REQUEST FOR PROPOSAL

RFP #879

FOR

THE FLORIDA LEGISLATURE

GROUP DENTAL INSURANCE

Proposals to be opened by the

Florida Legislature

Office of Legislative Services

Purchasing Office

111 West Madison Street, Room 874, (850) 717-0305

Tallahassee, Florida 32399-1400

At 3:00 p.m., August 29, 2016

Name of Proposer _____

Address _____

City _____ State _____ Zip Code _____

Signature _____

(Authorized Officer)

_____

(Printed or typed name)

Title: _____

F.E.I.D. _____ Date _____

Telephone Number (_____) _____

Email Address: _____

Website URL: _____

TABLE OF CONTENTS

SECTION 1: INTRODUCTION

The Florida Legislature (Legislature), as the Policyholder, by and through the Office of Legislative Services (OLS), is requesting competitive sealed proposals in anticipation of issuing and awarding a Contract for Group Dental Insurance Benefits and Administration for the issuance of a Group Dental Insurance Policy (Policy).

The terms "Proposer" and "Contractor" are used interchangeably herein with Proposer being a vendor who submits a Proposal and Contractor referring to the awarded vendor, if any, pursuant to the RFP.

The terms "Participating Provider," "Preferred Provider," and "Network Provider" may be used interchangeable to describe the dentists who have agreed to provide treatment under a contract with the Contractor.

The terms "Policy" and "Plan" refer to the Group Dental Insurance Policy.

The term "Insured" or "Claimant" used herein shall include all eligible employees and their eligible dependents, if any, pursuant to this Request for Proposal (RFP).

1.1 Insureds

The Policy will provide coverage to all eligible employees and their dependents, including active full-time employees of the Legislature, Elected Officials, and specific State of Florida employees, including staff in the Executive Office of the Governor, which includes the Division of Emergency Management staff, and one employee within the Department of Management Services (Insureds).

All entities named above are State of Florida employers (Employers) of the Insureds defined herein and covered for dental benefits under the Policy.

1.2 Objective

The Legislature's objective is to enter into a Contract with a responsive and responsible Contractor whose written Proposal is determined to be the most advantageous to the State of Florida, taking into consideration the price and other criteria set forth in the RFP and any other information known to the Legislature that demonstrates the Contractor's experience and competence to administer and provide the services herein.

1.3 Term

The term of the Policy will be for one (1) calendar year, with up to three (3) optional one (1) year renewals, exercisable in whole or in part by the Parties, as described in the Contract, attached hereto.

1.4 Special Accommodation

Any person requiring a special accommodation because of disability should call the Purchasing Office at 850/717-0305 at least five (5) work days prior to the response opening date. If you are hearing or speech impaired, please contact the Purchasing Office by using the Florida Relay Service which can be reached at 1-800-955-8771 (TDD).

1.5 RFP Coordinator

The RFP Coordinator is the sole point of contact for information regarding this RFP from the date of release of the RFP until the Notice of Intent to Award is posted on the website at www.leg.state.fl.us/RFP879.

All communication concerning this RFP, including but not limited to the Questions as referred herein, must be directed **by email only** to the RFP Coordinator of the Office of Legislative Services (OLS) Purchasing Office listed below. Unauthorized contact regarding this RFP with any other legislative employee can result in disqualification. There should be no oral communications with OLS or any legislative employee during the solicitation and any such oral communication will be considered unofficial and nonbinding to the Legislature.

The RFP Coordinator is:

Theresa Dollar
Office of Legislative Services
Purchasing Office
Room 874, Claude Pepper Building
111 West Madison Street
Tallahassee, FL 32399-1400
dollar.theresa@leg.state.fl.us

1.6 Must, Shall, Will and Is Required

Although this solicitation uses terms such as "must," "shall," "will," and "is required" and may define certain items as requirements, the Legislature reserves the right, in its discretion, to waive any minor irregularity, technicality, or omission if the Legislature determines that it is in the best interest of the State to do so. However, failure to provide requested information may result in the rejection of a proposal. There is no guarantee that the Legislature will waive an omission or deviation, or that any Proposal containing a deviation or omission will be considered for an award.

1.7 Schedule of Events

Issuance of RFP	July 29, 2016
Last date to submit the Confidentiality & Non-Disclosure Agreement for Census Information (Attachment F)	August 5, 2016
Last date to submit written questions	August 8, 2016
Anticipated Posting of Answers on website at www.leg.state.fl.us/RFP879	August 15, 2016
Proposals due by 3:00 p.m. for opening	August 29, 2016
Anticipated completion of Evaluation	September 23, 2016

Anticipated Notice of Intent to Award	October 21, 2016
Anticipated Execution of Contract	October 26, 2016
Anticipated Issuance of Policy	January 1, 2017
Anticipated Policy Effective Date	January 1, 2017

1.8 Official Notices or Amendments to the Solicitation Documents

All notices, decisions, intended decisions, addenda and other matters relating to this procurement will be electronically posted on the website at www.leg.state.fl.us/RFP879. The Legislature will post addenda to the RFP documents, including timeline updates on the website listed above.

IT IS THE SOLE RESPONSIBILITY OF PROPOSERS TO CHECK THIS WEBSITE FOR INFORMATION AND UPDATES.

1.9 Confidentiality and Non-Disclosure Agreement

In order to receive the Census Information, Proposers must submit the Confidentiality and Non-Disclosure Agreement, Attachment F, to the RFP Coordinator by the deadline contained in the Schedule of Events, of this RFP. Proposers who submitted a Confidentiality and Non-Disclosure Agreement and receive the Census Information but fail to submit a Proposal to the RFP shall destroy the confidential information, including any copies, by the time Proposals are due.

1.10 Questions

Questions for additional information or clarification may be submitted in writing **by email only** to the RFP Coordinator specified herein above and received no later than the date contained in the Schedule of Events of this RFP. Any questions received after the date and time indicated in the Schedule of Events of this RFP herein will not be considered.

All questions should be addressed as follows:

QUESTIONS RFP #879
GROUP DENTAL INSURANCE

To be considered, questions must be submitted in the following format:

Question #	RFP Section #	RFP Page #	Question

Written responses to all questions will be posted on the website specified herein on the date listed in the Schedule of Events of this RFP.

SECTION 2: SCOPE OF SERVICES

2.1 Scope

The Contractor will be responsible for providing Group Dental Insurance benefits and administration for dental and orthodontic benefits and expenses incurred by an Insured.

2.2 Current Group Dental Insurance Policy

Current benefits are provided by Ameritas Life Insurance Corp. through December 31, 2016. Dental premiums are paid by employers. All Proposals shall provide, at a minimum, the coverage provisions in the current Group Dental Insurance Policy, attached hereto as Attachment A.

2.3 Group Dental Insurance Plan

2.3.1 Preferred Provider Organization (PPO)

All Proposals shall provide a Preferred Provider Organization (PPO) Plan. The Legislature is not interested in any other dental insurance plan including, but not limited to, a prepaid dental plan, a self-funded dental plan, a dental health maintenance organization (HMO) plan or any other dental insurance plan with the same coinsurance payments.

2.3.2 Provider Directory

The Contractor must maintain and provide a directory of participating providers throughout the State of Florida that shall be accessed online by Insureds.

2.4 Group Dental Insurance Benefits

Procedure Type		Preferred Provider	Non-Preferred Provider
Preventive Services	Deductible	$0	$0
	Coinsurance Percentage Covered	100%	100%
Basic Services	Deductible	$0	$50
	Coinsurance Percentage Covered	80%	80%
Major Services	Deductible	$0	$50
	Coinsurance Percentage Covered	50%	50%

A Maximum Amount of $1,500.00 will be paid per Insured for covered dental services during each benefit period.

Orthodontic Services	Deductible	$0	$0
	Coinsurance Percentage Covered	50%	50%

A Maximum Amount of $1,500.00 will be paid per Insured for covered orthodontic services during the lifetime of the each Insured.

2.5 Dental Plan Effective Date

The coverage effective date is January 1, 2017, at 12:01am EST through December 31, 2017, at 12:01am EST.

2.6 Maximum Allowable Charge (MAC)

MAC amounts apply to dental charges from a Preferred Provider. MAC amounts should take into consideration the current actual fees charged by Preferred Providers in a given area, inflationary changes, and cost of dental care.

2.7 Usual, Customary and Reasonable Fees (UCR)

UCR amounts apply to dental charges from Non-Preferred Providers. UCR amounts should be, at a minimum, in the 90th percentile of industry data for determination of the UCR amounts taking into consideration current actual fees charged by dentists in a given area, inflationary changes and the cost of dental care. The Contractor must set usual, customary and reasonable (UCR) fees that are accepted in the dental insurance industry.

2.8 Carry Over Benefit

The Policy shall include a Carry Over Benefit for Dental expenses, allowing Insureds to carry over a portion of the unused benefits each year.

2.9 Waiting Periods, Continuation of Benefits and Termination

2.9.1 Waiting Periods

Group Dental Insurance benefits will be available to all Insureds on the effective date provided herein. All newly-hired Insureds will be eligible for Group Dental Insurance benefits on the first of the month following employment.

2.9.2 Continuation of Benefits and Termination

Insureds that terminate employment may continue Group Dental Insurance benefits up to a maximum of sixty (60) days after termination of employment and for which a premium payment is made.

2.10 Policy Rates

All proposed rates shall be guaranteed for the Policy period, including the proposed renewal rates, which shall be guaranteed through a renewal term, if any.

2.11 Claims Processing and Reporting Requirements

The Claims Process shall include, at a minimum:

2.11.1 The Contractor shall have a systematic claim filing process, claim notification procedures, a standard claim form which clearly outlines any additional material that may be required to be submitted with the claim form, and the Contractor's information such as address information, customer service telephone and facsimile numbers.

2.11.2 The Contractor shall have an established employee counseling claim processing service unit, which will assist Insureds with claim procedures, claim forms and coverage verification information.

2.11.3 The Contractor shall offer claim forms electronically and electronic claim submission. The Contractor is encouraged to allow all medical documentation to be submitted electronically by the providers.

2.11.4 The Contractor must have guidelines and procedures to assure that claims and benefits payments are processed in a timely and accurate manner, including access to claims filed and claims history.

2.11.5 The Contract shall provide monthly detailed claim reporting to the Legislature's Contract Manager. The detailed claim report shall provide the Insured's description (employee or dependent), claim number and benefit amount paid.

2.12 Loss Reports

The Contractor shall provide quarterly and annual Loss Reports that provide the total paid premiums, incurred claims, total claim amounts paid and total number of Insureds covered.

2.13 Service Requirements.

Service Requirements shall include, at a minimum:

2.13.1 The Contractor shall provide a Certificate of Insurance to the Policyholder by the effective date of the Policy. The Certificate of Insurance shall evidence coverage under the Policy including the group number and essential features of the insurance benefits including the Schedule of Benefits outlining benefits, definitions, general policy provisions, eligibility requirements and exclusions.

2.13.2 The Contractor shall provide Group Dental Insurance booklets, both electronically and in hardcopy, that outline the schedule of benefits, provider directories, and other important plan information. The cost for such booklets will be the responsibility of the Contractor. The Legislature will distribute booklets to all Insureds.

2.13.3 The Contractor shall provide Group Dental Insurance identification (ID) cards without social security numbers for each Insured that includes, at a minimum, the group name, policy number, employee's name, coverage type (single vs. family), toll free telephone number for Insurer and Insurer's claims mailing

address. An initial ID card is to be provided to all Insureds within 45 days of employment, including additional ID cards or updated ID cards, when changes or replacement cards are requested.

2.13.4 Newly-hired Insureds are immediately eligible and automatically enrolled. The Employers will administer enrollment, provide enrollment booklets, certificates of coverage and present benefit options to Insureds. Enrollment material must be supplied to the Employers for internal enrollment. The Contractor shall work with Employers during enrollment changes.

2.13.5 The Contractor must have guidelines and procedures to assure that all Preferred Providers create and submit a treatment plan to all Insureds before treatment is provided. The treatment plan should include a summary of all procedures for treatment and the cost associated with each procedure.

2.13.6 The Contractor shall provide and produce an easily understood Explanation of Benefits (EOB). The EOB must display the charges, allowed charges, deductible amounts and amount paid, including an explanation when claim payments are reduced or not paid for each Insured's dental procedures.

2.13.7 The Contractor must comply with all requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

2.13.8 The Contractor must be capable of recording and maintaining information regarding service-related or other complaints reported by Insureds and/or Insureds' representatives.

2.13.9 Vendor shall maintain a customer service unit dedicated, but not necessarily exclusive, to performing all aspects of Insured-related customer service and shall include a state of the art call center, including a toll-free customer service number which will permit access anywhere in the United States. Calls to the call center shall be accepted and answered promptly by a live customer service representative during the hours of 7:00 a.m. to 6:00 p.m., EST, Monday through Friday, excluding State holidays. The Contractor must have a telephone system and staff capacity adequate to respond to Insureds in a timely manner. The Contractor is encouraged to use advanced technology to ensure that Insured questions can be answered at times convenient for the Insured.

2.13.10 The Contractor must maintain a secure website for the Plan that will allow Insured access that allows Insured to obtain information, including but not limited to dental providers, plan benefit summary, claim information and identification cards.

2.13.11 The Contractor shall designate an Account Manager who has the authority to respond to the Policyholder and Insureds. The Account Manager, at a minimum, must be able to make decisions or report to a person who can make decisions

concerning process changes, reporting requirements and updates. The Account Manager is expected to maintain an up-to-date understanding and knowledge of the Legislature's account. It may be required that the Account Manager be available to meet with the Legislature. Any change in the assigned Account Manager must be approved by the Legislature.

2.14 Underwriting Information

2.14.1 The Current Group Dental Insurance Policy, attached hereto as Attachment A, contains the schedule of benefits, premium rates, and coverage terms and conditions.

2.14.2 The history of the Legislature's Policy rates and premium information is attached hereto as Attachment B.

2.14.3 The Group Dental Insurance Procedure Experience Report is attached hereto as Attachment C.

2.14.4 The Group Dental Insurance Experience Summary is attached hereto as Attachment D.

2.14.5 The Group Dental Insurance Carry Over Benefit Summary is attached hereto as Attachment E.

2.14.6 The Census Information file contains certain confidential/HIPAA protected information and data. Proposers must obtain the Census Information directly from the Legislature's RFP Coordinator specified herein in Section 1.5.
The Census Information includes the following information:

- Employer name;
- Job title;
- Date of birth;
- Gender;
- Home zip code;
- Coverage type (Insured Person or Insured Person w/Dependent).

To obtain this data, Proposers must **email** a fully completed copy of the Confidentiality and Non-Disclosure Agreement for Census Information (Attachment F) to the RFP Coordinator, by the time and date indicated in the Schedule of Events, of this RFP. The RFP Coordinator will email the Census information to the Proposer.

2.14.7 The Elected Officials included as Insureds, are comprised of 160 legislators who do not have scheduled work hours and are considered fulltime employees of the Legislature even though most, if not all, have other employment.

2.14.8 Group Dental Insurance is a noncontributory dental benefit program and automatic for all Insureds. The Legislature does allow Insureds to decline coverage. Premiums are paid by the employers.

2.14.9 Flexible Spending Accounts are available to all Insureds. The percentage of employee participation is unknown.

2.14.10 All Insureds are entitled to the Consolidated Omnibus Budget Reconciliation (COBRA) Act. Retirees are offered COBRA for a minimum period of 18 months.

2.15 Insurance Agents

At all times during the Policy Term, the Contractor is responsible for the performance of any and all work regardless of the use of an Insurance Agent by the Contractor. Contractors may allow submission of Proposals through one or more Florida resident licensed agents or Florida nonresident licensed agents (Agent), who are duly licensed and appointed by the Contractor in accordance with Chapter 624 and Chapter 626, of the Florida Statutes.

Information regarding any and all Agents shall be submitted with the Proposal by completing the Insurance Agent Information, attached hereto as Attachment L.

Commission, if any, shall be included in the rate provided on the Cost Proposal, attached hereto as Attachment N and paid in accordance with Chapter 626, of the Florida Statutes. The Legislature's Group Dental Insurance Policy is between the Insurer and the Legislature. Commissions paid to an appointed licensed Agent by the Insurer do not need to be disclosed to the Legislature.

2.16 Cancellation and Non-Renewal

The Contractor shall comply with all cancellation and non-renewal provisions required by Chapter 627, of the Florida Statutes, or other applicable Florida law.

2.17 Disclaimer of Specifications

All information contained herein is believed to be substantially correct. However, the responsibility for determining the full extent of the exposure to risk and verification of all information herein shall rest solely with the Proposer. Proposers are responsible for ensuring that the proposed Group Dental Insurance Policy provides, at a minimum, the coverage afforded under the current insurance Policy. The Legislature and its representatives shall not be responsible for any error or omission in the Scope of Services provided herein, nor for the failure on the part of the Proposer to determine the full extent of the exposure.

SECTION 3: INSTRUCTIONS FOR SUBMISSION

3.1 Submission of Proposals

Proposals must be received at or before the time specified in the Schedule of Events of this RFP.

Sealed Proposals must be submitted to the Office of Legislative Services Purchasing Office, Room 874, Pepper Building, 111 West Madison Street, Tallahassee, FL 32399-1400. Proposals received electronically or by facsimile will not be considered. It shall be the sole responsibility of the Proposer to see that their Proposal is received at the proper location on or before the stated time of the Proposal opening. All Proposals received after that time shall be returned unopened.

All Proposals shall be submitted in the format on the requisite forms, if provided. Proposals shall be properly executed in the name of and by the person, firm, or corporation submitting the Proposal.

Proposals must be submitted in two separate sealed parts: a Technical Proposal and a Cost Proposal. Proposal packages must be boxed or sealed and identified as follows:

- Name of Proposer: (Your Company's Name)
- RFP #879, Group Dental Insurance
- Proposal Type: (Technical or Cost)

3.2 Proposal Contents

A. Technical Proposal

The Proposer shall submit one (1) original version in hard copy and CD-ROM, and if applicable, one (1) redacted version in hard copy and CD-ROM. The Technical Proposal components described below must be packaged and identified as the Technical Proposal.

B. Cost Proposal

The Proposer shall submit one (1) original version in hard copy and CD-ROM, and if applicable, one (1) redacted version in hard copy and CD-ROM. The Cost Proposal components described below must be packaged and identified as the Cost Proposal.

The versions of the Proposal shall be identical regardless of the format.

3.3 Replacement/Withdrawal/Modification of Proposal

A Proposer may replace or withdraw a sealed Proposal at any time prior to the Proposal due date listed in the Section titled Schedule of Events of this RFP. No changes, modifications, or additions to the Proposals will be allowed after the Proposals have been opened.

3.4 Cost of Preparation

Neither the Legislature nor the State of Florida is liable for any costs incurred by a Proposer in responding to this RFP.

3.5 Firm Proposal

By submitting a Proposal, Proposers acknowledge and agree that their Proposal shall remain firm and shall not be withdrawn for one-hundred twenty (120) calendar days after the date that the Proposal is submitted.

3.6 Use of Proposal Contents

All documentation produced as part of this RFP becomes the exclusive property of the Legislature. All timely Proposals become the property of the Legislature and will not be returned to the Proposer. The Legislature will have the right to use any or all ideas or adaptations for the ideas presented in the Proposal. Selection or rejection of a Proposal will not affect this right.

3.7 Public Records/ Confidential Information

All electronic and written communications pertaining to this RFP, whether sent from or received by the Legislature, are public records upon the conclusion of the RFP process.

If any part of the Proposal contains documents, data, or records submitted in response to this RFP to be confidential, trade secret or otherwise not subject to disclosure pursuant to section 11.0431, Florida Statutes, the Florida Constitution or other authority, the Proposer must also simultaneously provide the Legislature with a separate redacted copy of its documents, data, or records and briefly describe in writing the grounds for claiming exemption from the public records law, including the specific statutory citation for such exemption. This redacted copy shall contain this RFP number and Proposer's name on the cover and shall be clearly titled "Redacted Copy." The Redacted Copy shall be provided to the Legislature at the same time the Proposer submits the documents, data or records to the Legislature and must only exclude or obliterate those exact portions that are claimed confidential, proprietary, or trade secret. The Redacted Copy shall be provided to the Legislature in hard copy and on a CD-ROM (electronic copy).

The Proposer shall be responsible for defending its determination that the redacted portions of its documents, data or records are confidential, trade secret or otherwise not subject to disclosure. Further, the Proposer shall protect, defend, and indemnify the Legislature for any and all claims arising from or relating to the Proposer's determination that the redacted portions of its Proposal are confidential, proprietary, trade secret or otherwise not subject to disclosure.

If the Proposer fails to submit a Redacted Copy with its Proposal, the Legislature may produce the entire documents, data or records submitted by the Proposer in answer to a public records request upon the conclusion of the solicitation.

3.8 Modifications to RFP Terms and Conditions

The Proposer may not apply any condition or change any term to any aspect of this RFP or the Proposal may be deemed non-responsive and not evaluated. Any attempt to redline, modify, or change this RFP and its contents, including the Policy or the Contract, may subject the Proposal to be deemed nonresponsive and not evaluated. Enhancements to the current coverage and current services will be evaluated as described herein.

3.9 Legislature's Reserved Rights

3.9.1 Rejection of Proposals

The Legislature may reject any Proposal not submitted in the manner specified by this RFP. The Legislature reserves the right to reject all Proposals at any time in its sole discretion, including after an award is made, when to do so would be in the best interest of the State of Florida, and by doing so the Legislature will have no liability to any Proposer.

3.9.2 Withdrawal of the RFP

The Legislature reserves the right to withdraw this RFP at any time in its sole discretion, including after an award is made, when to do so would be in the best interest of the State of Florida, and by doing so the Legislature will have no liability to any Proposer.

3.9.3 No Policy until Execution

No Policy shall be issued until such time as the Contractor and the Legislature formally execute a Contract for Group Dental Insurance Benefits and Administration.

3.9.4 Clarification

The Legislature may request clarification and/or a revised Cost Proposal which may include some, none, or all of the enhancements contained in the Proposer's Proposal at any point before the execution of a Contract.

3.10 Florida Substitute Form W9

A completed Substitute Form W-9 is required from vendors doing business with the State of Florida. Should the Legislature award any Contract pursuant to this RFP, the Contractor, if not already registered, must register as a vendor with the State of Florida, Department of Financial Services, within five business days of the award. The registration and requirements for registering and submitting electronically a Substitute Form W-9 are available at: https://flvendor.myfloridacfo.com/.

3.11 Procurement Protests

The Legislature is not an agency for purposes of Chapters 120 or 287 of the Florida Statutes. This RFP is not a competitive solicitation pursuant to Chapter 287 of the Florida Statutes, and the procedures for resolution of procurement protests contained in Chapter 120 of the Florida Statutes are inapplicable to this RFP.

3.12 Technical Proposal

3.12.1 Technical Proposal Mandatory Requirements for Responsiveness

The following items are minimum requirements to this RFP and must be included in the Technical Proposal, Tab 1, and if deficient, the Proposal may be deemed nonresponsive and not evaluated.

Tab 1, Mandatory Requirements, should include the following:

- A completed and signed Proposer's Information Coversheet (page 1) of this RFP. These documents must be signed by an individual (contact name and title of the individual) responsible for the organization's Proposal with binding signature authority.
- Certification of Minimum Qualifications (*Attachment H);*
- Certification of Preferred Providers (*Attachment I);*
- Proposer Certification (*Attachment J);*
- Disclosure Information (*Attachment K);*
- Insurance Agent Information, if applicable (*Attachment L);*
- Reference Form (*Attachment M*);
- The Proposer must submit a current copy of their registration with the Florida Department of State, Division of Corporations, and must maintain that status through the Term of the Policy, including any renewal period;
- The Proposer must submit a current Certificate of Authority as an authorized entity to conduct business and administer this Group Dental Policy in the State of Florida pursuant to Florida law.

3.12.2 Technical Proposal Content for Evaluation Total of 70 points

The Technical Proposal must be arranged in the sequence in which the requirements are referenced herein. Additional information may be submitted to accompany the Proposal. If submitting additional information, please mark it as supplemental.

AVAILABLE **POINTS**

Tab 2: Claims Processing and Reporting Requirements Criteria 0 – 30 points

Tab 2 of the Proposal shall be entitled **Claims Processing and Reporting Requirements Criteria**. The Claims Processing and Reporting Requirements Criteria proposed shall meet the requirements contained in the Scope of Services and those provided in the current Policy, and will be evaluated using the following considerations:

1.) The Proposal shall provide a description of the Proposer's customer service representatives, claims staff, and any other staff with a description of their customer service and claims experience and credentials or licensure. (5 points)
2.) The Proposal shall provide a description of the Proposer's entire claims process, including an explanation of the claim notification and the claim submission procedures through to the final resolution of the claim. (10 points)
3.) The Proposer should include a copy of all forms, including the Explanation of Benefits, utilized by the Contractor for this process. The Proposal shall demonstrate that the Proposer's organization has guidelines and procedures to assure that claims and benefits payments are processed in a timely and accurate manner. (10 points)
4.) The Proposer may offer enhancements, including performance measures or reporting, to claim processing and reporting that would better serve the Legislature. The Proposal shall indicate which enhancements, if any, are included within the Cost Proposal or the amount of an additional charge associated with the enhancement. (5 points)

Tab 3: Loss Reporting Criteria **0 – 5 points**

Tab 3 of the Proposal shall be entitled **Loss Reporting Criteria**. The Loss Reporting Criteria shall meet the requirements contained in the Scope of Services and that are provided in the current Policy. This section will be evaluated using the following considerations:

1.) The Proposal shall provide a description of the Proposer's loss reporting process, including an explanation of the loss report process, a sample loss report with detailed loss information by entity, and a sample loss report for the quarterly and annual claims processed. The Proposal shall demonstrate that the Proposer's organization has guidelines and procedures to assure that loss reports are processed in a timely and accurate manner. (5 points)

Tab 4: Service Criteria **0 - 10 points**

Tab 4 of the Proposal shall be entitled **Service Criteria**. The Service Criteria shall meet the requirements contained in the Scope of Services and that are provided in the current Policy. This section will be evaluated using the following considerations:

1.) The Proposal shall provide a description of the account management team. The Vendor shall maintain a dedicated, but not necessarily exclusive, account management team which should be able to devote the time and resources needed to successfully manage the account. The account management team shall be thoroughly familiar with vendor's functions and operations that relate directly or indirectly to the Legislature and the policy including but not limited to, provider networks, claims and enrollment systems, systems reporting capabilities, claims adjudication policies and procedures. The Proposal shall

outline the Proposer's training and quality assurance programs in place that will ensure high quality service to the Legislature. (5 points)

2.) The Proposer may offer additional service enhancements, including performance measures or reporting, that would better serve the Legislature. The Proposal shall indicate which enhancements, if any, are included within the Cost Proposal or the amount of an additional charge associated with the enhancement. (5 points)

Tab 5: Implementation Plan Criteria **0 - 5 points**

Tab 5 of the Proposal shall be entitled Implementation Plan Criteria. The Proposal shall provide a copy of all forms or documents that will be associated with the issuance of the Group Dental Policy. This includes the insurance application, an Employer Administration manual, a customer information questionnaire and user profile, monthly bill form and/or invoice, dental plan summary, identification cards, and samples of membership materials.

The Implementation Plan should include a schedule of events from the date of award to the effective date of the Policy, January 1, 2017, 12:01:00 a.m., EST, with specific due dates of all steps with the person(s) to be assigned responsibility for each event.

Vendor shall be one-hundred percent (100%) operational prior to the effective date. Vendor pays performance credits listed in the contract for failure to meet the operational milestone indicated above. (5 points)

A final Implementation Plan will be submitted to the Legislature for approval no later than ten (10) business days following execution of the Contract. If the Legislature deems the plan to be insufficient, Contractor shall work diligently to deliver an updated, final Implementation Plan satisfactory to the Legislature, recognizing that time is of the essence.

Tab 6: Reference Criteria **0 - 20 points**

Tab 6 of the Proposal shall be entitled Reference Criteria. This section will be evaluated using the contact information submitted on the Reference Contact Information Form, attached hereto as Attachment M. The Proposer should provide contact information for three (3) references for which Group Dental Insurance benefits were provided by the Proposer within the last three (3) years in the State of Florida. Preferably, references should be from government or public sector clients for whom the Proposer currently provides similar services to those sought in this RFP. References will not be accepted from: current employees of the Legislature, former legislative employees within the past three (3) years, persons currently or formerly employed by the Proposer's organization, board members of the Proposer's organization and relatives. The Legislature will contact, in its sole discretion, two

(2) of the References regarding the Proposer's performance of services. (10 points per reference)

SCORING SCALES (0-5 POINTS)

For each Proposal, the evaluators will assign the appropriate score for each criterion listed above, based on the scales below.

Scoring Scale (0-5)	
Numerical Score	Description
5	Superior: Proposal exhaustively addresses the evaluation criterion or demonstrates extraordinary experience related to the criterion
4	Excellent: Proposal extensively addresses the evaluation criterion or demonstrates exceptional experience related to the criterion
3	Acceptable: Proposal adequately addresses the evaluation criterion or demonstrates sufficient experience related to the criterion
2	Fair: Proposal minimally addresses the evaluation criterion or demonstrates nominal experience related to the criterion
1	Poor: Proposal inadequately addresses the evaluation criterion or demonstrates limited experience related to the criterion
0	Missing: Proposal does not address the evaluation criterion or does not demonstrate experience related to the criterion

SCORING SCALES (0-10 POINTS)

Scoring Scale (0-10)	
Numerical Score	Description
10	Superior: Proposal exhaustively addresses the evaluation criterion or demonstrates extraordinary experience related to the criterion
8	Excellent: Proposal extensively addresses the evaluation criterion or demonstrates exceptional experience related to the criterion
6	Acceptable: Proposal adequately addresses the evaluation criterion or demonstrates sufficient experience related to the criterion
4	Fair: Proposal minimally addresses the evaluation criterion or demonstrates nominal experience related to the criterion
2	Poor: Proposal inadequately addresses the evaluation criterion or demonstrates limited experience related to the criterion
0	Missing: Proposal does not address the evaluation criterion or does not demonstrate experience related to the criterion

For each Reference, the evaluators will assign a score from zero to ten (based on the scale below). The evaluator scores will then be added, and the total will be divided by the number of evaluators to get an average for each Reference. The two average scores for each Reference Form will be added to get the final score for the Reference Scoring

SCORING SCALE (0-10 POINTS)

Numerical Score	Description
10	Superior: Reference reports extraordinary experience and services from the Proposer for services similar in size and scope to this RFP
8	Excellent: Reference reports exceptional experience and services from the Proposer for services similar in size and scope to this RFP
6	Acceptable: Reference reports sufficient experience and services from the Proposer for services similar in size and scope to this RFP
4	Fair: Reference reports nominal experience and services from the Proposer for services similar in size and scope to this RFP
2	Poor: Reference reports limited experience and services from the Proposer for services similar in size and scope to this RFP
0	Missing: Reference does not provide experience and services from the Proposer for services similar in size and scope to this RFP

3.12.3 Cost Proposal **0 – 30 Points**

The Cost Proposal shall contain the Total Cost attached hereto as Attachment N. Points for cost will be determined by taking the lowest Combined Average Rate proposed and dividing that Combined Average Rate by the Proposer's Combined Average Rate, then multiplying by the maximum number of points for this section (30), submitted on Attachment N, Cost Proposal. The Combined Average Rate will be determined by adding the Insured Person Rate + the Insured Person w/Dependent Rate, then dividing by 2. The Proposal with the lowest Combined Average Rate will receive the maximum number of points for the category.

Lowest Proposal's Combined Average Rate / Proposer's Combined Average Rate X 30 = Points awarded for Proposer's proposal

Example Only:

Insured Person Rate:	$34.00
Insured Person w/Dependent Rate:	$80.00
Total	$114.00
Divided by Count	/2
Combined Average Rate	**$57.00**

$ 55.00 (Lowest Proposed Combined Average Rate) X 30 = 28.95 Points awarded
$ 57.00 (Proposer's Combined Average Rate Example)

The Proposal shall include the rates for the three (3) renewal years in order for the Cost Proposal to be deemed responsive and evaluated in Attachment N. However, the renewal years' rates will not be evaluated.

The Cost Proposal should not include the costs associated with any proposed enhancements contained in the Technical Reply Proposal. The cost for those enhancements will be evaluated in the Technical Reply criteria.

SECTION 4: EVALUATION METHODOLOGY

4.1 Proposal Responsiveness

The Purchasing Office will review all Proposals submitted to ensure that they have met all of the requirements in this RFP. Proposals that do not meet all requirements of the solicitation or fail to provide all required information or documents may be deemed non-responsive.

4.2 Proposal Evaluation Criteria

An evaluation team of no fewer than three (3) evaluators will individually rate the Technical Proposals based upon the established fair and objective criteria from this RFP. The Legislature reserves the right to seek clarifications and to request any information deemed necessary for proper evaluation from all Proposers deemed eligible for award and to determine the integrity, viability, qualifications of all Proposers when to do so would be in the best interest of the State of Florida.

The Proposal Evaluation Criteria and points available are as follows:

Criteria		Points	Weight
Technical Proposal			**70% or 70 points**
	Claim Processing and Reporting Requirements	30	
	Loss Reporting	5	
	Service	10	
	Implementation Plan	5	
	References	20	
Cost Proposal			**30% or 30 points**
	Combined Average Rate	30	

4.3 Selection and Contract Award

The Legislature anticipates awarding to a responsive and responsible Proposer, if any, whose written Proposal is determined to be the most advantageous to the State of Florida, taking into consideration the price and other criteria set forth in the RFP, and any other

information known to the Legislature that demonstrates the experience and competence of the Proposer to administer and provide a high quality and cost effective Policy.

4.4 Posting Notice of Intent to Award

If the Legislature decides to award a contract, it will post a Notice of Intent to Award on the website specified in this RFP. If the Legislature decides to reject all Proposals or withdraw the RFP, it will post a notice of its intent on the website specified herein this RFP.

SECTION 5: DRAFT CONTRACT

Contract for Dental Insurance Benefits and Administration

This awarded Contract is between the Florida Legislature, (Legislature), and _____, a _____ corporation licensed to do business in Florida, with a principal address of _____ (Contractor).

The Legislature requires the Contractor to provide administrative services as described herein. The goal of the competitive solicitation process was to seek a licensed and qualified Contractor for Dental Insurance benefits for all eligible insureds (Insureds), including active full-time employees of the Legislature, Elected Officials, and specific State of Florida employees, including staff in the Executive Office of the Governor, which includes the Division of Emergency Management staff, and one employee within the Department of Management Services.

Contract Documents

This Contract between the Legislature and the Contractor is comprised of this document and the following documents which are integrated into and made part hereof. In the event that there is a specific, direct, and irreconcilable conflict between any two or more provisions contained in this document and the component Exhibits and Attachments, the conflicting provisions will be given the following precedence:

a. This Contract;
b. Policy for Dental Insurance and all its endorsements, riders thereto;
c. Request for Proposal RFP #879, as adjusted by any addenda to the RFP, including the Questions and Answers to the RFP; and
d. Contractor's Proposal.

Contract Term; Renewal

The Contract shall become effective upon its execution and through December 31, 2017.

For budgeting purposes, the Contractor must confirm their renewal offer at or lower than the renewal rates submitted in the Attachment N, Cost Proposal, to the RFP, no later than thirty (30) days prior to the end of each fiscal year, or May 31.

Renewal of the Contract will be via a written amendment hereto and an endorsement to the Dental Insurance Policy (Policy) at or lower than the Contractor's renewal rate provided in Attachment N, Cost Proposal, to the RFP. This Contract may be renewed for a period not to exceed 3 years, exercisable in whole or part, upon mutual agreement of the Parties. The renewal must be in writing and signed by both parties and is contingent upon satisfactory performance and subject to availability of funds.

Termination for Convenience

The Legislature may terminate the Contract, in whole or in part, for any reason at any time, in the sole discretion of the Legislature, upon providing thirty (30) days written notice to the Contractor.

Choice of Law and Venue

The exclusive venue of any legal or equitable action that arises out of or relates to the Policy or this Contract (excluding adverse benefit determinations), shall be the appropriate state court in Leon County, Florida; in any such action, Florida law shall apply and the parties waive any right to jury trial.

Availability of Funds

The performance of the Policy shall be subject to and contingent upon the availability of funds lawfully appropriated by and to the Legislature and applicable for the purpose of the services specified.

Rates

The Policy Rates are contained in the Cost Proposal, Attachment N, to the RFP. The employers pay monthly in arrears after reconciling the Contractor's invoice, submitted based on enrollment.

Payment Terms

The Policy premium payments, based on the rates provided herein, will be paid monthly by each Employer of the Insureds to the Contractor in accordance with each Employer's Policies and Procedures, during the coverage month based on the prior month's payroll for employer contribution. Each Employer will be responsible for their administration and monthly premiums.

The Contractor agrees that the terms and conditions of payment are governed by sections 2.15 and 2.151, Joint Policies and Procedures of the Presiding Officers.

Indemnification

The Legislature intends that the Contractor be fully liable for the actions of its agents, employees, partners, or subcontracts and shall fully indemnify, defend and hold harmless the Legislature and its officers, agency and employees from suits, actions, damages and costs of every name and description, including attorney's fees, arising from or relating to personal injury and damage to real or personal tangible property alleged to be caused in whole or in part by negligent, reckless, or willful acts by the Contractor, its agents, employees, partners or subcontractors in the performance of this Contract to the fullest extent allowed by Florida law.

Limitation of Liability

Neither the Legislature nor the Contractor is liable to another for special, indirect, punitive, or consequential damages, including lost data or records even if the party has been advised that such damages are possible. No Party shall be liable for lost profits, lost revenue, or lost institutional operating savings.

Representations

The Contractor understands that any misstatements or lack of candor by the Contractor about the qualifications or availability of it or its personnel constitutes a breach of the resulting Policy and may be grounds for immediate termination of the Contractor's Policy with the Legislature. The Contractor represents further that it has had the opportunity to seek counsel and is not under duress from the Legislature or any other person.

Taxes

The Legislature does not pay any state or Federal taxes and all fees are exclusive of any taxes.

Waivers

The Legislature shall not be deemed to have waived any of its rights or remedies hereunder unless such waiver is in writing and signed by the Legislature. No delay or omission on the part of the Legislature in exercising any rights or remedies shall operate as a waiver of such right or remedy or any other rights or remedies. A waiver on any one occasion shall not be construed as a bar or waiver of any right or remedy on future occasions.

Prohibition Against Assignment

Neither the Policy nor this Contract may be assigned by the Contractor, in whole or in part.

Warranties

The Contractor warrants that it is qualified and possesses the requisite skills, knowledge, experience and necessary staff to provide the services as stated in the RFP.

The Contractor warrants that, to the best of its knowledge, there is no pending or threatened action, proceeding, or investigation, or any other legal or financial condition, that would in any way prohibit, restrain, or diminish the Contractor's ability to satisfy its Contract obligations. The Contractor warrants that neither it nor any affiliate is currently on the convicted vendor list maintained pursuant to section 287.133, of the Florida Statutes, or on any other state or the federal government. The Contractor shall immediately notify the Legislature in writing if its ability to perform is compromised in any manner during the term of the Contract.

The Contractor warrants that the Services will be provided in a professional manner and in accordance with the standards generally observed in the industry for similar services and will be provided with reasonable skill and care. The Contractor warrants that it shall use reasonable endeavors to maintain continuity in its staff engaged to provide the Services. The Contractor will use all reasonable endeavors to ensure that the Services will be free from harmful programming, scripts, virus, spyware, backdoors or other deleterious components. The Contractor shall work with and cooperate with the Legislature's personnel and insureds. The Contractor will obey all pertinent rules and regulations in the industry for similar services.

Confidentiality and Safeguarding Information

Contractor or Contractor's employees may have access to confidential information. The provisions of the Florida Public Records Act, Chapter 119, F.S., and other applicable state and federal laws will govern disclosure of any confidential information.

Contractor must implement procedures to ensure the protection and confidentiality of all data, files, and records involved with this Contract.

Except as necessary to fulfill the terms of this Contract and with the permission of the Legislature, Contractor and Contractor's employees shall not divulge to third parties any confidential information obtained by Contractor or its agents, distributors, resellers, subcontractors, officers, or employees in the course of performing Contract work, including, but not limited to, security procedures, business operations information, or commercial proprietary information in the possession of the State or the Legislature.

Contractor and Contractor's employees agree not to use or disclose any information concerning a recipient of services under the State or the Legislature for any purpose not in conformity with state and federal law or regulations except upon written consent of the recipient, or his responsible parent or guardian when authorized by law, if applicable.

If Contractor or Contractor's employees have access to confidential information in order to fulfill Contractor's obligations under this Contract, Contractor agrees to abide by all applicable Legislative security procedures and policies. Contractor (including its employees, subcontractors, agents, or any other individuals to whom Contractor exposes confidential information obtained under this Contract), shall not store, or allow to be stored, any confidential information on any portable storage media (*e.g*., laptops, thumb drives, hard drives, *etc*.) or peripheral device with the capacity to hold information. Failure to strictly comply with this provision shall constitute a breach of contract.

Contractor shall notify the Legislature in writing of any disclosure of unsecured confidential information by Contractor, its employees, agents or representatives which is not in compliance with the terms of the Contract (of which it becomes aware). Contractor also shall report to the Legislature any Security Incidents of which it becomes aware, including those incidents reported to the Contractor by its sub-contractors or agents. For purposes of this Contract, "Security Incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of Legislative information in Contractor's possession or electronic interference with Legislative operations; however, random attempts at access shall not be considered a security incident. Contractor shall make a report to the Legislature not more than seven (7) business days after Contractor learns of such use or disclosure. Contractor's report shall identify, to the extent known: (i) the nature of the unauthorized use or disclosure, (ii) the confidential information used or disclosed, (iii) who made the unauthorized use or received the unauthorized disclosure, (iv) what Contractor has done or shall do to mitigate any deleterious effect of the unauthorized use or disclosure, and (v) what corrective action Contractor has taken or shall take to prevent future similar unauthorized use or disclosure.

In the event of a breach of security concerning confidential personal information involved with this Contract, Contractor shall comply with section 501.171, F.S. When notification to affected persons is required under this section of the statute, Contractor shall provide that notification, but only after receipt of the Legislature's approval of the contents of the notice. Defined statutorily, and for purposes of this Contract, "breach of security" or "breach" means the unauthorized access of data in electronic form

containing personal data. Good faith acquisition of personal information by an employee or agent of Contractor is not a breach, provided the information is not used for a purpose unrelated to Contractor's obligations under this Contract or is not subject to further unauthorized use.

Notices

All legal or other notices and other communications required or permitted to be given under this Contract other than routine operational communications must be in writing and must be hand delivered, or mailed via U.S. mail or express overnight courier with a reliable system for tracking delivery, or confirmed facsimile or electronic mail with a copy sent by another means specified herein, addressed to the respective parties as follows:

To Legislature: The Florida Legislature
Office of Legislative Services, Coordinator
111 West Madison Street, Suite 874
Tallahassee, FL 32399-1400

The Florida Legislature
General Counsel, Office of Legislative Services
111 West Madison Street, Suite 874
Tallahassee, FL 32399

To Contractor:

The effective date of any notice under this Contract shall be the date of delivery or refusal of such notice, and not the date of mailing.

Contract Manager

The Contract Manager on behalf of the Legislature is the OLS HR Director, 111 W. Madison Street, Suite 874, Tallahassee, FL 32399-1400. The Contract Manager on behalf of the Contractor is _____. All written and verbal approvals referenced in the Contract must be obtained from the parties' Contract Managers or their designees, and all notices must be given to the parties' Contract Managers.

Public Records

Unless specially exempted by law, all records made or received by the Contractor in conjunction with this Contract may be public records available for inspection by the public in accordance with the provisions of Article I, Section 24, Florida Constitution, and Section 11.0431, Florida Statutes. If the Contractor receives a request for public records, the Contractor shall immediately notify the Legislature's Contract Manager of the request. Upon request by the Legislature Contract Manager, the Contractor will provide a copy or all the public records to be copied or inspected within a reasonable amount of time. The Contractor shall coordinate the production of records to the requestor with the Legislature's Contract Manager. However,

in order to assure that records subject to any exemption are not disclosed, the Contractor shall not allow any inspection of or otherwise disclose any information found in said documents or records unless and until so directed by the Legislature's Contract Manager. Refusal of the Contractor to allow public access to such records after approved by the Legislature's Contract Manager shall constitute grounds for termination of this Contract.

The Contractor shall ensure that records that are exempt or confidential are not disclosed for the duration of the Contract and after the expiration of the Contract. Such records shall be kept in accordance with the Legislature's retention schedule.

Data Remains Property of the Legislature

All claim records and eligibility data used by Contractor relating to this Contract shall remain the property of the Legislature.

Performance Credits

All claim reports shall be due to the Legislature by the 10th of the following month (Due Date) and all loss reports shall be due to the Legislature by the 10th of the following quarter (Due Date).

Should the Contractor fail to meet any Due Date specified above, the Contractor will issue a Performance Credit of $250 for each calendar day that the report Due Date is not met. The Performance Credit will offset the total payment contained in the next invoice submitted to the Legislature. The Contractor will be excused for failing to meet any report Due Date to the extent that such failure is caused by the Legislature. The Legislature may waive payment of any Performance Credits.

Additionally, Contractor agrees to issue a credit to the Legislature in the amount of $1,000 per calendar day that the dental plan is not fully operational on the Effective Date of the Policy, January 1, 2017, at 12:01 a.m. EST.

Compliance with Law

Contractor shall monitor federal and state legislation affecting the delivery of services under the Policy and promptly report to the Legislature on those issues prior to the effective date of any mandated changes. Contractor shall provide interpretation as to the impact of such laws or regulations under the Policy, and Contractor shall absorb the cost of programming all benefit design changes.

Entire Contract

This Contract constitutes the entire understanding of the parties to it and supersedes any prior Contracts, written or oral, related to the same subject matter. This Contract cannot be changed except in writing by the signature of both parties. However, reasonable changes to the Policy Administration may occur upon written request and justification by the Contractor and written approval by the Legislature's Contract Manager.

Execution in Counterparts

The Contract may be executed in counterparts, each of which shall be an original and all of which shall constitute one and the same contract. Delivery of an executed counterpart of a signature page to the Contract by e-mail, facsimile or other electronic transmission shall be effective as delivery of a manually executed counterpart.

Executed at Tallahassee, Florida, on the dates shown below.

The Florida Senate:

_____

By: _____

Title: _____

Date: _____

The Florida House of Representatives:

_____

By: _____

Title: _____

Date: _____

Contractor:

_____

By: _____

Title: _____

Date:_____

Attachment A
Current Group Dental Insurance Policy

AMERITAS LIFE INSURANCE CORP.
A UNIFI Company

A STOCK COMPANY
LINCOLN, NEBRASKA

GROUP DENTAL INSURANCE POLICY

The Policyholder	**FLORIDA LEGISLATURE**		
		Policy Number	**10-377396**
State of Delivery	**Florida**	**Plan Effective Date**	**May 1, 1998**
		Plan Change Effective Date	**January 1, 2010**
Premium Due Date 1st of each month.		**Renewal Date**	**January 1, 2011**

Ameritas Life Insurance Corp. agrees to pay, with respect to each Insured Person, the group insurance benefits provided in this policy.

This policy is issued to the Policyholder in consideration of the Policyholder's application and the payment of premiums, as provided herein.

This policy is delivered in and governed by the laws of the state of delivery.

If you should have any questions regarding your coverage or claim payments, you may contact us toll-free at 800-487-5553.

AMERITAS LIFE INSURANCE CORP.

Jan M. Connolly
Secretary

JoAnn M Martin
President

9000 FL Ed. 03-08

Ameritas

Ameritas Life Insurance Corp.

PO BOX 81889 / LINCOLN NE 68501-1889
800-659-2223

January 4, 2016

Address Service Requested . .

FLORIDA LEGISLATURE
BARBARA GLEASMAN
RM 701 CLAUDE PEPPER BL
111 W MADISON ST RM 701
TALLAHASSEE, FL 32399-6588

AMENDMENT RIDER

To be attached to and made a part of Group Policy Number 010-377396.

Issued to FLORIDA LEGISLATURE

It is hereby agreed that this policy is amended as follows:

1) The section entitled "TABLE OF MONTHLY PREMIUM RATES", on 9050 is deleted and the following is substituted:

Table of Monthly Premium Rates

CLASSES 01, 99		
Dental Care Insurance		
	$36.66	per Insured Person
	$43.12	per Dependent Unit
CLASSES 01, 99		
Orthodontic Insurance		
	$0.56	per Insured Person
	$6.14	per Dependent Unit

This Amendment Rider is effective January 1, 2016. Please verify the rates and place the rider with your Group Policy. A copy of this correspondence is being sent to the Policyholder, Broker, and appropriate Group Office.

We hope you have been satisfied with the service you have received from us. We appreciate your business and look forward to providing you with excellent service for many years to come. If there is anything we can do to better meet your needs, please let us know. We are always happy to answer your questions or assist you in any way we can.

Ameritas Life Insurance Corp.

JoAnn M Martin

President

c: TAMPA GROUP OFFICE

AMENDMENT RIDER

To be attached to and made a part of Group Policy Number 377396 and each Certificate of Insurance issued under such policy.

Issued to The Florida Legislature

It is hereby agreed that this policy and certificates issued under such policy are amended as follows:

1) The section entitled "TABLE OF MONTHLY PREMIUM RATES", on 9050 is deleted and the following is substituted:

TABLE OF MONTHLY PREMIUM RATES

Dental Care Insurance	$34.96 per Insured Person
	$41.12 per Dependent Unit
Orthodontic Insurance	$0.52 per Insured Person
	$5.84 per Dependent Unit

Rider is effective January 1, 2013.

Ameritas Life Insurance Corp.

JoAnn M Martin

JoAnn M. Martin
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 Control
Address:	P.O. Box 82657
	Lincoln, NE 68501-2657
Phone:	877-897-4328
Fax:	402-309-2579

The complaint will be carefully reviewed. If the initial claim was denied based on dental necessity or paid as an alternate benefit, then a licensed dentist 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
Florida Office of Insurance Regulation
200 East Gaines Street
Tallahassee, FL 32399-0300
(850) 413-3030

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	Employee Classified As An Elected Legislative Official Or Active Full-time Salaried Employee Of The Legislative Branch Of The State Of Florida
Class 99	Cobra For Child Only

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:

When a Participating Provider is used:	
Type 1, Type 2, and Type 3 Procedures	$0
When a Non-Participating Provider is used:	
Type 1 Procedures	$0
Combined Type 2 and Type 3 Procedures - Each Benefit Period	$50

	Participating Provider	Non-Participating Provider
Coinsurance Percentage:		
Type 1 Procedures	100%	100%
Type 2 Procedures	80%	80%
Type 3 Procedures	50%	50%

When a Non-Participating Provider is used:	
Maximum Amount - Each Benefit Period	$1,500
When a Participating Provider is used:	
Maximum Amount - Each Benefit Period	$1,500

ORTHODONTIC EXPENSE BENEFITS

Deductible Amount - Once per lifetime	$0
Coinsurance Percentage	50%
Maximum Benefit During Lifetime	$1,500

INCREASED DENTAL MAXIMUM BENEFIT

Carry Over Amount Per Insured Person – Each Benefit Period	$250
PPO Bonus – Each Benefit Period	$150
Benefit Threshold Per Insured Person – Each Benefit Period	$750
Maximum Carry Over Amount	$1,000

After the first Benefit Period following the coverage effective date, the Maximum Amount for Dental Expenses Per Insured Person as shown in the Schedule of Benefits may be increased by the Carry Over Amount if:

a) The Insured Person has submitted a claim for dental expenses incurred during the preceding Benefit Period; and

b) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

After the first Benefit Period following the coverage effective date, the Carry Over Amount will be increased by the PPO Bonus if:

a) The insured person has submitted a claim for dental expenses incurred during the preceding benefit period, and

b) At least one of the claims submitted by the insured person for dental expenses incurred during the preceding benefit period were expenses resulting from services rendered by a Participating Provider, and

c) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

In each succeeding Benefit Period in which the total dental expense benefits paid do not exceed the Benefit Threshold, the Insured Person will be eligible for the Carry Over Amount and the PPO Bonus.

The Carry Over Amount and the PPO Bonus can be accumulated from one Benefit Period to the next up to the Maximum Carry Over amount unless:

a) During any Benefit Period, dental expense benefits are paid in excess of the Threshold. In this instance, there will be no additional Carry Over Amount or PPO Bonus for that Benefit Period; or

b) During any Benefit Period, no claims for dental expenses incurred during the preceding Benefit Period are submitted. In this instance, there will be no Carry Over Amount or PPO Bonus for that Benefit Period, and any accumulated Carry Over Amounts, including any PPO Bonuses from previous Benefit Periods will be forfeited.

Eligibility for the Carry Over Amount and the PPO Bonus will be established or reestablished at the time the first claim in a Benefit Period is received for dental expenses incurred during that Benefit Period.

In order to properly calculate the Carry Over Amount and/or the PPO Bonus, claims should be submitted timely in accordance with the Proof of Loss provision found within the General Provisions. You have the right to request review of prior Carry Over Amount or PPO Bonus calculations. The request for review must be within 24 months from the date the Carry Over Amount or the PPO Bonus was established.

PREMIUMS

TABLE OF MONTHLY PREMIUM RATES

Dental Care Insurance	$34.12 per Insured Person
	$40.00 per Dependent Unit
Orthodontic Insurance	$0.48 per Insured Person
	$5.68 per Dependent Unit

ASSOCIATED GROUPS

THE FLORIDA LEGISLATURE
AUDITOR GENERAL STATE OF FLORIDA
EXECUTIVE OFFICE OF THE GOVERNOR
AGENCY FOR WORKFORCE INNOVATION
FLORIDA DEPARTMENT OF MANAGEMENT SERVICE

PAYMENT OF PREMIUMS. The first premium will be due on the Policy Effective Date to cover the period from that date to the first Premium Due Date. Other premiums will be due on or before each Premium Due Date. Premiums are payable at our Home Office or at some other location to which we and the Policyholder agree.

PREMIUM DUE DATE. The Premium Due Date will be the first day of the month that falls on or after the Policy Effective Date. If we agree with the Policyholder to the payment of premiums on a basis other than monthly, the Premium Due Date will be fixed to match the correct basis. If there is a change in the method of payment or Premium Due Date, a pro-rata charge in the premium due will be made.

PREMIUM STATEMENTS. The premium due as of any Premium Due Date is the number of units in force on such date for each type of insurance multiplied by the rate shown in the Table of Premium Rates. A premium statement will be made as of the Premium Due Date showing the premium payable. If premiums are payable on other than a monthly basis, each statement will show any pro-rata premium charges and credits in the last premium period due to changes in the number of Insureds and in the amount of insurance for which people are insured. This is subject to the rules below.

SIMPLIFIED ACCOUNTING. The premium will start on the Premium Due Date falling on or after the date the insurance or the increase in the insurance is effective for: a) a person becoming insured; or b) an increase in the amount of insurance on any person. The premium will stop on the Premium Due Date falling on or after the date of termination of insurance or through the date of service of the last paid claim. There will be no pro-rata charges or credits for a partial month. If premiums are payable other than monthly, charges and credits will be figured as though the Premium Due Date is monthly.

We will be liable for the return of unearned premiums to the Policyholder only for the 12 months before the date we receive evidence that a return is due.

ADJUSTMENTS IN PREMIUM RATES. We may change the rates shown in the Table of Premium Rates by giving the Policyholder at least 45 days advance written notice. We may change the rates at any time the Schedule of Benefits, or any other terms and conditions of the policy, are changed. We will not change the rates

until the Renewal Date shown on the policy cover or more than once in any 12 month period thereafter, unless there is a change in the Schedule of Benefits or a change in any other terms and conditions in the policy.

Notwithstanding the above, the Company reserves the right to change any one or more of the rates prior to the Renewal Date or more than once in any 12 month period thereafter upon the occurrence of one or both of the following:

1. We determine that the average number of dependent children for each Insured with Dependent coverage exceeds 4.0; and/or

2. We determine that the number of Insureds is less than 80% of the number of Insureds covered under the Policy as of either (i) the Plan Effective Date, if during the period of time between the Plan Effective Date and the Renewal Date, or (ii) the most recent 12 month anniversary of the Renewal Date.

Should either or both of the above occur and should we elect to change rates as a result, we agree to notify the Policyholder of the corresponding rate changes at least 45 days in advance of the Premium Due Date for which the rate change shall be effective. The right to change rates as well as the timing of such changes in the above two limited situations shall at all times be subject to applicable state laws and regulations.

RENEWAL DATE refers to the date each calendar year that the coverage issued under the group policy is considered for renewal. The Renewal Date(s) are shown on the policy cover.

DEFINITIONS

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

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

INSURED refers to a person:

a. who is a Member of the eligible class; and

b. who has qualified for insurance by completing the eligibility period, if any; and

c. for whom the insurance has become effective.

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

DEPENDENT refers to:

a. an Insured's spouse.

b. each child for whom the Insured or the Insured's spouse, is legally responsible, including:

i. natural born children;

ii. 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.

iii. children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

The child must be dependent upon the certificateholder for support and either living in the household of the certificateholder or is a full or part-time student.

A child ceases to be a dependent at the end of the calendar year in which the child:

i. ceases to be dependent on the policyholder or certificateholder for support;

ii. attains the age of 25; or

iii. ceases to live in the household of the policyholder or certificateholder and is not a full-time or part-time student

A child may still be deemed to be a dependent through the end of the calendar year in which the child turns 30 years of age, so long as the child:

i. maintains full-time or part-time status as a student or is a resident of Florida

ii. Is unmarried and does not have a dependent of his or her own; and

iii. Is not provided coverage as a named subscriber;

A child will be deemed to be a dependent so long as the child

i. is Totally Disabled due to mental or physical reasons; and

ii. becomes Totally Disabled 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 mental retardation 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.

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 employee classified as an elected legislative official or active full-time salaried employee of the legislative branch of the state of florida 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.

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

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the first of the month following 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 31 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 31-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 employee classified as an elected legislative official or active full-time salaried employee of the legislative branch of the state of florida 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.

Any husband or wife 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 not required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured is not required to contribute to the payment of insurance premiums for his or her dependents.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the policy, qualification will occur on the first of the month following the date of employment.

For persons who become Members after the Plan Effective Date of the policy, qualification will occur on the first of the month following the date of employment.

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

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

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

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.

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

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

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

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

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

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

i. the person was insured under a policy of group insurance providing like benefits which ended on the day immediately before the Effective Date of the policy providing this coverage; and

ii. the person is considered a Member or an eligible Dependent under the policy providing this coverage; and had the prior policy contained the same definition of eligibility, would have been a Member or Dependent under the prior policy.

TERMINATION DATES

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

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

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

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

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

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

DENTAL EXPENSE BENEFITS

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

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. The Insured person may select a Participating Provider or a Non-Participating Provider. A Participating Provider agrees to provide services at a discounted fee to our Insureds. A Non-Participating Provider is any other 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.

CONTINUATION. The coverage provided under this policy replaces former policy 049024, which was in effect April 30, 1998. Therefore, the following provisions apply:

a. any time limitations contained in this policy which makes a direct or implied reference to the Effective Date will be applied as if it referred to the Effective Date of the former policy if the former policy contained a similar time limitation.

b. this policy will be considered a continuation of the former policy for the purpose of determining eligibility and applying deductible amounts, coinsurance percentages and maximum amounts.

benefits for claims incurred prior to May 1, 1998, will be determined in accordance with the provisions of the former policy only.

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 limited to the lesser of:

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

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 your 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 general 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 x-ray films, 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 prosthetic crown, appliance, or fixed partial denture. 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, x-ray films 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 a maximum of $100 during the first benefit period for Type 1, 2 and 3 procedures.

2. for initial placement of any prosthetic crown, appliance, or fixed partial denture 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 prosthetic crown, appliance, or fixed partial denture must include the replacement of the extracted tooth or teeth.

3. for appliances, restorations, or procedures to:

    a. alter vertical dimension;
    b. restore or maintain occlusion; or
    c. splint or replace tooth structure lost as a result of abrasion or attrition.

4. for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.

5. to replace lost or stolen appliances.

6. for any treatment which is for cosmetic purposes.

7. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)

8. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).

9. for which the Insured person is paid benefits under any workmen’s compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

10. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.

11. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

12. because of war or any act of war, declared or not.

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 Benefit Year. A Benefit Year runs from September 1 through August 31.
- Ø Benefit Period means the period from September 1 of any year through August 31 of the next year. But during the first year a person is insured, a benefit period means the period from his or her effective date through August 31 of the next year
- Ø Covered Procedures are subject to all plan provisions, procedure and frequency limitations, and/or consultant review.
- Ø Reference to "traumatic injury" under this plan is defined as injury caused by external forces (ie. outside the mouth) and specifically excludes injury caused by internal forces such as bruxism (grinding of teeth).
- Ø Benefits for replacement prosthetic crown, appliance, or fixed partial denture 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 X-ray films, periodontal charting and supporting diagnostic data may be requested for our review.
- Ø We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive by our 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 - PARTICIPATING PROVIDERS - Maximum Allowable Charge

BENEFIT PERIOD - Benefit 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 2 year(s).
- Benefits will not be considered if performed on the same date as a D3220 or D9110.

ROUTINE EVALUATION: D0120, D0145

- Coverage is limited to 1 of any of these procedures per 5 month(s).
- Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under. Coverage will not be allowed if performed on the same date as a D9110.

LIMITED ORAL EVALUATION

D0140 Limited oral evaluation - problem focused.

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

COMPLETE SERIES OR PANORAMIC FILM

D0210 Intraoral - complete series (including bitewings).

D0330 Panoramic film.

COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330, D0340

- Coverage is limited to 1 of any of these procedures per 2 year(s).

OTHER XRAYS

D0220 Intraoral - periapical first film.

D0230 Intraoral - periapical each additional film.

D0240 Intraoral - occlusal film.

D0250 Extraoral - first film.

D0260 Extraoral - each additional film.

OCCLUSAL FILM: D0240

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

PERIAPICAL FILMS: D0220, D0230

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

BITEWING FILMS

D0270 Bitewing - single film.

D0272 Bitewings - two films.

D0273 Bitewings - three films.

D0274 Bitewings - four films.

D0277 Vertical bitewings - 7 to 8 films.

BITEWING FILMS: D0270, D0272, D0273, D0274

- Coverage is limited to 1 of any of these procedures per 5 month(s).
- D0277, also contribute(s) to this limitation.
- Coverage will not be considered if performed on the same date as a D0210. The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWING FILM: D0277

- Coverage is limited to 1 of any of these procedures per 2 year(s).
- Benefits will not be considered if performed on the same date as a D0210.

ORAL PATHOLOGY/LABORATORY

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

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

TYPE 1 PROCEDURES

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

PROPHYLAXIS (CLEANING) AND FLUORIDE

D1110 Prophylaxis - adult.
D1120 Prophylaxis - child.
D1203 Topical application of fluoride - child.
D1204 Topical application of fluoride - adult.
D1206 Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.

FLUORIDE: D1203, D1204, D1206

- Coverage is limited to 1 of any of these procedures per 5 month(s).
- Benefits are considered for persons age 18 and under.
- An adult fluoride is considered for individuals age 14 and over. A child fluoride is considered for individuals age 13 and under.

PROPHYLAXIS: D1110, D1120

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

SPACE MAINTAINERS

D1510 Space maintainer - fixed - unilateral.
D1515 Space maintainer - fixed - bilateral.
D1520 Space maintainer - removable - unilateral.
D1525 Space maintainer - removable - bilateral.
D1550 Re-cementation of space maintainer.
D1555 Removal of fixed space maintainer.

SPACE MAINTAINER: D1510, D1515, D1520, D1525

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

PERIODONTAL MAINTENANCE

D4910 Periodontal maintenance.

PERIODONTAL MAINTENANCE: D4910

- Coverage is limited to 1 of any of these procedures per 5 month(s).
- D1110, D1120, also contribute(s) to this limitation.
- Coverage is contingent upon evidence of full mouth active periodontal therapy. Benefits are not available if performed on the same date as any other periodontal procedure.

SURGICAL EXTRACTIONS

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.

BIOPSY OF ORAL TISSUE

D7285 Biopsy of oral tissue - hard (bone, tooth).
D7286 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 films.

TYPE 1 PROCEDURES

ANESTHESIA-GENERAL/IV

D9220 Deep sedation/general anesthesia - first 30 minutes.
D9221 Deep sedation/general anesthesia - each additional 15 minutes.
D9241 Intravenous conscious sedation/analgesia - first 30 minutes.
D9242 Intravenous conscious sedation/analgesia - each additional 15 minutes.

GENERAL ANESTHESIA: D9220, D9221, D9241, D9242

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

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310 Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.
D9430 Office visit for observation (during regularly scheduled hours) - no other services performed.
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

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

NON-SURGICAL MISCELLANEOUS

D0340 Cephalometric film.

COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330, D0340

- Coverage is limited to 1 of any of these procedures per 2 year(s).

MISCELLANEOUS

D0460 Pulp vitality tests.

MISCELLANEOUS

D0486 Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report.

TYPE 2 PROCEDURES

PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge

BENEFIT PERIOD - Benefit Year

For Additional Limitations - See Limitations

SEALANT

D1351 Sealant - per tooth.

SEALANT: D1351

- Coverage is limited to 1 of any of these procedures per 4 year(s).
- Benefits are considered for persons age 16 and under.
- Benefits are considered on permanent molars only.
- Coverage is allowed on the occlusal surface only.

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, 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.

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

- 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.

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, D2930, D2931, D2932, D2933, D2934

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

SEDATIVE FILLING

D2940 Sedative filling.

PULP CAP

D3110 Pulp cap - direct (excluding final restoration).

TYPE 2 PROCEDURES

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 Apexication/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.).
D3353 Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).
D3450 Root amputation - per root.
D3920 Hemisection (including any root removal), not including root canal therapy.

ENDODONTICS MISCELLANEOUS: D3333, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

D3310 Endodontic therapy, anterior tooth.
D3320 Endodontic therapy, bicuspid tooth.
D3330 Endodontic therapy, molar.
D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.
D3346 Retreatment of previous root canal therapy - anterior.
D3347 Retreatment of previous root canal therapy - bicuspid.
D3348 Retreatment of previous root canal therapy - molar.

ROOT CANALS: D3310, D3320, D3330, D3332

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

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

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

SURGICAL ENDODONTICS

D3410 Apicoectomy/periradicular surgery - anterior.
D3421 Apicoectomy/periradicular surgery - bicuspid (first root).
D3425 Apicoectomy/periradicular surgery - molar (first root).
D3426 Apicoectomy/periradicular surgery (each additional root).

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.

TYPE 2 PROCEDURES

D4260 Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.
D4261 Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.
D4263 Bone replacement graft - first site in quadrant.
D4264 Bone replacement graft - each additional site in quadrant.
D4265 Biologic materials to aid in soft and osseous tissue regeneration.
D4266 Guided tissue regeneration - resorbable barrier, per site.
D4267 Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal).
D4270 Pedicle soft tissue graft procedure.
D4271 Free soft tissue graft procedure (including donor site surgery).
D4273 Subepithelial connective tissue graft procedures, per tooth.
D4274 Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area).
D4275 Soft tissue allograft.
D4276 Combined connective tissue and double pedicle graft, per tooth.

BONE GRAFTS: D4263, D4264, D4265
- Each quadrant is limited to 1 of any of these procedures per 3 year(s).
- D4210, D4211, D4240, D4241, D4260, D4261, D4266, D4267, D4270, D4271, D4273, D4274, D4275, D4276, also contribute(s) to this limitation.
- Coverage is limited to treatment of periodontal disease.

DISTAL WEDGE: D4274
- Each quadrant is limited to 1 of any of these procedures per 3 year(s).
- D4210, D4211, D4240, D4241, D4260, D4261, D4263, D4264, D4265, D4266, D4267, D4270, D4271, D4273, D4275, D4276, also contribute(s) to this limitation.
- Coverage is limited to treatment of periodontal disease.

GINGIVECTOMY: D4210, D4211
- Each quadrant is limited to 1 of any of these procedures per 3 year(s).
- D4240, D4241, D4260, D4261, D4263, D4264, D4265, D4266, D4267, D4270, D4271, D4273, D4274, D4275, D4276, also contribute(s) to this limitation.
- Coverage is limited to treatment of periodontal disease.

GUIDED TISSUE REGENERATION: D4266, D4267
- Each quadrant is limited to 1 of any of these procedures per 3 year(s).
- D4210, D4211, D4240, D4241, D4260, D4261, D4263, D4264, D4265, D4270, D4271, D4273, D4274, D4275, D4276, also contribute(s) to this limitation.
- Coverage is limited to treatment of periodontal disease.

OSSEOUS SURGERY: D4240, D4241, D4260, D4261
- Each quadrant is limited to 1 of any of these procedures per 3 year(s).
- D4210, D4211, D4263, D4264, D4265, D4266, D4267, D4270, D4271, D4273, D4274, D4275, D4276, also contribute(s) to this limitation.
- Coverage is limited to treatment of periodontal disease.

TISSUE GRAFTS: D4270, D4271, D4273, D4275, D4276
- Each quadrant is limited to 1 of any of these procedures per 3 year(s).
- D4210, D4211, D4240, D4241, D4260, D4261, D4263, D4264, D4265, D4266, D4267, D4274, also contribute(s) to this limitation.
- Coverage is limited to treatment of periodontal disease.

CROWN LENGTHENING

D4249 Clinical crown lengthening - hard tissue.

CROWN LENGTHENING: D4249
- Coverage is limited to 1 of any of these procedures per 3 year(s).

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 3 year(s).

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342
- Each quadrant is limited to 1 of each of these procedures per 12 month(s).

TYPE 2 PROCEDURES

FULL MOUTH DEBRIDEMENT

D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis.

FULL MOUTH DEBRIDEMENT: D4355

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

NON-SURGICAL EXTRACTIONS

D7111 Extraction, coronal remnants - deciduous tooth.

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

SURGICAL EXTRACTIONS

D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.

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

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.

D7280 Surgical access of an unerupted tooth.

D7282 Mobilization of erupted or malpositioned tooth to aid eruption.

D7283 Placement of device to facilitate eruption of impacted tooth.

D7290 Surgical repositioning of teeth.

D7291 Transseptal fiberotomy/supra crestal fiberotomy, by report.

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.

D7460 Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.

D7461 Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.

D7465 Destruction of lesion(s) by physical or chemical method, by report.

D7471 Removal of lateral exostosis (maxilla or mandible).

D7472 Removal of torus palatinus.

D7473 Removal of torus mandibularis.

D7485 Surgical reduction of osseous tuberosity.

TYPE 2 PROCEDURES

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 (frenectomy or frenotomy) - separate procedure.
D7963 Frenuloplasty.
D7970 Excision of hyperplastic tissue - per arch.
D7971 Excision of pericoronal gingiva.
D7972 Surgical reduction of fibrous tuberosity.

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

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

BONE AUGMENTATION

D7950 Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report.
D7951 Sinus augmentation with bone or bone substitutes.
D7953 Bone replacement graft for ridge preservation - per site.

ANESTHESIA-LOCAL/NITROUS

D9210 Local anesthesia not in conjunction with operative or surgical procedures.
D9211 Regional block anesthesia.
D9215 Local anesthesia.
D9230 Analgesia, anxiolysis, inhalation of nitrous oxide.

THERAPEUTIC DRUG

D9610 Therapeutic parenteral drug, single administration.
D9612 Therapeutic parenteral drugs, two or more administrations, different medications.
D9630 Other drugs and/or medicaments, by reports.

OCCLUSAL ADJUSTMENT

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

OCCLUSAL ADJUSTMENT: D9951, D9952

- Coverage is limited to 1 of each of these procedures per 3 year(s).
- Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.

NON-SURGICAL MISCELLANEOUS

D0470 Diagnostic casts.

MISCELLANEOUS

D2951 Pin retention - per tooth, in addition to restoration.
D5982 Surgical stent.
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, 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 - PARTICIPATING PROVIDERS - Maximum Allowable Charge

BENEFIT PERIOD - Benefit Year

For Additional Limitations - See Limitations

INLAY RESTORATIONS

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

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

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

ONLAY RESTORATIONS

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

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

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.

CROWNS SINGLE RESTORATIONS

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

TYPE 3 PROCEDURES

D2794 Crown - titanium.
D2799 Provisional crown.

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

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.

RECEMENT

D2910 Recement inlay, onlay, or partial coverage restoration.
D2915 Recement cast or prefabricated post and core.
D2920 Recement crown.
D6092 Recement implant/abutment supported crown.
D6093 Recement implant/abutment supported fixed partial denture.
D6930 Recement fixed partial denture.

RECEMENT FIXED PARTIAL DENTURE: D6092, D6093, D6930

- Coverage is limited to 2 of each of these procedures per 2 year(s).

CORE BUILD-UP

D2950 Core buildup, including any pins.
D6973 Core build up for retainer, including any pins.

POST AND CORE

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

VENEERS

D2960 Labial veneer (resin laminate) - chairside.
D2961 Labial veneer (resin laminate) - laboratory.
D2962 Labial veneer (porcelain laminate) - laboratory.

LABIAL VENEERS: D2960, D2961, D2962

- Frequency is waived for accidental injury.
- Benefits are considered on anterior teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.

TEMPORARY CROWN

D2970 Temporary crown (fractured tooth).

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980 Crown repair, by report.
D6980 Fixed partial denture repair, by report.
D9120 Fixed partial denture sectioning.

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).

TYPE 3 PROCEDURES

D5213 Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).
D5214 Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).
D5225 Maxillary partial denture - flexible base (including any clasps, rests and teeth).
D5226 Mandibular partial denture - flexible base (including any clasps, rests and teeth).
D5281 Removable unilateral partial denture - one piece cast metal (including clasps and teeth).
D5670 Replace all teeth and acrylic on cast metal framework (maxillary).
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).
D5860 Overdenture - complete, by report.
D5861 Overdenture - partial, by report.
D6053 Implant/abutment supported removable denture for completely edentulous arch.
D6054 Implant/abutment supported removable denture for partially edentulous arch.
D6078 Implant/abutment supported fixed denture for completely edentulous arch.
D6079 Implant/abutment supported fixed denture for partially edentulous arch.

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5860, D6053, D6078

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5860, D6053, and D6078 are considered at an alternate benefit of a D5110/D5120.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5225, D5226, D5281, D5670, D5671, D5861, D6054, D6079

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5861, D6054, and D6079 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS

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

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

- Each arch is limited to 1 of each of these procedures per 12 month(s).
- Coverage is limited to dates of service more than 6 months after placement date.

DENTURE REPAIR

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

ADD TOOTH/CLASP TO EXISTING PARTIAL

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

DENTURE REBASES

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

TYPE 3 PROCEDURES

D5721 Rebase mandibular partial denture.

DENTURE REBASE: D5710, D5711, D5720, D5721

- Each arch is limited to 1 of any of these procedures per 12 month(s).
- Coverage is limited to dates of service more than 6 months after placement date.

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

- Each arch is limited to 1 of any of these procedures per 12 month(s).
- Coverage is limited to service dates more than 6 months after placement date.

TISSUE CONDITIONING

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

TISSUE CONDITIONING: D5850, D5851

- Coverage is limited to 1 of each of these procedures per 2 year(s).
- Coverage is limited to dates of service more than 12 months after placement of partial or complete denture.

PROSTHODONTICS - FIXED

D6058 Abutment supported porcelain/ceramic crown.
D6059 Abutment supported porcelain fused to metal crown (high noble metal).
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal).
D6061 Abutment supported porcelain fused to metal crown (noble metal).
D6062 Abutment supported cast metal crown (high noble metal).
D6063 Abutment supported cast metal crown (predominantly base metal).
D6064 Abutment supported cast metal crown (noble metal).
D6065 Implant supported porcelain/ceramic crown.
D6066 Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).
D6067 Implant supported metal crown (titanium, titanium alloy, high noble metal).
D6068 Abutment supported retainer for porcelain/ceramic FPD.
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal).
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal).
D6072 Abutment supported retainer for cast metal FPD (high noble metal).
D6073 Abutment supported retainer for cast metal FPD (predominantly base metal).
D6074 Abutment supported retainer for cast metal FPD (noble metal).
D6075 Implant supported retainer for ceramic FPD.
D6076 Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).
D6077 Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).
D6094 Abutment supported crown - (titanium).
D6194 Abutment supported retainer crown for FPD - (titanium).
D6205 Pontic - indirect resin based composite.
D6210 Pontic - cast high noble metal.
D6211 Pontic - cast predominantly base metal.

TYPE 3 PROCEDURES

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.
D6253 Provisional pontic.
D6545 Retainer - cast metal for resin bonded fixed prosthesis.
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis.
D6600 Inlay - porcelain/ceramic, two surfaces.
D6601 Inlay - porcelain/ceramic, three or more surfaces.
D6602 Inlay - cast high noble metal, two surfaces.
D6603 Inlay - cast high noble metal, three or more surfaces.
D6604 Inlay - cast predominantly base metal, two surfaces.
D6605 Inlay - cast predominantly base metal, three or more surfaces.
D6606 Inlay - cast noble metal, two surfaces.
D6607 Inlay - cast noble metal, three or more surfaces.
D6608 Onlay - porcelain/ceramic, two surfaces.
D6609 Onlay - porcelain/ceramic, three or more surfaces.
D6610 Onlay - cast high noble metal, two surfaces.
D6611 Onlay - cast high noble metal, three or more surfaces.
D6612 Onlay - cast predominantly base metal, two surfaces.
D6613 Onlay - cast predominantly base metal, three or more surfaces.
D6614 Onlay - cast noble metal, two surfaces.
D6615 Onlay - cast noble metal, three or more surfaces.
D6624 Inlay - titanium.
D6634 Onlay - titanium.
D6710 Crown - indirect resin based composite.
D6720 Crown - resin with high noble metal.
D6721 Crown - resin with predominantly base metal.
D6722 Crown - resin with noble metal.
D6740 Crown - porcelain/ceramic.
D6750 Crown - porcelain fused to high noble metal.
D6751 Crown - porcelain fused to predominantly base metal.
D6752 Crown - porcelain fused to noble metal.
D6780 Crown - 3/4 cast high noble metal.
D6781 Crown - 3/4 cast predominantly base metal.
D6782 Crown - 3/4 cast noble metal.
D6783 Crown - 3/4 porcelain/ceramic.
D6790 Crown - full cast high noble metal.
D6791 Crown - full cast predominantly base metal.
D6792 Crown - full cast noble metal.
D6793 Provisional retainer crown.
D6794 Crown - titanium.

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

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.

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

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

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

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

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, 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.

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

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

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

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

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

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

CAST POST AND CORE FOR PARTIALS

D6970 Post and core in addition to fixed partial denture retainer, indirectly fabricated.

D6972 Prefabricated post and core in addition to fixed partial denture retainer.

ORTHODONTIC EXPENSE BENEFITS

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.

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 your 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 active appliances are inserted. A Program will end when the services are done, or after eight calendar quarters starting with the day the appliances were inserted, whichever is earlier.

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

a. at the end of every quarter (three-month period) of a Program for an Insured who pursues a Program, but not beyond the date the Program ends; or

b. at the time the service is rendered for an Insured who incurs Covered Expenses but does not pursue a Program.

The Covered Expenses for a Program are based on the estimated cost of the Insured's Program. They are pro-rated by quarter (three-month periods) over the estimated length of the Program, up to a maximum of eight quarters. However, the first payment will be 25 percent of the total allowed Covered Expense. The last quarterly payment for a Program may be changed if the estimated and actual cost of the Program differ.

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

1. for a Program begun before the Insured became covered under this section.

2. in the first 36 months that a person is insured if the person is a Late Entrant except for a maximum payment of $300.

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 or stolen appliances.

COORDINATION OF BENEFITS

This section applies if an Insured person has dental coverage under more than one Plan definition below. All benefits provided under this policy are subject to this section.

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

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

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

1. "Plan" refers to the group policy and any of the following plans, whether insured or uninsured, providing benefits for dental services or supplies:

    a. Any group or blanket insurance policy.

    b. Any group Blue Cross, group Blue Shield, or group prepayment arrangement.

    c. Any labor/management, trusteed plan, labor organization, employer organization, or employee organization plan, whether on an insured or uninsured basis.

    d. Any coverage under a governmental plan that allows coordination of benefits, or any coverage required or provided by law. This does **not** include a state plan under Medicaid (TitleXVIII and XIX of the Social Security Act as enacted or amended). It also does not include any plan whose benefits by law are excess to those of any private insurance program or other non-governmental program.

2. "Plan" does **not** include the following:

    a. Individual or family benefits provided through insurance contracts, subscriber contracts, coverage through individual HMOs or other prepayment arrangements.

    b. Coverages for school type accidents only, including athletic injuries.

3. "Allowable Expense" refers to any necessary, reasonable and customary item of expense at least a portion of which is covered under at least one of the Plans covering the Insured person for whom that claim is made. When a Plan provides services rather than cash payments, the reasonable cash value of each service will be both an Allowable Expense and a benefit paid. Benefits payable under another Plan include benefits that would have been payable had a claim been made for them.

4. "Claim Determination Period" refers to a Benefit Period, but does not include any time during which a person has no coverage under this Plan.

5. "Custodial Parent" refers to a parent awarded custody of a minor child by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than half of the calendar year without regard to any temporary visitation.

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

1. A Plan that does not have a coordination of benefits provision is always considered primary and will pay benefits first.

2. If a Plan also has a coordination of benefits provision, the first of the following rules that describe which Plan pays its benefits before another Plan is the rule to use:

    a. The benefits of a Plan that covers a person as an employee, member or subscriber are determined before those of a Plan that covers the person as a dependent.

    b. If a Dependent child is covered by more than one Plan, then the primary Plan is the Plan of the parent whose birthday is earlier in the year if:

        i. the parents are married;

        ii. the parents are not separated (whether or not they ever have been married); or

        iii. a court decree awards joint custody without specifying that one party has the responsibility to provide Dental coverage.

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

    c. If the Dependent child is covered by divorced or separated parents under two or more Plans, benefits for that Dependent child will be determined in the following order:

        i. the Plan of the Custodial Parent;

        ii. the Plan of the spouse of the Custodial Parent;

        iii. the Plan of the non-Custodial Parent; and then

        iv. the Plan of the spouse of the non-Custodial Parent.

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

    d. The benefits of a Plan that cover a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a Plan that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.

    e. If a person whose coverage is provided under a right of continuation provided by a federal or state law also is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.

    f. The benefits of a Plan that has covered a person for a longer period will be determined first.

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

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

1. Release any information with respect to your coverage and benefits under the policy; and

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

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

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

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

GENERAL PROVISIONS

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

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

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

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

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

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.

GENERAL PROVISIONS (CONTINUED)

CONFORMITY WITH LAW. Any policy provision that conflicts with the laws of the state in which the policy is issued, when the policy is issued, is automatically changed to meet the minimum requirements of those laws.

ENTIRE CONTRACT. The policy and the application of the Policyholder constitute the entire contract between the parties. A copy of the Policyholder's application is attached to the policy when issued. All statements made by the Policyholder or an Insured will, in the absence of fraud, be considered representations and not warranties. No statement made to obtain insurance will be used to avoid the insurance or reduce the benefits of this policy unless it is in a written application signed by the Policyholder or Insured. A copy of this must have been given to the Policyholder or Insured.

No change in this policy will be valid unless approved in writing by one of our officers and given to the Policyholder for attachment to the policy. No agent has the authority to change this policy or waive any of its provisions. Any change in this policy will be valid even though an Insured may not have agreed to it.

INSURANCE DATA. The Policyholder will furnish, at our request, data necessary to administer this policy. The data will include, but not be limited to data:

i. necessary to calculate premiums;

ii. necessary to determine a person's effective date or termination date of insurance;

iii. necessary to determine the proper coverage level of insurance.

We shall have the right to inspect any of the Policyholder's records we find necessary to properly administer this policy. Any inspections will be at a time and place convenient to the Policyholder.

We will not refuse to insure a person who is eligible to be insured just because the Policyholder fails or errs in giving us the data necessary to include that person for coverage. An Insured's insurance will not stay in force nor an amount of insurance be continued after the termination date, according to the Conditions for Insurance, because the Policyholder fails or errors in giving us the necessary data concerning an Insured's termination.

CERTIFICATES. We will issue certificates to the Policyholder showing the coverage under the policy. The Policyholder will distribute a certificate to each insured Member. If the terms of the certificate differ from the policy, the terms stated in the policy will govern.

PARTICIPATION REQUIREMENTS. There are two requirements that must be met in order for the policy to be placed in force, and to remain in force:

a. a certain percentage of all Members qualified for insurance must be insured at all times; and

b. a certain number of Insureds must be insured at all times.

The Participation Requirements are as follows:

Percentage of Members-	100%
Number of Members-	1,755

TERMINATION OF THE POLICY. The Policyholder may terminate this policy as of any Premium Due Date by giving us written notice before that date.

We may terminate this policy on any Premium Due Date if the participation of Insureds and/or Dependents does not meet the requirements in "Conditions For Insurance." Written notice of termination of insurance must be given to the Policyholder at least 45 days before the date of termination.

If any premium is not paid when due, this policy will automatically be terminated as of the Premium Due Date, except as stated below.

GRACE PERIOD. This policy has a 30 day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 30 days. During the grace period, the policy will stay in force. If the Policyholder has not sent us a written request to terminate the policy and a premium is not paid by the end of the grace period, the policy will terminate at the end of the grace period. If the Policyholder gives us written notice of termination before the Premium Due Date, the policy will be terminated as of the date requested. The Policyholder will be liable for any unpaid premium for the time this policy was in force, including the grace period.

CONSIDERATION. This policy is issued to the Policyholder in consideration of the application and the payment of premiums specified in this policy.

TERMS AND CONDITIONS. Payment of any benefit under this policy is subject to the definitions and all other terms of this policy pertinent to the benefit.

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

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

CLAIMS FOR BENEFITS

Claims may be submitted by mailing the completed claim form along with any requested information to:

Ameritas Life Insurance Corp.
PO Box 82520
Lincoln, NE 68501

NOTICE OF DECISION OF CLAIM

We will evaluate your claim promptly after we receive it.

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

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

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

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

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

APPEAL PROCEDURE

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

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

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

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

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

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

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

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

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

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

Any request for appeal should be directed to:

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

Application is Hereby Made to

AMERITAS LIFE INSURANCE CORP.

by: FLORIDA LEGISLATURE

whose main office address is: RM 701 CLAUDE PEPPER BL
111 W MADISON ST RM 701
TALLAHASSEE, FL 32399-6588

for Group Policy No. 10-377396

This group policy is hereby approved. Its terms are hereby accepted.

This Acceptance Application is made in duplicate. One is attached to the policy. The other part has been returned to the Company.

It is agreed that this application supersedes any previous application for the group policy.

FLORIDA LEGISLATURE

(Full or Corporate Name of Applicant)

Dated at_____By_____
(Signature and Title)

On_____, 20__ Witness_____
(To be signed by Resident Agent where required by law)

This copy is to Remain Attached to the Policy

Attachment B
Group Dental Insurance Historical Rates and Premiums

Contractor	Policy Number	Term	Insured Rate	Insured with Dependent Rate	Total Combined Premium Paid
Ameritas Life Insurance Corp	377396	January 1, 2016 – December 31, 2016	$37.22	$86.48	*$814,131
Ameritas Life Insurance Corp	377396	January 1, 2015 – December 31, 2015	$35.48	$82.44	$1,564,244
Ameritas Life Insurance Corp	377396	January 1, 2014 – December 31, 2014	$35.48	$82.44	$1,582,607
Ameritas Life Insurance Corp	377396	January 1, 2013 – December 31, 2013	$35.48	$82.44	$1,612,329
Ameritas Life Insurance Corp	377396	January 1, 2012 – December 31, 2012	$34.60	$80.28	$1,582,540
Ameritas Life Insurance Corp	377396	January 1, 2011 – December 31, 2011	$34.60	$80.28	$1,576,213
Ameritas Life Insurance Corp	377396	January 1, 2010 – December 31, 2010	$34.60	$80.28	$1,628,006
*Represents period JAN 2016 JUN 2016					

Attachment C
Group Dental Insurance Procedure Experience Report

FLORIDA LEGISLATURE

Claim Payment Breakdown by Procedure Type

AMERITAS GROUP

Policy #: 377396 01/01/2016 through 06/30/2016

Dental Procedure Type	Proc Count	Total Claims	PPO Savings	Claim Savings	Remaining Eligible Charge	Total Deductible Paid by Member	Total Coinsurance Paid by Member	Total Claims Paid	% Total Ben Paid
TYPE 1	8,246	$552,366	$93,851	$63,071	$395,444	$0	$0	$395,444	59.4%
TYPE 2	1,438	$328,565	$57,267	$71,527	$199,771	$10,432	$39,184	$150,154	22.6%
TYPE 3	379	$276,997	$32,080	$77,552	$167,364	$2,725	$84,246	$80,393	12.1%
TYPE 4	2	$2,100	$0	$2,100	$0	$0	$0	$0	.0%
ORTHO	209	$80,910	$0	$48	$80,862	$0	$40,857	$40,005	6.0%
NONCLASSIFIED	283	$63,734	$0	$63,706	$27	$0	$0	$27	.0%
CREDITS	6	$0	$0	$725	-$725	$0	$0	-$725	-.1%
TOTAL	10,563	$1,304,672	$183,198	$278,729	$842,743	$13,157	$164,287	$665,298	100.0%

FLORIDA LEGISLATURE

Claim Payment Breakdown by Procedure Type

AMERITAS GROUP

Policy #: 377396 01/01/2015 through 12/31/2015

Dental Procedure Type	Proc Count	Total Claims	PPO Savings	Claim Savings	Remaining Eligible Charge	Total Deductible Paid by Member	Total Coinsurance Paid by Member	Total Claims Paid	% Total Ben Paid
TYPE 1	15,938	$1,042,821	$166,499	$117,217	$759,105	$0	$0	$759,105	54.6%
TYPE 2	3,497	$801,432	$143,842	$190,394	$467,196	$24,012	$92,799	$350,384	25.2%
TYPE 3	881	$640,522	$86,290	$154,654	$399,577	$5,602	$200,095	$193,881	14.0%
TYPE 4	1	$300	$0	$300	$0	$0	$0	$0	.0%
ORTHO	450	$180,346	$0	$1,097	$179,249	$0	$90,939	$88,311	6.4%
NONCLASSIFIED	529	$133,334	$0	$133,334	$0	$0	$0	$0	.0%
CREDITS	7	$0	$0	$1,460	-$1,460	$0	$0	-$1,460	-.1%
TOTAL	21,303	$2,798,755	$396,631	$598,457	$1,803,667	$29,614	$383,833	$1,390,221	100.0%

Attachment C
Group Dental Insurance Procedure Experience Report

FLORIDA LEGISLATURE

Claim Payment Breakdown by Procedure Type

AMERITAS GROUP

Policy #: 377396 01/01/2014 through 12/31/2014

Dental Procedure Type	Proc Count	Total Claims	PPO Savings	Claim Savings	Remaining Eligible Charge	Total Deductible Paid by Member	Total Coinsurance Paid by Member	Total Claims Paid	% Total Ben Paid
TYPE 1	17,018	$1,081,006	$150,696	$139,778	$790,532	$0	$0	$790,532	55.9%
TYPE 2	3,604	$737,941	$114,673	$164,115	$459,153	$25,654	$90,192	$343,307	24.3%
TYPE 3	952	$667,683	$68,475	$197,791	$401,416	$6,730	$202,345	$192,341	13.6%
ORTHO	412	$180,742	$0	$150	$180,592	$0	$90,670	$89,922	6.4%
NONCLASSIFIED	587	$119,207	$4,153	$115,014	$39	$0	$0	$39	.0%
CREDITS	12	$0	$0	$2,648	-$2,648	$0	$0	-$2,648	-.2%
TOTAL	22,585	$2,786,579	$337,998	$619,495	$1,829,084	$32,384	$383,207	$1,413,493	100.0%

FLORIDA LEGISLATURE

Claim Payment Breakdown by Procedure Type

AMERITAS GROUP

Policy #: 377396 01/01/2013 through 12/31/2013

Dental Procedure Type	Proc Count	Total Claims	PPO Savings	Claim Savings	Remaining Eligible Charge	Total Deductible Paid by Member	Total Coinsurance Paid by Member	Total Claims Paid	% Total Ben Paid
TYPE 1	16,231	$989,434	$114,029	$120,296	$755,109	$0	$0	$755,109	56.4%
TYPE 2	3,227	$686,032	$88,262	$158,836	$438,934	$26,836	$85,281	$326,818	24.4%
TYPE 3	887	$603,569	$56,202	$169,145	$378,221	$7,064	$189,941	$181,216	13.5%
TYPE 4	1	$565	$0	$565	$0	$0	$0	$0	.0%
ORTHO	364	$158,339	$0	$384	$157,955	$0	$79,650	$78,306	5.9%
NONCLASSIFIED	441	$97,183	$5,614	$91,538	$30	$0	$0	$30	.0%
CREDITS	16	$0	$0	$2,945	-$2,945	$0	$0	-$2,945	-.2%
TOTAL	21,167	$2,535,122	$264,107	$543,710	$1,727,304	$33,900	$354,872	$1,338,534	100.0%

Attachment C
Group Dental Insurance Procedure Experience Report

FLORIDA LEGISLATURE

Claim Payment Breakdown by Procedure Type

AMERITAS GROUP

Policy #: 377396 01/01/2012 through 12/31/2012

Dental Procedure Type	Proc Count	Total Claims	PPO Savings	Claim Savings	Remaining Eligible Charge	Total Deductible Paid by Member	Total Coinsurance Paid by Member	Total Claims Paid	% Total Ben Paid
TYPE 1	16,913	$1,052,574	$107,967	$151,393	$793,213	$0	$0	$793,213	53.8%
TYPE 2	3,703	$816,569	$92,047	$193,585	$530,937	$30,378	$104,175	$396,384	26.9%
TYPE 3	1,066	$737,936	$61,527	$212,613	$463,796	$8,150	$237,009	$218,637	14.8%
ORTHO	325	$143,687	$0	$34	$143,653	$0	$72,374	$71,279	4.8%
NONCLASSIFIED	354	$73,803	$2,551	$71,252	$0	$0	$0	$0	.0%
CREDITS	23	$0	$0	$4,456	-$4,456	$0	$0	-$4,456	-.3%
TOTAL	22,384	$2,824,569	$264,092	$633,332	$1,927,143	$38,528	$413,558	$1,475,057	100.0%

FLORIDA LEGISLATURE

Claim Payment Breakdown by Procedure Type

AMERITAS GROUP

Policy #: 377396 01/01/2011 through 12/31/2011

Dental Procedure Type	Proc Count	Total Claims	PPO Savings	Claim Savings	Remaining Eligible Charge	Total Deductible Paid by Member	Total Coinsurance Paid by Member	Total Claims Paid	% Total Ben Paid
TYPE 1	17,065	$1,008,615	$100,417	$136,039	$772,159	$0	$0	$772,159	55.6%
TYPE 2	3,360	$676,560	$78,386	$128,507	$469,666	$31,351	$89,367	$348,948	25.1%
TYPE 3	930	$624,835	$50,975	$163,927	$409,933	$7,580	$205,281	$197,073	14.2%
TYPE 4	1	$497	$0	$497	$0	$0	$0	$0	.0%
ORTHO	329	$147,105	$0	$0	$147,105	$0	$74,396	$72,709	5.2%
NONCLASSIFIED	386	$79,242	$2,243	$76,999	$0	$0	$0	$0	.0%
CREDITS	12	$0	$0	$2,481	-$2,481	$0	$0	-$2,481	-.2%
TOTAL	22,083	$2,536,854	$232,020	$508,450	$1,796,382	$38,931	$369,044	$1,388,408	100.0%

Attachment C
Group Dental Insurance Procedure Experience Report

FLORIDA LEGISLATURE

Claim Payment Breakdown by Procedure Type

AMERITAS GROUP

Policy #: 377396 01/01/2010 through 12/31/2010

Dental Procedure Type	Proc Count	Total Claims	PPO Savings	Claim Savings	Remaining Eligible Charge	Total Deductible Paid by Member	Total Coinsurance Paid by Member	Total Claims Paid	% Total Ben Paid
TYPE 1	17,965	$1,017,064	$69,837	$144,257	$802,970	$0	$0	$802,970	55.8%
TYPE 2	3,651	$664,689	$53,597	$140,916	$470,176	$34,768	$90,646	$344,763	23.9%
TYPE 3	1,080	$703,757	$42,760	$169,710	$491,287	$10,475	$248,446	$232,366	16.1%
ORTHO	361	$134,589	$0	$1,250	$133,340	$0	$67,998	$65,342	4.5%
NONCLASSIFIED	298	$65,416	$2,151	$63,228	$36	$0	$0	$36	.0%
CREDITS	30	$0	$0	$5,353	-$5,353	$0	$0	-$5,353	-.4%
TOTAL	23,385	$2,585,515	$168,346	$524,713	$1,892,456	$45,243	$407,090	$1,440,124	100.0%

Attachment D
Group Dental Insurance Experience Summary

FLORIDA LEGISLATURE
Monthly Experience Summary

AMERITAS GROUP

Policy #: 377396 *01/01/2016 through 06/30/2016*

LOB	Month	Premium $	Paid Claims $	Paid L/R	EE Lives	Dep Units
DEN	Jun 2016	$136,242	$111,461	82%	2,023	1,242
DEN	May 2016	$134,778	$99,917	74%	2,006	1,239
DEN	Apr 2016	$135,747	$120,854	89%	2,012	1,240
DEN	Mar 2016	$135,895	$118,337	87%	2,013	1,242
DEN	Feb 2016	$136,225	$88,051	65%	2,015	1,245
DEN	Jan 2016	$135,245	$126,678	94%	2,004	1,230
TOTAL		$814,131	$665,299		12,073	7,438

FLORIDA LEGISLATURE
Monthly Experience Summary

AMERITAS GROUP

Policy #: 377396 *01/01/2015 through 12/31/2015*

LOB	Month	Premium $	Paid Claims $	Paid L/R	EE Lives	Dep Units
DEN	Dec 2015	$129,028	$106,920	83%	2,012	1,233
DEN	Nov 2015	$129,771	$101,946	79%	2,024	1,238
DEN	Oct 2015	$130,267	$121,496	93%	2,021	1,232
DEN	Sep 2015	$129,264	$119,618	93%	2,010	1,229
DEN	Aug 2015	$127,672	$121,399	95%	1,999	1,230
DEN	Jul 2015	$129,701	$142,500	110%	2,010	1,242
DEN	Jun 2015	$131,089	$122,918	94%	2,011	1,250
DEN	May 2015	$126,866	$101,977	80%	2,013	1,251
DEN	Apr 2015	$131,772	$104,035	79%	2,032	1,262
DEN	Mar 2015	$133,046	$108,090	81%	2,038	1,267
DEN	Feb 2015	$131,555	$117,905	90%	2,029	1,261
DEN	Jan 2015	$134,213	$121,418	90%	2,054	1,267
TOTAL		$1,564,244	$1,390,221		24,253	14,962

Attachment D
Group Dental Insurance Experience Summary

FLORIDA LEGISLATURE
Monthly Experience Summary

AMERITAS GROUP

Policy #: 377396 01/01/2014 through 12/31/2014

LOB	Month	Premium $	Paid Claims $	Paid L/R	EE Lives	Dep Units
DEN	Dec 2014	$131,147	$119,386	91%	2,046	1,277
DEN	Nov 2014	$130,340	$89,166	68%	1,992	1,260
DEN	Oct 2014	$129,196	$124,863	97%	1,986	1,264
DEN	Sep 2014	$130,776	$116,546	89%	2,013	1,267
DEN	Aug 2014	$130,733	$128,625	98%	2,024	1,266
DEN	Jul 2014	$131,003	$128,549	98%	2,041	1,273
DEN	Jun 2014	$133,010	$130,477	98%	2,073	1,282
DEN	May 2014	$132,904	$106,172	80%	2,063	1,279
DEN	Apr 2014	$132,845	$114,057	86%	2,073	1,279
DEN	Mar 2014	$132,480	$106,495	80%	2,079	1,277
DEN	Feb 2014	$134,652	$111,963	83%	2,092	1,283
DEN	Jan 2014	$133,522	$137,198	103%	2,081	1,275
TOTAL		$1,582,607	$1,413,494		24,563	15,282

FLORIDA LEGISLATURE
Monthly Experience Summary

AMERITAS GROUP

Policy #: 377396 01/01/2013 through 12/31/2013

LOB	Month	Premium $	Paid Claims $	Paid L/R	EE Lives	Dep Units
DEN	Dec 2013	$134,001	$114,127	85%	2,081	1,283
DEN	Nov 2013	$134,909	$89,400	66%	2,090	1,294
DEN	Oct 2013	$134,165	$112,708	84%	2,083	1,293
DEN	Sep 2013	$133,832	$101,115	76%	2,077	1,295
DEN	Aug 2013	$134,150	$153,852	115%	2,074	1,302
DEN	Jul 2013	$136,181	$131,405	96%	2,071	1,312
DEN	Jun 2013	$134,524	$112,718	84%	2,058	1,311
DEN	May 2013	$133,275	$102,577	77%	2,053	1,308
DEN	Apr 2013	$129,689	$96,895	75%	2,060	1,310
DEN	Mar 2013	$135,985	$103,091	76%	2,082	1,323
DEN	Feb 2013	$135,747	$101,869	75%	2,079	1,325
DEN	Jan 2013	$135,870	$118,776	87%	2,069	1,322
TOTAL		$1,612,329	$1,338,533		24,877	15,678

Attachment D
Group Dental Insurance Experience Summary

FLORIDA LEGISLATURE
Monthly Experience Summary

AMERITAS GROUP

Policy #: 377396 *01/01/2012 through 12/31/2012*

LOB	Month	Premium $	Paid Claims $	Paid L/R	EE Lives	Dep Units
DEN	Dec 2012	$134,462	$116,182	86%	2,089	1,355
DEN	Nov 2012	$128,007	$109,491	86%	1,976	1,300
DEN	Oct 2012	$124,412	$124,708	100%	1,968	1,299
DEN	Sep 2012	$128,476	$96,196	75%	1,988	1,316
DEN	Aug 2012	$131,505	$138,934	106%	2,008	1,331
DEN	Jul 2012	$130,951	$126,608	97%	2,024	1,338
DEN	Jun 2012	$133,902	$125,456	94%	2,100	1,362
DEN	May 2012	$134,599	$120,324	89%	2,083	1,362
DEN	Apr 2012	$133,875	$135,600	101%	2,083	1,358
DEN	Mar 2012	$133,494	$134,868	101%	2,087	1,363
DEN	Feb 2012	$134,840	$103,328	77%	2,112	1,367
DEN	Jan 2012	$134,017	$143,361	107%	2,108	1,365
TOTAL		$1,582,540	$1,475,058		24,626	16,116

FLORIDA LEGISLATURE
Monthly Experience Summary

AMERITAS GROUP

Policy #: 377396 *01/01/2011 through 12/31/2011*

LOB	Month	Premium $	Paid Claims $	Paid L/R	EE Lives	Dep Units
DEN	Dec 2011	$134,336	$118,307	88%	2,108	1,365
DEN	Nov 2011	$136,313	$105,832	78%	2,125	1,372
DEN	Oct 2011	$127,809	$99,065	78%	1,994	1,280
DEN	Sep 2011	$127,264	$109,778	86%	1,991	1,294
DEN	Aug 2011	$127,203	$140,838	111%	2,007	1,308
DEN	Jul 2011	$131,030	$128,341	98%	2,040	1,322
DEN	Jun 2011	$131,536	$134,839	103%	2,038	1,323
DEN	May 2011	$130,844	$117,715	90%	2,032	1,323
DEN	Apr 2011	$128,573	$99,603	77%	2,045	1,327
DEN	Mar 2011	$133,282	$109,830	82%	2,083	1,338
DEN	Feb 2011	$134,237	$107,392	80%	2,093	1,347
DEN	Jan 2011	$133,787	$116,870	87%	2,085	1,351
TOTAL		$1,576,213	$1,388,409		24,641	15,950

Attachment D
Group Dental Insurance Experience Summary

FLORIDA LEGISLATURE

Monthly Experience Summary

AMERITAS GROUP

Policy #: 377396 *01/01/2010 through 12/31/2010*

LOB	Month	Premium $	Paid Claims $	Paid L/R	EE Lives	Dep Units
DEN	Dec 2010	$137,141	$123,955	90%	2,111	1,404
DEN	Nov 2010	$131,891	$108,124	82%	2,021	1,354
DEN	Oct 2010	$132,181	$113,568	86%	2,038	1,357
DEN	Sep 2010	$133,913	$123,483	92%	2,046	1,364
DEN	Aug 2010	$133,319	$141,711	106%	2,062	1,368
DEN	Jul 2010	$136,062	$110,458	81%	2,088	1,386
DEN	Jun 2010	$136,021	$135,083	99%	2,111	1,390
DEN	May 2010	$136,651	$110,761	81%	2,125	1,400
DEN	Apr 2010	$138,223	$105,509	76%	2,132	1,403
DEN	Mar 2010	$137,738	$113,798	83%	2,130	1,402
DEN	Feb 2010	$130,577	$137,171	105%	2,133	1,403
DEN	Jan 2010	$144,289	$116,501	81%	2,119	1,404
TOTAL		$1,628,006	$1,440,123		25,116	16,635

Attachment E
Group Dental Insurance Carry Over Benefit Summary

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1     GCDB0707P1M                  0362501AMERITAS LIFE INSURANCE CORP.                  *IMG*01003773960000000
      PAGE:  1               03875010400000 CARRYOVER BENEFIT SUMMARY                     04000010412500


      PREPARED:    9/05/2015010425000                                                  04250010437500
      AS-OF-DATE:  9/05/2015010425000                                                  04250010437500

                04375010450000                              REPORTING BENEFIT PERIOD DATE:   PLAN YEAR
      NAME:046250104FLORIDA LEGISLATURE                          START D0475 9/01/2015
     04875010500000                                              T05000010512 8/31/2016
 125010525000#:     377396                                   05250010537500
 5500000CATION:     TALLAHASSEE       FL                 05500010562500                                          0
      POL EFF DT:   09/01/1987                     05750010587500                                          0587501
      SUB:          000                       06000010612500                                       0612501062500


                                    06250010637500                                                  06375010650000
           AVAILABLE           06500010662500 ----------------------- NUMBER OF CLAIMANTS ----06625010675000-----
           CARRYOVER     06750010687500              ACTUAL CARRYOVER                    06875010700000 CARRYOVER
                  07000010712500              (A)  + (B)  + (C)  =  (D)          07125010725000    (F)     (G)
             07250010737500                   EMP    SPS    CHD    TOTAL   07375010750000   EMP    SPS    CHD


          $0.010 TO 0  $125.00  ............      0      0      0         05010775000          2      3      2
        $125.010 TO 0  $250.00  ............      3      0      0         35010775000        268    144    245
        $250.010 TO 0  $375.00  ............      2      0      0         25010775000          8      3      5
        $375.010 TO 0  $500.00  ............      2      0      0         25010775000         87     45     76
        $500.010 TO 0  $625.00  ............      0      0      0         05010775000          8      3      5
        $625.010 TO 0  $750.00  ............      1      0      1         25010775000        157    103    146
        $750.010 TO 0  $875.00  ............      0      0      1         15010775000         11      7     15
        $875.010    0$1,000.00  ............      6      3      1        105010775000        734    377    475
-                  ACTUAL CARRYOVER COLUMNS: THIS DOES NOT TAKE INTO ACCOUNT ANY CARRYOVER BENEFITS
                                  THAT HAVE BEEN UTILIZED DURING THE REPORTING BENEFIT PERIOD.
0                  PROJECTED CARRYOVER COLUMNS: INSUREDS THAT WOULD QUALIFY FOR CARRYOVER IF THEY
                                  SUBMIT A DENTAL CLAIM DURING THIS BENEFIT PERIOD.
-
                                  **** END OF REPORT ****                    REPORT ID: GCM21321
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This report is generated when the renewal is processed, as the data is listed 2015.

Attachment F
Confidentiality and Non-Disclosure Agreement

This Confidential and Non-Disclosure Agreement (the "Agreement") is made this ____ day of _____ 2016, by and between _____ hereinafter referred to as "the Proposer" and the Florida Legislature, hereinafter referred to as "Legislature."

The Proposer warrants and represents that it intends to submit a Proposal in response to the Legislature's solicitation entitled Group Dental Insurance, Request for Proposal (RFP) #879. The Legislature must provide the Proposer with access to certain confidential information (Confidential Information) including, but not limited to, demographic and identifying information on the Legislature's eligible Insured. All such information provided by the Legislature during this procurement process shall be considered Confidential Information regardless of the form, format, or media upon which or in which such information is contained or provided, regardless of whether it is oral, written, electronic, or any other form, and regardless of whether the information is marked as Confidential Information. As a condition for its receipt and further access to the Confidential Information, Proposer agrees as follows:

1. Proposer will not copy, disclose, publish, release, transfer, disseminate or use for any purpose in any form any Confidential Information received under this RFP, except in connection with the preparation of its Proposal to this RFP.
2. Proposer shall be liable for any violations by any of its employees who are provided or given access to Confidential Information or any incidental access obtained by unauthorized persons while in its control.
3. Proposer shall abide by the following procedures in handling the Legislature's Confidential Information:
    a. Upon receipt of the data, the Proposer will password protect the Confidential Information.
    b. Proposer's employees needing access to the Legislature's Confidential Information will be informed that:
        i. They are not to share the password or the Legislature's Confidential Information with any unauthorized person;
        ii. At the end of the solicitation process they will delete the Legislature's Confidential Information from any laptop, desktop or any other electronic shared system under their control and destroy any paper copies of such Confidential Information; and
        iii. They must confirm to the Proposer that they have so deleted or destroyed the Confidential Information.
    c. Files and passwords will be provided separately to appropriate users.

d. Proposer will maintain the list of persons granted access (Access List) to the Legislature's Confidential Information.

4. Proposer shall destroy the Confidential Information, including any copies, remaining in its possession within the later of five (5) business days of the Legislature's Notice of Intent to Award in connection with this solicitation. If the Proposer does not submit a Proposal, the Proposer shall destroy the Confidential Information including any copies by the time Proposals are due.

5. In the event the Legislature suffers any losses, damages, liabilities, expenses or costs (including by way of example only, attorney's fees and disbursements) that are attributable, in whole or in part to any failure by the Proposer or any employee of the Proposer to comply with the requirements of this Agreement, Proposer shall hold harmless and indemnify the Legislature and the State of Florida from and against any such losses, damages, liabilities, expenses and/or costs.

6. This Agreement shall be governed by the laws of the State of Florida. The Proposer consents to personal jurisdiction in Florida state court, and exclusive venue shall be Leon County, Florida.

7. The individual signing below warrants and represents that they are fully authorized to bind the Proposer to the terms and conditions specified in this Agreement.

Proposer: _____

By: _____

Print Name: _____

Title: _____

Address: _____

Email Address for Census Information submittal:_____

RFP No. #879

Attachment G
Policies 2.15 and 2.151, Joint Policies and Procedures
Invoice Processing

2.15 Invoice Processing Procedure

The Finance & Accounting Office will perform the following actions on each invoice:

(1) Audit each invoice, including any duplicate invoices, for compliance with the contractual agreement or purchase order and mathematical accuracy, and determine if the payment is properly authorized or not previously paid;

(2) Record information into the State's accounting system; and

(3) Maintain voucher files with supporting documentation, files of unpaid purchase orders, and other files as necessary to maintain adequate accounting control and documentation.

2.151 Invoice Processing Time Limits

(1) A voucher authorizing payment of an invoice submitted to a unit of the Legislature will be filed with the Department of Financial Services no later than 20 days after receipt of the invoice and receipt, inspection, and approval of the goods or services, except that, in the case of a bona fide dispute, the voucher will contain a statement of the dispute and authorize payment only in the amount not disputed. Approval and inspection of goods or services will take no longer than five working days unless the bid specifications, purchase order, or contract specifies otherwise. If a voucher filed within the 20-day period is returned by the Department of Financial Services because of an error, it will nevertheless be deemed timely filed. For the purposes of determining the receipt of invoice date, the Legislature is deemed to receive an invoice on the date on which a proper invoice is first received in the Finance & Accounting Office. The Legislature is deemed to receive an invoice on the date the invoice was postmarked if the Finance & Accounting Office failed to annotate the invoice with the date of receipt at the time it actually received the invoice.

(2) (a) The Finance & Accounting Office will keep a record of the date of receipt of the invoice; dates of receipt, inspection, and approval of the goods or services; date of filing of the voucher; and date of issuance of the warrant in payment thereof.

Attachment G
Policies 2.15 and 2.151, Joint Policies and Procedures
Invoice Processing

(b) If a warrant in payment of an invoice is not issued within 40 days after receipt of the invoice and receipt, inspection, and approval of the goods and services, the Legislature will pay to the vendor, in addition to the amount of the invoice, interest at a rate established pursuant to Section 55.03(1), *Florida Statutes*, on the unpaid balance from the expiration of such 40-day period until such time as the warrant is issued to the vendor. Interest will be added to the invoice at the time of submission to the Department of Financial Services for payment whenever possible. If addition of the interest penalty is not possible, the Legislature will pay the interest penalty payment within 15 days after issuing the warrant. The provisions of this paragraph apply only to undisputed amounts for which payment has been authorized. In the case of an error on the part of the vendor, the 40-day period will begin to run upon receipt by the Finance & Accounting Office of a corrected invoice or other remedy of the error.

(c) The Legislature may make partial payments to a contractor upon partial delivery of goods or services or upon partial completion of construction when a request for such partial payment is made by the contractor and approved by the legislative unit. Provisions of this section will apply to partial payments in the same manner as they apply to full payments.

(d) The Finance & Accounting Office is responsible for initiating the penalty payments required by this subsection, and the Legislature will use this policy as authority to make such payments.

(3) Travel and other reimbursements to state officers and employees will be the same as payments to vendors pursuant to this section.

Attachment H
Certification of Minimum Qualifications

Proposers shall complete the certification by putting an "X" in the appropriate box. This Attachment H – Certification of Minimum Qualifications, must be included in the Technical Proposal, Tab 1. A Proposer must meet the requirements identified and certify their compliance with the requirements through the following questions to be considered responsive and responsible.

PROPOSERS THAT INDICATE "NO" TO ANY OF THE QUESTIONS WILL BE CONSIDERED NON-RESPONSIVE VENDORS AND THEIR PROPOSAL WILL NOT BE FURTHER EVALUATED.

Certifications		Yes	No
Question 1	Does the Contractor certify that it meets or exceeds a Best's Key Rating of A- (Excellent) or a Financial Performance Rating of eight (Strong), from the current Best's Key Rating Guide®?		
Question 2	Does the Contractor certify that it meets or exceeds a Financial Size Category of VIII ($100,000,000 - $250,000,000) from the current Best's Key Rating Guide®?		
Question 3	Does the Contractor certify that their current book of business includes at least two dental insurance policies having a minimum of 1,500-2,000 covered employees?		
Question 4	Does the Contractor certify that the Contractor holds a current Certificate of Authority in the appropriate line of business as stipulated in Chapter 624, of the Florida Statutes, or is an eligible Contractor as stipulated in Chapter 626, of the Florida Statutes?		
Question 5	Does the Contractor certify that their appointed Insurance Agents are Florida resident licensed agents or Florida nonresident licensed agents duly licensed and appointed by the Contractor in accordance with Chapter 624, and Chapter 626, of the Florida Statutes?		
Question 6	Does the Contractor certify that it has a minimum of five (5) years of experience with Group Dental Insurance Services?		
Question 7	Does the Contractor certify that to the best knowledge of the person signing the Proposal, the Contractor, its affiliates, its subsidiaries, its directors, its officers or employees of any other organization associated with this RFP, have no delinquent obligations to the State, including a claim by the State for liquidated damages under any other contract?		
Question 8	Does the Contractor certify that it has a current registration with the Florida Department of State, Division of Corporations?		
Question 9	Does Contractor certify that it is not on the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List pursuant to section 215.473, Florida Statutes?		
Question 10	Does Contractor certify that it has read the entire solicitation document and agrees to all Terms and Conditions?		

RFP No. #879 Group Dental Insurance

Proposer:_____

Attachment I
Certification of Preferred Providers

Proposers shall complete this certification by putting an "X" in the appropriate box. This Attachment I – Certification of Preferred Providers, must be included in the Technical Proposal, Tab 1.
The Proposer must certify that it has at least one (1) Preferred Provider, including general dentist or dental specialist, within each county:

General Dentist/ Dental Specialist By County	Yes	No		General Dentist/ Dental Specialist By County	Yes	No		General Dentist/ Dental Specialist By County	Yes	No
Alachua				Hardee				Okeechobee		
Baker				Hendry				Orange		
Bay				Hernando				Osceola		
Bradford				Highlands				Palm Beach		
Brevard				Hillsborough				Pasco		
Broward				Holmes				Pinellas		
Calhoun				Indian River				Polk		
Charlotte				Jackson				Putnam		
Citrus				Jefferson				Santa Rosa		
Clay				Lafayette				Sarasota		
Collier				Lake				Seminole		
Columbia				Lee				St. Johns		
DeSoto				Leon				St. Lucie		
Dixie				Levy				Sumter		
Duval				Liberty				Suwannee		
Escambia				Madison				Taylor		
Flagler				Manatee				Union		
Franklin				Marion				Volusia		
Gadsden				Martin				Wakulla		
Gilchrist				Miami-Dade				Walton		
Glades				Monroe				Washington		
Gulf				Nassau						
Hamilton				Okaloosa						

RFP No. #879 Group Dental Insurance

Proposer:_____

Attachment J
Proposer Certification

As the person authorized to sign on behalf of _____
[proposer name], I certify the following:

1. The above-named Proposer understands that all information provided by and representations made by the Proposer are material and will be relied on by the Legislature in awarding the Contract. The Legislature reserves the right to investigate all representations and any other information the Legislature deems pertinent. Any misstatement will be treated as fraudulent concealment from the Legislature of true facts relating to the submission of the Proposal. A misrepresentation will be punishable by law, including but not limited to Chapter 817, Florida Statutes. Accordingly, all information and representations contained in this Proposal are true and accurate to the best of my knowledge, and no modifications have been made to the RFP forms submitted with the Proposer's Proposal.

2. The above-named Proposer has not been placed within the last thirty-six (36) months on the State of Florida's Convicted Vendor List or on a similar list maintained by any other governmental entity.

3. The above-named Proposer is not currently under suspension or debarment by the State of Florida or any other governmental entity.

4. The above-named Proposer and its affiliates, subsidiaries, directors, officers, and employees are not currently under any known investigation by any governmental authority and have not in the last ten (10) years been convicted or found liable for any act prohibited by law in any jurisdiction involving conspiracy or collusion with respect to bidding on any public Contract.

5. The above-named Proposer has not been defaulted by the State of Florida under any Contract.

6. The above-named Proposer has fully informed the Legislature in writing of all convictions of the Proposer; its affiliates (as defined in subsection 287.133(1)(a), Florida Statutes); and all directors, officers, and employees of the firm and its affiliates for violation of state or federal antitrust laws with respect to a public Contract for violation of any state or federal law involving fraud, bribery, collusion, conspiracy, or material misrepresentation with respect to a public Contract. This includes disclosure of the names of current employees who were convicted of Contract crimes while in the employ of another company.

7. Neither Proposer nor any person associated with it in the capacity of owner, partner, director, officer, principal, investigator, project director, manager, auditor or position involving the administration of federal funds:

    a. Has within the preceding three (3) years been convicted of or had a civil judgment rendered against them or is presently indicted for or otherwise criminally or civilly charged for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain or performing a federal, state or local government transaction or public Contract;

violation of federal or state falsification or destruction of records, making false statements or receiving stolen property; or

b. Has within a three-year (3) period preceding this certification had one or more federal, state or local government Contracts terminated for cause or default.

8. The submission is made in good faith and not pursuant to any agreement or discussion with, or inducement from, any firm or person to submit a complementary or noncompetitive Proposal.

9. Proposer has made a diligent inquiry of its employees and agents responsible for preparing, approving or submitting the Proposal and has been advised by each of them that he or she has not participated in any communication, consultation, discussion, agreement, collusion, act or other conduct inconsistent with any of the statements and representations made in the Proposal.

10. The prices and amounts have been arrived at independently and without consultation, communication or agreement with any other Proposer or potential Proposer; neither the prices nor the amounts, actual or approximate, have been disclosed to any Proposer or potential Proposer and they will not be disclosed before the RFP opening.

11. No attempt has been made or will be made to induce any firm or persons to refrain from submitting a Proposal for the Contract, or to submit a price(s) higher that the prices in this Proposal, or to submit any intentionally high or noncompetitive price(s) or other form of complementary Proposal.

_____ , its affiliates, subsidiaries, officers, director, and employees
(Name of Firm) are not currently under investigation by any governmental agency and have not in the last three years been convicted or found liable for any act prohibited by state or federal law in any jurisdiction, involving conspiracy or collusion with respect to the Proposal on any public Contract, except as follows:

_____

_____

Proposer:_____

Signature of Authorized Representative: _____

Name: _____

Title: _____

Date: _____

Attachment K
Disclosure Information

Upon reasonable inquiry, the organization discloses, on the lines below:

That the following identified owner, officer, director, employee, agent or lobbyist who is/was a current or former member, officer or employee of the Florida Legislature or any of its units and was, is, or will be significantly involved in preparing or approving this contract, representing the interests of the organization regarding this contract, or doing the work covered under this contract.

Name: _____ Title: _____

Name: _____ Title: _____

That the following identified current or former member or employee of the Florida Legislature owns, directly or indirectly, an interest of five percent (5%) or more of the total assets or capital stock in the company.

Name: _____ Title: _____

Name: _____ Title: _____

If none, check here _____

RFP #879: Group Dental Insurance

Name of Proposer: _____

By: _____
(Manual)

By: _____
(Typed)

Title or Position: _____

Telephone: _____ Date: _____

Attachment L
Insurance Agent Information

The following should be completed for the Florida resident or Florida nonresident Agent duly licensed and appointed by the Contractor associated with the Group Dental Insurance Policy.

Name of Insurance Agency: _____

Primary Point of Contact: _____

Mailing Address: _____

_____

Phone Number: _____ Fax Number: _____

Email Address: _____ Employer Identification No.: _____

Agent's Name and License Number:_____

Florida Resident Licensed Agent ☐ Florida Nonresident Licensed Agent ☐

Attachment M
Reference Contact Information

Please use the format below for submitting references.

Reference Client 1: _____

Contact Person and Title: _____

Mailing Address: _____

Phone Number: _____Email Address: _____

Type of Insurance Policy: _____

Policy Term: _____

Reference Client 2: _____

Contact Person and Title: _____

Mailing Address: _____

Phone Number: _____Email Address: _____

Type of Insurance Policy: _____

Policy Term: _____

Reference Client 3: _____

Contact Person and Title: _____

Mailing Address: _____

Phone Number: _____Email Address: _____

Type of Insurance Policy: _____

Policy Term: _____

RFP No. #879 Group Dental Insurance

Proposer:_____

Attachment N
COST PROPOSAL

Cost Proposal must be enclosed in a sealed envelope separate from the Technical Proposal as specified in Section 3.12.3 of this RFP.

Insured Person Rate (Including Orthodontic) $_____

Insured Person w/ Dependents (Including Orthodontic) $_____

Combined Average Rate $To be completed by the Legislature

*This figure is used to evaluate cost points.

Renewal Term Rate

YEAR 1	Insured Person Rate (Including Orthodontic)	$_____
	Insured Person w/ Dependents (Including Orthodontic)	$_____
YEAR 2	Insured Person Rate (Including Orthodontic)	$_____
	Insured Person w/ Dependents (Including Orthodontic)	$_____
YEAR 3	Insured Person Rate (Including Orthodontic)	$_____
	Insured Person w/ Dependents (Including Orthodontic)	$_____

RFP No. #879 Group Dental Insurance

Proposer:_____