BENEFIT
ARCHITECTS

Union Member
Dental & Vision
Insurance from
Humana®

Questions? **Contact your Local Benefit Representative**

Your Local Agent

BENEFIT ARCHITECTS

HD210 DHMO Dental Plan

Dental Benefits

HumanaDental Dental HMO plans stress quality and preventive care - the best way to avoid serious dental problems in the future. Your care is provided exclusively from a provider network of 20,800 dental locations which HumanaDental selects and screens. A HumanaDental Dental HMO also eliminates the burden of paperwork because there are no claims to file.

HOW DOES THE PLAN WORK?

Under your HumanaDental HD210 Series Dental HMO plan, you must select a primary dentist from the HumanaDental DHMO network. Visit **www.humanadental.com** and click 'Find a Dentist' from the navigation. On the next page, select 'DHMO', enter your zip code, then select 'HD210 DHMO/Prepaid Network' from the drop down list to select an in-network primary care dentist in your area, alternatively you can call HumanaDental Customer Service at (800) 233-4013 to find a network provider near you.

Your primary care dentist will provide all of your routine dental care. When you visit your primary care dentist, simply present your HumanaDental identification card. You may be required to pay a co-payment for some services provided by your primary care dentist, see the Schedule of Benefits for procedure costs. If the dental services provided are not listed as covered procedures under the Schedule of Benefits, the primary care dentist will bill you at a 25% discount off normal fees. The co-payments or discounted charges are billed at the time of service and will be the full portion of your cost for dental services, so there are no claims forms to file. You pay your dentist directly, if applicable.

Should you require the services of a specialist, you can choose any in-network specialist under the HumanaDental DHMO plan. This HumanaDental dental plan offers access to a dedicated network of oral surgeons, orthodontists, pedodontists, endodontists, periodontists and prostodontists focused on providing quality oral health care.

HumanaDental's HD Series Dental HMO plans are network-based products that emphasize prevention and cost containment. In order to receive services, you must select a primary dentist who participates in the HumanaDental DHMO network. The plans provide quality care and allow members to seek care from in-network specialists at a 25% discount off normal fees. These plans provide savings ranging from 20-60% on regular dental procedures. The plans do not cover services (except emergency care) received from out-of-network dentists.

BENEFIT ARCHITECTS

Building solutions for
LIFE ■ HEALTH ■ DISABILITY ■ DENTAL

BENEFIT ARCHITECTS

Your Local Agent

HD210 DHMO Dental Plan

- $10 Office Visits
- Low Co-Pays (see Schedule of Benefits)
- NO CHARGE for oral exams, bitewing x-rays, and cleanings
- No Annual Maximum Limitations
- No Claim Forms
- **NO WAITING PERIODS**

Select any Dentist from the Network – You can locate the provider nearest your home or office by visiting our website **www.humanadental.com** and clicking the DHMO icon.

PREMIUMS

	Bi-weekly
Employee Only	$8
Employee + One	$13
Employee + Family	$18

WHEN AM I ELIGIBLE?

If paying by payroll deduction, you must have two (2) deductions by following month.

If at any time you have a change of address, or phone number, take a leave of absence due to injury, etc. please be advised that you will be responsible for making arrangements to pay for your coverage until your allotments begin again.

QUESTIONS, CALL (800) 733-7236 Ext. 105

HOW TO ENROLL

1. **Complete and sign the Humana Dental HD210 DHMO Application**
2. **Choose a Payment option:** Payroll Deduction
   (Note that many federal agencies now require employees to initiate the payroll deduction process electronically)
   Payroll Deduction Option
   Choose Electronic method OR submit provided Form 1199-A.
   - ***Electronic***
     (Employee Express, MyPay, USDA National Finance Center)
     1. Go to the correct payroll site for your agency:
        www.employeeexpress.gov
        mypay.dfas.mil
        www.nfc.usda.gov (click on 'Employee Personal Page')
     2. Logon to the site with your ID and Password
     3. Navigate to the page to start the allotment
        - **Employee Express**: Financial Allotments
        - **MyPay**: Pay Changes, Allotment
        - **USDA NFC**: Self Service Tab, Financial Allotments
     4. Enter the allotment amount for the selected coverage
     5. Enter the **Bank Routing Number - 114000093** (Frost Bank)
     6. Enter the **Account Number - 860022527**
     7. Confirm your Saved changes.
   - ***Paper Form 1199A***
     Obtain the prefilled form by any of the following options:
     -Print the form directly from our websiteat: www.BenefitArchitects.com/HD210-1199pdf
     -Call us at 800-733-and we will mail, fax or email a prefilled form for you.
     1. Complete the prefilled Direct Deposit Form 1199A
     2. Section 1 Part A (Name and Address), Part C (SSN)
     3. Section 2 Agency Name and Payroll Address
     4. Take the completed, signed form to your payroll clerk for processing and fax a copy to (800) 238-2104
3. **Mail or fax your completed application to:**

Dental Plan
1301 Solana Blvd
Bldg 2 Suite 2320
Westlake, Texas 76262

Fax (800) 238-2104

Your Local Agent

BENEFIT ARCHITECTS

HD210 DHMO DENTAL PLAN

APPOINTMENTS

D9310 Consultation....$25
(diagnostic service provided by dentist other than practitioner providing treatment)
D9430 Office Visit (normal hours)....10
D9440 Office Visit (after regularly scheduled hours)....45
D9999 Emergency visit during regularly scheduled hours, by report....20
D9999 Broken appointments without 24 hr notice, per 15 min....10
(Maximum $40 per broken appointment, no charge will be made due to emergencies)

DIAGNOSTIC

D0120 Periodic oral evaluation (two per calendar year)....NO CHARGE
D0140 Limited/comprehensive/detailed and extensive oral eval....NO CHARGE
D0145 Oral eval for a patient under 3 years of age and counseling with primary caregiver....NO CHARGE
D0150 Limited/comprehensive/detailed and extensive oral eval (two per calendar year)....NO CHARGE
D0160 Limited/comprehensive/detailed and extensive oral eval....NO CHARGE
D0170 Re-evaluation—problem focused (not post-operative visit)....NO CHARGE
D0180 Comprehensive periodontal evaluation (two per calendar year)....25
D0210 X-Ray Intraoral—complete series including bitewings (once per three calendar years)....NO CHARGE
D0220 X-ray intraoral—periapical, first radiographic image....NO CHARGE
D0230 X-ray intraoral—periapical, each additional radiographic image....NO CHARGE
D0240 X-rays intraoral—occlusal radiographic image....NO CHARGE
D0250 Extraoral—first radiographic image....NO CHARGE
D0260 Extraoral—each additional radiographic image....NO CHARGE
D0270 X-ray bitewing—single radiographic image (two per calendar year)....NO CHARGE
D0272 X-ray bitewings—two radiographic images (two per calendar year)....NO CHARGE
D0273 X-ray bitewings—three radiographic images (two per calendar year)....NO CHARGE
D0274 Bitewings—four radiographic images (two per calendar year)....NO CHARGE
D0277 X-ray bitewings, vertical—7 to 8 radiographic images (two per calendar year)....NO CHARGE
D0330 Panoramic radiographic image (once per three calendar years)....NO CHARGE
D0350 Oral/facial photography images....NO CHARGE
D0415 Collect microorganisms culture & sensitivity....NO CHARGE
D0425 Caries susceptibility tests....NO CHARGE
D0431 Oral cancer screening using a special light source....65
D0460 Pulp vitality tests (not covered if a root canal is performed)....NO CHARGE
D0470 Diagnostic casts....NO CHARGE
D0472 Pathology report—gross examination of lesion....NO CHARGE
D0473 Pathology report—microscopic examination of lesion....NO CHARGE
D0474 Pathology report—microscopic examination of lesion and area....NO CHARGE

PREVENTIVE

D1110 Prophylaxis—adult, routine (two per calendar year, by primary care dentist)....NO CHARGE
D1120 Prophylaxis—child, routine (two per calendar year)....NO CHARGE
D1206 Topical application of fluoride varnish (for child <16) (two per calendar year)....NO CHARGE
D1208 Topical application of fluoride (not including prophylaxis)—child (up to 16 years of age)
(two per calendar year)....NO CHARGE
D1310 Nutrition counseling for the control or avoidance of dental disease....NO CHARGE
D1320 Tobacco counseling services for the control or prevention of oral disease....NO CHARGE
D1330 Oral hygiene instruction....NO CHARGE
D1351 Sealant - per tooth (permanent teeth only to age 16)....15
D1510* Space Maintainer—fixed - unilateral (through age 14)....75
D1515* Space maintainer—fixed, bilateral (through age 14)....105
D1520 Space maintainer-removable, unilateral (through age 14)....95
D1525* Space maintainer—removable, bilateral (through age 14)....100
D1550 Recementation of space maintainer....15

RESTORATIVE

D2140 Amalgam—one surface, primary or permanent....20
D2150 Amalgam—two surfaces, primary or permanent....25
D2160 Amalgam—three surfaces, primary or permanent....30
D2161 Amalgam—four or more surfaces, primary or permanent....35
D2940 Sedative filling....20

RESIN RESTORATION *(inlays and onlays limited to one per tooth every five years)*

D2330 Resin based composite—one surface, anterior....35
D2331 Resin based composite—two surfaces, anterior....50
D2332 Resin based composite—three surfaces, anterior....65
D2335 Resin based composite—four or more surfaces or involving incisal angle (anterior)....80
D2390 Resin based composite crown, anterior....80
D2391 Resin based composite—one surface, posterior....55
D2392 Resin based composite—two surfaces, posterior....70
D2393 Resin based composite—three surfaces, posterior....90
D2394 Resin based composite—four or more surfaces, posterior....100
D2510* Inlay—metallic, one surface....285
D2520* Inlay—metallic, two surfaces....295
D2530* Inlay—metallic, three or more surfaces....305
D2542* Onlay—metallic, two surfaces....310
D2543* Onlay—metallic, three surfaces....320
D2544* Onlay—metallic, four or more surfaces....330
D2610* Inlay—porcelain/ceramic, one surface....310
D2620* Inlay—porcelain/ceramic, two surfaces....320
D2630* Inlay—porcelain/ceramic, three or more surfaces....330
D2642* Onlay—porcelain/ceramic, two surfaces....335
D2643* Onlay—porcelain/ceramic, three surfaces....345
D2644* Onlay—porcelain/ceramic, four or more surfaces....355
D2650* Inlay—resin based composite, one surface....285
D2651* Inlay—resin based composite, two surfaces....295
D2652* Inlay—resin based composite, three or more surfaces....305
D2662* Onlay—resin based composite, two surfaces....310
D2663* Onlay—resin based composite, three surfaces....320
D2664* Onlay—resin based composite, four or more surfaces....350

CROWN AND BRIDGE

D2710* Crown—resin based composite, indirect....350
D2712* Crown—3/4 resin based composite, indirect....350
D2720* Crown—resin with high noble metal....350
D2721 Crown—resin with predominantly base metal....350
D2722* Crown—resin with noble metal....350
D2740* Crown—porcelain/ceramic substrate....350
D2750* Crown—porcelain fused to high noble metal....350
D2751 Crown—porcelain fused to predominantly base metal....350
D2752* Crown—porcelain fused to noble metal....350
D2780* Crown—3/4 cast high noble metal....350
D2781 Crown—3/4 cast predominantly base metal....350
D2782* Crown—3/4 cast noble metal....350
D2783* Crown—3/4 porcelain/ceramic....350
D2790* Crown—full cast high noble metal....350
D2791 Crown—full cast predominantly base metal....350
D2792* Crown—full cast noble metal....350
D2794* Crown—titanium....350
D2799 Provisional crown....NO CHARGE
D2910 Recement inlay, onlay or veneer....20
D2915 Recement cast or prefabricated post and core....NO CHARGE
D2920 Recement crown....20
D2929 Crown—prefabricated porcelain/ceramic crown—primary tooth....90
D2930 Prefabricated stainless steel crown—primary tooth....90
D2931 Prefabricated stainless steel crown—permanent tooth....30
D2932 Prefabricated resin crown....80
D2933 Prefabricated stainless steel crown with resin window....80
D2934 Prefabricated esthetic coated stainless steel crown—primary tooth....80
D2950 Core buildup, including any pins....65
D2951 Pin retention—per tooth, in addition to restoration....20
D2952* Cast post and core in addition to crown....125
D2953* Each additional cast post—same tooth....120
D2954 Prefabricated post and core in addition to crown....105
D2955 Post removal....15
D2957 Each additional prefabricated post—same tooth, base metal post....40
D2960 Labial veneer (resin laminate)—chairside....260
D2961* Labial veneer (resin laminate)—laboratory....360
D2962* Labial veneer (porcelain laminate)—laboratory....425
D2971 Additional procedure—new crown existing partial denture....60
D2980 Crown repair....15
D2981 Inlay repair....25
D2982 Onlay repair....25
D2983 Veneer repair....25
D6940 Stress breaker....160
D6950 Precision attachment....210

PROSTHODONTICS (FIXED) *(replacement limited to every five years, adjustments once per year)*

D6210* Pontic—cast high noble metal....350
D6211 Pontic—cast predominantly base metal....350
D6212* Pontic—cast noble metal....350
D6240* Pontic—porcelain fused to high noble metal....350
D6241 Pontic—porcelain fused to predominantly base metal....350
D6242* Pontic—porcelain fused to noble metal....350
D6750* Crown—porcelain fused to high noble metal....350
D6751 Crown—porcelain fused to predominantly base metal....350
D6752* Crown—porcelain fused to noble metal....350
D6790* Crown—full cast high noble metal....350
D6791 Crown—full cast predominantly base metal....350
D6792* Crown—full cast noble metal....350
D6794* Crown—titanium....350
D6930 Recement fixed partial denture (per unit)....30

PROSTHODONTICS *(replacement limited to every five years)*

D5110* Complete denture—maxillary....475
D5120* Complete denture—mandibular....475
D5130* Immediate denture—maxillary....475
D5140* Immediate denture—mandibular....475
D5211* Maxillary partial denture—resin base....450
D5212* Mandibular partial denture—resin base....450
D5213* Maxillary partial denture—cast metal framework, resin denture bases....475
D5214* Mandibular partial denture—cast metal framework, resin denture bases....475
D5225* Maxillary partial denture—flexible (including clasps, rests and teeth)....475
D5226* Mandibular partial denture—flexible (including clasps, rests and teeth)....475
D5281* Removable partial denture—one piece cast metal....395
D5410 Adjust complete denture—maxillary....20
D5411 Adjust complete denture—mandibular....20
D5421 Adjust partial denture—maxillary....20
D5422 Adjust partial denture—mandibular....20
D5660* Add clasp to existing partial denture....100

ENDODONTICS

D3110 Pulp cap—direct (excluding final restoration)....20
D3120 Pulp cap—indirect (excluding final restoration)....15
D3220 Therapeutic pulpotomy....55
D3221 Pulpal debridement, primary and permanent teeth....120
D3230 Pulpal therapy (resorbable filling)—anterior, primary tooth (excluding final restoration)....55
D3240 Pulpal therapy (resorbable filling)—posterior, primary tooth (excluding final restoration)....75
D3310 Root canal therapy—anterior (excluding final restoration)....135
D3320 Root canal therapy—bicuspid (excluding final restoration)....240
D3330 Root canal therapy—molar (excluding final restoration)....310
D3331 Treatment of root canal obstruction—non-surgical access....95
D3332 Incomplete endodontic therapy—inoperable or fractured tooth....95

HD210 DHMO SUMMARY OF BENEFITS

D3333 Internal root repair of perforation defects 100
D3351 Apexification/recalcification—initial visit 110
D3352 Apexification/recalcification—interim 85
D3353 Apexification/recalcification—final visit 110
D3410 Apicoectomy/periradicular surgery—anterior 165
D3421 Apicoectomy/periradicular surgery—bicuspid (first root) 170
D3425 Apicoectomy/periradicular surgery—molar (first root) 170
D3426 Apicoectomy/periradicular surgery (each additional root) 75
D3430 Retrograde filling—per root 45
D3450 Root amputation—per root (not covered in conjunction with procedure D3920) 110
D3910 Surgical procedure to isolate tooth with rubbed dam 35
D3920 Hemisection not included in root canal therapy 105
D3950 Root canal prepare and fit preformed dowel/post 20

PERIODONTICS (GUM TREATMENT)

D4210 Gingivectomy/gingivoplasty—four or more teeth, per quadrant 135
D4211 Gingivectomy/gingivoplasty per tooth—one to three teeth, per quadrant 75
D4240 Gingival flap, including root planing—four or more teeth, per quadrant 180
D4241 Gingival flap, including root planing—one to three teeth, per quadrant 135
D4245 Apically positioned flap 200
D4249 Clinical crown lengthening—hard tissue 175
D4260 Osseous surgery—four or more teeth or bounded spaces, per quadrant 400
D4261 Osseous surgery—one to three teeth, per quadrant 375
D4263 Bone replacement graft—first site in quadrant 240
D4264 Bone replacement graft—each additional site in quadrant bone 145
D4265 Biological materials which can aid soft and osseous tissue regeneration 115
D4266 Guided tissue regeneration—resorbable barrier, per site 290
D4267 Guided tissue regeneration—nonresorbable barrier, per site (includes membrane removal) 375
D4270 Pedicle soft tissue graft procedure 295
D4273 Subeptithelial connective tissue graft, tooth 400
D4274 Distal or proximal wedge procedure 105
D4275 Soft tissue allograft 425
D4277 Free soft tissue graft procedure (including donor site surgery)—first tooth 300
D4278 Free soft tissue graft procedure (including donor site surgery), each additional 225
D4320 Provisional splinting—intracoronal 120
D4321 Provisional splinting—extracoronal 100
D4341 Periodontal scaling and root planing, per quadrant (a maximum of four quadrants will be paid in any combinations, per 24 calendar months for procedures D4341 and D4342) 70
D4342 Periodontal scaling and root planing 1 to 3 teeth per quadrant (a maximum of 4 quadrants will be paid in any combinations, per 24 calendar months for procedures D4341 and D4342) 60
D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis (once per five calendar years) 65
D4381 Localized delivery of chemotherapeutic agents (per tooth) (limited to once per tooth per 12 months to a maximum of three tooth sites per quadrant, and performed no less than three months following active periodontal therapy) 65
D4910 Periodontal maintenance (covered only after active periodontal therapy) 55

EXTRACTIONS/ORAL AND MAXILLOFACIAL SURGERY

D7111 Coronal remnants, deciduous tooth .... NO CHARGE
D7140 Extraction, erupted tooth or exposed tooth 40
D7210 Surgical removal of erupted tooth 55
D7220 Removal of impacted tooth—soft tissue 60
D7230 Removal of impacted tooth—partially bony 85
D7240 Removal of impacted tooth—completely bony 105
D7241 Removal of impacted tooth—completely bony, unusual complications by report 140
D7250 Surgical removal of residual tooth roots 45
D7260 Oroantral fistula closure 400
D7261 Primary closure of a sinus perforation 250
D7270 Tooth stabilization of accidentally avulsed or displaced tooth 75
D7280 Surgical access of an unerupted tooth (excluding wisdom teeth) 135
D7282 Mobilization of erupted or malposed tooth to aid eruption 110
D7285 Biopsy of oral tissue—hard (bone, tooth) 400
D7286 Biopsy of oral tissue—soft (all others) 30
D7287 Exfoliative cytological sample collection 60
D7288 Brush biopsy—transepithelial sample collection 65
D7310 Alveoloplasty in conjunction with extractions—per quadrant 45
D7311 Alveoloplasty in conjunction with extractions— 1 to 3 teeth or tooth spaces, per quadrant 20
D7320 Alveoloplasty not in conjunction with extractions—per quadrant 85
D7321 Alveoloplasty not in conjunction with extractions—1 to 3 teeth or tooth spaces, per quadrant 45
D7450 Removal of benign odontogenic cyst or tumor—up to 1.25 cm 190
D7451 Removal of benign odontogenic cyst or tumor—greater than 1.25 cm 260
D7471 Removal of lateral exostosis (maxilla or mandible) 110
D7472 Removal of torus palatinus 75
D7473 Removal of torus mandibularis 75
D7485 Surgical reduction of osseous tuberosity 65
D7510 Incision and drainage of abscess—intraoral soft tissue 40
D7970 Excision hyperplastic tissue—per arch 90
D7971 Excision of pericoronal gingival 60

REPAIRS TO PROSTHETICS

D5510* Repair broken complete denture base 45
D5520* Replace missing or broken teeth—complete denture (each tooth) 45
D5610* Repair resin denture base 45
D5620* Repair cast framework 45
D5630* Repair or replace broken clasp 45
D5640* Replace broken teeth—per tooth 45
D5650* Add tooth to existing partial denture 45
D5670* Replace all teeth and acrylic framework—maxillary 235
D5671* Replace all teeth and acrylic framework—mandibular 290
D5710* Rebase complete maxillary denture 210
D5711* Rebase complete mandibular denture 210
D5720* Rebase maxillary partial denture 210
D5721* Rebase mandibular partial denture 210
D5730 Reline complete maxillary denture (chairside) 80
D5731 Reline complete mandibular denture (chairside) 80
D5740 Reline maxillary partial denture (chairside) 80
D5741 Reline mandibular partial denture (chairside) 80
D5750* Reline complete maxillary denture (laboratory) 125
D5751* Reline complete mandibular denture (laboratory) 125
D5760* Reline maxillary partial denture (laboratory) 125
D5761* Reline mandibular partial denture (laboratory) 125
D5810* Interim complete denture (maxillary) 275
D5811* Interim complete denture (mandibular) 275
D5820* Interim partial denture (maxillary) 135
D5821* Interim partial denture (mandibular) 135
D5850 Tissue conditioning, maxillary 40
D5851 Tissue conditioning, mandibular 40
D6214* Pontic titanium 350
D6245* Pontic—porcelain/ceramic 350
D6250* Pontic—resin with high noble metal 350
D6251 Pontic—resin with predominantly base metal 350
D6252* Pontic—resin with noble metal 350
D6253* Provisional pontic .... NO CHARGE
D6545* Retainer—cast metal, resin bonded fixed prosthesis 275
D6548* Retainer—porcelain/ceramic, resin bonded fixed prosthesis 275
D6600* Inlay—porcelain/ceramic, two surfaces 350
D6601* Inlay—porcelain/ceramic, three or more surfaces 350
D6602* Inlay—cast high noble metal, two surfaces 350
D6603* Inlay—cast high noble metal, three or more surfaces 350
D6604 Inlay—cast predominantly base metal, two surfaces 350
D6605 Inlay—cast predominantly base metal, three or more surfaces 350
D6606* Inlay—cast noble metal, two surfaces 350
D6607* Inlay—cast noble metal, three or more surfaces 350
D6608* Onlay—porcelain/ceramic, two surfaces 350
D6609* Onlay—porcelain/ceramic, three or more surfaces 350
D6610* Onlay—cast high noble metal, two surfaces 350
D6611* Onlay—cast high noble metal, three or more surfaces 350
D6612 Onlay—cast predominantly base metal, two surfaces 350
D6613 Onlay—cast predominantly base metal, three or more surfaces 350
D6614* Onlay—cast noble metal, two surfaces 350
D6615* Onlay—cast noble metal, three or more surfaces 350
D6624* Inlay titanium 350
D6634* Onlay titanium 350
D6710* Crown—indirect resin based composition 350
D6720* Crown—resin with high noble metal 350
D6721 Crown—resin with predominantly base metal 350
D6722* Crown—resin with noble metal 350
D6740* Crown—porcelain/ceramic 350
D6780* Crown—3/4 cast high noble metal 350
D6781 Crown—3/4 cast predominantly base metal 350
D6782* Crown—3/4 cast noble metal 350
D6783* Crown—3/4 porcelain/ceramic, denture 350

ADJUNCTIVE GENERAL SERVICE

D9110 Palliative (emergency) treatment 20
D9215 Local anesthesia .... NO CHARGE
D9220 General anesthesia—first 30 minutes (limited to the removal of partial, or complete bony impacted teeth) 185
D9221 General anesthesia—additional 15 minutes (limited to the removal of partial, or complete bony impacted teeth) 80
D9230 Analgesia (nitrous oxide), per 15 minutes 30
D9241 I.V. conscious sedation—first 30 minutes (limited to the removal of partial, or complete bony impacted teeth) 185
D9242 I.V. conscious sedation—additional 15 minutes (limited to the removal of partial, or complete bony impacted teeth) 80
D9450 Case presentation, detailed and extensive treatment planning .... NO CHARGE
D9951 Occlusal adjustment—limited 40
D9952 Occlusal adjustment—complete 185

BLEACHING

D9972 External bleaching in office—per arch 185
D9975 External bleaching at home—per arch 185

ORTHODONTICS

D8070 or D8080—children up to 19 years of age, up to 24 months of routine orthodontic treatment for Class I and Class II cases.
Consultation .... NO CHARGE
Evaluation 45
Records/treatment planning 250
Orthodontic treatment 1,900

D8090—adult 19 years of age and over, up to 24 months of routine orthodontic treatment for Class I and Class II cases.
Consultation .... NO CHARGE
Evaluation 45
Records/treatment planning 250
Orthodontic treatment 1,900

D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s) 455

NOTE: Not all participating dentists perform all listed procedures, including amalgams. Please consult your dentist prior to treatment for availabilty of services. Unlisted procedures may be eligible for up to a 25% discount. Members may contact a participating provider to determine if any discounts apply. **To find a participating dentist visit HumanaDental.com.** When crown and/or bridgework exceeds six units in the same treatment plan, the patient may be charged an additional $75 per unit. Some covered services are typically only offered by a specialist (like many oral surgery procedures). Additional exclusions and limitations are listed along with full plan information in your certificate of benefits. If you do not have a certificate of benefits, please review the Specialty Benefits Regulatory and Technical Information Guide available at Disclosure.Humana.com.

HD210 HMO Dental Plan

APPLICATION FORM

BENEFIT ARCHITECTS

ENROLLMENT INSTRUCTIONS:

1. Complete and sign the application at the bottom (Be sure to list all Family Members to be covered.)
2. Fax completed application to 817-238-2104
3. Start your payroll deduction online or with a paper 1199-A. (Detailed instructions on the back of this form.)
4. Completed applications, with two correct payroll deducted premiums received by the 15th of the month will become effective on the 1st of the following month.

LAST NAME , FIRST NAME		M.I.	DATE OF BIRTH / /
SOCIAL SECURITY # AFGE LOCAL #	Dental Facility #	AGENT CODE #	SEX ☐ M ☐ F
HOME ADDRESS		AREA CODE	HOME PHONE
CITY / STATE / ZIP CODE		AREA CODE	CELL PHONE
EMAIL ADDRESS		AREA CODE	BUSINESS PHONE

LIST ALL YOUR ELIGIBLE DEPENDENTS IF THEY ARE TO BE COVERED

	FIRST	M.I.	LAST	SEX	DATE OF BIRTH
SPOUSE:				☐ M ☐ F	/ /
CHILD:				☐ M ☐ F	/ /
CHILD:				☐ M ☐ F	/ /
CHILD:				☐ M ☐ F	/ /

PLEASE NOTE: Any person who, with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. I hereby consent, personally and on behalf of any family members enrolled, to the unrestricted release of my/our dental records maintained by participating dentists to Humana for, but not limited to, claims verification and quality assessment review, and to any other participating dentist who may be or become involved in my/our dental care.

AUTHORIZATION– Signature Required

I authorize Humana Dental/HumanaVision/Benefit Architects to make Bi-Weekly Deductions of:

DENTAL PLAN	☐ $8 Employee	☐ $13 Employee + 1	☐ $18 Employee + Family	☐ Waive
VISION PLAN	☐ $5 Employee	☐ $10 Employee + 1	☐ $14 Employee + Family	☐ Waive

PREMIUM PAYMENT AMOUNTS	
DENTAL PREMIUM	$
VISION PREMIUM	$
TOTAL ALLOTMENT	$

I am currently an American Federation of Government Employees ("AFGE") member in good standing. I wish to enroll in the HumanaDental Plan and/or the Humana Vision Plan. I have received and understand the outline of coverage. I authorize HumanaDental and/or HumanaVision ("HUMANA") or their agents to collect Bi-Weekly from my salary or other payment methods and to remit the amount deducted to HUMANA. The amount of deduction indicated above is approximate and may be corrected as instructed by HUMANA. This authorization shall cease (a) upon my giving written cancellation notice to you; or (b) automatically upon my termination as a member of AFGE. I understand this authorization does not waive or change any of the payment provisions of any policy(ies) issued to me by HUMANA and if this authorization terminates for any reason, any further payments required under said policy(ies) shall be made as provided in the policy(ies). I agree that the above-named organization is acting gratuitously and for my sole accommodation and not as an agent for HUMANA.

Applicant's Signature: ______________________ Date Signed: ______________

For questions or more information contact:

Dental Plan Administration (800) 733-7236 ext. 1005

Fax completed application to (800) 238-2104

Dental plan benefits Provided by:

HumanaDental Corporation HumanaDental Customer Service **(800) 233-4013**

Your Local Agent:

Your Local Agent

BENEFIT ARCHITECTS

TRADITIONAL PLUS 09
PPO Dental Plan

HUMANA Dental Benefits

TRADITIONAL PLUS 09
PPO Dental Plan

- $50 Annual Deductable per Person/ $150 Annual Deductable for Family*
- $5,000 Annual Benefit Maximum per Person**
- PPO contracted rates are 10-20% less than the dentists normal rates.
- No Enrollment Fee

**Waived on Preventative Services, excludes Orthodontia*
***Excludes Orthodontia*

PREMIUMS

	Bi-weekly
Employee Only	$14
Employee + One	$26
Employee + Family	$39

WHEN AM I ELIGIBLE?

If paying by payroll deduction, you must have two (2) deductions by the 15th of the month for eligibility to begin the first of the following month.

If at any time you have a change of address, or phone number, notify Benefit Architects and Humana Dental by phone. If you take a leave of absence due to injury, etc. please be advised that you will be responsible for making arrangements to pay for your coverage until your allotments begin again.

BENEFIT ARCHITECTS

Building Better Benefits.

BENEFIT ARCHITECTS

Your Local Agent

TRADITIONAL PLUS 09
PPO Dental Plan

The network plan that offers maximum coverage with the cost advantages of a traditional indemnity plan.

WHAT TO EXPECT FROM YOUR DENTAL PLAN

When you're experiencing tooth pain, you can rest assured that your HumanaDental PPO dental insurance will give you the peace of mind that it will be there for you, helping with the expense of that trip to the dentist.

HumanaDental's fully insured PPO emphasizes preventive care – routine oral examinations, cleanings and x-rays – the simplest way to keep those nasty toothaches away.

And you'll get these benefits at an affordable price whether you choose a dentist from one of HumanaDental's participating dental office locations or if you choose a dentist who is not in our network.

If you need to file a claim, HumanaDental will reimburse you from our state-of-the-art claims system that pays claims quickly and correctly.

Get more out of your dental plan by visiting humanadental.com

Want to know the status of a claim? Need to find a dentist closer to you? You can do all of this and more at www.humanadental.com. Registering for this service is simple and will give you access to your plan benefits, including your benefit information, claims status, a list of providers and the option to change your account information. Just a few clicks of the mouse, and you'll be checking out your benefits in no time.

QUESTIONS, CALL (800) 733-7236 Ext. 1005

HOW TO ENROLL

1. **Complete and sign the Humana Traditional Plus 09 Application**
2. **Choose a Payment option:** Payroll Deduction
   (Note that many federal agencies now require employees to initiate the payroll deduction process electronically)

Payroll Deduction Option
Choose Electronic method OR submit provided Form 1199-A.

- ***Electronic***
  (Employee Express, MyPay, USDA National Finance Center)

  1. Go to the correct payroll site for your agency:
     www.employeeexpress.gov
     mypay.dfas.mil
     www.nfc.usda.gov (click on 'Employee Personal Page')
  2. Logon to the site with your ID and Password
  3. Navigate to the page to start the allotment
     - **Employee Express**: Financial Allotments
     - **My Pay**: Pay Changes, Allotment
     - **USDA NFC**: Self Service Tab, Financial Allotments
  4. Enter the allotment amount for the selected premium
  5. Enter the **Bank Routing Number - 114000093** (Frost Bank)
  6. Enter the **Account Number - 860022527**
  7. Confirm or save your changes

- ***Paper Form 1199A***

  Obtain the prefilled form by any of the following options:
  - Print the form directly from our website at: *www.benefitarchitects.com/TP09-1199.pdf*
  - Call us at 800-733-7236 and we will mail, fax or email a prefilled form to you.

  1. Complete the prefilled Direct Deposit Form 1199A
  2. Section 1- Part A (Name and Address), Part C (SSN), and Part G (Amount of $14, $26 or $39) and Signature.
  3. Section 2 Agency Name and Payroll Address
  4. Take the completed, signed form to your payroll clerk for processing.

3. **Mail or fax your completed application to:**

BENEFIT ARCHITECTS

Dental Plan
1301 Solana Boulevard
Building 2 - Suite 2320
Westlake, TX 76262

Fax (800) 238-2104

BENEFIT ARCHITECTS

Your Local Agent

TRADITIONAL PLUS 09 PPO DENTAL PLAN

FREQUENTLY ASKED QUESTIONS

Q. How does a Traditional Plus dental plan work?

A. Under our PPO plans, you do not have to pre-select a primary dentist. When you want dental services, make your appointment with any licensed dentist. When you receive treatment from a participating HumanaDental PPO dentist, **you can save up to 20%** (varies by zip code) on average billed charges. The network is nationwide so you can find a participating dentist near your home or work, while you are on vacation or away at college. Once services are performed, you or your dentist must file a claim form in order to receive reimbursement. Your claim will be paid based on your group's schedule of benefits. The plan will pay a percentage of the eligible charges, up to the plan's annual limit for benefits.

Q. How do I select an in-network dentist?

A. Select a dentist by visiting www.humanadental.com

1) Go to www.humanadental.com
2) Click 'Find a Dentist'
3) Search by Coverage and Network, choose 'PPO'
4) Enter your zip code
5) Under 'Select Your Network', choose 'PPO/Traditional'

Q. How do I select an out-of-network dentist?

A. By choosing a general dentist not included in the preferred provider list at www.humanadental.com, you have selected an out-of-network provider. You will be charged the dentist's usual fees for treatment. When you use an out-of-network dentist, your out-of-pocket costs will be typically greater than using an in-network dentist. To ensure you do not receive additional charges, visit a participating PPO network dentist.

Q. When is predetermination required?

A. If planned treatment is going to cost more than $200, you should ask your dentist to file for predetermination of benefits prior to treatment. Predetermination is not necessary for emergency treatment.

Q. How does my bill get paid?

A. Each dentist bills separately. Your dentist may agree to file your insurance claim for you. If he or she does not, however, you may be required to pay the entire bill at time of service and will need to submit a claim to HumanaDental for your reimbursement. Your reimbursement will be based on whether you have met any applicable deductible or coinsurance amounts or not. All financial arrangements concerning payment are strictly between you and your dentist and should be determined prior to treatment.

Q. Where do I send my claims?

A. You can get a claim form from your Group Benefits Administrator, from HumanaDental's Customer Care department or from our website, www.myHumanaDental.com.

Mail your claim to:
Humana Specialty Benefits
P.O. Box 14611
Lexington, KY 40512-4611

Q. Can I go online to find out more about my plan or get assistance?

A. Yes. After you enroll, you can visit www.humanadental.com to learn about your plan, check your benefits, use our Provider Locator, change your dentist selection, order ID cards, send us an e-mail and more.

For questions or more information contact:

Dental Plan Administration (800) 733-7236 ext. 1005
Fax completed application to (800) 238-2104

Dental plan benefits Provided by:
HumanaDental Corporation HumanaDental Customer Service **(800) 233-4013**

Your Local Agent

BENEFIT ARCHITECTS

TRADITIONAL PLUS 09 PPO SUMMARY OF BENEFITS

ACCESS TO INFORMATION

Our toll-free Customer Care number at (800) 233-4013 has Customer Care Representatives who can provide the answers you need quickly and thoroughly.

FREEDOM TO CHOOSE ANY DENTIST

Participants are free to select from a panel of participating dentists or seek care from any non-participating dentist.

VALUABLE SAVINGS FROM NETWORK DENTISTS

Network dentists offer savings by agreeing to charge you based on negotiated maximum allowable contracted fee schedule. If you go to a non-participating dentist, the charged amount may be above that charged by a Participating Dentist.

NO BALANCE BILLING

A participating dentist has agreed not to charge you any amount for services above the negotiated maximum allowable fee amount. When utilizing a non-participating dentist, you will be responsible for any extra amount charged by the dentist over the HumanaDental negotiated maximum and the customary charge of the dentist.

EXAMPLE OF IN-NETWORK SAVINGS

PROCEDURE COSTING $1,000		
	$1,000	$1,000
In-Network Discount (up to 20%)	-200	N/A
	800	1,000
Reimbursement of 60%	-480	-600
Amount Paid by Member	**$320**	**$400**

PARTIAL LISTING OF COVERED SERVICES

TYPE I PREVENTIVE 60%

- Oral examinations
- X-rays
- Cleanings
- Topical fluoride treatment (through age 14, one per calendar year)
- Sealants (through age 14)

TYPE II BASIC SERVICES 45%

- Space maintainers (through age 14)
- Emergency care for pain relief
- Basic oral surgery services - basic extractions of erupted tooth or root
- Fillings (amalgam, composite for anterior teeth)
- Appliances for children (through age 14)
- Prefabricated stainless steel crowns
- Complex surgical extractions - surgical removal of erupted tooth, impacted tooth, and tooth roots
- Periodontics
- Endodontics (root canal)

TYPE III MAJOR SERVICES 30%

- Crowns
- Inlays and onlays
- Bridgework
- Dentures
- Denture relines and rebases
- Denture repair and adjustments

TYPE IV ORTHODONTIA .... 50% NO DEDUCTIBLE

Covered dependent child age 18 and under $2,000 lifetime maximum. The 12 month waiting period may be decreased or waived based on the number of months the member had dental coverage immediately before joining the HumanaDental plan. Members must have prior orthodontic coverage to reduce or waive the waiting period under orthodontia.

MAXIMUM BENEFITS

Lifetime		
Type I, II, III	Unlimited	Unlimited
Calendar Year		
Type I, II, III	$5,000	$5,000
Deductible* **		
Type I	None	None
Type II, III	$50	$50

MAJOR RESTORATIVE LIMITATIONS

The charges for Major Restorative services will be Covered Dental Expenses subject to the following:

1. the denture or partial denture must replace a Natural Tooth extracted while insured for Dental Benefits under this policy;
2. the fixed bridge (including a resin bonded fixed bridge) must replace a Natural Tooth extracted while insured for Dental Benefits under this policy;
3. the replacement of a partial denture, full denture, or fixed partial denture (including a resin bonded bridge), or the addition of teeth to a partial denture if: (a) replacement occurs at least five years after the initial date of insertion of the current full or partial denture or resin bonded bridge; (b) replacement occurs at least five years after the initial date of insertion of an existing implant or fixed bridge; (c) replacement prosthesis or the addition of a tooth to a partial denture is required by the
4. necessary extraction of a Functioning Natural Tooth while insured for Dental Benefits under this policy; or (d) replacement is made necessary by a Covered Dental Injury to a partial denture, full denture, or fixed partial denture (including a resin bonded bridge) provided the replacement is completed within12 months of the injury;
5. the replacement of crowns, cast restorations, inlays, onlays or other laboratory prepared restorations if: (a) replacement occurs at least five years after the initial date of insertion; and (b) they are not serviceable and cannot be restored to function; the replacement of an existing partial denture with fixed bridgework, only if upgrading to fixed bridgework is essential to the correction of the person's dental condition; and
6. the replacement of teeth up to the normal complement of 32.

EXCLUSIONS

Benefits will not be paid for:

1. procedures which are not included in the Schedule of Benefits; which are not medically necessary; which do not have uniform professional endorsement; are experimental or investigational in nature; for which the patient has no legal obligation to pay; or for which a charge would not have been made in the absence of insurance;
2. any procedure, service, or supply which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least three years, as determined by HumanaDental Insurance Company;
3. crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth which may be restored with an amalgam or composite resin filling;
4. appliances, inlays, cast restorations or other laboratory prepared restorations used primarily for the purpose of splinting;
5. any procedure, service, supply or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension; the alteration or restoration of occlusion including occlusal adjustment, bite registration, or bite analysis;
6. pulp caps, adult fluoride treatments, athletic mouthguards; myofunctional therapy; infection control; precision or semiprecision attachments; denture duplication; oral hygiene instruction; separate charges for acid etch; broken appointments; treatment of jaw fractures; orthognathic surgery; completion of claim forms; exams required by third party; personal supplies (e.g. water pik, toothbrush, floss holder, etc.); or replacement of lost or stolen appliances;
7. charges for travel time; transportation costs; or professional advice given on the phone;
8. procedures performed by a Dentist who is a member of Your immediate family;
9. any charges, including ancillary charges, made by a hospital, ambulatory surgical center, or similar facility;
10. charges for treatment rendered: (a) in a clinic, dental or medical facility sponsored or maintained by the employer of any member of Your family; or (b) by an employee of the employer of any member of Your family;
11. any procedure, service or supply required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joints or their associated structures;
12. charges for treatment performed outside of the United States other than for emergency treatment. Benefits for emergency treatment which is performed outside of the United States are limited to a maximum of $100 (US dollars) per year;
13. the care or treatment of an injury or sickness due to war or an act of war, declared or undeclared;
14. treatment for cosmetic purposes. Facings on crowns orbridge units on molar teeth will always be considered cosmetic;
15. any services or supplies which do not meet the standards set by the American Dental Association or which are not reasonably necessary, or customarily used, for dental care;
16. procedures that are a covered expense under any other medical plan (established by the employer) which provides group hospital, surgical, or medical benefits whether or not on an insured basis;
17. a sickness for which the patient can receive benefits under a workers' compensation act or similar law;
18. an injury that arises out of or in the course of a job or employment for pay or profit;
19. charges to the extent that they are more than the Prevailing Fee. If the amount of the Prevailing Fee for a service cannot be determined due to the unusual nature of the service, HumanaDental Insurance Company will determine the amount. HumanaDental Insurance Company will take into account: (a) the complexity involved; (b) the degree of professional skill required; and (c) other-pertinent factors;
20. Implants.

PREDETERMINATION

If Covered Dental Expenses for a procedure are expected to be more than $200 it is recommended that you send a Dental Treatment Plan in prior to beginning treatment, send preauthorization to HumanaDental, P.O. Box 8236 Chicago, IL 60680–8236. You and/or your dentist will be notified of the benefits payable based upon the Dental Treatment Plan. This brochure contains a brief description of the plan. A complete description of the coverage, including limitations on certain procedures is found in the Schedule of Benefits and Certificate of Group Dental Insurance.

This is not the certificate of benefits. Members can obtain the certificate of benefits from HumanaDental.

TRADITIONAL PLUS 09

PPO Dental Plan

APPLICATION FORM

BENEFIT ARCHITECTS

ENROLLMENT INSTRUCTIONS:

1. Complete and sign the application at the bottom (Be sure to list all Family Members to be covered.)
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3. Start your payroll deduction online or with a paper 1199-A. (Detailed instructions on the back of this form.)
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LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH / /
SOCIAL SECURITY #	AFGE LOCAL #	AGENT CODE #	SEX ☐ M ☐ F
HOME ADDRESS		AREA CODE	HOME PHONE
CITY	STATE / ZIP CODE	AREA CODE	CELL PHONE
EMAIL ADDRESS		AREA CODE	BUSINESS PHONE

LIST ALL YOUR ELIGIBLE DEPENDENTS IF THEY ARE TO BE COVERED

	FIRST	M.I.	LAST	SEX	DATE OF BIRTH
SPOUSE:				☐ M ☐ F	/ /
CHILD:				☐ M ☐ F	/ /
CHILD:				☐ M ☐ F	/ /
CHILD:				☐ M ☐ F	/ /

PLEASE NOTE: Any person who, with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. I hereby consent, personally and on behalf of any family members enrolled, to the unrestricted release of my/our dental records maintained by participating dentists to Humana for, but not limited to, claims verification and quality assessment review, and to any other participating dentist who may be or become involved in my/our dental care.

AUTHORIZATION– Signature Required

I authorize Humana Dental/HumanaVision/Benefit Architects to make Bi-Weekly Deductions of:

DENTAL PLAN	☐ $14 Employee	☐ $26 Employee + 1	☐ $39 Employee + Family	☐ Waive
VISION PLAN	☐ $5 Employee	☐ $10 Employee + 1	☐ $14 Employee + Family	☐ Waive

PREMIUM PAYMENT AMOUNTS	
DENTAL PREMIUM	$
VISION PREMIUM	$
TOTAL ALLOTMENT	$

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Your Local Agent:

BENEFIT ARCHITECTS

Your Local Agent

TRADITIONAL PLUS 14
PPO Dental Plan

HUMANA Dental Benefits

TRADITIONAL PLUS 14
PPO Dental Plan

- $50 Annual Deductable per Person/
  $150 Annual Deductable for Family*
- $5,000 Annual Benefit Maximum per Person**
- PPO contracted rates are 10-20% less than the dentists normal rates.
- No Enrollment Fee

**Waived on Preventative Services, excludes Orthodontia*
***Excludes Orthodontia*

PREMIUMS

	Bi-weekly
Employee Only	$22
Employee + One	$38
Employee + Family	$56

WHEN AM I ELIGIBLE?

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Your Local Agent

BENEFIT ARCHITECTS

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HOW TO ENROLL

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2. **Choose a Payment option:** Payroll Deduction
   (Note many federal agencies now require employees to initiate the payroll deduction process electronically)

Payroll Deduction Option
Choose Electronic method OR submit provided Form 1199-A.

- ***Electronic (BEST WAY)***
  (Employee Express, MyPay, USDA National Finance Center)
  1. Go to the correct payroll site for your agency:
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     mypay.dfas.mil
     www.nfc.usda.gov (click on 'Employee Personal Page')
  2. Logon to the site with your ID and Password
  3. Navigate to the page to start the allotment
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  6. Enter the **Account Number - 860022527**
  7. Confirm or Save your changes

- ***Paper Form 1199A***

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  - Print the form directly from our website at: *www.benefitarchitects.com/TP09-1199.pdf*
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- Complete the prefilled Direct Deposit Form 1199A
- Section 1- Part A (Name and Address), Part C (SSN), and Part G (Amount of $22, $38 or $56) and Signature.
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- Take the completed, signed form to your payroll clerk for processing.

3. **Mail or fax your completed application to:**

BENEFIT ARCHITECTS

Dental Plan
1301 Solana Boulevard
Building 2 - Suite 2320
Westlake, TX 76262

Fax (800) 238-2104

PPO High Option
Humana Dental Traditional Plus 14

Individual : $22/biweekly
Individual + One: $38/biweekly
Family: $56/biweekly

	If you use an IN-NETWORK dentist		If you use an OUT-OF-NETWORK dentist	
Calendar-year deductible (excludes orthodontia services)	Individual $50	Family $150	Individual $50	Family $150
	Deductible applies to all services excluding preventive services.			
Calendar-year annual maximum (excludes orthodontia services)	$5,000 After you reach the annual maximum amount, you will receive 30 percent coinsurance on preventive, basic, and major services for the rest of the year (excludes orthodontia.)			
Preventive services • Routine oral examinations (2 per year) • Bitewing x-rays (2 films under age 10, up to 4 films ages 10 and older) • Routine cleanings (2 per year) • Fluoride treatment (1 per year, through age 14) • Sealants (permanent molars, through age 14) • Space maintainers (primary teeth, through age 14) • Oral Cancer Screening (1 per year, ages 40 and older)	90% no deductible		90% no deductible	
Basic services • Emergency care for pain relief • Amalgam fillings (1 per tooth every 2 years, composite for anterior/front teeth) • Oral surgery (tooth extractions including impacted teeth) • Stainless steel crowns • Harmful habit appliances for children (1 per lifetime, through age 14) • Periodontics (periodontal cleanings 4 per year, scaling/root planing and surgery 1 per quadrant every 3 years) • Endodontics (root canals 1 per tooth per lifetime and 1 re-treatment)	50% after deductible		50% after deductible	
Major services • Crowns (1 per tooth every 5 years) • Inlays/onlays (1 per tooth every 5 years) • Bridges (1 per tooth every 5 years) • Dentures (1 per tooth ever 5 years) • Denture relines/rebases (1 every 3 years, following 6 months of denture use) • Denture repair and adjustments (following 6 months of denture use) • Implants (1 every 5 years limited to crowns, bridges, and dentures. Coverage limited to equivalent cost of a non-implant service. Implant placement itself is not covered)	50% after deductible		50% after deductible	
Orthodontia services	Child orthodontia - Covers children through age 18. Plan pays 50 percent (no deductible) of the covered orthodontia services, up to: $2,000 lifetime orthodontia maximum.			

Non-participating dentists can bill you for charges above the amount covered by your HumanaDental plan. To ensure you do not receive additional charges, visit a participating PPO Network dentist. Members and their families benefit from negotiated discounts on covered services by choosing dentists in our network. If a member visits a participating network dentist, the member will not receive a bill for charges more than the negotiated fee for covered services. If a member sees an out-of-network dentist, coinsurance will apply to the maximum allowable charge of one or more network providers in your geographic area. Out-of-network dentists may bill you for charges above the amount covered by your dental plan.

TRADITIONAL PLUS 14

PPO Dental Plan

APPLICATION FORM

BENEFIT ARCHITECTS

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LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH
SOCIAL SECURITY #	AFGE LOCAL #	AGENT CODE #	SEX ☐ M ☐ F
HOME ADDRESS		AREA CODE	HOME PHONE
CITY	STATE / ZIP CODE	AREA CODE	CELL PHONE
EMAIL ADDRESS		AREA CODE	BUSINESS PHONE

LIST ALL YOUR ELIGIBLE DEPENDENTS IF THEY ARE TO BE COVERED

	FIRST	M.I.	LAST	SEX	DATE OF BIRTH
SPOUSE:				☐ M ☐ F	/
CHILD:				☐ M ☐ F	/ /
CHILD:				☐ M ☐ F	/ /
CHILD:				☐ M ☐ F	/ /

PLEASE NOTE: Any person who, with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. I hereby consent, personally and on behalf of any family members enrolled, to the unrestricted release of my/our dental records maintained by participating dentists to Humana for, but not limited to, claims verification and quality assessment review, and to any other participating dentist who may be or become involved in my/our dental care.

AUTHORIZATION– Signature Required

I authorize Humana Dental/HumanaVision/Benefit Architects to make Bi-Weekly Deductions of:

DENTAL PLAN	☐ $22 Employee	☐ $38 Employee + 1	☐ $56 Employee + Family	☐ Waive
VISION PLAN	☐ $5 Employee	☐ $10 Employee + 1	☐ $14 Employee + Family	☐ Waive

PREMIUM PAYMENT AMOUNTS	
DENTAL PREMIUM	$
VISION PREMIUM	$
TOTAL ALLOTMENT	$

I am currently an American Federation of Government Employees ("AFGE") member in good standing. I wish to enroll in the Humana Dental Plan and/or the Humana Vision Plan. I have received and understand the outline of coverage. I authorize Humana Dental and/or Humana Vision ("HUMANA") or their agents to collect Bi-Weekly deductions from my salary or other payment methods and to remit the amount deducted to HUMANA. The amount of deduction indicated above is approximate and may be corrected as instructed by HUMANA. This authorization shall cease (a) upon my giving written cancellation notice to you; or (b) automatically upon my termination as a member of AFGE. I understand this authorization does not waive or change any of the payment provisions of any policy(ies) issued to me by HUMANA and if this authorization terminates for any reason, any further payments required under said policy(ies) shall be made as provided in the policy(ies). I agree that the above-named organization is acting gratuitously and for my sole accommodation and not as an agent for HUMANA.

Applicant's Signature: ______________________ Date Signed: ______________

For questions or more information contact:

Dental Plan Administration (800) 733-7236 ext. 1005

Fax completed application to (800) 238-2104

Dental plan benefits Provided by:

HumanaDental Corporation HumanaDental Customer Service **(800) 233-4013**

Your Local Agent

Humana Vision 130

Humana.com

Benefit Architects, Inc

Vision care services	If you use an IN-NETWORK provider (Member cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
Exam with dilation as necessary	$10	Up to $30
• Retinal imaging[1]	Up to $39	Not covered
Contact lens exam options[2]		
• Standard contact lens fit and follow-up	Up to $55	Not covered
• Premium contact lens fit and follow-up	10% off retail	Not covered
Frames[3]	$130 allowance 20% off balance over $130	$65 allowance
Standard plastic lenses[4]		
• Single vision	$15	Up to $25
• Bifocal	$15	Up to $40
• Trifocal	$15	Up to $60
• Lenticular	$15	Up to $100
Covered lens options[4]		
• UV coating	$15	Not covered
• Tint (solid and gradient)	$15	Not covered
• Standard scratch-resistance	$15	Not covered
• Standard polycarbonate - adults	$40	Not covered
• Standard polycarbonate - children <19	$40	Not covered
• Standard anti-reflective coating	$45	Not covered
• Premium anti-reflective coating	Premium anti-reflective coatings as follows:	Premium anti-reflective coatings as follows:
- Tier 1	$57	Not covered
- Tier 2	$68	Not covered
- Tier 3	80% of charge	Not covered
• Standard progressive (add-on to bifocal)	$15	Up to $40
• Premium progressive	Premium progressives as follows:	Premium progressives as follows:
- Tier 1	$110	Not covered
- Tier 2	$120	Not covered
- Tier 3	$135	Not covered
- Tier 4	$90 copay, 80% of charge less $120 allowance	Not covered
• Photochromatic / plastic transitions	$75	Not covered
• Polarized	20% off retail	Not covered
Contact lenses[5] (applies to materials only)		
• Conventional	$130 allowance, 15% off balance over $130	$104 allowance
• Disposable	$130 allowance	$104 allowance
• Medically necessary	$0	$200 allowance

BENEFIT ARCHITECTS

Humana Vision 130

Vision Care services	If you use an IN-NETWORK provider (Member cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
Frequency		
• Examination	Once every 12 months	Once every 12 months
• Lenses or contact lenses	Once every 12 months	Once every 12 months
• Frame	Once every 24 months	Once every 24 months
Diabetic Eye Care: care and testing for diabetic members		
• Examination - Up to (2) services per year	$0	Up to $77
• Retinal Imaging - Up to (2) services per year	$0	Up to $50
• Extended Ophthalmoscopy - Up to (2) services per year	$0	Up to $15
• Gonioscopy - Up to (2) services per year	$0	Up to $15
• Scanning Laser - Up to (2) services per year	$0	Up to $33

Optional benefits

1. Member costs may exceed $39 with certain providers. Members may contact their participating provider to determine what costs or discounts are available.
2. Standard contact lens exam fit and follow up costs and premium contact lens exam discounts up to 10% may vary by participating provider. Members may contact their participating provider to determine what costs or discounts are available.
3. Discounts may be available on all frames except when prohibited by the manufacturer.
4. Lens option costs may vary by provider. Members may contact their participating provider to determine if listed costs are available.
5. Plan covers contact lenses or frames, but not both.

Additional plan discounts

- Member may receive a 20% discount on items not covered by the plan at network Providers. Members may contact their participating provider to determine what costs or discounts are available. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Certain brand name Vision Materials may not be eligible for a discount if the manufacturer imposes a no-discount practice. Frame, Lens, & Lens Option discounts apply only when purchasing a complete pair of eyeglasses. If purchased separately, members receive 20% off the retail price.
- Members may also receive 15% off retail price or 5% off promotional price for LASIK or PRK from the US Laser Network, owned and operated by LCA Vision. Since LASIK or PRK vision correction is an elective procedure, performed by specialty trained providers, this discount may not always be available from a provider in your immediate location.

Your Local Agent

BENEFIT ARCHITECTS

Limitations and Exclusions:

In addition to the limitations and exclusions listed in your "Vision Benefits" section, this policy does not provide benefits for the following:

1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. Services:
   - That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
   - Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
   - Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
   - War or any act of war, whether declared or not;
   - Any act of international armed conflict; or
   - Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment.
6. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
7. Prescription drugs or pre-medications, whether dispensed or prescribed.
8. Any service not specifically listed in the Schedule of Benefits.
9. Any service that we determine:
   - Is not a visual necessity;
   - Does not offer a favorable prognosis;
   - Does not have uniform professional endorsement; or
   - Is deemed to be experimental or investigational in nature.
10. Orthoptic or vision training.
11. Subnormal vision aids and associated testing.
12. Aniseikonic lenses.
13. Any service we consider cosmetic.
14. Any expense incurred before your effective date or after the date your coverage under this policy terminates.
15. Services provided by someone who ordinarily lives in your home or who is a family member.
16. Charges exceeding the reimbursement limit for the service.
17. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
18. Plano lenses.
19. Medical or surgical treatment of eye, eyes, or supporting structures.
20. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
21. Any examination or material required by an Employer as a condition of employment.
22. Non-prescription sunglasses.
23. Two pair of glasses in lieu of bifocals.
24. Services or materials provided by any other group benefit plans providing vision care.
25. Certain name brands when manufacturer imposes no discount.
26. Corrective vision treatment of an experimental nature.
27. Solutions and/or cleaning products for glasses or contact lenses.
28. Pathological treatment.
29. Non-prescription items.
30. Costs associated with securing materials.
31. Pre- and Post-operative services.
32. Orthokeratology.
33. Routine maintenance of materials.
34. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the certificate.
35. Artistically painted lenses.

Vision health impacts overall health

Routine eye exams can lead to early detection of vision problems and other diseases such as diabetes, hypertension, multiple sclerosis, high blood pressure, osteoporosis, and rheumatoid arthritis [1].

[1] Thompson Media Inc.

BI-WEEKLY PREMIUMS

Employee Only	$5
Employee + One	$10
Employee + Family	$14

Humana Vision products insured by Humana Insurance Company, Humana Health Benefit Plan of Louisiana, The Dental Concern, Inc. or Humana Insurance Company of New York.

This is not a complete disclosure of the plan qualifications and limitations. Specific limitations and exclusions as contained in the Regulatory and Technical Information Guide will be provided by the agent. Please review this information before applying for coverage.

NOTICE: Your actual expenses for covered services may exceed the stated cost or reimbursement amount because actual provider charges may not be used to determine insurer and member payment obligations.

Standard Form 1199A (EG)
(Rev. August 2012)
Prescribed by Treasury Department
Treasury Dept. Cir. 1076

Humana OMB No. 1510-0007

DIRECT DEPOSIT SIGN-UP FORM

DIRECTIONS

- To sign up for Direct Deposit, the payee is to read the back of this form and fill in the information requested in Sections 1 and 2. Then take or mail this form to the financial institution. The financial institution will verify the information in Sections 1 and 2, and will complete Section 3. The completed form will be returned to the Government agency identified below.
- A separate form must be completed for each type of payment to be sent by Direct Deposit.
- The claim number and type of payment are printed on Government checks. (See the sample check on the back of this form.) This information is also stated on beneficiary/annuitant award letters and other documents from the Government agency.
- Payees must keep the Government agency informed of any address changes in order to receive important information about benefits and to remain qualified for payments.

SECTION 1 *(TO BE COMPLETED BY PAYEE)*

A NAME OF PAYEE *(last, first, middle initial)*

ADDRESS *(street, route, P.O. Box, APO/FPO)*

CITY STATE ZIP CODE

TELEPHONE NUMBER
AREA CODE

B NAME OF PERSON(S) ENTITLED TO PAYMENT

C CLAIM OR PAYROLL ID NUMBER
Prefix Suffix

D TYPE OF DEPOSITOR ACCOUNT [X] CHECKING [ ] SAVINGS

E DEPOSITOR ACCOUNT NUMBER
8 6 0 0 2 2 5 2 7

F TYPE OF PAYMENT *(Check only one)*

- [ ] Social Security
- [ ] Supplemental Security Income
- [ ] Railroad Retirement
- [ ] Civil Service Retirement (OPM)
- [ ] VA Compensation or Pension
- [ ] Fed. Salary/Mil. Civilian Pay
- [ ] Mil. Active ______
- [ ] Mil. Retire. ______
- [ ] Mil. Survivor ______
- [X] Other ______ *(specify)*

G THIS BOX FOR ALLOTMENT OF PAYMENT ONLY *(if applicable)*

TYPE	AMOUNT

PAYEE/JOINT PAYEE CERTIFICATION

I certify that I am entitled to the payment identified above, and that I have read and understood the back of this form. In signing this form, I authorize my payment to be sent to the financial institution named below to be deposited to the designated account.

SIGNATURE	DATE
SIGNATURE	DATE

JOINT ACCOUNT HOLDERS' CERTIFICATION *(optional)*

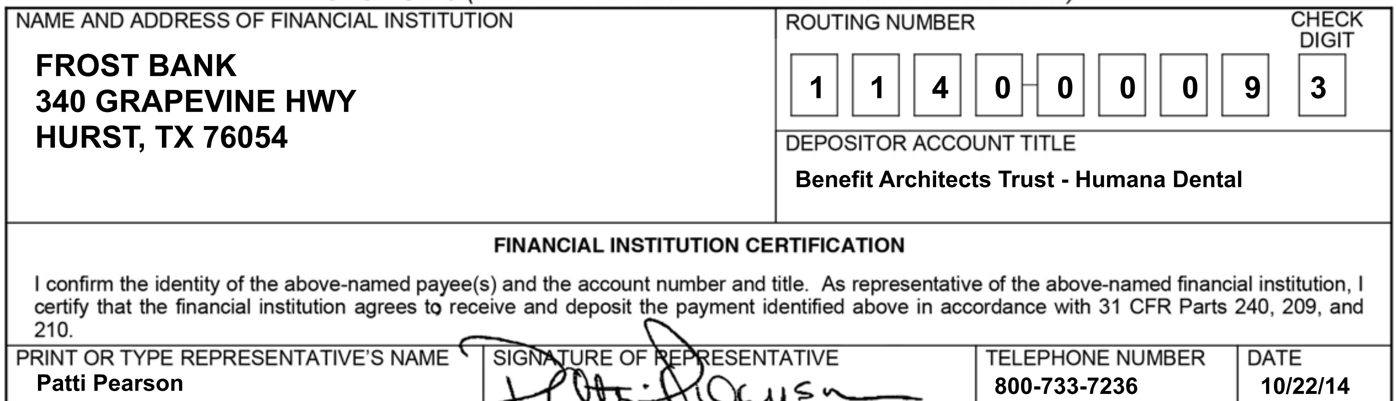
I certify that I have read and understood the back of this form, including the SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS.

SIGNATURE	DATE
SIGNATURE	DATE

SECTION 2 *(TO BE COMPLETED BY PAYEE OR FINANCIAL INSTITUTION)*

GOVERNMENT AGENCY NAME	GOVERNMENT AGENCY ADDRESS

SECTION 3 *(TO BE COMPLETED BY FINANCIAL INSTITUTION)*



NAME AND ADDRESS OF FINANCIAL INSTITUTION

FROST BANK
340 GRAPEVINE HWY
HURST, TX 76054

ROUTING NUMBER: 1 1 4 0 0 0 0 9 CHECK DIGIT: 3

DEPOSITOR ACCOUNT TITLE: **Benefit Architects Trust - Humana Dental**

FINANCIAL INSTITUTION CERTIFICATION

I confirm the identity of the above-named payee(s) and the account number and title. As representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209, and 210.

PRINT OR TYPE REPRESENTATIVE'S NAME	SIGNATURE OF REPRESENTATIVE	TELEPHONE NUMBER	DATE
Patti Pearson		800-733-7236	10/22/14

Financial institutions should refer to the GREEN BOOK for further instructions.
THE FINANCIAL INSTITUTION SHOULD MAIL THE COMPLETED FORM TO THE GOVERNMENT AGENCY IDENTIFIED ABOVE. Reset