

**COLUMBIA COUNTY, FLORIDA  
BOARD OF COUNTY COMMISSIONERS**

**REQUEST FOR PROPOSALS  
2026-K  
DENTAL AND VISION SERVICES**

The Board of County Commissioners (County) will receive sealed proposals in the office of Commissioners, 135 NE Hernando Avenue, Suite 203, Lake City, FL 32055, until **2:00 PM** local time on **JUNE 18<sup>TH</sup>, 2026** for the following:

**DENTAL AND VISION SERVICES**

To be eligible for consideration, all proposers must be registered in the State of Florida to practice their profession at the time of proposal. Proposers without a complete proposal described will be considered improper. The Request for Proposal information is available online only at: <https://www.columbiacountyfla.com/PurchasingBids.asp>

Submissions will be publicly opened in the Commissioner's Office at **2:00 PM, JUNE 18<sup>TH</sup>, 2026** or as soon thereafter as practical. Proposers are responsible for the delivery of submissions. Submissions may be withdrawn at any time prior to the opening. Late bids will not be accepted. Bids delivered in any other format other than specified in this solicitation will not be accepted. Questions regarding this solicitation must be received via email to [ejones@columbiacountyfla.com](mailto:ejones@columbiacountyfla.com) no later than **JUNE 12<sup>TH</sup>, 2026** at **5:00 PM** local time. Responses to those questions considered material to the solicitation shall be distributed via formal addenda.

Columbia County welcomes your response to this solicitation. Proposals should be prepared in accordance with the instructions herein and will be evaluated by the County as stated in the evaluation section of this document. The County reserves the right to waive any formalities, to reject any or all proposals or to re-advertise for proposals for these services. The County may withdraw all or part of this solicitation at any time to protect the interests of the County. All Proposers are asked to be thorough yet concise in their response. Failure to provide the response in the manner prescribed herein may be grounds for disqualification.

Only one bid set will be furnished with each company or corporation interested in bidding. The one complete bid set is to be submitted in a sealed envelope. Proposers shall indicate Bid Number, Project Title, and the name and address of the firm submitting the bid on the outside of the envelope.

All Proposers are advised that under Chapter 119, Florida Statutes, all responses are deemed a public record and open to the public as provided for in said statute.

## **SECTION I. GENERAL INSTRUCTIONS TO BIDDERS**

These instructions will bind bidders and conditions herein set forth, except as specifically qualified in special bid and contract terms issued with any individual bid.

1. The following criteria are used in determining low responsible bidder:
  - A. The ability, capacity and skill of bidder to perform required service.
  - B. Whether the bidder can perform service promptly or within specified time.
  - C. The determined character, integrity, reputation, judgment, experience and efficiency of bidder.
  - D. The performance of previous contracts with Columbia County or entities similar to Columbia County.
  - E. The suitability of equipment or material for County use.
  - F. The ability of bidder to provide future maintenance.
2. Payment Terms are net thirty (30) unless otherwise specified. Favorable terms, discounts, may be offered and will be considered in determining low bids if they are deemed by Purchasing Department to be advantageous to the County.
3. All bids should be tabulated, totaled and checked for accuracy. Where applicable, the provided unit price will prevail in case of discrepancies or other errors.
4. All requested information shall be included in the envelope. All desired information must be included for your bid to receive full consideration.
5. If anything on the bid request is not clear, you should contact the Purchasing Director immediately.
6. A bidders list is available at the Purchasing Office.
7. Quote all prices F.O.B. our warehouse or as specified in bid documents.
8. Each proposal shall be clearly marked on the outside of the envelope including Fed Ex, UPS or other delivery service envelopes, as a sealed bid. The name of the item being bid shall be shown on the outside in full.
9. The County shall not be liable for any bid opened prematurely if that bid was not sealed in a properly marked envelope.
10. If only one (1) bid is received, the bid may be rejected and re-advertised or excepted if determined to be in the counties best interest.
11. Bids received late will not be accepted. It is the bidder's sole responsibility to ensure proposals are timely delivered and received before the deadline.
12. Telephone and facsimile bids will not be accepted under any circumstances. Should a timely delivered bid be misplaced by the County but later found before ranking occurs, the

bid will be considered. A bidder may request a receipt showing the day and time a bid envelope is delivered to the appropriate office of the County.

13. Bids requiring bid bonds will not be accepted if bond is not enclosed. Cash or certified check will be accepted in lieu of bond except on construction projects with a project budget exceeding \$40,000.
14. Upon request of the Purchasing Office or County Manager, a bidder must provide proof that the bidder has the requisite organization, capital, plant, stock, ability, and experience to perform the contract contemplated by the Request for Proposals/Qualifications or Invitation to Bid.
15. Any alterations, erasures, additions, or omissions of required information or any changes to specifications or bidding schedule are done at the risk of the bidder. Any bid will be rejected that has a substantial variation, that is; a variation that affects price, quantity, and quality or delivery date (when delivery is required by a specific time).
16. When requested, samples will be furnished to the County free of expense, properly marked for identification and accompanied by a list where there is more than one (1) sample. The County reserves the right to mutilate or destroy any sample submitted whenever it may be to the best interest of the County to do so for the purpose of testing.
17. The County will reject any material, supplies or equipment that did not meet the specifications, even though the bidder lists the trade names or names of such material on the bid or price quotation form.
18. The unauthorized use of patented articles is done entirely at the risk of the successful bidder.
19. The ESTIMATED QUANTITY given in the specifications or advertisements is for the purpose of bidding only. The County may purchase more or less than the estimated quantity and the vendor must not assume that such estimated quantity is part of the contract.
20. Only the latest model equipment as evidenced by the manufacture's current published literature will be considered. Obsolete models of equipment not in production will not be acceptable. The equipment shall be composed of new parts and materials. Any unit containing used parts or having seen any service other than the necessary tests will be rejected. In addition to the equipment specifically called for in the specification, all equipment catalogued by the manufacturer as standard or required by the State of Florida shall be furnished with the equipment. Where required by the State of Florida Motor Vehicle Code, vehicles shall be inspected and bear the latest inspection sticker of the Florida Department of Revenue.
21. The successful bidder on motor vehicle equipment shall be required to furnish with delivery of vehicle, certificate of origin and any other appropriate documentation as required by the Florida Motor Vehicle Department.
22. Prospective bidders are required to examine the location of the proposed work or delivery

and determine, in their own way, the difficulties, which are likely to be encountered in the prosecution of the same.

23. All materials, equipment and supplies shall be subject to rigid inspection, under the immediate supervision of the Purchasing Department, its designee and /or the department to which they are delivered. If defective material, equipment, or supplies are discovered, the contractor, upon being instructed by the Purchasing Department or designee, shall remove, or make good such material, equipment, or supplies without extra compensation. It is expressly understood and agreed that the inspection of materials by the County will in no way lessen the responsibility of the Contractor release him from his obligation to perform and deliver to the County Sound and satisfactory materials, equipment, or supplies. The Contractor agrees to pay the costs of all tests upon defective material, equipment, or supplies or allow the costs to be deducted from any monies due him from the County.
24. Unless otherwise specified by the Purchasing Department all materials, supplies, or equipment quoted herein must be delivered within thirty (30) days from the day of notification or exceptions noted on bid sheets.
25. A contract will not be awarded to any corporation, firm, or individual who is, from any cause, in arrears to the County or who has failed in former contracts with the County to perform work satisfactorily, either to the character of the work, the fulfillment or guarantee, or the time consumed in completing the work.
26. Reasonable grounds for supposing that any bidder is interested in more than one proposal for the same item will be considered sufficient cause for rejection of all proposals in which he is interested.
27. Submitting a proposal when the bidder intends to sublet the contract may be a cause for rejection of bids or cancellation of the contract by the County Manager.
28. Unless otherwise specified, the County reserves the right to award each items separately or on a lump sum basis whichever is in the best interest of the County.
29. Respondents to this solicitation or persons acting on their behalf may not contact, between the release of the solicitation and the end of the 72-hour period following the agency posting the notice of intended award, excluding Saturdays, Sundays, and state holidays, any employee or officer of the executive or legislative branch concerning any aspect of this solicitation, except in writing to the procurement officer or as provided in the solicitation documents. Violation of this provision may be grounds for rejecting a response.
30. The County reserves the right to reject any quotations or specifications and the right to waive minor discrepancies as to all bidders equally, when such rejection or waiver is deemed to be in the best interest of the County. For unit priced items, the County may elect to purchase part, all, or none of the materials, supplies, or equipment specified in a bid.
31. The bidder or the bidder's authorized representative or agent must sign the bid in the space provided. Unsigned bids will be rejected. Signature must be "wet" signatures in ink. Typewritten or printed signatures will not be accepted.

32. Any bidder may withdraw his/her bid at any time before the time set for the opening of the bids.
33. It is mutually understood and agreed that if at any time the Purchasing Department or designee shall be of the opinion that the contract or any part thereof is unnecessarily delayed or that the rate of progress or delivery is unsatisfactory, or that the contractor is willfully violating any of the conditions or covenants of the agreement, or executing the same in bad faith, the Purchasing Department or his/her designee shall have the power to notify the contractor of the nature of the complaint. Notification shall constitute delivery of notice, or letter to address given in the proposal. If after three (3) working days of notification the conditions are not corrected to the satisfaction of the Purchasing Officer, he shall have the power to take whatever action necessary to complete the work or delivery and the expense shall be deducted from any paid by the County out of such monies as may become due to the said contractor. In case such expense shall exceed the last said sum, then and in that event, the bondsman or the contractor, his/her executors, administrators, successors, or assigns, shall pay the amounts of such excess to the County on notice made by the Purchasing Department or his/her designee of the excess due.
34. If the bidder proposes to furnish any item of foreign make or product, he shall write "foreign" together with the name of the originating country opposite such item on a proposal.
35. Any complaint from bidders relative to the invitation to bid or attached specifications shall be made prior to the time of opening bids; otherwise, the bidder waives any such complaint.
36. Contracts may be cancelled by the County with or without cause on thirty- (30) days advance written notice.
37. All contractors submitting bids for road projects in excess of \$250,000 must be pre-qualified with the Florida Department of Transportation and shall provide proof of such qualification.
38. Any bidder affected adversely by an intended decision with respect to the award of any bid, shall file with the Purchasing Department for Columbia County, a written notice of intent to file a protest not later than seventy-two (72) hours (excluding Saturdays, Sundays and legal holidays), after the posting of the bid tabulation. Protest procedures may be obtained in the Purchasing Department.
39. A person or affiliate who has been placed on the convicted vendor's list following a conviction for a public entity crime may not submit a bid on a contract to provide any goods or services to Columbia County, may not submit a bid on a contract with Columbia County for the construction or repair of a public building or public work, may not submit bids on leases of real property to Columbia County, may not be awarded or perform work as a contractor, supplier, subcontractor, or consultant under a contract with Columbia County, and may not transact business with Columbia County for a period of 36 months from the date of being placed on the convicted vendor list.
40. Vendor/Contractor shall utilize the U.S. Department of Homeland Security's E-Verify

system, in accordance with the terms governing use of the system, to confirm the employment eligibility of;

- A. All persons employed by the Vendor/Contractor during the term of the Contract to perform employment duties within Florida; and
- B. All persons, including subcontractors, assigned by the Vendor/Contractor to perform work pursuant to the contract with the County.

41. Contractor shall register on line at <https://www.columbiacountyfla.com/PurchasingBids.asp> for this specific project. All addendums are delivered via email through this website, and it is the contractor's responsibility to ensure all addendums are used in the bid submittal.

## **SECTION II. INTRODUCTION**

### **1. About Columbia County**

Located near the intersection of Interstates 10 and 75, Columbia County is home to approximately 70,000 residents. The County seat and largest city is Lake City, with a population of approximately 12,000. Lake City is located approximately 45 minutes north of Gainesville, and just over an hour west of Jacksonville. The area is largely rural, and has historically been an agriculturally based economy. The County has seen an approximate 25% increase in population growth from 2000 through 2018. The State of Florida has designated Columbia County as an Economically Distressed Rural County. The US Federal Government confirmed that census tract 1103 is now a Florida Opportunity Zone. The Opportunity Zone has a median household income of approximately \$37,000, which is lower than the median household income for the State of Florida of \$59,000.

### **2. Project Information**

## **SECTION III. SCOPE OF WORK**

### **Objective**

Columbia County is seeking one (1) company to offer an Employee Group Dental Insurance Program and one (1) company to offer an Employee Group Vision Insurance Program to its eligible active employees working equal to or more than 30 hours per week and their eligible dependents, retirees and their eligible dependents, and COBRA qualified beneficiaries on a standalone basis. The census can be found in **Attachment 1 – Census**.

The objective of this Solicitation is to obtain the best programs for Columbia County and establish contracts for the delivery of comprehensive Fully-Insured Employee Group Dental Insurance Program and Fully-Insured Employee Group Vision Insurance Program with the most competitive rates in the marketplace, professional plan administration, and the accessibility for employees and retirees to choose the dental and/or vision benefits that fits their needs from qualified providers who provide members with quality dental and/or vision care.

## **SECTION IV. SPECIFICATIONS**

Proposer's proposed product and plans should match the existing benefits to the utmost extent possible or improve Columbia County's existing benefits by expanding features for possible consideration at the sole discretion of Columbia County. The enhanced benefits are provided in

The current Dental Certificates can be found in **Attachments 2A and 2B**; and the current Vision Certificates are located in **Attachments 2 through 5**.

Deviations and/or enhancements from Columbia County's current dental and vision plans must be clearly identified in **Tab 4 (Project Understanding and Technical Approach)**

If an employee waives Medical coverage and does not enroll in the Medical benefits, the employee

is enrolled in Pak B. Pak B benefits package provides Dental Buy-Up and Vision Buy-Up benefits at zero cost to the employee and a reduced dependent cost. The difference in employee contributions can be found in the monthly rates and employer (ER) contribution section below:

<b>DENTAL RATE HISTORY</b>	<b>Dental Base</b>			<b>Dental Buy-Up</b>		
	<b>PY</b>	<b>CY</b>	<b>ER Monthly</b>	<b>PY</b>	<b>CY</b>	<b>ER Monthly</b>
	<b>Carrier</b>	<b>Carrier</b>	<b>Contribution</b>	<b>Carrier</b>	<b>Carrier</b>	<b>Contribution</b>
<b>Employee</b>	\$27.80	\$31.16	\$31.16	\$33.84	\$37.92	\$31.16 / \$37.92 (Pak B)
<b>Employee + 1 Dep</b>	\$54.80	\$61.40	\$31.16	\$65.50	\$73.40	\$31.16
<b>Employee + Family</b>	\$100.96	\$113.08	\$31.16	\$118.08	\$132.28	\$31.16

The current vision rates and employer contributions are as follows:

<b>VISION RATE HISTORY</b>	<b>Vision Base</b>			<b>Vision Buy-Up</b>		
	<b>PY</b>	<b>CY</b>	<b>ER Monthly</b>	<b>PY</b>	<b>CY</b>	<b>ER Monthly</b>
	<b>Carrier</b>	<b>Carrier</b>	<b>Contribution</b>	<b>Carrier</b>	<b>Carrier</b>	<b>Contribution</b>
<b>Employee</b>	\$5.88	\$5.88	\$5.88	\$6.56	\$6.56	\$5.88 / \$6.56 (Pak B)
<b>Employee &amp; Spouse</b>	\$11.44	\$11.44	\$5.88	\$12.60	\$12.60	\$5.88
<b>Employee &amp; Children</b>	\$10.60	\$10.60	\$5.88	\$11.80	\$11.80	\$5.88
<b>Employee &amp; Family</b>	\$16.16	\$16.16	\$5.88	\$17.82	\$17.82	\$5.88

Broker commission for Dental and Vision is 11%.

## **SECTION V. SUBMISSION REQUIREMENTS**

Proposers shall submit one (1) original response, marked “Original”, two (2) copies marked “Copy”, and one (1) flash drive of the proposal setting forth qualifications must be received in a sealed envelope clearly marked on the outside with the Proposer’s name and “**Sealed Proposal for RFP 2026-K**” by **2:00 PM EST on June 18<sup>th</sup>, 2026** addressed and delivered to:

**Columbia County Board of County Commissioners  
135 NE Hernando Avenue, Suite 203  
Lake City, FL 32055**

The deadline will be strictly observed. Proposals delivered to any other office or location will be rejected as non-responsive. Proposals shall be delivered by U.S. Mail, Federal Express or other such service or by hand. Delivery by facsimile or email is prohibited. It is the proposer's sole responsibility to ensure that its proposal is received at the proper location at or prior to the deadline.

Interested firms or individuals shall include the following information in their submittals in the exact order listed herein with separating page tabs in an 8.5 by 11-page format. Include page tabs so those evaluating the submittal can compare each section with others that are submitted. The proposals shall be bound, or in a three-ring binder, or equivalent folder. The Proposer should not withhold any information from the written response in anticipation of presenting the information

orally or in a demonstration.

Each Proposer shall submit adequate documentation to certify the Proposer's compliance with the County's requirements. Submissions shall be clear and concise and provide the information requested herein. The length of the entire submission shall not exceed fifty (50) pages in length not including Tabs 7 and 8.

Firms shall submit written qualifications and a proposed project approach, which clearly demonstrates their ability to provide quality services in a timely and cost effective manner.

The proposals will be opened publicly. At the opening of proposals, the Board shall prepare a register of proposals, which shall include the name of each proposer. Applicants shall supply the following information:

**Tab 1: Letter of Interest**

**Tab 2: Firm's Experience and Background**

**DENTAL:**

- A. State under what other or former name(s) the Proposer is currently operating under or has operated under.
- B. Provide a statement of any litigation or regulatory action that has been filed or is pending against your firm(s) in the last three years. If an action has been filed, state and describe the litigation or regulatory action filed, and identify the court or agency before which the action was instituted, the applicable case or file number, and the status or disposition for such reported action. If no litigation or regulatory action has been filed against your firm(s), provide a statement to that effect. For joint venture or team Proposers, submit the requested information for each member of the joint venture or team.
- C. How long has your organization been providing dental insurance? Use the chart below:

	<b>Years</b>
National	
Regional	
Columbia County	

- D. Provide the PPO/Indemnity enrollment data requested below for the organization submitting this proposal. Use chart below:

PPO/Indemnity Enrollment:

	1/1/2024	1/1/2025	1/1/2026
National PPO/Indemnity Enrollment			
Florida PPO/Indemnity Enrollment			
Columbia County PPO/Indemnity Enrollment			
<b>Total PPO/Indemnity Enrollment</b>			

- E. Detail any mergers/acquisitions involving your organization which have occurred in the last 12-month period, and any which are planned for the next 12 to 24 months.
- F. List the specific functions of the member services department (for example, assists members in choosing provider, answers members’ questions about claims, receives and responds to members’ complaints about providers, etc.).
- G. Provide information on your A.M. Best rating as well as Standard & Poor, Moody’s and Fitch rating.  
A.M. Best rating: \_\_\_\_\_  
Standard & Poor, Moody’s and Fitch rating: \_\_\_\_\_
- H. Provide an electronic copy (in a usable Excel format) of the Proposer’s match to the Top Utilized Providers under Columbia County’s Dental Program. Refer to **Tab 5** for the Excel spreadsheet to be completed (Note: there are 2 tabs in this Excel document – 1 for Dental; 1 for Vision Providers). If the provider is in your proposed network use “Par”, if the provider is not in your proposed network use “Non-Par” in the Excel spreadsheet.

**VISION:**

- A. State under what other or former name(s) the Proposer is currently operating under or has operated under.
- B. Provide a statement of any litigation or regulatory action that has been filed or is pending against your firm(s) in the last three years. If an action has been filed, state and describe the litigation or regulatory action filed, and identify the court or agency before which the action was instituted, the applicable case or file number, and the status or disposition for such reported action. If no litigation or regulatory action has been filed against your firm(s), provide a statement to that effect. For joint venture or team Proposers, submit the requested information for each member of the joint venture or team.

C. How long has your organization been providing vision insurance? Use the chart below:

	<b>Years</b>
National	
Regional	
Columbia County	

D. Provide the vision enrollment data requested below for the organization submitting this proposal. Use chart below:

Vision Enrollment:

	<b>1/1/2024</b>	<b>1/1/2025</b>	<b>1/1/2026</b>
National Enrollment			
Florida Enrollment			
Columbia County Enrollment			
<b>Total Enrollment</b>			

E. Detail any mergers/acquisitions involving your organization which have occurred in the last 12-month period, and any which are planned for the next 12 to 24 months.

F. List the specific functions of the member services department (for example, assists members in choosing provider, answers members’ questions about claims, receives and responds to members’ complaints about providers, etc.).

G. Provide information on your A.M. Best rating as well as Standard & Poor, Moody’s and Fitch rating.

A.M. Best rating: \_\_\_\_\_  
 Standard & Poor, Moody’s and Fitch rating: \_\_\_\_\_

H. Provide an electronic copy (in a usable Excel format) of the Proposer’s match to the Top Utilized Providers under Columbia County’s Dental Program. Refer to **Tab 5** for the Excel spreadsheet to be completed (Note: there are 2 tabs in this Excel document – 1 for Dental; 1 for Vision Providers). If the provider is in your proposed network use “Par”, if the provider is not in your proposed network use “Non-Par” in the Excel spreadsheet.

I.

**Tab 3: Staff Experience and Background**

**Dental and Vision**

A. For the assigned account service team, what is the current membership it has nationally for

the following products?  
DPPO

- B. Does Proposer have plans within the next 36 months to downsize or reduce the number of employees at the claims facility? Yes \_\_\_ No \_\_\_. If yes, please explain.
- C. Confirm the Proposer can successfully implement Columbia County in preparation for the 10/1/2026 effective date.
- D. Confirm the Proposer has the necessary representatives at Columbia County's open enrollment in August each year.

#### **Tab 4: Project Understanding and Technical Approach**

**Confirm the Proposer understands and agrees to each of the following. Explain any deviations where necessary:**

- A. Columbia County is seeking one (1) dental insurance company and one (1) vision insurance company to provide the requested fully insured Group Dental Insurance Plans and Group Vision Insurance Plans to the active employees, retirees and their eligible dependents.
- B. Provide Base and Buy-Up Group Dental PPO plans and Base and Buy-Up Group Vision plans that matches the current plans, including the maximum allowable charge (MAC) if services are provided by a participating provider who is a general dentist,; and usual and customary (U&C) if services are provided by a non participating provider. Any deviations to the plan shall be disclosed in the Proposer's response.
- C. Provide quality and effective dental plan administration.
- D. Provide realistic and competitive premiums for the requested services.
- E. Provide quality claims service and adjudication.
- F. Provide excellent and timely client and member services.
- G. Provide a large quality network of DPPO dentists, dental specialists and orthodontists with timely access for appointments and short wait periods for service.
- H. Provide a large quality network of vision optomotrists and ophthalmologists with timely access for appointments and short wait periods for service.
- I. Provide a comprehensive premium and claims reporting package. This package at a minimum will report by benefit plan, total premiums paid, total paid claims, number of participating employees and dependents and utilization on a monthly basis.
- J. Provide quality educational and informational materials concerning dental and/or vision health to the employees of Columbia County.
- K. Provide the employees and covered dependents access to a dedicated and secure online web site to provide eligibility, claims payment information, network provider information and other information pertinent to the Columbia County's employee benefit plans.
- L. Provide appropriate number of carrier representatives to assist Columbia County with educational seminars, health fairs, lunch and learns and other carrier related

educational and promotion activities.

- M. The successful Proposer is expected to provide prompt and professional member services. Each Proposer should identify the location and staffing levels of the member service center that will provide service to Columbia County and their eligible membership. A member service “800” telephone number, internet and website access and mobile app must be made available to Columbia County and its members.
- N. The successful Proposer is willing to aggressively contract with dentists currently used by Columbia County employees, both during implementation and an ongoing basis.

**Tab 5: Proposed Budget**

**THE PROPOSER’S COST OF THE FOLLOWING PLANS SHALL BE SUBMITTED ON THIS FORM. PROPOSER IS REQUESTED TO FILL IN THE APPLICABLE BLANKS ON THIS FORM AND COMPLETE AND SIGN THE LAST PAGE AS INSTRUCTED. IF A SEPARATE DOCUMENT IS ALSO SUBMITTED AND THE RATES ARE DIFFERENT THAN WHAT IS COMPLETED ON THIS FORM, THEN THIS FORM IS THE INFORMATION GOING TO BE USED FOR EVALUATION.**

**Employee Group Dental Insurance Program**

The proposed **Monthly Premium Rates** for providing all services stated in Scope of Services, including the Plan Designs. Monthly Premium Rates requested below should be provided on a per Plan Year basis.

**Plan 1 Dental PPO (currently named “Base Plan”) - Monthly Premium Rates**

- 1) Indicate below the proposed total monthly premium for each tier level for providing the PPO/Indemnity product:

**Matched Benefits**

Base Plan	Proposer Rate Guarantee				
	10/1/2026	10/1/2027	10/1/2028	10/1/2029	10/1/2030
Employee Only					
Employee + 1 Dependent					
Employee + Family					

**Plan 2 Dental PPO (currently named “Buy-Up Plan”) - Monthly Premium Rates**

- 2) Indicate below the proposed total monthly premium for each tier level for providing the PPO/Indemnity product:

**Matched Benefits**

Buy-Up Plan	Proposer Rate Guarantee				
	10/1/2026	10/1/2027	10/1/2028	10/1/2029	10/1/2030
Employee Only					
Employee + 1 Dependent					
Employee + Family					

**Plan Changes/Enhancements for Base and Buy-Up Dental PPO Plans**

- 3) Identify any cost impacts to your proposed plan design for the following benefit changes and/or enhancement scenarios:
- a) Change Plan designs to BASE and BUY-UP plans as follows: The current BUY-UP plan would be the new BASE Plan with the below change in benefit. The new BUY-UP plan would include the following benefit changes.
  - b) Provide rate impact from current plan design to each benefit change listed in the below table:

Type of Benefit	Proposer Description of Coverage	Rate Impact and Cost
New <b>Base</b> Plan:		
Increase Orthodontia Maximum to \$2,500.		
New <b>Buy-Up</b> Plan:		
- Increase Calendar Year Maximum to \$3,000		
-Change the Basic Services to 90%/10 coinsurance		
-Change the Major Services to 80%/20% coinsurance		
- Change UCR to 95%		
-Adding Denture cleaning to Preventative (including implants)		

**Employee Group Vision Insurance Program**

The proposed **Monthly Premium Rates** for providing all services stated in Scope of Services, including the Plan Designs. Monthly Premium Rates requested below should be provided on a per Plan Year basis.

## Plan 1 Vision Plan (currently named “Base Plan”) - Monthly Premium Rates

### Monthly Premium Rates – Base Vision Plan

- 1) Indicate below the proposed total monthly premium for each tier level for providing the PPO/Indemnity product:

#### Matched Benefits

Base Plan	Proposer Rate Guarantee				
	10/1/2026	10/1/2027	10/1/2028	10/1/2029	10/1/2030
Employee Only					
Employee + Spouse					
Employee + Children					
Employee & Family					

## Plan 2 Vision Plan (currently named “Buy-Up Plan”) - Monthly Premium Rates

- 2) Indicate below the proposed total monthly premium for each tier level for providing the PPO/Indemnity product:

#### Matched Benefits

Buy-Up Plan	Proposer Rate Guarantee				
	10/1/2026	10/1/2027	10/1/2028	10/1/2029	10/1/2030
Employee Only					
Employee + Spouse					
Employee + Children					
Employee + Family					

## Plan Changes/Enhancements for Base and Buy-Up Vision Plans

- 3) Identify any cost impacts to your proposed plan design for the following benefit changes and/or enhancement scenarios:

Type of Benefit	Proposer Description of Coverage	Rate Impact and Cost
Enhanced Buy-Up Plan:		
- Frames – increase from \$180 allowance to \$250 allowance		

- Elective contact lenses from \$180 allowance to \$250 allowance		
- Adding Venticular Lens		
- Adding Progressive Lens		

**Tab 6: References**

**Proposer is to complete the below reference information. If Proposer is responding to both Dental and Vision, complete both references.**

**Current DENTAL Client Serviced by Proposer:** List one (1) State of Florida public (minimum 500 employees) dental insurance plan a current client contracted with Proposer during the past two (2) years ending December 31, 2025.

Name of current client: \_\_\_\_\_

Address of current client: \_\_\_\_\_

Number of employees: \_\_\_\_\_

Contact name: \_\_\_\_\_

Contact email address: \_\_\_\_\_

Contact phone number: \_\_\_\_\_

Effective date of plan: \_\_\_\_\_

**Current VISION Client Serviced by Proposer:** List one (1) State of Florida public (minimum 500 employees) vision insurance plan a current client contracted with Proposer during the past two (2) years ending December 31, 2025.

Name of current client: \_\_\_\_\_

Address of current client: \_\_\_\_\_

Number of employees: \_\_\_\_\_

Contact name: \_\_\_\_\_

Contact email address: \_\_\_\_\_

Contact phone number: \_\_\_\_\_

Effective date of plan: \_\_\_\_\_

**I confirm the reference(s) provided in this section has been accurately disclosed.**

\_\_\_\_\_  
Signature of Proposer Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name.

\_\_\_\_\_  
Title

\_\_\_\_\_  
Name of Proposer

**Tab 7: Additional Materials**

- A. Any other information considered pertinent by the Proposer. Each Respondent may, but is not required to, include any other materials deemed necessary but not provided otherwise (such as promotional literature, white papers, etc.). They should be clearly marked “Additional Materials”. Note these materials may or may not be reviewed by any or all evaluators and will not be a part of the official evaluation except to the extent they support qualification and experience.

**Tab 8: Forms**

- A. Vendor Information and Signature Form
- B. Non-Collusion Affidavit
- C. Public Entity Crimes Form
- D. Drug-Free Workplace Certificate
- E. Conflict of Interest Statement
- F. Certificate Regarding Lobbying and Debarment, Suspension, and Other Responsibility Matters
- G. Human Trafficking Certificate
- H. Certificates of Insurance
- I. W-9
- J. Proposed Contract
- K. Provider Lists Utilization – Dental and Vision

**SECTION VI. SUBMISSION REVIEW**

1. Evaluation Criteria:

A. Network Access and Disruption

0-25 points

B. Financial Value	0-25 points
C. Plan Design Richness	0-20 points
D. Service and Administration	0-15 points
E. Reporting and Technology	0-5 points
F. Financial Stability and References	0-10 points
<b>TOTAL</b>	<b>0-100 points</b>

1. Selection Process

An evaluation committee will review all submissions received prior to the aforementioned deadline. A shortlist of firms will be determined from the responses received. The shortlist of firms **may** be invited for an interview and site visit prior to a final selection. The committee's rankings will be forwarded as a recommendation to the Board of County Commissioners for their review and consideration.

For firms invited to the interview process, presentations will be evaluated based on the following factors:

- A. Network Access and Disruption -Demonstrate a strong, accessible provider network with minimal disruption to current participants. Preference will be given to carriers with broad geographic coverage, strong specialist availability, and a high percentage of current providers participating in-network. The evaluation will consider provider accessibility in both urban and rural areas, as well as the availability of providers who accept new patients. Proposers should provide a detailed disruption analysis comparing current provider utilization to the proposed network. **25 POINTS**
- B. Financial Value - Provide competitive and sustainable pricing that delivers long-term value to both the employer and employees. Evaluations will consider total projected employer cost, payroll contributions, administrative fees, and rate guarantee provisions. Preference may be given to proposals offering multi-year rate stability and reasonable renewal caps. The County seeks solutions that balance affordability with overall benefit quality and network adequacy. **25 POINTS**
- C. Plan Design Richness - Provide comprehensive dental and vision benefits that support preventative care and employee satisfaction and minimize employee out-of-pocket expense exposure. Preference will be given to plans with fewer limitations, broader covered services and enhanced value and flexibility to participants. **20 POINTS**
- D. Service and Administration - The proposer should demonstrate the ability to provide accurate, efficient, and responsive service to members and the County. Evaluations will include claims administration and turnaround, service accuracy, customer service

responsiveness, implementation support and account management structure. The County values carriers with a demonstrated commitment to member satisfaction and operational efficiency. **15 POINTS**

- E. Reporting and Technology - Provide robust reporting capabilities and user-friendly technology solutions. Evaluation will include claims analytics, eligibility integration, online member tools, mobile application functionality, and data transparency. Preference may be given to carriers offering customizable reporting and enhanced digital member experience. The County seeks technology solutions that improve communication, access, and operational efficiency. **5 POINTS**
- F. Financial Stability and References - Demonstrate strong organizational stability and successful experience providing vision and dental to public-sector employers. Evaluation will consider financial ratings, client references, client retention history, implementation performance, and overall carrier reputation. Preference may be given to carriers with a proven record of reliable service and long-term client relationships. The County may contact references from Tab 6 and evaluation of prior performance as part of the review process. **10 POINTS**

Upon completion of the interview process, the committee will rank the firms. The committee will make a recommendation to the Board of Commissioners for approval to enter into contract negotiations with the firm selected as best suited to serve the needs of the County. If the negotiations with the first firm are unsuccessful, the committee will move to the second firm with similar negotiations and so on. Once an agreeable contract is in place, it will then be brought to the Board again for approval.

#### Proposed Timeline

Friday, June 12: Deadline for Questions – 5:00pm

Thursday, June 18: Bid Opening – 2:00pm

Wednesday, June 22: Shortlisting – Time TBD

Thursday, July 2: Board of County Commission Meeting– 9:30am

#### 2. Award/Rejection/Other

The County reserves the right to reject any and all proposals, waive any formalities, technical errors, and irregularities, and to recommend the award of a contract as may be deemed in the best interest of the County.

All proposals, materials, documents, etc. submitted in conjunction with the selection process shall become the property of the Board and may be disposed of without notification and shall be considered public information under Chapter 119, Florida Statutes.

The applicant selected shall be expected to comply with all federal, state, and local laws and regulations in the performance of services.

**SECTION VII. FORMS**

**FORM A  
VENDOR INFORMATION AND SIGNATURE FORM**

Vendor Name	
Trade License (If applicable)	
Contact Person(s)	
Street Address with City, State and Zip Code	
Mailing Address (If different from Above)	
Phone Number	
Fax Number	
E-Mail	
Proposer will do the work as	<input type="checkbox"/> Individual <input type="checkbox"/> Joint Venture <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation
Date and State of Incorporation	DATE: _____ STATE: _____
Name of partnership or joint venture	

By signing below, the submission shall be deemed a representation and certification by the Proposing Firm that you have investigated all aspects of the solicitation, have read and understand the solicitation, and acknowledge all addenda.

Authorized Signature:
Printed Name of Signer:
Date Signed:
Title of Signatory:

**FORM B  
NON-COLLUSION AFFIDAVIT**

STATE OF \_\_\_\_\_  
\_\_\_\_\_

COUNTY OF \_\_\_\_\_  
\_\_\_\_\_

I state that I \_\_\_\_\_ of \_\_\_\_\_  
\_\_\_\_\_

(Name and Title)

(Name of Firm)

am authorized to make this affidavit on behalf of my firm and its owner, directors and officers. I am the person responsible in my firm for the price(s) and amount(s) of this Response, and the preparation of the Response. I state that:

1. The price(s) and amount(s) of this Response have been arrived at independently and without consultation, communication or agreement with any other Provider, potential provider, Proposal, or potential Proposal.
2. Neither the price(s) nor the amount(s) of this Response, and neither the approximate price(s) nor approximate amount(s) of this Response, have been disclosed to any other firm or person who is a Provider, potential Provider, Proposal, or potential Proposal, and they will not be disclosed before Proposal opening.
3. No attempt has been made or will be made to induce any firm or persons to refrain from submitting a Response for this contract, or to submit a price(s) higher than the prices in this Response, or to submit any intentionally high or noncompetitive price(s) or other form of complementary Response.
4. The Response of my firm is made in good faith and not pursuant to any agreement or discussion with, or inducement from, any firm or person to submit a complementary or other noncompetitive Response.
5. \_\_\_\_\_, its affiliates, subsidiaries, officers, director, and employees  
(Name of Firm)  
are not currently under investigation, by any governmental agency and have not in the last three years been convicted or found liable for any act prohibited by State or Federal law in any jurisdiction, involving conspiracy or collusion with respect to Proposal, on any public contract, except as follows:

I state that I and the named firm understand and acknowledge that the above representations are material and important, and will be relied on by the Board of County Commissioners of Columbia County, Florida for which this Response is submitted. I understand and my firm understands that any misstatement in this affidavit is, and shall be treated as, fraudulent concealment from the State of Florida of the true facts relating to the submission of responses for this contract.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

Name of Organization: \_\_\_\_\_

Signed by: \_\_\_\_\_

Print Name: \_\_\_\_\_

Being duly sworn deposes and says that the information herein is true and sufficiently complete so as not to be misleading.

The foregoing instrument was executed before me this day \_\_\_\_\_ of \_\_\_\_\_ 20

\_\_\_\_\_,

by \_\_\_\_\_ as \_\_\_\_\_ of

\_\_\_\_\_, who personally swore or affirmed that he/she is authorized to execute this document and thereby bind the Corporation, and who is personally known to me OR has produced \_\_\_\_\_ as identification.

(stamp)

\_\_\_\_\_  
NOTARY PUBLIC, State of \_\_\_\_\_

**FORM C**  
**PUBLIC ENTITY CRIMES FORM**

SWORN STATEMENT UNDER SECTION 287.133(3) (a), FLORIDA STATUTES: THIS FORM MUST BE SIGNED IN THE PRESENCE OF A NOTARY PUBLIC OR OTHER OFFICER AUTHORIZED TO ADMINISTER OATHS.

1. This sworn statement is submitted with Proposal, ITN, or Contract Number \_\_\_\_\_.

2. This sworn statement is submitted by \_\_\_\_\_  
whose

[Name of entity submitting sworn statement]

business address is \_\_\_\_\_ and \_\_\_\_\_ (if applicable) its Federal Employer Identification Number (FEIN) is \_\_\_\_\_ (If the entity has no FEIN, include the Social Security Number of the individual signing this sworn statement: \_\_\_\_\_).

3. My name is \_\_\_\_\_ and my relationship to the above is \_\_\_\_\_  
[Please print name of individual signing]

4. I understand that a "public entity crime" as defined in section 287.133(l)(g), Florida Statutes, means a violation of any state or federal *law by* a person with respect to and directly related to the transaction of business with any public entity in Florida or with an agency or political subdivision of any other state or with the United States, including, but not limited to, any proposal or contract for goods or services to be provided to any public entity or an agency or political subdivision and involving antitrust, fraud, theft, bribery, collusion, racketeering, conspiracy, or material misrepresentation.

5. I understand that "convicted" or "conviction" as defined in section 287.133(l) (b), Florida Statutes, means a finding of guilt or a conviction of a public entity crime, with or without an adjudication of guilt, in any federal or state trial court of record relating to charges brought by indictment or information after July 1, 1989, as a result of a jury verdict, non-jury trial, or entry of a plea of guilty or nolo contendere.

6. I understand that "affiliate" as defined in section 287.133(l) (a), Florida Statutes, means:

- a. A predecessor or successor of a person convicted of a public entity crime; or
- b. An entity under the control of any natural person who is active in the management of the entity and who has been convicted of a public entity crime. The term "affiliate" includes those officers, directors, executives, partners, shareholders, employees, members, and agents who are active in the management of an affiliate. The ownership by one person of shares constituting a controlling interest in another person, or a pooling of equipment or income among persons when not for fair market value under an arm's length agreement, shall be a prima facie case that one person controls another person. A person who knowingly enters into a joint venture

with a person who has been convicted of a public entity crime in Florida during the preceding thirty-six (36) months shall be considered an affiliate.

7. I understand that a "person" as defined in section 287.133(1) (e), Florida Statutes, means any natural person or entity organized under the laws of any state or of the United States with the legal power to enter into a binding contract and which bids/proposals or applies to bids/proposals on contracts for the provision of goods or services let by a public entity, or which otherwise transacts or applies to transact business with a public entity. The term "person" includes those officers, directors, executives, partners, shareholders, employees, members, and agents who are active in management of an entity.

8. Based on information and belief, the statement, which I have marked below, is true in relation to the entity submitting this sworn statement. **[Please indicate which statement applies].**

\_\_\_\_ Neither the entity submitting this sworn statement, nor any officers, directors, executives, partners, shareholders, employees, members, or agents who is active in the management of the entity, nor any affiliate of the entity have been convicted of a public entity crime subsequent to July 1, 1989.

\_\_\_\_ The entity submitting this sworn statement, or one or more of the officers, directors, executives, partners, shareholders, employees, members, or agents who are active in the management of the entity, or an affiliate of the entity has been charged with and convicted of a public entity crime subsequent to July 1, 1989, AND **[Please indicate which additional statement applies].**

\_\_\_\_ There has been a proceeding concerning the conviction before a judge or hearing officer of the State of Florida, Division of Administrative Hearings, or a court of law having proper jurisdiction. The final order entered by the hearing officer or judge did not place the person or affiliate on the convicted Contractor list. **[Please attach a copy of the final order.]**

\_\_\_\_ The person or affiliate was placed on the convicted Contractor list. There has been a subsequent proceeding before a court of law having proper jurisdiction or a judge or hearing officer of the State of Florida, Division of Administrative Hearings. The final order entered by the judge or hearing officer determined that it was in the public interest to remove the person or affiliate from the convicted Contractor list. **[Please attach a copy of the final order.]**

\_\_\_\_ The person or affiliate has not been placed on any convicted vendor list. **[Please describe any action taken by or pending with the State of Florida, Department of Management Services.]**

By the signature(s) below, I/we, the undersigned, as authorized signatory to commit the firm, certify that the information as provided in FORM "C", Public Entity Crimes, is truthful and correct at the time of submission.

\_\_\_\_\_  
AFFIANT

\_\_\_\_\_  
Typed Name of AFFIANT

\_\_\_\_\_  
Title

STATE OF \_\_\_\_\_

County OF \_\_\_\_\_

The foregoing instrument was executed before me this day \_\_\_\_\_ of \_\_\_\_\_  
20\_\_\_\_, by \_\_\_\_\_ as \_\_\_\_\_ of  
\_\_\_\_\_, who personally swore or affirmed that  
he/she is authorized to execute this document and thereby bind the Corporation, and who is  
personally known to me OR has produced \_\_\_\_\_ as identification.

(stamp)

\_\_\_\_\_  
NOTARY PUBLIC, State of \_\_\_\_\_

**FORM D  
DRUG-FREE WORKPLACE CERTIFICATE**

**The drug-free certification form below must be signed and returned with the solicitation response.**

In order to have a drug-free workplace program, a business shall:

1. Publish a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the workplace and specifying the actions that will be taken against employees for violations of such prohibition.
2. Inform employees about the dangers of drug abuse in the workplace, the business' policy of maintaining a drug-free workplace, any available drug counseling, rehabilitation, and employee assistance programs, and the penalties that may be imposed upon employees for drug abuse violations.
3. Give each employee engaged in providing the commodities or contractual services that are under bid/proposal a copy of the statement specified in the first paragraph.
4. In the statement specified in the first paragraph, notify the employees that, as a condition of working on the commodities or contractual services that are under bid/proposal, the employee will abide by the terms of the statement and will notify the employer of any conviction of, or plea of guilty or nolo contendere to, any violation of chapter 893, Florida Statutes, or of any controlled substance law of the United States or any state, for a violation occurring in the workplace no later than five (5) days after such conviction.
5. Impose a sanction on, or require the satisfactory participation in, a drug abuse assistance or rehabilitation program if such is available in the employee's community, by any employee who is so convicted.
6. Make a good faith effort to continue to maintain a drug-free workplace through implementation of the foregoing provisions.
7. By the signature(s) below, I/we, the undersigned, as authorized signatory to commit the firm, certify that the information as provided in FORM "D", Drug-Free Workplace Certification, is truthful and correct at the time of submission.

\_\_\_\_\_  
AFFIANT

\_\_\_\_\_  
Typed Name of AFFIANT

\_\_\_\_\_  
Title

STATE OF \_\_\_\_\_

County OF \_\_\_\_\_

The foregoing instrument was executed before me this day \_\_\_\_\_ of \_\_\_\_\_  
20\_\_\_\_, by \_\_\_\_\_ as \_\_\_\_\_ of  
\_\_\_\_\_, who personally swore or affirmed that

he/she is authorized to execute this document and thereby bind the Corporation, and who is personally known to me OR has produced \_\_\_\_\_ as identification.

\_\_\_\_\_  
(stamp)  
\_\_\_\_\_

\_\_\_\_\_  
NOTARY PUBLIC, State of \_\_\_\_\_

**FORM E**  
**CONFLICT OF INTEREST STATEMENT**

STATE OF \_\_\_\_\_

COUNTY OF \_\_\_\_\_

Before me, the undersigned authority, personally appeared \_\_\_\_\_, who was duly sworn, deposes, and states:

1. I am the \_\_\_\_\_ of \_\_\_\_\_ with a local office  
(Insert Title) (Insert Company Name)  
in \_\_\_\_\_ and principal office in \_\_\_\_\_.  
Said entity is submitting this proposal/offer to project: \_\_\_\_\_.
2. The AFFIANT has made diligent inquiry and provided the information in this statement affidavit based upon its full knowledge.
3. The AFFIANT states that only one submittal for this solicitation has been submitted and tendered by the appropriate date and time and that said above stated entity has no financial interest in other entities submitting a proposal for the work contemplated hereby.
4. Neither the AFFIANT nor the above named entity has directly or indirectly entered into any agreement, participated in any collusion or collusive activity, or otherwise taken any action which in any way restricts or restrains the competitive nature of this solicitation, including but not limited to the prior discussion of terms, conditions, pricing, or other offer parameters required by this solicitation.
5. Neither the entity nor its affiliates, nor anyone associated with them, is presently suspended or otherwise prohibited from participation in this solicitation or any contract to follow thereafter by any government entity.
6. Neither the entity nor its affiliates, nor anyone associated with them, have any potential conflict of interest because and due to any other clients, contracts, or property interests in this solicitation or the resulting project.
7. I hereby also certify that no member of the entity's ownership or management or staff has a vested interest in any County Office or Department.
8. I certify that no member of the entity's ownership or management is presently applying, actively seeking, or has been selected for an elected position within Columbia County government.
9. In the event that a conflict of interest is identified in the provision of services, I, the undersigned will immediately notify the County in writing.

\_\_\_\_\_  
AFFIANT

\_\_\_\_\_  
Typed Name of AFFIANT

\_\_\_\_\_  
Title

STATE OF \_\_\_\_\_

County OF \_\_\_\_\_

The foregoing instrument was executed before me this day \_\_\_\_\_ of \_\_\_\_\_ 20

\_\_\_\_\_,  
by \_\_\_\_\_ as \_\_\_\_\_ of \_\_\_\_\_

\_\_\_\_\_, who personally swore or affirmed that he/she is authorized to execute this document and thereby bind the Corporation, and who is personally known to me OR has produced \_\_\_\_\_ as identification.

(stamp)

\_\_\_\_\_  
NOTARY PUBLIC, State of \_\_\_\_\_

**FORM F**  
**CERTIFICATE REGARDING LOBBYING AND DEBARMENT, SUSPENSION, AND**  
**OTHER RESPONSIBILITY MATTERS**

1. Lobbying

As required by Section 1352, Title 31 of the U.S. Code, and implemented at 28 CFR Part 69, for persons entering into a grant or cooperative agreement over \$100,000, as defined at 28 CFR Part 69, the applicant certifies that:

- A. No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the making of any federal grant, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal grant or cooperative agreement.
- B. If any funds other than federal appropriated funds have been paid or will be paid to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this federal grant or cooperative agreement, the undersigned shall complete and submit Standard Form LLL – “Disclosure of Lobbying Activities”, in accordance with its instructions.
- C. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subgrants, contracts under grants and cooperative agreements, and subcontracts) and that all subrecipients shall certify and disclose accordingly.

2. Debarment, Suspension and Other Responsibility Matters

As required by Executive Order 12549, Debarment and Suspension, and implemented at 28 CFR Part 67 –

- A. The applicant certifies that it and its principals:
  - I. Are not presently debarred, suspended, proposed for debarment, declared ineligible, sentenced to a denial of federal benefits by a State or Federal court, or voluntarily excluded from covered transactions by any federal department or agency;
  - II. Have not within a three-year period preceding this application been convicted of or had a civil judgement rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
  - III. Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (a)(ii) of this certification; and
  - IV. Have not within a three-year period preceding this application had one or more public transactions (Federal, State or local) terminated for cause or default. (b) Where the applicant is unable to certify to any of the statements in this certification, he or she shall attach an

explanation to this application.

As the duly authorized representative of the applicant, I hereby certify that applicant will comply with the above referenced certifications.

\_\_\_\_\_  
AFFIANT

\_\_\_\_\_  
Typed Name of AFFIANT

\_\_\_\_\_  
Title

STATE OF \_\_\_\_\_

County OF \_\_\_\_\_

The foregoing instrument was executed before me this day \_\_\_\_\_ of \_\_\_\_\_  
20\_\_\_\_, by \_\_\_\_\_ as \_\_\_\_\_ of  
\_\_\_\_\_, who personally swore or affirmed that he/she is  
authorized to execute this document and thereby bind the Corporation, and who is personally known to me  
OR has produced \_\_\_\_\_ as identification.

(stamp)

\_\_\_\_\_  
NOTARY PUBLIC, State of \_\_\_\_\_

**FORM G**  
**HUMAN TRAFFICKING AFFIDAVIT**

Affiant swears under pain and penalty of perjury that the company or entity does not use coercion for labor or services as defined by Florida Statute § 787.06 which is hereby incorporated by reference.

---

**(Company or Entity Name)**

**Affiant who is an Officer/Authorized Representative of Company or Entity:**

---

**(Signature)**

---

**(Printed Name)**

---

**(Date)**

STATE OF \_\_\_\_\_ )

COUNTY OF \_\_\_\_\_)

Sworn to and subscribed before me this \_\_\_ day of \_\_\_\_\_, 2026 by \_\_\_\_\_  
\_\_\_\_\_, by means of physical presence and \_\_\_\_\_ who is personally  
known to me or \_\_\_\_\_ has produced \_\_\_\_\_ as  
identification.

(NOTARY STAMP)

---

Notary Public

**FORM H**  
**CERTIFICATES OF INSURANCE**

Please attach proof of insurance.

**FORM I**  
**W-9**

Please attach W-9 form.

**FORM J**  
**PROPOSED CONTRACT**

Template of Proposed Service Agreement is attached (Do not complete)

**FORM K  
PROVIDER LIST - VISION**

PROV NPI	PROV NAME	PROV ADDRESS	PROV CITY	PROV STATE	PROV ZIP	CLAIM PPO	SUBMITTED CHARGES	New Network Status (Indicate "PAR" "NONPAR")	Does Provider Accept New Patients? (Indicate "Y" or "N")
1114012689	Herriott,Michael B	2469 W US Highway 90	Lake City	FL	32055	Y	31,989		
1164156246	Broome,Kimberly	125 SW Midtown Pl Ste 101	Lake City	FL	32025	Y	9,845		
1164156246	Broome,Frank A	125 SW Midtown Pl Ste 101	Lake City	FL	32025	Y	9,195		
1295921096	Avonda,William M	14480 NW 152nd Ln	Alachua	FL	32615	Y	6,794		
1235350208	Cole,Reaves C	621 SW Baya Dr Ste 101	Lake City	FL	32025	Y	6,590		
1124033832	Bedoya,Eduardo M	876 SW State Rd 247	Lake City	FL	32025	Y	1,660		
1043564982	Seymour,Ashley	12921 SW 1st Rd Ste 107	Newberry	FL	32669	Y	1,330		
1225463763	Jones,Douglas C	3324 W University Ave Ste A	Gainesville	FL	32607	Y	1,270		
1043304330	Optical,Walmart	2767 W US Highway 90	Lake City	FL	32055	Y	1,067		
1487012498	Seymour,Ashley	4313 NW 8th Ave	Gainesville	FL	32605	Y	1,005		
1164156246	Wasikowski,Lauren	125 SW Midtown Pl Ste 101	Lake City	FL	32025	Y	807		
1386047561	Lee,Chan	173 Grand Hill Pl	Holly Springs	NC	27540	Y	719		
1417418815	NVCONSOLIDATED VISION IN	3581 SOUTHWEST ARCHER ROAD	GAINESVILLE	FL	32608	N	644		
1134241540	Hoffman,Karen R	905 Park Ave Ste 100	Orange Park	FL	32073	Y	629		
0	Vista Eyecare Inc			GA	0	N	596		
1164156246	DeSai,Shruti	832 NW 57th St	Gainesville	FL	32605	Y	519		
0	Office of Recovery Servcs			UT	0	N	517		
1043304330	Optical,Walmart	2767 W US Hwy 90	Lake City	FL	32055	Y	463		
1467063057	Vision 8736,Pearle	6419 W Newberry Rd Ste B3	Gainesville	FL	32605	Y	459		
0	DiAnna J. McDowell	51 West Center St	Orem	UT	84057	N	456		
1477708428	Schlofman,Leonard A	292 Lafayette St	Starke	FL	32091	Y	431		
1770593295	Latour,Larry J	23352 W US Hwy 27 Ste 90	High Springs	FL	32643	Y	354		
1891894374	Optical,Sams	4001 SW 30th Pl	Gainesville	FL	32608	Y	299		
1740775600	Stewart-Bates,Emma	2677 SW 87th Dr	Gainesville	FL	32608	Y	260		
1467063057	Womack,John T	6419 W Newberry Rd Ste B3	Gainesville	FL	32605	Y	260		
1114012689	Coppola,Robert C	2469 W US Highway 90	Lake City	FL	32055	Y	259		

**PROVIDER LIST - DENTAL**

Provider Name	Provider Address	Provider City	ST	Zip	SSN/TIN	Total Charges Submitted	New Network Status (Indicate 'PAR' 'NONPAR')	Does Provider Accept New Patients? (Indicate 'Y' or 'N')
ABRABEN,REEVE G	1680 SW NEWLAND WAY STE 100	LAKE CITY	FL	32025-6917	593443160	5,488.00		
ACOSTA HERNANDEZ,MANUEL ALEJANDRO	2143 W US HIGHWAY 90 STE A	LAKE CITY	FL	32055-7726	871853615	3,962.00		
BOALES,OWEN J	1133 4TH ST NW	JASPER	FL	32052-5847	593620828	9,626.37		
CAMARGO,GELSON AUGUSTO A	2970 W US HIGHWAY 90 STE 101	LAKE CITY	FL	32055-4703	200185918	4,888.00		
D'ANNA,CALOGERO	10820 MARVIN JONES BLVD	DOWLING PARK	FL	32064-8243	832532851	9,753.00		
DEMMI,STEPHEN B	437 SW PERIMETER GLN	LAKE CITY	FL	32025-0498	593555804	1,080.00		
DENNIS,IAN C	18474 HIGH SPRINGS MAIN ST	HIGH SPRINGS	FL	32643-0545	510514612	522.00		
DICKENS,LAUREN KRISTINA	1310 NW 23RD AVE STE A	GAINESVILLE	FL	32605-3009	200185918	160.00		
ELLIS COBRAN,MORGAN R	2970 W US HIGHWAY 90 STE 101	LAKE CITY	FL	32055-4703	200185918	1,961.86		
FIOLA,CAROL SCHNEIDER	255 SW MAIN BLVD	LAKE CITY	FL	32025-7050	822960648	1,138.00		
GARRETT,LINDSAY MARIE	124 HOWARD ST E	LIVE OAK	FL	32064-3207	473292146	322.00		
GRACY,MEGAN JURECKO	2086 SW MAIN BLVD STE 113	LAKE CITY	FL	32025-0006	571206179	285.00		
GREENWALT,BRANDON L	12443 SAN JOSE BLVD STE 101	JACKSONVILLE	FL	32223-8647	471243578	261.00		
HARVEY,CLARA LYNN	255 SW MAIN BLVD	LAKE CITY	FL	32025-7050	822960648	3,252.00		
HARVEY,ROBERT J	1788 SW BARNETT WAY	LAKE CITY	FL	32025-6953	593529587	9,240.00		
HIGGINS,MARCUS A	602 RAILROAD AVE SE	LIVE OAK	FL	32064-3418	922191217	298.00		
KRIZNER-MEZA,MELISSA KAREN	255 SW MAIN BLVD	LAKE CITY	FL	32025-7050	822960648	2,835.00		
MARKHAM,SAMUEL DARREL	4650 NW 39TH PL STE I	GAINESVILLE	FL	32606-8157	20645217	1,745.00		
MASTERSON,CEILI ERIN	2143 W US HIGHWAY 90 STE A	LAKE CITY	FL	32055-7726	871853615	352.00		
MCNAIR,RAMEEK	1788 SW BARNETT WAY	LAKE CITY	FL	32025-6953	593529587	2,862.00		
PHILLIPS,TYLER WAYNE	2609 SANTA BARBARA BLVD STE 101	CAPE CORAL	FL	33914-4437	471706456	316.00		
PROWS,JACOB RONALD	2143 W US HIGHWAY 90 STE A	LAKE CITY	FL	32055-7726	871853615	2,948.00		
RENTZ,LESTER J	3012 US HIGHWAY 41 S	LAKE PARK	GA	31636-3467	202977606	125.00		
SKLAR,EMILY	2970 W US HIGHWAY 90 STE 101	LAKE CITY	FL	32055-4703	200185918	267.00		
SOLDATOS,CONSTANTINOS N	510 OHIO AVE S	LIVE OAK	FL	32064-3219	593622970	110.00		
STUART,KYLE J	255 SW MAIN BLVD	LAKE CITY	FL	32025-7050	822960648	643.00		
WHITE,LINDA R	602 RAILROAD AVE SE	LIVE OAK	FL	32064-3418	922191217	1,511.00		
ABRABEN,REEVE G	1680 SW NEWLAND WAY STE 100	LAKE CITY	FL	32025-6917	593443160	2,114.00		
ACOSTA HERNANDEZ,MANUEL ALEJANDRO	2143 W US HIGHWAY 90 STE A	LAKE CITY	FL	32055-7726	871853615	422.00		
ASSING,RICHARD A	724 LITHIA PINECREST RD	BRANDON	FL	33511-6117	593097305	122.00		
BAPTISTE,ASHLEY R	2970 W US HIGHWAY 90 STE 101	LAKE CITY	FL	32055-4703	200185918	1,308.00		

CAMARGO,GELSON AUGUSTO A	2970 W US HIGHWAY 90 STE 101	LAKE CITY	FL	32055-4703	200185918	3,541.84		
D'ANNA,CALOGERO	10820 MARVIN JONES BLVD	DOWLING PARK	FL	32064-8243	832532851	587.00		
DELMOND,JOSEPH A	5502 NW 43RD ST STE 1	GAINESVILLE	FL	32653-8397	473103534	120.00		
DEMMI,STEPHEN B	437 SW PERIMETER GLN	LAKE CITY	FL	32025-0498	593555804	2,509.00		
DENNIS,IAN C	18474 HIGH SPRINGS MAIN ST	HIGH SPRINGS	FL	32643-0545	510514612	2,440.00		
ELLIS COBRAN,MORGAN R	2970 W US HIGHWAY 90 STE 101	LAKE CITY	FL	32055-4703	200185918	3,193.59		
FIOLA,CAROL SCHNEIDER	255 SW MAIN BLVD	LAKE CITY	FL	32025-7050	822960648	3,702.00		
GARRETT,LINDSAY MARIE	124 HOWARD ST E	LIVE OAK	FL	32064-3207	473292146	1,869.00		
HARVEY,CLARA LYNN	255 SW MAIN BLVD	LAKE CITY	FL	32025-7050	822960648	2,991.00		
HARVEY,ROBERT J	1788 SW BARNETT WAY	LAKE CITY	FL	32025-6953	593529587	1,148.00		
HESTER,BRETT JAMES	3400 OLD US 41 N	VALDOSTA	GA	31602-1120	452803104	5,520.48		
HIGGINS,MARCUS A	602 RAILROAD AVE SE	LIVE OAK	FL	32064-3418	922191217	428.00		
KAILES,BETH E	2013 TOWN CENTER BLVD	FLEMING ISLE	FL	32003-6320	201860255	321.00		
KRIZNER-MEZA,MELISSA KAREN	255 SW MAIN BLVD	LAKE CITY	FL	32025-7050	822960648	5,639.00		
MARKHAM,SAMUEL DARREL	340 NW 76TH DR	GAINESVILLE	FL	32607-1593	20645217	330.00		
MASTERSON,CEILI ERIN	2143 W US HIGHWAY 90 STE A	LAKE CITY	FL	32055-7726	871853615	471.00		
MCNAIR,RAMEEK	1788 SW BARNETT WAY	LAKE CITY	FL	32025-6953	593529587	407.00		
MOURO,ANDREW ROBERT	1070 S MAIN ST STE 220	HOLLY SPRINGS	NC	27540-4205	993246544	1,197.00		
PFUNDHELLER,DUSTIN MARK	456 UNIVERSITY BLVD N	JACKSONVILLE	FL	32211-6954	332770031	135.00		
RENTZ,LESTER J	3012 US HIGHWAY 41 S	LAKE PARK	GA	31636-3467	202977606	623.00		
SKLAR,EMILY	2970 W US HIGHWAY 90 STE 101	LAKE CITY	FL	32055-4703	200185918	627.00		
SOLDATOS,CONSTANTINOS N	510 OHIO AVE S	LIVE OAK	FL	32064-3219	593622970	61.00		
STUART,KYLE J	255 SW MAIN BLVD	LAKE CITY	FL	32025-7050	822960648	3,421.00		
VAN,KIM T	724 LITHIA PINECREST RD	BRANDON	FL	33511-6117	593097305	376.00		
BRUMMETT,JAMES C	2341 NW 41ST ST STE A	GAINESVILLE	FL	32606-7442	883070452	671.00		
ELLIS COBRAN,MORGAN R	2970 W US HIGHWAY 90 STE 101	LAKE CITY	FL	32055-4703	200185918	2,690.00		
GRACY,MEGAN JURECKO	2086 SW MAIN BLVD STE 113	LAKE CITY	FL	32025-0006	571206179	1,950.00		
MCNAIR,RAMEEK	1788 SW BARNETT WAY	LAKE CITY	FL	32025-6953	593529587	196.00		
STUART,KYLE J	255 SW MAIN BLVD	LAKE CITY	FL	32025-7050	822960648	215.00		
GARRETT,LINDSAY MARIE	124 HOWARD ST E	LIVE OAK	FL	32064-3207	473292146	4,961.00		
KRIZNER-MEZA,MELISSA KAREN	255 SW MAIN BLVD	LAKE CITY	FL	32025-7050	822960648	3,415.00		
WIESE,COLLEEN M	14690 NW 151ST BLVD STE 20	ALACHUA	FL	32615-5328	870811809	378.00		
ABRABEN,REEVE G	1680 SW NEWLAND WAY STE 100	LAKE CITY	FL	32025-6917	593443160	1,829.00		
CAMARGO,GELSON AUGUSTO A	2970 W US HIGHWAY 90 STE 101	LAKE CITY	FL	32055-4703	200185918	600.00		
ELLIS COBRAN,MORGAN R	2970 W US HIGHWAY 90 STE 101	LAKE CITY	FL	32055-4703	200185918	456.00		
ABRABEN,REEVE G	1680 SW NEWLAND WAY STE 100	LAKE CITY	FL	32025-6917	593443160	752.00		

BRUMMETT, JAMES C	2341 NW 41ST ST STE A	GAINESVILLE	FL	32606-7442	883070452	873.00		
ABRABEN, REEVE G	1680 SW NEWLAND WAY STE 100	LAKE CITY	FL	32025-6917	593443160	243.00		
BROWN, KENJULA D	3599 UNIVERSITY BLVD S STE 604	JACKSONVILLE	FL	32216-4281	825003579	4,255.02		
HIGGINS, MARCUS A	602 RAILROAD AVE SE	LIVE OAK	FL	32064-3418	922191217	834.00		
KRIZNER-MEZA, MELISSA KAREN	255 SW MAIN BLVD	LAKE CITY	FL	32025-7050	822960648	420.00		
STUART, KYLE J	255 SW MAIN BLVD	LAKE CITY	FL	32025-7050	822960648	1,071.00		
CARTER, DERRICK	571 S 6TH ST	MACCLENNY	FL	32063-2605	392527568	468.00		
ELLIS COBRAN, MORGAN R	2970 W US HIGHWAY 90 STE 101	LAKE CITY	FL	32055-4703	200185918	512.00		
MARKHAM, SAMUEL DARREL	4650 NW 39TH PL STE I	GAINESVILLE	FL	32606-8157	20645217	1,845.00		
SKLAR, EMILY	2970 W US HIGHWAY 90 STE 101	LAKE CITY	FL	32055-4703	200185918	1,928.00		
ABRABEN, REEVE G	1680 SW NEWLAND WAY STE 100	LAKE CITY	FL	32025-6917	593443160	1,070.00		
DEMMI, STEPHEN B	437 SW PERIMETER GLN	LAKE CITY	FL	32025-0498	593555804	206.00		
ELLIS COBRAN, MORGAN R	2970 W US HIGHWAY 90 STE 101	LAKE CITY	FL	32055-4703	200185918	1,263.00		
FIOLA, CAROL SCHNEIDER	255 SW MAIN BLVD	LAKE CITY	FL	32025-7050	822960648	291.00		
HARVEY, CLARA LYNN	255 SW MAIN BLVD	LAKE CITY	FL	32025-7050	822960648	129.00		
ABRABEN, REEVE G	1680 SW NEWLAND WAY STE 100	LAKE CITY	FL	32025-6917	593443160	182.00		
ACOSTA HERNANDEZ, MANUEL ALEJANDRO	2143 W US HIGHWAY 90 STE A	LAKE CITY	FL	32055-7726	871853615	13,012.00		
MASTERSON, CEILI ERIN	2143 W US HIGHWAY 90 STE A	LAKE CITY	FL	32055-7726	871853615	832.00		
MCNAIR, RAMEEK	1788 SW BARNETT WAY	LAKE CITY	FL	32025-6953	593529587	79.00		
ABRABEN, REEVE G	1680 SW NEWLAND WAY STE 100	LAKE CITY	FL	32025-6917	593443160	6,938.00		
GRACY, MEGAN JURECKO	2086 SW MAIN BLVD STE 113	LAKE CITY	FL	32025-0006	571206179	1,600.00		
MCNAIR, RAMEEK	1788 SW BARNETT WAY	LAKE CITY	FL	32025-6953	593529587	5,066.00		
ABRABEN, REEVE G	1680 SW NEWLAND WAY STE 100	LAKE CITY	FL	32025-6917	593443160	395.00		
DEMMI, STEPHEN B	437 SW PERIMETER GLN	LAKE CITY	FL	32025-0498	593555804	246.00		
ELLIS COBRAN, MORGAN R	2970 W US HIGHWAY 90 STE 101	LAKE CITY	FL	32055-4703	200185918	854.00		
FIOLA, CAROL SCHNEIDER	255 SW MAIN BLVD	LAKE CITY	FL	32025-7050	822960648	343.00		
PATEL, SHILAN	1570 ROCK SPRINGS RD	APOPKA	FL	32712-2232	200185918	167.00		
HIGGINS, MARCUS A	602 RAILROAD AVE SE	LIVE OAK	FL	32064-3418	922191217	2,002.00		
WHITE, LINDA R	602 RAILROAD AVE SE	LIVE OAK	FL	32064-3418	922191217	7,604.00		
WIESE, COLLEEN M	14690 NW 151ST BLVD STE 20	ALACHUA	FL	32615-5328	870811809	9,974.00		
<b>KIDS ONLY DENTAL PLACE - LAKE CITY</b>	457 SW PERIMETER GLN	LAKE CITY	FL	32025	59-3531012			

Carrier	Relationship	Sex	DOB	Zip Code	County	Class	Benefit	Coverage Level
The Standard	Employee	F	06/12/1975	32025		Full Time Eligible	Dental	Employee
The Standard	Employee	F	06/12/1975	32025		Full Time Eligible	Vision	Employee + Spouse
The Standard	Spouse	M	01/06/1969	32025		Full Time Eligible	Vision	Employee + Spouse
The Standard	Employee	F	03/16/1981	32055-7154	Columbia County	Full Time Eligible	Dental	Employee + Family
The Standard	Child	F	03/18/2001	32055-7154	Columbia County	Full Time Eligible	Dental	Employee + Family
The Standard	Child	F	06/17/2004	32055-7154	Columbia County	Full Time Eligible	Dental	Employee + Family
The Standard	Employee	F	03/16/1981	32055-7154	Columbia County	Full Time Eligible	Vision	Employee + Child(ren)
The Standard	Child	F	06/17/2004	32055-7154	Columbia County	Full Time Eligible	Vision	Employee + Child(ren)
The Standard	Child	F	03/18/2001	32055-7154	Columbia County	Full Time Eligible	Vision	Employee + Child(ren)
The Standard	Employee	F	12/15/1960	32024		Full Time Eligible	Dental	Employee
The Standard	Employee	F	12/15/1960	32024		Full Time Eligible	Vision	Employee
The Standard	Employee	M	09/10/1965	32038-3433	Columbia County	Full Time Eligible	Dental	Employee
The Standard	Employee	M	09/10/1965	32038-3433	Columbia County	Full Time Eligible	Vision	Employee
The Standard	Employee	M	11/24/1986	32025	Columbia County	Full Time Eligible	Dental	Employee
The Standard	Employee	M	11/24/1986	32025	Columbia County	Full Time Eligible	Vision	Employee
The Standard	Employee	M	04/23/1965	32024-4514	Columbia County	Full Time Eligible	Dental	Employee
The Standard	Employee	M	04/23/1965	32024-4514	Columbia County	Full Time Eligible	Vision	Employee
The Standard	Employee	F	06/05/1953	32025		Full Time Eligible	Dental	Employee
The Standard	Employee	F	06/05/1953	32025		Full Time Eligible	Vision	Employee
The Standard	Employee	M	07/22/1957	32024		Retiree	Dental	Employee + One
The Standard	Spouse	F	03/28/1950	32024		Retiree	Dental	Employee + One
The Standard	Employee	M	07/22/1957	32024		Retiree	Vision	Employee + Spouse
The Standard	Spouse	F	03/28/1950	32024		Retiree	Vision	Employee + Spouse
The Standard	Employee	F	12/06/1979	32025-2311	Columbia County	Full Time Eligible	Dental	Employee
The Standard	Employee	F	12/06/1979	32025-2311	Columbia County	Full Time Eligible	Vision	Employee
The Standard	Employee	F	10/27/1972	32008-7613	Gilchrist County	Full Time Eligible	Dental	Employee
The Standard	Employee	F	10/27/1972	32008-7613	Gilchrist County	Full Time Eligible	Vision	Employee
The Standard	Employee	M	06/01/1963	32024		Retiree	Dental	Employee
The Standard	Employee	M	09/27/2000	32025		Full Time Eligible	Dental	Employee
The Standard	Employee	M	09/27/2000	32025		Full Time Eligible	Vision	Employee
The Standard	Employee	F	02/10/1989	32038		Full Time Eligible	Dental	Employee + One
The Standard	Spouse	M	04/16/1984	32038		Full Time Eligible	Dental	Employee + One
The Standard	Employee	F	02/10/1989	32038		Full Time Eligible	Vision	Employee + Spouse
The Standard	Spouse	M	04/16/1984	32038		Full Time Eligible	Vision	Employee + Spouse
The Standard	Employee	M	08/29/1972	32060		Full Time Eligible	Dental	Employee
The Standard	Employee	M	08/29/1972	32060		Full Time Eligible	Vision	Employee
The Standard	Employee	M	01/06/1993	32038-8841	Columbia County	Full Time Eligible	Dental	Employee
The Standard	Employee	M	01/06/1993	32038-8841	Columbia County	Full Time Eligible	Vision	Employee
The Standard	Employee	M	06/24/1969	32025-3318	Columbia County	Full Time Eligible	Dental	Employee
The Standard	Employee	M	06/24/1969	32025-3318	Columbia County	Full Time Eligible	Vision	Employee
The Standard	Employee	M	08/06/1961	32025		Full Time Eligible	Dental	Employee
The Standard	Employee	M	08/06/1961	32025		Full Time Eligible	Vision	Employee
The Standard	Employee	M	06/01/1973	32025-6978	Columbia County	Full Time Eligible	Dental	Employee
The Standard	Employee	M	06/01/1973	32025-6978	Columbia County	Full Time Eligible	Vision	Employee
The Standard	Employee	M	08/03/1975	33584-5222	Hillsborough County	Full Time Eligible	Vision	Employee
The Standard	Employee	F	11/08/1964	32038		Full Time Eligible	Dental	Employee
The Standard	Employee	F	11/08/1964	32038		Full Time Eligible	Vision	Employee
The Standard	Employee	M	05/31/1966	32024		Full Time Eligible	Dental	Employee + One
The Standard	Spouse	F	06/24/1968	32024		Full Time Eligible	Dental	Employee + One
The Standard	Employee	M	05/31/1966	32024		Full Time Eligible	Vision	Employee + Spouse
The Standard	Spouse	F	06/24/1968	32024		Full Time Eligible	Vision	Employee + Spouse
The Standard	Employee	F	12/30/1975	32025		Full Time Eligible	Dental	Employee + One
The Standard	Child	M	06/27/2011	32025		Full Time Eligible	Dental	Employee + One
The Standard	Employee	F	12/30/1975	32025		Full Time Eligible	Vision	Employee + Child(ren)
The Standard	Child	M	06/27/2011	32025		Full Time Eligible	Vision	Employee + Child(ren)
The Standard	Employee	F	03/25/1953	32056-3342	Columbia County	Retiree	Dental	Employee
The Standard	Employee	F	03/25/1953	32056-3342	Columbia County	Retiree	Vision	Employee
The Standard	Employee	F	11/11/1969	32055-4889	Columbia County	Full Time Eligible	Dental	Employee
The Standard	Employee	F	11/11/1969	32055-4889	Columbia County	Full Time Eligible	Vision	Employee
The Standard	Employee	F	06/06/1971	32025	Columbia County	Full Time Eligible	Dental	Employee
The Standard	Employee	F	06/06/1971	32025	Columbia County	Full Time Eligible	Vision	Employee
The Standard	Employee	M	05/12/1991	31562-4034	Charlton County	Full Time Eligible	Dental	Employee
The Standard	Employee	M	05/12/1991	31562-4034	Charlton County	Full Time Eligible	Vision	Employee
The Standard	Employee	M	04/17/1971	32056-0071	Columbia County	Full Time Eligible	Dental	Employee
The Standard	Employee	M	04/17/1971	32056-0071	Columbia County	Full Time Eligible	Vision	Employee
The Standard	Employee	F	11/19/1991	32024		Full Time Eligible	Dental	Employee
The Standard	Employee	F	11/19/1991	32024		Full Time Eligible	Vision	Employee
The Standard	Employee	F	03/03/1953	32025-2319	Columbia County	Retiree	Dental	Employee
The Standard	Employee	M	04/06/1952	32025-1961	Columbia County	Retiree	Dental	Employee
The Standard	Employee	M	04/06/1952	32025-1961	Columbia County	Retiree	Vision	Employee
The Standard	Employee	M	01/16/1953	32024-3319	Columbia County	Retiree	Dental	Employee
The Standard	Employee	F	09/11/1965	32025-5621	Columbia County	Full Time Eligible	Dental	Employee
The Standard	Employee	F	09/11/1965	32025-5621	Columbia County	Full Time Eligible	Vision	Employee
The Standard	Employee	M	04/16/1967	32025		Full Time Eligible	Dental	Employee
The Standard	Employee	M	04/16/1967	32025		Full Time Eligible	Vision	Employee
The Standard	Employee	F	02/02/1958	32024		Retiree	Dental	Employee
The Standard	Employee	F	02/02/1958	32024		Retiree	Vision	Employee
The Standard	Employee	M	09/16/1958	32060-6673	Suwannee County	Retiree	Dental	Employee
The Standard	Employee	M	02/07/1958	32024-4082	Columbia County	Retiree	Dental	Employee + One
The Standard	Spouse	F	11/11/1958	32024-4082	Columbia County	Retiree	Dental	Employee + One
The Standard	Employee	M	08/15/1957	32024-3391	Columbia County	Full Time Eligible	Dental	Employee
The Standard	Employee	M	08/15/1957	32024-3391	Columbia County	Full Time Eligible	Vision	Employee
The Standard	Employee	F	02/03/1958	32071-0209	Suwannee County	Retiree	Dental	Employee + One
The Standard	Spouse	M	08/25/1942	32071-0209	Suwannee County	Retiree	Dental	Employee + One
The Standard	Employee	M	05/20/1957	32024		Retiree	Vision	Employee
The Standard	Employee	M	07/05/1970	32071-4423	Suwannee County	Full Time Eligible	Dental	Employee
The Standard	Employee	M	07/05/1970	32071-4423	Suwannee County	Full Time Eligible	Vision	Employee
The Standard	Employee	M	05/09/1959	32055		Retiree	Dental	Employee
The Standard	Employee	M	05/09/1959	32055		Retiree	Vision	Employee
The Standard	Employee	F	02/18/1967	32038		Full Time Eligible	Dental	Employee + One
The Standard	Spouse	M	08/17/1965	32038		Full Time Eligible	Dental	Employee + One
The Standard	Employee	F	02/18/1967	32038		Full Time Eligible	Vision	Employee

The Standard Employee	M	02/03/1964	32038-3524	Columbia County	Full Time Eligible	Dental	Employee + One
The Standard Spouse	F	01/13/1963	32038-3524	Columbia County	Full Time Eligible	Dental	Employee + One
The Standard Employee	M	02/03/1964	32038-3524	Columbia County	Full Time Eligible	Vision	Employee + Spouse
The Standard Spouse	F	01/13/1963	32038-3524	Columbia County	Full Time Eligible	Vision	Employee + Spouse
The Standard Employee	F	06/09/1960	32055-6305	Columbia County	Full Time Eligible	Dental	Employee + One
The Standard Spouse	M	01/12/1954	32055-6305	Columbia County	Full Time Eligible	Dental	Employee + One
The Standard Employee	F	06/09/1960	32055-6305	Columbia County	Full Time Eligible	Vision	Employee + Spouse
The Standard Spouse	M	01/12/1954	32055-6305	Columbia County	Full Time Eligible	Vision	Employee + Spouse
The Standard Employee	M	10/24/1959	32038		Full Time Eligible	Dental	Employee
The Standard Employee	M	10/24/1959	32038		Full Time Eligible	Vision	Employee
The Standard Employee	F	11/22/1970	32024		Full Time Eligible	Dental	Employee
The Standard Employee	F	11/22/1970	32024		Full Time Eligible	Vision	Employee
The Standard Employee	F	02/10/1947	32061	Columbia County	Retiree	Dental	Employee + One
The Standard Spouse	M	12/15/1943	32061	Columbia County	Retiree	Dental	Employee + One
The Standard Employee	F	05/07/1966	32055		Full Time Eligible	Dental	Employee
The Standard Employee	F	05/07/1966	32055		Full Time Eligible	Vision	Employee
The Standard Employee	F	12/25/1962	32056		Full Time Eligible	Dental	Employee
The Standard Employee	F	12/25/1962	32056		Full Time Eligible	Vision	Employee
The Standard Employee	F	11/26/1965	32071-4110	Suwannee County	Full Time Eligible	Dental	Employee
The Standard Employee	F	11/26/1965	32071-4110	Suwannee County	Full Time Eligible	Vision	Employee
The Standard Employee	M	03/26/1976	32024		Full Time Eligible	Dental	Employee
The Standard Employee	M	03/26/1976	32024		Full Time Eligible	Vision	Employee + Child(ren)
The Standard Child	M	06/05/2012	32024		Full Time Eligible	Vision	Employee + Child(ren)
The Standard Child	M	12/09/2008	32024		Full Time Eligible	Vision	Employee + Child(ren)
The Standard Employee	M	10/11/1971	32025		Full Time Eligible	Dental	Employee
The Standard Employee	M	10/11/1971	32025		Full Time Eligible	Vision	Employee
The Standard Employee	M	08/20/1964	32096-2102	Hamilton County	Full Time Eligible	Dental	Employee + Family
The Standard Spouse	F	12/06/1971	32096-2102	Hamilton County	Full Time Eligible	Dental	Employee + Family
The Standard Child	F	03/24/2003	32096-2102	Hamilton County	Full Time Eligible	Dental	Employee + Family
The Standard Child	M	06/30/2004	32096-2102	Hamilton County	Full Time Eligible	Dental	Employee + Family
The Standard Child	F	02/09/2006	32096-2102	Hamilton County	Full Time Eligible	Dental	Employee + Family
The Standard Employee	M	08/20/1964	32096-2102	Hamilton County	Full Time Eligible	Vision	Employee + Family
The Standard Spouse	F	12/06/1971	32096-2102	Hamilton County	Full Time Eligible	Vision	Employee + Family
The Standard Child	M	06/30/2004	32096-2102	Hamilton County	Full Time Eligible	Vision	Employee + Family
The Standard Child	F	02/09/2006	32096-2102	Hamilton County	Full Time Eligible	Vision	Employee + Family
The Standard Child	F	03/24/2003	32096-2102	Hamilton County	Full Time Eligible	Vision	Employee + Family
The Standard Employee	F	03/12/1964	32056		Full Time Eligible	Dental	Employee
The Standard Employee	F	03/12/1964	32056		Full Time Eligible	Vision	Employee
The Standard Employee	F	11/22/1964	32025		Full Time Eligible	Dental	Employee
The Standard Child	M	09/06/2003	32025		Full Time Eligible	Dental	Employee
The Standard Employee	F	11/22/1964	32025		Full Time Eligible	Vision	Employee
The Standard Employee	M	03/16/1974	32094		Full Time Eligible	Dental	Employee
The Standard Employee	M	03/16/1974	32094		Full Time Eligible	Vision	Employee
The Standard Employee	M	05/07/1955	32055		Full Time Eligible	Dental	Employee
The Standard Employee	M	05/07/1955	32055		Full Time Eligible	Vision	Employee
The Standard Employee	F	08/14/1957	32060-7114	Suwannee County	Retiree	Dental	Employee + One
The Standard Spouse	M	06/11/1955	32060-7114	Suwannee County	Retiree	Dental	Employee + One
The Standard Employee	F	08/14/1957	32060-7114	Suwannee County	Retiree	Vision	Employee + Spouse
The Standard Spouse	M	06/11/1955	32060-7114	Suwannee County	Retiree	Vision	Employee + Spouse
The Standard Employee	F	11/19/1959	32025-4603	Columbia County	Retiree	Dental	Employee + One
The Standard Spouse	M	02/03/1958	32025-4603	Columbia County	Retiree	Dental	Employee + One
The Standard Employee	F	11/19/1959	32025-4603	Columbia County	Retiree	Vision	Employee + Spouse
The Standard Spouse	M	02/03/1958	32025-4603	Columbia County	Retiree	Vision	Employee + Spouse
The Standard Employee	M	01/06/1961	32055		Full Time Eligible	Dental	Employee
The Standard Employee	M	01/06/1961	32055		Full Time Eligible	Vision	Employee
The Standard Employee	F	01/23/1961	32055-1851	Columbia County	Retiree	Dental	Employee
The Standard Employee	F	01/23/1961	32055-1851	Columbia County	Retiree	Vision	Employee
The Standard Employee	F	10/20/1967	32055-5519	Columbia County	Retiree	Dental	Employee
The Standard Employee	F	10/20/1967	32055-5519	Columbia County	Retiree	Vision	Employee
The Standard Employee	M	10/07/1960	32025		Full Time Eligible	Dental	Employee
The Standard Employee	M	10/07/1960	32025		Full Time Eligible	Vision	Employee
The Standard Employee	M	10/12/1974	32055		Full Time Eligible	Dental	Employee
The Standard Employee	M	10/12/1974	32055		Full Time Eligible	Vision	Employee
The Standard Employee	M	05/20/1972	32055-5728	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	M	05/20/1972	32055-5728	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	F	01/07/1968	32025		Full Time Eligible	Dental	Employee
The Standard Employee	F	01/07/1968	32025		Full Time Eligible	Vision	Employee
The Standard Employee	M	07/14/1970	32025		Full Time Eligible	Dental	Employee
The Standard Employee	M	07/14/1970	32025		Full Time Eligible	Vision	Employee
The Standard Employee	M	03/28/1964	32055		Full Time Eligible	Dental	Employee + Family
The Standard Spouse	F	01/18/1974	32055		Full Time Eligible	Dental	Employee + Family
The Standard Child	M	12/20/2011	32055		Full Time Eligible	Dental	Employee + Family
The Standard Employee	M	03/28/1964	32055		Full Time Eligible	Vision	Employee + Family
The Standard Spouse	F	01/18/1974	32055		Full Time Eligible	Vision	Employee + Family
The Standard Child	M	12/20/2011	32055		Full Time Eligible	Vision	Employee + Family
The Standard Employee	F	04/26/1963	32024		Full Time Eligible	Dental	Employee + One
The Standard Spouse	M	11/06/1960	32024		Full Time Eligible	Dental	Employee + One
The Standard Employee	F	04/26/1963	32024		Full Time Eligible	Vision	Employee + Spouse
The Standard Spouse	M	11/06/1960	32024		Full Time Eligible	Vision	Employee + Spouse
The Standard Employee	M	01/19/1964	32055-5165	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	M	01/19/1964	32055-5165	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	F	10/20/1950	32025-7348	Columbia County	Retiree	Dental	Employee
The Standard Employee	F	02/24/1964	32055		Full Time Eligible	Dental	Employee
The Standard Employee	F	02/24/1964	32055		Full Time Eligible	Vision	Employee
The Standard Employee	F	04/04/1965	32038		Full Time Eligible	Dental	Employee
The Standard Employee	F	04/04/1965	32038		Full Time Eligible	Vision	Employee
The Standard Employee	M	11/08/1958	32024		Full Time Eligible	Dental	Employee
The Standard Employee	M	11/08/1958	32024		Full Time Eligible	Vision	Employee
The Standard Employee	F	02/03/1956	32025		Full Time Eligible	Dental	Employee
The Standard Employee	F	02/03/1956	32025		Full Time Eligible	Vision	Employee
The Standard Employee	F	05/13/1955	32055-8645	Columbia County	Retiree	Dental	Employee + One
The Standard Spouse	M	06/15/1954	32055-8645	Columbia County	Retiree	Dental	Employee + One
The Standard Employee	M	11/21/1966	32024		Full Time Eligible	Dental	Employee

The Standard Employee	M	11/21/1966	32024		Full Time Eligible	Vision	Employee
The Standard Employee	M	05/09/1962	32024		Full Time Eligible	Dental	Employee
The Standard Employee	F	09/09/1957	32056		Full Time Eligible	Dental	Employee + One
The Standard Child	F	07/25/1997	32056		Full Time Eligible	Dental	Employee + One
The Standard Employee	F	09/09/1957	32056		Full Time Eligible	Vision	Employee
The Standard Employee	M	01/14/1956	32025-3118	Columbia County	Retiree	Dental	Employee + One
The Standard Spouse	F	10/31/1958	32025-3118	Columbia County	Retiree	Dental	Employee + One
The Standard Employee	M	01/14/1956	32025-3118	Columbia County	Retiree	Vision	Employee + Spouse
The Standard Spouse	F	10/31/1958	32025-3118	Columbia County	Retiree	Vision	Employee + Spouse
The Standard Employee	M	03/02/1964	32094		Full Time Eligible	Dental	Employee + One
The Standard Spouse	F	02/01/1969	32094		Full Time Eligible	Dental	Employee + One
The Standard Employee	M	03/02/1964	32094		Full Time Eligible	Vision	Employee + Spouse
The Standard Spouse	F	02/01/1969	32094		Full Time Eligible	Vision	Employee + Spouse
The Standard Employee	M	06/24/1963	32055		Full Time Eligible	Dental	Employee
The Standard Employee	M	06/24/1963	32055		Full Time Eligible	Vision	Employee
The Standard Employee	F	06/26/1976	32060		Full Time Eligible	Dental	Employee + One
The Standard Spouse	M	02/03/1977	32060		Full Time Eligible	Dental	Employee + One
The Standard Employee	F	06/26/1976	32060		Full Time Eligible	Vision	Employee + Spouse
The Standard Spouse	M	02/03/1977	32060		Full Time Eligible	Vision	Employee + Spouse
The Standard Employee	F	10/13/1973	32025-8269	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	F	10/13/1973	32025-8269	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	F	05/17/1963	32038-4405	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	F	05/17/1963	32038-4405	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	F	12/30/1963	32024-3775	Columbia County	Retiree	Dental	Employee
The Standard Employee	F	12/30/1963	32024-3775	Columbia County	Retiree	Vision	Employee
The Standard Employee	F	02/14/1964	32055		Retiree	Dental	Employee
The Standard Employee	F	02/14/1964	32055		Retiree	Vision	Employee
The Standard Employee	M	07/27/1976	32643-6001	Gilchrist County	Full Time Eligible	Dental	Employee
The Standard Employee	M	07/27/1976	32643-6001	Gilchrist County	Full Time Eligible	Vision	Employee
The Standard Employee	M	08/05/1963	32025		Full Time Eligible	Dental	Employee
The Standard Employee	M	08/05/1963	32025		Full Time Eligible	Vision	Employee
The Standard Employee	F	09/04/1971	32063-5219	Baker County	Full Time Eligible	Dental	Employee + Family
The Standard Spouse	M	10/16/1973	32063-5219	Baker County	Full Time Eligible	Dental	Employee + Family
The Standard Child	M	11/27/2001	32063-5219	Baker County	Full Time Eligible	Dental	Employee + Family
The Standard Child	F	08/24/2004	32063-5219	Baker County	Full Time Eligible	Dental	Employee + Family
The Standard Employee	F	09/04/1971	32063-5219	Baker County	Full Time Eligible	Vision	Employee + Family
The Standard Spouse	M	10/16/1973	32063-5219	Baker County	Full Time Eligible	Vision	Employee + Family
The Standard Child	F	08/24/2004	32063-5219	Baker County	Full Time Eligible	Vision	Employee + Family
The Standard Child	M	11/27/2001	32063-5219	Baker County	Full Time Eligible	Vision	Employee + Family
The Standard Employee	F	06/18/1955	32024-5349	Columbia County	Retiree	Dental	Employee + One
The Standard Spouse	M	12/09/1954	32024-5349	Columbia County	Retiree	Dental	Employee + One
The Standard Employee	M	12/16/1958	32054		Full Time Eligible	Dental	Employee
The Standard Employee	M	12/16/1958	32054		Full Time Eligible	Vision	Employee
The Standard Employee	M	10/11/1967	32056		Full Time Eligible	Dental	Employee + One
The Standard Child	F	06/16/2005	32056		Full Time Eligible	Dental	Employee + One
The Standard Employee	M	10/11/1967	32056		Full Time Eligible	Vision	Employee
The Standard Employee	M	10/01/1956	32038		Full Time Eligible	Dental	Employee
The Standard Employee	M	10/01/1956	32038		Full Time Eligible	Vision	Employee
The Standard Employee	M	04/18/1972	32055-8908	Columbia County	Full Time Eligible	Dental	Employee + One
The Standard Spouse	F	04/03/1966	32055-8908	Columbia County	Full Time Eligible	Dental	Employee + One
The Standard Employee	M	04/18/1972	32055-8908	Columbia County	Full Time Eligible	Vision	Employee + Spouse
The Standard Spouse	F	04/03/1966	32055-8908	Columbia County	Full Time Eligible	Vision	Employee + Spouse
The Standard Employee	F	02/23/1968	32038		Full Time Eligible	Dental	Employee
The Standard Employee	F	02/23/1968	32038		Full Time Eligible	Vision	Employee
The Standard Employee	F	04/28/1962	32025-6803	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	F	04/28/1962	32025-6803	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	M	11/24/1961	32061		Full Time Eligible	Dental	Employee
The Standard Employee	M	11/24/1961	32061		Full Time Eligible	Vision	Employee
The Standard Employee	M	08/31/1972	32055		Full Time Eligible	Dental	Employee + One
The Standard Child	M	10/07/2011	32055		Full Time Eligible	Dental	Employee + One
The Standard Employee	M	08/31/1972	32055		Full Time Eligible	Vision	Employee
The Standard Employee	F	02/14/1963	32060-8145	Suwannee County	Full Time Eligible	Dental	Employee
The Standard Employee	F	02/14/1963	32060-8145	Suwannee County	Full Time Eligible	Vision	Employee
The Standard Employee	F	08/11/1968	32024-6303	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	F	08/11/1968	32024-6303	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	M	09/26/1978	32055		Full Time Eligible	Dental	Employee + One
The Standard Spouse	F	12/31/1969	32055		Full Time Eligible	Dental	Employee + One
The Standard Employee	M	09/26/1978	32055		Full Time Eligible	Vision	Employee + Spouse
The Standard Spouse	F	12/31/1969	32055		Full Time Eligible	Vision	Employee + Spouse
The Standard Employee	M	05/03/1966	32024-4383	Columbia County	Full Time Eligible	Dental	Employee + One
The Standard Spouse	F	12/11/1962	32024-4383	Columbia County	Full Time Eligible	Dental	Employee + One
The Standard Employee	M	05/03/1966	32024-4383	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	F	11/19/1966	32025		Full Time Eligible	Dental	Employee
The Standard Employee	F	11/19/1966	32025		Full Time Eligible	Vision	Employee
The Standard Employee	M	05/27/1976	32025-5982	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	M	05/27/1976	32025-5982	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	M	09/17/1954	32055-1411	Columbia County	Retiree	Dental	Employee
The Standard Employee	M	07/26/1954	32025-3199	Columbia County	Retiree	Dental	Employee
The Standard Employee	M	07/26/1954	32025-3199	Columbia County	Retiree	Vision	Employee
The Standard Employee	M	12/19/1956	32038-6613	Columbia County	Retiree	Dental	Employee
The Standard Employee	M	12/19/1956	32038-6613	Columbia County	Retiree	Vision	Employee
The Standard Employee	F	01/30/1962	32025		Full Time Eligible	Dental	Employee + One
The Standard Spouse	M	09/01/1961	32025		Full Time Eligible	Dental	Employee + One
The Standard Employee	F	01/30/1962	32025		Full Time Eligible	Vision	Employee + Spouse
The Standard Spouse	M	09/01/1961	32025		Full Time Eligible	Vision	Employee + Spouse
The Standard Employee	F	11/02/1959	32246-1387	Duval County	Retiree	Dental	Employee + One
The Standard Spouse	M	12/25/1952	32246-1387	Duval County	Retiree	Dental	Employee + One
The Standard Employee	F	11/02/1959	32246-1387	Duval County	Retiree	Vision	Employee + Spouse
The Standard Spouse	M	12/25/1952	32246-1387	Duval County	Retiree	Vision	Employee + Spouse
The Standard Employee	F	01/23/1968	32025-6224	Columbia County	Retiree	Dental	Employee
The Standard Employee	M	11/30/1960	32055		Full Time Eligible	Dental	Employee + One
The Standard Spouse	F	08/19/1953	32055		Full Time Eligible	Dental	Employee + One
The Standard Employee	M	11/30/1960	32055		Full Time Eligible	Vision	Employee + Spouse



The Standard Spouse	M	09/11/1962	32025		Full Time Eligible	Dental	Employee + One
The Standard Employee	F	05/20/1964	32025		Full Time Eligible	Vision	Employee + Spouse
The Standard Spouse	M	09/11/1962	32025		Full Time Eligible	Vision	Employee + Spouse
The Standard Employee	F	02/09/1971	32025		Full Time Eligible	Dental	Employee + Family
The Standard Spouse	M	05/11/1973	32025		Full Time Eligible	Dental	Employee + Family
The Standard Child	F	11/26/2000	32025		Full Time Eligible	Dental	Employee + Family
The Standard Child	F	03/10/2005	32025		Full Time Eligible	Dental	Employee + Family
The Standard Employee	F	02/09/1971	32025		Full Time Eligible	Vision	Employee
The Standard Employee	M	12/04/1992	32025-3917	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	M	12/04/1992	32025-3917	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	M	04/09/1993	32055		Full Time Eligible	Dental	Employee
The Standard Employee	M	04/09/1993	32055		Full Time Eligible	Vision	Employee
The Standard Employee	M	09/03/1965	32055		Full Time Eligible	Dental	Employee + One
The Standard Spouse	F	07/25/1951	32055		Full Time Eligible	Dental	Employee + One
The Standard Employee	M	09/03/1965	32055		Full Time Eligible	Vision	Employee
The Standard Employee	F	06/22/1961	32024		Full Time Eligible	Dental	Employee
The Standard Employee	F	06/22/1961	32024		Full Time Eligible	Vision	Employee
The Standard Employee	M	02/27/1977	32094-2916	Suwannee County	Full Time Eligible	Dental	Employee
The Standard Employee	M	02/27/1977	32094-2916	Suwannee County	Full Time Eligible	Vision	Employee
The Standard Employee	M	10/02/1960	32024		Retiree	Dental	Employee + One
The Standard Spouse	F	06/09/1960	32024		Retiree	Dental	Employee + One
The Standard Employee	M	10/02/1960	32024		Retiree	Vision	Employee + Spouse
The Standard Spouse	F	06/09/1960	32024		Retiree	Vision	Employee + Spouse
The Standard Employee	F	12/15/1965	32062-2535	Suwannee County	Full Time Eligible	Dental	Employee
The Standard Employee	F	12/15/1965	32062-2535	Suwannee County	Full Time Eligible	Vision	Employee
The Standard Employee	M	12/18/1960	32025-5022	Columbia County	Full Time Eligible	Dental	Employee + One
The Standard Spouse	F	08/09/1962	32025-5022	Columbia County	Full Time Eligible	Dental	Employee + One
The Standard Employee	M	12/18/1960	32025-5022	Columbia County	Full Time Eligible	Vision	Employee + Spouse
The Standard Spouse	F	08/09/1962	32025-5022	Columbia County	Full Time Eligible	Vision	Employee + Spouse
The Standard Employee	F	10/26/1971	32038	Columbia County	Full Time Eligible	Dental	Employee + One
The Standard Spouse	M	08/17/1959	32038	Columbia County	Full Time Eligible	Dental	Employee + One
The Standard Employee	F	10/26/1971	32038	Columbia County	Full Time Eligible	Vision	Employee + Spouse
The Standard Spouse	M	08/17/1959	32038	Columbia County	Full Time Eligible	Vision	Employee + Spouse
The Standard Employee	M	11/04/1953	32340-3558	Madison County	Full Time Eligible	Dental	Employee + Family
The Standard Spouse	F	04/17/1955	32340-3558	Madison County	Full Time Eligible	Dental	Employee + Family
The Standard Child	M	08/13/2001	32340-3558	Madison County	Full Time Eligible	Dental	Employee + Family
The Standard Employee	M	11/04/1953	32340-3558	Madison County	Full Time Eligible	Vision	Employee + Family
The Standard Spouse	F	04/17/1955	32340-3558	Madison County	Full Time Eligible	Vision	Employee + Family
The Standard Child	M	08/13/2001	32340-3558	Madison County	Full Time Eligible	Vision	Employee + Family
The Standard Employee	M	12/29/1977	32055-8667	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	M	12/29/1977	32055-8667	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	M	09/22/1967	32038-4274	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	M	09/22/1967	32038-4274	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	M	03/17/1992	32025-1890	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	M	03/17/1992	32025-1890	Columbia County	Full Time Eligible	Vision	Employee + Family
The Standard Spouse	F	11/30/1981	32025-1890	Columbia County	Full Time Eligible	Vision	Employee + Family
The Standard Child	F	08/19/2021	32025-1890	Columbia County	Full Time Eligible	Vision	Employee + Family
The Standard Employee	F	01/09/1989	32094-5049	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	F	01/09/1989	32094-5049	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	M	01/16/1973	32055		Full Time Eligible	Dental	Employee + One
The Standard Spouse	F	07/02/1981	32055		Full Time Eligible	Dental	Employee + One
The Standard Employee	M	01/16/1973	32055		Full Time Eligible	Vision	Employee + Spouse
The Standard Spouse	F	07/02/1981	32055		Full Time Eligible	Vision	Employee + Spouse
The Standard Employee	M	08/31/1993	32025-5671	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	M	08/31/1993	32025-5671	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	F	04/19/1973	32024-0379	Columbia County	Full Time Eligible	Vision	Employee + Family
The Standard Spouse	M	08/20/1964	32024-0379	Columbia County	Full Time Eligible	Vision	Employee + Family
The Standard Child	M	03/22/2002	32024-0379	Columbia County	Full Time Eligible	Vision	Employee + Family
The Standard Child	M	09/10/2003	32024-0379	Columbia County	Full Time Eligible	Vision	Employee + Family
The Standard Employee	M	08/07/1995	32094-2570	Suwannee County	Full Time Eligible	Dental	Employee
The Standard Employee	M	08/07/1995	32094-2570	Suwannee County	Full Time Eligible	Vision	Employee
The Standard Employee	M	10/06/1997	32025-0216	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	M	10/06/1997	32025-0216	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	M	08/02/1993	32025-1816	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	M	08/02/1993	32025-1816	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	F	03/01/1967	32060		Full Time Eligible	Dental	Employee + One
The Standard Spouse	M	08/21/1967	32060		Full Time Eligible	Dental	Employee + One
The Standard Employee	F	03/01/1967	32060		Full Time Eligible	Vision	Employee + Spouse
The Standard Spouse	M	08/21/1967	32060		Full Time Eligible	Vision	Employee + Spouse
The Standard Employee	F	04/29/1997	32025-1795	Columbia County	Ineligible	Dental	Employee
The Standard Employee	F	04/29/1997	32025-1795	Columbia County	Ineligible	Vision	Employee
The Standard Employee	M	09/30/1981	32024		Full Time Eligible	Dental	Employee
The Standard Employee	M	09/30/1981	32024		Full Time Eligible	Vision	Employee
The Standard Employee	M	03/20/2000	32025-3897	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	M	03/20/2000	32025-3897	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	F	06/15/1972	32055		Full Time Eligible	Dental	Employee
The Standard Employee	F	06/15/1972	32055		Full Time Eligible	Vision	Employee
The Standard Employee	M	03/17/1971	32055		Full Time Eligible	Dental	Employee + One
The Standard Spouse	F	09/12/1970	32055		Full Time Eligible	Dental	Employee + One
The Standard Employee	F	05/09/1971	32025-0464	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	F	05/09/1971	32025-0464	Columbia County	Full Time Eligible	Vision	Employee + Child(ren)
The Standard Child	M	12/26/2003	32025-0464	Columbia County	Full Time Eligible	Vision	Employee + Child(ren)
The Standard Employee	M	03/30/1991	32024-3127	Suwannee County	Full Time Eligible	Dental	Employee + Family
The Standard Spouse	F	07/03/1988	32024-3127	Suwannee County	Full Time Eligible	Dental	Employee + Family
The Standard Child	M	08/23/2018	32024-3127	Suwannee County	Full Time Eligible	Dental	Employee + Family
The Standard Child	M	12/17/2014	32024-3127	Suwannee County	Full Time Eligible	Dental	Employee + Family
The Standard Employee	F	03/21/1976	32025		Full Time Eligible	Dental	Employee
The Standard Employee	F	03/21/1976	32025		Full Time Eligible	Vision	Employee
The Standard Employee	M	11/08/1967	32025-1900	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	M	11/08/1967	32025-1900	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	F	08/25/1953	32025-3951	Columbia County	Retiree	Dental	Employee
The Standard Employee	M	05/30/1983	32217-3646	Duval County	Full Time Eligible	Dental	Employee
The Standard Employee	M	05/30/1983	32217-3646	Duval County	Full Time Eligible	Vision	Employee

The Standard Employee	F	03/18/1998	32025-6296	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	F	03/18/1998	32025-6296	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	F	10/04/1984	32055-5138	Columbia County	Full Time Eligible	Dental	Employee + One
The Standard Child	M	03/22/2008	32055-5138	Columbia County	Full Time Eligible	Dental	Employee + One
The Standard Employee	F	10/04/1984	32055-5138	Columbia County	Full Time Eligible	Vision	Employee + Child(ren)
The Standard Child	M	03/22/2008	32055-5138	Columbia County	Full Time Eligible	Vision	Employee + Child(ren)
The Standard Employee	F	05/02/1966	32024		Full Time Eligible	Dental	Employee
The Standard Employee	F	05/02/1966	32024		Full Time Eligible	Vision	Employee
The Standard Employee	M	11/08/1958	32024		Full Time Eligible	Dental	Employee
The Standard Employee	M	11/08/1958	32024		Full Time Eligible	Vision	Employee
The Standard Employee	M	07/04/1991	32025		Full Time Eligible	Dental	Employee
The Standard Employee	M	07/04/1991	32025		Full Time Eligible	Vision	Employee
The Standard Employee	F	07/27/1975	32024-2647	Suwannee County	Full Time Eligible	Dental	Employee
The Standard Employee	F	07/27/1975	32024-2647	Suwannee County	Full Time Eligible	Vision	Employee
The Standard Employee	F	07/18/1987	32055-4951	Columbia County	Full Time Eligible	Dental	Employee + One
The Standard Child	F	07/25/2006	32055-4951	Columbia County	Full Time Eligible	Dental	Employee + One
The Standard Employee	F	07/18/1987	32055-4951	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	M	05/26/1979	32071-1848	Suwannee County	Full Time Eligible	Dental	Employee
The Standard Employee	M	05/26/1979	32071-1848	Suwannee County	Full Time Eligible	Vision	Employee
The Standard Employee	M	06/04/1992	32025-4892	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	M	06/04/1992	32025-4892	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	F	10/03/1990	32025-5675	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	F	10/03/1990	32025-5675	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	F	11/08/1958	32024-4583	Columbia County	Retiree	Dental	Employee
The Standard Employee	F	11/08/1958	32024-4583	Columbia County	Retiree	Vision	Employee
The Standard Employee	M	02/14/1966	32024		Full Time Eligible	Dental	Employee + One
The Standard Spouse	F	09/15/1974	32024		Full Time Eligible	Dental	Employee + One
The Standard Employee	M	02/14/1966	32024		Full Time Eligible	Vision	Employee + Spouse
The Standard Spouse	F	09/15/1974	32024		Full Time Eligible	Vision	Employee + Spouse
The Standard Employee	F	05/13/1989	32024		Full Time Eligible	Dental	Employee + One
The Standard Child	F	06/10/2011	32024		Full Time Eligible	Dental	Employee + One
The Standard Employee	F	05/13/1989	32024		Full Time Eligible	Vision	Employee
The Standard Employee	M	07/23/1989	32024		Full Time Eligible	Dental	Employee
The Standard Employee	M	07/23/1989	32024		Full Time Eligible	Vision	Employee
The Standard Employee	F	11/18/1959	32025		Retiree	Dental	Employee
The Standard Employee	F	11/18/1959	32025		Retiree	Vision	Employee
The Standard Employee	M	01/14/1991	32024		Full Time Eligible	Dental	Employee
The Standard Employee	M	01/14/1991	32024		Full Time Eligible	Vision	Employee
The Standard Employee	M	12/16/1968	32055		Full Time Eligible	Dental	Employee
The Standard Employee	M	12/16/1968	32055		Full Time Eligible	Vision	Employee
The Standard Employee	M	10/24/1977	32055-9282	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	M	10/24/1977	32055-9282	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	F	03/06/1967	32025		Full Time Eligible	Dental	Employee + One
The Standard Spouse	M	04/09/1966	32025		Full Time Eligible	Dental	Employee + One
The Standard Employee	F	03/06/1967	32025		Full Time Eligible	Vision	Employee + Spouse
The Standard Spouse	M	04/09/1966	32025		Full Time Eligible	Vision	Employee + Spouse
The Standard Employee	F	12/09/1987	32055		Ineligible	Dental	Employee + Family
The Standard Spouse	M	02/17/1982	32055		Ineligible	Dental	Employee + Family
The Standard Child	M	07/31/2013	32055		Ineligible	Dental	Employee + Family
The Standard Child	F	11/10/2009	32055		Ineligible	Dental	Employee + Family
The Standard Employee	F	12/09/1987	32055		Ineligible	Vision	Employee
The Standard Employee	M	01/25/1972	32063		Full Time Eligible	Dental	Employee + Family
The Standard Spouse	F	11/17/1983	32063		Full Time Eligible	Dental	Employee + Family
The Standard Child	M	10/05/2004	32063		Full Time Eligible	Dental	Employee + Family
The Standard Child	M	06/22/2006	32063		Full Time Eligible	Dental	Employee + Family
The Standard Child	F	11/20/2008	32063		Full Time Eligible	Dental	Employee + Family
The Standard Employee	M	01/25/1972	32063		Full Time Eligible	Vision	Employee + Family
The Standard Spouse	F	11/17/1983	32063		Full Time Eligible	Vision	Employee + Family
The Standard Child	M	06/22/2006	32063		Full Time Eligible	Vision	Employee + Family
The Standard Child	M	10/05/2004	32063		Full Time Eligible	Vision	Employee + Family
The Standard Child	F	11/20/2008	32063		Full Time Eligible	Vision	Employee + Family
The Standard Employee	M	11/27/1975	32024		Full Time Eligible	Dental	Employee
The Standard Employee	M	11/27/1975	32024		Full Time Eligible	Vision	Employee
The Standard Employee	F	10/03/1984	32025		Full Time Eligible	Dental	Employee + Family
The Standard Child	M	04/23/2008	32025		Full Time Eligible	Dental	Employee + Family
The Standard Child	F	10/02/2011	32025		Full Time Eligible	Dental	Employee + Family
The Standard Employee	M	05/29/1985	32055		Full Time Eligible	Dental	Employee
The Standard Employee	M	05/29/1985	32055		Full Time Eligible	Vision	Employee
The Standard Employee	F	11/28/1968	32025		Full Time Eligible	Dental	Employee
The Standard Employee	F	11/28/1968	32025		Full Time Eligible	Vision	Employee
The Standard Employee	F	08/26/1967	32054		Full Time Eligible	Dental	Employee
The Standard Employee	F	08/26/1967	32054		Full Time Eligible	Vision	Employee
The Standard Employee	M	06/13/1986	32233-6946	Duval County	Full Time Eligible	Dental	Employee
The Standard Employee	M	06/13/1986	32233-6946	Duval County	Full Time Eligible	Vision	Employee
The Standard Employee	M	01/21/1979	32055	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	M	01/21/1979	32055	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	F	03/19/1984	32055		Full Time Eligible	Dental	Employee + One
The Standard Spouse	M	06/20/1982	32055		Full Time Eligible	Dental	Employee + One
The Standard Employee	F	03/19/1984	32055		Full Time Eligible	Vision	Employee + Spouse
The Standard Spouse	M	06/20/1982	32055		Full Time Eligible	Vision	Employee + Spouse
The Standard Employee	M	03/22/1995	32025-1684	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	M	03/22/1995	32025-1684	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	F	01/05/1973	32008-2962	Suwannee County	Full Time Eligible	Dental	Employee
The Standard Employee	F	01/05/1973	32008-2962	Suwannee County	Full Time Eligible	Vision	Employee
The Standard Employee	M	10/06/1979	32055		Full Time Eligible	Dental	Employee
The Standard Employee	M	10/06/1979	32055		Full Time Eligible	Vision	Employee
The Standard Employee	F	04/04/1979	32055		Full Time Eligible	Dental	Employee + One
The Standard Child	F	03/12/2006	32055		Full Time Eligible	Dental	Employee + One
The Standard Employee	F	04/04/1979	32055		Full Time Eligible	Vision	Employee
The Standard Employee	F	06/15/1986	32054-7981	Union County	Full Time Eligible	Dental	Employee
The Standard Employee	F	06/15/1986	32054-7981	Union County	Full Time Eligible	Vision	Employee
The Standard Employee	F	10/18/1978	32024		Full Time Eligible	Dental	Employee + Family
The Standard Spouse	M	03/17/1972	32024		Full Time Eligible	Dental	Employee + Family

The Standard	Child	F	06/13/2000	32024		Full Time Eligible	Dental	Employee + Family
The Standard	Employee	F	10/18/1978	32024		Full Time Eligible	Vision	Employee + Family
The Standard	Spouse	M	03/17/1972	32024		Full Time Eligible	Vision	Employee + Family
The Standard	Child	F	06/13/2000	32024		Full Time Eligible	Vision	Employee + Family
The Standard	Employee	M	02/20/1998	32038		Full Time Eligible	Dental	Employee
The Standard	Employee	M	02/20/1998	32038		Full Time Eligible	Vision	Employee
The Standard	Employee	F	02/10/1998	32024-1695	Columbia County	Full Time Eligible	Dental	Employee + One
The Standard	Spouse	M	10/28/1994	32024-1695	Columbia County	Full Time Eligible	Dental	Employee + One
The Standard	Employee	F	02/10/1998	32024-1695	Columbia County	Full Time Eligible	Vision	Employee + Spouse
The Standard	Spouse	M	10/28/1994	32024-1695	Columbia County	Full Time Eligible	Vision	Employee + Spouse
The Standard	Employee	M	01/29/1986	32024		Full Time Eligible	Dental	Employee + Family
The Standard	Spouse	F	05/28/1989	32024		Full Time Eligible	Dental	Employee + Family
The Standard	Child	F	06/25/2018	32024		Full Time Eligible	Dental	Employee + Family
The Standard	Child	M	04/03/2025	32024		Full Time Eligible	Dental	Employee + Family
The Standard	Employee	M	01/29/1986	32024		Full Time Eligible	Vision	Employee + Family
The Standard	Spouse	F	05/28/1989	32024		Full Time Eligible	Vision	Employee + Family
The Standard	Child	M	04/03/2025	32024		Full Time Eligible	Vision	Employee + Family
The Standard	Child	F	06/25/2018	32024		Full Time Eligible	Vision	Employee + Family
The Standard	Employee	M	12/13/1983	32025		Full Time Eligible	Dental	Employee
The Standard	Employee	M	12/13/1983	32025		Full Time Eligible	Vision	Employee
The Standard	Employee	F	10/30/1979	32024-0832	Columbia County	Full Time Eligible	Dental	Employee
The Standard	Employee	F	10/30/1979	32024-0832	Columbia County	Full Time Eligible	Vision	Employee
The Standard	Employee	M	02/15/1989	32680	Dixie County	Full Time Eligible	Dental	Employee
The Standard	Employee	M	02/15/1989	32680	Dixie County	Full Time Eligible	Vision	Employee
The Standard	Employee	F	02/01/1989	32025		Full Time Eligible	Dental	Employee + One
The Standard	Child	F	09/03/2010	32025		Full Time Eligible	Dental	Employee + One
The Standard	Employee	F	02/01/1989	32025		Full Time Eligible	Vision	Employee
The Standard	Employee	M	08/11/1999	32055		Full Time Eligible	Dental	Employee
The Standard	Employee	M	08/11/1999	32055		Full Time Eligible	Vision	Employee
The Standard	Employee	M	04/02/1985	32643		Full Time Eligible	Dental	Employee + Family
The Standard	Spouse	F	12/31/1989	32643		Full Time Eligible	Dental	Employee + Family
The Standard	Child	F	02/15/2023	32643		Full Time Eligible	Dental	Employee + Family
The Standard	Employee	M	04/02/1985	32643		Full Time Eligible	Vision	Employee
The Standard	Employee	M	01/03/2000	32055-6726	Columbia County	Full Time Eligible	Dental	Employee
The Standard	Employee	M	01/03/2000	32055-6726	Columbia County	Full Time Eligible	Vision	Employee
The Standard	Employee	F	01/27/2000	32025-7944	Columbia County	Full Time Eligible	Dental	Employee
The Standard	Employee	F	01/27/2000	32025-7944	Columbia County	Full Time Eligible	Vision	Employee
The Standard	Employee	M	12/06/1989	32024-2110	Suwannee County	Full Time Eligible	Dental	Employee
The Standard	Employee	M	12/06/1989	32024-2110	Suwannee County	Full Time Eligible	Vision	Employee
The Standard	Employee	M	01/11/1988	32055		Full Time Eligible	Dental	Employee + Family
The Standard	Spouse	F	05/15/1989	32055		Full Time Eligible	Dental	Employee + Family
The Standard	Child	M	04/17/2016	32055		Full Time Eligible	Dental	Employee + Family
The Standard	Child	F	02/10/2014	32055		Full Time Eligible	Dental	Employee + Family
The Standard	Child	M	08/02/2020	32055		Full Time Eligible	Dental	Employee + Family
The Standard	Employee	M	01/11/1988	32055		Full Time Eligible	Vision	Employee + Family
The Standard	Spouse	F	05/15/1989	32055		Full Time Eligible	Vision	Employee + Family
The Standard	Child	F	02/10/2014	32055		Full Time Eligible	Vision	Employee + Family
The Standard	Child	M	04/17/2016	32055		Full Time Eligible	Vision	Employee + Family
The Standard	Child	M	08/02/2020	32055		Full Time Eligible	Vision	Employee + Family
The Standard	Employee	M	07/07/1990	32060		Full Time Eligible	Dental	Employee
The Standard	Employee	M	07/07/1990	32060		Full Time Eligible	Vision	Employee
The Standard	Employee	F	05/01/1980	32060		Full Time Eligible	Dental	Employee
The Standard	Employee	F	05/01/1980	32060		Full Time Eligible	Vision	Employee
The Standard	Employee	F	05/04/1991	32096	Hamilton County	Full Time Eligible	Dental	Employee
The Standard	Employee	F	05/04/1991	32096	Hamilton County	Full Time Eligible	Vision	Employee
The Standard	Employee	M	05/10/1989	32025		Full Time Eligible	Dental	Employee
The Standard	Employee	M	08/20/1970	32024-4762	Columbia County	Full Time Eligible	Dental	Employee + One
The Standard	Spouse	F	10/19/1968	32024-4762	Columbia County	Full Time Eligible	Dental	Employee + One
The Standard	Employee	M	08/20/1970	32024-4762	Columbia County	Full Time Eligible	Vision	Employee + Spouse
The Standard	Spouse	F	10/19/1968	32024-4762	Columbia County	Full Time Eligible	Vision	Employee + Spouse
The Standard	Employee	M	03/15/1973	32024		Full Time Eligible	Dental	Employee + Family
The Standard	Spouse	F	02/19/1974	32024		Full Time Eligible	Dental	Employee + Family
The Standard	Child	M	08/08/2002	32024		Full Time Eligible	Dental	Employee + Family
The Standard	Child	M	02/09/2004	32024		Full Time Eligible	Dental	Employee + Family
The Standard	Employee	M	03/15/1973	32024		Full Time Eligible	Vision	Employee + Family
The Standard	Spouse	F	02/19/1974	32024		Full Time Eligible	Vision	Employee + Family
The Standard	Child	M	08/08/2002	32024		Full Time Eligible	Vision	Employee + Family
The Standard	Child	M	02/09/2004	32024		Full Time Eligible	Vision	Employee + Family
The Standard	Employee	F	07/24/1974	32055-5688	Columbia County	Full Time Eligible	Dental	Employee
The Standard	Employee	F	07/24/1974	32055-5688	Columbia County	Full Time Eligible	Vision	Employee
The Standard	Employee	M	10/15/1970	32024-0767	Columbia County	Full Time Eligible	Dental	Employee + One
The Standard	Spouse	F	01/21/1956	32024-0767	Columbia County	Full Time Eligible	Dental	Employee + One
The Standard	Employee	M	10/15/1970	32024-0767	Columbia County	Full Time Eligible	Vision	Employee
The Standard	Employee	M	03/22/1971	32024		Full Time Eligible	Dental	Employee
The Standard	Employee	M	03/22/1971	32024		Full Time Eligible	Vision	Employee
The Standard	Employee	M	06/29/1972	32024		Full Time Eligible	Dental	Employee + Family
The Standard	Spouse	F	09/29/1974	32024		Full Time Eligible	Dental	Employee + Family
The Standard	Child	M	07/02/2008	32024		Full Time Eligible	Dental	Employee + Family
The Standard	Employee	M	06/29/1972	32024		Full Time Eligible	Vision	Employee + Family
The Standard	Spouse	F	09/29/1974	32024		Full Time Eligible	Vision	Employee + Family
The Standard	Child	M	07/02/2008	32024		Full Time Eligible	Vision	Employee + Family
The Standard	Employee	M	03/15/1994	32024-1077	Columbia County	Full Time Eligible	Dental	Employee + One
The Standard	Child	F	01/19/2017	32024-1077	Columbia County	Full Time Eligible	Dental	Employee + One
The Standard	Employee	M	03/15/1994	32024-1077	Columbia County	Full Time Eligible	Vision	Employee
The Standard	Employee	F	03/19/1994	32055-5908	Columbia County	Full Time Eligible	Dental	Employee
The Standard	Employee	F	03/19/1994	32055-5908	Columbia County	Full Time Eligible	Vision	Employee
The Standard	Employee	M	03/19/1994	32066-3822	Lafayette County	Full Time Eligible	Dental	Employee
The Standard	Employee	M	03/19/1994	32066-3822	Lafayette County	Full Time Eligible	Vision	Employee
The Standard	Employee	M	03/21/1994	32025-5661	Columbia County	Full Time Eligible	Dental	Employee
The Standard	Employee	M	03/21/1994	32025-5661	Columbia County	Full Time Eligible	Vision	Employee
The Standard	Employee	F	03/23/1994	32025		Full Time Eligible	Dental	Employee + Family
The Standard	Spouse	M	12/13/1994	32025		Full Time Eligible	Dental	Employee + Family
The Standard	Child	F	04/05/2017	32025		Full Time Eligible	Dental	Employee + Family

The Standard	Child	M	11/01/2021	32025		Full Time Eligible	Dental	Employee + Family
The Standard	Child	M	04/13/2014	32025		Full Time Eligible	Dental	Employee + Family
The Standard	Employee	F	03/23/1994	32025		Full Time Eligible	Vision	Employee + Family
The Standard	Spouse	M	12/13/1994	32025		Full Time Eligible	Vision	Employee + Family
The Standard	Child	M	04/13/2014	32025		Full Time Eligible	Vision	Employee + Family
The Standard	Child	F	04/05/2017	32025		Full Time Eligible	Vision	Employee + Family
The Standard	Child	M	11/01/2021	32025		Full Time Eligible	Vision	Employee + Family
The Standard	Employee	M	08/30/1994	32025-6370	Columbia County	Full Time Eligible	Dental	Employee
The Standard	Employee	M	08/30/1994	32025-6370	Columbia County	Full Time Eligible	Vision	Employee
The Standard	Employee	M	01/06/1976	32055		Full Time Eligible	Dental	Employee
The Standard	Employee	M	01/06/1976	32055		Full Time Eligible	Vision	Employee + Family
The Standard	Spouse	F	05/16/1976	32055		Full Time Eligible	Vision	Employee + Family
The Standard	Child	F	08/28/2004	32055		Full Time Eligible	Vision	Employee + Family
The Standard	Child	M	04/10/2007	32055		Full Time Eligible	Vision	Employee + Family
The Standard	Employee	F	04/05/1974	32055		Full Time Eligible	Dental	Employee + One
The Standard	Child	M	08/31/2013	32055		Full Time Eligible	Dental	Employee + One
The Standard	Employee	F	04/05/1974	32055		Full Time Eligible	Vision	Employee + Child(ren)
The Standard	Child	M	08/31/2013	32055		Full Time Eligible	Vision	Employee + Child(ren)
The Standard	Employee	M	11/03/1994	32025		Full Time Eligible	Dental	Employee + One
The Standard	Spouse	F	01/05/1995	32025		Full Time Eligible	Dental	Employee + One
The Standard	Employee	M	11/03/1994	32025		Full Time Eligible	Vision	Employee
The Standard	Employee	M	01/18/1995	32024		Full Time Eligible	Dental	Employee
The Standard	Employee	M	01/18/1995	32024		Full Time Eligible	Vision	Employee
The Standard	Employee	F	03/13/1995	32055-5918	Columbia County	Full Time Eligible	Dental	Employee
The Standard	Employee	F	03/13/1995	32055-5918	Columbia County	Full Time Eligible	Vision	Employee
The Standard	Employee	F	11/19/1979	32024		Full Time Eligible	Dental	Employee + Family
The Standard	Child	F	06/18/2009	32024		Full Time Eligible	Dental	Employee + Family
The Standard	Child	F	04/01/2011	32024		Full Time Eligible	Dental	Employee + Family
The Standard	Employee	F	11/19/1979	32024		Full Time Eligible	Vision	Employee + Child(ren)
The Standard	Child	F	06/18/2009	32024		Full Time Eligible	Vision	Employee + Child(ren)
The Standard	Child	F	04/01/2011	32024		Full Time Eligible	Vision	Employee + Child(ren)
The Standard	Employee	M	03/12/1983	32024		Full Time Eligible	Dental	Employee
The Standard	Employee	M	03/12/1983	32024		Full Time Eligible	Vision	Employee
The Standard	Employee	M	06/30/1995	32061-7579	Columbia County	Full Time Eligible	Dental	Employee
The Standard	Employee	M	06/30/1995	32061-7579	Columbia County	Full Time Eligible	Vision	Employee
The Standard	Employee	M	11/18/1979	32038		Full Time Eligible	Vision	Employee
The Standard	Employee	M	11/28/1978	32055		Full Time Eligible	Dental	Employee
The Standard	Employee	M	11/28/1978	32055		Full Time Eligible	Vision	Employee
The Standard	Employee	F	05/22/1975	32024		Full Time Eligible	Dental	Employee
The Standard	Employee	F	05/22/1975	32024		Full Time Eligible	Vision	Employee
The Standard	Employee	F	10/12/1973	32024		Full Time Eligible	Dental	Employee
The Standard	Employee	F	10/12/1973	32024		Full Time Eligible	Vision	Employee
The Standard	Employee	M	08/16/1987	32024		Full Time Eligible	Dental	Employee + One
The Standard	Child	M	09/08/2015	32024		Full Time Eligible	Dental	Employee + One
The Standard	Employee	M	08/16/1987	32024		Full Time Eligible	Vision	Employee
The Standard	Employee	M	02/23/1975	32094-1532	Suwannee County	Full Time Eligible	Dental	Employee
The Standard	Employee	M	02/23/1975	32094-1532	Suwannee County	Full Time Eligible	Vision	Employee
The Standard	Employee	M	10/03/1972	32096		Full Time Eligible	Dental	Employee
The Standard	Child	M	09/23/2019	32096		Full Time Eligible	Dental	Employee
The Standard	Employee	M	10/03/1972	32096		Full Time Eligible	Vision	Employee
The Standard	Employee	F	09/09/1997	32024		Full Time Eligible	Dental	Employee
The Standard	Employee	F	09/09/1997	32024		Full Time Eligible	Vision	Employee
The Standard	Employee	F	01/26/1972	32060-8425	Suwannee County	Full Time Eligible	Dental	Employee
The Standard	Employee	F	01/26/1972	32060-8425	Suwannee County	Full Time Eligible	Vision	Employee
The Standard	Employee	M	04/28/2000	32025		Full Time Eligible	Dental	Employee
The Standard	Employee	M	05/09/1990	32024-0697	Columbia County	Full Time Eligible	Dental	Employee
The Standard	Employee	M	05/09/1990	32024-0697	Columbia County	Full Time Eligible	Vision	Employee
The Standard	Employee	M	07/29/1966	32024-1947	Columbia County	Full Time Eligible	Dental	Employee + One
The Standard	Spouse	F	11/16/1964	32024-1947	Columbia County	Full Time Eligible	Dental	Employee + One
The Standard	Employee	M	07/29/1966	32024-1947	Columbia County	Full Time Eligible	Vision	Employee + Spouse
The Standard	Spouse	F	11/16/1964	32024-1947	Columbia County	Full Time Eligible	Vision	Employee + Spouse
The Standard	Employee	F	03/28/1973	32094		Full Time Eligible	Dental	Employee
The Standard	Employee	F	03/28/1973	32094		Full Time Eligible	Vision	Employee
The Standard	Employee	M	10/10/1969	32055		Full Time Eligible	Dental	Employee
The Standard	Employee	M	10/10/1969	32055		Full Time Eligible	Vision	Employee
The Standard	Employee	M	07/09/1975	32055-0512	Columbia County	Full Time Eligible	Dental	Employee
The Standard	Employee	M	07/09/1975	32055-0512	Columbia County	Full Time Eligible	Vision	Employee
The Standard	Employee	M	07/15/1981	32055		Full Time Eligible	Dental	Employee
The Standard	Employee	M	07/15/1981	32055		Full Time Eligible	Vision	Employee
The Standard	Employee	M	03/23/1991	32680		Full Time Eligible	Dental	Employee + One
The Standard	Spouse	F	02/25/1994	32680		Full Time Eligible	Dental	Employee + One
The Standard	Employee	M	03/23/1991	32680		Full Time Eligible	Vision	Employee
The Standard	Employee	F	04/29/1992	32024-4052	Columbia County	Full Time Eligible	Dental	Employee
The Standard	Employee	F	04/29/1992	32024-4052	Columbia County	Full Time Eligible	Vision	Employee
The Standard	Employee	M	07/11/1984	32038-8330	Columbia County	Full Time Eligible	Dental	Employee + One
The Standard	Child	F	05/02/2008	32038-8330	Columbia County	Full Time Eligible	Dental	Employee + One
The Standard	Employee	M	07/11/1984	32038-8330	Columbia County	Full Time Eligible	Vision	Employee + Child(ren)
The Standard	Child	F	05/02/2008	32038-8330	Columbia County	Full Time Eligible	Vision	Employee + Child(ren)
The Standard	Employee	M	08/16/1980	32024		Full Time Eligible	Dental	Employee
The Standard	Employee	F	03/13/1970	32071-4016	Suwannee County	Full Time Eligible	Dental	Employee
The Standard	Employee	F	03/13/1970	32071-4016	Suwannee County	Full Time Eligible	Vision	Employee
The Standard	Employee	M	11/21/1994	32038-6641	Columbia County	Full Time Eligible	Dental	Employee
The Standard	Employee	M	11/21/1994	32038-6641	Columbia County	Full Time Eligible	Vision	Employee + Spouse
The Standard	Spouse	F	12/12/1994	32038-6641	Columbia County	Full Time Eligible	Vision	Employee + Spouse
The Standard	Employee	M	06/15/1985	32038-9274	Columbia County	Full Time Eligible	Dental	Employee + Family
The Standard	Spouse	F	11/04/1978	32038-9274	Columbia County	Full Time Eligible	Dental	Employee + Family
The Standard	Child	F	02/08/2012	32038-9274	Columbia County	Full Time Eligible	Dental	Employee + Family
The Standard	Employee	M	06/15/1985	32038-9274	Columbia County	Full Time Eligible	Vision	Employee + Family
The Standard	Spouse	F	11/04/1978	32038-9274	Columbia County	Full Time Eligible	Vision	Employee + Family
The Standard	Child	F	02/08/2012	32038-9274	Columbia County	Full Time Eligible	Vision	Employee + Family
The Standard	Employee	M	09/01/1987	32024		Full Time Eligible	Dental	Employee
The Standard	Employee	M	09/01/1987	32024		Full Time Eligible	Vision	Employee
The Standard	Employee	M	02/09/1977	32043		Full Time Eligible	Dental	Employee

The Standard Employee	M	02/09/1977	32043		Full Time Eligible	Vision	Employee
The Standard Employee	F	12/23/1974	32055-9236	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	F	12/23/1974	32055-9236	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	M	03/09/1996	32052-4020	Hamilton County	Full Time Eligible	Dental	Employee
The Standard Employee	M	03/09/1996	32052-4020	Hamilton County	Full Time Eligible	Vision	Employee
The Standard Employee	M	12/11/1981	32094		Full Time Eligible	Dental	Employee
The Standard Employee	M	12/11/1981	32094		Full Time Eligible	Vision	Employee
The Standard Employee	M	09/26/1978	32053		Full Time Eligible	Dental	Employee + Family
The Standard Child	F	01/07/2005	32024-3303	Columbia County	Full Time Eligible	Dental	Employee + Family
The Standard Child	F	12/02/2016	32025	Columbia County	Full Time Eligible	Dental	Employee + Family
The Standard Child	M	03/27/2013	32025	Columbia County	Full Time Eligible	Dental	Employee + Family
The Standard Child	M	02/10/2007	32025	Columbia County	Full Time Eligible	Dental	Employee + Family
The Standard Employee	M	09/26/1978	32053		Full Time Eligible	Vision	Employee + Child(ren)
The Standard Child	F	01/07/2005	32024-3303	Columbia County	Full Time Eligible	Vision	Employee + Child(ren)
The Standard Child	M	02/10/2007	32025	Columbia County	Full Time Eligible	Vision	Employee + Child(ren)
The Standard Child	F	12/02/2016	32025	Columbia County	Full Time Eligible	Vision	Employee + Child(ren)
The Standard Child	M	03/27/2013	32025	Columbia County	Full Time Eligible	Vision	Employee + Child(ren)
The Standard Employee	M	05/02/1986	32055		Full Time Eligible	Dental	Employee
The Standard Employee	M	05/02/1986	32055		Full Time Eligible	Vision	Employee
The Standard Employee	M	06/19/1997	32040-4626	Baker County	Full Time Eligible	Dental	Employee + One
The Standard Spouse	F	07/31/1998	32040-4626	Baker County	Full Time Eligible	Dental	Employee + One
The Standard Employee	M	06/19/1997	32040-4626	Baker County	Full Time Eligible	Vision	Employee
The Standard Employee	M	09/12/1997	32024		Full Time Eligible	Dental	Employee
The Standard Employee	M	09/12/1997	32024		Full Time Eligible	Vision	Employee
The Standard Employee	M	12/29/1998	32055		Full Time Eligible	Dental	Employee
The Standard Employee	M	12/29/1998	32055		Full Time Eligible	Vision	Employee
The Standard Employee	M	12/26/1998	32055-6214	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	M	12/26/1998	32055-6214	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	F	03/29/1983	32024-3152	Suwannee County	Full Time Eligible	Dental	Employee
The Standard Employee	F	03/29/1983	32024-3152	Suwannee County	Full Time Eligible	Vision	Employee
The Standard Employee	F	05/28/1989	32025-2439	Columbia County	Full Time Eligible	Dental	Employee + One
The Standard Spouse	M	09/20/1987	32025-2439	Columbia County	Full Time Eligible	Dental	Employee + One
The Standard Employee	F	05/28/1989	32025-2439	Columbia County	Full Time Eligible	Vision	Employee + Spouse
The Standard Spouse	M	09/20/1987	32025-2439	Columbia County	Full Time Eligible	Vision	Employee + Spouse
The Standard Employee	M	07/20/1981	32008		Full Time Eligible	Dental	Employee + One
The Standard Spouse	F	04/29/1980	32008		Full Time Eligible	Dental	Employee + One
The Standard Employee	M	07/20/1981	32008		Full Time Eligible	Vision	Employee + Family
The Standard Spouse	F	04/29/1980	32008		Full Time Eligible	Vision	Employee + Family
The Standard Child	F	10/25/2002	32008		Full Time Eligible	Vision	Employee + Family
The Standard Child	F	06/08/2009	32008		Full Time Eligible	Vision	Employee + Family
The Standard Child	F	04/12/2005	32008		Full Time Eligible	Vision	Employee + Family
The Standard Child	F	04/25/2007	32008		Full Time Eligible	Vision	Employee + Family
The Standard Child	F	09/26/2003	32008		Full Time Eligible	Vision	Employee + Family
The Standard Child	F	05/18/2011	32008		Full Time Eligible	Vision	Employee + Family
The Standard Child	M	09/19/2013	32008		Full Time Eligible	Vision	Employee + Family
The Standard Employee	M	08/12/1987	32025-6762	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	M	08/12/1987	32025-6762	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	F	05/19/1985	32060-7532	Suwannee County	Full Time Eligible	Dental	Employee + Family
The Standard Spouse	M	06/23/1982	32060-7532	Suwannee County	Full Time Eligible	Dental	Employee + Family
The Standard Child	M	05/24/2015	32060-7532	Suwannee County	Full Time Eligible	Dental	Employee + Family
The Standard Child	F	11/30/2016	32060-7532	Suwannee County	Full Time Eligible	Dental	Employee + Family
The Standard Employee	F	05/19/1985	32060-7532	Suwannee County	Full Time Eligible	Vision	Employee + Family
The Standard Spouse	M	06/23/1982	32060-7532	Suwannee County	Full Time Eligible	Vision	Employee + Family
The Standard Child	F	11/30/2016	32060-7532	Suwannee County	Full Time Eligible	Vision	Employee + Family
The Standard Child	M	05/24/2015	32060-7532	Suwannee County	Full Time Eligible	Vision	Employee + Family
The Standard Employee	M	03/27/1990	32094		Full Time Eligible	Dental	Employee + Family
The Standard Spouse	F	05/15/1990	32094		Full Time Eligible	Dental	Employee + Family
The Standard Child	F	02/19/2015	32094		Full Time Eligible	Dental	Employee + Family
The Standard Child	M	08/10/2007	32094		Full Time Eligible	Dental	Employee + Family
The Standard Child	F	02/17/2009	32094		Full Time Eligible	Dental	Employee + Family
The Standard Child	M	01/25/2014	32094		Full Time Eligible	Dental	Employee + Family
The Standard Employee	M	03/27/1990	32094		Full Time Eligible	Vision	Employee + Family
The Standard Spouse	F	05/15/1990	32094		Full Time Eligible	Vision	Employee + Family
The Standard Child	F	02/19/2015	32094		Full Time Eligible	Vision	Employee + Family
The Standard Child	M	08/10/2007	32094		Full Time Eligible	Vision	Employee + Family
The Standard Child	M	01/25/2014	32094		Full Time Eligible	Vision	Employee + Family
The Standard Child	F	02/17/2009	32094		Full Time Eligible	Vision	Employee + Family
The Standard Employee	F	03/29/1990	32038		Full Time Eligible	Dental	Employee + Family
The Standard Spouse	M	03/07/1987	32038		Full Time Eligible	Dental	Employee + Family
The Standard Child	M	06/28/2008	32038		Full Time Eligible	Dental	Employee + Family
The Standard Child	M	05/09/2011	32038		Full Time Eligible	Dental	Employee + Family
The Standard Child	M	01/28/2011	32038		Full Time Eligible	Dental	Employee + Family
The Standard Employee	F	03/29/1990	32038		Full Time Eligible	Vision	Employee + Family
The Standard Spouse	M	03/07/1987	32038		Full Time Eligible	Vision	Employee + Family
The Standard Child	M	06/28/2008	32038		Full Time Eligible	Vision	Employee + Family
The Standard Child	M	05/09/2011	32038		Full Time Eligible	Vision	Employee + Family
The Standard Child	M	01/28/2011	32038		Full Time Eligible	Vision	Employee + Family
The Standard Employee	M	10/01/1976	32055-7066	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	M	10/01/1976	32055-7066	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	M	12/09/1969	32025-1425	Columbia County	Full Time Eligible	Vision	Employee + Family
The Standard Spouse	F	10/28/1971	32025-1425	Columbia County	Full Time Eligible	Vision	Employee + Family
The Standard Child	M	05/02/2006	32025-1425	Columbia County	Full Time Eligible	Vision	Employee + Family
The Standard Employee	M	10/19/1967	32024		Full Time Eligible	Dental	Employee
The Standard Employee	M	10/19/1967	32024		Full Time Eligible	Vision	Employee
The Standard Employee	F	09/12/1966	32055-5665	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	F	09/12/1966	32055-5665	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	M	01/08/1992	32024		Full Time Eligible	Dental	Employee
The Standard Employee	M	01/08/1992	32024		Full Time Eligible	Vision	Employee
The Standard Employee	M	01/09/1992	32055-5271	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	M	01/09/1992	32055-5271	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	F	03/28/1984	32054-2602	Union County	Full Time Eligible	Dental	Employee + One
The Standard Spouse	M	09/02/1974	32054-2602	Union County	Full Time Eligible	Dental	Employee + One
The Standard Employee	F	03/28/1984	32054-2602	Union County	Full Time Eligible	Vision	Employee







The Standard Employee	M	04/14/2000	32038		Full Time Eligible	Dental	Employee
The Standard Employee	M	04/14/2000	32038		Full Time Eligible	Vision	Employee
The Standard Employee	M	09/28/1985	32025		Full Time Eligible	Dental	Employee
The Standard Employee	M	09/28/1985	32025		Full Time Eligible	Vision	Employee
The Standard Employee	M	01/28/1985	32615		Full Time Eligible	Dental	Employee
The Standard Employee	M	01/28/1985	32615		Full Time Eligible	Vision	Employee + Child(ren)
The Standard Child	F	02/19/2017	32615		Full Time Eligible	Vision	Employee + Child(ren)
The Standard Child	F	04/22/2009	32615		Full Time Eligible	Vision	Employee + Child(ren)
The Standard Employee	M	01/17/1984	32071-3443	Suwannee County	Full Time Eligible	Dental	Employee
The Standard Employee	F	03/24/1999	32071		Full Time Eligible	Dental	Employee + One
The Standard Child	F	11/23/2021	32071		Full Time Eligible	Dental	Employee + One
The Standard Employee	F	03/24/1999	32071		Full Time Eligible	Vision	Employee
The Standard Employee	F	04/06/1969	32055		Full Time Eligible	Dental	Employee
The Standard Employee	F	04/06/1969	32055		Full Time Eligible	Vision	Employee
The Standard Employee	F	05/27/1986	32024		Full Time Eligible	Dental	Employee
The Standard Employee	F	05/27/1986	32024		Full Time Eligible	Vision	Employee
The Standard Employee	F	11/30/1990	32055		Full Time Eligible	Dental	Employee
The Standard Employee	F	11/30/1990	32055		Full Time Eligible	Vision	Employee
The Standard Employee	F	06/10/1993	32025-0216	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	F	06/10/1993	32025-0216	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	M	04/18/1974	32055-4129	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	M	04/18/1974	32055-4129	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	F	04/24/1997	32696		Full Time Eligible	Dental	Employee
The Standard Employee	F	04/24/1997	32696		Full Time Eligible	Vision	Employee
The Standard Employee	F	07/25/1997	32025-2624	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	F	07/25/1997	32025-2624	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	F	01/26/1998	32025		Full Time Eligible	Dental	Employee
The Standard Employee	F	01/26/1998	32025		Full Time Eligible	Vision	Employee
The Standard Employee	M	03/24/1963	32094		Full Time Eligible	Dental	Employee
The Standard Employee	M	03/24/1963	32094		Full Time Eligible	Vision	Employee
The Standard Employee	F	06/24/2007	32055-9287	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	F	06/24/2007	32055-9287	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	M	03/16/2002	32024		Full Time Eligible	Dental	Employee
The Standard Employee	M	03/16/2002	32024		Full Time Eligible	Vision	Employee
The Standard Employee	M	02/20/2002	32055-5367	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	M	02/20/2002	32055-5367	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	M	02/22/2002	32094-3034	Suwannee County	Full Time Eligible	Dental	Employee
The Standard Employee	M	02/22/2002	32094-3034	Suwannee County	Full Time Eligible	Vision	Employee
The Standard Employee	F	05/10/2002	32025		Full Time Eligible	Dental	Employee
The Standard Employee	F	05/10/2002	32025		Full Time Eligible	Vision	Employee
The Standard Employee	M	03/04/2004	32025-0432	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	M	03/04/2004	32025-0432	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	M	06/25/2004	32091		Full Time Eligible	Dental	Employee
The Standard Employee	M	06/25/2004	32091		Full Time Eligible	Vision	Employee
The Standard Employee	F	12/20/2001	32055-2903	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	F	12/20/2001	32055-2903	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	F	01/03/2003	32025-4407	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	F	01/03/2003	32025-4407	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	M	09/03/2003	32024		Full Time Eligible	Dental	Employee
The Standard Employee	M	09/03/2003	32024		Full Time Eligible	Vision	Employee
The Standard Employee	F	05/26/2001	32055-2577	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	F	05/26/2001	32055-2577	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	F	05/29/2001	32054-5768	Union County	Full Time Eligible	Dental	Employee
The Standard Employee	F	05/29/2001	32054-5768	Union County	Full Time Eligible	Vision	Employee
The Standard Employee	M	06/24/2003	32024		Full Time Eligible	Dental	Employee
The Standard Employee	M	06/24/2003	32024		Full Time Eligible	Vision	Employee
The Standard Employee	M	09/06/2003	32025		Full Time Eligible	Dental	Employee
The Standard Employee	M	09/06/2003	32025		Full Time Eligible	Vision	Employee
The Standard Employee	M	06/05/2007	32087-2500	Baker County	Full Time Eligible	Dental	Employee
The Standard Employee	M	06/05/2007	32087-2500	Baker County	Full Time Eligible	Vision	Employee
The Standard Employee	M	03/06/2001	33509-2245	Hillsborough County	Full Time Eligible	Dental	Employee
The Standard Employee	M	03/06/2001	33509-2245	Hillsborough County	Full Time Eligible	Vision	Employee
The Standard Employee	F	05/28/2001	32055		Full Time Eligible	Dental	Employee
The Standard Employee	F	05/28/2001	32055		Full Time Eligible	Vision	Employee
The Standard Employee	F	02/14/2004	32024-6737	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	F	02/14/2004	32024-6737	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	M	10/10/2001	32607-2801	Alachua County	Full Time Eligible	Dental	Employee + One
The Standard Spouse	F	01/23/2002	32607-2801	Alachua County	Full Time Eligible	Dental	Employee + One
The Standard Employee	M	10/10/2001	32607-2801	Alachua County	Full Time Eligible	Vision	Employee + Spouse
The Standard Spouse	F	01/23/2002	32607-2801	Alachua County	Full Time Eligible	Vision	Employee + Spouse
The Standard Employee	F	02/25/2003	32055-4967	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	F	02/25/2003	32055-4967	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	M	09/17/2001	32064-4960	Suwannee County	Full Time Eligible	Dental	Employee
The Standard Employee	M	09/17/2001	32064-4960	Suwannee County	Full Time Eligible	Vision	Employee
The Standard Employee	M	01/03/1999	32055-3219	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	M	01/03/1999	32055-3219	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	F	03/18/1999	32055	Columbia County	Full Time Eligible	Dental	Employee
The Standard Employee	F	03/18/1999	32055	Columbia County	Full Time Eligible	Vision	Employee
The Standard Employee	M	02/27/1959	32025		Full Time Eligible	Dental	Employee
The Standard Employee	M	02/27/1959	32025		Full Time Eligible	Vision	Employee



## STANDARD INSURANCE COMPANY

A Stock Life Insurance Company  
900 SW Fifth Avenue  
Portland, Oregon 97204-1282  
(503) 321-7000

### CERTIFICATE GROUP DENTAL INSURANCE

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**The Policyholder**    **COLUMBIA COUNTY BOARD OF COUNTY COMMISSIONERS  
BOARD OF COUNTY COMMISSIONERS**

**Policy Number**    **160-162038**    **Insured Person**

**Plan Effective Date**    **October 1, 2020**    **Certificate Effective Date**  
**Refer to Exceptions on 9070**

**Plan Change Effective Date**    **October 1, 2024**

**Class Number 1**

Standard Insurance Company certifies that you will be insured for the benefits described on the following pages, according to all the terms of the group policy numbered above which has been issued to the Policyholder.

Possession of this certificate does not necessarily mean you are insured. You are insured only if you meet the requirements set out in this certificate.

The group policy may be amended or cancelled without the consent of the insured person.

**The group policy and this certificate are governed by the laws of the state in which the group policy was delivered.**

If you should have any questions regarding your coverage or claim payments, you may contact us toll-free at 800-547-9515.

**STANDARD INSURANCE COMPANY**



Daniel J. McMillan  
President and CEO

## FLORIDA - IMPORTANT INFORMATION TO INSUREDS

### We are here to serve you . . .

You have the right to receive medically appropriate care in a timely and convenient manner and to be an active participant in any decision making regarding treatment, care and services provided to you or one of your family members who are covered under this plan.

In order to provide you the best possible service, it is important that you provide any necessary information to your provider that will facilitate effective medical care and that you cooperate with your provider(s) by keeping appointments and following recommended treatment.

Please review your certificate of coverage carefully so that you fully understand the benefits provided. If you have a question about your policy or if you need assistance with a problem, feel free to contact us at the number shown below.

If you have a grievance or complaint regarding an adverse decision, you may call us below or document your concerns in writing. Written documentation can be sent to the following:

Name:	Quality Assurance
Address:	P.O. Box 82629 Lincoln, NE 68501-2629
Phone:	888-418-6811
Fax:	402-309-2579

The complaint will be carefully reviewed. If the initial claim was denied based on clinical necessity or paid as an alternate benefit, then a licensed provider will be involved in the review of the appeal. A written decision will be sent to the claimant within 15 business days following the receipt of the appeal.

### If you are not satisfied . . .

Should you feel you are not being treated fairly, we want you to know you may contact the Department of Financial Services with your complaint and seek assistance from the governmental agency that regulates insurance.

To contact them, write or call:

**Division of Consumer Services  
Department of Financial Services  
200 East Gaines Street  
Tallahassee, FL 32399-0321  
(877) 693-5236 or (850) 413-3089**

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**SCHEDULE OF BENEFITS  
OUTLINE OF COVERAGE**

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

<u>Benefit Class</u>	<u>Class Description</u>
Class 1	Eligible Employee Electing Low Dental

**DENTAL EXPENSE BENEFITS**

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

Deductible Amount:

Type 1 Procedures	\$0
Combined Type 2 and Type 3 Procedures - Each Benefit Period	\$50

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

Maximum Family Deductible	\$150
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Coinsurance Percentage:

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

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

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

## DEFINITIONS

**COMPANY** refers to Standard Insurance Company. The words "we", "us" and "our" refer to Company. Our Home Office address is 900 SW Fifth Avenue, Portland, Oregon 97204-1282.

**POLICYHOLDER** refers to the Policyholder stated on the face page of the policy.

**INSURED** refers to a person:

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

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

**DEPENDENT** refers to:

- a. an Insured's spouse.
- b. each child through the end of the year in which they turn 26 years of age, for whom the Insured or the Insured's spouse is legally responsible, including natural born children, newborn adopted children from the date of placement for adoption, any child placed with the Insured for adoption, a foster child or other child in court-ordered custody, placed pursuant to Chapter 63 of Florida Code and, children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws. Grandchildren, spouses of Dependents and other Dependent family members under the age of 26 are not eligible for coverage under this plan.
- c. each child through the end of the year in which they turn 26 but less than 30 who is a full-time student at an accredited school or college and is primarily dependent on the Insured or the Insured's spouse for support and maintenance.
- d. each child through the end of the year in which they turn 26 or older who is Totally Disabled and becomes Totally Disabled as defined below while insured as a dependent under b. or c. above. Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

**TOTAL DISABILITY** describes the Insured's Dependent as:

1. Continuously incapable of self-sustaining employment because of developmental disability or physical handicap; and
2. Chiefly dependent upon the Insured for support and maintenance.

**DEPENDENT UNIT** refers to all of the people who are insured as the dependents of any one Insured.

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

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

**LATE ENTRANT** refers to any person:

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

**PLAN EFFECTIVE DATE** refers to the date coverage under the policy becomes effective. The Plan Effective Date for the Policyholder is shown on the policy cover. The effective date of coverage for an Insured is shown in the Policyholder's records.

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

**PLAN CHANGE EFFECTIVE DATE** refers to the date that the policy provisions originally issued to the Policyholder change as requested by the Policyholder. The Plan Change Effective date for the Policyholder will be shown on the policy cover, if the Policyholder has requested a change. The plan change effective date for an Insured is shown in the Policyholder’s records or on the cover of the certificate.

## CONDITIONS FOR INSURANCE COVERAGE

### *ELIGIBILITY*

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

If employment is the basis for membership, a member of the Eligible Class for Insurance is any eligible employee electing low dental working at least 30 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

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

**ELIGIBLE CLASS FOR DEPENDENT INSURANCE.** Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the first of the month falling on or first following the latest of:

1. the day he or she qualifies for coverage as a Member;
2. the day he or she becomes a Member; or
3. the day he or she first has a dependent.

**COVERAGE FOR NEWBORN AND ADOPTED CHILDREN.** A newborn child will be covered from the date of birth. Coverage for a newborn child of a covered dependent other than a spouse will stop on the date the child attains eighteen months of age.

An adopted child, foster child and other child in court-ordered custody placed pursuant to Chapter 63 will be covered from the date of placement in the Insured's residence. A newborn adopted child will be covered from the date of birth if the Insured has agreed in writing to adopt the child prior to its birth and the child is ultimately placed in the Insured's residence.

Coverage for a newborn child shall consist of coverage for all covered Dental expenses, subject to applicable deductibles, coinsurance percentages, maximums and limitations, including the necessary care or treatment of congenital defects, birth abnormalities, including cleft lip and cleft palate and premature birth.

The Insured may give us written notice within 61 days of the date of birth or placement of a dependent child to start coverage. If timely notice is given, we will not charge an additional premium for the 61-day notice period. If timely notice is not given, we will charge the applicable additional premium from the date of birth or placement for an adopted child. We will not deny coverage for a child due to the failure of the Insured to notify us within 60 days of the child's birth or placement.

A Member must be an Insured to also insure his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any eligible employee electing low dental working at least 30 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

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

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

**CONTRIBUTION REQUIREMENTS.** Member Insurance: An Insured is required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

**SECTION 125.** This plan is provided as part of the Employer's Section 125 Plan. Each Member has the option under the Section 125 Plan of participating or not participating in this plan.

If a Member does not elect to participate when initially eligible, the Member may elect to participate at a subsequent Election Period. This Election Period will be held each year and those who elect to participate in this plan at that time will have their coverage become effective on October 1.

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

**ELIGIBILITY PERIOD.** For Members on the Plan Effective Date of the policy, coverage is effective immediately.

For persons who become Members after the Plan Effective Date of the policy, qualification will occur on the first of the month falling on or first following the eligibility period of 60 calendar day(s) of continuous active employment.

**OPEN ENROLLMENT.** If a Member does not elect to participate when initially eligible, the Member may elect to participate at the Policyholder's next enrollment period. This enrollment period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on October 1.

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

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

**EFFECTIVE DATE.** Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be the first of the month falling on or first following:

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.
2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.

3. the date we accept the Member and/or Dependent for insurance when the Member and/or Dependent is a Late Entrant. The Member and/or Dependent will be subject to any limitation concerning Late Entrants.

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

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

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

But any person who is not in active service or is totally disabled will be insured on the Effective Date if:

- i. the person was insured under a policy of group insurance providing like benefits which ended on the day immediately before the Effective Date of the policy providing this coverage; and
- ii. the person is considered a Member or an eligible Dependent under the policy providing this coverage; and had the prior policy contained the same definition of eligibility, would have been a Member or Dependent under the prior policy.

#### ***TERMINATION DATES***

**INSUREDS.** The insurance for any Insured, will automatically terminate on the end of the month falling on or next following the **earliest of**:

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

**DEPENDENTS.** The insurance for all of an Insured's dependents will automatically terminate on the end of the month falling on or next following the **earliest of**:

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

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

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

## DENTAL EXPENSE BENEFITS

We will determine dental expense benefits according to the terms of the group policy for dental expenses incurred by an Insured. An Insured person has the freedom of choice to receive treatment from any Provider.

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

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

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

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

**COVERED EXPENSES.** Covered Expenses include:

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

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

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

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

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

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

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

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

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

**EXTENSION OF BENEFITS.** The policy provides an extension of benefits if all the following conditions are met:

1. Only dental procedures, as defined within the Table of Dental Procedures, are eligible for this extension, **except** for the dental procedures performed for routine examinations, cleanings, radiographic images and sealants.
2. The dental procedures must have been performed within 90 days after an Insured's insurance terminates due to discontinuance of the policy.
3. The course of dental treatment or dental procedures must have been recommended to the Insured by a provider in writing and commenced while insurance was in effect for the Insured.
4. Any dental procedures performed in the 90-day extension period are subject to the same policy provisions that would have applied had the Insured's insurance still been in effect.
5. To be eligible for this extension, the Insured is not required to be totally disabled.

When all the foregoing conditions have been met, dental procedures performed after the insurance on an Insured terminates will be considered as if the Insured's insurance was still in effect.

This extension will terminate on the earlier of:

1. the end of the 90-day extension period; and
2. the date the Insured is covered under another group health plan providing similar dental coverage. However, the extension will not terminate if the succeeding plan excludes the dental procedures eligible for extension with a waiting period.

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

1. in the first 12 months that a person is insured if the person is a Late Entrant; except for evaluations, prophylaxis (cleanings), and fluoride application.
2. for initial placement of any dental prosthesis or prosthetic crown unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such dental prosthesis or prosthetic crown must include the replacement of the extracted tooth or teeth.

3. for appliances, restorations, or procedures to:
  - a. alter vertical dimension;
  - b. restore or maintain occlusion; or
  - c. splint or replace tooth structure lost as a result of abrasion or attrition.
4. for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.
5. to replace lost or stolen appliances.
6. for any treatment which is for cosmetic purposes.
7. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)
8. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).
9. for which the Insured person is paid benefits under any workmen's compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.
10. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.
11. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.
12. because of war or any act of war, declared or not. However, terrorism, or any act of terrorism, will not be excluded.

## TABLE OF DENTAL PROCEDURES

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

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

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.
- Covered Procedures are subject to all plan provisions, procedure and frequency limitations, and/or consultant review. Examples of procedures which may be subject to Alternate Benefits are crowns, inlays, onlays, fixed partial dentures, composite restorations, and overdentures. Examples of procedures which may be subject to plan payments based on consultant review are services related to oral maxillofacial surgery, fixed partial dentures, periodontics, and endodontics.
- Reference to "traumatic injury" under this plan is defined as any injury caused by an object or a force other than bruxism (grinding of teeth).
- Benefits for replacement dental prosthesis or prosthetic crown will be based on the prior placement date. Frequencies which reference Benefit Period will be measured forward within the limits defined as the Benefit Period. All other frequencies will be measured forward from the last covered date of service.
- We may request radiographs, periodontal charting, surgical notes, narratives, photos and/or a patient's records on any procedure for our dental consultants to review. Commonly reviewed procedures include: Periodontic procedures, Oral Maxillofacial Surgical procedures, Implants, Crowns, Inlays, Onlays, Core Build-Ups, Fixed Partial Dentures, Post and Cores, Veneers, Endodontic Retreatment, and Apexification/Recalcification procedures.
- We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive by our insured.
- A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.

## **TYPE 1 PROCEDURES**

**PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary**  
**PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge**  
**BENEFIT PERIOD - Calendar Year**  
**For Additional Limitations - See Limitations**

### **ROUTINE ORAL EVALUATION**

- D0120 Periodic oral evaluation - established patient.
- D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver.
- D0150 Comprehensive oral evaluation - new or established patient.
- D0180 Comprehensive periodontal evaluation - new or established patient.

**COMPREHENSIVE EVALUATION: D0150, D0180**

Coverage is limited to 1 of each of these procedures per provider.

In addition, D0150, D0180 coverage is limited to 2 of any of these procedures per 12 month(s).

D0120, D0145, also contribute(s) to this limitation.

If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

**ROUTINE EVALUATION: D0120, D0145**

Coverage is limited to 2 of any of these procedures per 12 month(s).

D0150, D0180, also contribute(s) to this limitation.

Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.

### **LIMITED ORAL EVALUATION**

- D0140 Limited oral evaluation - problem focused.
- D0170 Re-evaluation - limited, problem focused (established patient; not post-operative visit).

**LIMITED ORAL EVALUATION: D0140, D0170**

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

### **COMPLETE SERIES OR PANORAMIC**

- D0210 Intraoral - comprehensive series of radiographic images.
- D0330 Panoramic radiographic image.

**COMPLETE SERIES/PANORAMIC: D0210, D0330**

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

### **OTHER XRAYS**

- D0220 Intraoral - periapical first radiographic image.
- D0230 Intraoral - periapical each additional radiographic image.
- D0240 Intraoral - occlusal radiographic image.
- D0250 Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector.
- D0251 Extra-oral posterior dental radiographic image.

**PERIAPICAL: D0220, D0230**

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

### **BITEWINGS**

- D0270 Bitewing - single radiographic image.
- D0272 Bitewings - two radiographic images.
- D0273 Bitewings - three radiographic images.
- D0274 Bitewings - four radiographic images.
- D0277 Vertical bitewings - 7 to 8 radiographic images.

**BITEWINGS: D0270, D0272, D0273, D0274**

Coverage is limited to 2 of any of these procedures per 12 month(s).

D0277, also contribute(s) to this limitation.

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

**VERTICAL BITEWINGS: D0277**

## TYPE 1 PROCEDURES

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

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

### ORAL PATHOLOGY/LABORATORY

- D0472 Accession of tissue, gross examination, preparation and transmission of written report.
- D0473 Accession of tissue, gross and microscopic examination, preparation and transmission of written report.
- D0474 Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.

#### ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

Coverage is limited to 1 of any of these procedures per 12 month(s).

Coverage is limited to 1 examination per biopsy/excision.

### PROPHYLAXIS (CLEANING) AND FLUORIDE

- D1110 Prophylaxis - adult.
- D1120 Prophylaxis - child.
- D1206 Topical application of fluoride varnish.
- D1208 Topical application of fluoride-excluding varnish.
- D9932 Cleaning and inspection of removable complete denture, maxillary.
- D9933 Cleaning and inspection of removable complete denture, mandibular.
- D9934 Cleaning and inspection of removable partial denture, maxillary.
- D9935 Cleaning and inspection of removable partial denture, mandibular.

#### FLUORIDE: D1206, D1208

Coverage is limited to 1 of any of these procedures per 12 month(s).

Benefits are considered for persons age 13 and under.

#### PROPHYLAXIS: D1110, D1120

Coverage is limited to 2 of any of these procedures per 12 month(s).

D4346, D4910, also contribute(s) to this limitation.

An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

#### CLEANING AND INSPECTION OF REMOVABLE DENTURE: D9932, D9933, D9934, D9935

Coverage is limited to 2 of any of these procedures per 12 month(s).

Benefits are not available when performed on the same date as prophylaxis (cleaning) or periodontal maintenance.

### SEALANTS AND CARIES MEDICAMENTS

- D1351 Sealant - per tooth.
- D1352 Preventive resin restoration in a moderate to high caries risk patient-permanent.
- D1353 Sealant repair - per tooth.
- D1354 Application of caries arresting medicament-per tooth.
- D1355 Caries preventive medicament application - per tooth.

#### SEALANT: D1351, D1352, D1353

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

D1354, D1355, also contribute(s) to this limitation.

Benefits are considered for persons age 16 and under.

Benefits are considered on permanent molars only.

Coverage is allowed on the occlusal surface only.

### SPACE MAINTAINERS

- D1510 Space maintainer-fixed, unilateral-per quadrant.
- D1516 Space maintainer - fixed - bilateral, maxillary.
- D1517 Space maintainer - fixed - bilateral, mandibular.
- D1520 Space maintainer-removable, unilateral-per quadrant.
- D1526 Space maintainer - removable - bilateral, maxillary.
- D1527 Space maintainer - removable - bilateral, mandibular.
- D1551 Re-cement or re-bond bilateral space maintainer-maxillary.
- D1552 Re-cement or re-bond bilateral space maintainer-mandibular.

## TYPE 1 PROCEDURES

- D1553 Re-cement or re-bond unilateral space maintainer-per quadrant.
  - D1556 Removal of fixed unilateral space maintainer-per quadrant.
  - D1557 Removal of fixed bilateral space maintainer-maxillary.
  - D1558 Removal of fixed bilateral space maintainer-mandibular.
  - D1575 Distal shoe space maintainer - fixed, unilateral-per quadrant.
- SPACE MAINTAINER: D1510, D1516, D1517, D1520, D1526, D1527, D1575

Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date.

## APPLIANCE THERAPY

- D8210 Removable appliance therapy.
- D8220 Fixed appliance therapy.

APPLIANCE THERAPY: D8210, D8220

Coverage is limited to the correction of thumb-sucking.

## **TYPE 2 PROCEDURES**

**PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary**  
**PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge**  
**BENEFIT PERIOD - Calendar Year**  
**For Additional Limitations - See Limitations**

### **AMALGAM RESTORATIONS (FILLINGS)**

- D2140 Amalgam - one surface, primary or permanent.
- D2150 Amalgam - two surfaces, primary or permanent.
- D2160 Amalgam - three surfaces, primary or permanent.
- D2161 Amalgam - four or more surfaces, primary or permanent.

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

Coverage is limited to 1 of any of these procedures per 6 month(s).

D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, D9911, also contribute(s) to this limitation.

### **RESIN RESTORATIONS (FILLINGS)**

- D2330 Resin-based composite - one surface, anterior.
- D2331 Resin-based composite - two surfaces, anterior.
- D2332 Resin-based composite - three surfaces, anterior.
- D2335 Resin-based composite - four or more surfaces (anterior).
- D2391 Resin-based composite - one surface, posterior.
- D2392 Resin-based composite - two surfaces, posterior.
- D2393 Resin-based composite - three surfaces, posterior.
- D2394 Resin-based composite - four or more surfaces, posterior.
- D2410 Gold foil - one surface.
- D2420 Gold foil - two surfaces.
- D2430 Gold foil - three surfaces.
- D2990 Resin infiltration of incipient smooth surface lesions.

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

Coverage is limited to 1 of any of these procedures per 6 month(s).

D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

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

### **STAINLESS STEEL CROWN (PREFABRICATED CROWN)**

- D2390 Resin-based composite crown, anterior.
- D2928 Prefabricated porcelain/ceramic crown - permanent tooth.
- D2929 Prefabricated porcelain/ceramic crown - primary tooth.
- D2930 Prefabricated stainless steel crown - primary tooth.
- D2931 Prefabricated stainless steel crown - permanent tooth.
- D2932 Prefabricated resin crown.
- D2933 Prefabricated stainless steel crown with resin window.
- D2934 Prefabricated esthetic coated stainless steel crown - primary tooth.

STAINLESS STEEL CROWN: D2390, D2928, D2929, D2930, D2931, D2932, D2933, D2934

Replacement is limited to 1 of any of these procedures per 12 month(s).

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

### **RECEMENT**

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

## TYPE 2 PROCEDURES

### SEDATIVE FILLING

- D2940 Placement of interim direct restoration.
- D2941 Interim therapeutic restoration - primary dentition.
- D2991 Application of hydroxyapatite regeneration medicament - per tooth.

### ENDODONTICS MISCELLANEOUS

- D3220 Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.
- D3221 Pulpal debridement, primary and permanent teeth.
- D3222 Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.
- D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).
- D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).
- D3333 Internal root repair of perforation defects.
- D3351 Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.).
- D3352 Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.).
- D3353 Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).
- D3357 Pulpal regeneration - completion of treatment.
- D3430 Retrograde filling - per root.
- D3450 Root amputation - per root.
- D3920 Hemisection (including any root removal), not including root canal therapy.
- D3921 Decoronation or submergence of an erupted tooth.

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920, D3921

Procedure D3333 is limited to permanent teeth only.

### ENDODONTIC THERAPY (ROOT CANALS)

- D3310 Endodontic therapy, anterior tooth.
- D3320 Endodontic therapy, premolar tooth (excluding final restorations).
- D3330 Endodontic therapy, molar tooth (excluding final restorations).
- D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.
- D3346 Retreatment of previous root canal therapy - anterior.
- D3347 Retreatment of previous root canal therapy - premolar.
- D3348 Retreatment of previous root canal therapy - molar.

ROOT CANALS: D3310, D3320, D3330, D3332

Benefits are considered on permanent teeth only.

Allowances include intraoperative radiographic images and cultures but exclude final restoration.

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

Coverage is limited to 1 of any of these procedures per 12 month(s).

D3310, D3320, D3330, also contribute(s) to this limitation.

Benefits are considered on permanent teeth only.

Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative radiographic images and cultures but exclude final restoration.

### SURGICAL ENDODONTICS

- D3355 Pulpal regeneration - initial visit.
- D3356 Pulpal regeneration - interim medication replacement.
- D3410 Apicoectomy - anterior.
- D3421 Apicoectomy - premolar (first root).
- D3425 Apicoectomy - molar (first root).
- D3426 Apicoectomy (each additional root).
- D3471 Surgical repair of root resorption - anterior.
- D3472 Surgical repair of root resorption - premolar.
- D3473 Surgical repair of root resorption - molar.
- D3501 Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior.
- D3502 Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar.
- D3503 Surgical exposure of root surface without apicoectomy or repair of root resorption - molar.

### SURGICAL PERIODONTICS

## TYPE 2 PROCEDURES

- D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.
- D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.
- D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.
- D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.
- D4260 Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.
- D4261 Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.
- D4263 Bone replacement graft - retained natural tooth - first site in quadrant.
- D4264 Bone replacement graft - retained natural tooth - each additional site in quadrant.
- D4265 Biologic materials to aid in soft and osseous tissue regeneration, per site.
- D4270 Pedicle soft tissue graft procedure.
- D4273 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft.
- D4274 Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area).
- D4275 Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant or edentulous tooth position in graft.
- D4276 Combined connective tissue and pedicle graft, per tooth.
- D4277 Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft.
- D4278 Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site.
- D4283 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.
- D4285 Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.

### BONE GRAFTS: D4263, D4264, D4265

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

Coverage is limited to treatment of periodontal disease.

### GINGIVECTOMY: D4210, D4211

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

Coverage is limited to treatment of periodontal disease.

### OSSEOUS SURGERY: D4240, D4241, D4260, D4261

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

Coverage is limited to treatment of periodontal disease.

### TISSUE GRAFTS: D4270, D4273, D4275, D4276, D4277, D4278, D4283, D4285

Each quadrant is limited to 2 of any of these procedures per 3 year(s).

Coverage is limited to treatment of periodontal disease.

## NON-SURGICAL PERIODONTICS

- D4341 Periodontal scaling and root planing - four or more teeth per quadrant.
- D4342 Periodontal scaling and root planing - one to three teeth, per quadrant.
- D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.

### ANTIMICROBIAL AGENTS: D4381

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

### PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

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

## FULL MOUTH DEBRIDEMENT

- D4355 Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit.

### FULL MOUTH DEBRIDEMENT: D4355

## TYPE 2 PROCEDURES

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

### PERIODONTAL MAINTENANCE

D4346 Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation.

D4910 Periodontal maintenance.

PERIODONTAL MAINTENANCE: D4346, D4910

Coverage is limited to 2 of any of these procedures per 12 month(s).

D1110, D1120, also contribute(s) to this limitation.

Benefits are not available if performed on the same date as any other periodontal service.

Procedure D4910 is contingent upon evidence of full mouth active periodontal therapy.

Procedure D4346 is limited to persons age 14 and over.

### DENTURE REPAIR

D5511 Repair broken complete denture base, mandibular.

D5512 Repair broken complete denture base, maxillary.

D5520 Replace missing or broken teeth - complete denture - per tooth.

D5611 Repair resin partial denture base, mandibular.

D5612 Repair resin partial denture base, maxillary.

D5621 Repair cast partial framework, mandibular.

D5622 Repair cast partial framework, maxillary.

D5630 Repair or replace broken retentive/clasping materials per tooth.

D5640 Replace missing or broken teeth - partial denture - per tooth.

### DENTURE RELINES

D5730 Reline complete maxillary denture (direct).

D5731 Reline complete mandibular denture (direct).

D5740 Reline maxillary partial denture (direct).

D5741 Reline mandibular partial denture (direct).

D5750 Reline complete maxillary denture (indirect).

D5751 Reline complete mandibular denture (indirect).

D5760 Reline maxillary partial denture (indirect).

D5761 Reline mandibular partial denture (indirect).

D5765 Soft liner for complete or partial removable denture-indirect.

DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761, D5765

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

### NON-SURGICAL EXTRACTIONS

D7111 Extraction, coronal remnants - primary tooth.

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

### SURGICAL EXTRACTIONS

D7210 Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated.

D7220 Removal of impacted tooth - soft tissue.

D7230 Removal of impacted tooth - partially bony.

D7240 Removal of impacted tooth - completely bony.

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

D7250 Removal of residual tooth roots (cutting procedure).

D7251 Coronectomy - intentional partial tooth removal, impacted teeth only.

### OTHER ORAL SURGERY

D7260 Oroantral fistula closure.

D7261 Primary closure of a sinus perforation.

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

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

D7280 Exposure of an unerupted tooth.

D7282 Mobilization of erupted or malpositioned tooth to aid eruption.

D7283 Placement of device to facilitate eruption of impacted tooth.

## TYPE 2 PROCEDURES

- D7310 Alveoplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
- D7311 Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
- D7320 Alveoplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
- D7321 Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
- D7340 Vestibuloplasty - ridge extension (secondary epithelialization).
- D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).
- D7410 Excision of benign lesion up to 1.25 cm.
- D7411 Excision of benign lesion greater than 1.25 cm.
- D7412 Excision of benign lesion, complicated.
- D7413 Excision of malignant lesion up to 1.25 cm.
- D7414 Excision of malignant lesion greater than 1.25 cm.
- D7415 Excision of malignant lesion, complicated.
- D7440 Excision of malignant tumor - lesion diameter up to 1.25 cm.
- D7441 Excision of malignant tumor - lesion diameter greater than 1.25 cm.
- D7450 Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.
- D7451 Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
- D7460 Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.
- D7461 Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
- D7465 Destruction of lesion(s) by physical or chemical method, by report.
- D7471 Removal of lateral exostosis (maxilla or mandible).
- D7472 Removal of torus palatinus.
- D7473 Removal of torus mandibularis.
- D7485 Reduction of osseous tuberosity.
- D7490 Radical resection of maxilla or mandible.
- D7509 Marsupialization of odontogenic cyst.
- D7510 Incision and drainage of abscess - intraoral soft tissue.
- D7520 Incision and drainage of abscess - extraoral soft tissue.
- D7530 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.
- D7540 Removal of reaction producing foreign bodies, musculoskeletal system.
- D7550 Partial ostectomy/sequestrectomy for removal of non-vital bone.
- D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body.
- D7910 Suture of recent small wounds up to 5 cm.
- D7911 Complicated suture - up to 5 cm.
- D7912 Complicated suture - greater than 5 cm.
- D7961 Buccal/labial frenectomy (frenulectomy).
- D7962 Lingual frenectomy (frenulectomy).
- D7963 Frenuloplasty.
- D7970 Excision of hyperplastic tissue - per arch.
- D7972 Surgical reduction of fibrous tuberosity.
- D7979 Non-surgical sialolithotomy.
- D7980 Surgical sialolithotomy.
- D7983 Closure of salivary fistula.

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

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

### BIOPSY OF ORAL TISSUE

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

### PALLIATIVE

- D9110 Palliative treatment of dental pain - per visit.

PALLIATIVE TREATMENT: D9110

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

## TYPE 2 PROCEDURES

### ANESTHESIA-GENERAL/IV

- D9219 Evaluation for moderate sedation, deep sedation or general anesthesia.
- D9222 Deep sedation/general anesthesia - first 15 minutes.
- D9223 Deep sedation/general anesthesia - each subsequent 15 minute increment.
- D9239 Intravenous moderate (conscious) sedation/analgesia - first 15 minutes.
- D9243 Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment.

GENERAL ANESTHESIA: D9222, D9223, D9239, D9243

Coverage is only available with a cutting procedure. A maximum of four (D9222, D9223, D9239 or D9243) will be considered.

### PROFESSIONAL CONSULT/VISIT/SERVICES

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

CONSULTATION: D9310

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

OFFICE VISIT: D9430, D9440

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

### OCCLUSAL ADJUSTMENT

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

OCCLUSAL ADJUSTMENT: D9951, D9952

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

### MISCELLANEOUS

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

DESENSITIZATION: D9911

Coverage is limited to 1 of any of these procedures per 6 month(s).

D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, also contribute(s) to this limitation.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

### **TYPE 3 PROCEDURES**

**PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary**  
**PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge**  
**BENEFIT PERIOD - Calendar Year**  
**For Additional Limitations - See Limitations**

#### **INLAY RESTORATIONS**

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

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

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

#### **ONLAY RESTORATIONS**

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

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

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

D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.

Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

#### **CROWNS SINGLE RESTORATIONS**

- D2710 Crown - resin-based composite (indirect).
- D2712 Crown - 3/4 resin-based composite (indirect).
- D2720 Crown - resin with high noble metal.
- D2721 Crown - resin with predominantly base metal.
- D2722 Crown - resin with noble metal.
- D2740 Crown - porcelain/ceramic.
- D2750 Crown - porcelain fused to high noble metal.
- D2751 Crown - porcelain fused to predominantly base metal.
- D2752 Crown - porcelain fused to noble metal.
- D2753 Crown-porcelain fused to titanium and titanium alloys.
- D2780 Crown - 3/4 cast high noble metal.
- D2781 Crown - 3/4 cast predominantly base metal.
- D2782 Crown - 3/4 cast noble metal.
- D2783 Crown - 3/4 porcelain/ceramic.

## TYPE 3 PROCEDURES

- D2790 Crown - full cast high noble metal.
- D2791 Crown - full cast predominantly base metal.
- D2792 Crown - full cast noble metal.
- D2794 Crown - titanium and titanium alloys.

CROWN: D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794

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

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.

Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months. Coverage is limited to necessary placement resulting from decay or traumatic injury.

### CORE BUILD-UP

- D2950 Core buildup, including any pins when required.

CORE BUILDUP: D2950

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

### POST AND CORE

- D2952 Post and core in addition to crown, indirectly fabricated.
- D2954 Prefabricated post and core in addition to crown.

### FIXED CROWN AND PARTIAL DENTURE REPAIR

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

### CROWN LENGTHENING

- D4249 Clinical crown lengthening - hard tissue.

### PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

- D5110 Complete denture - maxillary.
- D5120 Complete denture - mandibular.
- D5130 Immediate denture - maxillary.
- D5140 Immediate denture - mandibular.
- D5211 Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth).
- D5212 Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth).
- D5213 Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
- D5214 Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
- D5221 Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth).
- D5222 Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth).

## TYPE 3 PROCEDURES

- D5223 Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
- D5224 Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
- D5225 Maxillary partial denture-flexible base (including retentive/clasping materials, rests, and teeth).
- D5226 Mandibular partial denture-flexible base (including retentive/clasping materials, rests, and teeth).
- D5227 Immediate maxillary partial denture-flexible base (including any clasps, rests and teeth).
- D5228 Immediate mandibular partial denture-flexible base (including any clasps, rests and teeth).
- D5282 Removable unilateral partial denture-one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary.
- D5283 Removable unilateral partial denture-one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular.
- D5284 Removable unilateral partial denture-one piece flexible base (including retentive/clasping materials, rests, and teeth)-per quadrant.
- D5286 Removable unilateral partial denture-one piece resin (including retentive/clasping materials, rests, and teeth)-per quadrant.
- D5670 Replace all teeth and acrylic on cast metal framework (maxillary).
- D5671 Replace all teeth and acrylic on cast metal framework (mandibular).
- D5810 Interim complete denture (maxillary).
- D5811 Interim complete denture (mandibular).
- D5820 Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary.
- D5821 Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular.
- D5863 Overdenture - complete maxillary.
- D5864 Overdenture - partial maxillary.
- D5865 Overdenture - complete mandibular.
- D5866 Overdenture - partial mandibular.
- D5876 Add metal substructure to acrylic full denture (per arch).
- D6110 Implant/abutment supported removable denture for edentulous arch - maxillary.
- D6111 Implant/abutment supported removable denture for edentulous arch - mandibular.
- D6112 Implant/abutment supported removable denture for partially edentulous arch - maxillary.
- D6113 Implant/abutment supported removable denture for partially edentulous arch - mandibular.
- D6114 Implant/abutment supported fixed denture for edentulous arch - maxillary.
- D6115 Implant/abutment supported fixed denture for edentulous arch - mandibular.
- D6116 Implant/abutment supported fixed denture for partially edentulous arch - maxillary.
- D6117 Implant/abutment supported fixed denture for partially edentulous arch - mandibular.
- D6118 Implant/abutment supported interim fixed denture for edentulous arch - mandibular.
- D6119 Implant/abutment supported interim fixed denture for edentulous arch - maxillary.

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5863, D5865, D5876, D6110, D6111, D6114, D6115  
Replacement is limited to 1 of any of these procedures per 5 year(s).

Frequency is waived for accidental injury.

Allowances include adjustments within 6 months after placement date. Procedures D5863, D5865, D6110, D6111, D6114 and D6115 are considered at an alternate benefit of a D5110/D5120. Benefits for procedure D5876 is contingent upon the related denture being covered.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5227, D5228, D5282, D5283, D5284, D5286, D5670, D5671, D5864, D5866, D6112, D6113, D6116, D6117

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

Frequency is waived for accidental injury.

Allowances include adjustments within 6 months of placement date. Procedures D5864, D5866, D6112, D6113, D6116 and D6117 are considered at an alternate benefit of a D5213/D5214.

### DENTURE ADJUSTMENTS

- D5410 Adjust complete denture - maxillary.
  - D5411 Adjust complete denture - mandibular.
  - D5421 Adjust partial denture - maxillary.
  - D5422 Adjust partial denture - mandibular.
- DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

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

## TYPE 3 PROCEDURES

### ADD TOOTH/CLASP TO EXISTING PARTIAL

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

### DENTURE REBASES

- D5710 Rebase complete maxillary denture.
- D5711 Rebase complete mandibular denture.
- D5720 Rebase maxillary partial denture.
- D5721 Rebase mandibular partial denture.
- D5725 Rebase hybrid prosthesis.

### TISSUE CONDITIONING

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

### PROSTHODONTICS - FIXED

- D6058 Abutment supported porcelain/ceramic crown.
- D6059 Abutment supported porcelain fused to metal crown (high noble metal).
- D6060 Abutment supported porcelain fused to metal crown (predominantly base metal).
- D6061 Abutment supported porcelain fused to metal crown (noble metal).
- D6062 Abutment supported cast metal crown (high noble metal).
- D6063 Abutment supported cast metal crown (predominantly base metal).
- D6064 Abutment supported cast metal crown (noble metal).
- D6065 Implant supported porcelain/ceramic crown.
- D6066 Implant supported crown - porcelain fused to high noble alloys.
- D6067 Implant supported crown - high noble alloys.
- D6068 Abutment supported retainer for porcelain/ceramic FPD.
- D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal).
- D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).
- D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal).
- D6072 Abutment supported retainer for cast metal FPD (high noble metal).
- D6073 Abutment supported retainer for cast metal FPD (predominantly base metal).
- D6074 Abutment supported retainer for cast metal FPD (noble metal).
- D6075 Implant supported retainer for ceramic FPD.
- D6076 Implant supported retainer for FPD - porcelain fused to high noble alloys.
- D6077 Implant supported retainer for metal FPD - high noble alloy.
- D6082 Implant supported crown-porcelain fused to predominantly base alloys.
- D6083 Implant supported crown-porcelain fused to noble alloys.
- D6084 Implant supported crown-porcelain fused to titanium and titanium alloys.
- D6086 Implant supported crown-predominantly base alloys.
- D6087 Implant supported crown-noble alloys.
- D6088 Implant supported crown-titanium and titanium alloys.
- D6094 Abutment supported crown - titanium and titanium alloys.
- D6097 Abutment supported crown-porcelain fused to titanium and titanium alloys.
- D6098 Implant supported retainer-porcelain fused to predominantly base alloys.
- D6099 Implant supported retainer for FPD-porcelain fused to noble alloys.
- D6120 Implant supported retainer-porcelain fused to titanium and titanium alloys.
- D6121 Implant supported retainer for metal FPD-predominantly base alloys.
- D6122 Implant supported retainer for metal FPD-noble alloys.
- D6123 Implant supported retainer for metal FPD-titanium and titanium alloys.
- D6194 Abutment supported retainer crown for FPD - titanium and titanium alloys.
- D6195 Abutment supported retainer-porcelain fused to titanium and titanium alloys.
- D6205 Pontic - indirect resin based composite.
- D6210 Pontic - cast high noble metal.
- D6211 Pontic - cast predominantly base metal.
- D6212 Pontic - cast noble metal.
- D6214 Pontic - titanium and titanium alloys.
- D6240 Pontic - porcelain fused to high noble metal.
- D6241 Pontic - porcelain fused to predominantly base metal.
- D6242 Pontic - porcelain fused to noble metal.

## TYPE 3 PROCEDURES

- D6243 Pontic-porcelain fused to titanium and titanium alloys.
  - D6245 Pontic - porcelain/ceramic.
  - D6250 Pontic - resin with high noble metal.
  - D6251 Pontic - resin with predominantly base metal.
  - D6252 Pontic - resin with noble metal.
  - D6545 Retainer - cast metal for resin bonded fixed prosthesis.
  - D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis.
  - D6549 Resin retainer - for resin bonded fixed prosthesis.
  - D6600 Retainer inlay - porcelain/ceramic, two surfaces.
  - D6601 Retainer inlay - porcelain/ceramic, three or more surfaces.
  - D6602 Retainer inlay - cast high noble metal, two surfaces.
  - D6603 Retainer inlay - cast high noble metal, three or more surfaces.
  - D6604 Retainer inlay - cast predominantly base metal, two surfaces.
  - D6605 Retainer inlay - cast predominantly base metal, three or more surfaces.
  - D6606 Retainer inlay - cast noble metal, two surfaces.
  - D6607 Retainer inlay - cast noble metal, three or more surfaces.
  - D6608 Retainer onlay - porcelain/ceramic, two surfaces.
  - D6609 Retainer onlay - porcelain/ceramic, three or more surfaces.
  - D6610 Retainer onlay - cast high noble metal, two surfaces.
  - D6611 Retainer onlay - cast high noble metal, three or more surfaces.
  - D6612 Retainer onlay - cast predominantly base metal, two surfaces.
  - D6613 Retainer onlay - cast predominantly base metal, three or more surfaces.
  - D6614 Retainer onlay - cast noble metal, two surfaces.
  - D6615 Retainer onlay - cast noble metal, three or more surfaces.
  - D6624 Retainer inlay - titanium.
  - D6634 Retainer onlay - titanium.
  - D6710 Retainer crown - indirect resin based composite.
  - D6720 Retainer crown - resin with high noble metal.
  - D6721 Retainer crown - resin with predominantly base metal.
  - D6722 Retainer crown - resin with noble metal.
  - D6740 Retainer crown - porcelain/ceramic.
  - D6750 Retainer crown - porcelain fused to high noble metal.
  - D6751 Retainer crown - porcelain fused to predominantly base metal.
  - D6752 Retainer crown - porcelain fused to noble metal.
  - D6753 Retainer crown-porcelain fused to titanium and titanium alloys.
  - D6780 Retainer crown - 3/4 cast high noble metal.
  - D6781 Retainer crown - 3/4 cast predominantly base metal.
  - D6782 Retainer crown - 3/4 cast noble metal.
  - D6783 Retainer crown - 3/4 porcelain/ceramic.
  - D6784 Retainer crown 3/4-titanium and titanium alloys.
  - D6790 Retainer crown - full cast high noble metal.
  - D6791 Retainer crown - full cast predominantly base metal.
  - D6792 Retainer crown - full cast noble metal.
  - D6794 Retainer crown - titanium and titanium alloys.
  - D6940 Stress breaker.
- FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794
- Replacement is limited to 1 of any of these procedures per 5 year(s).  
D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.  
Porcelain and resin benefits are considered for anterior and bicuspid teeth only.  
Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.  
Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.
- FIXED PARTIAL INLAY: D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624

## TYPE 3 PROCEDURES

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

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12.

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

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

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL PONTIC: D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252

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

D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097, D6098, D6099, D6120, D6121, D6122, D6123, D6194, D6195, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

IMPLANT SUPPORTED CROWN: D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097

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

D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

IMPLANT SUPPORTED RETAINER: D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6098, D6099, D6120, D6121, D6122, D6123, D6194, D6195

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

D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.

### **TYPE 3 PROCEDURES**

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

## ORTHODONTIC EXPENSE BENEFITS

Orthodontic expense benefits will be determined according to the terms of the policy for orthodontic expenses incurred by an Insured. We will determine orthodontic expense benefits according to the terms of the group policy for orthodontic expenses incurred by an Insured.

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

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

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

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

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

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

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

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

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

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

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

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

## COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies if an Insured person has dental coverage under more than one **Plan**. **Plan** is defined below. All benefits provided under this policy are subject to this section.

The order of benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan**. The **Secondary plan** may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total **Allowable expense**.

### DEFINITIONS

A. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. 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.

(1) **Plan** includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage other than the medical benefits coverage in automobile "no fault" and traditional "fault" type contracts; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) 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**.

B. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one **COB** provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.

C. The order of benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health care coverage under more than one **Plan**.

When **This plan** is primary, it determines payment for its benefits first before those of any other **Plan** without considering any other **Plan's** benefits. When **This plan** is secondary, it 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 expense**.

D. **Allowable expense** is a health care expense, including deductibles, coinsurance and co-payments, 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 a covered person is not an **Allowable expense**.

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

- (1) If a person is covered by 2 or more **Plans** that compute their benefit payments on the basis of 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**.
- (2) If a person 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**.
- (3) If a person is covered by one **Plan** that calculates its benefits or services on the basis of 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 shall be the **Allowable expense** 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 expense** used by the **Secondary plan** to determine its benefits.
- (4) The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. **Closed panel plan** is a **Plan** that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the **Plan**, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **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.

## **ORDER OF BENEFIT DETERMINATION RULES**

When a person is covered by two or more **Plans**, the rules for determining the order of benefit payments are as follows:

- A. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other **Plan**.
- B. (1) Except as provided in Paragraph B(2) below, a **Plan** that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both **Plans** state that the complying plan is primary.  
  
(2) 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 contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.
- C. A **Plan** may consider the benefits paid or provided by another **Plan** in calculating payment of its benefits only when it is secondary to that other **Plan**.
- D. 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, for example 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 the person 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:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

The **Plan** of the parent whose birthday falls earlier in the calendar year is the **Primary plan**; or

If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health 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**.

(c) For a dependent child covered under more than one **Plan** of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-off Employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. 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 as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, 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 is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.

(6) If the preceding rules do not 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 THE BENEFITS OF THIS PLAN**

A. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year 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 health 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 health care coverage.

B. If a covered person 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**.

#### **RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION**

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give the Company any facts it needs 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, the Company 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**. The Company 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 the amount of the payments made by the Company is more than it should have paid under this **COB** provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

## GENERAL PROVISIONS

**NOTICE OF CLAIM.** Written notice of a claim must be given to us within 90 days after the incurred date of the services provided for which benefits are payable.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Policyholder's name, Insured's name, and policy number. If it was not reasonably possible to give written notice within the 90 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

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

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

**TIME OF PAYMENT.** We will pay all benefits within 45 days of when we receive due proof.

If benefits are contested or denied, we will notify the Insured, in writing, which benefits are contested or denied within 45 days of when we received due proof. We will pay or deny any balance remaining on benefits for a claim within 60 days upon receipt of any additional information requested from the Insured. In no event will we hold a claim without paying or denying benefits any later than 120 days.

Payment is considered to be made on the date a draft or other valid instrument is placed in the United States mail in a properly addressed post paid envelope or, if not so posted, on the date of delivery.

We will pay interest at the rate of 10 percent per year on overdue payments on benefits for valid claims.

We will investigate any claim of improper billing of a claim by a Provider upon written notification by an Insured. We will determine if the Insured was properly billed for only those procedures that the Insured actually received. If we determine that the Insured was improperly billed, we will notify the Insured and the provider of our findings and will reduce the amount of payment by the amount determined to be improperly billed. If a reduction is made due to such notification by the Insured, we will pay the Insured 20 percent of the reduction up to \$500.

**PAYMENT OF BENEFITS.** Participating Providers have agreed to accept assignment of benefits for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, all benefits will be paid to the Insured unless otherwise indicated by the Insured's authorization to pay the Non-Participating Provider directly.

**FACILITY OF PAYMENT.** If an Insured or beneficiary is not capable of giving us a valid receipt for any payment or if benefits are payable to the estate of the Insured, then we may, at our option, pay the benefit up to an amount not to exceed \$3,000, to any relative by blood or connection by marriage of the Insured who is considered by us to be equitably entitled to the benefit.

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

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

**LEGAL PROCEEDINGS.** No legal action can be brought against us until 60 days after the Insured sends us the required proof of loss. No legal action against us can start more than the applicable statute of limitations after proof of loss is required.

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

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

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

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

## ERISA INFORMATION AND NOTICE OF YOUR RIGHTS

### A. **Eligibility and Benefits Provided Under the Group Policy**

Please refer to the **Conditions for Insurance** within the Group Policy and Certificate of Coverage for a detailed description of the eligibility for participation under the plan as well as the benefits provided. If this plan includes a participating provider (PPO) option, provider lists are furnished without charge, as a separate document.

If you have any questions about your benefits or concerns about our services related to this Group Policy, you may call Customer Service Toll Free at 1-800-547-9515.

### B. **Qualified Medical Child Support Order ("QMCSO")**

QMCSO Determinations. A Plan participant or beneficiary can obtain, without charge, a copy of the Plan's procedures governing Qualified Medical Child Support Order determinations from the Plan Administrator.

### C. **Termination Of The Group Policy**

The Group Policy which provides benefits for this plan may be terminated by the Policyholder at any time with prior written notice to Standard Insurance Company. It will terminate automatically if the Policyholder fails to pay the required premium. Standard Insurance Company may terminate the Group Policy on any Premium Due Date if the number of persons insured is less than the required minimum, or if Standard Insurance Company believes the Policyholder has failed to perform its obligations relating to the Group Policy.

After the first policy year, Standard Insurance Company may also terminate the Group Policy on any Premium Due Date for any reason by providing a 45-day advance written notice to the Policyholder.

The Group Policy may be changed in whole or in part. No change or amendment will be valid unless it is approved in writing by a Standard Insurance Company executive officer.

### D. **Claims For Benefits**

Claims procedures are furnished automatically, without charge, as a separate document.

### E. **Continuation of Coverage Provisions (COBRA)**

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) gives Qualified Beneficiaries the right to elect COBRA continuation after insurance ends because of a Qualifying Event. The law generally covers group health plans maintained by employers with 20 or more employees in the prior year. The law does not, however, apply to plans sponsored by the Federal government and certain church-related organizations.

#### i. **Definitions For This Section**

Qualified Beneficiary means an Insured Person who is covered by the plan on the day before a qualifying event. Any child born to or placed for adoption with a covered employee during the period of COBRA coverage is considered a qualified beneficiary.

A Qualifying Event occurs when:

1. The Member dies (hereinafter referred to as Qualifying Event 1);
2. The Member's employment terminates for reasons other than gross misconduct as determined by the Employer (hereinafter referred to as Qualifying Event 2);
3. The Member's work hours fall below the minimum number required to be a Member (hereinafter referred to as Qualifying Event 3);

4. The Member becomes divorced or legally separated from a Spouse (hereinafter referred to as Qualifying Event 4);
5. The Member becomes entitled to receive Medicare benefits under Title XVII of the Social Security Act (hereinafter referred to as Qualifying Event 5);
6. The Child of a Member ceases to be a Dependent (hereinafter referred to as Qualifying Event 6);
7. The Employer files a petition for reorganization under Title 11 of the U.S. Bankruptcy Code, provided the Member is retired from the Employer and is insured on the date the petition is filed (hereinafter referred to as Qualifying Event 7).

**ii. Electing COBRA Continuation**

- A. Each Qualified Beneficiary has the right to elect to continue coverage that was in effect on the day before the Qualifying Event. The Qualified Beneficiary must apply in writing within 60 days of the later of:
  1. The date on which Insurance would otherwise end; and
  2. The date on which the Employer or Plan Administrator gave the Qualified Beneficiary notice of the right to COBRA continuation.
- B. A Qualified Beneficiary who does not elect COBRA Continuation coverage during their original election period may be entitled to a second election period if the following requirements are satisfied:
  1. The Member's Insurance ended because of a trade related termination of their employment, which resulted in being certified eligible for trade adjustment assistance;
  2. The Member is certified eligible for trade adjustment assistance (as determined by the appropriate governmental agency) within 6 months of the date Insurance ended due to the trade related termination of their employment; and
  3. The Qualified Beneficiary must apply in writing within 60 days after the first day of the month in which they are certified eligible for trade adjustment assistance.

**iii. Notice Requirements**

1. When the Member becomes insured, the Plan Administrator must inform the Member and Spouse in writing of the right to COBRA continuation.
2. The Qualified Beneficiary must notify the Plan Administrator in writing of Qualifying Event 4 or 6 above within 60 days of the later of:
  - a. The date of the Qualifying Event; or
  - b. The date the Qualified Beneficiary loses coverage due to the Qualifying Event.

3. A Qualified Beneficiary, who is entitled to COBRA continuation due to the occurrence of Qualifying Event 2 or 3 and who is disabled at any time during the first 60 days of continuation coverage as determined by the Social Security Administration pursuant to Title II or XVI of the Social Security Act, must notify the Plan Administrator of the disability in writing within 60 days of the later of:
  - a. The date of the disability determination;
  - b. The date of the Qualifying Event; or
  - c. The date on which the Qualified Beneficiary loses coverage due to the Qualifying Event.
4. Each Qualified Beneficiary who has become entitled to COBRA continuation with a maximum duration of 18 or 29 months must notify the Plan Administrator of the occurrence of a second Qualifying Event within 60 days of the later of:
  - a. The date of the Qualifying Event; or
  - b. The date the Qualified Beneficiary loses coverage due to the Qualifying Event.
5. The Employer must give the Plan Administrator written notice within 30 days of the occurrence of Qualifying Event 1, 2, 3, 5, or 7.
6. Within 14 days of receipt of the Employer's notice, the Plan Administrator must notify each Qualified Beneficiary in writing of the right to elect COBRA continuation.

In order to protect your rights, Members and Qualified Beneficiaries should inform the Plan Administrator in writing of any change of address.

**iv. COBRA Continuation Period**

1. 18-month COBRA Continuation

Each Qualified Beneficiary may continue Insurance for up to 18 months after the date of Qualifying Event 2 or 3.

2. 29-month COBRA Continuation

Each Qualified Beneficiary, who is entitled to COBRA continuation due to the occurrence of Qualifying Event 2 or 3 and who is disabled at any time during the first 60 days of continuation coverage as determined by the Social Security Administration pursuant to Title II or XVI of the Social Security Act, may continue coverage for up to 29 months after the date of the Qualifying Event. All Insured Persons in the Qualified Beneficiary's family may also continue coverage for up to 29 months.

3. 36-Month COBRA Continuation

If you are a Dependent, you may continue Coverage for up to 36 months after the date of Qualifying Event 1, 4, 5, or 6. Each Qualified Beneficiary who is entitled to continue Insurance for 18 or 29 months may be eligible to continue coverage for up to 36 months after the date of their original Qualifying Event if a second Qualifying Event occurs while they are on continuation coverage.

Note: The total period of COBRA continuation available in 1 through 3 will not exceed 36 months.

4. COBRA Continuation For Certain Bankruptcy Proceedings

If the Qualifying Event is 7, the COBRA continuation period for a retiree or retiree's Spouse is the lifetime of the retiree. Upon the retiree's death, the COBRA continuation period for the surviving Dependents is 36 months from the date of the retiree's death.

v. **Premium Requirements**

Insurance continued under this provision will be retroactive to the date insurance would have ended because of a Qualifying Event. The Qualified Beneficiary must pay the initial required premium not later than 45 days after electing COBRA continuation, and monthly premium on or before the Premium Due Date thereafter. The monthly premium is a percentage of the total premium (both the portion paid by the employee and any portion paid by the employer) currently in effect on each Premium Due Date. The premium rate may change after you cease to be Actively at Work. The percentage is as follows:

18 month continuation - 102%

29 month continuation - 102% during the first 18 months, 150% during the next 11 months

36 month continuation - 102%

vi. When COBRA Continuation Ends

COBRA continuation ends on the earliest of:

1. The date the Group Policy terminates;
2. 31 days after the date the last period ends for which a required premium payment was made;
3. The last day of the COBRA continuation period.
4. The date the Qualified Beneficiary first becomes entitled to Medicare coverage under Title XVII of the Social Security Act;
5. The first date on which the Qualified Beneficiary is: (a) covered under another group Dental policy and (b) not subject to any preexisting condition limitation in that policy.

**F. Your Rights under ERISA**

As a participant in this Plan, you are entitled to certain rights and protections under the Employment Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

### **Receive Information About Your Plan and Benefits**

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

### **Continue Group Health Plan Coverage**

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

### **Prudent Actions by Plan Fiduciaries**

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to operate and administer this plan prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

### **Enforce Your Rights**

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### **Assistance with Your Rights**

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and

responsibilities under ERISA by calling those publications hotline of the Employee Benefits Security Administration

**CLAIMS REVIEW PROCEDURES  
AS REQUIRED UNDER  
EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)**

The following provides information regarding the claims review process and your rights to request a review of any part of a claim that is denied. Please note that certain state laws may also require specified claims payment procedures as well as internal appeal procedures and/or independent external review processes. Therefore, in addition to the review procedures defined below, you may also have additional rights provided to you under state law. If your state has specific grievance procedures, an additional notice specific to your state will also be included within the group policy and your certificate.

**CLAIMS FOR BENEFITS**

Claims may be submitted by mailing the completed claim form along with any requested information to:  
Standard Insurance Company  
PO Box 82622  
Lincoln, NE 68501-2622

**NOTICE OF DECISION OF CLAIM**

We will evaluate your claim promptly after we receive it.

**Dental Utilization Review Program.** Generally, utilization review means a set of criteria designed to monitor the use of, or evaluate the medical necessity, appropriateness, or efficiency of health care services. We have established a utilization review program to ensure that any guidelines and criteria used to evaluate the medical necessity of a health care service are clearly documented and include procedures for applying such criteria based on the needs of the individual patients. The program was developed in conjunction with licensed dentists and is reviewed at least annually to ensure that criteria are applied consistently and are current with dental technology, evidence-based research and any dental trends.

We will provide you written notice regarding the payment under the claim within 30 calendar days following receipt of the claim. This period may be extended for an additional 15 days, provided that we have determined that an extension is necessary due to matters beyond our control, and notify you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which we expect to render a decision. If the extension is due to your failure to provide information necessary to decide the claim, the notice of extension shall specifically describe the required information we need to decide the claim.

If we request additional information, you will have 45 days to provide the information. If you do not provide the requested information within 45 days, we may decide your claim based on the information we have received.

If we deny any part of your claim, you will receive a written notice of denial containing:

- a. The reasons for our decision.
- b. Reference to the parts of the Group Policy on which our decision is based.
- c. Reference to any internal rule or guideline relied upon in making our decision, along with your right to receive a copy of these guidelines, free of charge, upon request.
- d. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Dental practice.
- e. A description of any additional information needed to support your claim and why such information is necessary.
- f. Information concerning your right to a review of our decision.
- g. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA following an adverse benefit determination on review.

## **APPEAL PROCEDURE**

If all or part of a claim is denied, you may request a review in writing within 180 days after receiving notice of the benefit denial.

You may send us written comments or other items to support your claim. You may review and receive copies of any non-privileged information that is relevant to your appeal. There will be no charge for such copies. You may request the names of the experts we consulted who provided advice to us about your claim.

The appeal review will be conducted by the Plan's named fiduciary and will be someone other than the person who denied the initial claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based in whole or in part on a medical judgment, including determinations with regard to whether a service was considered experimental, investigational, and/or not medically necessary, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original judgment and will not be subordinate to that person. Our review will include any written comments or other items you submit to support your claim.

We will review your claim promptly after we receive your request.

If your appeal is about urgent care, you may call Toll Free at 877-897-4328, and an Expedited Review will be conducted. Verbal notification of our decision will be made within 72 hours, followed by written notice within 3 calendar days after that.

If your appeal is about benefit decisions related to clinical or medical necessity, a Standard Consultant Review will be conducted. A written decision will be provided within 30 calendar days of the receipt of the request for appeal.

If your appeal is about benefit decisions related to coverage, a Standard Administrative Review will be conducted. A written decision will be provided within 60 calendar days of the receipt of the request for appeal.

If we deny any part of your claim on review, you will receive a written notice of denial containing:

- a. The reasons for our decision.
- b. Reference to the parts of the Group Policy on which our decision is based.
- c. Reference to any internal rule or guideline relied upon in making our decision along with your right to receive a copy of these guidelines, free of charge, upon request.
- d. Information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.
- e. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Dental practice.
- f. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA.

Certain state laws also require specified internal appeal procedures and/or external review processes. In addition to the review procedures defined above, you may also have additional rights provided to you under state law. Please review your certificate for such information, call us, or contact your state insurance regulatory agency for assistance. In any event, you need not exhaust such state law procedures prior to bringing civil action under Section 502(a) of ERISA.

Any request for appeal should be directed to:

Quality Control, P.O. Box 82657, Lincoln, NE 68501-2657.



TheStandard®

## ***HIPAA Notice of Privacy Practices***

**To:** All Insureds covered under a Dental Insurance policy ("Health Plan") with Standard Insurance Company

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

Standard Insurance Company ("The Standard") is committed to protecting the health information that we maintain about you. As required by rules effective April 14, 2003, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), this notice provides you with information about your rights and our legal duties and practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures that The Standard will make of your protected health information.

"Protected health information" includes any identifiable information that we obtain from you or others that relates to your past, present or future health care and treatment or the payment for your health care and treatment. Your health care professional may have different policies or notices regarding his or her use and disclosure of your health information created in the health care professional's office or clinic.

The Standard reserves the right to change the terms of this notice and to make the revised notice effective for all protected health information we maintain. You may request a paper copy of the most current privacy notice from our office or access it on our Web site at [www.standard.com/hipaa](http://www.standard.com/hipaa).

### ***Permitted Uses and Disclosures of Your Health Information***

We will disclose health information about you when required to do so by federal, state or local law. For example, we may disclose health information when required by a court order, subpoena, warrant, summons or similar process. The following describes the purposes for which The Standard is permitted or required by law to use or disclose your Health Plan coverage information without your authorization:

**Treatment.** This means the provision, coordination or management of your health care and related services, including any referrals for health care from one health professional to another. For example, we may use or disclose health information about you to facilitate treatment or services by health care providers. We may disclose health information about you to other health care professionals who are involved in taking care of you.

**Payment.** This means activities to facilitate payment for the treatment and services you receive from health care professionals, including to obtain premium, to determine eligibility, coverage or benefit responsibilities under your insurance coverage, or to coordinate your insurance coverage. For example, the information on claim forms sent to us may include information that identifies you, as well as your diagnosis, and the procedures and supplies used. We may share this information with outside health care consultants performing a business service for The Standard. Likewise, we may share health information with other insurance carriers to coordinate benefit payments. We mail Explanation of Benefits forms and other information to the address we have on record for the primary member. In addition, claim information may be accessible through our website requiring an access code and our toll-free number.

**Health Care Operations.** This means the support functions related to treatment and payment, such as quality assurance activities, case management, underwriting, premium rating, business management and other general administrative activities. For example, we may use health information in connection with conducting quality assessment and improvement activities, underwriting, premium rating and other activities relating to your coverage, including auditing functions and fraud detection and reporting. We may also disclose health information to business associates if they need to receive health information to provide a service to us and by contract agree to abide by the same high standards of safeguarding your health information. We are prohibited from using or disclosing your genetic health information for underwriting purposes.

**Public Health Activities.** We may disclose health information to public health or legal authorities charged with preventing or controlling disease, injury (including abuse) or disability, or to a governmental agency or regulator with health care oversight responsibilities.

**Military and Veterans.** If you are a member of the armed forces, we may disclose health information about you as required by military command authorities.

**Workers' Compensation.** We may disclose health information about you for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

**Coroners and Medical Examiners.** We may disclose health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

**Organ and Tissue Donation.** We may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

**Research Purposes.** We may disclose health information for research purposes.

**Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute.

**Law Enforcement and National Security and Intelligence Activities.** We may disclose health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process. We may disclose health information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

**To Avert a Serious Threat to Health or Safety.** We may disclose health information to avert a serious threat to someone's health or safety. We may disclose health information to federal, state or local agencies engaged in disaster relief to allow such entities to carry out their responsibilities in specific disaster situations.

**Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care, (2) to protect your health and safety or the health and safety of others or (3) for the safety and security of the correctional institution.

**Disclosure to your Plan Sponsor.** Information may be disclosed to your plan sponsor for purposes of plan administration if the plan sponsor has certified that plan documents have been amended as required by HIPAA. De-identified summary health information may be disclosed to your plan sponsor for the purposes of obtaining health insurance bids or modifying, amending, or terminating the health plan.

In the following situations generally we must obtain your authorization before disclosing your health information:

**Sale of Protected Health Information.** We must obtain your authorization prior to selling your health information. If we will obtain financial remuneration for such sale, we must disclose that to you in the authorization.

**Psychotherapy Notes.** Most uses and disclosures of your psychotherapy notes require your authorization.

**Marketing.** We must obtain your authorization prior to using or disclosing your health information for marketing purposes in most situations. If we will obtain financial remuneration for such marketing, we must disclose that to you in the authorization.

**Other Uses and Disclosures of Your Health Information.** Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission in writing at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization, except to the extent that we have already taken action in reliance on your authorization.

### ***Your Rights Regarding Your Health Information***

The following describes your rights regarding the health information we maintain about you. To exercise your rights, you must submit your request in writing to Standard Insurance Company, Attn: Quality Assurance Specialist, PO Box 82629, Lincoln, NE 68501-2629.

**Right to Inspect and Copy.** You have the right to inspect and copy health information that we maintain about you. To inspect or copy your health information, you must submit your request in writing. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Please contact our Privacy Contact at the address or telephone number listed on the last page of this document if you have questions about access to your health information.

**Right to Amend.** If you feel that the health information we have about you is incorrect or incomplete, you may ask us in writing to amend the information. You have the right to request an amendment for as long as we maintain the information.

In addition, you must provide a reason that supports your request. Any agreed-upon correction to your health information will be included as an addition to, and not a replacement of, already existing records.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (1) is not part of the health information kept by us, (2) was not created by us, unless the person or entity that created the information is no longer available to make the amendment, (3) is not part of the information which you would be permitted to inspect and copy or (4) is accurate and complete.

**Right to an Accounting of Disclosures.** You have the right to request an accounting of disclosures of your health information made by us in the six years prior to the date that the accounting is requested (or shorter period as requested). This does not include disclosures (1) to carry out treatment, payment, or health care operations; (2) made to you or pursuant to your authorization; (3) for national security or intelligence purposes; (4) to corrections institutions or law enforcement officials or (5) made prior to April 14, 2003.

Your first request for an accounting in any 12-month period shall be provided without charge. A reasonable fee shall be imposed for each subsequent request for an accounting within the same 12-month period.

**Right to Request Restrictions.** You have the right to request a restriction or limitation of the health information we use or disclose about you for treatment, payment or health care operations. We are not required to agree to

your request unless your request is to restrict disclosure to a health plan for purposes of payment or health care operations when you or someone on your behalf (but not the health plan) has already made full payment.

To request restrictions, you must make your request in writing to our Privacy Contact indicated below. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both and (3) to whom you want the limits to apply.

**Right to Request Confidential Communications.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will accommodate reasonable requests. We will not ask you the reason for your request. Please make this request in writing to our Privacy Contact indicated below.

**Right to Breach Notification.** We are required by law to maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices with respect to your health information. We are also required by law to notify affected individuals following a breach of unsecured health information.

**Your Right to File a Complaint.** If you believe your privacy rights have been violated, please submit your complaint in writing to:

Standard Insurance Company  
Attn: Quality Assurance Specialist  
PO Box 82629  
Lincoln, NE 68501-2629

You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

***Privacy Contact***

If you have any questions or would like further information about this notice or your rights regarding your health information, please contact the Quality Assurance Specialist at 800.547.9515 or the above address.

This notice is revised effective September 23, 2016.



## STANDARD INSURANCE COMPANY

A Stock Life Insurance Company  
900 SW Fifth Avenue  
Portland, Oregon 97204-1282  
(503) 321-7000

### CERTIFICATE GROUP DENTAL INSURANCE

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**The Policyholder**     **COLUMBIA COUNTY BOARD OF COUNTY COMMISSIONERS  
BOARD OF COUNTY COMMISSIONERS**

**Policy Number**     **160-162038**     **Insured Person**

**Plan Effective Date**     **October 1, 2020**     **Certificate Effective Date**  
**Refer to Exceptions on 9070**

**Plan Change Effective Date**     **October 1, 2024**

**Class Number 3**

Standard Insurance Company certifies that you will be insured for the benefits described on the following pages, according to all the terms of the group policy numbered above which has been issued to the Policyholder.

Possession of this certificate does not necessarily mean you are insured. You are insured only if you meet the requirements set out in this certificate.

The group policy may be amended or cancelled without the consent of the insured person.

**The group policy and this certificate are governed by the laws of the state in which the group policy was delivered.**

If you should have any questions regarding your coverage or claim payments, you may contact us toll-free at 800-547-9515.

**STANDARD INSURANCE COMPANY**

A handwritten signature in black ink, appearing to read "Daniel J. McMillan". The signature is fluid and cursive, with the first name being the most prominent.

Daniel J. McMillan  
President and CEO

## FLORIDA - IMPORTANT INFORMATION TO INSUREDS

### We are here to serve you . . .

You have the right to receive medically appropriate care in a timely and convenient manner and to be an active participant in any decision making regarding treatment, care and services provided to you or one of your family members who are covered under this plan.

In order to provide you the best possible service, it is important that you provide any necessary information to your provider that will facilitate effective medical care and that you cooperate with your provider(s) by keeping appointments and following recommended treatment.

Please review your certificate of coverage carefully so that you fully understand the benefits provided. If you have a question about your policy or if you need assistance with a problem, feel free to contact us at the number shown below.

If you have a grievance or complaint regarding an adverse decision, you may call us below or document your concerns in writing. Written documentation can be sent to the following:

Name:	Quality Assurance
Address:	P.O. Box 82629 Lincoln, NE 68501-2629
Phone:	888-418-6811
Fax:	402-309-2579

The complaint will be carefully reviewed. If the initial claim was denied based on clinical necessity or paid as an alternate benefit, then a licensed provider will be involved in the review of the appeal. A written decision will be sent to the claimant within 15 business days following the receipt of the appeal.

### If you are not satisfied . . .

Should you feel you are not being treated fairly, we want you to know you may contact the Department of Financial Services with your complaint and seek assistance from the governmental agency that regulates insurance.

To contact them, write or call:

**Division of Consumer Services  
Department of Financial Services  
200 East Gaines Street  
Tallahassee, FL 32399-0321  
(877) 693-5236 or (850) 413-3089**

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**SCHEDULE OF BENEFITS  
OUTLINE OF COVERAGE**

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

<u>Benefit Class</u>	<u>Class Description</u>
Class 3	Eligible Employee Electing High Dental

**DENTAL EXPENSE BENEFITS**

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

Deductible Amount:

Type 1 Procedures	\$0
Combined Type 2 and Type 3 Procedures - Each Benefit Period	\$50

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

Maximum Family Deductible	\$150
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Coinsurance Percentage:

Type 1 Procedures	100%
Type 2 Procedures	80%
Type 3 Procedures	60%

Maximum Amount - Each Benefit Period	\$2,000
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**ORTHODONTIC EXPENSE BENEFITS**

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

## DEFINITIONS

**COMPANY** refers to Standard Insurance Company. The words "we", "us" and "our" refer to Company. Our Home Office address is 900 SW Fifth Avenue, Portland, Oregon 97204-1282.

**POLICYHOLDER** refers to the Policyholder stated on the face page of the policy.

**INSURED** refers to a person:

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

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

**DEPENDENT** refers to:

- a. an Insured's spouse.
- b. each child through the end of the year in which they turn 26 years of age, for whom the Insured or the Insured's spouse is legally responsible, including natural born children, newborn adopted children from the date of placement for adoption, any child placed with the Insured for adoption, a foster child or other child in court-ordered custody, placed pursuant to Chapter 63 of Florida Code and, children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws. Grandchildren, spouses of Dependents and other Dependent family members under the age of 26 are not eligible for coverage under this plan.
- c. each child through the end of the year in which they turn 26 but less than 30 who is a full-time student at an accredited school or college and is primarily dependent on the Insured or the Insured's spouse for support and maintenance.
- d. each child through the end of the year in which they turn 26 or older who is Totally Disabled and becomes Totally Disabled as defined below while insured as a dependent under b. or c. above. Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

**TOTAL DISABILITY** describes the Insured's Dependent as:

1. Continuously incapable of self-sustaining employment because of developmental disability or physical handicap; and
2. Chiefly dependent upon the Insured for support and maintenance.

**DEPENDENT UNIT** refers to all of the people who are insured as the dependents of any one Insured.

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

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

**LATE ENTRANT** refers to any person:

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

**PLAN EFFECTIVE DATE** refers to the date coverage under the policy becomes effective. The Plan Effective Date for the Policyholder is shown on the policy cover. The effective date of coverage for an Insured is shown in the Policyholder's records.

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

**PLAN CHANGE EFFECTIVE DATE** refers to the date that the policy provisions originally issued to the Policyholder change as requested by the Policyholder. The Plan Change Effective date for the Policyholder will be shown on the policy cover, if the Policyholder has requested a change. The plan change effective date for an Insured is shown in the Policyholder’s records or on the cover of the certificate.

**CONDITIONS FOR INSURANCE COVERAGE**  
*ELIGIBILITY*

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

If employment is the basis for membership, a member of the Eligible Class for Insurance is any eligible employee electing high dental working at least 30 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

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

**ELIGIBLE CLASS FOR DEPENDENT INSURANCE.** Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the first of the month falling on or first following the latest of:

1. the day he or she qualifies for coverage as a Member;
2. the day he or she becomes a Member; or
3. the day he or she first has a dependent.

**COVERAGE FOR NEWBORN AND ADOPTED CHILDREN.** A newborn child will be covered from the date of birth. Coverage for a newborn child of a covered dependent other than a spouse will stop on the date the child attains eighteen months of age.

An adopted child, foster child and other child in court-ordered custody placed pursuant to Chapter 63 will be covered from the date of placement in the Insured's residence. A newborn adopted child will be covered from the date of birth if the Insured has agreed in writing to adopt the child prior to its birth and the child is ultimately placed in the Insured's residence.

Coverage for a newborn child shall consist of coverage for all covered Dental expenses, subject to applicable deductibles, coinsurance percentages, maximums and limitations, including the necessary care or treatment of congenital defects, birth abnormalities, including cleft lip and cleft palate and premature birth.

The Insured may give us written notice within 61 days of the date of birth or placement of a dependent child to start coverage. If timely notice is given, we will not charge an additional premium for the 61-day notice period. If timely notice is not given, we will charge the applicable additional premium from the date of birth or placement for an adopted child. We will not deny coverage for a child due to the failure of the Insured to notify us within 60 days of the child's birth or placement.

A Member must be an Insured to also insure his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any eligible employee electing high dental working at least 30 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

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

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

**CONTRIBUTION REQUIREMENTS.** Member Insurance: An Insured is required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

**SECTION 125.** This plan is provided as part of the Employer's Section 125 Plan. Each Member has the option under the Section 125 Plan of participating or not participating in this plan.

If a Member does not elect to participate when initially eligible, the Member may elect to participate at a subsequent Election Period. This Election Period will be held each year and those who elect to participate in this plan at that time will have their coverage become effective on October 1.

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

**ELIGIBILITY PERIOD.** For Members on the Plan Effective Date of the policy, coverage is effective immediately.

For persons who become Members after the Plan Effective Date of the policy, qualification will occur on the first of the month falling on or first following the eligibility period of 60 calendar day(s) of continuous active employment.

**OPEN ENROLLMENT.** If a Member does not elect to participate when initially eligible, the Member may elect to participate at the Policyholder's next enrollment period. This enrollment period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on October 1.

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

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

**EFFECTIVE DATE.** Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be the first of the month falling on or first following:

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.
2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.

3. the date we accept the Member and/or Dependent for insurance when the Member and/or Dependent is a Late Entrant. The Member and/or Dependent will be subject to any limitation concerning Late Entrants.

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

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

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

But any person who is not in active service or is totally disabled will be insured on the Effective Date if:

- i. the person was insured under a policy of group insurance providing like benefits which ended on the day immediately before the Effective Date of the policy providing this coverage; and
- ii. the person is considered a Member or an eligible Dependent under the policy providing this coverage; and had the prior policy contained the same definition of eligibility, would have been a Member or Dependent under the prior policy.

#### ***TERMINATION DATES***

**INSUREDS.** The insurance for any Insured, will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

**DEPENDENTS.** The insurance for all of an Insured's dependents will automatically terminate on the end of the month falling on or next following the **earliest of:**

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

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

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

## DENTAL EXPENSE BENEFITS

We will determine dental expense benefits according to the terms of the group policy for dental expenses incurred by an Insured. An Insured person has the freedom of choice to receive treatment from any Provider.

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

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

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

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

**COVERED EXPENSES.** Covered Expenses include:

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

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

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

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

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

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

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

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

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

**EXTENSION OF BENEFITS.** The policy provides an extension of benefits if all the following conditions are met:

1. Only dental procedures, as defined within the Table of Dental Procedures, are eligible for this extension, **except** for the dental procedures performed for routine examinations, cleanings, radiographic images and sealants.
2. The dental procedures must have been performed within 90 days after an Insured's insurance terminates due to discontinuance of the policy.
3. The course of dental treatment or dental procedures must have been recommended to the Insured by a provider in writing and commenced while insurance was in effect for the Insured.
4. Any dental procedures performed in the 90-day extension period are subject to the same policy provisions that would have applied had the Insured's insurance still been in effect.
5. To be eligible for this extension, the Insured is not required to be totally disabled.

When all the foregoing conditions have been met, dental procedures performed after the insurance on an Insured terminates will be considered as if the Insured's insurance was still in effect.

This extension will terminate on the earlier of:

1. the end of the 90-day extension period; and
2. the date the Insured is covered under another group health plan providing similar dental coverage. However, the extension will not terminate if the succeeding plan excludes the dental procedures eligible for extension with a waiting period.

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

1. in the first 12 months that a person is insured if the person is a Late Entrant; except for evaluations, prophylaxis (cleanings), and fluoride application.
2. for initial placement of any dental prosthesis or prosthetic crown unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such dental prosthesis or prosthetic crown must include the replacement of the extracted tooth or teeth.

3. for appliances, restorations, or procedures to:
  - a. alter vertical dimension;
  - b. restore or maintain occlusion; or
  - c. splint or replace tooth structure lost as a result of abrasion or attrition.
4. for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.
5. to replace lost or stolen appliances.
6. for any treatment which is for cosmetic purposes.
7. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)
8. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).
9. for which the Insured person is paid benefits under any workmen's compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.
10. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.
11. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.
12. because of war or any act of war, declared or not. However, terrorism, or any act of terrorism, will not be excluded.

## TABLE OF DENTAL PROCEDURES

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

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

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.
- Covered Procedures are subject to all plan provisions, procedure and frequency limitations, and/or consultant review. Examples of procedures which may be subject to Alternate Benefits are crowns, inlays, onlays, fixed partial dentures, composite restorations, and overdentures. Examples of procedures which may be subject to plan payments based on consultant review are services related to oral maxillofacial surgery, fixed partial dentures, periodontics, and endodontics.
- Reference to "traumatic injury" under this plan is defined as any injury caused by an object or a force other than bruxism (grinding of teeth).
- Benefits for replacement dental prosthesis or prosthetic crown will be based on the prior placement date. Frequencies which reference Benefit Period will be measured forward within the limits defined as the Benefit Period. All other frequencies will be measured forward from the last covered date of service.
- We may request radiographs, periodontal charting, surgical notes, narratives, photos and/or a patient's records on any procedure for our dental consultants to review. Commonly reviewed procedures include: Periodontic procedures, Oral Maxillofacial Surgical procedures, Implants, Crowns, Inlays, Onlays, Core Build-Ups, Fixed Partial Dentures, Post and Cores, Veneers, Endodontic Retreatment, and Apexification/Recalcification procedures.
- We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive by our insured.
- A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.

## **TYPE 1 PROCEDURES**

**PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary**  
**PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge**  
**BENEFIT PERIOD - Calendar Year**  
**For Additional Limitations - See Limitations**

### **ROUTINE ORAL EVALUATION**

- D0120 Periodic oral evaluation - established patient.
- D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver.
- D0150 Comprehensive oral evaluation - new or established patient.
- D0180 Comprehensive periodontal evaluation - new or established patient.

**COMPREHENSIVE EVALUATION: D0150, D0180**

Coverage is limited to 1 of each of these procedures per provider.

In addition, D0150, D0180 coverage is limited to 2 of any of these procedures per 12 month(s).

D0120, D0145, also contribute(s) to this limitation.

If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

**ROUTINE EVALUATION: D0120, D0145**

Coverage is limited to 2 of any of these procedures per 12 month(s).

D0150, D0180, also contribute(s) to this limitation.

Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.

### **LIMITED ORAL EVALUATION**

- D0140 Limited oral evaluation - problem focused.
- D0170 Re-evaluation - limited, problem focused (established patient; not post-operative visit).

**LIMITED ORAL EVALUATION: D0140, D0170**

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

### **COMPLETE SERIES OR PANORAMIC**

- D0210 Intraoral - comprehensive series of radiographic images.
- D0330 Panoramic radiographic image.

**COMPLETE SERIES/PANORAMIC: D0210, D0330**

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

### **OTHER XRAYS**

- D0220 Intraoral - periapical first radiographic image.
- D0230 Intraoral - periapical each additional radiographic image.
- D0240 Intraoral - occlusal radiographic image.
- D0250 Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector.
- D0251 Extra-oral posterior dental radiographic image.

**PERIAPICAL: D0220, D0230**

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

### **BITEWINGS**

- D0270 Bitewing - single radiographic image.
- D0272 Bitewings - two radiographic images.
- D0273 Bitewings - three radiographic images.
- D0274 Bitewings - four radiographic images.
- D0277 Vertical bitewings - 7 to 8 radiographic images.

**BITEWINGS: D0270, D0272, D0273, D0274**

Coverage is limited to 2 of any of these procedures per 12 month(s).

D0277, also contribute(s) to this limitation.

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

**VERTICAL BITEWINGS: D0277**

## TYPE 1 PROCEDURES

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

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

### ORAL PATHOLOGY/LABORATORY

- D0472 Accession of tissue, gross examination, preparation and transmission of written report.
- D0473 Accession of tissue, gross and microscopic examination, preparation and transmission of written report.
- D0474 Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.

#### ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

Coverage is limited to 1 of any of these procedures per 12 month(s).

Coverage is limited to 1 examination per biopsy/excision.

### PROPHYLAXIS (CLEANING) AND FLUORIDE

- D1110 Prophylaxis - adult.
- D1120 Prophylaxis - child.
- D1206 Topical application of fluoride varnish.
- D1208 Topical application of fluoride-excluding varnish.
- D9932 Cleaning and inspection of removable complete denture, maxillary.
- D9933 Cleaning and inspection of removable complete denture, mandibular.
- D9934 Cleaning and inspection of removable partial denture, maxillary.
- D9935 Cleaning and inspection of removable partial denture, mandibular.

#### FLUORIDE: D1206, D1208

Coverage is limited to 1 of any of these procedures per 12 month(s).

Benefits are considered for persons age 13 and under.

#### PROPHYLAXIS: D1110, D1120

Coverage is limited to 2 of any of these procedures per 12 month(s).

D4346, D4910, also contribute(s) to this limitation.

An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

#### CLEANING AND INSPECTION OF REMOVABLE DENTURE: D9932, D9933, D9934, D9935

Coverage is limited to 2 of any of these procedures per 12 month(s).

Benefits are not available when performed on the same date as prophylaxis (cleaning) or periodontal maintenance.

### SEALANTS AND CARIES MEDICAMENTS

- D1351 Sealant - per tooth.
- D1352 Preventive resin restoration in a moderate to high caries risk patient-permanent.
- D1353 Sealant repair - per tooth.
- D1354 Application of caries arresting medicament-per tooth.
- D1355 Caries preventive medicament application - per tooth.

#### SEALANT: D1351, D1352, D1353

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

D1354, D1355, also contribute(s) to this limitation.

Benefits are considered for persons age 16 and under.

Benefits are considered on permanent molars only.

Coverage is allowed on the occlusal surface only.

### SPACE MAINTAINERS

- D1510 Space maintainer-fixed, unilateral-per quadrant.
- D1516 Space maintainer - fixed - bilateral, maxillary.
- D1517 Space maintainer - fixed - bilateral, mandibular.
- D1520 Space maintainer-removable, unilateral-per quadrant.
- D1526 Space maintainer - removable - bilateral, maxillary.
- D1527 Space maintainer - removable - bilateral, mandibular.
- D1551 Re-cement or re-bond bilateral space maintainer-maxillary.
- D1552 Re-cement or re-bond bilateral space maintainer-mandibular.

## TYPE 1 PROCEDURES

- D1553 Re-cement or re-bond unilateral space maintainer-per quadrant.
  - D1556 Removal of fixed unilateral space maintainer-per quadrant.
  - D1557 Removal of fixed bilateral space maintainer-maxillary.
  - D1558 Removal of fixed bilateral space maintainer-mandibular.
  - D1575 Distal shoe space maintainer - fixed, unilateral-per quadrant.
- SPACE MAINTAINER: D1510, D1516, D1517, D1520, D1526, D1527, D1575

Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date.

## APPLIANCE THERAPY

- D8210 Removable appliance therapy.
- D8220 Fixed appliance therapy.

APPLIANCE THERAPY: D8210, D8220

Coverage is limited to the correction of thumb-sucking.

## **TYPE 2 PROCEDURES**

**PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary**  
**PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge**  
**BENEFIT PERIOD - Calendar Year**  
**For Additional Limitations - See Limitations**

### **AMALGAM RESTORATIONS (FILLINGS)**

- D2140 Amalgam - one surface, primary or permanent.
- D2150 Amalgam - two surfaces, primary or permanent.
- D2160 Amalgam - three surfaces, primary or permanent.
- D2161 Amalgam - four or more surfaces, primary or permanent.

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

Coverage is limited to 1 of any of these procedures per 6 month(s).

D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, D9911, also contribute(s) to this limitation.

### **RESIN RESTORATIONS (FILLINGS)**

- D2330 Resin-based composite - one surface, anterior.
- D2331 Resin-based composite - two surfaces, anterior.
- D2332 Resin-based composite - three surfaces, anterior.
- D2335 Resin-based composite - four or more surfaces (anterior).
- D2391 Resin-based composite - one surface, posterior.
- D2392 Resin-based composite - two surfaces, posterior.
- D2393 Resin-based composite - three surfaces, posterior.
- D2394 Resin-based composite - four or more surfaces, posterior.
- D2410 Gold foil - one surface.
- D2420 Gold foil - two surfaces.
- D2430 Gold foil - three surfaces.
- D2990 Resin infiltration of incipient smooth surface lesions.

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

Coverage is limited to 1 of any of these procedures per 6 month(s).

D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

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

### **STAINLESS STEEL CROWN (PREFABRICATED CROWN)**

- D2390 Resin-based composite crown, anterior.
- D2928 Prefabricated porcelain/ceramic crown - permanent tooth.
- D2929 Prefabricated porcelain/ceramic crown - primary tooth.
- D2930 Prefabricated stainless steel crown - primary tooth.
- D2931 Prefabricated stainless steel crown - permanent tooth.
- D2932 Prefabricated resin crown.
- D2933 Prefabricated stainless steel crown with resin window.
- D2934 Prefabricated esthetic coated stainless steel crown - primary tooth.

STAINLESS STEEL CROWN: D2390, D2928, D2929, D2930, D2931, D2932, D2933, D2934

Replacement is limited to 1 of any of these procedures per 12 month(s).

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

### **RECEMENT**

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

## TYPE 2 PROCEDURES

### SEDATIVE FILLING

- D2940 Placement of interim direct restoration.
- D2941 Interim therapeutic restoration - primary dentition.
- D2991 Application of hydroxyapatite regeneration medicament - per tooth.

### ENDODONTICS MISCELLANEOUS

- D3220 Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.
- D3221 Pulpal debridement, primary and permanent teeth.
- D3222 Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.
- D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).
- D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).
- D3333 Internal root repair of perforation defects.
- D3351 Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.).
- D3352 Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.).
- D3353 Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).
- D3357 Pulpal regeneration - completion of treatment.
- D3430 Retrograde filling - per root.
- D3450 Root amputation - per root.
- D3920 Hemisection (including any root removal), not including root canal therapy.
- D3921 Decoronation or submergence of an erupted tooth.

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920, D3921

Procedure D3333 is limited to permanent teeth only.

### ENDODONTIC THERAPY (ROOT CANALS)

- D3310 Endodontic therapy, anterior tooth.
- D3320 Endodontic therapy, premolar tooth (excluding final restorations).
- D3330 Endodontic therapy, molar tooth (excluding final restorations).
- D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.
- D3346 Retreatment of previous root canal therapy - anterior.
- D3347 Retreatment of previous root canal therapy - premolar.
- D3348 Retreatment of previous root canal therapy - molar.

ROOT CANALS: D3310, D3320, D3330, D3332

Benefits are considered on permanent teeth only.

Allowances include intraoperative radiographic images and cultures but exclude final restoration.

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

Coverage is limited to 1 of any of these procedures per 12 month(s).

D3310, D3320, D3330, also contribute(s) to this limitation.

Benefits are considered on permanent teeth only.

Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative radiographic images and cultures but exclude final restoration.

### SURGICAL ENDODONTICS

- D3355 Pulpal regeneration - initial visit.
- D3356 Pulpal regeneration - interim medication replacement.
- D3410 Apicoectomy - anterior.
- D3421 Apicoectomy - premolar (first root).
- D3425 Apicoectomy - molar (first root).
- D3426 Apicoectomy (each additional root).
- D3471 Surgical repair of root resorption - anterior.
- D3472 Surgical repair of root resorption - premolar.
- D3473 Surgical repair of root resorption - molar.
- D3501 Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior.
- D3502 Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar.
- D3503 Surgical exposure of root surface without apicoectomy or repair of root resorption - molar.

### SURGICAL PERIODONTICS

## TYPE 2 PROCEDURES

- D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.
- D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.
- D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.
- D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.
- D4260 Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.
- D4261 Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.
- D4263 Bone replacement graft - retained natural tooth - first site in quadrant.
- D4264 Bone replacement graft - retained natural tooth - each additional site in quadrant.
- D4265 Biologic materials to aid in soft and osseous tissue regeneration, per site.
- D4270 Pedicle soft tissue graft procedure.
- D4273 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft.
- D4274 Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area).
- D4275 Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant or edentulous tooth position in graft.
- D4276 Combined connective tissue and pedicle graft, per tooth.
- D4277 Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft.
- D4278 Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site.
- D4283 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.
- D4285 Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.

### BONE GRAFTS: D4263, D4264, D4265

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

Coverage is limited to treatment of periodontal disease.

### GINGIVECTOMY: D4210, D4211

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

Coverage is limited to treatment of periodontal disease.

### OSSEOUS SURGERY: D4240, D4241, D4260, D4261

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

Coverage is limited to treatment of periodontal disease.

### TISSUE GRAFTS: D4270, D4273, D4275, D4276, D4277, D4278, D4283, D4285

Each quadrant is limited to 2 of any of these procedures per 3 year(s).

Coverage is limited to treatment of periodontal disease.

## NON-SURGICAL PERIODONTICS

- D4341 Periodontal scaling and root planing - four or more teeth per quadrant.
- D4342 Periodontal scaling and root planing - one to three teeth, per quadrant.
- D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.

### ANTIMICROBIAL AGENTS: D4381

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

### PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

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

## FULL MOUTH DEBRIDEMENT

- D4355 Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit.

### FULL MOUTH DEBRIDEMENT: D4355

## TYPE 2 PROCEDURES

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

### PERIODONTAL MAINTENANCE

D4346 Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation.

D4910 Periodontal maintenance.

PERIODONTAL MAINTENANCE: D4346, D4910

Coverage is limited to 2 of any of these procedures per 12 month(s).

D1110, D1120, also contribute(s) to this limitation.

Benefits are not available if performed on the same date as any other periodontal service.

Procedure D4910 is contingent upon evidence of full mouth active periodontal therapy.

Procedure D4346 is limited to persons age 14 and over.

### DENTURE REPAIR

D5511 Repair broken complete denture base, mandibular.

D5512 Repair broken complete denture base, maxillary.

D5520 Replace missing or broken teeth - complete denture - per tooth.

D5611 Repair resin partial denture base, mandibular.

D5612 Repair resin partial denture base, maxillary.

D5621 Repair cast partial framework, mandibular.

D5622 Repair cast partial framework, maxillary.

D5630 Repair or replace broken retentive/clasping materials per tooth.

D5640 Replace missing or broken teeth - partial denture - per tooth.

### DENTURE RELINES

D5730 Reline complete maxillary denture (direct).

D5731 Reline complete mandibular denture (direct).

D5740 Reline maxillary partial denture (direct).

D5741 Reline mandibular partial denture (direct).

D5750 Reline complete maxillary denture (indirect).

D5751 Reline complete mandibular denture (indirect).

D5760 Reline maxillary partial denture (indirect).

D5761 Reline mandibular partial denture (indirect).

D5765 Soft liner for complete or partial removable denture-indirect.

DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761, D5765

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

### NON-SURGICAL EXTRACTIONS

D7111 Extraction, coronal remnants - primary tooth.

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

### SURGICAL EXTRACTIONS

D7210 Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated.

D7220 Removal of impacted tooth - soft tissue.

D7230 Removal of impacted tooth - partially bony.

D7240 Removal of impacted tooth - completely bony.

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

D7250 Removal of residual tooth roots (cutting procedure).

D7251 Coronectomy - intentional partial tooth removal, impacted teeth only.

### OTHER ORAL SURGERY

D7260 Oroantral fistula closure.

D7261 Primary closure of a sinus perforation.

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

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

D7280 Exposure of an unerupted tooth.

D7282 Mobilization of erupted or malpositioned tooth to aid eruption.

D7283 Placement of device to facilitate eruption of impacted tooth.

## TYPE 2 PROCEDURES

- D7310 Alveoplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
- D7311 Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
- D7320 Alveoplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
- D7321 Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
- D7340 Vestibuloplasty - ridge extension (secondary epithelialization).
- D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).
- D7410 Excision of benign lesion up to 1.25 cm.
- D7411 Excision of benign lesion greater than 1.25 cm.
- D7412 Excision of benign lesion, complicated.
- D7413 Excision of malignant lesion up to 1.25 cm.
- D7414 Excision of malignant lesion greater than 1.25 cm.
- D7415 Excision of malignant lesion, complicated.
- D7440 Excision of malignant tumor - lesion diameter up to 1.25 cm.
- D7441 Excision of malignant tumor - lesion diameter greater than 1.25 cm.
- D7450 Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.
- D7451 Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
- D7460 Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.
- D7461 Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
- D7465 Destruction of lesion(s) by physical or chemical method, by report.
- D7471 Removal of lateral exostosis (maxilla or mandible).
- D7472 Removal of torus palatinus.
- D7473 Removal of torus mandibularis.
- D7485 Reduction of osseous tuberosity.
- D7490 Radical resection of maxilla or mandible.
- D7509 Marsupialization of odontogenic cyst.
- D7510 Incision and drainage of abscess - intraoral soft tissue.
- D7520 Incision and drainage of abscess - extraoral soft tissue.
- D7530 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.
- D7540 Removal of reaction producing foreign bodies, musculoskeletal system.
- D7550 Partial ostectomy/sequestrectomy for removal of non-vital bone.
- D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body.
- D7910 Suture of recent small wounds up to 5 cm.
- D7911 Complicated suture - up to 5 cm.
- D7912 Complicated suture - greater than 5 cm.
- D7961 Buccal/labial frenectomy (frenulectomy).
- D7962 Lingual frenectomy (frenulectomy).
- D7963 Frenuloplasty.
- D7970 Excision of hyperplastic tissue - per arch.
- D7972 Surgical reduction of fibrous tuberosity.
- D7979 Non-surgical sialolithotomy.
- D7980 Surgical sialolithotomy.
- D7983 Closure of salivary fistula.

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

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

### BIOPSY OF ORAL TISSUE

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

### PALLIATIVE

- D9110 Palliative treatment of dental pain - per visit.

PALLIATIVE TREATMENT: D9110

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

## TYPE 2 PROCEDURES

### ANESTHESIA-GENERAL/IV

- D9219 Evaluation for moderate sedation, deep sedation or general anesthesia.
- D9222 Deep sedation/general anesthesia - first 15 minutes.
- D9223 Deep sedation/general anesthesia - each subsequent 15 minute increment.
- D9239 Intravenous moderate (conscious) sedation/analgesia - first 15 minutes.
- D9243 Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment.

GENERAL ANESTHESIA: D9222, D9223, D9239, D9243

Coverage is only available with a cutting procedure. A maximum of four (D9222, D9223, D9239 or D9243) will be considered.

### PROFESSIONAL CONSULT/VISIT/SERVICES

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

CONSULTATION: D9310

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

OFFICE VISIT: D9430, D9440

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

### OCCLUSAL ADJUSTMENT

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

OCCLUSAL ADJUSTMENT: D9951, D9952

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

### MISCELLANEOUS

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

DESENSITIZATION: D9911

Coverage is limited to 1 of any of these procedures per 6 month(s).

D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, also contribute(s) to this limitation.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

### **TYPE 3 PROCEDURES**

**PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary**  
**PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge**  
**BENEFIT PERIOD - Calendar Year**  
**For Additional Limitations - See Limitations**

#### **INLAY RESTORATIONS**

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

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

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

#### **ONLAY RESTORATIONS**

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

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

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

D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.

Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

#### **CROWNS SINGLE RESTORATIONS**

- D2710 Crown - resin-based composite (indirect).
- D2712 Crown - 3/4 resin-based composite (indirect).
- D2720 Crown - resin with high noble metal.
- D2721 Crown - resin with predominantly base metal.
- D2722 Crown - resin with noble metal.
- D2740 Crown - porcelain/ceramic.
- D2750 Crown - porcelain fused to high noble metal.
- D2751 Crown - porcelain fused to predominantly base metal.
- D2752 Crown - porcelain fused to noble metal.
- D2753 Crown-porcelain fused to titanium and titanium alloys.
- D2780 Crown - 3/4 cast high noble metal.
- D2781 Crown - 3/4 cast predominantly base metal.
- D2782 Crown - 3/4 cast noble metal.
- D2783 Crown - 3/4 porcelain/ceramic.

## TYPE 3 PROCEDURES

- D2790 Crown - full cast high noble metal.
- D2791 Crown - full cast predominantly base metal.
- D2792 Crown - full cast noble metal.
- D2794 Crown - titanium and titanium alloys.

CROWN: D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794

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

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.

Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months. Coverage is limited to necessary placement resulting from decay or traumatic injury.

### CORE BUILD-UP

- D2950 Core buildup, including any pins when required.

CORE BUILDUP: D2950

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

### POST AND CORE

- D2952 Post and core in addition to crown, indirectly fabricated.
- D2954 Prefabricated post and core in addition to crown.

### FIXED CROWN AND PARTIAL DENTURE REPAIR

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

### CROWN LENGTHENING

- D4249 Clinical crown lengthening - hard tissue.

### PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

- D5110 Complete denture - maxillary.
- D5120 Complete denture - mandibular.
- D5130 Immediate denture - maxillary.
- D5140 Immediate denture - mandibular.
- D5211 Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth).
- D5212 Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth).
- D5213 Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
- D5214 Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
- D5221 Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth).
- D5222 Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth).

## TYPE 3 PROCEDURES

- D5223 Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
- D5224 Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
- D5225 Maxillary partial denture-flexible base (including retentive/clasping materials, rests, and teeth).
- D5226 Mandibular partial denture-flexible base (including retentive/clasping materials, rests, and teeth).
- D5227 Immediate maxillary partial denture-flexible base (including any clasps, rests and teeth).
- D5228 Immediate mandibular partial denture-flexible base (including any clasps, rests and teeth).
- D5282 Removable unilateral partial denture-one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary.
- D5283 Removable unilateral partial denture-one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular.
- D5284 Removable unilateral partial denture-one piece flexible base (including retentive/clasping materials, rests, and teeth)-per quadrant.
- D5286 Removable unilateral partial denture-one piece resin (including retentive/clasping materials, rests, and teeth)-per quadrant.
- D5670 Replace all teeth and acrylic on cast metal framework (maxillary).
- D5671 Replace all teeth and acrylic on cast metal framework (mandibular).
- D5810 Interim complete denture (maxillary).
- D5811 Interim complete denture (mandibular).
- D5820 Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary.
- D5821 Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular.
- D5863 Overdenture - complete maxillary.
- D5864 Overdenture - partial maxillary.
- D5865 Overdenture - complete mandibular.
- D5866 Overdenture - partial mandibular.
- D5876 Add metal substructure to acrylic full denture (per arch).
- D6110 Implant/abutment supported removable denture for edentulous arch - maxillary.
- D6111 Implant/abutment supported removable denture for edentulous arch - mandibular.
- D6112 Implant/abutment supported removable denture for partially edentulous arch - maxillary.
- D6113 Implant/abutment supported removable denture for partially edentulous arch - mandibular.
- D6114 Implant/abutment supported fixed denture for edentulous arch - maxillary.
- D6115 Implant/abutment supported fixed denture for edentulous arch - mandibular.
- D6116 Implant/abutment supported fixed denture for partially edentulous arch - maxillary.
- D6117 Implant/abutment supported fixed denture for partially edentulous arch - mandibular.
- D6118 Implant/abutment supported interim fixed denture for edentulous arch - mandibular.
- D6119 Implant/abutment supported interim fixed denture for edentulous arch - maxillary.

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5863, D5865, D5876, D6110, D6111, D6114, D6115  
Replacement is limited to 1 of any of these procedures per 5 year(s).

Frequency is waived for accidental injury.

Allowances include adjustments within 6 months after placement date. Procedures D5863, D5865, D6110, D6111, D6114 and D6115 are considered at an alternate benefit of a D5110/D5120. Benefits for procedure D5876 is contingent upon the related denture being covered.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5227, D5228, D5282, D5283, D5284, D5286, D5670, D5671, D5864, D5866, D6112, D6113, D6116, D6117

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

Frequency is waived for accidental injury.

Allowances include adjustments within 6 months of placement date. Procedures D5864, D5866, D6112, D6113, D6116 and D6117 are considered at an alternate benefit of a D5213/D5214.

## DENTURE ADJUSTMENTS

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

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

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

## TYPE 3 PROCEDURES

### ADD TOOTH/CLASP TO EXISTING PARTIAL

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

### DENTURE REBASES

- D5710 Rebase complete maxillary denture.
- D5711 Rebase complete mandibular denture.
- D5720 Rebase maxillary partial denture.
- D5721 Rebase mandibular partial denture.
- D5725 Rebase hybrid prosthesis.

### TISSUE CONDITIONING

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

### PROSTHODONTICS - FIXED

- D6058 Abutment supported porcelain/ceramic crown.
- D6059 Abutment supported porcelain fused to metal crown (high noble metal).
- D6060 Abutment supported porcelain fused to metal crown (predominantly base metal).
- D6061 Abutment supported porcelain fused to metal crown (noble metal).
- D6062 Abutment supported cast metal crown (high noble metal).
- D6063 Abutment supported cast metal crown (predominantly base metal).
- D6064 Abutment supported cast metal crown (noble metal).
- D6065 Implant supported porcelain/ceramic crown.
- D6066 Implant supported crown - porcelain fused to high noble alloys.
- D6067 Implant supported crown - high noble alloys.
- D6068 Abutment supported retainer for porcelain/ceramic FPD.
- D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal).
- D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).
- D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal).
- D6072 Abutment supported retainer for cast metal FPD (high noble metal).
- D6073 Abutment supported retainer for cast metal FPD (predominantly base metal).
- D6074 Abutment supported retainer for cast metal FPD (noble metal).
- D6075 Implant supported retainer for ceramic FPD.
- D6076 Implant supported retainer for FPD - porcelain fused to high noble alloys.
- D6077 Implant supported retainer for metal FPD - high noble alloy.
- D6082 Implant supported crown-porcelain fused to predominantly base alloys.
- D6083 Implant supported crown-porcelain fused to noble alloys.
- D6084 Implant supported crown-porcelain fused to titanium and titanium alloys.
- D6086 Implant supported crown-predominantly base alloys.
- D6087 Implant supported crown-noble alloys.
- D6088 Implant supported crown-titanium and titanium alloys.
- D6094 Abutment supported crown - titanium and titanium alloys.
- D6097 Abutment supported crown-porcelain fused to titanium and titanium alloys.
- D6098 Implant supported retainer-porcelain fused to predominantly base alloys.
- D6099 Implant supported retainer for FPD-porcelain fused to noble alloys.
- D6120 Implant supported retainer-porcelain fused to titanium and titanium alloys.
- D6121 Implant supported retainer for metal FPD-predominantly base alloys.
- D6122 Implant supported retainer for metal FPD-noble alloys.
- D6123 Implant supported retainer for metal FPD-titanium and titanium alloys.
- D6194 Abutment supported retainer crown for FPD - titanium and titanium alloys.
- D6195 Abutment supported retainer-porcelain fused to titanium and titanium alloys.
- D6205 Pontic - indirect resin based composite.
- D6210 Pontic - cast high noble metal.
- D6211 Pontic - cast predominantly base metal.
- D6212 Pontic - cast noble metal.
- D6214 Pontic - titanium and titanium alloys.
- D6240 Pontic - porcelain fused to high noble metal.
- D6241 Pontic - porcelain fused to predominantly base metal.
- D6242 Pontic - porcelain fused to noble metal.

## TYPE 3 PROCEDURES

- D6243 Pontic-porcelain fused to titanium and titanium alloys.
  - D6245 Pontic - porcelain/ceramic.
  - D6250 Pontic - resin with high noble metal.
  - D6251 Pontic - resin with predominantly base metal.
  - D6252 Pontic - resin with noble metal.
  - D6545 Retainer - cast metal for resin bonded fixed prosthesis.
  - D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis.
  - D6549 Resin retainer - for resin bonded fixed prosthesis.
  - D6600 Retainer inlay - porcelain/ceramic, two surfaces.
  - D6601 Retainer inlay - porcelain/ceramic, three or more surfaces.
  - D6602 Retainer inlay - cast high noble metal, two surfaces.
  - D6603 Retainer inlay - cast high noble metal, three or more surfaces.
  - D6604 Retainer inlay - cast predominantly base metal, two surfaces.
  - D6605 Retainer inlay - cast predominantly base metal, three or more surfaces.
  - D6606 Retainer inlay - cast noble metal, two surfaces.
  - D6607 Retainer inlay - cast noble metal, three or more surfaces.
  - D6608 Retainer onlay - porcelain/ceramic, two surfaces.
  - D6609 Retainer onlay - porcelain/ceramic, three or more surfaces.
  - D6610 Retainer onlay - cast high noble metal, two surfaces.
  - D6611 Retainer onlay - cast high noble metal, three or more surfaces.
  - D6612 Retainer onlay - cast predominantly base metal, two surfaces.
  - D6613 Retainer onlay - cast predominantly base metal, three or more surfaces.
  - D6614 Retainer onlay - cast noble metal, two surfaces.
  - D6615 Retainer onlay - cast noble metal, three or more surfaces.
  - D6624 Retainer inlay - titanium.
  - D6634 Retainer onlay - titanium.
  - D6710 Retainer crown - indirect resin based composite.
  - D6720 Retainer crown - resin with high noble metal.
  - D6721 Retainer crown - resin with predominantly base metal.
  - D6722 Retainer crown - resin with noble metal.
  - D6740 Retainer crown - porcelain/ceramic.
  - D6750 Retainer crown - porcelain fused to high noble metal.
  - D6751 Retainer crown - porcelain fused to predominantly base metal.
  - D6752 Retainer crown - porcelain fused to noble metal.
  - D6753 Retainer crown-porcelain fused to titanium and titanium alloys.
  - D6780 Retainer crown - 3/4 cast high noble metal.
  - D6781 Retainer crown - 3/4 cast predominantly base metal.
  - D6782 Retainer crown - 3/4 cast noble metal.
  - D6783 Retainer crown - 3/4 porcelain/ceramic.
  - D6784 Retainer crown 3/4-titanium and titanium alloys.
  - D6790 Retainer crown - full cast high noble metal.
  - D6791 Retainer crown - full cast predominantly base metal.
  - D6792 Retainer crown - full cast noble metal.
  - D6794 Retainer crown - titanium and titanium alloys.
  - D6940 Stress breaker.
- FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794
- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.
- FIXED PARTIAL INLAY: D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624

### TYPE 3 PROCEDURES

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

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12.

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

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

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL PONTIC: D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252

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

D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097, D6098, D6099, D6120, D6121, D6122, D6123, D6194, D6195, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

IMPLANT SUPPORTED CROWN: D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097

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

D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

IMPLANT SUPPORTED RETAINER: D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6098, D6099, D6120, D6121, D6122, D6123, D6194, D6195

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

D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.

### **TYPE 3 PROCEDURES**

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

## ORTHODONTIC EXPENSE BENEFITS

Orthodontic expense benefits will be determined according to the terms of the policy for orthodontic expenses incurred by an Insured. We will determine orthodontic expense benefits according to the terms of the group policy for orthodontic expenses incurred by an Insured.

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

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

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

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

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

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

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

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

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

The Covered Expenses for a Program are based on the estimated cost of the Insured's Program. They are pro-rated by quarter (three-month periods) over the estimated length of the Program, up to a maximum of eight quarters. However, the first payment will be 25 percent of the total allowed Covered Expense. The last quarterly payment for a Program may be changed if the estimated and actual cost of the Program differ.

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

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

## COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies if an Insured person has dental coverage under more than one **Plan**. **Plan** is defined below. All benefits provided under this policy are subject to this section.

The order of benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan**. The **Secondary plan** may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total **Allowable expense**.

### DEFINITIONS

A. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. 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.

(1) **Plan** includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage other than the medical benefits coverage in automobile "no fault" and traditional "fault" type contracts; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) 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**.

B. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one **COB** provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.

C. The order of benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health care coverage under more than one **Plan**.

When **This plan** is primary, it determines payment for its benefits first before those of any other **Plan** without considering any other **Plan's** benefits. When **This plan** is secondary, it 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 expense**.

D. **Allowable expense** is a health care expense, including deductibles, coinsurance and co-payments, 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 a covered person is not an **Allowable expense**.

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

- (1) If a person is covered by 2 or more **Plans** that compute their benefit payments on the basis of 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**.
- (2) If a person 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**.
- (3) If a person is covered by one **Plan** that calculates its benefits or services on the basis of 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 shall be the **Allowable expense** 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 expense** used by the **Secondary plan** to determine its benefits.
- (4) The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. **Closed panel plan** is a **Plan** that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the **Plan**, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **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.

## **ORDER OF BENEFIT DETERMINATION RULES**

When a person is covered by two or more **Plans**, the rules for determining the order of benefit payments are as follows:

- A. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other **Plan**.
- B. (1) Except as provided in Paragraph B(2) below, a **Plan** that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both **Plans** state that the complying plan is primary.  
  
(2) 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 contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.
- C. A **Plan** may consider the benefits paid or provided by another **Plan** in calculating payment of its benefits only when it is secondary to that other **Plan**.
- D. 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, for example 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 the person 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:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

The **Plan** of the parent whose birthday falls earlier in the calendar year is the **Primary plan**; or

If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health 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**.

(c) For a dependent child covered under more than one **Plan** of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-off Employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. 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 as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, 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 is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.

(6) If the preceding rules do not 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 THE BENEFITS OF THIS PLAN**

A. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year 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 health 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 health care coverage.

B. If a covered person 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**.

#### **RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION**

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give the Company any facts it needs 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, the Company 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**. The Company 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 the amount of the payments made by the Company is more than it should have paid under this **COB** provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

## GENERAL PROVISIONS

**NOTICE OF CLAIM.** Written notice of a claim must be given to us within 90 days after the incurred date of the services provided for which benefits are payable.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Policyholder's name, Insured's name, and policy number. If it was not reasonably possible to give written notice within the 90 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

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

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

**TIME OF PAYMENT.** We will pay all benefits within 45 days of when we receive due proof.

If benefits are contested or denied, we will notify the Insured, in writing, which benefits are contested or denied within 45 days of when we received due proof. We will pay or deny any balance remaining on benefits for a claim within 60 days upon receipt of any additional information requested from the Insured. In no event will we hold a claim without paying or denying benefits any later than 120 days.

Payment is considered to be made on the date a draft or other valid instrument is placed in the United States mail in a properly addressed post paid envelope or, if not so posted, on the date of delivery.

We will pay interest at the rate of 10 percent per year on overdue payments on benefits for valid claims.

We will investigate any claim of improper billing of a claim by a Provider upon written notification by an Insured. We will determine if the Insured was properly billed for only those procedures that the Insured actually received. If we determine that the Insured was improperly billed, we will notify the Insured and the provider of our findings and will reduce the amount of payment by the amount determined to be improperly billed. If a reduction is made due to such notification by the Insured, we will pay the Insured 20 percent of the reduction up to \$500.

**PAYMENT OF BENEFITS.** Participating Providers have agreed to accept assignment of benefits for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, all benefits will be paid to the Insured unless otherwise indicated by the Insured's authorization to pay the Non-Participating Provider directly.

**FACILITY OF PAYMENT.** If an Insured or beneficiary is not capable of giving us a valid receipt for any payment or if benefits are payable to the estate of the Insured, then we may, at our option, pay the benefit up to an amount not to exceed \$3,000, to any relative by blood or connection by marriage of the Insured who is considered by us to be equitably entitled to the benefit.

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

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

**LEGAL PROCEEDINGS.** No legal action can be brought against us until 60 days after the Insured sends us the required proof of loss. No legal action against us can start more than the applicable statute of limitations after proof of loss is required.

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

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

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

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

## ERISA INFORMATION AND NOTICE OF YOUR RIGHTS

### A. **Eligibility and Benefits Provided Under the Group Policy**

Please refer to the **Conditions for Insurance** within the Group Policy and Certificate of Coverage for a detailed description of the eligibility for participation under the plan as well as the benefits provided. If this plan includes a participating provider (PPO) option, provider lists are furnished without charge, as a separate document.

If you have any questions about your benefits or concerns about our services related to this Group Policy, you may call Customer Service Toll Free at 1-800-547-9515.

### B. **Qualified Medical Child Support Order ("QMCSO")**

QMCSO Determinations. A Plan participant or beneficiary can obtain, without charge, a copy of the Plan's procedures governing Qualified Medical Child Support Order determinations from the Plan Administrator.

### C. **Termination Of The Group Policy**

The Group Policy which provides benefits for this plan may be terminated by the Policyholder at any time with prior written notice to Standard Insurance Company. It will terminate automatically if the Policyholder fails to pay the required premium. Standard Insurance Company may terminate the Group Policy on any Premium Due Date if the number of persons insured is less than the required minimum, or if Standard Insurance Company believes the Policyholder has failed to perform its obligations relating to the Group Policy.

After the first policy year, Standard Insurance Company may also terminate the Group Policy on any Premium Due Date for any reason by providing a 45-day advance written notice to the Policyholder.

The Group Policy may be changed in whole or in part. No change or amendment will be valid unless it is approved in writing by a Standard Insurance Company executive officer.

### D. **Claims For Benefits**

Claims procedures are furnished automatically, without charge, as a separate document.

### E. **Continuation of Coverage Provisions (COBRA)**

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) gives Qualified Beneficiaries the right to elect COBRA continuation after insurance ends because of a Qualifying Event. The law generally covers group health plans maintained by employers with 20 or more employees in the prior year. The law does not, however, apply to plans sponsored by the Federal government and certain church-related organizations.

#### i. **Definitions For This Section**

Qualified Beneficiary means an Insured Person who is covered by the plan on the day before a qualifying event. Any child born to or placed for adoption with a covered employee during the period of COBRA coverage is considered a qualified beneficiary.

A Qualifying Event occurs when:

1. The Member dies (hereinafter referred to as Qualifying Event 1);
2. The Member's employment terminates for reasons other than gross misconduct as determined by the Employer (hereinafter referred to as Qualifying Event 2);
3. The Member's work hours fall below the minimum number required to be a Member (hereinafter referred to as Qualifying Event 3);

4. The Member becomes divorced or legally separated from a Spouse (hereinafter referred to as Qualifying Event 4);
5. The Member becomes entitled to receive Medicare benefits under Title XVII of the Social Security Act (hereinafter referred to as Qualifying Event 5);
6. The Child of a Member ceases to be a Dependent (hereinafter referred to as Qualifying Event 6);
7. The Employer files a petition for reorganization under Title 11 of the U.S. Bankruptcy Code, provided the Member is retired from the Employer and is insured on the date the petition is filed (hereinafter referred to as Qualifying Event 7).

**ii. Electing COBRA Continuation**

- A. Each Qualified Beneficiary has the right to elect to continue coverage that was in effect on the day before the Qualifying Event. The Qualified Beneficiary must apply in writing within 60 days of the later of:
  1. The date on which Insurance would otherwise end; and
  2. The date on which the Employer or Plan Administrator gave the Qualified Beneficiary notice of the right to COBRA continuation.
- B. A Qualified Beneficiary who does not elect COBRA Continuation coverage during their original election period may be entitled to a second election period if the following requirements are satisfied:
  1. The Member's Insurance ended because of a trade related termination of their employment, which resulted in being certified eligible for trade adjustment assistance;
  2. The Member is certified eligible for trade adjustment assistance (as determined by the appropriate governmental agency) within 6 months of the date Insurance ended due to the trade related termination of their employment; and
  3. The Qualified Beneficiary must apply in writing within 60 days after the first day of the month in which they are certified eligible for trade adjustment assistance.

**iii. Notice Requirements**

1. When the Member becomes insured, the Plan Administrator must inform the Member and Spouse in writing of the right to COBRA continuation.
2. The Qualified Beneficiary must notify the Plan Administrator in writing of Qualifying Event 4 or 6 above within 60 days of the later of:
  - a. The date of the Qualifying Event; or
  - b. The date the Qualified Beneficiary loses coverage due to the Qualifying Event.

3. A Qualified Beneficiary, who is entitled to COBRA continuation due to the occurrence of Qualifying Event 2 or 3 and who is disabled at any time during the first 60 days of continuation coverage as determined by the Social Security Administration pursuant to Title II or XVI of the Social Security Act, must notify the Plan Administrator of the disability in writing within 60 days of the later of:
  - a. The date of the disability determination;
  - b. The date of the Qualifying Event; or
  - c. The date on which the Qualified Beneficiary loses coverage due to the Qualifying Event.
4. Each Qualified Beneficiary who has become entitled to COBRA continuation with a maximum duration of 18 or 29 months must notify the Plan Administrator of the occurrence of a second Qualifying Event within 60 days of the later of:
  - a. The date of the Qualifying Event; or
  - b. The date the Qualified Beneficiary loses coverage due to the Qualifying Event.
5. The Employer must give the Plan Administrator written notice within 30 days of the occurrence of Qualifying Event 1, 2, 3, 5, or 7.
6. Within 14 days of receipt of the Employer's notice, the Plan Administrator must notify each Qualified Beneficiary in writing of the right to elect COBRA continuation.

In order to protect your rights, Members and Qualified Beneficiaries should inform the Plan Administrator in writing of any change of address.

**iv. COBRA Continuation Period**

1. 18-month COBRA Continuation

Each Qualified Beneficiary may continue Insurance for up to 18 months after the date of Qualifying Event 2 or 3.

2. 29-month COBRA Continuation

Each Qualified Beneficiary, who is entitled to COBRA continuation due to the occurrence of Qualifying Event 2 or 3 and who is disabled at any time during the first 60 days of continuation coverage as determined by the Social Security Administration pursuant to Title II or XVI of the Social Security Act, may continue coverage for up to 29 months after the date of the Qualifying Event. All Insured Persons in the Qualified Beneficiary's family may also continue coverage for up to 29 months.

3. 36-Month COBRA Continuation

If you are a Dependent, you may continue Coverage for up to 36 months after the date of Qualifying Event 1, 4, 5, or 6. Each Qualified Beneficiary who is entitled to continue Insurance for 18 or 29 months may be eligible to continue coverage for up to 36 months after the date of their original Qualifying Event if a second Qualifying Event occurs while they are on continuation coverage.

Note: The total period of COBRA continuation available in 1 through 3 will not exceed 36 months.

4. COBRA Continuation For Certain Bankruptcy Proceedings

If the Qualifying Event is 7, the COBRA continuation period for a retiree or retiree's Spouse is the lifetime of the retiree. Upon the retiree's death, the COBRA continuation period for the surviving Dependents is 36 months from the date of the retiree's death.

v. **Premium Requirements**

Insurance continued under this provision will be retroactive to the date insurance would have ended because of a Qualifying Event. The Qualified Beneficiary must pay the initial required premium not later than 45 days after electing COBRA continuation, and monthly premium on or before the Premium Due Date thereafter. The monthly premium is a percentage of the total premium (both the portion paid by the employee and any portion paid by the employer) currently in effect on each Premium Due Date. The premium rate may change after you cease to be Actively at Work. The percentage is as follows:

18 month continuation - 102%

29 month continuation - 102% during the first 18 months, 150% during the next 11 months

36 month continuation - 102%

vi. When COBRA Continuation Ends

COBRA continuation ends on the earliest of:

1. The date the Group Policy terminates;
2. 31 days after the date the last period ends for which a required premium payment was made;
3. The last day of the COBRA continuation period.
4. The date the Qualified Beneficiary first becomes entitled to Medicare coverage under Title XVII of the Social Security Act;
5. The first date on which the Qualified Beneficiary is: (a) covered under another group Dental policy and (b) not subject to any preexisting condition limitation in that policy.

**F. Your Rights under ERISA**

As a participant in this Plan, you are entitled to certain rights and protections under the Employment Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

### **Receive Information About Your Plan and Benefits**

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

### **Continue Group Health Plan Coverage**

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

### **Prudent Actions by Plan Fiduciaries**

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to operate and administer this plan prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

### **Enforce Your Rights**

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### **Assistance with Your Rights**

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and

responsibilities under ERISA by calling those publications hotline of the Employee Benefits Security Administration

**CLAIMS REVIEW PROCEDURES  
AS REQUIRED UNDER  
EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)**

The following provides information regarding the claims review process and your rights to request a review of any part of a claim that is denied. Please note that certain state laws may also require specified claims payment procedures as well as internal appeal procedures and/or independent external review processes. Therefore, in addition to the review procedures defined below, you may also have additional rights provided to you under state law. If your state has specific grievance procedures, an additional notice specific to your state will also be included within the group policy and your certificate.

**CLAIMS FOR BENEFITS**

Claims may be submitted by mailing the completed claim form along with any requested information to:  
Standard Insurance Company  
PO Box 82622  
Lincoln, NE 68501-2622

**NOTICE OF DECISION OF CLAIM**

We will evaluate your claim promptly after we receive it.

**Dental Utilization Review Program.** Generally, utilization review means a set of criteria designed to monitor the use of, or evaluate the medical necessity, appropriateness, or efficiency of health care services. We have established a utilization review program to ensure that any guidelines and criteria used to evaluate the medical necessity of a health care service are clearly documented and include procedures for applying such criteria based on the needs of the individual patients. The program was developed in conjunction with licensed dentists and is reviewed at least annually to ensure that criteria are applied consistently and are current with dental technology, evidence-based research and any dental trends.

We will provide you written notice regarding the payment under the claim within 30 calendar days following receipt of the claim. This period may be extended for an additional 15 days, provided that we have determined that an extension is necessary due to matters beyond our control, and notify you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which we expect to render a decision. If the extension is due to your failure to provide information necessary to decide the claim, the notice of extension shall specifically describe the required information we need to decide the claim.

If we request additional information, you will have 45 days to provide the information. If you do not provide the requested information within 45 days, we may decide your claim based on the information we have received.

If we deny any part of your claim, you will receive a written notice of denial containing:

- a. The reasons for our decision.
- b. Reference to the parts of the Group Policy on which our decision is based.
- c. Reference to any internal rule or guideline relied upon in making our decision, along with your right to receive a copy of these guidelines, free of charge, upon request.
- d. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Dental practice.
- e. A description of any additional information needed to support your claim and why such information is necessary.
- f. Information concerning your right to a review of our decision.
- g. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA following an adverse benefit determination on review.

## **APPEAL PROCEDURE**

If all or part of a claim is denied, you may request a review in writing within 180 days after receiving notice of the benefit denial.

You may send us written comments or other items to support your claim. You may review and receive copies of any non-privileged information that is relevant to your appeal. There will be no charge for such copies. You may request the names of the experts we consulted who provided advice to us about your claim.

The appeal review will be conducted by the Plan's named fiduciary and will be someone other than the person who denied the initial claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based in whole or in part on a medical judgment, including determinations with regard to whether a service was considered experimental, investigational, and/or not medically necessary, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original judgment and will not be subordinate to that person. Our review will include any written comments or other items you submit to support your claim.

We will review your claim promptly after we receive your request.

If your appeal is about urgent care, you may call Toll Free at 877-897-4328, and an Expedited Review will be conducted. Verbal notification of our decision will be made within 72 hours, followed by written notice within 3 calendar days after that.

If your appeal is about benefit decisions related to clinical or medical necessity, a Standard Consultant Review will be conducted. A written decision will be provided within 30 calendar days of the receipt of the request for appeal.

If your appeal is about benefit decisions related to coverage, a Standard Administrative Review will be conducted. A written decision will be provided within 60 calendar days of the receipt of the request for appeal.

If we deny any part of your claim on review, you will receive a written notice of denial containing:

- a. The reasons for our decision.
- b. Reference to the parts of the Group Policy on which our decision is based.
- c. Reference to any internal rule or guideline relied upon in making our decision along with your right to receive a copy of these guidelines, free of charge, upon request.
- d. Information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.
- e. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Dental practice.
- f. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA.

Certain state laws also require specified internal appeal procedures and/or external review processes. In addition to the review procedures defined above, you may also have additional rights provided to you under state law. Please review your certificate for such information, call us, or contact your state insurance regulatory agency for assistance. In any event, you need not exhaust such state law procedures prior to bringing civil action under Section 502(a) of ERISA.

Any request for appeal should be directed to:

Quality Control, P.O. Box 82657, Lincoln, NE 68501-2657.



TheStandard®

## ***HIPAA Notice of Privacy Practices***

**To:** All Insureds covered under a Dental Insurance policy ("Health Plan") with Standard Insurance Company

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

Standard Insurance Company ("The Standard") is committed to protecting the health information that we maintain about you. As required by rules effective April 14, 2003, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), this notice provides you with information about your rights and our legal duties and practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures that The Standard will make of your protected health information.

"Protected health information" includes any identifiable information that we obtain from you or others that relates to your past, present or future health care and treatment or the payment for your health care and treatment. Your health care professional may have different policies or notices regarding his or her use and disclosure of your health information created in the health care professional's office or clinic.

The Standard reserves the right to change the terms of this notice and to make the revised notice effective for all protected health information we maintain. You may request a paper copy of the most current privacy notice from our office or access it on our Web site at [www.standard.com/hipaa](http://www.standard.com/hipaa).

### ***Permitted Uses and Disclosures of Your Health Information***

We will disclose health information about you when required to do so by federal, state or local law. For example, we may disclose health information when required by a court order, subpoena, warrant, summons or similar process. The following describes the purposes for which The Standard is permitted or required by law to use or disclose your Health Plan coverage information without your authorization:

**Treatment.** This means the provision, coordination or management of your health care and related services, including any referrals for health care from one health professional to another. For example, we may use or disclose health information about you to facilitate treatment or services by health care providers. We may disclose health information about you to other health care professionals who are involved in taking care of you.

**Payment.** This means activities to facilitate payment for the treatment and services you receive from health care professionals, including to obtain premium, to determine eligibility, coverage or benefit responsibilities under your insurance coverage, or to coordinate your insurance coverage. For example, the information on claim forms sent to us may include information that identifies you, as well as your diagnosis, and the procedures and supplies used. We may share this information with outside health care consultants performing a business service for The Standard. Likewise, we may share health information with other insurance carriers to coordinate benefit payments. We mail Explanation of Benefits forms and other information to the address we have on record for the primary member. In addition, claim information may be accessible through our website requiring an access code and our toll-free number.

**Health Care Operations.** This means the support functions related to treatment and payment, such as quality assurance activities, case management, underwriting, premium rating, business management and other general administrative activities. For example, we may use health information in connection with conducting quality assessment and improvement activities, underwriting, premium rating and other activities relating to your coverage, including auditing functions and fraud detection and reporting. We may also disclose health information to business associates if they need to receive health information to provide a service to us and by contract agree to abide by the same high standards of safeguarding your health information. We are prohibited from using or disclosing your genetic health information for underwriting purposes.

**Public Health Activities.** We may disclose health information to public health or legal authorities charged with preventing or controlling disease, injury (including abuse) or disability, or to a governmental agency or regulator with health care oversight responsibilities.

**Military and Veterans.** If you are a member of the armed forces, we may disclose health information about you as required by military command authorities.

**Workers' Compensation.** We may disclose health information about you for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

**Coroners and Medical Examiners.** We may disclose health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

**Organ and Tissue Donation.** We may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

**Research Purposes.** We may disclose health information for research purposes.

**Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute.

**Law Enforcement and National Security and Intelligence Activities.** We may disclose health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process. We may disclose health information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

**To Avert a Serious Threat to Health or Safety.** We may disclose health information to avert a serious threat to someone's health or safety. We may disclose health information to federal, state or local agencies engaged in disaster relief to allow such entities to carry out their responsibilities in specific disaster situations.

**Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care, (2) to protect your health and safety or the health and safety of others or (3) for the safety and security of the correctional institution.

**Disclosure to your Plan Sponsor.** Information may be disclosed to your plan sponsor for purposes of plan administration if the plan sponsor has certified that plan documents have been amended as required by HIPAA. De-identified summary health information may be disclosed to your plan sponsor for the purposes of obtaining health insurance bids or modifying, amending, or terminating the health plan.

In the following situations generally we must obtain your authorization before disclosing your health information:

**Sale of Protected Health Information.** We must obtain your authorization prior to selling your health information. If we will obtain financial remuneration for such sale, we must disclose that to you in the authorization.

**Psychotherapy Notes.** Most uses and disclosures of your psychotherapy notes require your authorization.

**Marketing.** We must obtain your authorization prior to using or disclosing your health information for marketing purposes in most situations. If we will obtain financial remuneration for such marketing, we must disclose that to you in the authorization.

**Other Uses and Disclosures of Your Health Information.** Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission in writing at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization, except to the extent that we have already taken action in reliance on your authorization.

### ***Your Rights Regarding Your Health Information***

The following describes your rights regarding the health information we maintain about you. To exercise your rights, you must submit your request in writing to Standard Insurance Company, Attn: Quality Assurance Specialist, PO Box 82629, Lincoln, NE 68501-2629.

**Right to Inspect and Copy.** You have the right to inspect and copy health information that we maintain about you. To inspect or copy your health information, you must submit your request in writing. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Please contact our Privacy Contact at the address or telephone number listed on the last page of this document if you have questions about access to your health information.

**Right to Amend.** If you feel that the health information we have about you is incorrect or incomplete, you may ask us in writing to amend the information. You have the right to request an amendment for as long as we maintain the information.

In addition, you must provide a reason that supports your request. Any agreed-upon correction to your health information will be included as an addition to, and not a replacement of, already existing records.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (1) is not part of the health information kept by us, (2) was not created by us, unless the person or entity that created the information is no longer available to make the amendment, (3) is not part of the information which you would be permitted to inspect and copy or (4) is accurate and complete.

**Right to an Accounting of Disclosures.** You have the right to request an accounting of disclosures of your health information made by us in the six years prior to the date that the accounting is requested (or shorter period as requested). This does not include disclosures (1) to carry out treatment, payment, or health care operations; (2) made to you or pursuant to your authorization; (3) for national security or intelligence purposes; (4) to corrections institutions or law enforcement officials or (5) made prior to April 14, 2003.

Your first request for an accounting in any 12-month period shall be provided without charge. A reasonable fee shall be imposed for each subsequent request for an accounting within the same 12-month period.

**Right to Request Restrictions.** You have the right to request a restriction or limitation of the health information we use or disclose about you for treatment, payment or health care operations. We are not required to agree to

your request unless your request is to restrict disclosure to a health plan for purposes of payment or health care operations when you or someone on your behalf (but not the health plan) has already made full payment.

To request restrictions, you must make your request in writing to our Privacy Contact indicated below. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both and (3) to whom you want the limits to apply.

**Right to Request Confidential Communications.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will accommodate reasonable requests. We will not ask you the reason for your request. Please make this request in writing to our Privacy Contact indicated below.

**Right to Breach Notification.** We are required by law to maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices with respect to your health information. We are also required by law to notify affected individuals following a breach of unsecured health information.

**Your Right to File a Complaint.** If you believe your privacy rights have been violated, please submit your complaint in writing to:

Standard Insurance Company  
Attn: Quality Assurance Specialist  
PO Box 82629  
Lincoln, NE 68501-2629

You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

***Privacy Contact***

If you have any questions or would like further information about this notice or your rights regarding your health information, please contact the Quality Assurance Specialist at 800.547.9515 or the above address.

This notice is revised effective September 23, 2016.



## STANDARD INSURANCE COMPANY

A Stock Life Insurance Company  
900 SW Fifth Avenue  
Portland, Oregon 97204-1282  
(503) 321-7000

### CERTIFICATE GROUP EYE CARE INSURANCE

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**The Policyholder**    **COLUMBIA COUNTY BOARD OF COUNTY COMMISSIONERS  
BOARD OF COUNTY COMMISSIONERS**

**Policy Number**    **160-162038**    **Insured Person**

**Plan Effective Date**    **October 1, 2020**    **Certificate Effective Date**  
**Refer to Exceptions on 9070**

**Plan Change Effective Date**    **October 1, 2024**

**Class Number 2**

Standard Insurance Company certifies that you will be insured for the benefits described on the following pages, according to all the terms of the group policy numbered above which has been issued to the Policyholder.

Possession of this certificate does not necessarily mean you are insured. You are insured only if you meet the requirements set out in this certificate.

The group policy may be amended or cancelled without the consent of the insured person.

**The group policy and this certificate are governed by the laws of the state in which the group policy was delivered.**

If you should have any questions regarding your coverage or claim payments, you may contact us toll-free at 800-877-7195.

**STANDARD INSURANCE COMPANY**



Daniel J. McMillan  
President and CEO

## FLORIDA - IMPORTANT INFORMATION TO INSUREDS

### We are here to serve you . . .

You have the right to receive medically appropriate care in a timely and convenient manner and to be an active participant in any decision making regarding treatment, care and services provided to you or one of your family members who are covered under this plan.

In order to provide you the best possible service, it is important that you provide any necessary information to your provider that will facilitate effective medical care and that you cooperate with your provider(s) by keeping appointments and following recommended treatment.

Please review your certificate of coverage carefully so that you fully understand the benefits provided. If you have a question about your policy or if you need assistance with a problem, feel free to contact us at the number shown below.

If you have a grievance or complaint regarding an adverse decision, you may call us below or document your concerns in writing. Written documentation can be sent to the following:

Name:	Quality Assurance
Address:	P.O. Box 82629 Lincoln, NE 68501-2629
Phone:	888-418-6811
Fax:	402-309-2579

The complaint will be carefully reviewed. If the initial claim was denied based on clinical necessity or paid as an alternate benefit, then a licensed provider will be involved in the review of the appeal. A written decision will be sent to the claimant within 15 business days following the receipt of the appeal.

### If you are not satisfied . . .

Should you feel you are not being treated fairly, we want you to know you may contact the Department of Financial Services with your complaint and seek assistance from the governmental agency that regulates insurance.

To contact them, write or call:

**Division of Consumer Services  
Department of Financial Services  
200 East Gaines Street  
Tallahassee, FL 32399-0321  
(877) 693-5236 or (850) 413-3089**

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**SCHEDULE OF BENEFITS  
OUTLINE OF COVERAGE**

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

<u>Benefit Class</u>	<u>Class Description</u>
Class 2	Eligible Employee Electing Low Vision

**EYE CARE EXPENSE BENEFITS**

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

Deductible Amount:

When a Participating Provider is used:

Exams - Each Benefit Period	\$10
Contact Lens Fitting and Evaluation - Each Benefit Period	\$60
Frames, Lenses, and Medically Necessary Contacts - Each Benefit Period	\$10

When a Non-Participating Provider is used:

Exams - Each Benefit Period	\$10
Frames, Lenses, and Medically Necessary Contacts - Each Benefit Period	\$10

***Please refer to the EYE CARE EXPENSE BENEFITS page for details regarding frequency, limitations, and exclusions.***

## DEFINITIONS

**COMPANY** refers to Standard Insurance Company. The words "we", "us" and "our" refer to Company. Our Home Office address is 900 SW Fifth Avenue, Portland, Oregon 97204-1282.

**POLICYHOLDER** refers to the Policyholder stated on the face page of the policy.

**INSURED** refers to a person:

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

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

**DEPENDENT** refers to:

- a. an Insured's spouse.
- b. each child through the end of the year in which they turn 26 years of age, for whom the Insured or the Insured's spouse is legally responsible, including natural born children, newborn adopted children from the date of placement for adoption, any child placed with the Insured for adoption, a foster child or other child in court-ordered custody, placed pursuant to Chapter 63 of Florida Code and, children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws. Grandchildren, spouses of Dependents and other Dependent family members under the age of 26 are not eligible for coverage under this plan.
- c. each child through the end of the year in which they turn 26 but less than 30 who is a full-time student at an accredited school or college and is primarily dependent on the Insured or the Insured's spouse for support and maintenance.
- d. each child through the end of the year in which they turn 26 or older who is Totally Disabled and becomes Totally Disabled as defined below while insured as a dependent under b. or c. above. Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

**TOTAL DISABILITY** describes the Insured's Dependent as:

1. Continuously incapable of self-sustaining employment because of developmental disability or physical handicap; and
2. Chiefly dependent upon the Insured for support and maintenance.

**DEPENDENT UNIT** refers to all of the people who are insured as the dependents of any one Insured.

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

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

**PLAN EFFECTIVE DATE** refers to the date coverage under the policy becomes effective. The Plan Effective Date for the Policyholder is shown on the policy cover. The effective date of coverage for an Insured is shown in the Policyholder's records.

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

**PLAN CHANGE EFFECTIVE DATE** refers to the date that the policy provisions originally issued to the Policyholder change as requested by the Policyholder. The Plan Change Effective date for the Policyholder will be shown on the policy cover, if the Policyholder has requested a change. The plan change effective date for an Insured is shown in the Policyholder’s records or on the cover of the certificate.

**CONDITIONS FOR INSURANCE COVERAGE**  
*ELIGIBILITY*

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

If employment is the basis for membership, a member of the Eligible Class for Insurance is any eligible employee electing low vision working at least 30 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

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

**ELIGIBLE CLASS FOR DEPENDENT INSURANCE.** Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the first of the month falling on or first following the latest of:

1. the day he or she qualifies for coverage as a Member;
2. the day he or she becomes a Member; or
3. the day he or she first has a dependent.

**COVERAGE FOR NEWBORN AND ADOPTED CHILDREN.** A newborn child will be covered from the date of birth. Coverage for a newborn child of a covered dependent other than a spouse will stop on the date the child attains eighteen months of age.

An adopted child, foster child and other child in court-ordered custody placed pursuant to Chapter 63 will be covered from the date of placement in the Insured's residence. A newborn adopted child will be covered from the date of birth if the Insured has agreed in writing to adopt the child prior to its birth and the child is ultimately placed in the Insured's residence.

Coverage for a newborn child shall consist of coverage for all covered Eye Care expenses, subject to applicable deductibles, coinsurance percentages, maximums and limitations, including the necessary care or treatment of congenital defects, birth abnormalities, including premature birth.

The Insured may give us written notice within 61 days of the date of birth or placement of a dependent child to start coverage. If timely notice is given, we will not charge an additional premium for the 61-day notice period. If timely notice is not given, we will charge the applicable additional premium from the date of birth or placement for an adopted child. We will not deny coverage for a child due to the failure of the Insured to notify us within 60 days of the child's birth or placement.

A Member must be an Insured to also insure his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any eligible employee electing low vision working at least 30 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

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

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

**CONTRIBUTION REQUIREMENTS.** Member Insurance: An Insured is required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

**SECTION 125.** This plan is provided as part of the Employer's Section 125 Plan. Each Member has the option under the Section 125 Plan of participating or not participating in this plan.

If a Member does not elect to participate when initially eligible, the Member may elect to participate at a subsequent Election Period. This Election Period will be held each year and those who elect to participate in this plan at that time will have their coverage become effective on October 1.

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

**ELIGIBILITY PERIOD.** For Members on the Plan Effective Date of the policy, coverage is effective immediately.

For persons who become Members after the Plan Effective Date of the policy, qualification will occur on the first of the month falling on or first following the eligibility period of 60 calendar day(s) of continuous active employment.

**OPEN ENROLLMENT.** If a Member does not elect to participate when initially eligible, the Member may elect to participate at the Policyholder's next enrollment period. This enrollment period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on October 1.

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

**EFFECTIVE DATE.** Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be the first of the month falling on or first following:

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.
2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.

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

employer's business establishments or at some location to which the employer's business requires the employee to travel.

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

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

But any person who is not in active service or is totally disabled will be insured on the Effective Date if:

- i. the person was insured under a policy of group insurance providing like benefits which ended on the day immediately before the Effective Date of the policy providing this coverage; and
- ii. the person is considered a Member or an eligible Dependent under the policy providing this coverage; and had the prior policy contained the same definition of eligibility, would have been a Member or Dependent under the prior policy.

#### ***TERMINATION DATES***

**INSUREDS.** The insurance for any Insured, will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

**DEPENDENTS.** The insurance for all of an Insured's dependents will automatically terminate on the end of the month falling on or next following the **earliest of:**

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

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

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

## **EYE CARE EXPENSE BENEFITS**

If an Insured has Covered Expenses under this section, we pay benefits as described. The Insured can choose any provider at any time.

### **COVERED EXPENSES**

Covered Expenses include the lesser of:

- a. the charge for the covered procedure furnished; or
- b. the Maximum Covered Expense for such services or supplies shown in the Schedule of Eye Care Services.

Covered Expenses are the eye care expenses incurred by an Insured for services or supplies. We pay up to the Maximum Covered Expense shown in the Schedule of Eye Care Services.

### **DEDUCTIBLE AMOUNT**

The Deductible Amount is on the Schedule of Benefits. It is an amount of Covered Expenses for which no benefits are payable. It applies separately to each Insured. Benefits are paid only for those Covered Expenses that are over the Deductible Amount.

### **PARTICIPATING PROVIDERS**

A Participating Provider is a provider who has agreed to participate in the VSP network and agrees to provide services and supplies to the Insured at a discounted fee. For questions related to providers or benefit payments, VSP's Customer Care Division is available at (800) 877-7195.

### **NON-PARTICIPATING PROVIDERS**

A Non-Participating Provider is any other provider. Non-Participating providers may be referred to as Affiliate or Open Access Providers. Non-Participating Providers are not subject to our Quality Management Programs. Your out-of-pocket expenses may be greater when you visit a Non-Participating Provider. However, more cost savings or convenience may be available through VSP arrangements with Affiliate Providers. You may contact VSP's Customer Care Division for details at (800) 877-7195.

### **EYE CARE SUPPLIES**

Eye care supplies are all services listed on the Schedule of Eye Care Services. They exclude services related to Eye Care Exams.

### **REQUEST FOR SERVICES**

When requesting services, the Insured must advise the Participating Provider's office that he or she has coverage under this network plan. If the Insured receives services from a Participating Provider without this notification, the benefits may be limited to those for a Non-Participating Provider.

### **ASSIGNMENT OF BENEFITS**

We pay benefits to the Participating Provider for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, we pay benefits to the Insured unless arranged differently through an Affiliate or Open Access provider, or otherwise required by state regulation.

### **EXTENSION OF BENEFITS**

If your policy terminates, we will pay claims for eye care services and supplies that you received or ordered prior to your policy's termination. You will have six months following the date of service to submit your claim.

### **EXPENSES INCURRED**

An expense is incurred at the time a service is rendered or a supply item furnished.

**PROOF OF LOSS**

Written proof of loss must be given to us within 180 days after completion of the service for a claim to be covered. An exception may be made if the Insured shows it was not possible to submit the proof of loss within this period.

**LIMITATIONS**

This plan has the following limitation:

Some brands of spectacle frames may be unavailable at all locations for purchase as Covered Expenses, or may be subject to additional out-of-pocket expenses. Insureds may obtain details regarding frame brand availability from their treating provider or by calling VSP's Customer Care Division at (800) 877-7195.

**EXCLUSIONS**

This plan does not cover:

Services and/or materials not specifically included in this Schedule as covered Plan Benefits,

Plano lenses (lenses with refractive correction of less than plus or minus .50 diopter) except as specifically allowed in the frames benefit section below,

Services or materials that are cosmetic, including Plano contact lenses to change eye color and artistically painted Contact Lenses,

Two pairs of glasses in lieu of Bifocals,

Replacement of Spectacle Lenses, Frames, and/or contact lenses furnished under this plan that are lost or damaged, except at the normal intervals when services are otherwise available,

Orthoptics or vision training and any associated supplemental testing,

Medical or surgical treatment of the eyes,

Contact lens modification, polishing or cleaning,

The refitting of Contact Lenses after the initial 90-day fitting period,

Contact Lens insurance policies or service contracts,

Additional office visits associated with contact lens pathology,

Local, state and/or federal taxes, except where law requires us to pay,

Membership fees for any retail center in which an Affiliate or Open Access provider office may be located. Covered persons may be required to purchase a membership in such entities as a condition of accessing Plan Benefits.

## SCHEDULE OF EYE CARE SERVICES

The following is a complete list of eye care services for which benefits are payable under this section, You must first pay a Deductible for certain services as indicated on the Schedule of Benefits in the - Eye Care Expense Benefits section.

SERVICE	WHEN COVERED	PLAN MAXIMUM COVERED EXPENSE	
		<i>Participating Provider</i>	<i>Non-Participating Provider*</i>
<b>Vision Examination(s)</b>			
Eye Exam	Once every 12 months	Covered in Full	Up to \$ 45.00
Contact Lens Fitting & Evaluation	Once every 12 months	Covered in Full	See Elective Contact Lenses benefit below
<b>Complete Pair of Spectacles</b>			
<b>Lenses</b> (per pair, only one pair of lens type below allowed per covered period)			
Single Vision	Once every 12 months	Covered in Full	Up to \$ 30.00
Lined Bifocal	Once every 12 months	Covered in Full	Up to \$ 50.00
Lined Trifocal	Once every 12 months	Covered in Full	Up to \$ 65.00
Lenticular	Once every 12 months	Covered in Full	Up to \$100.00
<b>Frames</b>			
Single Frame	Once every 24 months	Up to \$130.00	Up to \$ 70.00
<b>Contact Lenses</b> (in lieu of Complete Pair of Spectacles)			
Elective	Once every 12 months	Up to \$130.00	Up to \$105.00
Medically Necessary**	Once every 12 months	Covered in Full	Up to \$210.00

**Low Vision** (for severe visual problems not correctable with regular lenses, as determined by the treating provider) Insureds can receive professional services for treatment of severe visual problems that are not correctable with regular lenses. The treating provider determines if an Insured's condition meets the criteria for coverage of this benefit. Insureds may contact VSP's Customer Care Division for details at (800-877-7195) for additional information.

\*Insureds may receive additional savings and some services may be covered in full by choosing to visit an Affiliate Non-Participating Provider.

\*\*The benefit for Medically Necessary contact lenses is in lieu of the Elective contact lenses benefit listed. The treating provider determines if an Insured meets the coverage criteria for this benefit.

## COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies if an Insured person has eye care coverage under more than one **Plan**. **Plan** is defined below. All benefits provided under this policy are subject to this section.

The order of benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan**. The **Secondary plan** may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total **Allowable expense**.

### DEFINITIONS

A. A **Plan** is any of the following that provides benefits or services for medical or eye care or treatment. 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.

(1) **Plan** includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage other than the medical benefits coverage in automobile "no fault" and traditional "fault" type contracts; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) 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**.

B. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one **COB** provision to certain benefits, such as eye care benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.

C. The order of benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health care coverage under more than one **Plan**.

When **This plan** is primary, it determines payment for its benefits first before those of any other **Plan** without considering any other **Plan's** benefits. When **This plan** is secondary, it 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 expense**.

D. **Allowable expense** is a health care expense, including deductibles, coinsurance and co-payments, 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 a covered person is not an **Allowable expense**.

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

- (1) If a person is covered by 2 or more **Plans** that compute their benefit payments on the basis of 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**.
- (2) If a person 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**.
- (3) If a person is covered by one **Plan** that calculates its benefits or services on the basis of 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 shall be the **Allowable expense** 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 expense** used by the **Secondary plan** to determine its benefits.
- (4) The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. **Closed panel plan** is a **Plan** that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the **Plan**, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **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.

## **ORDER OF BENEFIT DETERMINATION RULES**

When a person is covered by two or more **Plans**, the rules for determining the order of benefit payments are as follows:

- A. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other **Plan**.
- B. (1) Except as provided in Paragraph B(2) below, a **Plan** that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both **Plans** state that the complying plan is primary.  
  
(2) 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 contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.
- C. A **Plan** may consider the benefits paid or provided by another **Plan** in calculating payment of its benefits only when it is secondary to that other **Plan**.
- D. 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, for example 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 the person 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:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

The **Plan** of the parent whose birthday falls earlier in the calendar year is the **Primary plan**; or

If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health 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**.

(c) For a dependent child covered under more than one **Plan** of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-off Employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. 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 as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, 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 is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.

(6) If the preceding rules do not 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 THE BENEFITS OF THIS PLAN**

A. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year 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 health 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 health care coverage.

B. If a covered person 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**.

#### **RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION**

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give the Company any facts it needs 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, the Company 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**. The Company 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 the amount of the payments made by the Company is more than it should have paid under this **COB** provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

## GENERAL PROVISIONS

**NOTICE OF CLAIM.** Written notice of a claim must be given to us within 90 days after the incurred date of the services provided for which benefits are payable.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Policyholder's name, Insured's name, and policy number. If it was not reasonably possible to give written notice within the 90 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

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

**PROOF OF LOSS.** Written proof of loss must be given to us within 90 days after the incurred date of the services provided for which benefits are payable. If it is impossible to give written proof within the 90 day period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible. For Eye Care benefits that use either the EyeMed or VSP network, please refer to the limitations section on the Eye Care Expense Benefits page.

**TIME OF PAYMENT.** We will pay all benefits within 45 days of when we receive due proof.

If benefits are contested or denied, we will notify the Insured, in writing, which benefits are contested or denied within 45 days of when we received due proof. We will pay or deny any balance remaining on benefits for a claim within 60 days upon receipt of any additional information requested from the Insured. In no event will we hold a claim without paying or denying benefits any later than 120 days.

Payment is considered to be made on the date a draft or other valid instrument is placed in the United States mail in a properly addressed post paid envelope or, if not so posted, on the date of delivery.

We will pay interest at the rate of 10 percent per year on overdue payments on benefits for valid claims.

We will investigate any claim of improper billing of a claim by a Provider upon written notification by an Insured. We will determine if the Insured was properly billed for only those procedures that the Insured actually received. If we determine that the Insured was improperly billed, we will notify the Insured and the provider of our findings and will reduce the amount of payment by the amount determined to be improperly billed. If a reduction is made due to such notification by the Insured, we will pay the Insured 20 percent of the reduction up to \$500.

**PAYMENT OF BENEFITS.** Participating Providers have agreed to accept assignment of benefits for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, all benefits will be paid to the Insured unless otherwise indicated by the Insured's authorization to pay the Non-Participating Provider directly.

**FACILITY OF PAYMENT.** If an Insured or beneficiary is not capable of giving us a valid receipt for any payment or if benefits are payable to the estate of the Insured, then we may, at our option, pay the benefit up to an amount not to exceed \$3,000, to any relative by blood or connection by marriage of the Insured who is considered by us to be equitably entitled to the benefit.

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

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

**LEGAL PROCEEDINGS.** No legal action can be brought against us until 60 days after the Insured sends us the required proof of loss. No legal action against us can start more than the applicable statute of limitations after proof of loss is required.

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

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

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

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

## ERISA INFORMATION AND NOTICE OF YOUR RIGHTS

### A. **Eligibility and Benefits Provided Under the Group Policy**

Please refer to the **Conditions for Insurance** within the Group Policy and Certificate of Coverage for a detailed description of the eligibility for participation under the plan as well as the benefits provided. If this plan includes a participating provider (PPO) option, provider lists are furnished without charge, as a separate document.

### B. **Qualified Medical Child Support Order ("QMCSO")**

QMCSO Determinations. A Plan participant or beneficiary can obtain, without charge, a copy of the Plan's procedures governing Qualified Medical Child Support Order determinations from the Plan Administrator.

### C. **Termination Of The Group Policy**

The Group Policy which provides benefits for this plan may be terminated by the Policyholder at any time with prior written notice to Standard Insurance Company. It will terminate automatically if the Policyholder fails to pay the required premium. Standard Insurance Company may terminate the Group Policy on any Premium Due Date if the number of persons insured is less than the required minimum, or if Standard Insurance Company believes the Policyholder has failed to perform its obligations relating to the Group Policy.

After the first policy year, Standard Insurance Company may also terminate the Group Policy on any Premium Due Date for any reason by providing a 45-day advance written notice to the Policyholder.

The Group Policy may be changed in whole or in part. No change or amendment will be valid unless it is approved in writing by a Standard Insurance Company executive officer.

### D. **Claims For Benefits**

Claims procedures are furnished automatically, without charge, as a separate document.

### E. **Continuation of Coverage Provisions (COBRA)**

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) gives Qualified Beneficiaries the right to elect COBRA continuation after insurance ends because of a Qualifying Event. The law generally covers group health plans maintained by employers with 20 or more employees in the prior year. The law does not, however, apply to plans sponsored by the Federal government and certain church-related organizations.

#### i. **Definitions For This Section**

Qualified Beneficiary means an Insured Person who is covered by the plan on the day before a qualifying event. Any child born to or placed for adoption with a covered employee during the period of COBRA coverage is considered a qualified beneficiary.

A Qualifying Event occurs when:

1. The Member dies (hereinafter referred to as Qualifying Event 1);
2. The Member's employment terminates for reasons other than gross misconduct as determined by the Employer (hereinafter referred to as Qualifying Event 2);
3. The Member's work hours fall below the minimum number required to be a Member (hereinafter referred to as Qualifying Event 3);
4. The Member becomes divorced or legally separated from a Spouse (hereinafter referred to as Qualifying Event 4);

5. The Member becomes entitled to receive Medicare benefits under Title XVII of the Social Security Act (hereinafter referred to as Qualifying Event 5);
6. The Child of a Member ceases to be a Dependent (hereinafter referred to as Qualifying Event 6);
7. The Employer files a petition for reorganization under Title 11 of the U.S. Bankruptcy Code, provided the Member is retired from the Employer and is insured on the date the petition is filed (hereinafter referred to as Qualifying Event 7).

**ii. Electing COBRA Continuation**

- A. Each Qualified Beneficiary has the right to elect to continue coverage that was in effect on the day before the Qualifying Event. The Qualified Beneficiary must apply in writing within 60 days of the later of:
  1. The date on which Insurance would otherwise end; and
  2. The date on which the Employer or Plan Administrator gave the Qualified Beneficiary notice of the right to COBRA continuation.
- B. A Qualified Beneficiary who does not elect COBRA Continuation coverage during their original election period may be entitled to a second election period if the following requirements are satisfied:
  1. The Member's Insurance ended because of a trade related termination of their employment, which resulted in being certified eligible for trade adjustment assistance;
  2. The Member is certified eligible for trade adjustment assistance (as determined by the appropriate governmental agency) within 6 months of the date Insurance ended due to the trade related termination of their employment; and
  3. The Qualified Beneficiary must apply in writing within 60 days after the first day of the month in which they are certified eligible for trade adjustment assistance.

**iii. Notice Requirements**

1. When the Member becomes insured, the Plan Administrator must inform the Member and Spouse in writing of the right to COBRA continuation.
2. The Qualified Beneficiary must notify the Plan Administrator in writing of Qualifying Event 4 or 6 above within 60 days of the later of:
  - a. The date of the Qualifying Event; or
  - b. The date the Qualified Beneficiary loses coverage due to the Qualifying Event.

3. A Qualified Beneficiary, who is entitled to COBRA continuation due to the occurrence of Qualifying Event 2 or 3 and who is disabled at any time during the first 60 days of continuation coverage as determined by the Social Security Administration pursuant to Title II or XVI of the Social Security Act, must notify the Plan Administrator of the disability in writing within 60 days of the later of:
  - a. The date of the disability determination;
  - b. The date of the Qualifying Event; or
  - c. The date on which the Qualified Beneficiary loses coverage due to the Qualifying Event.
4. Each Qualified Beneficiary who has become entitled to COBRA continuation with a maximum duration of 18 or 29 months must notify the Plan Administrator of the occurrence of a second Qualifying Event within 60 days of the later of:
  - a. The date of the Qualifying Event; or
  - b. The date the Qualified Beneficiary loses coverage due to the Qualifying Event.
5. The Employer must give the Plan Administrator written notice within 30 days of the occurrence of Qualifying Event 1, 2, 3, 5, or 7.
6. Within 14 days of receipt of the Employer's notice, the Plan Administrator must notify each Qualified Beneficiary in writing of the right to elect COBRA continuation.

In order to protect your rights, Members and Qualified Beneficiaries should inform the Plan Administrator in writing of any change of address.

**iv. COBRA Continuation Period**

1. 18-month COBRA Continuation

Each Qualified Beneficiary may continue Insurance for up to 18 months after the date of Qualifying Event 2 or 3.

2. 29-month COBRA Continuation

Each Qualified Beneficiary, who is entitled to COBRA continuation due to the occurrence of Qualifying Event 2 or 3 and who is disabled at any time during the first 60 days of continuation coverage as determined by the Social Security Administration pursuant to Title II or XVI of the Social Security Act, may continue coverage for up to 29 months after the date of the Qualifying Event. All Insured Persons in the Qualified Beneficiary's family may also continue coverage for up to 29 months.

3. 36-Month COBRA Continuation

If you are a Dependent, you may continue Coverage for up to 36 months after the date of Qualifying Event 1, 4, 5, or 6. Each Qualified Beneficiary who is entitled to continue Insurance for 18 or 29 months may be eligible to continue coverage for up to 36 months after the date of their original Qualifying Event if a second Qualifying Event occurs while they are on continuation coverage.

Note: The total period of COBRA continuation available in 1 through 3 will not exceed 36 months.

4. COBRA Continuation For Certain Bankruptcy Proceedings

If the Qualifying Event is 7, the COBRA continuation period for a retiree or retiree's Spouse is the lifetime of the retiree. Upon the retiree's death, the COBRA continuation period for the surviving Dependents is 36 months from the date of the retiree's death.

v. **Premium Requirements**

Insurance continued under this provision will be retroactive to the date insurance would have ended because of a Qualifying Event. The Qualified Beneficiary must pay the initial required premium not later than 45 days after electing COBRA continuation, and monthly premium on or before the Premium Due Date thereafter. The monthly premium is a percentage of the total premium (both the portion paid by the employee and any portion paid by the employer) currently in effect on each Premium Due Date. The premium rate may change after you cease to be Actively at Work. The percentage is as follows:

18 month continuation - 102%

29 month continuation - 102% during the first 18 months, 150% during the next 11 months

36 month continuation - 102%

vi. When COBRA Continuation Ends

COBRA continuation ends on the earliest of:

1. The date the Group Policy terminates;
2. 31 days after the date the last period ends for which a required premium payment was made;
3. The last day of the COBRA continuation period.
4. The date the Qualified Beneficiary first becomes entitled to Medicare coverage under Title XVII of the Social Security Act;
5. The first date on which the Qualified Beneficiary is: (a) covered under another group Eye Care policy and (b) not subject to any preexisting condition limitation in that policy.

**F. Your Rights under ERISA**

As a participant in this Plan, you are entitled to certain rights and protections under the Employment Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

### **Receive Information About Your Plan and Benefits**

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

### **Continue Group Health Plan Coverage**

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

### **Prudent Actions by Plan Fiduciaries**

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to operate and administer this plan prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

### **Enforce Your Rights**

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### **Assistance with Your Rights**

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and

responsibilities under ERISA by calling those publications hotline of the Employee Benefits Security Administration

**CLAIMS REVIEW PROCEDURES  
AS REQUIRED UNDER  
EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)**

The following provides information regarding the claims review process and your rights to request a review of any part of a claim that is denied. Please note that certain state laws may also require specified claims payment procedures as well as internal appeal procedures and/or independent external review processes. Therefore, in addition to the review procedures defined below, you may also have additional rights provided to you under state law. If your state has specific grievance procedures, an additional notice specific to your state will also be included within the group policy and your certificate.

**CLAIMS FOR BENEFITS**

Claims may be submitted by mailing the completed claim form along with any requested information to:

Vision Service Plan  
Attn: Claims Services  
P.O. Box 385018  
Birmingham, AL 35238-5018

**NOTICE OF DECISION OF CLAIM**

We will evaluate your claim promptly after we receive it.

We will provide you written notice regarding the payment under the claim within 30 calendar days following receipt of the claim. This period may be extended for an additional 15 days, provided that we have determined that an extension is necessary due to matters beyond our control, and notify you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which we expect to render a decision. If the extension is due to your failure to provide information necessary to decide the claim, the notice of extension shall specifically describe the required information we need to decide the claim.

If we request additional information, you will have 45 days to provide the information. If you do not provide the requested information within 45 days, we may decide your claim based on the information we have received.

If we deny any part of your claim, you will receive a written notice of denial containing:

- a. The reasons for our decision.
- b. Reference to the parts of the Group Policy on which our decision is based.
- c. Reference to any internal rule or guideline relied upon in making our decision, along with your right to receive a copy of these guidelines, free of charge, upon request.
- d. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Eye Care practice.
- e. A description of any additional information needed to support your claim and why such information is necessary.
- f. Information concerning your right to a review of our decision.
- g. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA following an adverse benefit determination on review.

**APPEAL PROCEDURE**

If all or part of a claim is denied, you may request a review in writing within 180 days after receiving notice of the benefit denial.

You may send us written comments or other items to support your claim. You may review and receive copies of any non-privileged information that is relevant to your appeal. There will be no charge for such copies. You may request the names of the experts we consulted who provided advice to us about your claim.

The appeal review will be conducted by the Plan's named fiduciary and will be someone other than the person who denied the initial claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based in whole or in part on a medical judgment, including determinations with regard to whether a service was considered experimental, investigational, and/or not medically necessary, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original judgment and will not be subordinate to that person. Our review will include any written comments or other items you submit to support your claim.

We will review your claim promptly after we receive your request.

If your appeal is about urgent care, you may call Toll Free at 877-897-4328, and an Expedited Review will be conducted. Verbal notification of our decision will be made within 72 hours, followed by written notice within 3 calendar days after that.

If your appeal is about benefit decisions related to clinical or medical necessity, a Standard Consultant Review will be conducted. A written decision will be provided within 30 calendar days of the receipt of the request for appeal.

If your appeal is about benefit decisions related to coverage, a Standard Administrative Review will be conducted. A written decision will be provided within 60 calendar days of the receipt of the request for appeal.

If we deny any part of your claim on review, you will receive a written notice of denial containing:

- a. The reasons for our decision.
- b. Reference to the parts of the Group Policy on which our decision is based.
- c. Reference to any internal rule or guideline relied upon in making our decision along with your right to receive a copy of these guidelines, free of charge, upon request.
- d. Information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.
- e. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Eye Care practice.
- f. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA.

Certain state laws also require specified internal appeal procedures and/or external review processes. In addition to the review procedures defined above, you may also have additional rights provided to you under state law. Please review your certificate for such information, call us, or contact your state insurance regulatory agency for assistance. In any event, you need not exhaust such state law procedures prior to bringing civil action under Section 502(a) of ERISA.

Any request for appeal should be directed to:

Quality Control, P.O. Box 82657, Lincoln, NE 68501-2657.



TheStandard®

## ***HIPAA Notice of Privacy Practices***

**To:** All Insureds covered under a Eye Care Insurance policy ("Health Plan") with Standard Insurance Company

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

Standard Insurance Company ("The Standard") is committed to protecting the health information that we maintain about you. As required by rules effective April 14, 2003, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), this notice provides you with information about your rights and our legal duties and practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures that The Standard will make of your protected health information.

"Protected health information" includes any identifiable information that we obtain from you or others that relates to your past, present or future health care and treatment or the payment for your health care and treatment. Your health care professional may have different policies or notices regarding his or her use and disclosure of your health information created in the health care professional's office or clinic.

The Standard reserves the right to change the terms of this notice and to make the revised notice effective for all protected health information we maintain. You may request a paper copy of the most current privacy notice from our office or access it on our Web site at [www.standard.com/hipaa](http://www.standard.com/hipaa).

### ***Permitted Uses and Disclosures of Your Health Information***

We will disclose health information about you when required to do so by federal, state or local law. For example, we may disclose health information when required by a court order, subpoena, warrant, summons or similar process. The following describes the purposes for which The Standard is permitted or required by law to use or disclose your Health Plan coverage information without your authorization:

**Treatment.** This means the provision, coordination or management of your health care and related services, including any referrals for health care from one health professional to another. For example, we may use or disclose health information about you to facilitate treatment or services by health care providers. We may disclose health information about you to other health care professionals who are involved in taking care of you.

**Payment.** This means activities to facilitate payment for the treatment and services you receive from health care professionals, including to obtain premium, to determine eligibility, coverage or benefit responsibilities under your insurance coverage, or to coordinate your insurance coverage. For example, the information on claim forms sent to us may include information that identifies you, as well as your diagnosis, and the procedures and supplies used. We may share this information with outside health care consultants performing a business service for The Standard. Likewise, we may share health information with other insurance carriers to coordinate benefit payments. We mail Explanation of Benefits forms and other information to the address we have on record for the primary member. In addition, claim information may be accessible through our website requiring an access code and our toll-free number.

**Health Care Operations.** This means the support functions related to treatment and payment, such as quality assurance activities, case management, underwriting, premium rating, business management and other general administrative activities. For example, we may use health information in connection with conducting quality assessment and improvement activities, underwriting, premium rating and other activities relating to your coverage, including auditing functions and fraud detection and reporting. We may also disclose health information to business associates if they need to receive health information to provide a service to us and by contract agree to abide by the same high standards of safeguarding your health information. We are prohibited from using or disclosing your genetic health information for underwriting purposes.

**Public Health Activities.** We may disclose health information to public health or legal authorities charged with preventing or controlling disease, injury (including abuse) or disability, or to a governmental agency or regulator with health care oversight responsibilities.

**Military and Veterans.** If you are a member of the armed forces, we may disclose health information about you as required by military command authorities.

**Workers' Compensation.** We may disclose health information about you for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

**Coroners and Medical Examiners.** We may disclose health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

**Organ and Tissue Donation.** We may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

**Research Purposes.** We may disclose health information for research purposes.

**Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute.

**Law Enforcement and National Security and Intelligence Activities.** We may disclose health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process. We may disclose health information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

**To Avert a Serious Threat to Health or Safety.** We may disclose health information to avert a serious threat to someone's health or safety. We may disclose health information to federal, state or local agencies engaged in disaster relief to allow such entities to carry out their responsibilities in specific disaster situations.

**Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care, (2) to protect your health and safety or the health and safety of others or (3) for the safety and security of the correctional institution.

**Disclosure to your Plan Sponsor.** Information may be disclosed to your plan sponsor for purposes of plan administration if the plan sponsor has certified that plan documents have been amended as required by HIPAA. De-identified summary health information may be disclosed to your plan sponsor for the purposes of obtaining health insurance bids or modifying, amending, or terminating the health plan.

In the following situations generally we must obtain your authorization before disclosing your health information:

**Sale of Protected Health Information.** We must obtain your authorization prior to selling your health information. If we will obtain financial remuneration for such sale, we must disclose that to you in the authorization.

**Psychotherapy Notes.** Most uses and disclosures of your psychotherapy notes require your authorization.

**Marketing.** We must obtain your authorization prior to using or disclosing your health information for marketing purposes in most situations. If we will obtain financial remuneration for such marketing, we must disclose that to you in the authorization.

**Other Uses and Disclosures of Your Health Information.** Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission in writing at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization, except to the extent that we have already taken action in reliance on your authorization.

### ***Your Rights Regarding Your Health Information***

The following describes your rights regarding the health information we maintain about you. To exercise your rights, you must submit your request in writing to Standard Insurance Company, Attn: Quality Assurance Specialist, PO Box 82629, Lincoln, NE 68501-2629.

**Right to Inspect and Copy.** You have the right to inspect and copy health information that we maintain about you. To inspect or copy your health information, you must submit your request in writing. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Please contact our Privacy Contact at the address or telephone number listed on the last page of this document if you have questions about access to your health information.

**Right to Amend.** If you feel that the health information we have about you is incorrect or incomplete, you may ask us in writing to amend the information. You have the right to request an amendment for as long as we maintain the information.

In addition, you must provide a reason that supports your request. Any agreed-upon correction to your health information will be included as an addition to, and not a replacement of, already existing records.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (1) is not part of the health information kept by us, (2) was not created by us, unless the person or entity that created the information is no longer available to make the amendment, (3) is not part of the information which you would be permitted to inspect and copy or (4) is accurate and complete.

**Right to an Accounting of Disclosures.** You have the right to request an accounting of disclosures of your health information made by us in the six years prior to the date that the accounting is requested (or shorter period as requested). This does not include disclosures (1) to carry out treatment, payment, or health care operations; (2) made to you or pursuant to your authorization; (3) for national security or intelligence purposes; (4) to corrections institutions or law enforcement officials or (5) made prior to April 14, 2003.

Your first request for an accounting in any 12-month period shall be provided without charge. A reasonable fee shall be imposed for each subsequent request for an accounting within the same 12-month period.

**Right to Request Restrictions.** You have the right to request a restriction or limitation of the health information we use or disclose about you for treatment, payment or health care operations. We are not required to agree to

your request unless your request is to restrict disclosure to a health plan for purposes of payment or health care operations when you or someone on your behalf (but not the health plan) has already made full payment.

To request restrictions, you must make your request in writing to our Privacy Contact indicated below. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both and (3) to whom you want the limits to apply.

**Right to Request Confidential Communications.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will accommodate reasonable requests. We will not ask you the reason for your request. Please make this request in writing to our Privacy Contact indicated below.

**Right to Breach Notification.** We are required by law to maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices with respect to your health information. We are also required by law to notify affected individuals following a breach of unsecured health information.

**Your Right to File a Complaint.** If you believe your privacy rights have been violated, please submit your complaint in writing to:

Standard Insurance Company  
Attn: Quality Assurance Specialist  
PO Box 82629  
Lincoln, NE 68501-2629

You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

***Privacy Contact***

If you have any questions or would like further information about this notice or your rights regarding your health information, please contact the Quality Assurance Specialist at 800.547.9515 or the above address.

This notice is revised effective September 23, 2016.



## STANDARD INSURANCE COMPANY

A Stock Life Insurance Company  
900 SW Fifth Avenue  
Portland, Oregon 97204-1282  
(503) 321-7000

### CERTIFICATE GROUP EYE CARE INSURANCE

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**The Policyholder**     **COLUMBIA COUNTY BOARD OF COUNTY COMMISSIONERS  
BOARD OF COUNTY COMMISSIONERS**

**Policy Number**     **160-162038**     **Insured Person**

**Plan Effective Date**     **October 1, 2020**     **Certificate Effective Date**  
**Refer to Exceptions on 9070**

**Plan Change Effective Date**     **October 1, 2024**

**Class Number 4**

Standard Insurance Company certifies that you will be insured for the benefits described on the following pages, according to all the terms of the group policy numbered above which has been issued to the Policyholder.

Possession of this certificate does not necessarily mean you are insured. You are insured only if you meet the requirements set out in this certificate.

The group policy may be amended or cancelled without the consent of the insured person.

**The group policy and this certificate are governed by the laws of the state in which the group policy was delivered.**

If you should have any questions regarding your coverage or claim payments, you may contact us toll-free at 800-877-7195.

**STANDARD INSURANCE COMPANY**

A handwritten signature in black ink, appearing to read "Daniel J. McMillan". The signature is fluid and cursive, with the first name "Daniel" being particularly prominent.

Daniel J. McMillan  
President and CEO

## FLORIDA - IMPORTANT INFORMATION TO INSUREDS

### **We are here to serve you . . .**

You have the right to receive medically appropriate care in a timely and convenient manner and to be an active participant in any decision making regarding treatment, care and services provided to you or one of your family members who are covered under this plan.

In order to provide you the best possible service, it is important that you provide any necessary information to your provider that will facilitate effective medical care and that you cooperate with your provider(s) by keeping appointments and following recommended treatment.

Please review your certificate of coverage carefully so that you fully understand the benefits provided. If you have a question about your policy or if you need assistance with a problem, feel free to contact us at the number shown below.

If you have a grievance or complaint regarding an adverse decision, you may call us below or document your concerns in writing. Written documentation can be sent to the following:

Name:	Quality Assurance
Address:	P.O. Box 82629 Lincoln, NE 68501-2629
Phone:	888-418-6811
Fax:	402-309-2579

The complaint will be carefully reviewed. If the initial claim was denied based on clinical necessity or paid as an alternate benefit, then a licensed provider will be involved in the review of the appeal. A written decision will be sent to the claimant within 15 business days following the receipt of the appeal.

### **If you are not satisfied . . .**

Should you feel you are not being treated fairly, we want you to know you may contact the Department of Financial Services with your complaint and seek assistance from the governmental agency that regulates insurance.

To contact them, write or call:

**Division of Consumer Services  
Department of Financial Services  
200 East Gaines Street  
Tallahassee, FL 32399-0321  
(877) 693-5236 or (850) 413-3089**

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**SCHEDULE OF BENEFITS  
OUTLINE OF COVERAGE**

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

<u>Benefit Class</u>	<u>Class Description</u>
Class 4	Eligible Employee Electing High Vision

**EYE CARE EXPENSE BENEFITS**

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

Deductible Amount:

When a Participating Provider is used:

Exams - Each Benefit Period	\$10
Contact Lens Fitting and Evaluation - Each Benefit Period	\$60
Frames, Lenses, and Medically Necessary Contacts - Each Benefit Period	\$10

When a Non-Participating Provider is used:

Exams - Each Benefit Period	\$10
Frames, Lenses, and Medically Necessary Contacts - Each Benefit Period	\$10

***Please refer to the EYE CARE EXPENSE BENEFITS page for details regarding frequency, limitations, and exclusions.***

## DEFINITIONS

**COMPANY** refers to Standard Insurance Company. The words "we", "us" and "our" refer to Company. Our Home Office address is 900 SW Fifth Avenue, Portland, Oregon 97204-1282.

**POLICYHOLDER** refers to the Policyholder stated on the face page of the policy.

**INSURED** refers to a person:

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

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

**DEPENDENT** refers to:

- a. an Insured's spouse.
- b. each child through the end of the year in which they turn 26 years of age, for whom the Insured or the Insured's spouse is legally responsible, including natural born children, newborn adopted children from the date of placement for adoption, any child placed with the Insured for adoption, a foster child or other child in court-ordered custody, placed pursuant to Chapter 63 of Florida Code and, children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws. Grandchildren, spouses of Dependents and other Dependent family members under the age of 26 are not eligible for coverage under this plan.
- c. each child through the end of the year in which they turn 26 but less than 30 who is a full-time student at an accredited school or college and is primarily dependent on the Insured or the Insured's spouse for support and maintenance.
- d. each child through the end of the year in which they turn 26 or older who is Totally Disabled and becomes Totally Disabled as defined below while insured as a dependent under b. or c. above. Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

**TOTAL DISABILITY** describes the Insured's Dependent as:

1. Continuously incapable of self-sustaining employment because of developmental disability or physical handicap; and
2. Chiefly dependent upon the Insured for support and maintenance.

**DEPENDENT UNIT** refers to all of the people who are insured as the dependents of any one Insured.

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

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

**PLAN EFFECTIVE DATE** refers to the date coverage under the policy becomes effective. The Plan Effective Date for the Policyholder is shown on the policy cover. The effective date of coverage for an Insured is shown in the Policyholder's records.

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

**PLAN CHANGE EFFECTIVE DATE** refers to the date that the policy provisions originally issued to the Policyholder change as requested by the Policyholder. The Plan Change Effective date for the Policyholder will be shown on the policy cover, if the Policyholder has requested a change. The plan change effective date for an Insured is shown in the Policyholder’s records or on the cover of the certificate.

**CONDITIONS FOR INSURANCE COVERAGE**  
*ELIGIBILITY*

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

If employment is the basis for membership, a member of the Eligible Class for Insurance is any eligible employee electing high vision working at least 30 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

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

**ELIGIBLE CLASS FOR DEPENDENT INSURANCE.** Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the first of the month falling on or first following the latest of:

1. the day he or she qualifies for coverage as a Member;
2. the day he or she becomes a Member; or
3. the day he or she first has a dependent.

**COVERAGE FOR NEWBORN AND ADOPTED CHILDREN.** A newborn child will be covered from the date of birth. Coverage for a newborn child of a covered dependent other than a spouse will stop on the date the child attains eighteen months of age.

An adopted child, foster child and other child in court-ordered custody placed pursuant to Chapter 63 will be covered from the date of placement in the Insured's residence. A newborn adopted child will be covered from the date of birth if the Insured has agreed in writing to adopt the child prior to its birth and the child is ultimately placed in the Insured's residence.

Coverage for a newborn child shall consist of coverage for all covered Eye Care expenses, subject to applicable deductibles, coinsurance percentages, maximums and limitations, including the necessary care or treatment of congenital defects, birth abnormalities, including premature birth.

The Insured may give us written notice within 61 days of the date of birth or placement of a dependent child to start coverage. If timely notice is given, we will not charge an additional premium for the 61-day notice period. If timely notice is not given, we will charge the applicable additional premium from the date of birth or placement for an adopted child. We will not deny coverage for a child due to the failure of the Insured to notify us within 60 days of the child's birth or placement.

A Member must be an Insured to also insure his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any eligible employee electing high vision working at least 30 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

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

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

**CONTRIBUTION REQUIREMENTS.** Member Insurance: An Insured is required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

**SECTION 125.** This plan is provided as part of the Employer's Section 125 Plan. Each Member has the option under the Section 125 Plan of participating or not participating in this plan.

If a Member does not elect to participate when initially eligible, the Member may elect to participate at a subsequent Election Period. This Election Period will be held each year and those who elect to participate in this plan at that time will have their coverage become effective on October 1.

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

**ELIGIBILITY PERIOD.** For Members on the Plan Effective Date of the policy, coverage is effective immediately.

For persons who become Members after the Plan Effective Date of the policy, qualification will occur on the first of the month falling on or first following the eligibility period of 60 calendar day(s) of continuous active employment.

**OPEN ENROLLMENT.** If a Member does not elect to participate when initially eligible, the Member may elect to participate at the Policyholder's next enrollment period. This enrollment period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on October 1.

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

**EFFECTIVE DATE.** Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be the first of the month falling on or first following:

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.
2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.

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

employer's business establishments or at some location to which the employer's business requires the employee to travel.

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

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

But any person who is not in active service or is totally disabled will be insured on the Effective Date if:

- i. the person was insured under a policy of group insurance providing like benefits which ended on the day immediately before the Effective Date of the policy providing this coverage; and
- ii. the person is considered a Member or an eligible Dependent under the policy providing this coverage; and had the prior policy contained the same definition of eligibility, would have been a Member or Dependent under the prior policy.

#### ***TERMINATION DATES***

**INSUREDS.** The insurance for any Insured, will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

**DEPENDENTS.** The insurance for all of an Insured's dependents will automatically terminate on the end of the month falling on or next following the **earliest of:**

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

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

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

## **EYE CARE EXPENSE BENEFITS**

If an Insured has Covered Expenses under this section, we pay benefits as described. The Insured can choose any provider at any time.

### **COVERED EXPENSES**

Covered Expenses include the lesser of:

- a. the charge for the covered procedure furnished; or
- b. the Maximum Covered Expense for such services or supplies shown in the Schedule of Eye Care Services.

Covered Expenses are the eye care expenses incurred by an Insured for services or supplies. We pay up to the Maximum Covered Expense shown in the Schedule of Eye Care Services.

### **DEDUCTIBLE AMOUNT**

The Deductible Amount is on the Schedule of Benefits. It is an amount of Covered Expenses for which no benefits are payable. It applies separately to each Insured. Benefits are paid only for those Covered Expenses that are over the Deductible Amount.

### **PARTICIPATING PROVIDERS**

A Participating Provider is a provider who has agreed to participate in the VSP network and agrees to provide services and supplies to the Insured at a discounted fee. For questions related to providers or benefit payments, VSP's Customer Care Division is available at (800) 877-7195.

### **NON-PARTICIPATING PROVIDERS**

A Non-Participating Provider is any other provider. Non-Participating providers may be referred to as Affiliate or Open Access Providers. Non-Participating Providers are not subject to our Quality Management Programs. Your out-of-pocket expenses may be greater when you visit a Non-Participating Provider. However, more cost savings or convenience may be available through VSP arrangements with Affiliate Providers. You may contact VSP's Customer Care Division for details at (800) 877-7195.

### **EYE CARE SUPPLIES**

Eye care supplies are all services listed on the Schedule of Eye Care Services. They exclude services related to Eye Care Exams.

### **REQUEST FOR SERVICES**

When requesting services, the Insured must advise the Participating Provider's office that he or she has coverage under this network plan. If the Insured receives services from a Participating Provider without this notification, the benefits may be limited to those for a Non-Participating Provider.

### **ASSIGNMENT OF BENEFITS**

We pay benefits to the Participating Provider for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, we pay benefits to the Insured unless arranged differently through an Affiliate or Open Access provider, or otherwise required by state regulation.

### **EXTENSION OF BENEFITS**

If your policy terminates, we will pay claims for eye care services and supplies that you received or ordered prior to your policy's termination. You will have six months following the date of service to submit your claim.

### **EXPENSES INCURRED**

An expense is incurred at the time a service is rendered or a supply item furnished.

**PROOF OF LOSS**

Written proof of loss must be given to us within 180 days after completion of the service for a claim to be covered. An exception may be made if the Insured shows it was not possible to submit the proof of loss within this period.

**LIMITATIONS**

This plan has the following limitation:

Some brands of spectacle frames may be unavailable at all locations for purchase as Covered Expenses, or may be subject to additional out-of-pocket expenses. Insureds may obtain details regarding frame brand availability from their treating provider or by calling VSP's Customer Care Division at (800) 877-7195.

**EXCLUSIONS**

This plan does not cover:

Services and/or materials not specifically included in this Schedule as covered Plan Benefits,

Plano lenses (lenses with refractive correction of less than plus or minus .50 diopter) except as specifically allowed in the frames benefit section below,

Services or materials that are cosmetic, including Plano contact lenses to change eye color and artistically painted Contact Lenses,

Two pairs of glasses in lieu of Bifocals,

Replacement of Spectacle Lenses, Frames, and/or contact lenses furnished under this plan that are lost or damaged, except at the normal intervals when services are otherwise available,

Orthoptics or vision training and any associated supplemental testing,

Medical or surgical treatment of the eyes,

Contact lens modification, polishing or cleaning,

The refitting of Contact Lenses after the initial 90-day fitting period,

Contact Lens insurance policies or service contracts,

Additional office visits associated with contact lens pathology,

Local, state and/or federal taxes, except where law requires us to pay,

Membership fees for any retail center in which an Affiliate or Open Access provider office may be located. Covered persons may be required to purchase a membership in such entities as a condition of accessing Plan Benefits.

## SCHEDULE OF EYE CARE SERVICES

The following is a complete list of eye care services for which benefits are payable under this section, You must first pay a Deductible for certain services as indicated on the Schedule of Benefits in the - Eye Care Expense Benefits section.

SERVICE	WHEN COVERED	PLAN MAXIMUM COVERED EXPENSE	
		<i>Participating Provider</i>	<i>Non-Participating Provider*</i>
<b>Vision Examination(s)</b>			
Eye Exam	Once every 12 months	Covered in Full	Up to \$ 45.00
Contact Lens Fitting & Evaluation	Once every 12 months	Covered in Full	See Elective Contact Lenses benefit below
<b>Complete Pair of Spectacles</b>			
<b>Lenses</b> (per pair, only one pair of lens type below allowed per covered period)			
Single Vision	Once every 12 months	Covered in Full	Up to \$ 30.00
Lined Bifocal	Once every 12 months	Covered in Full	Up to \$ 50.00
Lined Trifocal	Once every 12 months	Covered in Full	Up to \$ 65.00
Lenticular	Once every 12 months	Covered in Full	Up to \$100.00
<b>Frames</b>			
Single Frame	Once every 24 months	Up to \$180.00	Up to \$ 70.00
<b>Contact Lenses</b> (in lieu of Complete Pair of Spectacles)			
Elective	Once every 12 months	Up to \$180.00	Up to \$145.00
Medically Necessary**	Once every 12 months	Covered in Full	Up to \$210.00

**Low Vision** (for severe visual problems not correctable with regular lenses, as determined by the treating provider) Insureds can receive professional services for treatment of severe visual problems that are not correctable with regular lenses. The treating provider determines if an Insured's condition meets the criteria for coverage of this benefit. Insureds may contact VSP's Customer Care Division for details at (800-877-7195) for additional information.

\*Insureds may receive additional savings and some services may be covered in full by choosing to visit an Affiliate Non-Participating Provider.

\*\*The benefit for Medically Necessary contact lenses is in lieu of the Elective contact lenses benefit listed. The treating provider determines if an Insured meets the coverage criteria for this benefit.

## COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies if an Insured person has eye care coverage under more than one **Plan**. **Plan** is defined below. All benefits provided under this policy are subject to this section.

The order of benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan**. The **Secondary plan** may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total **Allowable expense**.

### DEFINITIONS

A. A **Plan** is any of the following that provides benefits or services for medical or eye care or treatment. 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.

(1) **Plan** includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage other than the medical benefits coverage in automobile "no fault" and traditional "fault" type contracts; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) 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**.

B. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one **COB** provision to certain benefits, such as eye care benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.

C. The order of benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health care coverage under more than one **Plan**.

When **This plan** is primary, it determines payment for its benefits first before those of any other **Plan** without considering any other **Plan's** benefits. When **This plan** is secondary, it 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 expense**.

D. **Allowable expense** is a health care expense, including deductibles, coinsurance and co-payments, 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 a covered person is not an **Allowable expense**.

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

- (1) If a person is covered by 2 or more **Plans** that compute their benefit payments on the basis of 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**.
- (2) If a person 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**.
- (3) If a person is covered by one **Plan** that calculates its benefits or services on the basis of 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 shall be the **Allowable expense** 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 expense** used by the **Secondary plan** to determine its benefits.
- (4) The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. **Closed panel plan** is a **Plan** that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the **Plan**, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **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.

## **ORDER OF BENEFIT DETERMINATION RULES**

When a person is covered by two or more **Plans**, the rules for determining the order of benefit payments are as follows:

- A. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other **Plan**.
- B. (1) Except as provided in Paragraph B(2) below, a **Plan** that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both **Plans** state that the complying plan is primary.  
  
(2) 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 contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.
- C. A **Plan** may consider the benefits paid or provided by another **Plan** in calculating payment of its benefits only when it is secondary to that other **Plan**.
- D. 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, for example 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 the person 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:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

The **Plan** of the parent whose birthday falls earlier in the calendar year is the **Primary plan**; or

If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health 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**.

(c) For a dependent child covered under more than one **Plan** of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-off Employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. 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 as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, 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 is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.

(6) If the preceding rules do not 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 THE BENEFITS OF THIS PLAN**

A. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year 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 health 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 health care coverage.

B. If a covered person 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**.

#### **RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION**

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give the Company any facts it needs 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, the Company 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**. The Company 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 the amount of the payments made by the Company is more than it should have paid under this **COB** provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

## GENERAL PROVISIONS

**NOTICE OF CLAIM.** Written notice of a claim must be given to us within 90 days after the incurred date of the services provided for which benefits are payable.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Policyholder's name, Insured's name, and policy number. If it was not reasonably possible to give written notice within the 90 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

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

**PROOF OF LOSS.** Written proof of loss must be given to us within 90 days after the incurred date of the services provided for which benefits are payable. If it is impossible to give written proof within the 90 day period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible. For Eye Care benefits that use either the EyeMed or VSP network, please refer to the limitations section on the Eye Care Expense Benefits page.

**TIME OF PAYMENT.** We will pay all benefits within 45 days of when we receive due proof.

If benefits are contested or denied, we will notify the Insured, in writing, which benefits are contested or denied within 45 days of when we received due proof. We will pay or deny any balance remaining on benefits for a claim within 60 days upon receipt of any additional information requested from the Insured. In no event will we hold a claim without paying or denying benefits any later than 120 days.

Payment is considered to be made on the date a draft or other valid instrument is placed in the United States mail in a properly addressed post paid envelope or, if not so posted, on the date of delivery.

We will pay interest at the rate of 10 percent per year on overdue payments on benefits for valid claims.

We will investigate any claim of improper billing of a claim by a Provider upon written notification by an Insured. We will determine if the Insured was properly billed for only those procedures that the Insured actually received. If we determine that the Insured was improperly billed, we will notify the Insured and the provider of our findings and will reduce the amount of payment by the amount determined to be improperly billed. If a reduction is made due to such notification by the Insured, we will pay the Insured 20 percent of the reduction up to \$500.

**PAYMENT OF BENEFITS.** Participating Providers have agreed to accept assignment of benefits for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, all benefits will be paid to the Insured unless otherwise indicated by the Insured's authorization to pay the Non-Participating Provider directly.

**FACILITY OF PAYMENT.** If an Insured or beneficiary is not capable of giving us a valid receipt for any payment or if benefits are payable to the estate of the Insured, then we may, at our option, pay the benefit up to an amount not to exceed \$3,000, to any relative by blood or connection by marriage of the Insured who is considered by us to be equitably entitled to the benefit.

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

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

**LEGAL PROCEEDINGS.** No legal action can be brought against us until 60 days after the Insured sends us the required proof of loss. No legal action against us can start more than the applicable statute of limitations after proof of loss is required.

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

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

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

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

## ERISA INFORMATION AND NOTICE OF YOUR RIGHTS

### A. **Eligibility and Benefits Provided Under the Group Policy**

Please refer to the **Conditions for Insurance** within the Group Policy and Certificate of Coverage for a detailed description of the eligibility for participation under the plan as well as the benefits provided. If this plan includes a participating provider (PPO) option, provider lists are furnished without charge, as a separate document.

### B. **Qualified Medical Child Support Order ("QMCSO")**

QMCSO Determinations. A Plan participant or beneficiary can obtain, without charge, a copy of the Plan's procedures governing Qualified Medical Child Support Order determinations from the Plan Administrator.

### C. **Termination Of The Group Policy**

The Group Policy which provides benefits for this plan may be terminated by the Policyholder at any time with prior written notice to Standard Insurance Company. It will terminate automatically if the Policyholder fails to pay the required premium. Standard Insurance Company may terminate the Group Policy on any Premium Due Date if the number of persons insured is less than the required minimum, or if Standard Insurance Company believes the Policyholder has failed to perform its obligations relating to the Group Policy.

After the first policy year, Standard Insurance Company may also terminate the Group Policy on any Premium Due Date for any reason by providing a 45-day advance written notice to the Policyholder.

The Group Policy may be changed in whole or in part. No change or amendment will be valid unless it is approved in writing by a Standard Insurance Company executive officer.

### D. **Claims For Benefits**

Claims procedures are furnished automatically, without charge, as a separate document.

### E. **Continuation of Coverage Provisions (COBRA)**

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) gives Qualified Beneficiaries the right to elect COBRA continuation after insurance ends because of a Qualifying Event. The law generally covers group health plans maintained by employers with 20 or more employees in the prior year. The law does not, however, apply to plans sponsored by the Federal government and certain church-related organizations.

#### i. **Definitions For This Section**

Qualified Beneficiary means an Insured Person who is covered by the plan on the day before a qualifying event. Any child born to or placed for adoption with a covered employee during the period of COBRA coverage is considered a qualified beneficiary.

A Qualifying Event occurs when:

1. The Member dies (hereinafter referred to as Qualifying Event 1);
2. The Member's employment terminates for reasons other than gross misconduct as determined by the Employer (hereinafter referred to as Qualifying Event 2);
3. The Member's work hours fall below the minimum number required to be a Member (hereinafter referred to as Qualifying Event 3);
4. The Member becomes divorced or legally separated from a Spouse (hereinafter referred to as Qualifying Event 4);

5. The Member becomes entitled to receive Medicare benefits under Title XVII of the Social Security Act (hereinafter referred to as Qualifying Event 5);
6. The Child of a Member ceases to be a Dependent (hereinafter referred to as Qualifying Event 6);
7. The Employer files a petition for reorganization under Title 11 of the U.S. Bankruptcy Code, provided the Member is retired from the Employer and is insured on the date the petition is filed (hereinafter referred to as Qualifying Event 7).

**ii. Electing COBRA Continuation**

- A. Each Qualified Beneficiary has the right to elect to continue coverage that was in effect on the day before the Qualifying Event. The Qualified Beneficiary must apply in writing within 60 days of the later of:
  1. The date on which Insurance would otherwise end; and
  2. The date on which the Employer or Plan Administrator gave the Qualified Beneficiary notice of the right to COBRA continuation.
- B. A Qualified Beneficiary who does not elect COBRA Continuation coverage during their original election period may be entitled to a second election period if the following requirements are satisfied:
  1. The Member's Insurance ended because of a trade related termination of their employment, which resulted in being certified eligible for trade adjustment assistance;
  2. The Member is certified eligible for trade adjustment assistance (as determined by the appropriate governmental agency) within 6 months of the date Insurance ended due to the trade related termination of their employment; and
  3. The Qualified Beneficiary must apply in writing within 60 days after the first day of the month in which they are certified eligible for trade adjustment assistance.

**iii. Notice Requirements**

1. When the Member becomes insured, the Plan Administrator must inform the Member and Spouse in writing of the right to COBRA continuation.
2. The Qualified Beneficiary must notify the Plan Administrator in writing of Qualifying Event 4 or 6 above within 60 days of the later of:
  - a. The date of the Qualifying Event; or
  - b. The date the Qualified Beneficiary loses coverage due to the Qualifying Event.

3. A Qualified Beneficiary, who is entitled to COBRA continuation due to the occurrence of Qualifying Event 2 or 3 and who is disabled at any time during the first 60 days of continuation coverage as determined by the Social Security Administration pursuant to Title II or XVI of the Social Security Act, must notify the Plan Administrator of the disability in writing within 60 days of the later of:
  - a. The date of the disability determination;
  - b. The date of the Qualifying Event; or
  - c. The date on which the Qualified Beneficiary loses coverage due to the Qualifying Event.
4. Each Qualified Beneficiary who has become entitled to COBRA continuation with a maximum duration of 18 or 29 months must notify the Plan Administrator of the occurrence of a second Qualifying Event within 60 days of the later of:
  - a. The date of the Qualifying Event; or
  - b. The date the Qualified Beneficiary loses coverage due to the Qualifying Event.
5. The Employer must give the Plan Administrator written notice within 30 days of the occurrence of Qualifying Event 1, 2, 3, 5, or 7.
6. Within 14 days of receipt of the Employer's notice, the Plan Administrator must notify each Qualified Beneficiary in writing of the right to elect COBRA continuation.

In order to protect your rights, Members and Qualified Beneficiaries should inform the Plan Administrator in writing of any change of address.

**iv. COBRA Continuation Period**

1. 18-month COBRA Continuation

Each Qualified Beneficiary may continue Insurance for up to 18 months after the date of Qualifying Event 2 or 3.

2. 29-month COBRA Continuation

Each Qualified Beneficiary, who is entitled to COBRA continuation due to the occurrence of Qualifying Event 2 or 3 and who is disabled at any time during the first 60 days of continuation coverage as determined by the Social Security Administration pursuant to Title II or XVI of the Social Security Act, may continue coverage for up to 29 months after the date of the Qualifying Event. All Insured Persons in the Qualified Beneficiary's family may also continue coverage for up to 29 months.

3. 36-Month COBRA Continuation

If you are a Dependent, you may continue Coverage for up to 36 months after the date of Qualifying Event 1, 4, 5, or 6. Each Qualified Beneficiary who is entitled to continue Insurance for 18 or 29 months may be eligible to continue coverage for up to 36 months after the date of their original Qualifying Event if a second Qualifying Event occurs while they are on continuation coverage.

Note: The total period of COBRA continuation available in 1 through 3 will not exceed 36 months.

4. COBRA Continuation For Certain Bankruptcy Proceedings

If the Qualifying Event is 7, the COBRA continuation period for a retiree or retiree's Spouse is the lifetime of the retiree. Upon the retiree's death, the COBRA continuation period for the surviving Dependents is 36 months from the date of the retiree's death.

v. **Premium Requirements**

Insurance continued under this provision will be retroactive to the date insurance would have ended because of a Qualifying Event. The Qualified Beneficiary must pay the initial required premium not later than 45 days after electing COBRA continuation, and monthly premium on or before the Premium Due Date thereafter. The monthly premium is a percentage of the total premium (both the portion paid by the employee and any portion paid by the employer) currently in effect on each Premium Due Date. The premium rate may change after you cease to be Actively at Work. The percentage is as follows:

18 month continuation - 102%

29 month continuation - 102% during the first 18 months, 150% during the next 11 months

36 month continuation - 102%

vi. When COBRA Continuation Ends

COBRA continuation ends on the earliest of:

1. The date the Group Policy terminates;
2. 31 days after the date the last period ends for which a required premium payment was made;
3. The last day of the COBRA continuation period.
4. The date the Qualified Beneficiary first becomes entitled to Medicare coverage under Title XVII of the Social Security Act;
5. The first date on which the Qualified Beneficiary is: (a) covered under another group Eye Care policy and (b) not subject to any preexisting condition limitation in that policy.

**F. Your Rights under ERISA**

As a participant in this Plan, you are entitled to certain rights and protections under the Employment Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

### **Receive Information About Your Plan and Benefits**

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

### **Continue Group Health Plan Coverage**

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

### **Prudent Actions by Plan Fiduciaries**

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to operate and administer this plan prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

### **Enforce Your Rights**

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### **Assistance with Your Rights**

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and

responsibilities under ERISA by calling those publications hotline of the Employee Benefits Security Administration

**CLAIMS REVIEW PROCEDURES  
AS REQUIRED UNDER  
EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)**

The following provides information regarding the claims review process and your rights to request a review of any part of a claim that is denied. Please note that certain state laws may also require specified claims payment procedures as well as internal appeal procedures and/or independent external review processes. Therefore, in addition to the review procedures defined below, you may also have additional rights provided to you under state law. If your state has specific grievance procedures, an additional notice specific to your state will also be included within the group policy and your certificate.

**CLAIMS FOR BENEFITS**

Claims may be submitted by mailing the completed claim form along with any requested information to:

Vision Service Plan  
Attn: Claims Services  
P.O. Box 385018  
Birmingham, AL 35238-5018

**NOTICE OF DECISION OF CLAIM**

We will evaluate your claim promptly after we receive it.

We will provide you written notice regarding the payment under the claim within 30 calendar days following receipt of the claim. This period may be extended for an additional 15 days, provided that we have determined that an extension is necessary due to matters beyond our control, and notify you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which we expect to render a decision. If the extension is due to your failure to provide information necessary to decide the claim, the notice of extension shall specifically describe the required information we need to decide the claim.

If we request additional information, you will have 45 days to provide the information. If you do not provide the requested information within 45 days, we may decide your claim based on the information we have received.

If we deny any part of your claim, you will receive a written notice of denial containing:

- a. The reasons for our decision.
- b. Reference to the parts of the Group Policy on which our decision is based.
- c. Reference to any internal rule or guideline relied upon in making our decision, along with your right to receive a copy of these guidelines, free of charge, upon request.
- d. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Eye Care practice.
- e. A description of any additional information needed to support your claim and why such information is necessary.
- f. Information concerning your right to a review of our decision.
- g. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA following an adverse benefit determination on review.

**APPEAL PROCEDURE**

If all or part of a claim is denied, you may request a review in writing within 180 days after receiving notice of the benefit denial.

You may send us written comments or other items to support your claim. You may review and receive copies of any non-privileged information that is relevant to your appeal. There will be no charge for such copies. You may request the names of the experts we consulted who provided advice to us about your claim.

The appeal review will be conducted by the Plan's named fiduciary and will be someone other than the person who denied the initial claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based in whole or in part on a medical judgment, including determinations with regard to whether a service was considered experimental, investigational, and/or not medically necessary, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original judgment and will not be subordinate to that person. Our review will include any written comments or other items you submit to support your claim.

We will review your claim promptly after we receive your request.

If your appeal is about urgent care, you may call Toll Free at 877-897-4328, and an Expedited Review will be conducted. Verbal notification of our decision will be made within 72 hours, followed by written notice within 3 calendar days after that.

If your appeal is about benefit decisions related to clinical or medical necessity, a Standard Consultant Review will be conducted. A written decision will be provided within 30 calendar days of the receipt of the request for appeal.

If your appeal is about benefit decisions related to coverage, a Standard Administrative Review will be conducted. A written decision will be provided within 60 calendar days of the receipt of the request for appeal.

If we deny any part of your claim on review, you will receive a written notice of denial containing:

- a. The reasons for our decision.
- b. Reference to the parts of the Group Policy on which our decision is based.
- c. Reference to any internal rule or guideline relied upon in making our decision along with your right to receive a copy of these guidelines, free of charge, upon request.
- d. Information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.
- e. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Eye Care practice.
- f. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA.

Certain state laws also require specified internal appeal procedures and/or external review processes. In addition to the review procedures defined above, you may also have additional rights provided to you under state law. Please review your certificate for such information, call us, or contact your state insurance regulatory agency for assistance. In any event, you need not exhaust such state law procedures prior to bringing civil action under Section 502(a) of ERISA.

Any request for appeal should be directed to:

Quality Control, P.O. Box 82657, Lincoln, NE 68501-2657.



TheStandard®

## ***HIPAA Notice of Privacy Practices***

**To:** All Insureds covered under a Eye Care Insurance policy ("Health Plan") with Standard Insurance Company

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

Standard Insurance Company ("The Standard") is committed to protecting the health information that we maintain about you. As required by rules effective April 14, 2003, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), this notice provides you with information about your rights and our legal duties and practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures that The Standard will make of your protected health information.

"Protected health information" includes any identifiable information that we obtain from you or others that relates to your past, present or future health care and treatment or the payment for your health care and treatment. Your health care professional may have different policies or notices regarding his or her use and disclosure of your health information created in the health care professional's office or clinic.

The Standard reserves the right to change the terms of this notice and to make the revised notice effective for all protected health information we maintain. You may request a paper copy of the most current privacy notice from our office or access it on our Web site at [www.standard.com/hipaa](http://www.standard.com/hipaa).

### ***Permitted Uses and Disclosures of Your Health Information***

We will disclose health information about you when required to do so by federal, state or local law. For example, we may disclose health information when required by a court order, subpoena, warrant, summons or similar process. The following describes the purposes for which The Standard is permitted or required by law to use or disclose your Health Plan coverage information without your authorization:

**Treatment.** This means the provision, coordination or management of your health care and related services, including any referrals for health care from one health professional to another. For example, we may use or disclose health information about you to facilitate treatment or services by health care providers. We may disclose health information about you to other health care professionals who are involved in taking care of you.

**Payment.** This means activities to facilitate payment for the treatment and services you receive from health care professionals, including to obtain premium, to determine eligibility, coverage or benefit responsibilities under your insurance coverage, or to coordinate your insurance coverage. For example, the information on claim forms sent to us may include information that identifies you, as well as your diagnosis, and the procedures and supplies used. We may share this information with outside health care consultants performing a business service for The Standard. Likewise, we may share health information with other insurance carriers to coordinate benefit payments. We mail Explanation of Benefits forms and other information to the address we have on record for the primary member. In addition, claim information may be accessible through our website requiring an access code and our toll-free number.

**Health Care Operations.** This means the support functions related to treatment and payment, such as quality assurance activities, case management, underwriting, premium rating, business management and other general administrative activities. For example, we may use health information in connection with conducting quality assessment and improvement activities, underwriting, premium rating and other activities relating to your coverage, including auditing functions and fraud detection and reporting. We may also disclose health information to business associates if they need to receive health information to provide a service to us and by contract agree to abide by the same high standards of safeguarding your health information. We are prohibited from using or disclosing your genetic health information for underwriting purposes.

**Public Health Activities.** We may disclose health information to public health or legal authorities charged with preventing or controlling disease, injury (including abuse) or disability, or to a governmental agency or regulator with health care oversight responsibilities.

**Military and Veterans.** If you are a member of the armed forces, we may disclose health information about you as required by military command authorities.

**Workers' Compensation.** We may disclose health information about you for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

**Coroners and Medical Examiners.** We may disclose health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

**Organ and Tissue Donation.** We may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

**Research Purposes.** We may disclose health information for research purposes.

**Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute.

**Law Enforcement and National Security and Intelligence Activities.** We may disclose health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process. We may disclose health information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

**To Avert a Serious Threat to Health or Safety.** We may disclose health information to avert a serious threat to someone's health or safety. We may disclose health information to federal, state or local agencies engaged in disaster relief to allow such entities to carry out their responsibilities in specific disaster situations.

**Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care, (2) to protect your health and safety or the health and safety of others or (3) for the safety and security of the correctional institution.

**Disclosure to your Plan Sponsor.** Information may be disclosed to your plan sponsor for purposes of plan administration if the plan sponsor has certified that plan documents have been amended as required by HIPAA. De-identified summary health information may be disclosed to your plan sponsor for the purposes of obtaining health insurance bids or modifying, amending, or terminating the health plan.

In the following situations generally we must obtain your authorization before disclosing your health information:

**Sale of Protected Health Information.** We must obtain your authorization prior to selling your health information. If we will obtain financial remuneration for such sale, we must disclose that to you in the authorization.

**Psychotherapy Notes.** Most uses and disclosures of your psychotherapy notes require your authorization.

**Marketing.** We must obtain your authorization prior to using or disclosing your health information for marketing purposes in most situations. If we will obtain financial remuneration for such marketing, we must disclose that to you in the authorization.

**Other Uses and Disclosures of Your Health Information.** Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission in writing at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization, except to the extent that we have already taken action in reliance on your authorization.

### ***Your Rights Regarding Your Health Information***

The following describes your rights regarding the health information we maintain about you. To exercise your rights, you must submit your request in writing to Standard Insurance Company, Attn: Quality Assurance Specialist, PO Box 82629, Lincoln, NE 68501-2629.

**Right to Inspect and Copy.** You have the right to inspect and copy health information that we maintain about you. To inspect or copy your health information, you must submit your request in writing. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Please contact our Privacy Contact at the address or telephone number listed on the last page of this document if you have questions about access to your health information.

**Right to Amend.** If you feel that the health information we have about you is incorrect or incomplete, you may ask us in writing to amend the information. You have the right to request an amendment for as long as we maintain the information.

In addition, you must provide a reason that supports your request. Any agreed-upon correction to your health information will be included as an addition to, and not a replacement of, already existing records.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (1) is not part of the health information kept by us, (2) was not created by us, unless the person or entity that created the information is no longer available to make the amendment, (3) is not part of the information which you would be permitted to inspect and copy or (4) is accurate and complete.

**Right to an Accounting of Disclosures.** You have the right to request an accounting of disclosures of your health information made by us in the six years prior to the date that the accounting is requested (or shorter period as requested). This does not include disclosures (1) to carry out treatment, payment, or health care operations; (2) made to you or pursuant to your authorization; (3) for national security or intelligence purposes; (4) to corrections institutions or law enforcement officials or (5) made prior to April 14, 2003.

Your first request for an accounting in any 12-month period shall be provided without charge. A reasonable fee shall be imposed for each subsequent request for an accounting within the same 12-month period.

**Right to Request Restrictions.** You have the right to request a restriction or limitation of the health information we use or disclose about you for treatment, payment or health care operations. We are not required to agree to

your request unless your request is to restrict disclosure to a health plan for purposes of payment or health care operations when you or someone on your behalf (but not the health plan) has already made full payment.

To request restrictions, you must make your request in writing to our Privacy Contact indicated below. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both and (3) to whom you want the limits to apply.

**Right to Request Confidential Communications.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will accommodate reasonable requests. We will not ask you the reason for your request. Please make this request in writing to our Privacy Contact indicated below.

**Right to Breach Notification.** We are required by law to maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices with respect to your health information. We are also required by law to notify affected individuals following a breach of unsecured health information.

**Your Right to File a Complaint.** If you believe your privacy rights have been violated, please submit your complaint in writing to:

Standard Insurance Company  
Attn: Quality Assurance Specialist  
PO Box 82629  
Lincoln, NE 68501-2629

You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

***Privacy Contact***

If you have any questions or would like further information about this notice or your rights regarding your health information, please contact the Quality Assurance Specialist at 800.547.9515 or the above address.

This notice is revised effective September 23, 2016.

# EXPERIENCE BY MONTH

COLUMBIA COUNTY BOARD OF COUNTY  
160 - 162038



## DENTAL

Mar 17, 2026

RISK GROUP	MONTH	INFORCE PREMIUM	PAID CLAIMS	TOTAL EMPLOYEES
000	202502	0	-359	0
	202412	0	1,121	0
	202410	0	907	0
	202409	12,073	11,035	283
	202408	11,942	7,820	280
	202407	12,111	7,459	285
	202406	11,833	8,773	283
	202405	11,991	10,893	284
	202404	11,934	9,858	282
	202403	11,792	7,485	276
	202402	11,679	6,578	272
	202401	11,799	5,726	272
	202312	11,902	5,210	273
	202311	11,715	8,440	269
	202310	11,742	11,101	269
	202309	10,912	6,750	258
	202308	10,786	12,273	257
	202307	10,868	4,844	259
	202306	10,840	7,273	257
	202305	10,867	5,927	257
202304	11,175	6,033	262	
202303	11,120	11,149	260	
<b>Risk Group 000 - Total</b>		<b>219,082</b>	<b>156,296</b>	<b>5,138</b>
<b>Risk Group 000 - Average</b>		<b>9,958</b>	<b>7,104</b>	<b>234</b>
001 - EMPLOYEES ELECTING LOW DENTAL PLAN	202602	9,395	6,274	218
	202601	9,333	9,008	216
	202512	9,014	2,824	212
	202511	8,932	1,605	212
	202510	9,027	3,764	216
	202509	7,752	3,731	209
	202508	7,798	4,175	208
	202507	7,853	3,479	210
	202506	7,826	7,158	209
	202505	7,771	6,057	208
	202504	7,826	10,927	210
	202503	7,744	2,965	208
	202502	7,744	9,512	208
	202501	7,660	3,841	205
	202412	7,605	5,907	203
	202411	7,577	3,030	202
	202410	7,549	4,482	201
<b>Risk Group 001 - Total</b>		<b>138,406</b>	<b>88,740</b>	<b>3,555</b>
<b>Risk Group 001 - Average</b>		<b>8,142</b>	<b>5,220</b>	<b>209</b>
002 - EMPLOYEES ELECTING HIGH DENTAL PLAN	202602	9,812	4,667	175
	202601	9,923	10,039	177
	202512	10,034	6,715	179
	202511	9,845	3,036	174
	202510	9,642	4,712	173

# EXPERIENCE BY MONTH

COLUMBIA COUNTY BOARD OF COUNTY  
160 - 162038



## DENTAL

Mar 17, 2026

RISK GROUP	MONTH	INFORCE PREMIUM	PAID CLAIMS	TOTAL EMPLOYEES	
002 - EMPLOYEES ELECTING HIGH DENTAL PLAN	202509	8,642	4,815	180	
	202508	8,757	3,660	180	
	202507	8,941	6,441	182	
	202506	8,975	7,548	183	
	202505	8,939	6,177	181	
	202504	8,975	9,850	183	
	202503	9,108	7,649	186	
	202502	9,043	8,530	185	
	202501	9,161	10,621	186	
	202412	9,344	5,265	188	
	202411	9,158	9,732	185	
	202410	9,125	3,193	184	
	<b>Risk Group 002 - Total</b>		<b>157,423</b>	<b>112,653</b>	<b>3,081</b>
	<b>Risk Group 002 - Average</b>		<b>9,260</b>	<b>6,627</b>	<b>181</b>
<b>Period 1 - Total</b>		<b>514,911</b>	<b>357,689</b>	<b>11,774</b>	
<b>Period 1 - Average</b>		<b>27,360</b>	<b>18,951</b>	<b>624</b>	

# EXPERIENCE BY MONTH

COLUMBIA COUNTY BOARD OF COUNTY  
160 - 162038



## VISION

Mar 17, 2026

RISK GROUP	MONTH	INFORCE PREMIUM	PAID CLAIMS	TOTAL EMPLOYEES
000	202511	0	109	0
	202411	0	39	0
	202410	0	895	0
	202409	1,828	811	220
	202408	1,793	812	215
	202407	1,827	962	220
	202406	1,806	1,236	219
	202405	1,806	586	219
	202404	1,812	1,082	220
	202403	1,784	1,129	217
	202402	1,772	447	215
	202401	1,777	1,079	215
	202312	1,783	1,628	216
	202311	1,759	2,166	213
	202310	1,736	1,244	209
	202309	1,674	671	199
	202308	1,671	1,159	200
	202307	1,677	432	201
	202306	1,659	816	198
	202305	1,659	789	198
202304	1,693	757	202	
202303	1,676	1,235	200	
<b>Risk Group 000 - Total</b>		<b>33,192</b>	<b>20,085</b>	<b>3,996</b>
<b>Risk Group 000 - Average</b>		<b>1,509</b>	<b>913</b>	<b>182</b>
003 - EMPLOYEES ELECTING LOW VISION PLAN	202602	1,135	368	165
	202601	1,123	766	163
	202512	1,100	205	160
	202511	1,061	836	156
	202510	1,062	321	159
	202509	1,062	275	159
	202508	1,051	211	157
	202507	1,051	552	157
	202506	1,039	257	155
	202505	1,039	464	155
	202504	1,051	430	157
	202503	1,051	374	157
	202502	1,061	389	158
	202501	1,026	243	153
	202412	1,026	474	153
	202411	1,003	460	149
	202410	1,003	0	149
<b>Risk Group 003 - Total</b>		<b>17,944</b>	<b>6,627</b>	<b>2,662</b>
<b>Risk Group 003 - Average</b>		<b>1,056</b>	<b>390</b>	<b>157</b>
004 - EMPLOYEES ELECTING HIGH VISION PLAN	202602	1,924	833	216
	202601	1,937	1,036	217
	202512	1,939	642	219
	202511	1,944	1,278	218
	202510	1,921	1,104	217

# EXPERIENCE BY MONTH

COLUMBIA COUNTY BOARD OF COUNTY  
160 - 162038



## VISION

Mar 17, 2026

RISK GROUP	MONTH	INFORCE PREMIUM	PAID CLAIMS	TOTAL EMPLOYEES	
004 - EMPLOYEES ELECTING HIGH VISION PLAN	202509	1,794	1,078	208	
	202508	1,799	626	207	
	202507	1,824	569	209	
	202506	1,830	833	210	
	202505	1,816	717	207	
	202504	1,836	1,292	210	
	202503	1,842	1,565	211	
	202502	1,836	892	210	
	202501	1,853	1,102	210	
	202412	1,853	1,481	210	
	202411	1,848	1,265	210	
	202410	1,835	0	208	
	<b>Risk Group 004 - Total</b>		<b>31,631</b>	<b>16,313</b>	<b>3,597</b>
	<b>Risk Group 004 - Average</b>		<b>1,861</b>	<b>960</b>	<b>212</b>
<b>Period 1 - Total</b>		<b>82,767</b>	<b>43,026</b>	<b>10,255</b>	
<b>Period 1 - Average</b>		<b>4,425</b>	<b>2,262</b>	<b>550</b>	

# EXPERIENCE BY MONTH

COLUMBIA COUNTY BOARD OF COUNTY  
160 - 162038



**TOTAL**

Mar 17, 2026

RISK GROUP	MONTH	INFORCE PREMIUM	PAID CLAIMS	TOTAL EMPLOYEES
000	202511	0	109	0
	202502	0	-359	0
	202412	0	1,121	0
	202411	0	39	0
	202410	0	1,803	0
	202409	13,902	11,846	503
	202408	13,736	8,631	495
	202407	13,939	8,421	505
	202406	13,638	10,009	502
	202405	13,796	11,479	503
	202404	13,746	10,939	502
	202403	13,576	8,614	493
	202402	13,451	7,025	487
	202401	13,576	6,805	487
	202312	13,684	6,838	489
	202311	13,474	10,606	482
	202310	13,478	12,345	478
	202309	12,587	7,421	457
	202308	12,457	13,433	457
	202307	12,545	5,275	460
	202306	12,499	8,089	455
	202305	12,526	6,716	455
	202304	12,868	6,790	464
202303	12,797	12,384	460	
<b>Risk Group 000 - Total</b>		<b>252,274</b>	<b>176,381</b>	<b>9,134</b>
<b>Risk Group 000 - Average</b>		<b>10,511</b>	<b>7,349</b>	<b>381</b>
001 - EMPLOYEES ELECTING LOW DENTAL PLAN	202602	9,395	6,274	218
	202601	9,333	9,008	216
	202512	9,014	2,824	212
	202511	8,932	1,605	212
	202510	9,027	3,764	216
	202509	7,752	3,731	209
	202508	7,798	4,175	208
	202507	7,853	3,479	210
	202506	7,826	7,158	209
	202505	7,771	6,057	208
	202504	7,826	10,927	210
	202503	7,744	2,965	208
	202502	7,744	9,512	208
	202501	7,660	3,841	205
	202412	7,605	5,907	203
	202411	7,577	3,030	202
202410	7,549	4,482	201	
<b>Risk Group 001 - Total</b>		<b>138,406</b>	<b>88,740</b>	<b>3,555</b>
<b>Risk Group 001 - Average</b>		<b>8,142</b>	<b>5,220</b>	<b>209</b>
002 - EMPLOYEES ELECTING HIGH DENTAL PLAN	202602	9,812	4,667	175
	202601	9,923	10,039	177
	202512	10,034	6,715	179

# EXPERIENCE BY MONTH

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## TOTAL

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RISK GROUP	MONTH	INFORCE PREMIUM	PAID CLAIMS	TOTAL EMPLOYEES
002 - EMPLOYEES ELECTING HIGH DENTAL PLAN	202511	9,845	3,036	174
	202510	9,642	4,712	173
	202509	8,642	4,815	180
	202508	8,757	3,660	180
	202507	8,941	6,441	182
	202506	8,975	7,548	183
	202505	8,939	6,177	181
	202504	8,975	9,850	183
	202503	9,108	7,649	186
	202502	9,043	8,530	185
	202501	9,161	10,621	186
	202412	9,344	5,265	188
	202411	9,158	9,732	185
	202410	9,125	3,193	184
	<b>Risk Group 002 - Total</b>		<b>157,423</b>	<b>112,653</b>
<b>Risk Group 002 - Average</b>		<b>9,260</b>	<b>6,627</b>	<b>181</b>
003 - EMPLOYEES ELECTING LOW VISION PLAN	202602	1,135	368	165
	202601	1,123	766	163
	202512	1,100	205	160
	202511	1,061	836	156
	202510	1,062	321	159
	202509	1,062	275	159
	202508	1,051	211	157
	202507	1,051	552	157
	202506	1,039	257	155
	202505	1,039	464	155
	202504	1,051	430	157
	202503	1,051	374	157
	202502	1,061	389	158
	202501	1,026	243	153
	202412	1,026	474	153
202411	1,003	460	149	
202410	1,003	0	149	
<b>Risk Group 003 - Total</b>		<b>17,944</b>	<b>6,627</b>	<b>2,662</b>
<b>Risk Group 003 - Average</b>		<b>1,056</b>	<b>390</b>	<b>157</b>
004 - EMPLOYEES ELECTING HIGH VISION PLAN	202602	1,924	833	216
	202601	1,937	1,036	217
	202512	1,939	642	219
	202511	1,944	1,278	218
	202510	1,921	1,104	217
	202509	1,794	1,078	208
	202508	1,799	626	207
	202507	1,824	569	209
	202506	1,830	833	210
	202505	1,816	717	207
	202504	1,836	1,292	210
	202503	1,842	1,565	211
202502	1,836	892	210	

**EXPERIENCE BY MONTH**  
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**TOTAL**

Mar 17, 2026

RISK GROUP	MONTH	INFORCE PREMIUM	PAID CLAIMS	TOTAL EMPLOYEES
004 - EMPLOYEES ELECTING HIGH VISION PLAN	202501	1,853	1,102	210
	202412	1,853	1,481	210
	202411	1,848	1,265	210
	202410	1,835	0	208
<b>Risk Group 004 - Total</b>		<b>31,631</b>	<b>16,313</b>	<b>3,597</b>
<b>Risk Group 004 - Average</b>		<b>1,861</b>	<b>960</b>	<b>212</b>
<b>Period 1 - Total</b>		<b>597,678</b>	<b>400,714</b>	<b>22,029</b>
<b>Period 1 - Average</b>		<b>30,829</b>	<b>20,545</b>	<b>1,139</b>