

Employer: NC DPT OF TRANSPORTATION

Group Number: 570034

**Dental Plan
Certificate of Insurance
HumanaDental Insurance Company
1100 Employers Boulevard
Green Bay, WI 54344**

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 North Carolina laws. This certificate replaces any certificate previously issued under the provisions of the group policy.

Important cancellation information: Please read the “terminating coverage” provision. The page number is in the Table of Contents.

READ YOUR CERTIFICATION CAREFULLY

NOTICE

Insured may be subject to a waiting period for certain covered services



Gerald L. Ganoni
President

HUMANA.
Specialty Benefits

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READ YOUR CERTIFICATE CAREFULLY

**NOTICE OF THE INSURER'S RIGHT TO REFUSE
RENEWAL OF THIS POLICY**

We have the right to refuse renewal of this policy. We will notify your employer of the termination of coverage under the policy not later than 45 days prior to the termination date. Termination will not prejudice a claim existing on the termination date.

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Benefits

Policyholder (Employer): NC DPT OF TRANSPORTATION
Group Number: 570034
Coverage Effective Date: 01/01/2013

Summary of your benefits

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

Dental benefits

Individual maximum benefit:

\$500 per year per member for orthodontic services.

Individual maximum benefit:

\$2,000 per year per member for Preventive, Basic, Major and Orthodontic services.

Individual deductible:

\$75 per year per member for Basic and Major services.

Maximum family deductible:

Covered expenses applied to the plan deductible of each covered member are combined to a year maximum of \$225.

Orthodontic lifetime maximum benefit:

\$5,000 per member

Preventive Services:

Benefits are paid at 100%.

1. Routine teeth cleaning (prophylaxis)
2. Topical fluoride treatment
3. Sealants
4. X-rays
5. Oral examinations
6. Emergency exam and palliative care for pain relief
7. Space maintainers

Basic Services:

Benefits are paid at 80% after the deductible.

1. Fillings (amalgam and composite restorations)
2. Non-surgical extractions
3. Non-surgical residual root removal
4. Non-cast prefabricated crowns
5. Harmful habits and thumb-sucking appliances
6. Oral surgery

Benefits

Major Services:

Benefits are paid at 50% after the *deductible*.

1. Crowns
2. Inlays and onlays
3. Removable or fixed bridgework
4. Partial or complete dentures
5. Denture relines or rebases
6. Partial and denture repairs and adjustments
7. Periodontics (gum disease)
8. Endodontics (root canals) only the *late applicant* waiting period will apply to this *service*

Orthodontic Services:

Benefits are paid at 50%.

Please refer to the Orthodontic *services* Rider of *your* certificate to determine who is eligible for coverage under this *benefit*.

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Benefits

Waiting periods

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

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

If *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 the *member* had prior dental coverage immediately before their coverage with *us*.

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

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

Preventive Services:

No waiting periods apply to *Preventive services*.

Basic Services:

No waiting periods apply to *Basic services*, unless *members* are *late applicants*.

If a *member* is a *late applicant*, he or she must be insured under this policy for a period of 12 continuous months before *Basic services* will be covered.

Major Services:

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

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

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

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

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

Benefits

Orthodontic Services:

If *members* had 12 months of continuous orthodontic benefits under the prior dental plan, and coverage did not lapse between the prior plan and their effective date with this plan, then the effective date of orthodontic coverage is the effective date of this plan.

If *members* did not have 12 months of continuous orthodontic benefits under the prior dental plan, or there was a lapse in coverage between the prior plan and their effective date with this plan, those *members* must be insured under this plan for a period up to 12 consecutive months before *services* will be covered.

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Benefits

Your plan benefits

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

Preventive services

1. Oral evaluations (periodic, limited, comprehensive and problem focused) - two per year.
2. Periodontal evaluations - two per year.
3. Cleaning (prophylaxis), including all scaling and polishing procedures – two per year.
4. For members age 40 and older, oral cancer screening – one per year.
5. Intra-oral complete series X-rays (at least 14 films, including bitewings), or panoramic X-ray – once every five years. If the total cost of periapical and bitewing X-rays exceeds the cost of a complete series of X-rays, the plan will consider these as a complete series.
6. Bitewing X-rays – one set per year.
7. Other X-rays – only to diagnose specific treatment.
8. Topical fluoride treatment – provided to *dependents* age 14 and younger. *Service* is payable once per year.
9. Sealants – application provided to *dependents* age 14 and younger to the occlusal surface of permanent molars that are free of decay and restorations. *Service* is payable once per tooth per lifetime.
10. 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.
11. *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.

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. On anterior teeth – Composite restorations on molar and bicuspid teeth are considered an alternate *service* and will be payable as a comparable amalgam filling. *You* will be responsible for the remaining *expense incurred*. Multiple restorations on one surface are considered one restoration.

Benefits

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. 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.

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*.

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Benefits

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 twice per year.
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, full or partial dentures, and crowns.
2. Denture adjustments – procedure available only for adjustments done by a *dentist* other than the one providing the denture, or adjustments performed more than six months after initial installation.
3. Initial placement of laboratory-fabricated restorations when the tooth, as a result of extensive decay or traumatic injury, cannot be restored with a direct placement filling material. *Covered services* include inlays, onlays, crowns, veneers, core build-ups and posts. These *services* are covered only on permanent teeth. We will not cover the *expense incurred* for pin retention when done in conjunction with core build-up.
4. Initial placement of bridges, and full and partial dentures only if the functioning tooth (excluding third molars or teeth not fully in occlusion with an opposing tooth or prosthesis) was extracted while you are covered under this plan. *Covered expense* includes fixed bridges, removable partial dentures and full dentures. *Services* include all adjustments and relines within six months after installation and are payable only for treatment on permanent teeth. We will not cover replacement of congenitally missing teeth.
5. Replacement of bridges, partials, dentures, inlays, onlays, crowns or other laboratory-fabricated restorations. The existing major restoration or prosthesis can be replaced only if:
 - It has been at least five years since the prior insertion and is not, and can not be made, serviceable;

Benefits

- 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*.

Congenital defects or anomalies

Your covered *dependent* child, foster child and adopted child has *benefits* available for the treatment of congenital defects or anomalies, including cleft lip or palate if:

1. He/she has been covered under the policy since birth; or
2. He/she has been covered under the policy since placed in the adoptive or foster home.

Covered services will be payable the same as similar *services* under the policy.

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Benefits

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. Services or supplies for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Worker's Compensation Act only to the extent such services or supplies are the liability of the employee, employer or worker's compensation insurance carrier according to a final adjudication under the North Carolina Worker's Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Worker's Compensation Act.
2. *Services*:
 - That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with *sickness* or *bodily injury*.
3. Any loss caused or contributed by:
 - War or any act of war, whether declared or not;
 - Any act of international armed conflict; or
 - Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. *Your* failure to keep an appointment with the *dentist*.
6. Any *service* we consider *cosmetic dentistry* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. *We* consider the following *cosmetic dentistry* procedures:
 - Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid;
 - Any *service* 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;

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- 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 anesthesiologist.
12. Prescription drugs or pre-medications, whether dispensed or prescribed.
13. Any *service* not specifically listed in **Your plan benefits**.
14. Any *service* that we determine:
- Is not a *dental necessity*;
 - Does not offer a favorable prognosis;
 - Does not have uniform professional endorsement; or
 - Is deemed to be experimental or investigational in nature.
15. Orthodontic *services* unless specified in *your Summary of your benefits*.
16. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates (unless the *service* is eligible under **Extension of benefits**).
17. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
18. Charges exceeding the *reimbursement limit* for the *service*.
19. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.
20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, temporary dental *services*, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.
21. Repair and replacement of orthodontic appliances.

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Benefits

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.

Benefits

How your plan works

General benefit payments

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

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

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

Deductibles

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

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

Coinsurance

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

Waiting periods

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

Benefit maximums

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

Alternate services

If two or more *services* are acceptable to correct a dental condition, we will base the *benefits* payable on the *covered expenses* for the least expensive *covered service* that produces a professionally satisfactory result, as determined by us. We will pay up to the *reimbursement limit* for the least costly *covered service* and subject to any *deductible*, *coinsurance* and *maximum benefit*. *You* will be responsible for paying the excess amount.

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Benefits

If *you or your dentist* decide on a more costly treatment than *we* determine to be satisfactory for treatment of the condition, payment will be limited to the *reimbursement limit* and will be subject to any *deductible* and *coinsurance* for the least costly treatment. *You* will be responsible for the remaining *expense incurred*.

Pretreatment plan

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

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

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

An estimate for *services* is not necessary for *emergency care*.

Process and timing

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