



EMPLOYEE BENEFITS RFP
RFP 27-0003 Dental and Vision

ADDENDUM 3: Follow-up Question and Answers,

EyeMed Vison Certificate and Ameritas Dental Certificate

Company Name: Hendry County School District

Location: 300 W Cowboy Way, Labelle, FL 33935

Effective Date: January 1st, 2026

Humana:

Questions:

1) Please provide dental and **vision** experience for the time period of 1/2026 through 8/2026 that includes enrollment, claims, and premium? **All experience reports available have been provided. We are still hoping to obtain additional vision experience and will post if it is received.**

AETNA

Questions:

1. In the Scope of Coverage on Page 3 it notes that MetLife is the 2026 Dental and Vision carrier. Who was the prior carrier and how long was that contract in place? **EyeMed, 1/1/16 - 12/31/25**
2. Please confirm that MetLife has a rate cap noted of 7% as of 1/1/2028? **I apologize for any confusion on the rate guarantee. No rate cap, it should be rate guarantee through 12/31/28.**
3. Will the requested information above be sent after the September 15 deadline or will this be provided after receipt?

Questions Received after 2pm deadline

The Standard

1. Is 2026 dental experience available? The experience should be listed by month and show premiums received, claims paid, and lives covered. Available 2026 experience was provided in Addendum 1
2. What are the current dental funding rates?

	Monthly Funding	Employer Contribution	Employee Contribution
Employee	\$41.08	\$36.00	\$5.08
Family	\$73.02	\$36.00	\$37.02

3. Is broker compensation included in the ASO fee provided? Yes, broker compensation is \$1.74 PEPM
4. Are you able to provide more recent vision experience? The experience provided ends on 12/2025. All experience reports available have been provided. We are still hoping to obtain additional vision experience and will post if it is received.
5. Are the prior Ameritas plan dental booklet and Eyemed plan booklet available? Yes, will be shared with this addendum.

Delta Dental Insurance Company and affiliates

1. Can we get a benefit book for the prior Ameritas plan? Yes, will be shared with this addendum.
2. The experience received is from Ameritas and ends 12/31/25 MetLife Dental experience was shared with Addendum 1
3. I can use the old Ameritas experience, but I need a copy of the benefit book or summary page to go along with it. It is being provided with this addendum
4. Is there any experience available from MetLife? They switched to Met eff 1/1/26, so they may have 7 or 8 months of current carrier experience available. All experience reports available have been provided. We are still hoping to obtain additional vision experience and will post if it is received.
5. Is this group currently using Met's PDP network or PDP Plus? PDP Plus



FIDELITY SECURITY LIFE INSURANCE COMPANY

A STOCK COMPANY
(Herein Called "the Company")

If you have a question or complaint about this insurance, please write to us at the following address or call us toll-free:

3130 Broadway, Kansas City, Missouri 64111-2406
Phone 800-648-8624

POLICY NUMBER: VC-19

POLICYHOLDER: Hendry County School District

STATE OF ISSUE: Florida

POLICY EFFECTIVE DATE: January 1, 2016

POLICY ANNIVERSARY DATE: January 1 of the following year and each January 1 thereafter

Fidelity Security Life Insurance Company agrees to pay the benefits provided by the Policy in accordance with its terms and conditions.

The Policy is issued in consideration of the Policyholder's application (a copy of which is attached) and receipt by the Company of the premiums.

All periods of time under the Policy begin and end at 12:01 A.M. Local Time at the Policyholder's business address.

The Policy may be modified by mutual agreement between the Policyholder and the Company.

The Policy is issued by Fidelity Security Life Insurance Company at Kansas City, Missouri on the Policy Effective Date.

FIDELITY SECURITY LIFE INSURANCE COMPANY


President


Secretary

GROUP VISION INSURANCE POLICY
THIS IS A LIMITED BENEFIT POLICY
Please read the Policy carefully.

PREMIUMS

Premiums are payable in advance by the Policyholder. The first premium is due on the effective date of the Policy. 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 Insureds and their Dependents covered under the Policy. The premiums due will be determined by applying the premium rates then in effect for each plan provided by the Policy to the number of Insured Persons. All premiums are payable to the Company at the Company's home office or to any of the Company's authorized agents.

The premium due may be adjusted due to a change in insurance as requested by the Policyholder or as required by the Company as follows:

1. if an amount of insurance is added or increased during a calendar month, premiums will be increased as of the date the change becomes effective, unless otherwise mutually agreed;
2. if an amount of insurance is deleted or decreased during a calendar month, premium will cease or be decreased at the end of the calendar month in which the deletion or decrease occurred, unless otherwise mutually agreed;
3. if the Policyholder's contribution percentage is changed, premium will be adjusted at the end of the calendar month in which the change occurred, unless otherwise mutually agreed; or
4. if the number of eligible employees increases or decreases by more than 10% premium will be adjusted at the end of the calendar month in which the increase or decrease occurred, unless otherwise mutually agreed.

If premiums are due the Company, or premium refunds are due the Policyholder as a result of clerical error or delay in the reporting of dates and/or data to the Company, all premiums or refunds will be calculated at the current rate of premium payment and are limited to a maximum period of three months.

Premium Rate Change. The Company has the right to change the premium rate on any premium due date on or after the fourth Policy Anniversary Date. The Company will provide written notice at least 45 days before the date of change.

Grace Period. A grace period of 31 days will be allowed to the Policyholder for the payment of each 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 period, the Policy will terminate. The Policyholder will be required to pay premium for the grace period.

Return of Premium. The Company reserves the right to rescind the coverage for one or all Insureds due to misrepresentation or fraud on the Policyholder's application, if such misrepresentation materially affected the acceptance of the risk.

If, on the date coverage is rescinded, no claims have been paid under the Policy, the Company will return all premiums paid for such coverage to the Policyholder.

If, on the date coverage is rescinded, claims have been paid under the Policy, the Company reserves the right to deduct an amount equal to the amount of such claims paid from the premiums to be returned to the Policyholder.

TERMINATION OF POLICY

The Company may terminate or cancel the Policy on the earliest of the following:

1. on any date on or after the fourth Policy Anniversary Date. Written notice must be provided to the other party at least 45 days prior to termination;
2. the date the number or percentage of persons covered under the Policy does not meet the minimum participation requirements of 10;
3. the date the required premium has not been paid, except as provided in the Grace Period provision; or
4. the date 100% of the eligible employees are not covered when a contribution is not required by the employee.

The Policyholder may terminate the Policy on any date.

The Policyholder is responsible for notifying the Insured of the termination of the Policy.

CERTIFICATES

The Company will furnish a Certificate to the Policyholder which will set forth the essential features of the insurance coverage.

ADDITIONAL INSUREDS

Insured Persons may be added at any time if they meet the eligibility requirements stated in the Policyholder's application, and pay any required premium.

INCORPORATION PROVISION

The provisions of the attached Certificate and all Rider(s) issued to amend the Policy after the Policy Effective Date are made a part of the Policy.



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POLICY ANNIVERSARY DATE: January 1 of the following year and each January 1 thereafter

Fidelity Security Life Insurance Company represents that the Insured Person is insured for the benefits described on the following pages, subject to and in accordance with the terms and conditions of the Policy.

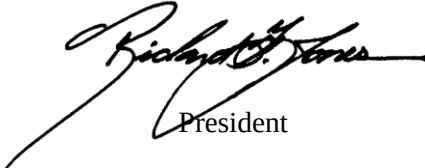
The Policy may be amended, changed, cancelled or discontinued without the consent of any Insured Person.

The Certificate explains the plan of insurance. An individual identification card will be issued to the Insured containing the group number and the Insured's effective date. The Certificate replaces all certificates previously issued to the Insured under the Policy.

All periods of time under the Policy will begin and end at 12:01 A.M. Local Time at the Policyholder's business address.

The Policy is issued by Fidelity Security Life Insurance Company at Kansas City, Missouri on the Policy Effective Date.

FIDELITY SECURITY LIFE INSURANCE COMPANY


President


Secretary

GROUP VISION INSURANCE CERTIFICATE
THIS IS A LIMITED BENEFIT CERTIFICATE
Please read the Certificate carefully.

THIS PLAN IS NOT MEDICARE SUPPLEMENT. If you are eligible for Medicare, please review "Choosing a Medigap Policy: A Guide to Health Insurance for People With Medicare," available from the Company.

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DEFINITIONS

Benefit Frequency means the period of time in which a benefit is payable as shown in the Schedule of Benefits.

The Benefit Frequency begins on the later of the Insured Person's effective date or last date services were provided to the Insured Person. Each new Benefit Frequency begins at the expiration of the previous Benefit Frequency.

Co-payment means the designated amount, if any, shown in the Schedule of Benefits each Insured Person must pay to a Provider before benefits are payable for a covered Vision Examination or Vision Materials per Benefit Frequency.

Comprehensive Eye Examination means a comprehensive ophthalmological service as defined in the Current Procedural Technology (CPT) and the Documentation Guidelines listed under "Eyes-examination items". Comprehensive ophthalmological service describes a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields and basic sensorimotor examination. It often includes, as indicated by examination, biomicroscopy, examination with cycloplegia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment programs.

Dependent means any of the following persons whose coverage under the Policy is in force and has not ended:

1. the Insured's lawful spouse;
2. each child from birth to age 25* who is living with the Insured and is primarily dependent upon the Insured or the Insured's spouse for support and maintenance;
3. each unmarried child to age 30* who does not have a dependent of his or her own and is a resident of Florida or a part-time or full-time student; or
4. each unmarried child: who is primarily dependent upon the Insured or the Insured's spouse for support and maintenance because the child is incapable of self-sustaining employment by reason of mental incapacity or physical handicap; who was so incapacitated and is an Insured Person under the Policy on his or her 25th* birthday; and who has been continuously so incapacitated since his or her 25th* birthday.

Child includes stepchild, foster child, legally adopted child, child legally placed in the Insured's home for adoption and child under the Insured's legal guardianship. A student is one who is enrolled for credit in the case of an accredited junior college, college or university; or a trade school.

**(Until the end of the calendar year in which the child reaches the limiting age.)*

Insured means an employee of the Policyholder who meets the eligibility requirements as shown in the Policyholder's application, and whose coverage under the Policy is in force and has not ended.

Insured Person means the Insured. Insured Person will also include the Insured's Dependents, if enrolled.

In-Network Provider means a Provider who has signed a Preferred Provider Agreement with the PPO.

Medically Necessary Contact Lenses means:

1. Keratoconus where the Insured Person is not correctable to 20/30 in either or both eyes using standard spectacle lenses, or the Provider attests to the specified level of visual improvement;
2. High Ametropia exceeding -10D or +10D in spherical equivalent in either eye;
3. Anisometropia of 3D in spherical equivalent or more; or
4. vision for an Insured Person can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle.

Out-of-Network Provider means a Provider, located within the PPO Service Area, who has not signed a Preferred Provider Agreement with the PPO.

Policy means the Policy issued to the Policyholder.

Policyholder means the Employer named as the Policyholder in the face page of the Policy.

PPO Service Area means the geographical area where the PPO is located.

Preferred Provider Agreement means an agreement between the PPO and a Provider that contains the rates and reimbursement methods for services and supplies provided by such Provider.

Preferred Provider Organization (“PPO”) means a network of Providers and retail chain stores within the PPO Service Area that has signed a Preferred Provider Agreement.

Provider means a licensed physician or optometrist who is operating within the scope of his or her license or a dispensing optician.

Vision Examination means any eye or visual examination covered under the Policy and shown in the Schedule of Benefits.

Vision Materials means those materials shown in the Schedule of Benefits.

EFFECTIVE DATES

Effective Date of Insured’s Insurance. The Insured’s insurance will be effective as follows:

1. if the Policyholder does not require the Insured to contribute toward the premium for this coverage, the Insured’s insurance will be effective on the date the Insured became eligible;
2. if the Policyholder requires the Insured to contribute toward the premium for this coverage, the Insured’s insurance will be effective on the date the Insured became eligible provided, the Insured has agreed to pay the required premium contributions; and
3. if the Insured fails to meet the requirements of 2 within 30 days after becoming eligible, the Insured’s coverage will not become effective until the Company has verified that the Insured has met these requirements. The Insured will then be advised of the Insured’s effective date.

Effective Date of Dependents’ Insurance. Coverage for Dependents becomes effective on the later of:

1. the date Dependent coverage is first included in the Insured’s coverage; or
2. the premium due date on or after the date the person first qualifies as the Insured’s Dependent. The Insured must agree to pay any premium contribution that may be required prior to coverage becoming effective.

If the Insured and the Insured’s spouse are both Insureds, one Insured may request to be a Dependent spouse of the other. A Dependent child may not be covered by more than one Insured.

Newborn Children. A Dependent child born while the Insured’s coverage is in force will be covered from the moment of birth for 31 days or greater, if elected by the Policyholder. However, coverage for a newborn child(ren) of a Dependent child will continue for 18 months after birth. In order to continue coverage beyond this period, the Insured must provide notice to the Company and agree to pay any premium contribution that may be required within this period.

Adopted Children. If a Dependent child is adopted or is placed with the Insured for adoption while the Insured’s coverage is in force, this child will be covered from the date of adoption or placement for 31 days or greater, if elected by the Policyholder. In case of a newborn child, coverage begins at the moment of birth if a written agreement to adopt such child has been entered into by the Insured prior to the child’s birth unless the child is not ultimately placed in the Insured’s residence. In order to continue coverage beyond this period, the Insured must provide notice to the Company. If proper notice has been given, coverage will continue without additional premium during the 31-day period unless the placement is disrupted prior to legal adoption and the child is removed from placement. If the Insured does not give the Company written notice within 31 days of the birth or placement, the Company will charge the applicable premium for coverage of such child during this 31-day

period. If notice is given within 60 days of the adoption, birth or placement of the child, the Company will not deny coverage for the child due to the Insured's failure to timely notify the Company of the adoption, birth or placement of the child. Coverage will end if the placement is disrupted prior to legal adoption and the child is removed from placement.

BENEFITS

Benefits are payable for each Insured Person as shown in the Schedule of Benefits for expenses incurred while this insurance is in force.

Comprehensive Eye Examination. An Insured Person is eligible for one Comprehensive Eye Examination in each Benefit Frequency.

In-Network Provider Benefits. The Insured Person must pay any Co-payment or any cost above the allowance shown in the Schedule of Benefits at the time the covered service is provided. Benefits will be paid to the In-Network Provider who will file a claim with the Company.

Out-of-Network Provider Benefits. The Insured Person must pay the Out-of-Network Provider the full cost at the time the covered service is provided and file a claim with the Company. The Company will reimburse the Insured Person for the Out-of-Network Provider benefits up to the maximum dollar amount shown in the Schedule of Benefits.

Vision Materials. If a Vision Examination results in an Insured Person needing corrective Vision Materials for the Insured Person's visual health and welfare, those Vision Materials prescribed by the Provider will be supplied, subject to certain limitations and exclusions of the Policy, as follows:

- *Lenses* provided one time in each Benefit Frequency.
- *Frames* provided one time in each Benefit Frequency.
- *Contact Lenses* provided one time in each Benefit Frequency in lieu of lenses.

LIMITATIONS

Fees charged by a Provider for services other than a covered benefit must be paid in full by the Insured Person to the Provider. Such fees or materials are not covered under the Policy.

Benefit allowances provide no remaining balance for future use within the same Benefit Frequency.

EXCLUSIONS

No benefits will be paid for services or materials connected with or charges arising from:

1. orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
2. medical and/or surgical treatment of the eye, eyes or supporting structures;
3. any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear;
4. services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
5. plano (non-prescription) lenses;
6. non-prescription sunglasses;
7. two pair of glasses in lieu of bifocals;
8. services or materials provided by any other group benefit plan providing vision care;

9. services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or
10. lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

TERMINATION OF INSURANCE

The Policyholder or the Company may terminate or cancel the Policy as shown in the Policy.

For All Insureds. The Insureds' insurance will cease on the earliest of the following dates:

1. the date the Policy ends;
2. the end of the last period for which any required premium contribution agreed to in writing has been made;
3. the date the Insured is no longer eligible for insurance; or
4. the date the Insured's employment with the Policyholder ends. The Policyholder may, at the Policyholder's option, continue insurance for individuals whose employment has ended, if the Policyholder:
 - a. does so without individual selection between Insureds; and
 - b. continues to pay any premium contribution for those individuals.

For Dependents. A Dependent's insurance will cease on the earlier of:

1. the date the Insured's coverage ends;
2. the date in which the Dependent ceases to be an eligible Dependent as defined in the Policyholder's application; or
3. the end of the last period for which any required premium contribution has been made.

A Dependent child will not cease to be a Dependent solely because of age if the child is:

1. not capable of self-sustaining employment due to mental incapacity or physical handicap that began before the age limit was reached; and
2. mainly dependent on the Insured for support.

The Company may ask for proof of the eligible Dependent child's incapacity and dependency two months prior to the date the Dependent child would otherwise cease to be covered.

The Company may require the same proof again, but will not ask for it more than once a year after this coverage has been continued for two years. This continued coverage will end:

1. on the date the Policy ends;
2. on the date the incapacity or dependency ends;
3. on the end of the last period for which any required premium contribution for the Dependent child has been made; or
4. 60 days following the date the Company requests proof and such proof is not provided to the Company.

CLAIMS

Notice of Claim. Written notice of claim must be given to the Company within 30 days after the occurrence or commencement of any loss covered by the Policy, or as soon as is reasonably possible. Notice given by or for the Insured Person to the Company at the Company's home office, to the Company's authorized administrator or to any of the Company's authorized agents with sufficient information to identify the Insured Person will be deemed as notice to the Company.

Claim Forms. The Company will furnish claim forms to the Insured Person within 15 days after notice of claim is received. If the Company does not provide the forms within that time, the Insured Person may send written proof of the occurrence, character and extent of loss for which the claim is made within the time stated in the Policy for filing proof of loss.

Proof of Loss. Written proof of loss must be furnished to the Company at the Company's home office within 90 days after the date of the loss. Failure to furnish proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within that time, if the proof is furnished as soon as reasonably possible. In no event, except in the absence of legal capacity, will proof of loss be accepted later than one year from the time proof is required.

Time Payment of Claims. Any benefit payable under the Policy will be paid immediately, but not more than 30 days, upon receipt of due written proof of loss.

Payment of Claims. All claims will be paid to the Insured, unless assigned. Any benefits payable on or after the Insured's death will be paid to the Insured's estate.

Right of Recovery. If payment for claims exceeds the amount for which the Insured Person is eligible under any benefit provision or rider of the Policy, the Company has the right to recover the excess of such payment from the Provider or the Insured.

Legal Actions. No Insured Person can bring an action at law or in equity to recover on the Policy until more than 60 days after the date written proof of loss has been furnished according to the Policy. No such action may be brought after the expiration of the applicable statute of limitations after the time written proof of loss is required to be furnished. If the time limit of the Policy is less than allowed by the laws of the state where the Insured Person resides, the limit is extended to meet the minimum time allowed by such law.

GENERAL PROVISIONS

Clerical Error. Clerical errors or delays in keeping records for the Policy will not deny insurance that would otherwise have been granted, nor extend insurance that otherwise would have ceased, and call for a fair adjustment of premium and benefits to correct the error.

Conformity to Law. Any provision of the Policy that is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

Entire Contract. The Policy, including any endorsements and riders, the Certificate, the Policyholder's application, which is attached to the Policy when issued, and the eligibility file, if any, are the entire contract between the parties. A copy of the Policy may be examined at the Office of the Policyholder during normal business hours. All statements made by the Policyholder or an Insured will, in the absence of fraud, be deemed representations and not warranties, and no such statement shall be used in defense to a claim hereunder unless it is contained in a written instrument signed by the Policyholder, the Insured, the Insured's beneficiary or personal representative, a copy of which has been furnished to the Policyholder, the Insured, the Insured's beneficiary or personal representative.

Amendments and Changes. No agent is authorized to alter or amend the Policy, or to waive any conditions or restrictions herein, or to extend the time for paying any premium. The Policy and the Certificate may be amended at any time by mutual agreement between the Policyholder and the Company without the consent of the Insured, but without prejudice to any loss incurred prior to the effective date of the amendment. No person except an Officer of the Company has authority on behalf of the Company to modify the Policy or to waive or lapse any of the Company's rights or requirements.

Incontestability. After the Policy has been in force for two years, it can only be contested for nonpayment of premiums. No statement made by an Insured Person can be used in a contest after the Insured Person's insurance has been in force for two years during the Insured Person's lifetime. No statement an Insured Person makes can be used in a contest unless it is in writing and signed by the Insured Person.

Insurance Data. The Policyholder must give the Company the names and ages of all individuals initially insured. The names of persons who later become eligible (whether or not the person becomes insured), and the names of those who cease to be eligible must also be given. The eligibility dates and any other necessary data must be given to the Company so that the premium can be determined.

The Company has the right to audit the Policyholder's books and records as the books and records relate to this insurance. The Company may authorize someone else to perform this audit. Any such inspection may be done at any reasonable time.

Workers' Compensation. The Policy is not a Workers' Compensation policy. The Policy does not satisfy any requirement for coverage by Workers' Compensation Insurance.

SCHEDULE OF BENEFITS

Insured Persons have the right to obtain vision care from the Provider of his or her choice. However, payment of benefits varies depending on the type of Provider chosen. Benefits are payable as shown in the following Schedule of Benefits:

<u>Benefit</u>	<u>In-Network</u>	<u>Out-of-Network</u>	<u>Benefit Frequency</u>
VISION EXAMINATION			
Comprehensive Eye Examination	\$10 Co-payment	up to \$40	12 months
VISION MATERIALS			
Standard Plastic Lenses			12 months
Single Vision	\$15 Co-payment	up to \$30	
Bifocal	\$15 Co-payment	up to \$50	
Trifocal	\$15 Co-payment	up to \$70	
Lenticular	\$15 Co-payment	up to \$70	
Frames	\$0 Co-payment, up to \$130 retail allowance	up to \$91	24 months
Contact Lenses (<i>only one option available per Benefit Frequency</i>)			12 months
Conventional	\$0 Co-payment, up to \$130 allowance	up to \$130	
Disposable	\$0 Co-payment, up to \$130 allowance	up to \$130	
Medically Necessary	Paid in full	up to \$210	
Lens Options			12 months
Standard Polycarbonate (For covered Dependent children under 19 years of age)	\$0 Co-payment	up to \$32	
Tint Solid or Gradient	\$0 Co-payment	up to \$12	
Standard Plastic Scratch Coating	\$0 Co-payment	up to \$12	
Standard Progressive Lenses (add on to Bifocal)	\$75 Co-payment	up to \$50	
Premium Progressive Lenses (add on to Bifocal)	\$75 Co-payment, up to \$110 allowance	up to \$50	



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AMENDATORY RIDER REGARDING REPLACEMENT COVERAGE

The Policy/Certificate to which this Amendment Rider is attached is amended as follows:

The following applies when the Policy serves to replace coverage an employer previously obtained through another plan or policy. In this provision, that other plan or policy is referred to as the prior plan. An employer's coverage under the Policy will not be considered as replacement coverage unless the employer's coverage under the Policy takes effect within 60 days after coverage under the prior plan ends.

In the absence of this provision, an Insured Person who was covered by the prior plan at the date of discontinuance might not qualify for coverage under the Policy because the person is not actively at work or is confined in a Hospital.

Each such person will be insured under the Policy if:

- (a) the person was insured under the prior plan, including coverage under the prior plan's extension of benefits provision, on the date the employer's coverage with the prior plan ended; and
- (b) the person is in a class of persons eligible for coverage under the Policy.

The benefits payable for the persons described above will be the benefits of the Policy less any amount payable under the prior plan pursuant to any extension of benefits provision.

This Rider takes effect on the effective date of the Policy/Certificate to which it is attached. This Rider terminates concurrently with the Policy/Certificate to which it is attached. It is subject to all the terms and conditions of the Policy/Certificate except as stated herein.

FIDELITY SECURITY LIFE INSURANCE COMPANY


President


Secretary



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AMENDMENT RIDER

By attachment of this Rider, the third paragraph of the **PREMIUMS** section in the Policy is amended to add the following:

5. if a government action, including fees, taxes and assessments, or change in law or regulation materially affects the Company's risk, premium may be adjusted and will be effective upon written notification from the Company at least 45 days before the date of change.

This Rider takes effect on the effective date of the Policy to which it is attached. This Rider terminates concurrently with the Policy to which it is attached. It is subject to all the definitions, limitations, exclusions and conditions of the Policy except as stated.

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AMENDMENT RIDER

By attachment of this Rider, the Policy/Certificate is amended by the following:

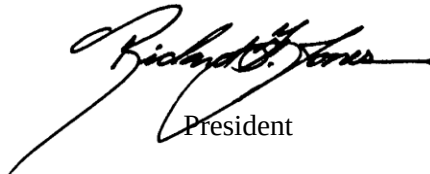
Any provision of the Policy/Certificate that provides coverage for a Dependent child up to a certain age is amended to cover such child to age 26, regardless of financial dependency, residency, student status, or marital status.

Coverage for an unmarried Dependent child will continue until the end of the calendar year in which the child attains age 30, provided the child:

- a. does not have a dependent of his or her own;
- b. is a resident of Florida or a full-time or part-time student; and
- c. is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other group, blanket, or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.

This Rider takes effect on the effective date of the Policy/Certificate to which it is attached. This Rider terminates concurrently with the Policy/Certificate to which it is attached. It is subject to all the definitions, limitations, exclusions and conditions of the Policy/Certificate except as stated.

FIDELITY SECURITY LIFE INSURANCE COMPANY


President


Secretary

FACTS

WHAT DOES Fidelity Security Life Insurance Company, Fidelity Security Life Insurance Company of New York (NY Only) and Affiliates DO WITH YOUR PERSONAL INFORMATION?

Why?

Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.

What?

The types of personal information we collect and share depend on the product or service you have with us. This information can include:

- Social Security number and transaction history
- medical information and insurance claim information
- assets and checking account information

When you are no longer our customer, we continue to share your information as described in this notice.

How?

All financial companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' personal information; the reasons Fidelity Security Life Insurance Company and Affiliates choose to share; and whether you can limit this sharing.

Reasons we can share your personal information	Does Fidelity Security Life share?	Can you limit this sharing?
For our everyday business purposes – such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus	Yes	No
For our marketing purposes – to offer our products and services to you	Yes	No
For joint marketing with other financial companies	Yes	No
For our affiliates' everyday business purposes – information about your transactions and experiences	Yes	No
For our affiliates' everyday business purposes – information about your creditworthiness	No	We don't share
For our affiliates to market to you	No	We don't share
For nonaffiliates to market to you	No	We don't share

Questions?

Call 800-648-8624 or go to www.fslins.com or www.ftj.com

Who we are	
Who is providing this notice?	Fidelity Security Life Insurance Company and Affiliates including our Administrative, Insurance and Financial Service Providers.
What we do	
How does Fidelity Security Life Insurance Company and Affiliates protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings. These physical, electronic and procedural safeguards were created to protect your information. We also limit employee access as appropriate.
How does Fidelity Security Life Insurance Company and Affiliates collect my personal information?	We collect your personal information, for example, when you ■ apply for insurance or pay insurance premiums ■ file an insurance claim or give us your contact information ■ show your driver's license We also collect your personal information from others, such as credit bureaus, affiliates, or other companies.
Why can't I limit all sharing?	Federal law gives you the right to limit only ■ sharing for affiliates' everyday business purposes – information about your creditworthiness ■ affiliates from using your information to market to you ■ sharing for nonaffiliates to market to you State laws and individual companies may give you additional rights to limit sharing.
Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. ■ <i>Our affiliates include Fidelity Security Life Insurance Company of New York, Forrest T. Jones & Company, Inc., Forrest T. Jones Consulting Company and National Pension & Group Consultants, Inc.</i>
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. ■ <i>Fidelity Security Life Insurance Company does not share with nonaffiliates so they can market to you.</i>
Joint marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. ■ <i>Our joint marketing partners include insurance agencies, broker dealers and investment advisor firms.</i>
Other important information	

Application for Vision Care Benefits
Underwritten by Fidelity Security Life Insurance Company
Kansas City, Missouri



I. GROUP INFORMATION

Group Name: Hendry County School District Tax ID#: 59-6000641
DBA Name (If other than above): _____
Business Address: 111 Curry Street City LaBelle State: FL ZIP: 33935
Mailing Address: P.O. BOX 1980 City LaBelle State: FL ZIP: 33975
Primary Contact: Willadine Spence Title: Senior Payroll Specialist
Phone Number: (863) 674-4553 Fax Number: (863) 674-4579
E-mail Address: spencew@hendry.k12.fl.us

Type of Business: ☐ Proprietorship ☐ Corporation ☒ Other (Specify): Public School
Service Area: ☐ National (United States – does not include Puerto Rico) ☒ State Specific (List) Florida

PLEASE NOTE THE FOLLOWING TYPE BUSINESSES REQUIRE PRIOR CARRIER APPROVAL:

☐ MEWA ☐ PEO ☐ Trust ☐ Union

If any subsidiary or affiliated companies are to be insured or any Employees/Members are working at a location other than the business address above, please explain. _____

Billing Contact Name: Denise Van Wagner Phone: (863) 674-4100
Billing Address: P.O. Box 1980 City: LaBelle State: FL ZIP: 33975

If you have subsidiaries, affiliated companies, or divisions who use another name and will be covered by this plan, AND require separate billing invoices, please attach the following information on a separate sheet of paper signed by you: • Name • Address • Billing Contact & Phone Number

Will this plan replace any existing coverage? ☒ Yes ☐ No

If "Yes," indicate name of existing insurer:

Name: Davis Vision

If "Yes," are any Employees/Members on COBRA continuation? ☐ Yes ☒ No How many? _____

Do you intend to offer Employees/Members COBRA continuation? ☒ Yes ☐ No

II. PLAN SELECTION

Please refer to the attached proposal page. Services are provided by EyeMed Vision Care.

III. PREMIUMS

Group's Premium Contribution for*: Employees/Members: 0 % Dependents: 0 %

Employee's/Member's Premium Contribution for: Employees/Members: 100 % Dependents: 100 %

Are Employee/Member and Dependent premiums paid through a Section 125 Plan? ☒ Yes ☐ No

Are Employee/Member and Dependent premiums collected via payroll deduction? ☒ Yes ☐ No

Premiums shall be payable at the rates included on the attached proposal page.

**If the Group's contribution percentage is changed or the number of eligible Employees/Members increases or decreases, premium may be adjusted as allowed under the Policy. The premium may be adjusted at the end of the calendar month in which the change occurred.*

IV. ELIGIBILITY

Number of Employees/Members: 871 Number Applying: _____

Number of Dependents: _____ Number of Retirees: 0

Are Domestic Partners covered under this Plan*? ☐ Yes ☒ No

Same Sex*? ☐ Yes ☒ No Opposite Sex*? ☐ Yes ☒ No

Dependent Children Covered to Age*: 25 ☒ 26**

Dependent Part-Time or Full-Time Students are covered to Age 30*.

**Unless state law has different requirements.*

***Dependent Children covered to age 26 regardless of financial dependency, residency, student status or marital status.*

Eligibility Reporting Contact (produces the eligibility file): Denise Van Wagner and Diana Blakey (blakeyd@hendry.k12.fl.us)

Address (if different from Group): _____

City: _____ State: _____ ZIP: _____

E-mail Address: vanwagnerd@hendry.k12.fl.us Phone: (863) 674-4100 Fax: (863) 674-4103

Eligibility Authorization Contact (Benefits Administrator or Third Party Administrator responsible for verifying vision election for Employees/Members):

Name: Willadine Spence Phone: (863) 674-4553

Days/Hours of Availability: M-F 7:30-4:00 E-mail Address: spencew@hendry.k12.fl.us

PROBATIONARY PERIOD

For New Employees/Members: ☒ 30 days ☐ 60 days ☐ 90 days ☐ 180 days ☐ Other _____

Probationary Period is waived for present Employees/Members: ☒ Yes ☐ No

Number of Employees/Members who have not yet completed the probationary period: _____

V. EFFECTIVE DATE

This plan will become effective at 12:01 a.m. Local Time at the Group's address herein, on the first day of January 1, 20 16, provided all of the following have been completed prior to this effective date:

- A. This application has been received and accepted by the Company (must be submitted 30 days in advance of the effective date).
 - B. EyeMed has been furnished a working file of all eligible Employees/Members, according to the layout guidelines. It is understood and agreed that EyeMed may rely on this information to provide services to individuals designated as eligible.
-

The Group hereby makes application to Fidelity Security Life Insurance Company for Vision Care Benefits. The Group agrees to maintain and furnish any records necessary to administer this plan and to forward premiums monthly.

The Group certifies that all the information shown on this application and any attachments are correct and complete as of the date this application is signed. The Group understands that the Company intends to rely on this information in determining whether or not the enrolling Employees/Members and their Dependents may become insured. It is further understood and agreed that **NO INSURANCE WILL BECOME EFFECTIVE UNTIL APPROVED BY THE COMPANY**; and that no field representative of the Company has the authority to modify any conditions of the application or the Policy by making any promise or representation. It is understood that the insurance as to any Employee/Member will not become effective on the date insurance should otherwise become effective if he or she is not at work on such date performing all duties of his or her occupation and otherwise meets the requirements of the Company.

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.

Dated at: LaBelle, FL this 4th day of September 20 15
Signed for the Group: [Signature] Title: Chief Financial Officer

VI. COMPANY DISPLAY NAME (Your Group name as it should appear to your employees)

Company Name School Board of Hendry County
(Maximum of 30 characters, including punctuation and spacing.)

**ATTENTION: THE DEPARTMENT OF INSURANCE REQUIRES THAT ONLY
THE AGENT AND/OR GENERAL AGENT WHO SOLD THE PRODUCT AND HOLDS A VALID
LIFE AND HEALTH LICENSE MAY COMPLETE THE CERTIFYING STATEMENT**

WRITING AGENT'S CERTIFYING STATEMENT

I certify that I have accurately recorded on this application the information supplied by the applicant, if such information has been provided directly to me for recording purposes, and I am properly licensed in the state in which the Group is domiciled.

Firm Name (print): Alexander & Company Tax ID No.: 58-1027379
Agent's Name (print): Dale Alexander SS#: _____
Address: 291 Heritage Walk City: Woodstock State: GA ZIP: 30188
Phone: (770) 517-5622 Fax: (770) 517-5623
Primary Contact: Melissa Chapman Secondary Contact: Zara White
Title: Account Advisor Title: Account Specialist
E-mail Address: mchapman@cafe125.com E-mail Address: zwhite@cafe125.com
Commission checks payable to: ☒ Firm
Florida Licensed Agent (print): Dale Alexander Florida License I.D. No.: 260768838
Florida Licensed Agent Signature: [Signature]



Vision Care Services	Member Cost In-Network	Out-of-Network Reimbursement*
Exam with Dilation as Necessary	\$10 Copay	\$40
Retinal Imaging Benefit	Up to \$39	N/A
Exam Options:		
Standard Contact Lens Fit and Follow-Up:	Up to \$40	N/A
Premium Contact Lens Fit and Follow-Up:	10% off Retail Price	N/A
Frames:		
Any available frame at provider location	\$0 Copay; \$130 Allowance, 20% off balance over \$130	\$91
Standard Plastic Lenses:		
Single Vision	\$15 Copay	\$30
Bifocal	\$15 Copay	\$50
Trifocal	\$15 Copay	\$70
Lenticular	\$15 Copay	\$70
Standard Progressive Lens	\$75 Copay	\$50
Premium Progressive Lens	\$75 Copay, 70% of Charge less \$110 Allowance	\$50
Lens Options:		
UV Treatment	\$12	N/A
Tint (Solid and Gradient)	\$0 Copay	\$12
Standard Plastic Scratch Coating	\$0 Copay	\$12
Standard Polycarbonate - Adults	\$35	N/A
Standard Polycarbonate - Kids under 19	\$0 Copay	\$32
Standard Anti-Reflective Coating	\$40	N/A
Polarized	30% off Retail Price	N/A
Other Add-Ons	30% off Retail Price	N/A
Contact Lenses		
(Contact lens allowance includes materials only)		
Conventional	\$0 Copay; \$130 allowance, 15% off balance over \$130	\$130
Disposable	\$0 Copay; \$130 allowance, plus balance over \$130	\$130
Medically Necessary	\$0 Copay, Paid-in-Full	\$210
Laser Vision Correction		
Lasik or PRK from U.S. Laser Network	15% off Retail Price or 5% off promotional price	N/A
Additional Pairs Benefit:	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A
Frequency:		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 24 months	
Monthly Rate		
Subscriber	\$5.89	
Subscriber + Family	\$13.55	

All plans are based on a 48-month contract term and 48-month rate guarantee.

Premium is subject to adjustment even during a rate guarantee period in the event of any of the following events: changes in benefits, employee contributions, the number of eligible employees, or the imposition of any new taxes, fees or assessments by Federal or State regulatory agencies

* Member Reimbursement Out-of-Network will be the lesser of the listed amount or the member's actual cost from the out-of-network provider. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see EyeMed's online provider locator to determine which participating providers have agreed to the discounted rate

Additional Discounts:

Member receives a 30% discount on items not covered by the plan at network Providers. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered.

Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision.

After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com.

The contact lens benefit allowance is not applicable to this service.

Benefit Allowances provide no remaining balance for future use within the same Benefit Frequency.

Certain brand name Vision Materials in which the manufacturer imposes a no-discount practice.

Rates are valid only when the quoted plan is the sole stand-alone vision plan offered by the group

Rates are valid for groups domiciled in the State of FL.

Fees quoted will be valid until the 1/1/2016 plan implementation date. Date quoted: 6/25/2015.

Rates assume Employer contribution of 20% or less for employees and dependents

Insured Plans are underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York

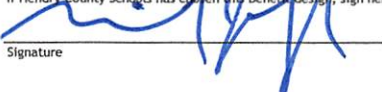
Policy number VC-19/VC-20, form number M-9083

RATES ASSUME LESS THAN 20% EMPLOYER CONTRIBUTION

Plan Exclusions:

- 1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures;
- 3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear
- 4) Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
- 5) Plano (non-prescription) lenses and/or contact lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals;
- 8) Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; 9) Services or materials provided by any other group benefit plan providing vision care;
- 10) Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

If Hendry County Schools has chosen this benefit design, sign here:

Signature 

Date 9/4/15 DK

**GROUP
DENTAL
PLAN**

HENDRY COUNTY SCHOOL DISTRICT

Plan Number: 10-301388

Administered by:



Ameritas Life Insurance Corp.

Non-Insurance Products/Services

From time to time we may arrange, at no additional cost to you or your group, for third-party service providers to provide you access to discounted goods and/or services, such as purchase of eye wear or prescription drugs. These discounted goods or services are not insurance. While we have arranged these discounts, we are not responsible for delivery, failure or negligence issues associated with these goods and services. The third-party service providers would be liable.

To access details about non-insurance discounts and third-party service providers, you may contact our customer connections team or your plan administrator.

These non-insurance goods and services will discontinue upon termination of your coverage or the termination of our arrangements with the providers, whichever comes first.

Dental procedures not covered under your plan may also be subject to a discounted fee in accordance with a participating provider's contract and subject to state law.

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**SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE**

The Coverage for each Member and each Covered Dependent will be based on the Member's class shown in this Schedule of Benefits.

Benefit Class

Class Description

Class 1

All Eligible Employees

DENTAL EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Member, reduced out of pocket costs.

Deductible Amount:

Type 1 Procedures	\$0
Combined Type 2 and Type 3 Procedures - Each Benefit Period	\$75

On the date that the members of one family have satisfied the Maximum Family Deductible shown below, no covered Expenses incurred after that date by any other family member will be applied toward the satisfaction of any Deductible Amount for the rest of that Benefit Period.

Maximum Family Deductible	\$ 150
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Benefit Percentage:

Type 1 Procedures	100%
Type 2 Procedures	80%
Type 3 Procedures	50%

Maximum Amount - Each Benefit Period	\$1,250
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ORTHODONTIC EXPENSE BENEFITS

Deductible Amount - Once per lifetime	\$0
Benefit Percentage	50%
Maximum Benefit During Lifetime	\$1,000

DEFINITIONS

COMPANY refers to Ameritas Life Insurance Corp. The words "we", "us" and "our" refer to Company. Our Home Office address is 5900 "O" Street, Lincoln, Nebraska 68510.

PLANHOLDER refers to the Planholder stated on the face page of this document.

MEMBER refers to a person:

- a. who is a Member of the eligible class; and
- b. who has qualified for coverage by completing the eligibility period, if any; and
- c. for whom the coverage has become effective.

CHILD. Child refers to the child of the Member or a child of the Member's spouse, if they otherwise meet the definition of Dependent.

DEPENDENT refers to:

- a. a Member's spouse.
- b. each child through the end of the year in which they turn age 26, for whom the Member or the Member's spouse is legally responsible, or is eligible under the federal laws identified below, including:
 - i. natural born children;
 - ii. adopted children, eligible from the date of placement for adoption;
 - iii. children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

Spouses of Dependents and children of Dependents may not be enrolled under this plan. Additionally, if the Planholder's separate medical plans are considered to have "grandfathered status" as defined in the federal Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act, Dependents may not be eligible Dependents under such medical plans if they are eligible to enroll in an eligible employer-sponsored health plan other than a group health plan of a parent for plan years beginning before January 1, 2014. Dependents that are ineligible under the Planholder's separate medical plans will be ineligible under this Plan as well.

- c. each child age 26 or older who:
 - i. is Totally Disabled as defined below; and
 - ii. becomes Totally Disabled while covered as a dependent under b. above.

Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

TOTAL DISABILITY describes the Member's Dependent as:

1. Continuously incapable of self-sustaining employment because of mental retardation or physical handicap; and
2. Chiefly dependent upon the Member for support and maintenance.

DEPENDENT UNIT refers to all of the people who are covered as the dependents of any one Member.

PROVIDER refers to any person who is licensed by the law of the state in which treatment is provided within the scope of the license.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. A Participating Provider is a Provider who has a contract with Us to provide services to Members at a discount. A Participating Provider is also referred to as a "Network Provider." The terms and conditions of the agreement with our network providers are available upon request. Members are required to pay the difference between the plan payment and the Participating Provider's contracted fees for covered services. A Non-Participating Provider is any other provider and may also be referred to as an "Out-of-Network Provider." Members are required to pay the difference between the plan payment and the provider's actual fee for covered services. Therefore, the out-of-pocket expenses may be lower if services are provided by a Participating Provider.

LATE ENTRANT refers to any person:

- a. whose Effective Date of coverage is more than 31 days from the date the person becomes eligible for coverage; or
- b. who has elected to become covered again after canceling a fee contribution agreement.

PLAN EFFECTIVE DATE refers to the date coverage under the plan becomes effective. The Plan Effective Date for the Planholder is January 1, 2014. The effective date of coverage for a Member is shown in the Planholder's records.

All coverage will begin at 12:01 A.M. on the Effective Date. It will end after 11:59 P.M. on the Termination Date. All times are stated as Standard Time of the residence of the Member.

CONDITIONS FOR COVERAGE

ELIGIBILITY

ELIGIBLE CLASS FOR MEMBERS. The members of the eligible class(es) are shown on the Schedule of Benefits. Each member of the eligible class (referred to as "Member") will qualify for such coverage on the day he or she completes the required eligibility period, if any. Members choosing to elect coverage will hereinafter be referred to as "Member."

If employment is the basis for membership, a member of the Eligible Class for Coverage is any full time active employee working at least 20 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Coverage is as defined by the Planholder.

Retirees are included in the Eligible Class for Coverage as defined by the Planholder.

If both spouses are Members and if either of them covers their dependent children, then the spouse, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for coverage as a dependent.

ELIGIBLE CLASS FOR DEPENDENT COVERAGE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Coverage under the plan and will qualify for this Dependent Coverage on the latest of:

1. the day he or she qualifies for coverage as a Member;
2. the day he or she first becomes a Member; or
3. the day he or she first has a dependent. For dependent children, a newborn child will be considered an eligible dependent upon reaching their 2nd birthday. The child may be added at birth or within 31 days of the 2nd birthday.

A Member must be covered to also cover his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Coverage is any person who is a full time active employee working at least 20 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Coverage is as defined by the Planholder.

Retirees are included in the Eligible Class for Dependent Coverage as defined by the Planholder.

Any spouse who elects to be a dependent rather than a member of the Eligible Class for Personal Coverage, as explained above, is not a member of the Eligible Class for Dependent Coverage.

When a member of the Eligible Class for Dependent Coverage dies and, if at the date of death, has dependents covered, the Planholder has the option of offering the dependents of the deceased employee continued coverage. If elected by the Planholder and the affected dependents, the name of such deceased member will continue to be listed as a member of the Eligible Class for Dependent Coverage.

CONTRIBUTION REQUIREMENTS. Member Coverage: A Member is not required to contribute to the payment of his or her coverage fees.

Dependent Coverage: A Member is required to contribute to the payment of coverage fees for his or her dependents.

SECTION 125. (Dependents Only) This plan is provided as part of the Planholder's Section 125 Plan. Each Member has the option under the Section 125 Plan of participating or not participating in this plan.

If a Member does not elect to participate when initially eligible, the Member may elect to participate at a subsequent Election Period. This Election Period will be held each year and those who elect to participate in this plan at that time will have their coverage become effective on January 1. A Member who elects to participate during an Election Period who did not elect to participate when initially eligible will be a Late Entrant and subject to Limitation No. 1 on 9219. (There is NO "open enrollment" under this plan.)

Members may change their election option only during an Election Period, except for a change in family status. Such events would be marriage, divorce, birth of a child, death of a spouse or child, or termination of employment of a spouse.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the plan, qualification will occur after an eligibility period defined by the Planholder is satisfied. The same eligibility period will be applied to all members.

For persons who become Members after the Plan Effective Date of the plan, qualification will occur after an eligibility period defined by the Planholder is satisfied. The same eligibility period will be applied to all members.

If employment is the basis for membership in the Eligible Class for Members, a Member whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for coverage.

ELIMINATION PERIOD. Certain covered expenses may be subject to an elimination period, please refer to the TABLE OF DENTAL PROCEDURES, DENTAL EXPENSE BENEFITS, and if applicable, the ORTHODONTIC EXPENSE BENEFITS pages for details.

EFFECTIVE DATE. Each Member has the option of being covered and covering his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the coverage fees. The Effective Date for each Member and his or her Dependents, will be the:

1. the date on which the Member qualifies for coverage, if the Member agrees to contribute on or before that date.
2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for coverage.
3. the date we accept the Member and/or Dependent for coverage when the Member and/or Dependent is a Late Entrant. The Member and/or Dependent will be subject to any limitation concerning Late Entrants.

EXCEPTIONS. If employment is the basis for membership, a Member must be in active service on the date the coverage, or any increase in coverage, is to take effect. If not, the coverage will not take effect until the day he or she returns to active service. Active service refers to the performance in the customary manner by an employee of all the regular duties of his or her employment with his or her employer on a full time basis at one of the employer's business establishments or at some location to which the employer's business requires the employee to travel.

A Member will be in active service on any regular non-working day if he or she is not totally disabled on that day and if he or she was in active service on the regular working day before that day.

If membership is by reason other than employment, a Member must not be totally disabled on the date the coverage, or any increase in coverage, is to take effect. The coverage will not take effect until the day after he or she ceases to be totally disabled.

TERMINATION DATES

MEMBERS. The coverage for any Member, will automatically terminate on the **earliest of:**

1. the date the Member ceases to be a Member;
2. the last day of the period for which the Member has contributed, if required, to the payment of coverage fees; or
3. the date the plan is terminated.

DEPENDENTS. The coverage for all of a Member's dependents will automatically terminate on the **earliest of:**

1. the date on which the Member's coverage terminates;
2. the date on which the Member ceases to be a Member;
3. the last day of the period for which the Member has contributed, if required, to the payment of coverage fees; or
4. the date all Dependent Coverage under the plan is terminated.

The coverage for any Dependent will automatically terminate on the day before the date on which the dependent no longer meets the definition of a dependent. For those Dependents whose coverage terminates because they no longer meet the definition of a Dependent as a result of a limiting age (See "Definitions"), coverage will continue in force throughout the remainder of that year but will automatically terminate December 31 of the year following the attainment of that limiting age.

CONTINUATION OF COVERAGE. If coverage ceases according to TERMINATION DATE, some or all of the coverages may be continued. Contact your plan administrator for details.

DENTAL EXPENSE BENEFITS

We will determine dental expense benefits according to the terms of the group plan for dental expenses incurred by a Member. A Covered person has the freedom of choice to receive treatment from any Provider.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted into each benefit type as shown in the Table of Dental Procedures. This amount is reduced by the Deductible, if any. The result is then multiplied by the Benefit Percentage(s) shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount, if any, shown in the Schedule of Benefits.

BENEFIT PERIOD. Benefit Period refers to the period shown in the Table of Dental Procedures.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Covered person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Amount shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by a Member.

COVERED EXPENSES. Covered Expenses include:

1. only those expenses for dental procedures performed by a Provider; and
2. only those expenses for dental procedures listed and outlined on the Table of Dental Procedures.

Covered Expenses are subject to "Limitations." See Limitations and Table of Dental Procedures.

Benefits payable for Covered Expenses also will be based on the lesser of:

1. the actual charge of the Provider.
2. the usual and customary ("U&C") as covered under your plan, if services are provided by a Non Participating Provider.
3. the Maximum Allowable Charge ("MAC") as covered under your plan.

Usual and Customary ("U&C") describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. From the array of charges ranked by amount, your Planholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by the provider and is not indicative of the appropriateness of the provider's fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage purchased by your Planholder.

MAC - The Maximum Allowable Charge is derived from the array of provider charges within a particular ZIP code area. These allowances are the charges accepted by dentists who are Participating Providers. The MAC is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.

ALTERNATIVE PROCEDURES. If two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care, the amount of the Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. Instead, this provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate alternative procedure is available. Accordingly, you may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

We may request pre-operative dental radiographic images, periodontal charting and/or additional diagnostic data to determine the plan allowance for the procedures submitted. We strongly encourage pre-treatment estimates so you understand your benefits before any treatment begins. Ask your provider to submit a claim form for this purpose.

EXPENSES INCURRED. An expense is incurred at the time the impression is made for an appliance or change to an appliance. An expense is incurred at the time the tooth or teeth are prepared for a dental prosthesis or prosthetic crown. For root canal therapy, an expense is incurred at the time the pulp chamber is opened. All other expenses are incurred at the time the service is rendered or a supply furnished.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. in the first 12 months that a person is covered if the person is a Late Entrant; except for evaluations, prophylaxis (cleanings), and fluoride application.
2. for initial placement of any dental prosthesis or prosthetic crown unless such placement is needed because of the extraction of one or more teeth while the covered person is covered under this plan. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such dental prosthesis or prosthetic crown must include the replacement of the extracted tooth or teeth.
3. for appliances, restorations, or procedures to:
 - a. alter vertical dimension;
 - b. restore or maintain occlusion; or
 - c. splint or replace tooth structure lost as a result of abrasion or attrition.
4. for any procedure begun after the covered person's coverage under this plan terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Member's coverage under this Plan terminates.
5. to replace lost or stolen appliances.
6. for any treatment which is for cosmetic purposes.
7. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)
8. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this plan, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).
9. for which the Covered person is entitled to benefits under any worker's compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.
10. for charges which the Covered person is not liable or which would not have been made had no coverage been in force.
11. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.
12. because of war or any act of war, declared or not.

TABLE OF DENTAL PROCEDURES

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY FOR YOUR PROCEDURE FREQUENCIES AND PROVISIONS.

The attached is a list of dental procedures for which benefits are payable under this section; and is based upon the Current Dental Terminology © American Dental Association. **No benefits are payable for a procedure that is not listed.**

- Ø Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- Ø Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is covered, a benefit period means the period from his or her effective date through December 31 of that year.
- Ø Covered Procedures are subject to all plan provisions, procedure and frequency limitations, and/or consultant review.
- Ø Reference to "traumatic injury" under this plan is defined as injury caused by external forces (ie. outside the mouth) and specifically excludes injury caused by internal forces such as bruxism (grinding of teeth).
- Ø Benefits for replacement dental prosthesis or prosthetic crown will be based on the prior placement date. Frequencies which reference Benefit Period will be measured forward within the limits defined as the Benefit Period. All other frequencies will be measured forward from the last covered date of service.
- Ø Radiographic images, periodontal charting and supporting diagnostic data may be requested for our review.
- Ø We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive by our Member.
- Ø A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.

TYPE 1 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary

PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

ROUTINE ORAL EVALUATION

D0120 Periodic oral evaluation - established patient.

D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver.

D0150 Comprehensive oral evaluation - new or established patient.

D0180 Comprehensive periodontal evaluation - new or established patient.

COMPREHENSIVE EVALUATION: D0150, D0180

- Coverage is limited to 1 of each of these procedures per 1 provider.
- In addition, D0150, D0180 coverage is limited to 1 of any of these procedures per 6 month(s).
- D0120, D0145, also contribute(s) to this limitation.
- If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ROUTINE EVALUATION: D0120, D0145

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D0150, D0180, also contribute(s) to this limitation.
- Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.

COMPLETE SERIES OR PANORAMIC

D0210 Intraoral - complete series of radiographic images.

D0330 Panoramic radiographic image.

COMPLETE SERIES/PANORAMIC: D0210, D0330

- Coverage is limited to 1 of any of these procedures per 3 year(s).

OTHER XRAYS

D0220 Intraoral - periapical first radiographic image.

D0230 Intraoral - periapical each additional radiographic image.

D0240 Intraoral - occlusal radiographic image.

D0250 Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector.

D0260 Extraoral - each additional radiographic image.

PERIAPICAL: D0220, D0230

- The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

BITEWINGS

D0270 Bitewing - single radiographic image.

D0272 Bitewings - two radiographic images.

D0273 Bitewings - three radiographic images.

D0274 Bitewings - four radiographic images.

D0277 Vertical bitewings - 7 to 8 radiographic images.

BITEWINGS: D0270, D0272, D0273, D0274

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D0277, also contribute(s) to this limitation.
- The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWINGS: D0277

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

PROPHYLAXIS (CLEANING) AND FLUORIDE

D1110 Prophylaxis - adult.

TYPE 1 PROCEDURES

D1120 Prophylaxis - child.
D1206 Topical application of fluoride varnish.
D1208 Topical application of fluoride-excluding varnish.
D9931 Cleaning and inspection of a removable appliance.

FLUORIDE: D1206, D1208

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- Benefits are considered for persons age 14 and under.

PROPHYLAXIS: D1110, D1120, D9931

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D4910, also contribute(s) to this limitation.
- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

SEALANT

D1351 Sealant - per tooth.
D1352 Preventive resin restoration in a moderate to high caries risk patient-permanent.
D1353 Sealant repair - per tooth.

SEALANT: D1351, D1352, D1353

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- Benefits are considered for persons age 14 and under.
- Benefits are considered on permanent molars only.
- Coverage is allowed on the occlusal surface only.

APPLIANCE THERAPY

D8210 Removable appliance therapy.
D8220 Fixed appliance therapy.

APPLIANCE THERAPY: D8210, D8220

- Coverage is limited to the correction of thumb-sucking.

TYPE 2 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary

PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

LIMITED ORAL EVALUATION

D0140 Limited oral evaluation - problem focused.

D0170 Re-evaluation - limited, problem focused (established patient; not post-operative visit).

LIMITED ORAL EVALUATION: D0140, D0170

- Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ORAL PATHOLOGY/LABORATORY

D0472 Accession of tissue, gross examination, preparation and transmission of written report.

D0473 Accession of tissue, gross and microscopic examination, preparation and transmission of written report.

D0474 Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- Coverage is limited to 1 examination per biopsy/excision.

SPACE MAINTAINERS

D1510 Space maintainer - fixed - unilateral.

D1515 Space maintainer - fixed - bilateral.

D1520 Space maintainer - removable - unilateral.

D1525 Space maintainer - removable - bilateral.

D1550 Re-cement or re-bond space maintainer.

D1555 Removal of fixed space maintainer.

SPACE MAINTAINER: D1510, D1515, D1520, D1525

- Benefits are considered for persons age 14 and under.
- Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date.

AMALGAM RESTORATIONS (FILLINGS)

D2140 Amalgam - one surface, primary or permanent.

D2150 Amalgam - two surfaces, primary or permanent.

D2160 Amalgam - three surfaces, primary or permanent.

D2161 Amalgam - four or more surfaces, primary or permanent.

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, D9911, also contribute(s) to this limitation.

RESIN RESTORATIONS (FILLINGS)

D2330 Resin-based composite - one surface, anterior.

D2331 Resin-based composite - two surfaces, anterior.

D2332 Resin-based composite - three surfaces, anterior.

D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior).

D2391 Resin-based composite - one surface, posterior.

D2392 Resin-based composite - two surfaces, posterior.

D2393 Resin-based composite - three surfaces, posterior.

D2394 Resin-based composite - four or more surfaces, posterior.

D2410 Gold foil - one surface.

D2420 Gold foil - two surfaces.

D2430 Gold foil - three surfaces.

D2990 Resin infiltration of incipient smooth surface lesions.

TYPE 2 PROCEDURES

COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

- Gold foils are considered at an alternate benefit of an amalgam/composite restoration.

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

- D2390 Resin-based composite crown, anterior.
- D2929 Prefabricated porcelain/ceramic crown - primary tooth.
- D2930 Prefabricated stainless steel crown - primary tooth.
- D2931 Prefabricated stainless steel crown - permanent tooth.
- D2932 Prefabricated resin crown.
- D2933 Prefabricated stainless steel crown with resin window.
- D2934 Prefabricated esthetic coated stainless steel crown - primary tooth.

STAINLESS STEEL CROWN: D2390, D2929, D2930, D2931, D2932, D2933, D2934

- Replacement is limited to 1 of any of these procedures per 12 month(s).
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

RECEMENT

- D2910 Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration.
- D2915 Re-cement or re-bond indirectly fabricated or prefabricated post and core.
- D2920 Re-cement or re-bond crown.
- D2921 Reattachment of tooth fragment, incisal edge or cusp.
- D6092 Re-cement or re-bond implant/abutment supported crown.
- D6093 Re-cement or re-bond implant/abutment supported fixed partial denture.
- D6930 Re-cement or re-bond fixed partial denture.

SEDATIVE FILLING

- D2940 Protective restoration.
- D2941 Interim therapeutic restoration - primary dentition.

ENDODONTICS MISCELLANEOUS

- D3220 Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.
- D3221 Pulpal debridement, primary and permanent teeth.
- D3222 Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.
- D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).
- D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).
- D3333 Internal root repair of perforation defects.
- D3351 Apexification/recalcification - initial visit (apical closure/calccific repair of perforations, root resorption, etc.).
- D3352 Apexification/recalcification - interim medication replacement (apical closure/calccific repair of perforations, root resorption, pulp space disinfection, etc.).
- D3353 Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calccific repair of perforations, root resorption, etc.).
- D3357 Pulpal regeneration - completion of treatment.
- D3430 Retrograde filling - per root.
- D3450 Root amputation - per root.
- D3920 Hemisection (including any root removal), not including root canal therapy.

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

- D3310 Endodontic therapy, anterior tooth.
- D3320 Endodontic therapy, bicuspid tooth.

TYPE 2 PROCEDURES

- D3330 Endodontic therapy, molar.
- D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.
- D3346 Retreatment of previous root canal therapy - anterior.
- D3347 Retreatment of previous root canal therapy - bicuspid.
- D3348 Retreatment of previous root canal therapy - molar.

ROOT CANALS: D3310, D3320, D3330, D3332

- Benefits are considered on permanent teeth only.
- Allowances include intraoperative radiographic images and cultures but exclude final restoration.

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D3310, D3320, D3330, also contribute(s) to this limitation.
- Benefits are considered on permanent teeth only.
- Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative radiographic images and cultures but exclude final restoration.

SURGICAL ENDODONTICS

- D3355 Pulpal regeneration - initial visit.
- D3356 Pulpal regeneration - interim medication replacement.
- D3410 Apicoectomy - anterior.
- D3421 Apicoectomy - bicuspid (first root).
- D3425 Apicoectomy - molar (first root).
- D3426 Apicoectomy (each additional root).
- D3427 Periradicular surgery without apicoectomy.

SURGICAL PERIODONTICS

- D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.
- D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.
- D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.
- D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.
- D4260 Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.
- D4261 Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.
- D4263 Bone replacement graft - first site in quadrant.
- D4264 Bone replacement graft - each additional site in quadrant.
- D4265 Biologic materials to aid in soft and osseous tissue regeneration.
- D4270 Pedicle soft tissue graft procedure.
- D4273 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft.
- D4274 Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area).
- D4275 Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant or edentulous tooth position in graft.
- D4276 Combined connective tissue and double pedicle graft, per tooth.
- D4277 Free soft tissue graft procedure (including recipient and donor surgical sites), first tooth or edentulous tooth, implant or edentulous tooth position in graft.
- D4278 Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site.

BONE GRAFTS: D4263, D4264, D4265

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

GINGIVECTOMY: D4210, D4211

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).

TYPE 2 PROCEDURES

- Coverage is limited to treatment of periodontal disease.

OSSEOUS SURGERY: D4240, D4241, D4260, D4261

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

TISSUE GRAFTS: D4270, D4273, D4275, D4276, D4277, D4278

- Each quadrant is limited to 2 of any of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

NON-SURGICAL PERIODONTICS

D4341 Periodontal scaling and root planing - four or more teeth per quadrant.

D4342 Periodontal scaling and root planing - one to three teeth, per quadrant.

D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.

CHEMOTHERAPEUTIC AGENTS: D4381

- Each quadrant is limited to 2 of any of these procedures per 2 year(s).

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

- Each quadrant is limited to 1 of each of these procedures per 2 year(s).

FULL MOUTH DEBRIDEMENT

D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis.

FULL MOUTH DEBRIDEMENT: D4355

- Coverage is limited to 1 of any of these procedures per 5 year(s).

PERIODONTAL MAINTENANCE

D4910 Periodontal maintenance.

PERIODONTAL MAINTENANCE: D4910

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D1110, D1120, also contribute(s) to this limitation.
- Coverage is contingent upon evidence of full mouth active periodontal therapy. Benefits are not available if performed on the same date as any other periodontal procedure.

NON-SURGICAL EXTRACTIONS

D7111 Extraction, coronal remnants - deciduous tooth.

D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal).

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.

D7220 Removal of impacted tooth - soft tissue.

D7230 Removal of impacted tooth - partially bony.

D7240 Removal of impacted tooth - completely bony.

D7241 Removal of impacted tooth - completely bony, with unusual surgical complications.

D7250 Surgical removal of residual tooth roots (cutting procedure).

D7251 Coronectomy-intentional partial tooth removal.

OTHER ORAL SURGERY

D7260 Oroantral fistula closure.

D7261 Primary closure of a sinus perforation.

D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.

D7272 Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).

D7280 Surgical access of an unerupted tooth.

D7282 Mobilization of erupted or malpositioned tooth to aid eruption.

D7283 Placement of device to facilitate eruption of impacted tooth.

D7310 Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.

D7311 Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.

D7320 Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.

TYPE 2 PROCEDURES

- D7321 Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
- D7340 Vestibuloplasty - ridge extension (secondary epithelialization).
- D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).
- D7410 Excision of benign lesion up to 1.25 cm.
- D7411 Excision of benign lesion greater than 1.25 cm.
- D7412 Excision of benign lesion, complicated.
- D7413 Excision of malignant lesion up to 1.25 cm.
- D7414 Excision of malignant lesion greater than 1.25 cm.
- D7415 Excision of malignant lesion, complicated.
- D7440 Excision of malignant tumor - lesion diameter up to 1.25 cm.
- D7441 Excision of malignant tumor - lesion diameter greater than 1.25 cm.
- D7450 Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.
- D7451 Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
- D7460 Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.
- D7461 Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
- D7465 Destruction of lesion(s) by physical or chemical method, by report.
- D7471 Removal of lateral exostosis (maxilla or mandible).
- D7472 Removal of torus palatinus.
- D7473 Removal of torus mandibularis.
- D7485 Surgical reduction of osseous tuberosity.
- D7490 Radical resection of maxilla or mandible.
- D7510 Incision and drainage of abscess - intraoral soft tissue.
- D7520 Incision and drainage of abscess - extraoral soft tissue.
- D7530 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.
- D7540 Removal of reaction producing foreign bodies, musculoskeletal system.
- D7550 Partial ostectomy/sequestrectomy for removal of non-vital bone.
- D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body.
- D7910 Suture of recent small wounds up to 5 cm.
- D7911 Complicated suture - up to 5 cm.
- D7912 Complicated suture - greater than 5 cm.
- D7960 Frenulectomy-also known as frenectomy or frenotomy-separate procedure not incidental to another procedure.
- D7963 Frenuloplasty.
- D7970 Excision of hyperplastic tissue - per arch.
- D7972 Surgical reduction of fibrous tuberosity.
- D7980 Sialolithotomy.
- D7983 Closure of salivary fistula.

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

- Coverage is limited to 5 of any of these procedures per 1 lifetime.

BIOPSY OF ORAL TISSUE

- D7285 Incisional biopsy of oral tissue - hard (bone, tooth).
- D7286 Incisional biopsy of oral tissue - soft.
- D7287 Exfoliative cytological sample collection.
- D7288 Brush biopsy - transepithelial sample collection.

PALLIATIVE

- D9110 Palliative (emergency) treatment of dental pain - minor procedure.

PALLIATIVE TREATMENT: D9110

- Not covered in conjunction with other procedures, except diagnostic x-ray radiographic images.

ANESTHESIA-GENERAL/IV

- D9219 Evaluation for deep sedation or general anesthesia.
- D9220 Deep sedation/general anesthesia - first 30 minutes.
- D9221 Deep sedation/general anesthesia - each additional 15 minutes.
- D9241 Intravenous moderate (conscious) sedation/analgesia - first 30 minutes.
- D9242 Intravenous moderate (conscious) sedation/analgesia - each additional 15 minutes.

TYPE 2 PROCEDURES

GENERAL ANESTHESIA: D9220, D9221, D9241, D9242

- Coverage is only available with a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report is required. A maximum of two additional units (D9221 or D9242) will be considered.

PROFESSIONAL CONSULT/VISIT/SERVICES

- D9310 Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.
- D9430 Office visit for observation (during regularly scheduled hours) - no other services performed.
- D9440 Office visit - after regularly scheduled hours.
- D9930 Treatment of complications (post-surgical) - unusual circumstances, by report.

CONSULTATION: D9310

- Coverage is limited to 1 of any of these procedures per 1 provider.

OFFICE VISIT: D9430, D9440

- Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.

OCCLUSAL ADJUSTMENT

- D9951 Occlusal adjustment - limited.
- D9952 Occlusal adjustment - complete.

OCCLUSAL ADJUSTMENT: D9951, D9952

- Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.

MISCELLANEOUS

- D0486 Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report.
- D2951 Pin retention - per tooth, in addition to restoration.
- D9911 Application of desensitizing resin for cervical and/or root surfaces, per tooth.

DESENSITIZATION: D9911

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, also contribute(s) to this limitation.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

TYPE 3 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary

PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

INLAY RESTORATIONS

- D2510 Inlay - metallic - one surface.
- D2520 Inlay - metallic - two surfaces.
- D2530 Inlay - metallic - three or more surfaces.
- D2610 Inlay - porcelain/ceramic - one surface.
- D2620 Inlay - porcelain/ceramic - two surfaces.
- D2630 Inlay - porcelain/ceramic - three or more surfaces.
- D2650 Inlay - resin-based composite - one surface.
- D2651 Inlay - resin-based composite - two surfaces.
- D2652 Inlay - resin-based composite - three or more surfaces.

INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652

- Inlays will be considered at an alternate benefit of an amalgam/composite restoration and only when resulting from caries (tooth decay) or traumatic injury.

ONLAY RESTORATIONS

- D2542 Onlay - metallic - two surfaces.
- D2543 Onlay - metallic - three surfaces.
- D2544 Onlay - metallic - four or more surfaces.
- D2642 Onlay - porcelain/ceramic - two surfaces.
- D2643 Onlay - porcelain/ceramic - three surfaces.
- D2644 Onlay - porcelain/ceramic - four or more surfaces.
- D2662 Onlay - resin-based composite - two surfaces.
- D2663 Onlay - resin-based composite - three surfaces.
- D2664 Onlay - resin-based composite - four or more surfaces.

ONLAY: D2542, D2543, D2544, D2642, D2643, D2644, D2662, D2663, D2664

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CROWNS SINGLE RESTORATIONS

- D2710 Crown - resin-based composite (indirect).
- D2712 Crown - 3/4 resin-based composite (indirect).
- D2720 Crown - resin with high noble metal.
- D2721 Crown - resin with predominantly base metal.
- D2722 Crown - resin with noble metal.
- D2740 Crown - porcelain/ceramic substrate.
- D2750 Crown - porcelain fused to high noble metal.
- D2751 Crown - porcelain fused to predominantly base metal.
- D2752 Crown - porcelain fused to noble metal.
- D2780 Crown - 3/4 cast high noble metal.
- D2781 Crown - 3/4 cast predominantly base metal.
- D2782 Crown - 3/4 cast noble metal.

TYPE 3 PROCEDURES

- D2783 Crown - 3/4 porcelain/ceramic.
D2790 Crown - full cast high noble metal.
D2791 Crown - full cast predominantly base metal.
D2792 Crown - full cast noble metal.
D2794 Crown - titanium.

CROWN: D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CORE BUILD-UP

D2950 Core buildup, including any pins when required.

CORE BUILDUP: D2950

- A pretreatment is strongly suggested for D2950. This is reviewed by our dental consultants and benefits are allowed when diagnostic data indicates significant tooth structure loss.

POST AND CORE

D2952 Post and core in addition to crown, indirectly fabricated.

D2954 Prefabricated post and core in addition to crown.

FIXED CROWN AND PARTIAL DENTURE REPAIR

- D2980 Crown repair necessitated by restorative material failure.
D2981 Inlay repair necessitated by restorative material failure.
D2982 Onlay repair necessitated by restorative material failure.
D2983 Veneer repair necessitated by restorative material failure.
D6980 Fixed partial denture repair necessitated by restorative material failure.
D9120 Fixed partial denture sectioning.

CROWN LENGTHENING

D4249 Clinical crown lengthening - hard tissue.

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

- D5110 Complete denture - maxillary.
D5120 Complete denture - mandibular.
D5130 Immediate denture - maxillary.
D5140 Immediate denture - mandibular.
D5211 Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).
D5212 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).
D5213 Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).
D5214 Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).
D5225 Maxillary partial denture - flexible base (including any clasps, rests and teeth).
D5226 Mandibular partial denture - flexible base (including any clasps, rests and teeth).
D5281 Removable unilateral partial denture - one piece cast metal (including clasps and teeth).
D5670 Replace all teeth and acrylic on cast metal framework (maxillary).

TYPE 3 PROCEDURES

- D5671 Replace all teeth and acrylic on cast metal framework (mandibular).
- D5810 Interim complete denture (maxillary).
- D5811 Interim complete denture (mandibular).
- D5820 Interim partial denture (maxillary).
- D5821 Interim partial denture (mandibular).
- D5863 Overdenture - complete maxillary.
- D5864 Overdenture - partial maxillary.
- D5865 Overdenture - complete mandibular.
- D5866 Overdenture - partial mandibular.
- D6110 Implant/abutment supported removable denture for edentulous arch - maxillary.
- D6111 Implant/abutment supported removable denture for edentulous arch - mandibular.
- D6112 Implant/abutment supported removable denture for partially edentulous arch - maxillary.
- D6113 Implant/abutment supported removable denture for partially edentulous arch - mandibular.
- D6114 Implant/abutment supported fixed denture for edentulous arch - maxillary.
- D6115 Implant/abutment supported fixed denture for edentulous arch - mandibular.
- D6116 Implant/abutment supported fixed denture for partially edentulous arch - maxillary.
- D6117 Implant/abutment supported fixed denture for partially edentulous arch - mandibular.

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5863, D5865, D6110, D6111, D6114, D6115

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5863, D5865, D6110, D6111, D6114 and D6115 are considered at an alternate benefit of a D5110/D5120.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5225, D5226, D5281, D5670, D5671, D5864, D5866, D6112, D6113, D6116, D6117

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5864, D5866, D6112, D6113, D6116 and D6117 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS

- D5410 Adjust complete denture - maxillary.
- D5411 Adjust complete denture - mandibular.
- D5421 Adjust partial denture - maxillary.
- D5422 Adjust partial denture - mandibular.

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

- Coverage is limited to dates of service more than 6 months after placement date.

DENTURE REPAIR

- D5510 Repair broken complete denture base.
- D5520 Replace missing or broken teeth - complete denture (each tooth).
- D5610 Repair resin denture base.
- D5620 Repair cast framework.
- D5630 Repair or replace broken clasp.
- D5640 Replace broken teeth - per tooth.

ADD TOOTH/CLASP TO EXISTING PARTIAL

- D5650 Add tooth to existing partial denture.
- D5660 Add clasp to existing partial denture.

DENTURE REBASES

- D5710 Rebase complete maxillary denture.
- D5711 Rebase complete mandibular denture.
- D5720 Rebase maxillary partial denture.
- D5721 Rebase mandibular partial denture.

DENTURE RELINES

- D5730 Reline complete maxillary denture (chairside).

TYPE 3 PROCEDURES

- D5731 Reline complete mandibular denture (chairside).
- D5740 Reline maxillary partial denture (chairside).
- D5741 Reline mandibular partial denture (chairside).
- D5750 Reline complete maxillary denture (laboratory).
- D5751 Reline complete mandibular denture (laboratory).
- D5760 Reline maxillary partial denture (laboratory).
- D5761 Reline mandibular partial denture (laboratory).
- DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761

- Coverage is limited to service dates more than 6 months after placement date.

TISSUE CONDITIONING

- D5850 Tissue conditioning, maxillary.
- D5851 Tissue conditioning, mandibular.

PROSTHODONTICS - FIXED

- D6058 Abutment supported porcelain/ceramic crown.
- D6059 Abutment supported porcelain fused to metal crown (high noble metal).
- D6060 Abutment supported porcelain fused to metal crown (predominantly base metal).
- D6061 Abutment supported porcelain fused to metal crown (noble metal).
- D6062 Abutment supported cast metal crown (high noble metal).
- D6063 Abutment supported cast metal crown (predominantly base metal).
- D6064 Abutment supported cast metal crown (noble metal).
- D6065 Implant supported porcelain/ceramic crown.
- D6066 Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).
- D6067 Implant supported metal crown (titanium, titanium alloy, high noble metal).
- D6068 Abutment supported retainer for porcelain/ceramic FPD.
- D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal).
- D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).
- D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal).
- D6072 Abutment supported retainer for cast metal FPD (high noble metal).
- D6073 Abutment supported retainer for cast metal FPD (predominantly base metal).
- D6074 Abutment supported retainer for cast metal FPD (noble metal).
- D6075 Implant supported retainer for ceramic FPD.
- D6076 Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).
- D6077 Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).
- D6094 Abutment supported crown - (titanium).
- D6194 Abutment supported retainer crown for FPD - (titanium).
- D6205 Pontic - indirect resin based composite.
- D6210 Pontic - cast high noble metal.
- D6211 Pontic - cast predominantly base metal.
- D6212 Pontic - cast noble metal.
- D6214 Pontic - titanium.
- D6240 Pontic - porcelain fused to high noble metal.
- D6241 Pontic - porcelain fused to predominantly base metal.
- D6242 Pontic - porcelain fused to noble metal.
- D6245 Pontic - porcelain/ceramic.
- D6250 Pontic - resin with high noble metal.
- D6251 Pontic - resin with predominantly base metal.
- D6252 Pontic - resin with noble metal.
- D6545 Retainer - cast metal for resin bonded fixed prosthesis.
- D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis.
- D6549 Resin retainer - for resin bonded fixed prosthesis.
- D6600 Retainer inlay - porcelain/ceramic, two surfaces.
- D6601 Retainer inlay - porcelain/ceramic, three or more surfaces.
- D6602 Retainer inlay - cast high noble metal, two surfaces.
- D6603 Retainer inlay - cast high noble metal, three or more surfaces.
- D6604 Retainer inlay - cast predominantly base metal, two surfaces.
- D6605 Retainer inlay - cast predominantly base metal, three or more surfaces.

TYPE 3 PROCEDURES

- D6606 Retainer inlay - cast noble metal, two surfaces.
- D6607 Retainer inlay - cast noble metal, three or more surfaces.
- D6608 Retainer onlay - porcelain/ceramic, two surfaces.
- D6609 Retainer onlay - porcelain/ceramic, three or more surfaces.
- D6610 Retainer onlay - cast high noble metal, two surfaces.
- D6611 Retainer onlay - cast high noble metal, three or more surfaces.
- D6612 Retainer onlay - cast predominantly base metal, two surfaces.
- D6613 Retainer onlay - cast predominantly base metal, three or more surfaces.
- D6614 Retainer onlay - cast noble metal, two surfaces.
- D6615 Retainer onlay - cast noble metal, three or more surfaces.
- D6624 Retainer inlay - titanium.
- D6634 Retainer onlay - titanium.
- D6710 Retainer crown - indirect resin based composite.
- D6720 Retainer crown - resin with high noble metal.
- D6721 Retainer crown - resin with predominantly base metal.
- D6722 Retainer crown - resin with noble metal.
- D6740 Retainer crown - porcelain/ceramic.
- D6750 Retainer crown - porcelain fused to high noble metal.
- D6751 Retainer crown - porcelain fused to predominantly base metal.
- D6752 Retainer crown - porcelain fused to noble metal.
- D6780 Retainer crown - 3/4 cast high noble metal.
- D6781 Retainer crown - 3/4 cast predominantly base metal.
- D6782 Retainer crown - 3/4 cast noble metal.
- D6783 Retainer crown - 3/4 porcelain/ceramic.
- D6790 Retainer crown - full cast high noble metal.
- D6791 Retainer crown - full cast predominantly base metal.
- D6792 Retainer crown - full cast noble metal.
- D6794 Retainer crown - titanium.
- D6940 Stress breaker.

FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL INLAY: D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL ONLAY: D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634

TYPE 3 PROCEDURES

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL PONTIC: D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6094, D6194, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

IMPLANT SUPPORTED CROWN: D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

IMPLANT SUPPORTED RETAINER: D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6194

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

ORTHODONTIC EXPENSE BENEFITS

Orthodontic expense benefits will be determined according to the terms of the plan for orthodontic expenses incurred by a Member.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted. This amount is reduced by the Deductible, if any. The result is then multiplied by the Benefit Percentage shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount shown in the Schedule of Benefits.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Covered person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Benefit During Lifetime shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by a Member during his or her lifetime.

COVERED EXPENSES. Covered Expenses refer to the usual and customary charges made by a provider for necessary orthodontic treatment rendered while the person is covered under this section. Expenses are limited to the Maximum Amount shown in the Schedule of Benefits and Limitations. All benefits are subject to the definitions, limitations and exclusions and are payable only when we determine they are necessary for the prevention, diagnosis, care or treatment of a covered condition and meet generally accepted dental protocols.

Usual and Customary ("U&C") describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. From the array of charges ranked by amount, your Planholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by the provider and is not indicative of the appropriateness of the provider's fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage purchased by your Planholder.

ORTHODONTIC TREATMENT. Orthodontic Treatment refers to the movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

TREATMENT PROGRAM. Treatment Program ("Program") means an interdependent series of orthodontic services prescribed by a provider to correct a specific dental condition. A Program will start when the bands, brackets, or appliances are placed. A Program will end when the services are done, or after eight calendar quarters starting with the day the appliances were inserted, whichever is earlier.

EXPENSES INCURRED. Benefits will be payable when a Covered Expense is incurred:

- a. at the end of every quarter (three-month period) of a Program for a Member who pursues a Program, but not beyond the date the Program ends; or
- b. at the time the service is rendered for a Member who incurs Covered Expenses but does not pursue a Program.

The Covered Expenses for a Program are based on the estimated cost of the Member's Program. They are pro-rated by quarter (three-month periods) over the estimated length of the Program, up to a maximum of eight quarters. The last quarterly payment for a Program may be changed if the estimated and actual cost of the Program differ.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. for a Program begun before the Member became covered under this section.
2. in the first 12 months that a person is covered if the person is a Late Entrant.
3. in any quarter of a Program if the Member was not covered under this section for the entire quarter.
4. if the Member's coverage under this section terminates.
5. for which the Member is entitled to benefits under any workmen's compensation or similar law, or for charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.
6. for charges the Member is not legally required to pay or would not have been made had no coverage been in force.
7. for services not required for necessary care and treatment or not within the generally accepted parameters of care.
8. because of war or any act of war, declared or not.
9. to replace lost, missing, or stolen orthodontic appliances.

COORDINATION OF BENEFITS

This section applies if a covered person has dental coverage under more than one Plan definition below. All benefits provided under this plan are subject to this section.

EFFECT ON BENEFITS. The Order of Benefit Determination rules below determine which Plan will pay as the primary Plan. If all or any part of an Allowable Expense under this Plan is an Allowable Expense under any other Plan, then benefits will be reduced so that, when they are added to benefits payable under any other Plan for the same service or supply, the total does not exceed 100% of the total Allowable Expense.

If another Plan is primary and this Plan is considered secondary, the amount by which benefits have been reduced during the Claim Determination Period will be used by us to pay the Allowable Expenses not otherwise paid which were incurred by you in the same Claim Determination Period. We will determine our obligation to pay for Allowable Expenses as each claim is submitted, based on all claims submitted in the current Claim Determination Period.

DEFINITIONS. The following apply only to this provision of the plan.

1. “Plan” refers to the group plan and any of the following plans, whether insured or uninsured, providing benefits for dental services or supplies:
 - a. Any group or blanket insurance policy.
 - b. Any group Blue Cross, group Blue Shield, or group prepayment arrangement.
 - c. Any labor/management, trusteed plan, labor organization, employer organization, or employee organization plan, whether on an insured or uninsured basis.
 - d. Any coverage under a governmental plan that allows coordination of benefits, or any coverage required or provided by law. This does **not** include a state plan under Medicaid (Title XVIII and XIX of the Social Security Act as enacted or amended). It also does not include any plan whose benefits by law are excess to those of any private insurance program or other non-governmental program.
2. “Plan” does **not** include the following:
 - a. Individual or family benefits provided through insurance contracts, subscriber contracts, coverage through individual HMOs or other prepayment arrangements.
 - b. Coverages for school type accidents only, including athletic injuries.
3. “Allowable Expense” refers to any necessary, reasonable and customary item of expense at least a portion of which is covered under at least one of the Plans covering the person for whom that claim is made. When a Plan provides services rather than cash payments, the reasonable cash value of each service will be both an Allowable Expense and a benefit paid. Benefits payable under another Plan include benefits that would have been payable had a claim been made for them.
4. “Claim Determination Period” refers to a Benefit Period, but does not include any time during which a person has no coverage under this Plan.
5. “Custodial Parent” refers to a parent awarded custody of a minor child by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than half of the calendar year without regard to any temporary visitation.

ORDER OF BENEFIT DETERMINATION. When two or more Plans pay benefits, the rules for determining the order of payment are as follows:

1. A Plan that does not have a coordination of benefits provision is always considered primary and will pay benefits first.
2. If a Plan also has a coordination of benefits provision, the first of the following rules that describe which Plan pays its benefits before another Plan is the rule to use:
 - a. The benefits of a Plan that covers a person as an employee, member or subscriber are determined before those of a Plan that covers the person as a dependent.
 - b. If a Dependent child is covered by more than one Plan, then the primary Plan is the Plan of the parent whose birthday is earlier in the year if:
 - i. the parents are married;
 - ii. the parents are not separated (whether or not they ever have been married); or
 - iii. a court decree awards joint custody without specifying that one party has the responsibility to provide dental coverage.

If both parents have the same birthday, the Plan that covered either of the parents longer is primary.

- c. If the Dependent child is covered by divorced or separated parents under two or more Plans, benefits for that Dependent child will be determined in the following order:
 - i. the Plan of the Custodial Parent;
 - ii. the Plan of the spouse of the Custodial Parent;
 - iii. the Plan of the non-Custodial Parent; and then
 - iv. the Plan of the spouse of the non-Custodial Parent.

However, if the specific terms of a court decree establish a parent's responsibility for the child's dental expenses and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Claim Determination Periods or Benefit Periods commencing after the Plan is given notice of the court decree.

- d. The benefits of a Plan that cover a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a Plan that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.
 - e. If a person whose coverage is provided under a right of continuation provided by a federal or state law also is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.
 - f. The benefits of a Plan that has covered a person for a longer period will be determined first.

If the preceding rules do not determine the primary Plan, the allowable expenses shall be shared equally between the Plans meeting the definition of Plan under this provision. In addition, this Plan will not pay more than what it would have paid had it been primary.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION. We may without your consent and notice to you:

1. Release any information with respect to your coverage and benefits under the plan; and
2. Obtain from any other insurance company, organization or person any information with respect to your coverage and benefits under another Plan.

You must provide us with any information necessary to coordinate benefits.

FACILITY OF PAYMENT. When other Plans make payments that should have been made under this Plan according to the above terms, we will, at our discretion, pay to any organizations making these payments any amounts that we decide will satisfy the intent of the above terms. Amounts paid in this way will be benefits paid under this Plan. We will not be liable to the extent of these payments.

RIGHT OF RECOVERY. When we make payments for Allowable Expenses in excess of the amount that will satisfy the intent of the above terms, we will recover these payments, to the extent of the excess, from any persons or organizations to or for whom these payments were made. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

GENERAL PROVISIONS

NOTICE OF CLAIM. Written notice of a claim must be given to us within 30 days after the incurred date of the services provided for which benefits are payable.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Planholder's name, Member's name, and plan number. If it was not reasonably possible to give written notice within the 30 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

CLAIM FORMS. When we receive the notice of a claim, we will send the claimant forms for filing proof of loss. If these forms are not furnished within 15 days after the giving of such notice, the claimant will meet our proof of loss requirements by giving us a written statement of the nature and extent of loss within the time limit for filing proofs of loss.

PROOF OF LOSS. Written proof of loss must be given to us within 90 days after the incurred date of the services provided for which benefits are payable. If it is impossible to give written proof within the 90 day period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible.

TIME OF PAYMENT. We will pay all benefits immediately when we receive due proof. Any balance remaining unpaid at the end of any period for which we are liable will be paid at that time.

PAYMENT OF BENEFITS. All benefits will be paid to the Insured unless otherwise agreed upon through your authorization or provider contracts.

FACILITY OF PAYMENT. If a Member or beneficiary is not capable of giving us a valid receipt for any payment or if benefits are payable to the estate of the Member, then we may, at our option, pay the benefit up to an amount not to exceed \$5,000 to any relative by blood or connection by marriage of the Member who is considered by us to be equitably entitled to the benefit.

Any equitable payment made in good faith will release us from liability to the extent of payment.

PROVIDER-PATIENT RELATIONSHIP. The Member may choose any Provider who is licensed by the law of the state in which treatment is provided within the scope of their license. We will in no way disturb the provider-patient relationship.

LEGAL PROCEEDINGS. No legal action can be brought against us until 60 days after the Member sends us the required proof of loss. No legal action against us can start more than five years after proof of loss is required.

INCONTESTABILITY. Any statement made by the Planholder to obtain the Plan is a representation and not a warranty. No misrepresentation by the Planholder will be used to deny a claim or to deny the validity of the Plan unless:

1. The Plan would not have been issued if we had known the truth; and
2. We have given the Planholder a copy of a written instrument signed by the Planholder that contains the misrepresentation.

The validity of the Plan will not be contested after it has been in force for one year, except for nonpayment of fees or fraudulent misrepresentations.

WORKER'S COMPENSATION. The coverage provided under the Plan is not a substitute for coverage under a worker's compensation or state disability income benefit law and does not relieve the Planholder of any obligation to provide such coverage.

