ATTALA COUNTY SCHOOLS

Dental Highlight Sheet

Effective Date: 4/1/2023

High Plan: Dental Plan Summary

Plan Benefit	
Type 1	100%
Type 2	80%
Type 3	50%
Deductible	$50/Calendar Year Type 2 & 3 Waived Type 1 No Family Maximum
Maximum *(per person)*	$1 250 per calendar year
Allowance	U&C
Dental Rewards®	Included
Waiting Period	12 months Type 3 only - New Hires/New Enrollees Only
Annual Open Enrollment	Included

Orthodontia Summary - Adult and Child Coverage

Allowance	U&C
Plan Benefit	50%
Lifetime Maximum *(per person)*	$1,000
Waiting Period	12 months New Hires/New Enrollees Only

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

Type 1

- Routine Exam (2 per benefit period)
- Bitewing X-rays (1 per benefit period)
- Full Mouth/Panoramic X-rays (1 in 3 years)
- Periapical X-rays
- Cleaning (2 per benefit period)
- Fluoride for Children 13 and under (1 per benefit period)
- Sealants (age 15 and under)
- Space Maintainers

Type 2

- Restorative Amalgams
- Restorative Composites
- Denture Repair
- Simple Extractions
- Anesthesia

Type 3

- Onlays
- Crowns (1 in 5 years per tooth)
- Crown Repair
- Endodontics (nonsurgical)
- Endodontics (surgical)
- Periodontics (nonsurgical)
- Periodontics (surgical)
- Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 5 years)
- Complex Extractions

Monthly Rates

Employee Only (EE)	$34.68
EE + Spouse	$72.76
EE + Children	$81.16
EE + Spouse & Children	$115.64

Ameritas Information

We're Here to Help

This plan was designed specifically for the associates of **ATTALA COUNTY SCHOOLS.** 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 ameritas.com.

Rx Savings

Our valued plan members and their covered dependents can save on prescription medications at over 60,000 pharmacies across the nation including CVS, Walgreens, Rite Aid and Walmart. This Rx discount is offered at no additional cost, and it is not insurance.

To receive this Rx discount, Ameritas plan members just need to visit us at ameritas.com and sign into (or create) a secure member account where they can access and print an online-only Rx discount savings ID card.

enrollment/change/waiver Group Insurance Form

Ameritas Life Insurance Corp. P.O. Box 81889 / Lincoln, NE 68501-1889 / 800-659-2223 / Fax: 402-467-7338

Policy and Div. # 010- ____________________

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

Cert. # ____________________

Name and Address of Employer (Policyholder) Attala Co Schools

Select plan ☐ High ☐ Low

1 to enroll ☒ Dental ☐ 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

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	Dental drop	Relationship	Sex	Date of birth	Social Security no.	College student?
1	☐	☐					☐
2	☐	☐					☐
3	☐	☐					☐
4	☐	☐					☐
5	☐	☐					☐

Please Sign (employee/policyholder) **The certificate provides dental 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 ____________________ Date ________
Employee Signature (do not print)

X ____________________ Date ________
Policyholder Signature (do not print)

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.