Employer:  
FLOYD COUNTY GOVERNMENT

Group Number: 671728

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Dental Plan
Certificate of Insurance
HumanaDental Insurance Company

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

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

**Benefits**
- Summary of your benefits ................................................................. 3
- Waiting periods .................................................................................. 5
- Your plan benefits .............................................................................. 6
- Limitations and exclusions (all services) ........................................... 11
- How your plan works ......................................................................... 14

**Claims**
- How we pay claims .......................................................................... 16
- Coordinating benefits with another insurer ..................................... 19
- Recovery rights .................................................................................. 22

**Eligibility**
- When you are eligible for coverage .................................................. 24
- Terminating coverage ........................................................................ 29
- Replacement provisions ..................................................................... 30

**Disclosures**
- Discount/access disclosure ................................................................. 31

**Shared Savings**
- Shared savings program .................................................................... 32

**Definitions** ....................................................................................... 33

(Kept words within text are defined in the Definitions section of this document.)
Policyholder (Employer): FLOYD COUNTY GOVERNMENT
Group Number: 671728
Coverage Effective Date: 01/01/2019

Summary of your benefits
This summary provides an overview of plan benefits. Refer to the Your plan benefits and Waiting periods provisions for detailed descriptions, including additional limitations or exclusions. Paid benefits are based on the reimbursement limit.

Dental benefits

Individual maximum benefit:
$2,000 per year per member for Preventive, Basic and Major services.

Individual deductible:
$50 per year per member for Basic and Major services.

Maximum family deductible:
Covered expenses applied to the plan deductible of each covered member are combined to a year maximum of $150.

Preventive Services:
Benefits are paid at 100%.
1. Routine teeth cleaning (prophylaxis)
2. Topical fluoride treatment
3. Sealants
4. X-rays
5. Oral examinations

Basic Services:
Benefits are paid at 80% after the deductible.
1. Fillings (amalgam and composite restorations)
2. Non-surgical extractions
3. Non-surgical residual root removal
4. Non-cast prefabricated crowns
5. Emergency exam and palliative care for pain relief
6. Space maintainers
7. Harmful habits and thumb-sucking appliances
8. Periodontics (gum disease)
9. Endodontics (root canals)
**Benefits**

**Major Services:**
Benefits are paid at 50% after the *deductible*.

1. Crowns
2. Inlays and onlays
3. Removable or fixed bridgework
4. Partial or complete dentures
5. Denture relines or rebases
6. Partial and denture repairs and adjustments
7. Oral Surgery
**Benefits**

**Waiting periods**

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

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

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

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

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

**Preventive Services:**
No waiting periods apply to Preventive services.

**Basic Services:**
No waiting periods apply to Basic services, unless the member is a late applicant.
If a member is a late applicant, he or she must be insured under this policy for a period of 12 continuous months before Basic services will be covered.

**Major Services:**
For Major Services, coverage is effective as follows:

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

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

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

For a late applicant added after the group's effective date under this policy, he or she MUST be insured under this policy for a period of 12 consecutive months before Major services will be covered.
Benefits

Your plan benefits

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

Preventive services

1. Oral evaluations (periodic, limited, comprehensive and problem focused) - two per year.
2. Periodontal evaluations - two per year.
3. Cleaning (prophylaxis), including all scaling and polishing procedures – two per year.
4. For members age 40 and older, oral cancer screening – one per year.
5. Intra-oral complete series X-rays (at least 14 films, including bitewings), or panoramic X-rays – once every five years. If the total cost of periapical and bitewing X-rays exceeds the cost of a complete series of X-rays, the plan will consider these as a complete series.
6. Bitewing X-rays – one set per year.
7. Other X-rays – only to diagnose specific treatment.
8. Topical fluoride treatment – provided to dependents age 14 and younger. Service is payable once per year.
9. Sealants – application provided to dependents age 14 and younger to the occlusal surface of permanent molars that are free of decay and restorations. Service is payable once per tooth per lifetime.

We will not cover preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.

Basic services

1. Amalgam restorations (fillings) – limited to one per tooth in a two year period. Multiple restorations on one surface are considered one restoration.
2. Composite restorations (fillings) limited to one per tooth in a two year period. On anterior teeth – Composite restorations on molar and bicuspid teeth are considered an alternate service and will be payable as a comparable amalgam filling. You will be responsible for the remaining expense incurred. Multiple restorations on one surface are considered one restoration.
3. Recementing of inlays, onlays, crowns and bridges.
4. Non-cast pre-fabricated crowns – service on primary teeth that cannot be adequately restored with amalgam or composite restorations.
Benefits

5. Space maintainers for retaining space when a primary tooth is prematurely lost. *Services* are payable only for dependents age 14 and younger for the installation of the initial appliance. Separate adjustment expenses will not be covered.

6. Fixed and removable appliances to inhibit thumb sucking and other harmful habits. *Services* are payable only for dependents age 14 and younger for the installation of the initial appliance. Separate adjustment expenses will not be covered.

7. *Emergency* care – treatment for the initial *palliative* care of pain and/or injury. *Services* include *palliative* procedures for treatment to the teeth and supporting structures. We will consider the *service* as a separate *benefit* only if no other *service*, except X-rays, is provided during the same visit.

**Simple oral surgery services**

1. Extraction - coronal remnants of a deciduous tooth.

2. Extraction - erupted tooth or exposed root.

**Periodontic services**

1. Periodontal scaling and root planing, available at a maximum of once per quadrant in a three-year period.

2. Scaling in presence of generalized moderate or severe gingival inflammation available based on *clinical review* a maximum of once a year. This service will reduce the number of routine cleanings available (under #3 in Preventive Services) so the total number of cleanings does not exceed two in a year per person.

3. Periodontal maintenance (following periodontal therapy) – procedure available twice per year.

4. Periodontal surgery, available at a maximum of once per quadrant in a three-year period. If more than one surgical *service* is performed on the same day, *we* will consider only the most inclusive *service* performed as a *covered service*.

5. Occlusal adjustments when performed in conjunction with periodontal surgery – available at a maximum of once per quadrant in a three-year period.

Separate fees for pre and post operative care and re-evaluation within three months are not covered.

**Endodontic services**

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

2. Apicoectomy - procedure available for permanent teeth only.

3. Partial pulpotomy for apexogenesis – procedure available for permanent teeth only.

4. Vital pulpotomy – procedure available for deciduous (baby) teeth only.

**Major/Prosthodontic services**

1. Repairs of bridges; full or partial dentures, and crowns.
2. Denture adjustments – procedure available only for adjustments done by a dentist other than the one providing the denture, or adjustments performed more than six months after initial installation.

3. Initial placement of laboratory-fabricated restorations when the tooth, as a result of extensive decay or traumatic injury, cannot be restored with a direct placement filling material. Covered services include inlays, onlays, crowns, veneers, core build-ups and posts. These services are covered only on permanent teeth. We will not cover the expense incurred for pin retention when done in conjunction with core build-up.

4. Initial placement of bridges, and full and partial dentures only if the functioning tooth (excluding third molars or teeth not fully in occlusion with an opposing tooth or prosthesis) was extracted while you are covered under this plan. Covered expense includes fixed bridges, removable partial dentures and full dentures. Services include all adjustments and relines within six months after installation and are payable only for treatment on permanent teeth. We will not cover replacement of congenitally missing teeth.

5. Replacement of bridges, partials, dentures, inlays, onlays, crowns or other laboratory-fabricated restorations. The existing major restoration or prosthesis can be replaced only if:

- It has been at least five years since the prior insertion and is not, and can not be made, serviceable;
- It is damaged beyond repair as a result of an accidental injury (non-chewing injury) while in the oral cavity; or
- Extraction of functioning teeth, excluding third molars or teeth not fully in occlusion with an opposing tooth or prosthesis, necessitates the replacement of the prosthesis.

These services are covered only on permanent teeth.

6. Denture relines or rebases – once in a three-year period.

We will not cover the replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
**Benefits**

**Complex oral surgery services**
1. Surgical extractions.

2. Bone Smoothing.

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

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

5. Surgical access of an erupted tooth.

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

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

8. Bone, cartilage, or synthetic grafts.

9. General anesthesia when medically necessary and administered by a dentist in conjunction with a covered oral surgical procedure.

No benefit is payable for:

1. Any services for orthognathic surgery.

2. Any services for destruction of lesions by any method.

3. Any services for tooth transplantation.

4. Any services for removal of a foreign body from the oral tissue or bone.

5. Any services for reconstruction of surgical, traumatic, or congenital defects of the facial bones.

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

7. Any services generally considered to be medical services.

8. Any separate fees for pre and post operative services.
Integral service
The following services are considered integral to the dental service. A separate fee for these services is not considered a covered expense.

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

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

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

General anesthesia is not a covered expense unless it is a medical necessity and administered by a dentist in conjunction with covered oral surgical procedures outlined in this section. Patient management or apprehension is not considered a medical necessity.
Limitations & exclusions (all services)
In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide benefits for the following:

1. Any expenses incurred while you qualify for any worker’s compensation or occupational disease act or law, whether or not you applied for coverage.

2. Services:
   - That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
   - Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
   - Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.

3. Any loss caused or contributed by:
   - War or any act of war, whether declared or not;
   - Any act of international armed conflict; or
   - Any conflict involving armed forces of any international authority.

4. Any expense arising from the completion of forms.

5. Your failure to keep an appointment with the dentist.

6. Any service we consider cosmetic dentistry unless it is necessary as a result of an accidental injury sustained while you are covered under this policy. We consider the following cosmetic dentistry procedures:
   - Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid;
   - Any service to correct congenital malformation;
   - Any service performed primarily to improve appearance; or
   - Characterizations and personalization of prosthetic devices.

7. Charges for:
   - Any type of implant and all related services, including crowns or the prosthetic device attached to it;
   - Precision or semi-precision attachments;
   - Overdentures and any endodontic treatment associated with overdentures;
   - Other customized attachments.
8. Any service related to:
   • Altering vertical dimension of teeth;
   • Restoration or maintenance of occlusion;
   • Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth;
   • Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
   • Bite registration or bite analysis.

9. Infection control, including but not limited to sterilization techniques.

10. Fees for treatment performed by someone other than a dentist except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards.

11. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.

12. Prescription drugs or pre-medications, whether dispensed or prescribed.

13. Any service not specifically listed in Your plan benefits.

14. Any service that we determine:
   • Is not a dental necessity;
   • Does not offer a favorable prognosis;
   • Does not have uniform professional endorsement; or
   • Is deemed to be experimental or investigational in nature.

15. Orthodontic services unless specified in your Summary of your benefits.

16. Any expense incurred before your effective date or after the date your coverage under this policy terminates (unless the service is eligible under Extension of benefits).

17. Services provided by someone who ordinarily lives in your home or who is a family member.

18. Charges exceeding the reimbursement limit for the service.

19. Treatment resulting from any intentionally self-inflicted injury or bodily illness.

20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, temporary dental services, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are considered an integral part of the entire dental service.

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

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

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

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

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

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

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

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

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

Alternate services
If two or more services are acceptable to correct a dental condition, we will base the benefits payable on the covered expenses for the least expensive covered service that produces a professionally satisfactory result, as determined by us. We will pay up to the reimbursement limit for the least costly covered service and subject to any deductible, coinsurance and maximum benefit. You will be responsible for paying the excess amount.
If you or your dentist decide on a more costly treatment than we determine to be satisfactory for treatment of the condition, payment will be limited to the reimbursement limit and will be subject to any deductible and coinsurance for the least costly treatment. You will be responsible for the remaining expense incurred.

**Pretreatment plan**

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

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

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

An estimate for services is not necessary for emergency care.

**Process and timing**

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

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

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

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

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

1. A complete dental chart showing:
   - Extractions;
   - Missing teeth;
   - Fillings;
   - Prosthesis;
   - Periodontal pocket depths;
   - Dates of previously performed work.

2. An itemized bill for all dental work.
3. The following exhibits:
   - X-rays;
   - Study models;
   - Laboratory and/or reports;
   - Patient records.

4. Authorizations to release any additional dental information or records.
5. Information about other insurance coverage.
6. Any information we need to determine benefits.

If you do not provide us with the necessary information, we will deny any related claims until you provide it to us.
Paying claims
We determine if benefits are available and pay promptly any amount due under this policy in the timeframe required by state law or by dentist contract. We may pay all or a portion of any benefit provided for covered expenses to the dentist unless you have notified us in writing by the time the claim form is submitted. Our payments are made in good faith and will fully discharge us of any liability to the extent of such payment.

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

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

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

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

1. Not a covered benefit: The service is not a covered service under the certificate.

2. Eligibility: You no longer are eligible under the Terminating coverage section of this certificate, or the expense incurred date was prior to your effective date.

3. Fraud: You make an intentional misrepresentation by not telling us the facts or withhold information necessary for us to administer this certificate.

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

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

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

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

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

**Legal actions**

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

**Claims paid incorrectly**

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

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

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

Benefits subject to this provision

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

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

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

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

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

Effect on benefits

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

All other plans are called secondary plans. The secondary plan may reduce the benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100 percent of the total allowable expense.
Order of benefit determination
To pay claims, it must be determined which plan is primary and which plan(s) is/are secondary. A plan will pay benefits first if it meets one of the following conditions:

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

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

3. In the case of dependent children covered under the plans of divorced or separated parents, the following rules apply:
   - The plan of a parent who has custody will pay benefits first.
   - The plan of a stepparent who has custody will pay benefits next.
   - The plan of a parent who does not have custody will pay benefits next.
   - The plan of a stepparent who does not have custody will pay benefits next.

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

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

If rules 1-4 do not determine the primary plan, the plan covering the person for the longest time is the primary plan. If it still cannot be determined which plan is the primary plan, we will waive the above rules and incorporate the rules identical with those of the other plan.

Coordinating benefits with Medicare
Coordinating benefits with Medicare will conform to federal statutes and regulations in all instances.

If you are eligible for Medicare benefits, whether enrolled or not, your benefits under this plan will be coordinated to the extent benefits are paid or would have been payable under Medicare as allowed by federal statutes and regulations. Medicare means Title XVIII, Parts A and B, of the Social Security Act, as enacted or amended.

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

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

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

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

1. Obtaining our consent before releasing any party from liability for payment of dental expenses.
3. Assisting our enforcement of recovery rights and doing nothing to prejudice our recovery rights.
4. Refraining from designating all (or any disproportionate part) of any recovery as exclusively for “pain and suffering.”

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

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

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

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

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

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

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

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

The recovery rights will be applied even though:

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

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

Definitions
The following terms are used in this section:

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

**Special enrollment date** means:

- The date of change in family status after the initial eligibility date as follows:
  - Date of marriage;
  - Date of divorce;
  - Date specified in a Qualified Medical Child Support Order (QMCSO);
  - Date specified in a National Medical Support Notice (NMSN);
  - Date of birth of a natural born child; or
  - Date of adoption of a child or date of placement of a child with the employee for the purpose of adoption; or

- The date of termination of coverage under a group dental plan or other dental insurance coverage, as specified under the "Special Enrollment" provision.

Eligibility date

**Employee eligibility date**

The employee is eligible for coverage on the date:

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

**Dependent eligibility date**

Each dependent is eligible for coverage on:

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

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

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

Employee enrollment

The employee must enroll as agreed by the policyholder and us. Depending on the total number of employees covered by the employer's policy, we may require any employee to provide evidence of health status whenever enrolling as permitted by laws, rules, or regulations.

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

Dependent enrollment

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

Depending on the total number of employees covered by the employer's policy, we may require any dependent to provide evidence of health status whenever enrolling as permitted by laws, rules, or regulations.

A dependent enrolled more than 31 days after the dependent's eligibility date or the special enrollment date will be a late applicant.

Adopted dependent enrollment

An adopted dependent will be covered automatically from the date of adoption, or placement of the child in the employee's home for the purpose of adoption, whichever occurs first, for 31 days.

An employee who already has dependent child coverage in force prior to a date of an adoption of a dependent, or placement of a dependent in the employee’s home for purpose of adoption, is not required to complete an enrollment form for the child. However, the employee must notify us within 31 days of the adoption or placement if he/she wishes to extend coverage beyond the initial 31 days of coverage.

An employee who does not have dependent child coverage, and wishes to extend coverage of an adopted dependent or a dependent placed with the employee for the purpose of adoption beyond the initial 31-day period, must enroll the dependent, as agreed by the policyholder and us, within 31 days after the date of adoption or placement, and pay any required premium contributions.

A dependent enrolled more than 31 days after the adoption or placement or the special enrollment date will be a late applicant.
Eligibility

Newborn dependent enrollment

An *employee* who already has *dependent* child coverage in force *prior* to the newborn’s date of birth is not required to complete an enrollment form for the newborn child. However, the *employee* must notify *us* of the birth.

An *employee* who does not have *dependent* child coverage must enroll the newborn *dependent*, as agreed by the *policyholder* and *us*, within 31 days after the date of birth.

Newborn dependent effective date

- If *we* receive enrollment on, prior to, or within 2 years of the newborn’s date of birth, *dependent* coverage is effective on the first of the month following receipt of the enrollment.
- If *we* receive enrollment between 2 years and 2 years and 31 days after the newborn’s date of birth, *dependent* coverage is effective on the child’s second birth date.
- If *we* receive enrollment more than 2 years and 31 days after the newborn’s date of birth, the newborn is considered a *late applicant*.

Special Enrollment

Loss of other coverage

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

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

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

Dependent special enrollment period

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

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

Effective date

Employee effective date

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

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

Employee delayed effective date

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

Dependent effective date

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

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

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

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

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

Adopted dependent effective date

- An adopted dependent’s effective date is the date of adoption or placement, whichever occurs first, and providing the adopted dependent is not a late applicant their coverage will continue beyond the initial 31 days of coverage with the date of adoption or placement as the effective date.

- If the adopted dependent is considered a late applicant, the adopted dependent’s new effective date of coverage will be the first of the month following receipt of the enrollment.

Note: Premium is due for any period of adopted dependent coverage whether the adopted dependent is enrolled or not, unless specifically not allowed by applicable law.

Benefit changes

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

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

Retired employee coverage

Retired employee eligibility date

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

Retired employee enrollment

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

Retired employee effective date

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

Retired employee benefit changes

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

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

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

Special provisions for active status

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

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

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

Replacement provisions

Applicability: This provision applies only if:

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

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

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

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

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

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

Teeth extracted prior to effective date: We will not pay for a prosthetic device to replace any teeth lost before you became insured under this plan unless the device also replaces one or more natural teeth lost or extracted after you became insured under this plan.

Modification of policy

This plan may be modified at any time by agreement between us and the policyholder without the consent of any member. Modifications will not be valid unless approved by our president, vice president, secretary or other authorized officer. The approval must be endorsed on, or attached to, the policy. No agent has the authority to modify the policy, waive any of the policy provisions, extend the time for premium payment, make or alter any contract, or waive any of the Company’s other rights or responsibilities.
Discount/access disclosure

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

Who has responsibility for these discounts?

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

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

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

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

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

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

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

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

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

Bodily injury: An injury due directly to an accident.

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

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

Covered expense: The reimbursement limit for a covered service.

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

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

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

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

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

**Dependent:** A covered employee’s:

1. Legally recognized spouse; or
2. Natural blood related child, step-child, legally adopted child, or child placed with the Employee for the purpose of adoption whose age is less than the limiting age;
3. A child, subject to legal guardianship, grandchild or other blood relative whose age is less than the limiting age and who depends on the Policyholder for more than fifty percent (50%) of the individual’s total support.

The limiting age for each dependent child is:

1. 26 years; or
2. 26 years if the child is a regular full-time student at an accredited secondary school, college or university. A dependent continues to be eligible for coverage for up to four months after the close of a school term only if enrolled as a full-time student for the next school term. Also, a dependent child’s coverage will remain in force during a medically necessary leave of absence until the earlier of one year after the first day of the medically necessary leave of absence; or the date coverage would otherwise terminate under the plan.

A covered dependent child who becomes an employee eligible for other group coverage no longer is eligible for coverage under this policy.

A covered dependent child who reaches the limiting age while insured under this policy remains eligible for benefits if:

1. Mentally retarded, or mentally or physically disabled;
2. Incapable of self-sustaining employment;
3. Dependent on the covered employee for at least fifty percent (50%) of support and maintenance; and
4. Unmarried.

You must furnish satisfactory proof to us within 120 days of attaining the limiting age and subsequently, at reasonable intervals during the two years following the child’s attainment of the limiting age, that the conditions continuously exist. After two years from the date the first proof was furnished, we may not request such proof more often than annually. If satisfactory proof is not submitted to us, the child’s coverage ceases on the date such proof is due.

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

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

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

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

**Expense incurred date:** The date on which:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

We, us and our: The insurance company as shown on the cover page of this certificate.

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

You and your: Any covered employee and/or dependent(s).
NOTICE TO INSURED REGARDING FILING OF COMPLAINTS WITH INSURANCE DEPARTMENT

Questions regarding your policy or coverage should be directed to:

HumanaDental Insurance Company
HumanaDental Correspondence Office
P.O. Box 14638
Lexington, KY 40512-4638
(800) 233-4013

If you (a) need immediate assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone, or email:

State of Indiana Department of Insurance
Consumer Services Division
Indiana Department of Insurance
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.in.gov/idoi.
NOTICE OF PROTECTION PROVIDED BY THE INDIANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the Indiana Life and Health Insurance Guaranty Association (“ILHIGA”) and the protection it provides for policyholders. ILHIGA was established to provide protection to policyholders in unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations. If this should happen, ILHIGA will typically arrange to continue coverage and pay claims, in accordance with Indiana law, with funding from assessments paid by other insurance companies.

Basic Protections Currently Provided by ILHIGA
Generally, an individual is covered by ILHIGA if the insurer was a member of the ILHIGA and the Individual lives in Indiana at the time the insurer is ordered into liquidation with a finding of insolvency. The coverage limits below apply only for companies placed in rehabilitation or liquidation on or after January 1, 2013.

Life Insurance
- $300,000 in death benefits
- $100,000 in cash surrender or withdrawal values

Health Insurance
- $500,000 in basic hospital, medical and surgical or major medical insurance benefits
- $300,000 in disability and long term care insurance
- $100,000 in other types of health insurance

Annuities
- $250,000 in present value of annuity benefits (including cash surrender or withdrawal values)
- $5,000,000 for covered unallocated annuities

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to basic hospital, medical and surgical or major medical insurance benefits.

The protections listed above apply only to the extent that benefits are payable under covered Policy(s). In no event will the ILHIGA provide benefits greater than those given in the life, annuity, or health insurance policy or contract. The statutory limits on ILHIGA coverage have changed over the years and coverage in prior years may not be the same as that set forth in this notice.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or variable annuity contract.

To learn more about the protections provided by ILHIGA, please visit ILHIGA website at www.inlifega.org or contact:

Indiana Life and Health Insurance Guaranty Association
3502 Woodview Trace Suite 100
Indianapolis, IN 46268
317-636-8204

Indiana Department of Insurance
311 West Washington Street, Suite 103
Indianapolis, IN 46204
317-232-2385

Form 1643 IN 12/16
The policy or contract that this notice accompanies might not be fully covered by ILHIGA and even if coverage is currently provided, coverage is (a) subject to substantial limitations and exclusions (some of which are described above), (b) generally conditioned on continued residence in Indiana, and (c) subject to possible change as a result of future amendments to Indiana law and court decisions.

Complaints to allege a violation of any provision of the Indiana Life and Health Insurance Guaranty Association Act must be filed with the Indiana Department of Insurance, 311 W. Washington Street, Suite 103, Indianapolis, IN 46204; (telephone) 317-232-2385.

Insurance companies and agents are not allowed by Indiana law to use the existence of ILHIGA or its coverage to encourage you to purchase any form of insurance (IC 27-89-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If there is any inconsistency between this notice and Indiana law, Indiana law will control.

Questions regarding the financial condition of a company or your life, health insurance policy or annuity should be directed to your insurance company or agent.
The following pages contain important information about certain federal laws. There may be differences between the Certificate of Insurance and this Notice packet. There may also be differences between this notice packet and state law. You are eligible for the rights more beneficial to you, unless preempted by state or federal law.

This section includes notices about:

Claims procedures

Federal legislation

Medical child support orders

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

General notice of COBRA continuation of coverage rights

Family and Medical Leave Act (FMLA)

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

Your Rights under ERISA

Discrimination Notice
Claim procedures

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

Discretionary authority

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

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

Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Procedural defects

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

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

- Any document designating an authorized representative must be submitted to Humana in advance or at the time an authorized representative commences a course of action on behalf of the covered person. Humana may verify the designation with the covered person prior to recognizing authorized representative status.

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

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

Claims decisions

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

Pre-service claims

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

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

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

Urgent-care claims (expedited review)

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

Notice of a favorable or adverse determination will be made by Humana as soon as possible, taking into account the medical urgency particular to the covered person's situation, but not later than 72 hours after receiving the Urgent-care Claim.
If a claim does not provide sufficient information to determine whether, or to what extent, services are covered under the plan, Humana will notify the Claimant as soon as possible, but not more than 24 hours after receiving the Urgent-care Claim. The notice will describe the specific information necessary to complete the claim. The Claimant will have a reasonable amount of time, taking into account the covered person's circumstances, to provide the necessary information – but not less than 48 hours.

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

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

**Concurrent-care decisions**

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

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

**Post-service claims**

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

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

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

**Initial denial notices**

Notice of a claim denial (including a partial denial) will be provided to Claimants by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time frames noted above. With respect to adverse decisions involving Urgent-care Claims, notice may be provided to Claimants orally within the time frames noted above. If oral notice is given, written notification must be provided no later than 3 days after oral notification.
A claims denial notice will convey the specific reason for the *adverse determination* and the specific plan provisions upon which the determination is based. The notice will also include a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary. The notice will disclose if any internal plan rule, protocol or similar criterion was relied upon to deny the claim. A copy of the rule, protocol or similar criterion will be provided to Claimants, free of charge, upon request.

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

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

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

### Appeals of Adverse Determinations

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Category</th>
<th>Decision Time Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent-care Claims</td>
<td>As soon as possible but no later than 72 hours after Humana receives the appeal request.</td>
</tr>
<tr>
<td>Pre-service Claims</td>
<td>Within a reasonable period but no later than 30 days after Humana receives the appeal request.</td>
</tr>
<tr>
<td>Post-service Claims</td>
<td>Within a reasonable period but no later than 60 days after Humana receives the appeal request.</td>
</tr>
<tr>
<td>Concurrent-care Decisions</td>
<td>Within the time periods specified above depending on the type of claim involved.</td>
</tr>
</tbody>
</table>

Appeals denial notices

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

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

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

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

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

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

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

Legal actions and limitations

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

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

Medical child support orders

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

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

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

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

Procedures for determining the qualified status of medical child support orders are available at no cost upon request from the plan administrator.
Continuation of coverage for full-time students during medical leave of absence

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

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

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

General notice of COBRA continuation coverage rights

Introduction

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

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

What is COBRA continuation coverage?

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

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

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.
If you are the spouse of an employee, you will become a qualified beneficiary if you too lose your coverage under the Plan because of the following qualifying events:

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

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

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

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

**When is COBRA coverage available?**

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

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

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

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

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

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

Disability extension of 18-month period of

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

Second qualifying event extension of 18-month period of

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

If You Have Questions

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

Keep your plan informed of address changes

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

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

Family and Medical Leave Act (FMLA)

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

Uniformed Services Employment and Reemployment Rights Act of 1994

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

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

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

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

Duration of coverage

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

- 24 months beginning the first day of absence from employment due to service in the uniformed services; or

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

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

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


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).

**? ? ? ? (Chinese):** ????????????????????????????????????????????????????????? (TTY: 711)

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

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

**????? (Russian):** ?????????: ????????? ????????? ?????????? ???? ?????????

**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).

**? ? ? (Japanese):** ?????: ????????????????????????????????????????????????????????? (TTY: 711)

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