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Policyholder (Employer): THE LINCOLN ELECTRIC COMPANY
Group Number: 790348
Coverage Effective Date: 01-01-2021

CompBenefits Insurance Company
Agreement And Certificate of Benefits

Provided that all Contributions and Copayments required by this Certificate are paid when due, CompBenefits Insurance Company (hereinafter referred to as "Company") hereby agrees to provide Benefits to the Subscriber subject to all the provisions, definitions, limitations, and conditions of this Certificate outlined below:

Bruce Broussard
President

Notice: if you or your family members are covered by more than one dental care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific dentists or specialists, and it may be impossible to comply with both plans at the same time. Read all of the rules very carefully, including the coordination of benefits section, and compare them to the rules of any other plan that covers you or your family.

I. Definitions

A. **"Agreement and Certificate of Benefits"** (hereinafter referred to as "Certificate") is that document provided to the Subscriber that specifies Benefits and conditions of Coverage.

B. **"Benefits"** are those Dental Care Services available to the Members as stated in their Certificates.

C. **"Contributions"** are those periodic payments due Company by Subscriber to receive Benefits as provided by the Certificate.

D. **"Copayment"** means the amount that an enrollee must pay in order to receive a specific service that is not fully prepaid.

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

F. **"Dental Care Services"** are those services to be performed by a Participating General Dentist or Participating Specialist pursuant to the terms of the Certificate and a Participating General Dentist Agreement or a Participating Specialist Agreement.

G. **"Dental Facility"** is the location of the Participating General Dentist's or Participating Specialist's office where Members shall receive Dental Care Services. Subscriber and Dependent must use the same Participating General Dentist's office. However, this does not apply to Participating Specialist's office.

H. **"Dependent"** means the following dependents of the Subscriber: a) the legal spouse; and b) all unmarried dependent children up to 26 years of age and dependent on the Subscriber for primary support, or up to age 26 if a full-time student and dependent upon the Subscriber for primary support. The term "children" also includes: a) adopted children and b) stepchildren and foster children living with the Subscriber in a parent- child relationship.

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

J. **"Enrollment Fee"** is a one-time application fee for non-group contracts.

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

L. **"Necessary Treatment"** is that set of Dental Care Services determined by the Participating General Dentist or Participating Specialist as required to establish and maintain Member's good oral health.

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

N. **"Participating General Dentists and Participating Specialists"** are those licensed dentists selected and contracted with Company as independent contractors to provide dental Benefits to Members.

O. **"Subscriber"** is an individual in good standing for whom the necessary Contributions and Copayments have been made in payment for Dental Care Services and to whom a Certificate evidencing coverage has been issued.

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

Q. **"Usual Charges"** are those fees that are customarily charged for Dental Care Services by the Participating General Dentist or Participating Specialist. Said charges are not determined by Company. Information regarding Usual Charges is available from Company.

II. Contributions and Copayments

It is agreed that in order for Member to be eligible for and entitled to receive Benefits provided by this Certificate, Company must receive all Contributions and Enrollment Fees (where applicable) in advance. The Participating General Dentist or Participating Specialist must receive any Copayments in accordance with their particular payment procedure.

III. Benefits

From the Effective Date, Company agrees to provide Benefits to Members through Participating General Dentists or Participating Specialists on a No Charge or Copayment basis in accordance with the Schedule of Benefits contained in this Certificate. Under no circumstances will a Participating General Dentist or a Participating Specialist see compensation from a Member except for approved Copayments There is no exclusion due to pre-existing dental conditions except in those instances in which treatment has been initiated but not yet completed prior to the Effective Date.

IV. Duration of Agreement

Except under the following conditions, Company and Subscriber shall maintain this Certificate in force for a period of not less than twelve (12) months:

A. Company may cancel this Certificate with forty-five (45) days written notice:

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

When a Member's behavior is disruptive, unruly, abusive, unlawful, fraudulent, or uncooperative.

2. If cancellation is effected by Company, all excess Contributions received by Company (excluding Enrollment Fees) over Usual Charges will be returned to Subscriber.

3. Cancellation of this Certificate by Company is without prejudice to any continuous loss which commenced while this Certificate was in force. Participating General Dentists and/or Participating Specialists shall complete all dental procedures undertaken upon the Member, until the specific treatment or procedure undertaken upon the Member has been completed or for ninety (90) days, whichever is the lesser period of time. This shall apply to acute care procedures only and shall not include non-acute continuing care which would require continuing periodic treatment.

B. Subscriber may cancel this Certificate:

1. By notifying Company in writing within thirty (30) days of the Effective Date. Provided no Dental Care Services have been rendered to the Member, all Contributions (excluding Enrollment Fees) will be refunded upon written request. If Dental Care Services have been received by the Member, then any Contribution refunds shall be first applied to the Usual Charges of the Participating General Dentist or Participating Specialist.

2. If the Subscriber permanently moves from the Company service area; unless by court order, the Subscriber is required to provide Dental Care Services for a dependent child. Cancellation shall become effective on the last day of the month in which written notification is received by Company

3. If the Subscriber seeks cancellation after the first thirty (30) days and during the first twelve (12) months of this Certificate, the Subscriber will not be entitled to any premium refund.

V. Continuation of Coverage

Unless cancellation of this Certificate is made for reasons specified in IV. A. 1. (a), (b), (c), or (d), Subscribers who continue to pay appropriate Contributions and Copayments will have their Certificates automatically renewed at the expiration of the first twelve (12) months. The following conditions also will apply:

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

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

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

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

It is possible that a given employer is exempt from COBRA, particularly if there are less than 20 employees at all times during the calendar year.

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

VI. Coverage for Newborn Children and Adding Additional Dependents

A. A child born to the Subscriber, while this Certificate is in force is covered under this Certificate from the moment of birth, up to thirty-one (31) days. If coverage is to continue, the Subscriber must notify Company within the thirty-one (31) day period and pay the required Contribution, if any. Coverage is for the same Benefits and under the same terms and conditions applicable for Dependent children. Adoptive children will be treated the same as newborn infants and eligible for coverage on the same basis upon anticipation of the adoption of the child.

B. Additional eligible Dependents of Subscriber may be added to this Certificate upon application to Company. When Dependents of a Subscriber become ineligible, upon application they may change their status and continue their Benefits as an individual Subscriber.

VII. Conversion Provisions for Group Plans

A. Company shall offer a converted contract to any Subscriber or covered Dependent whose group plan coverage has been terminated, and who has been continuously covered under Company for at least three (3) months immediately prior to termination. The converted contract will provide coverage and benefits similar to the terminated contract and will be similar to the non-group or group contract previously in effect.

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

1. Failure to pay any required premium or Contribution.

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

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

4. Disenrollment for cause as specified in IV.A.1.

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

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

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

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

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

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

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

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

VIII. General Provisions

A. Dental Facility Selection

1. Subscribers shall be entitled to select the Dental Facility of their choice from a listing of Dental Facilities provided at the time of original enrollment.

2. Subscribers shall be entitled to transfer from one Dental Facility to another upon written request and provided all Contributions and Copayments are currently paid. Transfers are limited to one (1) per calendar year per Subscriber.

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

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

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

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

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

B. Appointments

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

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

C. Emergency Care

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

1. Out-of-Area Emergency Care:

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

2. In-Service-Area Emergency Care:

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

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

D. Change in Contributions or Copayments

Subject to the limitations of any applicable agreement(s) between Company and Subscriber's employer, Company, at its discretion, may change the Contributions and/or Benefits by providing Subscriber with forty- five (45) days written notice prior to the Effective Date of the change. Changes in Contributions and Benefits will not be made to individual Certificates but will be made only on a class of Certificates. Subscriber shall have the right to cancel the Certificate, without penalty, if Subscriber does not wish to continue coverage because of proposed change.

E. Renewal

All Subscribers who continue to pay appropriate Contributions and Copayments will have their coverage renewed automatically, subject to all applicable provisions of this Certificate.

F. Grace Period

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

G. Reinstatement

The following guidelines shall apply to requests for reinstatement:

1. The Subscriber must submit an application for reinstatement to Company.

2. The Subscriber must remit to Company all Contributions for the period between the lapse Effective Date (previous last day of eligible coverage) and the reinstatement date.

Upon receipt by Company of the application and the appropriate Contributions, Company will notify Subscriber of the Effective Date of resumption of Benefits.

H. Dental Records

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

I. Limitations and Exclusions

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

2. Whenever any Contributions or Copayments are delinquent, Member will not be entitled to receive Benefits, transfer Dental Facilities, or enjoy any of the other privileges of a Member in good standing.

3. Company does not provide coverage for the following services:

    a. Cost of hospitalization and pharmaceuticals, drugs or medications.

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

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

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

e. Any dental treatment started prior to the Member's effective date for eligibility of benefits.

f. Services for injuries and conditions which are covered under Workers' Compensation or Employers' Liability laws.

g. Treatment for cysts, neoplasms and malignancies.

h. General anesthesia.

J. Incontestability

In the absence of fraud, all statements made by the Subscriber are considered representations and not warranties during the first two years of coverage. Company may avoid providing coverage at any time if Subscriber makes a material misrepresentation in a written application.

K. Conformity with Ohio Law

1. This Certificate shall be interpreted in accordance with the laws of the State of Ohio and any action or claim, including arbitration, shall be brought within the State of Ohio.
2. Any statute, act, ordinance, rule or regulation of any governmental authority with jurisdiction over Company shall have the effect of amending this Certificate to conform with the minimum requirements thereof.

3. In the event any portion of this Certificate is held to be void, it shall not affect any other provisions.

L. Notices

All notices, changes, or requests by Members shall be made in writing and shall be furnished by United States Mail to Company at its address as listed below:

CompBenefits Insurance Company, Rockside Square Two, 6133 Rockdside Road, Suite 304, Independence, OH, Tel. (800) 633-1262.

M. Notice of Independent Contractor Relationship

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

N. Open Enrollment for Group Plans

Company will offer group plans at least one open enrollment period of not less than thirty (30) days every eighteen (18) months. Such open enrollment periods will be offered for as long as the group exists unless Company and the Group mutually agree to a shorter period of time than eighteen (18) months.

O. **Coordination of Benefits**

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

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

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

PLANS THAT DO NOT COORDINATE

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

-- Individual (not group) policies or contracts
-- Medicaid
-- Group hospital indemnity plans which pay less than $100 per day
-- School accident coverage
-- Some supplemental sickness and accident policies

HOW COMPANY PAYS AS PRIMARY PLAN

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

HOW COMPANY PAYS AS SECONDARY PLAN

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

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

WHICH PLAN IS PRIMARY?

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

1. Non-coordinating Plan

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

2. Employee

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

3. Children (Parents Divorced or Separated)

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

4. Children & the Birthday Rule

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

5. Other Situations

For all other situations not described above, the order of benefits will be determined in accordance with the Ohio Insurance Department rule on Coordination of Benefits.

COORDINATION DISPUTES

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us. (For health maintenance organizations, reference certificate's description of appeal procedures). If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call (614) 644-2673 or 1-800-686-1526.

P. Insurance Fraud

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Q. Financial Statement

Upon written request of any Subscriber, Company will make available its most recent audited financial statement.

R. Insurance Department

The address and telephone number of the Ohio Insurance Department are as follows: 2100 Stella Court,

Columbus, OH 43215-1067 Tel. (800) 686-1526 or (614) 644-2673

S. Company Insolvency

Company is not a member of any guaranty fund. In the event of Company's insolvency, the Participating General Dentists and Participating Specialists have agreed not to bill, charge or seek reimbursement from Member. Member may, however, be financially responsible for dental care services rendered by a non- participating provider, whether or not Company authorized the use of the provider.

IX. Review and Mediation of Complaints

A. Informational Grievances

Any Member who has a grievance against Company for any matter arising out of a Subscriber Certificate or for covered Dental Care Services rendered thereunder may submit an informal oral grievance to Company.
Assistance with Company's grievance procedures, including assistance with informal oral grievances, may be obtained by calling Company's Member Services Department at (800) 342-5209. Oral grievances shall be submitted to Company's Grievance Coordinator. Informal oral grievances shall be responded to as soon as possible by the Grievance Coordinator. If the informal oral grievance involves a dental-related matter or claim, Company's Dental Director shall be involved in resolving said grievance. The Member has the right to file a formal written grievance with Company and to appeal to the State of Ohio Department of Insurance.

B. Submission of Formal Grievances

Any Member who has a grievance against Company for any matter arising out of a Subscriber Certificate or for covered Dental Care Services rendered thereunder may submit a formal written statement of the grievance to Company. Such written statement shall be specifically identified as a grievance, shall be submitted to Company within one (1) year from occurrence of the events upon which the grievance is based, and shall contain a statement of the action requested, the Member's name, address, telephone number, Member number, signature and the date. The statement should be sent to Grievance and Appeals Department PO Box 14729 Lexington KY 40512-4729. More information on and assistance with Company's grievance procedures may be obtained by calling Company's Member Services Department at (800) 342-5209.

C. Response to Formal Grievances

Company's Grievance Panel shall meet once a month to review written grievances submitted. If the Grievance Panel requires further information from the Member, then the Member may be asked to appear before the Grievance Panel. The Grievance Panel shall render a decision and communicate such decision, in writing, to the grievant within ten (10) days after the Grievance Panel's meeting. If the grievance involves a dental-related matter or claim, Company's Dental Director shall be involved in resolving said grievance. If the grievance involves denial of benefits or services, the written decision shall reference the specific provisions of this Certificate upon which the denial is based. All grievances shall be processed within sixty (60) days by Company. However, if the grievance involves collection of information from outside Company's service area, an additional thirty (30) days will be allowed for processing.

D. Appeal of Decision

If the Member is dissatisfied with the decision of the Grievance Panel, the Member may request reconsideration by the Grievance Panel and may request a personal appearance before the Grievance Panel. Such requests for reconsideration must be made within sixty (60) days after receipt of the Grievance Panel's initial written decision. In addition, a Member has the right to appeal to the State of Ohio Department of Insurance.

X. Entire Agreement

This Certificate constitutes the entire agreement between the parties.

XI. Agreement Language

Whenever the context hereof requires, the gender of all words shall include the masculine, feminine and neuter, and the number of all words shall include the singular and plural.

AMENDMENT
TO
AGREEMENT AND CERTIFICATE OF BENEFITS

The Agreement and Certificate of Benefits (“Certificate”) issued by Company to Subscriber is hereby amended, effective upon receipt of this Amendment, as follows:

The terms and conditions of that certain Certificate are hereby confirmed in their entirety with the exception that to the extent the terms and conditions of this Amendment are in conflict with the terms and conditions of the Certificate, the terms of this Amendment shall govern.

Section I. Definitions, Paragraph H. Dependent, is deleted and replaced in its entirety with the following:

H "Dependent" means the following dependents of the Subscriber: a) the legal spouse; b) all unmarried dependent children under 26 years of age, or under 26 if they are full-time students in an accredited college or university and dependent on the Subscriber for primary support, unless otherwise negotiated or covered by amendment to this Certificate; (the term "children" also includes adopted children, stepchildren and foster children living with the Subscriber in a parent-child relationship), and may include if negotiated, c) the domestic partner who; i) is the sex as Subscriber; ii) has lived with Subscriber at the same regular residence and been each other's sole domestic partner and intends to continue such indefinitely; iii) is not legally married to anyone else; iv) is 18 years of age or older; v) is not related to Subscriber, and vi) is financially interdependent with Subscriber.

It is agreed and acknowledged that this Amendment shall be effective upon receipt by Subscriber.

Schedule of Benefits and Subscriber Copayments

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ADA CODE	PROCEDURE	PATIENT PAYS
APPOINTMENTS		
9310	Consultation (diagnostic service provided by dentist other than practitioner providing treatment)	$20.00
9430	Office Visit (normal hours)	$5.00
9440	Office Visit (after regularly scheduled hours)	$35.00
9999	Emergency visit during regularly scheduled hours, by report	$20.00
9999	Broken appointments (without 24 hr notice, per 15 min) Maximum $40 per broke appointment. No charge will be made due to emergencies	$10.00
DIAGNOSTIC		
120	Periodic oral evaluation	NO CHARGE
140/150/160	Limited/Comprehensive oral evaluation	NO CHARGE
180	Comprehensive periodontal evaluation	$15.00
210	X-Ray Intraoral – complete series including bitewings	NO CHARGE
220	X-Ray Intraoral – periapical – first film	NO CHARGE
230	X-Ray Intraoral – periapical – each additional film	NO CHARGE
270	X-Ray Bitewing – single film	NO CHARGE
272	X-Ray Bitewings – two films	NO CHARGE
274	Bitewings – four films	NO CHARGE
330	Panoramic film	NO CHARGE
460	Pulp vitality tests	NO CHARGE
470	Diagnostic casts	NO CHARGE
PREVENTIVE CARE		
1110/1120	Prophylaxis – adult/child-routine (once every 6 months)	NO CHARGE
1110/1120	Prophylaxis – adult/child-routine (additional)	$25.00
1201	Topical application of fluoride (including prophylaxis) – child (up to 16 years of age)	NO CHARGE
1203	Topical application of fluoride (not including prophylaxis) – child (up to 16 years of age)	NO CHARGE
1330	Oral hygiene instruction	NO CHARGE
1351	Sealant – per tooth	$15.00
1510	Space Maintainer - fixed-unilateral	$55.00 + LAB
1515	Space Maintainer - fixed-bilateral	$55.00 + LAB
1520	Space Maintainer – removal – unilateral	$95.00 + LAB
1525	Space Maintainer – removal – bilateral	$95.00 + LAB
1550	Recementation of space Maintainer	$15.00
RESTORATIVE		
2140	Amalgam - one surface, primary or permanent	$20.00
2150	Amalgam - Two surfaces, primary or permanent	$25.00
2160	Amalgam - Three surfaces, primary or permanent	$30.00
2161	Amalgam - Four or more surfaces, primary or permanent	$40.00
2940	Sedative filling	$20.00
2999	Sedative base (under fillings), by report	NO CHARGE
RESIN RESTORATION		
2330	Resin - one surface, anterior	$40.00
2331	Resin - two surfaces, anterior	$45.00
2332	Resin - three surfaces, anterior	$55.00
2391	Resin - based composite - one surface, posterior	$70.00
2392	Resin - based composite - two surfaces, posterior	$90.00

Schedule of Benefits and Subscriber Copayments

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ADA CODE	PROCEDURE	PATIENT PAYS
2393	Resin - based composite - three surfaces, posterior	$110.00
2394	Resin - based composite - four or more surfaces, posterior	$130.00
2510	Inlay - metallic - one surface	$115.00
2520	Inlay - metallic - two surfaces	$125.00
2530	Inlay - metallic – three or more surfaces	$150.00
CROWN & BRIDGE		
2740	Crown - porcelain/ceramic substrate	$310.00 + LAB
2750*	Crown - porcelain fused to high noble metal	$310.00
2751	Crown - porcelain fused to predominantly base metal	$310.00
2752*	Crown - porcelain fused to noble metal	$310.00
2790*	Crown - full cast high noble metal	$310.00
2791	Crown - full cast predominantly base metal	$310.00
2792*	Crown - full cast noble metal	$310.00
2910	Recement inlay	$20.00
2920	Recement crown	$20.00
2930	Prefabricated stainless steel crown - primary tooth	$90.00
2950	Core buildup, including any pins	$50.00
2951	Pin retention - per tooth	$20.00
2952	Cast post and core in addition to crown	$100.00 + LAB
2953	Each additional cast post – same tooth	$100.00 + LAB
2954	Prefabricated post and core in addition to crown	$100.00
2962	Labial veneer (porcelain laminate) – laboratory	$310.00 + LAB
ENDODONTICS		
3220	Therapeutic pulpotomy	$40.00
3221	Pulpal debridement, primary and permanent teeth	$110.00
3310	Root canal therapy - anterior (excluding final restoration)	$150.00
3320	Root canal therapy - bicuspid (excluding final restoration)	$250.00
3330	Root canal therapy - molar (excluding final restoration)	$300.00
3410	Apicoectomy/periradicular surgery - anterior	$150.00
PERIODONTICS (Gum treatment)		
4210	Gingivectomy/gingivoplasty 4+ teeth per quad	$150.00
4211	Gingivectomy/gingivoplasty 1-3 teeth per quad	$45.00
4341	Periodontal scaling and root planning 4+ teeth per quad	$55.00
4342	Periodontal scaling and root planning 1-3 teeth per quad	$55.00
4355	Full mouth debridement to enable eval and diagnosis	$50.00
4381	Localized delivery of chemotherapeutic agents (per tooth)	$50.00
4910	Periodontal maintenance	$55.00
PROSTHODONTICS		
5110	Complete denture - maxillary	$325.00 + LAB
5120	Complete denture - mandibular	$325.00 + LAB
5130	Immediate denture - maxillary	$325.00 + LAB
5140	Immediate denture - mandibular	$325.00 + LAB
5211	Maxillary partial denture - resin base	$325.00 + LAB
5212	Mandibular partial denture - resin base	$325.00 + LAB
5213	Maxillary partial denture - cast metal framework, resin denture bases	$325.00 + LAB
5214	Mandibular partial denture - cast metal framework, resin denture bases	$325.00 + LAB
5410	Adjust complete denture - maxillary	$20.00
5411	Adjust complete denture - mandibular	$20.00

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ADA CODE	PROCEDURE	PATIENT PAYS
5421	Adjust partial denture - maxillary	$20.00
5422	Adjust partial denture - mandibular	$20.00
REPAIRS TO PROSTHETICS		
5510	Repair broken complete denture base	$20.00 + LAB
5520	Replace missing or broken teeth - complete denture (each tooth)	$20.00 + LAB
5610	Repair resin denture base	$20.00 + LAB
5630	Repair or replace broken clasp	$20.00 + LAB
5640	Replace broken teeth - per tooth	$20.00 + LAB
5650	Add tooth to existing partial denture	$35.00 + LAB
5730	Reline complete maxillary denture (chairside)	$55.00
5731	Reline complete mandibular denture (chairside)	$55.00
5740	Reline maxillary partial denture (chairside)	$55.00
5741	Reline mandibular partial denture (chairside)	$55.00
5750	Reline complete maxillary denture (laboratory)	$40.00 + LAB
5751	Reline complete mandibular denture (laboratory)	$40.00 + LAB
5760	Reline maxillary partial denture (laboratory)	$40.00 + LAB
5761	Reline mandibular partial denture (laboratory)	$40.00 + LAB
5850	Tissue conditioning - maxillary	$35.00
5851	Tissue conditioning - mandibular	$35.00
PROSTHODONTICS (Fixed)		
6210*	Pontic - cast high noble metal	$310.00
6211	Pontic - cast predominantly base metal	$310.00
6212*	Pontic - cast noble metal	$310.00
6240*	Pontic - porcelain fused to high noble metal	$310.00
6241	Pontic - porcelain fused predominantly base metal	$310.00
6242*	Pontic - porcelain fused to noble metal	$310.00
6750*	Crown – porcelain fused to high noble metal	$310.00
6751	Crown – porcelain fused to predominantly base metal	$310.00
6752*	Crown – porcelain fused to noble metal	$310.00
6790*	Crown - full cast high noble metal	$310.00
6791	Crown - full cast predominantly base metal	$310.00
6792*	Crown - full cast noble metal	$310.00
6930	Recement fixed partial denture (per unit)	$15.00
EXTRACTIONS/ORAL AND MAXILLOFACIAL SURGERY		
7111	Coronal remnants, deciduous tooth	$25.00
7140	Extraction, erupted tooth or exposed root	$25.00
7210	Surgical removal of erupted tooth	$45.00
7220	Removal of impacted tooth - soft tissue	$60.00
7230	Removal of impacted tooth - partially bony	$80.00
7240	Removal of impacted tooth - completely bony	$100.00
7250	Surgical removal of residual tooth roots	$45.00
7310	Alveoloplasty in conjunction with extractions - per quadrant	$45.00
7311	Alveoloplsty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$45.00
7320	Alveoloplasty not in conjunction with extractions – per quadrant	$80.00
7321	Alveoloplsty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$80.00
7510	Incision and drainage of abscess - intraoral	$30.00

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ADA CODE	PROCEDURE	PATIENT PAYS
ADJUNCTIVE GENERAL SERVICES		
9215	Local anesthesia	NO CHARGE
9230	Analgesia (nitrous oxide – per 15 minutes)	$20.00
9450	Case presentation, detailed and extensive treatment planning	NO CHARGE
9951	Occlusal adjustment - limited	$30.00
9952	Occlusal adjustment - complete	$175.00

* THE ABOVE COPAYMENTS DO NOT INCLUDE THE ADDITIONAL COST OF PRECIOUS (HIGH NOBLE) AND SEMI-PRECIOUS (NOBLE) METAL. THE ADDITIONAL COST OF PRECIOUS METAL SHALL NOT EXCEED $125 PER UNIT AND $75 PER UNIT FOR SEMI-PRECIOUS METAL.

NOTE:

1. NOT ALL PARTICIPATING DENTISTS PERFORM ALL LISTED PROCEDURES, INCLUDING AMALGAMS. PLEASE CONSULT YOUR DENTIST PRIOR TO TREATMENT FOR AVAILABILITY OF SERVICES.
2. WHEN CROWN AND/OR BRIDGEWORK EXCEEDS SIX UNITS IN THE SAME TREATMENT PLAN, THE PATIENT MAY BE CHARGED AN ADDITIONAL $50.00 PER UNIT.

SPECIALIST SERVICES

Should you need a specialist, (i.e., Endodontist, Orthodontist, Oral Surgeon, Periodontist, Pediatric Dentist), you may be referred by your Participating General Dentist, or you may refer yourself to any Participating Specialist. Upon identification of yourself as a CompBenefits member, you will receive a 25% reduction from usual and customary fees for services performed. Specialist services are available only in areas where the dental plan has a Participating Specialist.

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LIMITATIONS AND EXCLUSIONS

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

CompBenefits CompBenefits Company CompBenefits Insurance Company CompBenefits Dental, Inc. CompBenefits of Alabama, Inc. *CompBenefits of Georgia, Inc. American Dental Plan of North Carolina, Inc.*

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 or on a form approved in advance by Humana. 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.

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.

Important!

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618,
  Lexington, KY 40512-4618
  If you need help filing a grievance, call the number on your ID card or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their complaint portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. Call the number on your ID card (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Language assistance services, free of charge, are available to you. Call the number on your ID card (TTY: 711)

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call the number on your ID card **(TTY: 711)**... ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que figura en su tarjeta de identificación **(TTY: 711)**... 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電會員卡上的電話號碼 **(TTY: 711)**... CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số điện thoại ghi trên thẻ ID của quý vị **(TTY: 711)**... 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . ID 카드에 적혀 있는 번호로 전화해 주십시오 **(TTY: 711)**... PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tawagan ang numero na nasa iyong ID card **(TTY: 711)**... ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Наберите номер, указанный на вашей карточке-удостоверении **(телетайп: 711)**... ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele nimewo ki sou kat idantite manm ou **(TTY: 711)**... ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le numéro figurant sur votre carte de membre **(ATS: 711)**...UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Proszę zadzwonić pod numer podany na karcie identyfikacyjnej **(TTY: 711)**... ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para o número presente em seu cartão de identificação **(TTY: 711)**... ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero che appare sulla tessera identificativa **(TTY: 711)**... ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Wählen Sie die Nummer, die sich auf Ihrer Versicherungskarte befindet **(TTY: 711)**... 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。お手持ちの ID カードに記載されている電話番号までご連絡ください **(TTY: 711)**...

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

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

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم الهاتف الموجود على بطاقة الهوية الخاصة بك **(TTY: 711)**.