

**Delta Dental Premier  
Summary of Dental Plan Benefits  
For Group# 0009823-1001, 1101, 1002, 1102, 1003, 1103, 1004, 1104  
Christian Church (Disciples of Christ) Health Care Benefit Trust**

This Summary of Dental Plan Benefits should be read in conjunction with your Dental Care Certificate. Your Dental Care Certificate will provide you with additional information about your Delta Dental plan, including information about plan exclusions and limitations. In the event that you seek treatment from a dentist that does not participate in any of Delta Dental's programs, you may be responsible for more than the percentage indicated below.

**Control Plan** – Delta Dental of Indiana

**Benefit Year** – January 1 through December 31

**Covered Services -**

	Plan Pays	You Pay
<b>Class I Benefits</b>		
<b>Diagnostic and Preventive Services</b> - includes exams, cleanings, fluoride, and space maintainers	100%	0%
<b>Emergency Palliative Treatment</b> - to temporarily relieve pain	100%	0%
<b>Sealants</b> - to prevent decay of permanent teeth	100%	0%
<b>Radiographs</b> - X-rays	100%	0%
<b>Class II Benefits</b>		
<b>Major Restorative Services</b> - includes crowns	50%	50%
<b>Minor Restorative Services</b> - includes fillings	80%	20%
<b>Periodontic Services</b> - to treat gum disease	80%	20%
<b>Endodontic Services</b> - includes root canals	80%	20%
<b>Oral Surgery Services</b> - extractions and dental surgery	80%	20%
<b>Relines and Repairs</b> - to bridges and dentures	50%	50%
<b>Other Basic Services</b> - misc. services	80%	20%
<b>Class III Benefits</b>		
<b>Prosthetic Services</b> - includes bridges and dentures	50%	50%
<b>Implants</b> - endosteal implants to replace missing teeth	50%	50%
<b>Class IV Benefits</b>		
<b>Orthodontic Services</b> - includes braces	50%	50%
<b>Orthodontic Age Limit</b> -	To age 19	

- Oral exams are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- Fluoride treatments are payable twice per calendar year for people up to age 19.
- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) are payable once in any five-year period.
- Sealants are only payable once per tooth per lifetime for the occlusal surface of first permanent molars up to age nine and second permanent molars up to age 14. The surface must be free from decay and restorations.
- Composite resin (white) restorations are Covered Services on posterior teeth.
- Porcelain crowns are optional treatment on posterior teeth.
- Implants and implant related services are payable once per tooth in any five-year period.
- People with certain high-risk medical conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.

Having Delta Dental coverage makes it easy for our enrollees to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to the AXA Assistance USA, Inc. worldwide network of dentists and dental clinics. English-speaking AXA Assistance operators are available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

**Maximum Payment** – \$1,200 per person total per benefit year on all services except Orthodontics. \$1,000 per person total per lifetime on Orthodontic Services.

**Deductible** – \$50 deductible per person total per benefit year limited to a maximum deductible of \$150 per family per benefit year. The deductible does not apply to Diagnostic and Preventive services, Emergency Palliative Treatment, X-rays, Sealants, and Orthodontics Services.

**Waiting Period** – Employees who are eligible for dental benefits are covered on the first day of the calendar month following the date of eligibility if all eligibility and enrollment requirements of this plan are satisfied. Coverage will remain in effect for as long as the member maintains his or her eligible status, as defined by the Pension Fund.

**Eligible People** – Pension Plan members and those eligible for Pension Plan membership and their dependents may enroll. This means all persons employed by churches or organizations of the Christian Church and the Stone - Campbell tradition, for all such are eligible for the Pension Plan as well as the Churchwide Health Care Program and Christian Leadership Benefit Alliance located in: Alaska, California, Colorado, Connecticut, Delaware, Minnesota, New Jersey, New Mexico, Oklahoma, Oregon or Washington (1001, 1101); Arizona, Florida, Guam, Hawaii, Idaho, Illinois, Maine, Massachusetts, Michigan, Nebraska, Nevada, New Hampshire, New York, Rhode Island, Utah, Vermont, Virgin Islands, Washington, D.C. or Wyoming (1002, 1102); Alabama, Georgia, Kansas, Louisiana, Missouri, Montana, North Dakota, South Carolina, South Dakota, Texas, Virginia or Wisconsin (1003, 1103); Arkansas, Indiana, Iowa, Kentucky, Maryland, Mississippi, North Carolina, Ohio, Pennsylvania, Puerto Rico, Tennessee or West Virginia (1004, 1104) and COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) enrollees, if applicable.

Also eligible are your legal spouse, your dependent children to the end of the calendar year in which they turn 19, and your dependent unmarried children who are eligible to be claimed by you as a dependent under the U.S. Internal Revenue code during the current calendar year.

If you and your spouse are both eligible for coverage under this Policy, you may be enrolled together on one application card or separately on individual application cards, but not both. Your dependent children may only be enrolled on one application card. Delta Dental will not coordinate benefits if you and your spouse are both covered under this Policy. The Contractor pays the full cost of this plan.

Benefits will cease on the last day of the month.

# Eligibility Enrollment/Update

Check:  Michigan  Indiana  Ohio

Check one or both. Enrolling for:  Dental  Vision

Client Name: \_\_\_\_\_

Client#/Subclient# -

**Subscriber Information (please complete for all enrollments/updates:)** Example: **ABCDEF123456**

Subscriber Name (Last)  (First)  (M.I.)  Sex  Male  Female

Subscriber Social Security Number -- Birth Date -- Status\*  Active  Retiree  COBRA  Surviving Coverage Effective Date --

Street Address   Check here if this is a new address

City  State  ZIP Code -

**Plan Enrollment/Update Information (please indicate type of update and fill in appropriate information):**

Type of Update:  New Enrollment  Reinstatement  Change/Correction to Information  Termination of Benefits

Group Transfer From: Client/Subclient# - To: Client/Subclient# - Rate Code Change\* From:  To:  Effective Date of Change -- Change is for:  Subscriber  Dependent

**Enrollment/Corrections to Information (please fill in for spouse/dependents for first-time enrollment or corrections):**

**SPOUSE** Name (Last)  (First)  (M.I.)  Sex  Male  Female  
 Social Security Number -- Birth Date -- Status\*  Legal  Surviving

**DEPENDENT #1** Name (Last)  (First)  (M.I.)  Sex  Male  Female  
 Social Security Number -- Birth Date -- Status\*  IRS Dep.  Disabled  Surviving  Sponsored

**DEPENDENT #2** Name (Last)  (First)  (M.I.)  Sex  Male  Female  
 Social Security Number -- Birth Date -- Status\*  IRS Dep.  Disabled  Surviving  Sponsored

**DEPENDENT #3** Name (Last)  (First)  (M.I.)  Sex  Male  Female  
 Social Security Number -- Birth Date -- Status\*  IRS Dep.  Disabled  Surviving  Sponsored

**DEPENDENT #4** Name (Last)  (First)  (M.I.)  Sex  Male  Female  
 Social Security Number -- Birth Date -- Status\*  IRS Dep.  Disabled  Surviving  Sponsored

\*See reverse side for instructions and explanation of codes.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

1 Subscriber's Signature \_\_\_\_\_ Date \_\_\_\_\_

Please read the following information carefully before completing the other side of this form. You should fill out this form if you are enrolling for coverage or changing any information from an earlier enrollment. If you have any questions about filling out this form, your human resources or personnel department can help you.

**Subscriber Information** – This section must be completed for us to process your enrollment or update your records. All information should apply to you, the primary subscriber. Please print clearly or type.

**Effective Date:** The date that Delta Dental coverage takes effect for you and/or your dependents.

**Status Definitions** (Please select only one status):

**Active:** You are a current/active subscriber.

**Retiree:** You are retired and your group continues to provide you with dental benefits.

**COBRA:** You are no longer an active subscriber but you have continued self-paid coverage under COBRA. COBRA requires many employers to offer extended self-paid coverage to certain employees and qualified beneficiaries who lose group medical benefits coverage. **Please check with your human resources or personnel department.**

**Surviving:** The surviving spouse or child of a deceased subscriber.

**Plan Enrollment/Update Information** – This section should only be completed if you are: (1) Enrolling yourself or a family member for the first time, or (2) if your benefits were terminated and are not being reinstated or, (3) if you are making changes to your current enrollment information.

**Enrollment:** Check for first time enrollment for yourself or your dependents.

**Reinstatement:** Check for reinstatement coverage for yourself or your dependents.

**Change/Corrections:** Check if any changes are being submitted on the form.

**Termination of Benefits:** Check only if you are terminating Delta Dental coverage for yourself or a family member.

**Group Transfers:** When transferring from one group to another, all dependents will transfer unless otherwise indicated. This section should also be completed when transferring to COBRA.

When reporting a change or correction, the information that is incorrect or has changed should be listed on the line titled "from" and the correct information should be listed on the line titled "to".

When changing a rate code, please refer to the following explanation to select the code that describes who is being covered by your Delta Dental program.

**Rate Codes:**

- Rate 1** Employee Only
- Rate 2** Employee and spouse
- Rate 3** Employee, spouse and children
- Rate 5** Employee, one child, no spouse
- Rate 6** Employee and more than one child, no spouse

**Enrollment/Corrections To Information** – This section should be completed when: (1) enrolling dependents or, (2) if you have checked Changes/Corrections and are changing information that was previously submitted to Delta Dental. Please include both first and last names of any individuals for whom you are enrolling or submitting a change or correction.

**Dependent Status Definitions:**

**Legal:** Your current spouse

**Surviving:** The surviving spouse or child of a deceased subscriber.

**IRS Dependent:** An individual who is your dependent child according to the U.S. Internal Revenue Code. This could include your unmarried dependent child who is attending a university, college, community college, junior college or trade school on a full-time basis and for whom you provide principal support.

**Disabled:** Your permanently disabled child.

**Sponsored:** A dependent for whom you are legally responsible. Sponsored dependents could include parents, grandparents and foreign exchange students, **but only if specified in your group's contract with Delta Dental.**

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