



Policyholder (Employer): PINELLAS COUNTY SCHOOLS  
Group Number: 548085  
Coverage Effective Date: 01-01-2021

## 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 Group Dental Benefits

This Certificate of Group Dental Benefits (“Certificate”) outlines the features of the Group Contract for Dental Benefits (“Contract”) between CompBenefits Company. (“Company”) and Your group (“Group”). **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 their Certificates.
- B. **"Contributions"** are those periodic payments due Company in order for Members to receive Benefits as provided by the Certificate.
- C. **"Copayment"** is an additional fee the Participating General Dentist or Participating Specialist may charge Member when providing Dental Care Services not specified as "No Charge" in the Certificate.
- D. **"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.
- E. **"Covered Dental Injury"** means all damage to a covered person's mouth due to an accident caused by any sudden, unexpected impact from outside the oral cavity, and all complications arising from that damage.
- 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 unmarried dependent children from birth to age 26 and dependent upon the Subscriber for support, or age 26 through the end of the calendar year in which the child reaches the age of 26 if dependent upon the Subscriber for support and a full-time or part-time student or residing in the Subscriber's household. The term "children" also includes: a) adopted children and b) stepchildren and foster children living with the Subscriber in a parent-child relationship. Your domestic partner (in lieu of legal spouse) if Your Group elects to provide coverage for domestic partners as shown in the Contract. It is the obligation of the Subscriber to notify the Group 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. **"Member"** is a Subscriber and/or covered eligible Dependent of a Subscriber.
- K. **"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.
- L. **"Participating General Dentist" or "Participating Specialist"** are those licensed dentists selected and contracted with Company as independent contractors to provide dental Benefits to Members.

- M. **"Subscriber" "You" or "Your"** is the enrolled employee or member of the group in good standing for whom the necessary Contributions and Copayments have been made in payment for Covered Dental Care Services.
- N. **"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.
- O. **"Usual 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.

## **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 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 contained in 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. 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.

## **V. 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, You are responsible for charges exceeding the least expensive treatment cost.

## **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 in applying for or presenting any claims for benefits 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 a Participating General Dentist or 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 Member furnishes to the Company incorrect or incomplete information for the purposes of fraudulently obtaining services.
  5. When a Dental Facility is not available within the immediate geographical area of the Subscriber.
  6. 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.
  7. 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. Disenrollment and termination of Benefits will occur on the last day of the month after voluntary disenrollment.

## **VII. Continuation of Coverage**

Unless cancellation of this Certificate is made for reasons specified in VI.A.1. 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 annually after the two-year period following the Dependent's attainment of the limiting age.
- B. 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.

## **VIII. Coverage for Newborn Children and Adding Additional Dependents**

- A. 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.
- 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 within 30 days of the birth of such child; 2) the date You gain custody of the child under a temporary court order that grants You conservatorship of the child; or 3) the date the child is placed with You for adoption; and additional premium, if any, is paid.
- C. Additional eligible Dependents of Subscriber may be added to this Certificate upon application to Company. When Dependents of a Subscriber become ineligible, upon application they may change their status and continue their Benefits as an individual Subscriber.

## **IX. Conversion Provisions**

- 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 Company contract.
  - 4. Disenrollment for cause as specified in VI.A.1.
  - 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 or herself, upon termination of his or her coverage by reason of ceasing to be a qualified family Member under a group Company contract.

## **X. General Provisions**

### **A. Appointments**

All non-emergency Covered Dental Care Services rendered to Member shall be on a prior appointment basis during the normal office hours of the Participating General Dentist or Participating Specialist. In order to receive Benefits, Member must make an appointment with a Participating General Dentist or Participating Specialist, and the request for an appointment must be made after the Effective Date. When making an appointment, Member should inform Dental Facility that he or she is a Company Member.

Member may request an emergency appointment (treatment of accidental, painful, or urgent conditions) within twenty-four (24) hours of calling the Dental Facility, subject to the appropriate Copayment.

### **B. Emergency Care**

Emergency care means treatment due to injury, accident, or severe pain requiring the services of a dentist which occurs under circumstances where it is neither medically nor physically possible for the Member to be treated by any Company Participating General Dentist. An acute periodontal abscess and an acute periapical abscess which occur under circumstances where it is not possible for the Member to be treated by any Company Participating General Dentist are examples where emergency benefits would be applicable.

#### **1. Out-of-Area Emergency Care:**

When more than one hundred (100) miles from the nearest available Company 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 Company 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 usual fees less a 25% reduction.

If Emergency Care is required after Company's normal business hours, and it is not possible to contact a Company 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.

### **C. 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.

## **D. Limitations and Exclusions**

1. Major restorative services will be subject to the following:
  - a) denture, removable partial denture, or fixed partial denture must replace a natural tooth extracted while covered under this Certificate, however, this provision will not apply if the Contract replaces a prior group dental policy under which You were covered, and You are covered by this Certificate on the effective date of the Contract without a break in coverage, provided: a) the prosthetic replaces teeth that were extracted while insured under the prior policy; and b) the prosthetic work is completed within 12 months of the extraction;
  - b) the replacement of a partial denture, full denture, or the addition of teeth to a partial denture if: (i) replacement occurs at least five years after the initial date of insertion of the current full or partial denture or resin bonded bridge; (ii) replacement occurs at least five years after the initial date of insertion of an existing implant or fixed bridge; (iii) replacement prosthesis or the addition of a tooth to a partial denture is required by the necessary extraction of a functioning natural tooth while covered under this Certificate; or (iv) replacement is made necessary by a Covered Dental Injury to a partial denture, full denture, or fixed partial denture (including a resin bonded bridge) provided the replacement is completed within 12 months of the injury;
  - c) the replacement of crowns, cast restorations, inlays, onlays, fixed partial dentures or other laboratory prepared restorations only if: (i) replacement occurs at least eight years after the initial date of insertion; and (ii) they are not serviceable and cannot be restored to function;
  - d) the replacement of an existing partial denture with fixed bridgework, only if upgrading to fixed bridgework is essential to the correction of the person's dental condition;
  - e) the replacement of teeth up to the normal complement of 32; and
  - f) denture adjustments are limited to once every twelve (12) months starting twelve (12) months after placement.
2. 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 VIII, Paragraph B of this Certificate.
3. Whenever any Contributions or Copayments are delinquent, Member will not be entitled to receive Benefits, or enjoy any of the other privileges of a Member in good standing.
4. Orthodontic treatment, if a Covered Dental Care Service as shown in the Member's Schedule of Benefits, is limited to one twenty-four (24) month course of treatment.
5. Only one (1) periapical radiograph is an allowed benefit for root canal treatment.
6. The total number of periodontal maintenance and all other prophylaxis treatments combined are limited to two (2) per member every twelve (12) months.
7. Company does not provide coverage for the following services:
  - a) Pharmaceuticals, drugs or medications.
  - b) Services which in the opinion of the Participating General Dentist, Participating Specialist or Company are (a) not necessary; (b) not appropriate for the given condition or not customarily used for dental care; (c) do not have uniform professional endorsement or do not meet the standards set by the American Dental Association; (d) experimental or investigational in nature; (e) for which the Member has no legal obligation to pay; or (f) for which a charge would have been made in the absence of insurance.
  - c) 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.
  - d) 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.
  - e) Any dental treatment started prior to the Member's effective date for eligibility of benefits.

- f) Services for injuries and conditions which are covered under Workers' Compensation or Employers' Liability laws, or that arises out of or in the course of a job or employment for pay or profit.
- g) Treatment for cysts, neoplasms and malignancies.
- h) General anesthesia, IV sedation, and nitrous oxide, unless it is specifically listed on the Schedule of Benefits. When listed on the Schedule of Benefits, general anesthesia and IV sedation are covered only when medically necessary and provided in conjunction with other Covered Dental Services and performed by an Oral Surgeon, Periodontist, or Pediatric Dentist. The following rationales are not eligible for benefits: 1) pain control, unless documented allergy to local anesthetic; 2) anxiety; 3) fear of pain; 4) pain management; or 5) emotional inability to undergo surgery.
- i) Any procedure, service, or supply which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least three years, as determined by Company.
- j) Crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth which may be restored with an amalgam or composite resin filling.
- k) Appliances, inlays, cast restorations or other laboratory prepared restorations used primarily for the purpose of splinting.
- l) Any procedure, service, supply or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension; the alteration or restoration of occlusion including occlusal adjustment, bite restoration, or bite analysis.
- m) Adult fluoride treatments, athletic mouth guards, myofunctional therapy, infection control, precision or semi-precision attachments, denture duplication, oral hygiene instructions, radiograph duplication charges for claim submission, separate charges for acid etching, completion of claim fees, equipment or technology fees, exams required by third party, personal supplies (water pik, toothbrush, floss holder, etc.), or replacement of lost or stolen appliances.
- n) Any procedure, service or supply required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joints or their associated structures.
- o) Procedures that are a covered expense under any other medical plan (established by the employer) which provides group hospital, surgical, or medical benefits whether or not on an insured basis.
- p) Extraction of asymptomatic third molars, including extraction of erupted third molars for orthodontics.
- q) Cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance). Facings on crowns or fixed partial dentures on molar teeth will always be considered cosmetic.
- r) Dental implants and related services.
- s) Restoration of teeth that have been damaged by attrition, abrasion, or erosion.
- t) Resin bonded bridges, including associated retainers and pontics.
- u) Charges for travel time, transportation costs, or professional advice given on the phone.
- v) Procedures performed by a dentist who is a member of Your immediate family.
- w) Any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility.
- x) Any charges related to the review of any diagnostic biopsy, material, or specimens submitted to a pathologist, or pathology lab, for histological review.
- y) Charges for treatment rendered; (a) in a clinic, dental or medical facility sponsored or maintained by the employer of any Member; or (b) by an employee of any Member.
- z) Charges for treatment performed outside the United States other than for emergency treatment. Benefits for emergency treatment that is performed outside the United States is limited to \$100 (US dollars) per year.
- aa) Dental services required while serving in the armed forces, or the care or treatment of an injury or sickness due to war or an act of war, declared or undeclared.



## **E. 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.

## **F. Coordination of Benefits**

"Coordination of benefits" is the procedure used to pay dental care expenses when a person is covered by more than one plan. Company follows rules established by Florida law to decide which plan pays first and how much the other plan must pay. The objective is to make sure the combined payments of all plans are no more than your actual bills.

When you or your family members are covered by another group plan in addition to this one, we will follow Florida coordination of benefit rules to determine which plan is primary and which is secondary. You must submit all bills first to the primary plan. The primary plan must pay its full benefits as if you had no other coverage. If the primary plan denies the claim or does not pay the full bill, you may then submit the balance to the secondary plan.

Company pays for dental care only when you follow our rules and procedures. If our rules conflict with those of another plan, it may be impossible to receive benefits from both plans, and you will be forced to choose which plan to use.

### **PLANS THAT DO NOT COORDINATE**

Company will pay benefits without regard to benefits paid by the following kinds of coverage.

- Individual (not group) policies or contracts unless they contain a Coordination of Benefits Provision.
- Medicaid.
- Group hospital indemnity plans which pay less than \$100 per day.
- School accident coverage.
- Some supplemental sickness and accident policies.

### **HOW COMPANY PAYS AS PRIMARY PLAN**

When we are primary, we will pay the full benefit allowed by your contract as if you had no other coverage.

### **HOW COMPANY PAYS AS SECONDARY PLAN**

When we are secondary, our payments will be based on the balance left after the primary plan has paid. We will pay no more than that balance. In no event will we pay more than we would have paid had we been primary.

- We will pay only for dental care expenses that are covered by Company.
- We will pay only if you have followed all of our procedural requirements, including (care obtained from or arranged by your primary care physician, precertification, etc.).
- We will pay no more than the "allowable expenses" for the dental care involved. If our allowable expense is lower than the primary plan's, we will use the primary plan's allowable expense. That may be less than the actual bill.

## WHICH PLAN IS PRIMARY?

To decide which plan is primary, we have to consider both the coordination provisions of the other plan and which member of your family is involved in a claim. The Primary Plan will be determined by the first of the following which applies:

### 1. Non-coordinating Plan

If you have another group plan which does not coordinate benefits, it will always be primary.

### 2. Employee

The plan which covers you as an employee (neither laid off nor retired) is always primary.

### 3. Children (Parents Divorced or Separated)

If the court decree makes one parent responsible for dental care expenses, that parent's plan is primary. If the court decree gives joint custody and does not mention dental care, we follow the birthday rule. If neither of those rules applies, the order will be determined in accordance with the State Insurance Department rule on Coordination of Benefits.

### 4. Children & the Birthday Rule

When your children's dental care expenses are involved, we follow the "birthday rule." The plan of the parent with the first birthday in a calendar year is always primary for the children. If your birthday is in January and your spouse's birthday is in March, your plan will be primary for all of your children. However, if your spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.

### 5. Other Situations

For all other situations not described above, the order of benefits will be determined in accordance with the Florida Law on Coordination of Benefits.

## **XI. 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 there under, 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

Grievance and Appeals Department  
PO Box 14729  
Lexington KY 40512-4729  
or call, toll free at (800) 342-5209

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

# AdvantagePlus 2S

ANNUAL MAXIMUM (excludes Orthodontics): \$9,999,999  
 GENERAL DENTIST OFFICE VISIT COPAYMENT: \$0  
 SPECIALITY OFFICE VISIT COPAYMENT: \$

Co-payment amounts for listed procedures are applicable at either the Participating General Dentist or Participating Specialist.

## Schedule of benefits and subscriber co-payments

ADA CODE	PROCEDURE	PATIENT PAYS
<b>Preventive Services</b>		
D0120	Periodic oral examination (limit 2 every 12 months).....	\$0.00
D0140	Limited oral evaluation - problem focused (limit 2 every 12 months).....	\$0.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver (limit 1 every 12 months).....	\$0.00
D0150	Comprehensive oral evaluation - new or established patient (limit 1 every 24 months).....	\$0.00
D0160	Detailed and extensive oral evaluation - problem focused report (limit 1 every 12 months).....	\$0.00
D0170	Re-evaluation - limited problem focused (limit 1 every 12 months).....	\$0.00
D0180	Comprehensive periodontal evaluation - new or established patient (limit 1 every 24 months).....	\$0.00
D0210	Intraoral - Complete series (limit 1 every 3 years).....	\$0.00
D0220	Intraoral - Periapical - first film (limit 9 every 12 months including D0230).....	\$0.00
D0230	Intraoral - Periapical - each additional film (limit 9 every 12 months including D0220) ...	\$0.00
D0240	Intraoral - occlusal film .....	\$0.00
D0250	Extraoral - first film .....	\$0.00
D0260	Extraoral - each additional film .....	\$0.00
D0270	Bitewing - single film (limit 2 every 12 months).....	\$0.00
D0272	Bitewings - two films (limit 2 every 12 months).....	\$0.00
D0273	Bitewings - three films (limit 2 every 12 months) .....	\$0.00
D0274	Bitewings - four films (limit 2 every 12 months) .....	\$0.00
D0277	Vertical bitewings - 7 to 8 films (limit 2 every 12 months).....	\$0.00
D0330	Panoramic film (limit 1 every 3 years).....	\$0.00
D0470	Diagnostic casts.....	\$0.00
D1110	Prophylaxis - adult (limit 2 every 12 months, inclusive of D4910).....	\$0.00
D1120	Prophylaxis - child (limit 2 every 12 months, inclusive of D4910).....	\$0.00
D1203	Topical application of fluoride - child (limit 2 every 12 months for child <16).....	\$0.00
D1206	Topical fluoride varnish (limit 2 every 12 months for child <16).....	\$0.00
D1351	Sealant - per tooth (limit 1 per tooth every 12 months for child <14) .....	\$0.00

# AdvantagePlus 2S

ADA CODE	PROCEDURE	PATIENT PAYS
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## Basic Services

D1510	Space maintainer - fixed-unilateral (limited to child <14).....	\$0.00
D1515	Space maintainer - fixed-bilateral (limited to child <14).....	\$0.00
D1520	Space maintainer - removable-unilateral (limited to child <14).....	\$0.00
D1525	Space maintainer - removable-bilateral (limited to child <14) .....	\$0.00
D1550	Recementation of space maintainer .....	\$0.00
D2140	Amalgam - One surface primary or permanent .....	\$0.00
D2150	Amalgam - Two surfaces primary or permanent.....	\$0.00
D2160	Amalgam - Three surfaces primary or permanent .....	\$0.00
D2161	Amalgam – Four or more surfaces primary or permanent .....	\$0.00
D2330	Resin - Based composite - one surface anterior .....	\$0.00
D2331	Resin - Based composite - two surfaces anterior .....	\$0.00
D2332	Resin -Based composite - three surfaces anterior .....	\$0.00
D2335	Resin composite – 4 or more surfaces or involving incisal angle .....	\$0.00
D2390	Resin - Based composite crown anterior .....	\$0.00
D2391	Resin - Based composite - one surface posterior .....	\$0.00
D2392	Resin - Based composite - two surfaces posterior .....	\$0.00
D2393	Resin - Based composite - three surfaces posterior .....	\$0.00
D2394	Resin composite - four or more surfaces posterior .....	\$0.00
D4341	Periodontal scaling and root planing 4 or more teeth - quad (limit 1 per quad every 12 months) .....	\$0.00
D4342	Periodontal scaling and root planing 1-3 teeth - quad (limit 1 per quad every 12 months) .....	\$0.00
D4355	Full mouth debridement enable comprehensive evaluation and diagnosis (limit 1 every 5 years) .....	\$0.00
D4910	Periodontal maintenance (limit 2 every 12 months, inclusive of D1110 and D1120) .....	\$0.00
D7111	Extraction coronal remnants deciduous tooth .....	\$0.00
D7140	Extraction erupted tooth or exposed root .....	\$0.00

## Major Services

D2510	Inlay - metallic - one surface (limit 1 per tooth every 8 years) .....	\$313.00
D2520	Inlay - metallic - two surfaces (limit 1 per tooth every 8 years) .....	\$355.00
D2530	Inlay - metallic - 3 or more surfaces (limit 1 per tooth every 8 years) .....	\$410.00
D2542	Onlay - metallic - two surfaces (limit 1 per tooth every 8 years) .....	\$402.00
D2543	Onlay metallic three surfaces (limit 1 per tooth every 8 years) .....	\$420.00
D2544	Onlay metallic 4 or more surfaces (limit 1 per tooth every 8 years) .....	\$437.00
D2610	Inlay - porcelain/ceramic - one surface (limit 1 per tooth every 8 years) .....	\$368.00
D2620	Inlay - porcelain/ceramic - 2 surfaces (limit 1 per tooth every 8 years) .....	\$389.00
D2630	Inlay - porcelain/ceramic - 3 or more surfaces (limit 1 per tooth every 8 years) .....	\$414.00
D2642	Onlay - porcelain/ceramic - two surfaces (limit 1 per tooth every 8 years) .....	\$403.00
D2643	Onlay - porcelain/ceramic - three surfaces (limit 1 per tooth every 8 years) .....	\$434.00
D2644	Onlay - porcelain/ceramic - 4 or more surfaces (limit 1 per tooth every 8 years) .....	\$461.00
D2650	Inlay - resin based composite - 1 surface (limit 1 per tooth every 8 years) .....	\$242.00
D2651	Inlay - resin based composite - 2 surfaces (limit 1 per tooth every 8 years) .....	\$288.00
D2652	Inlay - resin based composite - 3 or more surfaces (limit 1 per tooth every 8 years) .....	\$303.00
D2662	Onlay - resin based composite - 2 surfaces (limit 1 per tooth every 8 years) .....	\$263.00
D2663	Onlay - resin based composite - 3 surfaces (limit 1 per tooth every 8 years) .....	\$310.00
D2664	Onlay - resin based composite - 4 or more surfaces (limit 1 per tooth every 8 years) .....	\$332.00
D2710	Crown resin based composite indirect (limit 1 per tooth every 8 years) .....	\$187.00
D2720	Crown - resin with high noble metal (limit 1 per tooth every 8 years).....	\$461.00
D2721	Crown - resin with predominantly base metal (limit 1 per tooth every 8 years).....	\$432.00
D2722	Crown - resin with noble metal (limit 1 per tooth every 8 years) .....	\$441.00

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ADA CODE	PROCEDURE	PATIENT PAYS
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**Major Services (continued)**

D2740	Crown - porcelain/ceramic substrate (limit 1 per tooth every 8 years) .....	\$411.00
D2750	Crown - porcelain fused to high noble metal (limit 1 per tooth every 8 years) .....	\$405.00
D2751	Crown - porcelain fused predominantly base metal (limit 1 per tooth every 8 years) .....	\$434.00
D2752	Crown - porcelain fused to noble metal (limit 1 per tooth every 8 years) .....	\$445.00
D2790	Crown - full cast high noble metal (limit 1 per tooth every 8 years) .....	\$450.00
D2791	Crown - full cast predominantly base metal (limit 1 per tooth every 8 years) .....	\$426.00
D2792	Crown - full cast noble metal (limit 1 per tooth every 8 years) .....	\$434.00
D2910	Recement inlay, onlay, or partial coverage restoration .....	\$41.00
D2920	Recement crown .....	\$36.00
D2930	Prefabricated stainless steel crown - primary tooth .....	\$115.00
D2931	Prefabricated stainless steel crown - permanent tooth .....	\$131.00
D2932	Prefabricated resin crown .....	\$142.00
D2940	Protective Restoration .....	\$44.00
D2950	Core buildup including any pins .....	\$94.00
D2951	Pin retention - per tooth in addition to restoration .....	\$23.00
D2952	Cast post and core in addition to crown .....	\$168.00
D2954	Prefabricated post and core in addition to crown .....	\$139.00
D3220	Therapeutic pulpotomy - remove pulp coronal dentinocementl junction .....	\$75.00
D3310	Anterior root canal .....	\$315.00
D3320	Bicuspid root canal .....	\$385.00
D3330	Molar root canal .....	\$428.00
D3346	Retreatment previous root canal therapy - anterior .....	\$424.00
D3347	Retreatment previous root canal therapy - bicuspid .....	\$500.00
D3348	Retreatment previous root canal therapy - molar .....	\$601.00
D3410	Apicoectomy/Periradicular surgery - anterior .....	\$361.00
D3421	Apicoectomy/Periradicular surgery - bicuspid .....	\$394.00
D3425	Apicoectomy/Periradicular surgery - molar .....	\$445.00
D3426	Apicoectomy/Periradicular surgery .....	\$148.00
D3430	Retrograde filling - per root .....	\$109.00
D4210	Gingivectomy or Gingivoplasty 4 or more contiguous or bound teeth spaces – quad (limit 1 every 12 months) .....	\$278.00
D4211	Gingivectomy or Gingivoplasty 1-3 contiguous or bound teeth space-quad (limit 1 every 12 months) .....	\$153.00
D4240	Gingival flap procedure 4 or more contiguous or bound teeth space – quad (limit 1 every 12 months) .....	\$421.00
D4241	Gingival flap procedure 1-3 contiguous or bound teeth space - quad (limit 1 every 12 months) .....	\$217.00
D4249	Clinical crown lengthening - hard tissue.....	\$481.00
D4260	Osseous surgery 4 or more contiguous or bound teeth spaces - quad .....	\$680.00
D4261	Osseous surgery 1-3 contiguous or bound teeth spaces - quad .....	\$354.00
D5110	Complete denture - maxillary (limit 1 every 5 years) .....	\$498.00
D5120	Complete denture - mandibular (limit 1 every 5 years) .....	\$642.00
D5130	Immediate denture - maxillary (limit 1 every 5 years) .....	\$700.00
D5140	Immediate denture - mandibular (limit 1 every 5 years) .....	\$700.00
D5211	Maxillary partial denture - resin base (limit 1 every 5 years) .....	\$542.00
D5212	Mandibular partial denture - resin base (limit 1 every 5 years) .....	\$629.00
D5213	Maxillary partial denture - cast metal framework with resin base (limit 1 every 5 years) .....	\$709.00
D5214	Mandibular partial denture - cast metal framework with resin base (limit 1 every 5 years) .....	\$709.00
D5410	Adjust complete denture - maxillary (limit 1 every 12 months) .....	\$35.00

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ADA CODE	PROCEDURE	PATIENT PAYS
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**Major Services (continued)**

D5411	Adjust complete denture - mandibular (limit 1 every 12 months) .....	\$35.00
D5421	Adjust partial denture - maxillary (limit 1 every 12 months) .....	\$35.00
D5422	Adjust partial denture - mandibular (limit 1 every 12 months) .....	\$35.00
D5510	Repair broken complete denture base .....	\$70.00
D5520	Replace missing or broken teeth - complete denture .....	\$59.00
D5610	Repair resin denture base .....	\$76.00
D5620	Repair cast framework .....	\$82.00
D5630	Repair or replace broken clasp .....	\$100.00
D5640	Replace broken teeth - per tooth .....	\$64.00
D5650	Add tooth to existing partial denture .....	\$88.00
D5660	Add clasp to existing partial denture .....	\$105.00
D5710	Rebase complete maxillary denture (limit 1 every 3 years) .....	\$261.00
D5711	Rebase complete mandibular denture (limit 1 every 3 years) .....	\$249.00
D5720	Rebase maxillary partial denture (limit 1 every 3 years) .....	\$246.00
D5721	Rebase mandibular partial denture (limit 1 every 3 years) .....	\$246.00
D5730	Reline complete maxillary denture (limit 1 every 3 years) .....	\$147.00
D5731	Reline complete mandibular denture (limit 1 every 3 years) .....	\$147.00
D5740	Reline maxillary partial denture (limit 1 every 3 years) .....	\$135.00
D5741	Reline mandibular partial denture (limit 1 every 3 years) .....	\$135.00
D5750	Reline complete maxillary denture (limit 1 every 3 years) .....	\$196.00
D5751	Reline complete mandibular denture (limit 1 every 3 years) .....	\$196.00
D5760	Reline maxillary partial denture (limit 1 every 3 years) .....	\$193.00
D5761	Reline mandibular partial denture (limit 1 every 3 years) .....	\$193.00
D5850	Tissue conditioning maxillary.....	\$61.00
D5851	Tissue conditioning mandibular .....	\$61.00
D6092	Recement implant or abutment supported crown .....	\$42.00
D6093	Recement implant or abutment supported fixed partial denture .....	\$57.00
D6210	Pontic - cast high noble metal (limit 1 every 8 years).....	\$378.00
D6211	Pontic - cast predominantly base metal (limit 1 every 8 years) .....	\$404.00
D6212	Pontic - cast noble metal (limit 1 every 8 years) .....	\$420.00
D6240	Pontic - porcelain fused to high noble metal (limit 1 every 8 years) .....	\$426.00
D6241	Pontic - porcelain fused predominantly base metal (limit 1 every 8 years) .....	\$393.00
D6242	Pontic - porcelain fused to noble metal (limit 1 every 8 years) .....	\$415.00
D6245	Pontic - porcelain/ceramic .....	\$439.00
D6250	Pontic - resin with high noble metal (limit 1 every 8 years) .....	\$420.00
D6251	Pontic - resin with predominantly base metal (limit 1 every 8 years) .....	\$388.00
D6252	Pontic - resin with noble metal (limit 1 every 8 years) .....	\$400.00
D6600	Inlay - porcelain/Ceramic two surfaces (limit 1 every 8 years) .....	\$355.00
D6601	Inlay - porcelain/ceramic 3 or more surfaces (limit 1 every 8 years) .....	\$373.00
D6602	Inlay - cast high noble metal two surfaces (limit 1 every 8 years) .....	\$380.00
D6603	Inlay - cast high noble metal 3 or more surfaces (limit 1 every 8 years) .....	\$418.00
D6604	Inlay - cast predominantly base metal 2 surfaces (limit 1 every 8 years) .....	\$372.00
D6605	Inlay - cast predominantly base metal 3 or more surfaces (limit 1 every 8 years) .....	\$394.00
D6606	Inlay - cast noble metal two surfaces (limit 1 every 8 years) .....	\$366.00
D6607	Inlay - cast noble metal 3 or more surfaces (limit 1 every 8 years) .....	\$406.00
D6608	Onlay - porcelain/ceramic two surfaces (limit 1 every 8 years) .....	\$386.00
D6609	Onlay - porcelain/ceramic 3 or more surfaces (limit 1 every 8 years) .....	\$403.00
D6610	Onlay - cast high noble metal two surfaces (limit 1 every 8 years) .....	\$409.00
D6611	Onlay - cast high noble metal 3 or more surfaces (limit 1 every 8 years) .....	\$448.00
D6612	Onlay - cast predominantly base metal 2 surfaces (limit 1 every 8 years) .....	\$407.00
D6613	Onlay - cast predominantly base metal 3 or more surfaces (limit 1 every 8 years).....	\$426.00

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## Major Services (continued)

D6614	Onlay - cast noble metal two surfaces (limit 1 every 8 years) .....	\$399.00
D6615	Onlay - cast noble metal 3 or more surfaces (limit 1 every 8 years) .....	\$414.00
D6720	Crown resin with high noble metal (limit 1 every 8 years) .....	\$474.00
D6721	Crown resin with predominantly base metal-denture (limit 1 every 8 years).....	\$450.00
D6722	Crown resin with noble metal (limit 1 every 8 years) .....	\$458.00
D6740	Crown porcelain/ceramic (limit 1 every 8 years) .....	\$499.00
D6750	Crown porcelain fused to high noble metal-denture (limit 1 every 8 years) .....	\$426.00
D6751	Crown porcelain fused predominantly base metal (limit 1 every 8 years) .....	\$453.00
D6752	Crown porcelain fused to noble metal (limit 1 every 8 years) .....	\$464.00
D6780	Crown - cast high noble metal (limit 1 every 8 years) .....	\$458.00
D6790	Crown full cast high noble metal-denture (limit 1 every 8 years) .....	\$469.00
D6791	Crown full cast predominantly base metal-denture (limit 1 every 8 years) .....	\$445.00
D6792	Crown full cast noble metal-denture (limit 1 every 8 years) .....	\$461.00
D6930	Recement fixed partial denture (limit 1 every 5 years) .....	\$57.00
D6970	Cast post and core add fixed partial denture retainer (limit 1 every 8 years) .....	\$157.00
D6972	Prefabricated post and core add fixed partial denture retainer (limit 1 every 8 years) ...	\$128.00
D6973	Core build up for retainer including any pins (limit 1 every 8 years).....	\$103.00
D7210	Surgical removal erupted tooth removal of bone and/or sectioning of tooth .....	\$91.00
D7220	Removal of impacted tooth - soft tissue .....	\$135.00
D7230	Removal of impacted tooth - partially bony .....	\$179.00
D7240	Removal of impacted tooth - completely bony .....	\$211.00
D7241	Removal impacted tooth - completely bony with unusual surgical complications .....	\$265.00
D7250	Surgical removal of residual tooth roots.....	\$114.00
D7310	Alveoloplasty conjunction with extractions - per quadrant .....	\$125.00
D7311	Alveoloplasty conjunction with extractions 1-3 teeth or spaces quad .....	\$97.00
D7320	Alveoloplasty not in conjunction with extractions - quad .....	\$181.00
D7321	Alveoloplasty not conjunction extractions 1-3 teeth or space quad .....	\$153.00
D7510	Incision and drainage abscess - intraoral soft tissue .....	\$120.00
D7520	Incision and drainage abscess - extraoral soft tissue .....	\$570.00
D7960	Frenulectomy separate procedure not incidental to another procedure.....	\$111.00
D7970	Excision of hyperplastic tissue - per arch (limit 1 every 8 years) .....	\$272.00
D9110	Palliative treatment dental pain - minor procedure .....	\$45.00
D9215	Local anesthesia in conjunction with operative or surgical procedures .....	\$0.00
D9241	IV conscious sedation/analgesia - 1st 30 minutes .....	\$144.00
D9242	IV conscious sedation/analgesia - each additional 15 minutes .....	\$60.00
D9310	Professional consultation by non-treating dentist .....	\$0.00
D9951	Occlusal adjustment - limited .....	\$58.00
D9952	Occlusal adjustment - complete .....	\$326.00

## Ortho 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 .....	\$0.00
Evaluation .....	\$35.00
Records/Treatment Planning .....	\$250.00
Orthodontic treatment .....	\$2,100.00



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**Ortho Services (continued)**

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 .....	\$0.00
	Evaluation.....	\$35.00
	Records/Treatment Planning .....	\$250.00
	Orthodontic treatment .....	\$2,300.00
D8680	Retention .....	\$450.00

**NOTE:**

1. Your Participating General Dentist and Participating Specialist office visit co-payment amounts, if applicable, are shown on your I.D. card. Your office visit co-payment is applicable for all dates of service and is in addition to the co-payment amounts listed for Covered Dental Care Services.
2. Not all Participating Dentists perform all listed procedures, including amalgams. Please consult your dentist prior to treatment for availability of services.
3. Additional exclusions and limitations are listed along with full plan information in your Certificate of Benefits.

**LIMITATIONS AND EXCLUSIONS**

1. Major restorative services will be subject to the following:
  - a. denture, removable partial denture, or fixed partial denture must replace a natural tooth extracted while covered under this Certificate, however, this provision will not apply if the Contract replaces a prior group dental policy under which you were covered, and you are covered by this Certificate on the effective date of the Contract without a break in coverage, provided: a) the prosthetic replaces teeth that were extracted while insured under the prior policy; and b) the prosthetic work is completed within 12 months of the extraction;
  - b. the replacement of a partial denture, full denture, or the addition of teeth to a partial denture if: (i) replacement occurs at least five years after the initial date of insertion of the current full or partial denture or resin bonded bridge; (ii) replacement occurs at least five years after the initial date of insertion of an existing implant or fixed bridge; (iii) replacement prosthesis or the addition of a tooth to a partial denture is required by the necessary extraction of a functioning natural tooth while covered under this Certificate; or (iv) replacement is made necessary by a Covered Dental Injury to a partial denture, full denture, or fixed partial denture (including a resin bonded bridge) provided the replacement is completed within 12 months of the injury;
  - c. the replacement of crowns, cast restorations, in-lays, onlays, fixed partial dentures or other laboratory prepared restorations only if: (i) replacement occurs at least eight years after the initial date of insertion; and (ii) they are not serviceable and cannot be restored to function;
  - d. the replacement of an existing partial denture with fixed bridgework, only if upgrading to fixed bridgework is essential to the correction of the person's dental condition;
  - e. the replacement of teeth up to the normal complement of 32; and
  - f. denture adjustments are limited to once every twelve (12) months starting twelve (12) months after placement.

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2. 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 B of this Certificate.
3. Whenever any Contributions or Copayments are delinquent, Member will not be entitled to receive Benefits, or enjoy any of the other privileges of a Member in good standing.
4. Orthodontic treatment, if a Covered Dental Care Service as shown in the Member's Schedule of Benefits, is limited to one twenty-four (24) month course of treatment.
5. Only one (1) periapical radiograph is an allowed benefit for root canal treatment.
6. The total number of periodontal maintenance and all other prophylaxis treatments combined are limited to two (2) per member every twelve (12) months.
7. Company does not provide coverage for the following services:
  - a. Pharmaceuticals, drugs or medications.
  - b. Services which in the opinion of the Participating General Dentist, Participating Specialist or Company are (a) not necessary; (b) not appropriate for the given condition or not customarily used for dental care; (c) do not have uniform professional endorsement or do not meet the standards set by the American Dental Association; (d) experimental or investigational in nature; (e) for which the Member has no legal obligation to pay; or (f) for which a charge would have been made in the absence of insurance.
  - c. 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.
  - d. 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.
  - e. Any dental treatment started prior to the Member's effective date for eligibility of benefits.
  - f. Services for injuries and conditions which are covered under Workers' Compensation or Employers' Liability laws, or that arises out of or in the course of a job or employment for pay or profit.
  - g. Treatment for cysts, neoplasms and malignancies.
  - h. General anesthesia, IV sedation, and nitrous oxide, unless it is specifically listed on the Schedule of Benefits. When listed on the Schedule of Benefits, general anesthesia and IV sedation are covered only when medically necessary and provided in conjunction with other Covered Dental Services and performed by an Oral Surgeon, Periodontist, or Pediatric Dentist. The following rationales are not eligible for benefits: 1) pain control, unless documented allergy to local anesthetic; 2) anxiety; 3) fear of pain; 4) pain management; or 5) emotional inability to undergo surgery.
  - i. Any procedure, service, or supply which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least three years, as determined by Company.
  - j. Crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth which may be restored with an amalgam or composite resin filling.
  - k. Appliances, inlays, cast restorations or other laboratory prepared restorations used primarily for the purpose of splinting.
  - l. Any procedure, service, supply or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension; the alteration or restoration of occlusion including occlusal adjustment, bite restoration, or bite analysis.
  - m. Adult fluoride treatments, athletic mouth guards, myofunctional therapy, infection control, precision or semi-precision attachments, denture duplication, oral hygiene instructions, radiograph duplication charges for claim submission, separate charges for acid etching, completion of claim fees, equipment or technology fees, exams required by third party, personal supplies (water pik, toothbrush, floss holder, etc.), or replacement of lost or stolen appliances.

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- n. Any procedure, service or supply required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joints or their associated structures.
- o. Procedures that are a covered expense under any other medical plan (established by the employer) which provides group hospital, surgical, or medical benefits whether or not on an insured basis.
- p. Extraction of asymptomatic third molars, including extraction of erupted third molars for orthodontics.
- q. Cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance). Facings on crowns or fixed partial dentures on molar teeth will always be considered cosmetic.
- r. Dental implants and related services.
- s. Restoration of teeth that have been damaged by attrition, abrasion, or erosion.
- t. Resin bonded bridges, including associated retainers and pontics.
- u. Charges for travel time, transportation costs, or professional advice given on the phone.
- v. Procedures performed by a dentist who is a member of Your immediate family.
- w. Any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility.
- x. Any charges related to the review of any diagnostic biopsy, material, or specimens submitted to a pathologist, or pathology lab, for histological review.
- y. Charges for treatment rendered; (a) in a clinic, dental or medical facility sponsored or maintained by the employer of any Member; or (b) by an employee of any Member.
- z. Charges for treatment performed outside the United States other than for emergency treatment. Benefits for emergency treatment that is performed outside the United States is limited to \$100 (US dollars) per year.
- aa. Dental services required while serving in the armed forces, or the care or treatment of an injury or sickness due to war or an act of war, declared or undeclared.

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*The CompBenefits Family of Companies*

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## **Notices**

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

**This section includes notices about:**

**Claim procedures**

**Federal legislation**

**Medical child support orders**

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

**General notice of COBRA continuation of coverage rights**

**Family and Medical Leave Act (FMLA)**

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

**Your Rights under ERISA**

**Discrimination Notice**

## **Claim procedures**

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

## **Discretionary authority**

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

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

## Claim procedures

### Definitions

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

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

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

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

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

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

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

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

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

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

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

## **Submitting a claim**

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

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

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

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

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

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

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

## **Procedural defects**

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

## Authorized representatives

A covered person may designate an authorized representative to act on his or her behalf in pursuing a benefit claim or appeal. The authorization must be in writing and authorize disclosure of health information. If a document is not sufficient to constitute designation of an authorized representative, as determined by Humana, the plan will not consider a designation to have been made. An assignment of benefits does not constitute designation of an authorized representative.

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

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

## Claims decisions

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

### *Pre-service claims*

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

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

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

### *Urgent-care claims (expedited review)*

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

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



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

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

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

### ***Concurrent-care decisions***

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

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

### ***Post-service claims***

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

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

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

### **Initial denial notices**

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

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

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

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

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

## **Appeals of Adverse determinations**

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

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

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

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

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

## Time periods for decisions on appeal

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

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

## Appeals denial notices

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

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

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

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

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

### **Exhaustion of remedies**

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

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

### **Legal actions and limitations**

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

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

### **Medical child support orders**

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

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

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

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

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

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

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

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

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

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

## **General notice of COBRA continuation coverage rights**

### **Introduction**

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

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

### **What is COBRA continuation coverage?**

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

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

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

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

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

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

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

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

### **When is COBRA coverage available?**

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

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

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

### **How is COBRA Coverage Provided?**

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

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

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

## **Disability extension of 18-month period of**

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

## **Second qualifying event extension of 18-month period of**

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

## **If You Have Questions**

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

## **Keep your plan informed of address changes**

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

## **Plan contact information:**

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

## **Family and Medical Leave Act (FMLA)**

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

## **Uniformed Services Employment and Reemployment Rights Act of 1994**

### ***Continuation of benefits***

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

### ***Eligibility***

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

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

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

### ***Duration of coverage***

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

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

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

### ***Other information***

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

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

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



## **Information about the plan and benefits**

Plan participants may:

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

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

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

## **Responsibilities of plan fiduciaries**

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

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

## **Continue group health plan coverage**

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

## **Claims determinations**

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

## **Enforce your rights**

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

- if a participant requests a copy of plan documents and does not receive them within 30 days, the participant may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$ 110 a day until the participant receives the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator;

- if a claim for benefits is denied or disregarded, in whole or in part, the participant may file suit in a state or Federal court;
- if the participant disagrees with the plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, the participant may file suit in Federal court;
- if plan fiduciaries misuse the plan's money, or if participants are discriminated against for asserting their rights, they may seek assistance from the U.S. Department of Labor, or may file suit in a Federal court.

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

### **Assistance with questions**

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

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

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

## **Discrimination is Against the Law**

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion.

Humana Inc. and its subsidiaries provide:

- Free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.
- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call the number on your ID card or if you use a TTY, call 711.

If you believe that Humana Inc. and its subsidiaries have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion, you can file a grievance with:

Discrimination Grievances  
P.O. Box 14618  
Lexington, KY 40512-4618

If you need help filing a grievance, call the number on your ID card or if you use a TTY, call 711.

You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

### **U.S. Department of Health and Human Services**

200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201

**1-800-368-1019, 800-537-7697 (TDD)**

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

# Multi-Language Interpreter Services

**English:** ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call the number on your ID card (TTY: 711).

**Español (Spanish):** ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que figura en su tarjeta de identificación (TTY: 711).

**繁體中文 (Chinese):** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電會員卡上的電話號碼 (TTY: 711)。

**Tiếng Việt (Vietnamese):** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số điện thoại ghi trên thẻ ID của quý vị (TTY: 711).

**한국어 (Korean):** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. ID 카드에 적혀 있는 번호로 전화해 주십시오 (TTY: 711).

**Tagalog (Tagalog – Filipino):** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tawagan ang numero na nasa iyong ID card (TTY: 711).

**Русский (Russian):** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Наберите номер, указанный на вашей карточке-удостоверении (телетайп: 711).

**Kreyòl Ayisyen (French Creole):** ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele nimewo ki sou kat idantite manm ou (TTY: 711).

**Français (French):** ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le numéro figurant sur votre carte de membre (ATS : 711).

**Polski (Polish):** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Proszę zadzwonić pod numer podany na karcie identyfikacyjnej (TTY: 711).

**Português (Portuguese):** ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para o número presente em seu cartão de identificação (TTY: 711).

**Italiano (Italian):** ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero che appare sulla tessera identificativa (TTY: 711).

**Deutsch (German):** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Wählen Sie die Nummer, die sich auf Ihrer Versicherungskarte befindet (TTY: 711).

**日本語 (Japanese):** 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。お手持ちの ID カードに記載されている電話番号までご連絡ください (TTY: 711)。

**فارسی (Farsi):**

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد با شماره تلفن روی کارت شناسایی تان تماس بگیرید (TTY: 711).

**Diné Bizaad (Navajo):** Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, námboo ninaaltsoos yézhí, bee nées ho'dólzin bikáá'ígíí bee hólne' (TTY: 711).

**العربية (Arabic):**

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم الهاتف الموجود على بطاقة الهوية الخاصة بك (رقم هاتف الصم والبكم: 711).