Proposal prepared for

City of Fort Lauderdale

Group DHMO and PPO Dental Plan Benefits

Solicitation 575-11928

Quote Date: April 11, 2017

Effective Date: January 1, 2018

Humana.

HUMANA OFFERING COMPANY STATEMENT

The benefits outlined in this proposal are offered by the following companies, hereafter referred to collectively as "Humana:"

- Fully insured dental HMO plans in Florida are offered by CompBenefits Company
- Fully insured dental PPO plans in Florida are insured by Humana Insurance Company

Note that Humana Inc. is the ultimate parent company and not an offering company. Humana Inc. holds no insurance licenses or health plan licenses.

Humana has provided information and responses that are consistent with current internal policies and procedures; however, clients will receive the newest and most innovative solutions that Humana has to offer at the time of implementation.

Humana.

3401 SW 160 Avenue
Miramar, Florida 33027

T 305-626-5546
C 954-599-7903

mtoffoli@humana.com

April 7, 2017

AnnDebra Diaz
Procurement Specialist II
City of Fort Lauderdale
City Hall, Procurement Services Division
100 North Andrews Avenue, #619
Fort Lauderdale, Florida 33301

Dear AnnDebra:

We appreciate the opportunity to respond to the City of Fort Lauderdale's (the City) request for a proposal. Over the past five years, we have collaborated directly with the City to deliver a comprehensive, integrated dental solution. Our proposed dental solution is to renew your current benefits that offer broad network access, customizable plan options, and patient education resources that save the City costs in the long-term by promoting healthy dental habits for your members and their families that simultaneously contribute to their lifelong well-being.

Commitment to Service
As the City's partner, our account management, service, and education support have been able to create a cohesive relationship. As your locally assigned health solutions client executive, I will strategize with the City and your consultant regarding the benefits program, provide competitive analysis and trends, and deliver annual plans to educate members on behavioral decisions. Plus a client experience manager (CEM), Julie Thorpe, is assigned to the City and is available to address any day-to-day service questions or concerns. Additionally, we will offer on-site "Ask Humana Days" where the City's employees and covered dependents have access to speak directly to a Humana representative about benefits, claims, network, or any other dental plan assistance they may need. When members call Humana's Customer Care department, they will be routed to a designated member service team that manages and fully understands the City's benefits.

Focus On Oral Health and Overall Well-being
Humana's mission is to promote lifelong health and well-being, which includes a healthy mouth and good oral hygiene. Medical studies have confirmed the direct correlation of health complications such as heart disease, diabetes, and stroke with poor oral health. This can even interfere with everyday functions such as breathing, eating, and speaking. As part of our offering to the City, members may receive four cleanings within a 12-month period to promote oral health and overall well-being.

Multi-Year Commitment
Humana's long-term partnership with the City is reflected in our proposal. We are offering a **three-year rate guarantee with two rate caps for years four and five**. Our commitment to the City is demonstrated in our proposed performance guarantees, which re-affirms our capabilities through these guidelines.

Ease in Administration
As the incumbent carrier, the existing online administration and relationship with third party vendors enables access for the City to manage changes quickly and efficiently. We understand the importance of access and flexibility in administering the billing. The City will have the option of self-billing or continuing to provide a monthly list bill, which can be decided during implementation.

Robust Benefit Design
Humana offers the City's employees and covered dependents two dental preferred provider organization (DPPO) plans and one dental health maintenance organization (DHMO) plan. Highlights of the plans include:

- **DPPO**
  - Customized rich benefits
  - Four cleanings within a 12-month period
  - Periodontics and endodontics are covered in Basic coverage
  - Orthodontia covered for adults and children
- **DHMO**
  - Referrals to specialists not required
  - Includes implant coverage
  - Orthodontia covered for adults and children

Extensive Provider Network and Choice
Our current Traditional PPO plan provides advantageous benefits for members who see both participating and out-of-network providers, granting true freedom of choice. Members receive in-network discounts when they visit one of Humana's over 280,000 contracted dentist locations. Specific to the City, **97.8 percent** of employees have access to two DPPO providers within 10 miles.

For the City, our existing DHMO plan is designed to deliver the greatest combination of low premiums and out-of-pocket expenses. By utilizing one of our quality in-network dentists, members save between 40 and 60 percent when they visit any of our 46,000 contracted dentist locations. Specific to the City, **96 percent** of employees have access to two DHMO providers within five miles.

Our proposal for the City considers the full spectrum of costs affected by dental plans, including premiums, claims, and the long-term effects dental care has on overall healthcare costs. Our contracted providers continue to undergo a careful study of their practice patterns to ensure their philosophy of care includes an emphasis on prevention and early detection. We constantly evolve our benefits with changes in dentistry and technology. Most importantly, we provide resources that empower members to take control of their oral health.

We are committed to advancing our long-term partnership with the City. Thank you for taking the time to review our renewal proposal that is structured in accordance with the provisions of your RFP. Please do not hesitate to call me at 305-626-5546 if you have any questions or need clarification regarding any aspect of this proposal. We look forward to meeting with the City to discuss how we can continue helping you achieve your dental benefit goals.

Sincerely,

Margaret Toffoli
Health Solutions Client Executive

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Florida
Office
of Insurance
Regulation

COMPBENEFITS COMPANY

Has duly qualified pursuant to Chapter 636, Florida Statutes for a Pre-Paid Limited Health Service Organization Certificate Of Authority and is hereby authorized to write the following line(s) of business:

712 – Optometric Services
451 – Dental Service Plan Corporation (PREPAID DENTAL)

Date of Issuance: October 24, 1978

No. 05 – 592531815

Kevin M. McCarty
Commissioner
Office of Insurance Regulation

Florida
Department
of Insurance

HUMANA INSURANCE COMPANY

is hereby authorized to transact insurance in the state of Florida.

This certificate signifies that the company has satisfied all requirements of the Florida Insurance Code for the issuance of a license and remains subject to all applicable laws of Florida.

Date of Issuance: May 19, 1988

No. 02-39-1263473

Tom Gallagher
Treasurer and Insurance Commissioner

Humana New Dental Fully Insured Account Implementation Project Timeline
For City of Fort Lauderdale

Plan Effective Date: January 1, 2018

	Task	Responsible Parties	Comments	Target Dates
1	**Carrier Selection**	The City		October 15, 2017
2	**Implementation Meeting:** Confirm Plan Designs Discuss Plan Structure Confirm Transfer of Eligibility Confirm Pre-/ Post-enrollment Communications and Materials Confirm ID Cards Claim Forms Confirm History Requirements (deductible carryover etc.) Confirm Weekly Meetings or Conference Calls	The City/ Humana	Typically held within two weeks of the carrier selection date.	October 29, 2017
3	**Finalize and Order Benefit Summaries / Enrollment Kits / Employee Meeting Materials**	The City/ Humana	Target is 30 - 45 days prior to the enrollment period. A 45 day lead is reflected in the "Target Date" listed.	November 3, 2017
4	**Confirm The CityApproval of: -** **Mock Structure** **-Mock Bill** **-Eligibility** **-Reporting Requirements**	The City	Target is 30 - 60 days prior to the enrollment period. A 60 day lead is reflected in the "Target Date" listed.	November 8, 2017
5	**Plan Design Testing**	Humana	Target is 15 -30 days prior to the Plan Effective Date. A 30 day lead is reflected in the "Target Date" listed.	December 2, 2017
6	**Training:** -Claims Processing Specialists -Contact Center	Humana	Target is 15 -30 days prior to the Plan Effective Date. A 30 day lead is reflected in the "Target Date" listed.	December 2, 2017
7	**Conduct Enrollment Meetings**	The City/ Humana	Based on Enrollment Period	
8	**Open Enrollment Begins**	The City	Target is 30 - 60 days prior to the Plan Effective Date. A 35 day lead is reflected in the "Target Date" listed.	October 9, 2017
9	**Open Enrollment Ends**	The City	Target is 15-30 days after Open Enrollment begins. A 30 day lead is reflected in the "Target Date" listed.	October 23, 2017
10	**Confirm Eligibility, Run Test Tape if Electronic Data Interchange or Web.**	The City/ Humana	Target is 90 days prior to the Plan Effective Date. A 90 day lead, for the first test tape, is reflected in the "Target Date" listed.	October 3, 2017
11	**Finalize Eligibility: Apply Production File**	Humana	Target is 45 days prior to the Plan Effective Date.	November 17, 2017
12	**ID Cards Issued (If Automated Enrollment Files are utilized by City of Fort Lauderdale) Open Enrollment Only**	Humana	Automated Enrollment - Humana will agree that 98% of ID cards will be available prior to the member/group's effective date contingent upon receiving "clean" enrollment data. "Clean" enrollment is defined as needing no additional information from the member or the group. The following requirements are necessary for this guarantee to be met: 1) a test file must be received 90 days prior to the effective date and must be an approved eligibility file; 2) group set up must be finalized and approved 60 days prior to the effective date; and 3) the final production file must be received 45 days prior to the effective date.	December 5, 2017
13	**Plan Effective Date**	The City		January 1, 2018
14	**Claims Testing**	Humana	Target is 30 days after Plan Effective Date.	January 31, 2018

HUMAINC-01 POOJARIVD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 3/22/2017

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME: Willis Towers Watson Certificate Center
Willis of Tennessee, Inc. c/o 26 Century Blvd P.O. Box 305191 Nashville, TN 37230-5191	PHONE (A/C, No, Ext): (877) 945-7378 FAX (A/C, No): (888) 467-2378 E-MAIL ADDRESS: certificates@willis.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Managed Care Indemnity, Inc.	C1354
INSURER B : Sentry Insurance a Mutual Company	24988
INSURER C : Sentry Casualty Company	28460
INSURER D :	
INSURER E :	
INSURER F :	

INSURED

CompBenefits Company
6101 Blue Lagoon Drive
Miami, FL 33126

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$ 3,000,000
	CLAIMS-MADE X OCCUR	X		P00025-1	01/01/2017	01/01/2018	DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 3,000,000
							MED EXP (Any one person)	$ 10,000
							PERSONAL & ADV INJURY	$ 3,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ 3,000,000
	X POLICY PRO-JECT LOC						PRODUCTS - COMP/OP AGG	$ 3,000,000
	OTHER:							$
B	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$ 2,000,000
	X ANY AUTO			90-04453-12	01/01/2017	01/01/2018	BODILY INJURY (Per person)	$
	OWNED AUTOS ONLY / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS ONLY / NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB CLAIMS-MADE						AGGREGATE	$
	DED RETENTION $							$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY						X PER STATUTE OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y / N (Mandatory in NH)	N / A		90-04453-08	01/01/2017	01/01/2018	E.L. EACH ACCIDENT	$ 2,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 2,000,000
							E.L. DISEASE - POLICY LIMIT	$ 2,000,000
A	Professional Liab.			P00025-1	01/01/2017	01/01/2018	Occ/Agg Limit:	3,000,000
C	Workers Compensation			90-04453-09	01/01/2017	01/01/2018	See Attached	

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

Contract Effective dates: 1/1/2018
Proposal Number: Bid 575-11928

City of Fort Lauderdale is included as an Additional Insured as respects to General Liability.

CERTIFICATE HOLDER

City of Fort Lauderdale
100 N. Andrews Avenue
3rd Floor Conference Room
Fort Lauderdale, FL 33301

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

ADDITIONAL COVERAGE SCHEDULE

COVERAGE	LIMITS
POLICY TYPE: Workers Compensation & Employers Liability **CARRIER: Sentry Casualty Company** **POLICY TERM: 1/1/2017 - 1/1/2018** **POLICY NUMBER: 90-04453-09**	**Per Statute** **$2,000,000 E.L. Each Accident** **$2,000,000 E.L. Disease - Each Employee** **$2,000,000 E.L. Disease - Policy Limit**

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This endorsement forms a part of Policy Number: P00025-1 **Effective Date:** 01/01/2017

Issued to: Humana Inc. **Endorsement No.:** 5

Issued by: Managed Care Indemnity, Inc.

BLANKET ADDITIONAL INSURED – COMMERCIAL GENERAL LIABILITY

Section II - WHO IS AN INSURED, is hereby amended to include the following:

5. As respects Commercial General Liability Insurance, any person or entity is an additional insured as required by contract, but only to the extent of such designation and only with respect to liability of the additional insured arising out of operations of the Named Insured. Coverage is not provided under this policy for the acts or omissions of such person or entity or the acts or omissions of its employees, agents or representatives."

Authorized Representative

HUMAINC-01 POOJARIVD

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Authorized Representative

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See **Specific Instructions** on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

CompBenefits Company

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:

☐ Individual/sole proprietor or single-member LLC ☑ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____

Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

500 West Main Street

Requester's name and address (optional)

6 City, state, and ZIP code

Louisville, Kentucky 40202

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

5	9	–	2	5	3	1	8	1	5

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here **Signature of U.S. person** ▶ [signature] **Date** ▶ January 15, 2015

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

Note. If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States:

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code* on page 3 and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships* above.

What is FATCA reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code* on page 3 and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account, list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note. ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C Corporation, or S Corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

Check the appropriate box in line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box in line 3.

Limited Liability Company (LLC). If the name on line 1 is an LLC treated as a partnership for U.S. federal tax purposes, check the "Limited Liability Company" box and enter "P" in the space provided. If the LLC has filed Form 8832 or 2553 to be taxed as a corporation, check the "Limited Liability Company" box and in the space provided enter "C" for C corporation or "S" for S corporation. If it is a single-member LLC that is a disregarded entity, do not check the "Limited Liability Company" box; instead check the first box in line 3 "Individual/sole proprietor or single-member LLC."

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space in line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)

2—The United States or any of its agencies or instrumentalities

3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

4—A foreign government or any of its political subdivisions, agencies, or instrumentalities

5—A corporation

6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession

7—A futures commission merchant registered with the Commodity Futures Trading Commission

8—A real estate investment trust

9—An entity registered at all times during the tax year under the Investment Company Act of 1940

10—A common trust fund operated by a bank under section 584(a)

11—A financial institution

12—A middleman known in the investment community as a nominee or custodian

13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 5[2]
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a)

J—A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Note. You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited Liability Company (LLC)* on this page), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at *www.ssa.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting IRS.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, or 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code* earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account[1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor[2]
4. a. The usual revocable savings trust (grantor is also trustee) b. So-called trust account that is not a legal or valid trust under state law	The grantor-trustee[1] The actual owner[1]
5. Sole proprietorship or disregarded entity owned by an individual	The owner[3]
6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
7. Disregarded entity not owned by an individual	The owner
8. A valid trust, estate, or pension trust	Legal entity[4]
9. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
10. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
11. Partnership or multi-member LLC	The partnership
12. A broker or registered nominee	The broker or nominee
13. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B))	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or DBA name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 2.

***Note.** Grantor also must provide a Form W-9 to trustee of trust.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov.* You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: *spam@uce.gov* or contact them at *www.ftc.gov/idtheft* or 1-877-IDTHEFT (1-877-438-4338).

Visit IRS.gov to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See **Specific Instructions** on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.
Humana Insurance Company

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:
☐ Individual/sole proprietor or single-member LLC ☑ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate
☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____
Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.
☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):
Exempt payee code (if any) _____
Exemption from FATCA reporting code (if any) _____
(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)
500 West Main Street

Requester's name and address (optional)

6 City, state, and ZIP code
Louisville, Kentucky 40202

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number
			–		–				

or

Employer identification number
3	9	–	1	2	6	3	4	7	3

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here **Signature of U.S. person** ▶ [signature] **Date** ▶ January 15, 2015

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

Note. If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States:

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code* on page 3 and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships* above.

What is FATCA reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code* on page 3 and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account, list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note. ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C Corporation, or S Corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

Check the appropriate box in line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box in line 3.

Limited Liability Company (LLC). If the name on line 1 is an LLC treated as a partnership for U.S. federal tax purposes, check the "Limited Liability Company" box and enter "P" in the space provided. If the LLC has filed Form 8832 or 2553 to be taxed as a corporation, check the "Limited Liability Company" box and in the space provided enter "C" for C corporation or "S" for S corporation. If it is a single-member LLC that is a disregarded entity, do not check the "Limited Liability Company" box; instead check the first box in line 3 "Individual/sole proprietor or single-member LLC."

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space in line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)

2—The United States or any of its agencies or instrumentalities

3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

4—A foreign government or any of its political subdivisions, agencies, or instrumentalities

5—A corporation

6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession

7—A futures commission merchant registered with the Commodity Futures Trading Commission

8—A real estate investment trust

9—An entity registered at all times during the tax year under the Investment Company Act of 1940

10—A common trust fund operated by a bank under section 584(a)

11—A financial institution

12—A middleman known in the investment community as a nominee or custodian

13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 5[2]
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a)

J—A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Note. You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited Liability Company (LLC)* on this page), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at *www.ssa.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting IRS.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, or 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code* earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account[1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor[2]
4. a. The usual revocable savings trust (grantor is also trustee) b. So-called trust account that is not a legal or valid trust under state law	The grantor-trustee[1] The actual owner[1]
5. Sole proprietorship or disregarded entity owned by an individual	The owner[3]
6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
7. Disregarded entity not owned by an individual	The owner
8. A valid trust, estate, or pension trust	Legal entity[4]
9. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
10. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
11. Partnership or multi-member LLC	The partnership
12. A broker or registered nominee	The broker or nominee
13. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B))	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or DBA name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 2.

***Note.** Grantor also must provide a Form W-9 to trustee of trust.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov.* You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: *spam@uce.gov* or contact them at *www.ftc.gov/idtheft* or 1-877-IDTHEFT (1-877-438-4338).

Visit IRS.gov to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

Humana Inc.
500 W Main St
Louisville, KY 40202-2946
www.humana.com

February 2, 2017

Dear Customer:

The integrity and effectiveness of claims processing depends on proper control identification, implementation, documentation, and testing. This report details the claims-processing controls Humana has in place, as well as the control tests performed by PricewaterhouseCoopers LLP.

Our commitment to high ethical standards extends to the areas of enterprise risk, control, and governance – issues of paramount concern to us, as they are to you. Humana respects the confidentiality of your claims data, and we treat your private information as if it were our own. In addition to safeguarding the security and privacy of your claims information, we can assure you that our goal is to maximize the efficient and effective processing of your claims.

If you or your independent accountant has questions about our controls, please contact your account executive. The account executive will discuss your inquiries with our internal audit department and respond to you.

On behalf of Humana, we appreciate your business and the opportunity to serve you.

Sincerely,

Brian P. LeClaire
Senior Vice President and
Chief Information Officer

Carl Daley
Vice President
Chief Audit Officer

ASO Medical Claims Processing

Report on Humana Inc.'s Description of its Claims Adjudication System and on the Suitability of the Design and Operating Effectiveness of its controls throughout the period October 1, 2015 to September 30, 2016

SOC 1 Report

MetaVance ("MTV") Platform

Humana

The report on Humana's Description of its Claims Adjudication System and on the Suitability of the Design and Operating Effectiveness of its Controls is confidential. The report is intended solely for use by the management of Humana, its user entities, and the independent auditors of its user entities.

This report is intended solely for use by the management of Humana, its user entities, and the independent auditors of its user entities, and is not intended and should not be used by anyone other than these specified parties.

Section I - Report of Independent Service Auditors

To the Management of Humana Inc.:

Scope

We have examined Humana Inc. ("Humana")'s description of its MetaVance ("MTV") claims processing system for processing administrative services only user entities' transactions ("MTV claims processing system") throughout the period October 1, 2015 to September 30, 2016 (the "description") and the suitability of the design and operating effectiveness of Humana's controls to achieve the related control objectives stated in the description. Our examination did not include the claims billing and reporting processes pertinent to level funded premium contracts. The description indicates that certain control objectives specified in the description can be achieved only if complementary user entity controls contemplated in the design of Humana's controls are suitably designed and operating effectively, along with related controls at the service organization. We have not evaluated the suitability of the design or operating effectiveness of such complementary user entity controls.

Humana uses subservice organizations for processing of pharmacy claims and to assist with quality reviews of provider updates. The description in Section III and Section IV includes only the control objectives and related controls of Humana, and excludes the control objectives and related controls of subservice organizations that process pharmacy claims and assist with quality reviews of provider updates. Our examination did not extend to controls of the subservice organizations that process pharmacy claims and assist with quality reviews of provider updates. We have not evaluated the suitability of design or operating effectiveness of such subservice organizations controls.

Service organization's responsibilities

In Section II, Humana has provided an assertion about the fairness of the presentation of the description and suitability of the design and operating effectiveness of the controls to achieve the related control objectives stated in the description. Humana is responsible for preparing the description and for the assertion, including the completeness, accuracy, and method of presentation of the description and the assertion, providing the services covered by the description, specifying the control objectives and stating them in the description, identifying the risks that threaten the achievement of the control objectives, selecting the criteria, and designing, implementing, and documenting controls that are suitably designed and operating effectively to achieve the related control objectives stated in the description.

PricewaterhouseCoopers LLP, 500 West Main Street, Ste. 1800, Louisville, KY 40202-2941
T: (502) 589 6100, F: (502) 585 7875, www.pwc.com/us

Service auditor's responsibilities

Our responsibility is to express an opinion on the fairness of the presentation of the description and on the suitability of the design and operating effectiveness of the controls to achieve the related control objectives stated in the description, based on our examination. We conducted our examination in accordance with attestation standards established by the American Institute of Certified Public Accountants. Those standards require that we plan and perform our examination to obtain reasonable assurance about whether, in all material respects, the description is fairly presented and the controls were suitably designed and operating effectively to achieve the related control objectives stated in the description throughout the period October 1, 2015 to September 30, 2016.

An examination of a description of a service organization's system and the suitability of the design and operating effectiveness of the service organization's controls to achieve the related control objectives stated in the description involves performing procedures to obtain evidence about the fairness of the presentation of the description and the suitability of the design and operating effectiveness of those controls to achieve the related control objectives stated in the description. Our procedures included assessing the risks that the description is not fairly presented and that the controls were not suitably designed or operating effectively to achieve the related control objectives stated in the description. Our procedures also included testing the operating effectiveness of those controls that we consider necessary to provide reasonable assurance that the related control objectives stated in the description were achieved. An examination engagement of this type also includes evaluating the overall presentation of the description and the suitability of the control objectives stated therein, and the suitability of the criteria specified by the service organization and described in management's assertion in Section II. We believe that the evidence we obtained is sufficient and appropriate to provide a reasonable basis for our opinion.

Inherent limitations

Because of their nature, controls at a service organization may not prevent, or detect and correct, all errors or omissions in processing or reporting transactions. Also, the projection to the future of any evaluation of the fairness of the presentation of the description, or conclusions about the suitability of the design or operating effectiveness of the controls to achieve the related control objectives is subject to the risk that controls at a service organization may become inadequate or fail.

Other information provided by the service organization

The information included in Section V, "Other Information Provided by Humana - Unaudited," is presented by management of Humana to provide additional information and is not a part of Humana's description of its MTV claims processing system made available to user entities during the period October 1, 2015 to September 30, 2016. Information about Humana's management responses to findings and Humana's disaster recovery plan and disaster recovery testing has not been subjected to the procedures applied in the examination of the description of the MTV claims processing system and of the suitability of the design and operating effectiveness of controls to achieve the related control objectives stated in the description of the MTV claims processing system and accordingly, we express no opinion on it.

Opinion

In our opinion, in all material respects, based on the criteria described in Humana's assertion in Section II,

a. the description fairly presents the MTV claims processing system that was designed and implemented throughout the period October 1, 2015 to September 30, 2016.

b. the controls related to the control objectives stated in the description were suitably designed to provide reasonable assurance that the control objectives would be achieved if the controls operated effectively throughout the period October 1, 2015 to September 30, 2016 and user entities applied the complementary user entity controls contemplated in the design of Humana's controls throughout the period October 1, 2015 to September 30, 2016.

c. the controls tested, which together with the complementary user entity controls referred to in the scope section of this report, if operating effectively, were those necessary to provide reasonable assurance that the control objectives stated in the description were achieved, operated effectively throughout the period October 1, 2015 to September 30, 2016.

Description of tests of controls

The specific controls tested and the nature, timing, and results of those tests are listed in Section IV.

Intended users and purpose

This report, including the description of tests of controls and results thereof in Section IV, is intended solely for the information and use of Humana, user entities of Humana's MTV claims processing system during some or all of the period October 1, 2015 to September 30, 2016, and the independent auditors of such user entities, who have a sufficient understanding to consider it, along with other information including information about controls implemented by user entities themselves, when assessing the risks of material misstatements of user entities' financial statements. This report is not intended to be and should not be used by anyone other than these specified parties. If report recipients are not user entities that have contracted for services with Humana for the period specified above or their independent auditors (herein referred to as a "non-specified user") and have obtained this report, or have access to it, use of this report is the non-specified user's sole responsibility and at the non-specified user's sole and exclusive risk. Non-specified users may not rely on this report and do not acquire any rights against PricewaterhouseCoopers LLP as a result of such access. Further, PricewaterhouseCoopers LLP does not assume any duties or obligations to any non-specified user who obtains this report and/or has access to it.

PricewaterhouseCoopers LLP

PricewaterhouseCoopers LLP
February 2, 2017

SECTION II – HUMANA'S ASSERTION

We have prepared the description of Humana's MetaVance ("MTV") claims processing system for processing administrative services only user entities' transactions (the "description") for user entities of the system during some or all of the period October 1, 2015 to September 30, 2016, and their user auditors who have a sufficient understanding to consider it, along with other information, including information about controls implemented by user entities of the system themselves, when assessing the risks of material misstatement of user entities' financial statements. We confirm, to the best of our knowledge and belief, that:

1. The description fairly presents the MTV claims processing system for processing administrative services only user entities' transactions made available to user entities of the system during some or all of the period October 1, 2015 to September 30, 2016 for processing their transactions. We acknowledge that our description does not include the claims billing and reporting processes pertinent to level funded premium contracts. The description indicates that certain control objectives specified in the description can be achieved only if complementary user entity controls contemplated in the design of Humana's controls are suitably designed and operating effectively, along with related controls at Humana. Humana uses subservice organizations for processing of pharmacy claims and to assist with quality reviews of provider updates. The description includes only those control objectives and related controls of Humana, and excludes the control objectives and related controls of the subservice organizations that process pharmacy claims and assist with quality reviews of provider updates. The criteria we used in making this assertion were that the description:

   i. Presents how the system made available to user entities of the system was designed and implemented to process relevant transactions, including, if applicable:

   - The types of services provided, including, as appropriate, the classes of transactions processed.
   - The procedures, within both automated and manual systems, by which services are provided, including as appropriate, procedures by which transactions are initiated, authorized, recorded, processed, corrected as necessary, and transferred to the reports and other information prepared for user entities of the system.
   - The related accounting records, supporting information, and specific accounts that are used to initiate, authorize, record, process, and report transactions; this includes the correction of incorrect information and how information is transferred to the reports presented to user entities of the system.
   - How the system captures and addresses significant events and conditions, other than transactions.
   - The process used to prepare reports or other information provided to user entities of the system.
   - Specified control objectives and controls designed to achieve those objectives including, as applicable, complementary user entity controls contemplated in the design of the service organization's controls.

- Other aspects of our control environment, risk assessment process, information and communication systems (including the related business processes), control activities, and monitoring controls that are relevant to processing and reporting transactions of user entities of the system.

ii. Does not omit or distort information relevant to the scope of the MTV claims processing system for processing administrative services only user entities' transactions, while acknowledging that the description is prepared to meet the common needs of a broad range of user entities of the system and the independent auditors of those user entities, and may not, therefore, include every aspect of the MTV claims processing system for processing administrative services only user entities' transactions that each individual user entity of the system and its auditor may consider important in its own particular environment.

2. The description includes relevant details of changes to the service organization's system during the period covered by the description.
3. The controls related to the control objectives stated in the description, which together with the complementary user entity controls referred to above, if operating effectively, were suitably designed and operated effectively throughout the period October 1, 2015 to September 30, 2016 to achieve those control objectives. The criteria we used in making this assertion were that:

   i. The risks that threaten the achievement of the control objectives stated in the description have been identified by the service organization;

   ii. The controls identified in the description would, if operating as described, provide reasonable assurance that those risks would not prevent the control objectives stated in the description from being achieved; and

   iii. The controls were consistently applied as designed, including whether manual controls were applied by individuals who have the appropriate competence and authority.

Brian LeClaire
Senior Vice President and
Chief Information Officer

Lisa Hebert
Director, Corporate Accounting Operations

Donna Hundley
Segment Vice President

SECTION III – HUMANA'S DESCRIPTION OF OPERATIONS AND CONTROL ENVIRONMENT

OVERVIEW OF OPERATIONS

Humana Inc. (www.humana.com - HUM) is headquartered in Louisville, KY with offices nationwide. Humana provides medical claims processing services to its Administrative Service Only (ASO) customers. In doing so, Humana procures and provides the human and computer resources needed to accomplish claims processing. Humana operates an Information Processing Center in Kentucky, which supports the computer network infrastructure. Humana performs a large amount of claims processing for itself and other entities.

The application system Humana uses to process claims is called the MetaVance System (MTV) application. MTV is an integrated adjudication system that interfaces with system logic, files and programs such as the following:

- Online Plan Loading – calculates plan benefits, monitors limitations and edits exclusions.
- Customer Enrollment/Eligibility – verifies individual and group enrollment.
- Provider Contracts and Maintenance – contains provider information.
- Other Insurance Information – used for Coordination of Benefit (COB) processing.
- Claim Check – claims auditing system that verifies the clinical accuracy of claims.

The claims process can be broken down into three major phases.

1. Initial receipt of claims from providers and subscribers

Humana uses three methods for receiving claims into MTV. The three methods are as follows:

- Outsourced Imaging Service – Humana contracts with an outsourced imaging services provider to process all mail for Humana. The vendor opens, sorts, scans and enters claims data and other correspondence into a vendor's proprietary system, which is electronically transmitted to Humana and loaded into the MTV system.
- Electronically Submitted Claims – Selected hospitals and providers can electronically submit claims directly to the MTV system for processing.
- Front End Processing – Less than one percent of claims are still received directly by Humana. These paper claims must be processed using the standard front end process. The office service staff sorts the claims by type of claim and delivers them to the Front End Clerks to be loaded into the MTV system.

2. Entry and adjudication of claims

The electronic claim is checked for validity and adjudicated in accordance with the member's appropriate coverage. System edits are triggered based on the comparison of submitted claim information with the respective group and provider contracts. Once processed, claims are paid, pended or rejected. The term pended is utilized to describe any transaction or process that is halted for further review. Once a transaction or process has pended, the stoppage is then described as a pend. Claims are pended if further investigation is required, rejected if submitted charges are not in compliance with contract limitations, or paid if no exceptions are found.

3. Payment of claims

A payment and Explanation of Benefits (EOB) are generated during the adjudication process.

Note: Humana may draw upon the assistance of contracted resources for staff augmentation, such as temporary staffing agencies. In these instances, resources perform their work under Humana processes, using Humana systems, and/or are managed or oversight is provided by Humana management.

CONTROL ENVIRONMENT, RISK ASSESSMENT, INFORMATION AND COMMUNICATION, AND MONITORING

With regard to the requirements of paragraph 13 of Public Company Accounting Oversight Board ("PCAOB") Release No. 2004-001 of March 9, 2004, the Company utilized criteria established in Internal Control – Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

Integrated Control - Integrated Framework Elements

The components of internal control as defined by the COSO report include the following.

- ***Control Environment*** – The control environment sets the tone of the organization, influencing the control consciousness of its people. It is the foundation for all other components of internal control, providing discipline and structure. Control environment factors include the integrity, ethical values and competence of the entity's people; management's philosophy and operating style; the way management assigns authority and responsibility, and organizes and develops its people; and the attention and direction provided by the Board of Directors (Board). Included in this area are anti-fraud activities.
- ***Risk Assessment*** – Every entity faces a variety of risks from external and internal sources that must be assessed. A precondition to risk assessment is establishment of objectives, linked at different levels and internally consistent. Risk assessment is the identification and analysis of relevant risks to achievement of the objectives, forming a basis for determining how risks should be managed. Because economic, industry, regulatory and operating conditions will continue to change, mechanisms are needed to identify and deal with the special risks associated with change.
- ***Control Activities –*** Control activities are the policies and procedures that help ensure management directives are carried out and the entity's objectives are achieved. They help ensure that necessary actions are taken to address risks. Control activities occur throughout the organization, at all levels and in all functions. They include a range of activities as diverse as approvals, authorizations, verifications, reconciliations, reviews of operating performance, security of assets and segregation of duties. Please refer to Section IV for Control Activities.
- ***Information and Communication –*** Pertinent information must be identified, captured and communicated in a form and timeframe that enables people to carry out their responsibilities. Information systems produce reports, containing operational, financial and compliance- related information, that make it possible to run and control the business. They deal not only with internally generated data, but also information about external events, activities and conditions necessary to make informed business decisions and create external reports. Effective communication also must occur in a broader sense, flowing down, across and up the organization. All personnel must receive a clear message from top management that control responsibilities must be taken seriously. They must understand their own role in the internal control system, as well as how individual activities relate to the work of others. They must have a means of communicating significant information upstream. There also needs to be effective communication with external parties, such as customers, suppliers, regulators and shareholders.

- ***Monitoring –*** Internal control systems need to be monitored – a process that assesses the quality of the system's performance over time. This is accomplished through ongoing monitoring activities, separate evaluations or a combination of the two. Ongoing monitoring occurs in the course of operations. It includes regular management and supervisory activities and other actions personnel take in performing their duties. The scope and frequency of separate evaluations will depend primarily on an assessment of risks and the effectiveness of ongoing monitoring procedures. Internal control deficiencies should be reported upstream, with serious matters reported to top management and the Board of Directors.

Control Environment

Organizational Structure

Humana has established an organizational structure that facilitates the flow of vital business information. Humana's operations are under the direction of the Board of Directors and Chief Executive Officer. The Board of Directors assigns authority and responsibilities to upper level management, which filters down through managers and supervisors to all associates. All the Board members are highly qualified, successful business professionals. The Board has established several committees to aid in monitoring Humana's operations. In particular, the Board has established an Audit Committee. The Audit Committee reviews the results of audits performed by Humana's Internal Auditors and the adequacy of Humana's internal control structure. The composition, activities and attitudes of the Board and the Audit Committee and the information provided to them result in effective monitoring and review of Humana's internal control and financial reporting controls.

Ethics

Humana is committed to maintaining high ethical standards in the conduct of its business. Humana understands and emphasizes that the key to upholding high ethical standards is through the daily decisions and actions of each and every associate. Management accepts overall responsibility for an ethical environment through its daily actions and by providing associates with a framework in which ethical behavior is expected as part of the daily course of business. This is in addition to the corporate and departmental policies and procedures in place to prevent and detect fraud and ensure that financial reporting and disclosure meets applicable regulatory requirements. Humana associates are provided a central 'Ethics Hotline' they can call 24 hours a day to report any concerns. Also, any member of the Humana Board of Directors can be contacted at any time by a stakeholder wanting to report potential ethics violations via Humana's website at Investor Relations. In addition, any external party may report any concerns, error, irregularities, potential instances of non-compliance with regulations, or potential unethical or fraudulent behavior to their appropriate Humana contact for review and resolution. These resources include their Humana account executive, their Humana provider contracting executive, Humana's Internal Audit, and/or Humana's confidential "Ethics Hotline" at 1-877-5THE KEY (1-877-584-3539).

Internal Audit

Humana maintains an internal audit function. The mission of Internal Audit is to provide independent, objective assurance and consulting services designed to add value and improve Humana's operations. The mission is achieved by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes. Through its review of key internal processes, Internal Audit provides management with analyses, recommendations, advice and other pertinent information concerning the areas reviewed to assist members of the organization in the effective discharge of their responsibilities. The scope of the work of the department is designed to ensure that risks are appropriately identified and managed, that information is accurate, reliable and timely, that associates' actions are in compliance with standards, procedures, laws and regulations and that quality and continuous improvement are fostered in the organization's control processes.

Humana's Internal Audit Department functions as a means of assisting the Audit Committee, the Board of Directors and management in assuring that appropriate risk management, control and governance processes are in place. It is the mission of Internal Audit to provide independent, objective assurance and consulting services designed to add value and to improve Humana's operations by bringing a systematic, disciplined approach to evaluate and to improve the effectiveness of risk management, control and governance processes. To ensure the objectivity in the performance of its duties, Internal Audit reports directly to both the Audit Committee of Humana's Board of Directors and Humana's Senior Vice President and Chief Financial Officer with a dotted line reporting to Humana's Chief Executive Officer. The Chief Audit Officer has full access to the Audit Committee. These reporting relationships ensure that appropriate attention is given to issues noted in audits performed by Internal Audit.

Human Resources

Humana maintains policies and procedures for hiring, training, promoting and compensating associates. These policies and procedures are maintained on Humana's Intranet site, including policies regarding associate investigations and the formal Code of Conduct. The formal Code of Conduct is communicated to each new associate.

Human Resources has a leader that is responsible for coordinating learning activities across the organization. In addition, Human Resource consultants are assigned to each functional area to assist in these functions. A succession planning process under Human Resources helps identify associates that may fill management roles across the organization.

On an annual basis, associate performance is reviewed against defined standards as set forth in the role descriptions. This information is used to provide feedback to associates on their performance as well as to ensure compensation is in line with associate contribution.

As part of the hiring process, reference checks are sought and routine background checks are conducted on all individuals considered for hire.

Risk Assessment

Humana's risk assessment process includes enterprise wide assessment and monitoring of risk by the Executive Committee, Operating Committee, Working Group of the Disclosure Committee and individual operating units.

Humana's Board of Directors has an Audit Committee that reports on all risk-related functions including Internal Audit and auditors external to Humana. The Audit Committee takes the assessment of risk within the organization very seriously and requires senior management and the Chief Audit Officer to align strategic direction against risks and provide feedback proactively.

Humana has an Operating Committee that consists of the Chief Operating Officer, Senior Vice Presidents and Vice Presidents from various areas within the organization. The Operating Committee reports to the Humana CEO. Periodic meetings are held to discuss corporate strategy and risks to that strategy.

Control stewards exist throughout Humana in critical business and information technology areas. Their function, as a control steward, is to ensure that risks to individual business and technology process areas are assessed and mitigated as needed. In addition, control stewards supply Internal Audit a quarterly survey attesting to the current risk and control environment. Internal Audit facilitates risk assessments of each business process/cycle and sub-process/cycle with the control stewards.

Individual associates perform annual compliance training which includes identifying and reporting issues that could potentially pose a risk to the organization. Humana has established a variety of mechanisms that associates can use to escalate identified risks both openly and privately.

Information and Communication

Humana maintains several mechanisms for ensuring associates have the information needed to completely and accurately carry out their responsibilities. Various communications are delivered by Corporate Communications and include email, Intranet, logon pages, manager distribution lists, lobby plasma screens and other forms of communication.

Control stewards maintain a narrative describing their business processes and controls. In addition, Corporate Policy and Procedures along with Human Resources posts policies to the Humana Intranet. The Intranet provides additional resources by department.

Individual departments maintain policies and procedures for their specific needs. An online knowledge base provides easy access to information on Humana systems.

The Director of Financial Reporting reviews recent Financial Accounting Standards Board ("FASB") updates and provides them to accounting staff as necessary. In addition, the Corporate Secretary reviews SEC and NYSE guidance to ensure compliance with public company filing and exchange listing requirements. State and federal regulatory changes relevant to Humana are identified by Policy and Regulatory Analysis Consulting ("PRAC") and passed to Regulatory Implementation to ensure compliance activities are undertaken.

Monitoring

At the enterprise level, the Executive Committee reviews key strategic intent (strategic plan) performance and budget to actual financial operating results. The Operating Committee reviews key performance metrics across the enterprise. Finance publishes a monthly financial report that is distributed to senior leaders, operating leadership and members of the Board. The monthly performance dashboard is also published. Information Technology senior leaders meet periodically with executive leadership to ensure Humana's technology infrastructure aligns with strategic objectives.

At the operating and activity level, the processes and sub-processes of the organization each have a control steward responsible for monitoring key controls of that activity. The key controls include those surrounding activity performance, information processing, safeguarding of assets and segregation of duties. Such controls are captured in the narrative documentation, reviewed and tested annually as a part of Internal Audit's assessment of the operating effectiveness and adequacy of the control environment.

Each quarter, Internal Audit surveys control stewards concerning changes in their operations that would need additional review of the control activities. This survey inquires about new personnel in key areas, new or changed information systems, new products and changes in business processes.

Deficiencies in controls, identified by Internal Audit or external auditors, are collected by Internal Audit and reported to the Working Group of the Disclosure Committee for assessment. Follow up on actions taken to address the deficiencies is noted and escalated to management as necessary. The Audit Committee receives updates on management's overall efforts to mitigate identified deficiencies.

Humana Pharmacy Services management holds monthly Steering Committee meetings with their Pharmacy Claims Adjudicator. The meeting includes Humana representation from multiple HPS areas (i.e. transaction processing, formulary, enrollment, benefit build). During the meetings any service level agreements that are not being met are discussed as well as issues or changes that have occurred at the Pharmacy Claims Adjudicator. Results as well as remediation activities for controls identified in the Argus SOC1 report are also discussed. Additionally, there are key contacts and general email boxes at the Pharmacy Claims Adjudicator which Humana employees can contact regarding specific questions or issues as they arise. Complementary User Entity Controls (CUECs) are listed within the Argus SOC 1 report. Humana maps the relevant CUECs to controls within the Humana control environment and performs testing of these controls.

APPLICATION SYSTEM OVERVIEW

The MTV application is a multi-tiered mainframe, client-server, and web system with Graphic User Interface (GUI) online data entry and memo- posting capabilities. The MTV core application programs, which contain the adjudication logic and perform transaction processing as described in this report, are written in COBOL and reside on the mainframe. MTV source code is owned and maintained by a third-party vendor. In-house MTV-related programs have been developed to support interfaces to other systems (e.g., Billing, Web interfaces, etc.).

MTV includes features such as claims adjudication, eligibility determination, benefit creation/maintenance, claims history retrieval, and provider and group data.

Transactions:

The major types of transactions that can be processed by the MTV system are:

- Processing of Hospital/Facilities Claims (i.e., UB 82/92) - Records the information related to filed institutional claims and approves claims for payment. (This includes paperless and paper claims).
- Processing of Physician Claims (i.e., HCFA) - Records the information related to filed professional claims and approves claims for payment. (This includes paperless and paper claims).
- Processing of Medicare Claims (i.e., HCFA) - Records the information related to filed institutional claims and approves claims for payment. (This includes paperless and paper claims).
- Payment of Claims - Processes and records payment of approved claims.
- Enrollments (i.e., Group Register) - MTV interfaces with the Group Health Enrollment System to record the addition, deletion or modification of information in the subscriber master file.
- Adjustments (i.e., Cash Recovery System) - Records the adjustments made to claims that have been finalized.
- Update of Reference Files (e.g., UCR, service codes) - Records changes made to standing data files referenced in the processing of Medicare, professional and institutional claims.

COMPLEMENTARY USER ENTITY CONTROLS

The MTV system was designed with the assumption that certain controls would be implemented by user organizations. In certain situations, the application of specified controls at user organizations is necessary to achieve certain control objectives contained in this report. The following user internal control considerations presented should not be regarded as a comprehensive list of all controls that should be applied by user organizations. There may be additional controls that would be appropriate for the processing of user transactions that are not identified in this report.

- Controls should be established to ensure that new or updated Claims Payment Agreements (CPA) are validated by the deadlines as stated in these agreements (control objective 6).
- Controls should be established to ensure authorized individuals of user organizations provide accurate/timely, complete and valid enrollment information to help ensure accurate/timely, complete and valid claims processing (control objective 7).
- Controls should be established to ensure that information (claims, participant data, etc.) submitted to Humana for processing is reviewed for completeness and accuracy (control objectives 7, 9 and 10).
- Controls should be established to ensure that sensitive information provided by Humana to user organizations is restricted to appropriate individuals (control objectives 6 and 11).
- Controls should be established to ensure that all required output is received from Humana, reviewed and reconciled for completeness and accuracy (including but not limited to invoices, bank reconciliations, stop loss reports and reimbursements); (control objectives 6 and 11).
- Controls should be established to ensure user organizations review their bills for accurate rates and membership numbers to monitor the accuracy of billings (control objective 11).
- Controls should be established to ensure that administration of Enrollment Secured Logon access is appropriately restricted and reviewed on a periodic basis (control objective 7).
- Controls should be established to ensure that enrollment transactions updated on the web receive an on-screen confirmation that the transaction was processed (control objective 7).
- Controls should be established to ensure that the claims expense and check register provided by Humana are reconciled to the customer's bank account (control objective 11).
- Controls should be established to ensure that a review is performed of instances of members' use of non-participating providers including an examination of whether claims were adjudicated according to plan benefits (control objectives 6 and 10).

SECTION IV - HUMANA'S CONTROL OBJECTIVES AND CONTROL ACTIVITIES AND PRICEWATERHOUSECOOPERS LLP'S TESTS OF OPERATING EFFECTIVENESS

For presentation purposes, Humana's control objectives, control descriptions and related control activities are included in Section IV, and are an integral part of Humana's description. PricewaterhouseCoopers LLP ("PricewaterhouseCoopers") tested relevant aspects of the control environment and control objectives as specified in Section IV. PricewaterhouseCoopers' testing covered only those controls provided by Humana and did not cover controls that may be specific to individual customers of Humana.

Tests of the control environment, monitoring, risk assessment and information and communication could include inquiry of appropriate management, supervisors, and staff personnel; observation of Humana's activities and operations; inspection of Humana's documents and records, and reperformance of selected Humana control activities. The results of these tests were considered in planning the nature, timing, and extent of testing of the control activities designed to achieve the control objectives. As inquiries were performed for substantially all of Humana controls, this test was not listed individually for every control listed in the tables in Section IV.

Additionally, observation and inspection procedures were performed as it relates to system generated reports, queries, and listings to assess the completeness and accuracy (reliability) of the information utilized in the performance of our testing of the control activities.

APPLICATION MAINTENANCE AND CHANGE CONTROL

Application Engineering Leadership is responsible for establishing application maintenance and change control policies and standards. Application Engineering Leadership is also responsible for adherence to application maintenance and change control policies and standards, including the overall System Development Life Cycle (SDLC). The SDLC describes the overall methodology that supports a standard approach to software development using appropriate industry best practices within Humana's Information Technology (IT) departments. Application Engineering Leadership is also responsible for SDLC monitoring and control for their respective development teams. The Project Management Competency Center (PMCC) is responsible for monitoring and governance of SDLC-related processes.

Initiation, Approval and Prioritization

Large, multifunctional requests (with an approximate threshold of greater than or equal to six full-time employee effort months) are initiated by business and/or IT representatives. These project requests are prioritized and approved for development by the Information Technology Prioritization Committee which is made up of both IT and business representatives.

Small, simple functional requests (with an approximate threshold of less than six full-time employee effort months) fall into two categories: enhancements and requests for maintenance. Enhancement requests are other initiatives that are necessary to support a development area but are not of sufficient size and complexity to be considered a large, multifunctional project. These enhancements are requested by business and/or IT representatives and are prioritized and approved for development locally by an IT Application Owner. Maintenance requests are small changes to existing systems to correct errors in programs, jobs, or procedures not operating as specified or not in conformance with accepted standards. They are requested, prioritized, and approved for development locally by an IT Application Owner or IT Support Owner. The requests can also be immediate fixes and may require retroactive documentation.

Testing, Sign-off, and Documentation

Programmers perform system testing to determine if modified programs are producing the expected results. Results of these tests are provided to Project Managers and/or IT Application Owners but are not required to be maintained beyond the completion of the production turn request. For application changes, the user requesting the change, or an assigned member of the project team, is required to perform user acceptance testing (UAT) once notified by the programmer that the change has been made in development. UAT documentation may consist of test plans, test scripts, and associated test results. A member of the project team documents the user approval for testing of the changes before the change is moved to production. When the change is requested by IT and IT is deemed the owner of the change, the production turn approval is the UAT approval.

For large, multifunctional requests, the project team members perform system testing to monitor for proper coordination between programs and to check the effect on the overall application. The results of this testing are maintained independently and provided to project managers and/or IT Application Owners, or may be included with results of UAT. Additionally, members of the project team may perform system and pilot and/or parallel testing in a Quality Assurance (QA) environment which mirrors the production environment to discover any possible flaws in the system modification as well as to determine whether any user requirements may have been overlooked. The method by which a program or system is tested is determined by the IT Application Owner and/or Project Manager as applicable.

The testing process occurs on all new or changed code to mitigate risk. All program modifications are made in the programmer's development library and if the change is part of a release, they are then transferred to the release test library. All requests are moved through developmental stages by approvals of milestones in their respective collaborative environments and monitored by release and/or project managers.

Once the modified program is tested, the testing is approved, verifying the program is functioning as documented in the original request. An approval to deploy to production is obtained and is the authorization to transfer the program into the production environment.

Migration

Programs are migrated to production via the turnover process. The current version of a program is maintained in the production library and the prior version is stored in a separate production library at the time of migration. Nightly backups of all production libraries are taken and can be used to recover a program if required. In January 2016 Humana began a migration from PANVALET to IBM's Partitioned Data Sets for code management. This effort is expected to take three years. During the period January through September 2016, JCL and datacards were migrated to Partitioned Data Sets. These were subject to movement into production through the migration tool, and, as described below, only certain personnel have access to transfer new or modified programs to production.

Access Control Facility II (ACF2) security software is used to secure the production environment. Programmers may browse and copy from the source library, but they cannot overwrite any source or object code such that only authorized changes are implemented. Only the Production Turn Center (PTC) personnel (not programmers) have the access capabilities through ACF2 to transfer new or modified programs to production. PTC managers review ACF2 security reports monthly to help ensure that access remains appropriate, and ACF2 write rules are also monitored (refer to the Logical Access Management section of the report).

Once the turnover package has been checked for completeness (i.e., review of relevant test approvals, source code comments, Job Control Language (JCL), etc.), the approver (a member of the IT Department for the particular application) approves the turn package. The system prohibits any associate from authorizing his or her own change. Verification of the authorizer is handled by the migration tool. The Turn Package then appears in a work queue for PTC personnel to process.

The source code is moved to secured libraries, restricted to only PTC personnel, by the migration tool when the request is submitted for approval. Should the code change be rejected, the code will be removed from the migration tool and sent back to the appropriate personnel. After changes have been made to the code, a new request for approval must be processed at which point the code is again moved to secured libraries until approval is obtained and code is migrated to production. Management has established a source code monitoring function that includes performing a weekly review of 10 changes to ensure the PTC process was followed appropriately. Fewer changes may be reviewed during shorter weeks (i.e., less than five business days), as a result of federal holidays and/or office closures.

Service requests that are necessary after hours (i.e. emergency changes) follow the Oneshot process (refer to the Computer Operations section of this report). If an emergency change service request cannot be handled using the Oneshot process, the PTC On-call or the developer may provide a JCL override.

IT application owners are responsible for maintaining and assigning approvers of production turnover and Oneshots.

Quality Assurance

The AudITSO – Compliance Audit and Compliance function performs monthly internal audits on application development projects within Application Engineering and Architectural Management (AEAM) to monitor and assess compliance with the SDLC process. AudITSO – Compliance obtains the population of all production code turns from Enterprise Turn Point (eTP). A random sampling method is used to select a minimum of 60 samples from production turns. Although a random sampling method is used, the intent is to perform a minimum of two reviews per year for each IT Turn Authorizer. Each sample is reviewed for the following: approval of the application development project, evidence of testing, and approval to deploy. Results of the review are communicated to IT Turn Authorizers and Project Managers. IT Turn Authorizers, Project Managers, and their managers are responsible for assuring the resolution of any discrepancy and/or unresolved issues. Discrepancies are reported to Application Engineering Leadership.

CONTROL OBJECTIVE 1: *Controls provide reasonable assurance that changes to existing applications and the development of new applications are authorized, tested, approved, properly implemented and documented.*			
Provided by Humana		***Procedures Performed by PricewaterhouseCoopers LLP***	
CONTROL ACTIVITIES		**TEST PROCEDURES**	**RESULTS**
Testing, Sign-off and Documentation			
1.1	Application changes require User Acceptance Testing (UAT) and approval.	**Inspection** Inspected a sample of application changes to determine whether UAT was completed and approved before the change was moved to production.	No exceptions noted.
Migration			
1.2	Production Turn Center managers review ACF2 security reports monthly to ensure that access remains appropriate based on current job responsibilities.	**Inspection** Inspected a sample of monthly ACF2 security reports showing individuals with access to PANVALET datasets to determine whether access was reviewed by the Production Turn Center Manager.	No exceptions noted.

CONTROL OBJECTIVE 1: *Controls provide reasonable assurance that changes to existing applications and the development of new applications are authorized, tested, approved, properly implemented and documented.*			
Provided by Humana		***Procedures Performed by PricewaterhouseCoopers LLP***	
CONTROL ACTIVITIES		**TEST PROCEDURES**	**RESULTS**
1.3	Once the turnover has been checked for completeness, the authorizer for the particular application approves the turn online, and Production Turn Center moves the change into production.	**Inspection** Inspected a sample of application software changes promoted to production via the online turnover system to determine whether the changes were approved by an authorized individual.	No exceptions noted.
1.4	Only approved code is moved to production.	**Observation** Observed that access to secured libraries where source code is locked down is appropriately restricted to authorized individuals and functions.	No exceptions noted.
1.5	Management has established a source code monitoring function that includes performing a weekly review of 10 changes to ensure the PTC process was followed appropriately. Fewer changes may be reviewed during shorter weeks (i.e., less than five business days), as a result of federal holidays and/or office closures.	**Inspection** Inspected a sample of management's weekly reviews of changes migrated to production to determine if the PTC process was followed.	No exceptions noted.

OPERATING SYSTEM SOFTWARE

Technical Services oversees online systems, distributed communication systems, system software, WAN, and LAN operating systems.

Hardware and System Software

Humana's Data Center houses two IBM mainframes. The mainframes encompass peripheral hardware and the IBM z/OS operating system. Time-Sharing Option (TSO) and Customer Information Control System (CICS) software products are provided and supported by IBM, and maintained by Technical Services. TSO provides an interactive environment on the Humana mainframe systems for program execution (interactive and batch), editing, printing, and managing data. Much of its functionality is provided by menu-driven full-screen utilities. CICS provides the enterprise online transaction processing environment for mission critical applications.

Upgrades and Maintenance to System Software

Operating system software changes, which are authorized by IT Infrastructure (ITI), include mainframe operating system releases and version upgrades as well as general system software maintenance updates. General maintenance includes preventative updates which are released quarterly. There may also be system patches applied along with the maintenance updates. For the abovementioned changes, systems programmers perform testing of the changes prior to submitting them for promotion to production. The testing is performed on Humana's test systems and is completed by the appropriate Technical Services and Computer Operations personnel including: Systems Software, Communication Systems, Performance and Tuning, and Database Administration. All operating system changes are installed in the test environment and validated after the Initial Program Load (IPL) reboot process in the test environment prior to implementation on systems in the production environment.

A Request for Change ticket is assigned to the Change Management team in a 'submitted' status once a change is ready for approval. The first level of approval is the Requester's Manager. Once that approval is obtained, Change Management will assign approval tasks to the Manager of the Implementation Group as well as the approvers listed on each Configuration Item. The approvers review the change and will either approve or reject the change.

When all the approvers have approved the change, the risk rating (calculated by the Risk Survey that the requester completes when creating the Request for Change ticket) determines whether the change needs further review by the Change Advisory Board (CAB). The CAB meets weekly to assess, prioritize and schedule system software changes. If the risk is low, further review is unnecessary and the change is scheduled. If the risk is medium or high, the CAB will need to approve the change before it is scheduled. The CAB is chaired by the Service Assurance group and consists of a group of subject matter experts from various IT and business areas. Production Control is involved during the CAB approval process. Operating system software changes are moved to production during the corresponding mainframe IPL. Validation of the IPL is documented and approved by the responsible manager in a Request for Change ticket.

Technical documentation, referred to as "Bluebooks," is maintained outside of the mainframe using a word processing tool. This documentation is updated when changes to system software are made.

Emergency system software changes are defined as changes to be done "as soon as possible" and "scheduled" following change control procedures. These changes are handled in the same manner as regular changes and do not include "unscheduled" outages. Unscheduled outages are indicative of unexpected system problems. Unscheduled IPLs are logged to the service ticketing workflow system, monitored by Computer Operations and tracked for closure.

CONTROL OBJECTIVE 2: *Controls provide reasonable assurance that changes to existing operating system software and the implementation of new operating system software are authorized, tested, approved, properly implemented and documented.*			
Provided by Humana		***Procedures Performed by PricewaterhouseCoopers LLP***	
CONTROL ACTIVITIES		**TEST PROCEDURES**	**RESULTS**
2.1	Operating system software changes are tested by Technical Services and Computer Operations prior to the changes being promoted to production.	**Inspection** Inspected change documentation for a sample of operating system software changes to determine whether evidence of testing existed.	No exceptions noted.
2.2	Operating system software changes, including system downtime associated with the changes, go through the Change Management process prior to being promoted to production. The CAB only approves changes with a medium or high risk rating. Operating system software changes are moved to production during the corresponding scheduled mainframe IPL.	**Inspection** Inspected a sample of the scheduled operating system software changes to determine whether the changes were approved in compliance with the Change Management process before the mainframe IPL.	No exceptions noted.
2.3	Unscheduled IPLs are logged to the internal service ticketing workflow system, monitored by Computer Operations and tracked for closure.	**Inspection** Inspected the population of the unscheduled IPLs from the mainframe to determine whether the IPL was logged to the internal ticketing system, monitored by Computer Operations and tracked for closure.	No exceptions noted.

LOGICAL ACCESS MANAGEMENT

The Enterprise Information Protection (EIP) Program, under the Chief Information Security Officer (CISO), is responsible and accountable for establishing information protection policies and standards, control guidance and assurance, and security strategies and architecture. Enterprise Information Protection Access Management (EIPAM) is responsible for establishing and administering users' access accounts and logical access levels for systems and computerized data throughout Humana in accordance with EIP policies and standards. Logical access to Humana claims systems (including MTV) is governed at the system, application and data levels. Operational procedures are outlined regarding the creation, modification and removal of Humana claims systems access accounts. Humana applications, systems, and data environments relevant to specific MTV control realms have been identified, defined, and are reviewed semi-annually to ensure proper scope and span of control.

1. System Level Logical Access

   There is no native system level access required for the MTV application. Access to MTV is managed at the application layer.

   ACF2 is the mainframe security system used to secure MTV application data. Authentication and password policies are maintained at the ACF2 level. The ability to alter ACF2 configuration is reviewed quarterly. The Global System Options (GSO) and password settings are stored in the ACF2 configurations. ACF2 system level authentication and password policies appropriately restrict user access to system resources by enforcing the following:

   - Passwords have minimum length.
   - Passwords are not blank.
   - Unsuccessful login attempts lock the account.

   Termination notifications for associates and contractors are sent to EIPAM via an automated nightly feed from HR. This information is exported to a daily file for automated processing of terminations. Weekly processes executed by EIPAM ensure all ACF2 access is disabled for terminated users.

   Transfers for users with access to ACF2 are processed using the standard transfer process. Personnel changes are reviewed to determine need for access review. Someone in the user's hierarchy reviews current access and responds to keep or delete access for confirmed transfers.

2. Application Level Logical Access

Requests for user access to Humana claims system follow the standard approval and provisioning processes. Specific approvals required for each asset (entitlement, role, group) are documented. This approval may include someone in the user's management hierarchy and/or one or more approver(s). To change a user's access account in Humana claims systems, a request is sent to EIPAM and also must follow the standard approval processes. Access to MTV is manually processed through the standard provisioning processes.

MTV has an integral security subsystem. Authentication and password policies are maintained at the MTV application level. The ability to alter MTV configuration is restricted to a limited number of authorized users within EIPAM and Technology Solution Services (TSS). The password settings are stored in the MTV configurations. MTV application authentication and password policies appropriately restrict user access to system resources by enforcing the following:

- Passwords have minimum password length.
- Passwords are not blank.
- Passwords expire at least every 90 days.

Access to administer MTV security is restricted to authorized users and follows the standard approval process. This access is reviewed quarterly by EIPAM.

Termination notifications for associates and contractors are sent to EIPAM via an automated nightly feed from HR. Access at the application level is terminated manually on a daily basis. Weekly processes executed by EIPAM ensure all MTV access is disabled for terminated users.

Transfers for MTV follow the same process outlined in the system level logical access process defined above.

MTV is designed to prevent conflicting access within a single user account. Each MTV user is authorized to have one primary account but may be authorized for one or more secondary accounts as required to perform business functions. Business functions that pose a potential segregation of duties within MTV have been identified by management. Reviews for potential duplicate accounts and conflicting access are performed on a risk-appropriate frequency. User access that may pose segregation of duties issues is researched for appropriateness.

An automated scripting tool (Winbatch) is used to automate entry of data into common fields within MTV. Humana claims systems Winbatch accounts are assigned to authorized operators and are managed through the Secured Multiple Account Authorization (SMAA) utility. The SMAA utility maintains operator accountability and facilitates login for Winbatch accounts. A monthly business owner review ensures there is restricted access to the Winbatch accounts. EIP performs a review of the controls at least annually.

Access to the following Humana claims systems functions is restricted to authorized users and is reviewed by the business:

Areas	Application Names	Review Frequency
Plan Load	MTV Plan Load	Quarterly
Enrollment	MTV Enrollment	Quarterly
Provider Contract and Rate Loading	Contract Information System (CIS)	Quarterly
Provider Contract and Rate Loading	Fee Schedule Management (FSM) System	Quarterly
Provider Contract and Rate Loading	MTV Contract Loading	Quarterly
Claims Adjudication	MTV Claims key functions	Quarterly

3. Logical Access to System and Application Programs and Data

The ability to directly update production systems and application programs and data files is controlled by ACF2 through the use of access rules. Access rules can be written for individuals and groups. Update access to programs and data is restricted to production jobs and authorized support personnel. Users are configured with *read* and *execute* access only and are required to obtain an exception approval from the Security Review Committee (SRC) for any *write* or *allocate* access along with the approval from the dataset owner.

Weekly reviews are performed to ensure users do not have unauthorized update or delete access to ACF2 production data. If a rule with write or update logical access for any user is found during the review, EIPAM investigates to ensure that an approved exception has been granted or the access is removed.

4. Material Access

Requests for DB2 elevated access follow the standard approval and provisioning process. Access to DB2 elevated rights is reviewed on a risk appropriate frequency for user and system accounts. Material DB2 elevated rights grant activity is reviewed at least weekly by EIPAM. Any anomalies in grants found within the review process are remediated.

Terminations at the data level follow the system level logical access process defined above.

Transfers for DB2 follow the system level logical access process defined above.

5. Quality Assurance

EIPAM performs a formal quality assurance audit at least weekly for a sample of requests to monitor accuracy of the EIPAM provisioning process. Findings are communicated and remediated.

CONTROL OBJECTIVE 3: *Controls provide reasonable assurance that logical access to system resources (i.e., programs, data and parameters) is restricted to properly authorized individuals.*			
Provided by Humana		***Procedures Performed by PricewaterhouseCoopers LLP***	
CONTROL ACTIVITIES		**TEST PROCEDURES**	**RESULTS**
System Level Access			
3.1	The ability to alter ACF2 configuration is reviewed quarterly.	**Inspection** Inspected a sample of quarterly security reviews for ACCOUNT, CONSULT, LEADER and SECURITY privileged accounts to determine whether the reports were reviewed.	No exceptions noted.
3.2	The GSO and password settings are stored in the ACF2 configurations.	**Inspection** Inspected GSO configurations at a point in time to determine whether the password configurations follow defined password policies.	No exceptions noted.
3.3	Termination notifications for associates and contractors are sent to EIPAM via a nightly HR feed. This information is exported to a daily file for automated processing of terminations.	**Observation** Observed that system access for a user appearing on the weekly terminations report had been revoked.	No exceptions noted.
3.4	Transfers are processed using the standard transfer process.	**Inspection** Inspected request emails for a sample of associates transferred during the period to determine whether requests were completed and authorized, or the access was marked to be revoked following the standard transfer process.	No exceptions noted.

CONTROL OBJECTIVE 3: *Controls provide reasonable assurance that logical access to system resources (i.e., programs, data and parameters) is restricted to properly authorized individuals.*			
Provided by Humana		***Procedures Performed by PricewaterhouseCoopers LLP***	
CONTROL ACTIVITIES		**TEST PROCEDURES**	**RESULTS**
Application Level Access			
3.5	Requests for user access to Humana claims system follow the standard approval and provisioning processes.	**Inspection** Inspected user access requests for a sample of associates granted ACF2 new access to determine whether requests were completed and authorized.	No exceptions noted.
		Inspection Inspected user access requests for a sample of associates granted MTV new access to determine whether requests were completed and authorized.	No exceptions noted.
3.6	The password settings are stored in the MTV configurations.	**Inspection** Inspected MTV configurations at a point in time to determine whether password configurations follow Humana password policies.	No exceptions noted.
3.7	User access that may pose segregation of duties issues is researched for appropriateness.	**Inspection** Inspected a sample of management's weekly review of users with access to multiple MTV accounts or templates to determine whether access was reviewed, exceptions were identified and duplicate access was removed.	No exceptions noted.

CONTROL OBJECTIVE 3: *Controls provide reasonable assurance that logical access to system resources (i.e., programs, data and parameters) is restricted to properly authorized individuals.*			
Provided by Humana		***Procedures Performed by PricewaterhouseCoopers LLP***	
CONTROL ACTIVITIES		**TEST PROCEDURES**	**RESULTS**
3.8	Humana claims system Winbatch accounts are assigned to authorized operators and are managed through the Secured Multiple Account Authorization (SMAA) utility. The SMAA utility maintains operator accountability and facilitates login for Winbatch accounts.	**Observation** Observed the SMAA key stroke emulator password utility to determine whether users are required to login to the key stroke emulator application accounts through individually assigned user IDs and passwords.	No exceptions noted.
3.9	A monthly business owner review ensures there is restricted access to the Winbatch accounts.	**Inspection** Inspected a sample of monthly MTV Winbatch security reviews to determine whether access for individuals with key stroke emulator IDs was reviewed by the key stroke emulator business owner.	No exceptions noted.
3.10	Access to the MTV Plan Load function to update plan and benefit information is restricted to authorized users and is reviewed by the business.	**Inspection** Inspected a sample of MTV Plan Load quarterly security reviews to determine whether access is reviewed by management and access updated appropriately.	No exceptions noted.

CONTROL OBJECTIVE 3: *Controls provide reasonable assurance that logical access to system resources (i.e., programs, data and parameters) is restricted to properly authorized individuals.*			
Provided by Humana		***Procedures Performed by PricewaterhouseCoopers LLP***	
CONTROL ACTIVITIES		**TEST PROCEDURES**	**RESULTS**
3.11	Access to the MTV Enrollment function is restricted to authorized users and is reviewed by the business.	**Inspection** Inspected a sample of MTV enrollment access reviews to determine whether access is reviewed on a quarterly basis.	No exceptions noted.
3.12	Access to the Contract Information System (CIS), Fee Schedule Management (FSM) System, and MTV Contract Loading functions is restricted to authorized users and is reviewed by the business.	**Inspection** Inspected a sample of CIS, Fee Schedule Management (FSM) and MTV Contract Loading functions access reviews to determine whether access for individuals who update provider records is reviewed by management and access updated appropriately.	No exceptions noted.
Secured Logons			
3.13	Access to the MTV Claims key functions is restricted to authorized users and is reviewed by the business.	**Inspection** Inspected a sample of MTV quarterly security reviews to determine whether access to MTV Claims key functions is reviewed to ensure access remains appropriate and functions are segregated.	No exceptions noted.

CONTROL OBJECTIVE 3: *Controls provide reasonable assurance that logical access to system resources (i.e., programs, data and parameters) is restricted to properly authorized individuals.*			
Provided by Humana		***Procedures Performed by PricewaterhouseCoopers LLP***	
CONTROL ACTIVITIES		**TEST PROCEDURES**	**RESULTS**
Access to Data			
3.14	Weekly reviews are performed to ensure users do not have unauthorized update or delete access to ACF2 production datasets.	**Inspection** Inspected a sample of weekly ACF2 reviews to determine whether users had unauthorized update or delete access to production datasets.	No exceptions noted.
3.15	Requests for user and system DB2 elevated access follow the standard approval and provisioning processes.	**Inspection** Inspected documentation for a sample of new DB2 access grants to determine whether the request was authorized appropriately prior to the completion of the ticket used to request the DB2 elevated access, and to determine whether the access requested was granted.	No exceptions noted.

CONTROL OBJECTIVE 3: *Controls provide reasonable assurance that logical access to system resources (i.e., programs, data and parameters) is restricted to properly authorized individuals.*			
Provided by Humana		***Procedures Performed by PricewaterhouseCoopers LLP***	
CONTROL ACTIVITIES		**TEST PROCEDURES**	**RESULTS**
3.16	Access to DB2 elevated rights is reviewed on a risk appropriate frequency for user and system accounts.	**Inspection** Inspected a sample of reviews of access to DB2 elevated rights to determine whether the access was reviewed by management.	No exceptions noted.
3.17	Access at the application level is terminated manually on a daily basis.	**Inspection** Inspected request emails for a sample of users terminated during the period to determine whether requests were completed and MTV application access was removed.	No exceptions noted.

CONTROL OBJECTIVE 3: *Controls provide reasonable assurance that logical access to system resources (i.e., programs, data and parameters) is restricted to properly authorized individuals.*			
Provided by Humana		***Procedures Performed by PricewaterhouseCoopers LLP***	
CONTROL ACTIVITIES		**TEST PROCEDURES**	**RESULTS**
3.18	Material DB2 elevated rights grant activity is reviewed at least weekly by EIPAM.	**Inspection** Inspected a sample of DB2 elevated rights grants to determine whether material DB2 elevated rights grant activity was reviewed and for instances noted where access was not properly provisioned, appropriate action was taken.	**Exception Noted.** For a sample of one of twenty DB2 access grants, noted that a review was not performed. This occurred because the report used to perform the review was missing one day's activity.
3.19	Humana applications, systems, and data environments relevant to specific MTV control realms have been identified, defined, and are reviewed semi-annually to ensure proper scope and span of control.	**Inspection** Inspected a sample semi-annual review evidencing that Humana applications, systems, and data environments relevant to specific MTV control realms have been identified and defined.	No exceptions noted.

COMPUTER OPERATIONS

Production Control is responsible for the monitoring of the mainframe hardware and software. The operators leverage various written manuals, as well as on-line documentation, to assist in the monitoring and error resolution processes. Additional areas of monitoring include; production batch and job logs, the Customer Information Control System (CICS) and production tasks. Any abends reported during these monitoring activities are logged in a service ticketing workflow system. Due to the critical nature of the systems being monitored by Production Control, the department operates continually year-round.

Job Scheduling

Humana has established standard processing procedures which define the steps that must be taken to process a job through production control. These procedures include specifics regarding the preparation of temporary schedules for production jobs. This procedure specifies that the Turnover Department is responsible for preparing the schedules of production jobs. All job schedules contain documentation including job sequence, prerequisites and conflicts to be considered for each job in the scheduling process, the individual or departments authorized to request the job, the run frequency and the processing priority of the job. The form is used to update CA-7 and a copy is maintained online. Job schedules may be submitted by developers but must be approved by IT management prior to migration into production.

The CA-7 Automated Production Control system is utilized to ensure jobs and programs are processed in accordance with the authorized schedules. CA-7 performs workload scheduling, workload sequencing, workflow control, job restart and documentation functions with regard to production job stream processing. Access to make changes to the schedule using the CA-7 software is restricted to individuals in Production Support who require such access for their job responsibilities. Management reviews CA-7 group access on a monthly basis to ensure that access is restricted to individuals in Production Support who require such access for their job responsibilities.

All permanent job schedule changes are processed through the standard mainframe change control process as small, simple functional requests (refer to the Application Maintenance and Change Control section of the report). Temporary schedule changes may only be requested by authorized application support staff or programmers associated with the job schedule being changed. Examples of temporary overrides of Job Control Language (JCL) include a dataset name override, generations of data override, or a one-time override procedure. Production Scheduling creates a ticket for the change request in Humana's ticketing system. The ticket number is added to the original Change Request and filed within the SharePoint Request Tool. This request includes the date, the job, the ticket number, the person who requested the change, instructions and the initials of the person who performed the schedule change. The ticket is then transferred to the appropriate IT System's Application group after the requested change is made.

Humana uses the Special Job Processing Request, known as a "oneshot", to process immediate modifications to programs and data during emergencies. Oneshot procedures are documented online and contain general information about the oneshot process, a statement of general policy of when to use oneshots and a note regarding oneshot request authorization. Oneshots are to be used for one time processing which deviates from the normal job schedule. Oneshots are requested online and require an IT Systems Applications management authorization if requested during business hours. Requests provide the following information: reason for the oneshot request, requestor's name and extension number, the name of the job to be run, special instructions to be followed, the processing date and time, estimated amount of time to run the job, the tape drives needed for the job, prerequisites for the job, any conflicts and the online system affected.

Oneshots submitted outside business hours do not require authorization before being run, but are retroactively authorized by the associated IT Systems Applications management. Management sign-off is expected within thirty days from the time the oneshot is run. The list of oneshot authorizers is kept current. Every Monday, the oneshot system emails approvers of all oneshot changes made after normal business hours to remind management of outstanding approvals required for the oneshots that were executed. An Aging Report is sent to the Production Control manager via email on the first of every month that notes the number of oneshots still requiring approvals organized by the approver and the length of time the approval has been outstanding. The Production Control manager calls approvers with authorizations outstanding past thirty days to investigate issues with granting the approvals.

Restart/Recovery Procedures

Escalation procedures and procedures for handling abends are maintained within the Operations Manual, containing a list of key individuals to contact if a problem occurs, steps for monitoring CA-7 queues, and procedures for processing production control requests.

Production Support monitors emergency situations, reruns, system failures, scheduling issues, and production job abends. Tickets are automatically generated by the Automation Point interface for job abends. Production Control utilizes Xmatters for on-call and event escalation. Resolution for these items is documented in the service ticketing workflow system. On a weekly basis, Service Desk produces an aging report indicating the number of tickets that were opened and addressed by Production Scheduling. The manager of Production Scheduling, as part of a weekly EOR, reviews the weekly aging report to ensure that abend tickets opened were addressed within 10 days. Any tickets not addressed within 10 days are detailed in the weekly review indicating actions in progress addressing those tickets. Production Control is responsible for monitoring system availability and downtime and for analyzing and reporting statistics to senior Technical Services management.

CONTROL OBJECTIVE 4: *Controls provide reasonable assurance that processing is appropriately authorized and scheduled, and deviations from scheduled processing are identified and resolved.*			
Provided by Humana		***Procedures Performed by PricewaterhouseCoopers LLP***	
CONTROL ACTIVITIES		**TEST PROCEDURES**	**RESULTS**
Job Scheduling			
4.1	Access to make changes to the schedule using the CA-7 software is restricted to individuals in Production Support who require such access for their job responsibilities. Management reviews CA-7 group access on a monthly basis to ensure that access is restricted to individuals in the Production Support groups who require such access for their job responsibilities.	**Inspection** Inspected a sample of CA-7 monthly security reviews to determine whether the authority levels of individuals with access to make changes to the CA-7 schedule have been reviewed by management.	No exceptions noted.
4.2	Temporary schedule changes are requested by authorized application support staff or the developer associated with the application, and documented in the service ticketing workflow system.	**Inspection** Inspected a sample of temporary schedule changes, to determine whether the request was submitted by an authorized application support associate or the developer associated with the application and documented in the service ticketing workflow system or Change Request.	No exceptions noted.
4.3	Permanent schedule changes and additions are approved by authorized IT personnel.	**Inspection** Inspected a sample of permanent schedule changes and additions to determine whether authorized IT personnel approved the changes.	No exceptions noted.

CONTROL OBJECTIVE 4: *Controls provide reasonable assurance that processing is appropriately authorized and scheduled, and deviations from scheduled processing are identified and resolved.*			
Provided by Humana		***Procedures Performed by PricewaterhouseCoopers LLP***	
CONTROL ACTIVITIES		**TEST PROCEDURES**	**RESULTS**
4.4	Oneshot requests require an IT Systems Applications management authorization if requested during business hours. Oneshot runs submitted outside work hours do not require authorization before being run, but are retroactively approved by authorized personnel.	**Inspection** Inspected a sample of oneshot requests to determine whether authorized personnel approved the oneshots.	No exceptions noted.
Restart/Recovery Procedures			
4.5	Production Support monitors emergency situations, reruns, system failures, scheduling issues and production job abends. Service tickets are routed to the assigned department for investigation and closure.	**Inspection** Inspected a sample of system errors from the log managed by Production Support to determine whether they were resolved.	No exceptions noted.

DATA TRANSMISSIONS

Electronic Transmissions (ET) is responsible for maintaining scheduled jobs and electronic file transfer processes to determine whether electronic data files are sent and received from submitters as expected, monitoring the managed file transfer production scheduling system to determine if jobs and processes ran successfully and following up on job failures that occur. Data files for which ET is responsible for transferring electronically include most customer enrollment files, as well as other data files used by Finance, Payroll, and Marketing areas. Claims data files are processed via eHUB (refer to the Claims Receipt and Entry section of this report). Enrollment files are subject to various edits and controls for accuracy and completeness. These controls are tested in the Enrollment section (refer to the Enrollment section of this report). Separate ET processes are created for each data file submitter, and only valid submitters are permitted to send to Humana servers or mainframe or be picked up by Humana. Data files are received or picked up from submitters and placed in predetermined locations within Humana's system (i.e. mainframe, servers, etc.) to be processed by other application programs.

Transmission of Transactions

ET is responsible for monitoring the production scheduling managed file transfer (MFT) system during business hours, and the team rotates on-call duties at night and on the weekend. When required, the electronic transmission MFT system runs "Checker Processes" during scheduled times throughout the day and night to determine if transmissions completed successfully. These "Checker Processes" are either built into the same job that it is monitoring, or it could be a separate job altogether. The production scheduling system has a status column with transmission codes to indicate successful completion of the mainframe job. If all customer files that are processed on a schedule are not received as expected, the production scheduling system will flag the job with a failure notification (e.g. abend), and Humana's Production Support department will notify ET to research and determine if a rerun is necessary. If Humana does not receive all files after the job reruns, the system will alert ET (or Production Support staff, who will then contact the ET staff on-call, if the job failure occurs at night or on the weekend) and the Production Support staff will open a service ticket to log the problem and resolution. If the process is set up as one without abends, an email notification will be sent to the ETDownJobs mailbox if a file is not received as expected. The ET Operations team will research to make sure there are no system issues. If the failure is not due to a system error and it is determined that the external partner has not sent a file, ET will notify the internal business contacts so they can take the appropriate action and work with the external partner to have the file sent as expected.

Communication Platforms

When Humana obtains an agreement with its customers to submit data via electronic transmissions, an Electronic Transmissions request is submitted in the Electronic Transmission Self – Service (ETSS) web tool. Only persons authorized by the applicable Business Function Area (BFA) owner have the access rights to submit a new transmission request. The BFA owner is a Business Director-level or above, who has verified that the new data transmission request is authorized and that the appropriate agreements and/or contracts are on file with Humana. The information provided in the ETSS request is used to determine the appropriate communication platform.

File transfers are either transmitted through a secure protocol, encrypted or both encrypted and transmitted securely. A server placed outside Humana's firewall in the Demilitarized Zone (DMZ) may be utilized. File transfers are locked down by the customer's Internet Protocol (IP) address based on an Approved User Access Control List, which is facilitated through ET in conjunction with Humana's Security Operations. In addition, for customers with high volume/high speed transfers (e.g. a clearinghouse), data transmissions may be conducted using a private, dedicated leased line.

CONTROL OBJECTIVE 5: *Controls provide reasonable assurance that data transmissions between the company and its user organizations, between the company and its third party vendors, and between the company and its providers are complete and secure.*			
Provided by Humana		***Procedures Performed by PricewaterhouseCoopers LLP***	
CONTROL ACTIVITIES		**TEST PROCEDURES**	**RESULTS**
Transmission of Transactions			
5.1	If a customer file is not received as expected, either the production process will abort and the scheduling system will flag the job with an error notification (e.g. abend), and Humana's Production Support department will notify Electronic Transmissions (ET) to research and determine if a rerun is necessary or an email notification will be sent to the ETDownJobs mailbox. In that case, the ET Operations team will research to verify that there are no system issues. If the external partner has not sent a file, ET will notify the internal business contacts so they can take the appropriate action.	**Observation** Observed a failed mainframe job in the production scheduling system online with the ET Operations of the Electronic Transmission System, to observe that failed jobs are flagged with a failure notification in the error column.	No exceptions noted.
		Observation Observed a failed mainframe job in the production scheduling system online with the ET Operations of the Electronic Transmission System, to observe that an automated email notification is sent to the ETDownJobs mailbox.	No exceptions noted.
5.2	Production Support monitors emergency situations, reruns, system failures, scheduling issues and production job abends. Service tickets are routed to the assigned department for investigation and closure.	**Inspection** Inspected a sample of system errors from the log managed by Production Support to determine whether they were resolved.	No exceptions noted.

CONTROL OBJECTIVE 5: *Controls provide reasonable assurance that data transmissions between the company and its user organizations, between the company and its third party vendors, and between the company and its providers are complete and secure.*			
Provided by Humana		***Procedures Performed by PricewaterhouseCoopers LLP***	
CONTROL ACTIVITIES		**TEST PROCEDURES**	**RESULTS**
Communication Platforms			
5.3	Files transferred over the Internet are sent through a secure connection and/or are encrypted.	**Inspection** Inspected an example of each transmission type through which files are transferred from Humana to external parties to determine whether files were sent through a secure connection or encrypted before transmission.	No exceptions noted.
5.4	For file transfers initiated by the customer, a server placed outside Humana's firewall in the DMZ may be utilized. File transfers are locked down by the customer's Internet Protocol (IP) address based on an Approved User Access Control List.	**Inspection** Inspected the network diagram at a point in time to determine whether a server placed outside Humana's firewall in the DMZ may be utilized.	No exceptions noted.
		Inspection Inspected a sample of users newly added to the Approved User Access Control List to determine whether users are identified and approved by the organization as appropriate for file transfers.	No exceptions noted.

MTV Product Build and Maintenance

Prior to sales, Product Development or Market Sales creates a plan design for concept and feasibility. The design goes through Pre-Sale Qualification (PSQ) review and solicits feedback from Product Build and various operational areas. A customer's benefits, administration of benefits and costs are established through the Request for Proposal (RFP) process. The Client Experience Manager (CEM) works with the new customer to develop a New Case Document (NCD) and tracks the plan from initial sale to actual claims payments in production. The NCD includes all of the program information, including confidentiality contact lists, enrollment information, Consolidated Omnibus Budget Reconciliation Act (COBRA), and medical benefits. All new and renewal customers receive a final NCD for review and approval (with an exception of "rate only change" plans). If the customer has not otherwise communicated necessary revisions to the plan within 14 days, it is considered implicit approval of the NCD. To load the plan and open the plan for claims payment, one of two things is needed: 1) signed approval of Claims Payment Agreement (CPA) section of the NCD by the customer, or 2) a Humana VP or Director signature on an Employer Plan Confirmation (EPC) form, if signed approval of the NCD is not provided.

A Group Set-Up (GSU) specialist uses paperwork provided by the CEM to define the sold benefits and group structure, and loads the group information in the Account Manager system. Once set-up in the Account Manager system has been completed, it is submitted to Underwriting for verification of the rates and benefits. Underwriting approves the group in Account Manager. Underwriting or the GSU Contract Specialist submits the groups to MTV and triggers the Single Interface Process (SIP). There is an overnight system process to update MTV with the group information. If the group doesn't feed as it should to downstream systems, then the GSU specialist reviews the Group Configuration Report which runs nightly and outlines any missing required information in the MTV system. The report is cumulative and discrepancies will remain on the report until they have been corrected. The report includes the group, the audit message, and the missing required information. A GSU Specialist investigates and resolved discrepancies on a daily basis, using the Group Configuration Report to determine the appropriate resolution for each error. Once the updates/corrections are resolved and the group feeds to downstream systems, the GSU Specialist can submit work tasks to the Empowerment Quality Innovative Partner team (E-QIP) for evaluation. All work tasks deemed critical will be sent to the E-QIP team for evaluation. If discrepancies found, then the task is submitted back the GSU specialist for corrections. Once complete, GSU specialist submits back to E-QIP for re-review. This keeps happening until all discrepancies are resolved. Once the tasks are completed, GSU Specialist will send a completion email to the CEM to ensure they coordinate any further tasks are completed within the GSO organization with downstream partners.

MTV Product Build Overview

MTV Product Build is primarily responsible for analyzing and interpreting product designs in the customer's NCD in order to create and build benefit packages. Each variation within a product requires a new benefit package to be created. A benefit package contains a high level description of the type of plan being offered. An example would include co-payment amounts, coinsurance amounts, and deductible amounts. Benefits are built specific to the NCD in the ProdPB (test) region and then migrated to the production region in MTV.

Building the Plan

When the group is sold or renewed, the New Case Document (NCD) is provided to Product Build to prioritize. Product Build management assigns a build specialist to begin the build process. Management assigns and monitors build inventory by reviewing scheduling reports in a recurring weekly meeting to allocate resources and ensure plans are implemented on a timely basis. The Product Build specialist works the assigned build according to the schedule.

Builds are classified as either New Business or Renewals. The build is reviewed by the Product Build specialist to determine if a similar benefit already exists. If it does, the specialist copies data and makes any necessary changes to define the benefit according to the group requests. A workbook is created to maintain data specific to that employer group policy. Entries identify which specific lifetime limits, deductibles and/or out-of-pockets apply to the requested policy. Entries define any accumulated amounts, age limits for benefits, or dollar limits that apply. The Product Build specialist builds the benefits in the MTV ProdPB region. The Product Build specialist submits a testing intake via SharePoint, with specifications of the build listed on the intake form.

Claims Testing

Claims testing, performed by E-QIP, is the final step to help ensure that the benefits built and loaded for a group will process in accordance with what was agreed upon by the customer. Claims testing is performed on builds requiring changes. Minor changes to plans (three or fewer changes), such as a change in co-pay, are changed in the test environment and are sent to claims testing using a special testing request. Special testing refers to claims run for that particular benefit change. Larger plan changes (more than three) require end-to-end (E2E) claims testing. During testing, test claims are processed in the ProdPB region of MTV to determine whether plan benefits were loaded in accordance with the group's NCD. Each test produces a set of the test results that are recorded. In the event that the test does not produce the desired results, or if there is a defect identified, the claims tester logs this defect into Process Metrics. The builder reviews the error and makes the appropriate correction. The claims tester then re-tests the claim in a process called defect resolution. Although most plans go into the production region defect free, some plans are moved into the production region with defects. These plans must have proper sign off by Claims Processing and Product Build management. Claims that are associated with specific plan benefits that are defected are pended by Claims Processing. The claims may be held until the defect is resolved or paid manually by a claims adjuster.

In addition, changes made to plans after they are in production, referred to as Plan Changes, also undergo claims testing based on the extent of the changes made. One offs and copy/renames do not require claims testing because no benefit changes are made.

Data Migration

Data migration is a process that moves the build configuration from the ProdPB region of MTV to the production region. The builder ensures that Product Build has received testing sign off and a signed NCD or EPC. Once the build is complete and all signature documents received, the builder fills out a Data Migration work request via SharePoint. The request form is filled out and the signed NCD or EPC is attached along with testing sign off. Data Migration must then run an overnight job that moves the plan from test to production. A Data Migration specialist validates that all constructed benefits have been migrated by reviewing MTV build tables. Once it is determined that benefit information was migrated successfully without errors, the Data Migration specialist closes the work request. If there are errors in the MTV build tables, the Data Migration specialist works to resolve them and the plan is resubmitted for migration. Once a plan is migrated to the production environment, it is reported through the monthly metrics meetings held by management.

Manual Updates

Manual updates are completed when small changes are needed. Such changes are not suited for Data Migration so they are addressed with manual updates. Only certain associates have the security to make manual updates and they must notify the Quality Consultant by email when they make a manual update. These manual updates are monitored weekly by the Quality Team. A report is pulled weekly that details all of the manual updates completed and compares this report to the emails received to validate the associate followed protocol. If there is not an email, the associate and their direct supervisor are notified and corrective action is taken. Once the weekly review is completed, it is saved along with any supporting documents in the weekly Evidence of Review.

CONTROL OBJECTIVE 6: *Controls provide reasonable assurance that plan and benefit information is created and maintained based on proper authorization and is recorded in the system completely and accurately.*			
Provided by Humana		***Procedures Performed by PricewaterhouseCoopers LLP***	
CONTROL ACTIVITIES		**TEST PROCEDURES**	**RESULTS**
6.1	The builder validates a signoff has been received from the group on the CPA/NCD or from a Humana Vice President or Director on the EPC prior to opening claims for payment.	**Inspection** Inspected a sample of plans loaded into MTV to determine whether the CPA/NCD was authorized by the customer. If the CPA/NCD form was not signed by the customer, documentation was inspected that evidenced an EPC was signed by a Humana Vice President or Director.	No exceptions noted.
6.2	Management monitors and adjusts plan load inventory by reviewing scheduling reports in a weekly meeting.	**Inspection** Inspected evidence for a sample of weeks to determine whether scheduling reports are reviewed and monitored by management on a weekly basis.	No exceptions noted.
6.3	Claims testing is performed on builds requiring changes, excluding special requests, plans that are similar to or identical to plans already built, and minor changes. Plans moved to production with defects must have proper sign off by Claims Processing and Product Build management. Claims testing and defects are documented and tracked.	**Inspection** Inspected a sample of plan builds requiring changes (excluding special requests, plans that are similar to or identical to plans already built, and minor changes) to determine whether: • Testing was conducted on the plan builds and test results were recorded and tracked. • Plan builds moved to production with defects had proper sign off by a Claims Processing and Product Build Manager or Supervisor.	No exceptions noted.

CONTROL OBJECTIVE 6: *Controls provide reasonable assurance that plan and benefit information is created and maintained based on proper authorization and is recorded in the system completely and accurately.*			
Provided by Humana		***Procedures Performed by PricewaterhouseCoopers LLP***	
CONTROL ACTIVITIES		**TEST PROCEDURES**	**RESULTS**
6.4	A Data Migration specialist validates that all constructed benefits have been migrated by reviewing MTV build tables, and working errors until they have been resolved.	**Observation** Observed a Humana associate review the results of a plan data pre-migration job run to determine whether the job logs are used to identify errors.	No exceptions noted.
		Inspection Inspected a sample of constructed benefits migrated to production to determine whether the constructed benefits had been reviewed by a Data Migration specialist.	No exceptions noted.
6.5	All Manual Updates made in production are reviewed weekly by the Quality Team to validate the associate notified management about the changes.	**Inspection** Inspected a sample of weekly reviews of manual updates to determine whether manual updates are reviewed by management.	No exceptions noted.

ENROLLMENT

The enrollment process consists of receiving names and addresses of eligible applicants by paper, automated and web processes. For each method of receiving enrollment information, the accuracy of enrollment information is verified and member cards, if necessary, are generated. Ongoing maintenance of enrollment includes processing name, address, Primary Care Physician (PCP) and coverage changes. In each of these instances, the member or group must provide complete and accurate enrollment information, so that records are updated to help ensure accurate and timely billing and claims processing.

Member's Responsibility

Members complete the necessary forms to enroll when they become eligible for coverage as specified under the plan. Criteria for determining eligible associates and dependents are included in the associated group's contract. The member is responsible for completing personal demographic information requested on the enrollment application. If the benefit chosen requires a PCP, the member provides Humana with that doctor's name chosen from Humana's provider network booklet or the web.

Changes in membership data can only be submitted by the member, subscriber, Benefit Administrator (BA), power of attorney, or account representative. Enrollment forms are signed by the member, which ensures validity. Changes can be processed by either the submission of a change of enrollment form or by calling Humana's customer service center. The information that is to be changed dictates the method used. If the change is related to the member's demographics, PCP, or termination, the request can be processed over the phone after the caller has been authenticated using the authentication grid in the Enrollment Commercial/Medicare National Call Quality Monitoring Guidelines. All other types of changes must be submitted via an enrollment change form.

Enrollment Process

Paper Enrollment

Each application is accompanied with a signature authorizing the enrollment. In addition, BAs employed by the customers are responsible for verifying that the appropriate Group Number, Benefit and Class are on each application in order to prevent a delay in processing. The individual Group Number is linked to the appropriate selling market and legal entity to ensure proper financial reporting. When the enrollment forms are completed by the group's BA, the originals are sent to a third party processor for processing.

Paper documents sent to Humana are scanned by a third party processor and tracked via Document Control Numbers (DCNs). DCNs are created by the third party and transmitted to Humana on a daily basis. The files are received by Electronic Transmissions (ET), and are processed as an Electronic Data Interface (EDI) file. The third party transmits to Humana a data and image file for each enrollment. Automated quality checks are used to verify that both files are received for each enrollment. If either the data or image file is not received but indicated to be sent by the third party, an email notification is produced to enrollment associates for resolution. After the enrollments have been received by Humana, they are routed to enrollment specialists at Humana and to enrollment vendor partners via a workflow tool and entered into Humana's web enrollment tool or directly to the Humana platform. Edits are in place to prevent processing of any applications missing key critical data. For the period October 1, 2015 through March 8, 2016,

upon receipt, each enrollment application completed by the third party vendor is tracked via online reporting and quality checks, until it is loaded into the Automated Enrollment (AE) system. Due to process redundancies, effective March 9, 2016, this separate manual tracking is no longer considered necessary. The percentage of enrollments received as paper enrollments is less than 1%.

EDI and Spreadsheet Enrollment

Automated Enrollment allows Humana to accept an electronic feed from a customer and process the eligibility of members automatically. One-time Spreadsheet Enrollment allows Humana to accept spreadsheets of Enrollment data in a specific format and process eligibility of members via the same upload format as EDI. The Enrollment Manager maintains a schedule of all groups to be enrolled via spreadsheet.

Once EDI is received from groups via ET and placed on the mainframe, EDI files begin processing via AE jobs. Spreadsheet files are received via secure email from external customers (brokers, agents, or the group) or internal Humana associates, and then processed via an AE job. The EDI and spreadsheet files are processed via mainframe jobs, unique for each group, to ensure data is formatted properly. If more than 15 errors are encountered for an EDI file, the job will abend. Jobs can abend for less than 15 errors depending on the severity of the error. Production Support will then generate a service ticket after which the on-call associate is notified; at this point the submitter must resubmit the file. If less than 15 errors occur, the file will complete the upload process and errors will appear on a pend report. These pends are worked as described in the section below entitled "Enrollment Data Quality Check and Flow (All Enrollments)." If a one-time Spreadsheet Enrollment is submitted with invalid data, the spreadsheet will not be processed and an automated communication is sent to Enrollment to have the file corrected and resubmitted.

Web Enrollment

Three Types:

1. Employee Self-Service (ESS) - Groups are required to provide a file of all employees eligible to elect benefits. Employees are able to view benefit information and enroll themselves through Humana's Enrollment Center in real-time.
2. Human Resource Benefit Administration (HRBA) - Benefits Administrators are able to submit new hires, terminations and life event changes using web event submissions that complete in enrollments in real-time.
3. IntelliChoice (Private Exchange - Defined Contribution) - Groups are required to provide a census file of all employees eligible to elect benefits. Employees are guided through a survey before being presented with personalized benefit options for enrollment. Benefit elections are collected via EDI file and transmitted for enrollment.

Member enrollment information may be entered via the web. The group is required to apply for and obtain a Secured Logon from EIPAM if they would like to use web enrollment. The customer can then designate users at their company that are allowed to add, change, and terminate members from specific groups. Edits are in place to prevent processing of any applications missing key critical data. Upon completing a web transaction, the user receives an on-screen confirmation indicating the completion of the update transaction.

Enrollment Data Quality Check and Flow *(All Enrollments)*

Transactions are loaded onto the AE system through batch and near real-time processing, where each transaction goes through a series of system edits checking for missing and/or incorrect data, including duplicate social security numbers, improper date ranges and other missing or invalid key critical data. Pended transaction reports are generated daily to identify enrollment transactions that fail to process in AE due to edit checks during batch processing. Any errors encountered will appear on a pend report. The errors are worked by either a third party processor or an internal Humana associate until resolved. Pends worked by an internal Humana associate or a third party associate are routed and tracked via Humana's workflow tool. Pends are resolved by comparing system data to source data to ensure data loading occurred as intended. If critical data is missing from the source data, a letter is generated and sent to the BA requesting the key critical data. Once the edits or pends are resolved, the enrollments are processed to the platform. This control is monitored in the Enrollment Front-end process. Pend inventory is monitored by management in daily inventory meetings.

In rare instances enrollment can be loaded directly into the CI platform where necessary, based on the enrollment type, when expedited claims processing or urgent access to care is required.

Secured Logons

Secured Logons (SL) is a stand-alone security administration system controlling user access to application functions and secured information via Humana's web sites. SL was designed as a single point of authentication for access to secured web functionality for all users including members, providers, agents/brokers, employer customers and Humana associates. The SL application is also used by Humana's IT Operations in managing and promoting web security access administration. It does this through a shared risk approach with its clients (providers, employers, agents, members) by enabling them to co-manage security administration using SL. This functionality is one of the primary values SL offers and is referred to as "delegated security access administration." The security administration role effectively "pushes out" security access management of data to those entities that have a stake in controlling access.

Humana's Security Administration Department is responsible for maintaining system access privileges for Humana associates, vendor partner associates as well as administering access for members, providers, agents/brokers, and employers. External users may be granted access to SL to perform business functions. Each client is required to apply for and obtain a SL account if they would like to use this functionality. To do so, an application signed by the Primary Controlling Authority (PCA) must be sent to Humana or an application is completed online. The online application uses identifiable information to authenticate the requestor. If approved, Humana will give the PCA a secured logon with a Personal Identification Number (PIN). The PCA can then designate users at their company that are allowed to perform transactions.

Quality Assurance

Center of Quality (COQ) audits enrollment transactions processed by Humana and the third party processor. During the audits, the enrollment source is compared with data in Humana's systems to validate accuracy and completeness. Results are tracked and reported for Humana associates and third party associate performance and continuous improvement efforts. Audit sample sizes are determined using a risk-based approach and intended to be sufficient for identifying opportunities for process improvement and understanding associate performance. The COQ supervisor reviews a report weekly to ensure the audits performed represent an appropriate sample. Enrollment managers regularly review audit results to monitor the performance of enrollment associates and the overall process.

CONTROL OBJECTIVE 7: *Controls provide reasonable assurance that member information is created and maintained based on proper authorization and is recorded in the system completely and accurately.*			
Provided by Humana		***Procedures Performed by PricewaterhouseCoopers LLP***	
CONTROL ACTIVITIES		**TEST PROCEDURES**	**RESULTS**
Enrollment Process – EDI and Spreadsheet Enrollment			
7.1	Each group's Electronic Data Interchange (EDI) file will abend if more than 15 formatting errors are encountered. Production Support will then generate a service ticket and the EDI IT Support Team will investigate and engage the proper resources to resolve the ticket.	**Inspection** Inspected an example abend for an EDI transaction where the EDI file had greater than 15 formatting errors.	No exceptions noted.
		Inspection Inspected a sample of EDI file abends processed via mainframe jobs to determine whether a service ticket was created and resolved.	No exceptions noted.
7.2	Spreadsheet enrollments loaded to production with improper data will not process and will generate an automated notification to the enrollment team, prompting them to fix the issue.	**Inquiry** Inquired with an enrollment manager regarding spreadsheet enrollment file abends to determine whether spreadsheet enrollments loaded to production with improper data will not process and will generate an automated notification to the enrollment team, prompting them to fix the issue.	No exceptions noted.
Secured Logons – Web Enrollment			
7.3	Humana grants external users access to Secured Logons (SL) once the user is authenticated using identifiable information.	**Observation** Observed the web ID application process to ensure access to SL is only granted after the external user is authenticated.	No exceptions noted.

CONTROL OBJECTIVE 7: *Controls provide reasonable assurance that member information is created and maintained based on proper authorization and is recorded in the system completely and accurately.*			
Provided by Humana		***Procedures Performed by PricewaterhouseCoopers LLP***	
CONTROL ACTIVITIES		**TEST PROCEDURES**	**RESULTS**
Enrollment Data Quality Check and Flow			
7.4	Transactions are loaded onto the AE system through batch processing, where system edits check for missing and/or incorrect critical data. Any errors encountered will appear on a pend report.	**Observation** Observed an enrollment specialist create enrollment records with missing or incorrect critical data elements to determine whether AE displayed a warning message and prevented processing for: • Missing social security number • Invalid dates (date of birth is future dated or blank) • Effective date prior to eligibility date	No exceptions noted.
		Inspection Inspected example pend reports utilized for tracking and resolution of pended enrollments at a point in time to determine whether pended enrollments were tracked to resolution.	No exceptions noted.
7.5	Commercial Enrollment inventory is monitored, via inventory reports, daily by management.	**Inspection** Inspected a sample of daily cumulative commercial enrollment inventory reports to determine whether the reports include information on aging statistics for enrollment pends and evidence that pends were being resolved by the AE Department	No exceptions noted.

PROVIDER CONTRACT AND RATE LOADING

Humana negotiates financially advantageous contracts with physicians and facilities. Humana offers both local (based in core market locations) and national networks.

Two systems are utilized for loading and maintaining the negotiated physician and facility contracts: Provider SinglePoint+ (PSP+) and Accelerated Provider Exchange (APEX). PSP+ is a web based system designed to track contract updates for both facility and physician providers from their inception to the eventual loading into the directory system and claims adjudication systems. Humana is developing and implementing APEX, which is a workflow tool, in phases, that introduces a level of automation to increase efficiency and accuracy to the provider contract load process. APEX will eventually replace PSP+. During the current cycle October 1, 2015 through September 30, 2016, inventory is present in both systems. About 75% of the volume appears in APEX. The remaining 25% is in PSP+. It is possible for all intents, new contracts, contract terminations, provider add to groups, amendments, provider leaving groups, and maintenance, to appear in both APEX and PSP+ inventory due to the phased approach and some complex scenarios unable to be accommodated in APEX during the current reporting cycle.

New and amended contracts follow the PSP+/APEX Workflow Guidelines housed in Mentor, a web-based documentation repository for Humana's policies and procedures. These guidelines define when signatures from the provider are required for new and amended contracts. The responses received from the market office are included in the APEX workflow or PSP+ task.

Provider Contracts and Rates

The Contract Information System (CIS) database houses financial deal terms for both facilities and physicians and is referred to by the system to price claims. The CIS record is referenced by the contract record in the claims adjudication system, which would otherwise contain the financial deal terms.

The contract loaders will first search for existing demographic records for the contract update presented to them in PSP+/APEX to determine if the provider exists within the system. From the search results, the contract loader selects the provider records that need to be updated. If a new contract is required, the effective date, CIS number and other relevant data is entered. The scope of the agreement with regards to which products and networks the contract or change applies is included in the APEX workflow or PSP+ task. PSP+ tasks may include a transmittal form that explains the scope of the agreement with regards to which products and networks the contract or change applies. Should any questions arise during the loading process regarding scope or intent of the contract, the market is contacted for answers which are recorded in APEX or PSP+. New providers requiring credentials approval are routed to Credentialing. Credentialing receives the task in a workflow queue within APEX or PSP+. Credentialing associates review the task in APEX or PSP+ to determine that an application has been attached. The Credentialing associate runs various tests (i.e., verifying the license, schooling and board certifications, hospital privileges, malpractice insurance, etc.) to determine if the provider can be loaded as a participating provider. Credentialing uses the workflow within APEX or PSP+ to process the provider credentialing information but the supporting documentation is stored in the Online Verification (OV) module of the Provider Information Management System (PIMS).

In some cases, a new fee schedule is needed for inclusion in the CIS record. A fee schedule is a list of healthcare common procedure codes and their related fees to be reimbursed to the provider. Fee Schedule Management (FSM) creates new schedules in a test environment on the mainframe.

Certain automated edits are built into the FSM system to avoid keying errors. If manually keying, an immediate edit will occur with a fee that exceeds $6,000 requiring the contract loader to accept the high value by pressing "enter" twice to help ensure accuracy, and if a component of the fee is keyed that is higher than the total fee, the entry is not accepted until the contract loader corrects the discrepancy. In addition there are other edits that occur such as invalid dates (new date is prior to previous effective date), invalid or obsolete codes being entered, or illogical or inappropriate codes being entered. These errors appear on a report that is used by FSM to correct the fee, or to report back to the originator (market office) the corrections needed on the original request. Fee values must be audited by someone independent of the person responsible for inputting the contract before the fee schedule is loaded into production. Any corrections are keyed by the originator. Fees are not moved into production until audit procedures are completed. A daily report is generated to identify fees not yet audited and a Fee Schedule analyst works the daily report. A monthly report is also generated identifying any fees that still need to be audited. Once complete, the notification of completed fee schedules is returned to the originator. The Provider Process Network Operations (PPNO) specialist then updates the PSP+ or APEX task to reflect the CIS ID to use for this contract.

When a new contract load or change involves numerous providers or contracts, Contract Load may request assistance in loading from Automated Update. A keystroke emulator, Winbatch, is utilized to perform the updates. A test run, made of 25 updates (or a minimum of 10% if less than 100 updates) is run through the script and test results are sent to the requestor. The requestor reviews the actions taken by the script. If the test results are not producing the desired effect, then the request is amended and the test is rerun. If the test results are producing the desired effect, the script is run for the entire file and reports of all updated records are delivered to the requestor. Any providers who did not receive the update, but should have, are captured on a separate report. The requestor uses the data on this report to reprocess updates that were not completed.

An Incorrect Payment Audit Request (IPAR) is completed when there is a retroactive change to a contract that impacts a claim(s). IPARs are sent to Financial Recovery (FR) for review to determine whether there are any underpaid and/or overpaid claims due to the change.

Monitoring

The PSP+ and APEX systems track provider loads from inception to final loading in the claims adjudication systems. Summarized metrics are monitored by PPNO management periodically, to ensure contract inventories in PSP+ and APEX are being appropriately managed timely for all contract loading areas. The reports include information on inventory and production. For the period of October 1, 2015 through June 22, 2016, the inventory reporting was summarized daily and provided PPNO management the ability to review the historical open inventory counts via a SharePoint site. Beginning June 23, 2016, the inventory reporting summarizes metrics and is provided to PPNO management for review.

Quality Assurance

On an annual basis, Provider Quality Assurance (PQA) performs a risk assessment of provider and claims activity to determine the most effective methodology to audit the Provider Load universe.

Sample selection is prioritized for providers with high dollar claims (top provider) and new provider contracts. Also, PQA provides performance feedback to all specialists. If a loader does not have top provider audits or new provider audits, additional audits are completed for the loader. This additional sample is random.

i. Top Financial Impact Provider Load and CIS Updates

Annually, PQA reviews claims volume and claims dollars for each provider. The goal is to include as many providers in the top financial provider list and establish a dollar threshold that leaves behind few providers with low dollars. Providers are ranked from highest to lowest based on claims dollar volume. At a minimum, 200 Top Financial Impact Provider Load and CIS updates on facility records and 500 Top Financial Impact Provider Load and CIS updates on physician records are audited monthly.

ii. New Loads

New Loads (Provider data and CIS builds) are next in prioritization, so that any potential errors are identified as soon as possible. At a minimum, 250 new facility records and 300 new physician records are audited monthly.

iii. Performance Management

PQA audits a sample of 20 updates (or 100% of the specialist's monthly production, if less than 20) per loader on a monthly basis. Performance Management is only required to be performed for the load specialists. Analysts are not audited for Performance Management. If audits are not available in the priority strata, a random sample is selected from the population. The 20 updates to be audited are not risk related but an agreement with operational business areas to provide uniform feedback to their loaders. Based on resource availability this number and program is subject to change as it is not risk driven.

The population is obtained weekly via feeds from Mainframe systems (MTV and CIS) and Intermediary systems (PSP+ and APEX). The feeds contain the following:

- Weekly claims adjudication systems records that have been modified through PSP+, APEX, or the Mainframe
- Facility and physician CIS updates
- Facility modeled CIS

The following are excluded from the population:

- Updates made to non-participating providers by the Provider Pend Group (PPG)
- Facility and physician fee schedule updates

Once an update is selected for audit, the audit database will create a standard audit template. The auditor determines whether the claims adjudication systems and PIMS information is completely and accurately loaded based on the documentation delivered via PSP+, APEX or communication with the contract negotiator. Additionally, the auditor also determines if the link to the CIS contract file is correct. The auditor populates the template with their findings and the database delivers the audit results to the contract loader's queue. Findings are reviewed with the contract loader and they indicate agreement with or rebut the finding. Agreed upon findings are corrected by the contract loader and then re-verified by the auditor before the audit is closed. Rebutted findings are reconciled and if necessary, escalated to management for resolution.

Audits are also performed at the third-party processor of provider loads performed by the third party. Based on total volume, the third-party is auditing about 75% of provider loads. Included are top financial impact provider loads, new loads, and performance management audits for the Leased/Brandover, ChoiceCare, Arizona, Georgia, Kentucky, Louisiana, Missouri, Ohio, New Jersey, Chicago and Texas networks. The third party audit process is similar to the audit process followed by the PQA team. The PQA team reviews all rebuttals of the third-party processor audits before the error(s) are evaluated for the audit to be evaluated for closing.

Feedback

Loaders and their leaders have access to defects assigned on a daily basis. On a weekly basis, PPNO gets a copy of all the audit data. All process and loader defects are included in this data. PPNO trends the audit results and utilizes the data to determine if there are any process failures or additional training necessary for contract loaders.

The Provider Quality Audit Manager reviews a monthly analysis of the audits conducted, including the total number of audits, number in error, accuracy rates, types of errors, etc. Metrics are reported to Provider Network Operations leadership on a monthly basis.

CONTROL OBJECTIVE 8: *Controls provide reasonable assurance that provider and rate information is created and maintained based on proper authorization and is recorded in the system completely and accurately.*			
Provided by Humana		***Procedures Performed by PricewaterhouseCoopers LLP***	
CONTROL ACTIVITIES		**TEST PROCEDURES**	**RESULTS**
Contract and Rate Loading Process			
8.1	New and amended contracts follow the PSP+/APEX Workflow Guidelines housed in Mentor.	**Inspection** Inspected a sample of new and amended contracts from SinglePoint+ and APEX to determine whether each contract was signed by the provider, and in instances where it was not, verified that National Network Organization guidelines were followed.	No exceptions noted.
8.2	Automated edits are built into the FSM system to avoid entry errors, including but not limited to: • Fee greater than $6,000, or if a component of the fee is higher than the total fee • Invalid dates (new date is prior to previous effective date) • Invalid or obsolete codes being entered, or invalid fee amount	**Observation** Observed a Physician Reimbursement Specialist enter sample fees schedules into the FSM System to determine whether automated edits are built into the fee schedule management system to avoid entry errors related to: • Fee greater than $6,000 or if a component of the fee is higher than the total fee • Invalid dates (new date is prior to previous effective date) • Invalid or obsolete codes being entered, or invalid fee amount	No exceptions noted.

CONTROL OBJECTIVE 8: *Controls provide reasonable assurance that provider and rate information is created and maintained based on proper authorization and is recorded in the system completely and accurately.*			
Provided by Humana		***Procedures Performed by PricewaterhouseCoopers LLP***	
CONTROL ACTIVITIES		**TEST PROCEDURES**	**RESULTS**
Monitoring			
8.3	Summarized metrics are monitored by management periodically, to help ensure that contract inventories are being appropriately managed.	**Observation** For the period October 1, 2015 to June 22, 2016, observed an example of the summarized metrics reports utilized by management to monitor contract inventories to determine whether the example reports are monitored and contract inventories are appropriately managed.	No exceptions noted.
		Observation For the period June 23, 2016 to September 30, 2016, observed an example of the summarized metrics that are provided to management to monitor contract inventories to determine whether the example metrics are monitored and contract inventories are appropriately managed.	No exceptions noted.

CONTROL OBJECTIVE 8: *Controls provide reasonable assurance that provider and rate information is created and maintained based on proper authorization and is recorded in the system completely and accurately.*			
Provided by Humana		***Procedures Performed by PricewaterhouseCoopers LLP***	
CONTROL ACTIVITIES		**TEST PROCEDURES**	**RESULTS**
Quality Assurance			
8.4	Monthly physician auditors examine a minimum of 500 audits on Top Financial Impact Provider Load and CIS Updates along with a minimum of 300 audits for new physician loads.	**Inspection** For a sample of months, inspected evidence that a minimum of 500 audits on Top Financial Impact Provider Load and CIS Updates, along with a minimum of 300 audits for new physician loads, were performed.	No exceptions noted.
		Inspection Obtained the population of physician audits, and for a sample of audits, inspected evidence that audits were performed as planned.	No exceptions noted.

CONTROL OBJECTIVE 8: *Controls provide reasonable assurance that provider and rate information is created and maintained based on proper authorization and is recorded in the system completely and accurately.*			
Provided by Humana		***Procedures Performed by PricewaterhouseCoopers LLP***	
CONTROL ACTIVITIES		**TEST PROCEDURES**	**RESULTS**
8.5	Monthly, facility auditors examine a minimum of 200 audits on Top Financial Impact Provider Load and CIS Updates along with a minimum of 250 audits for new facility loads.	**Inspection** For a sample of months, inspected evidence that a minimum of 200 audits on Top Financial Impact Provider Load and CIS Updates, along with a minimum of 250 audits for new facility loads, were performed.	No exceptions noted.
		Inspection Obtained the population of facility audits, and for a sample of audits, inspected evidence that audits were performed as planned.	No exceptions noted.
8.6	Annually, Provider Quality reexamines the audit methodology and process to ensure that they are valid and complete.	**Inspection** Inspected the annual review performed by Provider Quality to determine whether a reexamination was done of the audit methodology and process.	No exceptions noted.

CLAIMS RECEIPT AND ENTRY

Humana receives claims via three primary media:

1. Outsourced imaging services provider.
2. EDI via eHUB.
3. Manual claims submitted to and directly input into the system by Humana associates.

Outsourced Imaging Service Provider

A third party provides initial claims processing services to Humana. A website has been created by the third party to track incoming paper claims and correspondence from receipt to data entry for Humana monitoring and tracking purposes. Humana's Integrated Performance Analytics team monitors the website for number of claims returned, rejects/voids and data quality auditing.

Claims are scanned and logged by the third party upon receipt to ensure that the third party's inventory of claims is properly tracked through the process. Once documents are scanned, Humana receives (real-time) images of these claims via electronic transmission. Once the scanning processes are complete, claims are batched and sent to the next stage, Optical Character Recognition (OCR)/Intelligent Character Recognition (ICR), for processing. From OCR/ICR, claims processing is tracked and managed for data entry processing. Humana receives this information via the eHUB system and Humana Image View Station, which checks and balances the file, and uploads the information into the appropriate adjudication platform. For the daily reconciliations performed from October 1, 2015 to December 16, 2015, each day was subject to a reperformance of the reconciliation of claims sent to Humana (per the third party website) and the number of claims received by Humana (per Front End Operations). Any noted differences were within acceptable thresholds. Beginning December 17, 2015, daily reconciliations were performed by Humana's Integrated Performance Analytics team to monitor the number of claims sent to Humana by the third party (per the third party web site) against the number of claims received by Humana (per Front End Operations).

The outsourcing contract requires the third party to comply with pre-defined standards for accurately processing paper claims and correspondence.

Electronic Data Interchange

By using available EDI methods, providers eliminate the need for paper and receive streamlined payment of claims. Batch files of claims, whether submitted by the third party or directly from the provider, are reconciled for completeness by Humana before being interfaced to MTV.

The batch files are processed through eHUB, where the files are edited for structure and balancing. Files not in the correct format are rejected and returned to the submitter. Out of balance files are electronically sent back to the submitter. Claims sent via eHUB transmission are subject to Health Insurance Portability and Accountability Act (HIPAA) Data Elements Requirement and must include the National Provider Identifier (NPI).

Once claims are submitted to eHUB they are tracked by Humana from the trading partner that sent them. The volume of claims transmitted by each trading partner is recorded in the eHUB calendar. The volume of claim transmissions is then placed into a Clearinghouse report in order to show totals per trading partner for each day. The Clearinghouse report is maintained by the Process Integration Team area for monitoring purposes. The eHUB calendar is used to determine the general direction of expected receipts from clearinghouses. The Threshold report is a projection of expected receipts that is created based upon historical data. The Clearinghouse report is compared to the Threshold report to provide reasonableness of inventory received from the clearinghouse. While this comparison is based upon historical data, it is not exact. If any of the contracted clearinghouses are unreasonably above or below their expected receipts, the Process Integration Team area researches the current trends and may contact the respective clearinghouse to resolve discrepancies.

Batch files that pass the balancing edit and are in the correct format are then broken down into individual claims and assigned a Humana Electronic Claim Number (ECN) in eHUB. The claim is then stored in Humana's claims raw data storage where the production file is restricted. The member eligibility for each claim is validated against Humana's eligibility Operational Data Store (ODS). An eligibility selection process (based on a point system) is used to determine coverage and the Humana adjudication platform the claim should be sent to for processing. Claims submitted through eHUB are subject to eHUB duplicate claim checks. This is performed at the claim level, not the batch level. When an eHUB duplicate occurs, a response is created and sent directly back to the trading partner.

Claims must be validated against member eligibility before being processed. Once eligibility and coverage are determined, eHUB sends the claim to the appropriate adjudication platform. If eligibility cannot be determined, then the claim is routed to the Eligibility Exceptions Processing (EEP) queue within eHUB which is worked by Front End staff and a third party processor. The EEP queue is monitored via a weekly staff meeting. Claims are worked through the online workflow system. If eligibility cannot be determined, the claim is flagged to generate a member and provider letter. If eligibility can be determined, the specialist marks the claim for routing to the platform and it is removed from the EEP systems. The platforms send a response to eHUB indicating receipt of the claim. If no response is received within 48 hours the claim is included on the Missing Acknowledgement Report to be reviewed by an associate. A claim is not removed from this report until the adjudication platform acknowledges receipt of the claim.

Manual Claims (Front End Processing)

Manual claims make up less than one percent of Humana's total claims volume; therefore, the scope of this report does not include controls in place supporting the entry of manual claims by Humana.

***CONTROL OBJECTIVE 9**: Controls provide reasonable assurance that electronic or hard copy claims are received and recorded in the system completely and accurately.*			
Provided by Humana		***Procedures Performed by PricewaterhouseCoopers LLP***	
CONTROL ACTIVITIES		**TEST PROCEDURES**	**RESULTS**
Outsourced Imaging Service Provider			
9.1	For the daily reconciliations performed from October 1, 2015 to December 16, 2015, each day was subject to a reperformance of the reconciliation of claims sent to Humana (per the third party website) and the number of claims received by Humana (per Front End Operations).	**Inspection** For the period October 1, 2015 to December 16, 2015, inspected a sample of days to determine whether Integrated Performance Analytics reperformed the reconciliation of the number of claims sent to Humana by the third party (per the third party web site) against the number of claims received by Humana (per Front End Operations) by obtaining the reconciliation evidencing this reperformance.	No exceptions noted.
9.2	For the period December 17, 2015 to September 30, 2016, daily reconciliations were performed by Humana's Integrated Performance Analytics team to monitor the number of claims sent to Humana by the third party (per the third party web site) against the number of claims received by Humana (per Front End Operations).	**Inspection** For the period December 17, 2015 to September 30, 2016, inspected a sample of days to determine whether Integrated Performance Analytics monitored the number of claims sent to Humana by the third party (per the third party web site) against the number of claims received by Humana (per Front End Operations) by obtaining the reconciliation evidencing this review.	No exceptions noted.

***CONTROL OBJECTIVE 9**: Controls provide reasonable assurance that electronic or hard copy claims are received and recorded in the system completely and accurately.*			
Provided by Humana		***Procedures Performed by PricewaterhouseCoopers LLP***	
CONTROL ACTIVITIES		**TEST PROCEDURES**	**RESULTS**
Electronic Data Interchange			
9.3	Claims that are submitted through eHUB are rejected if there are suspected duplicate submissions and/or if claims are missing a required data element. Exceptions are returned to the submitter.	**Observation** Observed the eHUB Reject Report with the Claims Front End Manager to determine whether suspected duplicate claims and claims submitted with missing required data were rejected and recorded on the eHUB Reject Report.	No exceptions noted.
9.4	The volume of claim transmissions submitted to eHUB is placed into a Clearinghouse report in order to show totals per trading partner for each day and is reviewed for reasonableness. If any of the contracted clearinghouses are unreasonably above or below their expected receipts, the Process Integration Team area researches the current trends. The team may contact the respective clearinghouse to resolve discrepancies if the trends are unexplained.	**Inspection** Inspected the Clearinghouse Report that is utilized by Claims Front End Managers to monitor claims transmitted to Humana from the trading partners at a point in time to determine whether the report is populated from the eHUB calendar and monitored for appropriateness.	No exceptions noted.

***CONTROL OBJECTIVE 9**: Controls provide reasonable assurance that electronic or hard copy claims are received and recorded in the system completely and accurately.*			
Provided by Humana		***Procedures Performed by PricewaterhouseCoopers LLP***	
CONTROL ACTIVITIES		**TEST PROCEDURES**	**RESULTS**
9.5	EDI claims are reconciled from eHUB to the adjudication platform.	**Inspection** Inspected evidence of an example automated message generated by the eHUB loop back response which indicates any discrepancies that occur during the cumulative reconciliation of the total number of claims routed from eHUB to the adjudication platform and the total number of platform responses received into eHUB. Inspected documentation evidencing the Humana associate's review of the message and working of the rejected items.	No exceptions noted.
9.6	Claims must be validated against member eligibility before being processed. The EEP queue is monitored via a weekly staff meeting.	**Inspection** Inspected a sample of weekly staff meeting minutes and calendar invites to determine whether the EEP queue was monitored.	No exceptions noted.

CLAIMS AUTHORIZATION AND ADJUDICATION

The claims adjudication process begins when claims are entered into the MTV system. Claims that require no manual intervention are referred to as auto- adjudicated. Claims that require manual intervention are pended to an adjuster. If there are any claims with pends to be resolved, they are identified by group number or type of claim and routed to the appropriate queue within Humana Service Center claims areas. The adjusters for each area work from the queues to resolve any pends and approve or reject claims. Sometimes it is necessary to pend claims to another department for certain issues to be resolved, such as medical review, eligibility and product build. Pended claims are monitored on a periodic basis by claims adjusters and management in the respective areas via inventory and aging reports.

Claims Authorization

Adjusters are assigned screen limits based upon their job responsibility and skill level. These screen limits denote the maximum dollar limit that can be processed by each adjuster. Certain high dollar processors have dollar limits up to $100,000. When an adjuster receives a claim that is more than their dollar limit, the claim is routed through an automated workflow system to a team lead, supervisor, manager, or appointed adjuster, who adjudicates the claim and releases it for payment. The MTV system has an auto adjudication dollar limit of $40,000 paid amount.

Claims Processing

Duplicate Claims

When a claim is entered, MTV will identify claims previously entered with the same core data (e.g., date of service, dollar amount, procedure code, etc.) and alert the adjuster that a claim could be a duplicate if any matches are detected. After the adjuster is alerted, the adjuster then investigates the suspected duplicates by reviewing the Medical History Screen, where they view the matched claims side by side to determine if they are duplicate claims. This edit can be overridden, since it is not uncommon for two claims to have the same patient name and treatment.

Pending Claims

Adjudication edits and validations subject claims data to verification of required information which include, but are not limited to the following:

- Patient's name
- Social security number/member ID
- Status of patient
- Claim number
- Total dollar amount of the claim
- Provider tax ID
- Diagnosis code
- Date of service
- Procedure code
- Payee code
- Date claim received
- Eligibility
- Pre-authorization edits
- Humana fee schedule

Claims that do not pass these edits and validations are rejected or pended to claims adjusters for resolution. Claims are assigned pending status either by MTV or the adjuster. Once assigned pending status, the claims are either routed to a support unit for resolution or resolved within the unit.

Review and approval is obtained from the support areas prior to the pending status being resolved and before pending status is removed. Upon resolution of the pending status, the unit that assigned the pending status to the claim receives the ensuing correspondence from the respective support area, if required, and also receives the claim for finalization. There are instances such as subrogation, when a claim can be finalized by the support area and will not be returned to the Claims Processing Unit for completion.

The ability to turn system edits on or off is restricted to authorized personnel in the Claims Process Organization independent of Claims Adjudication. To alter system edits, a mainframe program change would need to be made through a small, simple functional change request. The MTV system has built in override codes that allow adjusters to override system edits. The ability to override system edits is restricted to authorized personnel within Claims Processing based on experience and training. In order to use sensitive overrides (such as Manual Calculation Contract, Referral, and Pre-certification) processors are required to attend training classes and pass a proficiency test.

Coordination of Benefits (COB)

COB applies when an enrollee has other health care coverage in addition to a Humana Health Care Plan. Benefits are coordinated with the other plans to ensure that appropriate claim payments are made by each plan. COB information is obtained through a variety of methods: email campaign, enrollment inquiry, the Voice Activated Technology system and custom form letters.

During claims processing, MTV performs a series of adjudication steps, including COB checks. Member COB information must be current for claims processing. To complete claims processing for members with other insurance, the adjuster must have complete Explanation of Benefits (EOB) information including the amount allowed and the amount being paid by other carriers. Once the EOB information has been obtained, the adjuster performs the calculation and inputs the information into MTV and the system calculates Humana's portion of the liability. MTV adjusters review the allocation for accuracy, if the adjuster determines the COB allocation needs to be changed due to other payment information, the COB adjusters have the authority to manually override and input the correct portion of Humana's liability. For all claims that originate in non-prompt pay states, Humana will either pend or reject claims until the member provides confirmation of whether other insurance exists.

If a claim is received prior to the initial request for COB information, the claim is pended and a request for COB information is sent in the form of an Employee Retirement Income Security Act (ERISA) delay letter. If the member does not respond after 51 days, Humana rejects the claim.

In those states with prompt-pay regulations, complete, accurate and valid claims are paid or rejected upon receipt. If appropriate, recovery of paid amounts is coordinated by Financial Recovery.

Transplant Claims

A transplant member is recognized by an indicator in MTV. This indicator pends the submitted claims to the transplant unit, which is specifically trained in handling the adjudication of transplant claims.

Financial Recovery of Overpayments

Humana has established a Financial Recovery process designed to detect potential claims overpayments.

Post pay audits are performed on a regular basis using queried data contained in a Structured Query Language (SQL) Server database. On a monthly basis, a series of reports are generated summarizing post pay audit results, and are forwarded to senior management for review.

Outside audit companies conduct audits of Humana claims for overpayments and contract exceptions and provide results to Financial Recovery. Results are loaded into the Financial Recovery system on a daily, weekly, bi-weekly, or monthly basis. The results include information on the provider, member, and claim number, date of service, rule, and amount.

In addition, adjusters, customer service representatives, claims processing personnel and Special Investigations Unit (SIU) associates are attentive to claims that appear to be overpayments. If a suspected overpayment is detected at any point in the claims process, the claim is forwarded to Financial Recovery where it will be investigated and resolved. Correspondence is sent out to the overpaid providers and if no response is received, the amounts may be deducted from the future payments. It is also a common practice for the providers to alert Humana if they have been overpaid because an overpayment can cause their records to be misstated.

Special Investigations

Claims identified as potentially fraudulent in nature are pended and then routed to the SIU. The pend is placed in MTV on a provider or a member. Based on SIU pend codes, a claims workflow system will route the claims to SIU. In addition, SIU has developed preprogrammed scripts that run each night via Winbatch, a keystroke emulator, to search for claims that do not need to be sent to SIU and can be adjudicated, or claims that can be denied up front. Claims are routed through a claims workflow system to the appropriate SIU associate to review the claim and determine next steps. SIU has the access in MTV to place the SIU provider flag on a provider. SIU runs a report quarterly to review the provider flags. Investigations are performed by SIU when fraud is suspected and include a comprehensive review of system files and pertinent information regarding the beneficiary, the claims involved and the provider.

Outsourced Claims Review

For certain specialty or high dollar claims, Humana engages other companies to review the claims for subrogation, correct coding and/or negotiate an improved cost. With each vendor, there are controls in place to determine that the vendor has received all the claims provided by Humana and that Humana has received the claims from the vendor. Aging reports allow Humana associates to monitor activity on a daily basis and reassign work to vendors. Inventories of claims outsourced to the vendors are worked by claims adjusters to ensure timely response and compliance with any relevant prompt pay regulations. At the time of invoice payment, the savings achieved are reviewed against those entered into the claims system to ensure that the corrected amounts have been entered. Any differences are reviewed and explained. In addition, a third party vendor provides pharmacy claims adjudication services to Humana. Humana has rights under contractual arrangement to audit shared services providers.

Quality Assurance

Performance Management

Claims processed by each adjuster are reviewed for financial, processing and payment accuracy by the quality audit specialists in the Claims Quality Organization (CQO). The adjustors' supervisors are notified of any errors identified during the assessment and steps are taken to correct the claim. Metrics are generated showing results such as financial accuracy, processing accuracy, overall accuracy, payment accuracy, total dollars overpaid, total underpaid and total dollars paid in error for each adjuster. These reports are distributed and used for the purpose of tracking performance, identifying error trends and identifying training needs.

Performance Plans are developed annually for adjusters to define expectations for each position. Expected accuracy rates are as follows:

- Financial accuracy – 99%
- Processing accuracy – 97%
- Payment accuracy – 98%

Platform Audit (Performance Guarantee Audit)

CQO auditors perform monthly audits of randomly sampled claims to monitor the accuracy of claims adjudication and Humana's compliance with performance guarantee clauses contained in customer contracts. Written audit guidelines for properly performing Platform Audits exist, are distributed to appropriate staff and are updated as the scope of audits change. A database is used to run a randomization query to pull the audit sample. Sample sizes are periodically reviewed and adjusted, if necessary.

For each claim selected, the Quality Auditor performs steps including, but not limited to, the following:

- The auditor determines whether the information in the system matches the scanned image (original claim document) to ensure the information was correctly input into the system.
- The claim is checked for any potential duplicates that may have been identified.
- The claim is checked for re-pricing and to ensure it was paid according to the correct fee schedule and contract.
- The claim is checked for any remarks that may have been input by the claims adjusters.
- The service provider is validated for accuracy.
- The claim is verified against the certificate to ensure benefits are being processed according to the plan document.
- The member is checked for validity.
- Where applicable, state mandates are also validated.

Monthly Statistics Reports for each group are distributed to operational leadership to monitor actual results versus target results as outlined in customer contracts. The reports include the following information:

- Summary of processing, payment, and financial accuracy for the month and YTD, as well as the accuracy targets as applicable.
- Monthly statistics (number of claims audited, number of errors, dollars paid in error).
- Error trending report.
- Audit detail.
- Financial impact grid (defines department financially responsible for error).

Management responsible for the errors ensures they are resolved and assessments are made for potential process improvements. Evaluations may be conducted to determine the most efficient method to resolve claims processing anomalies. If an anomaly is deemed remote or insignificant, a determination to not retrospectively identify and/or reprocess the claims can be made.

Variances are sent to the supervisor of the area and are date stamped by the database. The goal for variances to be agreed upon or disputed is 48 hours. CQO has a goal of 48 hours to respond to the receipt of a dispute.

CQO auditors perform end-to-end process audits by examining a stratified sample of 500 claims each month. Results are reported based on the platform. CQO also publishes a monthly snapshot of actual levels of quality in each measurement vs. goals that pinpoints main root causes of errors.

Each month, CQO undertakes an additional internal quality assurance procedure to assess and improve auditor performance by selecting a sample of ten completed audits per auditor to revalidate results. CQO has a precision goal of at least 96%.

CONTROL OBJECTIVE 10: *Controls provide reasonable assurance that recorded claims are processed completely and accurately and that final adjudication is authorized.*			
Provided by Humana		***Procedures Performed by PricewaterhouseCoopers LLP***	
CONTROL ACTIVITIES		**TEST PROCEDURES**	**RESULTS**
10.1	Claims pended reports are monitored by unit managers and claims adjusters on a periodic basis.	**Observation** Observed an example of the claims pended reports that are utilized by unit managers and claims adjusters to monitor pended claims to determine whether the example reports are monitored and pended claims are resolved.	No exceptions noted.
Claims Authorization			
10.2	MTV is coded to allow authorized adjudication of claims up to pre-determined and tiered dollar limits for both manual and automated processing. Claims will pend until an adjudicator with the appropriate dollar limit approves the claim.	**Observation** Observed a claims adjuster attempt to approve a claim above their dollar limit to determine whether the system would pend the claim.	No exceptions noted.
		Observation Observed a claim with a claim charge above the MTV system dollar limit to determine whether the claim was pended for manual approval by an adjuster with the appropriate dollar limit.	No exceptions noted.

CONTROL OBJECTIVE 10: *Controls provide reasonable assurance that recorded claims are processed completely and accurately and that final adjudication is authorized.*			
Provided by Humana		***Procedures Performed by PricewaterhouseCoopers LLP***	
CONTROL ACTIVITIES		**TEST PROCEDURES**	**RESULTS**
Claims Adjudication			
10.3	MTV identifies potential duplicate claims. An adjuster investigates the suspected duplicates, and rejects the claim if it is a duplicate claim. If the claim is not a duplicate the adjuster overrides the pend and submits the claim for payment.	**Observation** Observed the processing of a claim identified as a suspected duplicate in MTV online with a Claims Adjuster to determine whether: • MTV displayed a warning message indicating suspected duplication. • The adjuster accessed the alert screen, which displays all the matching claims identified. • The adjuster investigated the suspected duplicates by reviewing the Medical History screen.	No exceptions noted.
		Reperformance Reperformed processing in the MTV system for a sample claim to determine whether the claim was pended or rejected due to an exact duplicate edit.	No exceptions noted.
10.4	Adjudication edits and validations are used to verify claims data. Claims that do not pass these edits and validations are rejected or pended to claims adjusters.	**Reperformance** Reperformed processing within the MTV QA environment to determine whether claims were pended or rejected due to automated system edits for an example transaction of each of the following conditions: invalid eligibility; lack of pre-authorization, unbalanced total claim charge, inconsistent gender specific procedure codes, and exact duplicates.	No exceptions noted.

CONTROL OBJECTIVE 10: *Controls provide reasonable assurance that recorded claims are processed completely and accurately and that final adjudication is authorized.*			
Provided by Humana		***Procedures Performed by PricewaterhouseCoopers LLP***	
CONTROL ACTIVITIES		**TEST PROCEDURES**	**RESULTS**
Coordination of Benefits ("COB")			
10.5	To complete claims processing for members with other insurance, the adjuster must have complete Explanation of Benefits (EOB) information. MTV has the functionality to calculate Humana's portion of the liability, and the adjusters will review the allocation for accuracy. After review the adjuster will make any necessary corrections.	**Observation** Observed a claims adjuster to determine whether the adjuster completed COB fields per EOB information, and whether the system calculated Humana's portion of the liability based on COB information.	No exceptions noted.
		Reperformance Reperformed a sample COB calculation to determine whether Humana's portion of the liability was calculated accurately.	No exceptions noted.
Platform Audit (Performance Guarantee Audit)			
10.6	The Claims Quality Organization examines a sample of 500 claims per month for financial and processing accuracy. Humana utilizes a predetermined stratification method, based on claim dollar amounts, to determine the claim sample. Variances are reported and resolved.	**Inspection** Inspected a sample of claims audits to determine whether Platform Audits were performed to monitor the accuracy of claims adjudication and that variances were reported and resolved.	No exceptions noted.

CLAIMS FUNDING AND BILLING

The following processes for the claims funding and billing of Administrative Service Only (ASO) customers, do not apply to those customers who have entered into a Level Funded Premium agreement with Humana.

ASO Reporting

Administrative Service Only (ASO) customers are billed for claims paid on behalf of their group and an administrative fee per subscriber. Administrative fees are calculated by the billing system by multiplying the number of subscribers in the group by the established administrative fee per subscriber. ASO Finance generates a monthly invoice or Automated Clearing House (ACH) memo to customers for any claim related costs and fees that are not processed through the system. Items included on the Special Services Billing (SSB) may include pharmacy claims, capitation, financial recovery, shared savings fees, clinical fees, pharmacy rebates, Vitality rewards, subrogation fees, provider incentives, and state surcharges. These items, which are processed outside of MTV, are entered into a receivables system for invoicing and aging and are balanced to the general ledger prior to invoicing. Shared savings, subrogation, clinical, financial recovery and provider incentive fees are seen as part of the total claims line item when elected by the customer.

ASO Finance provides reporting to Humana's ASO custom and classic customers (please see the "ASO Banking and Reconciliation" section for descriptions of custom and classic customers). As part of the reporting package, a monthly recap is provided to classic customers that details the claims funded and the claims paid.

Customer Reporting Packages are also completed and sent to the customer by a third-party processor. The third party processor follows the same processes as the ASO Finance Team. Random audit checks are performed on Customer Reporting Packages to ensure the packages are complete and accurate. Random audit checks are performed for each Medical ASO Finance Customer three times per year unless the ASO customer has terminated its service for this period.

ASO Banking and Reconciliation

ASO groups are set up by Account Implementation managers using a Self-Funded Plan Sheet. This document includes the rates to be billed for administration fees, clinical fees and stop loss premium as well as stop loss attachment points used in reporting.

Humana's Treasury department completes a banking document that describes the banking arrangement the customer has agreed to for claims administration. Treasury sets up the bank accounts. Humana offers two basic banking options to ASO customers: custom banking or classic banking.

Custom banking uses a customer-owned checking account at a bank of their choice. Humana writes checks directly against the customer's bank account or uses Electronic Fund Transfer (EFT) and ASO Finance provides weekly check registers. The customer is responsible for reconciling the bank account.

Classic banking uses Humana owned bank accounts to process payments for the customer's medical claims. ASO Finance as well as the third party processor, provides the check registers, reconciled bank statements and supporting documentation to the customer each month.

Humana uses reverse positive pay for all classic customers' ASO checks. Checks identified as exceptions through this process are investigated by an ASO Finance associate or the third party processor. ASO Finance receives a daily listing of exceptions noted by the bank when compared to Humana's records. Humana notifies the bank each day of the items on the list that need to be corrected, paid, etc. In addition, Treasury manually runs a daily report on all accounts to review any ASO accounts that are not replenished. If there are problems, claims are held until payment is received.

Payments

ASO Finance generates invoices or ACH notifications to ASO customers for claim related expenses and services that are not paid from the claims system or the billing system. For custom groups an invoice is generated and sent electronically to the customer. Customers make payment directly to Humana. For a majority of classic customers, Humana's Accounts Receivable (AR) System sends a feed directly to the bank initiating the transfer, and ASO Finance completes the comparison of the ACH memo with the subsidiary AR system. ASO Finance also performs the reconciliation of the comparison after deducting amounts from the customer's account. Discrepancies would be detected through the classic customers' bank reconciliation that is performed by Humana and the third party processor.

ASO Finance and the third party processor prepare and send monthly reporting packages to each customer supporting all SSBs noted above. Prior to sending the invoices or ACH notifications to the customer, the supporting detail is reconciled to stated documents and variances are explained.

Stop Loss Claims Administration

Specific and aggregate stop loss contracts and attachment points are loaded into tables from the Self- Funded Plan Sheets approved by Underwriting. These tables, along with the total claims paid, are used to create stop loss reports for ASO Finance on a weekly and monthly basis. The specific stop loss reports are summarized by group and indicate any member who has exceeded their specific stop loss attachment point and the amount to be reimbursed to the group. ASO Finance prepares ACH requests or check requests to initiate prompt payment to the customer for the amount of specific stop loss claims on a weekly basis. The monthly aggregate stop loss report is used by ASO Finance to book an accrual to account for dollars to be reimbursed at the end of the contract. This reimbursement is normally at the end of the contract term. All settlements are reviewed and approved by ASO Finance management and Underwriting.

ASO SSB Administrative Fees and Claims Expense

The SSB administrative fees and claims expense balances are reconciled monthly to the Oracle Recap Document and the group level expense detail, excluding those items billed through claims.

Aging of Uncollected Balances

An aging report is reviewed for reasonableness by ASO Finance management. Uncollected amounts greater than 60 days are investigated and reviewed by management to identify the cause of any uncollected amounts. ASO Finance takes corrective action to collect outstanding amounts or correct billed amounts for items outstanding over 60 days. ASO Finance maintains a monthly aging report with explanations for all balances due greater than 60 days. The aging report is signed off by the Supervisors and then reviewed by ASO Finance management.

CONTROL OBJECTIVE 11: *Controls provide reasonable assurance that claims are billed completely and accurately.*			
Provided by Humana		***Procedures Performed by PricewaterhouseCoopers LLP***	
CONTROL ACTIVITY		**TEST PROCEDURE**	**RESULTS**
11.1	Customer reporting packages are randomly audited for each customer to ensure packages are complete and accurate.	**Inspection** Inspected a sample of audits performed on customer reporting packages to determine whether audits were performed as planned.	No exceptions noted.
		Inspection Inspected a sample claim and traced it from the adjudication platform to the customer reporting package. Inspected a sample claim and traced it from the customer reporting package to the adjudication platform. Traced that the claim was for the proper dollar amount, was assigned to the appropriate client and recorded during the appropriate timeframe.	No exceptions noted.

SECTION V – OTHER INFORMATION PROVIDED BY HUMANA - UNAUDITED

MANAGEMENT RESPONSES TO FINDINGS

The following represents management's response and status on the exceptions cited in Section IV of the report.

CONTROL OBJECTIVE 3: *Controls provide reasonable assurance that logical access to system resources (i.e., programs, data and parameters) is restricted to properly authorized individuals.*			
Provided by Humana		***Procedures Performed by PricewaterhouseCoopers LLP***	
CONTROL ACTIVITIES		**Results**	**Management Response**
3.18	Material DB2 elevated rights grant activity is reviewed at least weekly by EIPAM.	**Exception Noted.** For a sample of one of twenty DB2 access grants, noted that a review was not performed. This occurred because the report used to perform the review was missing one day's activity.	Management agrees with the finding. The process has been improved to address the manual error that led to this exception. There were additional mitigating controls in place at the time of this exception that addressed the associated risk.

DISASTER RECOVERY PLAN

Disaster Recovery Procedures have been established within Data Center Operations Support. It is the responsibility of this area to monitor the Disaster Recovery Plan's state of readiness and to coordinate and report on the annual testing of the plan.

The Humana Information Systems Disaster Recovery Plan is designed to provide recovery logistics and necessary procedures required in the event that an extended system outage should occur at the data center. Specifically, this manual addresses each of the following areas:

- Disaster Alert Procedures
- Executive Responsibilities
- Administrative Responsibilities
- Operational Responsibilities
- Facilities Restoration Responsibilities
- Support Responsibilities

Humana also maintains System and Application Recovery Procedures, which outline the necessary steps (specific to the system infrastructure and each application) to be taken if a disaster occurs. Additionally, they include the specific department/project team responsible for the successful completion of each step. All plans are regularly updated and hardcopies kept at an offsite storage facility.

DISASTER RECOVERY TESTING

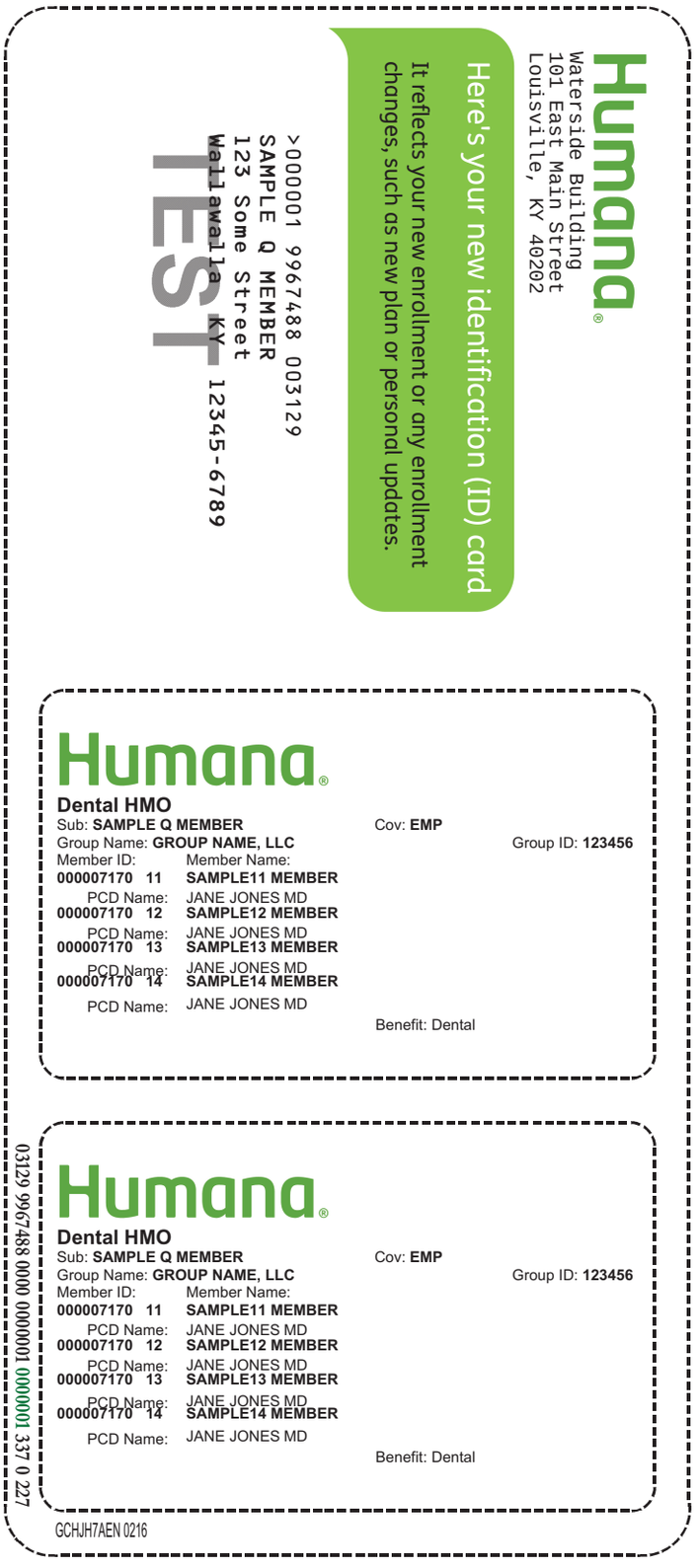
Humana has constructed a second data center which serves as the recovery site in the event of an extended outage to the Louisville Data Center. The site maintains enough capacity to support extensive recovery testing of its mainframe, network and server environments. Upon completion of each test, a test result summary report is prepared by the Disaster Recovery Administrator and distributed to members of the Disaster Recovery Team. Once review is completed, the results are summarized and provided to senior management in a written report.

Humana®

To: City of Fort Lauderdale (Dental Group)
From: Humana Inc.
Subject: SOC 1 Use Guidance
Date: February 2, 2017
Platform: MTV

Attached, please find the SOC 1 Report for the period of October 1, 2015 through September 30, 2016. The scope of this Report, as noted in Section 1, is specific to the MetaVance ("MTV") claims processing system for processing administrative services only user entities' transactions throughout the period October 1, 2015 through September 30, 2016. This report is provided to City of Fort Lauderdale (Dental Group), which is not a current ASO Medical Customer and is not authorized for further distribution.

Christopher Atzinger
Director of Audit Consulting



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Shipping Method: DIRECT
CARRIER: USPS
Address:
SAMPLE Q MEMBER
123 Some Street
Wallawalla, KY 12345-6789

Mailing/Meter Date:

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Insert #2
Insert #3
Insert #4
Insert #5
Insert #6
Insert #7
Insert #8
Insert #9
Insert #10
Insert #11
Insert #12

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MaxMover: N
FORMAT ID : DH002IL **TEMPLATE :** MTV_02A**CARD TYPE :** S
WORK TASK : 11000007170
BUSLEVEL5 : BAT**BUSLEVEL6 :** KY**BUSLEVEL7 :** TST **OP:** PRN

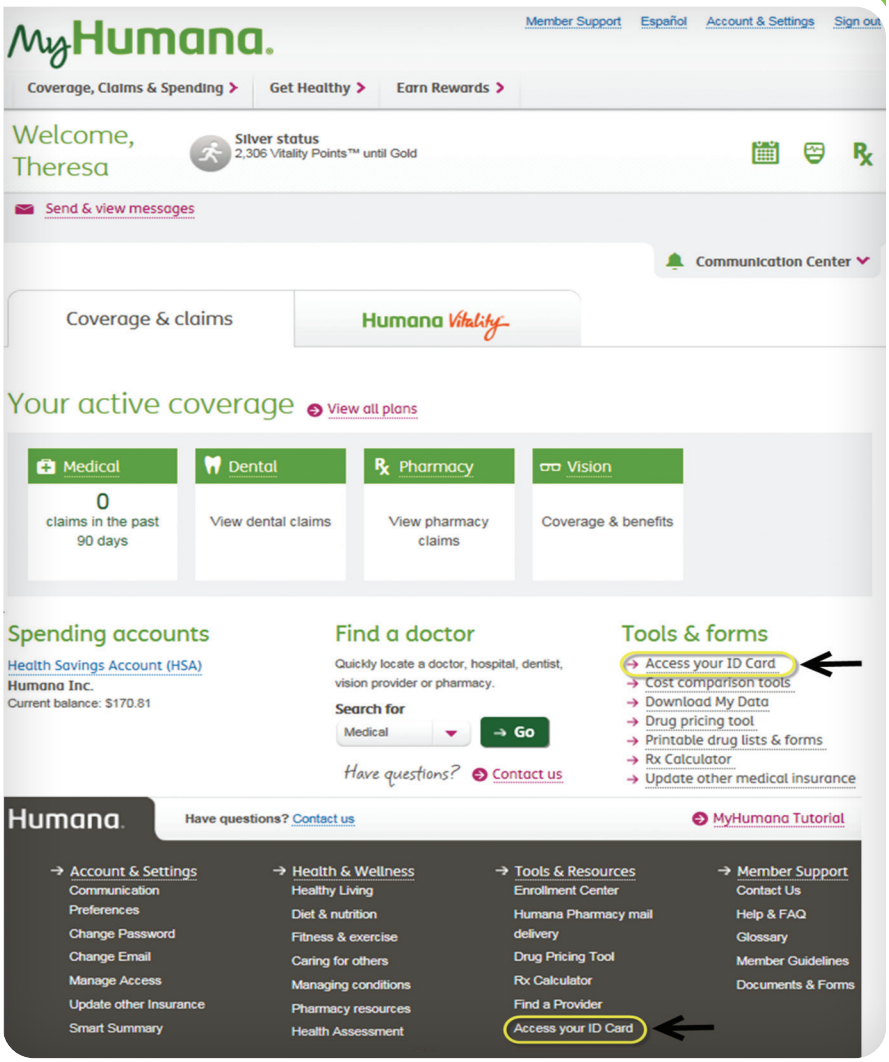
How to view a copy of your dental identification (ID) card

What do I do if I need to visit the dentist's office and I haven't received my member ID card?

You will have access to view and print your dental ID cards via the website or mobile app within 10 working days of enrollment.

Here's How

- Go to **Humana.com** and sign in/register for MyHumana (Have your Humana member ID or Social Security number available)
- Click "Access your ID Card" under "Tools & forms" in the lower right of your MyHumana home page or in the page's footer under "Tools & Resources"
- A new window will appear with links to the ID Card or Proof of coverage
- Print if desired

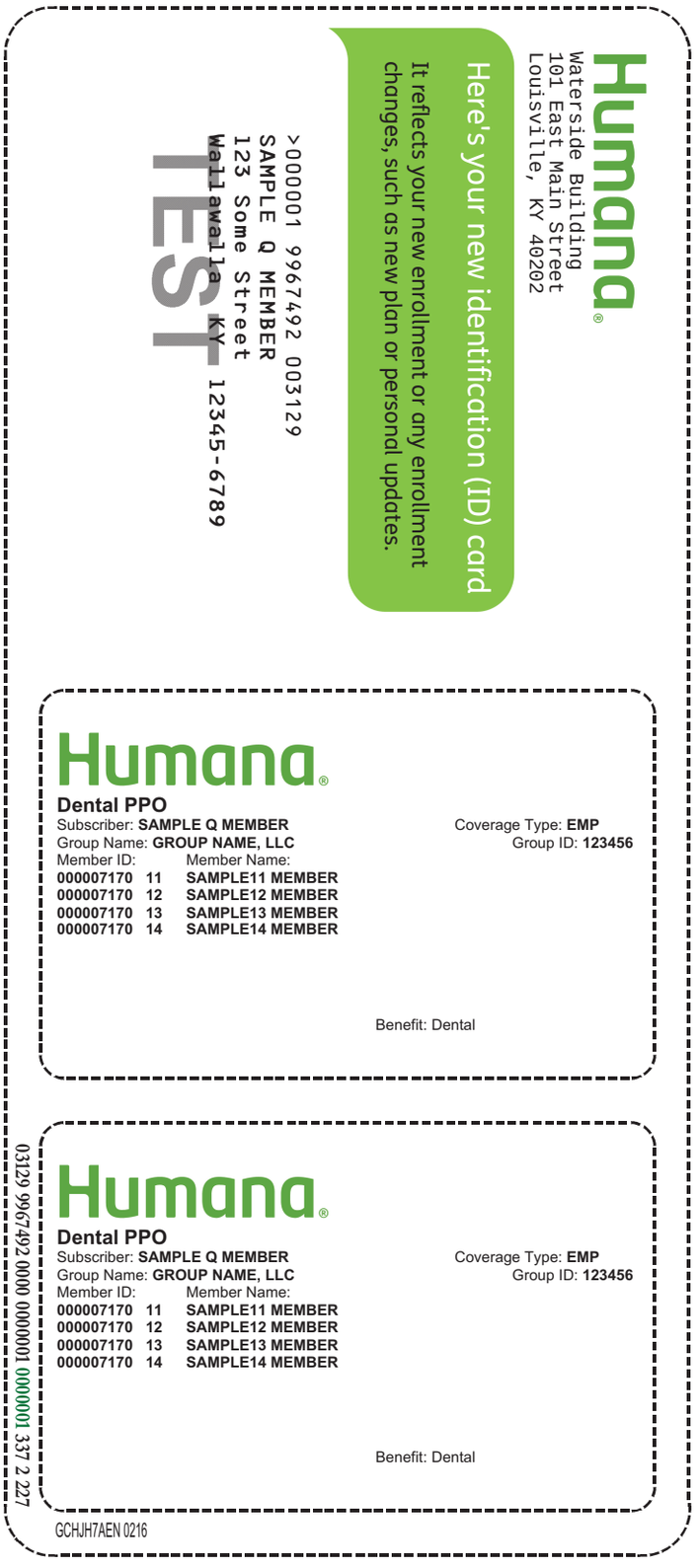


Call Customer Care at **1-866-4ASSIST (1-866-427-7478)** for assistance or more information

Humana®

Humana.com

GCHJCFTEN 0915



Shipper ID: 00000000
Shipping Method: DIRECT
CARRIER: USPS
Address:
SAMPLE Q MEMBER
123 Some Street
Wallawalla, KY 12345-6789

Mailing/Meter Date:

Insert #1 GCHJH7AEN 0216
Insert #2
Insert #3
Insert #4
Insert #5
Insert #6
Insert #7
Insert #8
Insert #9
Insert #10
Insert #11
Insert #12

Cycle Date: 20161202
PDF Date: Wed Mar 09, 2016 @ 12:04:53
MaxMover: N
FORMAT ID : DP001IL **TEMPLATE :** MTV_08A**CARD TYPE :** S
WORK TASK : 11000007170
BUSLEVEL5 : BAT**BUSLEVEL6 :** KY**BUSLEVEL7 :** TST **OP:** PRN

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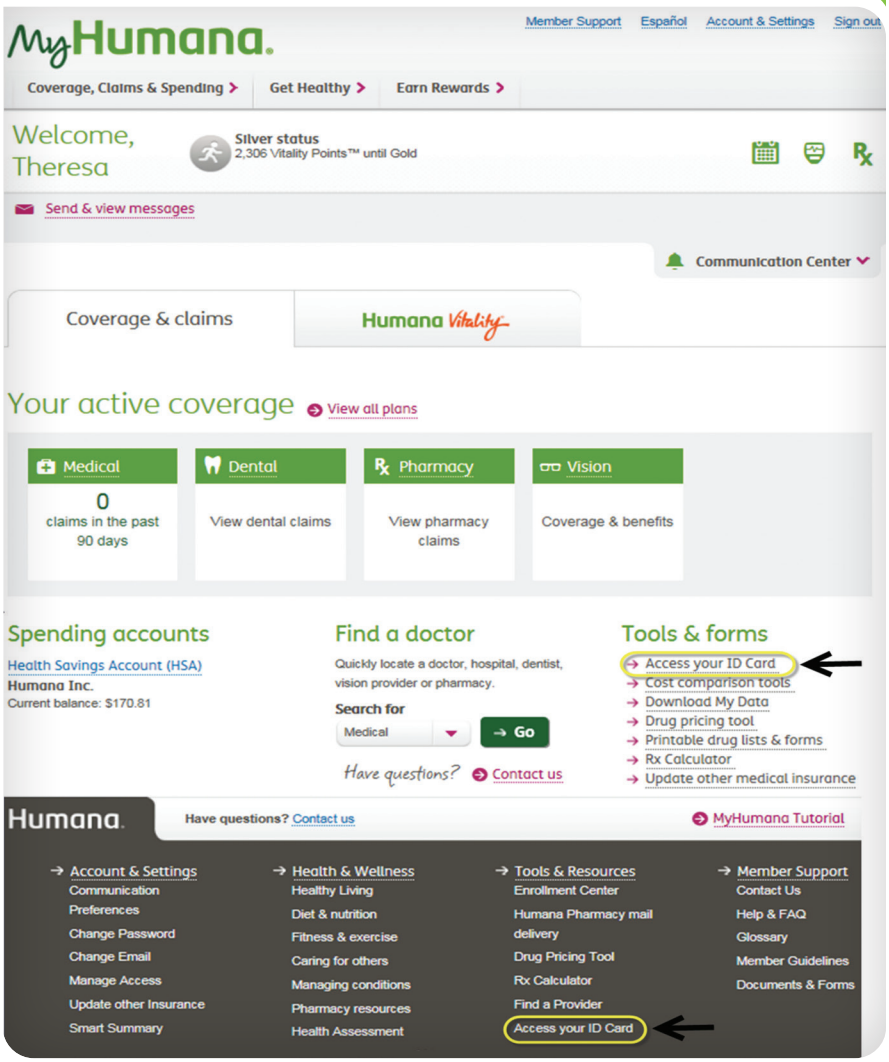

Call Customer Care at **1-866-4ASSIST (1-866-427-7478)** for assistance or more information

Humana®

Humana.com

GCHJCFTEN 0915

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F	8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number	10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY)	14. Gender ☐ M ☐ F	15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number	17. Employer Name	

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other	19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY)	22. Gender ☐ M ☐ F	23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "**A**") A _____ C _____ B _____ D _____

31a. Other Fee(s)

32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")	39. Enclosures (Y or N) ☐
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)	41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment	43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) / 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)	47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI	50. License Number	51. SSN or TIN
52. Phone Number ( ) -	52a. Additional Provider ID	

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI	55. License Number
56. Address, City, State, Zip Code	56a. Provider Specialty Code
57. Phone Number ( ) -	58. Additional Provider ID

HumanaDental: We're here to serve you

Dear Employee:

Thank you for considering a HumanaDental plan. We're committed to providing you with the benefits to promote good dental health—which impacts your overall health—and save on your out-of-pocket costs.

Please review the enclosed plan information and learn more about us. With HumanaDental:

- Experience exceptional service, including fast, accurate claims turnaround.
- Choose from a nationwide network of participating dentists.
- Use innovative technology: For claims and benefit information and more, you can log on to your personal home page on our Website, **Humana.com**, or call our automated information line.

- Read our *BrushUp* member newsletter for dental-related topics and to learn more about your plan benefits.

Please complete the enrollment form and return it to your benefits administrator. If you have questions about your benefits, contact your administrator.

Again, thanks for considering HumanaDental. We look forward to the opportunity to serve you.

Sincerely,

Jerry Ganoni
President
HumanaDental

Enclosures

Notice of Privacy Practices
For your personal health and financial information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The privacy of your personal and health information is important. You don't need to do anything unless you have a request or complaint.

We reserve the right to change our privacy practices and the terms of this notice at any time, as allowed by law. This includes the right to make changes in our privacy practices and the revised terms of our notice effective for all personal and health information we maintain. This includes information we created or received before we made the changes. When we make a significant change in our privacy practices, we will change this notice and send the notice to our health plan subscribers.

What is personal and health information?

Personal and health information - from now on referred to as "information" - includes both medical information and individually identifiable information, like your name, address, telephone number, or Social Security number. The term "information" in this notice includes any personal and health information created or received by a healthcare provider or health plan that relates to your physical or mental health or condition, providing healthcare to you, or the payment for such healthcare. We protect this information in all formats including electronic, written and oral information.

How do we protect your information?

In keeping with federal and state laws and our own policy, we have a responsibility to protect the privacy of your information. We have safeguards in place to protect your information in various ways including:

- Limiting who may see your information
- Limiting how we use or disclose your information
- Informing you of our legal duties about your information
- Training our associates about company privacy policies and procedures

How do we use and disclose your information?

We must use and disclose your information:

- To you or someone who has the legal right to act on your behalf
- To the Secretary of the Department of Health and Human Services
- Where required by law.

We have the right to use and disclose your information:

- To a doctor, a hospital, or other healthcare provider so you can receive medical care
- For payment activities, including claims payment for covered services provided to you by healthcare providers and for health plan premium payments
- For healthcare operation activities including processing your enrollment, responding to your inquiries and requests for services, coordinating your care, resolving disputes, conducting medical management, improving quality, reviewing the competence of healthcare professionals, and determining premiums
- For performing underwriting activities. However, we will not use any results of genetic testing or ask questions regarding family history.
- To your plan sponsor to permit them to perform plan administration functions such as eligibility, enrollment and disenrollment activities. We may share summary level health information about you with your plan sponsor in certain situations such as to allow your plan sponsor to obtain bids from other health plans. We will not share detailed health information to your plan sponsor unless you provide us your permission or your plan sponsor has certified they agree to maintain the privacy of your information.
- To contact you with information about health-related benefits and services, appointment reminders, or about treatment alternatives that may be of interest to you if you have not opted out as described below
- To your family and friends if you are unavailable to communicate, such as in an emergency
- To your family and friends or any other person you identify, provided the information is directly relevant to their involvement with your health care or payment for that care. For example, if a family member or a caregiver calls us with prior knowledge of a claim, we may confirm whether or not the claim has been received and paid.
- To provide payment information to the subscriber for Internal Revenue Service substantiation
- To public health agencies if we believe there is a serious health or safety threat
- To appropriate authorities when there are issues about abuse, neglect, or domestic violence
- In response to a court or administrative order, subpoena, discovery request, or other lawful process
- For law enforcement purposes, to military authorities and as otherwise required by law
- To assist in disaster relief efforts
- For compliance programs and health oversight activities
- To fulfill our obligations under any workers' compensation law or contract

Notice of Privacy Practices
(continued)

- To avert a serious and imminent threat to your health or safety or the health or safety of others
- For research purposes in limited circumstances
- For procurement, banking, or transplantation of organs, eyes, or tissue
- To a coroner, medical examiner, or funeral director.

Will we use your information for purposes not described in this notice?

In all situations other than described in this notice, we will request your written permission before using or disclosing your information. You may revoke your permission at any time by notifying us in writing. We will not use or disclose your information for any reason not described in this notice without your permission. The following uses and disclosures will require an authorization:

- Most uses and disclosures of psychotherapy notes
- Marketing purposes
- Sale of protected health information

What do we do with your information when you are no longer a member or you do not obtain coverage through us?

Your information may continue to be used for purposes described in this notice when your membership is terminated or you do not obtain coverage through us. After the required legal retention period, we destroy the information following strict procedures to maintain the confidentiality.

What are my rights concerning my information?

The following are your rights with respect to your information. We are committed to responding to your rights request in a timely manner.

- Access – You have the right to review and obtain a copy of your information that may be used to make decisions about you, such as claims and case or medical management records. You also may receive a summary of this health information. If you request copies, we may charge you a fee for each page, a per hour charge for staff time to locate and copy your information, and postage.
- Adverse Underwriting Decision – You have the right to be provided a reason for denial or adverse underwriting decision if your application for insurance is declined. *
- Alternate Communications – You have the right to receive confidential communications of information in a different manner or at a different place to avoid a life threatening situation. We will accommodate your request if it is reasonable.
- Amendment – You have the right to request an amendment of information we maintain about you if you believe the information is wrong or incomplete. We may deny your request if we did not create the information, we do not maintain the information, or the information is correct and complete. If we deny your request, we will give you a written explanation of the denial.
- Disclosure – You have the right to receive a listing of instances in which we or our business associates have disclosed your information for purposes other than treatment, payment, health plan operations, and certain other activities. We maintain this information and make it available to you for a period of six years at your request. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
- Notice – You have the right to receive a written copy of this notice any time you request.
- Restriction – You have the right to ask to restrict uses or disclosures of your information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement. You also have the right to agree to or terminate a previously submitted restriction.

What types of communications can I opt out of that are made to me?

- Appointment reminders
- Treatment alternatives or other health-related benefits or services

How do I exercise my rights or obtain a copy of this notice?

All of your privacy rights can be exercised by obtaining the applicable privacy rights request forms. You may obtain any of the forms by:

- Contacting us at 1-866-861-2762 at any time
- Accessing our Website at Humana.com and going to the Privacy Practices link

* This right applies only to our Massachusetts residents in accordance with state regulations.

Notice of Privacy Practices
(continued)

- E-mailing us at privacyoffice@humana.com
  Send completed request form to:
  Humana Inc.
  Privacy Office 003/10911
  101 E. Main Street
  Louisville, KY 40202

What should I do if I believe my privacy has been violated?

If you believe your privacy has been violated in any way, you may file a complaint with us by calling us at 1-866-861-2762 any time.

You may also submit a written complaint to the U.S. Department of Health and Human Services, Office of Civil Rights (OCR). We will give you the appropriate OCR regional address on request. You also have the option to e-mail your complaint to OCRComplaint@hhs.gov. We support your right to protect the privacy of your personal and health information. We will not retaliate in any way if you elect to file a complaint with us or with the U.S. Department of Health and Human Services.

What will happen if my private information is used or disclosed inappropriately?

You have a right to receive a notice that a breach has resulted in your unsecured private information being inappropriately used or disclosed. We will notify you in a timely manner if such a breach occurs.

PRIVACY NOTICE CONCERNING FINANCIAL INFORMATION

We and our affiliates understand that the privacy of your personal information is important to you. We take your privacy seriously and your trust in our ability to protect your private information is very important to us. This notice describes our policy regarding the confidentiality and disclosure of personal financial information.

How do we collect information about you?

We collect information about you and your family when you complete applications and forms. We also collect information from your dealings with us, our affiliates, or others. For example, we may receive information about you from participants in the healthcare system, such as your doctor or hospital, as well as from employers or plan administrators, credit bureaus, and the Medical Information Bureau.

What information do we receive about you?

The information we receive may include such items as your name, address, telephone number, date of birth, Social Security number, premium payment history, and your activity on our Website. This also includes information regarding your medical benefit plan, your health benefits, and health risk assessments.

Where will we disclose your information?

We may share your information with affiliated companies and non-affiliated third parties, as permitted by law. We may also provide your information to other financial institutions with which we have joint marketing agreements in order to provide you with offers for products and services you may find of value or which are health-related.

What can I prevent with an opt-out disclosure?

You can prevent the disclosures to non-affiliated third parties that provide products and services not offered by us or where the non-affiliated company provides services related to your plan by requesting to opt-out of such disclosures. Your opt-out request will apply to all members or individuals covered under your identification number or member account.

Your opt-out request will continue to apply until you revoke your request or terminate your membership.

How do I request an opt-out?

At any time you can tell us not to share any of your personal information with affiliated companies that provide offers other than our products or services. If you wish to exercise your opt-out option, or to revoke a previous opt out request, you need to provide the following information to process your request: your name, date of birth, and your member identification number. You can use any of the methods below to request or revoke your opt-out:

- Call us at 1-866-861-2762
- E-mail us at privacyoffice@humana.com.
- Send your opt-out request to us in writing:
  Humana Inc.
  Privacy Office 003/10911
  101 E. Main Street
  Louisville, KY 40202

We follow all federal and state laws, rules, and regulations addressing the protection of personal and health information. In situations when federal and state laws,

Notice of Privacy Practices
(continued)

rules, and regulations conflict, we follow the law, rule, or regulation which provides greater protection.

The following affiliates and subsidiaries also adhere to our privacy policies and procedures:

American Dental Plan of North Carolina, Inc.
American Dental Providers of Arkansas, Inc.
Arcadian Health Plan, Inc.
CarePlus Health Plans, Inc.
Cariten Health Plan, Inc.
Cariten Insurance Company
CHA HMO, Inc.
CompBenefits Company
CompBenefits Dental, Inc.
CompBenefits Insurance Company
CompBenefits of Alabama, Inc.
CompBenefits of Georgia, Inc.
CorpHealth, Inc. dba LifeSynch
CorpHealth Provider Link, Inc.
DentiCare, Inc.
Emphesys, Inc.
Emphesys Insurance Company
HumanaDental Insurance Company
Humana AdvantageCare Plan, Inc. fna Metcare Health Plans, Inc.
Humana Benefit Plan of Illinois, Inc. fna OSF Health Plans, Inc.
Humana Employers Health Plan of Georgia, Inc.
Humana Health Benefit Plan of Louisiana, Inc.
Humana Health Company of New York, Inc.
Humana Health Insurance Company of Florida, Inc.
Humana Health Plan of California, Inc.
Humana Health Plan of Ohio, Inc.
Humana Health Plan of Texas, Inc.
Humana Health Plan, Inc.
Humana Health Plans of Puerto Rico, Inc.
Humana Insurance Company
Humana Insurance Company of Kentucky
Humana Insurance Company of New York
Humana Insurance of Puerto Rico, Inc.
Humana MarketPOINT, Inc.
Humana MarketPOINT of Puerto Rico, Inc.
Humana Medical Plan, Inc.
Humana Medical Plan of Michigan, Inc.
Humana Medical Plan of Pennsylvania, Inc.
Humana Medical Plan of Utah, Inc.
Humana Pharmacy, Inc.
Humana Regional Health Plan, Inc.
Humana Wisconsin Health Organization Insurance Corporation
Kanawha Insurance Company*
Managed Care Indemnity, Inc.
Preferred Health Partnership, Inc.*
Preferred Health Partnership of Tennessee, Inc.
The Dental Concern, Inc.
The Dental Concern, Ltd.

* These affiliates and subsidiaries are only covered by the Privacy Notice Concerning Financial Information section.

Humana®

What's your dental IQ?

Did you know that making regular preventive visits to your dentist can help detect problems throughout your body such as heart disease, diabetes, and stroke?*

Your HumanaDental® plan focuses on prevention, early detection, and education.

* Perio.org

Go to MyDentalIQ.com to find out how to improve your oral health

You brush your teeth and floss daily and have regular dental checkups. What more can you do to improve your dental health?

Go to **MyDentalIQ.com** and take a free dental health assessment. You'll answer a few questions to help evaluate your family history, general health, daily routine, and eating habits. You'll receive a score that immediately rates your dental knowledge, along with a personalized action plan and tips. You can even print a copy of your plan to discuss with your dentist.

Humana®

Humana.com

GN51281HD 913

Manage your plan at MyHumana

Use **MyHumana** to manage your plan, understand your benefits, and take charge of your dental health.

As a Humana Dental member, you can:

- Find network dentists
- Check claims history and status
- View coverage details
- Review plan benefit details
- Order a replacement identification card
- View estimates for services
- Exchange secure messages with Humana

Registration is simple

Have your Humana Dental identification card ready and go to **Humana.com**. Click on "**Register**," then follow the instructions.

We're here to help

CALL 1-800-979-4760 FOR CUSTOMER CARE.

Humana®

Humana.com

GN67523HD 0813

Choose a participating dentist and save

When you visit a dentist who participates in the Humana Dental PPO Network[1], you can save up to 30 percent on average billed charges. Plus, the PPO (applies to Traditional Preferred, PPO, and Preventive Plus) network is nationwide so you can find a participating dentist near your home or work, when you're on vacation, or away at college.

For example: A member needs a dental service and has a Humana Dental PPO plan that pays 80 percent to a dentist who participates in our network and 50 percent to a dentist who does not.[2] The chart shows the member will save $90 for this service by visiting a participating dentist because of the Humana Dental discount.

	Retail charge	Amount billed	Humana Dental pays	Member pays
Participating dentist	$250	$175	$140 (80%)	$35
Nonparticipating dentist	$250	$250	$125 (50%)	$125
			Member savings	$90

Find a participating dentist

Go to **Humana.com** anytime and select "Find a healthcare provider." We update the list of participating dentists daily. You also can call 1-800-233-4013. A Humana Customer Care specialist will be happy to help you from 8 a.m. to 6 p.m. Monday through Friday.

We're here to help

Call 1-800-233-4013 for Customer Care.

Refer your dentist

If your dentist doesn't participate, please help us get your dentist in our PPO network. That way, you can continue to see the dentist you know and trust while receiving the best value from your plan. Simply add your name to the card below, give it to your dentist at your next visit, and ask him or her to return it to Humana.

[1] Plus network in Texas.
[2] Nonparticipating dentists can also bill you for charges above the amount covered by your Humana Dental plan. To ensure you do not receive additional charges, visit a participating PPO network dentist.
Example assumes member has met deductible. The chart is for illustrative purposes only.
Actual amounts and benefit plans vary by employer.

Refer your dentist

Add your name and give this card to your dentist to return to us. We'll make sure he or she gets the details about participating in the Humana Dental PPO Network.

Join the Humana Dental PPO Network

Your patient wants you to join our network. For details, complete and mail this card. Thank you! (**Please print)**

Date

Dentist's name

Specialty

Address

City State ZIP code

Telephone with area code

Patient name / employer group who referred you to the Humana Dental PPO Network

Humana®

GN67617HD 0813

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL

FIRST-CLASS MAIL PERMIT NO. 206 WAUKESHA, WI

POSTAGE WILL BE PAID BY THE ADDRESSEE

ATTN NETWORK DEVELOPMENT
HUMANA DENTAL
N19 W24133 RIVERWOOD DRIVE SUITE
300
WAUKESHA WI 53188-1174

Large Group Employee and Individual Application and Enrollment Form

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Large Group Employee and Individual Application and Enrollment Form as "Humana".

PPO, EPO and Indemnity plans insured by Humana Health Insurance Company of Florida, Inc. POS and HMO plans offered by Humana Medical Plan, Inc. Humana National POS plan offered by Humana Medical Plan, Inc. Life plans insured or administered by Humana Insurance Company. Prepaid, Basic, Intermediate and High Dental plans underwritten by The Dental Concern, Inc. Prepaid and AdvantagePlus Dental plans offered and administered by CompBenefits Company. All other Dental plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company. Vision plans insured or administered by Humana Insurance Company or CompBenefits Insurance Company or CompBenefits Company. Short Term Disability, Long Term Disability, Life and Workplace Voluntary plans insured or administered by Kanawha Insurance Company.

Print clearly and completely fill in each applicable circle.

Employer / Group name

Employer / Group city

State

Qualifying Event Instructions **Office use only**

❍ New business enrollment ❍ Open Enrollment event ❍ Marital status change ❍ Other_____

❍ New hire/Newly eligible ❍ Rehire/Reinstatement Qualifying event date (MM/DD/YYYY) Benefit effective date (MM/DD/YYYY)

❍ Dependent birth or adoption ❍ Loss of coverage

Employee / Individual information

Last name

First name

MI

Social security number

Date of birth (MM/DD/YYYY)

Area code

Phone number

Street address

Apt / Suite / PO box number

Gender ❍ Female ❍ Male

Language of choice ❍ English ❍ Spanish

City

State

Zip code

County / Parish

E-mail address

Employment status ❍ Full-time employee / individual ❍ Retiree ❍ COBRA Date of full-time hire (MM/DD/YYYY)

Do you have a disability that affects your ability to communicate or read? ❍ No ❍ Yes

Are you disabled or unable to perform normal work activities? ❍ No ❍ Yes If yes, indicate reason:_____

Annual Salary

$

Hours Worked per Week

Occupation

HMO/POSonly Primary care physician name

Primary care physician ID #

Current patient? ❍ Yes ❍ No

HMO/POSonly OBGYN Primary care physician name (if applicable)

Primary care physician ID #

Current patient? ❍ Yes ❍ No

Last name: First name:

Dependent information

Enter information for each covered dependent, including spouse.

1

Dependent last name | First name | MI | Gender ❍ Female ❍ Male

Social security number | Date of birth (MM/DD/YYYY) | Relationship ❍ Spouse ❍ Child ❍ Other:_____

Dependent status (if applicable): ❍ Full-time student ❍ Disabled
If disabled, indicate reason:_____

Not applicable for HumanaAccess HMO

HMO/POS only — Primary care physician name | Primary care physician ID # | Current patient? ❍ Yes ❍ No

HMO/POS only — OBGYN Primary care physician name (if applicable) | Primary care physician ID # | Current patient? ❍ Yes ❍ No

2

Dependent last name | First name | MI | Gender ❍ Female ❍ Male

Social security number | Date of birth (MM/DD/YYYY) | Relationship ❍ Spouse ❍ Child ❍ Other:_____

Dependent status (if applicable): ❍ Full-time student ❍ Disabled
If disabled, indicate reason:_____

Not applicable for HumanaAccess HMO

HMO/POS only — Primary care physician name | Primary care physician ID # | Current patient? ❍ Yes ❍ No

HMO/POS only — OBGYN Primary care physician name (if applicable) | Primary care physician ID # | Current patient? ❍ Yes ❍ No

3

Dependent last name | First name | MI | Gender ❍ Female ❍ Male

Social security number | Date of birth (MM/DD/YYYY) | Relationship ❍ Spouse ❍ Child ❍ Other:_____

Dependent status (if applicable): ❍ Full-time student ❍ Disabled
If disabled, indicate reason:_____

Not applicable for HumanaAccess HMO

HMO/POS only — Primary care physician name | Primary care physician ID # | Current patient? ❍ Yes ❍ No

HMO/POS only — OBGYN Primary care physician name (if applicable) | Primary care physician ID # | Current patient? ❍ Yes ❍ No

4

Dependent last name | First name | MI | Gender ❍ Female ❍ Male

Social security number | Date of birth (MM/DD/YYYY) | Relationship ❍ Spouse ❍ Child ❍ Other:_____

Dependent status (if applicable): ❍ Full-time student ❍ Disabled
If disabled, indicate reason:_____

Not applicable for HumanaAccess HMO

HMO/POS only — Primary care physician name | Primary care physician ID # | Current patient? ❍ Yes ❍ No

HMO/POS only — OBGYN Primary care physician name (if applicable) | Primary care physician ID # | Current patient? ❍ Yes ❍ No

Last name: | First name:

Use the following alternate address for these dependents: ❍ 1 ❍ 2 ❍ 3 ❍ 4

Street address

Apt / Suite / PO box number

City | State | Zip code | County

Medical

Do you wish to extend coverage for your dependent adult child(ren) up to age 30? ❍ No ❍ Yes

Coverage type: ❍ Employee / Individual only
❍ Employee / Individual & spouse
❍ Employee / Individual & child(ren)
❍ Family
❍ Other

Office use only
Group # | Benefit # | Class/Div #

Plan name | Network name

- Do you or any covered dependent(s) currently have other medical coverage, such as a spouse's plan, another Humana medical plan, or Medicare? ❍ Yes ❍ No If yes, list all: (This section must be completed for Humana to process any medical claims.)

Medicare ID or medical carrier name:
Starting date (MM/DD/YYYY) / /
End date, if applicable (MM/DD/YYYY) / /
Coverage Type (check all that apply)
❍ Employee / Individual
❍ Spouse
❍ Child(ren)

Medicare ID or medical carrier name:
Starting date (MM/DD/YYYY) / /
End date, if applicable (MM/DD/YYYY) / /
Coverage Type (check all that apply)
❍ Employee / Individual
❍ Spouse
❍ Child(ren)

- Have you or any covered dependent(s) had medical insurance from a company (including another Humana plan) in the past 18 months? ❍ Yes ❍ No If yes, list all: (This section must be completed for Humana to process any medical claims)

Prior medical carrier name:
Starting date (MM/DD/YYYY) / /
End date, if applicable (MM/DD/YYYY) / /
Coverage Type (check all that apply)
❍ Employee / Individual
❍ Spouse
❍ Child(ren)

Prior medical carrier name:
Starting date (MM/DD/YYYY) / /
End date, if applicable (MM/DD/YYYY) / /
Coverage Type (check all that apply)
❍ Employee / Individual
❍ Spouse
❍ Child(ren)

Health Savings Account (HSA) Applicable only with High Deductible Health Plan selection

Do you elect the Health Savings Account?
❍ Yes ❍ No If no, complete waiver section

If you have medical coverage under another plan, you may not be eligible for an HSA. Please check with your tax advisor for details.

Office use only
Group # | Benefit # | Class/Div #

Please refer to Humana's HSA contribution worksheet to calculate your maximum allowed contribution. You can find additional information on HSAs on Humana.com. Select the Quick Link for Spending Account information on the member page.

Beneficiary for this account will be the employee / individual 's estate. You may change beneficiary information on file with the bank that administers the HSA once the account is established.

Last name: First name:

Flexible Spending Account (FSA)

Do you elect the flexible health account?
❍ Yes ❍ No If no, complete waiver section

Annual amount elected:
$, .00

Office use only
Group # Benefit # Class/Div #
FSA HC

Start date (MM/DD/YYYY) / / End date (MM/DD/YYYY) / /

Do you elect the flexible dependent care account?
❍ Yes ❍ No If no, complete waiver section

Annual amount elected:
$, .00

Office use only
Group # Benefit # Class/Div #
FSA DC

Start date (MM/DD/YYYY) / / End date (MM/DD/YYYY) / /

Dental

Office use only Group # Benefit # Class/Div #

Coverage Type ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family ❍ Other

Plan name

- Within the past 12 months, have you or any covered family individual had any dental or orthodontia coverage, such as a spouse's dental coverage? ❍ Yes ❍ No If yes, list all: (This section must be completed for Humana to process any dental claims)

Current dental carrier name: Orthodontia coverage? ❍ Yes ❍ No Starting date (MM/DD/YYYY) / / End date, if applicable (MM/DD/YYYY) / /

Coverage Type (check all that apply) ❍ Employee / Individual ❍ Spouse ❍ Child(ren)

Prior dental carrier name: Orthodontia coverage? ❍ Yes ❍ No Starting date (MM/DD/YYYY) / / End date, if applicable (MM/DD/YYYY) / /

Coverage Type (check all that apply) ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family

HMO/POS only — Employee Primary care dentist name — Dentist ID # — Current patient? ❍ Yes ❍ No

		Employee Primary care dentist name	Dentist ID #	Current patient?
1	DHMO:			❍ Yes ❍ No
2	DHMO:			❍ Yes ❍ No
3	DHMO:			❍ Yes ❍ No

Basic Life / AD&D

Office use only Group # Benefit # Class/Div #

Do you elect basic employee / individual life coverage? ❍ Yes ❍ No If no, complete waiver section

Class (employer / group will provide you with this information if needed)

Do you elect basic dependent life? ❍ Yes ❍ No If no, complete waiver section

Last name: First name:

Voluntary Life / AD&D

Office use only Group # Benefit # Class/Div #

Do you elect voluntary employee / individual life coverage?

❍ Yes ❍ No If no, complete waiver section

If yes, amount elected (minimum of $15,000): $, .00

Voluntary dependent life selection (available only if employee / individual elects voluntary life coverage):

Do you elect voluntary spouse life coverage? ❍ Yes ❍ No If no, complete waiver section

If yes, voluntary spouse life coverage (minimum of $5,000): $, .00

Do you elect voluntary child(ren) life coverage? ❍ Yes ❍ No If no, complete waiver section

Vision

Office use only Group # Benefit # Class/Div #

Covered individual ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family ❍ Other

Plan name

Short Term Disability

Do you elect short term disability coverage?

❍ Yes ❍ No If no, complete waiver section

Buy-up percent/amount _____

Office use only

Group # Benefit # Class # Div #

Long Term Disability

Do you elect long term disability coverage?

❍ Yes ❍ No If no, complete waiver section

Buy-up percent/amount _____

Office use only

Group # Benefit # Class # Div #

Group Term Life / AD&D

Office use only Group # Benefit # Class # Div #

Coverage requested for (check all that apply)		Coverage requested (complete only if plan provides a choice of benefit schedules)	Cost per pay period
Employee / Individual	❍ Basic Term Life		$, .00
	❍ Supplemental Term Life*		$, .00
	❍ Basic AD&D		$, .00
	❍ Supplemental AD&D		$, .00
Spouse	❍ Basic Term Life		$, .00
	❍ Supplemental Term Life*		$, .00
	❍ Basic AD&D		$, .00
	❍ Supplemental AD&D		$, .00
Child(ren)	❍ Basic Term Life		$, .00
	❍ Supplemental Term Life*		$, .00
	❍ Basic AD&D		$, .00
	❍ Supplemental AD&D		$, .00

*Complete Evidence of Insurability form if selecting one of these benefit amounts.

Last name: First name:

Workplace Voluntary Benefits: Optional riders availability based on employer / group election.

Accident

Office use only Group # Benefit # Class # Div #

❍ Accident ❍ N ❍ Y **Benefit Level:** ❍ 1 ❍ 2 ❍ 3 ❍ 4

Coverage type: ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family

❍ Optional Hospital Intensive Care Unit Benefits Rider ❍ $150 ❍ $300 ❍ $450 ❍ $600
❍ Optional Fracture and Dislocation Benefits Rider ❍ $750 ❍ $1,500
❍ Optional Accident Total Disability Benefits Rider: Elimination Period ❍ 1 Day ❍ 7 Days ❍ 14 Days ❍ 30 Days
Elimination Benefit ❍ $400 ❍ $500 ❍ $600 ❍ $700 ❍ $800 ❍ $900 ❍ $1000

Accident - 2012

Office use only Group # Benefit # Class # Div #

❍ Accident ❍ N ❍ Y **Benefit Level:** ❍ 1 ❍ 2 ❍ 3 ❍ 4

Coverage type: ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family

Disability Income Plus

Office use only Group # Benefit # Class # Div #

❍ Disability Income Covering Accident and Sickness ❍ N ❍ Y
Base Benefit Period: ❍ 3 Month ❍ 6 Month ❍ 1 Year ❍ 2 Year ❍ 3 Year
Base Elimination Period: ❍ 0/7 ❍ 7/7 ❍ 0/14 ❍ 14/14 ❍ 30/30 ❍ 60/60 ❍ 90/90 ❍ 180/180 ❍ 365/365
❍ Disability Income Covering Accident and Sickness with Waiver of Elimination Period ❍ N ❍ Y
Base Benefit Period: ❍ 3 Month ❍ 6 Month ❍ 1 Year ❍ 2 Year ❍ 3 Year
Base Elimination Period: ❍ 0/7 ❍ 7/7 ❍ 0/14 ❍ 14/14
Monthly Benefit $, .00
Optional Disability Income Benefits: ❍ ICU/CCU Benefit ❍ $200 ❍ $400 ❍ $600 ❍ $800
❍ Physical Therapy Benefit
❍ COBRA Rider
COBRA Monthly Benefit $, .00

Disability Income Advantage

Office use only Group # Benefit # Class # Div #

❍ Disability Income Advantage ❍ N ❍ Y
Base Benefit Period: ❍ 3 Month ❍ 6 Month ❍ 1 Year ❍ 2 Year ❍ 3 Year
Base Elimination Period: ❍ 0/7 ❍ 7/7 ❍ 0/14 ❍ 14/14 ❍ 30/30 ❍ 60/60 ❍ 90/90 ❍ 180/180 ❍ 365/365
Monthly Benefit $, .00
Optional Riders: ❍ Hospital Confinement ❍ COBRA Rider
COBRA Monthly Benefit $, .00

Last name: First name:

Whole Life / AD&D

Office use only Group # Benefit # Class # Div #

❍ Whole Life / AD&D ❍ N ❍ Y ❍ Whole Life 99 ❍ Whole Life 65

Employee / Individual Benefit
$, .00

❍ AD&D Rider ❍ Automatic Premium Loan Option

❍ Automatic Benefit Increase Rider
❍ $1 / Week ❍ $2 / Week

❍ Employee Term Rider to 65
Employee / Individual Benefit
$_____

❍ Family Term Rider
Spouse Benefit $ _____
Child(ren) Benefit $ _____

Whole Life Spouse / AD&D

Office use only Group # Benefit # Class # Div #

Do you have existing life insurance policies or annuity contracts? ❍ No ❍ Yes
Will any of the policies applied for replace any coverage currently in force? ❍ No ❍ Yes

Prior life insurance carrier name	Policy #	**Prior coverage type:**
	Effective date _ _ / _ _ / _ _ _ _	❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family
Prior carrier phone # ( )	Term date _ _ / _ _ / _ _ _ _	

❍ Whole Life Spouse / AD&D ❍ N ❍ Y ❍ Whole Life 99 ❍ Whole Life 65

Spouse Benefit
$, .00

❍ AD&D Rider ❍ Automatic Premium Loan Option
❍ Family Term Rider (Child Coverage Only) Child(ren) Benefit Amount $_____

Whole Life Child(ren) / AD&D

Office use only Group # Benefit # Class # Div #

❍ Whole Life Child(ren) / AD&D ❍ N ❍ Y

Child(ren) listed here must also be included as dependents under the Enrollment Information section of this application.

❍ N ❍ Y **Coverage on Child 1** Child 1 Name_____ Child 1 Benefit $ _____
❍ N ❍ Y **Coverage on Child 2** Child 2 Name_____ Child 2 Benefit $ _____
❍ N ❍ Y **Coverage on Child 3** Child 3 Name_____ Child 3 Benefit $ _____

Level Term Life

Office use only Group # Benefit # Class # Div #

❍ Level Term Life ❍ N ❍ Y **Coverage type:** ❍ Employee / Individual only ❍ Spouse ❍ Child(ren) ❍ No Coverage
Base Plan: ❍ 10 Year Term ❍ 20 Year Term
Optional Benefit: ❍ Automatic Benefit Increase

Employee / Individual Benefit
$, .00

Spouse Benefit
$, .00

Child(ren) Benefit
$, .00

If your employer or group has elected the critical illness rider, to the best of your knowledge, does anyone on this application have a parent, brother, or sister with a history of heart attack, heart disease, stroke, or cancer diagnosis prior to age 60?

❍ N ❍ Y If yes, please indicate whether this applies to you (employee / individual), your spouse or a dependent.
❍ You (employee / individual) ❍ Spouse ❍ Dependent Name_____

Critical Illness Expense

Office use only Group # Benefit # Class # Div #

❍ Critical Illness ❍ N ❍ Y
❍ Critical Illness and Cancer ❍ N ❍ Y

Coverage type: ❍ Employee / Individual only ❍ Employee / Individual and spouse
❍ Employee / Individual and child(ren) ❍ Family

Optional Benefits: ❍ Automatic Benefit Increase ❍ Health Screening
❍ Return on Premium

Employee / Individual Benefit
$, .00

Does anyone on this application have a parent, brother, or sister with a history of heart attack, heart disease, stroke, or cancer diagnosis prior to age 60? ❍ N ❍ Y If yes, please indicate whether this applies to you (employee / individual), your spouse or a dependent.
❍ You (employee / individual) ❍ Spouse ❍ Dependent Name_____

Last name: First name:

Individual Lump Sum Cancer

Office use only Group # Benefit # Class # Div #

❍ Group Lump Sum Cancer ❍ N ❍ Y **Coverage type:** ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family

Does anyone on this application have a parent, brother, or sister with a history of cancer diagnosis prior to age 60?
❍ **N** ❍ **Y** If yes, please indicate whether this applies to you (employee / individual), your spouse or a dependent.
❍ You (employee / individual) ❍ Spouse ❍ Dependent Name_____

Rider: ❍ Automatic Benefit Increase ❍ Health Screenings

Benefit
$, .00

Cancer Expense

Office use only Group # Benefit # Class # Div #

❍ Cancer Expense ❍ N ❍ Y **Coverage type:** ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family

Base Benefit
$, .00

❍ Lump Sum Benefit (Equal to 50% of Base Benefit Amount) **Rider:** ❍ Hospital Indemnity Base Benefit Rider

Supplemental Health

Office use only Group # Benefit # Class # Div #

❍ Supplemental Health ❍ N ❍ Y **Coverage type:** ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family

Plan type: ❍ 1 ❍ 2 ❍ 3 ❍ 4

Beneficiary Information for Life, Disability and Workplace Voluntary Benefits

Primary beneficiary
Last name First name MI

Relationship to employee / individual

Secondary beneficiary
Last name First name MI

Relationship to employee / individual

Last name: | First name:

Evidence of Health Status - Do not submit more than 90 days prior to the effective date

Complete this section if you are selecting workplace voluntary (excludes Accident, Group Cancer and Group Disability Income) benefits.

1a. In the past 12 months has any applicant used any tobacco product? If yes, applies to: ❍ N ❍ Y

❍ You (employee) ❍ Dependent 1

❍ Dependent 2

❍ Dependent 3

❍ Dependent 4

1b. Is any applicant currently a smoker? If yes, applies to: ❍ N ❍ Y

❍ You (employee) ❍ Dependent 1

❍ Dependent 2

❍ Dependent 3

❍ Dependent 4

2.	In the past 12 months, have you missed 5 or more consecutive days of work due to an injury or illness other than as a result of a cold, the flu, back problems, strained/sprained/fractured/broken limb or as a result of pregnancy?	❍ N ❍ Y
3.	Has anyone on this application been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	❍ N ❍ Y
4.	Within the past 5 years, has anyone on this application been diagnosed by a licensed medical provider with diseases or conditions related to, counseled, consulted, or treated by a physician or licensed medical provider, including surgery, for any of the following:	

a.	Coronary artery disease, chest pain, heart surgery, or any disease of the arteries, or blood conditions; anemia; hemophilia; phlebitis; high blood pressure (reading higher than 140/90)?	❍ N ❍ Y
b.	Nervous, mental or emotional disorder; convulsions; epilepsy; unconsciousness; Multiple Sclerosis; Parkinson's Disease; Cerebral Palsy?	❍ N ❍ Y
c.	Stroke; Transient Ischemic Attack (TIA)?	❍ N ❍ Y
d.	Emphysema; asthma, or other disease of lungs, or respiratory organs?	❍ N ❍ Y
e.	End stage renal disease; disease of kidney?	❍ N ❍ Y
f.	Cancer, and/or cancerous tumor; including skin cancer?	❍ N ❍ Y
g.	Diabetes; liver or thyroid disease; hepatitis; cirrhosis; or enlargement of the lymph nodes?	❍ N ❍ Y
h.	Rheumatoid arthritis; or back conditions; or joint conditions?	❍ N ❍ Y
i.	Paralysis, or any other physical impairment or deformity?	❍ N ❍ Y
j.	Chronic Fatigue Syndrome/Fibromyalgia?	❍ N ❍ Y
k.	Diseases of the eye, ear, nose, or throat? Disease or disorder which has led or may lead to a permanent or progressive loss of vision, hearing or speech?	❍ N ❍ Y
l.	Alcoholism or drug habit?	❍ N ❍ Y

5.	Has anyone on this application been advised by a licensed medical provider to have any diagnostic test, hospitalization, or surgery that has not been completed within the past 5 years?	❍ N ❍ Y

Last name: | First name:

Evidence of Health Status (continued)

	First Name	MI	Height (ft/in)	Weight (lbs)
❍ Employee last name			'	
❍ Dependent 1 last name			'	
❍ Dependent 2 last name			'	
❍ Dependent 3 last name			'	
❍ Dependent 4 last name			'	

Excluding HIV/AIDS/ARC, if you answered "yes" to any of the questions above, please provide details below and specify the question number. Attach additional signed and dated sheets (reorder FL-51340-MH), if necessary.

Question# | Person Treated Last name | First Name

Condition | Treatments recieved

Medications | Scheduled treatments or medications

Date diagnosed (MM/DD/YYYY) / / | Date last seen by a doctor (MM/DD/YYYY) / /

Waiver (refusal of coverage)

I hereby waive coverage for (check all that apply):

Medical for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Dental for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Basic Life for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Voluntary Life for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Vision for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Group Term Life for:	❍ Myself		
Short Term Disability for:	❍ Myself		
Long Term Disability for:	❍ Myself		
Health Savings Account for:	❍ Myself		
Flexible Health Account for:	❍ Myself		
Flexible Dependent Care Account for:	❍ Myself		

Waive Coverage for Workplace Voluntary Benefits:

Whole Life for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Level Term Life for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Critical Illness Expense for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Group Lump Sum Cancer for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Cancer Expense for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Supplemental Health for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Accident for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Disability Income Plus for:	❍ Myself		
Disability Income Advantage for:	❍ Myself		

I decline to apply for group coverage because of:

- ❍ Spousal coverage
- ❍ Medicare supplement
- ❍ Individual coverage
- ❍ Coverage under another carrier's plan provided by my employer / group
- ❍ Other:

_____

Last name:	First name:

True and complete acknowledgement

I understand, agree, and represent:

- I have read the Large Group Employee and Individual Application and Enrollment Form or it has been read to me and answers provided are true and complete to the best of my knowledge and belief.
- Neither my employer / group nor the agent can waive any question, determine coverage or insurability, alter any contract or waive any of Humana's other rights and requirements.
- If the Large Group Employee and Individual Application and Enrollment Form for coverage is accepted, coverage will be effective on the date specified by Humana on the policy or certificate of insurance.
- If I have a new dependent as a result of a qualifying event, I may in the future be able to enroll myself or my dependents provided I request enrollment within 31 days after the qualifying event.
- If I or my dependents become eligible for premium or rate subsidies under Medicaid or the Children's Health Insurance Program (CHIP), I may in the future be able to enroll myself or my dependents provided I request enrollment within 60 days after the qualifying event. I understand eligibility for enrollment does not apply to a High Deductible Health Plan (HDHP).
- In the event that I should decide to apply for coverage hereafter, that subsequent Large Group Employee and Individual Application and Enrollment Form shall be subject to the applicable terms and conditions of the master group contract(s), policy provisions or certificate provisions which may require additional limitations and waiting periods.
- If I am declining coverage for myself or my dependents (including my spouse) because of other coverage, I may in the future be able to enroll myself or my dependents provided that I request enrollment within 31 days after my other coverage ends.
- If I am declining coverage for myself or my dependents (including my spouse) because of coverage under Medicaid or CHIP, I may in the future be able to enroll myself or my dependents provided that I request enrollment within 60 days after my coverage under these programs ends. I understand eligibility for enrollment does not apply to an HDHP.
- If any deductions are required for this coverage, I authorize those deductions from my earnings. If selecting the Health Savings Account (HSA), I authorize Humana or its banking partners to provide my account number to my employer / group for the purposes of depositing any contributions.
- If I am applying for coverage for my dependents (including my spouse) I attest by my signature below, I have gathered the necessary health information from my dependents in order to fully and truthfully complete the Large Group Employee and Individual Application and Enrollment Form.
- If I have selected workplace voluntary benefits, and if coverage is not issued as initially applied for, I hereby authorize Humana to decrease or increase the premium or rate amount stated on the Large Group Employee and Individual Application and Enrollment Form to cover the benefit actually issued.
- An act of fraud or an intentional misrepresentation of a material fact may void or terminate an individual's or group's coverage as specified under the terms of the Policy or Certificate. Providing incomplete, inaccurate, or untimely information may void, reduce, or increase past premium, or terminate an individual's coverage or the group's coverage.
- Rates or premium quoted and the effective date requested are not guaranteed. The final rate or premium and effective date will be determined upon underwriting review and approval of the Large Group Employee and Individual Application and Enrollment Form by Humana.
- Any person who willingly and knowingly submits this Large Group Employee and Individual Application and Enrollment Form containing a false, incomplete, or deceptive statement may be guilty of insurance fraud.

If you decide not to sign this agreement, we will decline to enroll you in an insurance product or to give you insurance benefits.

Authorization

My dependents and I understand and agree:

- The information obtained by use of this authorization may be used by Humana to make claims determinations, determine eligibility for coverage, eligibility for benefits under an existing policy and plan administration.
- Any information obtained will not be released by Humana to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc. or other persons or organizations performing health care operations or business or legal services in connection with this Large Group Employee and Individual Application and Enrollment Form, claim or as may be otherwise lawfully required, or as I (we) may further authorize.

Authorization for Release of Medical Records for Life or Disability

If my dependents or I have selected life or disability, I authorize any third party to have information regarding myself. This includes any medical or non-medical information and to share any and all such information with Humana, its reinsurer or its legal representatives, and its affiliates. Once personal and health (including medical, dental and pharmacy) information is disclosed pursuant to this authorization, the recipient may redisclose it and the information may not be protected by federal and state privacy requirements. This authorization is valid for 24 months and can be revoked at any time. The signature is true and accurate.

The Large Group Employee and Individual Application and Enrollment Form, together with any supplemental forms, will make up part of any contract and be the basis for any policy or certificate.

Last name:	First name:

Signature - Please sign below if enrolling or waiving any group coverage

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Employee / Individual or legal representative signature

Date ☐☐ / ☐☐ / ☐☐☐☐

Name and relationship of legal representative (if a covered dependent) _____

Agent / Producer Information

If applying for workplace voluntary benefits, this section to be completed by Agent or Producer.

1. Agent / Agency of Record:	**2. Agent / Agency of Record:**
Name (print)	Name (print)
Humana Agent #	Humana Agent #
Florida License ID #	Florida License ID #
Commission split:	Commission split:

1. Writing Agent / Producer:	**2. Writing Agent / Producer:**
Name (print)	Name (print)
Humana Agent #	Humana Agent #
Florida License ID #	Florida License ID #
Commission split:	Commission split:

Agent replacement question:

Will the coverage selected replace or change any existing life or disability insurance policy(s) and/or annuity(s)? ❍ N ❍ Y

As the Writing Agent / Producer, I acknowledge that I am responsible to meet with the primary applicant submitting the Large Group Employee and Individual Application and Enrollment Form in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the primary applicant in the benefit summary document or other plan literature.

Signed at _____ County _____ State

Writing Agent's Signature _____ Date __ __/__ __/__ __ __ __

000001050 THE DENTAL CONCERN, INC.
P.O. BOX 14611
LEXINGTON, KY 40512-4611

HUMANA

TEOBMTEOB146W0429201504200000451-MTV

[redacted]

Claim Receipt

Explanation of benefits and claim payments

THIS IS NOT A BILL

Patient

Name: [redacted]
Member ID: [redacted]
Relationship: Employee
Group name: [redacted]
Group ID: [redacted]
Plan Type: DPO
Birth Date: [redacted]

Subscriber

Name: [redacted]
Subscriber ID: [redacted]
Address: [redacted]

Claim Summary

Claim Number: 201504164069138
Provider: [redacted]
Service Date: 3/1/15 - 3/1/15
Processed on: 4/27/15
Benefits Paid to: [redacted]

Plan payment has been issued to your provider.

You may be responsible for paying some or all of the excluded charges to your provider.

	Provider Charges	Paid to Provider	What You Owe
Total Billed	**$200.00**		
Plan Discounts			
Excluded Charges			$109.00
Member Responsibility			
Copay			$0.00
Deductible			$0.00
Coinsurance			$36.40
Plan Paid		$54.60	
Claim Totals	**$200.00**	**$54.60**	**$145.40**

Amount you pay provider

Notes: Please compare these totals with the bill you receive from your provider.

Questions about your plan or this receipt call 1-800-233-4013 or visit WWW.HUMANA.COM

Claim Receipt

HUMANA

Explanation of benefits and claim payments

[redacted] - 011009958 01

Claim Detail

Claim Number: 201504164069138
Provider: [redacted]

Service Date: 03/01/15 - 03/01/15
Date Processed: 04/27/15

Provider	Service Date(s)	Service Code	Total Charge	Plan Discounts	Plan Exclusions	Reason Codes	Allowed Amount	Amount you may owe for claim: Copay	Deductible	Coinsurance	Plan Paid
[redacted]	3/1/15	D2150	200.00	0.00	109.00	45/6NZ	91.00	0.00	0.00	36.40	54.60
		Tooth Number 28									
Out-of-Network Provider											
Claim Totals			200.00	0.00	109.00		91.00	0.00	0.00	36.40	54.60

Reason Code Descriptions:

45/6NZ This service was performed by a non participating provider. You are responsible for any difference between the Maximum Allowable Fee (MAF) and the amount the provider bills you for the services. For additional information please refer to the Schedule of Benefits and Glossary section in your Benefit Plan Document.

Service Code Descriptions:

******All procedure(s) codes are supplied to Humana on the claim form by your provider. Any questions or concerns about these codes should be directed to your provider.******

D2150 (FI) Filling

Numbers to Watch (01/01/2015 to 12/31/2015):	Annual Limit	Amount Used	Amount Remaining
Primary Benefits			
Dental Standard Deductible Individual In Network	$25.00	$25.00	$0.00
Dental Standard Deductible Individual Out of Network	$50.00	$50.00	$0.00
Dental Standard Deductible Family In Network	$75.00	$50.00	$25.00
Dental Standard Deductible Family Out of Network	$150.00	$50.00	$100.00
Secondary Benefits			
Dental Standard Annual Maximum	$1,000.00	$96.80	$903.20
Dental Standard Annual Out of Network Maximum	$1,000.00	$96.80	$903.20

Benefits Unused to Date:	Annual Limit	Amount Used	Amount Remaining
Lifetime Maximum			
Dental Standard Orthodontic Maximum	$1,000.00	$0.00	$1,000.00

Special Messages:

What's my copayment? Is this covered? Has my claim been paid? Look it up anytime on your password-protected, personal home page on www.humana.com.

If you suspect fraud, please contact Humana, Inc., 1100 Employers Blvd., Green Bay, WI 54344 or call the Humana Fraud Hotline Number at 1-800-614-4126.

Your Appeal Rights

If you have a question about your claim, we want to help you find answers. Follow these steps when you need information or want to file an appeal about a claim.

You may request more explanation when your claim is denied or the cost of the service you received was not fully covered: Contact us[1] when you:

- Do not understand the reason for the denial;
- Do not understand why the cost was not fully covered;
- Cannot find the applicable provision in your Benefit Plan Document;
- Want a copy (free of charge) of the guideline, criteria or clinical rationale that we used to make our decision; or
- Disagree with the denial or the amount not covered and want to appeal.

If your claim was denied due to missing information, you or your provider may resubmit the claim with the complete information.[1]

If you are covered by more than one benefit plan, file all claims with each plan.

Appeals: All appeals for claim denials[1] (or any decision that does not cover expenses you believe should have been covered) must be sent to Grievance and Appeal, Humana Specialty Benefits, P.O. Box 14638, Lexington, KY 40512-4638 within 180 days of the date that you receive the denial.[2] We will provide a full and fair review of your claim. You may provide us with additional information that relates to your claim and you may request copies of information that we have that pertains to your claim. We will notify you of our decision in writing within 30 days of receiving your appeal.

External Review: You may have the right to pursue an independent medical review that may be available in your state. For details, please review your Benefit Plan Document or contact us.[1]

Court Review: If your plan is governed by ERISA (your employer can tell you) and you want a court to review our final decision, you may file a civil action under Section 502 (a) of the Employee Retirement Income Security Act (ERISA). Be sure you have exhausted your ERISA appeal rights.

[1] See address and phone number on the enclosed Explanation of Benefits if you have questions on this notice.
[2] Unless your plan or any applicable state law allows you additional time.

HUMANA

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GOOD FAITH EFFORT STATEMENT

Submitted by: Sandra Harper, Supplier Diversity Manager
Phone: 502-580-3077
Email: Sharper1@Humana.com

Humana's Supplier Diversity Program
At Humana, striving for a diverse supplier base makes good business sense. It is a reflection of the nature of our business and of the various customers and business communities we serve. Humana believes our Supplier Diversity Program positively impacts communities locally, regionally, and nationally, through the procurement of quality products and services.

Humana is committed to identifying procurement opportunities and maximizing participation whenever possible with certified Minority-Owned Business Enterprises (MBE), Woman-Owned Business Enterprises (WBE), and Small Business Enterprises (SBE), Lesbian, Gay, Bisexual, Trans-gender (LGBT), and Disabled-Owned Business Enterprises (DOBE) through our Supplier Diversity Program to compete for and do business with Humana.

MBE/WBE Good Faith Participation
Humana Inc. hereby submits this explanation with regard to meeting the City's MBE/WBE utilization requirements:

- Because this contract is in the nature of a services agreement, as opposed to finite project work (i.e., construction), Humana's utilization of suppliers of goods and services will be indirect in nature and primarily driven by the changing needs of Humana's associates and customers. At this time there have been no opportunities identified for subcontracting services in direct support of this contract. Humana has in the past, and will continue efforts to, conducted business with various diverse businesses located throughout the United States and our trust territories for providing goods and services in support of Humana's overall business needs.
- Humana's commitment for meeting required utilization goals with the contract will be based on a percentage of the total administrative cost associated with the contract considered. This would foster the City's policy for ensuring that as many MBE/WBEs as possible are provided maximum opportunity to compete for and win business throughout the life of the contract.

Humana's Good Faith Compliance Commitment
Humana's MBE/WBE commitment for the City is as follows:

- Term = January 1, 2018 through December 31, 2020
- Commitment/Reporting: If opportunities arise to utilize certified diverse firms for performing subcontracting services specific to this contract, Humana will determine a reasonable percentage of the administrative cost of the contract to be used for procuring these services from qualified diverse suppliers.
- Qualifying Suppliers: MBE/WBE suppliers qualifying for compliance utilization will hold certifications recognized by the City.
- Reporting Requirements: Reports detailing diverse utilization would be forwarded to the appropriate contact at frequency determined by the City.

Humana continuously reassesses major commodity spend as well as the overall need for certain goods and services in order to identify utilization opportunities for MBE/WBEs. These efforts include, but are not limited to:

- Identifying and inviting qualified MBE/WBEs to participate in Humana's RFP bidding processes for products and services by sourcing through national, regional, and local certifying agencies as indicated above
- Effectively using the services of available minority, women contractor groups, local minority and women business assistance offices, small business groups, and other organizations on a case-by-case basis to provide assistance in the recruitment and placement of minority/women business
- Providing access for MBE/WBE suppliers to identify themselves and the types of goods and services they provide by self-registration on Humana's website
- Assisting MBE/WBEs in qualifying for Humana's approved supplier lists
- Actively participating with advocacy groups in activities to promote Supplier Diversity and to match qualified MBE/WBEs with the appropriate corporate buyers as needed (i.e., memberships with regional affiliates of the National Minority Supplier Development Council, local/regional trade shows, outreach training seminars, etc.)

If awarded a contract with the City, Humana will make every reasonable good faith effort to give consideration for the utilization of diverse suppliers for providing goods and services, based on our business needs.

City of Fort Lauderdale • Procurement Services Division
100 N. Andrews Avenue, 619 • Fort Lauderdale, Florida 33301
954-828-5933 Fax 954-828-5576
purchase@fortlauderdale.gov

ADDENDUM NO. 1

RFP No. 575-11928
TITLE: Group DHMO and DPPO Dental Plan Benefits

ISSUED: March 24, 2017

This addendum is being issued to make the following change:

1. Section 3.6.4 shall now read:
   Dependent Coverage
   Eligible dependents shall include a covered employee's spouse if not divorced or legally separated or domestic partner and a covered employee's child to the end of the calendar year in which the child reaches age ***twenty six (26)***, if the child meets all of the following:

   (a) The child is dependent upon the employee for support and is not married.
   (b) The child is living in the household of the employee, or the child is a full-time or part time student.

   This definition shall apply to any and all plans offered by The City.

All other terms, conditions, and specifications remain unchanged.

AnnDebra Diaz, CPPB
Senior Procurement Specialist

Company Name: **Humana**
(please print)

Bidder's Signature: _____
Richard D. Remmers, Vice President, Group Segment

Date: **April 7, 2017**

Humana

Performance Guarantee Proposal - Specialty

City of Fort Lauderdale

Customer Service

SubCategory	Definition	Goal	Amount at Risk	Metric Reporting Type
Abandonment Rate	Percent of dental callers that ended the call prior to reaching a dental Customer Care specialist greater than five seconds.	5% or less over five (5) seconds	$555.	Global

Account Management

SubCategory	Definition	Goal	Amount at Risk	Metric Reporting Type
Account Management Responsiveness	Humana's Account Services will respond to correct eligibility issues within 24 hours.	Response within 24 hours	$555.	Client Specific

City of Fort Lauderdale

Account Management

SubCategory	Definition	Goal	Amount at Risk	Metric Reporting Type
Account Management Satisfaction	Humana acknowledges that its Account Management team must be responsive to the needs of our customers if Humana is to earn and sustain their trust. Therefore, Humana will perform annually a brief account management satisfaction survey to be completed by designated members of the client's benefits staff. The survey will address technical knowledge, accessibility, interpersonal skills, communication skills and overall performance. A scale from 1 to 5 will be used to measure performance; where 1 means "very unsatisfied" and 5 means "extremely satisfied". The survey tool will be provided to the client 30 days after the end of the third quarter of the guarantee period. Humana's goal is an overall satisfaction score of 3 or higher with results averaged based on responses to ALL questions. The survey results will be reported in the client's annual report card.	Overall account management satisfaction score of 3 or higher.	$555.	Client Specific

Account Management

SubCategory	Definition	Goal	Amount at Risk	Metric Reporting Type
Account Management Team Responsiveness	Humana's Account Management Team will respond to telephone calls and email messages within 24 hours.	Response within 24 hours	$555.	Client Specific

Claims Processing

SubCategory	Definition	Goal	Amount at Risk	Metric Reporting Type
Cycle Time - 14 Calendar Days	Cycle time is measured from the date a clean dental claim is received to the date it is processed. Clean claims are defined as not requiring any external information from a provider, participant, employer, or any other carrier in order to complete the claims.	90% in 10 business days (14 calendar days)	$555.	Global

Claims Processing

SubCategory	Definition	Goal	Amount at Risk	Metric Reporting Type
Financial Accuracy	The financial accuracy rate is defined as the percentage of dental dollars paid correctly. It is calculated by dividing the total dental claim dollars paid less the absolute value of overpayments and underpayments by the total dental claim dollars paid.	99%	$555.	Global

Implementation

SubCategory	Definition	Goal	Amount at Risk	Metric Reporting Type
ID Card Issuance - Ongoing	Humana will agree that 98% of ID cards (2/1 - 12/1 effective dates) will be mailed within 10 business days of receipt of eligibility files, contingent upon receiving "clean" enrollment data. "Clean" enrollment is defined as needing no additional information from the member or the group.	98%	$555.	Client Specific

Claims Processing

SubCategory	Definition	Goal	Amount at Risk	Metric Reporting Type
Payment Accuracy	Procedural accuracy is defined as the percentage of vision claims processed correctly. It is calculated by dividing the total number of vision claims processed correctly by the total number of audited vision claims. This calculation does not include payment errors, as those are reflected in payment accuracy.	98%	$555.	Global

Customer Service

SubCategory	Definition	Goal	Amount at Risk	Metric Reporting Type
Telephone Response	Percent of dental calls answered within “n” seconds.	70% within 30 seconds	$555.	Global

Humana agrees to meet the performance standards as outlined in providing administrative services for the above mentioned client. This agreement is effective 1/1/2018 to 12/31/2018.

Humana is willing to place a total of $5,000 of the annual base administrative fee and of the Chronic Condition Management fee at risk for failure to meet the stated performance standard. The base administrative fee excludes commissions, medical management, and any additional services purchased by the client, i.e., chronic condition management, HIPAA, COBRA, etc. Performance results will be reported annually and based on results indicated above. Payment of any penalties due to the client will be made based on annual results following the end of the plan year.

With respect to financial and payment accuracy data is obtained through ongoing random audits based on a statistically valid sampling of all claims represented for payment.

During implementation if significant changes to the Client's Plan, or in the event a benefit change notification is not received from the Client on a timely basis, Humana will not be responsible for performance results or penalty amounts as described within this Agreement.

In order for this contract to be binding, signatures are required from both the client and Humana representative. This signed exhibit must be returned to the Performance Guarantee Consultant for tracking purposes no later than 30 days post effective date.

Client Representative Signature/Date

Humana Representative Signature/ Date

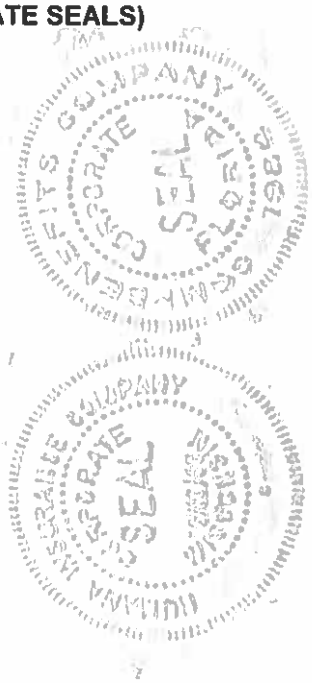
CERTIFICATE

I, **RALPH M. WILSON**, being the duly elected and qualified Vice President of **COMPBENEFITS COMPANY** and **HUMANA INSURANCE COMPANY** (the "Corporations"), do hereby certify that **RICHARD D. REMMERS** was duly elected as Vice President, Group Segment by the Board of Directors of both Corporations on April 21, 2016 as evidenced by the attached board resolutions (Exhibits A & B), and in such capacity is authorized to bind the Corporations in connection with the City of Fort Lauderdale Request for Proposal.

I further certify that the officer named above is in office as of this 7th day of April, 2017.

RALPH M. WILSON
Vice President

(CORPORATE SEALS)



UNANIMOUS CONSENT
OF THE BOARD OF DIRECTORS

The undersigned being all of the members of the Board of Directors of the entities listed on **Exhibit A** (the "Corporation"), do hereby unanimously consent to the adoption of the following resolutions:

RESOLVED, that each of the named persons on **Exhibit B** be, and hereby is, elected to the office of the Corporation set opposite his or her respective name to assume the duties and responsibilities fixed by the By-Laws of the Corporation, and to hold office until (a) the next annual election of the Corporation's officers at the first meeting of the Board of Directors after the 2017 Annual Meeting of Stockholders, or such other date as the Board may determine, or (b) death, resignation, or removal as provided in the By-Laws of the Corporation; and

WHEREAS, the Investment Committee of the Board of Directors of Humana Inc. ("Investment Committee") reviews and approves investment policy guidelines under the Investment Portfolio Guidelines for the subsidiaries of Humana Inc., including certain designated exceptions (the "Guidelines"). The Guidelines have been previously adopted and may be subsequently amended from time to time.

NOW, THEREFORE, BE IT RESOLVED, that the Corporation has reviewed such Guidelines and, based upon its review, and the recommendation of the Investment Committee, the Board of Directors of the Corporation hereby approves and adopts these Guidelines for the Corporation (defined for each subsidiary); and

FURTHER RESOLVED, that such Guidelines shall be in full force and effect until any subsequent procedures have been adopted by the Corporation's Board of Directors; and

FURTHER RESOLVED, that Brian A. Kane, Senior Vice President and Chief Financial Officer, Alan J. Bailey, Vice President and Treasurer, J. Dennis Humble, Director of Treasury Services, W. Mark Preston, Vice President-Investment Management and J. Kevin Horsley, Portfolio Manager. and their successors, are authorized to invest funds under the Guidelines, so long as the investments fall within the permissible range for the Corporation; and

FURTHER RESOLVED, that any two (2) of the individuals listed below ("Authorized Individual") when acting together in writing be and they hereby are authorized to:

Authorized Individual:
Brian A. Kane
Cynthia H. Zipperle
Alan J. Bailey
J. Dennis Humble
W. Mark Preston

- open and/or close bank accounts in the name of Humana Inc. and its subsidiaries (the "Corporation");

- establish, add or delete from a list of persons authorized to sign checks, either manually or by use of a facsimile signature, or otherwise withdraw funds from any such bank accounts via draft, oral order upon receipt of proper identification, wire transfer or other form of electronic transfer;

- open and/or close custodian accounts and to sign Letters of Safekeeping Instructions to banking institutions legally authorized to act as custodians, pursuant to which custodian accounts shall be established, maintained, amended or terminated, in a form and manner and upon such terms as shall be established by them for the proper handling and safekeeping of certain funds and securities of the Corporation; and

FURTHER RESOLVED, that only one signature will be required to:

- sign checks, either manually or by use of a facsimile signature, in the name of the Corporation;

- execute other agreements and other documents with certain banks, whereby such banks will provide various banking cash management services to the Corporation, as may be appropriate and necessary; and

FURTHER RESOLVED, that any bank is authorized to rely upon the foregoing resolution until receipt by it of written notice of any change or revocation thereof;

AND

WHEREAS, if required by a state regulatory agency or other governmental authority, the Audit Committee of the Board of Directors of Humana Inc. ("Audit Committee") reviews for Humana Inc. and its subsidiary entities, including the Corporation, issues identified in the internal control evaluation process.

NOW, THEREFORE, BE IT RESOLVED, that the Corporation hereby ratifies and acknowledges the actions taken by the Audit Committee on behalf of this Corporation concerning internal control issues;

AND

WHEREAS, the Corporation has developed and authorized a Quality Improvement Program whereby certain areas of the Corporation's operations relating to quality management are reviewed on an ongoing basis by the Quality Improvement Committee ("QIC") and reported on a quarterly basis to the Board of Directors.

NOW, THEREFORE, BE IT RESOLVED, that the actions of the QIC are hereby ratified and the Board of Directors authorizes the QIC to act on the Corporation's behalf;

AND

RESOLVED, that the Corporation has previously adopted, or will adopt, the Ethics Every Day guidelines ("Ethics Guidelines") established as part of the Corporate Compliance Program, and hereby ratifies any such adoption and any subsequent amendments thereto; and

FURTHER RESOLVED, that, as set out in the Ethics Guidelines, any potential conflict of interest shall be disclosed to the Humana Inc. Conflict of Interest Review Committee; and

FURTHER RESOLVED, that the Corporation reaffirms the establishment of annual training for all officers, directors and employees of the Corporation;

AND

RESOLVED, that, as applicable, the Corporation hereby ratifies any and all amendments or revisions to its inter-company service agreements required by certain provisions of the National Association of Insurance Commissioners Model Insurance Holding Company System Regulatory Act and cost allocation changes required by legislative actions and regulations;

AND

WHEREAS, the Corporation has established a policy for executing certain contracts and has granted certain individuals the authority to execute such contracts.

NOW, THEREFORE, BE IT RESOLVED, that the Corporation hereby ratifies the Procurement Policy ("Policy") previously established; and

FURTHER RESOLVED, that any of the officers of the Corporation are authorized and directed to take all steps as may be necessary to carry out the intent and purpose of the foregoing resolutions;

AND

FURTHER RESOLVED, that the Corporation hereby ratifies and adopts the form of Tax Allocation Agreement, as may be modified from time to time, in substantially the form as available in the Corporation's records.

[SIGNATURE PAGE FOLLOWS]

Dated this 21st day of April, 2016.

BRUCE D. BROUSSARD

JAMES E. MURRAY

BRIAN A. KANE

EXHIBIT A

ARCADIAN HEALTH PLAN, INC.
CAREPLUS HEALTH PLANS, INC.
CARITEN HEALTH PLAN INC.
COMPBENEFITS COMPANY
DENTICARE, INC.
HUMANA HEALTH PLAN OF CALIFORNIA, INC.
HUMANA HEALTH PLAN OF OHIO, INC.
HUMANA HEALTH PLAN OF TEXAS, INC.
HUMANA INSURANCE COMPANY
HUMANA MEDICAL PLAN, INC.
HUMANA MEDICAL PLAN OF MICHIGAN, INC.
HUMANA MEDICAL PLAN OF PENNSYLVANIA, INC.
HUMANA MEDICAL PLAN OF UTAH, INC.
HUMANA REGIONAL HEALTH PLAN, INC.

EXHIBIT B

COMPBENEFITS COMPANY

Elizabeth D. Bierbower	President
T. Alan Wheatley	President, Retail Segment
Tamara L. Quiram	Segment Vice President and President, Small Business and Large Group
Brian A. Kane	Senior Vice President and Chief Financial Officer
Stephen Arnhold	Vice President
Alan J. Bailey	Vice President and Treasurer
Jonathan A. Canine	Vice President and Appointed Actuary
J. Gregory Catron	Vice President and Chief Compliance Officer
Kenny W. Kan	Vice President and Chief Actuary
Joan O. Lenahan	Vice President and Corporate Secretary
Mark M. Matzke	Vice President, Employer Segment Leader
W. Mark Preston	Vice President – Investment Management
Richard D. Remmers	Vice President, Group Segment
D. Hank Robinson	Vice President – Tax
Ralph M. Wilson	Vice President
Tod J. Zacharias	Vice President
Cynthia H. Zipperle	Vice President and Chief Accounting Officer
Joseph C. Ventura	Vice President and Assistant Corporate Secretary

UNANIMOUS CONSENT
OF THE BOARD OF DIRECTORS

The undersigned being all of the members of the Board of Directors of the entities listed on **Exhibit A** (the "Corporation"), do hereby unanimously consent to the adoption of the following resolutions:

RESOLVED, that each of the named persons on **Exhibit B** be, and hereby is, elected to the office of the Corporation set opposite his or her respective name to assume the duties and responsibilities fixed by the By-Laws of the Corporation, and to hold office until (a) the next annual election of the Corporation's officers at the first meeting of the Board of Directors after the 2017 Annual Meeting of Stockholders, or such other date as the Board may determine, or (b) death, resignation, or removal as provided in the By-Laws of the Corporation; and

WHEREAS, the Investment Committee of the Board of Directors of Humana Inc. ("Investment Committee") reviews and approves investment policy guidelines under the Investment Portfolio Guidelines for the subsidiaries of Humana Inc., including certain designated exceptions (the "Guidelines"). The Guidelines have been previously adopted and may be subsequently amended from time to time.

NOW, THEREFORE, BE IT RESOLVED, that the Corporation has reviewed such Guidelines and, based upon its review, and the recommendation of the Investment Committee, the Board of Directors of the Corporation hereby approves and adopts these Guidelines for the Corporation (defined for each subsidiary); and

FURTHER RESOLVED, that such Guidelines shall be in full force and effect until any subsequent procedures have been adopted by the Corporation's Board of Directors; and

FURTHER RESOLVED, that Brian A. Kane, Senior Vice President and Chief Financial Officer, Alan J. Bailey, Vice President and Treasurer, J. Dennis Humble, Director of Treasury Services, W. Mark Preston, Vice President-Investment Management and J. Kevin Horsley, Portfolio Manager. and their successors, are authorized to invest funds under the Guidelines, so long as the investments fall within the permissible range for the Corporation; and

FURTHER RESOLVED, that any two (2) of the individuals listed below ("Authorized Individual") when acting together in writing be and they hereby are authorized to:

Authorized Individual:
Brian A. Kane
Cynthia H. Zipperle
Alan J. Bailey
J. Dennis Humble
W. Mark Preston

- open and/or close bank accounts in the name of Humana Inc. and its subsidiaries (the "Corporation");
- establish, add or delete from a list of persons authorized to sign checks, either manually or by use of a facsimile signature, or otherwise withdraw funds from any such bank accounts via draft, oral order upon receipt of proper identification, wire transfer or other form of electronic transfer;

- open and/or close custodian accounts and to sign Letters of Safekeeping Instructions to banking institutions legally authorized to act as custodians, pursuant to which custodian accounts shall be established, maintained, amended or terminated, in a form and manner and upon such terms as shall be established by them for the proper handling and safekeeping of certain funds and securities of the Corporation; and

FURTHER RESOLVED, that only one signature will be required to:

- sign checks, either manually or by use of a facsimile signature, in the name of the Corporation;

- execute other agreements and other documents with certain banks, whereby such banks will provide various banking cash management services to the Corporation, as may be appropriate and necessary; and

FURTHER RESOLVED, that any bank is authorized to rely upon the foregoing resolution until receipt by it of written notice of any change or revocation thereof;

AND

WHEREAS, if required by a state regulatory agency or other governmental authority, the Audit Committee of the Board of Directors of Humana Inc. ("Audit Committee") reviews for Humana Inc. and its subsidiary entities, including the Corporation, issues identified in the internal control evaluation process.

NOW, THEREFORE, BE IT RESOLVED, that the Corporation hereby ratifies and acknowledges the actions taken by the Audit Committee on behalf of this Corporation concerning internal control issues;

AND

WHEREAS, the Corporation has developed and authorized a Quality Improvement Program whereby certain areas of the Corporation's operations relating to quality management are reviewed on an ongoing basis by the Quality Improvement Committee ("QIC") and reported on a quarterly basis to the Board of Directors.

NOW, THEREFORE, BE IT RESOLVED, that the actions of the QIC are hereby ratified and the Board of Directors authorizes the QIC to act on the Corporation's behalf;

AND

RESOLVED, that the Corporation has previously adopted, or will adopt, the Ethics Every Day guidelines ("Ethics Guidelines") established as part of the Corporate Compliance Program, and hereby ratifies any such adoption and any subsequent amendments thereto; and

FURTHER RESOLVED, that, as set out in the Ethics Guidelines, any potential conflict of interest shall be disclosed to the Humana Inc. Conflict of Interest Review Committee; and

FURTHER RESOLVED, that the Corporation reaffirms the establishment of annual training for all officers, directors and employees of the Corporation;

AND

RESOLVED, that, as applicable, the Corporation hereby ratifies any and all amendments or revisions to its inter-company service agreements required by certain provisions of the National Association of Insurance Commissioners Model Insurance Holding Company System Regulatory Act and cost allocation changes required by legislative actions and regulations;

AND

WHEREAS, the Corporation has established a policy for executing certain contracts and has granted certain individuals the authority to execute such contracts.

NOW, THEREFORE, BE IT RESOLVED, that the Corporation hereby ratifies the Procurement Policy ("Policy") previously established; and

FURTHER RESOLVED, that any of the officers of the Corporation are authorized and directed to take all steps as may be necessary to carry out the intent and purpose of the foregoing resolutions;

AND

FURTHER RESOLVED, that the Corporation hereby ratifies and adopts the form of Tax Allocation Agreement, as may be modified from time to time, in substantially the form as available in the Corporation's records.

[SIGNATURE PAGE FOLLOWS]

Dated this 21st day of April, 2016.

BRUCE D. BROUSSARD

JAMES E. MURRAY

BRIAN A. KANE

EXHIBIT A

ARCADIAN HEALTH PLAN, INC.
CAREPLUS HEALTH PLANS, INC.
CARITEN HEALTH PLAN INC.
COMPBENEFITS COMPANY
DENTICARE, INC.
HUMANA HEALTH PLAN OF CALIFORNIA, INC.
HUMANA HEALTH PLAN OF OHIO, INC.
HUMANA HEALTH PLAN OF TEXAS, INC.
HUMANA INSURANCE COMPANY
HUMANA MEDICAL PLAN, INC.
HUMANA MEDICAL PLAN OF MICHIGAN, INC.
HUMANA MEDICAL PLAN OF PENNSYLVANIA, INC.
HUMANA MEDICAL PLAN OF UTAH, INC.
HUMANA REGIONAL HEALTH PLAN, INC.

EXHIBIT B

HUMANA INSURANCE COMPANY

Bruce D. Broussard	President and Chief Executive Officer
James E. Murray	Executive Vice President and Chief Operating Officer
Elizabeth D. Bierbower	President, Group Segment
T. Alan Wheatley	President, Retail Segment
Bruno R. Piquin	President, CarePlus and Puerto Rico
Tamara L. Quiram	Segment Vice President and President, Small Business and Large Group
Deborah M. Galloway	Regional President - Senior Products/Central Florida
Brian A. Kane	Senior Vice President and Chief Financial Officer
Brian P. LeClaire	Senior Vice President and Chief Information Officer
Heidi S. Margulis	Senior Vice President
Steven E. McCulley	Senior Vice President, Medicare Operations
Charles W. Dow, Jr.	Regional President-Senior Products/Great Lakes Region
Matthew G. Moore	Regional President – Senior Products/Central North Region
Stephen M. Arnhold	Vice President
Alan J. Bailey	Vice President and Treasurer
John E. Brown	Vice President – Medicare Service Operations
Renee J. Buckingham	Vice President and Division Leader – Eastern Division
Jonathan A. Canine	Vice President and Appointed Actuary
J. Gregory Catron	Vice President and Chief Compliance Officer
Mark S. El-Tawil	Vice President and Division Leader – Western Division
Jeffrey C. Fernandez	Segment Vice President, Medicare: West
William K. Fleming	Vice President
Kenny W. Kan	Vice President and Chief Actuary
Joan O. Lenahan	Vice President and Corporate Secretary
Mark M. Matzke	Vice President, Group Segment Leadership
Kevin R. Meriwether	Vice President and Division Leader – Southeastern Division
W. Mark Preston	Vice President-Investment Management
Richard D. Remmers	Vice President, Group Segment
George Renaudin	Segment Vice President, Medicare: East
D. Hank Robinson	Vice President - Tax
Ralph M. Wilson	Vice President
Tod J. Zacharias	Vice President
Cynthia H. Zipperle	Vice President and Chief Accounting Officer
Joseph C. Ventura	Vice President and Assistant Corporate Secretary

Humana 2020

2016 Progress Report

Humana doesn't just pay for medical care anymore – we're also in the business of health. Hundreds of thousands of people every year welcome us into their lives and let us support them in their well-being journey. Through these individual relationships, we believe we can play a part in improving the health of the communities we serve 20 percent by 2020. That's our Bold Goal.

How can we do this? Well, we can't do it alone. It requires a focused, integrated, long-term health strategy that includes excellent clinical capabilities; partnerships between community, clinical, and government leaders; and encouragement for the people of the communities we serve. Together, we can help people get healthy and stay healthy, all while lowering medical costs.

Healthy Days

At the national level, we're working with the Centers for Disease Control and Prevention (CDC) and using its Healthy Days measure to track improvements. This simple, four-question survey asks people how they feel about their mental and physical health, both of which are integral in assessing their willingness to change.

Since the launch of our goal, we have added significantly to our understanding of what drives Healthy and Unhealthy Days. We've published what we've learned in journals and are presenting our data at medical and population health conferences. We've also co-authored a study with the CDC, the Robert Wood Johnson Foundation, and Columbia University.

Our collective efforts to increase healthy days are paying off. More members are participating in our clinical programs, such as Humana At Home® and Personal Nurse®. We now have 1.1 million engaged members, which has helped more members become adherent to their medications and been instrumental in closing 3.9 million gaps in care.

34%

People with diabetes have 34 percent more Unhealthy Days than average

With knowledge comes power

The United States is facing a big health problem, due in many cases to limited access to healthcare. Three out of every four dollars spent on healthcare goes to chronic conditions – primarily the result of poor choices or limited access to resources that promote health.

We're learning about healthy behaviors that lead to fewer Unhealthy Days, too. These insights help us understand how to best prioritize health programs, partnerships, and community efforts to have a meaningful impact on communities. This strategic and collaborative approach will help us achieve our goal of improving health by 20 percent by 2020.

52

We found that for every five Unhealthy Days, hospital admissions increase by 52 per thousand members

Good Outcomes and Less Expense

In addition to helping physicians, strong partnerships benefit the economy and the local population. When you have a value-based model that supports and rewards physicians for the health of their patients, we can achieve instrumental change and lower healthcare costs.

Over the past year, our associates have also strengthened their commitment to health and well-being – both for personal and community purposes. They've rallied behind the idea that achieving their best health isn't accomplished by just eating healthier foods and exercising more; it's about embracing their whole self and acknowledging what it takes to be their best.




The Communities We Serve

SAN ANTONIO

San Antonio was the first community we approached, holding Clinical Town Halls, forming a Health Advisory Board with community stakeholders, and building partnerships with groups such as the grocery retailer, H-E-B, and the San Antonio Food Bank.

We've also taken a number of other steps to help improve health in San Antonio:

- We're working with Schertz Emergency Medical Services to reduce emergency calls and provide higher quality care
- We've initiated pilots with innovative diabetes-focused companies and launched our own app, complete with diabetes tracker tools, called MyHealth
- Through a partnership with H-E-B, we're helping shoppers make good food choices by offering Points through our Go365™ wellness program

LOUISVILLE

Humana has been in Louisville for over five decades and currently has a large number of associates and members here. These associates volunteer their time and energy in developing new initiatives, such as testing several new diabetes programs and increasing statin therapy in our population with diabetes by 15 percent. Some of our objectives in Louisville include:

- Addressing behavioral health, diabetes, and respiratory conditions (asthma, allergies, COPD, and smoking)
- Making Louisville a test market for at least four pilot programs tied to health barriers
- Creating a Louisville Health Advisory Board with community leaders and organizations to implement strategies to improve health

TAMPA BAY

Tampa Bay is adjusting to a changing population – one that's expanding, aging rapidly, and becoming more diverse. As one of Tampa Bay's leading healthcare companies, Humana's working with community leaders to take an innovative and collaborative approach to healthy living, specifically targeting diabetes, behavioral health, obesity, and barriers preventing families from obtaining healthy food.

Humana hosted a Clinical Town Hall in 2015 that brought together leaders from nearly 70 organizations. We formed a Health Advisory Board that works with more than 100 Bay area leaders to help make healthy living easier in Tampa Bay, including a host of local nonprofit organizations, healthcare providers, and community groups.

NATCHEZ

Natchez and Adams County, Mississippi were experiencing abnormally large health challenges, including high rates of obesity and obesity-induced conditions, including Type 2 diabetes, heart disease, and poor birth outcomes.

Humana teamed up with the Clinton Health Matters Initiative (CHMI) to improve health. Together, we created a five-year plan that focuses on physical activity, healthy eating, food quality, and improving the education and quality of care. Additionally, the Humana Foundation awarded a one-year, $250,000 grant for the Adams County Diabetes and Heart Disease Intervention Program.

The Journey Continues

Humana has made progress on our Bold Goal, but we still have a long way to go. We've been humbled by our experiences, and we're even more enthusiastic with how much we have learned and continue to learn. We're eager to share details on our next four communities of focus:

- **New Orleans, Louisiana**
- **Baton Rouge, Louisiana**
- **Knoxville, Louisiana**
- **Broward County, Florida**

+ Become a partner now. Find out how at **Humana.com/boldgoal**

EXECUTIVE SUMMARY

Creating Long-Term Oral Health

Over the past five years, the City and Humana have worked together to provide the dental benefits, network strength, and resources to improve your employees' oral health.

While other dental plans offer competitive rates, few offer long-term strategies to help members improve or maintain oral health. The money members save in premiums typically offsets through shallow network discounts or limited benefits, giving the illusion of savings and value.

Tooth decay is the most prevalent chronic disease, even though it is largely preventable. In 2011-2012, untreated tooth decay affected:[1]
- 17.5% of children 5-19
- 27.4% of adults 20-44
- 25.8% of adults 45-64
- 18.9% of seniors 65 and older

Unknowingly, many people still cannot afford the dental care they need. They put off treatment or often forgo it altogether until it's too late and their problem has worsened. The decision to put off preventable oral care is impacting people's overall health. Poor oral health has been linked to systemic health issues, including diabetes, heart disease, and strokes.[3, 4]

In 2014, 12.6% of adults 18-64 claimed to have not received needed dental care within the previous 12 months due to cost.[2]

Reliable dental plans offer benefits, network discounts, and educational resources to ensure people have the ability to take care of their oral health as soon as possible. By educating members on the importance of oral health, offering wide network access to quality dentists, and emphasizing prevention and early diagnosis, Humana's dental plans consider the full impact of oral health. By improving oral health, Humana will continue to save the City money in the long-term by helping your employees and their families live longer, healthier lives.

Periodontitis often does not carry any symptoms until it becomes advanced.[3]

Expect More from Humana Dental

When it comes to dental benefits, our goal is to make sure the City's employees want to utilize their benefits. We have tailored our dental plans to the City's needs, including options for customizing copayments, deductibles, and out-of-pocket maximums. Additionally, our wide network coverage includes significant discounts to continue to ensure your employees and their families receive high quality dental care without overpaying. The dental renewal solution we have specifically selected for the City includes:

- **Dental HMO/Prepaid**: Our dental HMO plans are best suited for members seeking the lowest combination of premiums and out-of-pocket expenses to ensure cost isn't an obstacle. By selecting a primary care dentist from our large dental HMO network—with over 46,000 dentist locations in specific markets—the selected dentist can serve as the member's central advocate for all dental care, providing referrals when necessary.
- **Dental Traditional Preferred (TRP)**: These plans, also known as Passive PPOs, offer members the freedom to visit any dentist they wish while still receiving maximum benefits. Our dental TRP plans utilize Humana's PPO dental networks—one of the largest in the nation with over 280,000 dentist locations. Members who see dentists participating in Humana's dental PPO network receive the greatest cost savings (up to 30 percent on out-of-pocket costs).

My Dental IQ℠

Early detection of chronic oral infections can help prevent other chronic diseases. Through Humana's exclusive and personalized My Dental IQ oral health assessment, members can better detect these issues with a quick, easy, and free online oral health assessment. Additionally, it can help explain the relationship between oral health and overall health, and provide actionable results and insights. Members also have the option of printing their individual feedback to discuss with their dentist.

Account Management

Upon renewal, Julie Thorpe will continue to serve as your client experience manager (CEM) and primary contact, providing support and guidance. Your assigned Account Management team will also continue to collaborate with the City's benefit administrators to promote and evolve your communication strategy, as necessary, to make sure it resonates with your employees.

Margaret Toffoli will continue to serve as your health solutions client executive (HSCE) and primary contact, providing support and guidance, as well as developing engagement strategies with the City. In addition to Margaret, a local consumer experience consultant will continue to oversee enrollment, education, engagement, and activation duties. Together, these two work with Humana's market vice president to coordinate activities and deliver services between the City, your broker, and Humana.

Comprehensive Reporting

To continue tracking your employees' utilization of their benefits, Humana's wide variety of dental reports track claims, membership, eligibility, and more to help the City understand how your employee population is utilizing their dental benefits. You will also continue to receive Humana's dental PPO PlanCompass reporting package to help you make the most informed decisions about your members' dental health, well-being, and use of the healthcare system.

The Perfect Experience

Customer service is an integral part of Humana's consumer engagement efforts. From our operational procedures to the recruitment and training of our Customer Care specialists, we are organized around a client-focused approach. As a consumer-centric company, we strive for proactive, personalized service through a key metric we brand internally as the Perfect Experience. This multifaceted approach to customer service encompasses:

- A focus on human capital, which begins with selecting the best talent and preparing and engaging those associates through extensive service orientation, practice, and ongoing training
- A commitment to developing a strong "outside in" perspective of every customer interaction, as well as the processes underlying those interactions
- A comprehensive call quality program that utilizes multiple methodologies to evaluate both associate performance and member satisfaction
- Direct feedback provided to all associates on the quality of their performance and the member's reception (via outbound surveys to customers), and establishing opportunities for improvement

MyHumana

Every Humana member can access their own personalized home page on **Humana.com**. Through the MyHumana portal, members can get information about their plans, coverage, claims, and wellness information. Compatible with all computers, mobile devices, and tablets, the site features:

- Administrative functions

- Benefits management functions
- Financial functions and decision tools
- Health and wellness resources

Mobile Capabilities

Through text, a phone's mobile browser, or Humana's mobile app, members can manage their dental plan needs virtually anywhere, anytime. The MyHumana mobile app leverages features in delivering on-the-go resources such as the ability to:

- View claims, coverage, benefits, and ID cards
- Search for in-network providers
- Send secure messages to Humana's Customer Care team

Working to Improve Tomorrow's Smiles

Ideal dental plans are built to be dynamic and forward-focused. Humana gives the City the tools you need to get your employees thinking about their oral health today and its impact on their future. By keeping up with changes in dentistry and technology, our benefit solutions are built to engage your population in their oral health so they live longer, healthier lives.

1. National Center for Health Statistics. "Health, United States, 2015: With Special Feature on Racial and Ethnic Health Disparities," U.S. Department of Health and Human Services, CDC, May 2016
2. "Gingivitis and periodontitis: Overview," U.S. National Library of Medicine, June 2014
3. Demmer RT, Desvarieux M. "Periodontal infections and cardiovascular disease: The heart of the matter," *Journal of the American Dental Association*, October 2006
4. Mealey BL. "Periodontal disease and diabetes: A two-way street." *Journal of the American Dental Association,* October 2006

EXPERIENCE AND QUALIFICATIONS

Indicate the firm's number of years of experience in providing the professional services as it relates the work contemplated.

Founded in 1961 by David Jones and Wendell Cherry, Humana started as a nursing home business, and later moved into the hospital business. By 1980, Humana had grown into the world's largest investor-owned hospital company. In 1983, we entered the medical insurance business and launched a health maintenance organization (HMO) designed to help employers control premium costs while at the same time providing better patient care coordination. We became one of the nation's largest hospital companies and one of the first healthcare companies to operate both hospitals and health benefits plans effectively.

Today, we are a leader in member engagement, providing guidance that leads to lower costs and a better health plan experience throughout our diversified customer portfolio, with fully insured and Administrative Services Only (ASO) dental plans through our Prepaid/DHMO, PPO, Traditional, Advantage Plus products.

We have been providing our group dental PPO plans for approximately 23 years since Humana's dental PPO network became operational in 1994. We have been providing our group DHMO plans for approximately 39 years since Humana's DHMO network became operational in 1978.

Provide details of past projects for agencies of similar size and scope.

Humana has numerous years of experience working with companies and public entities similar to the City. Our current clients of similar size in Florida are as follows:

- City of Miami Gardens
- Broward Sheriff Office
- City of Lauderhill
- School Board of Broward County
- State of Florida
- City of Cape Coral
- US Federal Employees
- Broward County
- City of Plantation

Please refer to Section 13 for our references, which includes past projects.

Indicate business structure, IE: Corp., Partnership, LLC.

Humana Inc. is a leading healthcare corporation that offers a wide range of health and wellness products and services that incorporate an integrated, holistic approach to lifelong well-being for employer groups, government programs, and individuals.

Firm should be registered as a legal entity in the State of Florida;

We are registered as a legal entity in the state of Florida.

Minority or Woman owned Business (if applicable);

Not applicable as Humana is not considered a minority or woman-owned business.

Company address, phone number, fax number, E-Mail address, web site, contact person(s), etc.

Humana's headquarters are located at 500 West Main Street, Louisville, Kentucky 40202.

Margaret Toffoli, the assigned health solutions client executive (HSCE) for the City, can be reached by telephone at 305-626-5546 or by email at mtoffoli@humana.com. Her office is located at 3401 South West 160th Avenue, Miramar, Florida 33027. Humana's website is located at **Humana.com**.

Relative size of the firm, including management, technical and support staff;

We are a Fortune 100 company and one of the nation's largest publicly traded employee benefits companies. As of December 31, 2016, Humana reported total assets of $25.4 billion and total revenues of $54.3 billion in 2016. We provide medical benefits to approximately 14.2 million members as well as specialty benefits to over 6.9 million members in dental, vision, life, disability, and workplace voluntary benefits plans. Humana currently has over 48,000 employees, which includes management, technical and support staff.

licenses and any other pertinent information shall be submitted.

Please refer to Attachment A for a copy of our Florida State License.

To simplify the approach to managing your plans, in addition to Margaret, we have also assigned the City a client experience manager (CEM), Julie Thorpe, who is currently your single point of contact. Our relationship-based model streamlines all of your Humana products to your benefits administrators, designated HR representatives, and agents, brokers, or consultants through one Humana associate.

Julie works directly with the City to ensure a smooth, seamless renewal and engage internal contacts across Humana to facilitate resolutions for all other issues as necessary. This simplifies the service experience by creating a trusted advocate to help the City by:

- Providing a dedicated contact who works with the City and builds a long-term relationship with your key personnel
- Demonstrating a commitment to excellence in service support through Humana's Perfect Experience service culture
- Responding quicker through a direct contact number for the City
- Resolving issues promptly (generally within two business days) as well as providing thorough feedback
- Answering any and all questions about our industry, no matter how small or complicated the question

Julie is available to assist the City through the renewal and enrollment to ensure any issues are addressed in a timely manner. Please note that individual member and provider inquiries will continue to be addressed through the Customer Care department.

APPROACH TO SCOPE OF WORK

Provide in concise narrative form, your understanding of the City's needs, goals and objectives as they relate to the project, and your overall approach to accomplishing the project. Give an overview on your proposed vision, ideas and methodology. Describe your proposed approach to the project. As part of the project approach, the proposer shall propose a scheduling methodology (time line) for effectively managing and executing the work in the optimum time. Also provide information on your firm's current workload and how this project will fit into your workload. Describe available facilities, technological capabilities and other available resources you offer for the project.

Additionally, the proposal should specifically address the following items. Each should be presented in the requested order, separated by tabs and listed in the table of contents.

Humana stands out from the competition because we believe proper oral health is an important component to overall health. We take a preventive approach to oral health through early detection and education, and offer a range of cost-effective dental plans for the City to tailor to your population, including options for customizing copayments, deductibles, and out-of-pocket maximums.

As a Fortune 100 company, we offer a wide range of health and wellness products and services that promote lifelong well-being for employer groups, government programs, and individuals. We provide specialty benefits to over 6.9 million members through dental, vision, life, disability, and workplace voluntary benefits plans. Some of the differentiators Humana has to offer include:

- **Network:** Our goal is to make sure people can get to the dentists and specialists they need. At Humana, we're constantly growing our networks, branching out into areas where our members need us. We can also work directly with the City to identify areas where your employees and their families need better access, and focus our outreach efforts to make sure our network works for you.
  - Our PPO and DHMO networks have been developed to create significant savings that are passed onto the City and your employees. With excellent nationwide access and attractive fee schedules, we provide employees with the maximum discounts.
  - All our contracted providers are required to meet exceptional quality of care and service levels to remain highly efficient and keep administration costs down.
- **Quality Care**: Our Quality Improvement Program evaluates, monitors, and facilitates improvement in the quality of care delivered to members. We also developed provider profiling applications that aid in monitoring the networks. Our processes utilize a proprietary dental practice pattern review model that analyzes approximately 40 clinical ratios to monitor utilization and practice patterns. We compare utilization at the market, state, and national level, and these reviews help improve both patient outcome and costs.
- **Education and Outreach:** We believe that educational tools play a vital role in the prevention of high-dollar claims. We educate members about the risks associated with periodontal disease and heart disease, diabetes, and other health issues through:
  - **eNewsletters**: Monthly issues educate dental members about their benefits and provides useful wellness content, including short articles on a variety of dental health topics.
  - **Lifestyle Discounts and MyHumana Savings Center**: We offer an array of value-added services and discount programs to provide affordability and access to care.

  - **Smart EOB®**: Our Smart EOB messaging allows us to look at claims and message members regarding the type of care they should receive, the frequency, and other wellness activities they can undertake to improve their oral health.
  - **Stay Smart Stay Healthy videos**: These quick and informative videos can help people select a plan, better understand healthcare costs, or plan for the unexpected.
  - **My Dental IQ:** Our free, online My Dental IQ oral health assessment encourages prevention and early detection, and can help explain the relationship between oral health and overall health. This tool provides actionable results and insights, and it allows members to print their individual feedback to discuss with their dentist.
- **Comprehensive Reporting:** Our Integrated Performance Analytics team developed our Dental PlanCompass standard report, focused on benefit utilization, including a utilization overview, breakouts by utilization category, and information around claim spend. PlanCompass goes beyond standard reporting functions to help employers make the most informed decisions possible. Our PlanCompass reporting package is prepared specifically for each client to help benefit administrators stay on top of their dental plan experience. Additionally, it is automated, includes dynamic insights, and has been redesigned to be more intuitive from a high-level, making it easier to derive trends and strategies.
- **Integration**: Humana's products are integrated to create the most seamless member experience possible.

Julie Thorpe will continue to serve as your CEM and primary contact, providing support and guidance. Your assigned Account Management team will also continue to collaborate with the City's benefit administrators to promote and evolve your communication strategy, as necessary, to make sure it resonates with your employees.

Although an implementation is not required, please refer to Attachment B for a copy of our implementation timeline.

BENEFIT PLANS

Proposers must provide complete benefit descriptions of the plans being proposed, including the proposed DHMO schedule with CDT codes and brief explanation of service. These descriptions must include all exclusions and limitations. In addition, an Excel file is attached, DHMO copays.xlsx, which lists dental procedures. Please fill in the DHMO copay for each procedure for the plan or plans you are proposing. You must indicate which procedures are not covered. If your plan covers procedures that are not listed, please add them to the file and highlight your entry. Provide this in Excel format on a Flash Drive.

Please review current benefit specifications. If your proposed plans do not meet these specifications, please include a description of all deviations in this tab.

Humana agrees that it can administer benefits substantially similar to those described in the City of Fort Lauderdale's contract summary submission.

Please refer to our attached Excel file with the complete DHMO copay schedule.

We have also provided a list of our benefit limitations and exclusions.

DHMO:
Limitations and Exclusions
Humana does not provide coverage for the following services:

- No service of any dentist other than a participating general dentist or participating specialist is covered, except out-of-area emergency care as provided in the Certificate
- Any procedures not specifically listed as covered benefits in the schedule of benefits
- Whenever any contributions or copayments are delinquent, members are not entitled to receive benefits, transfer dental facilities, or receive any other privileges of a member in good standing
- Any dental treatment started prior to the effective date for eligibility of benefits
  - This does not apply to orthodontic treatment in progress that was covered under the contract holder's prior plan
  - To be covered under this plan, orthodontic treatment must be shown on the schedule of benefits, and you must have the subsequent treatment provided by a participating provider
- Services that the participating general dentist, participating specialist, or Humana do not deem are necessary treatments to establish and/or maintain the member's oral health
- 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
- Any services that are not consistent with the normal and/or usual services provided by the participating general dentist or participating specialist or that the participating general dentist or participating specialist believe endangers the health of the member
- Any service or procedure that the participating general dentist or participating specialist is unable to perform because of the general health or physical limitations of the member
- 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

- Services performed primarily for cosmetic purposes, unless otherwise listed as covered cosmetic services on the schedule of benefits
- Services provided by a participating pediatric dentist are limited to children up to 7 years old
- 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
- Frequency and/or age limitations may apply; please refer to the schedule of benefits and copayments for details
- Workers' Compensation:
  - If we pay benefits, but determine that 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 the member.
  - The recovery rights will be applied even though:
    - The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise
    - No final determination is made that bodily injury or sickness was sustained in the course of, or resulted from, the member's employment
    - The amount of Workers' Compensation due to medical or healthcare is not agreed upon or defined by the member or the Workers' Compensation carrier
    - Medical or healthcare benefits are specifically excluded from the Workers' Compensation settlement or compromise
  - The member agrees that, in consideration for the coverage provided by the contract, we will be notified of any Workers' Compensation claim that members make, and the member agrees to reimburse Humana as described above
- Crowns, inlays, onlays, or veneers for the purpose of:
  - Altering vertical dimension of teeth
  - Restoration or maintenance of occlusion
  - Splinting teeth, including multiple abutments
  - Replacing tooth structure lost as a result of wear (abrasion, attrition, erosion, or abfraction)

Dental PPO:
Limitations and Exclusions (all services)
In addition to the limitations and exclusions listed in the plan benefits section, the policy does not provide benefits for the following:

- Any expenses incurred while the member qualifies for any Workers' Compensation or occupational disease act or law, whether or not the member applied for coverage
- Services:
  - That are free or that the member would not be required to pay for if the member did not have insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law
  - Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid)
  - Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury
- Any loss caused or contributed by:

  - War or any act of war, whether declared or not
  - Any act of international armed conflict
  - Any conflict involving armed forces of any international authority
- Any expense arising from the completion of forms
- The member's failure to keep an appointment with the dentist
- Any service we consider cosmetic unless it is necessary as a result of an accidental injury sustained while covered under this policy; we consider the following cosmetic procedures to include but are not limited to:
  - Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid
  - Any service to correct congenital malformation
  - Any service performed primarily to improve appearance
  - Characterizations and personalization of prosthetic devices
  - Any procedure to change the spacing and/or shape of the teeth
- Charges for:
  - Any type of implant and all related services, including crowns or the prosthetic device attached to it
  - Precision or semi-precision attachments
  - Overdentures and any endodontic treatment associated with overdentures
  - Other customized attachments
  - Any service for 3D imaging (cone beam images)
  - Temporary and interim dental services
  - Additional charges related to material or equipment used in the delivery of dental care
  - Charges rendered for treatment in a clinical or dental facility sponsored or maintained by the employer
  - The removal of any implants unless specified in the Summary of Your Benefits section of the member's Certificate
- Any service related to:
  - Altering vertical dimension of teeth
  - Restoration or maintenance of occlusion
  - Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth
  - Replacing tooth structures lost as a result of abrasion, attrition, erosion, or abfraction
  - Bite registration or bite analysis
- Infection control, including, but not limited to sterilization techniques
- Fees for treatment performed by someone other than a dentist except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist:
  - The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards
- Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist
- Prescription drugs or pre-medications, whether dispensed or prescribed
- Any service not specifically listed in the member's plan benefits
- Any service that we determine:
  - Is not eligible for benefits based upon clinical review
  - Does not offer a favorable prognosis
  - Does not have uniform professional acceptance, or
  - Is deemed to be experimental or investigational in nature

- Orthodontic services unless specified in the member's summary of benefits. Only the services specified in the orthodontic rider are covered orthodontic benefits under the plan
- Any expense incurred before the member's effective date or after the date coverage under this policy terminates (unless the service is eligible under extension of benefits)
- Services provided by someone who ordinarily lives in the member's home or who is a family member
- Charges exceeding the reimbursement limit for the service
- Treatment resulting from any intentionally self-inflicted injury or bodily illness
- Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, temporary dental services, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate service; these services are considered an integral part of the entire dental service
- Temporary dental services
- Repair and replacement of orthodontic appliances
- Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder, or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
- The oral surgery benefits under this plan do not include:
  - Any services for orthognathic surgery
  - Any services for destruction of lesions by any method
  - Any services for tooth transplantation
  - Any services for removal of a foreign body from the oral tissue or bone
  - Any services for reconstruction of surgical, traumatic, or congenital defects of the facial bones
  - Any separate fees for pre and post-operative care
- General anesthesia or conscious sedation is not a covered service unless it is based on clinical review of documentation provided and administered by a dentist or healthcare practitioner in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for covered services
- General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered:
  - Pain control unless a documented allergy to local anesthetic is provided
  - Anxiety
  - Fear of pain
  - Pain management
  - Emotional inability to undergo surgery
- Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning
- Replacement of any lost, stolen, damaged, misplaced, or duplicate major restoration, prosthesis, or appliance
- Any caries (decay) susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing, or charges for oral pathology procedures
- Separate fees for pre- and post-operative care and re-evaluation within 12 months are not considered covered services under the surgical periodontic services in this plan
- We do not cover services that generally are considered to be medical services except those specifically noted as covered in the member's Certificate

Excess coverage

We do not pay benefits for any accidental injury if other insurance provides payments or expense coverage, regardless of whether the other coverage is described as primary, excess, or contingent. If the member's claim against another insurer is denied or partially paid, we process the member's claim according to the terms and conditions of the Certificate. If we make a payment, the member agrees to assign us any right the member has against the other insurer for dental expenses we pay. Payments made by the other insurer are credited toward any applicable coinsurance or deductibles for the year.

CDT Code	Benefit	*CS150(City of Lakeland)*	*HS195(City of Fort Lauderdale)*
	Specialist Services	Not applicable	Copayment amounts are applicable when treatment is performed by participating specialists.
	Are charges for noble & high noble metal included in listed copays?	Not applicable	There is an additional charge for metal; not to exceed $200.
	Are lab charges included in listed copays?	Not applicable	Services also require separate payment of laboratory charges. The laboratory charges must be paid to the plan dentist in addition to any applicable copayment for the service.
	Charge for cases involving more than 6 crowns, implants and/or fixed bridge units	Not applicable	When crown and/or bridgework exceeds six units in the same treatment plan, the patient may be charged an additional $75 per unit.
	Office Visit Copay in addition to copay for specific service	Not applicable	No additional Office Visit
Diagnostic			
Clinical Oral Evaluations			
D0120	Periodic Oral Evaluation	$0	$0
D0140	Limited Oral Evaluation	$0	$0
D0145	Oral Evaluation for a Patient Under 3 Years of Age	Not Covered	$0
D0150	Comprehensive Oral Evaluation	$0	$0
D0160	Detailed and Extensive Oral Evaluation	$0	$0
D0170	Re-evaluation - Limited, Problem Focused	Not Covered	$0
D0180	Comprehensive Periodontal Evaluation	$10	$0
Pre-diagnostic Services			
D0190	Screening of a patient	Not Covered	Not Covered
D0191	Assessment of a patient	Not Covered	Not Covered
Radiographs/Diagnostic Imaging (Including Interpretation)			
D0210	Intraoral - Complete Series (Including Bitewings)	$0	$0
D0220	Intraoral - Periapical, First Film	$0	$0
D0230	Intraoral - Periapical, Each Additional Film	$0	$0
D0240	Intraoral - Occlusal Film	Not Covered	$0
D0250	Extraoral - First Film	Not Covered	$0
D0260	Extraoral - Each Additional Film	Not Covered	$0
D0270	Bitewing - Single Film	$0	$0
D0272	Bitewings - Two Films	$0	$0
D0273	Bitewings - Three Films	Not Covered	$0
D0274	Bitewings - Four Films	$0	$0
D0277	Vertical Bitewings - 7 to 8 Films	Not Covered	$0
D0290	Posterior-Anterior or Lateral Skull and Facial Bone Survey Film	Not Covered	Not Covered
D0310	Sialography	Not Covered	Not Covered
D0320	Temporomandibular Joint Arthrogram	Not Covered	Not Covered
D0321	Other Temporomandibular Joint Films, By Report	Not Covered	Not Covered
D0322	Tomographic Survey	Not Covered	Not Covered
D0330	Panoramic Film	$0	$0
D0340	Cephalometric Film	Not Covered	Not Covered
D0350	Oral/Facial Photographic Images	Not Covered	$0
D0360	Cone Beam CT	Not Covered	Not Covered
D0362	Cone Beam - Two-Dimensional Image Reconstruction	Not Covered	Not Covered
D0363	Cone Beam - Three-Dimensional Image Reconstruction	Not Covered	Not Covered
D0364	Cone Beam CT capture and interpretation with limited field of view	Not Covered	Not Covered
D0365	Cone Beam CT capture and interpretation with field of view of one full dental arch-mandible	Not Covered	Not Covered
D0366	Cone Beam CT capture and interpretation with field of view of one full dental arch-maxilla, with or without cranium	Not Covered	Not Covered
D0367	Cone Beam CT capture and interpretation with field of view of both jaws with or withour cranium	Not Covered	Not Covered
D0368	Cone Beam CT capture and interpretation for TMJ series	Not Covered	Not Covered
D0369	Maxillofacial MRI capture and interpretation	Not Covered	Not Covered
D0370	Maxillofacial ultrasound capture and interpretation	Not Covered	Not Covered
D0371	Sialoendoscopy capture and interpretation	Not Covered	Not Covered
Image Capture Only			
D0380	Cone Beam CT image capture with limited field of view-less than one whole jaw	Not Covered	Not Covered
D0381	Cone Beam CT image capture with field of view of one full dental arch-mandible	Not Covered	Not Covered
D0382	Cone Beam CT image capture with field of view of one full dental arch-maxilla, with or without cranium	Not Covered	Not Covered
D0384	Cone Beam image capture for TMJ series including two or more exposures	Not Covered	Not Covered
D0385	Maxillofacial MRI image capture	Not Covered	Not Covered
D0386	Maxillofacial ultrasound image capture	Not Covered	Not Covered
Image Capture Only			
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	Not Covered	Not Covered
Tests and Examinations			
D0415	Collection of Microorganisms for Culture and Sensitivity	Not Covered	$0
D0416	Viral Culture	Not Covered	Not Covered

D0417	Collection and Preparation of Saliva Sample for Laboratory Diagnostic Testing	Not Covered	Not Covered
D0418	Analysis of Saliva Sample	Not Covered	Not Covered
D0421	Genetic Test for Susceptibility to Oral Diseases	Not Covered	Not Covered
D0425	Caries Susceptibility Tests	Not Covered	$0
D0431	Adjunctive Pre-diagnostic Test, Not to Include Cytology or Biopsy Procedures	Not Covered	$50
D0460	Pulp Vitality Tests	$0	$0
D0470	Diagnostic Casts	$0	$0
Oral Pathology Laboratory			
D0472	Accession of Tissue, Gross Examination, Preparation and Transmission of Written Report	Not Covered	$0
D0473	Accession of Tissue, Gross and Microscopic Examination, Preparation and Transmission of Written Report	Not Covered	$0
D0474	Accession of Tissue, Gross and Microscopic Examination, Including Assessment of Surgical margins for presence of Disease, Preparation and Transmission of Written Report	Not Covered	$0
D0480	Accession of Exfoliative Cytologic Smears, Microscopic Examination, Preparation and Transmission of Written Report	Not Covered	Not Covered
D0486	Accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report	Not Covered	Not Covered
D0475	Decalcification Procedure	Not Covered	Not Covered
D0476	Special Stains for Microorganisms	Not Covered	Not Covered
D0477	Special Stains, not for Microorganisms	Not Covered	Not Covered
D0478	Immunohistochemical Stains	Not Covered	Not Covered
D0479	Tissue In-Situ Hybridization, Including Interpretation	Not Covered	Not Covered
D0481	Electron Microscopy - Diagnostic	Not Covered	Not Covered
D0482	Direct Immunofluorescence	Not Covered	Not Covered
D0483	Indirect Immunofluorescence	Not Covered	Not Covered
D0484	Consultation on Slides Prepared Elsewhere	Not Covered	Not Covered
D0485	Consultation, Including Preparation of Slides From Biopsy Material Supplied By Referring Source	Not Covered	Not Covered
D0502	Other Oral Pathology Procedures, By Report	Not Covered	Not Covered
D0999	Unspecified Diagnostic Procedure, By Report	Not Covered	Not Covered
Preventive			
Dental Prophylaxis			
D1110	Prophylaxis - Adult	$0	$0
	(Additional Cleaning, In Addition to the One Allowed Every 6 Months)	Not Covered	
D1120	Prophylaxis - Child	$0	$0
	(Additional Cleaning, In Addition to the One Allowed Every 6 Months)	Not Covered	
Topical Fluoride Treatment (Office Procedure)			
D1203	Topical Application of Fluoride - Child	$0	$0
D1204	Topical Application of Fluoride - Adult	Not Covered	$0
D1206	Topical Fluoride Varnish; Therapeutic Application for Moderate to High Caries Risk Patients	$0	$0
D1208	Topical application of fluoride	Not Covered	Not Covered
Other Preventive Services			
D1310	Nutritional Counseling for Control of Dental Disease	Not Covered	$0
D1320	Tobacco Counseling for the Control and Prevention of Oral Disease	Not Covered	$0
D1330	Oral Hygiene Instructions	$0	$0
D1351	Sealant - Per Tooth	$10	$0
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	Not Covered	Not Covered
Space Maintenance (Passive Appliances)			
D1510	Space Maintainer - Fixed - Unilateral	$45	$25
D1515	Space Maintainer - Fixed - Bilateral	$45	$25
D1520	Space Maintainer - Removable - Unilateral	$85	$35
D1525	Space Maintainer - Removable - Bilateral	$85	$35
D1550	Re-cementation of Space Maintainer	$10	$15
D1555	Removal of Fixed Space Maintainer	Not Covered	$15
Restorative			
Amalgam Restorations (Including Polishing)			
D2140	Amalgam - One Surface, Primary or Permanent	$0	$0
D2150	Amalgam - Two Surfaces, Primary or Permanent	$0	$0
D2160	Amalgam - Three Surfaces, Primary or Permanent	$0	$0
D2161	Amalgam - Four or More Surfaces, Primary or Permanent	$0	$0
Resin-Based Composite Restorations - Direct			
D2330	Resin-Based Composite - One Surface, Anterior	$35	$0
D2331	Resin-Based Composite - Two Surfaces, Anterior	$40	$0
D2332	Resin-Based Composite - Three Surfaces, Anterior	$50	$0
D2335	Resin-Based Composite - Four or More Surfaces or Involving Incisal Angle (Anterior)	Not Covered	$0
D2390	Resin-Based Composite Crown, Anterior	Not Covered	$30
D2391	Resin-Based Composite - One Surface, Posterior	$60	$30
D2392	Resin-Based Composite - Two Surfaces, Posterior	$80	$45
D2393	Resin-Based Composite - Three Surfaces, Posterior	$100	$65

D2394	Resin-Based Composite - Four or More Surfaces, Posterior	$120	$65
Gold Foil Restorations			
D2410	Gold Foil - One Surface	Not Covered	Not Covered
D2420	Gold Foil - Two Surfaces	Not Covered	Not Covered
D2430	Gold Foil - Three Surfaces	Not Covered	Not Covered
Inlay/Onlay Restorations			
D2510	*Inlay - Metallic - One Surface*	$95	$225
D2520	*Inlay - Metallic - Two Surfaces*	$105	$235
D2530	*Inlay - Metallic - Three or More Surfaces*	$130	$245
D2542	*Onlay - Metallic - Two Surfaces*	Not Covered	$245
D2543	*Onlay - Metallic - Three Surfaces*	Not Covered	$260
D2544	*Onlay - Metallic - Four or More Surfaces*	Not Covered	$270
D2610	*Inlay - Porcelain/Ceramic - One Surface*	Not Covered	$245
D2620	*Inlay - Porcelain/Ceramic - Two Surfaces*	Not Covered	$245
D2630	*Inlay - Porcelain/Ceramic - Three or More Surfaces*	Not Covered	$245
D2642	*Onlay - Porcelain/Ceramic - Two Surfaces*	Not Covered	$245
D2643	*Onlay - Porcelain/Ceramic - Three Surfaces*	Not Covered	$245
D2644	*Onlay - Porcelain/Ceramic - Four or More Surfaces*	Not Covered	$245
D2650	*Inlay - Resin-Based Composite - One Surface*	Not Covered	$245
D2651	*Inlay - Resin-Based Composite - Two Surfaces*	Not Covered	$245
D2652	*Inlay - Resin-Based Composite - Three or More Surfaces*	Not Covered	$245
D2662	*Onlay - Resin-Based Composite - Two Surfaces*	Not Covered	$245
D2663	*Onlay - Resin-Based Composite - Three Surfaces*	Not Covered	$245
D2664	*Onlay - Resin-Based Composite - Four or More Surfaces*	Not Covered	$245
Crowns - Single Restorations Only			
D2710	*Crown - Resin-Based Composite (Indirect)*	Not Covered	$245
D2712	*Crown - 3/4 Resin-Based Composite (Indirect)*	Not Covered	$245
D2720	*Crown - Resin with High Noble Metal*	Not Covered	$245
D2721	Crown - Resin with Predominantly Base Metal	Not Covered	$245
D2722	*Crown - Resin with Noble Metal*	Not Covered	$245
D2740	*Crown - Porcelain/Ceramic Substrate*	$280	$245
D2750	*Crown - Porcelain Fused to High Noble Metal*	$280	$245
D2751	Crown - Porcelain Fused to Predominantly Base Metal	$280	$245
D2752	*Crown - Porcelain Fused to Noble Metal*	$280	$245
D2780	*Crown - 3/4 Cast High Noble Metal*	Not Covered	$245
D2781	Crown - 3/4 Cast Predominantly Base Metal	Not Covered	$245
D2782	*Crown - 3/4 Cast Noble Metal*	Not Covered	$245
D2783	Crown - 3/4 Porcelain/Ceramic	Not Covered	$245
D2790	*Crown - Full Cast High Noble Metal*	$280	$245
D2791	Crown - Full Cast Predominantly Base Metal	$280	$245
D2792	*Crown - Full Cast Noble Metal*	$280	$245
D2794	*Crown - Titanium*	Not Covered	$245
D2799	Provisional Crown	Not Covered	$0
Other Restorative Services			
D2910	Recement Inlay, Onlay, or Partial Coverage Restoration	$15	$0
D2915	Recement Cast or Prefabricated Post and Core	Not Covered	$0
D2920	Recement Crown	$15	$0
D2929	Prefabricated porcelain/ceramic crown-primary tooth	Not Covered	Not Covered
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	$75	$25
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	Not Covered	$25
D2932	Prefabricated Resin Crown	Not Covered	$45
D2933	Prefabricated Stainless Steel Crown with Resin Window	Not Covered	$45
D2934	Prefabricated Esthetic Coated Stainless Steel Crown - Primary Tooth	Not Covered	Not Covered
D2940	Protective Restoration	$15	$0
D2950	Core Buildup, Including Any Pins	$45	$70
D2951	Pin Retention - Per Tooth, In Addition to Restoration	$15	$10
D2952	*Post and Core In Addition to Crown, Indirectly Fabricated*	$90	$50
D2953	*Each Additional Indirectly Fabricated Post - Same Tooth*	$90	$50
D2954	Prefabricated Post and Core In Addition to Crown	$90	$30
D2955	Post Removal (Not in Conjunction with Endodontic Therapy)	Not Covered	$10
D2957	Each Add Prefabricated Post - Same Tooth	Not Covered	$30
D2960	Labial Veneer (Resin Laminate) - Chairside	Not Covered	$250
D2961	*Labial Veneer (Resin Laminate) - Laboratory*	Not Covered	$300
D2962	*Labial veneer (Porcelain Laminate) - Laboratory*	$280	$350
D2970	Temporary Crown (Fractured Tooth)	Not Covered	$0
D2971	Additional Procedures to Construct New Crown Under Existing Partial Denture Framework	Not Covered	$50
D2975	Coping	Not Covered	Not Covered
D2980	Crown Repair, By Report	Not Covered	$0
D2981	Inlay repair necessitated by restorative material failure	Not Covered	Not Covered
D2982	Onlay repair necessitated by restorative material failure	Not Covered	Not Covered
D2983	Veneer repair necessitated by restorative material failure	Not Covered	Not Covered
D2990	Resin infiltration of incipient smooth surface lesions	Not Covered	Not Covered
D2999	Unspecified Restorative Procedure, By Report	Not Covered	Not Covered
Endodontics			
Pulp Capping			
D3110	Pulp Cap - Direct (Excluding Final Restoration)	Not Covered	$5

D3120	Pulp Cap - Indirect (Excluding Final Restoration)	Not Covered	$5
Pulpotomy			
D3220	Therapeutic Pulpotomy (Excluding Final Restoration) - Removal of Pulp Coronal to the Dentinocemental Junction and Application of Medicament	$35	$30
D3221	Pulpal Debridement, Primary and Permanent Teeth	$100	$55
D3222	Partial Pulpotomy for Apexogenesis - Permanent Tooth with Incomplete Root Development	Not Covered	Not Covered
Endodontic Therapy on Primary Teeth			
D3230	Pulpal Therapy (Resorbable Filling) - Anterior, Primary Tooth (Excluding Final Restoration)	Not Covered	$40
D3240	Pulpal Therapy (Resorbable Filling) - Posterior, Primary Tooth (Excluding Final Restoration)	Not Covered	$40
Endodontic Therapy			
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	$100	$100
D3320	Endodontic Therapy, Bicuspid Tooth (Excluding Final Restoration)	$200	$152
D3330	Endodontic Therapy, Molar (Excluding Final Restoration)	$250	$210
D3331	Treatment of Root Canal Obstruction; Non-Surgical Access	Not Covered	$85
D3332	Incomplete Endodontic Therapy; Inoperable, Unrestorable or Fractured Tooth	Not Covered	$96
D3333	Internal Root Repair or Perforation Defects	Not Covered	$85
Endodontic Retreatment			
D3346	Retreatment of Previous Root Canal Therapy - Anterior	Not Covered	$180
D3347	Retreatment of Previous Root Canal Therapy - Bicuspid	Not Covered	$280
D3348	Retreatment of Previous Root Canal Therapy - Molar	Not Covered	$325
Apexification/Recalcification Procedures			
D3351	Apexification/Recalcification - Initial Visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	Not Covered	$70
D3352	Apexification/Recalcification/pulpal regeneration - interim medication replacement (apical closure/calcific repair of perforations, root rsorption, pulp space disinfection, etc.)	Not Covered	$70
D3353	Apexification/Recalcification - Final Visit (Includes Completed Root Canal Therapy - Apical Closure/Calcific Repair of Perforations, Root Resorption, etc.)	Not Covered	$70
D3354	Pulpal Regeneration - (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp); does not include final restoration	Not Covered	Not Covered
Apicoectomy/Periradicular Services			
D3410	Apicoectomy/Periradicular Surgery - Anterior	$125	$95
D3421	Apicoectomy/Periradicular Surgery - Bicuspid (First Root)	Not Covered	$95
D3425	Apicoectomy/Periradicular Surgery - Molar (First Root)	Not Covered	$95
D3426	Apicoectomy/Periradicular Surgery (Each Additional Root)	Not Covered	$60
D3430	Retrograde Filling - Per Root	Not Covered	$60
D3450	Root Amputation - Per Root	Not Covered	$95
D3460	Endodontic Endosseous Implant	Not Covered	Not Covered
D3470	Intentional Reimplantation (Including Necessary Splinting)	Not Covered	Not Covered
Other Endodontic Procedures			
D3910	Surgical Procedure for Isolation of Tooth with Rubber Dam	Not Covered	$19
D3920	Hemisection (Including any Root Removal), Not Including Root Canal Therapy	Not Covered	$90
D3950	Canal Preparation and Fitting of Preformed Dowel or Post	Not Covered	$15
D3999	Unspecified Endodontic Procedure, By Report	Not Covered	Not Covered
Periodontics			
Surgical Services (Including Usual Postoperative Care)			
D4210	Gingivectomy of Gingivoplasty - Four or More Contiguous Teeth or Tooth Bounded Spaces Per Quadrant	$125	$110
D4211	Gingivectomy or Gingivoplasty - One to Three Contiguous Teeth or Tooth Bounded Spaces Per Quadrant	$40	$83
D4212	Gingivectomy of Gingivoplasty to allow access for restorative procedure, per tooth	Not Covered	Not Covered
D4230	Anatomical Crown Exposure - Four or More Teeth Per Quadrant	Not Covered	Not Covered
D4231	Anatomical Crown Exposure - One to Three Teeth Per Quadrant	Not Covered	Not Covered
D4240	Gingival Flap Procedure, Including Root Planing - Four or More Contiguous Teeth or Tooth Bounded Spaces Per Quadrant	Not Covered	$150
D4241	Gingival Flap Procedure, Including Root Planing - One to Three Contiguous Teeth or Tooth Bounded Spaces Per Quadrant	Not Covered	$113
D4245	Apically Positioned Flap	Not Covered	$165
D4249	Clinical Crown Lengthening - Hard Tissue	Not Covered	$150
D4260	Osseous Surgery (Including Flap Entry and Closure) - Four or More Contiguous Teeth or Tooth Bounded Spaces Per Quadrant	$350	$300
D4261	Osseous Surgery (Including Flap Entry and Closure) - One to Three Contiguous Teeth or Tooth Bounded Spaces Per Quadrant	$350	$225
D4263	Bone Replacement Graft - First Site in Quadrant	Not Covered	$180
D4264	Bone Replacement Graft - Each Additional Site in Quadrant	Not Covered	$95
D4265	Biologic Materials to Aid in Soft and Osseous Tissue Regeneration	Not Covered	$95
D4266	Guided Tissue Regeneration - Resorbable Barrier, Per Site	Not Covered	$215
D4267	Guided Tissue Regeneration - Nonresorbable Barrier, Per Site (Includes Membrane Removal)	Not Covered	$255
D4268	Surgical Revision Procedure, Per Tooth	Not Covered	Not Covered

D4270	Pedicle Soft Tissue Graft Procedure	Not Covered	$245
D4271	Free Soft Tissue Graft Procedure (Including Donor Site Surgery)	$225	$245
D4273	Subepithelial Connective Tissue Graft Procedures, Per Tooth	Not Covered	$75
D4274	Distal or Proximal Wedge Procedure (When Not performed in Conjunction With Surgical Procedures in the Same Anatomical Area)	Not Covered	$100
D4275	Soft Tissue Allograft	Not Covered	$380
D4276	Combined Connective Tissue and Double Pedicle Graft, Per Tooth	Not Covered	Not Covered
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	Not Covered	Not Covered
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	Not Covered	Not Covered
Non-Surgical Periodontal Service			
D4320	Provisional Splinting, Intracoronal	Not Covered	$95
D4321	Provisional Splinting, Extracoronal	Not Covered	$85
D4341	Periodontal Scaling and Root Planing - Four or More Teeth Per Quadrant	$50	$50
D4342	Periodontal Scaling and Root Planing - One to Three Teeth Per Quadrant	$50	$38
D4355	Full Mouth Debridement to Enable Comprehensive Evaluation and Diagnosis	$45	$50
D4381	Localized Delivery of Antimicrobial Agents Via a Controlled Release Vehicle Into Diseased Crevicular Tissue, Per Tooth, By Report	$45	$65
Other Periodontal Services			
D4910	Periodontal Maintenance	$50	$40
	Additional Periodontal Maintenance		
D4920	Unscheduled Dressing Change (by someone other than treating dentist)	Not Covered	Not Covered
D4999	Unspecified Periodontal Procedure, By Report	Not Covered	Not Covered
Prosthodontics (Removable)			
Complete Dentures			
D5110	*Complete Denture - Maxillary*	$300	$325
D5120	*Complete Denture - Mandibular*	$300	$325
D5130	*Immediate Denture - Maxillary*	$300	$350
D5140	*Immediate Denture - Mandibular*	$300	$350
Partial Dentures (Including Routine Post-delivery Care)			
D5211	*Maxillary Partial Denture - Resin Base (Including any Conventional Clasps, Rests and Teeth)*	$300	$400
D5212	*Mandibular Partial Denture - Resin Base (Including any Conventional Clasps, Rests and Teeth)*	$300	$400
D5213	*Maxillary Partial Denture - Cast Metal Framework with Resin Denture Bases (Including any Conventional Clasps, Rests and Teeth)*	$300	$425
D5214	*Mandibular Partial Denture - Cast Metal Framework with Resin Denture Bases (Including any Conventional Clasps, Rests and Teeth)*	$300	$425
D5225	*Maxillary Partial Denture - Flexible Base (Including any Clasps, Rests and Teeth)*	Not Covered	$425
D5226	*Mandibular Partial Denture - Flexible Base (Including any Clasps, Rests and Teeth)*	Not Covered	$425
D5281	*Removable Unilateral Partial Denture - One Piece Cast Metal (Including Clasps and Teeth)*	Not Covered	$300
Adjustments to Dentures			
D5410	Adjust Complete Denture - Maxillary	$15	$10
D5411	Adjust Complete Denture - Mandibular	$15	$10
D5421	Adjust Partial Denture - Maxillary	$15	$10
D5422	Adjust Partial Denture - Mandibular	$15	$10
Repairs to Complete Dentures			
D5510	*Repair Broken Complete Denture Base*	$15	$35
D5520	*Replace Missing or Broken Teeth - Complete Denture (Each Tooth)*	$15	$35
Repairs to Partial Dentures			
D5610	*Repair Resin Denture Base*	$15	$35
D5620	*Repair Cast Framework*	Not Covered	$35
D5630	*Repair or Replace Broken Clasp*	$15	$35
D5640	*Replace Broken Teeth - Per Tooth*	$15	$35
D5650	*Add Tooth to Existing Partial Denture*	$30	$35
D5660	*Add Clasp to Existing Partial Denture*	Not Covered	$35
D5670	*Replace All Teeth and Acrylic on Cast Metal Framework (Maxillary)*	Not Covered	$165
D5671	*Replace All Teeth and Acrylic on Cast Metal Framework (Mandibular)*	Not Covered	$165
Denture Rebase Procedures			
D5710	*Rebase Complete Maxillary Denture*	Not Covered	$75
D5711	*Rebase Complete Mandibular Denture*	Not Covered	$75
D5720	*Rebase Maxillary Partial Denture*	Not Covered	$75
D5721	*Rebase Mandibular Partial Denture*	Not Covered	$75

Denture Reline Procedures			
D5730	Reline Complete Maxillary Denture (Chairside)	$50	$65
D5731	Reline Complete Mandibular Denture (Chairside)	$50	$65
D5740	Reline Maxillary Partial Denture (Chairside)	$50	$65
D5741	Reline Mandibular Partial Denture (Chairside)	$50	$65
D5750	*Reline Complete Maxillary Denture (Laboratory)*	$35	$85
D5751	*Reline Complete Mandibular Denture (Laboratory)*	$35	$85
D5760	*Reline Maxillary Partial Denture (Laboratory)*	$35	$85
D5761	*Reline Mandibular Partial Denture (Laboratory)*	$35	$85
Interim Prosthesis			
D5810	*Interim Complete Denture (Maxillary)*	Not Covered	$230
D5811	*Interim Complete Denture (Mandibular)*	Not Covered	$230
D5820	*Interim Partial Denture (Maxillary)*	Not Covered	$160
D5821	*Interim Partial Denture (Mandibular)*	Not Covered	$170
Other Removable Prosthetic Services			
D5850	Tissue Conditioning, Maxillary	$30	$20
D5851	Tissue Conditioning, Mandibular	$30	$20
D5860	Overdenture - Complete, By Report	Not Covered	Not Covered
D5861	Overdenture - Partial, By Report	Not Covered	Not Covered
D5862	Precision Attachment, By report	Not Covered	$160
D5867	Replacement of Replaceable Part of Semi-Precision or Precision Attachment (Male or Female Component)	Not Covered	Not Covered
D5875	Modification of Removable Prosthesis Following Implant Surgery	Not Covered	Not Covered
D5899	Unspecified Removable Prosthodontic Procedure, By Report	Not Covered	Not Covered
Maxillofacial Prosthetics			
D5911	Facial Moulage (Sectional)	Not Covered	Not Covered
D5912	Facial Moulage (Complete)	Not Covered	Not Covered
D5913	Nasal Prosthesis	Not Covered	Not Covered
D5914	Auricular Prosthesis	Not Covered	Not Covered
D5915	Orbital Prosthesis	Not Covered	Not Covered
D5916	Ocular Prosthesis	Not Covered	Not Covered
D5919	Facial Prosthesis	Not Covered	Not Covered
D5922	Nasal Septal Prosthesis	Not Covered	Not Covered
D5923	Ocular Prosthesis, Interim	Not Covered	Not Covered
D5924	Cranial Prosthesis	Not Covered	Not Covered
D5925	Facial Augmentation Implant Prosthesis	Not Covered	Not Covered
D5926	Nasal Prosthesis, Replacement	Not Covered	Not Covered
D5927	Auricular Prosthesis, Replacement	Not Covered	Not Covered
D5928	Orbital Prosthesis, Replacement	Not Covered	Not Covered
D5929	Facial Prosthesis, Replacement	Not Covered	Not Covered
D5931	Obturator Prosthesis, Surgical	Not Covered	Not Covered
D5932	Obturator Prosthesis, Definitive	Not Covered	Not Covered
D5933	Obturator Prosthesis, Modification	Not Covered	Not Covered
D5934	Mandibular Resection Prosthesis with Guide Flange	Not Covered	Not Covered
D5935	Mandibular Resection Prosthesis without Guide Flange	Not Covered	Not Covered
D5936	Obturator Prosthesis, Interim	Not Covered	Not Covered
D5937	Trismus Appliance (Not for TMD Treatment)	Not Covered	Not Covered
D5951	Feeding Aid	Not Covered	Not Covered
D5952	Speech Aid Prosthesis, Pediatric	Not Covered	Not Covered
D5953	Speech Aid Prosthesis, Adult	Not Covered	Not Covered
D5954	Palatal Augmentation Prosthesis	Not Covered	Not Covered
D5955	Palatal Lift Prosthesis, Definitive	Not Covered	Not Covered
D5958	Palatal Lift Prosthesis, Interim	Not Covered	Not Covered
D5959	Palatal Lift Prosthesis, Modification	Not Covered	Not Covered
D5960	Speech Aid Prosthesis, Modification	Not Covered	Not Covered
D5982	Surgical Stent	Not Covered	Not Covered
D5983	Radiation Carrier	Not Covered	Not Covered
D5984	Radiation Shield	Not Covered	Not Covered
D5985	Radiation Cone Locator	Not Covered	Not Covered
D5986	Fluoride Gel Carrier	Not Covered	Not Covered
D5987	Commissure Splint	Not Covered	Not Covered
D5988	Surgical Splint	Not Covered	Not Covered
D5991	Topical Medicament Carrier	Not Covered	Not Covered
D5992	Adjust maxillofacial prosthetic appliance, by report	Not Covered	Not Covered
D5993	Maintenance and Cleaning of a Maxillofacial Prosthesis (Extra or Intraoral) Other Than Required Adjustments, By Report	Not Covered	Not Covered
D5999	Unspecified Maxillofacial Prosthesis, By Report	Not Covered	Not Covered
Implant Services			
Pre-Surgical Services			
D6190	Radiographic/surgical Implant Index, By Report	Not Covered	Not Covered
Surgical Services			
D6010	Surgical Placement of Implant Body: Endosteal Implant	Not Covered	Not Covered
D6012	Surgical Placement of Interim Implant Body for Transitional Prosthesis: Endosteal Implant	Not Covered	Not Covered
D6040	Surgical Placement: Eposteal Implant	Not Covered	Not Covered
D6050	Surgical Placement: Transosteal Implant	Not Covered	Not Covered
D6100	Implant Removal, By Report	Not Covered	Not Covered

D6101	Debridement of a periimplant defect and surface cleaning of exposed implant surfaces, including flap entry and closure	Not Covered	Not Covered
D6102	Ddebridement of osseous contouring of a periimplant defect; includes surface cleaning of exposed implant surfaces and flap entry and closure	Not Covered	Not Covered
D6103	Bone graft for repair of periimplant defect-not including flap entry and closure or, when indicated, placement of a barrier membrane or biologic materials to aid in osseous regeneration	Not Covered	Not Covered
D6104	Bone graft at time of implant placement	Not Covered	Not Covered
Implant Supported Prosthetics			
Supporting Structures			
D6051	Interim abutment	Not Covered	Not Covered
D6055	Connecting Bar - Implant Supported or Abutment Supported	Not Covered	Not Covered
D6056	Prefabricated Abutment - Includes Placement	Not Covered	Not Covered
D6057	Custom Abutment - Includes Placement	Not Covered	Not Covered
Implant/Abutment Supported Removable Dentures			
D6053	Implant/Abutment Supported Removable Denture for Completely Edentulous Arch	Not Covered	Not Covered
D6054	Implant/Abutment Supported Removable Denture for Partially Edentulous Arch	Not Covered	Not Covered
Implant/Abutment Supported Fixed Dentures (Hybrid Prosthesis)			
D6078	Implant/Abutment Supported Fixed Denture for Completely Edentulous Arch	Not Covered	Not Covered
D6079	Implant/Abutment Supported Fixed Denture for Partially Edentulous Arch	Not Covered	Not Covered
Single Crowns, Abutment Supported			
D6058	*Abutment Supported Porcelain/Ceramic Crown*	Not Covered	Not Covered
D6059	*Abutment Supported Porcelain Fused to Metal Crown (High Noble Metal)*	Not Covered	Not Covered
D6060	Abutment Supported Porcelain Fused to Metal Crown (Predominantly Base Metal)	Not Covered	Not Covered
D6061	*Abutment Supported Porcelain Fused to Metal Crown (Noble Metal)*	Not Covered	Not Covered
D6062	*Abutment Supported Cast Metal Crown (High Noble Metal)*	Not Covered	Not Covered
D6063	Abutment Supported Cast Metal Crown (Predominantly Base Metal)	Not Covered	Not Covered
D6064	*Abutment Supported Cast Metal Crown (Noble Metal)*	Not Covered	Not Covered
D6094	*Abutment Supported Crown - (Titanium)*	Not Covered	Not Covered
Single Crowns, Implant Supported			
D6065	*Implant Supported Porcelain/Ceramic Crown*	Not Covered	Not Covered
D6066	*Implant Supported Porcelain Fused to Metal Crown (Titanium, Titanium Alloy, or High Noble Metal)*	Not Covered	Not Covered
D6067	*Implant Supported Metal Crown (Titanium, Titanium Alloy, or High Noble Metal)*	Not Covered	Not Covered
Fixed Partial Denture, Abutment Supported			
D6068	Abutment Supported Retainer for Porcelain/Ceramic FPD	Not Covered	Not Covered
D6069	*Abutment Supported Retainer for Porcelain Fused to Metal FPD (High Noble Metal)*	Not Covered	Not Covered
D6070	Abutment Supported Retainer for Porcelain Fused to Metal FPD (Predominantly Base Metal)	Not Covered	Not Covered
D6071	*Abutment Supported Retainer for Porcelain Fused to Metal FPD (Noble Metal)*	Not Covered	Not Covered
D6072	*Abutment Supported Retainer for Cast Metal FPD (High Noble Metal)*	Not Covered	Not Covered
D6073	Abutment Supported Retainer for Cast Metal FPD (Predominantly Base Metal)	Not Covered	Not Covered
D6074	*Abutment Supported Retainer for Cast Metal FPD (Noble Metal)*	Not Covered	Not Covered
D6194	*Abutment Supported Retainer Crown for FPD- (Titanium)*	Not Covered	Not Covered
Fixed Partial Denture, Implant Supported			
D6075	Implant Supported Retainer for Ceramic FPD	Not Covered	Not Covered
D6076	*Implant Supported Retainer for Porcelain Fused to Metal FPD (Titanium, Titanium Alloy, or High Noble Metal)*	Not Covered	Not Covered
D6077	*Implant Supported Retainer for Cast Metal FPD (Titanium, Titanium Alloy, or High Noble Metal)*	Not Covered	Not Covered
Other Implant Services			
D6080	Implant Maintenance Procedures, Including Removal of Prosthesis, Cleansing of Prosthesis and Abutments and Reinsertion of Prosthesis	Not Covered	Not Covered
D6090	Repair Implant Supported Prosthesis, By Report	Not Covered	Not Covered
D6095	Repair Implant Abutment, By Report	Not Covered	Not Covered
D6091	Replacement of Semi-Precision or Precision Attachment (Male or Female Component) of Implant/Abutment Supported Prosthesis, Per Attachment	Not Covered	Not Covered
D6092	Recement Implant/Abutment Supported Crown	Not Covered	Not Covered
D6093	Recement Implant/Abutment Supported Fixed Partial Denture	Not Covered	Not Covered
D6199	Unspecified Implant Procedure, By Report	Not Covered	Not Covered
Prosthodontics, Fixed			
Fixed Partial Denture Pontics			
D6205	Pontic - Indirect Resin Based Composite	Not Covered	Not Covered

D6210	*Pontic - Cast High Noble Metal*	$280	$245
D6211	Pontic - Cast Predominantly Base Metal	$280	$245
D6212	*Pontic - Cast Noble Metal*	$280	$245
D6214	*Pontic - Titanium*	Not Covered	$245
D6240	*Pontic - Porcelain Fused to High Noble Metal*	$280	$245
D6241	Pontic - Porcelain Fused to Predominantly Base Metal	$280	$245
D6242	*Pontic - Porcelain Fused to Noble Metal*	$280	$245
D6245	*Pontic - Porcelain/Ceramic*	Not Covered	$245
D6250	*Pontic - Resin with High Noble Metal*	Not Covered	$245
D6251	Pontic - Resin with Predominantly Base Metal	Not Covered	$245
D6252	*Pontic - Resin with Noble Metal*	Not Covered	$245
D6253	*Provisional Pontic*	Not Covered	$0
D6254	Interim Pontic	Not Covered	Not Covered
Fixed Partial Denture Retainers - Inlays/Onlays			
D6545	*Retainer - Cast Metal for Resin Bonded Fixed Prosthesis*	Not Covered	$150
D6548	Retainer - Porcelain/Ceramic for Resin Bonded Fixed Prosthesis	Not Covered	Not Covered
D6600	*Inlay - Porcelain/Ceramic - Two Surfaces*	Not Covered	$245
D6601	*Inlay - Porcelain/Ceramic - Three or More Surfaces*	Not Covered	$245
D6602	*Inlay - Cast High Noble Metal, Two Surfaces*	Not Covered	$245
D6603	*Inlay - Cast High Noble Metal, Three or More Surfaces*	Not Covered	$245
D6604	Inlay - Cast Predominantly Base Metal, Two Surfaces	Not Covered	$245
D6605	Inlay - Cast Predominantly Base Metal, Three or More Surfaces	Not Covered	$245
D6606	*Inlay - Cast Noble Metal, Two Surfaces*	Not Covered	$245
D6607	*Inlay - Cast Noble Metal, Three or More Surfaces*	Not Covered	$245
D6624	Inlay - Titanium	Not Covered	Not Covered
D6608	*Onlay - Porcelain/Ceramic - Two Surfaces*	Not Covered	$245
D6609	*Onlay - Porcelain/Ceramic - Three or More Surfaces*	Not Covered	$245
D6610	*Onlay - Cast High Noble Metal, Two Surfaces*	Not Covered	$245
D6611	*Onlay - Cast High Noble Metal, Three or More Surfaces*	Not Covered	$245
D6612	Onlay - Cast Predominantly Base Metal, Two Surfaces	Not Covered	$245
D6613	*Onlay - Cast Predominantly Base Metal, Three or More Surfaces*	Not Covered	$245
D6614	*Onlay - Cast Noble Metal, Two Surfaces*	Not Covered	$245
D6615	*Onlay - Cast Noble Metal, Three or More Surfaces*	Not Covered	$245
D6634	Onlay - Titanium	Not Covered	Not Covered
Fixed Partial Denture Retainers - Crowns			
D6710	*Crown - Indirect Resin Based Composite*	Not Covered	$245
D6720	*Crown - Resin with High Noble Metal*	Not Covered	$245
D6721	Crown - Resin with Predominantly Base Metal	Not Covered	$245
D6722	*Crown - Resin with Noble Metal*	Not Covered	$245
D6740	*Crown - Porcelain/Ceramic*	Not Covered	$245
D6750	*Crown - Porcelain Fused to High Noble Metal*	$280	$245
D6751	Crown - Porcelain Fused to Predominantly Base Metal	$280	$245
D6752	*Crown - Porcelain Fused to Noble Metal*	$280	$245
D6780	*Crown - 3/4 Cast High Noble Metal*	Not Covered	$245
D6781	Crown - 3/4 Cast Predominantly Base Metal	Not Covered	$245
D6782	*Crown - 3/4 Cast Noble Metal*	Not Covered	$245
D6783	*Crown - 3/4 Porcelain/Ceramic*	Not Covered	$245
D6790	*Crown - Full Cast High Noble Metal*	$280	$245
D6791	Crown - Full Cast Predominantly Base Metal	$280	$245
D6792	*Crown - Full Cast Noble Metal*	$280	$245
D6794	*Crown - Titanium*	Not Covered	$245
D6793	Provisional Retainer Crown	Not Covered	Not Covered
D6795	Interim Retainer Crown	Not Covered	Not Covered
Other Fixed Partial Denture Services			
D6920	Connector Bar	Not Covered	Not Covered
D6930	Recement Fixed Partial Denture	$10	$0
D6940	Stress Breaker	Not Covered	$110
D6950	Precision Attachment	Not Covered	$195
D6970	*Cast Post and Core In Addition to Fixed Partial Denture Retainer, Indirectly Fabricated*	Not Covered	$50
D6972	Prefabricated Post and Core In Addition to Fixed Partial Denture Retainer	Not Covered	$30
D6973	Core Buildup for Retainer, Including Any Pins	Not Covered	$10
D6975	Coping - Metal	Not Covered	Not Covered
D6976	Each Additional Indirectly Fabricated Post - Same Tooth	Not Covered	$40
D6977	Each Additional Prefabricated Post - Same Tooth	Not Covered	$40
D6980	*Fixed Partial Denture Repair By Report*	Not Covered	$45
D6985	Pediatric Partial Denture, Fixed	Not Covered	Not Covered
D6999	Unspecified Fixed Prosthodontic Procedure, By Report	Not Covered	Not Covered
Oral and Maxillofacial Surgery			
Extractions			
D7111	Extraction of Coronal Remnants - Deciduous Tooth	$0	$5
D7140	Extraction, Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal)	$0	$5
Surgical Extractions			
D7210	Surgical Removal of Erupted Tooth Requiring Removal of Bone and/or Sectioning of Tooth, and Including Elevation of Mucoperiosteal Flap if Indicated	$40	$30

D7220	Removal of Impacted Tooth - Soft Tissue	$50	$50
D7230	Removal of Impacted Tooth - Partially Bony	$70	$65
D7240	Removal of Impacted Tooth - Completely Bony	$85	$80
D7241	Removal of Impacted Tooth - Completely Bony, with Unusual Surgical Complications	Not Covered	$100
D7250	Surgical Removal of Residual Tooth Roots (Cutting Procedure)	$35	$40
D7251	Coronectomy - Intentional Partial Tooth Removal	Not Covered	Not Covered
Other Surgical Procedures			
D7260	Oroantral Fistula Closure	Not Covered	Not Covered
D7261	Primary Closure of a Sinus Perforation	Not Covered	Not Covered
D7270	Tooth Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Tooth	Not Covered	$50
D7272	Tooth Transplantation (Includes Reimplantation from One Site to Another and Splinting and/or Stabilization)	Not Covered	Not Covered
D7280	Surgical Access of an Unerupted Tooth	Not Covered	$100
D7282	Mobilization of Erupted or Malpositioned Tooth to Aid Eruption	Not Covered	$90
D7283	Placement of Device to Facilitate Eruption of Impacted Tooth	Not Covered	$90
D7285	Biopsy of Oral Tissue - Hard (Bone, Tooth)	Not Covered	$150
D7286	Biopsy of Oral Tissue - Soft	Not Covered	$60
D7287	Exfoliative Cytological Sample Collection	Not Covered	$50
D7288	Brush Biopsy - Transepithelial Sample Collection	Not Covered	$50
D7290	Surgical Repositioning of Teeth	Not Covered	Not Covered
D7291	Transseptal Fiberotomy/Supra Crestal Fiberotomy, By Report	Not Covered	Not Covered
D7292	Surgical Placement; Temporary Anchorage Device (Screw Retained Plate) Requiring Surgical Flap	Not Covered	Not Covered
D7293	Surgical Placement; Temporary Anchorage Device Requiring Surgical Flap	Not Covered	Not Covered
D7294	Surgical Placement; Temporary Anchorage Device without Surgical Flap	Not Covered	Not Covered
D7295	Harvest of Bone Fur Use In Autogenous Grafting Procedure	Not Covered	Not Covered
Alveoloplasty - Surgical Preparation of Ridge for Dentures			
D7310	Alveoloplasty in Conjunction with Extractions - Four or More Teeth or Tooth Spaces, Per Quadrant	$35	$40
D7311	Alveoloplasty in Conjunction with Extractions - One to Three Teeth or Tooth Spaces, Per Quadrant	$35	$15
D7320	Alveoloplasty not in Conjunction with Extractions - Four or More Teeth or Tooth Spaces, Per Quadrant	$70	$60
D7321	Alveoloplasty not in Conjunction with Extractions - One to Three Teeth or Tooth Spaces, Per Quadrant	$70	$25
Vestibuloplasty			
D7340	Vestibuloplasty - Ridge Extension (Secondary Epithelialization)	Not Covered	Not Covered
D7350	Vestibuloplasty - Ridge Extension (Including Soft Tissue Grafts, Muscle Reattachment, etc.)	Not Covered	Not Covered
Surgical Excision of Soft Tissue Lesions			
D7410	Excision of Benign Lesion Up to 1.25 cm	Not Covered	Not Covered
D7411	Excision of Benign Lesion Greater than 1.25 cm	Not Covered	Not Covered
D7412	Excision of Benign Lesion, Complicated	Not Covered	Not Covered
D7413	Excision of Malignant Lesion Up to 1.25 cm	Not Covered	Not Covered
D7414	Excision of Malignant Lesion Greater than 1.25 cm	Not Covered	Not Covered
D7415	Excision of Malignant Lesion, Complicated	Not Covered	Not Covered
D7465	Destruction of Lesion(s) By Physical or Chemical Method, By Report	Not Covered	Not Covered
Surgical Excision of Intra-Osseous Lesions			
D7440	Excision of Malignant Tumor - Lesion Diameter Up to 1.25 cm	Not Covered	Not Covered
D7441	Excision of Malignant Tumor - Lesion Diameter Greater than 1.25 cm	Not Covered	Not Covered
D7450	Removal of Benign Odontogenic Cyst or Tumor - Lesion Diameter Up to 1.25 cm	Not Covered	Not Covered
D7451	Removal of Benign Odontogenic Cyst or Tumor - Lesion Diameter Greater than 1.25 cm	Not Covered	Not Covered
D7460	Removal of Benign Nonodontogenic Cyst or Tumor - Lesion Diameter Up to 1.25 cm	Not Covered	Not Covered
D7461	Removal of Benign Nonodontogenic Cyst or Tumor - Lesion Diameter Greater than 1.25 cm	Not Covered	Not Covered
Excision of Bone Tissue			
D7471	Removal of Lateral Exostosis (Maxilla or Mandible)	Not Covered	$80
D7472	Removal of Torus Palatinus	Not Covered	$60
D7473	Removal of Torus Mandibularis	Not Covered	$60
D7485	Surgical Reduction of Osseous Tuberosity	Not Covered	$60
D7490	Radical Resection of Maxilla or Mandible	Not Covered	Not Covered
Surgical Incision			
D7510	Incision and Drainage of Abscess - Intraoral Soft Tissue	$25	$35
D7511	Incision and Drainage of Abscess - Intraoral Soft Tissue - Complicated (Includes Drainage of Multiple Fascial Spaces)	Not Covered	$35
D7520	Incision and Drainage of Abscess - Extraoral Soft Tissue	Not Covered	$35
D7521	Incision and Drainage of Abscess - Extraoral Soft Tissue Complicated (Includes Drainage of Multiple Fascial Spaces)	Not Covered	$35
D7530	Removal of Foreign Body from Mucosa, Skin, or Subcutaneous Alveolar Tissue	Not Covered	Not Covered

D7540	Removal of Reaction Producing Foreign Bodies, Musculoskeletal System	Not Covered	Not Covered
D7550	Partial Ostectomy/Sequestrectomy for Removal of Non-vital Bone	Not Covered	Not Covered
D7560	Maxillary Sinusotomy for Removal of Tooth Fragment or Foreign Body	Not Covered	Not Covered
Treatment of Fractures - Simple			
D7610	Maxilla - Open Reduction (Teeth Immobilized, if Present)	Not Covered	Not Covered
D7620	Maxilla - Closed Reduction (Teeth Immobilized, if Present)	Not Covered	Not Covered
D7630	Mandible - Open Reduction (Teeth Immobilized, if Present)	Not Covered	Not Covered
D7640	Mandible - Closed Reduction (Teeth Immobilized, if Present)	Not Covered	Not Covered
D7650	Malar and/or Zygomatic Arch - Open Reduction	Not Covered	Not Covered
D7660	Malar and/or Zygomatic Arch - Closed Reduction	Not Covered	Not Covered
D7670	Alveolus - Closed Reduction, May Include Stabilization of Teeth	Not Covered	Not Covered
D7671	Alveolus - Open Reduction, May Include Stabilization of Teeth	Not Covered	Not Covered
D7680	Facial Bones - Complicated Reduction with Fixation and Multiple Surgical Approaches	Not Covered	Not Covered
Treatment of Fractures - Compound			
D7710	Maxilla - Open Reduction	Not Covered	Not Covered
D7720	Maxilla - Closed Reduction	Not Covered	Not Covered
D7730	Mandible - Open Reduction	Not Covered	Not Covered
D7740	Mandible - Closed Reduction	Not Covered	Not Covered
D7750	Malar and/or Zygomatic Arch - Open Reduction	Not Covered	Not Covered
D7760	Malar and/or Zygomatic Arch - Closed Reduction	Not Covered	Not Covered
D7770	Alveolus - Open Reduction Stabilization of Teeth	Not Covered	Not Covered
D7771	Alveolus - Closed Reduction Stabilization of Teeth	Not Covered	Not Covered
D7780	Facial Bones - Complicated Reduction with Fixation and Multiple Surgical Approaches	Not Covered	Not Covered
Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfuncti			
D7810	Open Reduction of Dislocation	Not Covered	Not Covered
D7820	Closed Reduction of Dislocation	Not Covered	Not Covered
D7830	Manipulation under Anesthesia	Not Covered	Not Covered
D7840	Condylectomy	Not Covered	Not Covered
D7850	Surgical Discectomy, with/without Implant	Not Covered	Not Covered
D7852	Disc Repair	Not Covered	Not Covered
D7854	Synovectomy	Not Covered	Not Covered
D7856	Myotomy	Not Covered	Not Covered
D7858	Joint Reconstruction	Not Covered	Not Covered
D7860	Arthrotomy	Not Covered	Not Covered
D7865	Arthroplasty	Not Covered	Not Covered
D7870	Arthrocentesis	Not Covered	Not Covered
D7871	Non-arthroscopic Lysis and Lavage	Not Covered	Not Covered
D7872	Arthroscopy - Diagnosis, with or without Biopsy	Not Covered	Not Covered
D7873	Arthroscopy - Surgical: Lavage and Lysis of Adhesions	Not Covered	Not Covered
D7874	Arthroscopy - Surgical: Disc Repositioning and Stabilization	Not Covered	Not Covered
D7875	Arthroscopy - Surgical: Synovectomy	Not Covered	Not Covered
D7876	Arthroscopy - Surgical: Discectomy	Not Covered	Not Covered
D7877	Arthroscopy - Surgical: Debridement	Not Covered	Not Covered
D7880	Occlusal Orthotic Device, By Report	Not Covered	Not Covered
D7899	Unspecified TMD Therapy By Report	Not Covered	Not Covered
Repair of Traumatic Wounds			
D7910	Suture of Recent Small Wounds up to 5 cm	Not Covered	$25
Complicated Suturing			
D7911	Complicated Suture - Up to 5 cm	Not Covered	Not Covered
D7912	Complicated Suture - Greater than 5 cm	Not Covered	Not Covered
Other Repair Procedures			
D7920	Skin Graft (Identify Defect Covered, Location and Type of Graft)	Not Covered	Not Covered
D7921	Collection and application of autologous blood concentrate product	Not Covered	Not Covered
D7940	Osteoplasty - For Orthognathic Deformities	Not Covered	Not Covered
D7941	Osteotomy - Mandibular Rami	Not Covered	Not Covered
D7943	Osteotomy - Mandibular Rami with Bone Graft; Includes Obtaining the Graft	Not Covered	Not Covered
D7944	Osteotomy - Segmented or Subapical	Not Covered	Not Covered
D7945	Osteotomy - Body of Mandible	Not Covered	Not Covered
D7946	LeFort I (Maxilla - Total)	Not Covered	Not Covered
D7947	LeFort I (Maxilla - Segmented)	Not Covered	Not Covered
D7948	LeFort II or LeFort III - without Bone Graft	Not Covered	Not Covered
D7949	LeFort II or LeFort III - with Bone Graft	Not Covered	Not Covered
D7950	Osseous, Osteoperiosteal, or Cartilage Graft of the Mandible or Maxilla - Autogenous or Nonautogenous, By Report	Not Covered	Not Covered
D7951	Sinus Augmentation with Bone or Bone Substitutes	Not Covered	Not Covered
D7952	Sinus augmentation via a vertical approach	Not Covered	Not Covered
D7953	Bone Replacement Graft for Ridge Preservation - Per Site	Not Covered	Not Covered
D7955	Repair of Maxillofacial Soft and/or Hard Tissue Defect	Not Covered	Not Covered
D7960	Frenulectomy (Frenectomy or Frenotomy) - Separate procedure	Not Covered	$50
D7963	Frenuloplasty	Not Covered	$50
D7970	Excision of Hyperplastic Tissue -Per Arch	Not Covered	$55
D7971	Excision of Pericoronal Gingival	Not Covered	$40
D7972	Surgical Reduction of Fibrous Tuberosity	Not Covered	Not Covered

D7980	Sialolithotomy	Not Covered	Not Covered
D7981	Excision of Salivary Gland, By Report	Not Covered	Not Covered
D7982	Sialodochoplasty	Not Covered	Not Covered
D7983	Closure of Salivary Fistula	Not Covered	Not Covered
D7990	Emergency Tracheotomy	Not Covered	Not Covered
D7991	Coronoidectomy	Not Covered	Not Covered
D7995	Synthetic Graft - Mandible or Facial Bones, By Report	Not Covered	Not Covered
D7996	Implant - Mandible for Augmentation Purposes (Excluding Alveolar Ridge), By Report	Not Covered	Not Covered
D7997	Appliance Removal (Not by Dentist who Placed Appliance), Includes Removal of Archbar	Not Covered	Not Covered
D7998	Intraoral Placement of a Fixation Device not in Conjunction with a Fracture	Not Covered	Not Covered
D7999	Unspecified Oral Surgery Procedure, By Report	Not Covered	Not Covered
Orthodontics			
Limited Orthodontic Treatment			
D8010	Limited Orthodontic Treatment of the Primary Dentition	Not Covered	Not Covered
D8020	Limited Orthodontic Treatment of the Transition Dentition	Not Covered	Not Covered
D8030	Limited Orthodontic Treatment of the Adolescent Dentition	Not Covered	Not Covered
D8040	Limited Orthodontic Treatment of the Adult Dentition	Not Covered	Not Covered
Interceptive Orthodontic Treatment			
D8050	Interceptive Orthodontic Treatment of the Primary Dentition	Not Covered	Not Covered
D8060	Interceptive Orthodontic Treatment of the Transitional Dentition	Not Covered	Not Covered
Comprehensive Orthodontic			
D8070	Comprehensive Orthodontic Treatment of the Transitional Dentition	$1,800	$1,850
D8080	Comprehensive Orthodontic Treatment of the Adolescent Dentition	$1,800	$1,850
D8090	Comprehensive Orthodontic Treatment of the Adult Dentition	$2,000	$1,850
Minor Treatment to Control Harmful Habits			
D8210	Removable Appliance Therapy	Not Covered	Not Covered
D8220	Fixed Appliance Therapy	Not Covered	Not Covered
Other Orthodontic Services			
D8660	Pre-Orthodontic Treatment Visit	Not Covered	Not Covered
D8670	Periodic Orthodontic Treatment Visit (As Part of Contract)	Not Covered	Not Covered
	Children (Up to 19th Birthday):		
	24 Month Treatment Fee		
	Charge Per Month for 24 Months		
	Adults:		
	24 Month Treatment Fee		
	Charge Per Month for 24 Months		
	Ortho Visits Beyond 24 Months of Active Treatment or Retention		
D8680	Orthodontic Retention (Removal of Appliances, Construction and Placement of Retainer (s))	$450	$300
D8690	Orthodontic Treatment (Alternative Billing to a Contract Fee)	Not Covered	Not Covered
D8691	Repair of Orthodontic Appliance	Not Covered	Not Covered
D8692	Replacement of Lost or Broken Retainer	Not Covered	Not Covered
D8693	Rebonding or Recementing; and/or Repair, as Required, of Fixed Retainers	Not Covered	$0
D8999	Unspecified Orthodontic Procedure, By Report	Not Covered	Not Covered
Adjunctive General Services			
Unclassified Treatment			
D9110	Palliative (Emergency) Treatment of Dental Pain - Minor Procedure	Not Covered	$10
D9120	Fixed Partial Denture Sectioning	Not Covered	$0
Anesthesia			
D9210	Local Anesthesia Not in Conjunction with Operative or Surgical Procedures	Not Covered	$0
D9211	Regional Block Anesthesia	Not Covered	$0
D9212	Trigeminal Division Block Anesthesia	Not Covered	$0
D9215	Local Anesthesia in Conjunction With Operative or Surgical Proedures	$0	$0
D9220	Deep Sedation/General Anesthesia - First 30 Minutes	Not Covered	$150
D9221	Deep Sedation/General Anesthesia - Each Additional 15 Minutes	Not Covered	$45
D9230	Inhalation of Nitrous Oxide/anxiolysis, analgesia	$15	$15
D9241	Intravenous Conscious Sedation/Analgesia - First 30 Minutes	Not Covered	$150
D9242	Intravenous Conscious Sedation/Analgesia - Each Additional 15 Minutes	Not Covered	$45
D9248	Non-intravenous Conscious Sedation	Not Covered	$15
Professional Consultation			
D9310	Consultation - Diagnostic Service Provided by Dentist or Physician other than Requesting Dentist or Physician	$15	$0
Professional Visits			
D9410	House/Extended Care Facility Call	Not Covered	Not Covered
D9420	Hospital or Ambulatory Surgical Center Call	Not Covered	Not Covered
D9430	Office Visit for Observation (During Regularly Scheduled Hours) - No other Services Performed	$5	$0
D9440	Office Visit - After Regularly Scheduled Hours	$35	$30
D9450	Case Presentation, Detailed and Extensive Treatment Planning	$0	$0

	Broken Appointment without 24 hour notice - Per 15 Minutes	Not Covered	
Drugs			
D9610	Therapeutic Parenteral Drug, Single Administration	Not Covered	$15
D9612	Therapeutic Parenteral Drugs, Two or More Administrations, Different Medications	Not Covered	$25
D9630	Other Drugs and/or Medicaments, By Report	Not Covered	$15
Miscellaneous Services			
D9910	Application of Desensitizing Medicament	Not Covered	$15
D9911	Application of Desensitizing Resin for Cervical and/or Root Surface, Per Tooth	Not Covered	Not Covered
D9920	Behavior Management, By Report	Not Covered	Not Covered
D9930	Treatment of Complications (Post-surgical) - Unusual Circumstances, By Report	Not Covered	Not Covered
D9940	Occlusal Guard, By Report	Not Covered	$85
D9941	Fabrication of Athletic Mouthguard	Not Covered	Not Covered
D9942	Repair and/or Reline of Occlusal Guard	Not Covered	$40
D9950	Occlusion Analysis - Mounted Case	Not Covered	Not Covered
D9951	Occlusal Adjustment - Limited	$25	$30
D9952	Occlusal Adjustment - Complete	$150	$100
D9970	Enamel Micro abrasion	Not Covered	Not Covered
D9971	Odontoplasty 1-2 Teeth; Includes Removal of Enamel Projections	Not Covered	Not Covered
D9972	External Bleaching, Per Arch	Not Covered	$125
D9973	External Bleaching, Per Tooth	Not Covered	Not Covered
D9974	Internal Bleaching, Per Tooth	Not Covered	Not Covered
D9975	External bleaching for home application, per arch; includes materials and fabricaiton of custom trays	Not Covered	Not Covered
D9999	Unspecified Adjunctive Procedure, By Report	$20	$10

Additional lab and metal charges may apply for procedures in italics.

SECTION VI - COST PROPOSAL PAGE

Proposer Name: Humana

Proposer agrees to supply the products and services at the prices bid below in accordance with the terms, conditions and specifications contained in this RFP.

	Fully-Insured DHMO for Management & Teamsters	Fully-Insured DPPO for Management & Teamsters	Fully-Insured DPPO for Firefighters
Employee Only	$16.77	$55.28	$32.43
Employee + Spouse	$29.35	$103.57	$59.27
Employee + Child or Children	$35.22	$106.47	$52.56
Employee + Family	$49.37	$134.20	$92.84

The premiums listed above are guaranteed for

1 year _____ 2 years _____ 3 years __X____ 4 years _____ 5 years

Rate cap and details for any renewal not guaranteed:
The renewal rates are guaranteed for three years from January 1, 2018 through December 31, 2020. January 1, 2021 renewal includes a rate cap of no more than 5% which includes all plans, the DHMO and DPPO(TRP). January 1, 2022 renewal rate cap of no more than 5% which includes all plans, the DHMO and DPPO(TRP).

Multi-year guarantees (especially 3 years) are preferred and will be factored into the evaluation.

Submitted by:

Richard D. Remmers	
Name (printed)	Signature
April 7, 2017	Vice President, Group Segment
Date	Title

Dental fully-insured renewal summary

City of Fort Lauderdale
Group 573978
Renewal date: January 1, 2018

Your current and renewal dental rates

Plan description	Coverage type	Enrollment	Current rate	Monthly premium	Renewal rate	Monthly premium
Plan 1						
Traditional Preferred MAF , 100/80/50; periodontics/endodontics in Basic, $1500 annual maximum; $100 deductible; deductible waived on preventive; child/adult orthodontia with $1500 lifetime maximum, composite coverage, oral surgery rider	Employee	144	$30.88	$4,447	$32.43	$4,669
	Employee & Spouse	51	$56.45	$2,879	$59.27	$3,023
	Employee & Child(ren)	51	$50.05	$2,553	$52.56	$2,680
	Family	145	$88.42	$12,821	$92.84	$13,462
	Total	391		$22,699		$23,834
Plan 2						
PPO MAF , 100/100/60 in-network, 100/60/60 out-of-network; periodontics/endodontics in Basic, $1500 annual maximum; $0 in-network deductible, $100 out-of-network deductible; deductible waived on preventive; child/adult orthodontia with $2500 lifetime maximum, implant coverage, composite coverage, oral surgery rider	Employee	400	$52.64	$21,058	$55.28	$22,111
	Employee & Spouse	205	$98.64	$20,221	$103.57	$21,232
	Employee & Child(ren)	95	$101.40	$9,633	$106.47	$10,114
	Family	279	$127.81	$35,660	$134.20	$37,443
	Total	979		$86,572		$90,900
Plan 3						
FL DHMO HS195 Implants	Employee	270	$16.77	$4,528	$16.77	$4,528
	Employee & Spouse	86	$29.35	$2,524	$29.35	$2,524
	Employee & Child(ren)	73	$35.22	$2,571	$35.22	$2,571
	Family	96	$49.37	$4,740	$49.37	$4,740
	Total	525		$14,363		$14,363

Rates are guaranteed for 3 years, January 1, 2018 through December 31, 2020. January 1, 2021 renewal includes a rate cap of no more than 5% which includes all plans, the DHMO and PPO/Traditional Preferred. January 1, 2022 renewal includes a rate cap of no more than 5% which includes all plans, the DHMO and PPO/Traditional Preferred.

Humana is committed to addressing the link between oral and overall health through member education and targeted benefits.

You also receive:

EyeMed Vision discount program, where you and your employees can save money with more than 65,000 providers at 23,000 locations nationwide including optometrists, ophthalmologists, opticians. Retail locations includes LensCrafters, Pearle, Sears Optical, JCPenney Optical and Target Optical.

Access anytime to dental benefits information through our automated information line (1-800-233-4013) and **HumanaDental.com.**

Humana

HumanaDental
Prepaid HS195 Plan with Implants

Florida

Feel good about choosing a HumanaDental plan

The HumanaDental HS Series dental plan has you covered for any circumstance. Whether you simply need routine dental care or unexpected dental treatment, you know what to expect with HumanaDental.

- No waiting periods
- No claims to file
- No annual maximums

Use your HumanaDental benefits

After you enroll in a plan and receive your ID card, you can manage your plan information on your personal home page on **HumanaDental.com**.

- You have the freedom to select any participating general dentist as your primary care dentist. To select a dental provider from our network, simply visit **HumanaDental.com**. Once there, you can also check your benefits, email us and get a new or temporary ID card. If you prefer, contact us at 1-800-342-5209.
- Life without claim forms! With the HumanaDental Prepaid plan you pay your dentist directly, when applicable.
- Your primary dentist will provide all of your routine dental care and you will pay any copayment or discounted charges at the time of service.

Good health starts with a healthy mouth

Make dental visits a priority

One of the first lines of defense in overall health is dental care. Regular dental cleanings can help manage problems throughout the body, such as heart disease, diabetes, and stroke. In fact, a healthy mouth can add 6.4 years to RealAge® life expectancy.[1] The HumanaDental Prepaid plan enables you to take better care of your teeth, and you'll pay less for your dental care doing so.

Go to MyDentalIQ.com

Take a health risk assessment that immediately rates your dental health knowledge. You'll receive a personalized action plan with health tips. You can print a copy of your scorecard to discuss with your dentist at your next visit.

Tips to ensure a healthy mouth

- Use a soft-bristled toothbrush
- Choose toothpaste with fluoride
- Brush for at least two minutes twice a day
- Floss daily
- Watch for signs of periodontal disease such as red, swollen, or tender gums
- Visit a dentist regularly for exams and cleanings

Questions?

Check out HumanaDental.com

Call 1-800-233-4013, Monday through Friday, 8 a.m. to 6 p.m. (TDD: 1-800-325-2025).

For exclusions and limitations, please review the Specialty Benefits Regulatory and Technical Information Guide available at **Disclosure.Humana.com**.

[1] Dr. Michael Roizen, RealAge.com

HumanaDental Prepaid HS195 Plan with Implants

The HumanaDental Prepaid plans focus on maintaining oral health, prevention and cost-containment. Members may see a primary care dentist as often as necessary. There are no yearly maximums, no deductibles to meet and no waiting periods. HS plans copayments for listed procedures are applicable only at a participating general dentist.

A primary care dentist (PCD) may decide that a member needs to see a contracted dental specialist. No referral is necessary to see a network specialist.

Specialists services: Should members need a specialist, (i.e., endodontist, oral surgeon, periodontist, pediatric dentist), they may be referred by a participating general dentist, or members can self-refer to any participating specialist. For HS plans, copayment amounts are applicable when treatment is performed by participating specialists.

Summary of services

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

Appointments		**Member pays**
D9310	Consultation (diagnostic service provided by dentist other than practitioner providing treatment)	no charge
D9430	Office visit (normal hours)	no charge
D9440	Office visit (after regularly scheduled hours)	$ 30.00
D9999	Broken appointments (without 24 hr. notice, per 15 min)—maximum $40 per broken appointment. No charge will be made due to emergencies	$ 10.00

Diagnostic		**Member pays**
D0120	Periodic oral examination (two per calendar year)	no charge
D0140	Limited/comprehensive/detailed and extensive oral eval	no charge
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	no charge
D0150	Limited/comprehensive/detailed and extensive oral eval (two per calendar year)	no charge
D0160	Limited/comprehensive/detailed and extensive oral eval	no charge
D0170	Re-evaluation—problem focused (not post-operative visit)	no charge
D0180	Comprehensive periodontal evaluation (two per calendar year)	no charge
D0210	X-ray intraoral—complete series including bitewings (once per three calendar years)	no charge
D0220	X-ray intraoral—periapical, first film	no charge
D0230	X-ray intraoral—periapical, each additional film	no charge
D0240	X-rays intraoral—occlusal film	no charge
D0250	Extraoral—first film	no charge
D0260	Extraoral—each additional film	no charge
D0270	X-ray bitewing—single film (two per calendar year)	no charge
D0272	X-ray bitewings—two films (two per calendar year)	no charge
D0273	X-ray bitewings—three films (two per calendar year)	no charge
D0274	Bitewings—four films (two per calendar year)	no charge
D0277	X-ray bitewings, vertical—seven to eight films (two per calendar year)	no charge
D0330	Panoramic film (once per three calendar years)	no charge
D0350	Oral/facial photography images	no charge
D0415	Collect microorganisms culture & sensitivity	no charge
D0425	Caries susceptibility tests	no charge
D0431	Oral cancer screening using a special light source.	$ 50.00
D0460	Pulp vitality tests (not covered if a root canal is performed)	no charge
D0470	Diagnostic casts	no charge
D0472	Pathology report—gross examination of lesion.	no charge
D0473	Pathology report—microscopic examination of lesion	no charge
D0474	Pathology report—microscopic examination of lesion and area	no charge

Preventive		**Member pays**
D1110	Prophylaxis—adult, routine (two per calendar year, by primary care dentist)	no charge
D1111	Additional—adult prophylaxis, with or without fluoride (maximum of two additional per year)	$ 35.00
D1120	Prophylaxis—child, routine (two per calendar year)	no charge
D1121	Additional—child prophylaxis, with or without fluoride (maximum of two additional per year)	$ 25.00
D1203	Topical application of fluoride (not including prophylaxis)—child (up to 16 years of age) (two per calendar year)	no charge
D1204	Topical application of fluoride—adult (two per calendar year, by primary care dentist).	no charge
D1206	Topical fluoride varnish (for child <16) (two per calendar year)	no charge
D1310	Nutrition counseling for the control or avoidance of dental disease.	no charge
D1320	Tobacco counseling services for the control or prevention of oral disease	no charge
D1330	Oral hygiene instruction	no charge
D1351	Sealant—per tooth (permanent teeth only to age 16)	no charge

D1510*	Space maintainer—fixed, unilateral (through age 14)	$ 25.00
D1515*	Space maintainer—fixed, bilateral (through age 14)	$ 25.00
D1520*	Space maintainer—removable, unilateral (through age 14)	$ 35.00
D1525*	Space maintainer—removable, bilateral (through age 14)	$ 35.00
D1550	Recementation of space maintainer	$ 15.00
D1555	Removal of fixed space maintainer	$ 15.00

Restorative		**Member pays**
D2140	Amalgam—one surface, primary or permanent	no charge
D2150	Amalgam—two surfaces, primary or permanent	no charge
D2160	Amalgam—three surfaces, primary or permanent	no charge
D2161	Amalgam—four or more surfaces, primary or permanent	no charge
D2940	Sedative filling	no charge

Resin restorative
(inlays and onlays limited to one per tooth every five years)

		Member pays
D2330	Resin based composite—one surface, anterior	no charge
D2331	Resin based composite—two surfaces, anterior	no charge
D2332	Resin based composite—three surfaces, anterior	no charge
D2335	Resin based composite—four or more surfaces or involving incisal angle (anterior)	no charge
D2390	Resin based composite crown, anterior	$ 30.00
D2391	Resin based composite—one surface, posterior	$ 30.00
D2392	Resin based composite—two surfaces, posterior	$ 45.00
D2393	Resin based composite—three surfaces, posterior	$ 65.00
D2394	Resin based composite—four or more surfaces, posterior	$ 65.00
D2510*	Inlay—metallic, one surface	$225.00
D2520*	Inlay—metallic, two surfaces	$235.00
D2530*	Inlay—metallic, three or more surfaces	$245.00
D2542*	Onlay—metallic, two surfaces	$245.00
D2543*	Onlay—metallic, three surfaces	$260.00
D2544*	Onlay—metallic, four or more surfaces	$270.00
D2610*	Inlay—porcelain/ceramic, one surface	$245.00
D2620*	Inlay—porcelain/ceramic, two surfaces	$245.00
D2630*	Inlay—porcelain/ceramic, three or more surfaces	$245.00
D2642*	Onlay—porcelain/ceramic, two surfaces	$245.00
D2643*	Onlay—porcelain/ceramic, three surfaces	$245.00
D2644*	Onlay—porcelain/ceramic, four or more surfaces	$245.00
D2650*	Inlay—resin based composite, one surface	$245.00
D2651*	Inlay—resin based composite, two surfaces	$245.00
D2652*	Inlay—resin based composite, three or more surfaces	$245.00
D2662*	Onlay—resin based composite, two surfaces	$245.00
D2663*	Onlay—resin based composite, three surfaces	$245.00
D2664*	Onlay—resin based composite, four or more surfaces	$245.00

Crown and bridge
(limited to one per tooth every five years)

		Member pays
D2710*	Crown—resin based composite, indirect	$245.00
D2712*	Crown—3/4 resin based composite, indirect	$245.00
D2720*	Crown—resin with high noble metal	$245.00
D2721	Crown—resin with predominantly base metal	$245.00
D2722*	Crown—resin with noble metal	$245.00
D2740*	Crown—porcelain/ceramic substrate	$245.00
D2750*	Crown—porcelain fused to high noble metal	$245.00
D2751	Crown—porcelain fused to predominantly base metal	$245.00
D2752*	Crown—porcelain fused to noble metal	$245.00
D2780*	Crown—3/4 cast high noble metal	$245.00
D2781	Crown—3/4 cast predominantly base metal	$245.00
D2782*	Crown—3/4 cast noble metal	$245.00
D2783*	Crown—3/4 porcelain/ceramic	$245.00
D2790*	Crown—full cast high noble metal	$245.00
D2791	Crown—full cast predominantly base metal	$245.00
D2792*	Crown—full cast noble metal	$245.00
D2794*	Crown—titanium	$245.00
D2799	Provisional crown	no charge
D2910	Recement inlay, onlay or veneer	no charge
D2915	Recement cast or prefabricated post and core	no charge
D2920	Recement crown	no charge
D2930	Prefabricated stainless steel crown—primary tooth	$ 25.00
D2931	Prefabricated stainless steel crown—permanent tooth	$ 25.00
D2932	Prefabricated resin crown	$ 45.00
D2933	Prefabricated stainless steel crown with resin window	$ 45.00
D2950	Core buildup, including any pins	$ 70.00
D2951	Pin retention—per tooth, in addition to restoration	$ 10.00
D2952*	Cast post and core in addition to crown	$ 50.00
D2953*	Each additional cast post—same tooth	$ 50.00
D2954	Prefabricated post and core in addition to crown	$ 30.00
D2955	Post removal	$ 10.00
D2957	Each additional prefabricated post—same tooth, base metal post	$ 30.00
D2960	Labial veneer (resin laminate)—chairside	$250.00
D2961*	Labial veneer (resin laminate)—laboratory	$300.00
D2962*	Labial veneer (porcelain laminate)—laboratory	$350.00
D2970	Temporary crown (fractured tooth)	no charge
D2971	Additional procedure—new crown existing partial denture	$ 50.00
D2980	Crown repair	no charge
D6940	Stress breaker	$110.00
D6950	Precision attachment	$195.00
D6970*	Cast post and core, in addition to fixed partial denture retainer	$ 50.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer, base metal post	$ 30.00
D6976*	Each additional cast post—same tooth	$ 40.00
D6977	Each additional prefabricated post—same tooth	$ 40.00
D6980*	Fixed partial denture repair, by report	$ 45.00

Prosthodontics (fixed)
(replacement limited to every five years, adjustments once per year)

		Member pays
D6210*	Pontic—cast high noble metal	$245.00
D6211	Pontic—cast predominantly base metal	$245.00
D6212*	Pontic—cast noble metal	$245.00
D6240*	Pontic—porcelain fused to high noble metal	$245.00
D6241	Pontic—porcelain fused to predominantly base metal	$245.00
D6242*	Pontic—porcelain fused to noble metal	$245.00
D6750*	Crown—porcelain fused to high noble metal	$245.00
D6751	Crown—porcelain fused to predominantly base metal	$245.00
D6752*	Crown—porcelain fused to noble metal	$245.00

D6790*	Crown—full cast high noble metal	$245.00
D6791	Crown—full cast predominantly base metal	$245.00
D6792*	Crown—full cast noble metal	$245.00
D6794*	Crown—titanium	$245.00
D6930	Recement fixed partial denture (per unit)	no charge
D6973	Core buildup for retainer, including any pins	$ 10.00

Prosthodontics

(replacement limited to every five years)		**Member pays**
D5110*	Complete denture—maxillary	$325.00
D5120*	Complete denture—mandibular	$325.00
D5130*	Immediate denture—maxillary	$350.00
D5140*	Immediate denture—mandibular	$350.00
D5211*	Maxillary partial denture—resin base	$400.00
D5212*	Mandibular partial denture—resin base	$400.00
D5213*	Maxillary partial denture—cast metal framework, resin denture bases	$425.00
D5214*	Mandibular partial denture—cast metal framework, resin denture bases	$425.00
D5225*	Maxillary partial denture—flexible (including clasps, rests and teeth)	$425.00
D5226*	Mandibular partial denture—flexible (including clasps, rests and teeth)	$425.00
D5281*	Removable partial denture—one piece cast metal	$300.00
D5410	Adjust complete denture—maxillary	$ 10.00
D5411	Adjust complete denture—mandibular	$ 10.00
D5421	Adjust partial denture—maxillary	$ 10.00
D5422	Adjust partial denture—mandibular	$ 10.00
D5660*	Add clasp to existing partial denture	$ 35.00

Endodontics

(each procedure limited to once per tooth per life)		**Member pays**
D3110	Pulp cap—direct (excluding final restoration)	$ 5.00
D3120	Pulp cap—indirect (excluding final restoration)	$ 5.00
D3220	Therapeutic pulpotomy	$ 30.00
D3221	Pulpal debridement, primary and permanent teeth	$ 55.00
D3230	Pulpal therapy (resorbable filling)—anterior, primary tooth (excluding final restoration)	$ 40.00
D3240	Pulpal therapy (resorbable filling)—posterior, primary tooth (excluding final restoration)	$ 40.00
D3310	Root canal therapy—anterior (excluding final restoration)	$100.00
D3320	Root canal therapy—bicuspid (excluding final restoration)	$152.00
D3330	Root canal therapy—molar (excluding final restoration)	$210.00
D3331	Treatment of root canal obstruction—non-surgical access	$ 85.00
D3332	Incomplete endodontic therapy—inoperable or fractured tooth	$ 96.00
D3333	Internal root repair of perforation defects	$ 85.00
D3346	Retreatment of previous root canal therapy—anterior	$180.00
D3347	Retreatment of previous root canal therapy—bicuspid	$280.00
D3348	Retreatment of previous root canal therapy—molar	$325.00
D3351	Apexification/recalcification—initial visit	$ 70.00
D3352	Apexification/recalcification—interim	$ 70.00
D3353	Apexification/recalcification—final visit	$ 70.00
D3410	Apicoectomy/periradicular surgery—anterior	$ 95.00
D3421	Apicoectomy/periradicular surgery—bicuspid (first root)	$ 95.00
D3425	Apicoectomy/periradicular surgery—molar (first root)	$ 95.00
D3426	Apicoectomy/periradicular surgery (each additional root)	$ 60.00
D3430	Retrograde filling—per root	$ 60.00
D3450	Root amputation—per root (not covered in conjunction with procedure D3920)	$ 95.00
D3910	Surgical procedure to isolate tooth with rubber dam	$ 19.00
D3920	Hemisection not included in root canal therapy	$ 90.00
D3950	Root canal prepare and fit preformed dowel/post	$ 15.00

Periodontics (gum treatment)		**Member pays**
D4210	Gingivectomy/gingivoplasty per quadrant	$110.00
D4211	Gingivectomy/gingivoplasty per tooth	$ 83.00
D4240	Gingival flap, including root planing—four or more teeth, per quadrant	$150.00
D4241	Gingival flap, including root planing—one to three teeth, per quadrant	$113.00
D4245	Apically positioned flap	$165.00
D4249	Clinical crown lengthening—hard tissue	$150.00
D4260	Osseous surgery—four or more teeth or bounded spaces, per quadrant	$300.00
D4261	Osseous surgery—one to three teeth, per quadrant	$225.00
D4263	Bone replacement graft—first site in quadrant	$180.00
D4264	Bone replacement graft—each additional site in quadrant bone	$ 95.00
D4265	Biological materials which can aid soft and osseous tissue regeneration	$ 95.00
D4266	Guided tissue regeneration—resorbable barrier, per site	$215.00
D4267	Guided tissue regeneration—nonresorbable barrier, per site (includes membrane removal)	$255.00
D4270	Pedicle soft tissue graft procedure	$245.00
D4271	Free soft tissue graft procedure (including donor site surgery)	$245.00
D4273	Subepithelial connective tissue graft, tooth	$ 75.00
D4274	Distal or proximal wedge procedure	$100.00
D4275	Soft tissue allograft	$380.00
D4320	Provisional splinting—intracoronal	$ 95.00
D4321	Provisional splinting—extracoronal	$ 85.00
D4341	Periodontal scaling and root planing, per quadrant (a maximum of four quadrants will be paid in any combinations, per 24 calendar months for procedures D4341 and D4342)	$ 50.00
D4342	Periodontal scaling and root planing one to three teeth per quadrant (a maximum of four quadrants will be paid in any combinations, per 24 calendar months for procedures D4341 and D4342)	$ 38.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis (once per five calendar years)	$ 50.00
D4381	Localized delivery of chemotherapeutic agents (per tooth) (limited to once per tooth per 12 months to a maximum of three tooth sites per quadrant, and performed no less than three months following active periodontal therapy)	$ 65.00
D4910	Periodontal maintenance (covered only after active periodontal therapy)	$ 40.00

D4911	Additional periodontal maintenance procedures (beyond two per 12 months)	$ 55.00

Extractions/oral and maxillofacial surgery		Member pays
D7111	Coronal remnants, deciduous tooth	$ 5.00
D7140	Extraction, erupted tooth or exposed tooth	$ 5.00
D7210	Surgical removal of erupted tooth	$ 30.00
D7220	Removal of impacted tooth—soft tissue	$ 50.00
D7230	Removal of impacted tooth—partially bony	$ 65.00
D7240	Removal of impacted tooth—completely bony	$ 80.00
D7241	Removal of impacted tooth—completely bony, unusual complications by report	$100.00
D7250	Surgical removal of residual tooth roots	$ 40.00
D7270	Tooth stabilization of accidentally avulsed or displaced tooth	$ 50.00
D7280	Surgical access of an unerupted tooth (excluding wisdom teeth)	$100.00
D7282	Mobilization of erupted or malposed tooth to aid eruption	$ 90.00
D7283	Placement of device to facilitate eruption of impacted tooth	$ 90.00
D7285	Biopsy of oral tissue—hard (bone, tooth)	$150.00
D7286	Biopsy of oral tissue—soft (all others)	$ 60.00
D7287	Exfoliative cytological sample collection	$ 50.00
D7288	Brush biopsy—transepithelial sample collection	$ 50.00
D7310	Alveoloplasty in conjunction with extractions—per quadrant	$ 40.00
D7311	Alveoloplasty in conjunction with extractions—one to three teeth or tooth spaces, per quadrant	$ 15.00
D7320	Alveoloplasty not in conjunction with extractions—per quadrant	$ 60.00
D7321	Alveoloplasty not in conjunction with extractions—one to three teeth or tooth spaces, per quadrant	$ 25.00
D7471	Removal of lateral exostosis (maxilla or mandible)	$ 80.00
D7472	Removal of torus palatinus	$ 60.00
D7473	Removal of torus mandibularis	$ 60.00
D7485	Surgical reduction of osseous tuberosity	$ 60.00
D7510	Incision and drainage of abscess—intraoral soft tissue	$ 35.00
D7511	Incision and drainage of abscess—intraoral soft tissue, complicated (includes drainage of multiple fascial spaces)	$ 35.00
D7520	Incision and drainage of abscess—extraoral soft tissue	$ 35.00
D7521	Incision and drainage of abscess—extraoral soft tissue, complicated (includes drainage of multiple fascial spaces)	$ 35.00
D7910	Suture of recent small wounds up to 5 cm	$ 25.00
D7960	Frenulectomy (frenectomy or frenotomy)—separate procedure	$ 50.00
D7963	Frenuloplasty	$ 50.00
D7970	Excision hyperplastic tissue—per arch	$ 55.00
D7971	Excision of pericoronoal gingiva	$ 40.00

Repairs to prosthetics		Member pays
D5510*	Repair broken complete denture base	$ 35.00
D5520*	Replace missing or broken teeth—complete denture (each tooth)	$ 35.00
D5610*	Repair resin denture base	$ 35.00
D5620*	Repair cast framework	$ 35.00
D5630*	Repair or replace broken clasp	$ 35.00
D5640*	Replace broken teeth—per tooth	$ 35.00
D5650*	Add tooth to existing partial denture	$ 35.00
D5670*	Replace all teeth and acrylic framework—maxillary	$165.00
D5671*	Replace all teeth and acrylic framework—mandibular	$165.00
D5710*	Rebase complete maxillary denture	$ 75.00
D5711*	Rebase complete mandibular denture	$ 75.00
D5720*	Rebase maxillary partial denture	$ 75.00
D5721*	Rebase mandibular partial denture	$ 75.00
D5730	Reline complete maxillary denture (chairside)	$ 65.00
D5731	Reline complete mandibular denture (chairside)	$ 65.00
D5740	Reline maxillary partial denture (chairside)	$ 65.00
D5741	Reline mandibular partial denture (chairside)	$ 65.00
D5750*	Reline complete maxillary denture (laboratory)	$ 85.00
D5751*	Reline complete mandibular denture (laboratory)	$ 85.00
D5760*	Reline maxillary partial denture (laboratory)	$ 85.00
D5761*	Reline mandibular partial denture (laboratory)	$ 85.00
D5810*	Interim complete denture (maxillary)	$230.00
D5811*	Interim complete denture (mandibular)	$230.00
D5820*	Interim partial denture (maxillary)	$160.00
D5821*	Interim partial denture (mandibular)	$170.00
D5850	Tissue conditioning, maxillary	$ 20.00
D5851	Tissue conditioning, mandibular	$ 20.00
D5862*	Precision attachment, by report	$160.00
D6214*	Pontic titanium	$245.00
D6245*	Pontic—porcelain/ceramic	$245.00
D6250*	Pontic—resin with high noble metal	$245.00
D6251	Pontic—resin with predominantly base metal	$245.00
D6252*	Pontic—resin with noble metal	$245.00
D6253*	Provisional pontic	no charge
D6545*	Retainer—cast metal, resin bonded fixed prosthesis	$150.00
D6600*	Inlay—porcelain/ceramic, two surfaces	$245.00
D6601*	Inlay—porcelain/ceramic, three or more surfaces	$245.00
D6602*	Inlay—cast high noble metal, two surfaces	$245.00
D6603*	Inlay—cast high noble metal, three or more surfaces	$245.00
D6604	Inlay—cast predominantly base metal, two surfaces	$245.00
D6605	Inlay—cast predominantly base metal, three or more surfaces	$245.00
D6606*	Inlay—cast noble metal, two surfaces	$245.00
D6607*	Inlay—cast noble metal, three or more surfaces	$245.00
D6608*	Onlay—porcelain/ceramic, two surfaces	$245.00
D6609*	Onlay—porcelain/ceramic, three or more surfaces	$245.00
D6610*	Onlay—cast high noble metal, two surfaces	$245.00
D6611*	Onlay—cast high noble metal, three or more surfaces	$245.00
D6612	Onlay—cast predominantly base metal, two surfaces	$245.00
D6613	Onlay—cast predominantly base metal, three or more surfaces	$245.00
D6614*	Onlay—cast noble metal, two surfaces	$245.00
D6615*	Onlay—cast noble metal, three or more surfaces	$245.00
D6710*	Crown—indirect resin based composition	$245.00
D6720*	Crown—resin with high noble metal	$245.00
D6721	Crown—resin with predominantly base metal	$245.00
D6722*	Crown—resin with noble metal	$245.00
D6740*	Crown—porcelain/ceramic	$245.00
D6780*	Crown—3/4 cast high noble metal	$245.00
D6781	Crown—3/4 cast predominantly base metal	$245.00
D6782*	Crown—3/4 cast noble metal	$245.00
D6783*	Crown—3/4 porcelain/ceramic, denture	$245.00

Adjunctive general service		Member pays
D9110	Palliative (emergency) treatment of dental pain—minor procedure	$ 10.00
D9120	Fixed partial denture sectioning	no charge
D9210	Local anesthesia not in conjunction with operative or surgical procedures	no charge
D9211	Regional block anesthesia	no charge
D9212	Trigeminal division block anesthesia	no charge
D9215	Local anesthesia	no charge
D9220	General anesthesia—first 30 minutes (limited to the removal of partial, or complete boney impacted teeth)	$150.00
D9221	General anesthesia—additional 15 minutes (limited to the removal of partial, or complete boney impacted teeth)	$ 45.00
D9230	Analgesia (nitrous oxide), per 15 minutes	$ 15.00
D9241	I.V. conscious sedation—first 30 minutes (limited to the removal of partial, or complete boney impacted teeth)	$150.00
D9242	I.V. conscious sedation—additional 15 minutes (limited to the removal of partial, or complete boney impacted teeth)	$ 45.00
D9248	Non-intravenous conscious sedation	$ 15.00
D9450	Case presentation, detailed and extensive treatment planning	no charge
D9610	Non-intravenous conscious sedation	$ 15.00
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	$ 25.00
D9630	Other drugs and/or medicaments, by report	$ 15.00
D9910	Application of desensitizing medicament	$ 15.00
D9940	Occlusal guard, by report	$ 85.00
D9942	Repair and/or reline of occlusal guard	$ 40.00
D9951	Occlusal adjustment—limited	$ 30.00
D9952	Occlusal adjustment—complete	$100.00

Bleaching		Member pays
D9972	External bleaching—per arch	$125.00

Orthodontics		Member pays
D8070	Comprehensive orthodontic treatment of the transitional dentition	$1,850.00
	Consultation	no charge
	Evaluation	$ 35.00
	Records/treatment planning	$ 250.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1,850.00
	Consultation	no charge
	Evaluation	$ 35.00
	Records/treatment planning	$ 250.00
D8090	Comprehensive orthodontic treatment of the adult dentition	$1,850.00
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$ 300.00
D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers	no charge

Implants (available for groups 10+ enrolled)

Coverage for implants:

- Implants and implant supported prostheses covered at a 50% coinsurance
- Annual Maximum Benefit of $1,500
- Lifetime Maximum Benefit of $10,000

NOTE:

- Not all participating dentists perform all listed procedures, including amalgams. Please consult your dentist prior to treatment for availabilty of services.
- Unlisted procedures are available at certain participating dentists usual fee less 25%. Visit HumanaDental.com to find a participating dentist who offers the discount on non-covered services.
- When crown and/or bridgework exceeds six units in the same treatment plan, the patient may be charged an additional $75 per unit
- Some covered services are typically only offered by a specialist (like many oral surgery procedures)
- Additional exclusions and limitations are listed along with full plan information in your certificate of benefits. If you do not have a certificate of benefits, please review the Specialty Benefits Regulatory and Technical Information Guide available at Disclosure.Humana.com.

Insured or administered by CompBenefits Company

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HumanaDental Traditional Preferred 09

HUMANA. Specialty Benefits

FLORIDA

City of Fort Lauderdale-Firefighters

Calendar-year deductible (excludes orthodontia services)	**Per person** $100	
Annual maximum (excludes orthodontia services)	$1,500	
Preventive services • Oral examinations • X-rays • Cleanings • Topical fluoride treatment • Sealants	100% no deductible	
Basic services • Space maintainers • Emergency care for pain relief • Basic oral surgery services - basic extractions of erupted tooth or root • Fillings (amalgam, composite for anterior teeth) • Appliances for children • Prefabricated stainless steel crowns • Complex surgical extractions - surgical removal of erupted tooth, impacted tooth, and tooth roots • Composite fillings for molars • Periodontics • Endodontics (root canal)	80% after deductible	
Major services • Crowns • Inlays and onlays • Bridgework • Dentures • Denture relines and rebases • Denture repair and adjustments	50% after deductible	
Orthodontia	Adult/child orthodontia. - Plan pays 50 percent (no deductible) of the covered orthodontia services, up to: $1,500 lifetime orthodontia maximum.	

Non-participating dentists can bill you for charges above the amount covered by your HumanaDental plan. To ensure you do not receive additional charges, visit a participating PPO Network dentist. If a member sees an out-of-network dentist, the coinsurance level will apply to the maximum allowable fee.

Waiting periods

Employer-sponsored funding: 10+ enrolled employees

Enrollment type	Preventive	Basic	Major	Orthodontia
Initial enrollment, open enrollment and timely add-on	No	No	No	No
Late applicant [1]	No	12 months	12 months	12 months

[1] Late applicants not allowed with open enrollment option.

HumanaDental Traditional Preferred 09

HUMANA. Specialty Benefits

Questions?

Simply call 1-800-233-4013 to speak with a friendly, knowledgeable Customer Care specialist, or visit **Humana.com**.

Feel good about choosing a HumanaDental plan

Make regular dental visits a priority

Regular cleanings can help manage problems throughout the body such as heart disease, diabetes, and stroke.* Your HumanaDental Traditional Preferred plan focuses on prevention and early diagnosis, providing four exams and cleanings every calendar year: two regular and two periodontal.

* www.perio.org

Go to MyDentalIQ.com

Take a health risk assessment that immediately rates your dental health knowledge. You'll receive a personalized action plan with health tips. You can print a copy of your scorecard to discuss with your dentist at your next visit.

Tips to ensure a healthy mouth

- Use a soft-bristled toothbrush
- Choose toothpaste with fluoride
- Brush for at least two minutes twice a day
- Floss daily
- Watch for signs of periodontal disease such as red, swollen, or tender gums
- Visit a dentist regularly for exams and cleanings

Did you know that 74 percent of adult Americans believe an unattractive smile could hurt a person's chances for career success?* HumanaDental helps you feel good about your dental health so you can smile confidently.

* American Academy of Cosmetic Dentistry

Use your HumanaDental benefits

Find a dentist

With HumanaDental' s Traditional Preferred plan, you can see any dentist. You save an average of 30 percent when you visit a dentist in HumanaDental' s Traditional Preferred Network. To find a dentist in HumanaDental' s Traditional Preferred Network, log on to **Humana.com** or call 1-800-233-4013.

Know what your plan covers

The other side of this page provides a summary of HumanaDental benefits. Your plan certificate describes in detail your HumanaDental benefits. You can find it on MyHumana, your personal page at **Humana.com** or call 1-800-233-4013.

See your dentist

Your HumanaDental identification card contains all the information your dentist needs to submit your claims. Be sure to share it with the office staff when you arrive for your appointment. If you don't have your card, you can print proof of coverage at **Humana.com**.

Learn what your plan paid

After HumanaDental processes your dental claim, you will receive an explanation of benefits or claims receipt. It provides detailed information on covered dental services, amounts paid, plus any amount you may owe your dentist. You can also check the status of your claim on MyHumana at **Humana.com** or by calling 1-800-233-4013.

HUMANA. Specialty Benefits

Insured or administered by HumanaDental Insurance Company

This is not a complete disclosure of plan qualifications and limitations. Your broker will provide you with specific limitations and exclusions as contained in the Regulatory and Technical Information Guide. Please review this information before applying for coverage. The amount of benefits provided depends upon the plan selected. Premiums will vary according to the selection made.

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Humana Dental PPO 09

FLORIDA

City of Fort Lauderdale

	If you use IN-NETWORK provider		If you use OUT-OF-NETWORK provider	
Calendar-year deductible (excludes orthodontia services)	Individual $0	Family $0	Individual $100	Family $300
Annual maximum (excludes orthodontia services)	$1,500			
Preventive services • Oral examinations • X-rays • Cleanings • Topical fluoride treatment (through age 14, one per calendar year) • Sealants (through age 14) • Emergency care for pain relief	100%		100% no deductible of maximum allowed fee	
Basic services • Space maintainers (through age 14) • Basic oral surgery services - basic extractions of erupted tooth or root • Fillings (amalgam, composite for anterior teeth) • Appliances for children (through age 14) • Prefabricated stainless steel crowns • Complex surgical extractions - surgical removal of erupted tooth, impacted tooth, and tooth roots • Composite fillings for molars • Denture repair and adjustments • Periodontics • Endodontics (root canal)	100%		60% after deductible of maximum allowed fee	
Major services • Crowns • Inlays and onlays • Bridgework • Dentures • Denture relines and rebases • Denture repair and adjustments • Implant	60%		60% after deductible of maximum allowed fee	
Orthodontia	Adult/child orthodontia - Plan pays 60 percent (no deductible) of the covered orthodontia services, up to: $2,500 lifetime orthodontia maximum.			

Non-participating dentists can bill you for charges above the amount covered by your HumanaDental plan. To ensure you do not receive additional charges, visit a participating PPO Network dentist.

Waiting periods

Employer-sponsored funding: 10+ enrolled employees

Enrollment type	Preventive	Basic	Major	Orthodontia
Initial enrollment, open enrollment and timely add-on	No	No	No	No
Late applicant [1]	No	12 months	12 months	12 months

[1] Late applicants not allowed with open enrollment option.

HumanaDental PPO 09

Waiting periods

Voluntary funding: 10+ enrolled employees

Enrollment type	Preventive	Basic	Major	Orthodontia
Initial enrollment, open enrollment and timely add-on	No	No	No	12 months [1]
Late applicant [2]	No	12 months	12 months	12 months

[1] The 12-month waiting period may be decreased or waived based on the number of months the member had dental coverage immediately before joining the HumanaDental plan. Members must have prior orthodontic coverage to reduce or waive the waiting period under orthodontia.

[2] Late applicants not allowed with open enrollment option.

Humana Dental PPO 09

Questions?

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Make regular dental visits a priority

Regular cleanings can help manage problems throughout the body such as heart disease, diabetes, and stroke.* Your HumanaDental PPO plan focuses on prevention and early diagnosis, providing four exams and cleanings every calendar year: two regular and two periodontal.

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- Watch for signs of periodontal disease such as red, swollen, or tender gums
- Visit a dentist regularly for exams and cleanings

Did you know that 74 percent of adult Americans believe an unattractive smile could hurt a person's chances for career success?* HumanaDental helps you feel good about your dental health so you can smile confidently.

* American Academy of Cosmetic Dentistry

Use your HumanaDental benefits

Find a dentist

With HumanaDental's PPO plan, you can see any dentist. Members and their families benefit from negotiated discounts on covered services by choosing dentists in the HumanaDental PPO Network. To find a dentist in HumanaDental's PPO Network, log on to **Humana.com** or call 1-800-233-4013.

Know what your plan covers

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See your dentist

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Learn what your plan paid

After HumanaDental processes your dental claim, you will receive an explanation of benefits or claims receipt. It provides detailed information on covered dental services, amounts paid, plus any amount you may owe your dentist. You can also check the status of your claim on MyHumana at **Humana.com** or by calling 1-800-233-4013.

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FLHHNPKEN

Policy Number: FL-70090-HC 3/08 et. al.

SECTION VII - NETWORK INFORMATION

Network Summary

Please list the current number of DHMO **dentists, not dental offices,** by category by county. For general dentists, list only those currently accepting members. ***If a provider has more than 1 office he or she should be counted only once.***

	Broward	Miami-Dade	Palm Beach	Martin
General Dentists	364	444	235	9
Pediatric Dentists	47	50	23	1
Oral Surgeons	22	33	25	0
Endodontists	20	18	35	1
Periodontists	33	20	23	2
Prosthodontists	9	1	3	0
Orthodontists	35	43	28	1

Please list the current number of PPO **dentists, not dental offices,** by category by county. ***If a provider has more than 1 office he or she should be counted only once.***

	Broward	Miami-Dade	Palm Beach	Martin
General Dentists	597	721	384	21
Pediatric Dentists	55	43	26	5
Oral Surgeons	29	35	26	1
Endodontists	27	25	24	1
Periodontists	37	26	16	7
Prosthodontists	11	1	5	0
Orthodontists	41	48	28	2

Specific Dentist Network

We have attached and Excel file, *specific providers.xlsx,* with two lists of providers:

- DHMO providers with members assigned
- DPPO providers utilized by City members. Please indicate which of these providers participate in your company's DPPO or DHMO network.

Include the completed form in your proposal. Also provide the completed form in Excel format on a Flash Drive.

*Please refer to our attached Excel sheet, which includes the completed provider list.

City of Fort Lauderdale
Top 250 DPPO Providers
Claims Paid 1/1/2016 - 12/31/2016

Company Name: Humana

Indicate which of the listed providers is included in your company's proposed DPPO network and include a hard copay as well as an Excel file in your response.

Rank	Federal Employer ID	Name	Address	City	State	Zip	In Network? Yes or No
1	461185149	Destefon, John J	30 NE 3rd St	Ft Lauderdale	FL	33301	Y
2	591389949	Rosenthal, Barry W	9200 NW 44th St	Sunrise	FL	33351	N
3	202058007	Leibowitz, Jayson R	10080 NW 1st Ct	Plantation	FL	33324	Y
4	650341505	Moore, Keith E	901 S Federal Hwy Ste 301	Fort Lauderdale	FL	33316	N
5	453626385	Young, Jared M	1930 Ne 34th Ct	Lighthouse Point	FL	33064	Y
6	592495753	Barr, Scott I	300 NW 70 Ave, #206	Plantation	FL	33317	N
7	203791829	Robinson, Sharon R	6738 W Sunrise Blvd, Ste 105	Plantation	FL	33313	Y
8	650666819	Bartlett, Jeffrey C	2440 E Sunrise Blvd	Fort Lauderdale	FL	33304	Y
9	943420892	Horst, Nadja A	104 SE 1st St	Ft Lauderdale	FL	33301	Y
10	461919850	Douglass, Richard C	660 N State Road 7, Ste 12	Plantation	FL	33317	Y
11	461543139	Alexander, Allison	113 SW 11th Ct, Ste A	Ft Lauderdale	FL	33315	Y
12	412220291	Giraldo, Andrea	114 SW 10th St	Fort Lauderdale	FL	33315	N
13	591541047	Bennett, James G	1023 Atlantic Blvd	Atlantic Beach	FL	32233	Y
14	223703976	Mankame, Dipak M	300 NW 70th Ave, Ste 109	Plantation	FL	33317	Y
15	650985810	Yang, James T	10189 Cleary Blvd, Ste 201	Plantation	FL	33324	Y
16	421650718	Stanton, Robert B	1776 N Pine Island Rd, Ste 300	Plantation	FL	33322	Y
17	650700287	George, Ronald A	4100 S Hospital Dr, Ste 107	Plantation	FL	33317	Y
18	208195969	Polasky, Dawn L	6231 N Federal Hwy, Ste 109	Ft Lauderdale	FL	33308	Y
19	271200319	Riley, Marilyn P	3909 N Andrews Ave	Oakland Park	FL	33309	Y
20	591425149	Wilentz, Abby T	7400 NW 5th St	Plantation	FL	33317	Y
21	592208015	Zenga, William T	2500 N University Dr, Ste 9	Sunrise	FL	33322	Y
22	760741305	Johnson Leong, Charmaine	2717 E Oakland Park Blvd Ste 1	Fort Lauderdale	FL	33306	N
23	200185918	Lane, Thomas R	1831 NE 45th St, Suite B	Fort Lauderdale	FL	33308	Y
24	271835567	Toral, Armando	4811 Hollywood Blvd, Ste A	Hollywood	FL	33021	Y
25	900723233	Benedetti, Ana P	1535 Sunset Dr	Coral Gables	FL	33143	N
26	264305407	Tendler, Minelle M	199 W Palmetto Park Rd, Ste D	Boca Raton	FL	33432	Y

City of Fort Lauderdale
Top 250 DPPO Providers
Claims Paid 1/1/2016 - 12/31/2016

Company Name: Humana

Indicate which of the listed providers is included in your company's proposed DPPO network and include a hard copay as well as an Excel file in your response.

Rank	Federal Employer ID	Name	Address	City	State	Zip	In Network? Yes or No
27	550881045	Freeman, Christopher S	8200 W Sunrise Blvd, Suite B-3	Plantation	FL	33322	Y
28	471820802	Rieger, Eric R	1200 Yamato Rd, Ste A4	Boca Raton	FL	33431	Y
29	202058007	Palenzuela, Mary A	10080 NW 1st Ct	Plantation	FL	33324	Y
30	650089306	Berger, Joel S	1890 N University Dr, Ste 210	Coral Springs	FL	33071	Y
31	202058007	Herbert, Brent	10080 NW 1st Ct	Plantation	FL	33324	Y
32	460771294	Naierman, Eric H	3333 Sheridan St	Hollywood	FL	33021	Y
33	650019957	Blitman, Robert	8430 W Broward Blvd, Ste 100	Plantation	FL	33324	Y
34	650075019	Boukzam, Mark A	4048 W Hillsboro Blvd	Deerfield Beach	FL	33442	Y
35	650969035	Canizales, Jacqueline	10640 Griffin Rd, Ste 107	Davie	FL	33328	Y
36	471526151	Berley, Joel A	7110 Southgate Blvd	Margate	FL	33068	Y
37	650746314	Hernandez, Peter M	10051 Pines Blvd Ste C	Pembroke Pines	FL	33024	N
38	651100498	Mccawley, Daniel W	1625 E Las Olas Blvd	Fort Lauderdale	FL	33301	N
39	471755265	Sherman, Richard L	2249 N University Dr	Pembroke Pines	FL	33024	Y
40	203141319	Kerns, James M	2991 Myrtle Oak Cir	Davie	FL	33328	Y
41	452816684	Martin, Sidney S	660 N State Road 7, Ste 12	Plantation	FL	33317	Y
42	650000707	Chencin, Josef	3015 Bayview Dr, Ste D	Fort Lauderdale	FL	33306	Y
43	650461148	Zakko, Dalal	2826 E Oakland Park Blvd, Ste 300	Fort Lauderdale	FL	33306	Y
44	260849265	Hernandez, Roland A	1625 SE 3rd Avenue, Suite 802	Ft Lauderdale	FL	33316	Y
45	204587282	Dixon, Scott E	1620 SE 4th Ave	Ft Lauderdale	FL	33316	N
46	275197554	Joh, Julia H	4301 N Federal Hwy, Ste 5	Pompano Beach	FL	33064	Y
47	043589759	Castillo, Pedro L	1300 N Federal Hwy, Suite 1	Lake Worth	FL	33460	N
48	611734577	Bates, Barbara A	1096 W Indiantown Rd, Ste 200	Jupiter	FL	33458	Y
49	650914866	Fredrick, Jason W	10156 W Indiantown Rd	Jupiter	FL	33478	Y
50	591425149	Lustman, Craig	809 State Route 208	Monroe	NY	10950	Y
51	650980524	Jones, Ian C	6300 W Atlantic Blvd	Margate	FL	33063	Y
52	461543139	Arocha, Arianny	113 SW 11th Ct Ste A	Fort Lauderdale	FL	33315	Y

City of Fort Lauderdale
Top 250 DPPO Providers
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Company Name: Humana

Indicate which of the listed providers is included in your company's proposed DPPO network and include a hard copay as well as an Excel file in your response.

Rank	Federal Employer ID	Name	Address	City	State	Zip	In Network? Yes or No
53	592603212	Heinsen, Gretchen	2480 E Commercial Blvd, Ste 2	Fort Lauderdale	FL	33308	Y
54	592681987	Barnard, Michael R	1209 W Broward Blvd	Ft Lauderdale	FL	33312	Y
55	471755265	Templeton, Patricia G	2249 N University Dr	Pembroke Pines	FL	33024	Y
56	650631864	Rozen, Henry	9154 Wiles Rd	Coral Springs	FL	33067	Y
57	650863385	Colella, Candace R	4690 N State Rd 7 Ste 201	Coconut Creek	FL	33073	N
58	161685076	Mazzei, Leanne	9387 W Sample Rd	Coral Springs	FL	33065	Y
59	592397569	Scharf, Blair	2801 N University Dr, Suite 101	Coral Springs	FL	33065	N
60	592211352	Behn, Jack W	8200 W Sunrise Blvd, Ste A1	Plantation	FL	33322	Y
61	134205825	Khakhria, Milan L	104 NW 100th Ave	Plantation	FL	33324	Y
62	650161743	Bracco, Brent J	2467 E Commercial Blvd	Fort Lauderdale	FL	33308	Y
63	650947659	Simon, David G	10115 Forest Hill Blvd Ste 301	Wellington	FL	33414	N
64	205407398	Chen, Timothy P	12741 Miramar Pkwy, Ste 203	Miramar	FL	33027	Y
65	650246176	Spector, Lawrence A	9132 Wiles Rd	Coral Springs	FL	33067	N
66	900723233	Benedetti, Ana P	1535 Sunset Dr	Coral Gables	FL	33143	N
67	592661313	Schloss, Christopher M	2916 Bayview Dr	Fort Lauderdale	FL	33306	N
68	271499087	Forum, Richard B	320 SE 18th St	Fort Lauderdale	FL	33316	N
69	261365336	Shelling, Robert	19615 State Road 7, Ste 33	Boca Raton	FL	33498	Y
70	453626385	Young, Catherine R	1930 NE 34th Ct	Lighthouse Point	FL	33064	Y
71	651147593	Listopad, Howard D	10161 W Sample Rd, Ste A	Coral Springs	FL	33065	Y
72	010574562	Jarrett, Brent J	7312 W Atlantic Blvd	Margate	FL	33063	Y
73	753136614	Maye, Frank J	19615 33 S State Rd 7	Boca Raton	FL	33498	Y
74	650401664	Weiner, Seymour	8200 W Sunrise Blvd, Ste B2	Plantation	FL	33322	Y
75	591928451	Wiener, B H	800 E Broward Blvd, Ste 305	Ft Lauderdale	FL	33301	Y
76	203987895	Malpica, Omar A	14201 W Sunrise Blvd Ste 106	Sunrise	FL	33323	N
77	611734577	Bates, Barbara A	1096 W Indiantown Rd, Ste 200	Jupiter	FL	33458	Y
78	591425149	Trupkin, Denis P	7400 NW 5th St	Plantation	FL	33317	Y

City of Fort Lauderdale
Top 250 DPPO Providers
Claims Paid 1/1/2016 - 12/31/2016

Company Name: Humana

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Rank	Federal Employer ID	Name	Address	City	State	Zip	In Network? Yes or No
79	461185149	Cook, Jonathan H	30 Ne 3Rd St	Ft Lauderdale	FL	33301	Y
80	112596095	Jaeger, Michael E	12012 S Shore Blvd, Ste 101	Wellington	FL	33414	Y
81	650937178	Fong, Ian S	1900 N University Dr, Ste 201	Pembroke Pines	FL	33024	Y
82	650766393	Rosenberg, Steven A	7500 NW 5th St, Ste 115	Plantation	FL	33317	Y
83	463189195	Hernandez Rivera, Ricardo N	522 E 25Tth St	Hialeah	FL	33013	Y
84	452733082	Bouchard Lavenka, Cynthia R	14771 Biscayne Blvd	North Miami	FL	33181	Y
85	272813237	Rubensteen, Evan	2151 NW 2nd Ave, Ste 102	Boca Raton	FL	33431	Y
86	650807157	Douglas, Easton	2609 W Oakland Park Blvd	Fort Lauderdale	FL	33311	N
87	452382491	Olivera, Marisabel	4800 NE 20th Ter, Ste 301S	Ft Lauderdale	FL	33308	Y
88	043683245	Ferrer, Deborah A	1500 E Broward Blvd	Ft Lauderdale	FL	33301	N
89	650456698	Graff, Brad W	3107 Stirling Rd, Ste 108	Ft Lauderdale	FL	33312	Y
90	261147142	Ginzler, Bradley M	12651 W Sunrise Blvd, Ste 204	Sunrise	FL	33323	Y
91	592550069	Mandell, Charles S	3220 Stirling Rd	Hollywood	FL	33021	Y
92	592343174	Llera, Julio A	2607 Davie Blvd	Fort Lauderdale	FL	33312	Y
93	760706979	Giol, Victor J	2474 SE Federal Hwy	Stuart	FL	34994	Y
94	592427954	Russo, Charles D	2801 N University Dr, Ste 102	Coral Springs	FL	33065	Y
95	208577828	Urrea Feldsberg, Helena	12301 Taft St Ste 300	Pembroke Pines	FL	33026	Y
96	651025280	Gomez, Luis F	4651 N State Road 7, Ste 4	Coconut Creek	FL	33073	Y
97	412132420	Warner, David K	1946 Wilton Dr	Wilton Manors	FL	33305	Y
98	454014601	Miresmaili, Mandana	3035 E Commercial Blvd	Fort Lauderdale	FL	33308	Y
99	592229420	Lipson, Frank D	333 NW 70th Ave, Ste 104	Plantation	FL	33317	Y
100	300012213	Quesada, Robert E	1500 E Broward Blvd	Fort Lauderdale	FL	33301	Y
101	263766926	Barbag, Adam C	9172 Glades Rd	Boca Raton	FL	33434	Y
102	591366609	Miller, Robert J	8903 Glades Rd Ste D6	Boca Raton	FL	33434	N
103	264848166	Moore, Keith E	901 S Federal Hwy Ste 301	Fort Lauderdale	FL	33316	N
104	272119748	Wagner, Robert M	1275 York Ave	New York	NY	10065	N

City of Fort Lauderdale
Top 250 DPPO Providers
Claims Paid 1/1/2016 - 12/31/2016

Company Name: Humana

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Rank	Federal Employer ID	Name	Address	City	State	Zip	In Network? Yes or No
105	273006462	Finkelstein, Heidi R	333 NW 70th Ave	Fort Lauderdale	FL	33317	N
106	270812901	Caponera, Rinaldo	7420 NW 5th St, Ste 108	Plantation	FL	33317	Y
107	412139274	Schaumberg, Jennifer S	21150 Biscayne Blvd, Ste 401	Aventura	FL	33180	Y
108	591425149	Babyak, George R	7400 Nw 5th St	Plantation	FL	33317	Y
109	208445461	Shehadeh, Eyad	973 N Nob Hill Rd	Plantation	FL	33324	Y
110	650713391	Nudelberg, Michael E	550 SW 3rd St	Pompano Beach	FL	33060	Y
111	650792969	Montamarta, Francisco T	100 S Military Trl, Ste 4	Deerfield Beach	FL	33442	Y
112	591541047	Rothberg, Melanie R	5458 Town Center Rd, Ste 16	Boca Raton	FL	33486	Y
113	260829624	Briceno Crespi, Carmen	7615 SW 62nd Ave	South Miami	FL	33143	N
114	473696720	Lepore, Krystina M	9109 Baymeadows Rd, Ste 1	Jacksonville	FL	32256	Y
115	264429924	Vultaggio, Francesco P	841 SE 8th Ave	Deerfield Bch	FL	33441	Y
116	650165775	Hosseini, Heather G	1040 Weston Rd, Ste 225	Weston	FL	33326	Y
117	464571377	Short, Steven T	5400 N Federal Hwy	Fort Lauderdale	FL	33308	Y
118	421598932	Roud, Taras	7015 Beracasa Way, Ste 101	Boca Raton	FL	33433	Y
119	650654799	Thomas, Christian M	3471 N Federal Hwy, Ste 501	Ft Lauderdale	FL	33306	Y
120	208036431	Marranzini Grosma, Maria G	4401 S Flamingo Rd, Ste 109	Davie	FL	33330	Y
121	651146878	Fuerst, Peter F	2706 N University Dr	Sunrise	FL	33322	Y
122	650184844	Marks, Lawrence H	5100 Hollywood Blvd Ste 2	Hollywood	FL	33021	N
123	650717556	Feuer, Mitchell R	900 S Federal Hwy	Hollywood	FL	33020	N
124	650688337	Simon, David S	7101 W McNab Rd, Ste 102	Tamarac	FL	33321	Y
125	010712049	Slatkoff, Joshua M	2151 NW Boca Raton Blvd, Ste 10	Boca Raton	FL	33431	Y
126	650668849	Wong, Albert G	300 NW 70th Ave, Suite 304	Plantation	FL	33317	N
127	201577593	Scerbo, Peter M	6600 W 12th Ave	Hialeah	FL	33012	N
128	542080841	Grandison, Nigel D	10117 Cleary Blvd	Plantation	FL	33324	Y
129	510446273	Najarian, Stephen	815 S University Dr, Ste 101	Plantation	FL	33324	Y
130	202996316	Bons, Brian K	1637 N Hiatus Rd	Pembroke Pines	FL	33026	N

City of Fort Lauderdale
Top 250 DPPO Providers
Claims Paid 1/1/2016 - 12/31/2016

Company Name: Humana

Indicate which of the listed providers is included in your company's proposed DPPO network and include a hard copay as well as an Excel file in your response.

Rank	Federal Employer ID	Name	Address	City	State	Zip	In Network? Yes or No
131	464401786	Garg, Arun K	700 N Hiatus Rd, Ste 102	Pembroke Pines	FL	33026	Y
132	462882102	Deture, Christopher N	1500 E Hillsboro Blvd	Deerfield Beach	FL	33441	Y
133	650132415	Blum, Michael R	648 NE 3rd Ave	Fort Lauderdale	FL	33304	Y
134	204399325	Smith, Austin F	10794 Pines Blvd, Ste 101	Pembroke Pines	FL	33026	Y
135	650787194	Taylor, Henderson P	3131 Inverrary Blvd W	Lauderhill	FL	33319	N
136	263118748	Sainsbury, James W	2700 E Bay Dr, Ste 207	Largo	FL	33771	Y
137	464114693	Selmic, Nadezda	401 E Las Olas Blvd, Ste 140	Fort Lauderdale	FL	33301	Y
138	592756022	Fistel, Alan	7522 Wiles Rd, Ste 104	Coral Springs	FL	33067	Y
139	592724644	Mccauley, Mark C	3115 South Federal Highway	Delray Beach	FL	33483	N
140	272813237	Gul, Yousaf A	4189 Southpoint Dr E	Jacksonville	FL	32216	Y
141	271509276	Taha, Ahmed A	1640 S Federal Hwy	Delray Beach	FL	33483	Y
142	275473032	Igualada Heine, Kristen N	8585 Sunset Dr, Ste 101	Miami	FL	33143	Y
143	582676964	Rosado, Itza M	12781 Miramar Pkwy, Ste 201	Miramar	FL	33027	Y
144	205614193	Benda, Natalia M	6361 N Andrews Ave	Fort Lauderdale	FL	33309	Y
145	270129674	Fox, Eric G	5551 N University Dr, Ste 203	Coral Springs	FL	33067	Y
146	650821596	Brady, Michael	4330 W Broward Blvd, Suit T	Plantation	FL	33317	N
147	650975638	Garcia, Kathy	1019 S University Dr	Plantation	FL	33324	Y
148	591693658	Bussell, Alan J	6269 N University Dr	Tamarac	FL	33321	Y
149	650121690	Garcia, Juan M	1490 W 49th Pl, Ste 450	Hialeah	FL	33012	Y
150	113697263	Most, Douglas S	544 NW University Blvd, Ste 105	Port Saint Lucie	FL	34986	Y
151	030576797	Sorroza, Jennifer P	435 E Sheridan St	Dania	FL	33004	Y
152	463455311	Israel, Elie	305 E Altamonte Springs Dr, Ste 1020	Altamonte Springs	FL	32701	Y
153	650559387	Pyle, Stephen J	2239 N Commerce Pkwy, Suite 1	Weston	FL	33326	N
154	650632466	Hernandez, Liliana J	4750 NW 7th St, Ste 10	Miami	FL	33126	Y
155	010718993	Nudel, Tatyana	7321 N State Road 7	Parkland	FL	33073	Y
156	650943768	Lichstrahl, Jared E	301 NW 84th Ave, Ste 203	Plantation	FL	33324	Y

City of Fort Lauderdale
Top 250 DPPO Providers
Claims Paid 1/1/2016 - 12/31/2016

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157	261669042	Brilliant, Margo K	18851 NE 29th Ave, Ste 300	Aventura	FL	33180	Y
158	260353884	Cimand, Tami	7797 N University Dr, Ste 201	Tamarac	FL	33321	Y
159	650908498	Darojat, Zuhdiyah M	305 E Altamonte Springs Dr, Ste 1020	Altamonte Springs	FL	32701	Y
160	263394448	Hilali, Manal	10151 W Commercial Blvd	Sunrise	FL	33351	Y
161	208737121	Browne, Andrew M	9789 Glades Rd	Boca Raton	FL	33434	N
162	465601000	Casas, Silvia B	951 NE 167th St, Ste 104	North Miami Beach	FL	33162	Y
163	650043559	Arenas, Jorge A	10271 Pines Blvd	Pembroke Pines	FL	33026	Y
164	650387750	Fedele, Mark W	500 NW Dixie Hwy South	Stuart	FL	34994	N
165	651030631	Arnold, Patrick B	4800 NE 20th Ter, Ste 205	Ft Lauderdale	FL	33308	Y
166	591263751	Bluth, Barry A	4175 SW 64th Ave, Ste 103-104	Davie	FL	33314	Y
167	592582825	Kushner, Benn M	10031 Pines Blvd, Ste W101	Pembroke Pines	FL	33024	Y
168	593752296	Bender, Fara	6169 Jog Rd, Suite B-5	Lake Worth	FL	33467	N
169	650976774	Ring, Christian D	1776 N Pine Island Rd, Ste 300	Plantation	FL	33322	Y
170	591944868	Parker, Stephen T	1003 N 35th Ave	Hollywood	FL	33021	N
171	200185918	Plower, Katarzyna J	2275 20th St	Vero Beach	FL	32960	Y
172	260518079	Rezaie, Yeganeh	3801 Hollywood Blvd, Ste 225	Hollywood	FL	33021	Y
173	592459372	Spoont, E R	21301 Powerline Rd, Suite 208	Boca Raton	FL	33433	Y
174	391221409	Steinmetz, Mark J	W3132 Van Roy Rd	Appleton	WI	54915	N
175	592051908	Rosenthal, Allen H	3836 N University Dr	Sunrise	FL	33351	Y
176	453740998	Sevel, Dennis S	1350 SW 160th Ave	Weston	FL	33326	Y
177	650234930	Gittess, Laurie B	1625 N Commerce Pkwy, Ste 317	Weston	FL	33326	Y
178	562338791	Kawa, Larry B	20423 State Road 7, Ste F18	Boca Raton	FL	33498	Y
179	273533121	James, Kevin K	685 Royal Palm Beach Blvd, Ste 204	Royal Palm Beach	FL	33411	Y
180	650518576	Davis Iii, John M	19 NE 22nd Ave	Pompano Beach	FL	33062	N
181	651081473	Neuls, Julia W	2633 E Commercial Blvd Ste B	Fort Lauderdale	FL	33308	N
182	201677120	Shullman, Howard B	12634 Pines Blvd	Pembroke Pines	FL	33027	N

City of Fort Lauderdale
Top 250 DPPO Providers
Claims Paid 1/1/2016 - 12/31/2016

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Rank	Federal Employer ID	Name	Address	City	State	Zip	In Network? Yes or No
183	592343174	Llera, Antonio J	2607 Davie Blvd	Fort Lauderdale	FL	33312	Y
184	048949574	Ghodsi, Shayan	9375 W Sample Rd	Coral Springs	FL	33065	Y
185	451484825	Friedland, Bryan J	4800 NE 20th Ter, Ste 215	Ft Lauderdale	FL	33308	Y
186	592530483	Ongley, B Linda	1945 N Pine Island Rd	Sunrise	FL	33322	Y
187	651021909	Romasan, Oana	1700 NE 26th St, Ste 1	Wilton Manors	FL	33305	Y
188	454337609	Bautista, Enrico S	1776 N Pine Island Rd, Ste 300	Plantation	FL	33322	Y
189	200185918	Rodriguez, Jorge A	11130 N Kendall Dr, Ste 202	Miami	FL	33176	Y
190	471565474	Fallah, Rouhollah	7100 W Commercial Blvd, Ste 108	Lauderhill	FL	33319	Y
191	454640768	Elliot, Jeffrey F	9600 W Sample Rd, Ste 504	Coral Springs	FL	33065	Y
192	471601631	Mingel, Marc A	6702 N University Dr	Tamarac	FL	33321	Y
193	901032331	Ochoa, Luis H	5740 Hollywood Blvd	Hollywood	FL	33021	Y
194	650601646	Porras, Edgar J	12251 Taft St, Ste 404	Pembroke Pines	FL	33026	Y
195	263005908	Spencer, Scott B	210 Jupiter Lakes Blvd, Bldg 5000 Ste 204	Jupiter	FL	33458	Y
196	650286174	Gorfinkel, Michael S	111 N Pine Island Rd, Ste 101	Plantation	FL	33324	Y
197	650879389	Klein, Mitchell J	7228 W Oakland Park Blvd	Lauderhill	FL	33313	Y
198	591290474	Ozga, Gary F	1296 S Federal Hwy	Pompano Beach	FL	33062	N
199	208754293	Roseff, Michael J	8784 Boynton Beach Blvd, Ste 103	Boynton Beach	FL	33472	Y
200	810671550	Aron, Robert S	1874 W Hillsboro Blvd	Deerfield Beach	FL	33442	N
201	911891746	Cirtaut, Linda M	Po Box 13828	Mill Creek	WA	98082	N
202	592289312	Berry, Bryan W	800 E Broward Blvd Ste 410	Ft Lauderdale	FL	33301	N
203	650908498	Proano Wise, Nancy L	2600 W Flagler St	Miami	FL	33135	Y
204	200185918	Waldee, Kerry G	817 S University Dr, Suite 103	Plantation	FL	33324	Y
205	582407716	Yates, David W	2474 SE Federal Hwy	Stuart	FL	34994	N
206	650731323	Krimsky, Peter K	7408 NW 5th St	Plantation	FL	33317	Y
207	651007689	Rothfield, Elizabeth A	4601 Hollywood Blvd	Hollywood	FL	33021	Y
208	591614126	Barogiannis, Constantinos	2440 E Commercial Blvd	Fort Lauderdale	FL	33308	N

City of Fort Lauderdale
Top 250 DPPO Providers
Claims Paid 1/1/2016 - 12/31/2016

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Rank	Federal Employer ID	Name	Address	City	State	Zip	In Network? Yes or No
209	223868692	Oklin, Richard S	6805 Pembroke Rd	Hollywood	FL	33023	Y
210	651077289	Bennett, David A	10305 NW 41st St, Ste 207	Doral	FL	33178	N
211	273480873	Anand, Payal M	2410 N University Dr	Coral Springs	FL	33065	Y
212	593694196	Huhn, Clete F	1100 S Orange Ave	Orlando	FL	32806	Y
213	650349658	Ziadie, Elizabeth T	9720 Stirling Rd, Ste 211	Cooper City	FL	33024	Y
214	650006275	Shiffman, Harvey S	8200 S Jog Rd, Ste 201	Boynton Beach	FL	33472	Y
215	461139956	Lekkas, Nick	2870 Ne 8th St	Homestead	FL	33033	Y
216	200185918	Hohimer Jr, David M	817 S University Dr Su	Plantation	FL	33324	Y
217	542079759	Kaufman, Robert H	4665 W Atlantic Ave	Delray Beach	FL	33445	Y
218	650144056	Cohen, Jeffrey	4324 Forest Hill Blvd	West Palm Beach	FL	33406	N
219	650854084	Meier, Scott F	500 University Blvd, Ste 112	Jupiter	FL	33458	Y
220	200010251	Marchetto, John J	1600 Town Center Blvd Ste A	Weston	FL	33326	N
221	592714865	Lunsford, Joseph L	6736 Forest Hill Blvd	Greenacres	FL	33413	N
222	260042734	Morrow, Richard S	1881 N University Dr, Ste 2012	Coral Springs	FL	33071	Y
223	582592630	Reilly, James W	1150 Hammond Dr Ste 200	Atlanta	GA	30328	N
224	650642600	Darling, Steven G	8190 S Jog Rd, Ste 200	Boynton Beach	FL	33472	N
225	591273519	Sands, James D	5890 Hallandale Beach Blvd	West Hollywood	FL	33023	Y
226	650481999	Wasserman, Alan G	22053 State Road 7	Boca Raton	FL	33428	Y
227	204132428	Saidi, Ardavan	119 Washington Ave, Suite 601	Miami Beach	FL	33139	N
228	650719035	Starkman, Jeffrey A	11682B US Highway 1, Ste 60	Palm Beach Gardens	FL	33408	Y
229	010924720	Kocher, Jennifer C	7593 Boynton Beach Blvd, Ste 200	Boynton Beach	FL	33437	Y
230	205495196	Gomez Trainor, Sandra P	1740 E Commercial Blvd	Fort Lauderdale	FL	33334	Y
231	650019957	Epstein, Mitchell R	8430 W Broward Blvd, Ste 100	Plantation	FL	33324	Y
232	650721202	Vallejo, Freddy A	600 S Pine Island Rd, Suit #201	Plantation	FL	33324	Y
233	592135962	Walsh, Joseph C	2600 N Military Trl Ste 3	Boca Raton	FL	33431	N
234	264306631	Shults, Randall C	1200 Corporate Center Way, Suite 100	Wellington	FL	33414	N

City of Fort Lauderdale
Top 250 DPPO Providers
Claims Paid 1/1/2016 - 12/31/2016

Company Name: Humana

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Rank	Federal Employer ID	Name	Address	City	State	Zip	In Network? Yes or No
235	592303705	Patel, Jitendra L	4651 NW 31st Ave	Tamarac	FL	33309	Y
236	451797933	Zombek, Steven J	Emerald Hills Medical Squ, 4480 Sheridan St	Hollywood	FL	33021	Y
237	830401313	Winton, Adam J	1201 E Sample Rd, Ste 101	Pompano Beach	FL	33064	Y
238	650981758	Stokesberry, Douglas A	9204 NE 6th Ave	Miami Shores	FL	33138	N
239	591967618	Lev, Robert J	8383 Pines Blvd	Pembroke Pines	FL	33024	Y
240	900923182	Fendrich, Laurence E	18431 Miramar Pkwy	Miramar	FL	33029	N
241	461424382	Friedel, Lee M	1605 Town Center Blvd, Ste B	Weston	FL	33326	Y
242	471526151	Krohn, Mel R	7500 NW 5th St, Ste 105	Plantation	FL	33317	Y
243	650795660	Baghdassarian, Rosemary	1608 E Commercial Blvd	Oakland Park	FL	33334	Y
244	203965948	Sajoo, Sameer	3471 N Federal Hwy Ste 200	Fort Lauderdale	FL	33306	N
245	264745380	Blanco, Yamilet	800 E Merritt Island Cswy, Ste 105	Merritt Island	FL	32952	Y
246	650962928	Eggnatz, Michael D	17190 Royal Palm Blvd, Suite #4	Weston	FL	33326	N
247	650796764	Desenze, Philip S	540 E McNab Rd, Ste E	Pompano Beach	FL	33060	Y
248	592655484	Malik, Sawan K	1027 SE 17th St	Fort Lauderdale	FL	33316	Y
249	203404121	Ardalan, Amir R	374 SW Prima Vista Blvd.	Port St. Lucie	FL	34983	N
250	651131832	Martinez, Mario J	6601 SW 80th St Ste 212	Miami	FL	33143	N

City of Fort Lauderdale
DHMO Top Providers Chosen by Subscriber Count

Company Name: Humana

Indicate which of the listed DHMO providers is included in your company's proposed DHMO network and include a hard copy as well as an Excel sheet in your proposal.

	Tax ID	Facility	Address	City	State	Zip	In Network? Yes or No
1	30576792	TLC Dental East	3001 E Commercial Blvd	Fort Lauderdale	FL	33308	Y
2	592681987	Barnard, DDS, Michael	1209 W Broward Blvd	Ft Lauderdale	FL	33312	Y
3	650461148	Bayview Dental Associates PA	2826 E Oklnd Prk Blvd Ste 300	Ft Lauderdale	FL	33306	Y
4	650908498	Sage Dental of Plantation PA	8440 W Broward Blvd	Plantation	FL	33324	Y
5	591399832	Emerald Hills Dental Center	3856 Sheridan St	Hollywood	FL	33021	Y
6	731723037	Jacardanda Dental Associates	600 S Pine Island Rd Ste 201	Plantation	FL	33324	Y
7	462896556	True Original Smiles Inc	5863 N University Dr	Tamarac	FL	33321	Y
8	30576797	TLC Dental North	7110 Southgate Blvd	N Lauderdale	FL	33068	Y
9	562315803	The Dental Group	2609 W Oakland Park Blvd	Ft Lauderdale	FL	33311	Y
10	650924956	Sage Dental of Pompano Beach P	1650 N Federal Hwy Ste 105	Pompano Beach	FL	33062	Y
11	263699117	Dr. Max A Zaslavsky	6451 N Federal Hwy	Ft Lauderdale	FL	33308	Y
12	592530483	Ongley/Jacaranda Square Dent	1945 N Pine Island Rd	Sunrise	FL	33322	Y
13	271436445	Sage Dental of Cooper City PLL	12129 Sheridan St	Hollywood	FL	33026	Y
14	203993947	Jeremy Gerber DMD PA	1332 SE 17th St	Fort Lauderdale	FL	33316	Y
15	421650718	Stanton Dental Excellence	5400 N Federal Hwy Ste 101	Ft Lauderdale	FL	33308	Y
16	272813237	Sage Dental of Coral Springs P	987 N University Dr	Coral Springs	FL	33071	Y
17	650132415	Centre for the Dental Arts	648 NE 3rd Ave	Fort Lauderdale	FL	33304	Y
18	650076718	Karpel, DDS, Joel	7193 W Oakland Park Blvd	Lauderhill	FL	33313	Y
19	471565474	Fresh Dental Smiles	7100 W Commercial Blvd Ste 108	Lauderhill	FL	33319	Y
20	203175411	Veneto Dental Care	3600 Red Rd Ste 604	Miramar	FL	33025	Y
21	263005908	Sage Dental of Coconut Creek P	5463 Lyons Rd Ste C	Coconut Creek	FL	33073	Y
22	650234930	Family Dental Associates	6130 W Atlantic Blvd Ste 4	Margate	FL	33063	Y
23	650129699	Plantation Dental Services	314 S University Dr	Plantation	FL	33324	Y
24	650467002	Dallas, DDS, Michele	620 NE 3rd St	Fort Lauderdale	FL	33301	Y
25	650509660	Sunrise Intracoastal Dtl Ctr	900 NE 26th Ave Ste 200	Fort Lauderdale	FL	33304	Y
26	650043559	G & G Dental Associates	7030 NW 57th St	Tamarac	FL	33319	Y
27	271168262	Healthy Family Dentistry	5350 W Hillsboro Blvd Ste 201	Coconut Creek	FL	33073	Y
28	203141319	James Kerns Dmd Pllc	6905 W Broward Blvd Ste 101	Plantation	FL	33317	Y
29	592549495	L G James DMD Professional	4101 S Hospital Dr Ste 4	Plantation	FL	33317	Y
30	30576799	TLC Dental Dania	435 E Sheridan St	Dania	FL	33004	Y
31	273480873	Coral Springs Smiles PA	2929 N University Dr Ste 203	Coral Springs	FL	33065	Y

City of Fort Lauderdale
DHMO Top Providers Chosen by Subscriber Count

Company Name: Humana

Indicate which of the listed DHMO providers is included in your company's proposed DHMO network and include a hard copy as well as an Excel sheet in your proposal.

	Tax ID	Facility	Address	City	State	Zip	In Network? Yes or No
32	650719035	Dental Health Grp II Pem Pines	140 S University Dr	Pembroke Pines	FL	33025	Y
33	592655484	Gentle Family Dentistry	10167 W Sunrise Blvd Ste 101	Plantation	FL	33322	Y
34	650322438	Mehler, DDS, Eric	7800 W Oaklnd Pk Blvd Ste 114	Sunrise	FL	33351	Y
35	474657069	Sage Dental Of Tamarac Pllc	5779 N University Dr	Tamarac	FL	33321	Y
36	205495196	Gomez Trainor, DDS PA, Sandra	1831 NE 45th St Ste A	Ft Lauderdale	FL	33308	N
37	591788725	Deerfield Dental Services	1800 W Hillsboro Blvd Ste 210	Deerfield Beach	FL	33442	Y
38	200171638	Dental Care Ctr of Hollywood	3900 Hollywood Blvd Ste 304	Hollywood	FL	33021	N
39	471035515	Optum Dental Care Llc	1854 N Nob Hill Rd	Plantation	FL	33322	Y
40	272808186	Sage Dental of Deerfield Beach	2265 W Hillsboro Blvd	Deerfield Bch	FL	33442	Y
41	650411776	Premiere Dental Care Center	17901 NW 5th St Ste 206	Pembroke Pines	FL	33029	Y
42	273944632	BL Dental Associates LLC	3233 Palm Ave	Hialeah	FL	33012	Y
43	592665788	Pine, DDS, Philip A.	1600 E Atlantic Blvd Fl 2	Pompano Beach	FL	33060	Y
44	223967347	Tamarac Dental Associates	7351 W Oaklnd Pk Blvd Ste 102	Lauderhill	FL	33319	Y
45	352163655	Howard Finnk DDS PA	10071 Sunset Strip	Sunrise	FL	33322	Y
46	473696720	Sage Dental Of Downtown Fort L	551 N Federal Hwy Ste 900	Fort Lauderdale	FL	33301	Y
47	593508140	Coast Dental - Sebring	901 US Highway 27 N Ste 60	Sebring	FL	33870	Y
48	263394448	Gentle Dentistry of Tamarac	10151 W Commercial Blvd	Sunrise	FL	33351	Y
49	650456698	Graff, DMD, PA, Brad W.	3107 Stirling Rd Ste 108	Ft Lauderdale	FL	33312	Y

NATIONAL DHMO AND DPPO NETWORKS / GEO ACCESS REPORTS

Please provide a complete listing of all national markets in which you have DHMO and DPPO networks that would be available to City retirees. Include a Geo Access report based on the census provided which includes zip codes. The geo access reports are required only for retirees living outside of the South Florida area.

The HS195 DHMO plan is available throughout the state of Florida and our dental PPO network is available nationwide.

Humana stands out from the competition because we believe proper oral health is an important component to overall health. We take a preventive approach to oral health through early detection and education, and offer a range of cost-effective dental plans for the City to tailor to your population, including options for customizing copayments, deductibles, and out-of-pocket maximums.

Network: Our goal is to make sure people can get to the dentists and specialists they need. At Humana, we're constantly growing our networks, branching out into areas where our members need us. We will continue to work directly with the City to identify any areas where your employees and their families need better access, and focus our outreach efforts to make sure our network continues to work for you.

- Our PPO and DHMO networks have been developed to create significant savings that are passed onto the City and your employees. With excellent nationwide access and attractive fee schedules, we provide employees with the maximum discounts.
- All of our contracted providers are required to meet exceptional quality of care and service levels to remain highly efficient and keep administration costs down.

Please refer to our network accessibility reports included in this tab.

Humana.

Humana Dental HMO HS195

City of Fort Lauderdale

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Report Contents

Access Overview

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Access Analysis

2 General Dentists in 5 miles

Employee Group

City of Fort Lauderdale

Dentist Group

General Dentist

Access Map

Employee locations

- ◆ With access
- ● Without access

643.89 miles

Comparison Graph

Percent of employees with access to a choice of dentists over miles

- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (City of Fort Lauderdale) employees accessing:

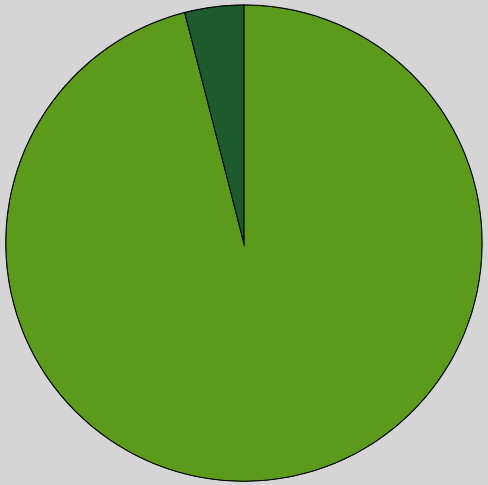
2 (General Dentist) dentists in 5 miles

Overall Access[1]

2,154 Employees
1,479 dentists at 1,608 locations (General Dentist)

2,067 (96.0%) Employees with access

87 (4.0%) Employees without access

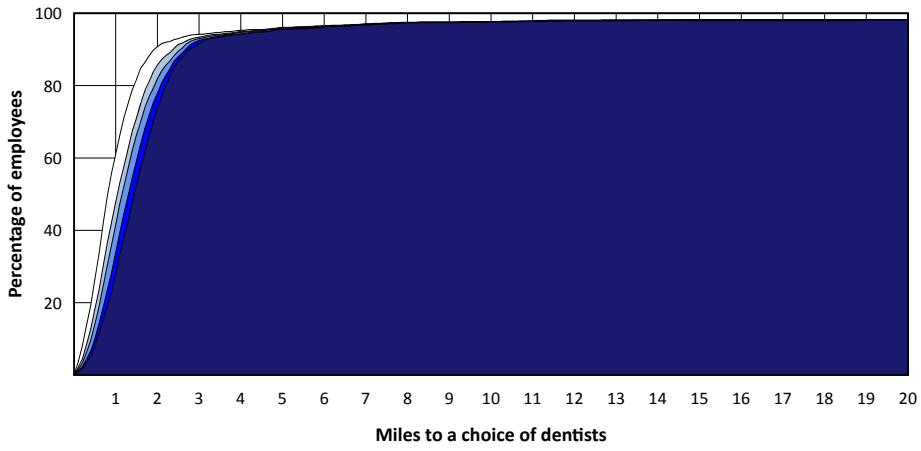


All Employees

Distances

	Average
Distance to 1st closest dentist	9.5 miles
Distance to 2nd closest dentist	9.8 miles
Distance to 3rd closest dentist	9.9 miles
Distance to 4th closest dentist	10.1 miles
Distance to 5th closest dentist	10.2 miles

Access Standard Comparison



Access Summary By City

March 24, 2017

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Access Analysis

2 General Dentists in 5 miles

Employee Group

City of Fort Lauderdale

Dentist Group

General Dentist

Areas With Access

Top 35 Cities in the market, sorted by the number of employees with access

[1] The Access Standard is defined as (City of Fort Lauderdale) employees accessing:

2 (General Dentist) dentists in 5 miles

[2] Provider counts represent:

#: Provider access points

Employees With Access

Employee Group	**2,154 employees** 2,067 (96.0%) employees with access	Dentist Group	**1,479 unique dentists at 1,608 unique locations** (22,256 total access points)

Key Geographic Areas

	City	Employee	With Access [1]		Counts [2]	Average Distance		
		#	#	%	#	1	2	3
With Access	Fort Lauderdale, FL	1,108	1,107	99.9	1,011	0.9	1.1	1.2
	Pompano Beach, FL	342	342	100.0	883	0.9	1.1	1.2
	Hollywood, FL	207	207	100.0	716	0.8	0.9	1.0
	Miami, FL	72	72	100.0	1,579	0.8	1.1	1.2
	Boca Raton, FL	45	45	100.0	237	1.2	1.4	1.8
	Deerfield Beach, FL	35	35	100.0	114	1.0	1.1	1.1
	Lake Worth, FL	30	30	100.0	229	1.3	1.4	1.5
	West Palm Beach, FL	34	28	82.4	209	1.3	1.6	1.8
	Boynton Beach, FL	25	25	100.0	262	1.3	1.6	2.1
	Port Saint Lucie, FL	19	16	84.2	239	3.1	3.4	3.5
	Dania, FL	15	15	100.0	15	0.8	1.2	1.3
	Hialeah, FL	14	14	100.0	219	0.8	0.9	1.1
	Pembroke Pines, FL	14	14	100.0	7	1.3	1.4	1.4
	Jupiter, FL	26	11	42.3	223	3.0	3.1	3.1
	Delray Beach, FL	10	10	100.0	259	0.7	1.0	1.5
	Wellington, FL	10	10	100.0	254	1.6	1.8	1.8
	Palm City, FL	8	8	100.0	3	2.6	2.6	2.6
	Hallandale, FL	7	7	100.0	11	0.7	0.8	0.9
	Opa Locka, FL	7	7	100.0	5	1.0	1.5	1.5
	North Miami Beach, FL	6	6	100.0	4	0.8	0.8	0.8
	Miami Beach, FL	4	4	100.0	115	0.4	0.4	0.4
	Miami Gardens, FL	4	4	100.0	126	1.4	1.6	1.7
	Stuart, FL	3	3	100.0	312	2.0	2.0	2.0
	Gainesville, FL	2	2	100.0	172	1.4	1.4	1.4
	Homestead, FL	2	2	100.0	53	2.0	2.0	2.0
	Jensen Beach, FL	3	2	66.7	119	2.9	2.9	2.9
	Lady Lake, FL	2	2	100.0	31	1.5	1.5	1.5
	Lake Mary, FL	2	2	100.0	13	0.8	1.2	1.2
	Loxahatchee, FL	12	2	16.7	0	3.2	3.2	3.4
	Ocala, FL	2	2	100.0	106	3.1	3.1	3.1
	Orlando, FL	2	2	100.0	972	0.9	0.9	1.5
	Palm Beach Gardens, FL	2	2	100.0	12	1.5	1.6	2.2
	Tavares, FL	2	2	100.0	0	2.9	2.9	2.9
	Vero Beach, FL	2	2	100.0	77	3.0	3.0	3.0
	Altamonte Springs, FL	1	1	100.0	159	0.3	0.3	0.3

Access Detail By Zip Code

March 24, 2017

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Access Analysis

2 General Dentists in 5 miles

Employee Group

City of Fort Lauderdale

Dentist Group

General Dentist

2 General Dentists in 5 miles

[1] The Access Standard is defined as (City of Fort Lauderdale) employees accessing:

2 (General Dentist) dentists in 5 miles

Employees With Access								
County	Zip Code	Employee	Dentist	With Access[1]		Average Distance		
		#	#	#	%	1	2	3
Alachua, FL	32605	1	131	1	100.0	1.2	1.2	1.2
	32606	1	36	1	100.0	1.5	1.5	1.5
Brevard, FL	32903	1	0	1	100.0	2.8	2.8	2.8
	32909	1	2	1	100.0	4.2	4.6	4.6
Broward, FL	33004	15	15	15	100.0	0.8	1.2	1.3
	33008	1	0	1	100.0	0.5	0.6	0.6
	33009	6	11	6	100.0	0.7	0.9	0.9
	33019	8	2	8	100.0	1.3	1.4	1.4
	33020	20	5	20	100.0	0.7	0.9	0.9
	33021	25	121	25	100.0	0.6	0.7	0.8
	33022	1	0	1	100.0	0.3	0.3	0.6
	33023	32	8	32	100.0	1.1	1.2	1.3
	33024	37	36	37	100.0	0.6	0.7	0.8
	33025	26	127	26	100.0	0.8	0.8	0.8
	33026	20	151	20	100.0	0.5	0.6	0.6
	33027	18	238	18	100.0	1.1	1.1	1.2
	33028	14	7	14	100.0	1.3	1.4	1.4
	33029	19	28	19	100.0	1.1	1.3	1.3
	33060	36	2	36	100.0	0.8	1.3	1.5
	33061	1	0	1	100.0	0.4	0.6	0.9
	33062	17	106	17	100.0	0.7	0.7	0.8
	33063	51	17	51	100.0	0.8	0.8	1.0
	33064	32	2	32	100.0	1.1	1.9	2.0
	33065	34	23	34	100.0	0.7	0.9	1.0
	33066	15	4	15	100.0	0.7	0.8	0.8
	33067	24	30	24	100.0	0.9	1.2	1.3
	33068	41	17	41	100.0	1.2	1.3	1.4
	33069	21	3	21	100.0	1.1	1.5	1.8
	33071	25	257	25	100.0	0.7	1.0	1.0
	33073	29	313	29	100.0	0.6	0.7	0.8
	33074	1	0	1	100.0	1.3	1.9	1.9
	33076	15	109	15	100.0	1.0	1.2	1.2
	33081	1	0	1	100.0	0.6	1.2	1.2
	33301	15	87	15	100.0	0.7	1.0	1.1
	33302	6	0	6	100.0	0.5	0.5	0.5
	33303	1	0	1	100.0	0.9	1.0	1.1
	33304	33	22	33	100.0	0.6	0.8	0.8
	33305	26	1	26	100.0	0.9	1.3	1.4
	33306	11	6	11	100.0	0.4	0.5	0.6
	33307	1	0	1	100.0	0.9	1.1	1.5

Continued on next page...

Access Detail By Zip Code

March 24, 2017

Created by...

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Access Analysis

2 General Dentists in 5 miles

Employee Group

City of Fort Lauderdale

Dentist Group

General Dentist

2 General Dentists in 5 miles

[1] The Access Standard is defined as (City of Fort Lauderdale) employees accessing:

2 (General Dentist) dentists in 5 miles

Employees With Access								
County	Zip Code	Employee	Dentist	With Access[1]		Average Distance		
		#	#	#	%	1	2	3
Broward, FL	33308	46	131	46	100.0	0.4	0.5	0.6
	33309	77	1	77	100.0	1.1	1.5	1.6
	33310	2	0	2	100.0	0.5	0.5	0.5
	33311	189	5	189	100.0	1.0	1.2	1.3
	33312	89	17	89	100.0	1.3	1.6	1.8
	33313	59	12	59	100.0	0.6	0.8	0.9
	33314	24	4	24	100.0	0.9	1.0	1.0
	33315	36	2	36	100.0	1.2	1.3	1.3
	33316	13	4	13	100.0	0.6	1.0	1.2
	33317	49	23	49	100.0	0.7	1.1	1.2
	33318	2	0	2	100.0	0.0	0.0	0.0
	33319	54	17	54	100.0	0.7	0.9	1.0
	33321	51	109	51	100.0	0.8	0.9	1.1
	33322	35	11	35	100.0	0.5	0.7	0.7
	33323	21	75	21	100.0	0.8	0.9	0.9
	33324	46	127	46	100.0	0.7	1.0	1.2
	33325	36	1	36	100.0	1.3	2.1	2.3
	33326	8	96	8	100.0	1.2	1.5	1.6
	33327	6	0	5	83.3	2.0	3.9	4.1
	33328	37	108	37	100.0	0.9	1.0	1.1
	33329	1	0	1	100.0	1.4	1.4	1.4
	33330	11	5	11	100.0	1.4	1.4	1.5
	33331	12	119	12	100.0	1.7	1.7	1.9
	33332	5	1	5	100.0	1.7	3.0	3.0
	33334	57	6	57	100.0	0.7	1.0	1.1
	33335	1	0	1	100.0	1.0	1.1	1.5
	33338	1	0	1	100.0	0.2	0.2	0.2
	33345	2	0	2	100.0	0.9	0.9	0.9
	33346	1	0	1	100.0	0.2	0.9	1.0
	33348	1	0	1	100.0	0.1	0.1	0.6
	33351	43	21	43	100.0	0.5	0.7	0.7
	33441	18	4	18	100.0	0.9	1.0	1.1
	33442	16	110	16	100.0	1.1	1.1	1.1
	33443	1	0	1	100.0	1.0	1.2	1.2
Citrus, FL	34442	1	0	1	100.0	4.8	4.8	4.8
Clay, FL	32003	1	99	1	100.0	0.6	0.6	0.6
Cobb, GA	30127	1	7	1	100.0	2.2	2.2	2.2
Duval, FL	32221	1	11	1	100.0	3.7	3.7	3.7
Escambia, FL	32514	1	0	1	100.0	2.3	3.3	3.3
Fulton, GA	30342	1	29	1	100.0	0.6	0.6	0.6

Continued on next page...

Access Detail By Zip Code

March 24, 2017

Created by...

Humana

Access Analysis

2 General Dentists in 5 miles

Employee Group

City of Fort Lauderdale

Dentist Group

General Dentist

2 General Dentists in 5 miles

[1] The Access Standard is defined as (City of Fort Lauderdale) employees accessing:

2 (General Dentist) dentists in 5 miles

Employees With Access								
County	Zip Code	Employee	Dentist	With Access[1]		Average Distance		
		#	#	#	%	1	2	3
Indian River, FL	32964	1	0	1	100.0	0.9	0.9	0.9
	32967	1	0	1	100.0	5.0	5.0	5.0
Lake, FL	32159	2	31	2	100.0	1.5	1.5	1.5
	32778	2	0	2	100.0	2.9	2.9	2.9
	34711	1	96	1	100.0	0.2	0.2	0.2
Lee, FL	33901	1	59	1	100.0	1.4	1.4	1.4
	33928	1	33	1	100.0	3.6	3.6	3.6
Leon, FL	32312	1	0	1	100.0	4.6	4.6	4.6
Marion, FL	34478	1	0	1	100.0	1.6	1.6	1.6
	34482	1	5	1	100.0	4.5	4.5	4.5
	34491	1	19	1	100.0	5.0	5.0	5.0
Martin, FL	33455	3	0	1	33.3	2.4	2.4	2.4
	34957	2	119	2	100.0	2.9	2.9	2.9
	34990	8	3	8	100.0	2.6	2.6	2.6
	34994	2	136	2	100.0	2.5	2.5	2.5
	34997	1	176	1	100.0	0.9	0.9	0.9
Miami-Dade, FL	33012	2	143	2	100.0	0.4	0.4	0.5
	33014	1	20	1	100.0	1.1	1.1	1.2
	33015	7	11	7	100.0	0.6	0.8	1.1
	33016	1	19	1	100.0	0.6	0.6	0.6
	33018	3	10	3	100.0	1.3	1.5	1.5
	33031	1	0	1	100.0	3.2	3.2	3.2
	33033	1	19	1	100.0	0.7	0.7	0.7
	33054	5	1	5	100.0	0.8	1.5	1.5
	33055	2	4	2	100.0	1.4	1.5	1.5
	33056	4	126	4	100.0	1.4	1.6	1.7
	33127	1	2	1	100.0	0.6	0.7	0.7
	33133	1	3	1	100.0	1.2	1.3	1.3
	33136	1	0	1	100.0	1.3	1.3	1.3
	33137	1	6	1	100.0	0.1	0.2	0.2
	33139	1	16	1	100.0	0.3	0.3	0.3
	33140	1	11	1	100.0	0.6	0.6	0.6
	33141	2	88	2	100.0	0.4	0.4	0.4
	33144	1	12	1	100.0	0.7	1.1	1.1
	33145	1	83	1	100.0	0.2	0.2	0.2
	33147	3	4	3	100.0	0.7	0.7	0.8
	33150	2	0	2	100.0	1.4	1.8	2.1
	33155	1	98	1	100.0	0.1	0.1	0.1
	33157	2	12	2	100.0	0.8	1.0	1.1
	33158	1	0	1	100.0	1.4	1.4	1.4

Continued on next page...

Access Detail By Zip Code

March 24, 2017

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Access Analysis

2 General Dentists in 5 miles

Employee Group

City of Fort Lauderdale

Dentist Group

General Dentist

2 General Dentists in 5 miles

[1] The Access Standard is defined as (City of Fort Lauderdale) employees accessing:

2 (General Dentist) dentists in 5 miles

Employees With Access								
County	Zip Code	Employee	Dentist	With Access[1]		Average Distance		
		#	#	#	%	1	2	3
Miami-Dade, FL	33160	6	4	6	100.0	0.8	0.8	0.8
	33161	2	2	2	100.0	0.7	1.3	2.1
	33162	8	24	8	100.0	0.5	0.7	0.8
	33165	1	24	1	100.0	0.6	0.6	0.8
	33167	4	4	4	100.0	0.9	0.9	0.9
	33168	2	0	2	100.0	1.5	1.5	1.5
	33169	10	6	10	100.0	0.7	1.2	1.4
	33173	3	21	3	100.0	0.5	0.5	0.5
	33177	1	6	1	100.0	1.9	2.1	2.1
	33178	3	79	3	100.0	1.8	3.6	3.6
	33179	9	185	9	100.0	0.6	0.8	0.9
	33180	1	59	1	100.0	0.2	0.2	0.5
	33181	1	16	1	100.0	0.9	0.9	1.5
	33183	2	5	2	100.0	1.1	1.3	1.3
	33185	2	3	2	100.0	0.9	1.2	1.3
	33186	3	144	3	100.0	0.4	0.5	0.8
	33187	1	11	1	100.0	3.9	3.9	3.9
	33189	1	148	1	100.0	0.6	0.6	0.6
	33193	1	11	1	100.0	0.3	0.3	0.3
	33196	1	13	1	100.0	1.6	1.6	2.0
	33245	1	0	1	100.0	0.4	0.4	0.4
Nassau, FL	32034	1	2	1	100.0	3.2	3.2	4.7
Okeechobee, FL	34974	1	0	1	100.0	3.8	3.8	3.8
Orange, FL	32803	1	77	1	100.0	1.1	1.1	1.1
	32809	1	93	1	100.0	0.7	0.7	1.8
Palm Beach, FL	33404	1	0	1	100.0	2.1	2.1	2.1
	33405	3	1	3	100.0	0.5	1.5	1.8
	33406	3	13	3	100.0	1.6	1.6	1.6
	33409	2	159	2	100.0	0.5	1.0	1.0
	33410	1	11	1	100.0	0.9	0.9	1.0
	33411	15	21	15	100.0	1.1	1.3	1.7
	33413	3	0	3	100.0	2.6	3.0	3.0
	33414	10	254	10	100.0	1.6	1.8	1.8
	33415	1	0	1	100.0	2.8	3.1	3.1
	33418	1	1	1	100.0	2.0	2.3	3.4
	33424	1	0	1	100.0	0.4	0.4	0.4
	33426	2	148	2	100.0	0.3	0.6	0.7
	33428	17	1	17	100.0	1.2	1.5	2.0
	33431	2	107	2	100.0	1.1	1.1	1.4
	33432	4	2	4	100.0	0.9	1.2	1.7

Continued on next page...

Access Detail By Zip Code

March 24, 2017

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Access Analysis

2 General Dentists in 5 miles

Employee Group

City of Fort Lauderdale

Dentist Group

General Dentist

2 General Dentists in 5 miles

[1] The Access Standard is defined as (City of Fort Lauderdale) employees accessing:

2 (General Dentist) dentists in 5 miles

Employees With Access								
County	Zip Code	Employee	Dentist	With Access[1]		Average Distance		
		#	#	#	%	1	2	3
Palm Beach, FL	33433	4	7	4	100.0	1.0	1.0	1.1
	33434	2	113	2	100.0	1.4	1.4	1.4
	33435	4	108	4	100.0	1.0	1.2	1.3
	33436	5	3	5	100.0	0.9	1.3	1.5
	33437	5	2	5	100.0	1.3	1.4	2.4
	33444	2	103	2	100.0	0.7	0.8	0.8
	33445	2	1	2	100.0	1.4	1.9	2.4
	33446	2	129	2	100.0	0.7	0.7	1.0
	33449	1	1	1	100.0	2.9	2.9	3.0
	33458	4	215	4	100.0	1.5	1.7	1.7
	33460	1	5	1	100.0	0.7	0.7	0.7
	33461	1	108	1	100.0	1.3	1.3	1.3
	33462	1	0	1	100.0	2.2	2.2	2.2
	33463	9	4	9	100.0	0.9	1.2	1.6
	33465	1	0	1	100.0	2.0	2.0	2.0
	33467	16	111	16	100.0	1.3	1.4	1.4
	33468	1	0	1	100.0	1.1	1.1	1.1
	33470	12	0	2	16.7	3.2	3.2	3.4
	33472	6	1	6	100.0	2.0	2.6	2.8
	33473	2	0	2	100.0	2.4	2.4	4.4
	33478	21	0	6	28.6	4.3	4.3	4.3
	33482	1	0	1	100.0	0.8	1.5	2.2
	33483	2	24	2	100.0	0.4	0.8	1.6
	33484	1	2	1	100.0	0.4	0.4	1.4
	33486	9	0	9	100.0	1.4	1.7	1.9
	33487	3	2	3	100.0	1.2	1.2	1.5
	33498	4	2	4	100.0	1.6	1.6	2.0
Pinellas, FL	33776	1	0	1	100.0	2.9	4.6	4.6
Polk, FL	33809	1	123	1	100.0	2.6	2.8	3.3
Seminole, FL	32714	1	90	1	100.0	0.3	0.3	0.3
	32746	2	13	2	100.0	0.8	1.2	1.2
	32773	1	78	1	100.0	0.7	0.7	0.7
St. Johns, FL	32086	1	26	1	100.0	1.5	1.5	1.5
St. Lucie, FL	34949	2	0	1	50.0	4.2	4.2	4.2
	34953	13	0	10	76.9	3.6	3.7	3.8
	34983	2	1	2	100.0	1.5	3.1	3.1
	34984	1	0	1	100.0	3.3	3.9	5.1
	34986	2	209	2	100.0	1.4	1.5	1.5
	34987	1	0	1	100.0	4.8	4.8	4.8
Volusia, FL	32118	1	0	1	100.0	1.6	1.6	1.6

Continued on next page...

Access Detail By Zip Code

March 24, 2017

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Access Analysis

2 General Dentists in 5 miles

Employee Group

City of Fort Lauderdale

Dentist Group

General Dentist

2 General Dentists in 5 miles

[1] The Access Standard is defined as (City of Fort Lauderdale) employees accessing:

2 (General Dentist) dentists in 5 miles

Employees With Access								
County	Zip Code	Employee #	Dentist #	With Access[1] #	With Access[1] %	Average Distance 1	Average Distance 2	Average Distance 3
Volusia, FL	32169	1	0	1	100.0	2.4	2.4	2.4
	32724	1	38	1	100.0	2.4	2.4	2.4
Grand Totals		**2,099**	**7,611**	**2,067**	**98.5**	**1.0**	**1.2**	**1.3**

Access Summary By City

March 24, 2017

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Access Analysis

2 General Dentists in 5 miles

Employee Group

City of Fort Lauderdale

Dentist Group

General Dentist

Areas Without Access

Bottom 35 Cities in the market, sorted by the number of employees without access

[1] The Access Standard is defined as (City of Fort Lauderdale) employees accessing:

2 (General Dentist) dentists in 5 miles

[2] Provider counts represent:

#: Provider access points

Employees Without Access

Employee Group	2,154 employees 87 (4.0%) employees without access	Dentist Group	1,479 unique dentists at 1,608 unique locations (22,256 total access points)

Key Geographic Areas

	City	Employee	Without Access[1]		Counts[2]	Average Distance		
		#	#	%	#	1	2	3
Without Access	Jupiter, FL	26	15	57.7	223	7.0	7.1	7.1
	Loxahatchee, FL	12	10	83.3	0	9.4	9.4	9.7
	West Palm Beach, FL	34	6	17.6	209	8.0	8.0	8.2
	Lake Placid, FL	3	3	100.0	0	17.9	17.9	17.9
	Port Saint Lucie, FL	19	3	15.8	239	6.3	6.5	6.5
	Hobe Sound, FL	3	2	66.7	0	6.8	6.8	6.8
	Inverness, FL	2	2	100.0	13	6.1	6.1	6.1
	Live Oak, FL	2	2	100.0	0	29.5	29.9	29.9
	Sautee Nacoochee, GA	2	2	100.0	0	31.2	31.2	31.2
	Advance, NC	1	1	100.0	0	197.3	200.1	200.1
	Albertville, AL	1	1	100.0	0	57.2	57.2	78.2
	Anacortes, WA	1	1	100.0	0	1,996.6	1,996.6	1,996.6
	Arlington, TX	1	1	100.0	0	609.7	610.2	610.5
	Astor, FL	1	1	100.0	0	20.6	20.6	20.6
	Augusta, GA	1	1	100.0	5	7.2	7.2	7.2
	Austin, TX	1	1	100.0	0	645.8	647.3	647.3
	Bellefonte, PA	1	1	100.0	0	566.3	566.3	566.3
	Blairsville, GA	1	1	100.0	0	42.4	42.4	42.4
	Bloomingdale, NJ	1	1	100.0	0	670.8	674.2	674.2
	Bothell, WA	1	1	100.0	0	1,976.8	1,976.8	1,976.8
	Boulder, CO	1	1	100.0	0	1,140.5	1,140.5	1,140.5
	Bronson, FL	1	1	100.0	0	20.4	24.0	24.4
	Center Tuftonboro, NH	1	1	100.0	0	905.3	908.6	908.6
	Chipley, FL	1	1	100.0	0	24.6	43.5	43.5
	Clifton Park, NY	1	1	100.0	0	786.5	789.5	789.5
	Flat Rock, NC	1	1	100.0	0	111.3	111.3	111.3
	Fort Lauderdale, FL	1,108	1	0.1	1,011	1.6	5.8	6.0
	Fort Pierce, FL	2	1	50.0	24	5.3	5.3	5.3
	Georgetown, KY	1	1	100.0	0	233.5	233.5	233.5
	Greenville, PA	1	1	100.0	0	524.0	524.0	524.0
	Hephzibah, GA	1	1	100.0	0	11.0	11.0	11.0
	Hermitage, TN	1	1	100.0	0	119.9	119.9	119.9
	Hickory, NC	1	1	100.0	0	161.3	162.7	162.7
	Huntington, WV	1	1	100.0	0	291.5	291.5	291.5
	Jamaica, NY	1	1	100.0	0	673.7	677.4	677.4

Access Detail By Zip Code

March 24, 2017

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Access Analysis

2 General Dentists in 5 miles

Employee Group

City of Fort Lauderdale

Dentist Group

General Dentist

2 General Dentists in 5 miles

[1] The Access Standard is defined as (City of Fort Lauderdale) employees accessing:

2 (General Dentist) dentists in 5 miles

Employees Without Access								
County	Zip Code	Employee #	Dentist #	Without Access[1] #	Without Access[1] %	Average Distance 1	Average Distance 2	Average Distance 3
Boulder, CO	80305	1	0	1	100.0	1,140.5	1,140.5	1,140.5
Broward, FL	33327	6	0	1	16.7	1.6	5.8	6.0
Brown, WI	54180	1	0	1	100.0	677.4	677.4	677.4
Cabell, WV	25705	1	0	1	100.0	291.5	291.5	291.5
Carroll, NH	03816	1	0	1	100.0	905.3	908.6	908.6
Catawba, NC	28602	1	0	1	100.0	161.3	162.7	162.7
Centre, PA	16823	1	0	1	100.0	566.3	566.3	566.3
Citrus, FL	34450	1	0	1	100.0	6.1	6.1	6.1
	34452	1	0	1	100.0	6.0	6.0	6.0
Collier, FL	34145	1	0	1	100.0	14.0	14.6	14.6
Davidson, TN	37076	1	0	1	100.0	119.9	119.9	119.9
Davie, NC	27006	1	0	1	100.0	197.3	200.1	200.1
Fort Bend, TX	77459	1	0	1	100.0	514.4	516.1	516.1
Greenville, SC	29356	1	0	1	100.0	110.9	110.9	110.9
Henderson, NC	28731	1	0	1	100.0	111.3	111.3	111.3
Henry, GA	30252	1	0	1	100.0	5.0	9.4	9.4
Highlands, FL	33852	3	0	3	100.0	17.9	17.9	17.9
Knox, TN	37918	1	0	1	100.0	110.2	110.2	110.2
Lake, FL	32102	1	0	1	100.0	20.6	20.6	20.6
Lake, OH	44077	1	0	1	100.0	521.5	521.5	521.5
Lamar, MS	39475	1	0	1	100.0	142.3	142.5	142.8
Levy, FL	32621	1	0	1	100.0	20.4	24.0	24.4
Marshall, AL	35951	1	0	1	100.0	57.2	57.2	78.2
Martin, FL	33455	3	0	2	66.7	6.8	6.8	6.8
Mercer, PA	16125	1	0	1	100.0	524.0	524.0	524.0
Monroe, FL	33037	1	4	1	100.0	3.4	7.1	7.1
	33070	1	0	1	100.0	10.8	12.7	12.7
Oconee, SC	29693	1	0	1	100.0	52.1	52.1	52.1
Orange, CA	92663	1	0	1	100.0	1,819.6	1,820.6	1,820.7
Palm Beach, FL	33412	6	0	6	100.0	8.0	8.0	8.2
	33470	12	0	10	83.3	9.4	9.4	9.7
	33478	21	0	15	71.4	7.0	7.1	7.1
Passaic, NJ	07403	1	0	1	100.0	670.8	674.2	674.2
Pima, AZ	85739	1	0	1	100.0	1,417.2	1,418.3	1,418.4
Pulaski, AR	72120	1	0	1	100.0	404.7	404.7	404.7
Queens, NY	11432	1	0	1	100.0	673.7	677.4	677.4
Richmond, GA	30815	1	0	1	100.0	11.0	11.0	11.0
	30906	1	0	1	100.0	7.2	7.2	7.2
Saratoga, NY	12065	1	0	1	100.0	786.5	789.5	789.5
Scott, KY	40324	1	0	1	100.0	233.5	233.5	233.5

Continued on next page...

Access Detail By Zip Code

March 24, 2017

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Access Analysis

2 General Dentists in 5 miles

Employee Group

City of Fort Lauderdale

Dentist Group

General Dentist

2 General Dentists in 5 miles

[1] The Access Standard is defined as (City of Fort Lauderdale) employees accessing:

2 (General Dentist) dentists in 5 miles

Employees Without Access								
County	Zip Code	Employee #	Dentist #	Without Access[1] #	Without Access[1] %	Average Distance 1	Average Distance 2	Average Distance 3
Skagit, WA	98221	1	0	1	100.0	1,996.6	1,996.6	1,996.6
Snohomish, WA	98012	1	0	1	100.0	1,976.8	1,976.8	1,976.8
St. Lucie, FL	34949	2	0	1	50.0	5.3	5.3	5.3
	34953	13	0	3	23.1	6.3	6.5	6.5
	34957	1	0	1	100.0	5.2	5.7	6.0
Stark, OH	44662	1	0	1	100.0	453.0	453.0	453.0
Suwannee, FL	32060	2	0	2	100.0	29.5	29.9	29.9
Tarrant, TX	76001	1	0	1	100.0	609.7	610.2	610.5
Travis, TX	78730	1	0	1	100.0	645.8	647.3	647.3
Union, GA	30512	1	0	1	100.0	42.4	42.4	42.4
Washington, FL	32428	1	0	1	100.0	24.6	43.5	43.5
White, GA	30571	2	0	2	100.0	31.2	31.2	31.2
Grand Totals		**112**	**4**	**87**	**77.7**	**213.0**	**213.7**	**214.0**

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Humana Dental PPO Network

City of Fort Lauderdale

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April 3, 2017

Contents

April 3, 2017

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Report Contents

Access Overview

April 3, 2017

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Access Analysis
2 General Dentists in 5 miles

Employee Group
City of Fort Lauderdale

Dentist Group
General Dentists

Access Map
Employee locations
◆ With access
● Without access

643.89 miles

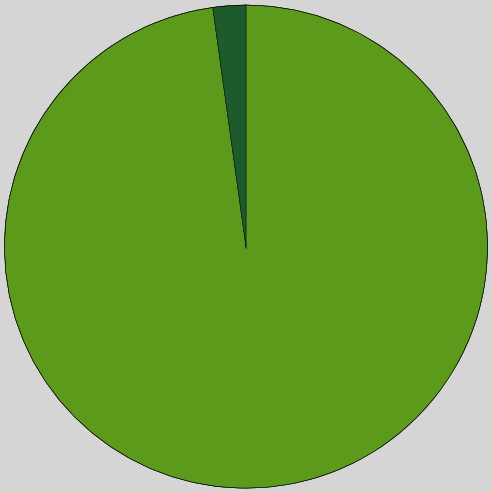
Comparison Graph
Percent of employees with access to a choice of dentists over miles
1st closest
2nd closest
3rd closest
4th closest
5th closest

[1] The Access Standard is defined as (City of Fort Lauderdale) employees accessing:
2 (General Dentists) dentists in 5 miles

Overall Access[1]

2,154 Employees
239,045 dentists at 47,429 locations (General Dentists)

2,106 (97.8%) Employees with access
48 (2.2%) Employees without access

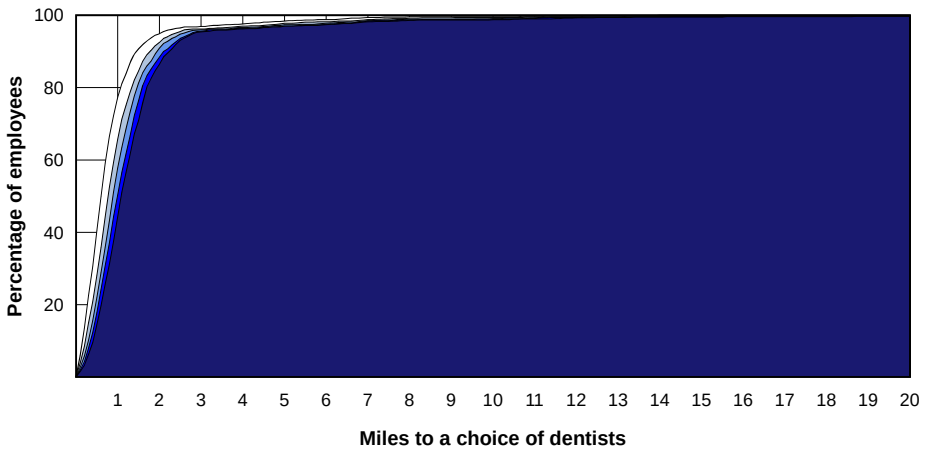


All Employees

Distances

	Average
Distance to 1st closest dentist	0.9 mile
Distance to 2nd closest dentist	1.1 miles
Distance to 3rd closest dentist	1.3 miles
Distance to 4th closest dentist	1.4 miles
Distance to 5th closest dentist	1.5 miles

Access Standard Comparison



Access Summary By City

April 3, 2017

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Access Analysis
2 General Dentists in 5 miles

Employee Group
City of Fort Lauderdale

Dentist Group
General Dentists

Areas With Access
Top 36 Cities in the market, sorted by the number of employees with access

[1] The Access Standard is defined as (City of Fort Lauderdale) employees accessing:
2 (General Dentists) dentists in 5 miles

[2] Provider counts represent:
#: Provider access points

Employees With Access

Employee Group		Dentist Group	
	2,154 employees 2,106 (97.8%) employees with access		**239,045 unique dentists at 47,429 unique** (239,045 total access points)

Key Geographic Areas

	City	Employee	With Access[1]		Counts[2]	Average Distance		
		#	#	%	#	1	2	3
With Access	Fort Lauderdale, FL	1,108	1,108	100.0	1,700	0.7	0.9	1.0
	Pompano Beach, FL	342	342	100.0	1,109	0.7	0.8	1.0
	Hollywood, FL	207	207	100.0	983	0.7	0.8	0.9
	Miami, FL	72	72	100.0	2,677	0.6	0.7	0.9
	Boca Raton, FL	45	45	100.0	447	0.7	1.0	1.1
	Deerfield Beach, FL	35	35	100.0	161	0.6	0.8	1.0
	West Palm Beach, FL	34	31	91.2	360	1.2	1.5	2.0
	Lake Worth, FL	30	30	100.0	347	0.8	1.0	1.1
	Boynton Beach, FL	25	25	100.0	455	0.8	0.9	1.0
	Port Saint Lucie, FL	19	19	100.0	693	1.6	1.6	2.0
	Dania, FL	15	15	100.0	19	0.7	0.8	1.2
	Hialeah, FL	14	14	100.0	481	0.5	0.6	0.7
	Pembroke Pines, FL	14	14	100.0	6	0.9	1.1	1.4
	Jupiter, FL	26	11	42.3	318	2.6	2.8	2.8
	Delray Beach, FL	10	10	100.0	378	0.5	0.5	0.6
	Wellington, FL	10	10	100.0	323	0.9	1.3	1.4
	Palm City, FL	8	8	100.0	5	2.0	2.5	2.5
	Hallandale, FL	7	7	100.0	157	0.6	0.6	0.7
	Opa Locka, FL	7	7	100.0	11	0.7	1.2	1.4
	North Miami Beach, FL	6	6	100.0	12	0.6	0.7	0.8
	Miami Beach, FL	4	4	100.0	264	0.4	0.4	0.4
	Miami Gardens, FL	4	4	100.0	150	0.9	1.5	1.7
	Hobe Sound, FL	3	3	100.0	2	2.0	3.4	5.3
	Jensen Beach, FL	3	3	100.0	141	1.4	1.4	3.3
	Stuart, FL	3	3	100.0	494	0.4	0.4	0.5
	Gainesville, FL	2	2	100.0	326	1.1	1.2	1.4
	Homestead, FL	2	2	100.0	103	2.0	2.0	2.0
	Inverness, FL	2	2	100.0	124	2.4	2.4	6.1
	Lady Lake, FL	2	2	100.0	49	0.6	0.6	0.6
	Lake Mary, FL	2	2	100.0	304	0.4	0.5	0.5
	Loxahatchee, FL	12	2	16.7	1	3.2	3.2	3.4
	Ocala, FL	2	2	100.0	306	2.9	3.1	3.1
	Orlando, FL	2	2	100.0	2,366	0.6	0.8	0.9
	Palm Beach Gardens, FL	2	2	100.0	31	1.4	1.4	1.5
	Tavares, FL	2	2	100.0	15	1.2	1.2	1.2
	Vero Beach, FL	2	2	100.0	202	2.4	2.8	2.9

Access Detail By Zip Code

April 3, 2017

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Access Analysis
2 General Dentists in 5 miles

Employee Group
City of Fort Lauderdale

Dentist Group
General Dentists

2 General Dentists in 5 miles

[1] The Access Standard is defined as (City of Fort Lauderdale) employees accessing:
2 (General Dentists) dentists in 5 miles

Employees With Access								
County	Zip Code	Employee	Dentist	With Access[1]		Average Distance		
		#	#	#	%	1	2	3
Alachua, FL	32605	1	177	1	100.0	0.9	1.2	1.2
	32606	1	113	1	100.0	1.2	1.2	1.5
Boulder, CO	80305	1	61	1	100.0	0.2	0.2	0.2
Brevard, FL	32903	1	1	1	100.0	1.6	2.8	2.8
	32909	1	22	1	100.0	1.0	1.1	1.1
Broward, FL	33004	15	19	15	100.0	0.7	0.8	1.2
	33008	1	0	1	100.0	0.4	0.5	0.5
	33009	6	157	6	100.0	0.6	0.6	0.7
	33019	8	3	8	100.0	1.3	1.4	1.4
	33020	20	11	20	100.0	0.5	0.7	0.8
	33021	25	181	25	100.0	0.4	0.6	0.7
	33022	1	0	1	100.0	0.3	0.3	0.3
	33023	32	7	32	100.0	0.9	1.1	1.2
	33024	37	76	37	100.0	0.5	0.6	0.7
	33025	26	161	26	100.0	0.7	0.8	0.8
	33026	20	205	20	100.0	0.4	0.5	0.6
	33027	18	195	18	100.0	0.7	1.1	1.1
	33028	14	6	14	100.0	0.9	1.1	1.4
	33029	19	144	19	100.0	1.0	1.0	1.1
	33060	36	9	36	100.0	0.6	0.7	1.0
	33061	1	0	1	100.0	0.4	0.4	0.6
	33062	17	163	17	100.0	0.6	0.6	0.7
	33063	51	28	51	100.0	0.6	0.7	0.8
	33064	32	10	32	100.0	0.8	1.2	1.4
	33065	34	51	34	100.0	0.7	0.8	0.9
	33066	15	5	15	100.0	0.7	0.8	0.8
	33067	24	37	24	100.0	0.8	1.1	1.2
	33068	41	23	41	100.0	0.6	0.9	1.0
	33069	21	9	21	100.0	0.7	0.9	1.1
	33071	25	344	25	100.0	0.5	0.8	0.9
	33073	29	291	29	100.0	0.6	0.6	0.7
	33074	1	0	1	100.0	1.3	1.9	1.9
	33076	15	139	15	100.0	0.9	1.0	1.0
	33081	1	0	1	100.0	0.6	1.1	1.2
	33301	15	144	15	100.0	0.5	0.6	0.7
	33302	6	0	6	100.0	0.3	0.5	0.5
	33303	1	0	1	100.0	0.3	0.3	0.5
	33304	33	138	33	100.0	0.5	0.6	0.7
	33305	26	16	26	100.0	0.4	0.5	0.6
	33306	11	14	11	100.0	0.2	0.3	0.3

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Access Detail By Zip Code

April 3, 2017

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Access Analysis
2 General Dentists in 5 miles

Employee Group
City of Fort Lauderdale

Dentist Group
General Dentists

2 General Dentists in 5 miles

[1] The Access Standard is defined as (City of Fort Lauderdale) employees accessing:
2 (General Dentists) dentists in 5 miles

Employees With Access								
County	Zip Code	Employee	Dentist	With Access[1]		Average Distance		
		#	#	#	%	1	2	3
Broward, FL	33307	1	0	1	100.0	0.7	0.8	0.9
	33308	46	185	46	100.0	0.4	0.5	0.5
	33309	77	3	77	100.0	0.8	1.1	1.3
	33310	2	0	2	100.0	0.5	0.5	0.5
	33311	189	8	189	100.0	0.8	1.0	1.1
	33312	89	94	89	100.0	0.9	1.0	1.2
	33313	59	20	59	100.0	0.5	0.6	0.8
	33314	24	4	24	100.0	0.8	0.9	0.9
	33315	36	6	36	100.0	1.1	1.1	1.2
	33316	13	9	13	100.0	0.6	0.9	0.9
	33317	49	43	49	100.0	0.9	1.0	1.1
	33318	2	0	2	100.0	0.1	0.1	0.1
	33319	54	23	54	100.0	0.6	0.8	1.0
	33321	51	163	51	100.0	0.7	0.9	0.9
	33322	35	22	35	100.0	0.5	0.6	0.6
	33323	21	89	21	100.0	0.9	1.1	1.2
	33324	46	188	46	100.0	0.6	0.7	0.9
	33325	36	1	36	100.0	1.3	2.0	2.1
	33326	8	150	8	100.0	0.6	0.9	1.1
	33327	6	0	6	100.0	1.7	1.9	1.9
	33328	37	177	37	100.0	0.6	0.8	0.8
	33329	1	0	1	100.0	0.3	0.3	1.4
	33330	11	13	11	100.0	1.1	1.2	1.4
	33331	12	148	12	100.0	1.6	1.6	1.6
	33332	5	5	5	100.0	1.4	1.4	1.7
	33334	57	8	57	100.0	0.5	0.7	0.8
	33335	1	0	1	100.0	0.7	0.8	0.9
	33338	1	0	1	100.0	0.1	0.1	0.1
	33345	2	0	2	100.0	0.9	0.9	0.9
	33346	1	0	1	100.0	0.2	0.9	0.9
	33348	1	0	1	100.0	0.1	0.1	0.1
	33351	43	29	43	100.0	0.5	0.5	0.6
	33441	18	10	18	100.0	0.6	0.7	0.9
	33442	16	151	16	100.0	0.5	0.9	1.0
	33443	1	0	1	100.0	0.6	0.8	1.0
Brown, WI	54180	1	3	1	100.0	0.7	0.7	0.7
Cabell, WV	25705	1	6	1	100.0	1.3	1.3	2.3
Catawba, NC	28602	1	24	1	100.0	1.7	1.7	1.7
Citrus, FL	34442	1	0	1	100.0	4.8	4.8	4.8
	34450	1	0	1	100.0	2.1	2.1	6.1

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Access Detail By Zip Code

April 3, 2017

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Access Analysis
2 General Dentists in 5 miles

Employee Group
City of Fort Lauderdale

Dentist Group
General Dentists

2 General Dentists in 5 miles

[1] The Access Standard is defined as (City of Fort Lauderdale) employees accessing:
2 (General Dentists) dentists in 5 miles

Employees With Access								
County	Zip Code	Employee	Dentist	With Access[1]		Average Distance		
		#	#	#	%	1	2	3
Citrus, FL	34452	1	2	1	100.0	2.7	2.7	6.0
Clay, FL	32003	1	271	1	100.0	0.4	0.4	0.6
Cobb, GA	30127	1	15	1	100.0	1.8	2.1	2.1
Collier, FL	34145	1	9	1	100.0	1.2	1.2	1.2
Davidson, TN	37076	1	51	1	100.0	0.4	0.4	1.2
Duval, FL	32221	1	111	1	100.0	3.7	3.7	3.7
Escambia, FL	32514	1	0	1	100.0	2.3	2.3	2.8
Fort Bend, TX	77459	1	176	1	100.0	0.5	0.5	0.5
Fulton, GA	30342	1	156	1	100.0	0.4	0.4	0.6
Greenville, SC	29356	1	0	1	100.0	3.7	3.7	4.2
Henry, GA	30252	1	0	1	100.0	5.0	5.0	5.0
Indian River, FL	32964	1	0	1	100.0	0.6	0.6	0.7
	32967	1	0	1	100.0	4.2	5.0	5.0
Knox, TN	37918	1	44	1	100.0	0.9	0.9	0.9
Lake, FL	32159	2	42	2	100.0	0.6	0.6	0.6
	32778	2	15	2	100.0	1.2	1.2	1.2
	34711	1	158	1	100.0	0.2	0.2	0.2
Lake, OH	44077	1	2	1	100.0	4.3	4.4	4.4
Lee, FL	33901	1	68	1	100.0	0.5	0.5	1.4
	33928	1	32	1	100.0	0.5	0.5	0.5
Leon, FL	32312	1	2	1	100.0	2.1	2.1	2.5
Marion, FL	34478	1	0	1	100.0	1.3	1.6	1.6
	34482	1	8	1	100.0	4.5	4.5	4.5
	34491	1	26	1	100.0	2.6	5.0	5.0
Marshall, AL	35951	1	3	1	100.0	4.3	4.6	4.6
Martin, FL	33455	3	2	3	100.0	2.0	3.4	5.3
	34957	2	141	2	100.0	0.5	0.5	2.8
	34990	8	5	8	100.0	2.0	2.5	2.5
	34994	2	207	2	100.0	0.2	0.2	0.3
	34997	1	285	1	100.0	0.9	0.9	0.9
Mercer, PA	16125	1	10	1	100.0	0.2	1.0	1.3
Miami-Dade, FL	33012	2	193	2	100.0	0.2	0.4	0.4
	33014	1	39	1	100.0	0.9	1.1	1.1
	33015	7	168	7	100.0	0.5	0.6	0.6
	33016	1	34	1	100.0	0.4	0.4	0.4
	33018	3	13	3	100.0	0.8	0.9	1.0
	33031	1	0	1	100.0	3.2	3.2	3.2
	33033	1	34	1	100.0	0.7	0.7	0.7
	33054	5	1	5	100.0	0.8	1.5	1.5
	33055	2	10	2	100.0	0.4	0.7	1.4

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Access Detail By Zip Code

April 3, 2017

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Access Analysis
2 General Dentists in 5 miles

Employee Group
City of Fort Lauderdale

Dentist Group
General Dentists

2 General Dentists in 5 miles

[1] The Access Standard is defined as (City of Fort Lauderdale) employees accessing:
2 (General Dentists) dentists in 5 miles

Employees With Access								
County	Zip Code	Employee	Dentist	With Access[1]		Average Distance		
		#	#	#	%	1	2	3
Miami-Dade, FL	33056	4	150	4	100.0	0.9	1.5	1.7
	33127	1	3	1	100.0	0.6	0.7	0.7
	33133	1	11	1	100.0	0.2	0.7	1.0
	33136	1	0	1	100.0	0.8	0.8	1.1
	33137	1	8	1	100.0	0.1	0.2	0.2
	33139	1	96	1	100.0	0.3	0.3	0.3
	33140	1	15	1	100.0	0.5	0.5	0.5
	33141	2	140	2	100.0	0.4	0.4	0.4
	33144	1	31	1	100.0	0.4	0.5	0.6
	33145	1	33	1	100.0	0.2	0.2	0.2
	33147	3	5	3	100.0	0.5	0.7	0.7
	33150	2	1	2	100.0	0.9	1.1	1.4
	33155	1	165	1	100.0	0.1	0.1	0.1
	33157	2	30	2	100.0	0.7	1.0	1.0
	33158	1	0	1	100.0	1.3	1.4	1.4
	33160	6	12	6	100.0	0.6	0.7	0.8
	33161	2	9	2	100.0	0.5	0.6	0.6
	33162	8	40	8	100.0	0.4	0.5	0.5
	33165	1	46	1	100.0	0.6	0.6	0.6
	33167	4	4	4	100.0	0.9	0.9	0.9
	33168	2	2	2	100.0	0.5	0.6	1.5
	33169	10	8	10	100.0	0.6	0.9	1.2
	33173	3	37	3	100.0	0.3	0.3	0.4
	33177	1	12	1	100.0	1.6	1.6	1.6
	33178	3	147	3	100.0	0.8	0.9	1.7
	33179	9	251	9	100.0	0.6	0.6	0.7
	33180	1	77	1	100.0	0.3	0.3	0.3
	33181	1	26	1	100.0	0.5	0.9	0.9
	33183	2	28	2	100.0	1.0	1.2	1.2
	33185	2	6	2	100.0	0.7	0.8	1.3
	33186	3	313	3	100.0	0.4	0.4	0.8
	33187	1	14	1	100.0	3.8	3.9	3.9
	33189	1	202	1	100.0	0.6	0.6	0.6
	33193	1	13	1	100.0	0.3	0.3	0.3
	33196	1	18	1	100.0	0.9	0.9	1.6
	33245	1	0	1	100.0	0.1	0.4	0.5
Monroe, FL	33037	1	6	1	100.0	4.0	4.0	7.0
	33070	1	3	1	100.0	0.5	0.5	1.0
Nassau, FL	32034	1	24	1	100.0	0.6	0.6	0.6
Okeechobee, FL	34974	1	0	1	100.0	3.3	3.8	3.8

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Access Detail By Zip Code

April 3, 2017

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Access Analysis
2 General Dentists in 5 miles

Employee Group
City of Fort Lauderdale

Dentist Group
General Dentists

2 General Dentists in 5 miles

[1] The Access Standard is defined as (City of Fort Lauderdale) employees accessing:
2 (General Dentists) dentists in 5 miles

Employees With Access								
County	Zip Code	Employee	Dentist	With Access[1]		Average Distance		
		#	#	#	%	1	2	3
Orange, CA	92663	1	10	1	100.0	0.1	0.4	0.6
Orange, FL	32803	1	209	1	100.0	0.6	1.0	1.1
	32809	1	142	1	100.0	0.6	0.6	0.6
Palm Beach, FL	33404	1	3	1	100.0	1.1	1.2	2.0
	33405	3	5	3	100.0	0.5	0.6	0.8
	33406	3	41	3	100.0	1.1	1.2	1.2
	33409	2	224	2	100.0	0.3	0.4	0.6
	33410	1	30	1	100.0	0.7	0.8	0.9
	33411	15	43	15	100.0	1.0	1.1	1.3
	33412	6	1	3	50.0	3.0	4.6	8.0
	33413	3	0	3	100.0	1.3	2.1	2.5
	33414	10	323	10	100.0	0.9	1.3	1.4
	33415	1	5	1	100.0	1.3	1.3	1.3
	33418	1	1	1	100.0	2.0	2.0	2.0
	33424	1	0	1	100.0	0.2	0.4	0.4
	33426	2	267	2	100.0	0.3	0.5	0.7
	33428	17	5	17	100.0	0.7	1.1	1.2
	33431	2	181	2	100.0	0.4	1.0	1.0
	33432	4	48	4	100.0	0.4	0.6	0.6
	33433	4	28	4	100.0	0.5	0.6	0.7
	33434	2	154	2	100.0	1.2	1.4	1.4
	33435	4	144	4	100.0	0.7	0.7	1.0
	33436	5	8	5	100.0	0.8	0.9	1.0
	33437	5	24	5	100.0	0.7	0.7	0.8
	33444	2	140	2	100.0	0.7	0.7	0.8
	33445	2	17	2	100.0	0.5	0.5	0.5
	33446	2	171	2	100.0	0.7	0.7	0.7
	33449	1	7	1	100.0	1.7	1.7	1.7
	33458	4	307	4	100.0	1.2	1.2	1.2
	33460	1	10	1	100.0	0.5	0.6	0.7
	33461	1	154	1	100.0	0.5	0.6	0.9
	33462	1	3	1	100.0	1.9	2.2	2.2
	33463	9	12	9	100.0	0.6	0.8	1.0
	33465	1	0	1	100.0	1.8	1.8	2.0
	33467	16	161	16	100.0	0.8	1.0	1.1
	33468	1	0	1	100.0	0.7	1.1	1.1
	33470	12	1	2	16.7	3.2	3.2	3.4
	33472	6	12	6	100.0	0.9	1.2	1.2
	33473	2	0	2	100.0	1.7	1.8	1.8
	33478	21	0	6	28.6	3.9	4.2	4.2

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Access Detail By Zip Code

April 3, 2017

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Access Analysis
2 General Dentists in 5 miles

Employee Group
City of Fort Lauderdale

Dentist Group
General Dentists

2 General Dentists in 5 miles

[1] The Access Standard is defined as (City of Fort Lauderdale) employees accessing:
2 (General Dentists) dentists in 5 miles

Employees With Access								
County	Zip Code	Employee	Dentist	With Access[1]		Average Distance		
		#	#	#	%	1	2	3
Palm Beach, FL	33482	1	0	1	100.0	0.4	0.4	0.5
	33483	2	38	2	100.0	0.3	0.4	0.8
	33484	1	12	1	100.0	0.4	0.4	0.4
	33486	9	12	9	100.0	0.9	0.9	1.1
	33487	3	4	3	100.0	0.7	0.9	1.1
	33498	4	7	4	100.0	0.9	1.2	1.3
Passaic, NJ	07403	1	1	1	100.0	1.0	1.6	1.6
Pima, AZ	85739	1	5	1	100.0	1.8	2.6	2.6
Pinellas, FL	33776	1	2	1	100.0	0.3	0.9	2.0
Polk, FL	33809	1	150	1	100.0	0.9	1.2	1.2
Pulaski, AR	72120	1	2	1	100.0	2.2	2.9	3.8
Queens, NY	11432	1	38	1	100.0	0.0	0.1	0.2
Richmond, GA	30906	1	22	1	100.0	1.8	1.8	2.8
Saratoga, NY	12065	1	31	1	100.0	1.3	1.6	1.6
Scott, KY	40324	1	40	1	100.0	0.8	1.0	1.0
Seminole, FL	32714	1	215	1	100.0	0.4	0.4	0.4
	32746	2	304	2	100.0	0.4	0.5	0.5
	32773	1	87	1	100.0	0.7	0.7	0.7
Skagit, WA	98221	1	3	1	100.0	1.7	2.4	2.5
Snohomish, WA	98012	1	22	1	100.0	0.7	0.7	0.7
St. Johns, FL	32086	1	120	1	100.0	1.4	1.5	1.5
St. Lucie, FL	34949	2	0	1	50.0	4.2	4.2	4.7
	34953	13	14	13	100.0	1.8	1.8	2.4
	34957	1	0	1	100.0	3.3	3.3	4.4
	34983	2	5	2	100.0	1.3	1.5	1.5
	34984	1	0	1	100.0	1.3	1.3	1.3
	34986	2	412	2	100.0	0.6	0.6	0.6
	34987	1	12	1	100.0	1.8	1.8	1.8
Tarrant, TX	76001	1	7	1	100.0	1.5	1.5	1.7
Travis, TX	78730	1	3	1	100.0	2.6	2.6	2.6
Volusia, FL	32118	1	2	1	100.0	1.1	1.4	2.5
	32169	1	0	1	100.0	2.4	2.4	2.4
	32724	1	111	1	100.0	2.3	2.3	2.3
Grand Totals		**2,135**	**13,433**	**2,106**	**98.6**	**0.8**	**0.9**	**1.1**

Access Summary By City

April 3, 2017

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Access Analysis
2 General Dentists in 5 miles

Employee Group
City of Fort Lauderdale

Dentist Group
General Dentists

Areas Without Access
Bottom 36 Cities in the market, sorted by the number of employees without access

[1] The Access Standard is defined as (City of Fort Lauderdale) employees accessing:
2 (General Dentists) dentists in 5 miles

[2] Provider counts represent:
#: Provider access points

Employees Without Access

Employee Group		Dentist Group	
	2,154 employees 48 (2.2%) employees without access		**239,045 unique dentists at 47,429 unique** (239,045 total access points)

Key Geographic Areas

	City	Employee	Without Access[1]		Counts[2]	Average Distance		
		#	#	%	#	1	2	3
Without Access	Jupiter, FL	26	15	57.7	318	6.7	6.9	6.9
	Loxahatchee, FL	12	10	83.3	1	3.6	8.0	9.4
	Lake Placid, FL	3	3	100.0	1	4.4	15.2	15.2
	West Palm Beach, FL	34	3	8.8	360	1.8	6.0	8.0
	Live Oak, FL	2	2	100.0	6	6.9	7.0	9.3
	Sautee Nacoochee, GA	2	2	100.0	0	12.4	30.5	30.7
	Advance, NC	1	1	100.0	0	6.9	6.9	6.9
	Astor, FL	1	1	100.0	0	15.4	15.4	15.4
	Bellefonte, PA	1	1	100.0	0	11.7	12.2	12.2
	Blairsville, GA	1	1	100.0	2	5.1	5.1	19.6
	Bronson, FL	1	1	100.0	0	13.2	13.2	13.2
	Center Tuftonboro, NH	1	1	100.0	0	11.2	11.2	11.2
	Chipley, FL	1	1	100.0	6	6.9	6.9	6.9
	Flat Rock, NC	1	1	100.0	0	6.2	6.2	6.4
	Fort Pierce, FL	2	1	50.0	38	5.3	5.3	5.8
	Hephzibah, GA	1	1	100.0	1	4.7	10.0	10.0
	Navarre, OH	1	1	100.0	0	5.6	5.6	5.9
	Purvis, MS	1	1	100.0	0	11.3	11.3	11.4
	Westminster, SC	1	1	100.0	0	12.7	12.7	28.4

Access Detail By Zip Code

April 3, 2017

Created by...
Humana

Access Analysis
2 General Dentists in 5 miles

Employee Group
City of Fort Lauderdale

Dentist Group
General Dentists

2 General Dentists in 5 miles

[1] The Access Standard is defined as (City of Fort Lauderdale) employees accessing:
2 (General Dentists) dentists in 5 miles

Employees Without Access								
County	Zip Code	Employee	Dentist	Without Access[1]		Average Distance		
		#	#	#	%	1	2	3
Carroll, NH	03816	1	0	1	100.0	11.2	11.2	11.2
Centre, PA	16823	1	0	1	100.0	11.7	12.2	12.2
Davie, NC	27006	1	0	1	100.0	6.9	6.9	6.9
Henderson, NC	28731	1	0	1	100.0	6.2	6.2	6.4
Highlands, FL	33852	3	1	3	100.0	4.4	15.2	15.2
Lake, FL	32102	1	0	1	100.0	15.4	15.4	15.4
Lamar, MS	39475	1	0	1	100.0	11.3	11.3	11.4
Levy, FL	32621	1	0	1	100.0	13.2	13.2	13.2
Oconee, SC	29693	1	0	1	100.0	12.7	12.7	28.4
Palm Beach, FL	33412	6	1	3	50.0	1.8	6.0	8.0
	33470	12	1	10	83.3	3.6	8.0	9.4
	33478	21	0	15	71.4	6.7	6.9	6.9
Richmond, GA	30815	1	1	1	100.0	4.7	10.0	10.0
St. Lucie, FL	34949	2	0	1	50.0	5.3	5.3	5.8
Stark, OH	44662	1	0	1	100.0	5.6	5.6	5.9
Suwannee, FL	32060	2	2	2	100.0	6.9	7.0	9.3
Union, GA	30512	1	2	1	100.0	5.1	5.1	19.6
Washington, FL	32428	1	6	1	100.0	6.9	6.9	6.9
White, GA	30571	2	0	2	100.0	12.4	30.5	30.7
Grand Totals		**60**	**14**	**48**	**80.0**	**6.4**	**9.2**	**10.4**

Proposal Questionnaire

Responses to the following questions are to be included in your proposal and also in an electronic format (CD) as a Word document.

General

1. Where are your company's claims and customer service offices located that will be servicing this account? Are there any plans to locate those member call centers out of the country? If so, please elaborate.

   DPPO
   Humana services all of the City's claims and customer service needs for the dental PPO plans from our headquarters in De Pere, Wisconsin, near Green Bay.

   DHMO
   Humana services all of the City's claims needs for the DHMO plans from our Chicago, Illinois office. Customer service is provided from one of Humana's two Customer Care centers located in Tampa, Florida or Atlanta, Georgia.

2. Is your company willing to provide a dedicated toll free number (and dedicated staff) for servicing this account?

   Humana will be providing one toll-free number that members may access for the DHMO and DPPO plans. When members from the City contact us and enter their information, a designated Customer Care team managing the City's account will be available to assist.

   For daily account management services, the City currently has a direct access to Julie Thorpe, who will continue to serve as your client experience manager (CEM) and primary contact, providing support and guidance. Your assigned Account Management team will also continue to collaborate with the City's benefit administrators to promote and evolve your communication strategy, as necessary, to make sure it resonates with your employees.

   Margaret Toffoli will continue to serve as your health solutions client executive (HSCE) and primary contact, providing support and guidance, as well as developing educational and benefit strategies with the City and your consultant.

3. Is your company capable of providing the following reports on a monthly basis? If not, please provide a description of reports the company is capable of providing and their frequency. Please list the reports you are not able to provide in the deviation section of your proposal.

   DPPO Plans

   Monthly paid claims separated by plan option, by network, non-network, by employee, by dependent
   Quarterly Utilization reports by category of services and CDT code
   Monthly Paid Claims and Premium by Plan (by Firefighters & All other groups)

Quarterly Summary Reports of customer service calls providing the number of calls and categorizing the reasons for the calls such as benefit inquiries, claim issues, provider issues, network assistance.

DHMO Plans

Monthly total revenue and expenses including capitation, fee for service and administration.
Number of encounters by CDT code and description, by month
Denied claim report indicating the reasons for denial
Quarterly Utilization reports by category of services
Quarterly Summary Reports of customer service calls for the City providing the number of calls and categorizing the reasons for the calls such as benefit inquiries, claim issues, provider issues, network assistance.

Humana agrees to continue providing the reports the City currently receives.

4. Please provide your website address and a description of the services and capabilities for employers and members available at that site.

Humana's dental website, HumanaDental.com, provides the following tools and information for the City's benefits administrator:

- **Find a dentist**
- **Add, edit, delete employee and/or dependent information**
- **Update coverage**
- **View enrollment information**
- **View and print enrollment forms**
- **View a bill**
- **Exchange secure messages with Humana's Customer Care team**
- **Access an administration guide**
- **Check eligibility information and Certificate of Benefits/Subscriber Agreement**
- **Request a replacement ID card**
- **Change company contact and billing information**
- **View a summary of benefits**
- **View the vision discount program**
- **Administer website security access**
- **Locate Humana contact information**
- **View complementary and alternative medicine CAM discount services**
- **Request reports**

HumanaDental.com also allows members to:

- **View eligibility details: General information about the plan selected at enrollment**
- **View plan design summary: Summary of benefits, including copayments and deductibles**
- **View claims status and/or Explanation of Benefits (EOB) for recent claims: View last 18 months of claims data**
- **Send questions to Customer Care specialists: Exchange secure messages with Humana's Customer Care team**

- **Access provider directories to find a dentist (listing is updated daily)**
- **Refer a dentist**
- **Check annual accumulated benefits**
- **Request a replacement ID card**
- **Check predeterminations: View last 18 months of claims data**
- **Check waiting periods**
- **View the vision discount program and locate a provider**
- **Locate Humana contact information**
- **View complementary and alternative medicine (CAM) discount services**
- **Submit a web feedback form**

Humana continually adds new functions and enhances current features to make the website effective and give users the information and insight they need.

5. How often is your online directory of providers updated for terminations and additions?

   Humana's online directories are updated daily.

6. Does your company have the ability to take automatic weekly eligibility updates from the City's payroll system, Cyborg, and/or Cigna Guided Solutions?

   Yes, as your current dental carrier, Humana is able to accept weekly eligibility updates from the City's payroll system.

7. Are the DPPO and DHMO plans both serviced through the same toll-free number and website?

   Although both plans are serviced through the same website, Humana provides separate DPPO and DHMO toll-free numbers.

8. Is your organization currently in compliance with Florida Department of Financial Services statutes and requirements? If no, describe why not.

   Yes, Humana is in compliance with the Florida Department of Financial Services statues and requirements.

9. Is member satisfaction information linked to provider compensation? If so, how?

   Humana does not base any part of the participating dentist compensation on consumer satisfaction measures. Dentist compensation is based strictly on the clearly defined terms of the participating dentist agreement.

   Customer satisfaction is monitored with dentists through the member grievance resolution process. Complaint rates for each dentist are routinely captured and considered as part of the recredentialing process. In situations where complaint rates are higher than

average, Humana works with dentists to improve performance. Failure to improve performance can result in the termination of the participating dentist agreement.

10. How many verbal and written complaints were received per 1,000 members during 2015 and 2016?

    During 2015 and 2016, our complaints per 1,000 members (both verbal and written) averaged 0.09 percent.

11. Are claim forms ever required of patients? If so, under what circumstances?

    Claim forms are not typically required from patients as the dentists submit most claims. If a member's dentist does not submit a bill directly, Humana accepts a claim from the member and reimburses as the member desires. Humana accepts any standard claim form or an itemized bill. Dental claims forms are available at HumanaDental.com.

12. What percentage of your primary care providers are capitated? Specialty providers?

    DPPO
    This is not applicable to the proposed plan option.

    DHMO
    All of Humana's primary care providers (100 percent) are capitated. Specialty providers are paid on a discount fee-for service arrangement on a per claim basis.

13. What percentage of orthodontists, maxillofacial surgeons, endodontists and periodontists have certification in their specialty from an accredited program?

    Humana's network dentists are not required to be board certified or board eligible. Participating specialists are required to demonstrate evidence of appropriate specialty training, which is verified during the credentialing process. Actual requirements vary from state to state; however, Humana verifies each dentist meets the requirements of their state during the credentialing process.

14. What process is in place for members to nominate dentists to the DHMO and/or DPPO network? Include the estimated timeframe in which the process will be completed.

    Humana encourages members to nominate dentists through dental referral cards (which can be used during open enrollment), via our dental website, or by calling the Customer Care team's toll-free number. In addition, the City's administrators can forward information directly to their Humana contact. We typically follow up on dentist referrals from members and employers within 48 business hours.

DHMO

1. What is the current average waiting time for setting appointments for

	Broward	Miami-Dade	Palm Beach	Martin
General Dentists	_____	_____	_____	_____
Specialists	_____	_____	_____	_____

Humana does not track waiting times by county. Currently the average waiting period for a routine appointment for a new patient is two to three weeks and 24 hours for emergency care.

2. Does your proposed DHMO plan require the member to select a general dentist and what are the requirements for changing DHMO dentists?

Under the proposed DHMO plan, members are required to select a participating dental office before receiving care. A transfer request received by the 15th of the month is effective on the first of the following month. A transfer is allowed only if there is no outstanding balance owed to the member's current dentist.

Newly selected dentists are notified when new patient names appear on their monthly eligibility list. Members former dentists are also notified via monthly eligibility listings.

3. Can each family member select his or her own dentist when using the DHMO?

Yes, each family member may select his or her own participating dentist.

4. How often are members permitted to change their selection of a dentist?

Members may change selected dentists at any time, but not more than once per month.

5. Does your plan require a referral to a specialist dentist? If yes, please explain the process and turn-around time for the referral.

To better serve clients, Humana eliminated the gatekeeper system for specialist referrals. If members require the services of participating specialists, preauthorization is not required; members self-refer to specialists.

6. Please provide a description of the process and estimated timeline to add DPPO Dentists and DPPO dentists to your network.

Humana's dental network development philosophy of "*providing the network you need*" includes a strategic recruiting campaign customized for each client. Our approach is to identify dentists who are currently utilized via claims history or disruption reports, and to target the most used providers for participation in our dental network. This process begins upon notification from the City that they have selected Humana as their dental benefits administrator, and continues until final disposition with the providers not currently participating is reached.

We also periodically review claims history reports that identify the dentists of choice of our members. Recruitment efforts continue on these providers as well as those dentists referred directly by members to the Customer Care department or website on an on-going basis.

When expanding the network to fit the City, our specific timeline is as follows:

- **The City provides electronic letterhead for us to contact new dentists. In lieu of letterhead, the City can simply allow us to use their name in our recruitment letters. Letters are mailed to these providers within three weeks of the City's request to Humana.**
- **Our dental Network Development staff contacts these providers within 10 days from mailing, either by phone or by mail.**
- **Follow-up calls are made weekly thereafter until final disposition is reached.**
- **We provide monthly updates to the City of contracting status, including comments on those who have declined and their reason (i.e., will not provide a discount, retiring, practice too busy, etc.)**
- **Once we receive a signed contract and the dentist properly credentialed, we add the provider into our systems on a high priority basis. We also update our online directory to reflect additions and these changes are highlighted on a monthly status report.**

We selectively deploy electronic methods of contracting with providers. The dentist then reviews the contract, and this process can take from one to six weeks depending on the volume of our dental members that have requested the provider's participation in Humana's network. Depending on the effective date of the client's dental coverage, our recruiters make every attempt to expedite the process and avoid disruption for its members.

7. Does your plan include a copay for each dentist office visit in addition to the copay for each defined service provided?

   There is no charge for office visits during the provider's regular office hours.

8. Please describe any plans for future DHMO network growth in Broward, Miami-Dade, Palm Beach and Martin Counties. Be specific and include number and type of dentists targeted by county. If no growth is planned, please say so.

   Humana's DHMO is one of the largest in the South Florida market. We are always recruiting providers who meet our credentialing requirements. We currently do not have a specific goal of dentists targeted by county for this growth opportunity. However, as seen in the growth by county below, we are actively recruiting DHMO providers:

   - **In 2016, 12 general dentists left the network and 506 general dentists were added.**
   - **In 2016, six specialists left the network and 257 specialists were added.**

9. What is the maximum number of members that may be assigned to a specific dentist before a practice is closed to new members? Include a description of how often this is measured and if the calculation includes other DHMO plan members.

Humana regularly monitors the number of members in each participating dental office. Depending on the size of the professional staff and general appointment capacity of the dental office, a target ratio of 500 to 1,000 members per dental office is preferred.

10. How many participating general dentists in Broward, Miami-Dade, Palm Beach and Martin Counties left your DHMO network in 2016? How many were added in 2016?

    In 2016, 12 general dentists left the network and 506 general dentists were added.

11. How many participating specialist dentists in Broward, Miami-Dade, Palm Beach and Martin Counties left your DHMO network in 2016? How many were added in 2016?

    In 2016, six specialists left the network and 257 specialists were added.

12. Please describe your credentialing criteria and process for DHMO providers.

    The credentialing and recredentialing process for general and specialty dentists is a critical component of Humana's fully integrated Quality Management program. Our credentialing process begins with the dentist's initial application to join the network. To ensure the most complete assessment of dental credentials possible, we perform primary source verification of each participating dentist's credentials in-house. Our credentialing is the fastest in the industry, with the flexibility to credential providers within 10 to 14 days.

    During credentialing, our Network staff collects and verifies the following information:
    - **Active dental license in good standing**
    - **Dental license disciplinary history, if any exists**
    - **Adequate professional liability insurance coverage**
    - **Specialty board certification, if applicable**
    - **Five-year work history**
    - **Education and training**
    - **Valid DEA certification or an alternate plan of prescription**
    - **Signed dentist attestation form**
    - **Medicare/Medicaid sanctions from the National Practitioner Data Bank (NPDB)**
    - **Five-year professional liability claims history**
    - **Previous or current state sanctions, restrictions, and/or limits on scope of practice**
    - **Status of clinical privileges for hospital-based practitioners**
    - **Detailed history of general health**
    - **Detailed history of chemical dependency**
    - **Detailed history of mental health**
    - **Detailed history of conviction for fraud of felony**

    Credentialing information is passed onto our dental director (or Peer Review/Credentialing committee in certain states) for review, assessment, and final determination. The committee is composed of the dental director and a staff of participating general dentists and specialists who meet monthly to review credentialing matters and any quality issues related to the network.

Recredentialing is performed every third year throughout the dentist's term of participation, except in Illinois where it is every two years. The following items are verified as part of the recredentialing process:

- **Active dental license in good standing**
- **Dental license disciplinary history, if any exists**
- **Adequate professional liability insurance coverage**
- **Specialty board certification, if applicable**
- **Valid DEA certification or an alternate plan of prescription**
- **Signed dentist attestation form**
- **Medicare/Medicaid sanctions from the NPDB**
- **Five-year professional liability claims history**
- **Previous or current state sanctions, restrictions, and/or limits on scope of practice**

The recredentialing information is passed on to the dental director or Peer Review/Credentialing committee and compared against established company guidelines. The dental director or committee must grant approval for continued participation in the network.

13. How many general dentists are not accepting new patients? Please provide this information separately for Broward, Miami-Dade, Palm Beach Counties and Monroe counties.

Broward	**9 facilities**
Miami-Dade	**12 facilities**
Palm Beach	**10 facilities**
Martin	**1 facility**

14. What is the 2016 turnover percentage for your DHMO network of general dentists?

Our 2016 turnover in Broward, Miami-Dade, Palm Beach, and Martin counties was 2 percent.

15. What is the process for a newly-added DHMO member to receive services if he does not yet appear in the provider's eligibility file?

Some providers may only see members once they are added to the provider's roster. In those cases, we encourage members to contact Humana for assistance and possible reassignment to another dentist, especially for emergency treatments.

16. How are emergency dental services provided and/or reimbursed for members who may be out of area at time of service?

The plan covers dental emergencies 24 hours, seven days a week, no matter where the member is located. If a member has a dental emergency, they are covered for palliative (emergency) treatment. Palliative treatment involves only what is necessary to control unexpected pain or more-than-usual bleeding, prevent complication 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 the participating dentist can see the member. The member's emergency care benefit does not include procedures that are 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. If a member has an emergency that involves extensive accidental or traumatic injury to the teeth or mouth, or that affects the member's ability to breathe or swallow, they should contact a medical physician.

When more than 100 miles from the nearest participating dentist, a member obtains reimbursement for expenses for emergency care by any licensed dentist, less applicable copayments, up to $100 per member per year, after presenting an itemized statement of emergency services from the dental office. Humana must be notified of the treatment within 90 days to receive reimbursement.

17. Provide a description of benefits available for TMJ. Include details regarding any required authorization processes.

This is not applicable to the proposed plan option. TMJ is not a covered benefit.

18. Does your proposed DHMO plan include coverage for implants? If yes, please explain the coverage.

Yes, implants and implant supported prostheses are covered at a 50 percent copayment. Humana's proposed plan has an annual maximum benefit of $1,500 and an annual lifetime benefit of $10,000.

19. Does your proposed DHMO plan include coverage for resin-based composite fillings on posterior teeth? If so, please specify any price differences in filling materials.

Yes, please refer to the attached DHMO Co-Pay schedule:

D2330	**Resin-Based Composite - One Surface, Anterior**	**No charge**
D2331	**Resin-Based Composite - Two Surfaces, Anterior**	**No charge**
D2332	**Resin-Based Composite - Three Surfaces, Anterior**	**No charge**
D2335	**Resin-Based Composite - Four or More Surfaces or Involving Incisal Angle (Anterior)**	**No charge**
D2390	**Resin-Based Composite Crown, Anterior**	**$30**
D2391	**Resin-Based Composite - One Surface, Posterior**	**$30**
D2392	**Resin-Based Composite - Two Surfaces, Posterior**	**$45**
D2393	**Resin-Based Composite - Three Surfaces, Posterior**	**$65**
D2394	**Resin-Based Composite - Four or More Surfaces, Posterior**	**$65**

20. What benefits, if any, are included for the detection of oral cancer?

For members who are 40 years old and above, we offer oral cancer screening one time per year.

21. For services that are limited to a certain number of occurrences within a plan year, such as prophylaxis, periodontal maintenance, bitewings and periodic exams, please specify how the frequency is monitored (i.e. days, months, etc.). What limitations and guidelines does your company use to determine when a member is eligible for subsequent occurrences?

    Frequency is based upon last date of service regardless if the claim was paid by the plan or not paid. Humana has removed the 90 day limitation between cleanings and deep scaling.

DPPO

1. Are members required to select a dentist when enrolled in the PPO?

   It is not necessary to enroll with a dentist for the DPPO product. Employees and their family members receive care from any dentist and can switch dentists as often as necessary. Humana encourages members to seek care from dentists participating in the Humana DPPO network to receive higher benefits.

2. What is the average turn around for a clean non-network claim submission?

   Turnaround time is measured from the date a claim is received to the processed date. Humana guarantees 90 percent of claims are processed within 14 calendar days. "Processed" is defined as paid, denied or pended due to missing external information. Humana's dental claims processing involves in-depth checking and verification on pended claims rather than the decline of a pended claim.

3. Please describe the credentialing criteria for PPO dentists.

   The credentialing and recredentialing process for general and specialty dentists is a critical component of Humana's fully integrated Quality Management program. Our credentialing process begins with the dentist's initial application to join the network. To ensure the most complete assessment of dental credentials possible, we perform primary source verification of each participating dentist's credentials in-house. Our credentialing is the fastest in the industry, with the flexibility to credential providers within 10 to 14 days.

   During credentialing, our Network staff collects and verifies the following information:
   - **Active dental license in good standing**
   - **Dental license disciplinary history, if any exists**
   - **Adequate professional liability insurance coverage**
   - **Specialty board certification, if applicable**
   - **Five-year work history**
   - **Education and training**
   - **Valid DEA certification or an alternate plan of prescription**
   - **Signed dentist attestation form**
   - **Medicare/Medicaid sanctions from the NPDB**
   - **Five-year professional liability claims history**
   - **Previous or current state sanctions, restrictions, and/or limits on scope of practice**
   - **Status of clinical privileges for hospital-based practitioners**

- **Detailed history of general health**
- **Detailed history of chemical dependency**
- **Detailed history of mental health**
- **Detailed history of conviction for fraud of felony**

Credentialing information is passed onto our dental director (or Peer Review/Credentialing committee in certain states) for review, assessment, and final determination. The committee is composed of the dental director and a staff of participating general dentists and specialists who meet monthly to review credentialing matters and any quality issues related to the network.

Re-credentialing is performed every third year throughout the dentist's term of participation, except in Illinois where it is every two years. The following items are verified as part of the re-credentialing process:

- **Active dental license in good standing**
- **Dental license disciplinary history, if any exists**
- **Adequate professional liability insurance coverage**
- **Specialty board certification, if applicable**
- **Valid DEA certification or an alternate plan of prescription**
- **Signed dentist attestation form**
- **Medicare/Medicaid sanctions from the NPDB**
- **Five-year professional liability claims history**
- **Previous or current state sanctions, restrictions, and/or limits on scope of practice**

The re-credentialing information is passed on to the dental director or Peer Review/Credentialing committee and compared against established company guidelines. The dental director or committee must grant approval for continued participation in the network.

4. Are non-network claims paid subject to usual, customary and reasonable allowances or a schedule of allowances?

Non-network claims expenses are subject to the usual and customary (U&C) amounts established for out-of-network providers. U&C means the lesser of:

- **The fee determined by comparing charges for similar services to a national database adjusted to the geographical area where the services or procedures were performed**
- **The fee most often charged in the geographical area where the service was performed**
- **The fee most often charged by the provider**
- **The fee which is recognized as reasonable by a discerning person**

Non-network claims expenses are subject to the maximum allowable fee established for out-of-network providers.

5. Describe your company's method of determining usual, customary and reasonable charges.

   The U&C fee level for fully insured dental client's fee means the lesser of:
   - **The fee determined by comparing charges for similar services to a national database adjusted to the geographical area where the services or procedures were performed**
   - **The fee most often charged in the geographical area where the service was performed**
   - **The fee most often charged by the provider**

6. What database does your company use for reasonable and customary profiles? How often is it updated?

   Humana uses proprietary information to calculate the maximum allowable fee level for fully insured clients. This data is updated twice per year.

7. What percentile is typically used for dental R&C? What are the options?

   The U&C fee level for fully insured dental client's fee means the lesser of:
   - **The fee determined by comparing charges for similar services to a national database adjusted to the geographical area where the services or procedures were performed**
   - **The fee most often charged in the geographical area where the service was performed**
   - **The fee most often charged by the provider**

8. Can your system allow certain tolerance ranges to be applied to reasonable and customary limits? Describe.

   Humana has a $3 system tolerance. This means if the provider charges more than $3 of the maximum allowable fee, Humana pays the claim. If the provider charges more than $3 over the maximum allowable fee, members are balance billed for the total amount over the maximum allowable fee.

9. Are participating dentist offices required to file claims on behalf of their members as part of the provider contract?

   If the normal billing practice is to submit claims on behalf of the patient, then the dentist must, by contract, following the same procedure for Humana. Humana's contracts with network dentists require dentists to submit claims no more than 30 days after the month of providing covered services.

   If the dentist's normal practice is to collect at the time of service, then this has to be the normal, standard practice for all patients. Humana's staff is available via toll-free telephone numbers to answer any questions the dentist's office staff may have regarding claims processing or other issues.

10. Do your proposed DPPO plans include coverage for resin-based composite fillings on posterior teeth? If so, please specify any price differences in filling materials.

    Yes, resin-based composite restorations (fillings) on molar and bicuspid teeth are covered and will be a payable filling under basic services. Multiple restorations on one surface are considered one restoration. This benefit is limited to once per tooth in a two-year period.

11. What benefits, if any, are included for the detection of oral cancer?

    Humana's dental PPO and Traditional Preferred/Plus plans include coverage for oral cancer screening for members aged 40 and older, once per year. We currently provide coverage specifically for Vizilite as a modality of treatment under the oral cancer screening benefit.

12. For services that are limited to a certain number of occurrences within a plan year, such as prophylaxis, periodontal maintenance, bitewings and periodic exams, please specify how the frequency is monitored (i.e. days, months, etc.). What limitations and guidelines does your company use to determine when a member is eligible for subsequent occurrences?

    Frequency is based upon last date of service regardless if the claim was paid by the plan or not paid.

DEVIATIONS FROM RFP

Proposers should provide a list of any deviations to the general provisions and requested benefits and provisions outlined in this RFP. If there are no deviations, a statement to this effect must be provided. Deviations to the City's requirements may deem the Proposer non-responsive, as determined by the City.

Humana agrees that it can administer benefits substantially similar to those described in the City of Fort Lauderdale's contract summary submission.

Humana has provided the following deviations to the City's General Conditions, Special Terms and Conditions and Technical Specifications/Scope of Services below:

General Conditions
These instructions are standard for all contracts for commodities or services issued through the City of Fort Lauderdale Procurement Services Division. The City may delete, supersede, or modify any of these standard instructions for a particular contract by indicating such change in the Invitation to Bid (ITB) Special Conditions, Technical Specifications, Instructions, Proposal Pages, Addenda, and Legal Advertisement. In this general conditions document, Invitation to Bid (ITB), Request for Qualifications (RFQ), and Request for Proposal (RFP) are interchangeable.

PART I BIDDER PROPOSAL PAGE(S) CONDITIONS:

1.02 DELIVERY: Time will be of the essence for any orders placed as a result of this ITB. The City reserves the right to cancel any orders, or part thereof, without obligation if delivery is not made in accordance with the schedule specified by the Bidder and accepted by the City.

This is not applicable to the dental services we are proposing to the City.

1.03 PACKING SLIPS: It will be the responsibility of the awarded Contractor, to attach all packing slips to the OUTSIDE of each shipment. Packing slips must provide a detailed description of what is to be received and reference the City of Fort Lauderdale purchase order number that is associated with the shipment. Failure to provide a detailed packing slip attached to the outside of shipment may result in refusal of shipment at Contractor's expense.

This is not applicable to the dental services we are proposing to the City.

1.04 PAYMENT TERMS AND CASH DISCOUNTS: Payment terms, unless otherwise stated in this ITB, will be considered to be net 45 days after the date of satisfactory delivery at the place of acceptance and receipt of correct invoice at the office specified, whichever occurs last. Bidder may offer cash discounts for prompt payment but they will not be considered in determination of award. If a Bidder offers a discount, it is understood that the discount time will be computed from the date of satisfactory delivery, at the place of acceptance, and receipt of correct invoice, at the office specified, whichever occurs last.

We produce premium statements for the next month's premium, which is due on the first of the month for the entire month of coverage. If we do not receive the premium by the 16th of that month, we send a reminder. If the premium is still not received by the end of the month, coverage

terminates from the end of the month in which Humana last received a payment. For terminations and coverage changes to appear on that statement, the City must submit them before the 10th of the month.

The City can be set-up or considered for self-billing. For all self-billed clients, Humana requires the following:

- Account establishment on our Automated Account Reconciliation System (AARS)
- Premium rosters sent monthly (criteria requirements provided by the AARS team and the roster total must match the check)
- Monthly response to discrepancy listing provided by the billing representative

The City is required to send a premium roster every month once the payment is made. This premium roster must equal the check amount or we are unable to reconcile the account efficiently.

1.07 VARIANCES: For purposes of bid evaluation, Bidder's must indicate any variances, no matter how slight, from ITB General Conditions, Special Conditions, Specifications or Addenda in the space provided in the ITB. No variations or exceptions by a Bidder will be considered or deemed a part of the bid submitted unless such variances or exceptions are listed in the bid and referenced in the space provided on the bidder proposal pages. If variances are not stated, or referenced as required, it will be assumed that the product or service fully complies with the City's terms, conditions, and specifications.

By receiving a bid, City does not necessarily accept any variances contained in the bid. All variances submitted are subject to review and approval by the City. If any bid contains material variances that, in the City's sole opinion, make that bid conditional in nature, the City reserves the right to reject the bid or part of the bid that is declared, by the City as conditional.

Humana has provided variances to the City's proposal within our response.

1.09 MINORITY AND WOMEN BUSINESS ENTERPRISE PARTICIPATION AND BUSINESS DEFINITIONS: The City of Fort Lauderdale wants to increase the participation of Minority Business Enterprises (MBE), Women Business Enterprises (WBE), and Small Business Enterprises (SBE) in its procurement activities. If your firm qualifies in accordance with the below definitions please indicate in the space provided in this ITB.

Minority Business Enterprise (MBE) "A Minority Business" is a business enterprise that is owned or controlled by one or more socially or economically disadvantaged persons. Such disadvantage may arise from cultural, racial, chronic economic circumstances or background or other similar cause. Such persons include, but are not limited to: Blacks, Hispanics, Asian Americans, and Native Americans.

The term "Minority Business Enterprise" means a business at least 51 percent of which is owned by minority group members or, in the case of a publicly owned business, at least 51 percent of the stock of which is owned by minority group members. For the purpose of the preceding sentence, minority group members are citizens of the United States who include, but are not limited to: Blacks, Hispanics, Asian Americans, and Native Americans.

Women Business Enterprise (WBE) a "Women Owned or Controlled Business" is a business enterprise at least 51 percent of which is owned by females or, in the case of a publicly owned business, at least 51 percent of the stock of which is owned by females.

Small Business Enterprise (SBE) "Small Business" means a corporation, partnership, sole proprietorship, or other legal entity formed for the purpose of making a profit, which is independently owned and operated, has either fewer than 100 employees or less than $1,000,000 in annual gross receipts.

BLACK, which includes persons having origins in any of the Black racial groups of Africa.

WHITE, which includes persons whose origins are Anglo-Saxon and Europeans and persons of Indo-European decent including Pakistani and East Indian.

HISPANIC, which includes persons of Mexican, Puerto Rican, Cuban, Central and South American, or other Spanish culture or origin, regardless of race.

NATIVE AMERICAN, which includes persons whose origins are American Indians, Eskimos, Aleuts, or Native Hawaiians.

ASIAN AMERICAN, which includes persons having origin in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands.

Please refer to Attachment J for our Good Faith Effort statement.

1.10 MINORITY-WOMEN BUSINESS ENTERPRISE PARTICIPATION

It is the desire of the City of Fort Lauderdale to increase the participation of minority (MBE) and women-owned (WBE) businesses in its contracting and procurement programs. While the City does not have any preference or set aside programs in place, it is committed to a policy of equitable participation for these firms. Proposers are requested to include in their proposals a narrative describing their past accomplishments and intended actions in this area. If proposers are considering minority or women owned enterprise participation in their proposal, those firms, and their specific duties have to be identified in the proposal. If a proposer is considered for award, he or she will be asked to meet with City staff so that the intended MBE/WBE participation can be formalized and included in the subsequent contract.

Please refer to Attachment J for our Good Faith Effort statement.

1.11 SCRUTINIZED COMPANIES

Subject to Odebrecht Construction, Inc., v. Prasad, 876 F.Supp.2d 1305 (S.D. Fla. 2012), affirmed, Odebrecht Construction, Inc., v. Secretary, Florida Department of Transportation, 715 F.3d 1268 (11th Cir. 2013), with regard to the "Cuba Amendment," the Contractor certifies that it is not on the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List or the Scrutinized Companies that Boycott Israel List created pursuant to Section 215.4725, Florida Statutes (2016), that it is not engaged in a boycott of Israel, and that it does not have business operations in Cuba or Syria, as provided in

section 287.135, Florida Statutes (2016), as may be amended or revised. The City may terminate this Agreement at the City's option if the Contractor is found to have submitted a false certification as provided under subsection (5) of section 287.135, Florida Statutes (2016), as may be amended or revised, or been placed on the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List or the Scrutinized Companies that Boycott Israel List created pursuant to Section 215.4725, Florida Statutes (2016), or is engaged in a boycott of Israel or has been engaged in business operations in Cuba or Syria, as defined in Section 287.135, Florida Statutes (2016), as may be amended or revised.

This is not applicable to the dental services we are proposing to the City.

PART III BIDDING AND AWARD PROCEDURES:

3.02 MODEL NUMBER CORRECTIONS: If the model number for the make specified in this ITB is incorrect, or no longer available and replaced with an updated model with new specifications, the Bidder shall enter the correct model number on the bidder proposal page. In the case of an updated model with new specifications, Bidder shall provide adequate information to allow the City to determine if the model bid meets the City's requirements.

This is not applicable to the dental services we are proposing to the City.

3.03 PRICES QUOTED: Deduct trade discounts, and quote firm net prices. Give both unit price and extended total. In the case of a discrepancy in computing the amount of the bid, the unit price quoted will govern. All prices quoted shall be F.O.B. destination, freight prepaid (Bidder pays and bears freight charges, Bidder owns goods in transit and files any claims), unless otherwise stated in Special Conditions. Each item must be bid separately. No attempt shall be made to tie any item or items contained in the ITB with any other business with the City.

This is not applicable to the dental services we are proposing to the City.

3.04 TAXES: The City of Fort Lauderdale is exempt from Federal Excise and Florida Sales taxes on direct purchase of tangible property. Exemption number for EIN is 59-6000319, and State Sales tax exemption number is 85-8013875578C-1.

Humana is not exempt from premium tax; therefore, any premiums will include state and federal tax.

3.05 WARRANTIES OF USAGE: Any quantities listed in this ITB as estimated or projected are provided for tabulation and information purposes only. No warranty or guarantee of quantities is given or implied. It is understood that the Contractor will furnish the City's needs as they arise.

This is not applicable to the dental services we are proposing to the City.

3.06 APPROVED EQUAL: When the technical specifications call for a brand name, manufacturer, make, model, or vendor catalog number with acceptance of APPROVED EQUAL, it shall be for the purpose of establishing a level of quality and features desired and acceptable to the City. In such cases, the City will be receptive to any unit that would be considered by qualified City personnel as an approved equal. In that the specified make and model represent a level of quality and features desired by the City, the Bidder must state clearly in the bid any variance from those specifications. It is the Bidder's responsibility to provide adequate information, in the bid, to enable the City to ensure that the bid meets the required criteria. If adequate information is not submitted with the bid, it may be rejected. The City will be the sole judge in determining if the item bid qualifies as an approved equal.

This is not applicable to the dental services we are proposing to the City.

3.07 MINIMUM AND MANDATORY TECHNICAL SPECIFICATIONS: The technical specifications may include items that are considered minimum, mandatory, or required. If any Bidder is unable to meet or exceed these items, and feels that the technical specifications are overly restrictive, the bidder must notify the Procurement Services Division immediately. Such notification must be received by the Procurement Services Division prior to the deadline contained in the ITB, for questions of a material nature, or prior to five (5) days before bid due and open date, whichever occurs first. If no such notification is received prior to that deadline, the City will consider the technical specifications to be acceptable to all bidders.

This is not applicable to the dental services we are proposing to the City.

3.09 SAMPLES AND DEMONSTRATIONS: Samples or inspection of product may be requested to determine suitability. Unless otherwise specified in Special Conditions, samples shall be requested after the date of bid opening, and if requested should be received by the City within seven (7) working days of request. Samples, when requested, must be furnished free of expense to the City and if not used in testing or destroyed, will upon request of the Bidder, be returned within thirty (30) days of bid award at Bidder's expense. When required, the City may request full demonstrations of units prior to award. When such demonstrations are requested, the Bidder shall respond promptly and arrange a demonstration at a convenient location. Failure to provide samples or demonstrations as specified by the City may result in rejection of a bid.

This is not applicable to the dental services we are proposing to the City.

3.10 LIFE CYCLE COSTING: If so specified in the ITB, the City may elect to evaluate equipment proposed on the basis of total cost of ownership. In using Life Cycle Costing, factors such as the following may be considered: estimated useful life, maintenance costs, cost of supplies, labor intensity, energy usage, environmental impact, and residual value. The City reserves the right to use those or other applicable criteria, in its sole opinion that will most accurately estimate total cost of use and ownership.

This is not applicable to the dental services we are proposing to the City.

3.12 USE OF OTHER GOVERNMENTAL CONTRACTS: The City reserves the right to reject any part or all of any bids received and utilize other available governmental contracts, if such action is in its best interest.

Humana has provided a comprehensive and competitive proposal for services that is specific to the City's RFP. There are many factors included in pricing that do not allow us to apply these contractual provisions to other parties, such as determination of rates on a case-by-case basis, client-specific service requirements, and employee population by entity. We feel this approach provides a custom designed and priced response for the City. We are happy to work with additional entities to price appropriately for those specific entities upon request.

3.13 QUALIFICATIONS/INSPECTION: Bids will only be considered from firms normally engaged in providing the types of commodities/services specified herein. The City reserves the right to inspect the Bidder's facilities, equipment, personnel, and organization at any time, or to take any other action necessary to determine Bidder's ability to perform. The Procurement Director reserves the right to reject bids where evidence or evaluation is determined to indicate inability to perform.

Humana does not allow fully insured groups to conduct audits without prior approval or negotiation. Should approval occur, there are limitations to the data we can share with the fully insured group. However, this can be discussed further upon being selected as a finalist.

PART IV BONDS AND INSURANCE

4.02 INSURANCE: If the Contractor is required to go on to City property to perform work or services as a result of ITB award, the Contractor shall assume full responsibility and expense to obtain all necessary insurance as required by City or specified in Special Conditions.

The Contractor shall provide to the Procurement Services Division original certificates of coverage and receive notification of approval of those certificates by the City's Risk Manager prior to engaging in any activities under this contract. The Contractors insurance is subject to the approval of the City's Risk Manager. The certificates must list the City as an ADDITIONAL INSURED for General Liability Insurance, and shall have no less than thirty (30) days written notice of cancellation or material change. Further modification of the insurance requirements may be made at the sole discretion of the City's Risk Manager if circumstances change or adequate protection of the City is not presented. Bidder, by submitting the bid, agrees to abide by such modifications.

Humana can provide additional insured status to any certificate holder requesting it, but in regards to general liability coverage only.

Humana does not provide copies of our insurance policies or endorsements; however, we will provide the standard Acord insurance certificate as proof of insurance.

Modifications to the insurance requirements can be made at renewal. Changes cannot be made while the policy is in force except to be compliant with state and federal regulations.

PART V PURCHASE ORDER AND CONTRACT TERMS:

5.03 SAFETY STANDARDS: All manufactured items and fabricated assemblies shall comply with applicable requirements of the Occupation Safety and Health Act of 1970 as amended, and be in compliance with Chapter 442, Florida Statutes. Any toxic substance listed in Section 38F-41.03 of the Florida Administrative Code delivered as a result of this order must be accompanied by a completed Safety Data Sheet (SDS).

This is not applicable to the dental services we are proposing to the City.

5.04 ASBESTOS STATEMENT: All material supplied must be 100% asbestos free. Bidder, by virtue of bidding, certifies that if awarded any portion of the ITB the bidder will supply only material or equipment that is 100% asbestos free.

This is not applicable to the dental services we are proposing to the City.

5.05 OTHER GOVERNMENTAL ENTITIES: If the Bidder is awarded a contract as a result of this ITB, the bidder may, if the bidder has sufficient capacity or quantities available, provide to other governmental agencies, so requesting, the products or services awarded in accordance with the terms and conditions of the ITB and resulting contract. Prices shall be F.O.B. delivered to the requesting agency.

Humana's proposed plans, rates, and fees were developed solely for the City.

5.08 INDEMNITY/HOLD HARMLESS AGREEMENT: The Contractor agrees to protect, defend, indemnify, and hold harmless the City of Fort Lauderdale and its officers, employees and agents from and against any and all losses, penalties, damages, settlements, claims, costs, charges for other expenses, or liabilities of every and any kind including attorney's fees, in connection with or arising directly or indirectly out of the work agreed to or performed by Contractor under the terms of any agreement that may arise due to the bidding process. Without limiting the foregoing, any and all such claims, suits, or other actions relating to personal injury, death, damage to property, defects in materials or workmanship, actual or alleged violations of any applicable Statute, ordinance, administrative order, rule or regulation, or decree of any court shall be included in the indemnity hereunder.

Humana agrees to indemnify and hold the City harmless from and against damages, claims, or liabilities that arise as a result of acts or omissions on our part or the part of our employees in the performance of the contract.

Humana's contracts do not include a hold harmless provision that indemnifies the City for general legal action from members, employees, subcontractors, or other vendors. We do not indemnify the City as a result of the acts or omissions of third parties, including its members' service providers.

5.09 TERMINATION FOR CAUSE: If, through any cause, the Contractor shall fail to fulfill in a timely and proper manner its obligations under this Agreement, or if the Contractor shall violate any of the provisions of this Agreement, the City may upon written notice to the Contractor terminate the right of the Contractor to proceed under this Agreement, or with such part or parts of the Agreement as to which there has been default, and may hold the Contractor liable for any damages caused to the City by reason of such default and termination. In the event of such termination, any completed services performed by the Contractor under this Agreement shall, at the option of the City, become the City's property and the Contractor shall be entitled to receive equitable compensation for any work completed to the satisfaction of the City. The Contractor, however, shall not be relieved of liability to the City for damages sustained by the City by reason of any breach of the Agreement by the Contractor, and the City may withhold any payments to the Contractor for the purpose of setoff until such time as the amount of damages due to the City from the Contractor can be determined.

Humana respectfully requests 60 days to cure any default. To the extent that Humana has developed, or licensed from a third-party, intellectual property provided to the City, and such development was independent of the use of the City's materials, and Humana or such third-party licensor has established right, title, and interest in that intellectual property prior to the effective date of the agreement, then Humana and its licensors retain such right, title, and interest.

Humana cannot agree to the following statement from the City:
The Contractor, however, shall not be relieved of liability to the City for damages sustained by the City by reason of any breach of the Agreement by the Contractor, and the City may withhold any payments to the Contractor for the purpose of setoff until such time as the amount of damages due to the City from the Contractor can be determined.

5.10 TERMINATION FOR CONVENIENCE: The City reserves the right, in its best interest as determined by the City, to cancel contract by giving written notice to the Contractor thirty (30) days prior to the effective date of such cancellation.

Humana's plan agreement includes a cancellation clause, which is based on a 90-day notification before the end of any contract period or at the end of any contract period. Immediate termination upon written notice occurs based on specified events. Flexibility of this clause is available upon mutual agreement.

5.12 RECORDS/AUDIT: The Contractor shall maintain during the term of the contract all books of account, reports and records in accordance with generally accepted accounting practices and standards for records directly related to this contract. The Contractor agrees to make available to the City Auditor or designee, during normal business hours and in Broward, Miami-Dade or Palm Beach Counties, all books of account, reports and records relating to this contract should be retained for the duration of the contract and for three years after the final payment under this Agreement, or until all pending audits, investigations or litigation matters relating to the contract are closed, whichever is later.

Typically, Humana does not allow fully insured groups to conduct audits without prior approval or negotiation. Should approval occur, there are limitations to the data we can share with the fully insured group. However, this can be discussed further upon being selected as a finalist.

5.18 PATENTS AND ROYALTIES: The Contractor, without exception, shall indemnify and save harmless the City and its employees from liability of any nature and kind, including cost and expenses for or on account of any copyrighted, patented or un-patented invention, process, or article manufactured or used in the performance of the contract, including its use by the City. If the Contractor uses any design, device, or materials covered by letters, patent or copyright, it is mutually agreed and understood without exception that the bid prices shall include all royalties or costs arising from the use of such design, device, or materials in any way involved in the work.

The foregoing infringement indemnification shall not apply if such claim or action arises directly from use of the related deliverable by the City in violation of the terms of this agreement.

Additionally, in the event that such infringement claim or action has occurred in vendor's judgment is likely to occur, the City shall allow vendor, at vendor's option and expense, to

(i) Procure for the City the right to continue using the deliverable at no additional charge; or

(ii) Modify such deliverable to become non-infringing (provided that such modification does not, in the City's judgment, negatively impact client's intended use of the deliverable) at no additional charge; or

(iii) Replace said deliverable with an equally suitable, compatible, and functionally equivalent non-infringing product at no additional charge; or

(iv) If none of the foregoing alternatives are reasonably available to vendor, vendor may request in writing that client cease use of the subject deliverable and upon vendor's refund to the client of all moneys, fees, costs, and expenses paid by the City in respect of such deliverable, the City shall cease use of such deliverable.

5.21 LOCATION OF UNDERGROUND FACILITIES: If the Contractor, for the purpose of responding to this solicitation, requests the location of underground facilities through the Sunshine State One-Call of Florida, Inc. notification system or through any person or entity providing a facility locating service, and underground facilities are marked with paint, stakes or other markings within the City pursuant to such a request, then the Contractor, shall be deemed non-responsive to this solicitation in accordance with Section 2-184(5) of the City of Fort Lauderdale Code of Ordinances.

This is not applicable to the dental services we are proposing to the City.

5.22 PUBLIC RECORDS

IF THE CONTRACTOR HAS QUESTIONS REGARDING THE APPLICATION OF CHAPTER 119, FLORIDA STATUTES, TO THE CONTRACTOR'S DUTY TO PROVIDE PUBLIC RECORDS RELATING TO THIS CONTRACT. CONTACT THE CUSTODIAN OF PUBLIC RECORDS AT: (954-828-5002, PRRCONTRACT@FORTLAUDERDALE.GOV, CITY CLERK'S OFFICE, 100 NORTH ANDREWS AVENUE, FORT LAUDERDALE, FLORIDA 33301)

Contractor shall:

1. **Keep and maintain public records that ordinarily and necessarily would be required by the City in order to perform the service.**
2. **Upon request from the City's custodian of public records, provide the City with a copy of the requested records or allow the records to be inspected or copied within a reasonable time at a cost that does not exceed the cost provided in Chapter 119, Florida Statutes (2016), as may be amended or revised, or as otherwise provided by law.**
3. **Ensure that public records that are exempt or confidential and exempt from public records disclosure requirements are not disclosed except as authorized by law for the duration of the contract term and following completion of this contract if the Contractor does not transfer the records to the City.**
4. **Upon completion of the Contract, transfer, at no cost, to the City all public records in possession of the Contractor or keep and maintain public records required by the City to perform the service. If the Contractor transfers all public records to the City upon completion of this Contract, the Contractor shall destroy any duplicate public records that are exempt or confidential and exempt from public records disclosure requirements. If the Contractor keeps and maintains public records upon completion of this Contract, the Contractor shall meet all applicable requirements for retaining public records. All records stored electronically must be provided to the City, upon request from the City's custodian of public records, in a format that is compatible with the information technology systems of the City.**

We agree to return or destroy protected health information (PHI) at the conclusion of the contract if feasible. In many situations, it may not be feasible to destroy PHI due to documentation retention guidelines, rules, and regulations. If this is the case with regard to the City's PHI, we agree to continue to protect such data as required until such time that the data may be returned or destroyed.

Special Terms and Conditions

2.6 Invoices/Payment

The City will accept invoices no more frequently than once per month. Each invoice shall fully detail the related costs and shall specify the status of the particular task or project as of the date of the invoice with regard to the accepted schedule for that task or project. Payment will be made within forty-five (45) days after receipt of an invoice acceptable to the City, in accordance with the Florida Local Government Prompt Payment Act. If, at any time during the contract, the City shall not approve or accept the Contractor's work product, and agreement cannot be reached between the City and the Contractor to resolve the problem to the City's satisfaction, the City shall negotiate with the Contractor on a payment for the work completed and usable to the City.

We produce premium statements for the next month's premium, which is due on the first of the month for the entire month of coverage. If we do not receive the premium by the 16th of that month, we send a reminder. If the premium is still not received by the end of the month, coverage terminates from the end of the month in which Humana last received a payment. For terminations and coverage changes to appear on that statement, the City must submit them before the 10th of the month.

The City can be set-up or considered for self-billing. For all self-billed clients, Humana requires the following:

- Account establishment on our Automated Account Reconciliation System (AARS)
- Premium rosters sent monthly (criteria requirements provided by the AARS team and the roster total must match the check)
- Monthly response to discrepancy listing provided by the billing representative

The City is required to send a premium roster every month once the payment is made. This premium roster must equal the check amount or we are unable to reconcile the account efficiently.

2.8 Payment Method

The City of Fort Lauderdale has implemented a Procurement Card (P-Card) program which changes how payments are remitted to its vendors. The City has transitioned from traditional paper checks to payment by credit card via MasterCard or Visa. This allows you as a vendor of the City of Fort Lauderdale to receive your payment fast and safely. No more waiting for checks to be printed and mailed. Payments will be made utilizing the City's P-Card (MasterCard or Visa). Accordingly, firms must presently have the ability to accept credit card payment or take whatever steps necessary to implement acceptance of a credit card before the commencement of a contract. See Contract Payment Method form attached.

We accept ACH payments via the online billing tool through **Humana.com** known as eBilling. ACH payments can be set up for one-time payments or as recurring monthly payments. Wire transfers are also available.

Humana is unable to provide a P-Card payment method at this time. We will continue to offer the City the easy to use payment option that is currently offered.

2.12 Responsiveness

In order to be considered responsive to the solicitation, the firm's proposal shall fully conform in all material respects to the solicitation and all of its requirements, including all form and substance.

Humana has provided clarifications to the City's proposal throughout our response.

2.13 Responsibility

In order to be considered as a responsible firm, firm shall be fully capable to meet all of the requirements of the solicitation and subsequent contract, must possess the full capability, including financial and technical, to perform as contractually required, and must be able to fully document the ability to provide good faith performance.

Humana has provided clarifications to the City's proposal throughout our response.

2.14 Minimum Qualifications

In order to be considered, a Proposer must, as of the proposal return date specified in this RFP and throughout the duration of its program, meet the following applicable minimum qualifications. Proposer must provide documentation of existing qualifications in the proposal.

Dental Maintenance Organization

- **Authorized by the Florida Department of Financial Services to provide the goods and services requested in the RFP.**
- **Comply with any requirements imposed upon the Proposer by the Florida Department of Insurance with respect to quality assurance.**

Insurance Company and PPO Dental Plan

- **Licensed by the State of Florida Department of Insurance to provide the goods and services requested in the RFP; and**
- **Hold an A.M. Best rating of "A" or better and a financial size category of IV or higher or hold an A.M. Best financial performance rating of "6" or better for those insurers with a letter rating of NA-2 or NA-3 and a financial size category of IV or higher.**

Managed Care Indemnity, Inc. (MCII) provides General Liability, Professional Liability, and Errors and Omissions coverage. MCII is a wholly owned subsidiary of Humana Inc. It is a captive insurance company domiciled in Vermont and regulated by the Vermont Department of Insurance. The reserves are set by an independent actuarial firm and audited by an outside auditing firm, and therefore MCII is not rated by A. M. Best or any other rating company.

2.18 Insurance Requirements

2.18.1 The Contractor shall furnish proof of insurance requirements as indicated below. The coverage is to remain in force at all times during the contract period. The following minimum insurance coverage is required. The City is to be added as an "additional insured" with relation to General Liability Insurance. This MUST be written in the description section of the insurance certificate, even if you have a check-off box on your insurance certificate. Any costs for adding the City as "additional insured" will be at the contractor's expense.

Humana can provide additional insured status to any certificate holder requesting it, but in regards to general liability coverage only.

Please refer to Attachment C for a copy of our Certificate of Insurance.

2.18.2 The City of Fort Lauderdale shall be given notice 10 days prior to cancellation or modification of any stipulated insurance. The insurance provided shall be endorsed or amended to comply with this notice requirement. In the event that the insurer is unable to accommodate, it shall be the responsibility of the Contractor to provide the proper notice. Such notification will be in writing by registered mail, return receipt requested and addressed to the Procurement Services Division.

Humana's plan agreement includes a cancellation clause, which is based on a 90-day notification before the end of any contract period or at the end of any contract period. Immediate termination upon written notice occurs based on specified events. Flexibility of this clause is available upon mutual agreement.

If actual enrollment varies by more than 10 percent or significant plan changes impact the service processes, we retain the right to change rates accordingly upon renewal and will provide a notice to the City in advance of more than 30 days.

2.18.3 The Contractor's insurance must be provided by an A.M. Best's "A-" rated or better insurance company authorized to issue insurance policies in the State of Florida, subject to approval by the City's Risk Manager. Any exclusions or provisions in the insurance maintained by the contractor that precludes coverage for work contemplated in this RFP shall be deemed unacceptable, and shall be considered breach of contract.

Managed Care Indemnity, Inc. (MCII) provides General Liability, Professional Liability, and Errors and Omissions coverage. MCII is a wholly owned subsidiary of Humana Inc. It is a captive insurance company domiciled in Vermont and regulated by the Vermont Department of Insurance. The reserves are set by an independent actuarial firm and audited by an outside auditing firm, and therefore MCII is not rated by A. M. Best or any other rating company.

Workers' Compensation and Employers' Liability Insurance
Limits: Workers' Compensation – Per Florida Statute 440
Employers' Liability - $500,000

Any firm performing work on behalf of the City of Fort Lauderdale must provide Workers' Compensation insurance. Exceptions and exemptions will be allowed by the City's Risk Manager, if they are in

accordance with Florida Statute. For additional information contact the Department of Financial Services, Workers' Compensation Division at (850) 413-1601 or on the web at www.fldfs.com .

We agree to the $500,000 limit on a per occurrence basis.

Commercial General Liability Insurance
Covering premises-operations, products-completed operations, independent contractors and contractual liability.

Limits: Combined single limit bodily injury/property damage $1,000,000. This coverage must include, but not limited to:

a. **Coverage for the liability assumed by the contractor under the indemnity provision of the contract.**
b. **Coverage for Premises/Operations**
c. **Products/Completed Operations**
d. **Broad Form Contractual Liability**
e. **Independent Contractors**

We agree to the $1 million limit on a per occurrence basis.

Automobile Liability Insurance
Covering all owned, hired and non-owned automobile equipment.
Limits: Bodily injury $250,000 each person, $500,000 each occurrence
Property damage $100,000 each occurrence

We agree to the limits on a per occurrence basis.

Professional Liability (Errors & Omissions)
Consultants
Limits: $2,000,000 per occurrence

We agree to the $2 million limit on a per occurrence basis.

2.18.4 A copy of ANY current Certificate of Insurance should be included with your proposal.

Please refer to Attachment C for a copy of our Certificate of Insurance.

2.18.5 In the event that you are the successful Proposer, you will be required to provide a certificate naming the City as an "additional insured" for General Liability. Certificate holder should be addressed as follows:
City of Fort Lauderdale
Procurement Services Division
100 N. Andrews Avenue, Room 619
Fort Lauderdale, FL 33301

Humana agrees, with the following clarifications:

- Managed Care Indemnity, Inc. (MCII) provides general liability, professional liability, and errors and omissions coverage. MCII is a captive insurance company domiciled in Vermont and regulated by the Vermont DOI. The reserves are set by an independent actuarial firm and audited by an outside auditing firm, and therefore MCII is not rated by A. M. Best or any other rating company.
- Humana has agreements in place with a variety of vendors for business and administrative services, as well as member services. All vendors contracting with Humana undergo a due diligence process prior to contracting. Humana is the sole point of contact with respect to all contracts with insured groups. Furthermore, Humana provides all operational supervision of subcontractors. Humana is responsible for the performance of its subcontractors and as needed handles subcontractor performance issues. Subcontractors are responsible for their own insurance programs.

Humana can provide additional insured status to any certificate holder requesting it, but in regards to general liability coverage only.

2.21 Canadian Companies

The City may enforce in the United States of America or in Canada or in both countries a judgment entered against the Contractor. The Contractor waives any and all defenses to the City's enforcement in Canada, of a judgment entered by a court in the United States of America. All monetary amounts set forth in this Contract are in United States dollars.

This is not applicable to Humana.

2.25 Service Organization Controls

The Contactor shall provide a current SSAE 16, SOC 2, Type I report with their proposal. Awarded Contractor will be required to provide an SSAE 16, SOC 2, Type II report annually during the term of this contract. If the Contractor cannot provide the SSAE 16, SOC 2, Type I report at time of proposal submittal, a current SOC 3 report will be accepted.

Please refer to Attachment E for our sample SSAE-16 report; we can provide updates to the City upon request.

2.26 Business Associate Agreement

The City shall require recommended awarded Proposer, and possibly any sub-contractor to execute a Business Associate Agreement. A Sample Business Associate Agreement is attached as Exhibit A. The sample document does not need to be executed and provided with your RFP, but will need to be executed upon award of contract.

Humana is classified as a covered entity, not a business associate, when providing services under a fully insured arrangement. Therefore, "business associate" language does not apply to our fully insured contracts.

3.3 Scope of Request for Proposals

Fully-insured Cost Proposals are requested for the following:

- **DHMO Plan for Management and General Employees**

- **DPPO Plan for Management and General Employees**
- **DPPO Plan for Firefighters**

No other plan options or configurations are requested at this time.

The City is requesting a single source dental provider capable of providing both plan options as well as integrated member services for the members and the City. Proposals for independent stand-alone DHMO and DPPO plans will not be considered. Independent dental companies who partner with another dental company to provide the DPPO and DHMO benefits will not be considered.

A single source dental provider is one that bears the risk for both the DHMO and the DPPO plans. Partnership arrangements between two unrelated companies to split the risks are not acceptable.

The City is requesting a dedicated, toll-free number for its employees to address service and benefit questions. Proposers who are not able to offer this benefit must clearly indicate this in the Deviations section of your proposal.

Humana will be providing one toll-free number that members may access for the DHMO and DPPO plans. When members from the City contact us and enter their information, a designated customer service team managing the City's account will be available to assist.

For daily account management services, the City currently has a direct access to Julie Thorpe, who will continue to serve as your Client Experience Manager (CEM) and primary contact, providing support and guidance. Your assigned Account Management team will also continue to collaborate with the City's benefit administrators to promote and evolve your communication strategy, as necessary, to make sure it resonates with your employees.

Margaret Toffoli will continue to serve as your Health Solutions Client Executive (HSCE) and primary contact, providing support and guidance, as well as developing educational and benefit strategies with the City and your consultant.

3.4 Agent and Broker Participation

While the services of insurance agents or brokers are not requested, Florida licensed insurance agents may submit proposals for consideration based on Florida State Statute 624.1275. Any agent proposing must disclose all commission and/or bonus arrangements that are included in the proposed rates. In addition, a list of services offered as well as the agent's resume and references must be included in Tab VII of your response.

This is not applicable to the proposed plan option.

3.6.6 Communications

The successful company shall provide $2,000 annually to the City for the purpose of preparing and distributing benefit enrollment materials. Summary plan descriptions and benefit plan outlines shall be included in proposed premium and will be made available online.

Printed directories are not required. All members will be directed to use the online directory provided by the selected company.

Humana offers a $2,00 credit for expenses related to enrollment/communication materials production, etc. related specifically to the Humana plan. The City would need to provide an itemized invoice for reasonable expenses in these areas.

3.7 Performance Guarantees

The City wishes the successful Proposer to be a true partner in the administration of the dental plan and is requesting that the following performance guarantees be included in your proposal. Each standard is to be measured quarterly and reported to the City by the end of the month following the quarter.

Implementation Performance Guarantees	Performance Commitment	Liquidated Damages % Amount
Identification Card Delivery Performance Standard	98% of Identification Cards mailed within 10 business days of receipt of complete and accurate eligibility data.	0.25% of annual premium
Call Readiness Performance Commitment	Service Center(s) ready to respond to customer inquiries as of open enrollment period.	0.25% of annual premium

Secure Internet Portals Commitment

Employer and member portals fully functional and available to City and participants as of open enrollment period.		0.25% of annual premium
Overall Satisfaction with Implementation Services Performance Standard	Based on a mutually agreed upon Satisfaction Survey (standard will be measured and reported to Employer annually after open enrollment implementation).	0.25% of annual premium

Ongoing Performance Guarantees	Measure Method	Liquidated Damages % Amount
I.D. Card Production (ongoing)	98% of Identification Cards mailed within 10 business days of receipt of complete and accurate eligibility data (standard will be measured and reported to Employer quarterly).	0.25% of annual premium
Claims Processing	Time to Process: 90% of claims accurately processed in 10 business days from the date a claim is received to the date it is processed (i.e., paid, pended or denied) excluding weekends and holidays (clean claims only). Standard will be measured and reported to Employer quarterly.	0.25% of annual premium

Member Services
Hold Time

- **Guarantee that hold time will be 3 minutes or less (standard will be measured and reported to Employer quarterly)**
- **0.25% of annual premium**

Average Speed of Answer
- **Guarantee that 80% of calls answered by live representative within 20 seconds or less (standard will be measured and reported to Employer quarterly)**
- **0.25% of annual premium**

Abandonment Rate
- **Guarantee that the call abandonment rate will be 4% or less (standard will be measured and reported to Employer quarterly).**
- **0.25% of annual premium**

Service Manager Performance Standard
- **Response to telephone calls and email messages within 24 hours 0.25% of annual premium**

Resolution of Eligibility Issues
- **Response rate of 24 hours to correct eligibility issues**
- **0.25% of annual premium**
- **Liquidated damages amount is not to exceed $12,000 per quarter, maximum $48,000 per year.**

Please refer to Attachment L for our proposed Performance Guarantees.

THIS IS A NON-PARTICIPATING GROUP DENTAL INSURANCE POLICY

Group Policy Number: 427672

Issued To: HARO_2009_ARVTPO01

Effective Date: 04/15/2009

This Policy is delivered in and governed by the laws of: <State>

HUMANADENTAL INSURANCE COMPANY, GREEN BAY, WISCONSIN, (hereafter called the Insurer) agrees, subject to all terms and provisions of the Policy, to pay benefits as described in the Employee's Certificate of Insurance, incorporated by reference herein with respect to each Covered Person under the Policy.

The Policy is issued in consideration of the application of the Policyholder, a copy of which is attached and made part of the Policy, and such Policyholder's payment of premiums as provided and insured under the Policy.

The Policy and the insurance it provides become effective at 12:01 A.M. (Standard Time) of the effective date stated above. The Policy and the insurance it provides terminates at 12:01 A.M. (Standard Time) of the date of termination. The provisions stated above and on the following pages are part of the Policy.

IN WITNESS WHEREOF HumanaDental Insurance Company has caused this Policy to be issued at the address of the Policyholder, as of the policy effective date.

GERALD L. GANONI
PRESIDENT

Table of contents

Benefits

The benefits applicable to the Employee's Group Insurance Plan are the benefits specified in the Employer Group Application and approved by the Insurer, shown in the Certificate of Insurance, incorporated by reference herein.

Increases or decreases in amounts of individual employee's insurance

The Policyholder may elect that increases or decreases as specified below will be effective on the first day of the calendar month coinciding with or next following the increase or decrease, or on an immediate basis. Such election may be made on the Employer Group Application at the time the Employer becomes the Policyholder, or at such later date as may be agreed to in writing by the Insurer.

Individual employee's changes resulting in an increase in insurance under the policy

1. Any Employee's change resulting in an increase in that Employee's amount of insurance under the Policy will, subject to provision #2 or #3 below, become effective on the date of change. An increase will apply to covered conditions occurring on or after the effective date of the increase. The Insurer must be notified of the change no more than 31 days following the date of change. If the Insurer is not notified within 31 days of the date of change, any additional or increased insurance will become effective on the date the Insurer receives written notification and approves the change.

2. If an Employee is NOT in Active Status on the date an increase in the amount of insurance is to become effective, the effective date of the increase will be deferred until the date next following the date the Employee returns to Active Status.

3. If a Retired Employee is Totally Disabled on the date an increase in the amount of insurance is to become effective, the effective date will be deferred until the date the Retired Employee is no longer Totally Disabled.

Individual covered person's changes resulting in a decrease in insurance under the policy

4. Any change resulting in a decrease in any Covered Person's amount of insurance under the Policy will become effective on the date the Insurer approves the change. However, no such decrease will act to prejudice any existing claim incurred prior to the date of the change.

Selection

Amounts of insurance provided by the Policy are available only on a basis which precludes individual selection.

Definitions

The Insurer shall apply the terms and meanings shown below wherever used in the Policy to determine the intent and administration of insurance benefits.

Covered dependent

Covered Dependent means a Dependent whose coverage under the Policy is in effect in accordance with the "Requirements for Insurance Coverage" provisions of the Policy.

Covered person

Covered Person means the Employee and/or the Employee's Covered Dependent(s).

Insurer

Insurer means the Insurance Company as stated on the Policy face page. The Insurer in its capacity as claims administrator has authority to make claim determination as described in section 503 of ERISA. The Insurer shall make final decisions under the Policy or Group Plan with respect to determining eligibility for coverage and paying claims for benefits, including appeals of denied claims. As claims administrator, the Insurer shall have full and exclusive discretionary authority to:

1. Interpret the Policy or Group Plan provisions;
2. Make decisions regarding eligibility for coverage and benefits; and
3. Resolve factual questions relating to coverage and benefits.

This in no way negates any appeal rights the insured may have.

Policyholder

The legal entity named as the Policyholder on the Face Page of this Policy.

Subsidiaries or affiliates

Any Employer which is a subsidiary or affiliate of the Policyholder is eligible under the Policyholder's Group Insurance Plan provided under the Policy if the following conditions are met:

1. The subsidiary or affiliate has been approved for coverage under the Policy, in writing, by both the Policyholder and the Insurer;
2. The legal relationship between the Policyholder and the subsidiary or affiliate is in conformity with all applicable laws of the state in which the Policyholder is organized;
3. The subsidiary or affiliate is listed in the Employer Group Application of the Policyholder, or in any amendment thereto.

An Employee of such a subsidiary or affiliate of the Policyholder shall be considered to be an Employee of the Policyholder.

A subsidiary or affiliate of the Policyholder shall cease to be eligible in the Policyholder's Group Insurance Plan provided under the Policy on the earliest of the following:

1. The date the legal relationship between the Policyholder and the subsidiary or affiliate is no longer in conformity with all applicable laws of the state in which the Policyholder is located;
2. The date the Policy terminates; or
3. The date the Policyholder's written notice of its intent to terminate the participation of the subsidiary or affiliate is received by the Insurer, or on any later date as may be stated in such notice.

The insurance of any Employee of a subsidiary or affiliate of the Policyholder, and the insurance of such Employee's Covered Dependents, shall immediately terminate on the date the subsidiary or affiliate ceases participation in the Policyholder's Group Insurance Plan.

Requirements for insurance coverage

THE FOLLOWING PROVISIONS APPLY TO THE PLAN OF BENEFITS AS REQUESTED ON THE EMPLOYER GROUP APPLICATION BY THE POLICYHOLDER.

Eligibility

The Policyholder must indicate eligible classes of Covered Persons under the Policy as defined below:

1. The Policyholder will indicate Employee classes which are eligible for insurance under the Policyholder's Plan in the Employer Group Application. Regular active full-time Employees, if employed by the Policyholder and paid a reasonable salary or wage, are in an eligible class. The eligible class may also include actively employed proprietors, partners, corporate officers and directors.

2. The Policyholder's Group Insurance Plan may provide coverage for active full-time or retired Employees and/or Dependents of active, full-time or retired Employees. The Retiree Class will be eligible only if the Policyholder has 26 or more eligible full-time Employees in an Active Status. No part-time or temporarily employed person may be included in an eligible class, unless the Policyholder's Employer Group Application makes specific reference that part-time or temporarily employed persons are included and is approved by the Insurer.

3. No Dependent may be included in an eligible class unless the Dependent's parent or spouse is an Employee covered under the Policy.

Date eligible

The Policyholder's Group Insurance Plan may provide one of the following as the Date Eligible for Employees, or Employees and Dependents as provided by the Policy. The Date Eligible must be elected by the Policyholder in the Employer's Group Application.

Immediate date eligible

1. Each Employee included in an Eligible Class and who is in Active Status on the effective date of this policy will be eligible under the Policy on that date, provided the Employee has completed any required Waiting period indicated on the Employer Group Application.

2. Each Employee included in an Eligible Class and who is in Active Status on the effective date of this Policy, and who had partially satisfied the required Waiting Period prior to the Policyholder's effective date under the Policy, will be eligible for insurance under the Policy on the first day after completion of the Waiting Period.

3. Each Employee who enters an Eligible Class and who is in Active Status AFTER the date the Employer becomes the Policyholder, will be eligible for coverage:
   - On the day immediately following completion of any required Waiting Period; or
   - On the Employee's date of employment, if a Waiting Period is not required.

Deferred date eligible

1. Each Employee included in an Eligible Class and who is in Active Status on the effective date of this Policy will be eligible under the Policy on that date, provided the Employee has completed any required Waiting Period indicated on the Employer Group Application.

2. Each Employee included in an Eligible Class and who is in Active Status on the effective date of this Policy, and who had partially satisfied the required Waiting Period prior to the effective date of this Policy, will be eligible under the Policy on the first day of the calendar month coinciding with or next following the date of completion of the Waiting Period.

3. Each Employee who enters an Eligible Class AFTER the effective date of this Policy will be eligible under the Policy on the first day of the calendar month coinciding with or next following:
   - Completion of any required Waiting Period; or
   - The Employee's date of employment, if a Waiting Period is not required.

Effective date

The Effective date provision for Employee's of the Policyholder is stated in the Employer Group Application. It may be immediately following or the first of the month following completion of the Waiting Period, if any, or if the Employee is a Late Applicant, the date approved by the Insurer; but in no event will the Employee's Effective Date be prior to the date that Employee's enrollment forms are received by the Insurer. The Employee must enroll on forms furnished and accepted by the Insurer.

If an Employee is not in Active Status on the effective date shown on the Employee's Schedule of Benefits, the Delayed Effective Date Provision applies.

1. Each Employee must request insurance coverage for him or herself and, if so desired, for eligible Dependents.

2. If the request for insurance is submitted to and approved by the Insurer BEFORE the Employee's and/or Dependent's eligibility date, insurance will become effective on the Eligibility Date.

3. If the request for insurance is submitted to and approved by the Insurer AFTER the Eligibility Date, but within thirty-one days after Employee's and/or Dependent's Eligibility Date, insurance will become effective on:

   - The date the enrollment form is received by the Insurer, if the Insurer has agreed with the Policyholder to make coverage effective on an Immediate Date Eligible basis; or

- The first day of the calendar month coinciding with or next following the date the Insurer approves coverage, if the Insurer has agreed with the Policyholder to make coverage effective on a Deferred Date Eligible basis.

4. If the request for insurance is submitted to the Insurer MORE THAN thirty-one days after the Employee's or eligible Dependent's Eligibility Date, the Employee or Dependent is a Late Applicant. The Effective Date of Insurance will be the date designated by the Insurer.

Termination of insurance

Termination of the Covered Person's insurance will occur on the first day of the calendar month following the date the first of the following events occurs with respect to the Policyholder's Group Insurance Plan.

1. The Policyholder no longer satisfies the minimum Underwriting and Participation Requirements of the Insurer, as specified on the Employer Group application.

   The Insurer reserves the right to waive or modify the Underwriting and Participation Requirements.

2. The Policyholder, acting with the knowledge and written consent of the Insurer, deletes an Optional Benefit under the policy from the Policyholder's Group Insurance Plan. Termination will occur with respect to such deleted Optional Benefit Coverage.

3. The Policyholder, acting with the knowledge and written consent of the Insurer, deletes an eligible class of Covered Persons from the Policyholder's Group Insurance Plan. Termination will occur only with respect to Covered Persons included in the terminated class.

4. The Policyholder fails to remit premium when due, except that coverage is continued during the Grace Period applicable to the due but unpaid premium. The Policyholder will be required to pay premium for the grace period.

5. The Policyholder may terminate this Policy by giving written notice to the Insurer not later than thirty days prior to the desired termination date.

6. The Policyholder may, with the consent of the Insurer, terminate participation under any provisions of the Policy. Termination will occur on a date mutually agreeable to the Policyholder and the Insurer.

7. The Insurer may terminate this Policy by giving written notice to the Policyholder not later than thirty-one days prior to the termination date. Termination will not prejudice a claim incurred prior to the termination date.

Upon termination of this Policy, it is the Policyholder's responsibility to notify all Employees insured under this Policy of such termination. If a Policyholder requires contributions toward the payment of insurance premiums from the Employees covered through the Employer, the Policyholder is obligated to refund to the Employees the portion of the contribution, if any, which the Policyholder collected for any period of time following the termination of the Policy.

General provisions

Entire contract
The Policy, Employer Group Application of the Policyholder, and individual applications constitute the entire contract between parties.

All statements made by the Policyholder or by any Covered Person will be deemed representations and not warranties.

Certificates
The Insurer will issue to the Policyholder, for delivery to each covered Employee, an individual certificate setting forth a statement of the insurance protection to which the Employee is entitled, to whom benefits are payable under the Policy.

Information to be furnished
The Policyholder will furnish the Insurer information required to enable the Insurer to administer the provisions of the Policy and to determine the premiums to be charged. All of the Policyholder's records which have a bearing on the insurance provided under the Policy will be available for inspection by the Insurer when and as often as required.

Modification of policy
1. This Policy may be modified at anytime by written agreement between the Insurer and the Policyholder without consent of any Employee or Beneficiary.

2. This Policy may also be amended by the Insurer at anytime without the consent of the Policyholder. The Policyholder will be notified of such amendment, in writing, at least thirty-one days prior to its effective date. Payment of premium beyond the effective date of the endorsement constitutes the Policyholder's consent to amendment.

3. No modification will be valid unless approved by the President, Vice-President, Secretary, or other authorized officer of the Insurer.

4. No agent has authority to modify the Policy or waive any of the Policy provisions, to extend time for premium payment, or bind the Insurer by making any promise or representation.

Sequence of the policy
The Policy follows a letter-number sequence. It is not necessary that the Policy include all letters or numbers in complete sequence to be correct.

Premiums

Premium rate change

The Policy premiums will be calculated as specified in the "Premium Computation" section below. The Insurer reserves the right to change any premium rate when the:

1. Terms of the Policy are changed;
2. Policyholder changes the terms of this Policy with the written consent of the Insurer; or
3. Insurer provides written notice to the Policyholder that rates are to be changed not later than thirty-one days prior to the change in premiums.

Premium computation

1. The first premium is due on this Policy's effective date. Subsequent premiums are due on the first day of each calendar month thereafter. The required premium due on each premium due date is the sum of the premiums for all covered Employees under this Policy. All premiums are payable to the Insurer at the Insurer's address.

2. If an individual's insurance coverage or policy benefits are modified other than on a premium due date, the change in premium resulting from the modification will become effective as follows:

    - Group with 2 – 99 eligible employees the change in premium will be effective on the date the change in coverage becomes effective.
    - Group with over 99 eligible employees:

        - If the change is effective on or before the 15th of the month, the change in premium will be effective on the first of the month during which the change in coverage is effective;
        - If the change is effective after the 15th of the month, the change in premium will be effective on the first of the month following the effective date of change in coverage.

To determine the applicable employer group size for premium changes please reference the Small Employer definition on the Employer Group Application.

3. If premiums are due for the Insurer or premium refunds are due for the Policyholder or Employee as a result of clerical error in the reporting of data to the Insurer, all premiums or refunds will be calculated at the current rate of premium payment.

The effective date of a change in premium will only vary from the above upon mutual written agreement between the policyholder and us.

Grace period

A grace period of thirty-one days will be allowed to the Policyholder for the payment of each required premium due after the first premium. The Policy will remain in force during the grace period. If the required premium is not paid by the end of the 31 day grace period, the Policy will terminate. The Policyholder will be required to pay premium for the grace period.

Unpaid premium

Any premium due and unpaid or covered by any note or written order may be deducted from the claim payment of an eligible claim under the Policy.

Discounted Premium Disclosure

From time to time, We may offer prospective or renewing Policyholders discounted premium for the selection of multiple lines of coverage with Us.

Return of premium

1. The Insurer reserves the right to rescind coverage on one or all Employees due to misrepresentation or fraud on an application form.

2. If on the date coverage is rescinded no dental claims have been paid under the Policy, the Insurer will return to the Policyholder or Employee all premiums paid for such coverage.

3. If on the date coverage is rescinded dental claims have been paid under the Policy, the Insurer reserves the right to deduct an amount equal to the amount of such dental claims paid from the premiums returned to the Policyholder or Employee.

GRIEVANCE AND APPEAL PROCEDURES

Proposers should provide a description of the grievance and appeal procedure for DHMO and DPPO plan participants. Be specific in terms of timelines and expected turnarounds.

The first step of the grievance process for members with complaints is to contact Humana's Customer Care department via our toll-free number. Our dental associates resolve 90 percent of disputes during their first contact with members. If the complaint is about quality of care, timeliness, available services, or the provider's attitude, the complaint is forwarded to the quality assurance department.

If a verbal complaint is not resolvable, the member has the right to submit a written grievance.

Humana's appeals process abides by Employee Retirement Income Security Act (ERISA) rules. The denial of a service can occur at any level of claims processing, and whenever we determine that a service is not covered, our denial letters and Explanations of Benefits (EOB) include the steps members may follow to request an appeal review of a claim.

First-level appeals review
A claimant appealing a claims payment decision must submit the appeal in writing within 180 days of receiving the denial. One of our grievance and appeals specialists reviews the appeal using ERISA rules and state regulations as a guideline and recommends a decision to the supervisor. We may also contact the American Dental Examiners (ADE), a professional dental claims review firm, for an opinion. The specialist:

- Reviews pertinent information to determine if a decision can be made or if additional information is necessary
- Requests additional information
- Sends an interim response when necessary

After receiving the necessary information, the specialist either reverses the decision and allows payment of the charges, or upholds the denial based on the contract and/or benefit language.

Second-level appeals review (subject to state mandates)
If the claimant does not agree with the first-level review decision, he or she may have the right under ERISA rules and regulations to submit an appeal for a second-level review, in which the grievance and appeal analyst reviews all of the information submitted and may request additional information to reviews the case. Based on the information received and background of the case, the grievance and appeal analyst has the option to:

- Reverse the previous decision
- Refer the case to another area
- Reaffirm the denial

Exhaustion
After completing the appeals process, a claimant has exhausted his or her administrative remedies under the plan. The 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. All of the following must apply:

- The plan must be governed by ERISA
- The claimant has exhausted his or her ERISA appeal rights
- The claim was not approved on appeal

If we fail to complete a claims determination or appeal within the established time limits, the claim is considered denied.

Expected Timelines
Humana handles both appeals and grievances according to state and federal regulations that determine acknowledgment and completion timeframes. Our goal is to respond to 98 percent of dental appeals within 30 days of receipt by sending a letter to the claimant and a copy to the member. Additionally, we process all grievances within 60 days of receipt. If a grievance involves the collection of information from outside the service area, an additional 30 days must be allowed for processing.

DHMO QUALITY ASSURANCE

Provide a detailed description of your DHMO and DPPO provider Quality Assurance program.

Humana's Quality Management program provides initial and ongoing assessments of each participating dental office. The program's primary purpose is to regularly verify that each dental office:

- Complies with national and state mandated rules and regulations
- Has the physical capability to provide contracted services to plan participants
- Maintains professional credentials (which are verified prior to acceptance into the network)
- Provides members with contractual benefits

Monitoring Providers

We regularly monitor the number of members in each dental office. Depending on the size of the office's professional staff and overall appointment capacity, we look for a target ratio of no more than 1,000 subscribers per general dentist office, and 2,000 subscribers per specialist office. Additionally, participating dentists are required to offer Humana members the same appointment access as their other patients. Wait time is monitored through our dental complaint and grievance process, and if we detect patterns, we will contact the provider in question.

We also utilize a set of proprietary clinical ratios in monitoring practice patterns. We developed a proprietary dental practice pattern review model that analyzes approximately 40 clinical ratios to monitor utilization and practice patterns. We compare utilization at the market, state, and national level, and these reviews help improve both patient outcome and costs. This allows us the ability to quickly identify aberrant practice patterns and responding to them in a consistent and efficient manner, which generates overall savings and promotes quality dental care.

Beyond Humana's initial credentialing and ongoing recredentialing criteria, we use standard dental protocol approved by the American Dental Association (ADA), including utilization frequency on a national basis. If a dentist is identified as being over utilized (i.e. submitted a higher percentage of procedure codes relative to the population), this is reviewed by an external Credentialing Committee, which is comprised of both general and specialty practitioners, to determine whether or not an excessive pattern has occurred. If so, we contact the provider for further explanation, which may potentially lead to their termination from the network. This same review process occurs for non-network dentists.

Grievance Process

If a member submits a complaint about quality of care, timeliness, available services, or the provider's attitude, the complaint is forwarded to the quality assurance department. If a verbal complaint is not resolvable, the member has the right to submit a written grievance. Humana's Grievance department reviews complaints against both contracted and non-contracted providers. When a complaint is filed, the circumstances surrounding the incident are investigated. When applicable, we contact the dentist to discuss the problem. Each grievance/appeal is handled according to state and federal regulations that determine acknowledgment and completion timeframes.

Provider Investigation

When we suspect potential insurance fraud, waste, or abuse (FWA), Humana's Special Investigation Unit (SIU) conducts an in-depth analysis to determine if there is a pattern or if it is an isolated occurrence.

Outside of our standard grievance procedures, there are several claims submittal instances that trigger a provider investigation, including when:

- Multiple codes are submitted for what appears to be the same procedures
- Valid codes are submitted with a different descriptor Submitted procedures do not have universal professional endorsement
- Submitted procedures have a poor prognosis (i.e., crowns or bridges on teeth with significant periodontal problems)
- An excessive number of services are performed on the same day
- We receive a claim for the retreatment of work previously performed that falls within our frequency limitations (i.e. replacement of crowns within five years of the previous placement)
- Submitted procedures are billed using invalid CDT codes

If we identify a pattern, we flag the provider, contact and question their office, review all of their past claims as well as subsequent claims prior to payment. If the problem continues, the dentist is brought before the Peer Review Committee to determine whether or not he or she is performing to universally accepted standards. If not, the Peer Review Committee recommends the Credentialing Committee to remove the provider from Humana's dental network.

If a new dentist submits an appeal because work performed was denied due to frequency, our professional consultants investigate to determine if there was a problem with the original work. If we identify a potential issue, we contact the original dentist. Depending on the situation, we may ask the original provider for a refund or some type of adjustment for substandard work. If the work in question appears to be more than an isolated occurrence, we take further action as necessary.

PROOF OF INCORPORATION

Proposers should furnish proof of State of Incorporation and State in which licensed.

Please refer to Attachment A for our Florida State Licenses and Attachment D for our W-9 forms, which provide proof of our State of Incorporation for the offering companies included in our proposal for the City.

AUTHORIZATION TO PROVIDE SERVICES

Proposers should provide certification from the appropriate State offices that your company is authorized to provide the services contained within your proposal.

Please refer to Section 20 for a copy of our sample Certificate of Benefits/Subscriber Agreements and Attachment A for our Florida State Licenses for the offering companies included in our proposal to the City.

SECTION VIII - REFERENCES

Provide references for **four (4) current clients.** We would prefer that these be Florida public sector employers with more than 500 subscribers.

1. Name of Organization - Broward Sheriff's Office
   Total Number of Full-Time Employees -
   Name & Title of Contact Elizabeth Parker, Benefits Manager
   Telephone Number 954-831-8355
   Fax Number 954-321-4541
   E-mail Address - Elizabeth_Parker@sheriff.org
   Type of Benefits Provided - Dental and Vision
   Number of Employees Covered Dental-10,402, Vision-5,967
   Plan Inception Date January 1, 1991

2. Name of Organization Broward County School Board
   Total Number of Full-Time Employees -
   Name & Title of Contact Glenn C. Parks, Accountant V, Benefits Department
   Telephone Number 754-321-3100
   Fax Number 954-747-4678
   E-mail Address - glenn.parks@browardschools.com
   Type of Benefits Provided - Dental and Vision
   Number of Employees Covered Dental- 24,000, Vision-51,323
   Plan Inception Date January 1, 1989

3. Name of Organization Broward County Clerk of Courts
   Total Number of Full-Time Employees -
   Name & Title of Contact Frank Giallorenzo, HR Director
   Telephone Number 954-831-6213
   Fax Number Not available
   E-mail Address - Not available
   Type of Benefits Provided - Medical, Dental and Vision
   Number of Employees Covered Medical-1,118, Dental-935, Vision-933
   Plan Inception Date January 1, 2004

Reference Form, continued

4. Name of Organization Town of Palm Beach
   Total Number of Full-Time Employees 765
   Name & Title of Contact Kennie Wells, Assistant Director of Human Resources
   Telephone Number 561-227-6326
   Fax Number 561-838-5451
   E-mail Address kwells@townofpalmbeach.com
   Type of Benefits Provided Dental
   Number of Employees Covered 443
   Plan Inception Date January 1, 2011

The above four references are from **current clients** with whom your firm has contracts. Please provide two (2) references from **former clients** with whom your company may no longer have the contract or contract expired within the past 12 months. We would prefer that these be Florida public sector employers with more than 500 subscribers.

5. Name of Organization City of Delray Beach
   Total Number of Full-Time Employees
   Name & Title of Contact Sue Radig, Benefits Administrator
   Telephone Number 561-243-7154
   Fax Number 561-243-7082
   E-mail Address [redacted]com
   Type of Benefits Provided Dental and Vision
   Number of Employees Covered Dental-326, Vision-267
   Plan Inception Date March 1, 2001

6. Name of Organization City of West Palm Beach
   Total Number of Full-Time Employees [redacted]
   Name & Title of Contact Patricia Brosamer, Human Resources Officer
   Telephone Number 561-659-8028
   Fax Number 561-494-1035
   E-mail Address [redacted]
   Type of Benefits Provided Dental and Vision
   Number of Employees Covered Dental-1,354, Vision-3,489
   Plan Inception Date February 1, 1993

PROPOSING COMPANY HISTORY

Proposers should indicate number of years the company has offered group dental plans.

We have been providing our group dental PPO plans for approximately 23 years since Humana's dental PPO network became operational in 1994.

We have been providing our group DHMO plans for approximately 39 years since Humana's DHMO network became operational in 1978.

MINIMUM QUALIFICATIONS

Proposers should provide documentation of minimum qualification as stated in this RFP.

In order to be considered, a Proposer must, as of the proposal return date specified in this RFP and throughout the duration of its program, meet the following applicable minimum qualifications. Proposer must provide documentation of existing qualifications in the proposal.

Understood and agreed.

Dental Maintenance Organization

- **Authorized by the Florida Department of Financial Services to provide the goods and services requested in the RFP.**
- **Comply with any requirements imposed upon the Proposer by the Florida Department of Insurance with respect to quality assurance.**

  Confirmed. Humana is authorized by the Florida Department of Financial Services to provide the goods and services requested in the RFP and we comply with any quality assurance requirements.

Insurance Company and PPO Dental Plan

- **Licensed by the State of Florida Department of Insurance to provide the goods and services requested in the RFP; and**

  Confirmed. Please refer to Attachment A for a copy of our Florida State Licenses for the offering companies included in our proposal for the City.

- **Hold an A.M. Best rating of "A" or better and a financial size category of IV or higher or hold an A.M. Best financial performance rating of "6" or better for those insurers with a letter rating of NA-2 or NA-3 and a financial size category of IV or higher.**

  CompBenefits Company and Humana Insurance Company both currently have an A.M. Best rating of A-. Both companies also carry a financial size category higher than IV.

Proposers shall satisfy each of the following requirements cited below. Failure to do so may result in the proposal being deemed non-responsive.

Understood and agreed.

2.14.2 Before awarding a contract, the City reserves the right to require that a Proposer submit such evidence of qualifications as the City may deem necessary. Further, the City may consider any evidence of the financial, technical, and other qualifications and abilities of a firm or principals, including previous experiences of same with the City and performance evaluation for services, in making the award in the best interest of the City.

Understood and agreed.

2.14.3 Firm or principals shall have no record of judgments, pending lawsuits against the City or criminal activities involving moral turpitude and not have any conflicts of interest that have not been waived by the City Commission.

Understood and agreed.

2.14.4 Neither firm nor any principal, officer, or stockholder shall be in arrears or in default of any debt or contract involving the City, (as a party to a contract, or otherwise); nor have failed to perform faithfully on any previous contract with the City.

Understood and agreed.

SAMPLE CONTRACTS

Proposers must include samples of any and all contracts and certificates of coverage that would be executed by the City under the proposed plans. This information should be included in Tab 9 of your proposal. NOTE: If your terms and conditions conflict with the City's terms and conditions, Proposer may be deemed NON-RESPONSIVE.

Please refer to Tab 9, as requested in the City's RFP, for our sample contracts.

SAMPLE ADMINISTRATION FORMS

Proposers should include a sample identification card, claims forms, enrollment forms and explanation of benefits forms.

Please refer to the following attachments in the Attachments section of our proposal for the requested samples:

- Attachment F – Sample Identification Card
- Attachment G – Sample Claim Form
- Attachment H – Sample Enrollment Form
- Attachment I – Sample Explanation of Benefits

MINORITY/WOMEN (M/WBE) PARTICIPATION

If your firm is a certified minority business enterprise as defined by the Florida Small and Minority Business Assistance Act of 1985, provide copies of your certification(s). If your firm is not a certified M/WBE, describe your company's previous efforts, as well as planned efforts in meeting M/WBE procurement goals under Florida Statutes 287.09451.

Please refer to Attachment J for our Good Faith Effort Statement.

BID/PROPOSAL CERTIFICATION

Please Note: If responding to this solicitation through BidSync, the electronic version of the bid response will prevail, unless a paper version is clearly marked **by the bidder** in some manner to indicate that it will supplant the electronic version. All fields below must be completed. If the field does not apply to you, please note N/A in that field.

If you are a foreign corporation, you may be required to obtain a certificate of authority from the department of state, in accordance with Florida Statute §607.1501 (visit http://www.dos.state.fl.us/).

Company: (Legal Registration) CompBenefits Company EIN (Optional): 59-2531815

Address: 5775 Blue Lagoon Drive, Suite 400

City: Miami State: FL Zip: 33126

Telephone No. 305-626-5546 FAX No. 305-370-6517 Email: Mtoffoli@humana.com

Delivery: Calendar days after receipt of Purchase Order **(section 1.02 of General Conditions)**: N/A

Total Bid Discount **(section 1.05 of General Conditions)**: N/A

Does your firm qualify for MBE or WBE status **(section 1.09 of General Conditions)**: MBE No WBE No

ADDENDUM ACKNOWLEDGEMENT - Proposer acknowledges that the following addenda have been received and are included in the proposal:

Addendum No.	Date Issued	Addendum No.	Date Issued	Addendum No.	Date Issued
1	3/24/2017				

VARIANCES: If you take exception or have variances to any term, condition, specification, scope of service, or requirement in this competitive solicitation you must specify such exception or variance in the space provided below or reference in the space provided below all variances contained on other pages within your response. Additional pages may be attached if necessary. No exceptions or variances will be deemed to be part of the response submitted unless such is listed and contained in the space provided below. The City does not, by virtue of submitting a variance, necessarily accept any variances. If no statement is contained in the below space, it is hereby implied that your response is in full compliance with this competitive solicitation. If you do not have variances, simply mark N/A. **If submitting your response electronically through BIDSYNC you must also click the "Take Exception" button.**

Humana has provided clarifications to the RFP in Section 8.

The below signatory hereby agrees to furnish the following article(s) or services at the price(s) and terms stated subject to all instructions, conditions, specifications addenda, legal advertisement, and conditions contained in the bid/proposal. I have read all attachments including the specifications and fully understand what is required. By submitting this signed proposal I will accept a contract if approved by the City and such acceptance covers all terms, conditions, and specifications of this bid/proposal. The below signatory also hereby agrees, by virtue of submitting or attempting to submit a response, that in no event shall the City's liability for respondent's direct, indirect, incidental, consequential, special or exemplary damages, expenses, or lost profits arising out of this competitive solicitation process, including but not limited to public advertisement, bid conferences, site visits, evaluations, oral presentations, or award proceedings exceed the amount of Five Hundred Dollars ($500.00). This limitation shall not apply to claims arising under any provision of indemnification or the City's protest ordinance contained in this competitive solicitation.

Submitted by:

Richard D. Remmers
Name (printed)


Signature

April 7, 2017
Date:

Vice President, Group Segment
Title

revised 04/10/15

BID/PROPOSAL CERTIFICATION

Please Note: If responding to this solicitation through BidSync, the electronic version of the bid response will prevail, unless a paper version is clearly marked **by the bidder** in some manner to indicate that it will supplant the electronic version. All fields below must be completed. If the field does not apply to you, please note N/A in that field.

If you are a foreign corporation, you may be required to obtain a certificate of authority from the department of state, in accordance with Florida Statute §607.1501 (visit http://www.dos.state.fl.us/).

Company: (Legal Registration) Humana Insurance Company EIN (Optional): 39-1263473

Address: 1100 Employers Boulevard

City: De Pere State: WI Zip: 54115

Telephone No. 305-626-5546 FAX No. 305-370-6517 Email: Mtoffoli@humana.com

Delivery: Calendar days after receipt of Purchase Order **(section 1.02 of General Conditions)**: N/A

Total Bid Discount **(section 1.05 of General Conditions)**: N/A

Does your firm qualify for MBE or WBE status **(section 1.09 of General Conditions)**: MBE No WBE No

ADDENDUM ACKNOWLEDGEMENT - Proposer acknowledges that the following addenda have been received and are included in the proposal:

Addendum No.	Date Issued	Addendum No.	Date Issued	Addendum No.	Date Issued
1	3/24/2017				

VARIANCES: If you take exception or have variances to any term, condition, specification, scope of service, or requirement in this competitive solicitation you must specify such exception or variance in the space provided below or reference in the space provided below all variances contained on other pages within your response. Additional pages may be attached if necessary. No exceptions or variances will be deemed to be part of the response submitted unless such is listed and contained in the space provided below. The City does not, by virtue of submitting a variance, necessarily accept any variances. If no statement is contained in the below space, it is hereby implied that your response is in full compliance with this competitive solicitation. If you do not have variances, simply mark N/A. **If submitting your response electronically through BIDSYNC you must also click the "Take Exception" button.**

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Submitted by:

Richard D. Remmers
Name (printed)


Signature

April 7, 2017
Date:

Vice President, Group Segment
Title

revised 04/10/15

NON-COLLUSION STATEMENT:

By signing this offer, the vendor/contractor certifies that this offer is made independently and *free* from collusion. Vendor shall disclose below any City of Fort Lauderdale, FL officer or employee, or any relative of any such officer or employee who is an officer or director of, or has a material interest in, the vendor's business, who is in a position to influence this procurement.

Any City of Fort Lauderdale, FL officer or employee who has any input into the writing of specifications or requirements, solicitation of offers, decision to award, evaluation of offers, or any other activity pertinent to this procurement is presumed, for purposes hereof, to be in a position to influence this procurement.

For purposes hereof, a person has a material interest if they directly or indirectly own more than 5 percent of the total assets or capital stock of any business entity, or if they otherwise stand to personally gain if the contract is awarded to this vendor.

In accordance with City of Fort Lauderdale, FL Policy and Standards Manual, 6.10.8.3,

3.3. City employees may not contract with the City through any corporation or business entity in which they or their immediate family members hold a controlling financial interest (e.g. ownership of five (5) percent or more).

3.4. Immediate family members (spouse, parents and children) are also prohibited from contracting with the City subject to the same general rules.

Failure of a vendor to disclose any relationship described herein shall be reason for debarment in accordance with the provisions of the City Procurement Code.

NAME	RELATIONSHIPS
*	*
_____	_____
_____	_____
	_____
	_____

In the event the vendor does not indicate any names, the City shall interpret this to mean that the vendor has indicated that no such relationships exist.

*Humana does not employ any individuals that hold a 5 percent or more controlling financial interest in the company in the state of Florida.

LOCAL BUSINESS PREFERENCE

Humana is a Fortune 100 company with multiple subsidiaries; the offering subsidiaries for the City's proposed dental plans are Humana Insurance Company and CompBenefits Company.

Humana has a strong local presence in Broward County, with a market office and over 1,000 associates in Miramar, Florida. However, the majority of Humana's Miramar employees report through other subsidiaries. Additionally, the Miramar office location handles business for many Humana subsidiaries and is not classified as an office specifically for Humana Insurance Company or CompBenefits Company.

Therefore, while neither offering subsidiary qualifies as a Class A, B, or C according to the City's definitions, Humana, as a corporation, maintains a permanent place of business with full-time associates in Broward County.

One of the offering subsidiaries, Humana Insurance Company, also has a local business license in Fort Lauderdale; please find documentation on the following pages. CompBenefits Company is not subject to the City's license tax, as it is licensed as an LHSO.

Although Humana is based in Kentucky and Wisconsin, we have a strong presence in Broward County, where the county Fort Lauderdale is based.

Florida Local Business Tax
10/1/2016 to 9/30/2017

Municipal Name: FORT LAUDERDALE

City Assigned ID Number: _____

Company Name and Address:
Humanadental Insurance Company
P.O.Box 740026
Louisville, KY 40201

Due Date: 09/30/2016
FEIN: 390714280
NAIC Number: 70580

	Number of Employees or Square Footage	Amount Due
Tax assessed on Number of Employees.....		
Tax assessed on Square Footage.....		
Local Business tax for Insurance Companies		157.50
Additional taxes not included in the line above		
Administrative Fees.....		
Initial Application Fee.....		
Total Amount Due.....		157.50

Signature: _____
Name and Title: Annette Richey, Tax Manager
Phone: (502) 580-3791
Date: 09/22/2016

City of Fort Lauderdale
100 N Andrews Ave
Fort Lauderdale, FL 33301

CONTRACT PAYMENT METHOD BY P-CARD

THIS FORM MUST BY SUBMITTED WITH YOUR RESPONSE

The City of Fort Lauderdale has implemented a Procurement Card (P-Card) program which changes how payments are remitted to its vendors. The City has transitioned from traditional paper checks to payment by credit card via MasterCard or Visa. This allows you as a vendor of the City of Fort Lauderdale to receive your payment fast and safely. No more waiting for checks to be printed and mailed.

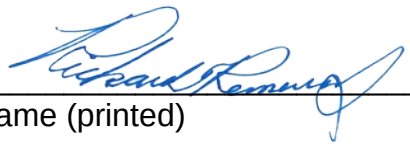
Payments will be made utilizing the City's P-Card (MasterCard or Visa). Accordingly, firms must presently have the ability to accept credit card payment or take whatever steps necessary to implement acceptance of a credit card before the commencement of a contract.

Please indicate which credit card payment you prefer:

_____ Master Card

_____ Visa Card

Company Name: **Humana**



Richard D. Remmers
Name (printed) Signature

April 7, 2017 **Vice President, Group Segment**
Date: Title

Humana is currently unable to accept credit card payments. We can accept an online payment via electronic funds transfer; either one-time or recurring payments.

CompBenefits Company

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

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

Certificate of Dental Benefits

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

I. Definitions

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

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

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

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

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

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

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

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

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

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

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

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

M. **"Necessary Treatment"** is the extent of care and treatment that is the generally accepted, proven and established practice by most dentists with similar experience and training. Such care and treatment must not be provided primarily for the convenience of the patient or the dentist. To determine Necessary Treatment, *we* may require preoperative dental radiographs (X-rays) and other pertinent information.

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

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

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

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

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

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

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

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

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

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

II. Contributions and Copayments

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

III. Benefits

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

IV. Eligibility and Enrollment

A. Subscriber

1. Subscriber Eligibility Date

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

2. Subscriber Effective Date

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

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

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

B. Dependent

1. Dependent eligibility date

   a. Each Dependent is eligible for coverage on:

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

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

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

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

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

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

2. Dependent effective date

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

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

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

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

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

V. Coverage for Newborn and Adopted Children

A. Newborn Dependent effective date

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

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

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

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

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

VI. Disenrollment from the Dental Plan – Termination of Benefits

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

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

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

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

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

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

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

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

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

1. Termination date listed in the Contract;

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

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

4. The date You enter the military fulltime;

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

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

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

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

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

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

VII. Dental Facility Selection

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

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

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

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

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

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

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

VIII. Pre-Treatment Estimate

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

IX. Alternate Treatment

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

X. General Provisions

A. Appointments for Service

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

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

B. Broken Appointments

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

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

C. Emergency Care

1. Out-of-Area Emergency Care:

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

2. In-Service-Area Emergency Care:

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

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

D. Dental Records

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

XI. Limitations and Exclusions

Company does not provide coverage for the following services:

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

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

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

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

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

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

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

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

Member.

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

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

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

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

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

N. Worker's Compensation

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

2. The recovery rights will be applied even though:

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

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

   c. The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by you or the Workers' Compensation carrier; or

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

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

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

1. Altering vertical dimension of teeth;

2. Restoration or maintenance of occlusion;

3. Splinting teeth, including multiple abutments; or

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

XII. Notice of Independent Contractor Relationship

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

XIII. Review and Mediation of Complaints

A. Informal Grievances

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

B. Submission of Formal Grievances

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

C. Response to Formal Grievances

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

D. Appeal of Decision

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

E. Contact Information

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

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

XIV. Continuation of Coverage

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

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

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

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

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

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

XV. Conversion Provision

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

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

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

1. Failure to pay any required premium or Contribution.

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

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

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

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

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

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

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

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

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

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

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

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CompBenefits Company

Schedule of Benefits and Subscriber Copayments

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

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

Preventive

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

Restorative

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

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

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

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

Prosthodontics (fixed) – Replacement limited to every 5 (five) years, adjustments once per year

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

Prosthodontics – Replacement limited to every 5 (five) years

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

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

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

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

Periodontics

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

Extractions/oral and maxillofacial surgery

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

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

Repair to prosthetics

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

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

Adjunctive General Service

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

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

Bleaching

D9972	External Bleaching - Per Arch	$125

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

Orthodontic Services

D8070 / D8080

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

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

D8680 Retention $300

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

Implant Services:

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

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

NOTE:

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

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

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

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

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

Offered and Administered by CompBenefits Company, a Humana company

Notices

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

This section includes notices about:

Claims procedures

Federal legislation

- **Medical child support orders**
- **Continuation of coverage for full-time students during medical leave of absence**
- **General notice of COBRA continuation of coverage rights**
- **Family and Medical Leave Act (FMLA)**
- **Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)**
- **Your Rights under ERISA**

Discrimination Notice

Claim procedures

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

Discretionary authority

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

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

Claim procedures

Definitions

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

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

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

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

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

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

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

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

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

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

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

Submitting a claim

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

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

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

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

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

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

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

Procedural defects

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

Authorized representatives

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

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

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

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

Claims decisions

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

Pre-service claims

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

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

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

Urgent-care claims (expedited review)

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

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

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

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

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

Concurrent-care decisions

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

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

Post-service claims

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

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

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

Initial denial notices

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

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

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

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

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

Appeals of Adverse Determinations

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

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

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

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

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

Time periods for decisions on appeal

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

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.

Discrimination is Against the Law

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

Humana Inc. and its subsidiaries provide:

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

- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

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

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

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

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

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**

Multi-Language Interpreter Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Employer: CITY OF FORT LAUDERDALE

Group Number: 573978

Dental Plan
Certificate of Insurance

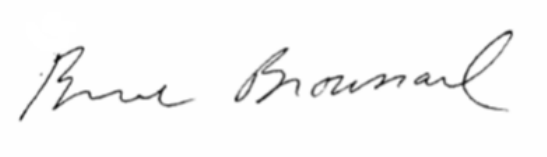
Humana Insurance Company

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

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

This certificate contains a deductible and excess coverage provision.

If *you* should have any questions arise regarding *your* coverage, or if *you* need assistance in resolving a complaint, contact *us* at 1-800-233-4013.



Bruce Broussard
President

Humana

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Policyholder (Employer): CITY OF FORT LAUDERDALE
Group Number: 573978
Coverage Effective Date: 01/01/2017

Summary of your benefits

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

Any *covered expense* that is applied to any *maximum benefit* or *deductible* will be applied equally toward the satisfaction of both the PPO Provider and corresponding Non-PPO Provider *maximum benefit* or *deductible*.

Dental benefits

Individual maximum benefit:
$1,500 per *year* per *member* for Preventive, Basic and Major *services* when *services* are provided by a PPO *dentist.*

$1,500 per *year* per *member* for Preventive, Basic and Major *services* when *services* are provided by a Non-PPO *dentist.*

Individual deductible:
$0 per *year* per *member* for Basic and Major *services* when *services* are provided by a PPO *dentist*.

$100 per *year* per *member* for Basic and Major *services* when *services* are provided by a Non-PPO *dentist*.

Maximum family deductible:
Covered expenses applied to the plan *deductible* of each covered *member* are combined to a *year* maximum of $0 when *services* are provided by a PPO *dentist*.

Covered expenses applied to the plan *deductible* of each covered *member* are combined to a *year* maximum of $300 when *services* are provided by a Non-PPO *dentist.*

Orthodontic lifetime maximum benefit
$2,500 per *member* when *services* are provided by a PPO *dentist.*

$2,500 per *member* when *services* are provided by a Non-PPO *dentist.*

Preventive Services:
Preferred Provider Benefits: Benefits are paid at 100%.
Non-Preferred Provider Benefits: Benefits are paid at 100%.

1. Routine teeth cleaning (prophylaxis)
2. Topical fluoride treatment
3. Sealants
4. Oral examinations
5. Complete intra-oral X-ray series
6. Panoramic X-rays
7. Bitewing X-rays

Basic Services:
Preferred Provider Benefits: Benefits are paid at 100% after the *deductible*.
Non-Preferred Provider Benefits: Benefits are paid at 60% after the *deductible*.

1. Fillings (amalgam and composite restorations)
2. Non-surgical extractions
3. Non-surgical residual root removal
4. Non-cast prefabricated crowns
5. Emergency exam and palliative care for pain relief
6. Space maintainers
7. Harmful habits and thumb-sucking appliances
8. Partial and denture repairs and adjustments
9. Oral surgery
10. Periapical X-rays
11. Periodontics (gum disease)
12. Endodontics (root canals)

Major Services:
Preferred Provider Benefits: Benefits are paid at 60% after the *deductible*.
Non-Preferred Provider Benefits: Benefits are paid at 60% after the *deductible*.

1. Crowns
2. Inlays and onlays
3. Removable or fixed bridgework
4. Partial or complete dentures
5. Denture relines or rebases

Orthodontic Services:
Preferred Provider Benefits: Benefits are paid at 60%.
Non-Preferred Provider Benefits: Benefits are paid at 60%.

Please refer to the Orthodontic Services Rider of *your* certificate to determine who is eligible for coverage under this *benefit*.

Waiting periods

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Groups with fewer than 10 dental lives, orthodontic coverage is effective 12 months after the effective date of the covered *member* added after the effective date of the group's Policy.

Groups with more than 10 dental lives, orthodontia coverage is effective on the effective date of coverage.

Your plan benefits

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

Preventive services

1. Oral evaluations (periodic, limited, comprehensive and problem focused) - two per *year*.

2. Periodontal evaluations - two per *year*.

3. Cleaning (prophylaxis), including all scaling and polishing procedures – four per *year*. Only four cleanings will be allowed per *year,* either for routine cleanings or periodontal cleanings.

4. For members age 40 and older, oral cancer screening – one per *year*.

5. Intra-oral complete series X-rays (at least 14 films, including bitewings), or panoramic X-ray – once every three years. If the total cost of periapical and bitewing X-rays exceeds the cost of a complete series of X-rays, the plan will consider these as a complete series.

6. Bitewing X-rays – two sets per *year*.

7. Topical fluoride treatment – provided to *dependents* age 14 and younger. *Service* is payable once per *year*.

8. Sealants – application provided to *dependents* age 14 and younger to the occlusal surface of permanent molars that are free of decay and restorations. *Service* is payable once per tooth per lifetime**.**

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

Basic services

1. Amalgam restorations (fillings) – limit to one per tooth in a two *year* period. Multiple restorations on one surface are considered one restoration.

2. Composite restorations (fillings) limited to one per tooth in a two *year* period. Multiple restorations on one surface are considered one restoration.

3. Recementing of inlays, onlays, crowns and bridges.

4. Non-cast pre-fabricated crowns – *service* on primary teeth that cannot be adequately restored with amalgam or composite restorations.

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

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

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

8. Full or partial denture repair.

9. Denture adjustments – procedure available only for adjustments done by a *dentist* other than the one providing the denture, or adjustments performed more than six months after initial installation.

10. Other X-rays – only to diagnose specific treatment.

Simple oral surgery services

1. Extraction - coronal remnants of a deciduous tooth.
2. Extraction - erupted tooth or exposed root.

Complex oral surgery services

1. Surgical extractions.
2. Bone Smoothing.
3. Trim or Remove over growth or non vital tissue or bone.
4. Removal of tooth or root from sinus and closing opening between mouth and sinus.
5. Surgical access of an erupted tooth.
6. Mobilization of erupted or malpositioned tooth to aid eruption; or, surgical reposition of teeth.
7. Excision or removal of benign oral cysts or tumors.
8. Bone, cartilage, or synthetic grafts.
9. General anesthesia when *medically necessary* and administered by a *dentist* in conjunction with a covered oral surgical procedure.

No benefit is payable for:

1. Any *services* for orthognathic surgery.
2. Any *services* for destruction of lesions by any method.
3. Any *services* for tooth transplantation.
4. Any *services* for removal of a foreign body from the oral tissue or bone.
5. Any *services* for reconstruction of surgical, traumatic, or congenital defects of the facial bones.
6. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
7. Any *services* generally considered to be medical services.
8. Any separate fees for pre and post operative *services*.

Periodontic services

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

2. Periodontal maintenance (following periodontal therapy) – procedure available four times per *year*. Only four cleanings will be allowed per *year,* either for routine cleanings or periodontal cleanings.

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

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

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

Endodontic services

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

2. Apicoectomy - procedure available for permanent teeth only.

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

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

Major/Prosthodontic services

1. Repairs of bridges and crowns.

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

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

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

   - It has been at least five years since the prior insertion and is not, and cannot be made, serviceable;
   - It is damaged beyond repair as a result of an *accidental injury* (non-chewing injury) while in the oral cavity; or

- Extraction of functioning teeth, excluding third molars or teeth not fully in occlusion with an opposing tooth or prosthesis, necessitates the replacement of the prosthesis.

These *services* are covered only on permanent teeth.

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

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

Integral service

The following *services* are considered integral to the dental *service*. A separate fee for these *services* is not considered a *covered expense.*

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

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

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

General anesthesia is not a *covered expense* unless it is a *medical necessity* and administered by a *dentist* in conjunction with covered oral surgical procedures outlined in this section. Patient management or apprehension is not considered a *medical necessity*.

Additional benefits for newborns

If the *employee* has dependent coverage, a child born to the *employee* or any of the *employee's* covered *dependents* while this policy is in effect is covered from the moment of birth for the same *benefits* and under the same terms and conditions that are applicable for other children covered as *dependents* under the policy.

Coverage for such newborn child consists of *benefits* for *services* which are a *dental necessity* for the treatment of a *bodily injury* or *sickness*, including the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, or premature birth; and transportation costs, not to exceed $1,000 to and from the nearest available facility appropriately staffed and equipped to treat the newborn's condition. The transportation must be certified by the attending physician as necessary to protect the health and safety of the newborn child, and is subject to the *reimbursement limit*.

Coverage for the newborn child to an *employee's* covered *dependent* terminates 18 months after the child's date of birth or according to the **Terminating coverage** provision in the certificate, whichever is earliest.

If *you* are an *employee* with single coverage currently in force, refer to the **When you are eligible for coverage** provision for information on addition *dependent* coverage.

Limitations & exclusions (all services)

In addition to the limitations and exclusions listed in **Your plan benefits** section, this policy does not provide *benefits* for the following:

1. Any expense arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which benefits are paid under any Workers' Compensation or Occupational Disease Act or Law.

2. *Services*:

   - That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;

   - Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or

   - Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with *sickness* or *bodily injury*.

3. Any loss caused or contributed by:

   - War or any act of war, whether declared or not, excluding terrorism;
   - Any act of international armed conflict; or
   - Any conflict involving armed forces of any international authority.

4. Any expense arising from the completion of forms.

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

6. Any *service we* consider *cosmetic dentistry* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. *We* consider the following *cosmetic dentistry* procedures:

   - Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid;
   - Any *service* to correct congenital malformation; unless the *service* is for treatment of a covered newborn as allowed under the **Additional benefits for newborns** section of **Your plan benefits**;
   - Any *service* performed primarily to improve appearance; or
   - Characterizations and personalization of prosthetic devices.

7. Charges for:

   - Any type of implant and all related services, including crowns or the prosthetic device attached to it;
   - Precision or semi-precision attachments;
   - Overdentures and any endodontic treatment associated with overdentures;
   - Other customized attachments.

8. Any *service* related to:

    - Altering vertical dimension of teeth;
    - Restoration or maintenance of occlusion;
    - Splinting teeth, including multiple abutments, or any *service* to stabilize periodontally weakened teeth;
    - Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
    - Bite registration or bite analysis.

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

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

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

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

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

14. Any *service* that *we* determine:

    - Is not a *dental necessity*;
    - Does not offer a favorable prognosis;
    - Does not have uniform professional endorsement; or
    - Is deemed to be experimental or investigational in nature.

15. Orthodontic *service*s unless specified in *your* **Summary of your benefits**.

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

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

18. Charges exceeding the *reimbursement limit* for the *service*.

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

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

21. Repair and replacement of orthodontic appliances.

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

23. Any non-emergent dental expenses incurred for services rendered outside of the United States.

How your plan works

General benefit payments

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

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

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

Deductibles

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

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

Coinsurance

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

Waiting periods

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

Benefit maximums

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

Alternate services

If two or more *service*s are acceptable to correct a dental condition, *we* will base the *benefits* payable on the *covered expenses* for the least expensive *covered service* that produces a professionally satisfactory result, as determined by *us. We* will pay up to the *reimbursement limit* for the least costly *covered service* and subject to any *deductible, coinsurance* and *maximum benefit*. *You* will be responsible for paying the excess amount.

If *you* or *your dentist* decide on a more costly treatment than *we* determine to be satisfactory for treatment of the condition, payment will be limited to the *reimbursement limit* and will be subject to any *deductible* and *coinsurance* for the least costly treatment. *You* will be responsible for the remaining *expense incurred*.

Pretreatment plan

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

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

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

An estimate for *services* is not necessary for *emergency* care.

Process and timing

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

How we pay claims

Identification numbers

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

Claim forms

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

Submitting claim information and proof of loss

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

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

1. A complete dental chart showing:

    - Extractions;
    - Missing teeth;
    - Fillings;
    - Prosthesis;
    - Periodontal pocket depths;
    - Dates of previously performed work.

2. An itemized bill for all dental work.
3. The following exhibits:

    - X-rays;
    - Study models;
    - Laboratory and/or reports;
    - Patient records.

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

If *you* do not provide *us* with the necessary information, *we* will deny any related claims until *you* provide it to *us*.

Payment of the Claim

Once *we* receive all the necessary information, *we* will determine if *benefits* are available, and if they are, *we* will pay any amount due under this *policy* within 45 days of receipt of the claim. If *we* cannot process *your* claim due to lack of information, *we* will notify *you*, or whoever is claiming payment under the *policy* if it is not *you*, of the information needed within 45 days of receipt of claim. Once *we* have received the necessary information, *we* will process *your* claim within 60 days of receipt of information. *We* may pay all or a portion of any *benefit* provided for *covered expenses* to the provider unless *you* or the *covered person* has notified *us* in writing by the time the claim form is submitted.

Extension of benefits

Benefits are payable for *covered expenses* which are:

1. Recommended in writing by a *health care practitioner*;
2. Initiated while this coverage is in force and for a specific *bodily injury* or *sickness* incurred while this coverage is in force (see definition of *expense incurred date*);
3. Provided for *services* other than routine examination, prophylaxis, x-rays, sealants, or orthodontic *services*; and
4. Completed within the first 90 days following the termination date of *your* coverage, if such termination was other than voluntary.

Benefits for *covered expenses* for treatment due to such *bodily injury* or *sickness* will continue until the earliest of the following:

1. The end of the first 90 days immediately following the termination date of *your* coverage; or
2. The date a succeeding plan provides similar benefits for treatment due to such *bodily injury* or *sickness*.

These benefits are subject to the provisions and conditions of the policy.

Reasons for denying a claim

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

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

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

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

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

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

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

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

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

How to Challenge Our Claim Decision (Appeal Rights)

If a *covered person* disagrees with *our* decision on payment of a particular claim, the *covered person* can request a second review of the claim, also known as an appeal. To request this review, *you* must send *us* a letter requesting a second claim review within 60 days from the time *you* received notice of *our* claim payment decision. The *covered person* may also send any documents or information that are relevant to *our* decision of how to pay the claim.

Legal actions

You cannot bring a legal action to recover a claim until 60 days after the date written proof of loss is made. No action may be brought after the expiration of the applicable statute of limitations after such proof of loss is required to be given.

Claims paid incorrectly

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

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

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

Coordinating benefits with another insurer

Benefits subject to this provision

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

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

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

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

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

Effect on benefits

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

All other plans are called secondary plans. The secondary plan may reduce the *benefits* so that the total *benefits* paid or provided by all plans during a claim determination period are not more than 100 percent of the total allowable expense.

Order of benefit determination

To pay claims, it must be determined which plan is primary and which plan(s) is/are secondary. A plan will pay benefits first if it meets one of the following conditions:

1. The plan that covers the person as an *employee* submitting the claim, except when that person is also a Medicare beneficiary and Medicare is secondary to the plan covering the person as a *dependent* of an active *employee*. In that case the Order of benefit determination is:

   - The benefits of the plan covering the person as an employee, employee or subscriber is primary;
   - The benefits of the plan of an active employee covering the person as a *dependent* is secondary; and then
   - Medicare benefits.

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

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

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

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

5. When the person is covered under a COBRA continuation plan (as provided under the Consolidation Omnibus Budget Reconciliation Act of 1987) and is also covered under another group plan, the benefits of the plan which covers the person as an *employee* or as the *employee's dependent* will be determined before the benefits of a plan covering the person as a former *employee* or as the former *employee's dependent*.

If rules 1-5 do not determine the primary plan, the plan covering the person for the longest time is the primary plan. If it still cannot be determined which plan is the primary plan, *we* will waive the above rules and incorporate the rules identical with those of the other plan.

Excess coverage

We will not pay benefits for any *accidental injury* if other insurance will provide payments or expense coverage, regardless of whether the other coverage is described as primary, excess or contingent. If *your* claim against another insurer is denied or partially paid, *we* will process *your* claim according to the terms and conditions of this certificate. If *we* make a payment, *you* agree to assign to *us* any right *you* have against the other insurer for dental expenses *we* pay. Payments made by the other insurer will be credited toward any applicable *coinsurance* or *calendar year deductibles*.

Coordinating benefits with Medicare

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

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

Right of recovery

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

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

Right to necessary information

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

Recovery rights

Your obligation in the recovery process

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

1. Obtaining *our* consent before releasing any party from liability for payment of dental expenses.
2. Providing *us* with a copy of any legal notices arising from *your* injury and its treatment.
3. Assisting *our* enforcement of recovery rights and doing nothing to prejudice *our* recovery rights.
4. Refraining from designating all (or any disproportionate part) of any recovery as exclusively for "pain and suffering."

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

Right of subrogation

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

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

Right of reimbursement

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

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

Assignment of recovery rights

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

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

Limitations to recovery rights

Any such Right of Subrogation or Reimbursement provided to *us* under this policy shall not apply or shall be limited to the extent that the Florida Statutes or the Courts of Florida eliminate or restrict such rights.

Workers' compensation

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

The recovery rights will be applied even though:

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

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

Definitions

The following terms are used in this section:

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

Special enrollment date means:

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

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

Eligibility date

Employee eligibility date

The *employee* is eligible for coverage on the date:

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

Dependent eligibility date

Each *dependent* is eligible for coverage on:

- The date the *employee* is eligible for coverage, if he or she has *dependents* who may be covered on that date;

- The date of the *employee's* marriage for any *dependents* (spouse or child) acquired on that date;

- The date of birth of the *employee's* natural-born child;

- The date of placement of the child for the purpose of adoption by the *employee*; or

- The date a foster child is placed in the *employee's* home;

- The date any child for whom the *employee* is the legal guardian, who is dependent on the *employee* for health care coverage pursuant to a valid court order, or who lives with the *employee* in a normal parent-child relationship and qualifies for the dependent exemption as defined in the Internal Revenue Code and Federal Tax Regulations. *We* have the right to request proof of the child's dependency status at any time; or

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

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

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

Employee enrollment

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

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

Dependent enrollment

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

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

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

Newborn dependent enrollment

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

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

Newborn dependent effective date

- If *we* receive enrollment on, prior to, or within 2 years of the newborn's date of birth, *dependent* coverage is effective on the first of the month following receipt of the enrollment.

- If *we* receive enrollment between 2 years and 2 years and 31 days after the newborn's date of birth, *dependent* coverage is effective on the child's second birth date.
- If *we* receive enrollment more than 2 years and 31 days after the newborn's date of birth, the newborn is considered a *late applicant*.

Foster Child effective date

Coverage for a foster child or a child otherwise placed in the *employee* or covered spouse's custody by a court order, prior to the child's eighteenth birthday, will be provided from the date of placement if, on the date of placement, the *employee* had dependent coverage. No coverage will be provided under this provision for the child who is not ultimately placed in the *employee's* home. For a child in the *employee's* custody, coverage will terminate the date the *employee* no longer has legal custody.

Special Enrollment

Loss of other coverage

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

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

- You declined enrollment under the policy at the time of initial enrollment because:
  - You were covered under a group dental plan at the time of eligibility and your coverage terminated as a result of:
    - Termination of employment or eligibility;
    - Reduction in number of hours of employment;
    - Divorce, legal separation or death of a spouse; or
    - Termination of your employer's contribution for the coverage; or

  - You had COBRA continuation coverage under another plan at the time of eligibility and such coverage has since been exhausted; and
    - You stated, at the time of initial enrollment, that coverage under the group dental plan, or COBRA continuation was your reason for declining enrollment; and
    - You were covered under an alternate plan provided by the employer and you are replacing coverage with the policy;
- You apply for coverage within 31 days after termination of coverage under the group dental plan or COBRA.

Dependent special enrollment period

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

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

Effective date

Employee effective date

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

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

Employee delayed effective date

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

Dependent effective date

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

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

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

Benefit changes

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

Incontestability: After *you* have been insured for two years, *we* cannot contest the validity of coverage except for nonpayment of premium. Absent of fraud, all statements made by *you* will be deemed representations and not warranties. Statements *you* make cannot be contested unless they are in writing with *your* signature. A copy of the form must then be given to *you*.

Retired employee coverage

Retired employee eligibility date

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

Retired employee enrollment

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

Retired employee effective date

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

Retired employee benefit changes

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

Terminating coverage

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

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

Special provisions for active status

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

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

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

Continuation of coverage during military leave

An *employee* called to active duty or state active duty is eligible for continuation if they are:

1. A member of the Florida National Guard; or
2. A Florida resident and a member of any branch of the United States military reserves.

Any *employee's dependents* who have coverage under this plan immediately prior to the date of the *employee's* covered absence are also eligible to elect continuation.

You or an appropriate military authority, must notify *your employer* of *your* intent to continue coverage under this section. Notification must occur prior to reporting to active duty or state active duty, unless such notice is precluded by military necessity or if such notice is impossible or unreasonable.

Coverage available under any insurance sponsored by the Department of Defense will be coordinated with *benefits* available under this plan, as allowed by the Department of Defense.

Premium payment

If continuation coverage is elected under this section, coverage will have the same premium in effect as for other *members* under this same plan, unless the *employee* requests coverage changes that might alter the premium in effect prior to such activation.

Reinstatement

We will reinstate coverage for the *members* who elected not to continue coverage under this plan while on active duty or state active duty:

1. After receipt of that person's request for reinstatement upon return from active duty or state active duty; and
2. If reinstatement is requested within 30 days after returning to work with the same *employer*.

Upon reinstatement of coverage, no additional waiting period will be applied for any condition that existed at the time the *member* was called to active duty or state active duty.

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 a change of address.

Replacement provisions

Applicability: This provision applies only if:

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

Delayed effective date: *We* will waive the Delayed Effective Date provision if it applies to *you* when *you* would otherwise be eligible for dental coverage on *your employer's* effective date under this policy. Dental coverage is then provided to *you* until the date *your* dental coverage would otherwise terminate according to the **Terminating coverage** provision stated in the certificate.

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

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

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

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

Modification of policy

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

Discount/access disclosure

From time to time, *we* may offer or provide *you* with access to discount programs. In addition, *we* may arrange for third-party service providers such as optometrists, *dentists* and laboratories to provide *you* with discounts on goods and *services*.

Who has responsibility for these discounts?

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

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

Shared savings program

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

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

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

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

Definitions

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

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

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

Bodily injury: An injury due directly to an accident.

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

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

Covered expense: The *reimbursement limit* for a *covered service*.

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

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

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

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

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

Dependent: A covered *employee's*:

1. Lawful spouse; and

2. Natural blood related child, stepchild, foster child or legally adopted child whose age is less than the limiting age. Each child must qualify as a dependent as defined by the U.S. Internal Revenue Code. This child must receive at least 50 percent support and maintenance from the covered *employee;* or

3. Covered *dependent's* newborn child. Coverage for such child terminates 18 months after the date of birth or the date as determined by the **Terminating coverage** provision, whichever is earlier.

The limiting age for each *dependent* child is:

1. The child's 26 birthday; or
2. The end of the calendar year the child reaches 26, if such child is dependent upon the employee for support and:

    - Living in the household of the employee; or

    - In regular full-time or part-time attendance at an accredited secondary school, college or university. A *dependent* continues to be eligible for coverage for up to four months after the close of a school term only if enrolled as a full-time or part-time student for the next school term.

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

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

1. Mentally or physically disabled;
2. Incapable of self-sustaining employment;
3. Dependent on the covered *employee* for at least 50 percent of support and maintenance.

If a claim is denied, *you* must furnish satisfactory proof to *us* that the above conditions continuously existed on and after the date the limiting age was reached. *We* may not request proof more often than annually after two years from the date the first proof was furnished. If *we* do not receive satisfactory proof, the child's coverage ends on the date proof is due.

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

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

Definitions

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

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

Expense incurred date: The date on which:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. The fee most often charged in the geographical area where the *service* was performed;
2. The fee most often charged by the provider;
3. The fee that is recognized as reasonable by a prudent person;
4. The fee determined by comparing charges for similar *services* to a national database adjusted to the geographical area where the *services* or procedures were performed;
5. At *our* choice the fee determined by using a national Relative Value Scale. Relative Value Scale means a methodology that values procedures and *services* relative to each other that includes, but is not limited to, a scale in terms of difficulty, work, risk, as well as the material and outside costs of providing the *service*, as adjusted to the geographic area where the *services* or procedures were performed;
6. In the case of *services* rendered by providers with whom *we* have agreements, the fee that *we* have negotiated with that provider;
7. The fee based on rates negotiated with one or more participating providers in the geographic area for the same or similar *services;*
8. The fee based on a percentage of the fee Medicare allows for the same or similar *services* provided in the same geographic area.

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

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

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

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

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

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

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

Definitions

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

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

You and your: Any covered *employee* and/or *dependent(s)*.

PPO provisions

What is a preferred provider organization (PPO)?

A Preferred Provider Organization (PPO) is a network or group of *dentists* who are contracted to furnish, at negotiated fees, dental *services* for *you* under this plan.

Reasons to use a PPO provider

1. *We* negotiate fees for dental *services*. The negotiated fees lower costs for *you* when *you* use *dentists* in the PPO Network.
2. *You* may receive a better *benefit* and *your* out-of-pocket expenses are lowered.
3. *You* have a wide variety of *dentists* in the PPO to help *you* with *your* dental care needs.

You have the freedom to choose the *dentist* of *your* choice. However, *you* will receive *maximum benefits* by seeing a PPO Network *dentist*. If *you* visit a non-participating PPO *dentist*, *you* may be billed for any *expense incurred* that exceeds *our reimbursement limits*.

How to select a provider

A list of participating *dentists* in *your* PPO is available on *our* Web site and is updated daily. If *you* do not have Internet access, *dentist* lists are available by calling *us*. *Our* telephone number and Web site address are listed on the back of *your* dental identification card.

If *you* are traveling or need *emergency* care and are unable to access care from a PPO *dentist*, *benefits* will be paid at the out-of-network level.

Bruce Broussard
President

Supplemental dental expense benefit

Orthodontic services

This Supplemental Dental Expense Benefit is part of the certificate. The benefits outlined will be effective the latter of:

1. The effective date of *your* certificate; or
2. Completion of any applicable *waiting period*.

Please refer to the Waiting Periods provision to verify if an orthodontic *waiting period* applies to *you*.

We pay *benefits* based on *our reimbursement limits* and *your* orthodontic m*aximum benefit*. Except as modified below, all plan terms, conditions and limitations apply.

Covered services for orthodontia treatment

Covered services for orthodontic treatment include those that are:

1. For the treatment of--and appliances for--tooth guidance, interception and correction; and
2. Related to covered orthodontic treatment including:

    - X-rays;
    - Exams;
    - Space regainers; and/or
    - Study models.

How benefits will be paid if treatment begins <u>after</u> you are eligible for orthodontic benefits with us.

In order to have the full orthodontic treatment be considered for *benefits* under this plan, bands and appliances must be inserted after:

1. *Your* effective date under this plan; and
2. Exhaustion of any orthodontic *waiting period*.

If *services* are eligible under this plan at the time orthodontic appliances or bands are initially inserted, *we* will pay the lesser of:

1. 25 percent of the total *treatment plan* charge;
2. 25 percent of the total *maximum benefit* payable; or
3. The *dentist's* initial fee.

We will pay the remaining installments at the end of each quarter while *you* are covered for orthodontic benefits under this plan. If for any reason the *treatment plan* is terminated before treatment is completed, *we* will not pay further *benefits*.

Supplemental dental expense benefit

How benefits will be paid if treatment was started before you were eligible for orthodontic benefits with us.

Services for orthodontic treatment received prior to *your* effective date, or prior to exhaustion of the orthodontic *waiting period*, are not *covered services*.

Benefits are available only for the portion of the treatment after:

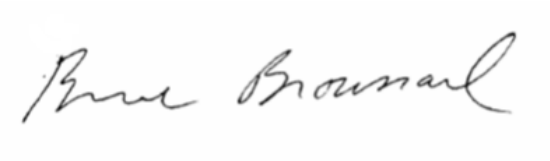
1. *Your* effective date under this plan; and
2. Exhaustion of any orthodontic *waiting period*.

Benefits will be prorated to account for the portion of treatment completed prior to orthodontic eligibility.

Additionally, if *you* had orthodontic coverage under *your* prior dental plan, any benefits paid by *your* prior plan, will be applied to the Orthodontic Lifetime Maximum Benefit of this plan.

To obtain more information about *your* coverage, please feel free to contact our Customer Service Department at:

Humana Insurance Department
1100 Employers Blvd
Green Bay, WI 54344
1-800-233-4013



Bruce Broussard
President

Composite rider

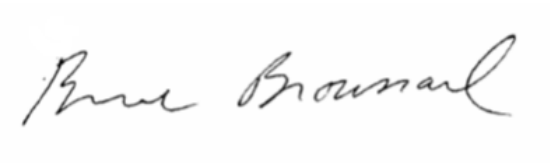
Humana Insurance Company

Change in plan rider:
Coverage for Resin-based Composite Restorations

Your certificate is amended to include this plan rider. The effective date of the rider is the latter of the effective date of *your* certificate or the date this rider is added to *your* certificate. *Benefits* are subject to all policy terms, conditions and limitations.

The following Resin-based Composite restoration benefit is added to *your* certificate as follows:

Resin-based Composite restorations (fillings) on molar and bicuspid teeth are covered and will be a payable filling under basic services. Multiple restorations on one surface are considered one restoration. Limited to once per tooth in a two year period.



Bruce Broussard
President

Domestic partners

Change in plan rider:

Coverage for domestic partners

Your certificate is amended to include this plan rider. The effective date of the rider is the latter of the effective date of *your* certificate or the date this rider is added to *your* certificate. *Benefits* are subject to all policy terms, conditions and limitations.

The following definitions are added to *your* certificate:

Domestic partners: The *employee* and another individual of the same or opposite sex who:

1. Cohabit;

2. Have an exclusive mutual commitment to be jointly responsible for each other's common welfare and share financial obligations;

3. Are not related by blood to a degree of closeness that would prohibit legal marriage in the state where they legally live;

4. Are not married to, or legally separated from, anyone else;

5. Are not in another domestic partnership; solely to obtain insurance coverage;

6. Are not in this domestic partnership solely to obtain insurance coverage;

7. Are both at least age 18 and competent to consent to contract; and

8. Have filed registration of a Declaration of Domestic Partnership, or its equivalent, in the city, county or state where they live, if it offers the ability for registration. If registration of a Declaration of Domestic Partnership or its equivalent is not available in *your* city, county or state, *we* reserve the right to require an affidavit from the domestic partners attesting that the above requirements are met.

We may periodically request that *you* furnish satisfactory proof to *us* that the requirements of domestic partners continue to be met. Domestic partners are subject to all terms and provisions of the certificate including, but not limited to, all eligibility requirements and termination provisions. *Your* domestic partner may be identified as a spouse on identification cards or the certificate, however, *your* domestic partner and *your* domestic partner's dependent child(ren) are not eligible for COBRA or state continuation.

Domestic partner's dependent child: Any child:

1. Who lives with the domestic partner in a parent/child relationship;
2. Who is the domestic partner's unmarried natural blood related child, stepchild or legally adopted child;
3. Who is younger than the limiting age of a *dependent* child;
4. Who is primarily dependent upon the domestic partner for support;
5. Who is not covered by any other dental plan; and
6. Who is not entitled to coverage through another dental plan because of a Qualified Medical Child Support Order.

Domestic partners

A domestic partner's dependent child(ren) are subject to all terms and provisions of the certificate including, but not limited to, all eligibility requirements and termination provisions.

When you are eligible for coverage

In addition to the **Dependent coverage, Eligibility date** section in *your* certificate, the following applies to domestic partners and any domestic partner's dependent child(ren):

1. For the *employee's* domestic partner, the eligibility date will be the earlier of:

    - The date of registration of the Declaration of Domestic Partnership; or
    - The date the *employee* submits to the *employer* or *us* an affidavit attesting that a domestic partnership exists and all requirements of the definition of domestic partner are met.

2. For a domestic partner's dependent child(ren)**:**

    - The eligibility date of the *employee's* domestic partner for any domestic partner's dependent child(ren) acquired on that date; or
    - The date the child meets the definition of a domestic partner's dependent child.

The effective date of a domestic partner's dependent child will not be before the effective date of the *employee's* domestic partner.

Terminating coverage

In addition to the **Terminating coverage** provision in *your* certificate, the following applies to domestic partners and any domestic partner's dependent child(ren).

The *employee's* domestic partner and any dependent child(ren) allowed eligibility will terminate on:

1. The date one of the domestic partners dies.
2. The date one of the domestic partners marries.
3. The earliest of the following:

    - The date one domestic partner gives or sends to the other partner a written notice that he or she is terminating the domestic partnership;

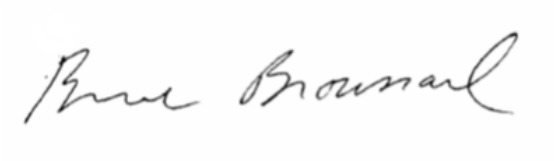
    - The date the *employee* submits to the *employer* notification to terminate the domestic partnership;

- The date indicated on the Notice of Termination of Domestic Partnership or its equivalent, as filed in the city, county or state where the domestic partners live if it offers the ability to terminate a domestic partnership;

- The date any of the requirements of the domestic partner definition is not met; or

- For any domestic partner's dependent child(ren), the date any of the requirements of domestic partner's dependent child(ren) definition is not met.

The coverage of any domestic partner's dependent child(ren) will terminate upon termination of the *employee's* domestic partner.



Bruce Broussard
President

Change in Plan Rider:
Coverage for Open Enrollment

Your certificate is amended to include this plan rider. The effective date of the rider is the latter of the effective date of *your* certificate or the date this rider is added to *your* certificate. *Benefits* are subject to all policy terms, conditions and limitations, including waiting periods.

Open enrollment period

The open enrollment period is the annual period during which eligible *employees* may apply for coverage for themselves and their eligible *dependents* as outlined in the **Employer Group Application** (see your employer for details).

To enroll for coverage

The *employee* must complete the enrollment/change form provided by *us*, carefully listing each person to be covered. Enrollment during the open enrollment period will be allowed if *we* receive the completed forms within the open enrollment period. Any reference to *late applicants* within the Eligibility section of *your* certificate and/or Policy is removed. *Late applicants* are not eligible for coverage, and must wait until the following open enrollment periods to apply.

When you are eligible for coverage section in your certificate is amended as follows:

The eligibility date of coverage is amended as follows:

Employee coverage:

The *employee* is eligible for coverage on the date:

1. The eligibility requirements stated in the Employer Group Application, or as otherwise agreed to by *us* and the *policyholder*, are satisfied;
2. The *employee* is in an *active status*, or;
3. The employer's annual anniversary date.

Dependent coverage:

Each *dependent* is eligible for coverage on the date:

1. The *employee* is eligible for coverage, if he or she has *dependents* who may be covered on that date;

2. Of the *employee's* marriage for any *dependents* (spouse or child) acquired on that date;

3. Of birth of the *employee's* natural-born child;

4. Of placement of the child for the purpose of adoption by the *employee*; Coverage shall begin from the moment of birth, if a written agreement to adopt such child has been entered into by the *employee* prior to the birth of such child, whether or not the agreement is enforceable;

5. The date a child under age 18 is placed in the *employee's* home as a foster child;

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

7. The date of birth of a child born to an *employee's* covered *dependent*; or

8. Of the *employer's* annual anniversary date.

Please check your Schedule of Benefits for waiting periods that may apply to *you*.

To obtain more information about *your* coverage, please feel free to contact our Customer Service Department at:

Humana Insurance Department
1100 Employers Blvd
Green Bay, WI 54344
1-800-233-4013

Bruce Broussard
President

Change in plan rider: Coverage for implants

Your certificate is amended to include this plan rider. The effective date of the rider is the latter of the effective date of *your* certificate or the date this rider is added to *your* certificate. *Benefits* are subject to all policy terms, conditions and limitations.

The following Implant benefit is added to *your* certificate as follows:

Implants and the prosthesis over the implant will be allowed as a benefit payable under Major s*ervices* on *your* Summary of Your Benefits subject to the Individual Maximum Benefit. *Services* payable are the lesser of $1500 or the Individual Maximum Benefit. Implants and implant supported prostheses covered under this plan are limited to the replacement of permanent teeth extracted while insured 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.

To obtain more information about *your* coverage, please feel free to contact our Customer Service Department at:

Humana Insurance Department
1100 Employers Blvd
Green Bay, WI 54344
1-800-233-4013

Bruce Broussard
President

Humana

Humana.com
Toll Free 800-233-4013
1100 Employers Blvd
Green Bay WI 54344

Insured by Humana Insurance Company
In Kentucky, insured by The Dental Concern, Inc.

Florida Notice:

Effective July 1, 1994, certain victims of violent crime do not have to meet the deductible or copayment provision of any insurance policy for the treatment of their crime-related injuries pursuant to the Florida Crimes Compensation Act, excluding 960.28. Eligibility under the Florida Crimes Compensation Act is determined when victims of violent crime apply for services with the Office of the Attorney General, Division of Victim Services. When victims are determined eligible, they are given written notification which references their insurance exemption. If you are eligible under the Florida Crimes Compensation Act, please forward a copy of such written notification to us to report your status.

DISCOUNT/ACCESS DISCLOSURE

From time to time, we may offer or provide access to discount programs to persons who become insureds. In addition, we may arrange for third party service providers such as optometrists, dentists, and laboratories to provide discounts on goods and services to persons who become insureds. Some of these third party service providers may make payments to us when insureds take advantage of these discount programs. These payments offset the cost to us of making these programs available and may help reduce the costs of your plan administration. Although we have arranged for third parties to offer discounts on these goods and services, these discount programs are not insured benefits under this Policy. The third party service providers are solely responsible to insureds for the provision of any such goods and/or services. We are not responsible for any such goods and/or services, nor are we liable if vendors refuse to honor such discounts. Further, we are not liable to insureds for the negligent provision of such goods and/or services by third party service providers. Discount programs may not be available to persons who "opt out" of marketing communications and where otherwise restricted by law.

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 or appeal. The authorization must be in writing and authorize disclosure of health information. If a document is not sufficient to constitute designation of an authorized representative, as determined by Humana, the plan will not consider a designation to have been made. An assignment of benefits does not constitute designation of an authorized representative.

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

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

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

Claims decisions

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

Pre-service claims

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

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

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

Urgent-care claims (expedited review)

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

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

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

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

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

Concurrent-care decisions

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

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

Post-service claims

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

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

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

Initial denial notices

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

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

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

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

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

Appeals of Adverse Determinations

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

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

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

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

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

Time periods for decisions on appeal

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

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

Appeals denial notices

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

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

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

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

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

Exhaustion of remedies

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

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

Legal actions and limitations

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

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

Medical child support orders

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

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

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

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

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

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

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

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

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

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

General notice of COBRA continuation coverage rights

Introduction

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

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

What is COBRA continuation coverage?

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

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

- Your hours of employment are reduced; or

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

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

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

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

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

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

When is COBRA coverage available?

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

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

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

How is COBRA Coverage Provided?

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

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

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

Disability extension of 18-month period of

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

Discrimination is Against the Law

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

Humana Inc. and its subsidiaries provide:

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

- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

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

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

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

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

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**

Multi-Language Interpreter Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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