Voluntary Dental

Good news about dental benefits for members of
Red River Federal Credit Union

Your Dental Plan

As a valued member of Red River Federal Credit Union, you have the opportunity to enroll in a group dental program.

Plan Features:

- Freedom to Choose any Dentist, Including Specialists
- Nationwide Coverage
- Fast and Accurate Claims Service
- No Referrals Required

How the Plan Works

This dental plan provides a variety of benefits and allows you and your family to use any dentist or specialist you choose. The plan pays the lesser of the provider's actual fee or the Maximum Covered Expense shown in the Schedule of Dental Services and as described in your Group Certificate. Benefits are paid after any applicable deductible has been met, up to the annual maximum. Allowable Charges are based on charges being made by providers in the area where the dental services are performed. Claim payments may be made to you or your dentist, whichever you prefer, unless benefits have been assigned to the provider.

IMPORTANT:

Coverage for eligible members will begin the first day of the month following enrollment. You must sign up by the Initial Enrollment Deadline, or forfeit the opportunity until the next plan anniversary date.

Plan frequencies, limitations and waiting periods apply.

Contact Member Service Corporation with any questions, 615-790-8500 or 1-800-537-9035.

The insurance policy or policies described in this document are underwritten by Union Security Insurance Company, a subsidiary of Assurant, Inc. Assurant Employee Benefits, a business unit of Assurant, Inc., markets life, disability and dental benefits plans as well as related products and services. In this document, the terms, "we", "us", "our", and the like, refer to each as applicable.

Savings You Can See

Monthly Deduction	
Member	$20.07
Member + 1 Dependent	$37.84
Member + 2 or more Dependents	$59.74

Freedom Schedule

Benefit Maximum:	
Per Person, Per Policy Year	$1,000
Deductible:	
Per Person, Per Policy Year	$50
Waived for Type I Services	Yes

Type I Preventive Dental Services	Maximum Covered Expense
Oral Evaluations, once in any 6-month period	$20
Fluoride Treatment - once in any 12-month period, *Only for children under age 14*	$16
Routine Dental Cleanings, adult/child once in any 6-month period	$41/30
Harmful Habit Appliance, limited once per person *Only for children under age 16*	$195
Space Maintainer, removable-bilateral *Only for children under age 16*	$264
Sealant, per permanent molar *Only for children under age 16*	$24

Type II Basic Dental Services, Including:

Simple Extraction, per tooth	$39
X-Rays, bitewing - 4 films	$19
Panoramic X-Ray	$36
Filling, one surface	$36
Incision and Drainage, Extraoral	$71
Therapeutic Drug Injections	$17

Type III Major Dental Services, Including:

Root Canal, molar	$343
Removal of Impacted Tooth (completely bony)	$83
Scaling & Root Planing, per quadrant	$45
Complete upper or lower dentures	$240
Partial upper or lower dentures	$240
Crown	$200
Reline or Rebase upper or lower denture	$71

Waiting Periods for Certain Services	From Your Effective Date
Type III Services	*6 months*

Waiting Periods do not apply to:
Treatment of an Accidental Non-Chewing Injury; or Re-cementing of or Repairs to Inlays, Onlays, Crowns or Fixed Partial Dentures (Bridges)

Other Policy Provisions

Benefit Adjustments
Benefits will be coordinated with any other dental coverage. Under the Alternative Treatment provision, benefits will be payable for the most economical services or supplies meeting broadly accepted standards of dental care. If the cost of a proposed Dental Treatment Plan exceeds $300, it should be submitted for an estimate of benefits payable.

Eligibility
Full-time member, spouse and unmarried dependent children less than age 19 or 25 if a full-time student or less than 24 if not a full-time student and dependent upon the insured for support and maintenance.

Late Entrants
If you elect coverage more than 31 days after your Eligibility Date, your Effective Date will be delayed to the next plan Anniversary Date.

This is a brief description only. It is not a Certificate of Coverage. Please see the Group Policy, which alone determines all rights, benefits, and applicable Limitations and Exclusions. We and the policyholder have the option to cancel the group policy.

Limitations & Exclusions

Benefits are not payable for:

Treatment which is not dentally necessary, does not have uniform professional endorsement or is experimental or investigational in nature; treatment of the temporomandibular joint; treatment related to changing or maintaining vertical dimension, altering or restoring occlusion, bite registration or bite analysis; treatment which does not have a reasonably favorable prognosis; treatment provided primarily for cosmetic purposes; replacement of natural teeth missing on the effective date of insurance; orthodontic treatment, unless such insurance is provided under the list of covered dental services.

Treatment not included in the list of covered dental services; treatment started before the date insurance begins; treatment started before any applicable waiting period has been served; treatment completed after insurance ends; athletic mouthguards; replacement of lost or stolen appliances; myofunctional therapy; infection control; oral hygiene instruction; broken appointments; completion of claim forms; exams required by a third party; travel time; transportation costs; professional advice given on the phone.

Treatment received due to war, riot, assault or felony; treatment for a work-related injury; treatment of an intentionally self-inflicted injury; treatment performed outside of the United States, other than emergency dental treatment; treatment provided by the person's employer or a member of the person's immediate family; treatment for which a charge would not have been made in the absence of insurance; treatment for which the insured does not have to pay; treatment that has not been both delivered to and accepted by the insured.

Group Insurance Enrollment Card

FRAUD STATEMENTS

Please read the following before completing the attached form.

- **If you live in the states of Arkansas or Louisiana, the following statement applies to you:**
  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 fines and confinement in prison.
- **If you live in the state of California, the following statement applies to you:**
  For your protection California law requires the following to appear on the form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
- **If you live in the state of Colorado, the following statement applies to you:**
  It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
- **If you live in the District of Columbia, the following statement applies to you:**
  WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
- **If you live in the state of Florida, the following statement applies to you:**
  Any person who knowingly and 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.
- **If you live in the state of Kansas, Maryland or Oregon, the following statement applies to you:**
  Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.
- **If you live in the state of New Jersey, the following statement applies to you:**
  Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
- **If you live in the state of Virginia, the following statement applies to you:**
  Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.
- **If you live in a state other than mentioned above, the following statement applies to you:**
  Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

To avoid unnecessary delays, be sure all parts of the Application are completed according to the instructions, and DO NOT SEPARATE the pages.

Group Insurance Enrollment Card

DETACH AND RETURN TO
MEMBER SERVICE CORPORATION
P.O. Box 389
Franklin, Tennessee 37065

(Please print clearly.)

Group **Red River Federal Credit Union I394**	Effective	Location/Division

Member First Name | MI | Last Name

Address | City | State | Zip

Social Security No.	Birthdate	Phone	Sex ☐ M ☐ F

DENTAL COVERAGE

I APPLY FOR:
- ☐ Member only
- ☐ Member and eligible dependents

Choose One:
- ☐ Savings Account Number_________________
- ☐ Checking Account Number_________________

Do you have eligible dependents? ☐ Yes ☐ No If "Yes," complete below to enroll them.	Relation	Sex	Birthdate Mo	Day	Year	For children age 19 or older, indicate if a full-time student. Yes	No
Spouse							
Child(ren)							

☐ List additional Children on reverse side and check box.

- If the address of any child is different than the employee's address, please show that **child's name and address** below.

  ____

- If requesting coverage for a dependent child other than a son or daughter, please forward legal custody papers.

To the best of my knowledge and belief, each of the statements and answers supplied in this form is complete and true, and they constitute the sole basis for, and are the inducement for, the issuance of any insurance.

I hereby apply as indicated herein for the insurance for which I am not now insured and for which I am or may become eligible under the terms of Union Security Insurance Company's group policy or policies (including any future amendments) applying to, or requested to apply to, the employer named above. If such insurance becomes effective, I authorize deductions from my earnings of my contributions required from time to time toward the cost of such insurance. I represent that I am an active full-time employee of that employer. When necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

Date ___________________________ Signature ____