DINA DENTAL PLAN™

Passive PPO Dental Plan (100/80/50/50)

Annual Benefit - Per Person $1,000

Percentage of Covered Benefits per Policy Year

	TYPE I	TYPE II	TYPE III*	ORTHO*
COINSURANCE	**100%**	**80%**	**50%**	**50%**

Calendar Year Deductible, Per Person $50 / $150

This deductible applies to Type II and III services

Payment is based upon allowable charges in the area in which service is rendered. Services provided at a non-contracting provider are paid at the 90th percentile.

TYPE I (PREVENTIVE SERVICES)

Including:

- No waiting period, no deductible
- Routine Exams
- Prophylaxis (cleanings-one per 6 months)
- Emergency exams for dental pain (minor procedures)
- Fluoride treatments for dependent children under age 19 (one per 12 months)
- Bitewing X-rays (once per 6 months)

TYPE II (BASIC SERVICES)

Including:

- No waiting period
- Full mouth or panorex X-rays (1 per 36 months)
- Simple restorative services (fillings)
- Simple extractions
- Sealants for children ages 6-15 (1 per tooth)

ORTHODONTIC SERVICES

- 12 month waiting period (takeover provisions apply for employees with proof of prior dental insurance)
- $50 separate deductible
- 50% coverage
- $1000 lifetime maximum benefit
- Children under 19 only

TYPE III (MAJOR SERVICES)

Including:

- 12 month waiting period (takeover provisions apply for employees with proof of prior dental insurance)
- Major restorative services (crowns and inlays)
- Prosthetics (bridges, dentures)
- Replacement of prosthodontics, dentures, crowns and inlays
- Denture relines
- Space maintainers
- Oral Surgery
- General anesthesia (for services dentally necessary)
- Endodontics/root canal therapy
- Periodontics

Monthly Rates:
UFCW Local 496

Employee Only	$ 36.18
Employee + One	$ 68.56
Employee + Family	$114.84

Group #L60093-D

See Any Dentist

To save money, you may choose an in-network dentist at www.dentemax.com

DENTEMAX

Marketed and Administered by:	*Underwritten By:*
DINA DENTAL 11969 Bricksome Avenue, Suite A Baton Rouge, LA 70816 (225) 291-3172 ~ (800) 376-3462 FAX (225) 292-3075	**GUARANTY ASSURANCE COMPANY** 11969 Bricksome Ave, Suite A Baton Rouge, LA 70816 (225) 291-3172 ~ (800) 376-3462 FAX (225) 292-3075

Limitations and Exclusions

Covered Expenses Will Not Include and No Benefits Will Be Payable:

1. For major services in the first 12 months that the Insured is covered, except as may be provided in the Takeover Benefits provision.
2. For any treatment which is for cosmetic purposes or to correct congenital malformations, except for medically necessary care and treatment of congenital cleft lip and palate.
3. To replace any prosthetic appliance, crown, inlay or onlay restoration, or fixed bridge within five years of the date of the last placement of these items, unless required because of an accidental bodily injury sustained while the Insured is covered. Replacement is not covered if the item can be repaired.
4. For initial placement of any prosthetic appliance or fixed bridge unless such placement is needed because of the extraction of natural teeth during the same period of continuous coverage. But the extraction of a third molar (wisdom tooth) will not qualify the item for payment. Any such appliance or fixed bridge must include the replacement of the extracted tooth or teeth. Coverage does not include the part of the cost that applies specifically to replacement of teeth extracted prior to the period of coverage.
5. For addition of teeth to an existing prosthetic appliance or fixed bridge unless for replacement of natural teeth extracted during the same period of continuous coverage.
6. For any expense incurred or procedure begun before the Insured's current period of continuous coverage.
7. For any expense incurred or procedure begun after the Insured's insurance under this section terminates, except for a prosthetic appliance, fixed bridge, crown, or inlay or onlay restoration for which both (a) the procedure begins before insurance ends and (b) the item's final placement is within 90 days after insurance ends.
8. To duplicate appliances or replace lost or stolen appliances.
9. For appliances, restorations or procedures to:
    a. alter vertical dimension;
    b. restore or maintain occlusion;
    c. splint or replace tooth structure lost as a result of abrasion or attrition; or
    d. treat jaw fractures or disturbances of the temporomandibular joint.
10. For education or training in, and supplies used for, dietary or nutritional counseling, personal oral hygiene or dental plaque control.
11. For broken appointments or the completion of claim forms.
12. For orthodontia service or for any services associated with orthodontic therapy when this optional coverage is not elected and the premium is not paid.
13. For sealants which are:
    a. not applied to a permanent molar;
    b. applied before age 6 or after attaining age 16; or
    c. reapplied to a molar within three years from the date of a previous sealant application.
14. For subgingival curettage or root planning (procedure numbers 4220 and 4341) unless the presence of periodontal disease is confirmed by both x-rays and pocket depth summaries of each tooth involved.
15. Because of an Insured's injury arising out of, or in the course of, work for wage or profit.
16. For an Insured's sickness, injury or condition for which he or she is eligible for benefits under any Workers Compensation Act or similar laws.
17. For charges for which the Insured is not liable or which would not have been made had no insurance been in force.
18. For services which are not recommended by a dentist, not required for necessary care and treatment, or do not have a reasonably favorable prognosis.
19. Because of war or any act of war, declared or not, or while on full-time active duty in the armed forces of any country.
20. To an Insured if payment is not legal where the Insured is living when expenses are incurred.
21. For any services related to: equilibration, bite registration or bite analysis.
22. For crowns for the purpose of periodontal splinting.
23. For charges for: any implants; overdentures; precision or semi-precision attachments and associated endodontic treatment; other customized attachments; or specialized prosthodontic techniques or characterizations.
24. For charges for myofunctional therapy, orthognathic surgery or athletic mouthguards.
25. For procedures for which benefits are payable under the employer's medical expense benefits plan for employees and their dependents.
26. Services or supplies provided by a family member or a member of the Insured's household.

Note: This is a general outline of covered benefits and does not include all the benefits, limitations and exclusions of the policy. See your certificate for details.

Predetermination of Benefits: As a service to protect the Insured, Guaranty Assurance Company will provide predetermination of benefits for recommended treatment plans that exceed $300. This predetermination of benefits explains which of the recommended procedures will be covered and at what amount. This benefit helps Insured's better understand their coverage. The Insured should submit the treatment plan to Guaranty Assurance Company for review and predetermination of benefits before the service begins.

TAKEOVER BENEFITS

Takeover means that you are given credit for waiting periods for like coverage's accumulated under your existing plan. No credit is given for deductibles satisfied under your existing plan.

1. In order to provide Takeover Benefits your employer's current dental plan must have been in effect continuously for at least 12 months prior to the effective date of this plan.
2. All employees insured on the effective date with continuous coverage from the prior group dental contract are eligible for Takeover Benefits. Waiting periods will be reduced by the amount of time insured under the prior plan.
3. A minimum of five (5) enrolled members are needed for an employer to be eligible for Takeover Benefits.
4. Takeover Benefits must be requested and are subject to the approval of Guaranty Assurance Company.

Electronic Claim Filing Information
Payor ID: CX090
Website: www.emdeon.com

Mailing Address & Fax # for Claims
DINA Dental Plan
101 Parklane Blvd, Ste 301
Sugar Land, TX 77478
Customer Service (866) 436-3093
Fax (281) 313-7154

DINA Dental Plan™
Guaranty Assurance Company
101 Parklane Blvd, Ste 301
Sugar Land, TX 77478

DINA Dental Plan™
Customer Service (866) 436-3093
Email to: dina@fcldental.com
Fax: (832) 415-0131

Application/Change Form for Membership and Dental Insurance

UFCW Local 496 ~ Group #L60093-D

Last Name:	First Name:	Middle Initial:
Mailing Address:		
City:	State:	Zip:
Phone:	SSN:	Date of Birth: / Male ☐ Female ☐
Date of Hire:	Date of Termination (if cancelling):	

Add ☐ **Effective Date:** _____
Delete ☐ **Notes:** _____
Change ☐ _____
Cancel ☐ _____
Other ☐ _____

Enrollment Status	Passive PPO Plan
Employee Only ☐	$ 36.18
Employee + One ☐	$ 68.56
Employee + Family ☐	$114.84

Include coverage for the listed dependents. Unmarried children up to age 25 may be covered as a dependent.

Dependents	First, Middle Initial, Last Name	Social Security Number	Date of Birth	Male	Female
Spouse				☐	☐
• Child				☐	☐
• Child				☐	☐
• Child				☐	☐
• Child				☐	☐
• Child				☐	☐
• Child				☐	☐

Do you or any dependents listed above have other dental insurance coverage? Yes ☐ No ☐

Membership in the DINA Dental Plan and dental insurance is requested for all persons named in this application. Please Note: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to a fine and confinement in prison. If any contribution from me is necessary to pay part of the cost of insurance, I authorize my employer to deduct the contribution from my wages.

Applicant's Signature: _____ **Date Signed:** _____

Agent's Signature: _____ Patrick D. Taylor **DINA Agent #** 31401

Takeover: Yes ☐ No ☐ Prior Carrier & Expiration Date: _____

Premium Payment Mode (Select Only One)

Monthly Options: (Bank Draft & Credit Card Only)	Bank Draft ☐	Credit Card ☐

Payroll Deduction:	Weekly ☐	Bi-Weekly ☐	Semi-Monthly ☐	Monthly ☐

Other Options:

Quarterly ☐	Semi-Annually ☐	Annually ☐

Company Use Only

Group # 60093	Dentist #	Dentist's Name:	Certificate #
Mode Premium $	Monthly Premium $	Amount Paid with App $	

APP19