REQUEST FOR PROPOSAL (RFP)
Franklin County School Board
Purchasing Department

Release Date: March 14, 2019
RFP No.: 2019-002
RFP Title: Group Dental, Vision and Employee Voluntary Insurance Products
Contact: Shannon Venable/svenable@franklin.k12.fl.us
Phone: 850-670-2810

The Franklin County School Board ("School Board") solicits your insurance company to submit a proposal on the above referenced goods or services. All terms, specifications and conditions set forth in this request are incorporated by this reference into your response. This proposal must be submitted to The Franklin County School Board, Purchasing Department, 85 School Road, Suite One, Eastpoint, Florida 32328, no later than **10:00 A.M.** local time on **April 2, 2019** and plainly marked RFP No. **2019-002**. Proposals are due and will be opened at this time.

REQUIRED SUBMITTAL CHECKLIST - *For each item below, insert bidder Authorized Agent initials verifying that forms are accurately completed, signed by an officer of the business and returned with the bid.* ***Failure to provide all requested documents may result in your proposal being declared non-responsive.***

___ Bidder Acknowledgement Form
___ Dispute Contact – pg. 5 , item 22
___ Product Line Statement of Benefits and Premium Proposals
___ Proposal Response – Section VI, pg. 14
___ Conflict of Interest Certificate (Exhibit A)
___ Vendor Application (Exhibit B)
___ Request for Taxpayer ID Number & Certification (Exhibit C)
___ Customer Reference (Exhibit D)
___ Vendor Questionnaire (Exhibit E)
___ Drug Free Workplace Certification (Exhibit F)
___ Certification Regarding Debarment (Exhibit G)
___ Sworn Statement / Jessica Lunsford Act (Exhibit H)
___ Affidavit For Claiming Local Purchasing Preference (Exhibit I)

THE FOLLOWING MUST BE COMPLETED, SIGNED AND RETURNED AS PART OF YOUR BID. BIDS WILL NOT BE ACCEPTED WITHOUT THIS FORM, SIGNED BY AN AUTHORIZED AGENT OF THE BIDDER.

Authorized Representative's Name/Title	Authorized Representative's Signature	Date

Company's Name	Telephone Number	FAX Number

Address	City	State	Zip Code

Area Representative	Telephone Number	FAX Number

Federal Employer's Identification Number (FEIN)	Email

Signature of Authorized Officer/Agent:	Typed or Printed Name

*(Proposal **must** be signed by an officer or employee having authority to legally bind the bidder)*

I certify that I have not divulged, discussed, or compared this proposal with any other Proposers and have not colluded with any other proposer in the preparation of this proposal in order to gain an unfair advantage in the award of this contract. I acknowledge that all information contained herein is part of the public domain as defined in the Public Records Act, Chapter 119, F.S.

By signing and submitting this proposal I certify that I am authorized to sign this proposal for this vendor and further certify unconditional acceptance of the contents of this RFP, all Attachments, Worksheets, Appendices, Supplemental Materials, and the contents of any Addendum released hereto.

NO RESPONSE – I HEREBY SUBMIT THIS AS A "NO RESPONSE" FOR THE REASON(S) CHECKED BELOW

☐ Remove our name from this bid list only ☐ Insufficient time to respond to the RFP ☐ Could not meet insurance requirements
☐ Keep our company on bid list for future bids ☐ Could not meet specifications ☐ Our product schedule would not permit us to perform
☐ We do not offer the product or service requested. ☐ Other_____

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BID IDENTIFICATION LABEL

NOTICE TO ALL BIDDERS: A label has been provided to properly identify your bid. Place the bid in a sealed envelope, type the name and address of the bidder on the label and affix the label to the front of the envelope.

The School Board Purchasing office is open from 8:00 a.m. - 4:00 p.m. Monday through Friday. If you are hand delivering a proposal, a Purchasing representative will be available to time/date stamp your submittal during these hours.

Cut out the label below and attach it to your envelope.

Sealed Bid – DO NOT OPEN **Sealed Bid – DO NOT OPEN**

Bid Title: **Group Dental, Vision, and Employee Voluntary Insurance Products**

Bid No.: **2019-002**

Bids Due: **April 2, 2019 @ 10:00 A.M.**

From: _____

Address: _____

_____

Deliver To: Franklin County Schools
Purchasing Department
85 School Road, Suite One
Eastpoint, Florida 32328

Sealed Bid – DO NOT OPEN **Sealed Bid – DO NOT OPEN**

I. GENERAL TERMS AND CONDITIONS

1. INTRODUCTION. The Franklin County School Board (the Board) is soliciting proposals for the purpose of identifying qualified companies to provide group dental, vision, and employee voluntary (accident, cancer, critical care, term life, hospital insurance, etc.) products, all in accordance with Conditions, Specifications, and/or Special Provisions attached hereto.

2. SCHOOL BOARD CONTACT: All questions for additional information regarding this RFP must be directed to the designated Purchasing Agent noted on the title page.

All contact and requests for clarifications should be submitted via e-mail to: **svenable@franklin.k12.fl.us** no later than **March 27, 2019**. Responses will be distributed no later than **March 28, 2019.**

Prospective bidders shall not contact any member of the Franklin County School Board, Superintendent or staff regarding this bid prior to posting of the final tabulation and award recommendation on the website and in the Purchasing Office. Any such contact shall be cause for rejection of your proposal.

3. DEFINITIONS: The term "Bidder" as used within this Request for Proposal (RFP) refers to the person, company or organization responding to this RFP. The Bidder is responsible for understanding and complying with the terms and conditions herein. The term "School Board" refers to the School Board of Franklin County, Florida.

4. BIDDER'S RESPONSIBILITY: It is the responsibility of the bidder to obtain all pages of the RFP package and all attachments thereto, together with any addenda to the RFP package that may be issued prior to the RFP due date. RFP package and addenda as well as general information can be found at https://vrapp.vendorregistry.com/Bids/View/BidsList?BuyerId=f15301dc-b9da-411c-a316-04a41c93255f.

Before submitting their Bid, each bidder is required to carefully examine the RFP specifications and to completely familiarize themselves with all of the terms and conditions that are contained within this request. Ignorance on the part of the bidder will in no way relieve them of any of the obligations and responsibilities which are a part of this RFP.

5. AWARD: In the event of contract award, this contract shall be awarded all or none to the responsible and responsive bidder(s) whose bid is determined to be the most advantageous to the District, taking into consideration price, product quality, and other requirements as set forth in this RFP. **Low cost proposal is but one of the evaluation parameters and does guarantee contract award.** The awarded contractor(s) understands and agrees that the contract shall not be construed as an exclusive agreement and further agrees that the District may secure identical and/or similar services or products from other sources at any time in conjunction with or in replacement of the contractor's services.

Once proposals are evaluated, the Purchasing Department will post a Notice of Intent to Award by electronic posting at https://vrapp.vendorregistry.com/Bids/View/BidsList?BuyerId=f15301dc-b9da-411c-a316-04a41c93255f on or about **April 11, 2019** for a period of 72 hours or three business days, whichever is later. Failure to file a protest within the time prescribed in section 120.57 (3) , Florida Statutes, or failure to post the bond or other security required by law within the time allowed for filing a bond shall constitute a waiver of proceedings under chapter 120, Florida Statutes.

It is anticipated that a recommendation for award will be presented to the School Board for consideration at its **April 25, 2019** meeting.

6. ORIGINAL AND RENEWAL TERM: Unless otherwise indicated in the detailed specifications the award resulting from this RFP shall be in effect for twelve (12) months and will begin after school board approval, **on July 1, 2019 through June 30, 2020**. The award resulting from this RFP (or any portion thereof) has the option of being renewed for three (3) additional years through **June 30, 2022.** The School Board, through its Purchasing Department, will, if considering a renewal or extension, request a letter of intent to renew or extend from one or more awardees, prior to the end of the current contract period. The awardees will be notified when the recommendation has been acted upon by The School Board. The Bidder agrees to these conditions by signing this proposal.

7. RESERVATION FOR REJECTION OR AWARD: The School Board reserves the right to reject any or all bids, to waive irregularities or technicalities, and to request rebids. The School Board reserves the right to award on an individual item basis, any combination of items, total low bid or, if an alternate bid is accepted, on such terms as are specified for the alternate bid, whichever manner is in the best interest of the School Board.

8. CONTRACT: The submission of your bid constitutes a firm offer by the bidder. Upon acceptance by the School Board, the Purchasing Department will issue a notice of award and purchase order(s) for any supplies, equipment and/or services as a result of this RFP. The RFP and the corresponding purchase order(s) will constitute the complete agreement between the successful bidder and the School Board. Unless otherwise stipulated in the RFP documents or agreed to in writing by both parties, no other contract documents shall be issued or accepted.

9. FIRM OFFER: Any proposal may be withdrawn until the date and time set for the opening of the RFP. Any proposal not so withdrawn shall constitute an irrevocable offer to provide the School Board the services/products set forth in this RFP. Such offer shall be held open for a period of sixty (60) days from RFP opening date or until one of the bids has been awarded by the School Board.

10. CONFIDENTIALITY: Bidders shall be aware that all proposals provided with a RFP are subject to public disclosure and will not be afforded confidentiality with the exception of "sealed" financial statements.

11. PUBLIC RECORDS LAW: Pursuant to Florida Statutes Chapter 119.071(1), proposals received as a result of this RFP will not become public record until thirty (30) days after the date of opening or until posting of a recommendation for award, whichever occurs first. Thereafter, all proposal documents or other materials submitted by all bidders in response to this RFP will be open for inspection by any person and in accordance with Chapter 119, Florida Statutes. To the extent a Bidder asserts any portion of its proposal is exempt or confidential from disclosure under Florida's public records, the burden shall be on the bidder to obtain a protective order from a jurisdictional court protecting such information from disclosure under Florida's public records laws and also timely provide a certified copy of such protective order to the School Board prior to the School Board's release of such information into the public domain.

12. USE OF OTHER CONTRACTS: The School Board reserve the right to utilize any other District contract, any State of Florida Contract, any contract awarded by any other City or County governmental agencies, any other School Board, any other Community College/State University system, any cooperative bid agreement, or to directly negotiate/purchase per School Board policy and/or State Board Rule 6A-1.012(6) in lieu of any offer received or award made as a result of this RFP, If it is in the best interest to do so. The School Board also reserves the right to separately bid any single order or to purchase any item on this RFP if it is in its best interest to do so.

13. JOINT-BIDDING, COOPERATIVE PURCHASING AGREEMENT: All bidders submitting a response to this RFP agree that such response also constitutes a proposal to all State Agencies and Political Subdivisions of the State of Florida under the same conditions, for the same prices and for the same effective period as this RFP, should the bidder(s) deem it in the best interest of their business to do so. This agreement in no way restricts or interferes with any state agency or political subdivision of the State of Florida to rebid any or all items.

State agencies wishing to make purchases from this agreement are required to follow the provisions of s. 287.042(16) (a), F.S. This statute

requires the Department of Management Services to determine that the requestor's use of the contract is cost-effective and in the best interest of the State.

Pursuant to their own governing laws, and subject to the agreement of the Contractor, other entities may be permitted to make purchases at the terms and conditions contained herein. Non-Customer purchases are independent of the agreement between Customer and Contractor, and Customer shall not be a party to any transaction between the Contractor and any other purchaser.

The purchasing agreements and state term contracts available under s. 287.056 have been reviewed.

14. RFP PREPARATION COSTS: Neither the School Board nor its representatives shall be liable for any expenses incurred in connection with the preparation of a response to this RFP.

15. BID BONDS AND PERFORMANCE BONDS: Bid bonds, **when required** shall be submitted with the bid in the amount specified in the detailed specifications. Bid bonds will be returned to unsuccessful bidders. After Acceptance of a bid, the School Board will notify the successful bidder to submit a recorded payment and performance bond in the amount specified in the detailed specifications**.**

16. RFP OPENING AND FORM: Proposal openings will be public on the date and time specified on the Bidder's Acknowledgement Form. All Proposals received after the time indicated will be rejected as non-responsive and returned unopened to sender. Proposals by Email, fax, telegram, or verbally by telephone or in person will not be accepted. The School Board is not responsible for lost or late delivery of Bids by the U.S. Postal Service or other delivery services used by the Bidder.

17. CLARIFICATIONS AND INTERPRETATIONS: The School Board reserves the right to allow for clarification of questionable entries, and for the bidder to withdraw items with obvious mistakes. In the event of a conflict between the General Bid Terms and Conditions and any Special terms and Conditions attached hereto, the Special Terms and Conditions shall have precedence. Any questions concerning terms, conditions or specifications will be directed to the designated Purchasing Agent referenced on the RFP Acknowledgement. Any ambiguities or inconsistencies shall be brought to the attention of the designated Purchasing Agent in writing at least five workdays prior to the opening date of the proposal. Failure to do so, on the part of the bidder will constitute an acceptance by the bidder of consequent decision. An addendum to the RFP shall be issued and posted for those interpretations that may affect the eventual outcome of this RFP. It is the bidder's responsibility to assure the receipt of all addendum issued. No person is authorized to give oral interpretations of, or make oral changes to the RFP. Therefore oral statements given before the RFP opening date will not be binding. The School Board will consider no interpretations binding unless provided for by issuance of an addendum. Addenda will be made available at least five workdays prior to the opening date at https://vrapp.vendorregistry.com/Bids/View/BidsList?BuyerId=f15301dc-b9da-411c-a316-04a41c93255f. The bidder shall acknowledge receipt of all addenda by signing and enclosing said addenda with their proposal.

18. EVALUATION CRITERIA: Primary factors used to decide the award hereunder will be price, availability and responsiveness. Other factors that may be used in the evaluation of this RFP will be: (1.) administrative costs incurred by the School Board in association with the discharge of any subsequent award; (2.) alternative payment terms; (3.) Bidder's past performance. The School Board reserves the right to evaluate by lot, by partial lot, or by item, and to accept or reject any proposal in its entirety or in part, and to waive minor irregularities if the proposal is otherwise valid. In the event of a price extension error, the unit price will be accepted as correct. The School Board has sole discretion in determining testing and evaluation methods.

19. DEFAULT: In the event that the awarded bidder should breach this contract, the School Board reserves the right to seek all remedies in law and/or in equity.

20. FUNDING OUT/CANCELLATION OR TERMINATION WITH OR WITHOUT CAUSE:

A. WITH CAUSE: In the event any of the provisions of the Contract are violated by the bidder, the Superintendent or designee shall give written notice to the bidder stating the deficiencies and unless the deficiencies are corrected within ten days, recommendation will be made to the School Board or its designee for immediate cancellation. Upon cancellation, hereunder the School Board may pursue any and all legal remedies as provided herein and by law. In the event that it is subsequently determined that a cancellation under this paragraph was incorrect, the termination shall be converted to a termination for convenience pursuant to the next paragraph.

B. WITHOUT CAUSE: The School Board or its designee reserves the right to terminate any contract resulting from this RFP at any time and for no reason whatsoever, upon giving 30 days prior written notice to the bidder. If the Contract should be terminated for convenience as provided herein, the School Board shall be relieved of all obligations under said Contract. The School Board or its designee shall only be required to pay to the successful bidder that amount of the Contract actually performed to the date of termination.

C. FUNDING OUT: Florida School Laws prohibit the School Board or its designee from creating obligations on anticipation of budgeted revenues from one fiscal year to another without year-to-year extension provisions in the contracts. It is necessary that fiscal funding out provisions be included in all RFPs in which the terms are for periods of longer than one year. Therefore, the following funding out provisions are an integral part of this RFP and must be agreed to by all bidders:

The School Board or its designee may, during the contract period, terminate or discontinue the items covered in this RFP for lack of appropriated funds upon the same terms and conditions.

Such prior written notice will state:

1. That the lack of appropriated funds is the reason for termination, and
2. School Board agrees not to replace the equipment or services being terminated with equipment and services with functions similar to those performed by the equipment covered in this RFP from another vendor in the succeeding funding period.

"This written notification will thereafter release the School Board of Franklin County, Florida of all further obligations in any way related to such products covered herein".

21. TIE BID: According to FS 287.087, tie bid preference shall be awarded to Bidders with Drug Free Work Place programs. Whenever two or more are equal with regard to price, quality, and service, a bid received from a business that certifies that it has implemented a Drug Free Work Place program shall be given preference in the award process. In the event both Bidders have a Drug Free Work Place, preference shall be awarded in the following order: Local Vendors as specified in School Board Policy 6450. If both Bidders meet all requirements, according to standard purchasing practice, the Director of Purchasing will flip a coin to break the tie. Bidder's company name closest to the letter "A" will always be assigned heads in the coin toss.

22. DISPUTE: In case of any doubt or difference of opinion as to the items to be furnished hereunder, the decision of the School Board shall be final and binding on both parties. In the event a dispute occurs, or a clarification of contract terms becomes necessary, ***please indicate your company representative for arbitration proceedings.***

Representative's Name: _____

Telephone Number: _____

Our School Board Representatives will be:

Mrs. Barbara Sanders
Sanders and Duncan, P.A.
(850) 653-8976

23. PROTESTING BID SPECIFICATIONS: Any person desiring to protest the conditions/specifications in this RFP or any Addenda thereto, shall file a written notice of protest within 72 hours after receipt of the RFP or Addendum and shall file a formal written protest within ten days after the date the notice of protest was filed. Saturdays, Sundays and legal holidays or days during which the School Board administration is closed shall be excluded in the computation of the 72 hour period. If the tenth calendar day falls on a Saturday, Sunday or legal holiday, the formal written protest must be received on or before 4:00 p.m. of the next calendar day that is not a Saturday, Sunday, legal holiday, or day during which the School Board administration is closed.

Failure to file a protest within the time prescribed in section 120.57 (3), Florida Statutes, or failure to post the bond or other security required by law within the time allowed for filing a bond shall constitute a waiver of proceedings under chapter 120, Florida Statutes and School Board Policy 6326. Failure to follow any other requirements in the bid protest procedures established by the School Board of Franklin County, Florida shall constitute a waiver of all protest rights.

24. PROTESTS TO CONTRACT AWARD: The School Board shall provide notice of a decision or intended decision concerning a solicitation, contract award, or exceptional purchase by electronic posting which can be accessed at the Purchasing Department's website at https://vrapp.vendorregistry.com/Bids/View/BidsList?BuyerId=f15301dc-b9da-411c-a316-04a41c93255f. Any person desiring to protest the intended decision shall file a written notice of protest, within 72 hours after the official posting in the Purchasing Department office of the Notice of Intent to Award concerning this RFP, and shall file a formal written protest within ten days after filing the notice of protest. Saturdays, Sundays, legal holidays and days during which the School Board administration is closed shall be excluded in the computation of the 72-hour period. If the tenth calendar day falls on a Saturday, Sunday or legal holiday, the formal written protest must be received on or before 4:00 p.m. of the next calendar day that is not a Saturday, Sunday, legal holiday or day during which the School Board administration is closed. Section 120.57(3) (b), Florida Statutes, states that "the formal written protest shall state with particularity the facts and law upon which the protest is based." Any person who files an action protesting an intended award shall post with the Purchasing Department, at the time of filing the formal written protest, a bond payable to the Franklin County School Board consistent with F.A.C. Rule 28-110.005(2), and School Board Policy 6326. The bond shall be conditioned upon the payment of all costs which may be adjudged against protester in an Administrative hearing in which the action is brought and any subsequent appellate court proceeding. **For the purpose of calculating a protest bond, this contract is valued at approximately $214,000.** This is only an estimate and actual volume could vary up or down. Failure to file a notice of protest within the time prescribed by Section 120.57(3), Florida Statutes, shall constitute a waiver of proceedings under Chapter 120, Florida Statutes and School Board Policy 6326.

25. GOVERNING LAW AND VENUE: All legal proceedings brought in connection with this contract shall only be brought in a state or federal court located in the state of Florida. Venue in state court shall be in Franklin County, Florida. Venue in federal court shall be in the United States District Court, Northern District of Florida, Tallahassee division. Each party hereby agrees to submit to the personal jurisdiction of these courts for any lawsuits filed there against such party arising under or in connection with this contract. In the event that a legal proceeding is brought for the enforcement of any term of the contract, or any right arising there from, the parties expressly waive their respective rights to have such action tried by jury trial and hereby consent to the use of non-jury trial for the adjudication of such suit. All questions concerning the validity, operation, interpretation, construction and enforcement of any terms, covenants or conditions of this contract shall in all respects be governed by and determined in accordance with the laws of the State of Florida without giving effect to the choice of law principles thereof and unless otherwise preempted by federal law.

26. COMPLIANCE WITH STATE/FEDERAL REGULATIONS: All contracts involving federal funds will contain certain provisions required by applicable sections of CFR 34, Section 80.36(l) and Part 85.510, Florida Statute 257.36, or Florida Administrative Code Chapter 1B. The bidder certifies by signing the RFP that the bidder and his/her principals are not presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from participation in federally funded transactions and may, in certain instances, be required to provide a separate written certification to this effect.

During the term of any contract with the School Board, in the event of debarment, suspension, proposed debarment, declared ineligible or voluntarily excluded from participation in federally funded transactions, the Bidder shall immediately notify the Director of Purchasing, in writing. Bidders will also be required to provide access to records, which are directly pertinent to the contract and retain all required records for three (3) years after the School Board makes final payment.

For all contracts involving Federal funds in excess of $10,000, the School Board reserves the right to terminate the contract for cause, as well as for convenience, by issuing a certified notice to the Bidder.

27. COMPLIANCE WITH SCHOOL CODE: Bidder agrees to comply with all sections of the Florida K-20 Education Code, Title XLVIII, Florida Statutes as it presently exists and further as it may be amended from time to time. Further, Contractor agrees that failure to comply with the Florida K-20 Education Code shall constitute a material breach of this Contract and may result in the termination of this Contract by the School Board.

28. NONDISCRIMINATION NOTIFICATION AND CONTACT INFORMATION: No person shall on the basis of gender, marital status, sexual orientation, race, religion, national origin, age, color, pregnancy or disability be denied employment, receipt of services, access to or participation in school activities or programs if qualified to receive such services, or otherwise be discriminated against or placed in a hostile environment in any educational program or activity including those receiving federal financial assistance, except as provided by law." No person shall deny equal access or a fair opportunity to meet to, or discriminate against, any group officially affiliated with the Boy Scouts of America, or any other youth group listed in Title 36 of the United States Code as a patriotic society.

An employee, student, parent or applicant alleging discrimination with respect to employment, or any educational program or activity may contact:

Karen Peddie
Equity Coordinator and Title IX Compliance Officer
Franklin County School District
85 School Road, Suite One, Eastpoint, Florida 32328
(850) 670-2810 / kpeddie@franklin.k12.fl.us

A student or parent alleging discrimination as it relates to Section 504 of the Rehabilitation Act may contact:

Dr. Sue Summers, 504 Specialist
Franklin County School District
85 School Road, Suite One, Eastpoint, FLORIDA 32328
(850) 670-2810 / summers@franklin.k12.fl.us

29. LOCAL PREFERENCE: This RFP is subject to the local preference provisions as specified in School Board Policy 6450.

30. FLORIDA PREFERENCE: This RFP is subject to §287.084 Florida Statutes, which requires, among other things, the following: "A vendor whose principal place of business is outside this state must accompany any written bid, proposal, or reply documents with a written opinion of an attorney at law licensed to practice law in that foreign state, as to the preferences, if any or none, granted by the law of that state to its own business entities whose principal places of business are in that foreign state in the letting of any or all public contracts." Any bidder, regardless of whether its principal place of business is located inside or outside of this state, who submits any written bid, proposal or reply documents is responsible for understanding and complying with the requirements of §287.084 Florida Statutes.

31. CHARTER SCHOOLS: Items or services awarded under this contract shall be made available to Charter Schools approved by the School Board. The School Board is not responsible or liable for purchases that may be made by Charter Schools.

II. LICENSURE, INSURANCE AND LIABILITY

1. OCCUPATIONAL LICENSE: The contractor shall be responsible for obtaining and maintaining throughout the contract period any required occupational license and other licenses required pursuant to the laws of Franklin County or the State of Florida.

2. WORKER'S COMPENSATION: Bidders shall obtain and maintain during the life of the contract Workers' Compensation Insurance in compliance with Chapter 440, Florida Statutes for all of his employees employed on the project. In case any work is sublet, bidder shall require subcontractors similarly to provide Workers' Compensation Insurance.

3. LIABILITY: Where bidders are required to enter or go onto School Board property to deliver materials, perform work or provide services as a result of a RFP award, the bidder assumes full duty, obligation and expense of obtaining all necessary licenses, permits and insurance, and shall be fully responsible for its own negligent or willful acts or omissions.

4. INSURANCE AND INDEMNIFICATION: This General Condition is NOT subject to negotiation and any Bidder submitting a proposal that fails to accept these conditions will be rejected as "non-responsive", unless bidder is entitled to sovereign immunity by action of the Florida Legislature. Each party agrees to be fully responsible for its acts of negligence, or its agents' acts of negligence when acting within the scope of their employment and agrees to be liable for any damages resulting from said negligence to the extent allowable pursuant to Section 768.28, Florida Statutes. Nothing herein is intended to serve as a waiver of sovereign immunity by the School Board. Nothing herein shall be construed as consent by the School Board to be sued by third parties in any matter arising out of any contract. Bidder shall hold harmless and defend the School Board and its agents and employees from all suits and actions, including attorney's fees and all costs of litigation and judgments of any name and description arising out of or incidental to the performance of this contract or work performed there under. This provision shall also pertain to any claims brought against the School Board by an employee of the named Bidder, any Subcontractor, or anyone directly or indirectly employed by any of them. The bidder's obligation under this provision shall not be limited in any way by the agreed upon contract price as shown in this Contract or the bidder's limit of, or lack of, sufficient insurance protection.

5. RISK OF LOSS: The bidder assumes the following risks: (1.) all risks of loss or damage to all goods, work in process, materials and equipment until the delivery thereof as herein provided; (2.) all risks of loss or damage to third persons and their property until delivery of all goods as herein provided; (3.) all risks of loss or damage to any property received by the bidder or held by the bidder or its suppliers for the account of the School Board, until such property has been delivered to the School Board; (4) all risks of loss or damage to any of the goods or part thereof rejected by the School Board, from the time of shipment thereof to bidder until redelivery thereof to the School Board.

6. PUBLIC ENTITY CRIMES: Pursuant to Florida Statute 287.133 a Bidder, person, or affiliate who has been placed on the convicted Vendors list following a conviction for a public entity crime may not submit a RFP on a contract to provide any goods or services to a public entity for the construction or repair of a public building or public work, may not submit RFPs on leases of real property to a public entity, may not be awarded or perform work as a contractor, supplier, subcontractor, or consultant under a contract with any public entity, and may not transact business with any public entity in excess of the threshold amount provided in Florida State Statute, Section 287.017, for CATEGORY TWO for a period of 36 months from the date of being placed on the convicted vendor list.

7. PATENTS AND COPYRIGHTS: Bidders agree to indemnify and save harmless the School Board, its officers, employees, agents, or representatives using the goods specified herein from any loss, damage or injury arising out of a claim or suit at law or equity for actual or alleged infringement of letters of patent by reason of the buying, selling or using the goods supplied under this RFP, and will assume the defense of any and all suits and will pay all costs and expenses thereto.

8. AUDITS, RECORDS, AND RECORDS RETENTION: REQUIRED PUBLIC RECORDS ACKNOWLEDGEMENT

To the extent Contractor is required to comply with the Florida Public Records Law, Chapter 119, Florida Statutes, in the performance of its duties under this contract, Contractor will specifically:

- **A.** Keep and maintain public records required by FCSB to perform the service.
- **B.** Upon request from FCSB's custodian of public records, provide FCSB with a copy of the requested records or allow the records to be inspected or copied within a reasonable time at a cost that does not exceed the cost provided in the Chapter 119, Florida Statutes or as otherwise provided by law.
- **C.** Ensure that public records that are exempt or confidential and exempt from public records disclosure requirements are not disclosed except as authorized by law for the duration of the contract term and following completion of the Agreement if Contractor does not transfer the records to FCSB.
- **D.** Upon completion of the Agreement, transfer, at no cost to FCSB, all public records in possession of the Contractor or keep and maintain public records required by FCSB to perform the service. If Contractor transfers all public records to FCSB upon completion of the Agreement, Contractor shall destroy any duplicate public records that are exempt or confidential and exempt from public records disclosure requirements. If Contractor keeps and maintains public records upon completion of the Agreement, Contractor shall meet all applicable requirements for retaining public records. All records stored electronically must be provided to FCSB, upon request of FCSB's custodian of public records, in a format that is compatible with the information technology systems of FCSB.
- **E.** The failure of the Contractor to comply with the provisions set forth herein shall constitute a default and material breach of this Agreement, which may result in immediate termination, with no penalty to FCSB.

PUBLIC RECORDS NOTICE

IF CONTRACTOR HAS QUESTIONS REGARDING THE APPLICATION OF CHAPTER 119, FLORIDA STATUTES, TO CONTRACTOR'S DUTY TO PROVIDE PUBLIC RECORDS RELATING TO THIS AGREEMENT, CONTACT THE CUSTODIAN OF PUBLIC RECORDS, KAREN PEDDIE, AT KPEDDIE@FRANKLIN.K12.FL.US, (850)670-2810, 85 SCHOOL ROAD, SUITE ONE,

III. GOODS AND SERVICES

1. WARRANTY: All goods and services furnished by the bidder, relating to and pursuant to this RFP will be warranted to meet or exceed the Specifications contained herein. In the event of breach, the bidder will take all necessary action, at bidder's expense, to correct such breach in the most expeditious manner possible.

2. PRICING: All pricing submitted will include all packaging, handling, shipping charges and delivery to any point within Franklin County, Florida to a secure area or inside delivery. **The School Board is exempt and does not pay Federal Excise and State of Florida sales taxes.**

3. PRICE ESCALATION: In the event of unforeseen circumstances that directly impact the pricing and/or servicing of this contract, the School Board reserves the right to negotiate the established bid price with the contractor at any time during the duration of this contract after completion of the initial contract term. Price negotiations will be at the sole discretion of the School Board.

The School Board may consider pricing increases of the bid item(s) if the following conditions occur:

- **A.** There is a verifiable price increase of the bid item(s) to the contract supplier.
- **B.** The contractor submits to the School Board, in writing, notification of price increases.
- **C.** The price increase shall be comparable to documented manufacturers' or distributors' price changes or changes in industry related indices.
- **D.** The contractor shall submit the above information to the Director of Purchasing thirty (30) calendar days prior to the effective date of the price increase. Requests for price increases may only be made after the first term of the contract.

When the contractor complies with the abovementioned conditions, the Director of Purchasing will review the information to determine if it is in the best interest of the School Board to adjust the pricing on the products proposal, in conjunction with the contractor's effective date of price increase. The School Board reserves the right to deny any requests for price increases. The contractor must receive written notification from the Director of Purchasing that the School Board is in acceptance of the new prices before processing any orders with the new costs.

4. QUANTITIES: Quantities listed in the RFP are estimates provided for bidder information purposes only. No guarantee is given or implied as to the exact quantities, which will be purchased from this RFP. The School Board reserves the right to increase or decrease all estimated quantities during the term of this contract or to delete any item or items as it deems appropriate, without affecting the bid pricing or the terms and conditions of the RFP.

5. MOST FAVORED CUSTOMER STATUS: The awarded bidder shall afford the School Board the most favored customer status for all items herein. Accordingly, if during the term of this contract, the contractor offers more favorable promotional or contract pricing to another entity for the same specification with similar quantities and conditions, the price under this contract shall be immediately reduced to the lower price. Additionally, if a current state of Florida contract, or other viable piggyback contract contains more favorable pricing for the same specification with similar quantities and conditions, the contractor will be afforded an opportunity to adjust its contract price to match that of the state of Florida contract. Should the contractor decline, FCSB reserves the right to purchase the item(s) from the state of Florida or alternate piggyback contract.

6. TERMS OF PAYMENT / INVOICING: The normal terms of payment will be Net 30 Days from receipt and acceptance of goods or services and contractor's invoice. Itemized invoices, each bearing the Purchase Order Number must be mailed on the day of shipment. Invoicing subject to cash discounts will be mailed on the day that they are dated.

7. PURCHASING CARDS: The School Board may choose to use a "Purchasing Card" for ordering of goods and materials or payment of invoices under this contract. The bidder, by submitting a proposal, agrees to accept this manner of payment and may not add additional handling charges or service fees to purchases made with the School Board's Purchasing Card(s). Refusal to accept this condition may cause the proposal to be declared non-responsive, or result in revocation of the contract, if already awarded. No third party payment, i.e. Pay pal will be considered.

8. TRANSPORTATION AND TITLE: (1) Title to the goods will pass to the School Board upon receipt and acceptance at the destination indicated herein. Until acceptance, the Bidder retains the sole insurable interest in the goods. (2) The shipper will prepay all transportation charges. The School Board will not accept collect freight charges. (3) No premium carriers will be used for the School Board's account without prior written consent of the Director of Purchasing.

IV. BIDDER REQUIREMENTS

1. REFERENCES: Each Bidder is required to submit a list of three (3) customer references using the format on the attached "Customer Reference Form" Exhibit D. The Bidder must be the prime contractor for each customer/contract referenced. All references shall be for work performed over the last year at commercial, multi-residential developments and/or institutional complexes for contracts of comparable size. Newly formed companies, corporations, joint ventures; etc. may use an incorporator as a referenced entity. At least one contract/customer shall have been serviced for a minimum of one year. Failure to provide verifiable references may result in the bidder not being considered for award. Unsatisfactory references may result in the bidder not being considered for award.

2. LEVEL 2 SCREENING REQUIREMENTS: The following provisions, which implement the requirements of School Board Policy 8475, Florida Statute Sections 1012.315, 1012.32, 1012.465 (Jessica Lunsford Act), 1012.467 and 1012.468 are included as additional terms and conditions of the contract:

Finger Printing and Background Check:

The bidder/contractor agrees to comply with all requirements of School Board Policy 8475 and Florida Statute Sections 1012.315, 1012.32, 1012.465 (Jessica Lunsford Act), 1012.467 and 1012.468 by certifying that any/all employees have completed the mandatory background screenings as required by the referenced policy and statutes and shall provide the School Board with proof of compliance. These certifications will be provided to the Franklin County School Board, Safety & Security Department in advance of the Bidder/contractor providing any/all services as required herein. The Bidder/contractor will bear the cost of acquiring the background screening required and any/all fees imposed by the Florida Department of Law Enforcement and or the School Board to maintain the fingerprints provided with respect to Bidder/contractor and its employees. Contractor agrees to indemnify and hold harmless the School Board, its officers, agents and employees from any liability in the form of physical injury, death, or property damage resulting from the Contractor's failure to comply with the requirements of these cited policies and statutes. The Bidder/contractor will follow procedures for obtaining employees background screening as established by the Franklin County School Board, Human Resources Department.

Where:	Franklin County School Board – Human Resources Department 85 School Road, Suite One Eastpoint, Florida 32328
When:	Monday-Friday 8:00 a.m. – 4:00 p.m.
Point of Contact:	Karen Peddie @ 850-670-2810

FCSB Policy 8475 is subject to review and change. As a provision of this

contract, if awarded, any changes made to this policy will automatically become a part of and be incorporated in this contract. It is the responsibility of the awardee(s) to be aware of any changes that may occur.

3. RECIPROCITY OF FLORIDA SCHOOL I.D. BADGES: If contractor has a Level II clearance registered with another Florida School Board, they may be able to obtain a Franklin County School Board vendor I.D. badge. Contractor should check with the Human Resources Department Fingerprint Services office to verify clearance and obtain a vendor I.D. badge.

4. IDENTIFICATION: All personnel employed by the bidder, including any subcontractor and subcontractor's employees when applicable, shall display at all times an identification badge which shall include the employee's name, the employer's name and either a physical description or a photograph of the employee. Employees without proper identification shall not be permitted to work under the terms of this Agreement.

5. CONTACT WITH STUDENTS: No employees or independent contractors, material men, suppliers or anyone involved in any manner with projects resulting from this proposal shall have direct or indirect contact with students at project sites. A violation of this provision shall result in immediate termination of the offender and issuance of a trespass notice from the School Board. Bidder/Proposer shall be responsible for insuring compliance by all employees, independent contractors and sub-contractors or other persons involved in any manner with projects resulting from this proposal.

6. WEAPONS AND FIREARMS: The School Board prohibits any contractor from possessing, storing, making, or using a weapon, including a concealed weapon, on School Board property and any setting that is under the control and supervision of the School Board as specified in School Board Policy 7217. Violations will be subject to the immediate termination of the contract.

7. SMOKING AND TOBACCO PRODUCTS: Smoking and the use of tobacco products are prohibited on school property, including all buildings and grounds. A fine may be assessed for the first offense and termination of the Agreement may be imposed for any second or additional offense.

8. ATTIRE: Proper attire shall be worn at all times.

- **A.** Shirts shall be worn awhile on school property at all times. (No tank tops or undershirts will be permitted).
- **B.** Clothing displaying nudity, obscene language, obscene symbols or pro-drug slogans is prohibited.
- **C.** Proper shoes to insure the individual's safety shall be worn at all times.

9. INSPECTIONS AND TESTING: The School Board will have the right to inspect and test any of the goods or services covered by this RFP. All goods or services are subject to the School Board's inspection and approval upon arrival or completion. If rejected, goods will be held for disposal at the bidder's risk. Such inspection, or the waiver thereof, however, will not relieve the bidder from full responsibility for furnishing goods or services conforming to the requirements of this Bid or the Bid Specifications, and will not prejudice any claim, right, or privilege the School Board may have because of the use of defective or unsatisfactory goods or service. All deficiencies noted by the School Board will be submitted to the contractor for correction within ten (10) calendar days after submission of deficiencies to the contractor. An additional inspection of the goods or service may be conducted to insure corrective action was taken.

10. STOP WORK ORDER: The School Board may at any time, by written notice to the Bidder stop all or any part of the work for this contract award. Upon receiving such notice, the bidder will take all reasonable steps to minimize additional costs during the period of work stoppage. The School Board may subsequently either cancel the stop work order resulting in an equitable adjustment in the delivery schedule and/or the price, or terminate the work in accordance with the provisions of the RFP terms and conditions.

- **A.** Materials or work are not in conformance with applicable codes, standards, School Board specifications and/or accepted practices.
- **B.** The contractor's activities result in damage to School board property.
- **C.** The contractor's activities interfere with the normal operation of the facility.
- **D.** Contractor's personnel are not properly licensed to perform the work or as it pertains to school facilities, the contractor's personnel have not received their Level II background clearances.
- **E.** Any other condition, situation, or circumstance, which in the opinion of the School Board Authorized Representative would be a detriment to the best interests of the School Board if allowed to persist.

11. SAFETY: The bidder shall be responsible for instructing their employees in all safety measures. All equipment used by the bidder shall be free from defects or wear that may in any way constitute a hazard to any person or persons on School Board property. At no time shall equipment be operated without guards, shields, or other manufactures recommended safety accessories in place and functioning as intended by the manufacturer. All current OSHA safety standards shall be reinforced including, but not limited to, the following rules:

- **A.** All OSHA and Federal required safety equipment shall be installed and functioning on all equipment.
- **B.** All equipment shall be in sound working condition and must meet all OSHA Safety Standards. All workers shall be aware of and trained in the operation of all safety equipment required for this project.
- **C.** The Bidder shall ensure that employees are equipped with proper safety items such as glasses, hard hats, gloves, etc.
- **D.** All incidents on campus involving School Board property or personnel shall be reported to the Director of Maintenance Services Department and the Campus Administrator immediately upon occurrence.
- **E.** All debris shall be removed to an environmentally approved landfill or recycling center.

12. EMERGENCIES: In any emergency affecting the safety of persons and property, the awarded contractor shall act immediately to prevent threatened damage, injury or loss. Any emergency must be reported to an authorized School Board representative immediately and no later than twenty-four (24) hours from the time that the emergency is discovered by the contractor.

13. DAMAGE TO SCHOOL BOARD OWNED PROPERTY: Any damage to property, equipment, grounds, buildings, etc. that is caused by the awarded contractor will be reported to the School Board within twenty-four (24) hours of discovery. The awarded contractor will have ten (10) working days after report to present its written response to the claimed damages. The awarded contractor, upon approval by an authorized School Board representative, may make repairs that are deemed within its capability. The School Board reserves the right to make immediate repairs to correct damages that are safety hazards or that pose a detrimental effect to the School Board's operations. Costs of any replacement or repairs made by the School Board for damages caused by the awarded contractor shall be deducted from any monies due to the contractor. This shall not prevent the School Board from seeking damages should replacement/repair costs exceed the amount of monies owed to the awarded contractor. When requested, Bidder shall cooperate with any ongoing School Board investigation involving personal injury, economic loss or damage to The School Board's facilities or personal property therein.

14. SUBCONTRACTING: The awarded contractor(s) shall be the primary service provider(s) and shall perform all requested inspections and

repairs. Subcontracting for these base services is not allowed.

A. The School Board, for work where the contractor(s) are requested to perform additional services, may allow subcontracting.

B. Any work or service to be performed by a subcontractor must have the prior approval of the School Board. The School Board reserves the right to reject any subcontractor. Rejection of any subcontractor shall not entitle the contractor to adjustment of bid prices. The contractor shall inform the School Board Authorized Representative prior to scheduling any subcontractor's visit to any School Board facility.

C. Failure by the contractor to have a subcontractor approved by the School Board will not relieve the contractor of the responsibility to meet, comply with, and fulfill all of the terms and conditions of this Agreement.

D. The contractor(s) shall be held fully responsible and liable for the supervision and performance of all work performed by subcontractors. The School Board shall not be responsible for resolution of disputes between the Bidder and any subcontractor.

E. The personnel of all subcontractors shall meet all of the requirements as stated herein to include, but not limited to FCSB Policy 8475 and the Jessica Lunsford Act.

15. ON-CAMPUS DIRECTIVES

A. Upon arrival and departure onto any School Board school campus, the contractor's employees shall enter their company information into the Visitor/Vendor Log Tool provided in the Administrative office of each campus.

B. Contractor shall strictly limit its operations to the designated work areas and shall not permit any employees to enter any other portions of School Board property without School Board's expressed prior written consent.

C. All employees shall enter and leave School Board facilities only through the ingress and egress points designated, from time to time, by The School Board.

D. The contractor shall be responsible for the removal of all trash and debris occasioned by this contract. Failure to adhere to this requirement will result in the costs of the performance of this work by others being charged to the contractor.

E. Any existing surface or subsurface improvements, including, but not limited to, pavements, curbs, sidewalks, pipes, utilities, footings, structures, trees and shrubbery, not indicated in the contract documents to be removed or altered, shall be protected by contractor from damage during the prosecution of any project. Any such improvements so damaged shall be restored by contractor to condition at least equal to that existing at the time of contractor's commencement of any project.

F. Proper safety barricades, protective, and covering devices shall be used to divert traffic and protect personnel. Normal safety signs, necessary lighting and temporary fencing/barricades around work areas shall be installed and maintained in accordance with OSHA requirements while the work is in progress. Materials must be secured in accordance with OSHA regulations when not in use.

16. BIDDER ACCESSIBLITY: The successful bidder shall provide a liable and responsible representative to be accessible by a Franklin County toll free local telephone call during regular business hours. Local off-hours answering service for emergencies shall be available for bidder notification twenty-four (24) hours a day, seven (7) days per week, all year, including holidays.

17. CONTACT PERSON: The successful Bidder shall be notified of the name and phone number of the School Board contact person. Only the School Board contact person may authorize changes to the scope of work.

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V. SCOPE OF WORK

A. INTRODUCTION AND GENERAL INFORMATION: The Board is soliciting competitive proposals on behalf of the Employee Benefits Department from qualified insurance companies to provide group dental and vision and voluntary employee insurance products as described herein. The scope of work as outlined in this RFP establishes the minimum requirements to be provided by the successful bidder(s).

The District and its governing board were created pursuant to Section 4. Article IX of the Constitution of the State of Florida. The District is an independent taxing and reporting entity managed, controlled, operated, administered, and supervised by District school officials in accordance with relevant provisions of the Florida K-20 Education Code, Chapters 1000 – 1013, Florida Statutes**.** The School Board consists of five elected officials responsible for the adoption of policies, which govern the operation of District public schools. The Superintendent of Schools is responsible for the administration and management of the schools within the applicable parameters of state laws, State Board of Education Rules and School Board policies.

The Board has a staff of approximately 200 people, including instructional, instructional support, administrative, support positions, and temporary positions such as substitutes. The Board has approximately 45 retirees participate on the dental and/or vision insurance policy only.

B. INSURANCE COMPANY REQUIREMENTS: Proposers must be licensed to do business in Florida subject to the provisions of the Florida Insurance Department.

C. BOARD'S BROKER AGENT OF RECORD: The Board's insurance broker of record is US Employee Benefits Group. The agent of record is John Bradley Hoard. jbhoard@usebsg.com.

D. INSURANCE COMPANY REPRESENTATIVE: Successful proposers shall appoint, by name, a company representative who shall be responsible for servicing the contract resulting from the award of this RFP. The appointed representative shall be responsible for functions as necessary to insure that the account will be maintained in a professional manner.

E. CONTRACT PERIOD: It is the intent of the Board that the successful carriers will be the insurance provider for the identified product for a period of twelve (12) months with an option to renew for three (3) additional one (1) year periods. The policy periods are to commence on July 1, 2019, with an effective date of July 1, 2019.

F. RENEWAL: The proposer and the Board covenant and agree that this proposal or subsequent contract may, with the mutual approval of the awarded contractor and the Board be renewed under the same terms and conditions of this proposal or contract for three (3) additional contract periods of one (1) year each for a total possible contract period not to three (3) years. The Board shall notify the proposer of its intent to exercise this option in writing prior to the termination of each contract period. Renewal is pursuant to Board approval.

G. ANNUAL RENEWAL RATES: The Board intends to provide the best affordable insurance coverage to its employees on an updateable basis utilizing cost containment strategies. Therefore, the contracts will be reviewed annually and cost containment strategies will be explored with the awarded contractors. **April 15th** of each year will be the deadline for negotiating renewal rates. The Board reserves the right to cancel the contract after any annual review and rebid as best meets the needs of the Board.

H. PROPOSAL EVALUATION CRITERIA: The District will evaluate proposals and select a carrier based on all of the information available. While cost is an important factor, it should be understood that the **District is not under any obligation to accept the lowest cost proposal**. It is our desire that your proposal for plan benefits be based upon exact minimum requirements as described herein. Any deviation should be submitted as an **alternate proposal** and clearly explained. **ALL** proposals will be evaluated on the following criteria:

	CRITERION	Percentage
1	Cost (including, but not limited to, administrative, retention, commissions and liability risks to the District)	35%
2	Overall Plan Benefits (literature, administration requirements of District, enrollment requirements, etc.)	25%
3	Provider Network (geo-proximity of providers and physicians who will accept new patients and the match-up between the current top providers and network providers proposed.)	25%
4	Service Reputation/Capability (The service reputation and administration capabilities of proposers. This includes such items as enrollment assistance, service responsiveness, and communication with our Agent and School Board staff on program administration, quality of billings, and Internet Website.)	15%
	Total	100%

The Proposals will be reviewed and evaluated by the School Board's Insurance Committee and by the Board's insurance broker of record US Employee Benefits Services Group.

I. PROPOSAL REQUIREMENTS: All proposers are required to return the attached proposal sheets **(Pages 14 through and including 19 if proposing on all product lines)**, (original and seven (7) copies). All information must be furnished and then proposal **must** be signed by an authorized representative or officer of the proposing company. **The accompanying sheet(s) relevant to the insurance product(s) your proposal addresses along with your statement of benefits and premium proposals.**

A. Employee and employer requirements for settlement of claims should be included in your quotation.
B. A list of three (3) references of similar size groups which shall include:
    a. Clients name
    b. Individual contact
    c. E-mail address
    d. Phone number
C. Summary statement detailing the primary advantages of your plan and why the Board should choose your plan over all other plans. Be specific.

Proposals are to be prepared simply, providing a straight forward, concise description of the insurance company's capabilities to satisfy the requirements of this proposal. Emphasis should be on completeness and clarity of content. Repetition of the terms and conditions of this proposal request, without additional explanation, will not be considered sufficiently responsive. Your proposal document should duplicate the plan benefits as shown in this request and corresponding exhibits. Comprehensive documentation and supplemental information should be enclosed as an attachment or exhibit to your proposal.

The absence of any of the required supporting information may be cause for declaring your proposal non-responsive. Any additional information the proposer feels will enhance their overall proposal evaluation may be included.

J. RATES: Rates are to be firm from the effective date of the contract to the next anniversary date and no increase in premiums will be made during the interim. Proposer should specify if your rate guarantee is for longer than a twelve (12) month period. Rates may be negotiated between the Boards agent of record and the proposer prior to the initial contract inception. The Board requests that the proposer clearly identify if they are submitting their best and final offer for the initial contract period beginning July 1, 2019. **It is understood and agreed that all proposed premium changes will be submitted for approval no later than April 15th of each year**.

K. <u>IMPLEMENTATION SCHEDULE</u>:
The proposed schedule for selecting and awarding this contract is as follows:

Advertising of Request for Proposals	March 14, 2019
Final date for submission of questions by Bidders	March 27, 2019
Answers to all questions posted to web site	March 28, 2019
Opening of Proposals	April 2, 2019
Evaluation of Proposals	April 10, 2019
Posting of recommendation for award	April 18, 2019
Anticipated Board consideration date	April 25, 2019
Contract inception date	July 1, 2019

L. SPECIFICATIONS

GENERAL
Proposals are being solicited for insurance products for active employees, eligible dependents and retirees to include Group Dental and Voluntary Group Vision, and Voluntary Accident, Cancer, Critical Care, Hospitalization, Intensive Care, Specified Health Event, and Term Life Insurance. Proposers are expected to provide proposals on a fully insured basis.

Proposals from insurance carriers with less than an AM Best Rating of 'A' will not be accepted.

Group Dental is made available to eligible employees of the District as identified by the applicable collective bargaining agreement. Employees, retirees and dependents may maintain coverage by paying the full amount of the premiums for voluntary insurance products. Eligible employees and their dependents may continue their benefits while on an approved leave of absence by paying the full amount of the premiums. Dependent coverage shall include spouse and eligible dependent children.

TERMINATION OF INSURANCE
Termination of insurance shall not prejudice any claim commencing prior to the effective date of termination. Employees will be covered through the paid to date.

PLAN IMPLEMENTATION
It is a requirement that the carriers awarded this contract provide representatives to assist with implementation, open enrollment, employee communications and ongoing assistance with routine plan administration as requested by the Boards broker of record. It is also a requirement that benefits be able to be enrolled in the District's chosen benefits administration platform.

MASTER AGREEMENT
The insurance carrier will be required to provide a group master agreement to the District.

EXPLANATORY LITERATURE
The insurance company shall provide subscriber Printed Certificate of Coverage cards, if applicable, and summary plan description for distribution to all covered employees of the Franklin County School Board.

CLAIMS PROCESSING
Claims will be processed and paid by the insurance company.

EMPLOYEE CONTRIBUTIONS
The District will make twenty-four (24) employee payroll deductions and pay total premiums to the company selected in twelve (12) payments.

EMPLOYEE PREMIUM DEDUCTIONS
With the exception of the Board paid Group Dental Insurance employees must contribute 100% of the premiums when electing voluntary products. **The premiums are deducted on a twelve (12) month basis and should be quoted as a twelve (12) month rate.** Retirees are charged premiums based on the group rate.

COMMISSIONS
It is the intent of the Board to have the current Broker Agent of Record deal directly with all insurance carriers. Please include in your quoted rate the standard commission approved to be paid to the broker US Employee Benefits Services Group.

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VI. QUESTIONNAIRE AND RESPONSE

A. PROPOSAL REQUIREMENTS: Bidders must submit **one (1) original and seven (7) copies** of their completed proposal. All proposals submitted in response to this RFP shall become the property of the District. Proposals should be sealed and mailed or hand delivered to: Franklin County Schools, Purchasing Department, Attn: Shannon Venable, 85 School Road, Suite One, Eastpoint, FL 32328.

If any director, officer, employee, agent or other representative of a bidder, including any other parties that may be involved in a joint venture or a consortium with the bidder, makes, from and after the date of issuance of this RFP, any representation or solicitation to any member of the School Board or any official, employee or agent of the District, with the exception of, Shannon Venable, Director of Purchasing with respect to the bidder's response or any other bidder's response, the District shall be entitled to reject that respondent's proposal. A representation for the purposes of this requirement can be considered to be anything said or written to any school board member, official, employee or agent which provides information advancing the interests of a proposal.

1. By submission of this proposal, the proposer certifies:

   A. Prices in this RFP have been arrived at independently, without consultation, communication, or agreement for the purpose of restricting competition.

   B. Prices in this RFP have not knowingly been disclosed by the proposer and will not be prior to award to any other proposer.

   C. No attempt has been made nor will be by the proposer to induce any other person or firm to submit a proposal for the purpose of restricting competition.

B. The individual signing this proposal certifies that he/she is authorized to represent the company offering and is legally responsible for the decision as to the prices and supporting documentation provided.

C. Check to acknowledge all required submittals are included:

_____ One original hard copy and seven (7) copies
_____ Employee and employer requirements for settlement of claims should be included in your quotation.
_____ A list of three (3) references of similar size groups.
_____ Summary statement detailing the primary advantages of your plan and why the Board should choose your plan over all other plans.
_____ Summary of benefits and cost proposal.

D. Proposal submitted by: **Company/Home Office** with authority for rates, determination of dividends, renewal actions, etc.

Name _____

Mailing Address _____
(Include City/State/Zip)

Phone No. _____ Fax No. _____ Website: _____

Claims office and representative responsible for payments for this account.

Name _____

Address _____
(include City, State, Zip)

Phone No._____ Fax No. _____ E-Mail: _____

State of Incorporation _____ Taxpayer Identification Number _____

What are your current ratings with the various rating companies?

_____

_____

1. Proposers are requested to submit fully insured proposals duplicating the current schedule of benefits for any or all products of interest. Any change in benefits or alternative plan design must be fully explained. Proposers are advised that the Board will not consider plans that contain substantial reductions in benefits. Proposer agrees to this provision. (Circle One) **Yes No**

2. Consideration should be given to the costs to build out the connectivity file(s) between your EDI team and the benefit administration vendor. Proposer acknowledges these costs and will consider them when submitting your proposal. (Circle One) **Yes No** Please explain your proposed offer.

3. Consideration should be given to a per employee per month stipend to the Board to mitigate the administration costs of our benefit administration system. Proposer acknowledges these costs and will consider them when submitting your proposal. (Circle One) **Yes No** Please explain your proposed offer.

4. The Board seeks a streamlined process for delivering enrollment data to the carrier of choice to assist with timely enrollments, changes and terminations as well as streamlining billing. Proposer acknowledges these costs and will consider them when submitting your proposal. (Circle One) **Yes No** Please explain your proposed offer.

5. Enrollers utilized from the Proposer's company must be compensated by salary or paid per-diem and not receive any commission based compensation. Proposer agrees to this provision. (Circle One) **Yes No**

6. The following reports, at a minimum, will be required on a monthly basis.
   a) Paid premiums and claims experience
   b) Enrollment by plan and status
   c) Reconciliation and discrepancy reports
   d) List of employees with coverage at least quarterly
   e) Various utilization reports

Proposer agrees to this provision. (Circle One) **Yes No**

7. In the first enrollment, Proposer must offer a true open enrollment (no medical evidence of insurability or waiting period) for all current eligible employees, same for all future new employees. Proposer agrees to this provision. (Circle One) **Yes No**

8. Does your proposal include stand-alone products? (Circle One) **Yes No**

9. If multi-lines are awarded will you negotiate premium cost savings? (Circle One) **Yes No**

10. Does your proposal include the cost of on-site service visits, enrollment meetings and employee booklets? (Circle One) **Yes No**

11. Does your company offer a local service representative, an 800 number and a minimum ten (10) day turnaround on claims? (Circle One) **Yes No** **Please explain.**

12. Describe your company's enrollment services.

13. What is your procedure for enrollment of employees who become eligible after plan inception?

14. Provide a sample group administration guide or information regarding group set up, billing, procedures, and available forms.

15. The Board has a wellness program. Are you willing to provide incentives such as wellness dollars to the Board? If so, please explain.

16. The following products are currently being offered to the Board employees:
    - Group Dental Insurance **(Board Paid)**
    - Voluntary Group Vision Insurance
    - Accident
    - Cancer
    - Critical Care
    - Hospitalization
    - Intensive Care
    - Specified Health Event
    - Term Life

17. For Dental proposals only, the Proposer must provide their 90% Usual and Customary (U&C) reimbursements for the outlined procedure codes in the chart below for Zip Code 323XX.

CDT Code	Description	Zip 323
		90th U&C
120	Oral Exam	
150	Complete oral evaluation	
210	X-rays - complete series	
274	X-rays - four bitewings	
1110	Adult cleaning	
1120	Child cleaning	
1208	Fluoride	
2391	Posterior composite - one surface	
2392	Posterior composite - two surface	
2750	Crown - porcelain high noble	
2752	Crown - porcelain fused noble	
3330	Endodontic - molar	
4341	Perio scaling and root planing	
4910	Perio maintenance cleaning	
7140	Extraction of erupted tooth	

Your proposal can include any or all of these product lines. The following pages include product line specific questions to be answered and returned with your proposal along with your plan benefits summary and proposed premium rates. The current summary of plan benefits and census is attached as Exhibit K.

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E. DENTAL

1. Proposed dental plans must offer two (2) or more options. Proposer agrees to this provision. (Circle One) **Yes No**

2. Does your plan provide a guaranteed issue and waiver of waiting periods for all currently eligible employees for first enrollment and all future new hires? (Circle One) **Yes No**

3. Awarded company must accept 834 compliant EDI file feed to carrier. Proposer agrees to this provision (Circle One) **Yes No**

4. Does your plan grandfather all current employees who have current coverages? (Circle One) **Yes No**

5. Is your plan portable for retirees? (Circle One) **Yes No**

6. All plans must have no waiting period on Major services. Proposer agrees to this provision (Circle One) **Yes No**

7. Comprehensive enrollment booklets (electronically) and communications campaign to all employees and retirees is required. Proposer agrees to this provision (Circle One) **Yes No**

8. The Board is requesting a one (1) year rate hold. What is the guaranteed rate hold of your plan?

9. The District's open enrollment dates are mid- April through mid-May with final negotiated renewal agreements due each year by April 15th. Proposer agrees to this provision. (Circle One) **Yes No**

10. Rates proposed are to be shown as twelve (12) monthly deductions. Proposer agrees to this provision. (Circle One) **Yes No**

11. Are your proposed plan benefits as good as or better than the current plan? (Circle One) **Yes No**

Rate Guarantee Period: 7/1/19 through _____

Are all rates valid regardless of actual enrollment on 7/1/19: (Circle One) **Yes No**

Are all rates/plans presented on a stand-alone basis? (Circle One) **Yes No**

Authorized Signature	**Print Name**
Title	**Firm**
E-mail	**Phone No:**

F. VISION

1. Does your plan provide a guaranteed issue and waiver of waiting periods for all currently eligible employees for first enrollment and all future new hires? (Circle One) **Yes No**

2. Awarded company must accept 834 compliant EDI file feed to carrier. Proposer agrees to this provision (Circle One) **Yes No**

3. Does your plan grandfather all current employees who have current coverages? (Circle One) **Yes No**

4. Is your plan portable for retirees? (Circle One) **Yes No**

5. Comprehensive enrollment booklets (electronically) and communications campaign to all employees and retirees is required. Proposer agrees to this provision (Circle One) **Yes No**

6. The Board is requesting a one (1) year rate hold. What is the guaranteed rate hold of your plan?

7. The District's open enrollment dates are mid- April through mid-May with final negotiated renewal agreements due each year by April 15th. Proposer agrees to this provision. (Circle One) **Yes No**

8. Rates proposed are to be shown as twelve (12) monthly deductions. Proposer agrees to this provision. (Circle One) **Yes No**

9. Are your proposed plan benefits as good as or better than the current plan? (Circle One) **Yes No**

Rate Guarantee Period: 7/1/19 through _____

Are all rates valid regardless of actual enrollment on 7/1/19: (Circle One) **Yes No**

Are all rates/plans presented on a stand-alone basis? (Circle One) **Yes No**

Authorized Signature	**Print Name**
Title	**Firm**
E-mail	**Phone No:**

G. CANCER, ACCIDENT, CRITICAL CARE, HOSPITALIZATION, INTENSIVE CARE, SPECIFIED HEALTH EVENT, AND TERM LIFE

1. If proposing on multi-lines, please clarify which plans of coverage you are offering.

2. Does your plan provide a guaranteed issue and waiver of waiting periods for all currently eligible employees for first enrollment and all future new hires? (Circle One) **Yes** **No**

3. Awarded company must accept 834 compliant EDI file feed to carrier. Proposer agrees to this provision (Circle One) **Yes** **No**

4. Does your plan grandfather all current employees who have current coverages? (Circle One) **Yes** **No**

5. Is your plan portable for retirees? (Circle One) **Yes** **No**

6. Comprehensive enrollment booklets (electronically) and communications campaign to all employees and retirees is required. Proposer agrees to this provision (Circle One) **Yes** **No**

7. The Board is requesting a one (1) year rate hold. What is the guaranteed rate hold of your plan?

8. The districts open enrollment dates are mid-April through mid-May with final negotiated renewal agreements due each year by April 15th. Proposer agrees to this provision. (Circle One) **Yes** **No**

9. Rates proposed are to be shown as twelve (12) monthly deductions. Proposer agrees to this provision. (Circle One) **Yes** **No**

10. Are your proposed plan benefits as good or better than the current plan? (Circle One) **Yes** **No**

Rate Guarantee Period: 7/1/19 through _____

Are all rates valid regardless of actual enrollment on 7/1/19: (Circle One) **Yes** **No**

Are all rates/plans presented on a stand-alone basis? (Circle One) **Yes** **No**

Authorized Signature	**Print Name**
Title	**Firm**
E-mail	**Phone No:**

EXHIBIT A

CONFLICT OF INTEREST CERTIFICATE

Bidder **must** execute either Section I or Section II hereunder relative to Florida Statute 112.313(12). Failure to execute either section may result in rejection of this bid proposal.

SECTION I

I hereby certify that no official or employee of the School Board requiring the goods or services described in these specifications has a material financial interest in this company.

Signature	*Company Name*
Name of Official (Type or print)	*Business Address*
	City, State, Zip Code

SECTION II

I hereby certify that the following named Franklin County School Board official(s) and employee(s) having material financial interest(s) (in excess of 5 %) in this company have filed Conflict of Interest Statements with the Supervisor of Elections, 47 Avenue F, Apalachicola, Franklin County, Florida prior to bid opening.

Name	**Title or Position**	**Date of Filing**

Signature	*Company Name*
Name of Official (Type or print)	*Business Address*
	City, State, Zip Code

EXHIBIT B

FRANKLIN COUNTY SCHOOLS

APPLICATION FOR VENDOR STATUS

(IRS W-9 Facsimile)

COMPANY NAME: _____

CONTACT PERSON: _____

PHONE NUMBER: (___) _____ **FAX NUMBER:** (___)_____

CORRESPONDENCE ADDRESS: _____

CITY: _____ **STATE:** _____

ZIP + 4: _____ - _____ _____ _____ _____

REMITTANCE: NAME (if different from above): _____

ADDRESS: _____

CITY: _____ **STATE:** _____

ZIP + 4: _____ - _____ _____ _____ _____

EMAIL ADDRESS: _____ **WEBSITE:** _____

PLEASE CHECK APPROPRIATE BOX: ☐ Individual/Sole Proprietor ☐ S Corporation ☐ C Corporation ☐ Partnership
☐ Other_____ ☐ LLC – Type (Check one) ☐ C ☐ S ☐ P

TAX IDENTIFICATION NUMBER:_____- _____ OR _____ - _____ - _____
Federal Employer Identification Number Social Security Number

Section 6109 of the Internal Revenue Service Code requires you to provide your correct TIN to persons, businesses, or agencies that are required to file information returns with the IRS. Purchase orders will not be issued to vendors who fail to provide a TIN.

PLEASE INDICATE THE FOLLOWING: ***Minority Vendor?** ☐ Yes ☐ No Male ☐ Female ☐

**If yes, certification required – (Please submit with form)*

Race: Caucasian: ☐ Hispanic: ☐ African American: ☐ Asian: ☐
American Indian: ☐ Other: _____

By: _____ _____ _____
Signature Printed Name Date

FCSB site contact requesting vendor:_____ _____
Name Phone/Email

NOTE: ONLINE VENDOR REGISTRATION MAY BE COMPLETED AT ANY TIME AND IS **REQUIRED** UPON ACCEPTING BID AWARD.

Online vendor registration is located at:
https://vrapp.vendorregistry.com/Vendor/Register/Index/franklin-county-district-school-board-fl-vendor-registration

EXHIBIT C

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

Request for Taxpayer Identification Number and Certification

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

Print or type
See Specific Instructions on page 2.

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

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

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

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

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

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

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

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

Social security number
___ – ___ – ____

or

Employer identification number
___ – _____

Part II Certification

Under penalties of perjury, I certify that:

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

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

Sign Here | **Signature of U.S. person** ▶ | **Date** ▶

General Instructions

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

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

Purpose of Form

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

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

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

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

By signing the filled-out form, you:

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

EXHIBIT D

CUSTOMER REFERENCE FORM

RFP No. 2019-002 – Group Dental, Vision and Employee Voluntary Insurance Products

Please provide all requested information for each reference.

Company Name: _____

Business Type: _____

Contact Person: _____

Telephone: _____

Email: _____

Date Last Supplied Products or Services: _____

Company Name: _____

Business Type: _____

Contact Person: _____

Telephone: _____

Email: _____

Date Last Supplied Products or Services: _____

Company Name: _____

Business Type: _____

Contact Person: _____

Telephone: _____

Email: _____

Date Last Supplied Products or Services: _____

EXHIBIT E

VENDOR QUESTIONNAIRE

RFP No. 2019-002 – Group Dental, Vision and Employee Voluntary Insurance Products

Please provide written responses to the following questions. If the answer to any of the questions is `Yes`, Vendor shall describe fully the circumstances, reasons therefore, the current status, and ultimate disposition of each matter that is the subject of this inquiry.

1. Has Vendor been declared in default of any contract?
☐ Yes ☐ No

2. Has Vendor forfeited any payment of performance bond issued by a surety company on any contract?
☐ Yes ☐ No

3. Has an uncompleted contract been assigned by Vendor's surety company on any payment of performance bond issued to Vendor arising from its failure to fully discharge all contractual obligations there under?
☐ Yes ☐ No

4. Within the past three years, has Vendor filed for reorganization, protection from creditors, or dissolution under the bankruptcy statutes?
☐ Yes ☐ No

5. Is Vendor now the subject of any litigation in which an adverse decision might result in a material change in the firm's financial position or future viability?
☐ Yes ☐ No

6. Is Vendor currently involved in any state of a fact-finding, negotiations, or resistance to a merger, friendly acquisition, or hostile take-over, either as a target or as a pursuer?
☐ Yes ☐ No

7. Within the next year, does Vendor plan any personnel reductions? If so, explain by attachment.
☐ Yes ☐ No

8. Within the next year, does Vendor plan any divestments? If so, explain by attachment.
☐ Yes ☐ No

EXHIBIT F

DRUG FREE WORKPLACE

Preference shall be given to vendors submitting a certification with their bid/proposal certifying they have a drug-free workplace in accordance with Section 287.087, Florida Statutes. Whenever two or more bids that are equal with respect to price, quality, and service are received by the State or by any political subdivision for the procurement of commodities or contractual services, a bid received from a business that certifies that it has implemented a drug-free workplace program shall be given preference in the award process. Established procedures for processing tie bids will be followed if none of the tied vendors have a drug-free workplace program. In order to have a drug-free workplace program, a business shall:

IDENTICAL TIE BIDS – Preference shall be given to businesses with drug-free workplace programs. Whenever two or more bids, which are equal with respect to price, quality, and service, are received by the State or any political subdivision for the procurement of commodities or contractual services, a bid received from a business that certifies that it has implemented a drug-free workplace program shall be given preference in the award process. Established procedure for processing tie bids shall be followed if none of the tied vendors 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's 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 a copy of the statement specified in subsection (1).

4) In the statement specified in subsection (1), notify the employees that, as a condition of working on the commodities or contractual services that are under bid, the employee s 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 or of any controlled substance law of the United States or any state, for a violation occur ring 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 this section.

As the person authorized to sign the statement, I certify that this firm complies fully with the above requirements.

VENDOR'S SIGNATURE: _____

EXHIBIT G

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION -LOWER TIER COVERED TRANSACTIONS

(BEFORE COMPLETING CERTIFICATION, READ INSTRUCTIONS ON THE FOLLOWING PAGE)

1. The prospective lower tier participant certifies, by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.
2. Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

Organization Name	PR/Award Number or Project Name
Name(s) of Authorized Representative(s)	Title(s) of Authorized Representative(s)
Signature(s)	Date

Form AD-1048 (1/92)

INSTRUCTIONS FOR CERTIFICATION OF DEBARMENT

1. By signing and submitting this form, the prospective lower tier participant is providing the certification set out on the reverse side in accordance with these instructions.

2. The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

3. The prospective lower tier participant shall provide immediate written notice to the person to whom this proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

4. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this proposal is submitted for assistance in obtaining a copy of those regulations.

5. The prospective lower tier participant agrees by submitting this form that, should the proposed covered transaction be enterd into, it shall not knowingly enter into any lower tier covered transaction with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency with which this transaction originated.

6. The prospective lower tier participant further agrees by submitting this form that it will include this clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion -Lower Tier Covered Transactions," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or voluntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Non-procurement List.

8. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

9. Except for transactions authorized under paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

Form AD-IO48 (1/92) U. S. GPO: 1996-757-776/201 07

EXHIBIT H

SWORN STATEMENT – NEW CONTRACTS SWORN STATEMENT PURSUANT TO SECTION 1012.465, FLORIDA STATUTES AS AMENDED BY HB 1877, THE JESSICA LUNSFORD ACT

THIS FORM MUST BE SIGNED AND SWORN TO IN THE PRESENCE OF A NOTARY PUBLIC OR OTHER OFFICIAL AUTHORIZED TO ADMINISTER OATHS.

1. This sworn statement is submitted to The School Board of Franklin County, Florida *(hereinafter "Board" or "School Board")* by _____
(Print individual's name and title)

for _____
(Print name of entity submitting sworn statement)

whose business address is _____

_____

and its Federal Employer Identification Number (FEIN) is _____
If the entity has no FEIN, include the Social Security Number (SSN) of the individual signing this sworn statement and so indicate.

2. I, _____ am duly authorized to make this sworn statement
(Print individual's name and title)

on behalf of: _____

_____

_____
(Print name of entity submitting sworn statement)

3. I understand that during the 2005 Legislative Session, House Bill 1877, The Jessica Lunsford Act (hereinafter "The Act" or "Act") was passed and approved by Governor Bush on May 2, 2005, with an effective date of September 1, 2005.

4. I understand that the Act amends the background screening requirements of section 1012.465, Florida Statutes (2004) for all non-instructional school district employees or **"contractual personnel"** by requiring all non-instructional school district employees or contractual personnel who are permitted access on school grounds when students are present to undergo and pass "level 2 background screening," and further I understand the Act defines **"contractual personnel"** to include any vendor, individual, or entity under contract with the Board.

5. I understand that pursuant to section 1012.465, Florida Statutes as amended by the Act, non-instructional school district employees or contractual personnel who are permitted access on school grounds when students are present, who have direct contact with students or who have access to or control of school funds must meet level 2 screening requirements as described in sections 1012.32 and 435.04, Florida Statutes.

6. I understand that as a _____ *(eg. a charter bus company)*
(Type of entity)
all contractual personnel, as defined in section 1012.465, Florida Statutes, must meet Level 2 screening requirements as outlined in sections 1012.32 and 435.04, Florida Statutes in order to do business with the School Board.

7. I understand that "level 2 screening requirements" as defined in sections 1012.32 and 435.04, Florida Statutes means that fingerprints of all contractual personnel must be obtained and submitted to the Florida Department of Law Enforcement for state processing and to the Federal Bureau of Investigation for federal processing.

8. I understand that the School Board has implemented Board Policy 8475 to comply with level 2 screening requirements, as defined in sections 1012.32 and 435.04, Florida Statutes. I understand that my company must comply with these local procedures as they are developed or amended from time to time.

9. I understand that any costs and fees associated with the required background screening will be borne by my company.

10. I understand that any personnel of the contractor found through fingerprint processing and subsequent level 2 background screening to have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to any offense outlined in Section 435.04, Florida Statutes (or any similar statute of another jurisdiction), **shall not be permitted** to come onto school grounds or any leased premises where school-sponsored activities are taking place when students are present, shall not be permitted direct contact with students, and shall not be permitted to have access to school district funds.

11. I understand that the failure of any of the company's or my affected personnel to meet level 2 screening standards as required by section 1012.465, Florida Statutes, may disqualify my company from doing business with the School Board.

12. I hereby certify that the foregoing statement is true and correct in relation to the company for which I am submitting this sworn statement. I further certify that this statement is being given knowingly and voluntarily by me on behalf of my company.

The company submitting this sworn statement agrees to be bound by the provisions of SECTIONS 1012.32, 1012.465, AND 435.04 OF THE FLORIDA STATUTES AS AMENDED BY HB 1877, THE JESSICA LUNSFORD ACT 2005.

I CERTIFY THAT THE SUBMISSION OF THIS FORM TO THE SCHOOL BOARD OF FRANKLIN COUNTY, FLORIDA ON BEHALF OF THE COMPANY IDENTIFIED IN PARAGRAPH ONE (1) ABOVE BINDS THE COMPANY TO FULLY COMPLY WITH THE BACKGROUND SCREENING REQUIREMENTS OF SECTIONS 1012.32, AND 435.04, FLORIDA STATUTES.

_____

(Signature)

Sworn to and subscribed before me this _____ day of _____ 20_____

_____ is personally known to me ☐ OR produced identification ☐

by showing _____

(Type of Identification)

Notary Public – State of _____ My commission expires on: _____

_____ _____

Signature of Notary Public *(Printed, typed or stamped commissioned name of Notary Public)*

EXHIBIT I

AFFIDAVIT FOR CLAIMING LOCAL PURCHASING PREFERENCE

RFP No. 2019-002 – Group Dental, Vision and Employee Voluntary Insurance Products

Proposer/Bidder/Quoter/Supplier affirms that it is a local or adjacent county business as defined by Policy #6450 of Franklin County Schools and the regulations thereto.

A Franklin/adjacent county vendor is a private independent vendor that has been licensed for at least six (6) months preceding the bid or proposal opening, as required by local, State, and Federal law to provide the goods, services, or construction to be purchased. The vendor must have a physical business address, staffed by at least one (1) person, in the geographical boundaries of Franklin County or in the adjacent counties of Gulf, Liberty, or Wakulla, Florida. The vendor, on a day-to-day basis, should provide to the School Board the needed goods and/or services substantially from the local business address. Post Office boxes are not verifiable and shall not be used for the purpose of establishing said physical address.

Please complete the following in support of the self-certification:

Business Name: _____

Address: _____

_____

_____ _____ _____

Phone *Fax* *Email*

County: _____ Length of time at this location: _____ # of employees at this location ____

State of FLORIDA

County of _____

Sworn to and subscribed before me, a Notary Public for the above State and County, on this _____ day of _____, 20 _____.

_____ _____

Notary Public *My Commission Expires*

EXHIBIT J INDEMNIFICATION AND INSURANCE

In consideration of this Contract, if awarded, the Vendor agrees without reservation to the indemnification and insurance clauses contained herein. These clauses are attached to and form a part of **RFP No. 2019-002 – Group Dental, Vision, and Employee Voluntary Insurance Products.**

The Vendor shall hold harmless, indemnify and defend the indemnities (as hereinafter defined) against any claim, action, loss, damage, injury, liability, cost or expense of whatsoever kind or nature including, but not by way of limitation, attorneys' fees and court costs arising out of bodily injury to persons including death, or damage to tangible property arising out of or incidental to the performance of this Contract (including goods and services provided thereto) by or on behalf of the Vendor, whether or not due to or caused in part by the negligence or other culpability of the indemnities, excluding only the sole negligence or culpability of the indemnities. The following shall be deemed to be indemnities: The School Board of Franklin County, Florida and its members, officers and employees.

INSURANCE

Prior to being recommended for award, the Vendor has five business days after notification to submit proof of insurance as required herein. Failure to submit a fully completed certificate of insurance signed by an authorized representative of the insurer providing such insurance coverage's may cause the Vendor to be considered non-responsive and not eligible for award of the Contract. The insurance coverage's and limits shall meet, at a minimum, the following requirements:

1. **Commercial General Liability Insurance in an amount not less than $1,000,000 combined single limit per occurrence for bodily injury and property damage.**
2. **Automobile Liability Insurance covering all owned, non-owned and hired vehicles used in connection with the operation of the Vendor, in an amount not less than $1,000,000 combined single limit per occurrence for bodily injury and property damage.**
3. **Workers' Compensation Insurance for all employees of the Vendor as required by Florida Statutes.**
4. **The School Board of Franklin County, Florida" must be listed as additional insured on all liability coverage's except Workers' Compensation.**

The insurance coverage required shall include those classifications, as listed in standard liability insurance manuals, which most nearly reflect the operations of the Vendor.

All insurance policies shall be issued by companies with either of the following qualifications:

1. The company must be:

- **a.** authorized by subsisting certificates of authority by the Department of Insurance of the State of Florida or
- **b.** an eligible surplus lines insurer under Florida Statutes. In addition, the insurer must have a Best's Rating of "A" or better and a Financial Size Category of "IV" or better according to the latest edition of Best's Key Rating Guide, published by A.M. Best Company.

or

2. With respect only to the Workers' Compensation insurance, the company must be:

- **a.** authorized as a group self-insurer pursuant to Florida Statutes or
- **b.** authorized as a commercial self-insurance fund pursuant to Florida Statutes

Neither approval nor failure to disapprove the insurance furnished by the Vendor to the School Board shall relieve the Vendor of the Vendor's full responsibility to provide insurance as required by this Contract.

The Vendor shall be responsible for assuring that the insurance remains in force for the duration of the contractual period; including any and all option years that may be granted to the Vendor. The certificate of insurance shall contain the provision that the School Board be given no less than thirty (30) days written notice of cancellation. If the insurance is scheduled to expire during the contractual period, the Vendor shall be responsible for submitting new or renewed certificates of insurance to the School Board at a minimum of thirty (30) calendar days in advance of such expiration.

Unless otherwise notified, the certificate of insurance must be delivered to the following address:

Franklin County School Board
Purchasing Department
Attn: Shannon Venable,
Director of Purchasing
85 School Road, Suite One
Eastpoint, Florida 32328

The name and address of Franklin County Public Schools, as shown directly above, must be listed as Certificate Holder on the Certificate of Insurance as well as clearly noted as "Additional Insured". The Vendor may be in default of this Contract for failure to maintain the insurance as required by this Contract. Any questions and/or inquiries should be directed to Shannon Venable (850) 670-2810.

Exhibit K

Franklin County School Board
Eye Care Highlight Sheet

Plan 1: Balanced Care Vision I Plan Summary **Effective Date: 1/1/2015**

	VSP Network	Out of Network
Deductibles		
	$10 Exam	$10 Exam
	$10 Eye Glass Lenses or Frames*	$10 Eye Glass Lenses or Frames
Annual Eye Exam	Covered in full	Up to $52
Lenses (per pair)		
Single Vision	Covered in full	Up to $55
Bifocal	Covered in full	Up to $75
Trifocal	Covered in full	Up to $95
Lenticular	Covered in full	Up to $125
Progressive	See lens options	NA
Contacts		
Fit & Follow Up Exams	Participant cost up to $60	No benefit
Elective	Up to $130	Up to $105
Medically Necessary	Covered in full	Up to $210
Frames	$130	Up to $70
Frequencies (months)		
Exam/Lens/Frame	12/12/24 Based on date of service	12/12/24 Based on date of service

**Deductible applies to a complete pair of glasses or to frames, whichever is selected.*

Lens Options (participant cost)*

	VSP Network	Out of Network
Progressive Lenses	Up to provider's contracted fee for Lined Trifocal Lenses. The patient is responsible for the difference between the base lens and the Progressive Lens charge.	Up to Lined Trifocal allowance.
Std. Polycarbonate	Covered in full for dependent children $25 adults	No benefit
Solid Plastic Dye	$13 (except Pink I & II)	No benefit
Plastic Gradient Dye	$15	No benefit
Photochromatic Lenses (Glass & Plastic)	$27-$76	No benefit
Scratch Resistant Coating	$15-$29	No benefit
Anti-Reflective Coating	$39-$75	No benefit
Ultraviolet Coating	$14	No benefit

**Lens Option participant costs vary by prescription, option chosen and retail locations.*

Monthly Rates

Employee Only (EE)	$7.78
EE + Spouse	$15.36
EE + Children	$17.24
EE + Spouse & Children	$25.22

Franklin County School Board
Eye Care Highlight Sheet

Additional Balanced Care Vision I Features

Contact Lenses Elective	Allowance can be applied to disposables, but the dollar amount must be used all at once (provider will order 3 or 6 month supply). Applies when contacts are chosen in lieu of glasses. For plans without a separate contact lens fit & follow up exam allowance, the cost of the fitting and evaluation is deducted from the contact allowance.
Additional Glasses	20% discount off the retail price on additional pairs of prescription glasses (complete pair).
Frame Discount	VSP offers a 20% discount off the remaining balance in excess of the frame allowance.
Laser VisionCare	VSP offers an average discount of 15% on LASIK and PRK. The maximum out-of-pocket per eye for participants is $1,800 for LASIK and $2,300 for custom LASIK using Wavefront technology, and $1,500 for PRK. In order to receive the benefit, a VSP provider must coordinate the procedure.
Low Vision	With prior authorization, 75% of approved amount (up to $1,000 is covered every two years).

Eye Care Plan Participant Service

Balanced Care Vision I eye care from The Standard features the money-saving eye care network of VSP. Customer service is available to plan participants through VSP's well-trained and helpful service representatives. Call or go online to locate the nearest VSP network provider, view plan benefit information and more.

VSP Call Center: 1-800-877-7195
- Service representative hours: 5 a.m. to 7 p.m. PST Monday through Friday, 6 a.m. to 2:30 p.m. PST Saturday
- Interactive Voice Response available 24/7

Locate a VSP provider at: standard.com/services
View plan benefit information at: vsp.com

Section 125

This plan is provided as part of the Policyholder's Section 125 Plan. Each employee has the option under the Section 125 Plan of participating or not participating in this plan. If an employee does not elect to participate when initially eligible, he/she may elect to participate at the Policyholder's next Annual Election Period.

This form is a benefit highlight, not a certificate of insurance.

Franklin County School District
Dental Highlight Sheet

Low Plan 1: Dental Plan Summary **Effective Date: 1/1/2018**

Plan Benefit	
Type 1	100%
Type 2	80%
Type 3	50%
Deductible	$50/Calendar Year Type 2 & 3
	Waived Type 1
	$150/family
Maximum *(per person)*	$1,000 per calendar year
Allowance	90th U&C
Waiting Period	None
Annual Eye Exam	None
LASIK Assist℠	None
Annual Open Enrollment	None

Orthodontia Summary - Child Only Coverage

Allowance	U&C
Plan Benefit	50%
Lifetime Maximum *(per person)*	$1,000
Waiting Period	None

Sample Procedure Listing (*Current Dental Terminology* © American Dental Association.)

Type 1	Type 2	Type 3
• Routine Exam (1 in 6 months)	• Restorative Amalgams	• Onlays
• Bitewing X-rays (1 in 12 months)	• Restorative Composites	• Crowns (1 in 10 years per tooth)
• Full Mouth/Panoramic X-rays (1 in 5 years)	• Endodontics (nonsurgical)	• Crown Repair
• Periapical X-rays	• Endodontics (surgical)	• Periodontics (nonsurgical)
• Cleaning (1 in 6 months)	• Simple Extractions	• Periodontics (surgical)
• Fluoride for Children 13 and under (1 in 12 months)	• Anesthesia	• Denture Repair
• Sealants (age 13 and under)		• Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 10 years)
• Space Maintainers		• Complex Extractions

About The Standard

As a leading provider of employee benefits products and services, Standard Insurance Company is dedicated to meeting the unique insurance needs of each customer. More than 27,100 groups trust The Standard for group insurance products and services, and the company covers nearly 7 million employees.

Founded in Portland, Oregon, in 1906, The Standard has built a national reputation for delivering quality insurance products, personalized service and strong financial performance. The Standard wrote its first group insurance policy in 1951, and it remains in force today as a testament to the company's commitment to building successful long-term relationships.

Customer Service

Your local Standard Insurance Company Employee Benefits Sales and Service Office will provide most of the ongoing service for your plan and can be reached at 800.633.8575 during normal business hours. We will assign your company a service representative who will provide regular contact and address questions and concerns related to the plan or the services we provide.

Franklin County School District
Dental Highlight Sheet

We also make it easy for covered employees and dentists to contact us to confirm eligibility or request claims information by calling **1-800-547-9515.** Our customer service representatives are available Monday through Thursday from 5:00 a.m. until 10:00 p.m. Pacific Time and until 4:30 p.m. Pacific Time on Friday. For plan information any time, access our automated voice response system or go online to standard.com.

Dental Network Information

Employees and dependents have access to an extensive nationwide network of member dentists. The cost-saving benefits of visiting a network member dentist are automatically available to all employees and dependents who are covered by any of The Standard's dental plans and who live in areas where the nationwide network is available. To find member dentists in your area, visit: **http://www.standard.com/dental** and click on "Find a Dentist."

Pretreatment

While we don't require a pretreatment authorization form for any procedure, we recommend them for any dental work you consider expensive. As a smart consumer, it's best for you to know your share of the cost up front. Simply ask your dentist to submit the information for a pretreatment estimate to our customer relations department. We'll inform both you and your dentist of the exact amount your insurance will cover and the amount that you will be responsible for. That way, there won't be any surprises once the work has been completed.

Late Entrant Provision

We strongly encourage you to sign up for coverage when you are initially eligible. If you choose not to sign up during this initial enrollment period, you will become a late entrant. Late entrants will be eligible for only exams, cleanings, and fluoride applications for the first 12 months they are covered.

This form is a benefit highlight, not a certificate of insurance. This policy has exclusions, limitations, reductions of benefits, and terms under which the policy may be continued in force or terminated. Please contact The Standard [or your employer] for additional information, including costs and complete details of coverage.

Franklin County School District
Dental Highlight Sheet

High Plan 1: Dental Plan Summary **Effective Date: 1/1/2018**

Plan Benefit	
Type 1	100%
Type 2	80%
Type 3	50%
Deductible	$50/Calendar Year Type 2 & 3
	Waived Type 1
	$150/family
Maximum *(per person)*	$1,500 per calendar year
Allowance	90th U&C
Waiting Period	None
Annual Eye Exam	None
LASIK Assist℠	None
Annual Open Enrollment	Included

Orthodontia Summary - Child Only Coverage

Allowance	U&C
Plan Benefit	50%
Lifetime Maximum *(per person)*	$1,000
Waiting Period	None

Sample Procedure Listing (*Current Dental Terminology* © American Dental Association.)

Type 1	Type 2	Type 3
• Routine Exam (1 in 6 months)	• Full Mouth/Panoramic X-rays (1 in 5 years)	• Onlays
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• Periapical X-rays	• Restorative Composites	• Crown Repair
• Cleaning (1 in 6 months)	• Endodontics (nonsurgical)	• Denture Repair
• Fluoride for Children 13 and under (1 in 12 months)	• Endodontics (surgical)	• Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 10 years)
• Sealants (age 13 and under)	• Periodontics (nonsurgical)	
• Space Maintainers	• Periodontics (surgical)	
	• Simple Extractions	
	• Complex Extractions	
	• Anesthesia	

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Franklin County School District
Dental Highlight Sheet

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While we don't require a pretreatment authorization form for any procedure, we recommend them for any dental work you consider expensive. As a smart consumer, it's best for you to know your share of the cost up front. Simply ask your dentist to submit the information for a pretreatment estimate to our customer relations department. We'll inform both you and your dentist of the exact amount your insurance will cover and the amount that you will be responsible for. That way, there won't be any surprises once the work has been completed.

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 January 1.

Late Entrant Provision

We strongly encourage you to sign up for coverage when you are initially eligible. If you choose not to sign up during this initial enrollment period, you will become a late entrant. Late entrants will be eligible for only exams, cleanings, and fluoride applications for the first 12 months they are covered.

Section 125

This plan is provided as part of the Policyholder's Section 125 Plan. Each employee has the option under the Section 125 Plan of participating or not participating in this plan. If an employee does not elect to participate when initially eligible, he/she may elect to participate at the Policyholder's next Annual Election Period.

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STANDARD INSURANCE COMPANY

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

CERTIFICATE
GROUP DENTAL INSURANCE

The Policyholder **FRANKLIN COUNTY SCHOOL DISTRICT**

Policy Number **160-756091** **Insured Person**

Plan Effective Date **January 1, 2018** **Certificate Effective Date**
Refer to Exceptions

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

J. Greg Ness
President

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:	402-309-2580

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 Florida Office of Insurance Regulation 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 Regulation
200 East Gaines Street
Tallahassee, FL 32399
(877) 693-5236 or (850) 413-3089

TABLE OF CONTENTS

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.

Benefit Class	Class Description
Class 1	Eligible Employee Electing Low Plan

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

Coinsurance Percentage:	
Type 1 Procedures	100%
Type 2 Procedures	80%
Type 3 Procedures	50%

Maximum Amount - Each Benefit Period	$1,000

ORTHODONTIC EXPENSE BENEFITS

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

The Maximum Benefit shown above will be modified for:

a. any person who was insured for an Orthodontic Expense Benefit under the prior carrier on December 31, 2017, and
b. on January 1, 2018 is both:

   i. insured under the policy, and

   ii. currently undergoing a Treatment Program which would have been a covered Treatment Program under the prior carrier had the prior carrier's coverage remained in force.

The modification will result in a reduction of the Maximum Benefit based on:

a. the normal benefit payable under the policy for the current Treatment Program, minus

b. any amounts to which the person is entitled from the prior carrier for such Treatment Program.

Nothing stated above, however, will act to provide coverage or increase benefits, when the Treatment Program is subject to any limitation shown on 9260.

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.

DOMESTIC PARTNER. Refers to two unrelated individuals who share the necessities of life, live together, and have an emotional and financial commitment to one another, similar to that of a spouse.

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

DEPENDENT refers to:

a. an Insured's spouse or Domestic Partner.

b. each child through the end of the year in which they turn 26 years of age, for whom the Insured, the Insured's spouse, or the Insured's Domestic Partner 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 age 26 or older who is Totally Disabled and becomes Totally Disabled as defined below while insured as a dependent under b. above. Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

TOTAL DISABILITY describes the 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 plan working at least 20 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.

Retirees are included in the Eligible Class for Insurance 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 latest of:

1. the day he or she qualifies for coverage as a Member;

2. the day he or she first becomes a Member; or

3. the day he or she first has a dependent.

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 plan working at least 20 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

Retirees are included in the Eligible Class for Dependent Insurance 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 policy 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 policy.

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 policy at that time will have their insurance become effective on January 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, no eligibility period is required.

For persons who become Members after the Plan Effective Date of the policy, no eligibility period is required.

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 January 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:

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.

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. a. 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, unless the insured person is covered on January 1, 2018. For those Insureds covered on January 1, 2018, see b.

    b. Limitation a. will be waived for those Insureds whose coverage was effective on January 1, 2018 and

        i. the person has the tooth extracted while insured under the prior contract: and

ii. has a dental prosthesis or prosthetic crown installed to replace the extracted tooth while insured under our contract;

but such extraction and installation must take place within a twelve-month period; and

iii. the dental prosthesis or prosthetic crown noted above must be an initial placement.

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.**

- Ø Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.

- Ø Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a Benefit Period means the period from his or her effective date through December 31 of that year.

- Ø Covered Procedures are subject to all plan provisions, procedure and frequency limitations, and/or consultant review. 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.

- Ø 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).

- Ø Benefits for replacement dental prosthesis or prosthetic crown will be based on the prior placement date. Frequencies which reference Benefit Period will be measured forward within the limits defined as the Benefit Period . All other frequencies will be measured forward from the last covered date of service.

- Ø 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.

- Ø We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive by our insured.

- Ø A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.

TYPE 1 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary

PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

ROUTINE ORAL EVALUATION

D0120 Periodic oral evaluation - established patient.

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

D0150 Comprehensive oral evaluation - new or established patient.

D0180 Comprehensive periodontal evaluation - new or established patient.

COMPREHENSIVE EVALUATION: D0150, D0180

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

ROUTINE EVALUATION: D0120, D0145

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

COMPLETE SERIES OR PANORAMIC

D0210 Intraoral - complete series of radiographic images.

D0330 Panoramic radiographic image.

COMPLETE SERIES/PANORAMIC: D0210, D0330

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

- Coverage is limited to 1 of any of these procedures per 5 year(s).
- The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

PROPHYLAXIS (CLEANING) AND FLUORIDE

D1110 Prophylaxis - adult.

TYPE 1 PROCEDURES

D1120 Prophylaxis - child.
D1206 Topical application of fluoride varnish.
D1208 Topical application of fluoride-excluding varnish.
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 1 of any of these procedures per 6 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.

PROSTHODONTIC PROPHYLAXIS: D9932, D9933, D9934, D9935

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- Not allowed when done on the same date as periodontal services.

SEALANT

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

SEALANT: D1351, D1352, D1353

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- Benefits are considered for persons age 13 and under.
- Benefits are considered on permanent molars only.
- Coverage is allowed on the occlusal surface only.

SPACE MAINTAINERS

D1510 Space maintainer - fixed - unilateral.
D1515 Space maintainer - fixed - bilateral.
D1520 Space maintainer - removable - unilateral.
D1525 Space maintainer - removable - bilateral.
D1550 Re-cement or re-bond space maintainer.
D1555 Removal of fixed space maintainer.
D1575 Distal shoe space maintainer - fixed - unilateral.

SPACE MAINTAINER: D1510, D1515, D1520, D1525, 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

LIMITED ORAL EVALUATION

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

LIMITED ORAL EVALUATION: D0140, D0170

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

ORAL PATHOLOGY/LABORATORY

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

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

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

AMALGAM RESTORATIONS (FILLINGS)

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

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

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

RESIN RESTORATIONS (FILLINGS)

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

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

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

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

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

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2390 Resin-based composite crown, anterior.
D2929 Prefabricated porcelain/ceramic crown - primary tooth.

TYPE 2 PROCEDURES

D2930 Prefabricated stainless steel crown - primary tooth.
D2931 Prefabricated stainless steel crown - permanent tooth.
D2932 Prefabricated resin crown.
D2933 Prefabricated stainless steel crown with resin window.
D2934 Prefabricated esthetic coated stainless steel crown - primary tooth.

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

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

RECEMENT

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

SEDATIVE FILLING

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

ENDODONTICS MISCELLANEOUS

D3220 Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.
D3221 Pulpal debridement, primary and permanent teeth.
D3222 Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.
D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).
D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).
D3333 Internal root repair of perforation defects.
D3351 Apexification/recalcification - initial visit (apical closure/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.

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

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

TYPE 2 PROCEDURES

- 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).
- D3427 Periradicular surgery without apicoectomy.

NON-SURGICAL EXTRACTIONS
- D7111 Extraction, coronal remnants - primary tooth.
- D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal).

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

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

PALLIATIVE TREATMENT: D9110
- Not covered in conjunction with other procedures, except diagnostic x-ray radiographic images.

ANESTHESIA-GENERAL/IV
- D9219 Evaluation for deep sedation or general anesthesia.
- 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. Verification of the dentist's anesthesia permit and a copy of the anesthesia report are required. 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 1 provider.

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

THERAPEUTIC DRUG
- D9610 Therapeutic parenteral drug, single administration.
- D9612 Therapeutic parenteral drugs, two or more administrations, different medications.

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

TYPE 2 PROCEDURES

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

CROWNS SINGLE RESTORATIONS

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

TYPE 3 PROCEDURES

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

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

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CORE BUILD-UP

D2950 Core buildup, including any pins when required.

CORE BUILDUP: D2950

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

POST AND CORE

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

FIXED CROWN AND PARTIAL DENTURE REPAIR

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

SURGICAL PERIODONTICS

D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.
D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.
D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.
D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.
D4260 Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.
D4261 Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.
D4263 Bone replacement graft - 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.
D4270 Pedicle soft tissue graft procedure.

TYPE 3 PROCEDURES

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 double 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.

CROWN LENGTHENING

D4249 Clinical crown lengthening - hard tissue.

NON-SURGICAL PERIODONTICS

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

CHEMOTHERAPEUTIC AGENTS: D4381
- Each quadrant is limited to 2 of any of these procedures per 2 year(s).

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342
- Each quadrant is limited to 1 of each of these procedures per 2 year(s).

FULL MOUTH DEBRIDEMENT

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

FULL MOUTH DEBRIDEMENT: D4355
- Coverage is limited to 1 of any of these procedures per 5 year(s).

OTHER PERIODONTAL SERVICES

D4346 Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation.
D4910 Periodontal maintenance.

OTHER PERIODONTAL SERVICES: D4346, D4910
- Coverage is limited to 1 of any of these procedures per 6 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.

TYPE 3 PROCEDURES

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

D5110 Complete denture - maxillary.
D5120 Complete denture - mandibular.
D5130 Immediate denture - maxillary.
D5140 Immediate denture - mandibular.
D5211 Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).
D5212 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).
D5213 Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).
D5214 Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).
D5221 Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth).
D5222 Immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth).
D5223 Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).
D5224 Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).
D5225 Maxillary partial denture - flexible base (including any clasps, rests and teeth).
D5226 Mandibular partial denture - flexible base (including any clasps, rests and teeth).
D5281 Removable unilateral partial denture - one piece cast metal (including clasps and teeth).
D5670 Replace all teeth and acrylic on cast metal framework (maxillary).
D5671 Replace all teeth and acrylic on cast metal framework (mandibular).
D5810 Interim complete denture (maxillary).
D5811 Interim complete denture (mandibular).
D5820 Interim partial denture (maxillary).
D5821 Interim partial denture (mandibular).
D5863 Overdenture - complete maxillary.
D5864 Overdenture - partial maxillary.
D5865 Overdenture - complete mandibular.
D5866 Overdenture - partial mandibular.
D6110 Implant/abutment supported removable denture for edentulous arch - maxillary.
D6111 Implant/abutment supported removable denture for edentulous arch - mandibular.
D6112 Implant/abutment supported removable denture for partially edentulous arch - maxillary.
D6113 Implant/abutment supported removable denture for partially edentulous arch - mandibular.
D6114 Implant/abutment supported fixed denture for edentulous arch - maxillary.
D6115 Implant/abutment supported fixed denture for edentulous arch - mandibular.
D6116 Implant/abutment supported fixed denture for partially edentulous arch - maxillary.
D6117 Implant/abutment supported fixed denture for partially edentulous arch - mandibular.
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, D6110, D6111, D6114, D6115

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5863, D5865, D6110, D6111, D6114 and D6115 are considered at an alternate benefit of a D5110/D5120.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5281, D5670, D5671, D5864, D5866, D6112, D6113, D6116, D6117

- Replacement is limited to 1 of any of these procedures per 10 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.

TYPE 3 PROCEDURES

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

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

DENTURE REPAIR
D5511 Repair broken complete denture base, mandibular.
D5512 Repair broken complete denture base, maxillary.
D5520 Replace missing or broken teeth - complete denture (each 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 clasp-per tooth.
D5640 Replace broken teeth - per tooth.

ADD TOOTH/CLASP TO EXISTING PARTIAL
D5650 Add tooth to existing partial denture.
D5660 Add clasp to existing partial denture-per tooth.

DENTURE REBASES
D5710 Rebase complete maxillary denture.
D5711 Rebase complete mandibular denture.
D5720 Rebase maxillary partial denture.
D5721 Rebase mandibular partial denture.

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

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

TISSUE CONDITIONING
D5850 Tissue conditioning, maxillary.
D5851 Tissue conditioning, mandibular.

PROSTHODONTICS - FIXED
D6058 Abutment supported porcelain/ceramic crown.
D6059 Abutment supported porcelain fused to metal crown (high noble metal).
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal).
D6061 Abutment supported porcelain fused to metal crown (noble metal).
D6062 Abutment supported cast metal crown (high noble metal).
D6063 Abutment supported cast metal crown (predominantly base metal).
D6064 Abutment supported cast metal crown (noble metal).
D6065 Implant supported porcelain/ceramic crown.
D6066 Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).
D6067 Implant supported metal crown (titanium, titanium alloy, high noble metal).
D6068 Abutment supported retainer for porcelain/ceramic FPD.
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal).
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal).
D6072 Abutment supported retainer for cast metal FPD (high noble metal).

TYPE 3 PROCEDURES

D6073 Abutment supported retainer for cast metal FPD (predominantly base metal).
D6074 Abutment supported retainer for cast metal FPD (noble metal).
D6075 Implant supported retainer for ceramic FPD.
D6076 Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).
D6077 Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).
D6094 Abutment supported crown - (titanium).
D6194 Abutment supported retainer crown for FPD - (titanium).
D6205 Pontic - indirect resin based composite.
D6210 Pontic - cast high noble metal.
D6211 Pontic - cast predominantly base metal.
D6212 Pontic - cast noble metal.
D6214 Pontic - titanium.
D6240 Pontic - porcelain fused to high noble metal.
D6241 Pontic - porcelain fused to predominantly base metal.
D6242 Pontic - porcelain fused to noble metal.
D6245 Pontic - porcelain/ceramic.
D6250 Pontic - resin with high noble metal.
D6251 Pontic - resin with predominantly base metal.
D6252 Pontic - resin with noble metal.
D6545 Retainer - cast metal for resin bonded fixed prosthesis.
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis.
D6549 Resin retainer - for resin bonded fixed prosthesis.
D6600 Retainer inlay - porcelain/ceramic, two surfaces.
D6601 Retainer inlay - porcelain/ceramic, three or more surfaces.
D6602 Retainer inlay - cast high noble metal, two surfaces.
D6603 Retainer inlay - cast high noble metal, three or more surfaces.
D6604 Retainer inlay - cast predominantly base metal, two surfaces.
D6605 Retainer inlay - cast predominantly base metal, three or more surfaces.
D6606 Retainer inlay - cast noble metal, two surfaces.
D6607 Retainer inlay - cast noble metal, three or more surfaces.
D6608 Retainer onlay - porcelain/ceramic, two surfaces.
D6609 Retainer onlay - porcelain/ceramic, three or more surfaces.
D6610 Retainer onlay - cast high noble metal, two surfaces.
D6611 Retainer onlay - cast high noble metal, three or more surfaces.
D6612 Retainer onlay - cast predominantly base metal, two surfaces.
D6613 Retainer onlay - cast predominantly base metal, three or more surfaces.
D6614 Retainer onlay - cast noble metal, two surfaces.
D6615 Retainer onlay - cast noble metal, three or more surfaces.
D6624 Retainer inlay - titanium.
D6634 Retainer onlay - titanium.
D6710 Retainer crown - indirect resin based composite.
D6720 Retainer crown - resin with high noble metal.
D6721 Retainer crown - resin with predominantly base metal.
D6722 Retainer crown - resin with noble metal.
D6740 Retainer crown - porcelain/ceramic.
D6750 Retainer crown - porcelain fused to high noble metal.
D6751 Retainer crown - porcelain fused to predominantly base metal.
D6752 Retainer crown - porcelain fused to noble metal.
D6780 Retainer crown - 3/4 cast high noble metal.
D6781 Retainer crown - 3/4 cast predominantly base metal.
D6782 Retainer crown - 3/4 cast noble metal.
D6783 Retainer crown - 3/4 porcelain/ceramic.
D6790 Retainer crown - full cast high noble metal.
D6791 Retainer crown - full cast predominantly base metal.
D6792 Retainer crown - full cast noble metal.
D6794 Retainer crown - titanium.
D6940 Stress breaker.

TYPE 3 PROCEDURES

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

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

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

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

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

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

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

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6094, D6194, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

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

TYPE 3 PROCEDURES

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5281, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

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

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

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.

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.
D7310 Alveoloplasty 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 Alveoloplasty 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.

TYPE 3 PROCEDURES

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.
D7510 Incision and drainage of abscess - intraoral soft tissue.
D7520 Incision and drainage of abscess - extraoral soft tissue.
D7530 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.
D7540 Removal of reaction producing foreign bodies, musculoskeletal system.
D7550 Partial ostectomy/sequestrectomy for removal of non-vital bone.
D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body.
D7910 Suture of recent small wounds up to 5 cm.
D7911 Complicated suture - up to 5 cm.
D7912 Complicated suture - greater than 5 cm.
D7960 Frenulectomy-also known as frenectomy or frenotomy-separate procedure not incidental to another procedure.
D7963 Frenuloplasty.
D7970 Excision of hyperplastic tissue - per arch.
D7972 Surgical reduction of fibrous tuberosity.
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 1 lifetime.

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 on or after the Insured's 19th birthday.

3. for a Program begun before the Insured became covered under this section, unless the Insured was covered for Orthodontic Expense Benefits under the prior carrier on December 31, 2017 and are both:

   a. insured under this policy; and
   b. currently undergoing a Treatment Program on January 1, 2018.

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 $5,000, 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.

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**.

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.