paid
28. Amount of check and who it was issued to
29. Amount of the individual deductible for the employee/plan member
30. Indicates how much of the individual deductible was met
31. Amount of the annual maximum for the employee/plan member
32. Indicates how much of the annual maximum was met
33. Amount of the orthodontia maximum for the employee/plan member
34. Indicates how much of the orthodontia maximum was met
35. ERISA Statement – the patient's right to appeal a partial or full denial of a service
36. Number assigned to a remark code
37. Explanation of how the service was processed

Humana Employee Enrollment Form - Dental, Life, Vision

FLORIDA

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in this application as "Humana".

Life plans insured or administered by Humana Insurance Company.

Prepaid, Basic, Intermediate and High Dental plans underwritten by The Dental Concern, Inc. Prepaid and AdvantagePlus Dental plans offered and administered by CompBenefits Company. All other Dental plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company.

Vision plans insured or administered by Humana Insurance Company, CompBenefits Insurance Company or CompBenefits Company.

Please print clearly and fill in each applicable circle.

Proposed effective date: ___/___/___

Company name	Company city	State
--------------	--------------	-------

Enrollment Information

Relationship	Last name, First name MI	Height (ft / in)	Weight (lbs.)	Gender	Full-time student?	Date of birth	Disabled? If yes, indicate reason.
Employee		/		<input type="radio"/> F <input type="radio"/> M	N/A	___/___/___	<input type="radio"/> N Reason: <input type="radio"/> Y
Spouse		/		<input type="radio"/> F <input type="radio"/> M	N/A	___/___/___	<input type="radio"/> N Reason: <input type="radio"/> Y
Child		/		<input type="radio"/> F <input type="radio"/> M	<input type="radio"/> N <input type="radio"/> Y	___/___/___	<input type="radio"/> N Reason: <input type="radio"/> Y
Child		/		<input type="radio"/> F <input type="radio"/> M	<input type="radio"/> N <input type="radio"/> Y	___/___/___	<input type="radio"/> N Reason: <input type="radio"/> Y
Child		/		<input type="radio"/> F <input type="radio"/> M	<input type="radio"/> N <input type="radio"/> Y	___/___/___	<input type="radio"/> N Reason: <input type="radio"/> Y
Other (specify):		/		<input type="radio"/> F <input type="radio"/> M	<input type="radio"/> N <input type="radio"/> Y	___/___/___	<input type="radio"/> N Reason: <input type="radio"/> Y

Do you wish to cover your dependent adult child(ren)? N Y

EMPLOYEE INFORMATION:	HOURS WORKED PER WEEK:	<input type="radio"/> RETIREE	DATE OF FULL-TIME HIRE: ___/___/___
SSN #	Street address	APT / Suite / Box	
City	State	Zip code	Phone # ()
Language: <input type="radio"/> English <input type="radio"/> Spanish	Email address		

Dental	Group #: _____	Benefit #: _____	Class/Div: _____
Coverage type:	<input type="radio"/> Employee only <input type="radio"/> Employee and spouse <input type="radio"/> Employee and child(ren) <input type="radio"/> Family <input type="radio"/> NO COVERAGE (complete waiver)		Plan name

Prior dental coverage during the past 12 months (individual or other group coverage)? <input type="radio"/> N <input type="radio"/> Y			
Prior dental insurance carrier name	Prior coverage type: <input type="radio"/> Employee only <input type="radio"/> Employee and spouse <input type="radio"/> Employee and child(ren) <input type="radio"/> Family	Effective date ___/___/___	Policy #
Prior orthodontia coverage in the past 12 months? <input type="radio"/> N <input type="radio"/> Y		Term date ___/___/___	Prior carrier phone # ()

Basic Life	Group #: _____	Benefit #: _____	Class/Div: _____
Primary beneficiary name (Last, First MI)		Secondary beneficiary name (Last, First MI)	
Class (employer will provide you with this information if needed)	Annual salary (if applicable) \$	Basic dependent life? <input type="radio"/> N <input type="radio"/> Y If no, complete waiver section.	

Voluntary Life	Group #: _____	Benefit #: _____	Class/Div: _____
Voluntary employee life coverage? <input type="radio"/> N <input type="radio"/> Y	Amount (min \$15,000) \$	Primary beneficiary name (Last, First MI)	Secondary beneficiary name (Last, First MI)
Voluntary spouse life coverage? <input type="radio"/> N <input type="radio"/> Y	Amount (min. \$5,000) \$	Voluntary child(ren) life coverage? <input type="radio"/> N <input type="radio"/> Y	Annual employee salary (if applicable) \$

Vision	Group #: _____	Benefit #: _____	Class/Div: _____
Coverage type:	<input type="radio"/> Employee only <input type="radio"/> Employee and spouse <input type="radio"/> Employee and child(ren) <input type="radio"/> Family <input type="radio"/> NO COVERAGE (complete waiver)		Plan name

Proposal for

City of Fort Lauderdale

HUMANA.
Specialty Benefits

Commissions (Response to Section 4.21)

Rates are net of commissions and assume the agent will be compensated on a consulting fee basis.