Humana.

The entity providing coverage is

A DENTAL HEALTH MAINTENANCE ORGANIZATION

COMPBENEFITS

Offered and administered by DentiCare, Inc (d/b/a as CompBenefits), a Humana Company
1100 Employers Blvd
Green Bay, WI 54344
866-427-7478
Humana.com

EVIDENCE OF COVERAGE

Please see the attached Schedule of Benefits at the back of this EOC for the list of covered services and copayments applicable to your plan.

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Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

DentiCare, Inc (d/b/a as CompBenefits)

To get information or file a complaint with your insurance company or HMO:

Call: Customer Care at 866-427-7478
Toll Free: 866-427-7478
Email: HumanaResolution@Humana.com

Mail: Grievance and Appeal Department
P. O. Box 14546
Lexington, KY 40512-4546

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:
Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

DentiCare, Inc (d/b/a as CompBenefits)

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Customer Care at 866-427-7478
Teléfono gratuito: 866-427-7478
Correo electrónico: HumanaResolution@Humana.com
Dirección postal: Grievance and Appeal Department
P. O. Box 14546
Lexington, KY 40512-4546

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

SPECIAL COMMUNICATION NEEDS

If You have special communication needs

We want the plan to be convenient for all members, particularly those with special needs. That is why we offer many materials in Spanish, English or other. If You are not comfortable speaking in English, You can still call Customer Care at 866-427-7478. We have a number of bilingual Customer Care Representatives. If You have a disability affecting Your ability to communicate or read, this Evidence of Coverage is also available on audiocassette, in large type, Braille, and through the use of an interpreter.

Si usted necesita asistencia especial para comunicarse

Queremos que el plan sea conveniente para todos nuestros miembros, en especial aquellos quienes tengan requerimientos especiales. Con este fin ofrecemos muchos materiales impresos en espanol e ingles. Si no se siente comodo comunicandose en ingles , puede llamar sin embargo a Servicios Para Miembros al 1-866-427-7478. Tenemos a varios representantes bilingues. Si tiene alguna invalidez que afecte sus posibilidades de comunicarse o de leer, este manual es disponible en forma de audio cassette, en letra mayuscula, en letra para desprovistos de vista y tambien por medio de un interprete.

INTRODUCING THE DHMO DENTAL PLAN

Welcome to the Plan, a single service dental health maintenance organization ("DHMO"). We are pleased that You have selected Our coverage for Your dental needs. This Evidence of Coverage ("EOC") contains a description of Covered Dental Care Benefits as well as Copayments, limitations and exclusions. There is a helpful glossary located in the appendix of this EOC that gives definitions of dental terminology found in this EOC. You have a responsibility to know what services are covered under your dental plan. **Please read this EOC carefully**. If You have questions about what Your dental plan covers, please refer to your Handbook and Schedule of Benefits or call Customer Care at 866-427-7478.

HOW THE DHMO PLAN WORKS

Your dental plan is designed to help You and Your family obtain comprehensive dental care by offering inexpensive preventive care and reduced rates for many other dental treatments. You will only pay a Copayment for Covered Dental Care services or treatments You receive at the time services are performed, unless You make other payment arrangements with Your Participating Dentist. You should ask Your Participating Dentist for a benefit determination and cost estimate before You receive any dental treatment.

GETTING STARTED

Selecting Your Dentist

First, You must select a Participating General Dentist from a list of dentists participating in the Plan network as Your primary care dentist ("PCD"). A directory of all the Participating Dentists will be provided for You upon request. The directory is sorted by city, and lists all the dentists in the facility, the address, telephone number, and if the dentist is accepting new patients. Provider directories are updated frequently and available on Our Website, however, paper copies can be requested from Customer Care. If You need assistance finding a PCD, call Customer Care at 866-427-7478 or use the provider locator function on our website at Humana.com. Once You have located a PCD, please contact our Customer Care department with Your selection.

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

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

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

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

In the event the Covered Dental Care Services You need are not available through Participating Dentists, the Plan, upon the request of a Participating Dentist, within the time appropriate to the circumstances relating to the delivery of the Covered Dental Care Services and the condition of the patient, but in no event to exceed five (5) business days after receipt of reasonably requested documentation, allow a referral to a non-Participating Dentist and shall reimburse the non-Participating Dentist at the usual and customary or an agreed rate less the Copayment amount. You are responsible for paying the Copayment amount to the non-Participating Dentist. Contact Us if You receive a bill for covered services from any physician or provider, including a facility-based physician or other health care practitioner. For purposes of determining whether Covered Dental Care Services are available through Participating Dentists, the Plan shall offer its entire network, rather than limited provider networks within the Plan's delivery network. The Plan shall not require You to change Your PCD to receive Covered Dental Care Services that are not available within the limited provider network. The Plan will provide for a review by a specialist of the same or similar specialty as the type of dentist or provider to whom a referral is requested before the Plan authorizes a referral to a non-Participating Dentist.

Identification Card

You will be issued an identification card upon enrollment in the Plan. The card identifies You as a Plan Member. If Your card is lost or stolen, call Customer Care at 866-427-7478 to get a new card mailed to You. You may also request a new card via Our website at Humana.com.

Making an Appointment

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

Broken Appointments

The time that the dentist sets aside for Your appointment is very valuable. Broken appointments are more than just an inconvenience or a discourtesy, they greatly add to the expense of the program as a delay in treatment may require more complex and costlier procedures. This will be reflected in higher Copayments applicable to You. Also, the time the dentist scheduled for You could have been used for other patients for needed dental care. Therefore, should You break an appointment without at least 24 hours notice, a fee may be charged for the block of time reserved. This fee is determined by the dentist, is not covered by Us, and is Your responsibility.

Specialty Care

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

Second Opinions

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

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

Pre-Treatment Estimate

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

Alternate Treatment

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

EMERGENCY CARE

The Plan covers dental emergencies 24 hours a day, seven days a week, no matter where You are. If You have a dental emergency, You are covered for palliative (emergency) treatment. Palliative treatment involves only those things necessary to control unexpected pain or more than usual bleeding, prevent complications related to an infection, or prevent the loss of a tooth from a traumatic injury. Emergency dental service is intended to relieve pain caused by an acute condition until Your PCD can see You. **Your emergency care benefit does not include procedures that may be required, but are not necessary for the relief of pain**. For example, root canals and crowns may be necessary treatments but are not covered under emergency care benefits.

What is considered an emergency dental service?

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

What should you do in an emergency?

You can receive palliative (emergency) treatment from any licensed dentist. In the event You receive palliative (emergency) treatment from a non-Participating Dentist, You will be reimbursed for the cost of the emergency care minus any applicable Copayments. In order to be reimbursed for the services, You must have an itemized statement and receipt showing the services paid in full from the treating dentist. We must be notified of such treatment within ninety (90) days of its receipt, or as soon as reasonably possible. Contact Us if You receive a bill for covered services from any physician or provider, including a facility-based physician or other health care practitioner.

IF YOU HAVE A COMPLAINT

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

Complaints

Our Customer Care Department is available by phone Monday through Friday, 8:00 AM to 6:00 PM Eastern Time to assist members in addressing any dissatisfaction with their dental plan benefits and / or participating dental office. You can call Customer Care at 866-427-7478 or submit a Complaint in writing. Written Complaints should be mailed to:

Attn: Grievance Coordinator
Humana/CompBenefits
P.O. Box 14546
Lexington, KY 40512-4546

If You submit a written Complaint please include Your concern, specific details, dates, and Your name and contact information. Should You have any question about submitting a written Complaint, call Customer Care at 866-427-7478. Complaints must be submitted to Us within one year of the occurrence of events upon which the Complaint is based, or as soon as reasonably possible if it was not reasonably possible to submit Your Complaint within such time. Your Complaint will be acknowledged in writing within five (5) business days of receipt, and if the Complaint was made orally, it will be accompanied by a one-page Complaint form that prominently and clearly states that the form must be returned to Us for prompt resolution of the Complaint. Written Complaints will be researched and resolved and a response letter explaining the Plan's resolution of the Compliant will be sent to You within 30 days from the date of receipt. The letter will include Our resolution of the Complaint, the specific dental and contractual reasons for the resolution, the specialization of any dentist or other provider consulted, and a complete description of the process of appeal including the deadlines for the appeals process and the deadlines for the final decision on the appeal.

In the event the Complaint concerns a dental emergency, We shall investigate and resolve a Complaint concerning a dental emergency in accordance with the dental immediacy of the case and not later than one business day after We receive the Complaint.

Appeal of Complaint Resolution

If the Complaint is not resolved to Your satisfaction, You have the right within 60 days of the initial determination to Appeal the resolution of Your Complaint and appear in person before a Complaint Appeal panel at the site where You normally receive dental services or at an agreed upon location, or You may address a written Appeal directly to the panel at:

Attn: Quality Manager
Humana/CompBenefits
P.O. Box 14546
Lexington, KY 40512-4546
866-427-7478

We will send You an acknowledgment letter within five (5) business days of the receipt of Your Appeal request. You will be contacted to make arrangements for a meeting or to submit Your written Appeal. The Plan shall complete the appeals process not later than the thirtieth (30^{th}) calendar day after the date the written request for appeal is received. Not later than the fifth (5^{th}) business day before the date the Appeal panel is scheduled to meet, unless You agree otherwise, We shall provide You or Your designated representative: 1) any documentation to be presented to the Appeal panel by Plan staff; 2) the specialization of any dentists or providers consulted during the investigation; and 3) the name and affiliation of each Plan representative on the Appeal panel. The Appeal panel consists of an equal number of Plan staff members, dentists or other providers, and enrollees who were not previously involved in the disputed decision. The dentists or other providers on the Appeal panel must have experience in the area of care that is in dispute and be independent of any dentist or provider who made any previous determination. If specialty care is in dispute, the Appeal panel will include a person who is a specialist in the field of care to which the appeal relates. They will consider all information presented and give a decision on the Appeal. Once the Appeal panel reaches a decision, You will receive a letter with specific clinical and contractual criteria used to reach the decision. Should You disagree with the decision of the appeal panel, or at anytime You are dissatisfied, You have the right to contact the **Texas Department of Insurance** in writing at the following:

Consumer Protection, MC: CO-CP
Texas Department of Insurance
P.O. Box 12030
Austin, TX 78711-2023
1-800-252-3439
ConsumerProtection@tdi.texas.gov

The Plan is prohibited from retaliating against You or the Contractholder for filing a complaint against the Plan or for appealing a Plan decision. The Plan is also prohibited from retaliating against a dentist because the dentist has on behalf of a member filed a complaint against the Plan or appealed a Plan decision.

In the event the Appeal involves ongoing emergency dental treatment, the investigation and resolution of an Appeal of a complaint relating to an ongoing emergency shall be concluded in accordance with the dental immediacy of the case, and not later than one business day after Your request for an Appeal is received. Because of the ongoing emergency, We shall provide, instead of an Appeal panel, a review by a dentist who: 1) has not previously reviewed the case; and 2) is of the same or a similar specialty as the dentist or provider who would typically managed the dental condition, procedure, or treatment under consideration for review in the appeal. The dentist or provider reviewing the appeal may interview You or Your designated representative and shall decide the Appeal. The dentist or provider may deliver initial notice of the decision on the Appeal orally if the dentist or provider subsequently provides written notice of the decision not later than the third (3rd) day after the date of the decision.

ELIGIBILITY AND COVERAGE

Eligibility and Enrollment

A. You:

1. Your Eligibility Date

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

   The Subscriber must reside, live, or work in the Service Area and the legal residence of any enrolled Dependents must be the same as the Subscriber, or the Subscriber must reside, live, or work in the Service Area and the residence of any enrolled Dependents must be:

   a. in the Service Area with the person having temporary or permanent conservatorship or guardianship of the Dependents, including adoptees or children who have become the subject of a suit for adoption by the enrollee, where the Subscriber has legal responsibility for the health care of the Dependents;
   b. in the Service Area under other circumstances where the Subscriber is legally responsible for the health care of the Dependents;
   c. in the Service Area with the Subscriber's spouse; or
   d. anywhere in the United States for a child whose coverage under a plan is required by a medical support order.

2. Your Effective Date

   a. You must enroll as agreed by the Contractholder and Us.
   b. Your effective date provision is stated in the Contractholder's Application. It may be the first of the month following completion of the Probationary Period or the Special Enrollment Date.
   c. If You enroll more than 31 days after Your Eligibility Date or Special Enrollment Date, You are late and will be eligible to enroll during the next Open Enrollment Period.

B. Dependent

1. Dependent Eligibility Date

a. Each Dependent is eligible for coverage on:
   i. The date You are eligible for coverage, if You have Dependents who may be covered on that date;
   ii. The date of Your marriage for any Dependents (spouse or child) acquired on that date;
   iii With respect to newborn or adopted children, the date described in section titled Coverage for Newborn and Adopted Children;
   iv. The date a child is considered to be the child of member, if the member is a party to a suit in which the member seeks to adopt the child.
   v. 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 You to provide coverage for a child or spouse as specified in such orders.
   vi. You may cover Your Dependents only if You are also covered.
   vii. A Dependent child who enrolls for other dental coverage through any employment is no longer eligible for coverage under the Contract. If a Dependent child becomes a Subscriber of the Contractholder, he or she is no longer eligible as a Dependent and must make application as an eligible Subscriber.

2. Dependent effective date

a. Check with the Contractholder immediately on how to enroll for Dependent coverage. You must enroll for Dependent coverage and enroll additional Dependents as agreed by the Contractholder and Us.
b. If We receive enrollment on, prior to, or within 31 days of the Dependent's Eligibility Date that Dependent is effective the first of the month following that date.
c. If We receive enrollment on, prior to, or within 31 days of the Dependent's Special Enrollment Date, that dependent is effective the first of the month following that date.
d. If We receive enrollment more than 31 days after the Dependent's Eligibility Date, or the Special Enrollment Date, that Dependent is considered late and will be eligible to enroll during the next Open Enrollment Period.

However, no Dependent's effective date will be prior to Your effective date of coverage.

(Please see the definition of Dependent in this EOC for more details.)

Coverage for Newborn and Adopted Children

A. If You already have Dependent child coverage in force prior to the newborn's date of birth, You are not required to complete an enrollment form for the newborn child. However, You must notify Us of the birth.

B. Newborn Dependent effective date

1. If We receive enrollment on or within 31 days of the newborn's date of birth, that Dependent is covered as of the date of birth**.**

2. If We receive enrollment between 32 days and 2 years after the newborn's date of birth, Dependent coverage is effective on the first of the month following receipt of the enrollment.

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

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

C. A child placed with You for adoption will be covered from the earlier of: 1) the date of birth if a petition for adoption is filed within 30 days of the birth of such child; 2) the date You gain custody of the child under a temporary court order that grants You conservatorship of the child; or 3) the date the child is placed with You for adoption; and additional Contribution, if any, is paid. You must enroll such child within 31 days after either of these events. If such child is not enrolled within 31 days, such child is considered a late applicant and will not be able to enroll until the next Open Enrollment Period as determined by the Contractholder and Us.

CANCELATION AND NON-RENEWAL

A. Plan may cancel a Member's coverage with forty-five (45) days written notice for the following reasons:

1. Nonpayment of amounts due under the Contract, after not less than 30-days written notice, except no additional written notice will be required for failure to pay premium;

2. After not less than 15-days written notice, in the case of fraud or intentional misrepresentation of a material fact, except as described in Incontestability section of this EOC;

3. After not less than 15-days written notice, in the case of fraud in the use of services or facilities;

4. Immediately, subject to continuation of coverage provision, if applicable, for failure to meet eligibility requirements other than the requirement that the Subscriber reside, live, or work in the Service Area; and

5. After not less than 30-days written notice, where the Subscriber does not reside, live, or work in the Service Area of the HMO or area for which the HMO is authorized to do business, but only if the HMO terminates coverage uniformly without regard to any health status-related factor of enrollees, except that an HMO may not cancel coverage for a child who is the subject of a medical support order because the child does not reside, live, or work in the Service Area.

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

1. Termination date listed in the Contract;

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

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

4. The date You enter the military fulltime;

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

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

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

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

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

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

In addition to any other Contributions for which the Contractholder is liable, the Contractholder is liable for an enrollee's Contributions from the time the enrollee is no longer eligible for coverage under the contract until the end of the month in which the Contractholder notifies the Plan that the enrollee is no longer eligible for coverage by the Contract; and the enrollee remains covered by the Contract until the end of that period.

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

CONTINUATION OF COVERAGE

If Your coverage under the Contract is terminated for any reason, except involuntary termination for cause, and You were continuously covered under this Plan for 3 consecutive months prior to losing coverage, You can transfer Your dental benefits to an individual plan or You can continue Your group coverage subject to the eligibility provisions below:

1. Continuation of group coverage must be requested in writing within 60 days following the later of: (a) the date the group coverage would otherwise terminate; or (b) the date the Member is given notice of the right of continuation by the Contractholder.

2. A Member electing continuation must pay to the Contractholder on a monthly basis, in advance, the amount of contribution required by the Contractholder, plus two percent of the group rate for the coverage being continued under the group Contract, on the due date of each payment.

3. The Member must make the payment no later than the 45th day after the date of the initial election for coverage and on the due date of each payment thereafter. Following the first payment made after the initial election for coverage, the payment of any other premium shall be considered timely if made on or before the 30th day after the date on which the payment is due.

4. Continuation may not terminate until the earliest of: (a) the date the maximum continuation period provided by law would end, which is: (i) for any Member not eligible for continuation coverage under Title X, Consolidated Omnibus Budget Reconciliation Act of 1985 (29 U.S.C. Section 1161 et seq.) (COBRA), nine (9) months after the date the Member elects to continue the group coverage; or (ii) for any Member eligible for continuation coverage under COBRA, six (6) additional moths following any period of continuation coverage provided under COBRA; (b) the date on which failure to make timely payments would terminate coverage; (c) the date the group coverage terminates in its entirety; (d) the date on which the Member is covered for similar services and benefits by another dental insurance policy or dental subscriber contract or

dental practice or other prepayment plan. If a Member loses coverage due to a change in marital status, that Member shall be issued coverage which the Plan is then issuing which most nearly approximates the coverage of the Contract which was in effect prior to the change in marital status. The new coverage will be issued without evidence of insurability and will have the same effective date as the Contract under which coverage was afforded prior to the change in marital status.

GENERAL PROVISIONS

Entire Contract

The Contract, this EOC, applications, if any, and any attachments constitute the entire contract between the parties and that, to be valid, any change in the form must be approved by an officer of the HMO and attached to the affected form and no agent has the authority to change the form or waive any of the provisions.

Exclusions and Limitations

Plan does not provide coverage for the following:

A. No service of any dentist other than a Participating General Dentist or Participating Specialty Dentist will be covered by Plan, except for emergency care as described in the Emergency Care section. This does not include services performed by non-Participating Dentists approved by the Plan.

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

C. Whenever any Contributions or Copayments are delinquent, Member will not be entitled to receive Benefits (except for palliative (emergency) treatment) or transfer Dental Facilities.

D. Any dental treatment started prior to the Member's effective date for eligibility of benefits, other than Covered Dental Care Services in progress if such treatment is completed by a Participating Dentist. This also does not apply to Orthodontic treatment in progress that was covered under the Contractholder’s prior plan. To be covered under this Plan, Orthodontic treatment must be shown on your Schedule of Benefits and You must have the subsequent treatment provided by a Participating Dentist.

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

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

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

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

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

J. Services provided by a Participating Pediatric Dentist are limited to children through age eighteen.

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

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

M. Worker's Compensation

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

2. The recovery rights will be applied even though:
   a. The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;
   b. No final determination is made that bodily injury or sickness was sustained in the course of, or resulted from, Your employment;
   c. The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by You or the Workers' Compensation carrier; or
   d. Medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

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

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

1. Altering vertical dimension of teeth;

2. Restoration or maintenance of occlusion;

3. Splinting teeth, including multiple abutments; or

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

The Plan does not exclude from coverage, Covered Dental Care Services for a Member who is unable to undergo dental treatment in an office setting or under local anesthesia due to a documented physical, mental, or medical reason as determined by a Member's physician or by the dentist providing the dental care.

Incontestability

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

Conformity with Texas Law

If this EOC contains any provision or part of a provision not in conformity with Insurance Code Chapter 1271 (concerning Benefits Provided by Health Maintenance Evidence of Coverage; Charges) or other applicable laws, the remaining provisions and parts of provisions that can be given effect without the invalid provision or part of a provision are not rendered invalid but must be construed and applied as if they were in full compliance with Insurance Code Chapter 1271 and other applicable laws.

Notice of Independent Contractor Relationship

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

Claims

The Plan shall, not later than the 45th day after receipt of notice of a clean paper claim, or not later than the 30th day after receipt of a clean electronic claim: (1) pay the claim in accordance with any contracts We may have with the provider; (2) pay any portion of claim that is not in dispute and notify the provider in writing of the reason for the disputed amount; or (3) notify the provider in writing why the claims will not be paid.

If We need additional information from the provider to determine payment, We will request in writing that the provider submit clarification of the claim or additional documentation, not later than the 30th day after the date We receive a clean claim.

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

Dental Records

Dental records concerning services rendered to Member shall remain the property of the Participating Dentist. Member may obtain copies of their dental records for a reasonable fee directly payable to the Participating Dentist. Member agrees that his/her dental records may be reviewed by the Plan in order to fulfill its obligations under the contract. The Plan agrees to honor confidentiality of said data.

Grace Period

This EOC has a thirty-one (31) day Grace Period. This provision means that if any required premium is not paid on or before the Due Date, it may be paid subsequently during the Grace Period. During the Grace Period, the contract will stay in force. If full payment is not received within the Grace Period, coverage will be terminated effective the first day of the Grace Period. Members will be liable for the cost of Benefits they receive during the Grace Period.

Reinstatement

If any renewal premium is not paid within the time granted to the Contractholder for payment, a subsequent acceptance of premium by CompBenefits or by any agent authorized by CompBenefits to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Contract; provided, that if CompBenefits or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Contract will be reinstated upon approval of such application by CompBenefits or lacking approval, upon the forty-fifth day following the date of such conditional receipt unless CompBenefits has previously notified the Contractholder in writing of its disapproval of such application. The reinstated Contract shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after such date. In all other respects, the Contractholder and CompBenefits shall have the same rights thereunder as they had under the Contract immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

Changes in Contributions

The Plan has the right to change the Contributions charged upon sixty (60) days prior written notice to the Contractholder of the amount of the increase and the date on which the increase is to take effect.

DEFINITIONS

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

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

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

Contract means the Contract for Dental Benefits between Us and the Contractholder.

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

Contributions are those periodic payments due Plan by Contractholder to receive Benefits as provided by the EOC and Schedule of Benefits.

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

Covered Dental Care Services are those services to be performed by a Participating General Dentist or Participating Specialty Dentist pursuant to the terms of this EOC and a Participating General Dentist Agreement or a Participating Specialty Dentist Agreement. To be covered by Plan, services must be (a) necessary; and (b) appropriate for the given condition.

Dental Facility is any location which the Participating General Dentist or Participating Specialist have established, or contractually arranged to provide Dental Care Services to Members.

Dependent means any of the following persons:

1. Your spouse or domestic partner;
2. Your unmarried children or grandchildren;
   a from birth to age 26 and dependent upon You for support; or
   b at least 26 years of age and:
      i primarily dependent upon You for support because of mental or physical handicap;
      ii was incapacitated and covered under this EOC on his or her 26th birthday; and continues to be incapacitated beyond his 26th birthday. We may require proof of the continued incapacitation. Such proof will not be required more often than once each year starting on the date the child reaches the limiting age.

The term "children" also includes adopted children, party to a suit in which the Member seeks to adopt a child, stepchildren, and foster children living with You in a parent-child relationship.

A Dependent may include Your domestic partner (in lieu of legal spouse) if the Contractholder elects to provide coverage for domestic partners as shown in the Contract.

It is Your obligation to notify the Contractholder of the Dependent status or changes in Dependent status.

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

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

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

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

Participating General Dentist and Participating Specialty Dentist (hereinafter referred to as "Participating Dentist") are those licensed dentists selected and contracted with the Plan as independent contractors to provide Covered Dental Care Services to Members. Participating General Dentists may include dentists that are contractually arranged to provide Dental Care Services to Members at an onsite clinic.

Primary Care Dentist (PCD) is the Participating General Dentist within Our DHMO network whom you have selected to handle your dental care. Participating Care Dentists may include dentists that are contractually arranged to provide Dental Care Services to Members at an onsite clinic.

Reconstructive surgery for craniofacial abnormalities means surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

Service Area means the entire state of Texas.

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

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

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

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

You or **Your** means the Subscriber.

We, **Us**, **Our** or **Plan** means CompBenefits, a Humana company.

GLOSSARY OF DENTAL TERMINOLOGY

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

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

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

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

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

Apicoectomy - amputation of the root of the tooth.

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

Bridge - a prosthetic replacement of one or more missing teeth on a framework that cannot be removed by the patient.

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

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

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

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

Debridement - removal of foreign matter.

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

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

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

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

Extraction - removal of a tooth.

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

Gingiva - the gums.

Gingivectomy - the excision or removal of gingiva.

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

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

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

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

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

Intraoral - inside the mouth.

Labial - pertaining to or around the lip.

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

Mandible (mandibular – adj.) - lower jaw.

Maxilla (maxillary – adj.) - upper jaw.

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

Oral - pertaining to the mouth.

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

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

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

Osseous - bony.

Palliative - action that relieves pain but is not curative.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Teledentistry – A dental service that is delivered by a dentist, or a health professional acting under the delegation and supervision of a dentist, acting within the scope of the dentist's or health professional's license or certification to a patient at a different physical location than the dentist or health professional using telecommunications or information technology.

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

- A health maintenance organization (HMO) plan provides no benefits for services you receive from out-of-network physicians or providers, with specific exceptions as described in your evidence of coverage and below.

- You have the right to an adequate network of in-network physicians and providers (known as *network physicians and providers*).

- If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance at: www.tdi.texas.gov/consumer/complfrm.html.

- If your HMO approves a referral for out-of-network services because no network physician or provider is available, or if you have received out-of-network emergency care, the HMO must, in most cases, resolve the out-of-network physician's or provider's bill so that you only have to pay any applicable in-network copayment, coinsurance, and deductible amounts.

- You may obtain a current directory of network physicians and providers at the following website: Humana.com or by calling 866-427-7478 for assistance in finding available network physicians and providers. If you relied on materially inaccurate directory information, you may be entitled to have a claim by an out-of-network physician or provider paid as if it were from a network physician or provider, if you present a copy of the inaccurate directory information to the HMO, dated not more than 30 days before you received the service.

Service Area

The Service Area for this plan is the entire state of Texas. The following is a map of the areas that have PCD locations. Please note that PCD locations may change from time to time. To find a PCD, please refer to the Provider Directory, call Customer Care at 866-427-7478 or use the provider locator function on Our Website at **Humana.com.**

The following map shows the Service Area covered by this Evidence of Coverage:

Humana.

Compbenefits

Schedule of Benefits and Subscriber Copayments

Office visit copayment	$0

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

ADACode	Procedure	Patient Pays
Appointments		
D9310	Consultation (diagnostic service provided by dentist other than requesting dentist)	$5
D9430	Office visit (during regularly scheduled hours)	$0
D9440	Office visit (after regularly scheduled hours)	$35
D9986	Missed appointment	$10
D9987	Cancelled appointment	$10
D9999	Emergency visit (during regularly scheduled hours)	$20
Diagnostic		
D0120	Periodic oral evaluation - established patient (limited to two per *year*)	$0
D0140	Limited oral evaluation - problem focused	$0
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	$0
D0150	Comprehensive oral evaluation - new or established patient (limited to two per *year*)	$0
D0160	Detailed and extensive oral evaluation - problem focused, by report	$0
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$0
D0171	Re-evaluation – post-operative office visit	$0
D0180	Comprehensive periodontal evaluation - new or established patient (limited to two per *year*)	$15
D0190	Screening of a patient	$0
D0191	Assessment of a patient	$0
D0210	Intraoral - comprehensive series of radiographic images (limited to 1 D0210 or D0709 every 3 years)	$0
D0220	Intraoral - periapical first radiographic image	$0
D0230	Intraoral - periapical each additional radiographic image	$0
D0240	Intraoral - occlusal radiographic image	$0
D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	$0

D0251	Extra-oral posterior dental radiographic image (limited to one D0251 or D0705 per *year*)	$0
D0270	Bitewing - single radiographic image (limited to two per *year*)	$0
D0272	Bitewings - two radiographic images (limited to two per *year*)	$0
D0273	Bitewings - three radiographic images (limited to two per *year*)	$0
D0274	Bitewings - four radiographic images (limited to two per *year*)	$0
D0277	Vertical bitewings - 7 To 8 radiographic images (limited to two per *year*)	$0
D0310	Sialography	$105
D0320	Temporomandibular joint arthrogram, including injection	$175
D0321	Other temporomandibular joint radiographic images, by report	$105
D0322	Tomographic survey	$105
D0330	Panoramic radiographic image (limited to one D0330 or D0701 every 3 years)	$0
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis	$30
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	$0
D0364	Cone beam CT capture and interpretation with limited field of view – less than one whole jaw (only covered in conjunction with the surgical placement of an implant; limited to a total of only one D0364, D0365, D0366 or D0367 per *year*)	$120
D0365	Cone beam CT capture and interpretation with field of view of one Full dental arch – mandible (only covered in conjunction with the surgical placement of an implant; limited to a total of only one D0364, D0365, D0366 or D0367 per *year*)	$120
D0366	Cone beam CT capture and interpretation with field of view of one Full dental arch – maxilla, with or without cranium (only covered in conjunction with the surgical placement of an implant; limited to a total of only one D0364, D0365, D0366 or D0367 per *year*)	$120
D0367	Cone beam CT capture and interpretation with field of view of both jaws; with or without cranium (only covered in conjunction with the surgical placement of an implant; limited to a total of only one D0364, D0365, D0366 or D0367 per *year*)	$140
D0368	Cone beam CT capture and interpretation for TMJ series including two or more exposures (limited to 1 per *year*)	$125
D0369	Maxillofacial MRI capture and interpretation	$125
D0370	Maxillofacial ultrasound capture and interpretation	$110
D0371	Sialoendoscopy capture and interpretation	$110
D0380	Cone beam CT image capture with limited field of view – less than one whole jaw	$100
D0381	Cone beam CT image capture with field of view of one full dental arch – mandible	$90
D0382	Cone beam CT image capture with field of view of one full dental arch – maxilla, with or without cranium	$90
D0383	Cone beam CT image capture with field of view of both jaws; with or without cranium	$120
D0384	Cone beam CT image capture for TMJ series including two or more exposures	$90
D0385	Maxillofacial MRI image capture	$110
D0386	Maxillofacial ultrasound image capture	$110
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	$0
D0393	Virtual treatment simulation using 3D image volume or surface scan	$0
D0394	Digital subtraction of two or more images or image volumes of the same modality	$0
D0395	Fusion of two or more 3D image volumes of one or more modalities	$0
D0414	Laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report	$0
D0415	Collection of microorganisms for culture and sensitivity	$0
D0419	Assessment of salivary flow by measurement	$0
D0425	Caries susceptibility tests	$0

D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	$50
D0460	Pulp vitality tests (not covered if root canal is performed)	$0
D0470	Diagnostic casts	$0
D0472	Accession of tissue, gross examination, preparation and transmission of written report	$0
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	$0
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	$0
D0480	Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report	$0
D0486	Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report	$0
D0502	Other oral pathology procedures, by report	$0
D0600	Non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin, and cementum	$0
D0601	Caries risk assessment and documentation, with a finding of low risk	$0
D0602	Caries risk assessment and documentation, with a finding of moderate risk	$0
D0603	Caries risk assessment and documentation, with a finding of high risk	$0
D0701	Panoramic radiographic image – image capture only (limited to one D0330 or D0701 every 3 years)	$0
D0702	2-D cephalometric radiographic image – image capture only	$30
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only	$5
D0705	Extra-oral posterior dental radiographic image – image capture only (limited to one D0251 or D0705 per *year*)	$0
D0706	Intraoral – occlusal radiographic image – image capture only	$0
D0707	Intraoral – periapical radiographic image – image capture only	$5
D0708	Intraoral – bitewing radiographic image – image capture only	$0
D0709	Intraoral – complete series of radiographic images – image capture only (limited to one D0210 or D0709 every 3 years)	$0

Preventive

D1110	Prophylaxis - adult (limited to two per *year*, by primary care dentist)	$0
D1120	Prophylaxis - child (limited to two per *year*)	$0
D1206	Topical application of fluoride varnish (limited to two per *year*; for child <16)	$0
D1208	Topical application of fluoride - excluding varnish (limited to two per *year*; for child <16)	$0
D1310	Nutrition counseling for the control of dental disease	$0
D1320	Tobacco counseling services for the control or prevention of oral disease	$0
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use	$0
D1330	Oral hygiene instructions	$0
D1351	Sealant - per tooth (permanent teeth only; through age 15)	$10
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth	$5
D1353	Sealant repair – per tooth	$5
D1354	Interim caries arresting medicament application – per tooth	$5

D1355	Caries preventive medicament application – per tooth	$5
D1510*	Space maintainer - fixed unilateral - per quadrant (through age 14)	$50
D1516*	Space maintainer – fixed bilateral, maxillary (through age 14)	$70
D1517*	Space maintainer – fixed bilateral, mandibular (through age 14)	$70
D1520*	Space maintainer - removable - Unilateral - per quadrant (through age 14)	$85
D1526*	Space maintainer - removable - bilateral, maxillary (through age 14)	$90
D1527*	Space maintainer - removable - bilateral, mandibular (through age 14)	$90
D1551	Re-cement or re-bond bilateral space maintainer – maxillary	$10
D1552	Re-cement or re-bond bilateral space maintainer – mandibular	$10
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant	$10
D1556	Removal of fixed unilateral space maintainer - per quadrant	$5
D1557	Removal of fixed bilateral space maintainer - maxillary	$5
D1558	Removal of fixed bilateral space maintainer - mandibular	$5
D1575	distal shoe space maintainer – fixed unilateral - per quadrant (through age 14; primary teeth only)	$130

Restorative

D2140	Amalgam - one surface, primary or permanent	$5
D2150	Amalgam - two surfaces, primary or permanent	$5
D2160	Amalgam - three surfaces, primary or permanent	$5
D2161	Amalgam - four or more surfaces, primary or permanent	$5
D2410	Gold foil - one surface	$45
D2420	Gold foil - two surfaces	$60
D2430	Gold foil - three surfaces	$85
D2921	Reattachment of tooth fragment, incisal edge or cusp	$20
D2940	Placement of interim direct restoration	$10
D2949	Restorative foundation for an indirect restoration	$25
D2975	Coping	$70
D2990	Resin infiltration of incipient smooth surface lesions	$15

Resin Restorative (inlays and onlays limited to one per tooth every 5 years)

D2330	Resin-based composite - one surface, anterior	$30
D2331	Resin-based composite - two surfaces, anterior	$40
D2332	Resin-based composite - three surfaces, anterior	$45
D2335	Resin-based composite - four or more surfaces, anterior	$65
D2390	Resin-based composite - crown, anterior	$70
D2391	Resin-based composite - one surface, posterior	$45
D2392	Resin-based composite - two surfaces, posterior	$55
D2393	Resin-based composite - three surfaces, posterior	$80
D2394	Resin-based composite - four or more surfaces, posterior	$90
D2510*	Inlay - metallic - one surface	$225
D2520*	Inlay - metallic - two surfaces	$235
D2530*	Inlay - metallic - three or more surfaces	$245
D2542*	Onlay - metallic - two surfaces	$250
D2543*	Onlay - metallic - three surfaces	$260
D2544*	Onlay - metallic - four or more surfaces	$270
D2610*	Inlay - porcelain/ceramic, one surface	$250
D2620*	Inlay - porcelain/ceramic, two surfaces	$260
D2630*	Inlay - porcelain/ceramic, three or more surfaces	$270
D2642*	Onlay - porcelain/ceramic, two surfaces	$275

D2643*	Onlay - porcelain/ceramic, three surfaces	$285
D2644*	Onlay - porcelain/ceramic, four or more surfaces	$295
D2650*	Inlay - resin based composite, one surface	$225
D2651*	Inlay - resin based composite, two surfaces	$235
D2652*	Inlay - resin based composite, three or more surfaces	$245
D2662*	Onlay - resin based composite, two surfaces	$250
D2663*	Onlay - resin based composite, three surfaces	$260
D2664*	Onlay - resin based composite, four or more surfaces	$270

Crown and Bridge (Crowns limited to one per tooth every 5 years)

D2710*	Crown - resin-based composite (indirect)	$270
D2712*	Crown -3/4 resin-based composite (indirect)	$270
D2720*	Crown - resin with high noble metal	$270
D2721	Crown - resin with predominantly base metal	$270
D2722*	Crown - resin with noble metal	$270
D2740*	Crown - porcelain/ceramic	$270
D2750*	Crown - porcelain fused to high noble metal	$270
D2751	Crown - porcelain fused to predominantly base metal	$270
D2752*	Crown - porcelain fused to noble metal	$270
D2753*	Crown - porcelain fused to titanium and titanium alloys	$270
D2780*	Crown - 3/4 cast high noble metal	$270
D2781	Crown - 3/4 cast predominantly base metal	$270
D2782*	Crown - 3/4 cast noble metal	$270
D2783*	Crown - 3/4 porcelain/ceramic	$270
D2790*	Crown - full cast high noble metal	$270
D2791	Crown - full cast predominantly base metal	$270
D2792*	Crown - full cast noble metal	$270
D2794*	Crown - titanium and titanium alloy	$270
D2799	Interim crown - further treatment or completion of diagnosis necessary prior to final impression	$0
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$15
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$0
D2920	Re-cement or re-bond crown	$15
D2928	Prefabricated porcelain/ceramic crown – permanent tooth	$75
D2929	Prefabricated porcelain/ceramic crown - primary tooth	$75
D2930	Prefabricated stainless steel crown - primary tooth	$75
D2931	Prefabricated stainless steel crown - permanent tooth	$25
D2932	Prefabricated resin crown	$50
D2933	Prefabricated stainless steel crown with resin window	$50
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	$50
D2950	Core buildup, including any pins when required	$50
D2951	Pin retention - per tooth, in addition to restoration	$15
D2952*	Post and core, in addition to crown, indirectly fabricated	$95
D2953*	Each additional indirectly fabricated post - same tooth	$100
D2954	Prefabricated post and core in addition to crown	$85
D2955	Post removal	$10
D2957	Each additional prefabricated post - same tooth	$35
D2960	Labial veneer (resin laminate) - direct	$250
D2961*	Labial veneer (resin laminate) - indirect	$300
D2962*	Labial veneer (porcelain laminate) - indirect	$350
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework	$50

D2980	Crown repair necessitated by restorative material failure	$0
D2981	Inlay repair necessitated by restorative material failure	$0
D2982	Onlay repair necessitated by restorative material failure	$0
D2983	Veneer repair necessitated by restorative material failure	$0
D6940	Stress breaker	$150
D6950	Precision attachment	$195

Prosthodontics (fixed) - Replacement limited to every 5 years, adjustments once a year

D6205	Pontic - indirect resin based composite	$490
D6210*	Pontic - cast high noble metal	$270
D6211	Pontic - cast predominantly base metal	$270
D6212*	Pontic - cast noble metal	$270
D6240*	Pontic - porcelain fused to high noble metal	$270
D6241	Pontic - porcelain fused to predominantly base metal	$270
D6242*	Pontic - porcelain fused to noble metal	$270
D6243*	Pontic - porcelain fused to titanium and titanium alloys	$270
D6750*	Retainer crown - porcelain fused to High Noble metal	$270
D6751	Retainer crown - porcelain fused to Predominantly Base metal	$270
D6752*	Retainer crown - porcelain fused to noble metal	$270
D6753*	Retainer crown - porcelain fused to titanium and titanium alloys	$270
D6790*	Retainer crown - full cast high noble metal	$270
D6791	Retainer crown - full cast predominantly base metal	$270
D6792*	Retainer crown - full cast noble metal	$270
D6793	Interim retainer crown - further treatment or completion of diagnosis necessary prior to final impression	$90
D6794*	Retainer crown titanium and titanium alloys	$270
D6930	Re-cement or re-bond fixed partial denture	$15
D6980	Fixed partial denture repair necessitated by restorative material failure	$40

Prosthodontics - Replacement limited to every 5 years

D5110*	Complete denture - maxillary	$375
D5120*	Complete denture - mandibular	$375
D5130*	Immediate denture - maxillary	$375
D5140*	Immediate denture - mandibular	$375
D5211*	Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	$400
D5212*	Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	$400
D5213*	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$425
D5214*	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$425
D5221*	Immediate maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth)	$263
D5222*	Immediate mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth)	$263
D5223*	Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$413
D5224*	Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$413
D5225*	Maxillary partial denture - flexible (Including retentive/clasping materials, rests and teeth)	$425

D5226*	Mandibular partial denture - flexible (Including retentive/clasping materials, rests and teeth)	$425
D5227*	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	$425
D5228*	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	$425
D5282*	Removable unilateral partial denture - one piece metal (including retentive/clasping materials, rests and teeth), maxillary	$350
D5283*	Removable unilateral partial denture - one piece metal (including retentive/clasping materials, rests and teeth), mandibular	$350
D5284*	Removable unilateral partial denture – one piece flexible base (including retentive/clasping materials, rests and teeth) - per quadrant	$350
D5286*	Removable unilateral partial denture – one piece resin (including retentive/clasping materials, rests and teeth) - per quadrant	$350
D5410	Adjust complete denture - maxillary	$15
D5411	Adjust complete denture - mandibular	$15
D5421	Adjust partial denture - maxillary	$15
D5422	Adjust partial denture - mandibular	$15
D5660*	Add clasp to existing partial denture - per tooth	$90
D5862	Precision attachment, by report	$105
D5875	Modification of removable prosthesis following implant surgery	$40
D5876	Add metal substructure to acrylic full denture (per arch)	$30
D5899	Unspecified removable prosthodontic procedure, by report	$0

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

D3110	Pulp cap - direct (excluding final restoration)	$15
D3120	Pulp cap - indirect (excluding final restoration)	$10
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$40
D3221	Pulpal debridement, primary and permanent teeth	$85
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$30
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$45
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$50
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$110
D3320	Endodontic therapy, premolar tooth (excluding final restorations)	$195
D3330	Endodontic therapy, molar tooth (excluding final restorations)	$250
D3331	Treatment of root canal obstruction; non-surgical access	$80
D3332	Incomplete endodontic therapy; inoperable or fractured tooth	$80
D3333	Internal root repair of perforation defects	$90
D3346	Retreatment of previous root canal therapy - anterior	$115
D3347	Retreatment of previous root canal therapy - premolar	$160
D3348	Retreatment of previous root canal therapy - molar	$220
D3351	Apexification/recalcification - initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	$90
D3352	Apexification/recalcification - interim medication replacement (includes any necessary radiographs)	$80
D3353	Apexification/recalcification - final visit (includes any necessary radiographs)	$90
D3410	Apicoectomy - anterior	$135
D3421	Apicoectomy - premolar (first root)	$120

D3425	Apicoectomy - molar (first root)	$120
D3426	Apicoectomy (each additional root)	$60
D3428	Bone graft in conjunction with periradicular surgery – per tooth, single site	$20
D3429	Bone graft in conjunction with periradicular surgery – each additional contiguous tooth in the same surgical site	$18
D3430	Retrograde filling - per root	$40
D3431	Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery	$105
D3432	Guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery	$105
D3450	Root amputation - per root (not covered in conjunction with procedure D3920)	$95
D3460	Endodontic endosseous implant	$490
D3470	Intentional reimplantation (including necessary splinting)	$120
D3471	Surgical repair of root resorption – anterior	$70
D3472	Surgical repair of root resorption – premolar	$115
D3473	Surgical repair of root resorption – molar	$85
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	$70
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	$70
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption – molar	$70
D3910	Surgical procedure to isolate tooth with rubber dam	$20
D3911	Intraorifice barrier	$0
D3920	Hemisection (including any root removal), not including root canal therapy	$90
D3921	Decoronation or submergence of an erupted tooth	$60
D3950	Canal preparation and fitting of performed dowel or post	$15

Periodontics

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$120
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$55
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$40
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$150
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$120
D4245	Apically positioned flap	$175
D4249	Clinical crown lengthening – hard tissue	$150
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	$350
D4261	Osseous surgery (including elevation of a Full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	$325
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$180
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$95
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site	$95
D4266	Guided tissue regeneration, natural teeth - resorbable barrier, per site	$230
D4267	Guided tissue regeneration, natural teeth - nonresorbable barrier, per site	$275
D4268	Surgical revision procedure, per tooth	$0
D4270	Pedicle soft tissue graft procedure	$260

D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	$350
D4274	Mesial/distal or proximal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$90
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	$380
D4276	Combined connective tissue and double pedicle graft, per tooth	$45
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft	$265
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site	$130
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	$210
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	$228
D4322	Splint – intra-coronal; natural teeth or prosthetic crowns	$95
D4323	Splint – extra-coronal; natural teeth or prosthetic crowns	$85
D4341	Periodontal scaling and root planing, four or more teeth; per quadrant (A maximum of four (4) quadrants will be paid in any combinations D4342, per 2 years)	$55
D4342	Periodontal scaling and root planing- one to three teeth, per quadrant (A maximum of four (4) quadrants will be paid in any combinations D4341, per 2 years)	$50
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation (limited to 1 per *year*; cross reduces D1110, D1120)	$55
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit (limited to once in a 5 *year* period)	$50
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth (limited to one per tooth per *year* to a maximum of three (3) tooth sites per quadrant, and performed no less than three (3) months following active periodontal therapy.)	$60
D4910	Periodontal maintenance (covered only after active periodontal therapy)	$45
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	$15
D4921	Gingival irrigation with a medicinal agent – per quadrant	$5

Extractions/Oral and Maxillofacial Surgery

D7111	Extraction of coronal remnants - primary tooth	$0
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$0
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$40
D7220	Removal of impacted tooth - soft tissue	$55
D7230	Removal of impacted tooth - partially bony	$70
D7240	Removal of impacted tooth - completely bony	$85
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$110
D7250	Removal of residual tooth roots (cutting procedure)	$40
D7251	Coronectomy – intentional partial tooth removal, impacted teeth only	$105
D7260	Oroantral fistula closure	$350
D7261	Primary closure of a sinus perforation	$225

D7270	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth	$55
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)	$70
D7280	Exposure of an unerupted tooth	$100
D7282	Mobilization of erupted or malposed tooth to aid eruption	$90
D7283	Placement of device to facilitate eruption of impacted tooth	$40
D7284	Excisional biopsy of minor salivary glands	$120
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)	$350
D7286	Incisional biopsy of oral tissue-soft	$120
D7287	Exfoliative cytological sample collection	$50
D7288	Brush biopsy - transepithelial sample collection	$55
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$20
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$40
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$15
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$75
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$30
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	$245
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$700
D7410	Excision of benign lesion up to 1.25 cm	$18
D7411	Excision of benign lesion greater than 1.25 cm	$35
D7412	Excision of benign lesion, complicated	$35
D7450	Removal of benign odontogenic cyst or tumor -up to 1.25cm	$160
D7451	Removal of benign odontogenic cyst or tumor -greater than 1.25cm	$235
D7471	Removal of lateral exotosis (maxilla or mandible)	$90
D7472	Removal of torus palatinus	$65
D7473	Removal of torus mandibularis	$65
D7485	Reduction of osseous tuberosity	$60
D7510	Incision and rainage of abscess - Intraoral soft tissue	$35
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$18
D7520	Incision and drainage of abscess - extraoral soft tissue	$18
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$18
D7880	Occlusal orthotic device, by report (limited to1 per 2 years)	$105
D7881	Occlusal orthotic device adjustment	$5
D7910	Suture of recent small wounds up to 5 cm	$20
D7921	Collection and application of autologous blood concentrate product	$90
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	$0
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report	$245
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	$560
D7952	Sinus augmentation via a vertical approach	$350
D7961	Buccal / labial frenectomy (frenulectomy)	$20
D7962	Lingual frenectomy (frenulectomy)	$20
D7963	Frenuloplasty	$35

D7970	Excision hyperplastic tissue - per arch	$85
D7971	Excision of pericoronal gingival	$55
D7972	Surgical reduction of fibrous tuberosity	$90
D7994	Surgical placement: zygomatic implant	$840

Repair to Prosthetics

D5511*	Repair broken complete denture base, mandibular	$35
D5512*	Repair broken complete denture base, maxillary	$35
D5520*	Replace missing or broken teeth - complete denture - per tooth	$35
D5611*	Repair resin partial denture base, mandibular	$35
D5612*	Repair resin partial denture base, maxillary	$35
D5621*	Repair cast partial framework, mandibular	$35
D5622*	Repair cast partial framework, maxillary	$35
D5630*	Repair or replace broken retentive clasping materials - per tooth	$35
D5640*	Replace missing or broken teeth - partial denture - per tooth	$35
D5650*	Add tooth to existing partial denture - per tooth	$35
D5670*	Replace all teeth and acrylic on cast metal framework -maxillary	$210
D5671*	Replace all teeth and acrylic on cast metal framework - mandibular	$225
D5710*	Rebase complete upper denture	$200
D5711*	Rebase complete lower denture	$200
D5720*	Rebase maxillary partial denture	$200
D5721*	Rebase mandibular partial denture	$200
D5725*	Rebase hybrid prosthesis	$200
D5730	Reline complete maxillary denture (direct)	$60
D5731	Reline complete mandibular denture (direct)	$60
D5740	Reline maxillary partial denture (direct)	$60
D5741	Reline mandibular partial denture (direct)	$60
D5750*	Reline complete maxillary denture (indirect)	$95
D5751*	Reline complete mandibular denture (indirect)	$95
D5760*	Reline maxillary partial denture (indirect)	$95
D5761*	Reline mandibular partial denture (indirect)	$95
D5765*	Soft liner for complete or partial removable denture – indirect	$95
D5810*	Interim complete denture (maxillary)	$250
D5811*	Interim complete denture (mandibular)	$250
D5820*	Interim partial denture (including retentive/clasping materials, rests, and teeth) - maxillary	$80
D5821*	Interim partial denture (including retentive/clasping materials, rests, and teeth) - mandibular	$80
D5850	Tissue conditioning, maxillary	$30
D5851	Tissue conditioning, mandibular	$30
D5982*	Surgical stent	$70
D5987*	Commissure splint	$70
D5988*	Surgical splint	$70
D6214*	Pontic titanium and titanium alloys	$270
D6245*	Pontic - porcelain/ceramic	$270
D6250*	Pontic - resin with High Noble Metal	$270
D6251	Pontic - resin with predominantly base metal	$270
D6252*	Pontic - resin with noble metal	$270
D6253*	Interim pontic - further treatment or completion of diagnosis necessary prior to final impression	$0
D6545*	Retainer - cast metal, resin bonded fixed prosthesis	$250
D6548*	Retainer - porcelain/ceramic, resin bonded fixed prosthesis	$250

D6549	Retainer – for resin bonded fixed prosthesis	$250
D6600*	Retainer inlay - porcelain/ceramic, two surfaces	$270
D6601*	Retainer inlay - porcelain/ceramic, three or more surfaces	$270
D6602*	Retainer inlay - cast high noble metal, two surfaces	$270
D6603*	Retainer inlay - cast high noble metal, three or more surfaces	$270
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$270
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$270
D6606*	Retainer inlay - cast noble metal, two surfaces	$270
D6607*	Retainer inlay - cast noble metal, three or more surfaces	$270
D6608*	Retainer onlay - porcelain/ceramic, two surfaces	$270
D6609*	Retainer onlay - porcelain/ceramic, three or more surfaces	$270
D6610*	Retainer onlay - cast high noble metal, two surfaces	$270
D6611*	Retainer onlay - cast high noble metal, three or more surfaces	$270
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$270
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$270
D6614*	Retainer onlay - cast noble metal, two surfaces	$270
D6615*	Retainer onlay - cast noble metal, three or more surfaces	$270
D6624*	Retainer inlay - titanium	$270
D6634*	Retainer onlay - titanium	$270
D6710*	Retainer crown - indirect resin based composite	$270
D6720*	Retainer crown - resin with high noble metal	$270
D6721	Retainer crown - resin with predominantly base metal	$270
D6722*	Retainer crown - resin with noble metal	$270
D6740*	Retainer crown - porcelain/ceramic	$280
D6780*	Retainer crown - 3/4 cast high noble metal	$270
D6781	Retainer crown - 3/4 cast predominantly base metal	$270
D6782*	Retainer crown - 3/4 cast noble metal	$270
D6783*	Retainer crown - 3/4 porcelain/ceramic	$270
D6784*	Retainer crown - 3/4 titanium and titanium alloys	$270

Adjunctive General Service

D9110	Palliative treatment of dental pain - per visit	$5
D9120	Fixed partial denture sectioning	$0
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$0
D9211	Regional block anesthesia	$0
D9212	Trigeminal division block anesthesia	$0
D9215	Local anesthesia in conjunction with operative or surgical procedures	$0
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	$0
D9222	Deep sedation/general anesthesia – first 15 minutes	$83
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment	$71
D9230	Inhalation of nitrous oxide/analgesia anxiolysis	$15
D9239	Intravenous moderate (conscious) sedation/anesthesia – first 15 minutes	$83
D9243	Intravenous moderate (conscious) sedation/anesthesia – each subsequent 15 minute increment	$71
D9248	Non-intravenous conscious sedation	$5
D9311	Consultation with a medical health care professional	$0
D9450	Case presentation, subsequent detailed and extensive treatment planning	$0
D9610	Therapeutic parenteral drug, single administration	$5
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	$18
D9613	Infiltration of sustained release therapeutic drug, per quadrant	$35
D9630	Drugs or medicaments dispensed in the office for home use	$5
D9910	Application of desensitizing medicament	$5

D9911	Application of desensitizing resin for cervical and/or root surface, per tooth	$0
D9912	Pre-visit patient screening	$0
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	$0
D9932	Cleaning and inspection of removable complete denture, maxillary	$0
D9933	Cleaning and inspection of removable complete denture, mandibular	$0
D9934	Cleaning and inspection of removable partial denture, maxillary	$0
D9935	Cleaning and inspection of removable partial denture, mandibular	$0
D9941	Fabrication of athletic mouthguard (limited to 1 per *year*)	$70
D9942	Repair and/or reline of occlusal guard	$30
D9943	Occlusal guard adjustment	$5
D9944	Occlusal guard – hard appliance, full arch (limited to 1 per 2 years)	$90
D9945	Occlusal guard – soft appliance, full arch (limited to 1 per 2 years)	$85
D9946	Occlusal guard – hard appliance, partial arch (limited to 1 per 2 years)	$85
D9950	Occlusion analysis - mounted case	$50
D9951	Occlusal adjustment - limited	$35
D9952	Occlusal adjustment - complete	$165
D9961	Duplicate/copy patient's records	$0
D9973	External bleaching - per tooth	$20
D9990	Certified translation or sign-language services – per visit	$0
D9991	Dental case management – addressing appointment compliance barriers	$0
D9992	Dental case management – care coordination	$0
D9993	Dental case management – motivational interviewing	$0
D9994	Dental case management – patient education to improve oral health literacy	$0
D9995	Teledentistry – synchronous; real-time encounter	$0
D9996	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	$0
D9997	Dental case management - patients with special health care needs	$0

Bleaching

D9972	External bleaching performed in the office - per arch	$175
D9975	External bleaching performed at home - per arch	$175

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

Orthodontic Services

D8010
Limited orthodontic treatment of the primary dentition

Consultation	$0
Evaluation	$45
Records/Treatment Planning…	$250
Orthodontic treatment	$850

D8020
Limited orthodontic treatment of the transitional dentition

Consultation	$0
Evaluation	$45
Records/Treatment Planning	$250
Orthodontic treatment	$850

D8030
Limited orthodontic treatment of the adolescent dentition

Consultation	$0
Evaluation	$45
Records/Treatment Planning…	$250
Orthodontic treatment	$800

D8040
Limited orthodontic treatment of the adult dentition

Consultation	$0
Evaluation	$45
Records/Treatment Planning	$250
Orthodontic treatment	$1,000

D8070
Comprehensive Orthodontic treatment of the transitional dentition

Consultation	$0
Evaluation	$45
Records/Treatment Planning	$250
Orthodontic treatment	$1,900

D8080
Comprehensive Orthodontic treatment of the adolescent dentition

Consultation	$0
Evaluation	$45
Records/Treatment Planning	$250
Orthodontic treatment	$1,900

D8090
Comprehensive Orthodontic treatment of the adult dentition

Consultation	$0
Evaluation	$45
Records/Treatment Planning	$250
Orthodontic treatment	$1,900

D8210	Removable appliance therapy	$50
D8220	Fixed appliance therapy	$50
D8660	Pre-orthodontic treatment examination to monitor growth and development	$50
D8670	Periodic orthodontic treatment visit	$0
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$455
D8681	Removable orthodontic retainer adjustment	$0
D8695	Removal of fixed orthodontic appliances for reasons other than completion of treatment	$140
D8698	Re-cement or re-bond fixed retainer – maxillary	$0
D8699	Re-cement or re-bond fixed retainer – mandibular	$0
D8701	Repair of fixed retainer, includes reattachment – upper	$0
D8702	Repair of fixed retainer, includes reattachment – lower	$0

Implant Services:

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

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

D6010	Surgical placement of implant body: endosteal implant
D6011	Surgical access to an implant body (second stage implant surgery) (limited to 1 per 5 years)
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant
D6013	Surgical placement of mini implant
D6040	Surgical placement: eposteal implant
D6050	Surgical placement: transosteal implant
D6055	Connecting bar – implant supported or abutment supported
D6056	Prefabricated abutment – includes modification and placement
D6057	Custom fabricated abutment – includes placement
D6058	Abutment supported porcelain/ceramic crown
D6059	Abutment supported porcelain fused to metal crown (high noble metal)
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)
D6061	Abutment supported porcelain fused to metal crown (noble metal)
D6062	Abutment supported cast metal crown (high noble metal)
D6063	Abutment supported cast metal crown (predominantly base metal)
D6064	Abutment supported cast metal crown (noble metal)
D6065	Implant supported porcelain/ceramic crown
D6066	Implant supported crown - porcelain fused to high noble alloys
D6067	Implant supported crown - high noble alloys
D6068	Abutment supported retainer for porcelain/ceramic FPD
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)
D6072	Abutment supported retainer for cast metal FPD (high noble metal)
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)
D6074	Abutment supported retainer for cast metal FPD (noble metal)
D6075	Implant supported retainer for ceramic FPD
D6076	Implant supported retainer for FPD - porcelain fused to high noble alloys
D6077	Implant supported retainer for metal FPD - high noble alloys
D6080	Implant maintenance procedures when full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments (limited to 1 per *year*)
D6081	Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure (limited to 1 per implant per 3 years not performed in conjunction with D1110, D4910 or D4346)
D6082	Implant supported crown - porcelain fused to predominantly base alloys
D6083	Implant supported crown - porcelain fused to noble alloys
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys
D6085	Provisional implant crown
D6086	Implant supported crown - predominantly base alloys

D6087	implant supported crown - noble alloys
D6088	Implant supported crown - titanium and titanium alloys
D6089	Accessing and retorquing loose implant screw- per screw (limited to 1 per 5 years)
D6090	Repair of implant/abutment supported prosthesis, by report (limited to 1 per 5 years)
D6091	Replacement of replaceable part of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment (limited to 1 per 3 years)
D6092	Re-cement or re-bond implant/abutment supported crown (limited to 1 per 5 years)
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture (limited to 1 per 5 years)
D6094	Abutment supported crown - titanium and titanium alloys
D6096	Remove broken implant retaining screw (limited to 1 per 5 years)
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys
D6098	Implant supported retainer - porcelain fused to predominantly base alloys
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys
D6100	Surgical removal of implant body (limited to 1 per 5 years)
D6101	Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure (limited to 1 per 5 years)
D6102	Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure (limited to 1 per 5 years)
D6103	Bone graft for repair of peri-implant defect – does not include flap entry and closure (limited to 1 per 5 years)
D6104	Bone graft at time of implant placement (limited to 1 per 5 years)
D6110	Implant/abutment supported removable denture for edentulous arch – maxillary
D6111	Implant/abutment supported removable denture for edentulous arch – mandibular
D6112	Implant/abutment supported removable denture for partially edentulous arch – maxillary
D6113	Implant/abutment supported removable denture for partially edentulous arch – mandibular
D6114	Implant/abutment supported fixed denture for edentulous arch – maxillary
D6115	Implant/abutment supported fixed denture for edentulous arch – mandibular
D6116	Implant/abutment supported fixed denture for partially edentulous arch – maxillary
D6117	Implant/abutment supported fixed denture for partially edentulous arch – mandibular
D6118	Implant/abutment supported interim fixed denture for edentulous arch – mandibular
D6119	Implant/abutment supported interim fixed denture for edentulous arch – maxillary
D6120	Implant supported retainer – porcelain fused to titanium and titanium alloys
D6121	Implant supported retainer for metal FPD – predominantly base alloys
D6122	Implant supported retainer for metal FPD – noble alloys
D6123	Implant supported retainer for metal FPD – titanium and titanium alloys
D6180	Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis abutment (limited to 1 per *year*)
D6190	Radiographic/surgical implant index, by report (limited to 1 per 5 years)
D6191	Semi-precision abutment - placement
D6192	Semi-precision attachment - placement
D6194	Abutment supported retainer crown for FPD – titanium and titanium alloys
D6195	Abutment supported retainer - porcelain fused to titanium and titanium alloys
D6198	Remove interim implant component (limited to 1 per 5 years)
D7996	Implant - mandible
D7953	Bone replacement graft for ridge preservation (limited to 1 per 5 years)

NOTE:

1. Not all Participating Dentists perform all listed procedures, including amalgams. Please consult Your dentist prior to treatment for availability of services.
2. Some Covered Dental Care Services are typically only offered by a specialist (like many oral surgery procedures).
3. When crown and/or bridgework exceeds six units in the same treatment plan, the patient may be charged and additional $75 per unit.
4. Additional exclusions and limitations are listed along with Full plan information in your Certificate of Dental Benefits.
5. Copayment amounts for listed procedures are applicable at either the Participating General Dentist or Participating Specialist. Specialist services are only available in areas where the dental plan has a Participating Specialist.

Offered and Administered by DentiCare, Inc. (d/b/a CompBenefits), a Humana company

Notices

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

This section includes notices about:

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, an internal appeal or an external review. The designation must be in writing and must be made by the covered person on Humana's Appointment of Representation (AOR) Form. The date of the covered person's signature must be on or after the denial of the disputed claims, approvals, or authorization. An assignment of benefits does not constitute designation of an authorized representative.

Humana's AOR Form must be submitted to Humana at the time or prior to the date an authorized representative commences a course of action on behalf of the covered person. At the same time, the authorized representative should also provide notice of commencement of the action on behalf of the covered person to the covered person, which Humana may verify with the covered person prior to recognizing authorized representative status.

When a health care provider intends to appeal on behalf of the member for a non-urgent care claim, the provider must indicate in their appeal request that they are appealing on behalf of the member and include a completed Humana AOR form. If an AOR form is not included with the request, the form will be sent to the provider.

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. An authorized representative may make decisions independent of the covered person, such as whether and how to appeal a claim denial.

Claims decisions

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

Pre-service claims

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

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

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

Urgent-care claims (expedited review)

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

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

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

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

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

Concurrent-care decisions

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

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

Post-service claims

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

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

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

Initial denial notices

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

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

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

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

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

Appeals of Adverse Determinations

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

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

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

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

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

Time periods for decisions on appeal

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

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

Appeals denial notices

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

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

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

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

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

Exhaustion of remedies

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

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

Legal actions and limitations

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

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

Medical child support orders

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

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

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

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

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

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

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

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

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

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

General notice of COBRA continuation coverage rights

Introduction

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

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

What is COBRA continuation coverage?

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

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

- Your hours of employment are reduced; or

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

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

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

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

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

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

When is COBRA coverage available?

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

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

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

How is COBRA Coverage Provided?

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

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

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

Disability extension of 18-month period of

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

Second qualifying event extension of 18-month period of

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

If You Have Questions

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

Keep your plan informed of address changes

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

Plan contact information:

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

Family and Medical Leave Act (FMLA)

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

Uniformed Services Employment and Reemployment Rights Act of 1994

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

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

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

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

Duration of coverage

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

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

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

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

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

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

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

Information about the plan and benefits

Plan participants may:

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

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

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

Responsibilities of plan fiduciaries

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

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

Continue group health plan coverage

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

Claims determinations

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

Enforce your rights

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

- if a participant requests a copy of plan documents and does not receive them within 30 days, the participant may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until the participant receives the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator;
- if a claim for benefits is denied or disregarded, in whole or in part, the participant may file suit in a state or Federal court;
- if the participant disagrees with the plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, the participant may file suit in Federal court;
- if plan fiduciaries misuse the plan's money, or if participants are discriminated against for asserting their rights, they may seek assistance from the U.S. Department of Labor, or may file suit in a Federal court.

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

Assistance with questions

- Contact the group health plan human resources department or the plan administrator with questions about the plan;

- For questions about ERISA rights, contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or:

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

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

Notice of Non-Discrimination

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate or exclude people because of their race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services. Humana Inc.:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids, or language assistance services contact **877-320-1235 (TTY: 711)**. Hours of operation: 8 a.m. – 8 p.m., Eastern time. If you believe that Humana Inc. has not provided these services or discriminated on the basis of race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services, you can file a grievance in person or by mail or email with Humana Inc.'s Non-Discrimination Coordinator at P.O. Box 14618, Lexington, KY 40512-4618, **877-320-1235 (TTY: 711)**, or **accessibility@humana.com**. If you need help filing a grievance, Humana Inc.'s Non-Discrimination Coordinator can help you.

You can also file a 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, S.W., Room 509F, HHH Building Washington, D.C. 20201. **800-368-1019**, **800-537-7697 (TDD)**.

California members or residents:

You may also call the California Department of Insurance toll-free hotline number: **800-927-HELP (4357)**, to file a grievance.

This notice is available at **www.humana.com/legal/non-discrimination-disclosure**.

Auxiliary aids and services, free of charge, are available to you. **877-320-1235 (TTY: 711).** Hours of operation: 8 a.m. – 8 p.m., Eastern time.

Humana Inc. and its subsidiaries provide free auxiliary aids and services to people with disabilities when auxiliary aids and services are necessary to ensure an equal opportunity to participate. Services include qualified sign language interpreters, video remote interpretation, and written information in other formats.

English: Call the number above to receive free language assistance services.

Español (Spanish): Llame al número que se indica arriba para recibir servicios gratuitos de asistencia lingüística.

繁體中文 (Chinese): 您可以撥打上面的電話號碼以獲得免費的語言協助服務。

Tiếng Việt (Vietnamese): Gọi số điện thoại ở trên để nhận các dịch vụ hỗ trợ ngôn ngữ miễn phí.

한국어 **(Korean)** 무료 언어 지원 서비스를 받으려면 위 번호로 전화하십시오.

Tagalog (Tagalog – Filipino) Tawagan ang numero sa itaas para makatanggap ng mga libreng serbisyo sa tulong sa wika.

Русский (Russian): Позвоните по вышеуказанному номеру, чтобы получить бесплатную языковую поддержку.

العربية (Arabic): اتصل برقم الهاتف أعلاه للحصول على خدمات المساعدة اللغوية المجانية.

French Creole (Haitian Creole): Kreyòl Ayisyen (French Creole) Rele nimewo ki e dike anwo a pou resevwa sèvis éd gratis nan lang.

Français (French): Appelez le numéro ci-dessus pour recevoir des services gratuits d'assistance linguistique.

Polski (Polish) Aby skorzystać z bezpłatnej pomocy językowej, należy zadzwonić pod wyżej podany numer.

Português (Portuguese): Ligue para o número acima para receber serviços gratuitos de assistência no idioma.

Italiano (Italian) Chiamare il numero sopra indicato per ricevere servizi di assistenza linguistica gratuiti.

日本語 (Japanese): 無料の言語支援サービスを受けるには、上記の番号までお電話ください。

Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

فارسی (Farsi): برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

हिंदी (Hindi): भाषा सहायता सेवाएं मुफ्त में प्राप्त करने के लिए ऊपर के नंबर पर कॉल करें।

հայերեն (Armenian): Զանգահարեք վերը նշված հեռախոսահամարով՝ անվճար լեզվական օգնության ծառայություններ ստանալու համար:

ગુજરાતી (Gujarati): મફત ભાષા સહાય સેવાઓ મેળવવા માટે ઉપર આપેલા નંબર પર કૉલ કરો.

Hmoob (Hmong) Hu rau tus xov tooj saum toj sauv kom tau txais kev pab txhais lus dawb.

This notice is available at **www.humana.com/legal/multi-language-support**.