Agenda Item #: **3Z4**

PALM BEACH COUNTY
BOARD OF COUNTY COMMISSIONERS

AGENDA ITEM SUMMARY

Meeting Date: 10/7/2008 | [X] **Consent** | [ ] **Regular** | [ ] **Ordinance** | [ ] **Public Hearing**

Department

Submitted By: Risk Management

I. EXECUTIVE BRIEF

Motion and Title: Staff recommends motion to approve:

A) Selection committee's recommendation to select Assurant Employee Benefits as the provider for the County's triple-option, employee paid, dental insurance program (RFP No. 08/095 – DL)

B) Wrap Around Agreement with Union Security Insurance Company to provide fully insured, employee-paid dental plans

C) Group Dental Service Agreement with Union Security Insurance Company to provide a Managed Care Dental Plan (under the "Plus Plan" with Ortho Specialty Benefit Amendment) for the period January 1, 2009 through December 31, 2011,with guaranteed rates for three (3) years and two (2) annual options to renew

D) Policy No. G 5,303,634 – "Active/MAC" Network PPO Plan with Union Security Insurance Company to provide a maximum allowable cost network PPO Plan for the period January 1, 2009 through December 31, 2011, with guaranteed rates for three (3) years and two (2) annual options to renew the plan.

E) Policy No. G 5,303,634 – "True" PPO with Union Security Insurance Company to provide a true dental PPO plan for the period January 1, 2009 through December 31, 2011, with guaranteed rates for three (3) years and two (2) annual options to renew the plan.

F) Group Dental Insurance Preliminary Application with Union Security Insurance Company to accompany Policy No. G 5,303,634, Active/MAC and True PPO plans.

Summary: (Summary continued on page 3)

Background and Policy Issues: (Continued on page 3)

Attachments:

1. Wrap Around Agreement with Assurant, Inc.
2. Group Dental Service Agreement with Union Security Insurance Company
3. Union Security Insurance Company Policy Number G 5,303,634 – Active/MAC PPO
4. Union Security Insurance Company Policy Number G 5,303,634 - True PPO
5. Group Dental Insurance Preliminary Application (to accompany Union Security Insurance Company PPO Policies)

Recommended by:

Nancy L. Bolton — 9/18/08
Department Director — **Date**

Approved By:

J. Ulm — 10/1/08
Assistant County Administrator — **Date**

II. FISCAL IMPACT ANALYSIS

A. Five Year Summary of Fiscal Impact:

Fiscal Years	2009	2010	2011	2012	2013
Capital Expenditures	$_____	_____	_____	_____	_____
Operating Costs	$ 0	$ 0	_____	_____	_____
External Revenues	$_____	$_____	_____	_____	_____
Program Income (County)	---------	----------	---------	----------	---------
In Kind Match (County)	---------	----------	---------	----------	---------
NET FISCAL IMPACT	$0 *See below	$0			
# ADDITIONAL FTE POSITIONS (Cumulative)	—0---	-----0-----	---------	----------	---------

Is Item Included In Current Budget? Yes_____ No. _____
Budget Account No.: Fund Agency Org. Object Reporting Category_____

B. Recommended Sources of Funds/Summary of Fiscal Impact:
* Employees pay the full cost of the plan

C. Departmental Fiscal Review: Gary Kaplan

III. REVIEW COMMENTS

A. OFMB Fiscal and/or Contract Administration Comments:

Ahwillhite 9.29.08
28 9/26/08 OFMB CN 9/22/08 Contract Administration 9/29/08
9/29/08

B. Legal Sufficiency:

Assistant County Attorney 10/1/08

C. Other Department Review:

_____
Department Director

This summary is not to be used as a basis for payment.

Summary (continued from page 1): An RFP was issued for a voluntary, employee pay-all triple option managed care dental program (DHMO, PPO/Scheduled and True PPO) which would provide comprehensive dental benefits to County employees and their eligible dependents while maintaining affordable rates. Responses from Assurant Employee Benefits and Standard Insurance Company were evaluated by a five member selection committee. Both companies offered PPO plans at comparable levels of benefits and associated rates, but Assurant Employee Benefits offered all three plans, including an improved alternative to the currently offered PPO/Scheduled plan. The selection committee voted to recommend and negotiate with Assurant Employee Benefits. The plans being recommended for approval include replacement of the existing PPO/Scheduled plan with an "Active/MAC" (maximum allowable cost) PPO plan, which provides improved coverage as compared to the expiring plan. The rates on all three plans are guaranteed for three years. Rates for all proposed plans are offered at small decrease or held at the rates currently in effect, depending on which tier of coverage is chosen by the employee. In addition to employees of Palm Beach County Board of County Commissioners, the employees of Palm Tran, Inc. and the Supervisor of Elections will also be eligible to participate in these plans. Countywide (TKF)

Background and Policy Issues: The Board has permitted a voluntary, employee pay-all dental program since 1978. On September 1, 2002 employees of Palm Tran, Inc. joined the plans. Since January 1, 2005, triple-option plans have been provided by Assurant Employee Benefits. The current program structure offers a dental maintenance organization plan (DHMO) which is similar to a medical HMO, in that it only covers services by specified network dentists. Also offered is a PPO/scheduled plan which pays scheduled reimbursement for care provided both in and out of network, and a "true PPO" plan, in which members can select any dentist and be covered at a fixed percentage of 100%, 80% or 50%, depending on the type of services rendered.

For the upcoming plan year beginning January 1, 2009, staff issued an RFP for a triple-option dental program. The proposal requested an improved alternative plan for the current PPO/scheduled plan, which has been considered confusing to members, and limited in its reimbursement schedule. The five member selection committee evaluated the RFP's based on the following criteria:

1. Comparison to existing networks
2. Plan design and benefit slate
3. Ability to perform
4. Price proposal
5. Rate guarantee beyond one year
6. Flexibility in meeting requirements
7. Carrier financial ratings
8. Small Business Enterprise

Proposals were reviewed for the two responsive responsible proposers, Standard Insurance Company and Assurant Employee Benefits. A discussion was held as to the merits of each proposal. Both firms were qualified to provide the services being sought by the County. Assurant Employee Benefits is the incumbent, and has provided the County with excellent service. Standard Insurance is the incumbent Life and Disability carrier and has also provided the County with excellent service. Standard Insurance did not propose a DHMO plan, which is the plan the majority of employees have historically selected. However, the RFP allowed the Committee to select free standing plans if it was determined to be in the best interest of the County.

Both pricing proposals were competitive when compared to existing rates. The incumbent carrier proposed an alternative to the current scheduled PPO plan, which represented an improvement in benefits, at a competitive price. The proposed new PPO Plan provides a higher reimbursement for those who go to a "in-network" dentist while still providing reduced coverage for those who go out of network. The new plan will provide greater benefits at a similar cost than the expiring plan, which reimbursed members at a lesser rate. Standard Insurance proposed two nearly identical plans at competitive premiums, but no alternative to the Scheduled PPO. The selection

(continued from page 3)

committee voted to remain with the incumbent carrier at the following rates, which are guaranteed for three years.

DHMO MONTHLY RATE COMPARISON

	CURRENT	RECOMMENDED
EMP. ONLY	$11.81	$11.81
EMP. + 1	$20.20	$20.20
EMP. + 2/MORE	$27.37	$27.37
EMP. + FAM	$36.11	$36.11

"ACTIVE/MAC" PPO MONTHLY RATE COMPARISON

	CURRENT	RECOMMENDED
EMP. ONLY	$18.67	$18.75
EMP. + 1	$36.16	$35.60
EMP. + 2/MORE	$45.88	$43.55
EMP + FAM	$63.36	$60.46

"TRUE" PPO MONTHLY RATE COMPARISON

	CURRENT	RECOMMENDED
EMP. ONLY	$26.36	$24.79
EMP. + 1	$50.52	$47.51
EMP. + 2/MORE	$58.36	$54.89
EMP + FAM	$82.53	$77.62

MARSH

CERTIFICATE OF INSURANCE

CERTIFICATE NUMBER
ATL-001583001-01

PRODUCER

Marsh USA Inc.
3475 Piedmont Road, NE
Suite 1200
Atlanta, GA 30305
Attn: Atlanta.Certrequest@marsh.com Fax#212-948-0337

664412-all-all-08-09

INSURED

Assurant, Inc.
11222 Quail Roost Dr.
Miami, FL 33157

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER OTHER THAN THOSE PROVIDED IN THE POLICY. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES DESCRIBED HEREIN.

COMPANIES AFFORDING COVERAGE

COMPANY A Liberty Mutual Insurance Company

COMPANY B N/A

COMPANY C N/A

COMPANY D

COVERAGES This certificate supersedes and replaces any previously issued certificate for the policy period noted below. 4

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

CO LTR	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS	
A	**GENERAL LIABILITY**	TB2-651-004240-038	01/09/08	01/09/09	GENERAL AGGREGATE	$ 2,000,000
	[X] COMMERCIAL GENERAL LIABILITY				PRODUCTS - COMP/OP AGG	$ 1,000,000
	[ ] CLAIMS MADE [X] OCCUR				PERSONAL & ADV INJURY	$ 1,000,000
	[ ] OWNER'S & CONTRACTOR'S PROT				EACH OCCURRENCE	$ 1,000,000
					FIRE DAMAGE (Any one fire)	$ 1,000,000
					MED EXP (Any one person)	$ 10,000
A	**AUTOMOBILE LIABILITY**	AS2-651-004240-048	01/09/08	01/09/09	COMBINED SINGLE LIMIT	$ 1,000,000
	[X] ANY AUTO					
	[ ] ALL OWNED AUTOS				BODILY INJURY (Per person)	$
	[ ] SCHEDULED AUTOS					
	[ ] HIRED AUTOS				BODILY INJURY (Per accident)	$
	[ ] NON-OWNED AUTOS					
					PROPERTY DAMAGE	$
	GARAGE LIABILITY				AUTO ONLY - EA ACCIDENT	$
	[ ] ANY AUTO				OTHER THAN AUTO ONLY:	
					EACH ACCIDENT	$
					AGGREGATE	$
	EXCESS LIABILITY				EACH OCCURRENCE	$
	[ ] UMBRELLA FORM				AGGREGATE	$
	[ ] OTHER THAN UMBRELLA FORM					$
A	**WORKERS COMPENSATION AND EMPLOYERS' LIABILITY**	WA7-65D-004240-018 (AOS)	01/09/08	01/09/09	[X] WC STATU-TORY LIMITS [ ] OTH-ER	
A	THE PROPRIETOR/ PARTNERS/EXECUTIVE OFFICERS ARE: [X] INCL [ ] EXCL	WC7-651004240-028 (OR)	01/09/08	01/09/09	EL EACH ACCIDENT	$ 1,000,000
					EL DISEASE-POLICY LIMIT	$ 1,000,000
					EL DISEASE-EACH EMPLOYEE	$ 1,000,000
	OTHER					

DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES/SPECIAL ITEMS

The Certificate Holder is included as an Additional Insured with regards to the General Liability policy where required by written contract. A Waiver of Subrogation is included where required by written contract.

CERTIFICATE HOLDER

Palm Beach County
c/o Purchasing Department
50 South Military Trail, Suite 110
West Palm Beach, FL 33415

CANCELLATION

SHOULD ANY OF THE POLICIES DESCRIBED HEREIN BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE INSURER AFFORDING COVERAGE WILL ENDEAVOR TO MAIL 30 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED HEREIN, BUT FAILURE TO MAIL SUCH NOTICE SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER AFFORDING COVERAGE, ITS AGENTS OR REPRESENTATIVES, OR THE ISSUER OF THIS CERTIFICATE.

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.
BY: Ted L. Young

Ted L. Young

MM1(3/02)

VALID AS OF: 09/17/08

ATTACHMENT #1

WRAP AROUND AGREEMENT FOR GROUP DENTAL INSURANCE

This Wrap Around Agreement entered into this __ day of _____,20__ by and between PALM BEACH COUNTY, a political subdivision of the State of Florida, (hereinafter referred to as "County", and UNION SECURITY INSURANCE COMPANY, a corporation authorized to do business in the state of Florida, (hereinafter referred to as "Provider".)

WHEREAS, the Board of County Commissioners issued RFP No. 08-095/DL for group dental insurance and UNION SECURITY INSURANCE COMPANY was the top ranked proposer; and

WHEREAS, UNION SECURITY INSURANCE COMPANY requires separate policies and/or agreements to be signed for the various types of coverage offered; and

WHEREAS, the parties wish to clarify, via this Wrap Around Agreement, the full group dental insurance offered by UNION SECURITY INSURANCE COMPANY to the Board of County Commissioners of Palm Beach County, Florida, including, but not limited to the employees of Palm Tran, Inc. and the Supervisor of Elections.

NOW, THEREFORE, in consideration of the mutual premises and covenants herein contained, it is agreed as follows:

1. **Contract - Document Priority.** The Group Dental Service Agreement with Union Security Insurance Co. (DHMO Policy), and the two PPO dental insurance policies issued by Union Security Insurance Co. Insurance Company No. G 5,303,634 for "True PPO" and "Active/MAC PPO" are attached to the Wrap Around Agreement and made a part hereof as Exhibits A, B and C respectively. To the extent that the provisions of this Wrap Around Agreement are in conflict with Exhibits A through C, the provisions of this Wrap Around Agreement are controlling. Further the Request for Proposal (RFP), including addendums, and the Provider's proposal in response to the RFP, including all subsequent clarifying memorandum, are attached to this Wrap Around Agreement and made a part hereof as Composite Exhibit "D". In the event of a discrepancy between this Wrap Around, RFP and the proposals by Provider, this Wrap Around Agreement will prevail.

2. **Rates, Benefits and Renewals.** The rates and benefit schedules are incorporated in the attachments. There will be no change in rates or benefits for the initial term which shall be January 1, 2009 until December 31, 2011. At the sole option of the County, the County may renew the contract for two (2) subsequent one (1) year periods. For calendar year 2009, Provider agrees that there shall be no rate increases for the DHMO Policy or associated ADA Copayment Codes. Provider will provide County with a 180-day Tentative Renewal Rate Notice and a 120-day Final Renewal Rate Notice prior to each renewal period which shall include any benefit changes. If County elects to renew the Agreement for any of the renewal periods, County shall provide a 45-day written Notice of Intent to Renew prior to an anniversary date.

3. **Indemnification.** The Provider shall indemnify and save harmless and defend the County, its agents, servants, and employees from and against any and all claims, liability, losses, and/or cause of action which may arise from any act or omission of the Provider, its agents, servants, or employees in the performance of services under this Agreement, including, but not limited to the denial of claims. The indemnification provided hereinunder shall specifically exclude any claims by employees for payment of dental services authorized by an employee which are not covered under the employee's plan benefits including applicable co-payments.

4. **Insurance Requirements**

It shall be the responsibility of the PROVIDER to provide evidence of the following minimum amounts of insurance coverage to Palm Beach County, c/o Purchasing Department, 50 South Military Trail, Suite 110, West Palm Beach, FL 33415, Attention: **Dennis Leaf.**

The PROVIDER shall, on a primary basis and at its sole expense, maintain in full force and effect, at all times during the life of this Contract, insurance coverages and limits (including endorsements) as described herein. Failure to maintain the required insurance will be considered default of the Contract. The requirements contained herein, as well as COUNTY's review or acceptance of insurance maintained by PROVIDER, are not intended to and shall not in any manner limit or qualify the liabilities and obligations assumed by PROVIDER under the Contract. PROVIDER shall agree to provide the COUNTY with at least ten (10) day prior notice of any cancellation, non-renewal or material change to the insurance coverages. Further, PROVIDER shall agree that all insurance coverage required herein shall be provided by PROVIDER to COUNTY on a primary basis.

a. Commercial General Liability: PROVIDER shall maintain Commercial General Liability at a limit of liability not less than $500,000 Each Occurrence. Coverage shall not contain any endorsement(s) excluding Contractual Liability or Cross Liability.

b. Business Auto Liability: PROVIDER shall maintain Business Auto Liability at a limit of liability not less than $500,000 Each Occurrence for all owned, non-owned, and hired automobiles. In the event PROVIDER owns no automobiles, the Business Auto Liability requirement shall be amended allowing PROVIDER to maintain only Hired & Non-Owned Auto Liability. This amended requirement may be satisfied by way of endorsement to the Commercial General Liability, or separate Business Auto coverage form.

c. Workers' Compensation Insurance & Employer's Liability: PROVIDER shall maintain Workers' Compensation & Employer's Liability in accordance with Florida Statute Chapter 440.

d.. Additional Insured Clause: Except as to Business Auto, Workers' Compensation and Employer's Liability (and Professional Liability, when applicable) the Certificate(s) of Insurance shall clearly confirm that coverage required by the Contract has been endorsed to include Palm Beach County as an Additional Insured.

e. Waiver of Subrogation: PROVIDER, if found legally liable, hereby waives any and all rights of Subrogation against the COUNTY, its officers, employees and agents for each required policy. When required by the insurer, or should a policy condition not permit an insured to enter into a pre-loss agreement to waive subrogation without an endorsement, then PROVIDER shall notify the insurer and request the policy be endorsed with a Waiver of Transfer of Rights of Recovery Against Others, or its equivalent. This Waiver of Subrogation requirement shall not apply to any policy which includes a condition to the policy specifically prohibiting such an endorsement or voids coverage should PROVIDER enter into such an agreement on a pre-loss basis.

f.. Certificates of Insurance: Within a minimum of five (5) days of the COUNTY's request to do so, the PROVIDER shall deliver to the COUNTY Certificate(s) of Insurance evidencing that all types and amounts of insurance coverages required by this Contract have been obtained and are in full force and effect. During the term of the Contract and prior to each subsequent renewal thereof, the PROVIDER shall provide this evidence to the COUNTY prior to the expiration date of each and every insurance required herein. Such Certificate(s) of Insurance shall include a minimum ten (10) day endeavor to notify due to cancellation of coverage.

h. Self Insurance: If PROVIDER is self-insured for any or all of the coverages listed above, a Certification of Self-Insurance must be attached. The Certification of Self-Insurance must demonstrate sufficient financial resources and ability to meet its financial obligations and compensate for damages awarded in professional liability judgments.

i. Umbrella or Excess Liability: If necessary, PROVIDER may satisfy the minimum limits required above for either Commercial General Liability, Business Auto Liability, and Employer's Liability coverage under Umbrella or Excess Liability. The Umbrella or Excess Liability shall have an Aggregate limit not less than the highest "Each Occurrence" limit for either Commercial General Liability, Business Auto Liability, or Employer's Liability. The COUNTY shall be specifically endorsed as an "Additional Insured" on the Umbrella or

Excess Liability, unless the Certificate of Insurance notes the Umbrella or Excess Liability provides coverage on a "Follow-Form" basis.

j. Right to Revise or Reject: COUNTY, by and through its Risk Management Department in cooperation with the contracting/monitoring department, reserves the right to review, modify, reject, or accept any required policies of insurance, including limits, coverages, or endorsements, herein from time to time throughout the term of this Contract. COUNTY reserves the right, but not the obligation, to review and reject any insurer providing coverage because of poor financial condition or failure to operate legally.

5. **Membership I.D. Cards.** Provider agrees to distribute membership cards to all covered employees prior to the effective date of coverage, January 1, 2009.

6. **ERISA.** The parties acknowledge that the County is not subject to ERISA regulations and all reference thereto in Exhibits A through C is inapplicable.

7. **No Minimum Participation Requirements.** Provider acknowledges that there are no minimum participation requirements and any reference thereto in Exhibits A through C is inapplicable.

8. **Waiting Periods.** There shall be no waiting periods for currently covered employees or currently covered dependents.

9. **COBRA Administration.** Provider agrees to provide all COBRA related services, including, but not limited to notices and premium collection.

10. **Grace Period.** The parties agree that a forty-five (45) day grace period shall be applicable for all premium payments, and any provision in Exhibits A through C to the contrary is inapplicable.

11. **Confidentiality of Employee Information.** Provider understands and agrees that certain information obtained about County employees, including, but not limited to, medical information and social security numbers, is exempt from disclosure under the Florida Sunshine laws. Provider will take all necessary steps to safeguard this information unless otherwise required by law, and agrees to defend, indemnify and hold harmless the County for any claims, damages and liabilities, including attorneys fees and costs, which may arise from the intentional or negligent disclosure of such information. Additionally, Provider specifically agrees that it will not, in any way, sell or distribute, in whole or in part, any listing of employee names, addresses or telephone numbers. Further, the parties agree to abide by all applicable state and federal regulations, including, but not limited to HIPAA.

12. **Reporting.** Provider will provide quarterly reports to County on claims experience.

13. **Notices.** All notices required in this Agreement shall be sent by certified mail, return receipt requested, and if sent to the County shall be mailed to:

Nancy Bolton, Director of Risk Management
Palm Beach County
160 Australian Avenue
West Palm Beach, Florida 33406

with courtesy copies of notices to the following:

Tanya Russell, Group Insurance Specialist
Palm Tran, Inc.
3201 Electronics Way
West Palm Beach, Florida 33407-4618

Amparo Korey
Supervisor of Elections
240 S. Military Trail
West Palm Beach, Florida 33416

and if sent to the Provider shall be mailed to:

Steve Lepley, Sales Associate
Assurant Employee Benefits
5401 West Kennedy Blvd.
Suite 760, 7th floor
Tampa, FL 33609

14. **Access and Audits**. The Provider shall maintain adequate records to justify all charges to the County for at least three (3) years after completion of this Agreement. The County shall have access to such books, records, and documents as required in this section for the purpose of inspection or audit during normal business hours, at the Provider's place of business.

15. **Severability**. If any term or provision of this Agreement, or the application thereof to any person or circumstances shall, to any extent, be held invalid or unenforceable, to remainder of this Agreement, or the application of such terms or provision, to persons or circumstances other than those as to which it is held invalid or unenforceable, shall not be affected, and every other term and provision of this Agreement shall be deemed valid and enforceable to the extent permitted by law.

16. **Remedies.** This Agreement shall be governed by the laws of the State of Florida. Any and all legal action necessary to enforce the contract will be held in Palm Beach County. No remedy herein conferred upon any party is intended to be exclusive of any other remedy, and each and every such remedy shall be cumulative and shall be in addition to every other remedy given hereunder or now or hereafter existing at law or in equity or by statute or otherwise. No single or partial exercise by any party of any right, power, or remedy hereunder shall preclude any other or further exercise thereof.

17. **Nondiscrimination.** The Provider warrants and represents that all of its employees are treated equally during employment without regard to race, color, religion, disability, sex, age, national origin, ancestry, marital status, or sexual orientation.

18. **Modifications to Agreement.** Modifications to this Agreement can only be made upon mutual written consent of the parties. Provider agrees that no changes shall be made to the policies or Group Dental Service Agreement (Exhibits A through C) without the written approval of County.

(The rest of this page is left blank intentionally)

Signed, sealed and delivered
in the presence of:

UNION SECURITY INSURANCE COMPANY, a corporation authorized to do business in the state of Florida

BY: Kimberly K Reese

TITLE: 2ND VP, RISK

(CORPORATE SEAL)

COUNTY:

ATTEST:

PALM BEACH COUNTY, FLORIDA, a Political subdivision of the state of Florida, by its Board of County Commissioners

SHARON R. BOCK, Clerk & Comptroller

BY: _____
Deputy Clerk

BY: _____
Addie L. Greene, Chairperson

(SEAL)

THE SUPERVISOR OF ELECTIONS OF PALM BEACH COUNTY

BY: C. W. Anderson

Its Supervisor of Elections

APPROVED AS TO FORM AND LEGAL SUFFICIENCY:

BY: _____
County Attorney

APPROVED AS TO TERMS AND CONDITIONS:

BY: Nancy L Bolds
Department Director

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Union Security Insurance Company
2323 Grand Boulevard
Kansas City, MO 64108
800.443.2995

GROUP DENTAL SERVICE AGREEMENT

It is agreed between Palm Beach County Board of County Commissioners ("Group") and Union Security Insurance Company ("Company") as follows:

ARTICLE I
COVERAGE INFORMATION

1.1 **Group:**

Name: Palm Beach County Board of County Commissioners

Address: 160 Australian Avenue, Suite 401

City, State, Zip: West Palm Beach, Florida 33406

1.2 **Group Coverage Basis**:

☒ Contributory ☐ Non-Contributory

1.3 **Class of Members to be Covered:**

☒ Active ☐ Retired

1.4 **Form of Coverage (choose one):**

☐ Group requests coverage under the Plus Plan with the Specialty Benefit Amendment (SBA).
☒ Group requests coverage under the Plus Plan with the Ortho Specialty Benefit Amendment (OSBA).
☐ Group requests coverage under the Plus Plan without the Specialty Benefit Amendment (SBA).

1.5 **Total Group Prepayment Fee:** The Total Group Prepayment Fee is obtained by multiplying the number of Subscribers in each Fee Category by the Prepayment Fee for that category and adding the results. It is due and payable from Group as set out in this Agreement.

Fee Category	Plan Fee	+	SBA Fee	=	Monthly Prepayment Fee
Subscriber Only	$ 9.82	$	1.99	$	11.81
Subscriber + One	$ 16.61	$	3.59	$	20.20
Subscriber + Two	$ 23.03		4.34		27.37
Subscriber + Family	$ 27.18		8.93		36.11

1.6 **Group Administration Fee:**

☒ Not Applicable ☐ Applicable: A group Administration Fee of $10 for the initial month and $10 for each subsequent month is due and payable from Group with the Total Group Prepayment Fee.

1.7 **Initial Fee Guarantee Period:** Company will not change the Prepayment Fee for any Fee Category, or the applicability and amount of any Administration Fee, for the first 24 months during which Agreement is in effect (or for the entire period during which Agreement is in effect, if that is a shorter period).

1.8 **Effective Date, Initial Plan Year, Anniversary Date:** This Agreement becomes effective on the first day of January, 2008 ("Effective Date"). Agreement's initial Plan Year begins on the Effective Date and lasts for a period of 12 months, unless terminated before the end of that period by Company or Group. Agreement may be renewed pursuant to the renewal provisions of Agreement unless first terminated by Company or Group. If Agreement is renewed, Agreement's first Anniversary Date is the first day of January, 2009, with subsequent Anniversary Dates on the first day of January in each succeeding calendar year.

ARTICLE II
ENTIRE CONTRACT

2.1 **Entire Contract:** The Group Dental Service Agreement, Evidence of Coverage, Copayment Schedule and any applicable exhibits or amendments, hereinafter called "Agreement," form the entire agreement of the parties. This Agreement may be amended or modified. Changes must be in writing executed by Group and an authorized officer of Company.

ARTICLE III
DEFINITIONS

The following terms shall be defined as follows:

3.1 **Administration Fee:** The Group's Administration Fee (if applicable) is the fee paid by Group in addition to the Total Group Prepayment Fee.

3.2 **Anniversary Date:** The first Anniversary Date is the day after the initial Plan Year ends. The Anniversary Date occurs on the same date in each subsequent calendar year.

3.3 **Copayment:** Shall mean a per-service fee charged to Member by Plan Provider as identified in the Copayment Schedule.

3.4 **Dental Emergency:** The sudden and unexpected onset of an acute condition involving severe pain, requiring immediate dental care for temporary pain relief.

3.5 **Dependent:** Subscriber's spouse or domestic partner and Subscriber's natural children from and after moment of birth; adopted children from: a) date of placement or b) moment of birth if Subscriber has entered into an agreement to adopt such child prior to the birth of the child; stepchildren; and foster children. To be eligible, all such children must be under age nineteen (19) years (the "Limiting Age") and unmarried. To be eligible, stepchildren and foster children must also be chiefly dependent on Subscriber for maintenance and support. Dependents will be covered until the end of the calendar year in which they reach the Limiting Age. Eligibility may be extended past the Limiting Age for unmarried children under twenty-five (25) years who live in the Subscriber's household and are chiefly dependent on Subscriber for support and maintenance. Eligibility may also be extended past the Limiting Age for unmarried children under age twenty-five (25) years who are registered students in full-time or part-time attendance at a school, college or university. Dependents who are living in Subscriber's household and are chiefly dependent on Subscriber for support and maintenance or who are registered students in full-time or part-time attendance at a school, college or university will be covered until the end of the calendar year in which they reach twenty-five (25) years of age. Eligibility may be extended past the Limiting Age for unmarried children who are not capable of self-sustaining employment due to a disability or physical handicap and are chiefly dependent on Subscriber for maintenance and support. If Company requests proof of a Dependent's eligibility, Subscriber must furnish proof within 31 days of Company's request. Company will not require proof of a Dependent's continuing eligibility more than once a year.

3.6 **Effective Date:** The date coverage begins under Agreement.

3.7 **Emergency Services:** Those dental services required for temporary pain relief in a Dental Emergency.

3.8 **Enrollment Form**: Shall mean the Group Enrollment Form.

3.9 **Fee Categories:** Member classifications used to determine the applicable Prepayment Fee for each Member's coverage under Agreement.

3.10 **Initial Fee Guarantee Period:** The period of time beginning on the Effective Date during which the Company agrees not to change the Prepayment Fee charged for any Fee Category, or the applicability or amount of any Administration Fee.

3.11 **Member:** Shall mean a Subscriber or Dependent who is enrolled in Plan.

3.12 **Non-Plan Dentist:** A general dentist who is not a Plan Dentist.

3.13 **Non-Plan Provider:** A Non-Plan Dentist or a Non-Plan Specialist, or a hygienist or technician acting with or assisting such a dentist.

3.14 **Non-Plan Specialist:** A dentist practicing in a dental specialty who is not a Plan Specialist.

3.15 **Plan Benefits:** Shall mean benefits for services provided under Agreement, subject to any limitations and exclusions.

3.16 **Plan Dentist:** Shall mean a licensed General Dentist who, at time Plan Benefits are provided, is under contract with Company to provide certain dental services to Members. Copayments listed in the **PLAN DENTIST SERVICES** Section of the Copayment Schedule apply only to Plan Dentists who perform the corresponding services listed in the Copayment Schedule. The Plan Dentist selected by Member may not perform all listed services. In order to fully understand payment responsibility for dental services,

Member should discuss availability of services and the proposed treatment and its cost with selected Plan Dentist prior to receiving treatment.

3.17 **Plan Provider:** Shall mean a Plan Dentist or Plan Specialist who, at time Plan Benefits are provided, is under contract with Company to provide services to Members. The term shall include any hygienists and technicians recognized by the dental profession who act with and assist Plan Dentist or Plan Specialist. A list of Plan Providers shall be published in Plan Dentist Directory. Company has sole discretion to determine which providers may be Plan Providers. Plan Providers are independent contractors in private practice and are neither employees nor agents of Company. Company cannot guarantee the availability of any specific provider as a Plan Provider. The status of providers as Plan Providers is subject to change.

3.18 **Plan Specialist:** Shall mean a licensed dentist practicing in a dental specialty who, at time Plan Benefits are provided, is under contract with Company to provide dental specialty services to Members. Some examples of "dentists practicing in a dental specialty" are endodontists, periodontists, oral surgeons, orthodontists and pedodontists. If Group purchases the Specialty Benefit Amendment, each Plan Specialist will participate in only one of the following two categories:

Non-SBA Plan Specialist – offers any dental specialty service he provides to Members at a specific reduction from his normal retail charge.

SBA Plan Specialist – offers certain dental specialty services he provides to Members for specified Copayments (services and Copayments listed in the **PLAN SPECIALIST SERVICES** Section of the Copayment Schedule) and offers all other dental specialty services he provides to Members at a specific reduction from his normal retail charge.

In order to fully understand payment responsibility for dental specialty services, Member should discuss the proposed treatment and its cost with Plan Specialist prior to receiving treatment. Availability of specific types of specialty services from Plan Specialists (or SBA or Non-SBA Plan Specialists) depends on which types of dentists are Plan Specialists. Company cannot guarantee the availability of any specific type of dentist as a Plan Specialist (or an SBA or Non-SBA Plan Specialist). Types of dentists who are Plan Specialists (or SBA or Non-SBA Plan Specialists) may vary from time to time in different parts of the Service Area. If Group purchases the Specialty Benefit Amendment, the Copayments listed in the **PLAN SPECIALIST SERVICES** Section of the Copayment Schedule apply only to SBA Plan Specialists who perform the corresponding services listed in the Copayment Schedule. The SBA Plan Specialist selected by Member may not perform all listed services.

3.19 **Plan Year:** The initial Plan Year begins on the Effective Date and lasts until the day before the first Anniversary Date. Each subsequent Plan Year begins on the Anniversary Date and lasts for a period of twelve (12) calendar months.

3.20 **Prepayment Fee:** The periodic fee paid to Company for each Member's coverage.

3.21 **Service Area:** The geographic area where Plan Benefits are available. The extent of the Service Area is within the sole discretion and determination of Company.

3.22 **Subscriber:** Shall mean an employee, member, or beneficiary of Group who is eligible to participate in Plan under the eligibility requirements determined by Group.

3.23 **Total Group Prepayment Fee:** The sum of the Prepayment Fees for coverage of all Members.

ARTICLE IV
PREPAYMENT FEE, ADMINISTRATION FEE, AND ELIGIBILITY

4.1 **Prepayment Fee and Administration Fee:** Group shall pay Company the Prepayment Fee for each enrolled Member. Group shall also pay Company the Administration Fee (if applicable) at the same time and in the same manner as the Prepayment Fees. The Total Group Prepayment Fee and (if applicable) Administration Fee shall be paid in a single payment. This starts on the Effective Date and continues on the first day of each month thereafter while Agreement is in force.

After the Initial Fee Guarantee Period, Company reserves the right to change any Prepayment Fee and to change the applicability and amount of any Administration Fee upon sixty (60) days written notice to Group. Payment of any amended Prepayment Fee or Administration Fee indicates acceptance of the amended Prepayment Fee or Administration Fee.

4.2 **Grace Period:** This Agreement has a thirty (30) day grace period. This means that if any required prepayment fee is not paid on or before the date it is due, it may be paid subsequently during the grace period. During the grace period, the Agreement will stay in force.

4.3 **Provision of Plan Benefits/Plan Providers:** Group acknowledges that unless there is a need for Emergency Services, Agreement provides exclusively for services performed by a Plan Provider. Company shall not have any liability due to treatment by any Non-Plan Provider, physician, hospital, other person, institution or group. Each Member shall select a Plan Dentist from Plan Dentist Directory furnished by Company to Group. Agreement provides for services only. It is not an insurance policy. It does not reimburse Member or Group, except for Emergency Services.

4.4 **Eligibility List:** Group shall be responsible for providing Company, by the 20th day of the month, the names and other identifying data for each Member to be covered in order for eligibility to be effective on the 1st day of the succeeding month, unless otherwise noted in this Agreement. Group shall identify those Members who are newly eligible to receive Plan Benefits. Group shall name the Plan Dentist selected by each Member who is newly eligible. Group shall identify those Members whose coverage will terminate. Group shall be responsible for payment of Prepayment Fees due Company for Members. Payment shall continue until notice of a change in eligibility is provided by Group to Company.

4.5 **Eligibility:** Group shall determine eligibility for participation in Plan. Company may rely upon such decision until Group provides notice of a change in eligibility. Any disputes or inquiries from Members regarding eligibility, including renewal or continuation of coverage, shall be referred by Company to Group. Group shall advise Company of its decision. Each Member must work or live in Plan Service Area in order to participate in Plan.

Subscriber and his Dependent(s) are eligible to become Members of Plan during the open enrollment period set by Group. Group may allow enrollment to take place other than during open enrollment for reasons including, but not limited to, Subscriber becoming a new employee of Group, loss of eligibility under other dental benefit plans, or a change in Dependent status. If an additional Prepayment Fee is required for a newly added Dependent, Group must notify Company and pay the additional Prepayment Fee within thirty-one (31) days after that date.

4.6 **Coverage of Members:** The Effective Date of coverage for Subscriber or Dependent shall be the first day of the month after written notice and payment of the Prepayment Fee is accepted by Company. Each Subscriber or Dependent enrolled in Plan and whose proper Prepayment Fee has been accepted by Company on or before the 20th day of a month will be covered beginning the first day of the following month. Each Subscriber or Dependent enrolled in Plan and whose proper Prepayment Fee has been accepted by Company after the 20th day, but by the last day, of the month will be covered beginning the first day of the second following month. However, Subscriber's newborn natural children and newborn adopted children (if Subscriber has entered into a written agreement to adopt such child prior to the birth of the child) will be covered from the moment of birth. Children placed with Subscriber for the purpose of adoption will be covered from the moment of placement.

4.7 **Enrollment Forms:** Each Member shall complete an Enrollment Form or suitable proof of enrollment.

ARTICLE V
BENEFITS

5.1 **Plan Benefits:** Company shall provide benefits for dental services to Members as set forth in the Evidence of Coverage and Copayment Schedule. Services are subject to limitations and exclusions. Services are provided for the term of Agreement. Company reserves the right to change Plan Benefits after the initial Plan Year. Notice of change is subject to sixty (60) days written notice to Group.

5.2 **Copayments and Other Charges:** Member is responsible for payment of all Copayments, any additional laboratory fees for certain dental services as stated in the Copayment Schedule, and all charges for services that are not Plan Benefits. Member must pay dental provider at the time service is rendered. Member may have an option to pay according to provider's billing procedures.

5.3 **Current Dental Terminology:** The most current dental terminology may not be reflected in Agreement. However, Plan Benefits will be based on the most current dental terminology. From time to time, and with at least thirty (30) days written notice to Group, Company reserves the right to update Agreement to reflect the most current dental terminology.

ARTICLE VI
MEMBER/PLAN PROVIDER RELATIONSHIP

6.1 **Member/Plan Provider Relationship:** The relationship between Member and Plan Provider shall be an independent professional one. Plan Provider shall be solely responsible, without intrusion by Company or Group for all services within the professional relationship between Member and Plan Provider. Company has the right to refuse Plan Benefits, and Plan Provider has the right to refuse treatment, to any Member who: (1) fails to follow a prescribed course of treatment; (2) fails to keep confirmed appointments; (3) fails or refuses to make required payments (including but not limited to Copayments, laboratory fees or missed appointment fees) or any charges for non-covered procedures; (4) uses the relationship for illegal purposes; or (5) otherwise makes the professional relationship unduly burdensome.

6.2 **Plan Provider Facilities:** The operation and maintenance of Plan Provider's facilities and equipment shall be completely under the control of Plan Provider. This includes the selection of staff, supervision of personnel and operation of the professional practice. It also includes rendition of any particular professional service or treatment.

6.3 **Providers Not Participating with Plan:** Company does not review practice standards of Non-Plan Providers. Members who obtain services from Non-Plan Providers should separately assess the practice standards and skills of those providers.

ARTICLE VII
ADMINISTRATION

7.1 **Distribution of Plan Materials and Notices to Members:** Company may be obligated under state law to give notice or Plan materials to Member. If so, it shall be sufficient for Company to give notice or Plan materials to the Group's delegate, unless state law requires otherwise. Group shall then be responsible for providing notice or Plan materials to Subscribers.

7.2 **Selection of Provider:**

A. Plan Dentist: Each Member shall select a Plan Dentist from Plan Dentist Directory. To obtain Plan Benefits, Member shall contact selected Plan Dentist. Either Member or Plan Dentist may request a change of Plan Provider selection by contacting Company.

B. Plan Specialist:

Without Specialty Benefit Amendment: If Member requires specialty services covered under Plan that cannot be provided by Member's selected Plan Dentist, Member may obtain services from a Plan Specialist. No referral from the selected Plan Dentist is needed. Plan does not cover services received from Non-Plan Providers.

With Specialty Benefit Amendment: Under the Specialty Benefit Amendment, Member may obtain services from a Plan Specialist. No referral from the selected Plan Dentist is needed. Member's out-of-pocket amount may vary depending on whether services are received from an SBA Plan Specialist or a Non-SBA Plan Specialist. Plan does not cover services received from Non-Plan Providers.

7.3 **Emergency Services:** Procedures for obtaining Emergency Services are in the Evidence of Coverage. A copy of the procedures may also be obtained by contacting Company.

7.4 **Assignment of Benefits:** Member's coverage is intended for sole use and benefit of Member. Coverage cannot be transferred to a third party.

ARTICLE VIII
MEMBER GRIEVANCE PROCESS

8.1 **Grievance Procedures:** Inquiries, complaints or grievances may be submitted by telephone or in writing to Company or Plan Provider. Member also has the right to contact the Florida Department of Insurance for assistance, at any time, by calling its consumer hotline (800.342.2762) or by addressing mail to 200 East Gaines Street, Larson Building, Tallahassee, Florida 32399-3000.

A. Definition: A grievance or complaint is defined as any dissatisfaction regarding plan administration, a denial, reduction or termination of a benefit; the way a benefit is provided, or disenrollment decisions. Any such complaint, or grievance, will be considered informal if it is received verbally. A complaint or grievance will not be considered formal until received by Company in writing.

B. Informal Grievance: Member may contact Company Customer Service department at 800.443.2995 regarding any inquiry, complaint or grievance that cannot be resolved to Member's satisfaction. This occurs after speaking directly with the dentist or other concerned party. Company Customer Service Representative will assess and resolve Member's concern. If Member is not satisfied with the resolution, Member may file a written complaint to Company. Company Customer Service Representative will provide Member with the guidelines. In addition, such representative may provide a complaint form to be completed.

C. Formal Grievance: Company expects receipt of a completed complaint form or correspondence from Member expressing dissatisfaction with service or care delivered by Company or Plan Dentist. Any formal grievance may be mailed to: Company Director of Customer Service, P.O. Box 830069, Birmingham, AL 35282-8320. Company will investigate the complaint and will provide a written resolution to Member within sixty (60) calendar days. In matters of quality of care or clinical issues, an appropriate health professional will be consulted. If the complaint is not resolved to Member's satisfaction, Company shall provide an appeal procedure.

8.2 **Appeal Procedure:** If Member is not satisfied with the resolution of a written complaint, Member may request an appeal of Company's assessment. Upon receipt of an appeal request, Company will provide Member with Company's written appeal process as defined by Company or applicable State law.

ARTICLE IX
TERM AND TERMINATION

9.1 **Term:** After the initial Plan Year, each Plan Year of Agreement shall have a twelve month term. It shall be automatically renewed at the Anniversary Date unless otherwise terminated.

9.2 **Termination:** Agreement may be terminated as follows:

A. During the initial Plan Year by Company:

1. For failure to pay proper monthly Prepayment Fees or (if applicable) the proper monthly Administration Fee prior to the 10th of the month in which such fees are due, subject to the grace period explained in the PREPAYMENT FEE, ADMINISTRATION FEE, AND ELIGIBILITY article.

2. For fraud or misrepresentation of fact in obtaining coverage under Plan, effective immediately upon prior written notice to Group.

3. For material breach of any provision of Agreement, upon forty-five (45) days written notice to Group.

B. At Anniversary Date, upon sixty (60) days prior written notice by Company to Group or by Group to Company.

C. After the initial Plan Year, without cause, upon sixty (60) days prior written notice by Company to Group or by Group to Company.

9.3 **Services in Progress at Termination:** If Member's enrollment ends for any reason, each Plan Provider is required to complete all dental services initiated prior to the date

Member's enrollment ends. Member's financial responsibility for such services is determined according to the terms of Agreement in effect on the last day of Member's enrollment.

9.4 **Member Termination:** Member coverage shall terminate as follows:

A. On the last day of the month for which Group has placed Member on eligibility list and has paid Member's proper Prepayment Fee.

B. If Member commits fraud or material misrepresentation in the use of services or facilities, coverage for Member will terminate immediately upon written notice.

C. If Member commits fraud or material misrepresentation on Enrollment Form submitted by Member, coverage will terminate immediately upon written notice. This provision will not be enforced after two (2) years from the time Member's coverage begins.

D. If Group and/or Company terminates Agreement, coverage for Member shall cease on the termination date of Agreement. This shall be subject to any notice required by state law.

E. Coverage for Subscriber's Dependents will be terminated if the coverage for Subscriber terminates for any reason. This is subject to continuation privileges for certain Dependents as set forth herein.

F. Once a Member is no longer qualified as a Dependent, coverage for that Member will terminate.

G. If Member no longer works or lives in Plan Service Area.

9.5 **Conversion Privilege:** If any Subscriber or Dependent of a Subscriber ceases to meet eligibility requirements of Group and has been continuously covered under Plan for at least 3 months, he may convert to an individual dental plan. This occurs without furnishing evidence of insurability. In order to obtain an individual dental plan, Member must submit a completed individual enrollment form and all required Prepayment Fees to Plan within thirty-one (31) days after termination date. Company will notify Member in writing of coverage effective date. Conversion privileges shall not be made available to any Member terminated due to:

1. failure to pay required prepayment fee or contribution,

2. fraud or material misrepresentation in applying for benefits under the Group Agreement,

3. willful and knowing misuse of Plan identification or documents,

4. willful and knowing furnishing to Company incorrect or incomplete information to obtain coverage from Plan,

5. no longer working or residing in the Plan Service Area,

6. disruptive, unruly, abusive or uncooperative behavior that impaired Company's ability to furnish services to other Members,

or to any Member who will have similar replacement coverage within 31 days.

9.6 **Continuation of Coverage under COBRA:** If under the provisions of Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Public Law 99-272, Member is granted the right to continuation of coverage beyond the date Member's coverage would otherwise terminate, the following applies. Agreement shall be deemed to allow continuation of coverage as necessary to comply with the provisions of applicable statutes. Member should contact Group concerning eligibility.

ARTICLE X
GENERAL PROVISIONS

10.1 **Amendments:** By mutual consent, Company and Group may modify, amend or alter Agreement. Such change shall be in writing and duly executed by both parties, except to the extent Company updates Plan Benefits to be based on the most current dental terminology. Any change shall be attached to Agreement. Company may amend Agreement unilaterally to comply with germane law.

10.2 **Waiver:** The waiver by either party of one or more defaults shall not be construed as a waiver of any other or future default. This applies to any covenant or other condition contained in Agreement. Only an authorized officer of Company may waive any conditions or restrictions of Agreement. Only an authorized officer of Company can amend Agreement, extend time for making a payment or bind Company by making any promise or representation. Such promise or representation shall be in writing. No change in Agreement shall be valid unless endorsed by an authorized officer of Company.

10.3 **Notice:** Notice to either party under this Agreement shall be in writing. Notice shall be sent to the address shown in Agreement.

10.4 **Terms:** Throughout Agreement, the singular shall include the plural and the plural the singular. The masculine shall include the neuter and feminine. The neuter shall include the masculine and feminine.

10.5 **Invalidity:** If any provision of Agreement is determined to be illegal or invalid, all other provisions remain valid. This is true unless the illegality or invalidity prevents the purposes of Agreement from being realized.

10.6 **Assignment of Agreement:** No assignment of Agreement is binding upon Company or Group unless Company and Group agree to it in writing. Any such assignment shall not waive a party's right to withhold its consent to any other assignment. There may occur a merger or acquisition involving Group. If so, Agreement shall remain in force with the surviving entity for the balance of the term of Agreement.

10.7 **Acknowledgment:** Each of the parties acknowledges that it has read Agreement and understands its contents. Each party acknowledges it executes Agreement voluntarily.

10.8 **Authority:** Group represents it has the authority under applicable law and its charter instrument to execute Agreement.

10.9 **Worker's Compensation:** Agreement is not in place of and does not affect any requirement for coverage by Worker's Compensation.

10.10 **Governing Law:** Agreement shall be governed by and construed according to laws of the State of Florida.

10.11 **Circumstances Beyond Company's Control:** Rendition of dental services may be delayed or made impractical due to circumstances not within Company's control. If this

occurs, neither Company nor Plan Provider shall have any liability or obligation to provide services on account of such delay. This includes, but is not limited to, complete or partial destruction of facilities, war, riot and civil insurrection. It also includes labor disputes or disability of a significant number of Plan Providers.

10.12 **Major Disaster or Epidemic:** If a major disaster or epidemic occurs, Plan Provider shall render dental services as practical according to his judgment. Such disaster or epidemic may limit available facilities or personnel. In such a situation, neither Company nor Plan Provider shall have any liability or obligation for delay or failure to provide dental services.

10.13 **ERISA:** If Group is regulated under the Employee's Retirement Income Security Act of 1974 (ERISA), Company will work with Group in supplying Group with any information in its possession in meeting any reporting requirements. Company is not and shall not be the chosen administrator or fiduciary for reporting requirements.

IN WITNESS WHEREOF, the parties have affixed their signature to this Agreement.

COMPANY: Union Security Insurance Company	GROUP: Palm Beach County Board of County Commissioners
By: _____ Signature	By: _____ Signature
KIMBERLY R. REESE, 2ND VP Print Name and Title	_____ Print Name and Title
09-22-08 Date	_____ Date

Approved as to Terms and Conditions

Nancy L Bolton
Department Director

ATTACHMENT #3

Union Security Insurance Company agrees to provide the insurance described in this and the following pages of the *policy*, subject to payment of premiums.

Policyholder:	Palm Beach County Board of Commissioners
Policy Number:	G 5,303,634
Delivered In:	Florida and governed by its laws.
Effective Date:	January 1, 2009 - The date the *policy* takes effect which is also its date of issue.
Premium Due Dates:	The first premium is due on the Effective Date. Future premiums are due on the first day of each month after that.
Policy Anniversary:	January 1, 2010, and each January 1 after that.
Insurance Provided:	Group Dental Insurance – Contributory Group Dental Insurance for Dependents – Contributory

Kenneth A. Jones
Secretary

Michael J Peninger
Executive Vice-President

Union Security Insurance Company 2323 Grand Boulevard Kansas City Missouri 64108-2670

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GENERAL DEFINITIONS

These terms have the meanings shown here when *italicized*. The pronouns "we", "us", "our", "you", and "your" are not *italicized*.

Active work means working *full-time* for the *policyholder* or an *associated company* at your usual place of business.

Associated company means any company shown in the *policy* which is owned by or affiliated with the *policyholder*.

Contributory means you pay part or all of the premium.

Covered dependent means an *eligible dependent* who is insured under the *policy*.

Covered person means an eligible employee or member of the *policyholder*, or an *associated company* who has become insured for a coverage.

Doctor means a person, other than you, acting within the scope of his or her license to practice medicine and perform surgery.

Eligible class means a class of persons eligible for insurance under the *policy*. This class is based on employment or membership in a group.

Full-time means working at least 30 hours per week, unless indicated otherwise in the *policy*.

Home office means our office in Kansas City, Missouri.

Injury means accidental bodily injury. It does not mean intentionally self-inflicted injury while sane or insane.

No-fault motor vehicle coverage means a motor vehicle plan that pays disability or medical benefits without considering who was at fault in any accident that occurs.

Policy means the group policy issued by us to the *policyholder* that describes the benefits for which you may be eligible.

Policyholder means the entity to whom the *policy* is issued.

Proof of good health means evidence acceptable to us of the good health of a person.

We, us, and our mean Union Security Insurance Company.

You and your mean an eligible employee or member of the *policyholder* or an *associated company* who has become insured for a coverage.

DEFINITIONS FOR DENTAL INSURANCE

Accidental non-chewing injury means an *injury* (other than a chewing injury) sustained while insured under the *policy*, which is caused solely and exclusively by an accident which could not be predicted in advance, and which could not be avoided. A chewing injury is any *injury* which occurs during the act of biting or chewing, regardless of whether the *injury* is caused by biting or chewing food, biting on a foreign object not expected to be a normal constituent of food, parafunctional or abnormal habits such as (but not limited to) chewing on eyeglass frames or pencils, biting down on a suddenly dislodged or loose dental appliance, or biting or chewing on any other object for any other reason.

Allowable charge means:

- For a covered dental service rendered by a *preferred provider*, the *allowable charge* is based on an amount, as determined by us, that the *preferred provider* has agreed to accept. Our determination of what is an *allowable charge* is final for the purposes of determining benefits payable under the policy.

- For a covered dental service rendered by a *non-preferred provider*, the benefit payable will not exceed what would have been payable if a *preferred provider* rendered the services.

Benefit year means a period of 12 consecutive months, which begins on the date you become insured under the *policy*. Subsequent *benefit years* begin on each succeeding anniversary of the date you became insured under the *policy*.

Continuous coverage/continuously covered means, with respect to a *transfer insured's* coverage under the *prior plan*, the most recent period of continuous coverage under the *prior plan* ending on the day before the effective date of this *policy*.

Dental hygienist means an individual who is licensed to practice dental hygiene and acting under the supervision of a *dentist* within the scope of that license in treating the dental condition.

Dental insurance means the group dental insurance under the *policy* issued by us to the *policyholder*.

Dentally necessary and dental necessity mean a service or *treatment* which is appropriate with the diagnosis and which is in accordance with accepted dental standards. The service or *treatment* must be essential for the care of the teeth and supporting tissues.

Dental treatment plan means the *dentist's* report of recommended *treatment* which contains:

- a list of the charges and dental procedures required for the *dentally necessary* care;

- any supporting pre-operative x-rays; and

- any other appropriate diagnostic materials required by us.

Dentist means an individual who is licensed to practice dentistry and acting within the scope of that license in treating the dental condition.

Denturist means an individual who is licensed to make dentures and acting within the scope of that license in treating the dental condition.

Emergency dental treatment means any *dentally necessary treatment* that is rendered as the direct result of unforeseen events or circumstances, which require prompt attention.

DEFINITIONS FOR DENTAL INSURANCE (continued)

Functioning natural tooth means a *natural tooth* which is performing its normal role in the chewing process in the person's upper or lower arch and which is opposed in the person's other arch by another *natural tooth* or prosthetic replacement.

Immediate family means a person who is related to you or your spouse in any of the following ways: parent, spouse, child, brother, sister, or grandparent.

Medicare means a portion of Title XVIII of the United States Social Security Act of 1965, as amended.

Natural tooth means any tooth or part of a tooth that is organic and formed by the natural development of the body. Organic portions of the tooth include the crown enamel and dentin, the root cementum and dentin, and the enclosed pulp.

Non-preferred provider means a *dentist, dental hygienist,* dental office, medical center, or any dental care provider who is not a participant in our *preferred provider plan* at the time covered dental services are provided.

Orthodontic treatment means the corrective movement of teeth through the bone by means of an active appliance to correct a handicapping malocclusion (a malocclusion severely interfering with a person's ability to chew food) of the mouth. We will make the determination of the severity of the malocclusion.

Other group dental expense coverage means:

- any other group policy providing benefits for dental expenses; or
- any plan providing dental expense benefits (whether through a dental services organization or other party providing prepaid health or related services) which is arranged through any employer or through direct contact with persons eligible for that plan.

Policy year means the period of time which begins on the *policy* anniversary date of each calendar year and ends on the day before the next following yearly *policy* anniversary date. The first *policy year* begins on the *policy* effective date. The last *policy year* ends on the day *dental insurance* under the *policy* ends.

Preferred provider means a *dentist, dental hygienist*, dental office, or medical center or any dental care provider who is a participant in our *preferred provider plan.*

Preferred provider plan means the dental care delivery system established by the plan manager in which *preferred providers* participate and under which we provide certain dental benefits.

Prior Plan means the policy(ies) or plan(s) providing dental care coverage to persons of the group, which is (are) replaced by insurance under our *policy* on the *policy* effective date.

Sound tooth means a *natural tooth* that is fully restored to function, does not have any decay, is not more susceptible to *injury* than a virgin tooth, and is without periodontal disease.

Transfer insured means a person who both is insured under our *policy* on the *policy* effective date (without regard to the Exception to Effective Date provision) and was covered under the *prior plan* on the day just before that; but only so long as the person remains continuously insured under our *policy.* The Exception to Effective Date provision does not apply to such *transferred insureds*. The Continuance of Insurance provision applies to such *transferred insureds* that are not at *active work* on the *policy* effective date. However, the maximum continuation period will begin on the *policy* effective date.

Treatment means any dental consultation, service, supply, or procedure that is needed for the care of the teeth and supporting tissues.

SUMMARY OF GROUP INSURANCE

This summary is intended to help understand the group insurance policy. It does not change any of its provisions.

Dental Insurance

The *policy* pays benefits if a *covered person* or *covered dependent* incurs covered dental expenses in excess of the deductible amount. The co-insurance percentage and the deductible may vary according to the service performed. The *policy* explains which dental expenses receive limited or no benefits. In addition, waiting periods may apply to some procedures.

If a *covered person* or *covered dependent* has more than one dental expense plan, benefits under the *policy* may be reduced so that all benefits received are not more than the actual expenses.

In the following pages, the provisions that describe a particular coverage were designed to be used in both the *policy* and the certificate. Therefore the terms "you" and "your" are used to refer to the *covered person*.

Please read
the insurance
policy carefully

GROUP POLICY SCHEDULE

Eligible Class: For employee insurance – Each *full-time* employee of the *policyholder* or an *associated company,*

- who is at *active work*, and
- who is working in the United States of America,

except any temporary or seasonal worker.

For dependent insurance - Each person eligible and insured for employee insurance.

Associated Companies: None

Present Service Requirement: 60 days

Future Service Requirement: 60 days

Entry Date: An eligible person will become insured on the first of the month occurring on or after the day all eligibility requirements are met.

Minimum Participation Requirements:

Number: 10 Percentage: 20%

SCHEDULE

Dental Insurance

Deductible Amount	**PPO Plan** (In-Network Plan)	**Non-PPO Plan** (Out-of-Network Plan)
Individual Deductible Amount Per *Policy Year*:	$50	$100
Individual Deductible Amount for Type IV Services Per *Policy Year*:	$0	$0

The Individual Deductible does not apply to Type IV In-Network or Out-of-Network Dental Services.

Covered dental services incurred toward the deductible amount apply to both the PPO and Non-PPO Plans.

Coinsurance Percentages	**PPO Plan** (In-Network Plan)	**Non-PPO Plan** (Out-of-Network Plan)
Type I Services:	100%	80%
Type II Services:	70%	50%
Type III Services:	40%	25%
Type IV Services:	50%	25%

The deductible amount does not apply and the co-insurance percentages are 100% for all *covered dental expenses* received for the *treatment* of crime-related injuries of a *covered person* or *covered dependent* determined eligible under the Florida Crimes Compensation Act.

SCHEDULE (continued)

Benefit Maximums:	**PPO Plan** (In-Network Plan)	**Non-PPO Plan** (Out-of-Network Plan)
Policy Year Maximum:	$1,000	$500
Overall Benefit Maximums:		
Type IV Services:	$1,000	$1,000

Amounts applied to the benefit maximums will apply to both the PPO Plan and Non-PPO Plan maximums.

Covered dental services are based on current dental terminology and are updated periodically. The most current dental terminology may not be reflected in the Listing of Covered Dental Services. However, benefits will be payable based on the most current dental terminology.

Discounts on dental care products are available. Please visit the For Members site at www.assurantemployeebenefits.com for details.

Waiting Periods

There are waiting periods which must be fulfilled before benefits will be payable for specified dental services. Please see Waiting Periods for Insured Persons Generally under the Special Limitations provision and the detailed list of waiting periods shown below.

Type III Dental Services**

All Services under "Endodontics"	6 months
Denture Reline or Rebase Procedures, Adjustments to Dentures or other Removable Prosthetic Services under "Major Restorations—Maintenance"	6 months
Prefabricated Stainless Steel or Prefabricated Resin Crowns under "Major Restorations—Initial (New) or Replacement"	6 months
All Services under "Complex Oral Surgery"	12 months
All Services under "Major and Minor Periodontics"	12 months
Other Services under "Major Restorations—Initial (New) or Replacement	
Inlay—Onlay Restorations, Crowns (except Prefabricated Stainless Steel or Prefabricated Resin Crowns), Core Build-ups, or Posts and Cores	
Initial (New) or Replacement	12 months
Complete or Partial Dentures or addition of teeth to existing Partial Dentures	12 months
Fixed Partial Dentures or Diagnostic Casts	12 months

** These Waiting Periods for Type III Dental Services do not apply to Covered Dental Services *dentally necessary* for *treatment* of an *accidental non-chewing injury* sustained while insured; or re-cementing of or repairs to inlays, onlays, crowns, or fixed partial dentures.

Type IV Dental Services

All Services (Orthodontic Services)	12 months

Note: Type IV Dental Services available only to *covered dependent* children who are under age 19.

Vision Plan

You and your *covered dependents* are eligible for discounted vision services. The discounted vision services are provided through a third party vendor and are not covered under an insured plan. The discounted vision services offered include discounts on eye exams, prescription glasses, and services related to prescription contact lenses.

ELIGIBILITY AND TERMINATION PROVISIONS

Eligible Persons

To be eligible for insurance, a person must:

- be a member of an *eligible class*; and
- complete any Service Requirement shown in the Schedule by continuous service with the employer, the *policyholder*, or an *associated company*.

The Present Service Requirement applies to persons in an *eligible class* on the Effective Date of the *policy*. The Future Service Requirement applies to persons who become members of an *eligible class* after that.

Effective Date for an Eligible Person

A person must apply for insurance on a form acceptable to us, and agree to pay part or all of the premium.

- If a person applies and we receive the application before becoming eligible, insurance will take effect on the Entry Date shown in the Schedule in the *policy*.
- If the application is made on the date the person becomes eligible, or within 31 days after that, insurance will take effect on the Entry Date occurring on or after the date of the application.
- If application is made more than 31 days after the day the person becomes eligible, or after insurance ended because the premium was not paid, then application must be made during an annual enrollment period. *Dental insurance* will then take effect on the policy anniversary occurring on or after the date of the application.

Exception to Effective Date

If an eligible person is not at *active work* on the day insurance would otherwise take effect, insurance will not take effect until the person returns to *active work*. If the day insurance would normally take effect is not a regular work day for a person, insurance will take effect on that day if the person is able to do his or her regular job.

When a Person's Insurance Ends

A *covered person's* insurance will end on the earliest of:

- the day the *policy* ends;
- the day the *policy* is changed to end the insurance for a person's *eligible class*;
- the last day of the month in which a person is no longer in an *eligible class*;
- the last day of the month in which a person stops *active work*;
- the day a required contribution was not paid; or

- the day a *covered person* becomes covered under an optional dental plan which is sponsored by the employer, or the *policyholder*, or an *associated company* and provided through a Dental Maintenance Organization.

Continuance of Insurance

If a person is unable to perform *active work* for a reason shown below, the *policyholder* may continue the person's insurance and the person's dependent insurance, if any, on a premium-paying basis provided the person remains in other respects a member of the *eligible class*. The continuance cannot be more than the maximum continuance shown below. Continuance must be based on a uniform policy, and not individual selection.

The maximum continuance for *dental insurance* is the longest applicable period described below:

- 12 months* for *injury*, sickness, or pregnancy;
- 3 months* for lay-off, leave of absence (other than a family or medical leave of absence described below), or change to part-time; or
- the end of the period the *policyholder* is required to allow* for a family or medical leave of absence under:
  - the federal Family and Medical Leave Act; or
  - any similar state law.

* after the last day of *active work*.

Reinstatement

If a person re-enters an Eligible Class within 12 months after insurance ends, the person will not have to complete the Service Requirement again. All other provisions of the *policy* will apply.

ELIGIBILITY AND TERMINATION PROVISIONS FOR DEPENDENTS

Eligible Dependents

Your *eligible dependents* are:

- your lawful spouse, and
- your unmarried children who are less than age 19, or
- less than age 25 if a full-time or part-time student, or less than age 25 if living in your home and dependent upon you for support and maintenance. Children meeting these requirements may be covered for *dental insurance* until the end of the calendar year in which the child reaches age 25.

Children are covered for *dental insurance* from birth. "Children" include any adopted children. A child will be considered adopted on the date of placement in your home. However, if you agreed in writing to adopt the child before birth, *dental insurance* will begin on the date of birth. Stepchildren and foster children are also included if they depend on you for support and maintenance. "Children" also include any children for whom you are the legal guardian, who reside with you on a permanent basis and depend on you for support and maintenance.

An *eligible dependent* will not include any person who is a member of an *eligible class*. An *eligible dependent* may not be covered by more than 1 *covered person*.

Dependent Effective Date

You must apply for dependent insurance on a form acceptable to us. You must also agree to pay your share of the premium.

- If you apply before the dependent becomes eligible, dependent insurance will take effect on the Entry Date shown in the Schedule in the *policy*.
- If you apply on the date the dependent becomes eligible, or within 31 days after that, dependent insurance will take effect on the Entry Date occurring on or after the date of your application.
- If you apply more than 31 days after the date the dependent becomes eligible or after dependent insurance ended because the premium was not paid, then application must be made during an annual enrollment period. Dependent insurance will take effect on the policy anniversary occurring on or after the date of application.

Exception to Dependent Effective Date

Dependent insurance will not take effect until your insurance for the same coverage under the *policy* takes effect.

If an *eligible dependent* is in a hospital or similar facility on the day insurance would otherwise take effect, it will not take effect until the day after the *eligible dependent* leaves the hospital or similar facility. This exception does not apply to a child born while dependent insurance is in effect.

When Dependent Insurance Ends

A dependent's insurance will end on the earliest of:

- the day the *policy* ends;
- the day the *policy* is changed to end dependent insurance;
- the last day of the month in which that dependent is no longer eligible;
- the day your insurance for the same coverage under the *policy* ends;
- the day a required contribution for dependent insurance was not paid; or
- the day the dependent becomes covered under an optional dental plan which is sponsored by your employer, or the *policyholder*, or an *associated company* and provided through a Dental Maintenance Organization.

SPECIAL DEPENDENT INSURANCE CONTINUANCE PROVISIONS

As specified below, dependent *dental insurance* may continue, subject to the provisions that describe when insurance ends, and all other terms and conditions of the *policy*. Premiums are required for any coverage continued.

Physically Handicapped or Mentally Retarded Dependent Children

Dependent *dental insurance* for an *eligible dependent* child will continue beyond the date a child attains an age limit, if, on that date, he or she:

- is unable to earn a living because of physical handicap or mental retardation; and
- is chiefly dependent upon you for support and maintenance.

If we deny a claim because the child has attained an age limit, we must receive proof of the above within 120 days after the child attains the age limit.

Dependent *dental insurance* will end when the child is able to earn a living or is no longer dependent on you for support and maintenance.

Students

Dependent *dental insurance* for an *eligible dependent* child will continue beyond the date the child is no longer a student until the earliest of:

- the end of the 3rd calendar month following the month in which the child is no longer a student, unless the child has not reached the end of the calendar year in which the child reaches age 25 and the child is living in your home and dependent upon you for support and maintenance;
- the end of the calendar year in which the child reaches age 25; and
- the date the child becomes eligible for *other group dental expense coverage*.

SPECIAL FEDERAL CONTINUANCE PROVISIONS

Under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and your *covered dependents* may have the right to continue *dental insurance* coverage beyond the date insurance would otherwise terminate. You should contact the *policyholder* concerning your right to continue coverage.

DENTAL INSURANCE

Insurance Provided

We will pay benefits for covered dental expenses identified in the *policy* when incurred by you or a *covered dependent*, while covered under the *policy*. We will pay the coinsurance percentage shown in the Schedule after you or a *covered dependent* have satisfied any deductible required for the *policy year*, subject to all the terms and conditions of the *policy*.

Covered dental expenses will only include *treatment* provided to you or a *covered dependent* for which, as outlined in the Listing of Covered Dental Services provision, the date started and the date completed occur while the person is insured under the *policy*. No payment will be made for a program of dental *treatment* already in progress on the effective date of a person's insurance, except as stated in the Limited Benefits for Transferred Insureds' Services provision. No payment will be made for dental *treatment* completed after your or a *covered dependent's* insurance under the *policy* ends, except as stated in the Limited Extension of Benefits After Insurance Ends provision.

Preferred Provider Plan

This *policy* includes a *preferred provider plan*. We will provide the benefits of the *preferred provider plan*, as shown in the Schedule, for covered expenses incurred by you or a *covered dependent* if the *treatment* is provided by a *preferred provider*. You will receive maximum benefits available under the *policy* when you obtain covered dental services from a *preferred provider*. You or a *covered dependent* must be identified as being insured under the *preferred provider plan* each time *treatment* is received, to obtain the benefits of the *preferred provider plan*. We will provide the benefits of the non-preferred provider plan, as shown in the Schedule, for covered dental expenses incurred by you or a *covered dependent* if the *treatment* is provided by a *non-preferred provider*.

We reserve the right to terminate a *preferred provider* or the *preferred provider plan*. If we do terminate a *preferred provider* or the *preferred provider plan*, the benefit for a covered dental service will be the benefit payable for a covered dental service from a *non-preferred provider*.

Deductible

The deductible is the amount shown in the Schedule and will be applied to each type of dental services as indicated in the Schedule. The deductible is the amount of covered dental expenses that you and each *covered dependent* must incur in a *policy year* before we will pay benefits. When covered dental expenses equal to the deductible amount have been incurred and submitted to us, the deductible will be satisfied. We will not pay benefits for covered dental expenses applied to the deductible.

If the deductible amount is increased during a *policy year*, further covered dental expenses must be incurred after the date of increase to satisfy the additional deductible for that *policy year*.

The deductible will apply to you and each *covered dependent* separately each *policy year*.

Policy Year Maximum

The maximum benefit payable to you and each *covered dependent* during a *policy year* is shown in the Schedule. This maximum will apply even if coverage for you or a *covered dependent* ends and starts again within the same *policy year* or if you or a *covered dependent* have been covered both as an employee and a dependent.

Date Started and Date Completed

We consider a dental *treatment* to be started as follows:

- for a full or partial denture, the date the first impression is taken;
- for a fixed bridge, crown, inlay and onlay, the date the teeth are first prepared;
- for root canal therapy, on the date the pulp chamber is first opened;
- for periodontal surgery, the date the surgery is performed; and
- for all other *treatment*, the date *treatment* is rendered.

We consider a dental *treatment* to be completed as follows:

- for a full or partial denture, the date a final completed appliance is first inserted in the mouth;
- for a fixed partial denture, crown, inlay and onlay, the date an appliance is cemented in place; and
- for root canal therapy, the date a canal is permanently filled.

(See Type IV: Dental Services for start and completion dates for *orthodontic treatment*.)

Pre-estimate

Whenever the expected cost of a *treatment* exceeds $300, we recommend that a *dental treatment plan* be submitted to us for review before *treatment* begins. The *dental treatment plan* should be accompanied by supporting preoperative x-rays and any other appropriate diagnostic materials as requested by us. We will notify you and your *dentist* of the benefits payable based upon the *dental treatment plan*. In estimating the amount of benefits payable, consideration will be given to the least costly alternative procedures and materials that may accomplish a result that meets broadly accepted standards of professional dental care as determined by us.

If a *dental treatment plan* is not completed within six months of the pre-estimate, we may consider it invalid. We may request the submission of a new *dental treatment plan*.

If you and your *dentist* decide on a more costly method of *treatment* than that pre-estimated by us, benefits payable for covered dental services for the more costly *treatment* will be limited to the benefits that would have been payable for covered dental services for the least costly alternative *treatment*. We will not pay the excess amount. Since this may result in significant out-of-pocket expense, we strongly encourage you to receive a pre-estimate for any *dental treatment plan* that is expected to exceed $300 in cost.

In addition to a *dental treatment plan*, before *orthodontic treatment* begins we may request any of the following information to help determine benefits payable for orthodontic services:

- full mouth dental X-rays;
- cephalometric X-rays and analysis;
- diagnostic casts (study models); and
- a statement specifying:
    - degree of overjet, overbite, crowding and open bite;

- whether teeth are impacted, in crossbite, or congenitally missing;
- length of *orthodontic treatment*; and
- total *orthodontic treatment* charge.

Alternative Benefits

In determining the benefits payable on a claim, we will consider other alternative procedures and materials that can be used to treat a dental problem or disease. The covered dental expense for a covered dental service provided will be limited to the *allowable charge* for the least costly covered dental service that accomplishes a result which meets broadly accepted standards of professional dental care as determined by us. You and your *dentist* may decide on a more costly procedure or material than we have determined to be satisfactory for the *treatment* of the dental problem or disease. In this event, we will not pay the excess amount. The benefit payable will be limited to the benefit that would have been payable had the least costly covered dental service been provided instead.

Covered Dental Expenses

Covered dental expenses for a *preferred provider* will include only the amount that the *preferred provider* has agreed to accept for expenses incurred by you or a *covered dependent*. Covered dental expenses for a *non-preferred provider* will include only the lesser of the *dentist's* actual charge or the *allowable charge* for expenses incurred by you or a *covered dependent*. The *treatment* must be:

- performed by or under the direction of a *dentist*, or performed by a *dental hygienist* or *denturist*;
- *dentally necessary*; and
- started and completed while you or your *covered dependent* are insured, except as otherwise provided in the Limited Benefits for Transfer Insureds' Services Started Under Prior Plan and Limited Extension of Benefits After Insurance Ends provisions.

Expenses submitted to us must identify the *treatment* performed in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature or by narrative description. We reserve the right to request X-rays, narratives and other diagnostic information, as we see fit, to determine benefits.

We will only pay benefits for covered dental expenses incurred for *treatment* that, in our opinion, has a reasonably favorable prognosis for the patient.

We consider a temporary *treatment* to be an integral part of the final *treatment*. The sum of the fees for temporary and final *treatment* will be used to determine whether the charges are an *allowable charge*.

The Listing of Covered Dental Services is a complete list of covered dental services. We will not pay benefits for expenses incurred for any service not listed below, unless we agree to accept an unlisted service as a covered dental service. We will not accept any unlisted service which is not similar to, or which does not accomplish a result similar to, a listed service. In any event, the choice of whether or not to accept an unlisted service is solely ours. If we do accept an unlisted service as a covered dental service, benefits will be payable on a basis consistent with benefits for similar covered dental services which would provide the least costly adequate *treatment* of your or your *covered dependent's* dental condition according to broadly accepted standards of professional dental care as determined by us.

Listing of Covered Dental Services

Maximum frequencies, maximum dollar amounts and other limits are shown here and under Special Limitations and General Exclusions for certain services. Services performed outside these limits are not covered dental services. Covered dental services are based on current dental terminology and are updated periodically. The most current dental terminology may not be reflected in the Listing of Covered Dental Services. However, benefits will be payable based on the most current dental terminology.

Type I Dental Services

- Clinical Oral Evaluations
  - No more than 1 time in any 6 months in a row. Benefits are based on the *allowable charge* for periodic oral evaluation.
- Dental Prophylaxis
  - No more than 1 time in any 6 months in a row (frequency combined with periodontal maintenance procedure). Total number of combined dental prophylaxis services and periodontal maintenance procedures not to exceed 4 in a 12-month period.
- Topical Fluoride Treatment
  - No more than 1 time in any 12 months in a row. Only for children under age 14 years.
- Sealants
  - No more than 1 time per tooth per person. Only for children under age 16 years. Only for permanent molar teeth.
- Space Maintenance (Passive Appliances)
  - Only for children under age 16 years. Service is deemed to include all adjustments made, or recementing done, within 6 months of installation.
- Treatment To Control Harmful Habits
  - Not covered if orthodontic related. Once per person. Only for children under age 16 years.
- Radiographs—Diagnostic Imaging
  - Bitewings—no more than 1 time in any 12 months in a row.
- Genetic Test for Susceptibility to Oral Diseases
  - No more than 1 test per lifetime. Limited to persons over age 18.

Type II Dental Services

- Radiographs—Diagnostic Imaging

- Complete Series (Including Bitewings) or Panoramic Film—No more than 1 time in any 60 months in a row. A complete series is deemed to include bitewing x-rays and 10 or more periapical x-rays, or a panoramic film.
  - One of either service no more than 1 time in any 60 months in a row. Benefits for a panoramic film may also be payable in connection with the removal of impacted teeth.
- Periapical—no more than 4 x-rays in any 12 months in a row.
- Occlusal Film—no more than 2 films in any 12 months in a row.
- Extraoral—no more than 2 films in any 12 months in a row.
- Sialography

- Minor Restorations (Fillings)
  - Amalgam and Composite Restorations
    - Replacement of existing minor restoration (filling) is deemed to be a covered dental service only if at least 24 months have passed since existing minor restoration (filling) was placed, unless required by new decay in an additional tooth surface.
    - The service is deemed to include local anesthesia.
    - Multiple restorations on one surface are deemed to be a single restoration.
    - Mesial-lingual, distal-lingual, mesial-facial, and distal-facial resin restorations on anterior teeth are deemed to be single surface restorations.

- Other Restorative Services
  - Pin Retention—no more than 1 time per restoration. Deemed to be a covered dental service only in conjunction with amalgam or resin restoration.

- Oral Surgery
  - Minor Oral Surgery—Each service is deemed to include local anesthesia and routine postoperative care.
    - Simple Extractions (Does not include Surgical Extractions)
    - Surgical Incision and Drainage of Abscess
    - Extraction, erupted tooth or exposed root (elevation and/or forceps removal)

- Other Type II Services
  - Bacteriologic Studies for Determination of Pathologic Agents

- Palliative (Emergency) Treatment of Dental Pain—Minor Procedure—Deemed to be a separate covered dental service only if no other service is rendered during the visit, except x-rays.
- Therapeutic Drug Injection
- Accession and examination of tissue

Type III Dental Services

(The following services may be subject to waiting periods.)

- Complex Oral Surgery
  - Surgical Extractions
- Other Complex Oral Surgery Procedures
  - Oroantral Fistula Closure
  - Tooth Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Tooth and/or Alveolus
  - Tooth Transplantation
  - Surgical Exposure of Impacted or Unerupted Tooth to Aid Eruption
  - Biopsy of Oral Tissue
  - Transseptal Fiberotomy
  - Alveoplasty
  - Vestibuloplasty
  - Removal of lateral exostosis—maxilla or mandible
  - Removal of Foreign Body, Skin, or Subcutaneous Areolar Tissue
  - Removal of Reaction-Producing Foreign Bodies Musculoskeletal System
  - Maxillary Sinusotomy for Removal of Tooth Fragment or Foreign Body
  - Frenulectomy (Frenectomy or Frenotomy) Separate Procedure
  - Excision of Hyperplastic Tissue - Per Arch
  - Excision of Pericoronal Gingiva
  - Sialolithotomy
  - Excision of Salivary Gland
  - Sialodochoplasty

- Closure of Salivary Fistula

If more than one complex surgical procedure is performed per area of the mouth, only the most inclusive surgical procedure performed will be considered a covered dental expense.

- Adjunctive General Services—Each service is deemed a separate covered dental service only when medically required for a complex oral surgery which is itself a covered dental service. Our decision is final for the purposes of determining covered dental services under the policy.
  - Anesthesia
  - Intravenous Sedation
- Endodontics—For applicable procedures, the service is deemed to include all pre-operative, operative, and post-operative x-rays, local anesthesia, and routine follow-up care.
  - Pulpotomy—Only for Deciduous Teeth
  - Endodontic Therapy
  - Endodontic Retreatment—Service is deemed a covered dental service if at least 24 months have passed since the initial treatment.
  - Apexification-Recalcification Procedures
  - Apicoectomy Surgery
  - Periradicular Services
    - Retrograde Filling
    - Root Amputation
- Other Endodontic Procedures
  - Hemisection (Including any root removal), Not Including Endodontic Therapy—covered dental services do not include fixed partial dentures replacing the extracted part of a hemisected tooth.
- Minor Periodontics
  - Adjunctive Periodontal Service
    - Provisional Splinting—covered dental services do not include inlays, onlays, crowns, or other cast or prepared restorations made for the purpose of splinting

- Scaling and Root Planing—no more than 1 time per area of the mouth in any 24 months in a row. The benefit for three or more quadrants of scaling and root planing, performed during the same appointment, will be limited to benefits equivalent to one quadrant of scaling and root planing. Benefits for prophylaxis and scaling and root planing, performed during the same appointment, will be based on the *allowable charge* for a prophylaxis. Benefits for scaling and root planing and periodontal maintenance, performed during the same appointment, will be based on the *allowable charge* for periodontal maintenance.
- Occlusal Adjustment—No more than 1 full mouth treatment in any 12 months in a row. Only when performed with periodontal surgery (regardless of whether the periodontal surgery itself is a covered dental service).

- Other Periodontal Services
  - Periodontal Maintenance
    - No more than 1 time in any 3 months in a row (frequency combined with dental prophylaxis services). Total number of combined periodontal maintenance procedures and dental prophylaxis services not to exceed 4 in a 12-month period.
    - Service is deemed to include scaling and root planing, a recall evaluation, charting, polishing of teeth, and oral hygiene instruction.
- Major Periodontics—For applicable procedures, services are deemed to include local anesthesia, temporary restorations and appliances, and one-year follow-up care.
  - Surgical Services—If more than one periodontal surgical service is performed per area of the mouth, only the most inclusive surgical service performed will be considered a covered dental expense. The following surgeries are covered only if more than 36 months have passed since gingivectomy, flap surgery, or osseous surgery was performed in that same area of the mouth.
    - Gingivectomy or Gingivoplasty
    - Gingival Flap Procedure
    - Osseous Surgery
  - Clinical Crown Lengthening
  - Guided Tissue Regeneration
  - Soft Tissue Graft
  - Subepithelial Connective Tissue Graft
  - Distal or Proximal Wedge
  - Occlusal Guard—No more than 1 in any 24 months in a row.

- Localized Delivery of Antimicrobial Agents Via a Controlled Release Vehicle into Diseased Crevicular Tissue, Per Tooth by Report
  - No more than 1 application per tooth in any 12-month period.
- Major Restorations—Initial (New) or Replacement. For applicable procedures, the service is deemed to include local anesthesia, temporary restorations and appliances, and one-year follow-up care.
  - Inlay/Onlay Restorations
    - Benefits are based on the *allowable charge* of a metallic inlay or onlay.
  - Crowns
    - Benefits are based on the *allowable charge* for predominantly base metal.
    - For children under age 16 years, covered dental services for crowns on deciduous or primary teeth are limited to prefabricated stainless steel or prefabricated resin crowns.
  - Labial Veneers (Only for Anterior Teeth)
  - Other Restorative Services—Only under unusual circumstances when required, as determined by us, for retention and preservation of the tooth. Service is deemed to include pins.
    - Core Build-up, Including Any Pins
    - Cast Post And Core
    - Prefabricated Post And Core
- Complete Dentures And Partial Dentures
  - Service is deemed to include all replacement teeth and all clasps and rests.
- Fixed Partial Denture Pontics
  - Fixed Partial Denture Retainers, Inlays/Onlays, And Crowns—Benefits based on the *allowable charge* for predominantly base metal.
    - Two or more contiguous spans of fixed partial denture work, regardless of the number of pontics and abutments involved, are deemed to be a single fixed partial denture with benefits payable based on a single date completed. Benefits for such a fixed partial denture will not be applied to more than one *policy year*.
- Tissue Conditioning
  - No more than 1 time in any 36 months in a row.
  - Only if at least 12 months have passed since the insertion of a full or partial denture.

- Major Restorations—Maintenance—For applicable procedures, the service is deemed to include local anesthesia, temporary restorations and appliances, and one-year follow-up care. Covered only if more than 6 months have passed since the initial insertion.
    - Recement Inlays
    - Recement Crown
    - Recement Fixed Partial Denture
    - Crown Repair
- Repairs To Complete Dentures, Partial Dentures Or Fixed Partial Dentures
    - Only if more than 6 months have passed since the initial insertion.
- Adjustment To Dentures
    - No more than 1 time in any 12 months in a row. Only if more than 6 months have passed since the initial insertion.
- Denture Rebase Procedures
    - No more than 1 time in any 36 months in a row. Only if more than 12 months have passed since the initial insertion.
- Denture Reline Procedures
    - No more than 1 time in any 36 months in a row. Only if more than 12 months have passed since the initial insertion.
- Other Type III Services
    - Diagnostic Casts—No more than 1 time in any 36 months in a row. Only if required for extensive bilateral prosthetic dentistry other than dentures. Not a covered dental service if for orthodontic evaluation.

Type IV Dental Services

(The following services may be subject to waiting periods).

- Limited Orthodontic Treatment
- Interceptive Orthodontic Treatment
- Comprehensive Orthodontic Treatment
- Minor Treatment To Control Harmful Habits

Covered dental expenses for *orthodontic treatment* are subject to the following:

A covered dental expense for a covered dental service for *orthodontic treatment* is the lesser of the provider's actual fee or the *allowable charge*. A covered dental expense for orthodontic exposure or extraction of teeth is deemed incurred on the date the service is completed and benefits are payable based on that date as stated in this provision. Covered dental expenses for orthodontic evaluation and

orthodontic treatment are deemed incurred on a monthly basis beginning with the date *orthodontic treatment* is started and continuing throughout the course of *orthodontic treatment* according to the rules stated in this provision.

Covered Dental Expenses for *orthodontic treatment*, do not include, and we will not pay orthodontic expenses for, orthodontic evaluation or exposure or extraction of teeth which is not an essential preliminary (as determined by us) to *orthodontic treatment* which is actually performed. Only the services listed above will be considered to be covered dental services for *orthodontic treatment*. The services will only be covered if they are:

- essential, as determined by us, to correct a *covered dependent* child's handicapping malocclusion (or as an essential preliminary to such correction, as determined by us); and
- the *covered dependent* child is under age 19 years on the date the *orthodontic treatment* is started.

Upon our receipt of proof that covered dental expenses have been incurred for covered dental services for exposure or extraction of teeth prior to and in connection with *orthodontic treatment* for a *covered dependent* child who is insured for orthodontic expense benefits (and who is under age 19 years on the date that *orthodontic treatment* is started), we will calculate and pay benefits as follows:

a) Determine the lesser of the dentist's actual fee or the *allowable charge* for each such service completed. The result, subject to all other *policy* provisions, is the covered dental expense for that service.

b) Determine the coinsurance percentage for each such covered dental expense.

c) Total all such coinsurance percentage to obtain the benefit for the submitted claim, subject to the Overall Benefit Maximum for Type IV Dental Services and all other *policy* provisions.

Upon our receipt of proof that covered dental expenses have been incurred for covered dental services for *orthodontic treatment* and any evaluation prior to and in connection with that *treatment* for a *covered dependent* child who is insured for orthodontic expense benefits (and who is under age 19 years on the date that *orthodontic treatment* is started), we will calculate and pay monthly benefits as follows:

a) Determine the lesser of the *dentist's* actual fee or the *allowable charge* for each covered dental service for the entire planned course of *orthodontic treatment* which has started and for each covered dental service for evaluation which was completed prior to and in connection with that *orthodontic treatment*. Add the results.

b) Determine 50% of the resulting total.

c) Determine the lesser of that amount or the available Overall Benefit Maximum for Orthodontic Services remaining.

d) If the *dentist* did not make a separate charge for initial insertion of the first orthodontic appliance(s), divide the result in (c) by one more than the total number of months in the entire planned course of an *orthodontic treatment* to get a monthly benefit amount (the same amount for the initial and each subsequent monthly benefit).

e) If the *dentist* did make a separate charge for initial insertion of the first orthodontic appliance(s), determine 25% of the result in (c) to get an initial monthly benefit amount. Divide the remaining 75% of the result in (c) by the total number of months in the entire planned course of *orthodontic treatment* to get a subsequent monthly benefit amount.

f) The initial monthly benefit is payable on the date the *orthodontic treatment* is started. A subsequent monthly benefit is payable on the date each month of ongoing *treatment* is completed in that planned course of *orthodontic treatment*, but only if both: (1) the month of ongoing *treatment* is a covered dental service; and (2) we receive proof that *treatment* continued during that month.

g) All monthly benefits otherwise payable as stated above are subject to the Overall Benefit Maximum for Type IV Services and all other *policy* provisions.

If the *dentist* deliberately does not collect (that is, forgives) some or all of the amounts due from you, we will recalculate the benefits payable according to the above rules; but we will use the amount which the *dentist* accepted as payment in full (that is, the original fee less the amounts forgiven) as the charge actually made by the provider. You will then owe us the amount of any overpayment we may have made.

The *Policy Year* Maximum does not apply to benefits payable for covered dental expenses for orthodontics. Instead, the Overall Benefit Maximum for Type IV Services shown in the Schedule applies to benefits payable for such expenses. The Overall Benefit Maximum for Type IV Services is the limit on the total amount of benefits payable for covered dental expenses incurred for a *covered dependent* child's covered dental services for *orthodontic treatment* in his lifetime. A single Overall Benefit Maximum for Type IV Services applies to a child even if his insurance has been interrupted or he has been insured both as a *covered person* and as a *covered dependent*.

The Waiting Period for orthodontic dental services is shown in the Schedule, and starts on the later of: (a) the *policy* effective date; or (b) the *covered dependent* child's effective date of insurance (most recent effective date if previously insured). If the date started for *orthodontic treatment* is before the waiting period ends, the entire course of *orthodontic treatment* is excluded from being a covered dental service. If the date started for any other dental service for *orthodontic treatment* is before the Waiting Period ends, the service is excluded from being a covered dental service.

Orthodontic treatment is deemed started on the date the first active orthodontic appliance is first inserted. Each month of ongoing *orthodontic treatment* following that date is deemed completed on the monthly anniversary of that date in each following calendar month. (For *orthodontic treatment* deemed started on the last day of a calendar month, the monthly anniversaries are deemed to be the last day of each following calendar month.) A covered dental service for orthodontic evaluation or exposure or extraction of teeth will be considered started and completed on the date that the service is actually performed.

The entire course of *orthodontic treatment*, and any preliminary orthodontic evaluation or exposure or extraction of teeth, are excluded from being covered dental services (and no benefits are payable) if the date started for the *orthodontic treatment* is on or after the date your *covered dependent* child reaches age 19 years.

The entire course of *orthodontic treatment* is excluded from being a covered dental service (and no benefits are payable) if the date started is before any of the following dates: (a) the effective date of this *policy*; or (b) the effective date of the *covered dependent's* insurance (most recent effective date if previously insured); or (c) the end of the waiting period.

Special Limitations

Waiting Periods for Insured Persons Generally

You and your *covered dependents* must serve a waiting period for one or more Types of Dental Services. A waiting period is a stated period of time starting on the effective date of your or a *covered dependent's* insurance. ("Effective date" means the most recent effective date of *dental insurance* if you or a *covered dependent* were previously insured.) If the date started for a service is before the applicable waiting period ends, the service is excluded from being a covered dental service. The Types of Dental Services with waiting periods and the lengths of such waiting periods are shown in the Schedule.

Major Restorations

Covered Dental Expenses and covered dental services do not include, and we will not pay benefits for, the following:

- Inlays, onlays, crowns, cast restorations, veneers or other laboratory prepared restorations:
  - on teeth which may be restored with a direct placement filling material;
  - in the absence of extensive decay or fracture;
  - for loss of tooth structure due to attrition or abrasion; or
  - for children under age 16 years, except for prefabricated stainless steel or prefabricated resin crowns on deciduous or primary teeth.
- The initial placement of a complete or partial denture unless:
  - it includes the replacement of a *functioning natural tooth* extracted while you or your *covered dependent* are insured under the *policy*; and
  - that tooth cannot be added to an existing partial denture. We will not pay benefits for the initial placement of a complete or partial denture which replaces only those *natural teeth* missing on the date your or your *covered dependents'* insurance begins.
- The initial placement of a fixed partial denture unless:
  - it includes the replacement of a *functioning natural tooth* extracted while insured under the *policy*; and
  - that tooth was not an abutment to an existing fixed partial denture that is less than 7 years old (5 years old if a cast metal, resin bonded fixed retainer). Benefits for such initial placement are limited to benefits for the replacement of those *functioning natural teeth* which were extracted while you or your *covered dependent* are insured under the *policy* and were not abutments to an existing fixed partial denture less than 7 years old (5 years old if a cast metal, resin bonded fixed retainer). We will not pay benefits to replace *natural teeth* missing on the date that your or your *covered dependent's* insurance begins.
- The replacement of inlays, onlays, crowns, core build-ups, cast restorations, or other laboratory prepared restorations unless:
  - at least 7 years have passed since the last placement (5 years for labial veneers, 3 years for prefabricated stainless steel or prefabricated resin crowns); and
  - they are not serviceable and cannot be restored to function.
- The replacement of a complete or partial denture, or the addition of teeth to a partial denture, unless:

- replacement occurs at least 5 years after the initial date of insertion of the existing denture, provided the existing denture is not serviceable and cannot be restored to function; or
- the addition of a tooth to a partial denture is required due to the *dentally necessary* extraction of a *functioning natural tooth* while you or your *covered dependent* are insured under the *policy*; or
- the replacement is made *dentally necessary* by an *accidental non-chewing injury* to a *sound natural tooth*, provided the replacement is completed within 12 months of the injury.

- The replacement of a fixed partial denture unless:
  - replacement occurs at least 7 years (5 years for a cast metal, resin bonded fixed retainer) after the initial date of insertion of the existing fixed partial denture, provided the existing fixed partial denture is not serviceable and cannot be restored to function; or
  - replacement is required due to the *dentally necessary* extraction of a *functioning natural tooth* while *you or your covered dependent* are insured under the *policy*, *provided* that the extracted tooth was not serving as an abutment to the existing fixed partial denture; or
  - replacement is made, provided the replacement is made *dentally necessary* by an *accidental non-chewing injury* to a *sound natural tooth*, and is completed within 12 months of the injury.
- The replacement of an existing partial denture with fixed partial denture work unless upgrading to fixed partial denture work is essential, as determined by us, to the correction of *your or your covered dependent's* dental condition.
- The replacement of teeth beyond the normal complement.
- Appliances, inlays, onlays, crowns, or other cast or laboratory prepared restorations used primarily for the purpose of splinting.
- Facings on crowns or fixed partial dentures on molar teeth (which are always considered cosmetic under the *policy*).
- Implants, insertion of implants or related appliances, or surgical removal of implants.

Coverage Under the Group's Medical Plan

If benefits for any covered dental expenses are provided under your employer's medical plan (if any), benefits otherwise payable for those expenses under the *policy* will be reduced by the amount of benefits payable for those expenses under your employer's medical plan.

General Exclusions

Covered dental expenses and covered dental services do not include, and we will not pay benefits for, the following:

- *treatment* which:

- is not included in the list of covered dental services; or
- has a date started before your or a *covered dependent's* insurance begins; or
- has a date started before any applicable Waiting Period has been served; or
- has a date completed after your or a *covered dependent's* insurance ends, except as may be specifically provided under Limited Extension of Benefits After Insurance Ends.

- any *treatment*, the sole or primary purpose of which relates to:
  - the change or maintenance of vertical dimension; or
  - the alteration or restoration of occlusion except for occlusal adjustment in conjunction with periodontal surgery (regardless of whether the periodontal surgery itself is a covered dental service); or
  - bite registration; or
  - bite analysis.
- any *treatment* required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joint or its associated structures.
- athletic mouthguards; replacement of lost or stolen appliances; myofunctional therapy; infection control; oral hygiene instruction; separate charges for acid etch; treatment of jaw fractures; orthognathic surgery; personal supplies; broken appointments; completion of claim forms; exams required by a third party; travel time; transportation costs; professional advice given on the phone.
- *treatment* which:
  - is not *dentally necessary*; or
  - does not have uniform professional endorsement; or
  - is experimental or investigational in nature.
- *treatment* which does not have a reasonably favorable prognosis, as determined by us.
- *treatment* provided primarily for cosmetic purposes.
- *treatment* received as a result of disease, defect, or injury due to war or an act of war (declared or undeclared), taking part in a riot or insurrection, or committing or attempting to commit an assault or felony.
- *treatment* of *injury* arising out of, or in the course of, doing any work for pay, profit, or gain, whether on your or a *covered dependent's* job or any other job, and for which benefits are paid under any applicable Workers' Compensation law.
- *treatment* of an intentionally self-inflicted injury.

- *treatment* performed outside of the United States of America, other than *emergency dental treatment*. However, for such *emergency dental treatment*, the benefits payable shall not exceed the *allowable charge* for the *treatment* at your employer's principal address (shown in the application for insurance) in the USA.
- *treatment* rendered by a dental clinic or similar clinic that is operated by your or your spouse's employer, labor union, or similar group.
- *treatment* of a provider who is a member of your or your spouse's *immediate family.*
- *treatment* for which a charge would not have been made in the absence of insurance.
- *treatment* for which you or your *covered dependent* do not have to pay, except when payment of such benefits is required by law and only to the extent required by law.
- *treatment* that has not been both delivered to and accepted by you or your *covered dependent*.
- *orthodontic treatment*, unless such insurance is provided under the list of covered dental services.

Limited Extension of Benefits After Insurance Ends

If an otherwise non-orthodontic covered dental service is started while you or your *covered dependent* are insured under the *policy* (and after any applicable waiting periods are served), but is completed after the day your or your *covered dependent's* insurance ends, we will pay benefits for otherwise covered dental expenses incurred for that service subject to all of the following rules:

- Benefits are not available to you or your *covered dependent* if, on the day after insurance ends, you or your *covered dependent*, obtain, or are eligible to obtain, dental care coverage under any group or governmental plan;
- Benefits are not available to you or your *covered dependent* if insurance ends because any required premium contributions were stopped while still eligible for insurance;
- Benefits are not available for any *treatment* started after the day your or your *covered dependent's* insurance ends;
- Benefits are payable only in the amount that would have been payable, and subject to the same provisions that would have applied, had your or your *covered dependent's* insurance still been in effect;
- Benefits are payable only if the *treatment* is completed within 90 days after the date your or your *covered dependent*'s insurance ends, unless you or your *covered dependent* become injured or sick after the *treatment* is started and that is the only reason the *treatment* could not be completed during those 90 days. Then, benefits are payable only if the *treatment* is completed before the earlier of:
    - the date 90 days after the first date the *injury* or sickness no longer prevents the *treatment* from being completed; or
    - the date 91 days after the date your or your *covered dependent's* insurance ends;

- We will not pay any benefits for *treatment* which is completed on or after the first date you or your *covered dependent* obtain, or are eligible to obtain dental care coverage under any group or governmental plan.

Limited Extension of Orthodontic Benefits After Insurance Ends

Any month of ongoing *orthodontic treatment* which has a date completed after the earliest of the following dates is excluded from being a covered dental service (and no benefits are payable for that month of *orthodontic treatment*):

- the day before the *policy* is amended to exclude *orthodontic treatment* from the coverage provided to *covered dependent* children of the class of employees to which you belong; or
- the date the *covered dependent's* insurance ends.

NOTE: We will make one exception to this exclusion. If a month of ongoing *orthodontic treatment* has a date completed after the earlier of the above dates, but that month of *orthodontic treatment* began while both this coverage under the *policy* and the *covered dependent's* insurance were in effect, we will pay a benefit for that month of *orthodontic treatment* in the same amount, and subject to the same *policy* provisions, that would have applied if both this coverage and the *covered dependent's* insurance were still in effect.

Limited Benefits for Transfer Insureds' Services Started Under Prior Plan

Our *policy* excludes benefits for services started before the date your or your *covered dependent's* insurance under our *policy* begins. However, if you or your *covered dependent* are a *transfer insured*, we will calculate and pay limited benefits as follows for otherwise-covered dental expenses for services started while you or your *covered dependent* were *continuously covered* under the *prior plan*, but completed while you or your *covered dependent* are insured under our *policy*:

1. Determine the amount (if any) that would have been payable had the service been started and completed while you or your *covered dependent* were *continuously covered* under the *prior plan*.
2. Determine the amount (if any) that would have been payable had the service been started and completed while you or your *covered dependent* were insured under our *policy*.
3. If either amount is zero, there is no benefit payable under this provision.
4. If both amounts are nonzero, we will prorate the lesser of the two amounts according to our established proration schedule to determine a prorated benefit for each part of the service performed.

   We will pay a prorated benefit only for that part of the service that is performed:

   a) while you or your *covered dependent* are insured under our *policy*; and

   b) after the end of any period during which the *prior plan* extends benefits for the service.

   We will not pay any benefit for any part of the service that is performed either:

   a) before you or your *covered dependent* are insured under our *policy*; or

   b) in any period during which the *prior plan* extends benefits for the service.

Transfer Insureds' Orthodontic Services Started Under Prior Plan

The above calculation for benefits payable for Transfer Insureds' Services Started Under the Prior Plan does not apply to dental services for *orthodontic treatment*. The *policy* excludes benefits for *orthodontic treatment* started before the *covered dependent child's* insurance under our *policy* begins. However, if the *covered dependent* child is a *transfer insured*, we will calculate and pay limited benefits as follows for otherwise-covered dental expenses for *orthodontic treatment* which started while the *covered dependent* child was *continuously covered* under the *prior plan* and is still ongoing when the *covered dependent* child's insurance under our *policy* begins:

1. We must receive proof that benefits were paid and are payable under the *prior plan* for that *orthodontic treatment*, and that the total of such benefits for:

   a) that ongoing orthodontic treatment; plus

   b) any evaluation prior to and in connection with the *orthodontic treatment*; plus

   c) any exposure or extraction of teeth prior to and in connection with the *orthodontic treatment*;

   is less than the amount of the Overall Benefit Maximum for Type IV Services under our *policy*.

   If we do not receive such proof, no benefit is payable under this provision.

2. If we receive such proof, we will determine whether or not benefits would have been provided had that ongoing *orthodontic treatment* been started while the *covered dependent* child was insured under our *policy* (without regard to any Waiting Periods that might otherwise apply). If no such benefits would have been provided, no benefit is payable under this provision.

3. We will calculate the portion of the Overall Benefit Maximum available for that ongoing *orthodontic treatment* under our *policy* as being the lesser of:

   a) the Overall Benefit Maximum for Type IV Services under our *policy*; or

   b) any overall benefit maximum for orthodontics under the *prior plan*; reduced by the total orthodontic benefits paid or payable under the *prior plan* as described in (1) above.

4. We will calculate a monthly benefit for that ongoing *orthodontic treatment* using the rules in the Type IV Dental Services provision, but with the reduced Overall Benefit Maximum as described in (3) above replacing the Overall Benefit Maximum for Type IV Services under our *policy* in that calculation.

5. The monthly benefit described in (4) above will be payable on the date each month of treatment is completed in the planned course of treatment, but only if:

   a) that month of treatment begins while the *covered dependent* child is insured under our *policy*; and

   b) that month of treatment would have been a covered dental service under our *policy* had the *orthodontic treatment* started while the *covered dependent* child was insured under our *policy* (without regard to any Waiting Periods that might otherwise apply); and

   c) we receive proof that *orthodontic treatment* continued during that month.

All monthly benefits otherwise payable as stated in (5) above are subject to the reduced Overall Benefit Maximum as described in (3) above and all other provisions of the *policy*.

Transfer Insureds' Teeth Extracted Under Prior Plan

Under Major Restorations in the Special Limitations provision, items pertain to complete and partial dentures and fixed partial dentures. These items all have references to missing *natural teeth* or to *functioning natural teeth* that have been extracted. For the purpose of applying these limitations where you or your *covered dependent* are a *transfer insured*, a *functioning natural tooth* which was extracted while you or your *covered dependent* were *continuously covered* under the *prior plan*, but no earlier than 12 months before the effective date of this *policy*, will be deemed to have been extracted while insured under this *policy*.

Credit Given To Transfer Insureds For Waiting Periods

In the DENTAL INSURANCE section under Waiting Periods for Insured Persons Generally, our *policy* provides in general that you and your *covered dependents* must serve a Waiting Period for certain Type III Dental Services. The Types of Dental Services with waiting periods are shown in the Schedule, together with the lengths of such waiting periods in months. On the *policy* effective date, each *transfer insured* is deemed to have served 12 months of each such waiting period (or the whole waiting period, if it is less than or equal to 12 months)—but only with regard to Types of Dental Services shown in the Schedule.

Transfer Insureds' Waiting Period for Type IV Services

The above credit for time served toward a Waiting Period applies only to the Waiting Periods for Type III Dental Services, if applicable, and not to Type IV Dental Services for *orthodontic treatment*. Under the Waiting Period provision in the Schedule, there is a Waiting Period for Type IV Dental Services for *orthodontic treatment*. On the *policy* effective date, each *transfer insured* is deemed to have served 12 months of that Waiting Period (or the whole Waiting Period), if it is less than or equal to 12 months.

COORDINATION OF BENEFITS

Applicability

The Coordination of Benefits (COB) provision applies when you or a *covered dependent* has dental care coverage under more than one *plan*. *Plan* is defined below. All of the benefits provided under the *policy* are subject to *this provision.*

Definitions

Allowable expense means a dental care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any *plan* covering the person. When a *plan* provides benefits in the form of services, the reasonable cash value of each service will be considered an *allowable expense* and a benefit paid. An expense that is not covered by any *plan* covering the person is not an *allowable expense.* In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging you or a *covered dependent* is not an *allowable expense.*

The following are examples of expenses that are not *allowable expenses*:

- If you or a *covered dependent* is covered by 2 or more *plans* that compute their benefit payments on the basis of:
    - *dentally necessary, usual and customary* fees; or
    - relative-value, schedule-reimbursement methodology; or
    - other similar reimbursement methodology,

any amount in excess of the highest reimbursement amount for a specific benefit is not an *allowable expense.*

- If you or a covered *dependent* is covered by 2 or more *plans* that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an *allowable expense.*
- If you or a *covered dependent* is covered by one *plan* that calculates its benefits or services on the basis of:
    - *dentally necessary, usual and customary* fees; or
    - relative-value, schedule-reimbursement methodology; or
    - other similar reimbursement methodology; and
    - another *plan* that provides its benefits or services on the basis of negotiated fees;

the *primary plan's* payment arrangement will be the *allowable expenses* for all *plans*.

However, if the provider has contracted with the *secondary plan* to provide:

- the benefit or service for a specific negotiated fee; or
- payment amount that is different than the *primary plan's* payment arrangement; and
- if the provider's contract permits,

the negotiated fee or payment shall be the *allowable expenses* used by the *secondary plan* to determine its benefits.

- The amount of any benefit reduction by the *primary plan* because you or a *covered dependent* has failed to comply with the *plan* provisions is not an *allowable expense.* Examples of these types of *plan* provisions include:
  - any required second opinion,
  - some form of predetermination of *treatment*, and
  - preferred provider arrangements.

Birthday refers only to month and day in a calendar year and does not include the year of birth.

Claim means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of:

- services (including supplies); or
- payment for all or a portion of the expenses incurred; or
- combination of services or expenses shown above; or
- indemnification.

Claim period means a calendar year. A *claim period* will not start before a person's effective date of insurance under *this plan* nor extend beyond the last day the person is covered under *this plan.*

Closed-panel plan is a *plan* that provides dental care benefits to you or a *covered dependent* primarily in the form of services through a panel of providers that

- have contracted with or are employed by the *plan*, and
- excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

Consolidated Omnibus Budget Reconciliation Act of 1985 or "COBRA" means coverage provided under a right of continuation compliant with federal law.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one-half of the calendar year excluding any temporary visitation.

Medicaid means Title XIX of the Social Security Act of 1965 as amended.

Plan means any of the following that provides benefits or services for dental care or *treatment*;

- Group and non-group insurance contracts, dental service prepayment coverage, or subscriber plans;
- Dental Maintenance Organization (DMO) contracts or Health Maintenance Organization (HMO) contracts;

- Closed-panel plans or other forms of group or group-type coverage, as permitted by law or regulation (whether insured or uninsured);
- Dental benefits under group or individual automobile contracts, as permitted by state law or regulation; and
- Medicare or any other federal governmental plan, as permitted by law.

If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same *plan* and there is no COB among those separate contracts.

Plan does not include any of the following:

- Hospital indemnity coverage or other fixed indemnity coverage;
- Accident-only coverage;
- Specified disease or specified accident coverage;
- Limited benefit health coverage, as defined by state law;
- School accident-type coverage;
- Benefits for non-dental services provided under long-term care coverage;
- Medicare supplement coverage;
- A state plan under Medicaid; or
- Coverage under a governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

Each contract for coverage shown above is a separate *plan*. If a *plan* has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate *plan*.

Primary plan means the *plan* that pays or provides its benefits first, according to its terms of coverage and without regard to benefits under any other *plan*.

Except as provided below, a *plan* that does not contain a COB provision that is consistent with *this provision* is always the *primary plan* unless the provisions of both *plans* state that the *plan* with a COB provision is the *primary plan*.

Coverage that is obtained by virtue of membership in a group that is:

- designed to supplement a part of a basic package of benefits, and
- provides that this supplementary coverage,

shall be excess to any other parts of the *plan* provided by the *policyholder*.

An example of this type of situation is insurance-type coverage that is written in connection with a *closed-panel plan* to provide out-of-network benefits.

Secondary plan means the *plan* that determines its benefits after those of another *plan* and may reduce the benefits it pays so that all *plan* benefits do not exceed 100% of the total *allowable expenses* incurred by you or a covered dependent during the *claim period*.

This plan means the benefits provided by the *policy*. When there are more than two *plans*, *this plan* may be a *primary plan* to one or more other *plans*, and may be a *secondary plan* to a different *plan(s)*.

This provision means the provision for coordination between the benefits of *this plan* and other *plans*.

Other definitions that may apply to *this provision* appear in the Definitions provisions of this *policy*.

Order of Benefit Determination

When you or a *covered dependent* has dental care coverage under more than one *plan*, each *plan* determines its order of benefits using the first of the following rules that apply:

1. Non-Dependent or Dependent

   The *plan* that covers the person other than as a dependent, e.g., as an employee, member, policyholder, subscriber or retiree is the *primary plan* and the *plan* that covers the person as a dependent is the *secondary plan*.

   However, if

   - you or a *covered dependent* is a Medicare beneficiary and,
   - as a result of federal law,
     - Medicare is secondary to the *plan* covering the person as a dependent; and
     - primary to the *plan* covering the person as other than a dependent (e.g., a retired employee);

   then, the order of benefits between the two *plans* is reversed so that

     - the *plan* covering the person as an employee, member, policyholder, subscriber or retiree is the *secondary plan*, and
     - the other *plan* is the *primary plan*.

2. Dependent Child Covered Under More Than One Plan

   Unless there is a court decree stating otherwise, when a dependent child is covered by more than one *plan* the order of benefits is determined as follows:

   - For a covered dependent child whose parents are married or are living together, whether or not they have ever been married:
     - The *primary plan* is the *plan* of the parent whose *birthday* falls earlier in the calendar year; or
     - If both parents have the same *birthday*, the *primary plan* is the *plan* that has covered the parent the longest.

- For a covered dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
    - If a court decree states that one of the parents is responsible for the dependent child's dental care expenses or dental care coverage and the *plan* of that parent has actual knowledge of those terms, that *plan* is the *primary plan*. This rule applies to *plan* years commencing after the *plan* is given notice of the court decree;
    - If a court decree states that both parents are responsible for the *covered dependent* child's dental care expenses or dental care coverage, benefits will be determined according to the *birthday* rule described above;
    - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the dental care expenses or dental care coverage of the *covered dependent* child, benefits will be determined according to the *birthday* rule described above; or
    - If there is no court decree allocating responsibility for the dependent child's dental care expenses or dental care coverage, the order of benefits for the child are as follows:
        - The *plan* covering the *custodial parent*;
        - The *plan* covering the spouse of the *custodial parent*;
        - The *plan* covering the non-*custodial parent*; and then
        - The *plan* covering the spouse of the non-*custodial parent*.
- For a covered dependent child covered under more than one plan of individuals who are the parents of the child, benefits will be determined according to the birthday and longer or shorter rules, as if those individuals were the parents of the child.

3. Active Employee or Retired or Laid-off Employee

    - The *primary plan* is the *plan* that covers a person as an active employee, e.g., an employee who is neither laid off nor retired.
    - The *secondary plan* is the *plan* covering that same person as a retired or laid-off employee.

    The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee.

    If the other *plan* does not have this rule, and therefore, the *plans* do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rules described in item 1 above can determine the order of benefits.

4. COBRA or State Continuation Coverage

    If you or your *covered dependent* has coverage provided under

    - COBRA, or
    - continuation provided by state or other federal continuation law, and

    is covered under another *plan*, then

- the *primary plan* is the *plan* covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree, and

- the *secondary plan* is the plan providing coverage under COBRA, state or other federal continuation law.

If the other *plan* does not have this rule, and therefore, the *plans* do not agree on the order of benefits, this rule is ignored. This rule does not apply if the *birthday* rule can determine the order of benefits.

5. Longer or Shorter Length of Coverage

- The *primary plan* is the *plan* that covered the person as an employee, member, policyholder, subscriber or retiree longer.

- The *secondary plan* is the *plan* that covered the person the shorter length of time.

If none of the rules described above determine the order of benefits, the *allowable expenses* shall be shared equally between the *plans* meeting the definition of *plan*. In addition, *this plan* will not pay more than it would have paid had it been the *primary plan*.

Effect on Benefits

When *this plan* is the *secondary plan*, it may reduce its benefits so that the total benefits paid or provided by all *plans* during a *claim period* are not more than the total *allowable expenses*.

In determining the amount to be paid for any *claim*, the *secondary plan* will calculate the benefits it would have paid in the absence of other dental care coverage and apply that calculated amount to any *allowable expense* under its *plan* that is unpaid by the *primary plan*. The *secondary plan* may then reduce its payment by the amount so that, when combined with the amount paid by the *primary plan*, the total benefits paid or provided by all *plans* for the *claim* do not exceed the total *allowable expense* for that *claim*.

In addition, the *secondary plan* shall credit to its *plan* deductible any amounts it would have credited to its deductible in the absence of other dental care coverage.

If you or a *covered dependent* is enrolled in two or more *closed-panel plans* and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one *closed panel plan*, COB shall not apply between that *plan* and other *closed-panel plans*.

If you or a *covered dependent* is covered by more than one dental benefit *plan*, you should file all your claims with each *plan*.

Right to Receive and Release Needed Information

Certain facts about dental care coverage and services are needed to apply the rules of *this provision* and to determine benefits payable under *this plan* and other *plans*. We may get the facts we need from or give them to other organizations or persons for the purpose of:

- applying the rules of *this provision*; and

- determining benefits payable under this *plan* and other *plans* covering the person claiming benefits.

We need not tell, or get the consent of, any person to do this. Each person claiming benefits under *this plan* must give us any facts we need to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another *plan* may include an amount that should have been paid under *this plan*. If it does, we may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under *this plan*. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If we pay more than we should have paid under *this provision*, we may recover the excess from one or more of the persons it has paid or for whom it has paid. Or, we may recover the excess from any other person or organization that may be responsible for the benefits or services provided for you or a *covered dependent*. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

CLAIM PROVISIONS

Payment of Benefits

We will pay benefits when we receive all the required proof of covered loss.

To Whom Payable

We will pay dental benefits directly to the providers of dental services for *treatment* of you or your *covered dependents*, if you have assigned your benefits to the providers. We will pay dental benefits to you, if you have not assigned your benefits to the providers. After your death, we have the option to pay any benefits due to your spouse, to the providers of the *treatment*, or to your estate.

Authority

We have the sole discretionary authority to determine eligibility for participation or benefits and to interpret the terms of the Policy. All determinations and interpretations made by us are conclusive and binding on all parties.

Filing a Claim

1. Your *dentist* should send us notice of claim for dental *treatment*. You must send us notice of all other claims. We must have written notice of any insured loss within 30 days after it occurs, or as soon as reasonably possible. You can send the notice to our *home office*, one of our regional claims offices, or to one of our agents. We need enough information to identify you as a *covered person*. If charges for dental *treatment* are expected to be $300 or more, you can receive an estimate of benefits payable before *treatment* begins by following the procedures outlined in the Pre-estimate provision. The *preferred provider* will send notice of all dental expenses incurred under the *preferred provider plan*.

2. Within 15 days after the date of the notice, we will send you certain claim forms. The forms must be completed and sent to our *home office* or one of our regional claims offices. If you do not receive the claim forms within 15 days, we will accept a written description of the exact nature and extent of the loss. The *preferred provider* will provide initial written proof of any dental expenses incurred under the *preferred provider plan*.

3. The time limit for filing a claim is 90 days after the date of the loss.

4. To decide our liability, we may require:

   - itemized bills,
   - proof of benefits from other sources, and
   - proof that you have applied for all benefits from other sources, and that you have furnished any proof required to get them.

   For dental expenses, we may require additional information to determine our liability, including, but not limited to:

   - a complete dental charting indicating extractions, missing teeth, fillings, prosthesis, periodontal pocket depths, orthodontic relationship and the dates work was previously performed, and
   - preoperative x-rays, study models, laboratory and/or hospital reports.

We will ask you to authorize the sources of medical and dental services to release your medical information. If you do not furnish any required information or authorize its release, we will not pay benefits.

If it is not reasonably possible to give proof on time, we will not deny or reduce your claim if you give us proof as soon as reasonably possible. However, you must give us proof within 1 year from the date of loss unless you are legally incapacitated.

Physical Exam

We may ask you to be examined as often as we require at any time we choose. We will pay for any exam we require.

Limit on Legal Action

No action at law or in equity may be brought against the *policy* until at least 60 days after you file proof of loss. No action can be brought after the statute of limitations in your state has expired, but, in any case, not more than 6 years after the time written proof of loss is required to be given.

Incontestability

The validity of the *policy* cannot be contested after it has been in force for 2 years, except if premiums are not paid.

Any statement made by the *policyholder* or a *covered person* will be considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to the *covered person* or the *beneficiary*.

No statement, except fraudulent misstatement, made by a *covered person* about insurability will be used to deny a claim for a loss incurred or *disability* starting after coverage has been in effect for 2 years.

No claim for loss starting 2 or more years after the *covered person's* effective date may be reduced or denied because a disease or physical condition existed before the person's effective date, unless the condition was specifically excluded by a provision in effect on the date of loss.

Overpayment

If a benefit is paid under the *policy* and it is later shown that a lesser amount should have been paid, we will be entitled to a refund of the excess amount from the provider or you.

Subrogation Rights

In the event of any payments for benefits provided to you or a *covered dependent* under the *policy*, we, to the extent of our payments, will be subrogated to all rights of recovery you or your dependent have against any person or organization. You or your dependent will execute and deliver any instruments and papers as may be required and do whatever else is necessary to secure those rights to us and will do nothing after loss to prejudice our rights.

Right to Reimbursement

If you or a *covered dependent*: (a) seek legal recourse (whether by suit, settlement, judgment or otherwise) against any person or organization; and (b) recover payment, in whole or in part, from any such person or organization for the benefits previously paid under the *policy*, then you or your dependent must reimburse us for all payments made under the *policy* for which you have received reimbursement.

Any payments made prior to determination of work-related injury, will be reimbursed upon determination of such payment.

However, the reimbursement will not exceed: (a) the amount of the benefit payments made under the *policy* for which payment is recovered from any person or organization; or (b) the amount recovered from any such person or organization as payment for the same covered dental expenses.

You or your *covered dependents* are not obligated by this provision to seek legal action against any person or organization for which benefits have been paid under the *policy.*

Any such right of Subrogation or Reimbursement provided to Union Security Insurance Company under this *policy* shall not apply or shall be limited to the extent that the Florida statutes or the courts of Florida eliminate or restrict such rights.

GENERAL PROVISIONS

Entire Contract

The *policy* and the *policyholder's* application attached to it are the entire contract. Any statement made by you or the *policyholder* is considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to you.

Errors

An error in keeping records will not cancel insurance that should continue nor continue insurance that should end. We will adjust the premium, if necessary, but not beyond 3 years before the date the error was found. If the premium was overpaid, we will refund the difference. If the premium was underpaid, the difference must be paid to us.

Misstatements

If any information about a person is misstated, the facts will determine whether insurance is in effect and in what amount. We will equitably adjust the premium.

Individual Certificates

We will send certificates to the *policyholder* to give to each *covered person*. The certificate will state the insurance to which the person is entitled. It does not change the provisions of the *policy*.

Workers' Compensation

The *policy* is not in place of, and does not affect any state's requirements for coverage by Workers' Compensation insurance.

Agency

Neither the *policyholder*, any employer, any *associated company*, nor any administrator appointed by the foregoing is our agent. We are not liable for any of their acts or omissions.

GENERAL PROVISIONS (continued)

Changing the Policy

The *policyholder* owns the *policy*. The *policy* may be changed at any time by an endorsement or amendment agreed upon by the *policyholder* and us. A change must be approved by one of our executive officers. No agent can change the *policy* or waive any of its provisions.

Required Data

The *policyholder* must give us all data needed to administer the insurance and determine premiums. The *policyholder* must also give us any other information we require. We may inspect the *policyholder's* records relating to the insurance provided by the *policy*.

Policyholder's Assignment

The *policyholder* may assign the *policy*. This will not affect the rights of any *covered person* or *beneficiary*. We will not be responsible for the validity of any assignment. We must receive written notice of an assignment at our *home office*.

When the Policy Ends

The *policy* will end on the earliest of the following dates:

- the date the grace period ends, if the premium has not been paid; or
- the date we cancel the *policy*, after giving the *policyholder* 45 days written notice; or
- the date we receive written notice from the *policyholder*, or the date shown in the notice, whichever is later.

The *policy* will also end if the number or percentage of persons covered under the *policy* does not meet the Minimum Participation Requirements shown in the Schedule.

If the Participation Requirements are not met, we will notify the *policyholder* 45 days in advance that insurance will end. We consider that notice is given when delivered or mailed to the last known address of the *policyholder*.

If the date the *policy* ends is not the same as the date to which premiums have been paid, the difference in premium:

- must be paid to us, if underpaid; or
- will be refunded by us, if overpaid.

PREMIUMS

Premium Payments

The *policyholder* must pay all premiums in advance at our *home office* or to one of our agents. The *policyholder* may request on any policy anniversary that the frequency of premium payment be changed to any frequency we offer for such *policy*.

Grace Period

If any premium is not paid when due, the *policy* will be in default on that date. The *policyholder* has a grace period of 31 days after that date to pay the premium. In any case, the *policyholder* must pay the premium for coverage in force during the grace period.

Calculation of Premiums

The first premium is due on the effective date. Future premiums are due on each premium due date. The premium is based on the premium rate and the amount of insurance. We will furnish premium rates to the *policyholder* with an explanation of how to apply them.

Our Right to Change Premium Rates

We may change the premium rate:

- after the first policy anniversary; or
- when our liability changes.

Unless our liability changes:

- we will not change the rates more than once in any period of 12 consecutive months; and
- we will give the *policyholder* 45 days advance written notice of an increase in rates.

ENDORSEMENTS AND AMENDMENTS

At the request of the *policyholder*, for dependent dental insurance, the term "spouse" shall also mean a domestic partner. A "domestic partner" is defined in the *policyholder's* Declaration of Domestic Partnership agreement.

APPLICATION

to Union Security Insurance Company

by Palm Beach County Board of Commissioners

for group policy no. G 5,303,634

This application is executed in duplicate. One copy is to be attached to the *policy*. The other is to be returned to Union Security Insurance Company.

It is agreed that this Application replaces any prior application for the *policy*.

10 or more lives must be insured on the Effective Date of the *policy*. In addition, the number of lives to be insured on that date must be 20% of those eligible for insurance at that time.

Palm Beach County Board of Commissioners
(Full or Corporate Name of Applicant)

by _____
(Signature and Title)

Signed at _____ Date _____

Witness _____
(To be signed by Resident Agent where required by law)

This copy is to remain attached to the *policy*.

Union Security Insurance Company 2323 Grand Boulevard Kansas City Missouri 64108-2670

Approved as to Terms & Conditions

Nancy L Bolton
Director, Risk Management

APPLICATION

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Palm Beach County Board of Commissioners
(Full or Corporate Name of Applicant)

by _____
(Signature and Title)

Signed at _____ Date _____

Witness _____
(To be signed by Resident Agent where required by law)

This copy is to be returned to the *home office.*

This copy to be returned to the Risk Operations address listed below:
Union Security Insurance Company—Risk Operations/Case Issue
P.O. Box 830069, Birmingham, AL 35282-8320

Union Security Insurance Company 2323 Grand Boulevard Kansas City Missouri 64108-2670

Approved as to Terms & Conditions

Nancy L Bolton
Director, Risk Management

ATTACHMENT #4

Union Security Insurance Company agrees to provide the insurance described in this and the following pages of the *policy*, subject to payment of premiums.

Policyholder:	Palm Beach County Board of County Commissioners
Policy Number:	G 5,303,634
Delivered In:	Florida and governed by its laws.
Effective Date:	January 1, 2008 - The date the *policy* takes effect which is also its date of issue.
Premium Due Dates:	The first premium is due on the Effective Date. Future premiums are due on the first day of each month after that.
Policy Anniversary:	January 1, 2009, and each January 1 after that.
Insurance Provided:	Group Dental Insurance – Contributory Group Dental Insurance for Dependents – Contributory

Kenneth A. Jones
Assistant Secretary

Michael J Peninger
Executive Vice-President

Union Security Insurance Company 2323 Grand Boulevard Kansas City Missouri 64108-2670

True PPO Plan

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GENERAL DEFINITIONS

These terms have the meanings shown here when *italicized*. The pronouns "we", "us", "our", "you", and "your" are not *italicized*.

Active work means working *full-time* for the *policyholder* or an *associated company* at your usual place of business. However, *active work* does not apply to any retired persons covered under the *policy*.

Associated company means any company shown in the *policy* which is owned by or affiliated with the *policyholder*.

Contributory means you pay part or all of the premium.

Covered dependent means an *eligible dependent* who is insured under the *policy*.

Covered person means an eligible employee or member of the *policyholder*, or an *associated company* who has become insured for a coverage.

Doctor means a person, other than you, acting within the scope of his or her license to practice medicine and perform surgery.

Eligible class means a class of persons eligible for insurance under the *policy*. This class is based on employment or membership in a group.

Full-time means working at least 30 hours per week, unless indicated otherwise in the *policy*.

Home office means our office in Kansas City, Missouri.

Injury means accidental bodily injury. It does not mean intentionally self-inflicted injury while sane or insane.

No-fault motor vehicle coverage means a motor vehicle plan that pays disability or medical benefits without considering who was at fault in any accident that occurs.

Policy means the group policy issued by us to the *policyholder* that describes the benefits for which you may be eligible.

Policyholder means the entity to whom the *policy* is issued.

Proof of good health means evidence acceptable to us of the good health of a person.

We, us, and our mean Union Security Insurance Company.

You and your mean an eligible employee or member of the *policyholder* or an *associated company* who has become insured for a coverage.

DEFINITIONS FOR DENTAL INSURANCE

Accidental non-chewing injury means an *injury* (other than a chewing injury) sustained while insured under the *policy*, which is caused solely and exclusively by an accident which could not be predicted in advance, and which could not be avoided. A chewing injury is any *injury* which occurs during the act of biting or chewing, regardless of whether the *injury* is caused by biting or chewing food, biting on a foreign object not expected to be a normal constituent of food, parafunctional or abnormal habits such as (but not limited to) chewing on eyeglass frames or pencils, biting down on a suddenly dislodged or loose dental appliance, or biting or chewing on any other object for any other reason.

Allowable charge means:

- For a covered dental service rendered by a *preferred provider*, the *allowable charge* is based on an amount, as determined by us, that the *preferred provider* has agreed to accept.

- For a covered dental service rendered by a *non-preferred provider*, the *allowable charge* is the *reasonable charge*. The *reasonable charge* is the amount, as determined by us, accepted by providers in the area for like dental services. Our determination of what is an *allowable charge* or *reasonable charge* is final for the purposes of determining benefits payable under the *policy*.

Benefit year means a period of 12 consecutive months, which begins on the date you become insured under the *policy*. Subsequent *benefit years* begin on each succeeding anniversary of the date you became insured under the *policy*.

Continuous coverage/continuously covered means, with respect to a *transfer insured's* coverage under the *prior plan*, the most recent period of continuous coverage under the *prior plan* ending on the day before the effective date of this *policy*.

Dental hygienist means an individual who is licensed to practice dental hygiene and acting under the supervision of a *dentist* within the scope of that license in treating the dental condition.

Dental insurance means the group dental insurance under the *policy* issued by us to the *policyholder*.

Dentally necessary and dental necessity mean a service or *treatment* which is appropriate with the diagnosis and which is in accordance with accepted dental standards. The service or *treatment* must be essential for the care of the teeth and supporting tissues.

Dental treatment plan means the *dentist's* report of recommended *treatment* which contains:

- a list of the charges and dental procedures required for the *dentally necessary* care;

- any supporting pre-operative x-rays; and

- any other appropriate diagnostic materials required by us.

Dentist means an individual who is licensed to practice dentistry and acting within the scope of that license in treating the dental condition.

Denturist means an individual who is licensed to make dentures and acting within the scope of that license in treating the dental condition.

Emergency dental treatment means any *dentally necessary treatment* that is rendered as the direct result of unforeseen events or circumstances, which require prompt attention.

DEFINITIONS FOR DENTAL INSURANCE (continued)

Functioning natural tooth means a *natural tooth* which is performing its normal role in the chewing process in the person's upper or lower arch and which is opposed in the person's other arch by another *natural tooth* or prosthetic replacement.

Immediate family means a person who is related to you or your spouse in any of the following ways: parent, spouse, child, brother, sister, or grandparent.

Medicare means a portion of Title XVIII of the United States Social Security Act of 1965, as amended.

Natural tooth means any tooth or part of a tooth that is organic and formed by the natural development of the body. Organic portions of the tooth include the crown enamel and dentin, the root cementum and dentin, and the enclosed pulp.

Non-preferred provider means a *dentist, dental hygienist,* dental office, medical center, or any dental care provider who is not a participant in our *preferred provider plan* at the time covered dental services are provided.

Orthodontic treatment means the corrective movement of teeth through the bone by means of an active appliance to correct a handicapping malocclusion (a malocclusion severely interfering with a person's ability to chew food) of the mouth. We will make the determination of the severity of the malocclusion.

Other group dental expense coverage means:

- any other group policy providing benefits for dental expenses; or
- any plan providing dental expense benefits (whether through a dental services organization or other party providing prepaid health or related services) which is arranged through any employer or through direct contact with persons eligible for that plan.

Policy year means the period of time which begins on the *policy* anniversary date of each calendar year and ends on the day before the next following yearly *policy* anniversary date. The first *policy year* begins on the *policy* effective date. The last *policy year* ends on the day *dental insurance* under the *policy* ends.

Preferred provider means a *dentist, dental hygienist*, dental office, or medical center or any dental care provider who is a participant in our *preferred provider plan.*

Preferred provider plan means the dental care delivery system established by the plan manager in which *preferred providers* participate and under which we provide certain dental benefits.

Prior Plan means the policy(ies) or plan(s) providing dental care coverage to persons of the group, which is (are) replaced by insurance under our *policy* on the *policy* effective date.

Sound tooth means a *natural tooth* that is fully restored to function, does not have any decay, is not more susceptible to *injury* than a virgin tooth, and is without periodontal disease.

Transfer insured means a person who both is insured under our *policy* on the *policy* effective date (without regard to the Exception to Effective Date provision) and was covered under the *prior plan* on the day just before that; but only so long as the person remains continuously insured under our *policy.* The Exception to Effective Date provision does not apply to such *transferred insureds*. The Continuance of Insurance provision applies to such *transferred insureds* that are not at *active work* on the *policy* effective date. However, the maximum continuation period will begin on the *policy* effective date.

Treatment means any dental consultation, service, supply, or procedure that is needed for the care of the teeth and supporting tissues.

SUMMARY OF GROUP INSURANCE

This summary is intended to help understand the group insurance policy. It does not change any of its provisions.

Dental Insurance

The *policy* pays benefits if a *covered person* or *covered dependent* incurs covered dental expenses in excess of the deductible amount. The co-insurance percentage and the deductible may vary according to the service performed. The *policy* explains which dental expenses receive limited or no benefits. In addition, waiting periods may apply to some procedures.

If a *covered person* or *covered dependent* has more than one dental expense plan, benefits under the *policy* may be reduced so that all benefits received are not more than the actual expenses.

In the following pages, the provisions that describe a particular coverage were designed to be used in both the *policy* and the certificate. Therefore the terms "you" and "your" are used to refer to the *covered person*.

Please read
the insurance
policy carefully

GROUP POLICY SCHEDULE

Eligible Class:

For employee insurance: Each *full-time* permanent employee of the *policyholder* or an *associated company,*

- who is at *active work*, and
- who is working in the United States of America,

except any temporary or seasonal worker.

For dependent insurance - Each person eligible and insured for employee insurance.

The Eligible Class also includes each retired employee of the *policyholder* or an *associated company*, who meets the eligibility or participation rules established by the *policyholder.*

Associated Companies: Palm Tran Inc., Supervisor of Elections

Present Service Requirement: 60 days

Future Service Requirement: 60 days

Entry Date: An eligible person will become insured on the first of the month occurring on or after the day all eligibility requirements are met.

Minimum Participation Requirements:

Number: 35 Percentage: 20%

SCHEDULE

Dental Insurance

Deductible Amount	**PPO Plan** (In-Network Plan)	**Non-PPO Plan** (Out-of-Network Plan)
Individual Deductible Amount Per *Policy Year*:	$50	$100
Individual Deductible Amount for Type IV Services Per *Policy Year*:	$0	$0

The Individual Deductible does not apply to Type I In-Network Dental Services.

Covered dental services incurred toward the deductible amount apply to both the PPO and Non-PPO Plans.

Coinsurance Percentages	**PPO Plan** (In-Network Plan)	**Non-PPO Plan** (Out-of-Network Plan)
Type I Services:	100%	90%
Type II Services:	80%	70%
Type III Services:	50%	40%
Type IV Services:	50%	50%

SCHEDULE (continued)

The deductible amount does not apply and the coinsurance percentages are 100% for all *covered dental expenses* received for the *treatment* of crime-related injuries of a *covered person* or *covered dependent* determined eligible under the Florida Crimes Compensation Act.

Benefit Maximums:	**PPO Plan** (In-Network Plan)	**Non-PPO Plan** (Out-of-Network Plan)
Policy Year Maximum:	$1,250	$1,000
Overall Benefit Maximums:		
Type IV Services:	$1,000	$1,000

Amounts applied to the benefit maximums will apply to both the PPO Plan and Non-PPO Plan maximums.

Covered dental services are based on current dental terminology and are updated periodically. The most current dental terminology may not be reflected in the Listing of Covered Dental Services. However, benefits will be payable based on the most current dental terminology.

Discounts on dental care products are available. Please visit the For Members site at www.assurantemployeebenefits.com for details.

Waiting Periods

There are waiting periods which must be fulfilled before benefits will be payable for specified dental services. Please see Waiting Periods for Insured Persons Generally under the Special Limitations provision and the detailed list of waiting periods shown below.

Type III Dental Services**

All Services under "Endodontics"	6 months
Denture Reline or Rebase Procedures, Adjustments to Dentures or other Removable Prosthetic Services under "Major Restorations—Maintenance"	6 months
Prefabricated Stainless Steel or Prefabricated Resin Crowns under "Major Restorations—Initial (New) or Replacement"	6 months
All Services under "Complex Oral Surgery"	12 months
All Services under "Major and Minor Periodontics"	12 months
Other Services under "Major Restorations—Initial (New) or Replacement	
Inlay—Onlay Restorations, Crowns (except Prefabricated Stainless Steel or Prefabricated Resin Crowns), Core Build-ups, or Posts and Cores	
Initial (New) or Replacement	12 months
Complete or Partial Dentures or addition of teeth to existing Partial Dentures	12 months
Fixed Partial Dentures or Diagnostic Casts	12 months

SCHEDULE (continued)

** These Waiting Periods for Type III Dental Services do not apply to Covered Dental Services *dentally necessary* for *treatment* of an *accidental non-chewing injury* sustained while insured; or re-cementing of or repairs to inlays, onlays, crowns, or fixed partial dentures.

Type IV Dental Services

All Services (Orthodontic Services) 12 months

Note: Type IV Dental Services available only to *covered dependent* children who are under age 19.

Vision Plan

You and your *covered dependents* are eligible for discounted vision services. The discounted vision services are provided through a third party vendor and are not covered under an insured plan. The discounted vision services offered include discounts on eye exams, prescription glasses, and services related to prescription contact lenses.

Plan Changes

A *covered person* may change his or her plan of insurance only during November 1 through November 30 of each year, the annual enrollment period agreed upon by the *policyholder* and us, unless the *covered person* undergoes a change in family status. A plan change made during the annual enrollment period will take effect on the next following policy anniversary.

A *covered person* may change his or her plan within 31 days of a change in family status. The effective date of the change will be the Entry Date occurring on or after the date of the request.

A "change in family status" means the marriage or divorce of the *covered person*, the birth or adoption of a child of the *covered person*, the death of a spouse or child of the *covered person*, the termination of employment of the *covered person's* spouse.

The "Waiting Period for Insured Persons Generally" provision will apply to changes made during an annual enrollment period and changes made due to change in family status.

ELIGIBILITY AND TERMINATION PROVISIONS

Eligible Persons

To be eligible for insurance, a person must:

- be a member of an *eligible class*; and
- complete any Service Requirement shown in the Schedule by continuous service with the employer, the *policyholder*, or an *associated company*.

The Present Service Requirement applies to persons in an *eligible class* on the Effective Date of the *policy*. The Future Service Requirement applies to persons who become members of an *eligible class* after that.

Effective Date for an Eligible Person

A person must apply for insurance on a form acceptable to us, and agree to pay part or all of the premium.

- If a person applies and we receive the application before becoming eligible, insurance will take effect on the Entry Date shown in the Schedule in the *policy*.
- If the application is made on the date the person becomes eligible, or within 31 days after that, insurance will take effect on the Entry Date occurring on or after the date of the application.
- If application is made more than 31 days after the day the person becomes eligible, or after insurance ended because the premium was not paid, then application must be made during an annual enrollment period. *Dental insurance* will then take effect on the policy anniversary occurring on or after the date of the application.

Exception to Effective Date

If an eligible person is not at *active work* on the day insurance would otherwise take effect, insurance will not take effect until the person returns to *active work*. If the day insurance would normally take effect is not a regular work day for a person, insurance will take effect on that day if the person is able to do his or her regular job.

When a Person's Insurance Ends

A *covered person's* insurance will end on the earliest of:

- the day the *policy* ends;
- the day the *policy* is changed to end the insurance for a person's *eligible class*;
- the last day of the month in which a person is no longer in an *eligible class*;
- the last day of the month in which a person stops *active work*;
- the day a required contribution was not paid; or
- the day a *covered person* becomes covered under an optional dental plan which is sponsored by the employer, or the *policyholder*, or an *associated company* and provided through a Dental Maintenance Organization.

ELIGIBILITY AND TERMINATION PROVISIONS (continued)

Continuance of Insurance

If a person is unable to perform *active work* for a reason shown below, the *policyholder* may continue the person's insurance and the person's dependent insurance, if any, on a premium-paying basis provided the person remains in other respects a member of the *eligible class*. The continuance cannot be more than the maximum continuance shown below. Continuance must be based on a uniform policy, and not individual selection.

The maximum continuance for *dental insurance* is the longest applicable period described below:

- 12 months* for *injury*, sickness, or pregnancy;
- 6 months* for lay-off, leave of absence (other than a family or medical leave of absence described below), or change to part-time; or
- the end of the period the *policyholder* is required to allow* for a family or medical leave of absence under:
    - the federal Family and Medical Leave Act; or
    - any similar state law.

* after the last day of *active work*.

Reinstatement

If a person re-enters an Eligible Class within 12 months after insurance ends, the person will not have to complete the Service Requirement again. All other provisions of the *policy* will apply.

ELIGIBILITY AND TERMINATION PROVISIONS FOR DEPENDENTS

Eligible Dependents

Your *eligible dependents* are:

- your lawful spouse, and
- your unmarried children who have reached the end of the calendar year in which the child has reached the age of 19, or
- less than age 25 if a full-time or part-time student, or less than age 25 if living in your home and dependent upon you for support and maintenance. Children meeting these requirements may be covered for *dental insurance* until the end of the calendar year in which the child reaches age 25.

Children are covered for *dental insurance* from birth. "Children" include any adopted children. A child will be considered adopted on the date of placement in your home. However, if you agreed in writing to adopt the child before birth, *dental insurance* will begin on the date of birth. Stepchildren and foster children are also included if they depend on you for support and maintenance. A Grandchild born to an *eligible dependent* on the Plan. "Children" also include any children for whom you are the legal guardian, who reside with you on a permanent basis and depend on you for support and maintenance.

An *eligible dependent* may not be covered by more than 1 *covered person*.

Dependent Effective Date

You must apply for dependent insurance on a form acceptable to us. You must also agree to pay your share of the premium.

- If you apply before the dependent becomes eligible, dependent insurance will take effect on the Entry Date shown in the Schedule in the *policy*.
- If you apply on the date the dependent becomes eligible, or within 31 days after that, dependent insurance will take effect on the Entry Date occurring on or after the date of your application.
- If you apply more than 31 days after the date the dependent becomes eligible or after dependent insurance ended because the premium was not paid, then application must be made during an annual enrollment period. Dependent insurance will take effect on the policy anniversary occurring on or after the date of application.

Exception to Dependent Effective Date

Dependent insurance will not take effect until your insurance for the same coverage under the *policy* takes effect.

If an *eligible dependent* is in a hospital or similar facility on the day insurance would otherwise take effect, it will not take effect until the day after the *eligible dependent* leaves the hospital or similar facility. This exception does not apply to a child born while dependent insurance is in effect.

When Dependent Insurance Ends

A dependent's insurance will end on the earliest of:

- the day the *policy* ends;

ELIGIBILITY AND TERMINATION PROVISIONS FOR DEPENDENTS (continued)

- the day the *policy* is changed to end dependent insurance;
- the last day of the month in which that dependent is no longer eligible;
- the day your insurance for the same coverage under the *policy* ends;
- the day a required contribution for dependent insurance was not paid; or
- the day the dependent becomes covered under an optional dental plan which is sponsored by your employer, or the *policyholder*, or an *associated company* and provided through a Dental Maintenance Organization.

SPECIAL DEPENDENT INSURANCE CONTINUANCE PROVISIONS

As specified below, dependent *dental insurance* may continue, subject to the provisions that describe when insurance ends, and all other terms and conditions of the *policy.* Premiums are required for any coverage continued.

Physically Handicapped or Mentally Retarded Dependent Children

Dependent *dental insurance* for an *eligible dependent* child will continue beyond the date a child attains an age limit, if, on that date, he or she:

- is unable to earn a living because of physical handicap or mental retardation; and
- is chiefly dependent upon you for support and maintenance.

If we deny a claim because the child has attained an age limit, we must receive proof of the above within 120 days after the child attains the age limit.

Dependent *dental insurance* will end when the child is able to earn a living or is no longer dependent on you for support and maintenance.

Students

Dependent *dental insurance* for an *eligible dependent* child will continue beyond the date the child is no longer a student until the earliest of:

- the end of the 3rd calendar month following the month in which the child is no longer a student, unless the child has not reached the end of the calendar year in which the child reaches age 25 and the child is living in your home and dependent upon you for support and maintenance;
- the end of the calendar year in which the child reaches age 25; and
- the date the child becomes eligible for *other group dental expense coverage.*

Surviving Dependents

If you are a retired employee and death occurs while covered under the *policy, dental insurance* for your *covered dependent* spouse will continue after your death until the date:

- the *policy* ends;
- the *policy* is changed to end dependent insurance;
- that dependent is no longer eligible;
- a required contribution for dependent insurance is not paid; or
- the dependent becomes eligible for other group dental expense coverage.

Benefits will be paid to your lawful spouse, if living. If not, benefits will be paid to your child or children, if living. But if the child is a minor or otherwise not competent to file a valid release, benefits will be paid to an appointed legal representative, committee, or guardian of the child.

SPECIAL FEDERAL CONTINUANCE PROVISIONS

Under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and your *covered dependents* may have the right to continue *dental insurance* coverage beyond the date insurance would otherwise terminate. You should contact the *policyholder* concerning your right to continue coverage.

DENTAL INSURANCE

Insurance Provided

We will pay benefits for covered dental expenses identified in the *policy* when incurred by you or a *covered dependent*, while covered under the *policy*. We will pay the coinsurance percentage shown in the Schedule after you or a *covered dependent* have satisfied any deductible required for the *policy year*, subject to all the terms and conditions of the *policy*.

Covered dental expenses will only include *treatment* provided to you or a *covered dependent* for which, as outlined in the Listing of Covered Dental Services provision, the date started and the date completed occur while the person is insured under the *policy*. No payment will be made for a program of dental *treatment* already in progress on the effective date of a person's insurance, except as stated in the Limited Benefits for Transferred Insureds' Services provision. No payment will be made for dental *treatment* completed after your or a *covered dependent's* insurance under the *policy* ends, except as stated in the Limited Extension of Benefits After Insurance Ends provision.

Preferred Provider Plan

This *policy* includes a *preferred provider plan*. We will provide the benefits of the *preferred provider plan*, as shown in the Schedule, for covered expenses incurred by you or a *covered dependent* if the *treatment* is provided by a *preferred provider*. You will receive maximum benefits available under the *policy* when you obtain covered dental services from a *preferred provider*. You or a *covered dependent* must be identified as being insured under the *preferred provider plan* each time *treatment* is received, to obtain the benefits of the *preferred provider plan*. We will provide the benefits of the non-preferred provider plan, as shown in the Schedule, for covered dental expenses incurred by you or a *covered dependent* if the *treatment* is provided by a *non-preferred provider*.

We reserve the right to terminate a *preferred provider* or the *preferred provider plan*. If we do terminate a *preferred provider* or the *preferred provider plan*, the benefit for a covered dental service will be the benefit payable for a covered dental service from a *non-preferred provider*.

Deductible

The deductible is the amount shown in the Schedule and will be applied to each type of dental services as indicated in the Schedule. The deductible is the amount of covered dental expenses that you and each *covered dependent* must incur in a *policy year* before we will pay benefits. When covered dental expenses equal to the deductible amount have been incurred and submitted to us, the deductible will be satisfied. We will not pay benefits for covered dental expenses applied to the deductible.

If the deductible amount is increased during a *policy year*, further covered dental expenses must be incurred after the date of increase to satisfy the additional deductible for that *policy year*.

The deductible will apply to you and each *covered dependent* separately each *policy year*.

Policy Year Maximum

The maximum benefit payable to you and each *covered dependent* during a *policy year* is shown in the Schedule. This maximum will apply even if coverage for you or a *covered dependent* ends and starts again within the same *policy year* or if you or a *covered dependent* have been covered both as an employee and a dependent.

Date Started and Date Completed

We consider a dental *treatment* to be started as follows:

- for a full or partial denture, the date the first impression is taken;

- for a fixed bridge, crown, inlay and onlay, the date the teeth are first prepared;
- for root canal therapy, on the date the pulp chamber is first opened;
- for periodontal surgery, the date the surgery is performed; and
- for all other *treatment*, the date *treatment* is rendered.

We consider a dental *treatment* to be completed as follows:

- for a full or partial denture, the date a final completed appliance is first inserted in the mouth;
- for a fixed partial denture, crown, inlay and onlay, the date an appliance is cemented in place; and
- for root canal therapy, the date a canal is permanently filled.

(See Type IV: Dental Services for start and completion dates for *orthodontic treatment*.)

Pre-estimate

Whenever the expected cost of a *treatment* exceeds $300, we recommend that a *dental treatment plan* be submitted to us for review before *treatment* begins. The *dental treatment plan* should be accompanied by supporting preoperative x-rays and any other appropriate diagnostic materials as requested by us. We will notify you and your *dentist* of the benefits payable based upon the *dental treatment plan*. In estimating the amount of benefits payable, consideration will be given to the least costly alternative procedures and materials that may accomplish a result that meets broadly accepted standards of professional dental care as determined by us.

If a *dental treatment plan* is not completed within six months of the pre-estimate, we may consider it invalid. We may request the submission of a new *dental treatment plan*.

If you and your *dentist* decide on a more costly method of *treatment* than that pre-estimated by us, benefits payable for covered dental services for the more costly *treatment* will be limited to the benefits that would have been payable for covered dental services for the least costly alternative *treatment*. We will not pay the excess amount. Since this may result in significant out-of-pocket expense, we strongly encourage you to receive a pre-estimate for any *dental treatment plan* that is expected to exceed $300 in cost.

In addition to a *dental treatment plan*, before *orthodontic treatment* begins we may request any of the following information to help determine benefits payable for orthodontic services:

- full mouth dental X-rays;
- cephalometric X-rays and analysis;
- diagnostic casts (study models); and
- a statement specifying:
    - degree of overjet, overbite, crowding and open bite;
    - whether teeth are impacted, in crossbite, or congenitally missing;
    - length of *orthodontic treatment*; and

- total *orthodontic treatment* charge.

Alternative Benefits

In determining the benefits payable on a claim, we will consider other alternative procedures and materials that can be used to treat a dental problem or disease. The covered dental expense for a covered dental service provided will be limited to the *allowable charge* for the least costly covered dental service that accomplishes a result which meets broadly accepted standards of professional dental care as determined by us. You and your *dentist* may decide on a more costly procedure or material than we have determined to be satisfactory for the *treatment* of the dental problem or disease. In this event, we will not pay the excess amount. The benefit payable will be limited to the benefit that would have been payable had the least costly covered dental service been provided instead.

Covered Dental Expenses

Covered dental expenses for a *preferred provider* will include only the amount that the *preferred provider* has agreed to accept for expenses incurred by you or a *covered dependent*. Covered dental expenses for a *non-preferred provider* will include only the lesser of the *dentist's* actual charge or the *allowable charge* for expenses incurred by you or a *covered dependent*. The *treatment* must be:

- performed by or under the direction of a *dentist*, or performed by a *dental hygienist* or *denturist*;
- *dentally necessary*; and
- started and completed while you or your *covered dependent* are insured, except as otherwise provided in the Limited Benefits for Transfer Insureds' Services Started Under Prior Plan and Limited Extension of Benefits After Insurance Ends provisions.

Expenses submitted to us must identify the *treatment* performed in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature or by narrative description. We reserve the right to request X-rays, narratives and other diagnostic information, as we see fit, to determine benefits.

We will only pay benefits for covered dental expenses incurred for *treatment* that, in our opinion, has a reasonably favorable prognosis for the patient.

We consider a temporary *treatment* to be an integral part of the final *treatment*. The sum of the fees for temporary and final *treatment* will be used to determine whether the charges are an *allowable charge*.

The Listing of Covered Dental Services is a complete list of covered dental services. We will not pay benefits for expenses incurred for any service not listed below, unless we agree to accept an unlisted service as a covered dental service. We will not accept any unlisted service which is not similar to, or which does not accomplish a result similar to, a listed service. In any event, the choice of whether or not to accept an unlisted service is solely ours. If we do accept an unlisted service as a covered dental service, benefits will be payable on a basis consistent with benefits for similar covered dental services which would provide the least costly adequate *treatment* of your or your *covered dependent's* dental condition according to broadly accepted standards of professional dental care as determined by us.

Listing of Covered Dental Services

Maximum frequencies, maximum dollar amounts and other limits are shown here and under Special Limitations and General Exclusions for certain services. Services performed outside these limits are not covered dental services. Covered dental services are based on current dental terminology and are updated periodically. The most current dental terminology may not be reflected in the Listing of Covered Dental Services. However, benefits will be payable based on the most current dental terminology.

DENTAL INSURANCE (continued)

Type I Dental Services

- Clinical Oral Evaluations
  - No more than 1 time in any 6 months in a row. Benefits are based on the *allowable charge* for periodic oral evaluation.
- Dental Prophylaxis
  - No more than 1 time in any 6 months in a row. (Frequencies combined with periodontal maintenance.)
- Topical Fluoride Treatment
  - No more than 1 time in any 12 months in a row. Only for children under age 14 years.
- Sealants
  - No more than 1 time per tooth per person. Only for children under age 16 years. Only for permanent molar teeth.
- Space Maintenance (Passive Appliances)
  - Only for children under age 16 years. Service is deemed to include all adjustments made, or recementing done, within 6 months of installation.
- Treatment To Control Harmful Habits
  - Not covered if orthodontic related. Once per person. Only for children under age 16 years.
- Radiographs—Diagnostic Imaging
  - Bitewings—no more than 1 time in any 12 months in a row.

Type II Dental Services

- Radiographs—Diagnostic Imaging
  - Complete Series (Including Bitewings) or Panoramic Film—No more than 1 time in any 60 months in a row. A complete series is deemed to include bitewing x-rays and 10 or more periapical x-rays, or a panoramic film.
    - One of either service no more than 1 time in any 60 months in a row. Benefits for a panoramic film may also be payable in connection with the removal of impacted teeth.
  - Periapical—no more than 4 x-rays in any 12 months in a row.
  - Occlusal Film—no more than 2 films in any 12 months in a row.
  - Extraoral—no more than 2 films in any 12 months in a row.
  - Sialography

- Minor Restorations (Fillings)
  - Amalgam and Composite Restorations
    - Replacement of existing minor restoration (filling) is deemed to be a covered dental service only if at least 24 months have passed since existing minor restoration (filling) was placed, unless required by new decay in an additional tooth surface.
    - The service is deemed to include local anesthesia.
    - Benefits for composite restorations are based on the *allowable charge* of amalgam restorations on posterior teeth.
    - Multiple restorations on one surface are deemed to be a single restoration.
    - Mesial-lingual, distal-lingual, mesial-facial, and distal-facial resin restorations on anterior teeth are deemed to be single surface restorations.
- Other Restorative Services
  - Pin Retention—no more than 1 time per restoration. Deemed to be a covered dental service only in conjunction with amalgam or resin restoration.
- Oral Surgery
  - Minor Oral Surgery—Each service is deemed to include local anesthesia and routine postoperative care.
    - Simple Extractions (Does not include Surgical Extractions)
    - Surgical Incision and Drainage of Abscess
    - Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
- Other Type II Services
  - Bacteriologic Studies for Determination of Pathologic Agents
  - Palliative (Emergency) Treatment of Dental Pain—Minor Procedure—Deemed to be a separate covered dental service only if no other service is rendered during the visit, except x-rays.
  - Therapeutic Drug Injection
  - Accession and examination of tissue

Type III Dental Services

(The following services may be subject to waiting periods.)

- Complex Oral Surgery

- Surgical Extractions

- Other Complex Oral Surgery Procedures
  - Oroantral Fistula Closure
  - Tooth Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Tooth and/or Alveolus
  - Tooth Transplantation
  - Surgical Exposure of Impacted or Unerupted Tooth to Aid Eruption
  - Biopsy of Oral Tissue
  - Transseptal Fiberotomy
  - Alveoplasty
  - Vestibuloplasty
  - Removal of lateral exostosis—maxilla or mandible
  - Removal of Foreign Body, Skin, or Subcutaneous Areolar Tissue
  - Removal of Reaction-Producing Foreign Bodies Musculoskeletal System
  - Maxillary Sinusotomy for Removal of Tooth Fragment or Foreign Body
  - Frenulectomy (Frenectomy or Frenotomy) Separate Procedure
  - Excision of Hyperplastic Tissue - Per Arch
  - Excision of Pericoronal Gingiva
  - Sialolithotomy
  - Excision of Salivary Gland
  - Sialodochoplasty
  - Closure of Salivary Fistula

  If more than one complex surgical procedure is performed per area of the mouth, only the most inclusive surgical procedure performed will be considered a covered dental expense.

- Adjunctive General Services—Each service is deemed a separate covered dental service only when medically required for a complex oral surgery which is itself a covered dental service. Our decision is final for the purposes of determining covered dental services under the policy.
  - Anesthesia
  - Intravenous Sedation

- Endodontics—For applicable procedures, the service is deemed to include all pre-operative, operative, and post-operative x-rays, local anesthesia, and routine follow-up care.
  - Pulpotomy—Only for Deciduous Teeth
  - Endodontic Therapy
  - Endodontic Retreatment—Service is deemed a covered dental service if at least 24 months have passed since the initial treatment.
  - Apexification-Recalcification Procedures
  - Apicoectomy Surgery
  - Periradicular Services
    - Retrograde Filling
    - Root Amputation
- Other Endodontic Procedures
  - Hemisection (Including any root removal), Not Including Endodontic Therapy—covered dental services do not include fixed partial dentures replacing the extracted part of a hemisected tooth.
- Minor Periodontics
  - Adjunctive Periodontal Service
    - Provisional Splinting—covered dental services do not include inlays, onlays, crowns, or other cast or prepared restorations made for the purpose of splinting
    - Scaling and Root Planing—no more than 1 time per area of the mouth in any 24 months in a row. The benefit for three or more quadrants of scaling and root planing, performed during the same appointment, will be limited to benefits equivalent to one quadrant of scaling and root planing. Benefits for prophylaxis and scaling and root planing, performed during the same appointment, will be based on the *allowable charge* for a prophylaxis. Benefits for scaling and root planing and periodontal maintenance, performed during the same appointment, will be based on the *allowable charge* for periodontal maintenance.
    - Occlusal Adjustment—No more than 1 full mouth treatment in any 12 months in a row. Only when performed with periodontal surgery (regardless of whether the periodontal surgery itself is a covered dental service).
- Other Periodontal Services
  - Periodontal Maintenance—no more than 1 time in any 6 months in a row. Service is deemed to include scaling and root planing, a recall evaluation, charting, polishing of teeth, and oral hygiene instruction. (Frequencies combined with prophylaxis.)

- Major Periodontics—For applicable procedures, services are deemed to include local anesthesia, temporary restorations and appliances, and one-year follow-up care.
  - Surgical Services—If more than one periodontal surgical service is performed per area of the mouth, only the most inclusive surgical service performed will be considered a covered dental expense. The following surgeries are covered only if more than 36 months have passed since gingivectomy, flap surgery, or osseous surgery was performed in that same area of the mouth.
    - Gingivectomy or Gingivoplasty
    - Gingival Flap Procedure
    - Osseous Surgery
  - Clinical Crown Lengthening
  - Guided Tissue Regeneration
  - Soft Tissue Graft
  - Subepithelial Connective Tissue Graft
  - Distal or Proximal Wedge
  - Occlusal Guard—No more than 1 in any 24 months in a row.
- Major Restorations—Initial (New) or Replacement. For applicable procedures, the service is deemed to include local anesthesia, temporary restorations and appliances, and one-year follow-up care.
  - Inlay/Onlay Restorations
    - Benefits are based on the *allowable charge* of a metallic inlay or onlay.
  - Crowns
    - Benefits are based on the *allowable charge* for predominantly base metal.
    - For children under age 16 years, covered dental services for crowns on deciduous or primary teeth are limited to prefabricated stainless steel or prefabricated resin crowns.
  - Labial Veneers (Only for Anterior Teeth)
  - Other Restorative Services—Only under unusual circumstances when required, as determined by us, for retention and preservation of the tooth. Service is deemed to include pins.
    - Core Build-up, Including Any Pins
    - Cast Post And Core
    - Prefabricated Post And Core

DENTAL INSURANCE (continued)

- Complete Dentures And Partial Dentures
  - Service is deemed to include all replacement teeth and all clasps and rests.
- Fixed Partial Denture Pontics
  - Fixed Partial Denture Retainers, Inlays/Onlays, And Crowns—Benefits based on the *allowable charge* for predominantly base metal.
    - Two or more contiguous spans of fixed partial denture work, regardless of the number of pontics and abutments involved, are deemed to be a single fixed partial denture with benefits payable based on a single date completed. Benefits for such a fixed partial denture will not be applied to more than one *policy year*.
- Tissue Conditioning
  - No more than 1 time in any 36 months in a row.
  - Only if at least 12 months have passed since the insertion of a full or partial denture.
- Major Restorations—Maintenance—For applicable procedures, the service is deemed to include local anesthesia, temporary restorations and appliances, and one-year follow-up care. Covered only if more than 6 months have passed since the initial insertion.
  - Recement Inlays
  - Recement Crown
  - Recement Fixed Partial Denture
  - Crown Repair
- Repairs To Complete Dentures, Partial Dentures Or Fixed Partial Dentures
  - Only if more than 6 months have passed since the initial insertion.
- Adjustment To Dentures
  - No more than 1 time in any 12 months in a row. Only if more than 6 months have passed since the initial insertion.
- Denture Rebase Procedures
  - No more than 1 time in any 36 months in a row. Only if more than 12 months have passed since the initial insertion.
- Denture Reline Procedures
  - No more than 1 time in any 36 months in a row. Only if more than 12 months have passed since the initial insertion.
- Other Type III Services

- Diagnostic Casts—No more than 1 time in any 36 months in a row. Only if required for extensive bilateral prosthetic dentistry other than dentures. Not a covered dental service if for orthodontic evaluation.

Type IV Dental Services

(The following services may be subject to waiting periods).

- Limited Orthodontic Treatment
- Interceptive Orthodontic Treatment
- Comprehensive Orthodontic Treatment
- Minor Treatment To Control Harmful Habits

Covered dental expenses for *orthodontic treatment* are subject to the following:

A covered dental expense for a covered dental service for *orthodontic treatment* is the lesser of the provider's actual fee or the *allowable charge*. A covered dental expense for orthodontic exposure or extraction of teeth is deemed incurred on the date the service is completed and benefits are payable based on that date as stated in this provision. Covered dental expenses for orthodontic evaluation and *orthodontic treatment* are deemed incurred on a monthly basis beginning with the date *orthodontic treatment* is started and continuing throughout the course of *orthodontic treatment* according to the rules stated in this provision.

Covered Dental Expenses for *orthodontic treatment*, do not include, and we will not pay orthodontic expenses for, orthodontic evaluation or exposure or extraction of teeth which is not an essential preliminary (as determined by us) to *orthodontic treatment* which is actually performed. Only the services listed above will be considered to be covered dental services for *orthodontic treatment*. The services will only be covered if they are:

- essential, as determined by us, to correct a *covered dependent* child's handicapping malocclusion (or as an essential preliminary to such correction, as determined by us); and
- the *covered dependent* child is under age 19 years on the date the *orthodontic treatment* is started.

Upon our receipt of proof that covered dental expenses have been incurred for covered dental services for exposure or extraction of teeth prior to and in connection with *orthodontic treatment* for a *covered dependent* child who is insured for orthodontic expense benefits (and who is under age 19 years on the date that *orthodontic treatment* is started), we will calculate and pay benefits as follows:

a) Determine the lesser of the dentist's actual fee or the *allowable charge* for each such service completed. The result, subject to all other *policy* provisions, is the covered dental expense for that service.

b) Determine the coinsurance percentage for each such covered dental expense.

c) Total all such coinsurance percentage to obtain the benefit for the submitted claim, subject to the Overall Benefit Maximum for Type IV Dental Services and all other *policy* provisions.

Upon our receipt of proof that covered dental expenses have been incurred for covered dental services for *orthodontic treatment* and any evaluation prior to and in connection with that *treatment* for a *covered dependent* child who is insured for orthodontic expense benefits (and who is under age 19 years on the date that *orthodontic treatment* is started), we will calculate and pay monthly benefits as follows:

a) Determine the lesser of the *dentist's* actual fee or the *allowable charge* for each covered dental service for the entire planned course of *orthodontic treatment* which has started and for each covered dental service for evaluation which was completed prior to and in connection with that *orthodontic treatment*. Add the results.

b) Determine 50% of the resulting total.

c) Determine the lesser of that amount or the available Overall Benefit Maximum for Orthodontic Services remaining.

d) If the *dentist* did not make a separate charge for initial insertion of the first orthodontic appliance(s), divide the result in (c) by one more than the total number of months in the entire planned course of an *orthodontic treatment* to get a monthly benefit amount (the same amount for the initial and each subsequent monthly benefit).

e) If the *dentist* did make a separate charge for initial insertion of the first orthodontic appliance(s), determine 25% of the result in (c) to get an initial monthly benefit amount. Divide the remaining 75% of the result in (c) by the total number of months in the entire planned course of *orthodontic treatment* to get a subsequent monthly benefit amount.

f) The initial monthly benefit is payable on the date the *orthodontic treatment* is started. A subsequent monthly benefit is payable on the date each month of ongoing *treatment* is completed in that planned course of *orthodontic treatment*, but only if both: (1) the month of ongoing *treatment* is a covered dental service; and (2) we receive proof that *treatment* continued during that month.

g) All monthly benefits otherwise payable as stated above are subject to the Overall Benefit Maximum for Type IV Services and all other *policy* provisions.

If the *dentist* deliberately does not collect (that is, forgives) some or all of the amounts due from you, we will recalculate the benefits payable according to the above rules; but we will use the amount which the *dentist* accepted as payment in full (that is, the original fee less the amounts forgiven) as the charge actually made by the provider. You will then owe us the amount of any overpayment we may have made.

The *Policy Year* Maximum does not apply to benefits payable for covered dental expenses for orthodontics. Instead, the Overall Benefit Maximum for Type IV Services shown in the Schedule applies to benefits payable for such expenses. The Overall Benefit Maximum for Type IV Services is the limit on the total amount of benefits payable for covered dental expenses incurred for a *covered dependent* child's covered dental services for *orthodontic treatment* in his lifetime. A single Overall Benefit Maximum for Type IV Services applies to a child even if his insurance has been interrupted or he has been insured both as a *covered person* and as a *covered dependent*.

The Waiting Period for orthodontic dental services is shown in the Schedule, and starts on the later of: (a) the *policy* effective date; or (b) the *covered dependent* child's effective date of insurance (most recent effective date if previously insured). If the date started for *orthodontic treatment* is before the waiting period ends, the entire course of *orthodontic treatment* is excluded from being a covered dental service. If the date started for any other dental service for *orthodontic treatment* is before the Waiting Period ends, the service is excluded from being a covered dental service.

Orthodontic treatment is deemed started on the date the first active orthodontic appliance is first inserted. Each month of ongoing *orthodontic treatment* following that date is deemed completed on the monthly anniversary of that date in each following calendar month. (For *orthodontic treatment* deemed started on the last day of a calendar month, the monthly anniversaries are deemed to be the last day of each following calendar month.) A covered dental service for orthodontic evaluation or exposure or extraction of teeth will be considered started and completed on the date that the service is actually performed.

The entire course of *orthodontic treatment*, and any preliminary orthodontic evaluation or exposure or extraction of teeth, are excluded from being covered dental services (and no benefits are payable) if the date started for the *orthodontic treatment* is on or after the date your *covered dependent* child reaches age 19 years.

The entire course of *orthodontic treatment* is excluded from being a covered dental service (and no benefits are payable) if the date started is before any of the following dates: (a) the effective date of this *policy*; or (b) the effective date of the *covered dependent's* insurance (most recent effective date if previously insured); or (c) the end of the waiting period.

Special Limitations

Waiting Periods for Insured Persons Generally

You and your *covered dependents* must serve a waiting period for one or more Types of Dental Services. A waiting period is a stated period of time starting on the effective date of your or a *covered dependent's* insurance. ("Effective date" means the most recent effective date of *dental insurance* if you or a *covered dependent* were previously insured.) If the date started for a service is before the applicable waiting period ends, the service is excluded from being a covered dental service. The Types of Dental Services with waiting periods and the lengths of such waiting periods are shown in the Schedule.

Major Restorations

Covered Dental Expenses and covered dental services do not include, and we will not pay benefits for, the following:

- Inlays, onlays, crowns, cast restorations, veneers or other laboratory prepared restorations:
  - on teeth which may be restored with a direct placement filling material;
  - in the absence of extensive decay or fracture;
  - for loss of tooth structure due to attrition or abrasion; or
  - for children under age 16 years, except for prefabricated stainless steel or prefabricated resin crowns on deciduous or primary teeth.
- The initial placement of a complete or partial denture unless:
  - it includes the replacement of a *functioning natural tooth* extracted while you or your *covered dependent* are insured under the *policy*; and
  - that tooth cannot be added to an existing partial denture. We will not pay benefits for the initial placement of a complete or partial denture which replaces only those *natural teeth* missing on the date your or your *covered dependents'* insurance begins.
- The initial placement of a fixed partial denture unless:
  - it includes the replacement of a *functioning natural tooth* extracted while insured under the *policy*; and

- that tooth was not an abutment to an existing fixed partial denture that is less than 7 years old (5 years old if a cast metal, resin bonded fixed retainer). Benefits for such initial placement are limited to benefits for the replacement of those *functioning natural teeth* which were extracted while you or your *covered dependent* are insured under the *policy* and were not abutments to an existing fixed partial denture less than 7 years old (5 years old if a cast metal, resin bonded fixed retainer). We will not pay benefits to replace *natural teeth* missing on the date that your or your *covered dependent's* insurance begins.

- The replacement of inlays, onlays, crowns, core build-ups, cast restorations, or other laboratory prepared restorations unless:
  - at least 7 years have passed since the last placement (5 years for labial veneers, 3 years for prefabricated stainless steel or prefabricated resin crowns); and
  - they are not serviceable and cannot be restored to function.

- The replacement of a complete or partial denture, or the addition of teeth to a partial denture, unless:
  - replacement occurs at least 5 years after the initial date of insertion of the existing denture, provided the existing denture is not serviceable and cannot be restored to function; or
  - the addition of a tooth to a partial denture is required due to the *dentally necessary* extraction of a *functioning natural tooth* while you or your *covered dependent* are insured under the *policy*; or
  - the replacement is made *dentally necessary* by an *accidental non-chewing injury* to a *sound natural tooth*, provided the replacement is completed within 12 months of the injury.

- The replacement of a fixed partial denture unless:
  - replacement occurs at least 7 years (5 years for a cast metal, resin bonded fixed retainer) after the initial date of insertion of the existing fixed partial denture, provided the existing fixed partial denture is not serviceable and cannot be restored to function; or
  - replacement is required due to the *dentally necessary* extraction of a *functioning natural tooth* while *you or your covered dependent* are insured under the *policy*, *provided* that the extracted tooth was not serving as an abutment to the existing fixed partial denture; or
  - replacement is made, provided the replacement is made *dentally necessary* by an *accidental non-chewing injury* to a *sound natural tooth*, and is completed within 12 months of the injury.

- The replacement of an existing partial denture with fixed partial denture work unless upgrading to fixed partial denture work is essential, as determined by us, to the correction of *your or your covered dependent's* dental condition.

- The replacement of teeth beyond the normal complement.

- Appliances, inlays, onlays, crowns, or other cast or laboratory prepared restorations used primarily for the purpose of splinting.

- Facings on crowns or fixed partial dentures on molar teeth (which are always considered cosmetic under the *policy*).

- Implants, insertion of implants or related appliances, or surgical removal of implants.

Coverage Under the Group's Medical Plan

If benefits for any covered dental expenses are provided under your employer's medical plan (if any), benefits otherwise payable for those expenses under the *policy* will be reduced by the amount of benefits payable for those expenses under your employer's medical plan.

General Exclusions

Covered dental expenses and covered dental services do not include, and we will not pay benefits for, the following:

- *treatment* which:
  - is not included in the list of covered dental services; or
  - has a date started before your or a *covered dependent's* insurance begins; or
  - has a date started before any applicable Waiting Period has been served; or
  - has a date completed after your or a *covered dependent's* insurance ends, except as may be specifically provided under Limited Extension of Benefits After Insurance Ends.

- any *treatment*, the sole or primary purpose of which relates to:
  - the change or maintenance of vertical dimension; or
  - the alteration or restoration of occlusion except for occlusal adjustment in conjunction with periodontal surgery (regardless of whether the periodontal surgery itself is a covered dental service); or
  - bite registration; or
  - bite analysis.

- any *treatment* required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joint or its associated structures.

- athletic mouthguards; replacement of lost or stolen appliances; myofunctional therapy; infection control; oral hygiene instruction; separate charges for acid etch; treatment of jaw fractures; orthognathic surgery; personal supplies; broken appointments; completion of claim forms; exams required by a third party; travel time; transportation costs; professional advice given on the phone.

- *treatment* which:
  - is not *dentally necessary*; or
  - does not have uniform professional endorsement; or

- is experimental or investigational in nature.

- *treatment* which does not have a reasonably favorable prognosis, as determined by us.

- *treatment* provided primarily for cosmetic purposes.

- *treatment* received as a result of disease, defect, or injury due to war or an act of war (declared or undeclared), taking part in a riot or insurrection, or committing or attempting to commit an assault or felony.

- *treatment* of *injury* arising out of, or in the course of, doing any work for pay, profit, or gain, whether on your or a *covered dependent's* job or any other job, and for which benefits are paid under any applicable Workers' Compensation law.

- *treatment* of an intentionally self-inflicted injury.

- *treatment* performed outside of the United States of America, other than *emergency dental treatment*. However, for such *emergency dental treatment*, the benefits payable shall not exceed the *allowable charge* for the *treatment* at your employer's principal address (shown in the application for insurance) in the USA.

- *treatment* rendered by a dental clinic or similar clinic that is operated by your or your spouse's employer, labor union, or similar group.

- *treatment* of a provider who is a member of your or your spouse's *immediate family.*

- *treatment* for which a charge would not have been made in the absence of insurance.

- *treatment* for which you or your *covered dependent* do not have to pay, except when payment of such benefits is required by law and only to the extent required by law.

- *treatment* that has not been both delivered to and accepted by you or your *covered dependent*.

- *orthodontic treatment*, unless such insurance is provided under the list of covered dental services.

Limited Extension of Benefits After Insurance Ends

If an otherwise non-orthodontic covered dental service is started while you or your *covered dependent* are insured under the *policy* (and after any applicable waiting periods are served), but is completed after the day your or your *covered dependent's* insurance ends, we will pay benefits for otherwise covered dental expenses incurred for that service subject to all of the following rules:

- Benefits are not available to you or your *covered dependent* if, on the day after insurance ends, you or your *covered dependent*, obtain, or are eligible to obtain, dental care coverage under any group or governmental plan;

- Benefits are not available to you or your *covered dependent* if insurance ends because any required premium contributions were stopped while still eligible for insurance;

- Benefits are not available for any *treatment* started after the day your or your *covered dependent's* insurance ends;

- Benefits are payable only in the amount that would have been payable, and subject to the same provisions that would have applied, had your or your *covered dependent's* insurance still been in effect;

- Benefits are payable only if the *treatment* is completed within 90 days after the date your or your *covered dependent*'s insurance ends, unless you or your *covered dependent* become injured or sick after the *treatment* is started and that is the only reason the *treatment* could not be completed during those 90 days. Then, benefits are payable only if the *treatment* is completed before the earlier of:

    - the date 90 days after the first date the *injury* or sickness no longer prevents the *treatment* from being completed; or

    - the date 91 days after the date your or your *covered dependent's* insurance ends;

- We will not pay any benefits for *treatment* which is completed on or after the first date you or your *covered dependent* obtain, or are eligible to obtain dental care coverage under any group or governmental plan.

Limited Extension of Orthodontic Benefits After Insurance Ends

Any month of ongoing *orthodontic treatment* which has a date completed after the earliest of the following dates is excluded from being a covered dental service (and no benefits are payable for that month of *orthodontic treatment*):

- the day before the *policy* is amended to exclude *orthodontic treatment* from the coverage provided to *covered dependent* children of the class of employees to which you belong; or

- the date the *covered dependent's* insurance ends.

NOTE: We will make one exception to this exclusion. If a month of ongoing *orthodontic treatment* has a date completed after the earlier of the above dates, but that month of *orthodontic treatment* began while both this coverage under the *policy* and the *covered dependent's* insurance were in effect, we will pay a benefit for that month of *orthodontic treatment* in the same amount, and subject to the same *policy* provisions, that would have applied if both this coverage and the *covered dependent's* insurance were still in effect.

Limited Benefits for Transfer Insureds' Services Started Under Prior Plan

Our *policy* excludes benefits for services started before the date your or your *covered dependent's* insurance under our *policy* begins. However, if you or your *covered dependent* are a *transfer insured*, we will calculate and pay limited benefits as follows for otherwise-covered dental expenses for services started while you or your *covered dependent* were *continuously covered* under the *prior plan*, but completed while you or your *covered dependent* are insured under our *policy*:

1. Determine the amount (if any) that would have been payable had the service been started and completed while you or your *covered dependent* were *continuously covered* under the *prior plan*.

2. Determine the amount (if any) that would have been payable had the service been started and completed while you or your *covered dependent* were insured under our *policy*.

3. If either amount is zero, there is no benefit payable under this provision.

4. If both amounts are nonzero, we will prorate the lesser of the two amounts according to our established proration schedule to determine a prorated benefit for each part of the service performed.

   We will pay a prorated benefit only for that part of the service that is performed:

   a) while you or your *covered dependent* are insured under our *policy*; and

   b) after the end of any period during which the *prior plan* extends benefits for the service.

   We will not pay any benefit for any part of the service that is performed either:

   a) before you or your *covered dependent* are insured under our *policy*; or

   b) in any period during which the *prior plan* extends benefits for the service.

Transfer Insureds' Orthodontic Services Started Under Prior Plan

The above calculation for benefits payable for Transfer Insureds' Services Started Under the Prior Plan does not apply to dental services for *orthodontic treatment*. The *policy* excludes benefits for *orthodontic treatment* started before the *covered dependent child's* insurance under our *policy* begins. However, if the *covered dependent* child is a *transfer insured*, we will calculate and pay limited benefits as follows for otherwise-covered dental expenses for *orthodontic treatment* which started while the *covered dependent* child was *continuously covered* under the *prior plan* and is still ongoing when the *covered dependent* child's insurance under our *policy* begins:

1. We must receive proof that benefits were paid and are payable under the *prior plan* for that *orthodontic treatment*, and that the total of such benefits for:

   a) that ongoing orthodontic treatment; plus

   b) any evaluation prior to and in connection with the *orthodontic treatment*; plus

   c) any exposure or extraction of teeth prior to and in connection with the *orthodontic treatment*;

   is less than the amount of the Overall Benefit Maximum for Type IV Services under our *policy*.

   If we do not receive such proof, no benefit is payable under this provision.

2. If we receive such proof, we will determine whether or not benefits would have been provided had that ongoing *orthodontic treatment* been started while the *covered dependent* child was insured under our *policy* (without regard to any Waiting Periods that might otherwise apply). If no such benefits would have been provided, no benefit is payable under this provision.

3. We will calculate the portion of the Overall Benefit Maximum available for that ongoing *orthodontic treatment* under our *policy* as being the lesser of:

   a) the Overall Benefit Maximum for Type IV Services under our *policy*; or

   b) any overall benefit maximum for orthodontics under the *prior plan*; reduced by the total orthodontic benefits paid or payable under the *prior plan* as described in (1) above.

4. We will calculate a monthly benefit for that ongoing *orthodontic treatment* using the rules in the Type IV Dental Services provision, but with the reduced Overall Benefit Maximum as described in (3) above replacing the Overall Benefit Maximum for Type IV Services under our *policy* in that calculation.

5. The monthly benefit described in (4) above will be payable on the date each month of treatment is completed in the planned course of treatment, but only if:

   a) that month of treatment begins while the *covered dependent* child is insured under our *policy*; and

   b) that month of treatment would have been a covered dental service under our *policy* had the *orthodontic treatment* started while the *covered dependent* child was insured under our *policy* (without regard to any Waiting Periods that might otherwise apply); and

   c) we receive proof that *orthodontic treatment* continued during that month.

All monthly benefits otherwise payable as stated in (5) above are subject to the reduced Overall Benefit Maximum as described in (3) above and all other provisions of the *policy*.

Transfer Insureds' Teeth Extracted Under Prior Plan

Under Major Restorations in the Special Limitations provision, items pertain to complete and partial dentures and fixed partial dentures. These items all have references to missing *natural teeth* or to *functioning natural teeth* that have been extracted. For the purpose of applying these limitations where you or your *covered dependent* are a *transfer insured*, a *functioning natural tooth* which was extracted while you or your *covered dependent* were *continuously covered* under the *prior plan*, but no earlier than 12 months before the effective date of this *policy*, will be deemed to have been extracted while insured under this *policy*.

Credit Given To Transfer Insureds For Waiting Periods

In the DENTAL INSURANCE section under Waiting Periods for Insured Persons Generally, our *policy* provides in general that you and your *covered dependents* must serve a Waiting Period for certain Type III Dental Services. The Types of Dental Services with waiting periods are shown in the Schedule, together with the lengths of such waiting periods in months. On the *policy* effective date, each *transfer insured* is deemed to have served 12 months of each such waiting period (or the whole waiting period, if it is less than or equal to 12 months)—but only with regard to Types of Dental Services shown in the Schedule.

Transfer Insureds' Waiting Period for Type IV Services

The above credit for time served toward a Waiting Period applies only to the Waiting Periods for Type III Dental Services, if applicable, and not to Type IV Dental Services for *orthodontic treatment*. Under the Waiting Period provision in the Schedule, there is a Waiting Period for Type IV Dental Services for *orthodontic treatment*. On the *policy* effective date, each *transfer insured* is deemed to have served 12 months of that Waiting Period (or the whole Waiting Period), if it is less than or equal to 12 months.

COORDINATION OF BENEFITS

Applicability

All of the benefits provided under the *policy* are subject to *this provision.*

Definitions

Allowable expense means any *dentally necessary, allowable charge*, at least a portion of which is covered under 1 or more of the *plans* which covers the person:

- for whom claim is made, and
- on whose account payment is legally required.

When a *plan* provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be both an *allowable expense* and a benefit paid.

When benefits are reduced because the person does not comply with the provisions of a plan, the amount of the reduction will not be considered an *allowable expense.* However, any services rendered by a non-HMO/DMO provider for which the HMO/DMO denies payment will be considered an *allowable expense.*

Claim period means a *policy year.* A *claim period* will not start before a person's effective date of insurance under *this plan* nor extend beyond the last day the person is covered under *this plan.*

Medicaid means Title XIX of the Social Security Act of 1965 as amended.

Plan means any plan which provides benefits or services for medical or dental care or *treatment* through:

- group insurance coverage;
- group hospital, medical, or dental service prepayment coverage, group or individual practice or other group prepayment coverage, or group-type coverage through Health Maintenance Organizations (HMOs) or Dental Maintenance Organizations (DMOs);
- a labor-management trusteed plan, union welfare plan, employer or employee organization plan or any other arrangement of benefits, not available to the general public, which is based on membership in a group;
- coverage under government programs or coverage required or provided by any statute, except *Medicaid.* Benefits and services provided by Part A and Part B of *Medicare* are included. If you or a *covered dependent* are eligible for, but not covered under both Part A and Part B of *Medicare* for any reason, the benefits or services that would have been payable if you or the *covered dependent* had been covered, will be included, unless prohibited by state law or regulation; or
- *no-fault motor vehicle coverage* or a Motor Vehicle Financial Responsibility Act, unless prohibited by state law or regulation.

Plan does not include any of the following:

- *school accident coverage*;
- the first $30 per day of benefits under a group or group-type hospital indemnity benefit, written on a non-expense incurred basis;

- *Medicaid*; and does not include a law or *plan* when, by law, its benefits are in excess of those of any private or other non-governmental plan; or

- *no-fault motor vehicle coverage* or a Motor Vehicle Financial Responsibility Act, which, according to its rules, determines its benefits after the benefits of *this plan* have been determined, or any optional *no-fault motor vehicle coverage*; or

- Medicare supplement coverage.

The term *plan* will be construed separately for each policy, contract, or other arrangement for benefits or services. It will also be construed separately for:

- that part of any policy, contract, or other arrangement which has the right to consider the benefits or services of other *plans* in determining its benefits; and

- that part which does not.

Primary plan means a *plan* whose benefits for health care coverage must be determined without considering the existence of any other *plan*. A *plan* is primary if:

- the *plan* has no order of benefit determination rules, or it has rules which differ from *this provision*; or

- under the order of benefit determination rules, *this plan* determines its benefits first.

School accident coverage means coverage for elementary, high school, or college students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis.

Secondary plan is not a *primary plan*, and may consider the benefits of the *primary plan* and the benefits of any other *plan* which, under the rules of *this provision*, has its benefits determined before those of that *secondary plan*.

This plan means the benefits provided by the *policy*.

This provision means the provision for coordination between the benefits of *this plan* and other *plans*.

Other definitions which may apply to this Coordination of Benefits section appear in the Definitions sections of this *policy*.

Order of Benefit Determination

The rules to establish the order of benefit determination for each *plan* are as follows:

- A *plan* which covers the claimant as an employee, member or subscriber (that is, other than as a dependent) will determine its benefits before a *plan* which covers the claimant as a dependent. However, if the claimant is also a *Medicare* beneficiary, and as the result of the rule established by Title XVIII of the Social Security Act and implementing regulations,

    - the *plan* covering the claimant as a dependent will determine its benefits before *Medicare*; and

    - *Medicare* will determine its benefits before the *plan* covering the claimant as other than a dependent (e.g. a retired employee). Then the *plan* covering the claimant as a dependent will determine its benefits before the *plan* covering the claimant as other than a dependent.

- In the event that the claimant is a dependent child whose parents are not divorced or separated, benefits for the child are determined in this order:

  - first, the *plan* which covers the claimant as a dependent child of the parent whose birthdate occurs earlier in a calendar year; and

  - second, the *plan* which covers the claimant as a dependent child of the parent whose birthdate occurs later in the calendar year.

  If both parents have the same birthdate, benefits for the child are determined in this order:

  - first the *plan* which covered the parent longer; and

  - second, the *plan* which covered the other parent for a shorter period of time.

  If the other *plan* does not contain this exact rule regarding dependents, then this rule will not apply, and the rules set forth in the other *plan* will determine the order of benefits.

- In the event that the claimant is a dependent child whose parents are divorced or separated, benefits for the child are determined in this order:

  - When the parent with custody of the child has not remarried,

    - first, the *plan* which covers the child as a dependent of the parent with custody; and

    - second, the *plan* which covers the child as a dependent of the parent without custody; or

  - When the parent with custody of the child has remarried,

    - first, the *plan* which covers the child as a dependent of the parent with custody; and

    - second, the *plan* which covers that child as a dependent of the stepparent; and

    - finally, the *plan* which covers that child as a dependent of the parent without custody; or

  - When the parents have joint custody of the child and the court does not decree which parent is responsible for the health care expenses of the child, then benefits for the child will be determined according to the birthdate rule described above.

  - If the specific terms of a court decree that one parent is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the *plan* of that parent has actual knowledge of these terms, then

    - first, the *plan* of parent with financial responsibility; and

    - second, the *plan* of the other parent.

    This does not apply to any *claim period* during which any benefits are actually paid or provided before the entity has that actual knowledge.

- If the specific terms of a court decree state that both parents are responsible for the health care expenses of the child but gives physical custody of the child to a particular parent, then benefits for the child will be determined according to the birthday rule described above.

- A *plan* which covers the claimant as a laid-off or retired employee, or as a dependent of that person, will determine its benefits after a *plan* covering such claimant as an employee, other than a laid-off or retired employee, or as a dependent of that person.

  If a *plan* does not have a provision regarding laid-off or retired employees, which results in each *plan* determining its benefits after the other, then this rule will not apply.

- When the claimant whose coverage is provided under a federal or state continuation law is also covered under another *plan*, benefits are determined in this order:

  - first, the *plan* which covers the claimant as an employee; and
  - second, the *plan* which covers the claimant under a continuation law.

  If the other *plan* does not have a provision regarding coverage provided under continuation laws, then this rule will not apply.

- When none of the rules described above establish an Order of Benefit Determination, a *plan* which has covered the claimant longer will determine its benefits before a *plan* which has covered that claimant for a shorter period of time.

Effect on Benefits

A *primary plan's* benefits are not reduced because of the existence of another *plan*.

When there are more than two *plans*, *this plan* may be a *primary plan* to one or more other *plans*, and may be a *secondary plan* to a different *plan(s)*.

When *this plan* is a *secondary plan*, benefits payable under *this plan* will be reduced so that when they are added to the benefits payable under all other *plans*, they will not exceed the total *allowable expenses* incurred by you or the *covered dependent* during the *claim period*. Benefits payable under any other *plan* include the benefits that would have been payable had the claim for them been made. Except for Part A and Part B of *Medicare*, you or the *covered dependent* must actually be covered by the other *plans*.

We will exclude the benefits payable under any *plan* in determining the above reduction if:

- that other *plan* contains a provision which requires it to determine its benefits after the benefits of *this plan*, and
- the rules set forth in the Order of Benefit Determination require us to decide the benefits of *this plan* before the other *plan*.

When a reduction is made, each benefit that would have been payable in the absence of *this provision* will be reduced proportionately or in some other manner which we consider fair. The reduced amount will be charged against any benefit limit of *this plan* that may apply.

Right to Receive and Release Necessary Information

A claimant will furnish any information necessary to implement *this provision*. We may release or obtain any information, with respect to the claimant, which we deem necessary. This information may be released to or received from any insurer, other organization, or person. This may be done without the consent of or notice to the claimant. In so acting, we will be free from any liability.

Facility of Payment

When payments which should have been made under *this plan*, by the terms of *this provision*, have been made under any other *plans*, we have the right to pay to any organization making the other payments any amounts we determine are due to satisfy the intent of *this provision*. Any amount we pay in good faith will release us from further liability for that amount.

Recovery of Our Payment

If we pay more than the maximum amount required to satisfy the intent of *this provision* at that time, we have the right to recover the excess paid. We may make recovery from any persons to, or for, or with respect to whom the payments were made, or from any other insurers or organizations. This includes the reasonable cash value of any benefits provided as a service.

CLAIM PROVISIONS

Payment of Benefits

We will pay benefits when we receive all the required proof of covered loss.

To Whom Payable

We will pay dental benefits directly to the providers of dental services for *treatment* of you or your *covered dependents*, if you have assigned your benefits to the providers. We will pay dental benefits to you, if you have not assigned your benefits to the providers. After your death, we have the option to pay any benefits due to your spouse, to the providers of the *treatment*, or to your estate.

Authority

We have the sole discretionary authority to determine eligibility for participation or benefits and to interpret the terms of the Policy. All determinations and interpretations made by us are conclusive and binding on all parties.

Filing a Claim

1. Your *dentist* should send us notice of claim for dental *treatment*. You must send us notice of all other claims. We must have written notice of any insured loss within 30 days after it occurs, or as soon as reasonably possible. You can send the notice to our *home office*, one of our regional claims offices, or to one of our agents. We need enough information to identify you as a *covered person*. If charges for dental *treatment* are expected to be $300 or more, you can receive an estimate of benefits payable before *treatment* begins by following the procedures outlined in the Pre-estimate provision. The *preferred provider* will send notice of all dental expenses incurred under the *preferred provider plan*.

2. Within 15 days after the date of the notice, we will send you certain claim forms. The forms must be completed and sent to our *home office* or one of our regional claims offices. If you do not receive the claim forms within 15 days, we will accept a written description of the exact nature and extent of the loss. The *preferred provider* will provide initial written proof of any dental expenses incurred under the *preferred provider plan*.

3. The time limit for filing a claim is 90 days after the date of the loss.

4. To decide our liability, we may require:

   - itemized bills,
   - proof of benefits from other sources, and
   - proof that you have applied for all benefits from other sources, and that you have furnished any proof required to get them.

   For dental expenses, we may require additional information to determine our liability, including, but not limited to:

   - a complete dental charting indicating extractions, missing teeth, fillings, prosthesis, periodontal pocket depths, orthodontic relationship and the dates work was previously performed, and
   - preoperative x-rays, study models, laboratory and/or hospital reports.

We will ask you to authorize the sources of medical and dental services to release your medical information. If you do not furnish any required information or authorize its release, we will not pay benefits.

If it is not reasonably possible to give proof on time, we will not deny or reduce your claim if you give us proof as soon as reasonably possible. However, you must give us proof within 1 year from the date of loss unless you are legally incapacitated.

Physical Exam

We may ask you to be examined as often as we require at any time we choose. We will pay for any exam we require.

Limit on Legal Action

No action at law or in equity may be brought against the *policy* until at least 60 days after you file proof of loss. No action can be brought after the statute of limitations in your state has expired, but, in any case, not more than 6 years after the time written proof of loss is required to be given.

Incontestability

The validity of the *policy* cannot be contested after it has been in force for 2 years, except if premiums are not paid.

Any statement made by the *policyholder* or a *covered person* will be considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to the *covered person* or the *beneficiary*.

No statement, except fraudulent misstatement, made by a *covered person* about insurability will be used to deny a claim for a loss incurred or *disability* starting after coverage has been in effect for 2 years.

No claim for loss starting 2 or more years after the *covered person's* effective date may be reduced or denied because a disease or physical condition existed before the person's effective date, unless the condition was specifically excluded by a provision in effect on the date of loss.

Overpayment

If a benefit is paid under the *policy* and it is later shown that a lesser amount should have been paid, we will be entitled to a refund of the excess amount from the provider or you.

Subrogation Rights

In the event of any payments for benefits provided to you or a *covered dependent* under the *policy*, we, to the extent of our payments, will be subrogated to all rights of recovery you or your dependent have against any person or organization. You or your dependent will execute and deliver any instruments and papers as may be required and do whatever else is necessary to secure those rights to us and will do nothing after loss to prejudice our rights.

Right to Reimbursement

If you or a *covered dependent*: (a) seek legal recourse (whether by suit, settlement, judgment or otherwise) against any person or organization; and (b) recover payment, in whole or in part, from any such person or organization for the benefits previously paid under the *policy*, then you or your dependent must reimburse us for all payments made under the *policy* for which you have received reimbursement.

Any payments made prior to determination of work-related injury, will be reimbursed upon determination of such payment.

However, the reimbursement will not exceed: (a) the amount of the benefit payments made under the *policy* for which payment is recovered from any person or organization; or (b) the amount recovered from any such person or organization as payment for the same covered dental expenses.

You or your *covered dependents* are not obligated by this provision to seek legal action against any person or organization for which benefits have been paid under the *policy.*

Any such right of Subrogation or Reimbursement provided to Union Security Insurance Company under this *policy* shall not apply or shall be limited to the extent that the Florida statutes or the courts of Florida eliminate or restrict such rights.

GENERAL PROVISIONS

Entire Contract

The *policy* and the *policyholder's* application attached to it are the entire contract. Any statement made by you or the *policyholder* is considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to you.

Errors

An error in keeping records will not cancel insurance that should continue nor continue insurance that should end. We will adjust the premium, if necessary, but not beyond 3 years before the date the error was found. If the premium was overpaid, we will refund the difference. If the premium was underpaid, the difference must be paid to us.

Misstatements

If any information about a person is misstated, the facts will determine whether insurance is in effect and in what amount. We will equitably adjust the premium.

Individual Certificates

We will send certificates to the *policyholder* to give to each *covered person.* The certificate will state the insurance to which the person is entitled. It does not change the provisions of the *policy.*

Workers' Compensation

The *policy* is not in place of, and does not affect any state's requirements for coverage by Workers' Compensation insurance.

Agency

Neither the *policyholder*, any employer, any *associated company*, nor any administrator appointed by the foregoing is our agent. We are not liable for any of their acts or omissions.

GENERAL PROVISIONS (continued)

Changing the Policy

The *policyholder* owns the *policy*. The *policy* may be changed at any time by an endorsement or amendment agreed upon by the *policyholder* and us. A change must be approved by one of our executive officers. No agent can change the *policy* or waive any of its provisions.

Required Data

The *policyholder* must give us all data needed to administer the insurance and determine premiums. The *policyholder* must also give us any other information we require. We may inspect the *policyholder's* records relating to the insurance provided by the *policy*.

Policyholder's Assignment

The *policyholder* may assign the *policy*. This will not affect the rights of any *covered person* or *beneficiary*. We will not be responsible for the validity of any assignment. We must receive written notice of an assignment at our *home office*.

When the Policy Ends

The *policy* will end on the earliest of the following dates:

- the date the grace period ends, if the premium has not been paid; or
- the date we cancel the *policy*, after giving the *policyholder* 45 days written notice; or
- the date we receive written notice from the *policyholder*, or the date shown in the notice, whichever is later.

The *policy* will also end if the number or percentage of persons covered under the *policy* does not meet the Minimum Participation Requirements shown in the Schedule.

If the Participation Requirements are not met, we will notify the *policyholder* 45 days in advance that insurance will end. We consider that notice is given when delivered or mailed to the last known address of the *policyholder*.

If the date the *policy* ends is not the same as the date to which premiums have been paid, the difference in premium:

- must be paid to us, if underpaid; or
- will be refunded by us, if overpaid.

PREMIUMS

Premium Payments

The *policyholder* must pay all premiums in advance at our *home office* or to one of our agents. The *policyholder* may request on any policy anniversary that the frequency of premium payment be changed to any frequency we offer for such *policy*.

Grace Period

If any premium is not paid when due, the *policy* will be in default on that date. The *policyholder* has a grace period of 31 days after that date to pay the premium. In any case, the *policyholder* must pay the premium for coverage in force during the grace period.

Calculation of Premiums

The first premium is due on the effective date. Future premiums are due on each premium due date. The premium is based on the premium rate and the amount of insurance. We will furnish premium rates to the *policyholder* with an explanation of how to apply them.

Our Right to Change Premium Rates

We may change the premium rate:

- after the second policy anniversary; or
- when our liability changes.

Unless our liability changes:

- we will not change the rates more than once in any period of 12 consecutive months; and
- we will give the *policyholder* 45 days advance written notice of an increase in rates.

ENDORSEMENTS AND AMENDMENTS

At the request of the *policyholder*, for dependent dental insurance, the term "spouse" shall also mean a domestic partner. A "domestic partner" is defined in the *policyholder's* Declaration of Domestic Partnership agreement.

APPLICATION

to Union Security Insurance Company

by Palm Beach County Board of County Commissioners

for group policy no. G 5,303,634

This application is executed in duplicate. One copy is to be attached to the *policy*. The other is to be returned to Union Security Insurance Company.

It is agreed that this Application replaces any prior application for the *policy*.

10 or more lives must be insured on the Effective Date of the *policy*. In addition, the number of lives to be insured on that date must be 20% of those eligible for insurance at that time.

Palm Beach County Board of County Commissioners
(Full or Corporate Name of Applicant)

by _____
(Signature and Title)

Signed at _____ Date _____

Witness _____
(To be signed by Resident Agent where required by law)

This copy is to remain attached to the *policy*.

Union Security Insurance Company 2323 Grand Boulevard Kansas City Missouri 64108-2670

Approved as to Terms & Conditions

Nancy L. Ballm
Director, Risk Management

APPLICATION

to Union Security Insurance Company

by Palm Beach County Board of County Commissioners

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10 or more lives must be insured on the Effective Date of the *policy.* In addition, the number of lives to be insured on that date must be 20% of those eligible for insurance at that time.

Palm Beach County Board of County Commissioners
(Full or Corporate Name of Applicant)

by _____
(Signature and Title)

Signed at _____ Date _____

Witness _____
(To be signed by Resident Agent where required by law)

This copy is to be returned to the *home office.*

This copy to be returned to the Risk Operations address listed below:
Union Security Insurance Company—Risk Operations/Case Issue
P.O. Box 830069, Birmingham, AL 35282-8320

Union Security Insurance Company 2323 Grand Boulevard Kansas City Missouri 64108-2670

Approved as to Terms & Conditions

Nancy L. Bolton
Director, Risk Management

ATTACHMENT #5

Group Insurance Preliminary Application

ASSURANT Employee Benefits

Policy no. G 5,303,634

UNDERWRITING COMPANY: UNION SECURITY INSURANCE COMPANY (THE COMPANY)
(WE, US OR OUR WHEN USED HEREIN REFER TO THE COMPANY.)

APPLICANT INFORMATION *(You and your when used herein refer to Applicant.)*

1. Exact legal name *(as it will appear in the contract and/or certificate)*. Please explain if different from deposit check.
Palm Beach County Board of County Commissioners

2. Full address and contact numbers of main office. **Note: If PO Box is used, a street address must also be included.**
Address 301 Olive Avenue
City West Palm Beach County Palm Beach State Florida ZIP 33401
Telephone no. 561-233-5400 Fax no. 233-5420 E-mail address

Note: The contract will be issued in the state where the main office is located unless otherwise requested and approved.

3. Correspondent's name and title
☐ Mr. ☐ Mrs. ☒ Ms. Nancy Bolton Title Director, Risk Management
Is Correspondent an employee of the applicant? ☒ Yes ☐ No If "No," form KC2692 Appointment of Correspondent must be completed, including full address, and submitted with this preliminary application.

Renewal letters to be sent to:
☒ Same as above with copy to broker
☐ Other *(Please provide name, title and full address.)* with copy to broker
Nancy Bolton, 160 Australian Avenue, Suite 401, West Palm Beach, Florida 33406

APPLICANT'S BUSINESS INFORMATION

4. Nature of business *(Give details of products, services, manufacturing process and materials used.)*
Years in business 99 Employer Tax ID no. 59-6000785 SIC code NAICS code *(optional)*

5. Business is organized as:
☐ Corporation ☐ Partnership ☐ Proprietorship
☐ Government Funded Non-Profit ☐ Other Non-Profit ☐ Trust
☐ Sub-Chapter S Corp ☐ Professional Corporation ☐ Professional Association
☐ Limited Partnership (LP) ☐ Limited Liability Company (LLC) ☐ Limited Liability Partnership (LLP)
☐ Prof. Limited Liability Co. (PLCC) ☐ Limited Liability Limited Partnership (LLLP) ☒ Political Subdivision
☐ Federal Agency Executive Branch ☐ Yes ☐ No If "Yes," subject to Executive Order 11246? ☐ Yes ☐ No
☐ Church Group If this is checked, it is: ☐ ERISA ☒ Non-ERISA
☐ Other *(Specify.)*

6. Financial Status *(If you answer yes to any part, please provide explanation below.)*
☐ Yes ☒ No Has Applicant ever filed or does it anticipate filing for bankruptcy or similar insolvency?
☐ Yes ☒ No Does Applicant anticipate ceasing, materially reducing or altering active business operations?
☐ Yes ☒ No Has Applicant opted out or does it anticipate opting out of Worker's Compensation, Social Security or PERS (if applicable)?

Explanation:

AFFILIATE OR SUBSIDIARY INFORMATION

7. Indicate any affiliates or subsidiaries to be covered. An affiliate or subsidiary is a separate firm owned or controlled by the Applicant. Its employees will be insured under the policy **only** if requested below and approved by the Company. Please complete all the requested information for each affiliate or subsidiary to be covered under the policy. See question 5 for business type.

Name
Palm Tran Inc.

Address
3201 Electronics Way West Palm Beach, FL 33407

Nature of Business	Business Type	SIC Code
Transportation/bus	Mass Transit	

No. of Employees	Percentage owned by Applicant
540	100%

Name
Palm Beach County Supervisor of Elections

Address
240 S. Military Trail West Palm Beach, FL 33415

Nature of Business	Business Type	SIC Code
Const. Officer	Local Gov't	

No. of Employees	Percentage owned by Applicant
40	0% (covered per Interlocal Agreement)

Name

Address

Nature of Business	Business Type	SIC Code

No. of Employees	Percentage owned by Applicant

Is separate billing required? ☒ Yes ☐ No If "Yes," give complete details in question 12 of this application.

8. Coverages requested and effective date of coverage(s) *(Please specify if dates differ by coverage.)*

Life and Accidental Death & Dismemberment Insurance

Check all that apply and complete required fields	Employer Contribution %	No. of Eligible Employees/ Dependents	No. of Participating Employees/ Dependents
☐ Employer Paid (with matching AD&D)			
☐ Employer Paid (without AD&D)			
☐ Additional Contributory Life			
☐ Dependent Life			
☐ Voluntary Life (with matching AD&D)			
☐ Voluntary Life (without AD&D)			
☐ Voluntary Dependent Life			

For Voluntary Life, indicate the number of eligible males _____ eligible females _____
Will the plan(s) requested replace other coverage as of the effective date of our coverage, if approved? ☐ Yes ☐ No
If "Yes," please provide a copy of prior carrier contract and bill. If "No," please explain. _____
Are you currently making application for any similar group insurance program? ☐ Yes ☐ No If "Yes," please explain.

Short and Long Term Disability Insurance

Check all that apply and complete required fields	Employer Contribution %	No. of Eligible Employees	No. of Participating Employees
☐ Employer Paid Short Term Disability			
☐ Employer Paid Long Term Disability			
☐ Voluntary Short Term Disability			
☐ Voluntary Long Term Disability			

Are any of your employees eligible for a State Disability Plan? ☐ Yes ☐ No If "Yes," which state(s) _____
Do you provide salary continuance or any kind of income replacement plan (formal or informal) other than the coverages requested above? ☐ Yes ☐ No If "Yes," which of the following best describe the plan? Check all that apply:
☐ Salary Continuance ☐ Short Term Disability ☐ Long Term Disability ☐ Other *(Please describe.)* _____
Do you or can your employees elect to "gross up" (include as taxable income) the cost of disability coverage? ☐ Yes ☐ No
Will the plan(s) requested replace other coverages as of the effective date of our coverage, if approved? ☐ Yes ☐ No
If "Yes," please provide a copy of prior carrier contract and bill. If "No," please explain. _____
Are you currently making application for any similar group insurance program? ☐ Yes ☐ No If "Yes," please explain.

Dental Insurance

Check all that apply and complete required fields	Employer Contribution %	No. of Eligible Employees/ Dependents	No. of Participating Employees/ Dependents
☐ Employer Paid Dental			
☐ Dependent Dental			
☒ Voluntary Dental	0	4200	489
☒ Voluntary Dependent Dental	0		

Will the plan(s) requested replace other coverage as of the effective date of our coverage, if approved? ☒ Yes ☐ No
If "Yes," please provide a copy of prior carrier contract and bill. If "No," please explain. Union Security - changing to Active MAC PPO
Are you currently making application for any similar group insurance program? ☐ Yes ☒ No If "Yes," please explain.

Other* (must also purchase a fully insured product)

☐ Employee Assistance Program Select type: ☐ Phone and Online ☐ In Person Assessment ☐ Short Term Counseling
If elected, complete form KC3325 Employee Assistance Program Agreement.
☐ Healthy Solutions Discount Card If elected, please complete the Healthy Solutions Group Information form.
* Products provided by third-party vendors under separate agreements with Applicant.

BILLING AND ADMINISTRATION

9. Do you have a Section 125 Plan? ☒ Yes ☐ No **If "No," please proceed to question 10.**
Will any of the requested coverages be part of the Section 125 Plan? ☒ Yes ☐ No
If "Yes," please indicate whether contributions are: ☐ Post-tax ☐ Pre-tax ☒ Post or Pre-tax at individual election
If any part of the contributions are post-tax, please indicate the percentage of premium paid post-tax _____ %.
Open Enrollment Period for Section 125 Plan _____ Please note, Life Events will be defined per our standard language unless a copy of your 125 Plan is submitted for review and approval.
Section 125 Plan included? ☐ Yes ☒ No

10. Who will bill the coverages requested?
☐ The Company (with online administration included at no cost)
☒ Policyholder (Self-Administration) If this option is selected, the Company can prepare the initial bill for all employer paid coverages. Do you want the Company to prepare the initial bill? ☐ Yes ☒ No
For Self-Administration you must agree to provide a complete census to the Company upon request and at least once a year.
☐ Third Party Administrator **Note: TPA must be approved by the Company prior to submitting case and Applicant must complete and submit form KC2691, Appointment of Third Party Administrator.**

11. Premium is to be billed: ☒ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually
Additional options for Voluntary coverages: ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly

12. Are separate billing accounts required? ☒ Yes ☐ No If "Yes," provide name, address and contact name for each.
Palm Beach County BCC - 160 Australian Ave, Suite 401, West Palm Beach, FL 33406
Palm Tran, Inc. - 3201 Electronics Way, West Palm Beach, FL 33407
Supervisor of Elections - 240 S. Military Trail, West Palm Beach, FL 33415
If more space is needed, please provide an attached list and indicate here that an attachment exists. ☐ Attachment

13. For Life Insurance, will you maintain beneficiary information? ☐ Yes ☐ No If "Yes," you must agree to maintain all records pertaining to the beneficiary of life insurance and all subsequent beneficiary changes. Note: All assignments or irrevocable designations must be submitted to the Company for review and approval, accompanied by the original enrollment form.
If you are not maintaining beneficiaries, you must agree to submit the original enrollment form and all subsequent beneficiary changes to the Company.

14. The following applies to **all** coverages unless otherwise stated.
A. Service Requirement for current employees (hired on or before the effective date) 60 ☒ Days ☐ Months
The first of the month next following or concurrent with the date of hire (following sixty days of full time employment)
B. Service Requirement for future employees (hired after the effective date) same as above ____ ☐ Days ☐ Months
C. Entry date: ☐ Immediate ☒ 1st of the month occurring on or after ☐ First of the payroll cycle (*Voluntary dental only*)
☐ Other *(Specify.)* _____
Note: For Voluntary coverages entry date cannot be immediate.
D. Full-time definition: ☒ Standard (30 hours for employer paid, 20 hours for Voluntary coverages)
☐ Other *(requires Home Office approval)*. Please specify request _____
E. Effective date for changes due to salary changes for **employer paid** coverages ☐ Immediate ☐ Policy Anniversary
☐ 1st of month occurring on or after ☐ Other *(Specify.)* _____
F. Effective date for changes due to salary changes for **Voluntary** coverages ☐ Immediate ☐ Policy Anniversary
☐ Other *(Specify.)* _____
G. Effective date for changes due to age for **employer paid** coverages ☐ Immediate ☐ Policy Anniversary
☐ 1st of month occurring on or after ☐ Other *(Specify.)* _____

H. Effective date for changes due to age for **Voluntary** coverages ☐ Policy Anniversary
☐ Other *(Specify.)* _____

I. Termination date for Dental coverage ☐ Immediate *(not available for Voluntary dental)*
☐ End of the payroll cycle *(Voluntary dental only)* ☒ End of the month in which employment terminates.

J. Annual enrollment Late October *(Should coincide with applicant's medical plan or 2 months prior to Policy Anniversary.)*

CERTIFICATE AND CONTRACT INFORMATION

15. Certificates are provided in electronic format for all coverages. Please review the following statement regarding your responsibilities in relation to electronic certificates.

Significance: Electronic Certificates ("e-certs") provide important information about insurance coverage and protection for insureds under the policy. You must agree that you will: (1) Distribute e-certs to insureds under the policy; (2) not release or otherwise transfer e-certs to third parties (other than insureds), without the Company's prior written approval; (3) not alter, modify or otherwise change e-certs and will ensure that adequate security is in place to prevent insureds from doing the same; (4) take measures to ensure that the system furnishing e-certs results in actual receipt of the information by each insured (use return-receipt electronic mail features or periodic review/surveys to confirm receipt) and (5) convey to each insured the **significance** of e-certs, that the certificate is being furnished electronically and that the insured may request and receive a paper copy at no charge.

☐ If you are unable to comply with e-cert responsibilities, check here and paper certificates will be provided to you.

16. Summary Plan Description (SPD): ERISA Plan Information. ERISA requires employers to distribute SPD's for most employer-sponsored benefit plans. To the best of our knowledge, the certificate can serve as your SPD if certain plan information and a statement of ERISA rights are provided with the certificate.

Should we include ERISA information for an SPD? ☐ Yes ☒ No If "Yes," supply the following information.

Name of the plan _____

If other than the policyholder, please provide the full name, address and phone number of the:

Plan sponsor _____

Plan administrator _____

Agent for service of legal process _____

Plan number(s) _____ Note: the plan number is PN501 unless another number is assigned by the employer or the Plan Administrator.

EMPLOYEE INFORMATION AND VERIFICATION

17. Employees at active work

☒ Applicant certifies that all employees are at active work at their usual place of business on date signed on page 6.
☐ There are employees who are not at active work at their usual place of business on date signed on page 6. They are listed below.

Name	Date of Birth	Age	Insurance Amount	Nature of Illness or Reason for Absence

18. Are any employees located outside the United States? ☐ Yes ☒ No If "Yes," please provide the name of the employee(s), location and country of citizenship. Advise how long the employees will be located outside the United States.

_____

_____

_____

Please note, employees working outside the United States are not covered by the policy unless agreed to, in writing, by the Company.

19. If this Preliminary Application is being signed after the requested effective date, you must complete the following:
☐ Applicant certifies that there have been no claims incurred since the requested effective date and Applicant is unaware of any changes in medical condition or status.

APPLICANT AGREEMENT

A. $ 0 has been paid by the Applicant to be applied toward the first premium due for coverages requested in this Preliminary Application. This amount will be returned if the requested insurance does not become effective. Cashing of the check by the Company is not acceptance and approval of this Preliminary Application.

B. The Applicant certifies that the information contained herein is true and correct to the best of the Applicant's knowledge and belief and understands that it forms the basis for its request for insurance. Omission or misstatement of known information on this Preliminary Application could affect the validity of any insurance issued and cause denial of a claim.

C. The Applicant understands that the requested insurance will:
   1. Be issued only if the requested insurance is acceptable to the Company and is legally permissible;
   2. Be issued under a group policy(ies) in the language customarily used by the Company;
   3. Be subject to the Company's usual underwriting requirements (including evidence of insurability, if applicable);
   4. Take effect on the date determined by the Company; and
   5. Not be effective until this Preliminary Application is approved and accepted by the Home Office of the Company in Kansas City, MO.

D. The Applicant understands that no agent or broker has the authority to accept or guarantee acceptance of the requested insurance.

E. The Applicant understands that this Preliminary Application may be a request to participate in the Company's Small Group or Voluntary Trust Plans as determined by the Company's underwriting rules. If this item E applies and the Company approves and accepts this Preliminary Application, Applicant agrees to be bound by the terms of the group policy(ies) issued to the Trustees of the applicable Trust Plans.

F. The Applicant agrees to offer the requested insurance to all of its eligible employees.

G. The effective date of the requested insurance for which an employee is required to submit evidence of insurability will be determined in accord with the group policy's terms and will be subject to the active work requirement. The Applicant agrees not to:
   1. Collect or pay premiums (other than the initial deposit) for such insurance before receiving the Company's approval notice; and
   2. Distribute material describing the policy coverage to persons to be insured without the Company's prior written consent.

H. The requested coverage provides benefits for the employee welfare benefit plan established and maintained by the employer - Applicant under the Employee Retirement Income Security Act (ERISA), unless otherwise exempted by law.

I. If the requested insurance is approved and accepted, that insurance will automatically terminate if the premiums are not paid before the end of the grace period following the due date. Payment of premiums for coverage during the grace period is required. Insurance coverage will terminate if the number or percentage of participants falls below that required by the group policy.

J. No one except the President, Senior Vice President or Chief Financial Officer of the Company may make, alter or discharge contracts or waive any of the Company's rights or requirements.

Applicant's Signature _____ Print name _____

Title _____ Date *(required)* _____

Company's representative _____ Date _____

PRODUCER INFORMATION

1. Individual or firm *(legal name)* _____

Writing agent of firm _____
Address _____
City/State/ZIP _____
E-mail address _____
Phone no. _____ Fax no. _____
Payee no. _____ Production Split _____%
License no. _____
Producer _____
Signature _____ Date _____

2. Individual or firm *(legal name)* _____

Writing agent of firm _____
Address _____
City/State/ZIP _____
E-mail address _____
Phone no. _____ Fax no. _____
Payee no. _____ Production Split _____%
License no. _____
Producer _____
Signature _____ Date _____

Note: Agent/Broker must note his/her license number for contract state.