

MOUNT HOLYOKE.



Group Number: 009135-7401

Upon completion, please return to your HR Department. Please print clearly.

Name: _____ Effective Date: _____ (to be completed by Employer)

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Sex: _____ Social Security #: _____

| PLEASE LIST ALL ELIGIBLE DEPENDENTS COVERED UNDER YOUR POLICY | | | | |
|---|---|---------------|------------|---|
| First Name | Last Name (if different from subscriber) | Date of Birth | Sex M/F | Check here if Dependent is over 19 and a Full Time Student |
| S P O U S E : | | | | |
| C H I L D R E N : | | | | |
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Reason for Submission (Check One)

New Addition

Individual Family

Termination

Name change

Address change

Add dependent to family

Remove dependent _____ name

Status Change

Individual to Family Family to Individual

COBRA Reinstatement of Subscriber

Individual Family

I certify that all information is true and correct to the best of my knowledge. Also, I understand that the effective date and termination date of my membership will be determined by my employer or plan sponsor in accordance with the underwriting guidelines of Delta Dental of Massachusetts. In addition, if my employer requires employee contributions for this coverage, I authorize the deduction of this amount from my wages.

Employee Signature

Date

Employer Authorization

Date

This chart represents the approximate level of coverage for services performed by dentists who participate in the Delta Dental Premier network. It also indicates any limitations that may exist for each service. The limitations reflect the availability of coverage only. It is up to you and your dentist to determine the need and frequency of dental procedures. Please see the reverse side of this page for information about how to use your plan.

**Delta Dental Premier
Group # 009135-7401
Plan B**

| Type I Preventive | Type II Basic Restorative | Type III Major Restorative |
|---|---|--|
| Deductible: None | Calendar Year Deductible: Types II & III Combined, \$50 Individual, \$150 Family | |
| Covered at 100% | Covered at 80% | Covered at 50% |
| <p>Diagnostic: Comprehensive Evaluation - <i>Once every 60 months per dentist</i> Periodic Oral Exams - <i>Once every 6 months</i> Full Mouth X-rays - <i>Once every 60 months</i> Bitewing X-rays - <i>Once every 6 months</i> Single Tooth X-rays - <i>As needed</i></p> <p>Preventive: Teeth Cleaning - <i>Once every 6 months</i></p> <p>Periodontal Cleaning - <i>Once every 3 months following active periodontal treatment, not to exceed 2 in a calendar year if combined with preventive cleanings</i></p> <p>Fluoride Treatments - <i>Once every 6 months for members under age 19</i> Space Maintainers (required due to the premature loss of teeth) - <i>For members under age 14 and not for the replacement of primary or permanent anterior teeth</i></p> <p>Sealants - <i>Unrestored permanent molars, once per tooth for members through age 15. Sealants are also covered for members aged 16 up to age 19 for those who have had a recent cavity and are at risk for decay</i></p> <p>Chlorhexidine Mouthrinse - <i>This is a covered benefit only when administered and dispensed in your dentist's office following scaling and root planning</i></p> <p>Fluoride Toothpaste - <i>This is a covered benefit only when administered and dispensed in your dentist's office following periodontal surgery</i></p> | <p>Restorative: Silver Fillings - <i>Once every 24 months per surface per tooth</i> White Fillings - <i>Once every 24 months per surface per tooth on front teeth; single surface only on back teeth</i> Temporary Fillings - <i>Once per tooth</i> Stainless Steel Crowns - <i>Once every 24 months per tooth</i></p> <p>Oral Surgery: <i>Oral surgical benefits not provided when rendered in a surgical day care or hospital setting</i> Simple Extractions Surgical Extractions</p> <p>Periodontics: Periodontal Surgery - <i>Periodontal benefits not provided when rendered in a surgical day care or hospital setting</i> Scaling and Root Planing - <i>Once in 24 months, per quadrant</i></p> <p>Endodontics: Root Canal Treatment - <i>Once per tooth</i> Vital Pulpotomy - <i>Limited to deciduous teeth</i></p> <p>Prosthetic Maintenance: Bridge or Denture Repair - <i>Once within 12 months, same repair</i> Rebase or Reline of Dentures - <i>Once within 36 months</i> Recement of Crowns and Onlays - <i>Once per tooth</i></p> <p>Emergency Dental Care: Minor Treatment for Pain Relief - <i>Three occurrences in 12 months</i> General Anesthesia - <i>Allowed with covered surgical services only</i></p> | <p>Prosthodontics: Dentures - <i>Once within 60 months</i> Fixed Bridges and Crowns (when part of a bridge) - <i>Once within 60 months</i></p> <p>Major Restorative: Crowns (when teeth cannot be restored with regular fillings) - <i>Once within 60 months per tooth</i></p> |
| Calendar Year Maximum: \$1,000 per person. | Limitations Do Apply. | |

Eligible dependents are covered up to age 26 or for two years past the loss of dependent status, whichever occurs first.

An Endosteal Implant is covered as Type III to replace one missing tooth (in lieu of a three unit bridge, and when the adjacent teeth do not require crowns.) Once per 60 months per implant.

Domestic Partner Coverage

Rollover Max Available - Limitations Apply - Visit www.deltadentalma.com/pdf/07/rollovermax.pdf to view program rules and details.

Identification Cards

As a Delta Dental Premier member, you will receive two identification cards from Delta Dental shortly after your enrollment. Both cards are issued in the subscriber's name, but can be used by everyone covered under your dental plan.

Choosing a Delta Dental Premier Dentist

You'll enjoy great benefits when you receive your dental care from a dentist in Delta Dental Premier's network of more than 6,000 dentist-locations (that's 96% of practicing dentists in Massachusetts), including: •Lower out-of-pocket costs: Participating dentists often accept discounted fees for their services. Since your co-payments are based on these discounted fees, you pay lower out-of-pocket costs than you would if you went to a non-participating dentist.

•No claims for you to handle.

•Direct payment: Delta Dental pays the dentist directly, so you don't have to pay the dentist the covered amount up front and wait for a reimbursement check.

To find out if your dentist is part of the Delta Dental Premier network, check the *Directory of Participating Dentists*, visit our Web site at www.deltamass.com, or call our Customer Service department at 1-800-872-0500.

About Non-Participating Dentists and Out-of-Network Coverage

Your dental plan provides coverage for services received from dentists who don't participate in the Delta Dental Premier network. However, your out-of-pocket expenses may be more. Out-of-network coverage is only available for those services covered by your Delta Dental Premier plan, and is subject to the same limitations and exclusions. Delta Dental's payment for services received from non-participating dentists is based on either the dentist's fee or the maximum plan allowance for non-participating dentists, whichever is lower. If you utilize the services of a nonparticipating dentist whose fees are higher than the maximum plan allowance, you will be responsible for the difference between Delta Dental's payment and the dentist's total submitted charge.

The Claims Process

Delta Dental Premier Dentists

•Simply provide your dentist with the information that is printed on your ID card.

•The dentist will submit your claim to Delta Dental.

•If you have a patient responsibility, Delta Dental will send you an Explanation of Benefits (EOB) detailing what Delta Dental paid the dentist under your plan's coverage and the remaining patient balance, which you pay directly to the dentist.

•If you receive a treatment that is not covered under your plan, you may be billed at the dentist's normal rate rather than Delta Dental's negotiated rate. **Also, if you receive a treatment after you have exhausted your maximum, or if you receive a treatment which will cause you to exceed your maximum, you may be billed at the dentist's normal rate rather than Delta Dental's negotiated rate.** To avoid any unexpected out-of-pocket expenses, we recommend that you visit Delta Dental's Web site at www.deltamass.com or call Customer Service at 1-800-872-0500 to determine your remaining benefits.

Non-Participating Dentists

•Simply provide your dentist with the information that is printed on your ID card. Your dentist will collect his/her fees directly from you.

•Delta Dental will reimburse you based on a claim form that you submit to: Delta Dental, P.O. Box 9695, Boston, MA 02114. Your dentist may be willing to prepare and submit the claim for you.

•You are responsible for the difference between what Delta Dental pays and what the dentist charges.

•If you receive a treatment that is not covered under your plan, you may be billed at the dentist's normal rate rather than Delta Dental's negotiated rate. **Also, if you receive a treatment after you have exhausted your maximum, or if you receive a treatment which will cause you to exceed your maximum, you may be billed at the dentist's normal rate rather than Delta Dental's negotiated rate.** To avoid any unexpected out-of-pocket expenses, we recommend that you visit Delta Dental's Web site at www.deltamass.com or call Customer Service at 1-800-872-0500 to determine your remaining benefits.

Coordination of Benefits

If your family is covered by more than one dental plan (or a medical plan that offers dental coverage), Delta Dental will coordinate benefits with the other carrier. In determining coverage, total payments from both carriers cannot exceed the allowable charge for the service. If you have a question about Coordination of Benefits (COB), please contact our Customer Service department at 1-800-872-0500

Other Claims Information

•You may want to ask your dentist to submit a pre-treatment estimate to Delta Dental for any procedure that exceeds \$300. This will enable us to help you estimate any out-of-pocket expenses you may incur.

•All claims must be submitted within one year.

•If a claim is denied, you can request an appeal by writing to Delta Dental within 180 days of receiving notice on the claim. Send appeals to Delta Dental, P.O. Box 9695, Boston, MA 02114.

•Under your plan's subrogation clause, you may be required to reimburse Delta Dental for claim payments if you also receive payment from a third party who is held liable for an injury that required the dental care.

Where to Get More Information

If you have further questions, please contact Delta Dental's Customer Service department at 1-800-872-0500.

This information should be used only as a guideline for your dental benefits plan. For detailed information on your group's plan, riders, terms and conditions, or limitations and exclusions, please see the subscriber certificate. Copies of the Subscriber Certificate are available through your benefits administrator.

At your request, interpreter and translation services related to administrative procedures are available to you or a covered family member.

خدمات ترجمة فورية/ترجمة
في حالة طلبكم نقوم بتوفير مترجمين وخدمات ترجمة تتعلق بالإجراءات الإدارية.

អ្នកបកប្រែ ឬអ្នកបកប្រែ

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翻譯服務

如果您提出要求，我們可以為您提供相關的行政禮節的翻譯服務。

Services de traduction et d'interprétariat.

Les services de traduction et d'interprétariat en connexion avec les procédures administratives sont disponibles sur demande

Услуги устного/письменного перевода.

По Вашему требованию будут предоставлены услуги устного и письменного перевода, связанные с административными процедурами.

Sèvis Entèprèt ak Tradiksyon Si w mande sèvis entèprèt ak tradiksyon pou prosede administratif, nap mete yo a dispozisyon ou.

Servizi di interpretariato e traduzione A richiesta, sono disponibili servizi di interpretariato e traduzione relazionati con pratiche amministrative.

ບໍລິການແປພາສາ ແລະ ນາຍພາສາ

ຕາມທີ່ທ່ານຂໍມາ, ພວກເຮົາມີບໍລິການນາຍ ແປພາສາ ແລະ ການແປພາສາທີ່ກ່ຽວກັບຂັ້ນຕອນການບໍລິຫານໃຫ້ທ່ານແລະ ສມາຊິກໃນຄອບຄົວຂອງທ່ານ

Serviços de tradutor(a)/intérprete Se assim o solicitar, estão disponíveis serviços de tradução e interpretação para os procedimentos administrativos.

Υπηρεσίες Διερμηνείας/Μεταφραστών

Μετά από αίτησή σας, υπηρεσίες διερμηνείας και μεταφραστών οχημάτων με διολκηκτικές διαιρέσεις είναι στη διάθεσή σας.

Servicios de interpretación/traducción Si usted lo solicita, se encuentran a su disposición servicios de interpretación y traducción para asistirle en procedimientos administrativos.

Your Plan is Administered by:
Delta Dental of Massachusetts
1-800-872-0500



Delta Dental of Massachusetts
465 Medford Street, Boston, MA 02129
www.deltamass.com

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