Town of Hudson

Dental Highlight Sheet

Policy #25788

Dental Plan Summary LOW PLAN

Coinsurance	In Network	Out of Network
Type 1	Maximum Covered Expense	Maximum Covered Expense
Type 2	Maximum Covered Expense	Maximum Covered Expense
Type 3	Maximum Covered Expense	Maximum Covered Expense
Deductible	NONE	$50/Calendar Year Type 2 & 3 Waived Type 1 No Family Maximum
Maximum *(per person)*	$1,000 per calendar year	$1,000 per calendar year
Allowance	Contracted Fee	MCE
Waiting Period	None	None
Annual Eye Exam	None	None

Sample Procedure Listing (*Current Dental Terminology* © American Dental Association.)

In Network and Out of Network

Type 1	Type 2	Type 3
• Routine Exam (2 per benefit period)	• Full Mouth/Panoramic X-rays (1 in 3 years)	• Onlays
• Bitewing X-rays (2 per benefit period)	• Periapical X-rays	• Crowns (1 in 5 years per tooth)
• Cleaning (2 per benefit period)	• Sealants (age 16 and under)	• Crown Repair
• Fluoride for Children 18 and under (1 per benefit period)	• Restorative Amalgams	• Endodontics (nonsurgical)
• Space Maintainers	• Restorative Composites	• Endodontics (surgical)
	• Denture Repair	• Periodontics (nonsurgical)
	• Simple Extractions	• Periodontics (surgical)
	• Complex Extractions	• Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 5 years)
	• Anesthesia	

Ameritas Information

We're Here to Help

This plan was designed specifically for the associates of Town of Hudson. At Ameritas Group, we do more than provide coverage - we make sure there's always a friendly voice to explain your benefits, listen to your concerns, and answer your questions. Our customer relations associates will be pleased to assist you 7 a.m. to midnight (Central Time) Monday through Thursday, and 7 a.m. to 6:30 p.m. on Friday. You can speak to them by calling toll-free: 800-487-5553. For plan information any time, access our automated voice response system or go online to ameritasgroup.com/member.

PPO Information

Go online to ameritasgroup.com/member to find the participating network dentists who are most convenient for you. The plan you belong to is PPO - Nationwide. While using a PPO dentist will almost always lower your out of pocket costs, every Ameritas Group plan gives you the freedom to visit any dentist you choose.

Pretreatment

While we don't require a pretreatment authorization form for any procedure, we recommend them for any dental work you consider expensive. As a smart consumer, it's best for you to know your share of the cost up front. Simply ask your dentist to submit the information for a pretreatment estimate to our customer relations department. We'll inform both you and your dentist of the exact amount your insurance will cover and the amount that you will be responsible for. That way, there won't be any surprises once the work has been completed.

Late Entrant Provision

We strongly encourage you to sign up for coverage when you are initially eligible. If you choose not to sign up during this initial enrollment period, you will become a late entrant. Late entrants will be eligible for only exams, cleanings, and fluoride applications for the first 12 months they are covered.

Town of Hudson

Dental Highlight Sheet
Policy # 25788

AMERITAS GROUP

Dental Plan Summary HIGH PLAN

Coinsurance	In Network	Out of Network
Type 1	100%	100%
Type 2	80%	80%
Type 3	50%	50%
Deductible	NONE	$50/Calendar Year Type 2 & 3 Waived Type 1 No Family Maximum
Maximum *(per person)*	$1,000 per calendar year	$1,000 per calendar year
Allowance	Contracted Fee	90th U&C
Waiting Period	None	None
Annual Eye Exam	None	None

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In Network and Out of Network

Type 1	Type 2	Type 3
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• Bitewing X-rays (2 per benefit period)	• Periapical X-rays	• Crowns (1 in 5 years per tooth)
• Cleaning (2 per benefit period)	• Sealants (age 16 and under)	• Crown Repair
• Fluoride for Children 18 and under (1 per benefit period)	• Restorative Amalgams	• Endodontics (nonsurgical)
• Space Maintainers	• Restorative Composites	• Endodontics (surgical)
	• Denture Repair	• Periodontics (nonsurgical)
	• Simple Extractions	• Periodontics (surgical)
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enrollment/change/waiver

group insurance form

Notice: Before enrolling, please review carefully.

COBRA: If individual is a continuee
Qualifying Event _____
Date of Event _____

AMERITAS LIFE INSURANCE CORP.
P.O. Box 81889
Lincoln, NE 68501-1889
800-659-2223 / Fax: 402-467-7338

Important: Your plan has no waiting (elimination) period. If you decided to waive coverage during your initial enrollment period, your services are limited to evaluations, prophylaxis (cleanings), and fluoride application for 12 months.

Policy and Div. # **010-**_____ Cert. #_____ **Select plan** ☐ High ☐ Low

Name and Address of Employer (Policyholder) _____

1 to enroll ☐ **Dental** ☐ **Eye Care** ☐ To terminate all coverages

employee information Marital Status ☐ Single ☐ Married ☐ Civil Union* ☐ Domestic Partner* *As defined by state law or your Group.

Social Security number _____ Dept. number _____

Employee's last name, first name, MI _____

Date of birth_____ ☐ Male ☐ Female Full time date of hire_____ ☐ Rehire: Rehire date_____

Occupation _____

Hours worked each week _____ Are your earnings paid: ☐ Hourly or ☐ Salaried

Street address _____ City_____ State_____ ZIP_____

E-mail address (limit of 60 characters) _____

Are you covered under another **dental** insurance plan? . . . . . **Employee:** ☐ Yes ☐ No **Dependents:** ☐ Yes ☐ No
Are you covered under another **eye care** insurance plan? . . . . . **Employee:** ☐ Yes ☐ No **Dependents:** ☐ Yes ☐ No

dependent coverage information List all eligible dependents to be added or deleted. (Employee must be enrolled to cover dependents)

print full legal name (last, first. MI)	dental add	eye care add	dental drop	eye care drop	relationship	sex	date of birth	social security no.	college student?
1									
2									
3									
4									
5									

please sign (employee/policyholder) **The certificate provides dental and eye care benefits only. Review your certificate carefully.**
As an employee, I hereby apply for, or waive (if indicated), group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary. *THE FOLLOWING APPLIES ONLY TO SECTION 125 FLEXIBLE BENEFITS PLANS:* I am signing up for coverage until the next enrollment period except in the case of a life event. This information was explained in the plan's solicitation materials which I have read and understand. I represent that the information I have provided is complete and accurate to the best of my knowledge. The policyholder certifies the date of employment, job title, hours worked and salary information are correct according to the Policyholder's records.

X _____ X _____
Employee Signature (do not print) **Date** **Policyholder Signature (do not print)** **Date**

In several states, we are required to advise you of the following: Any person who knowingly and with intent to defraud provides false, incomplete, or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, is guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim. (State-specific statements on back.)

Employee late entrant date _____
Dependent late entrant date _____

Effective Date	Class	Dep. Code

2 to change

☐ **Name change** New Name_____ Old Name_____

☐ **Add dependent coverage**
- ☐ If due to marriage, what is the date of marriage?_____ ☐ If due to birth/adoption, what is the date of event?_____
- ☐ If due to loss of coverage, date and reason: _____
- ☐ If other, the date of event and please explain: _____

☐ **Drop dependent coverage** Number of dependents still covered: _____ Effective date of drop: _____
- ☐ Due to divorce ☐ Due to death ☐ Due to annual election period ☐ Exceeds maximum age to qualify as dependent
- ☐ Other (please explain)_____

3 to waive IF YOU DO NOT WANT COVERAGE, COMPLETE THE WAIVER SECTION. THE WAIVER MAY NOT BE ALLOWED FOR THIS PLAN, CHECK WITH YOUR EMPLOYER. I have been given an opportunity to apply for Group Insurance offered by my employer, and have decided not to accept the offer for:
☐ **myself** (does not apply to TRUST policies) ☐ **spouse/domestic partner** ☐ **child(ren) only** ☐ **spouse/domestic partner and child(ren)**

because _____

Name of insurance company and employer of dependent _____
Should I desire to apply for this group insurance in the future, I realize that a "late entrant" penalty may be applied.