HUMANA®
Specialty Benefits

CompBenefits Company

a Prepaid Limited Health Services Organization
licensed under Chapter 636, Florida Statutes

5775 Blue Lagoon Drive, Suite 400
Miami, FL 33126-2034

Certificate of Dental Benefits

This Certificate of Dental Benefits ("Certificate") outlines the features of the Contract for Dental Benefits ("Contract") between CompBenefits Company ("Company") and the Contractholder. **Read it carefully to become familiar with Your coverage.** The Contract must be consulted to determine the exact terms and conditions of coverage. Your coverage may be terminated or amended in whole or in part under the terms and provisions of the Contract.

I. Definitions

A. **"Benefits"** are those Covered Dental Care Services available to the Members as stated in the Certificate.

B. **"Contractholder"** means that person or organization named in the Application form.

C. **"Contributions"** are those periodic payments due Company in order for Members to receive Benefits as provided by the Certificate.

D. **"Copayment"** is the dollar amount the Member is required to pay when receiving Covered Dental Care Services.

E. **"Copayment Benefits"** are those Covered Dental Care Services for which there are reduced fees which are due and payable directly by the Member to the Participating General Dentist or Participating Specialist at the time the services are rendered or in accordance with the particular payment procedures of the Participating General Dentist or Participating Specialist.

F. **"Covered Dental Care Services"** are those services to be performed by a Participating General Dentist or Participating Specialist pursuant to the terms of the Certificate and a Participating General Dentist Agreement or a Participating Specialist Agreement. To be covered by Company, services must be (a) necessary; and (b) appropriate for the given condition. The Company may use the professional review of a dentist to determine the necessity and/or appropriateness of a given course of treatment.

G. **"Dental Facility"** is the location of the Participating General Dentist's or Participating Specialist's office where Members shall receive Dental Care Services.

H. **"Dependent"** means the following dependents of the Subscriber: a) the legal spouse; and b) all dependent children under 26 years of age, or under 26 if they are full-time students in an accredited college or university and dependent on the Subscriber for primary support (unless otherwise negotiated or covered by amendment to this Certificate). The term "children" also includes: a) adopted children and b) stepchildren and foster children living with the Subscriber in a parent-child relationship. A Dependent may include Your domestic partner (in lieu of legal spouse) if the Contractholder elects to provide coverage for domestic partners as shown in the Contract. It is the obligation of the Subscriber to notify the Contractholder of Dependent status or change in Dependent status.

I. **"Effective Date"** is the first day that a Member is entitled to receive Benefits designated in the Certificate.

J. **"Eligibility Date"** means the date You or Your Dependent is eligible to participate in the plan, based on the requirements in the Contractholder Application.

K. **"Emergency"** is a sudden, serious dental condition caused by an accident or dental disease that would lead a prudent layperson to reasonably conclude, if not treated immediately, would result in serious harm to the dental health of the Member.

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

M. **"Necessary Treatment"** is 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 not be provided primarily for the convenience of the patient or the dentist. To determine Necessary Treatment, *we* may require preoperative dental radiographs (X-rays) and other pertinent information.

N. **"No Charge Benefits"** are those Covered Dental Care Services for which there are no additional fees due the Participating General Dentist or Participating Specialist by Member.

O. **"Normal Billed Charges"** are those fees that are customarily charged for services by the Participating General Dentist or Participating Specialist. Said charges are not determined by Company.

P. **"Open Enrollment Period"** is the period of time, subsequent to Your Eligibility Date, during which You may enroll in benefits. Typically, an Open Enrollment Period occurs once within a 12 month period, or as otherwise agreed upon by Your Contractholder and Us.

Q. **"Participating General Dentist" or "Participating Specialist"** are those licensed dentists selected and contracted with Company as independent contractors to provide Covered Dental Care Services to Members.

R. **"Primary Care Dentist"** or **"PCD"** is the Participating General Dentist within Our network whom you have selected to handle your dental care.

S. **"Probationary Period"** is the length of time that must pass prior to becoming eligible to enroll in benefits as defined by Your Contractholder and agreed upon by Us.

T. **"Special Enrollment Date"** is the date You and/or Your Dependent(s) become eligible to enroll in benefits due to a qualifying life event.

U. **"Subscriber" "You" or "Your"** is the enrolled member of the Contractholder in good standing for whom the necessary Contributions and Copayments have been made in payment for Covered Dental Care Services.

V. **"Treatment Plan"** is that individual proposal by the Participating General Dentist or Participating Specialist outlining the recommended course of the Member's treatment. A written copy may be requested by the Member from the Participating General Dentist or Participating Specialist.

W. **"We", "Us" or "Our"** means the Company.

II. Contributions and Copayments

It is agreed that in order for Member to be eligible for and entitled to receive Benefits provided by this Certificate, Company must receive all Contributions in advance. The Participating General Dentist or Participating Specialist must receive any Copayments on the date of service in accordance with their particular payment procedure.

III. Benefits

From the Effective Date, Company agrees to provide Benefits to Members through Participating General Dentists or Participating Specialists on a No Charge Benefits or Copayment Benefits basis in accordance with the Member's Schedule of Benefits attached to this Certificate. There is no exclusion due to pre existing dental conditions except in those instances in which treatment has been initiated but not yet completed prior to the Effective Date.

IV. Eligibility and Enrollment

A. Subscriber

1. Subscriber Eligibility Date

   The Subscriber is eligible for coverage on the date the eligibility requirements stated in the Contractholder Application, or as otherwise agreed to by Us and the Contractholder, are satisfied.

2. Subscriber Effective Date

    a. The Subscriber must enroll as agreed by the Contractholder and Us.

    b. The Subscriber's effective date provision is stated in the Contractholder Application. It may be the first of the month following completion of the Probationary Period or the Special Enrollment Date.

    c. If the Subscriber enrolls more than 31 days after his or her Eligibility Date or Special Enrollment Date, he or she is late and will be eligible to enroll during the next Open Enrollment Period.

B. Dependent

1. Dependent eligibility date

    a. Each Dependent is eligible for coverage on:

        i. The date the Subscriber is eligible for coverage, if the Subscriber has Dependents who may be covered on that date;

        ii. The date of the Subscriber's marriage, or any Dependents (spouse or child) acquired on that date;

        iii. With respect to newborn or adopted children, the date described in Section V, Coverage for Newborn and Adopted Children; or

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

        v. The Subscriber may cover his or her Dependents only if the Subscriber is also covered.

        vi. A Dependent child who enrolls for other dental coverage through any employment is no longer eligible for coverage under the Contract. If a Dependent child becomes a Subscriber of the Contractholder, he or she is no longer eligible as a Dependent and must make application as an eligible Subscriber.

2. Dependent effective date

   a. Check with the Contractholder immediately on how to enroll for dependent coverage. The Subscriber must enroll for Dependent coverage and enroll additional Dependents as agreed by the Contractholder and Us.

   b. If we receive enrollment on, prior to, or within 31 days of the Dependent's eligibility date that dependent is effective the first of the month following that date.

   c. If we receive enrollment on, prior to, or within 31 days of the Dependent's Special Enrollment Date, that dependent is effective the first of the month following that date.

   d. If we receive enrollment more than 31 days after the dependent's eligibility date, or the Special Enrollment Date, that dependent is considered late and will be eligible to enroll during the next Open Enrollment period.

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

V. Coverage for Newborn and Adopted Children

A. Newborn Dependent effective date

1. A child born to the Subscriber while this Certificate is in force is covered under this Certificate from the moment of birth, up to thirty (30) days. If coverage is to continue, the Subscriber must notify Company within sixty (60) days from the date of birth and pay the required Contribution, if any.

2. If we receive enrollment between 61 days and 2 years after the newborn's date of birth, Dependent coverage is effective on the first of the month following receipt of the enrollment.

3. If we receive enrollment between 2 years and 2 years and 31 days after the newborn's date of birth, Dependent coverage is effective on the child's second birthday.

4. If we receive enrollment more than 2 years and 31 days after the newborn's date of birth, the newborn is considered a late applicant and will not be able to enroll until the next Open Enrollment Period as determined by the Contractholder and Us.

B. 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 withing 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 Contribution, if any, is paid. You must enroll such child within 31 days after either of these events. If such child is not enrolled within 31 days, such child is considered a late applicant and will not be able to enroll until the next Open Enrollment Period as determined by the Contractholder and Us.

VI. Disenrollment from the Dental Plan – Termination of Benefits

A. Except for nonpayment of Contributions or termination of eligibility, Company may

cancel this Certificate as to a Member's coverage with forty-five (45) days written notice for the following reasons:

1. When a Member commits any action of fraud or material misrepresentation involving company.

2. When a Member's behavior is disruptive, unruly, abusive, unlawful, fraudulent, or uncooperative to the extent that the Member's continuing participation seriously impairs the ability of Company, the Participating General Dentist, or the Participating Specialist to provide services to the Member and/or to other Members.

3. When a Member misuses the documents provided as evidence of benefits available pursuant to the Contract or this Certificate.

4. When a Participating General Dentist is not available within the immediate geographical area of the Subscriber.

5. When reasonable efforts by the Company to establish and maintain a satisfactory patient relationship are unsuccessful or when the Member has indicated unreasonable refusal to accept necessary treatment. When a Member refuses to accept treatment from two (2) Dental Facilities, proof of unreasonable refusal shall be presumed conclusively.

6. Prior to cancellation, the Company shall make every effort to resolve the problem through its grievance procedure and to determine that the Member's behavior is not due to use of the Dental Care Services provided or mental illness.

B. Your coverage may end as stated below and in the Contractholder Application. Coverage terminates on the earliest of the following events:

1. Termination date listed in the Contract;

2. Failure to pay premium by the required due date;

3. The date the Contractholder terminates the Contract or no longer meets Our participation requirements;

4. The date You enter the military fulltime;

5. When You no longer are eligible for coverage as outlined in the Contractholder Application;

6. When You are no longer an eligible Member of the Contractholder, as defined by the Contractholder;

7. For a Dependent, the date the Subscriber's insurance terminates;

8. For a Dependent, the date he/she no longer meets the definition of a dependent;

9. A Subscriber's retirement date unless the Contractholder Application provides coverage for retirees; or

10. For any benefit that may be deleted from the Contract, the date it is deleted.

VII. Dental Facility Selection

A. Member must select the PCD of his/her choice from a listing of PCD's provided at the time of original enrollment. The Member must select and be assigned to a PCD prior to obtaining Covered Dental Care Services.

B. Members may request to transfer from one PCD to another, provided all Contributions and Copayments are currently paid. Transfers are limited to one (1) per month per Member. The PCD transfer will be effective the first day of the following month provided the transfer request is received by Us by the 15th day of the month. PCD transfer requests received after the 15th day of the month will be effective the first day of the month following the next following month.

C. Company reserves the right to transfer Members to another Dental Facility for the following reasons:

1. If chosen Dental Facility is no longer under contract with Company to provide Benefits.

2. If chosen Dental Facility is determined by Company to be unable to effectively render Benefits to the Member.

3. If efforts to establish a satisfactory dentist/patient relationship between Member and a Participating General Dentist or Participating Specialist have failed.

4. If Member has unreasonably refused to accept Necessary Treatment from a particular Participating General Dentist, then a transfer will be made in order to obtain a second Necessary Treatment opinion.

VIII. Pre-Treatment Estimate

If the cost of a Member's services are expected to exceed $300, the Company recommends that You ask the dentist to submit a Treatment Plan for a Pre-Treatment Estimate to our Claims Department. The Claims Department will process the Treatment Plan and send You a copy of the estimate of benefits for planned services. The estimate is based upon Benefits available at the time of processing and may change if other claims are submitted prior to completion of treatment. This gives You the opportunity to know exactly the amount of Benefits allowable before any fees are incurred.

IX. Alternate Treatment

The treatment of a dental condition is often discretionary, that is there is more than one way to treat a dental problem. For example, either a crown or a filling could be used to restore a tooth. Another example is in some cases a fixed partial denture or a removable partial denture may be used. If more than one type of service can be used to treat a dental condition, Company has the right to base Benefits on the least expensive service. If the Member and the Member's dentist decide that the Member wants the alternative treatment, the Member will be responsible for charges exceeding the least expensive treatment cost.

X. General Provisions

A. Appointments for Service

1. All non-emergency Covered Dental Care Services rendered to Member shall be on a prior appointment basis during the normal office hours of the PCD to which the member has been assigned. In order to receive Benefits, Member must make an appointment with his/her PCD, and the request for an appointment must be made after the Effective Date. When making an appointment, Member should inform PCD he or she is a Company Member.

2. Member may request an emergency appointment (treatment of accidental, painful, or urgent conditions) within twenty four (24) hours of calling his/her PCD, subject to the appropriate Copayment.

B. Broken Appointments

The time that the dentist sets aside for Your appointment is very valuable. Broken appointments are more than just an inconvenience or a discourtesy; they greatly add to the expense of the program as a delay in treatment may require more complex and costlier procedures. This will be reflected in higher Copayments applicable to You. Also, the time the dentist scheduled for You could have been used for other patients for needed dental care.

Therefore, should You break an appointment without at least 24 hours notice, a fee may be charged for the block of time reserved. This fee, as determined by the PCD, is not covered by Us and is Your responsibility.

C. Emergency Care

1. Out-of-Area Emergency Care:

When more than one hundred (100) miles from the nearest available Participating General Dentist, Member may obtain reimbursement for expenses for Emergency Care rendered by any licensed dentist, less applicable Company copayments, up to one hundred dollars ($100) per Member per year, upon presentation of an itemized statement of emergency services from the dental office. Company must be notified of such treatment within ninety (90) days of its receipt.

2. In-Service-Area Emergency Care:

When Member is within one hundred (100) miles of any Participating General Dentist, during Company's normal business hours the Member should first contact his/her Participating General Dentist and request an emergency appointment. If his/her dentist is unable to render Emergency Care, Member should contact Company Member Services Department and request assistance in obtaining Emergency Care from another Company Dental Facility at that Facility's Normal Billed Charges less a 25% reduction.

If Emergency Care is required after Company's normal business hours, and it is not possible to contact a Participating General Dentist, Member may obtain reimbursement for expenses for Emergency Care rendered by any licensed Dentist, less applicable Company copayments, up to one hundred dollars ($100) per Member per year, upon presentation of an itemized statement of emergency services from the dental offices. Company must be notified of such treatment within ninety (90) days of its receipt.

D. Dental Records

Dental records concerning services rendered to Member shall remain the property of the Participating General Dentist or Participating Specialist. Member agrees that his/her dental records may be reviewed by Company as deemed necessary for claims processing purposes and in compiling utilization and/or similar data. Company agrees to honor confidentiality of said data.

XI. Limitations and Exclusions

Company does not provide coverage for the following services:

A. No service of any dentist other than a Participating General Dentist or Participating Specialist will be covered by Company, except out-of-area emergency care as provided in Section X, Paragraph C of the Certificate.

B. Any procedures not specifically listed as a covered benefit in the Schedule of Benefits.

C. 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.

D. Any dental treatment started prior to the Member's effective date for eligibility of benefits. This does not apply to Orthodontic treatment in progress that was covered under the Contractholder’s prior plan. To be covered under this Plan, Orthodontic treatment must be shown on your Schedule of Benefits and You must have the subsequent treatment provided by a Participating Provider.

E. Services which in the opinion of the Participating General Dentist, Participating Specialist, or Company are not Necessary Treatment to establish and/or maintain the Member’s oral health.

F. Any services that are not appropriate or customarily performed for the given condition, do not have uniform professional endorsement, do not have a favorable prognosis, or are experimental or investigational.

G. Any service that is not consistent with the normal and/or usual services provided by the Participating General Dentist or Participating Specialist or which in the opinion of the Participating General Dentist or Participating Specialist would endanger the health of the Member.

H. Any service or procedure which the Participating General Dentist or Participating Specialist is unable to perform because of the general health or physical limitations of the

Member.

I. Procedures, appliances or restorations to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ); or replacement of lost, missing or stolen appliances.

J. Services performed primarily for cosmetic purposes, unless otherwise listed as covered cosmetic services on your Schedule of Benefits.

K. Services provided by a Participating Pediatric Dentist are limited to children through age seven.

L. Removal of asymptomatic third molars is not covered unless pathology (disease) exists. Examples of symptomatic conditions include decay, cysts, unmanageable periodontal disease, infection, and resorption of adjacent tooth.

M. Frequency and/or age limitations may apply. See your Schedule of Benefits and Co-payments for details.

N. Worker's Compensation

1. 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.

2. The recovery rights will be applied even though:

   a. The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;

   b. No final determination is made that bodily injury or sickness was sustained in the course of, or resulted from, your employment;

   c. 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

   d. Medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

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

O. Crowns, inlays, onlays, or veneers for the purpose of:

1. Altering vertical dimension of teeth;

2. Restoration or maintenance of occlusion;

3. Splinting teeth, including multiple abutments; or

4. Replacing tooth structure lost as a result of wear (abrasion, attrition, erosion or abfraction).

XII. Notice of Independent Contractor Relationship

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

XIII. Review and Mediation of Complaints

A. Informal Grievances

If You have a concern about a Dental Facility or the Dental Plan, You can call the Company's Member Services Department at the telephone number listed below and explain Your concern to one of the Member Services Representatives. Most questions/concerns are able to be addressed at the time of Your first phone call by reviewing Your dental plan, normal procedures as described in this Certificate, and interpreting what might appear to be complicated typical dental office procedure. Should You consider this informal grievance procedure unsatisfactory, You have the right to file a formal written grievance with Company and/or submit Your grievance directly to the State of Florida Department of Financial Services, Office of Insurance Regulation.

B. Submission of Formal Grievances

If You have a grievance against Company for any matter arising out of this Certificate or for Covered Dental Care Services rendered thereunder, You may submit a formal written statement of the grievance to Company. Such written statement shall be specifically identified as a grievance, shall be submitted to Company within one (1) year from occurrence of the events upon which the grievance is based, and shall contain a statement of the action requested, the Member's name, address, telephone number, Member number, signature and the date. The statement should be sent to the Company's Grievance Coordinator at Company's address as listed below. More information on and assistance with Company's grievance procedures may be obtained by calling Company's Member Services Department number listed below.

C. Response to Formal Grievances

The Grievance Coordinator will investigate the grievance, gather all of the relevant facts, review the case with the appropriate parties and respond in writing to You and the Participating General Dentist or Participating Specialist, if appropriate, within ten (10) days of completion of the review. If the grievance involves a dental related matter or claim, the Company's Dental Director shall be involved in the resolution. If it involves denial of benefits or services, the written decision shall state the specific provisions of this Certificate upon which the denial is based. All grievances shall be processed within sixty (60) days, however, if the grievance involves collection of information from outside the Plan's service area, an additional thirty (30) days will be allowed for processing.

D. Appeal of Decision

If You are dissatisfied with the formal grievance decision, You may request reconsideration by the Company's Grievance Panel and may request a personal appearance before the Grievance Panel. Such requests for reconsideration must be made within sixty (60) days after receipt of the written decision. In addition, a Member always has the right to grieve directly to the State of Florida Department of Financial Services, Office of Insurance Regulation, at anytime.

E. Contact Information

CompBenefits Company
Attn: Quality Manager
P.O. Box 14729
Lexington, KY 40512-4729
(877) 603-5516 ext. 4960

Florida Department of Financial Services
Office of Insurance Regulation
Consumer Assistance
200 East Gaines Street
Tallahassee, FL 32399-032
or call toll free Consumer Hotline at (800) 342-2762

XIV. Continuation of Coverage

Unless cancellation of this Certificate is made for reasons specified in VI.(A) Subscribers who continue to pay appropriate Contributions and Copayments will have their Certificates automatically renewed at the expiration of the first twelve (12) months. The following conditions also will apply:

A. At the attainment of the applicable age, coverage as a Dependent shall be extended if the individual is and continues to be both:

1. Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and

2. Chiefly dependent upon the Subscriber for support and maintenance, provided proof of such incapacity and dependency is furnished to Company by the Subscriber within thirty-one (31) days of the Dependent's attainment of the limiting age and subsequently as may be required by Company, but not more frequently than once every two (2) years.

B. If applicable, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that certain employers maintaining group medical and dental plans offer employees and their Dependents the opportunity to continue their coverage when such coverage ends under certain conditions.

More information about COBRA continuation can be obtained from a Subscriber's employer. COBRA does not apply to coverage maintained on any basis other than that through an employer-employee relationship.

XV. Conversion Provision

A. A Member who has been continuously covered under the Contract for at least three (3)

months, and who loses that coverage, may request to be converted to individual coverage within thirty-one (31) days after losing the coverage without providing evidence of insurability. The Member must pay Contributions at individual rates.

B. A Member shall not be entitled to have a converted contract issued to him or her if termination of his or her coverage occurred for any of the following reasons:

1. Failure to pay any required premium or Contribution.

2. Replacement of any discontinued coverage by similar coverage within thirty-one (31) days.

3. Fraud or material misrepresentation in applying for any benefits under the Certificate.

4. Disenrollment for cause as specified in VI.(A).

5. Willful and knowing misuse of the Company identification card or Certificate by the Member.

6. Willful and knowing furnishing to Company by the Member of incorrect or incomplete information for the purpose of fraudulently obtaining coverage or benefits from Company.

7. The Subscriber has left the geographic area of Company with the intent to relocate or establish a new residence outside Company's geographic area.

C. Subject to the conditions set forth above, the conversion privilege shall also be available to:

1. The surviving spouse and/or children, if any, at the death of the Subscriber, with respect to the spouse and such children whose coverage under the Company contract terminate by reason of such death.

2. To the former spouse whose coverage would otherwise terminate because of annulment or dissolution of marriage, if the former spouse is dependent for financial support.

3. To the spouse of the Subscriber upon termination of coverage of the spouse, while the Subscriber remains covered under a group Company contract, by reason of ceasing to be a qualified family Member under the group contract.

4. To a child solely with respect to himself of herself, upon termination of his or her coverage by reason of ceasing to be a qualified family Member under a group Company contract.

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Schedule of Benefits and Subscriber Copayments

Copayment amounts for listed procedures are applicable at the Participating General Dentist or Participating Specialist.

ADACode	Procedure	Patient Pays
Appointments		
D9310	Consultation (Normally Not The Same Dentist Who Provides The Treatment)	$0
D9430	Office Visit for Observation - No Other Services Performed	$0
D9440	Office Visit - After Regularly Scheduled Hours	$30
D9999	Broken appointments (without 24 hour notice, per 15 min) — maximum $40 per broken appointment. No charge will be made due to emergencies	$10
Diagnostic		
D0120	Periodic Oral Evaluation (limited to twice in any 12 calendar months)	$0
D0140	Limited Oral Evaluation - Problem Focused	$0
D0145	Oral Evaluation for a Patient Under Three Years of Age and Counseling with Primary Caregiver	$0
D0150	Comprehensive Oral Evaluation - New or Established Patient (limited to twice in any 12 calendar months)	$0
D0160	Detailed and Extensive Oral Evaluation - Problem Focused, By Report	$0
D0170	Re-evaluation - Problem Focused (Not Post-Operative Visit)	$0
D0180	Comprehensive Periodontal Evaluation - New or Established Patient (limited to twice in any 12 calendar months)	$0
D0210	X-Rays - Complete Series including bitewings (limit once in any 3 calendar years)	$0
D0220	X-Rays Intraoral Periapical, First Film	$0
D0230	X-Rays Intraoral Periapical, Each Additional Film	$0
D0240	X-Rays Intraoral - Occlusal Film	$0
D0250	Extraoral - first film	$0
D0260	Extraoral - each additional film	$0
D0270	X-Rays (Bitewing) - Single Film (limit twice in any 12 calendar months)	$0
D0272	X-Rays (Bitewings) - Two Films (limit twice in any 12 calendar months)	$0
D0273	X-Rays (Bitewings) - Three films (limit twice in any 12 calendar months)	$0
D0274	X-Rays (Bitewings) - Four Films (limit twice in any 12 calendar months)	$0
D0277	X-Rays (Bitewings, Vertical) - 7 to 8 Films (limit twice in any 12 calendar months)	$0
D0330	X-Rays Panoramic Film (limit once in any 3 calendar years)	$0
D0350	Oral/facial photographic images	$0
D0415	Collection of microorganisms for culture and sensitivity	$0
D0425	Caries susceptibility tests	$0
D0431	Oral Cancer Screening Using a Special Light Source	$50
D0460	Pulp Vitality Tests (not covered if a root canal is performed)	$0
D0470	Diagnostic Casts	$0
D0472	Pathology Report - Gross Examination of Lesion	$0
D0473	Pathology Report - Microscopic Examination of Lesion	$0
D0474	Pathology Report - Microscopic Examination of Lesion and Area	$0

Preventive

D1110	Cleaning - Adult (limit twice in any 12 calendar months, by primary care dentist)	$0
D1111	Additional - Adult Prophylaxis, With or Without Fluoride (Maximum of 2 Additional per year)	$35
D1120	Cleaning – Child (limit twice in any 12 calendar months)	$0
D1121	Additional – Child Prophylaxis, With or Without Fluoride (Maximum of 2 Additional per year)	$25
D1203	Topical Fluoride Application - Child (up to 16 years of age) (limit twice in any 12 calendar months)	$0
D1204	Topical application of fluoride, prophylaxis not included – adult (limit twice in any 12 calendar months, by primary care dentist)	$0
D1206	Topical Fluoride Varnish; Therapeutic Application for Moderate to High Caries Risk Patients (for child under 16 years of age) (limit twice in any 12 calendar months)	$0
D1310	Nutritional counseling for control of dental disease	$0
D1320	Tobacco counseling for the control and prevention of oral disease	$0
D1330	Oral Hygiene Instructions	$0
D1351	Sealant - Per Tooth (limited to permanent teeth only to age 16)	$0
D1510*	Space Maintainer - Fixed Unilateral (through age 14)	$25
D1515*	Space Maintainer - Fixed Bilateral (through age 14)	$25
D1520*	Space Maintainer - Removable - Unilateral (through age 14)	$35
D1525*	Space Maintainer - Removable - Bilateral (through age 14)	$35
D1550	Recementation of Space Maintainer	$15
D1555	Removal of fixed Space Maintainer	$15

Restorative

D2140	Amalgam - One Surface, Primary or Permanent	$0
D2150	Amalgam - Two Surfaces, Primary or Permanent	$0
D2160	Amalgam - Three Surfaces, Primary or Permanent	$0
D2161	Amalgam - Four or More Surfaces, Primary or Permanent	$0
D2940	Protective Restoration	$0

Resin restorative – Inlays and onlays limited to one per tooth every 5 (five) years

D2330	Resin-Based Composite - One Surface, Anterior	$0
D2331	Resin-Based Composite - Two Surfaces, Anterior	$0
D2332	Resin-Based Composite - Three Surfaces, Anterior	$0
D2335	Resin-Based Composite - Four or More Surfaces or Involving Incisal Angle (Anterior)	$0
D2390	Resin-Based Composite Crown, Anterior	$30
D2391	Resin-Based Composite - One Surface, Posterior	$30
D2392	Resin-Based Composite - Two Surfaces, Posterior	$45
D2393	Resin-Based Composite - Three Surfaces, Posterior	$65
D2394	Resin-Based Composite - Four or More Surfaces, Posterior	$65
D2510*	Inlay - Metallic - One Surface	$225
D2520*	Inlay - Metallic - Two Surfaces	$235
D2530*	Inlay - Metallic - Three or More Surfaces	$245
D2542*	Onlay - Metallic - Two Surfaces	$245
D2543*	Onlay - Metallic - Three Surfaces	$260
D2544*	Onlay - Metallic - Four or More Surfaces	$270
D2610*	Inlay - porcelain/ceramic - one surface	$245
D2620*	Inlay - porcelain/ceramic - two surfaces	$245
D2630*	Inlay - porcelain/ceramic - three or more surfaces	$245
D2642*	Onlay - porcelain/ceramic - two surfaces	$245
D2643*	Onlay - porcelain/ceramic - three surfaces	$245
D2644*	Onlay - porcelain/ceramic - four or more surfaces	$245
D2650*	Inlay - resin-based composite - one surface	$245

D2651*	Inlay - resin-based composite - two surfaces	$245
D2652*	Inlay - resin-based composite - three or more surfaces	$245
D2662*	Onlay - resin-based composite - two surfaces	$245
D2663*	Onlay - resin-based composite - three surfaces	$245
D2664*	Onlay - resin-based composite - four or more surfaces	$245
	Crown and bridge – Crowns limited to one per tooth every 5 (five) years	
D2710*	Crown - resin based composite (indirect)	$245
D2712*	Crown - 3/4 resin-based composite (indirect)	$245
D2720*	Crown - Resin with High Noble Metal	$245
D2721	Crown - Resin with Predominantly Base Metal	$245
D2722*	Crown - Resin with Noble Metal	$245
D2740*	Crown - Porcelain/Ceramic Substrate	$245
D2750*	Crown - Porcelain Fused to High Noble Metal	$245
D2751	Crown - Porcelain Fused to Predominantly Base Metal	$245
D2752*	Crown - Porcelain Fused to Noble Metal	$245
D2780*	Crown - 3/4 Cast High Noble Metal	$245
D2781	Crown - 3/4 Cast Predominantly Base Metal	$245
D2782*	Crown - 3/4 Cast Noble Metal	$245
D2783*	Crown - 3/4 Porcelain/Ceramic	$245
D2790*	Crown - Full Cast High Noble Metal	$245
D2791	Crown - Full Cast Predominantly Base Metal	$245
D2792*	Crown - Full Cast Noble Metal	$245
D2794*	Crown - Titanium	$245
D2799	Provisional crown	$0
D2910	Recement Inlay, Onlay or Veneer	$0
D2915	Recement Cast or Prefabricated Post and Core	$0
D2920	Recement Crown	$0
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	$25
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	$25
D2932	Prefabricated Resin Crown	$45
D2933	Prefabricated Stainless Steel Crown with Resin Window	$45
D2950	Core Buildup, Including Any Pins	$70
D2951	Pin Retention - Per Tooth, In Addition to Restoration	$10
D2952*	Cast Post and Core, In Addition to Crown	$50
D2953*	Each Additional Cast Post - Same Tooth	$50
D2954	Prefabricated Post and Core In Addition to Crown	$30
D2955	Post removal (not in conjunction with endodontic therapy)	$10
D2957	Each Additional Prefabricated Post - Same Tooth -Base Metal Post	$30
D2960	Labial Veneer (Resin Laminate) - Chairside	$250
D2961*	Labial veneer (resin laminate) - laboratory	$300
D2962*	Labial veneer (porcelain laminate) - laboratory	$350
D2970	Temporary Crown (fractured tooth)	$0
D2971	Additional procedures to construct new crown under existing partial denture framework	$50
D2980	Crown Repair	$0
D6940	Stress Breaker	$110
D6950	Precision attachment (separate from prosthesis)	$195
D6970*	Cast Post and Core, In Addition to Fixed Partial Denture Retainer	$50
D6972	Prefabricated Post and Core In Addition to Fixed Partial Denture Retainer-Base Metal Post	$30
D6976*	Each Additional Cast Post - Same Tooth	$40
D6977	Each Additional Prefabricated Post - Same Tooth	$40
D6980*	Fixed Partial Denture Repair, By Report	$45
	Prosthodontics (fixed) – Replacement limited to every 5 (five) years, adjustments once per year	

D6210*	Pontic - Cast High Noble Metal	$245
D6211	Pontic - Cast Predominantly Base Metal	$245
D6212*	Pontic - Cast Noble Metal	$245
D6240*	Pontic - Porcelain Fused to High Noble Metal	$245
D6241	Pontic - Porcelain Fused to Predominantly Base Metal	$245
D6242*	Pontic - Porcelain Fused to Noble Metal	$245
D6750*	Crown - Porcelain Fused to High Noble Metal	$245
D6751	Crown - Porcelain Fused to Predominantly Base Metal	$245
D6752*	Crown - Porcelain Fused to Noble Metal	$245
D6790*	Crown - Full Cast High Noble Metal	$245
D6791	Crown - Full Cast Predominantly Base Metal	$245
D6792*	Crown - Full Cast Noble Metal	$245
D6794*	Crown Titanium	$245
D6930	Recement Fixed Partial Denture	$0
D6973	Core Buildup For Retainer, Including Any Pins	$10

Prosthodontics – Replacement limited to every 5 (five) years

D5110*	Full Upper Denture	$325
D5120*	Full Lower Denture	$325
D5130*	Immediate Full Upper Denture	$350
D5140*	Immediate Full Lower Denture	$350
D5211*	Upper Partial Denture - Resin Base (Including Clasps, Rests and Teeth)	$400
D5212*	Lower Partial Denture - Resin Base (Including Clasps, Rests and Teeth)	$400
D5213*	Upper Partial Denture - Metal (Including Clasps, Rests and Teeth)	$425
D5214*	Lower Partial Denture - Metal (Including Clasps, Rests and Teeth)	$425
D5225*	Upper Partial Denture - Flexible (Including Clasps, Rests and Teeth)	$425
D5226*	Lower Partial Denture - Flexible (Including Clasps, Rests and Teeth)	$425
D5281*	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	$300
D5410	Adjust Complete Denture Upper	$10
D5411	Adjust Complete Denture Lower	$10
D5421	Adjust Partial Denture Upper	$10
D5422	Adjust Partial Denture Lower	$10
D5660*	Add Clasp to Existing Partial Denture	$35

Endodontics (each procedure limited to once per tooth per life)

D3110	Pulp Cap - Direct (Excluding Final Restoration)	$5
D3120	Pulp Cap - Indirect (Excluding Final Restoration)	$5
D3220	Pulpotomy - Removal of Pulp, Not Part of a Root Canal	$30
D3221	Pulpal Debridement (Not to be used when root canal is done on the same day)	$55
D3230	Pulpal Therapy (Resorbable Filling) - Anterior, Primary Tooth (Excluding Final Restoration)	$40
D3240	Pulpal Therapy (Resorbable Filling) - Posterior, Primary Tooth (Excluding Final Restoration)	$40
D3310	Anterior Root Canal (Permanent Tooth) (Excluding Final Restoration)	$100
D3320	Bicuspid Root Canal (Permanent Tooth) (Excluding Final Restoration)	$152
D3330	Molar Root Canal (Permanent Tooth) (Excluding Final Restoration)	$210
D3331	Treatment of Root Canal Obstruction; Non-Surgical Access	$85
D3332	Incomplete Endodontic Therapy; Inoperable or Fractured Tooth	$96
D3333	Internal Root Repair of Perforation Defects	$85
D3346	Retreatment of Previous Root Canal Therapy – Anterior	$180
D3347	Retreatment of Previous Root Canal Therapy – Bicuspid	$280
D3348	Retreatment of Previous Root Canal Therapy – Molar	$325
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$70
D3352	Apexification/recalcification - interim medication replacement	

	(apical closure/calcific repair of perforations, root resorption, etc.)	$70
D3353	Apexification/recalcification - final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)	$70
D3410	Apicoectomy/Periradicular Surgery Anterior	$95
D3421	Apicoectomy/Periradicular Surgery - Bicuspid (FirstRoot)	$95
D3425	Apicoectomy/Periradicular Surgery - Molar (First Root)	$95
D3426	Apicoectomy/Periradicular Surgery (Each Additional Root)	$60
D3430	Retrograde Filling - Per Root	$60
D3450	Root Amputation - Per Root (Not Covered in Conjunction with Procedure D3920)	$95
D3910	Surgical procedure for isolation of tooth with rubber dam	$19
D3920	Hemisection (including any root removal), not including root canal therapy	$90
D3950	Canal preparation and fitting of preformed dowel or post	$15

Periodontics

D4210	Gingivectomy or Gingivoplasty - 4 or More Teeth, Per Quadrant	$110
D4211	Gingivectomy or Gingivoplasty - 1 to 3 Teeth, Per Quadrant	$83
D4240	Gingival Flap, Including Root Planing - 4 or More Teeth, Per Quadrant	$150
D4241	Gingival Flap, Including Root Planing - 1 to 3 Teeth, Per Quadrant	$113
D4245	Apically Positioned Flap	$165
D4249	Clinical Crown Lengthening - Hard Tissue	$150
D4260	Osseous Surgery - 4 or More Teeth or Bounded Spaces, Per Quadrant	$300
D4261	Osseous Surgery - 1 to 3 Teeth, Per Quadrant	$225
D4263	Bone Replacement Graft - First Site in Quadrant	$180
D4264	Bone Replacement Graft - Each Additional Site in Quadrant Bone	$95
D4265	Biologic materials to aid in soft and osseous tissue regeneration	$95
D4266	Guided Tissue Regeneration - Resorbable Barrier, Per Site	$215
D4267	Guided Tissue Regeneration - Nonresorbable Barrier, Per Site (Includes Membrane Removal)	$255
D4270	Pedicle Soft Tissue Graft Procedure	$245
D4271	Free Soft Tissue Graft Procedure (Including Donor Site Surgery)	$245
D4273	Subepithelial connective tissue graft procedures, per tooth	$75
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	$100
D4275	Soft Tissue Allograft	$380
D4320	Provisional splinting - intracoronal	$95
D4321	Provisional splinting - extracoronal	$85
D4341	Periodontal Scaling and Root Planing, Four or More Teeth or Bounded Teeth Spaces Per Quadrant (limited to a maximum of four (4) quadrants will be paid in any combination per 24 calendar months.)	$50
D4342	Periodontal Scaling and Root Planing- One to Three Teeth, Per Quadrant (limited to a maximum of four (4) quadrants will be paid in any combination per 24 calendar months.)	$38
D4355	Full Mouth Debridement to Allow Evaluation and Diagnosis (limit once every 5 calendar years)	$50
D4381	Localized Delivery of Chemotherapeutic Agents, Per Tooth, By Report (limited to once per tooth per (12) months to a maximum of three (3) tooth sites per quadrant, and performed no less than three (3) months following active periodontal therapy.)	$65
D4910	Periodontal Maintenance (covered only after active periodontal therapy)	$40
D4911	Additional Periodontal Maintenance Procedures (Beyond 2 per 12 months)	$55

Extractions/oral and maxillofacial surgery

D7111	Extraction of Coronal Remnants - Deciduous Tooth	$5
D7140	Extraction, Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal)	$5
D7210	Surgical Removal of Erupted Tooth - Removal of Bone and/or Sectioning of Tooth And including elevation of mucoperiosteal flap if indicated	$30

D7220	Removal of Impacted Tooth - Soft Tissue	$50
D7230	Removal of Impacted Tooth - Partially Bony	$65
D7240	Removal of Impacted Tooth - Completely Bony	$80
D7241	Removal of Impacted Tooth - Completely Bony, Unusual Complications by Report	$100
D7250	Surgical Removal of Residual Tooth Roots (Cutting Procedure)	$40
D7270	Tooth Stabilization of Accidentally Evulsed or Displaced Tooth	$50
D7280	Surgical Access of an Unerupted Tooth (Excluding Wisdom Teeth)	$100
D7282	Mobilization of erupted or malpositioned tooth to air eruption	$90
D7283	Placement of Device to Facilitate Eruption of Impacted Tooth	$90
D7285	Biopsy of Oral Tissue - Hard (Bone, Tooth)	$150
D7286	Biopsy of Oral Tissue - Soft (All Others)	$60
D7287	Exfoliative Cytological Sample Collection	$50
D7288	Brush Biopsy - Transepithelial Sample Collection	$50
D7310	Alveoloplasty with Extractions - Per Quadrant	$40
D7311	Alveoloplasty with Extractions - Localized, Per Quadrant	$15
D7320	Alveoloplasty not in Conjunction with Extractions -Per Quadrant	$60
D7321	Alveoloplasty not in Conjunction with Extractions -Localized, Per Quadrant	$25
D7471	Removal of Lateral Exostosis (Maxilla or Mandible)	$80
D7472	Removal of Torus Palatinus	$60
D7473	Removal of Torus Mandibularis	$60
D7485	Surgical Reduction of Osseous Tuberosity	$60
D7510	Incision and Drainage of Abscess - Intraoral Soft Tissue	$35
D7511	Drainage of Multiple Facial Spaces	$35
D7520	Incision and Drainage of Abscess – Extraoral Soft Tissue	$35
D7521	Incision and Drainage of Abscess – Extraoral Soft Tissue – Complicated (includes Drainage of multiple Facial Spaces)	$35
D7910	Suture of Recent Small Wounds Up to 5 Cm	$25
D7960	Frenulectomy (frenectomy or frenotomy) – separate procedure	$50
D7963	Frenuloplasty	$50
D7970	Excision of hyperplastic tissue - per arch	$55
D7971	Excision of pericoronal gingiva	$40

Repair to prosthetics

D5510*	Repair Broken Complete Denture Base	$35
D5520*	Replace Missing or Broken Teeth - Complete Denture (Each Tooth)	$35
D5610*	Repair Resin Denture Base	$35
D5620*	Repair Cast Framework	$35
D5630*	Repair or Replace Broken Clasp	$35
D5640*	Replace Broken Teeth - Per Tooth	$35
D5650*	Add Tooth to Existing Partial Denture	$35
D5670*	Replace all teeth and acrylic on cast metal framework (maxillary)	$165
D5671*	Replace all teeth and acrylic on cast metal framework (mandibular)	$165
D5710*	Rebase Complete Upper Denture	$75
D5711*	Rebase Complete Lower Denture	$75
D5720*	Rebase Upper Partial Denture	$75
D5721*	Rebase Lower Partial Denture	$75
D5730	Reline Complete Upper Denture (Chairside)	$65
D5731	Reline Complete Lower Denture (Chairside)	$65
D5740	Reline Upper Partial Denture (Chairside)	$65
D5741	Reline Lower Partial Denture (Chairside)	$65
D5750*	Reline Complete Upper Denture (Laboratory)	$65
D5751*	Reline Complete Lower Denture (Laboratory)	$85
D5760*	Reline Upper Partial Denture (Laboratory)	$85
D5761*	Reline Lower Partial Denture (Laboratory)	$85
D5810*	Interim Complete Denture (Upper)	$230
D5811*	Interim Complete Denture (Lower)	$230

D5820*	Interim Partial Denture (Upper)	$160
D5821*	Interim Partial Denture (Lower)	$170
D5850	Tissue Conditioning, Upper	$20
D5851	Tissue Conditioning, Lower	$20
D5862*	Precision Attachment, by report	$160
D6214*	Pontic Titanium	$245
D6245*	Pontic - Porcelain/Ceramic	$245
D6250*	Pontic - Resin with High Noble Metal	$245
D6251	Pontic - Resin with Predominantly Base Metal	$245
D6252*	Pontic - Resin with Noble Metal	$245
D6253*	Provisional pontic	$0
D6545*	Retainer - cast metal for resin bonded fixed prosthesis	$150
D6600*	Inlay - porcelain/ceramic, two surfaces	$245
D6601*	Inlay - porcelain/ceramic, three or more surfaces	$245
D6602*	Inlay - Cast High Noble Metal, Two Surfaces	$245
D6603*	Inlay - Cast High Noble Metal, Three or More Surfaces	$245
D6604	Inlay - Cast Predominantly Base Metal, Two Surfaces	$245
D6605	Inlay - Cast Predominantly Base Metal, Three or More Surfaces	$245
D6606*	Inlay - Cast Noble Metal, Two Surfaces	$245
D6607*	Inlay - Cast Noble Metal, Three or More Surfaces	$245
D6608*	Onlay - porcelain/ceramic, two surfaces	$245
D6609*	Onlay - porcelain/ceramic, three or more surfaces	$245
D6610*	Onlay - Cast High Noble Metal, Two Surfaces	$245
D6611*	Onlay - Cast High Noble Metal, Three or More Surfaces	$245
D6612	Onlay - Cast Predominantly Base Metal, Two Surfaces	$245
D6613	Onlay - Cast Predominantly Base Metal, Three or More Surfaces	$245
D6614*	Onlay - Cast Noble Metal, Two Surfaces	$245
D6615*	Onlay - Cast Noble Metal, Three or More Surfaces	$245
D6710*	Crown - indirect resin based composite	$245
D6720*	Crown - Resin with High Noble Metal	$245
D6721	Crown - Resin with Predominantly Base Metal	$245
D6722*	Crown - Resin with Noble Metal	$245
D6740*	Crown - Porcelain/Ceramic	$245
D6780*	Crown - 3/4 Cast High Noble Metal	$245
D6781	Crown - 3/4 Cast Predominantly Base Metal	$245
D6782*	Crown - 3/4 Cast Noble Metal	$245
D6783*	Crown - 3/4 porcelain/ceramic	$245

Adjunctive General Service

D9110	Palliative (Emergency Treatment of Dental Pain – Minor Procedure)	$10
D9120	Fixed Partial Denture Sectioning	$0
D9210	Local Anesthesia Not in Conjunction with Operative or Surgical Procedures	$0
D9211	Regional Block Anesthesia	$0
D9212	Trigeminal Division Block Anesthesia	$0
D9215	Local Anesthesia in conjunction with operative or surgical procedures	$0
D9220	General Anesthesia - First 30 Minutes (Limited to the Removal of Partial, or Complete Boney Impacted Teeth)	$150
D9221	General Anesthesia - Additional 15 Minutes (Limited to the Removal of Partial, or Complete Boney Impacted Teeth)	$45
D9230	Administration of Nitrous Oxide/anxiolysis, analgesia (per 15 minutes)	$15
D9241	I.V. Conscious Sedation - First 30 Minutes (Limited to the Removal of Partial, or Complete Boney Impacted Teeth)	$150
D9242	I.V. Conscious Sedation - Additional 15 Minutes (Limited to the Removal of Partial, or Complete Boney Impacted Teeth)	$45
D9248	Non-intravenous Conscious Sedation	$15
D9450	Case Presentation, Detailed and Extensive Treatment Planning	$0

D9610	Therapeutic Parenteral drug, Single Administration	$15
D9612	Therapeutic Parenteral drug, Two or More Administrations	$25
D9630	Other Drugs and/or Medicaments, by Report	$15
D9910	Application of Desensitizing Medicament	$15
D9940	Occlusal Guard, by Report	$85
D9942	Repair and/or Reline of Occlusal Guard	$40
D9951	Occlusal Adjustment Limited	$30
D9952	Occlusal Adjustment Complete	$100

Bleaching

D9972	External Bleaching - Per Arch	$125

* Services marked with a single asterisk (*) also require separate payment of laboratory charges (not to exceed $200). The laboratory charges must be paid to the Participating Dentist in addition to any applicable copayment for the service.

Orthodontic Services

D8070 / D8080

Comprehensive Orthodontic treatment of the transitional/adolescent dentition. Children up to 19 years of age up to 24 months of routine orthodontic treatment for Class I and Class II cases.
Consultation..... $0
Evaluation..... $35
Records/Treatment Planning…..... $250
Orthodontic treatment..... $1,850

D8090 Comprehensive Orthodontic treatment of the transitional/adult dentition. Adults 19 years of age and older up to 24 months of routine orthodontic treatment for Class I and Class II cases.
Consultation..... $0
Evaluation..... $35
Records/Treatment Planning..... $250
Orthodontic treatment..... $1,850

D8680 Retention $300

D8693 Rebonding or recementing; and/or repair, as required, of fixed retainers..... $0

Implant Services:

Implants and implant supported prostheses are covered with a 50% copayment up to an annual maximum benefit of $1,500 and a $10,000 lifetime maximum benefit. The Member is responsible for payment of the copayment and any amounts in excess of the annual maximum benefit. No benefits for implants and implant supported prostheses are available after the lifetime maximum is met.

Implants and implant supported prostheses covered under this plan are limited to the replacement of permanent teeth extracted while covered under this plan, or for replacement of a prior prosthesis if it has been at least five years since the prior insertion, and is not, and cannot be made serviceable.

NOTE:

1. Not all Participating Dentists perform all listed procedures, including amalgams. Please consult Your dentist prior to treatment for availability of services.

2. Some Covered Dental Care Services are typically only offered by a specialist (like many oral surgery procedures).

3. When crown and/or bridgework exceeds six units in the same treatment plan, the patient may be charged and additional $75 per unit.

4. Additional exclusions and limitations are listed along with full plan information in your Certificate of Dental Benefits.

5. Copayment amounts for listed procedures are applicable at either the Participating General Dentist or Participating Specialist. Specialist services are only available in areas where the dental plan has a Participating Specialist.

Offered and Administered by CompBenefits Company, a Humana company

Notices

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

This section includes notices about:

Claims and Appeal Procedures

Federal Legislation

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

Privacy and Confidentiality Statement

CLAIMS AND APPEALS PROCEDURES

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

DISCRETIONARY AUTHORITY

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

1) Interpret plan provisions.

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

3) Resolve factual questions relating to coverage and benefits.

CLAIMS PROCEDURES

Definitions

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

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

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

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

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

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

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

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

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

Submitting a Claim

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

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

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

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

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

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

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

Procedural Defects

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

Authorized Representatives

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

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

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

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

Claims Decisions

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

Pre-service Claims

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

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

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

Urgent-care Claims (expedited review)

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

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

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

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

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

Concurrent-care Decisions

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

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

Post-service Claims

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

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

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

Initial Denial Notices

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

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

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

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

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

APPEALS OF ADVERSE DETERMINATIONS

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

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

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

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

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

Time Periods for Decisions on Appeal

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

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

Appeals Denial Notices

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

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

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

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

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

EXHAUSTION OF REMEDIES

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

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

LEGAL ACTIONS AND LIMITATIONS

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

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

MEDICAL CHILD SUPPORT ORDERS

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

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

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

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

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

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

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

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

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

Introduction

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

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

What is COBRA Continuation Coverage?

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

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

- Your hours of employment are reduced, or

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

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

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

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

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

When is COBRA Coverage Available

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

You Must Give Notice of Some Qualifying Events

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

How is COBRA Coverage Provided?

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

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

Disability Extension of 18-Month Period of Continuation Coverage

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

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

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

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

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

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

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

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

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

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

Category 1 Medicare eligibles are:

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

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

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

Calculation and Payment of Benefits

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

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

FAMILY AND MEDICAL LEAVE ACT (FMLA)

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

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

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

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

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

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

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

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

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

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

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

YOUR RIGHTS UNDER ERISA

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

Information About the Plan and Benefits

Plan participants may:

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

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

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

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

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

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

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

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

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

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

Assistance with Questions

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

PRIVACY AND CONFIDENTIALITY STATEMENT

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

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

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

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

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

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

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

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

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