The Dental Care PLUS GROUP

Benefit Summary

GREATER CINCINNATI INSURANCE CONSORTIUM

Product: DHMO

Network: Dental Care Plus

Benefit Year: The 12 month period beginning January 1st and ending December 31st (calendar year)

Annual Maximum Benefit: $2500 per Member

Orthodontic Lifetime Maximum Benefit: $1500 per Eligible Member
Limited to subscriber, spouse, and eligible dependent children under age 26.

Deductible: $50 per Member, per Benefit Year
$100 per Family, per Benefit Year

The deductible applies to Basic and Major Benefits only

Covered Dental Services	Deductible Applied	Percentage of Allowable Expense Paid by the Plan	Member Copayment
Preventive Benefits	No	100%	None
Basic Benefits	Yes	80%	20%
Major Benefits	Yes	60%	40%
Orthodontic Benefits	No	60% Limited to subscriber, spouse, and eligible dependent children under age 26.	40%

Endodontic Services are covered as Basic Benefits.
Periodontic Services are covered as Basic Benefits.
Sealants are covered as Basic Benefits.

Dependent children are eligible for coverage until age 26.

A complete description of benefits, limitations and exclusions are available in the Summary Plan Description.
Members must receive services from a Dental Care Plus dentist.

Covered Services

The Dental Care PLUS GROUP
The plus is service.

This is a summary only. A complete description of covered services, limitations and exclusions is available in the member handbook or certificate of insurance.

Preventive and Diagnostic Services

Routine oral examinations: limited to two visits each year
Prophylaxis (cleaning): limited to two each year
Topical application of fluoride: limited to two treatments each year to children under age 18
Bitewing X-Rays: limited to one set each year
Vertical bitewing X-Rays: limited to once every three years (7-8 films)
Periapical X-Rays: limited to five films per year
Full-mouth X-Rays (complete series or panoramic): limited to once every three years
Extraoral X-Rays
Referral consultations and examinations performed by a specialist

Emergency Services

Emergency/limited oral examinations
Office visit after hours: for emergencies only
Emergency palliative treatment

Sealants & Preventive Resin Restorations

Permanent molar teeth only: limited to children under 15 years of age and once every five years per tooth

Space Maintainers

Space maintainer – fixed, unilateral: limited to children under 19 years of age
Distal shoe space maintainer – fixed, unilateral: limited to children under 8 years of age

Oral Surgery

Extractions
- Simple single-tooth extractions
- Root removal – exposed roots

Surgical Extractions
- Removal of an erupted tooth (uncomplicated)
- Removal of impacted tooth – soft tissue
- Removal of impacted tooth – partially bony
- Removal of impacted tooth – completely bony
- Removal of impacted tooth – completely bony, with complications
- Surgical removal of residual roots

Alveoloplasty and vestibuloplasty
Incision and drainage of abscess
Biopsy and examination
General anesthesia or intravenous sedation: only when necessary and provided in connection with oral surgery

Endodontic Services

Root canal therapy, traditional
Retreatment of previous root canal: must be at least three years following previous root canal treatment on the same tooth
Recalcification and apexification

Periodontic Services

Emergency treatment (periodontal abscess, acute periodontitis, etc.)
Periodontal scaling and root planing: limited to four quadrants once per 12 months as a definitive treatment when pocket depths of at least 4mm are demonstrated
Scaling in presence of generalized moderate or severe gingival inflammation: limited to once in a 24 month period when clinical documentation demonstrates that 30% or more of teeth are involved.
Surgical periodontics (including post-surgical visits): limited to two additional recalls in the first year following complex surgery
Gingivectomy, osseous and muco-gingival surgery, gingival grafting
Guided tissue regeneration
Periodontal maintenance procedure: limited to two each year following a history of periodontal disease

Restorative Services

Gold restorations and crowns are covered only as treatment for decay or traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a covered partial denture or fixed bridge.
Amalgam, composite and sedative fillings: limited to once every two years per tooth (same surfaces only)
Inlays, Onlays, Crowns, Post and Core: limited to once every five years on same tooth
Pins: pin retention as part of restoration when used instead of gold or crown restoration
Stainless-steel crowns: when tooth cannot be adequately restored with filling material
Recementation of inlays, onlays, crowns, bridges, and space maintainers
Repairs to crowns and bridges

Prosthodontic Services

Fixed bridge: limited to one original or replacement prosthesis every five years
Complete upper or lower denture: limited to one original or replacement prosthesis every five years
Partial upper or lower denture: limited to one original or replacement prosthesis every five years
Relining and rebasing: limited to once every three years
Full and partial denture repairs

Orthodontic Services*

Orthodontic benefits refer to plan design for individual lifetime maximum.
Comprehensive orthodontic treatment
Other orthodontic treatment: limited to one appliance per individual
Appliance for tooth guidance
Orthodontic retention appliance
All benefits paid toward orthodontia services by your current employer's previous dental carrier(s) will be applied to the Dental Care Plus lifetime orthodontia maximum.

Call us at (800) 367-9466 or visit our website at DentalCarePlus.com with any questions you have about service or coverage.

Coverage of services vary from Preventive, Basic and Major categories. Refer to your Member Handbook or Summary Plan Description for a detailed benefit description and waiting periods. *May or may not apply to your specific plan. Please refer to your benefit summary in your packet or your benefits administrator for details.
Dental insurance plans are issued by Dental Care Plus, Inc., located at 100 Crowne Point Place, Cincinnati, OH 45241. Domicile: Ohio. NAIC No. 96265.

Your dental benefits.

The Dental Care PLUS GROUP
The plus is service.

Your employer took a smart step by partnering with The Dental Care Plus Group (DCPG) for your dental benefits. We are proud to be your company's preferred dental insurance carrier and look forward to serving you.

Having dental insurance just makes sense – both for your physical health and your budget. Better oral health can lead to better overall health as well as save you money on more involved, costly dental services or health problems.

Who we are

Here at DCPG, we specialize in dental benefits and have for more than 30 years. That experience might just qualify us as the experts in dental. It's a role we're happy to fill. We've worked with your employer to present you with solid, affordable coverage and extensive access to dentists.

Already enrolled?

Great! The contents of this packet contain the most up-to-date information about your plan. Follow the instructions provided by your employer for any required paperwork.

Ready to enroll?

It's easy to get started. Enroll in a plan by completing the required paperwork and submitting it to your benefits administrator. On or around your effective date, you will receive your member ID cards in the mail. From there, it's really easy to get started using your benefits. And we want you to use your dental benefits because when you do, it shows in your smile.

Get the dental care you need with:

- **No waiting periods on any services including preventive, basic or major.** Start seeing your dentist immediately on your effective date.
- **Two cleanings per benefit year.** We don't require you to wait six months between cleanings.
- **White fillings on all teeth.** Breathe a sigh of relief knowing you can have white (composite) fillings on all your teeth, even those teeth in the back of your mouth. Your plan won't require silver fillings on certain teeth.
- **Fourth quarter deductible carryover.** Say you need dental services and you pay your deductible in the last three months of your plan year. We'll go ahead and consider your deductible paid for the next plan year as well. This is just a fancy way of saying: we like to save you money.

Customer service that's on point.

Have a question about what your plan covers? Or maybe a claims question? Go ahead, give us a call.

When you call during business hours, a person will answer the phone, not a recording. That means no long wait times or recorded voice menus. You can reach our customer service department Monday through Friday from 8:00 am until 4:30 pm EST at (800) 367-9466. Or send us a message anytime by visiting the "Contact Us" page on our website: DentalCarePlus.com.

Member services

Go online

Our member portal is a one-stop-shop to review benefit information, check the status of claims or order new ID cards. You can also access the Oral Health Center, use the dental cost estimator and sign up to receive our Member Checkup eLetter – all excellent ways to receive tips on improving your dental health.

Once you have enrolled in a plan, register for the member portal by visiting DentalCarePlus.com, selecting **"Group Member"** in the top right corner, then clicking on **"Login"** to get started.

Find a dentist

With our online provider search, it's easy to find an in-network dentist or specialist. Simply visit fad.dentalcareplus.com or click on the "Find a Dentist" tab at the top of DCPG's home page. Once there, choose your network (found on the benefit summary document in this packet, on your member ID card or by asking your benefits administrator), then decide if you want to search by ZIP code, county or the dentist's last name. If you find that your dentist isn't listed, fill out a nomination form (included in this packet or available on our website) so we may begin the process of inviting them to join our network.

Hearing health is included

Your dental plan comes with a hearing program that can save you money on devices including name-brand hearing aids and batteries.

You can easily get on the path to better hearing by calling EPIC Hearing Health Care at (888) 899-1485 or visiting EpicHearing.com to access this program.

EPIC HEARING HEALTHCARE

If you have questions, please contact your benefits administrator. If you'd like to learn more about The Dental Care Plus Group, visit DentalCarePlus.com.

The Dental Care PLUS GROUP
The plus is service.

Connect with us.

Make sure to follow us on social media!

linkedin.com/company/the-dental-care-plus-group @DC_Plus facebook.com/DentalCarePlus

Wait, there's more.

These tips will help you save time and money as you make the most of your benefits:

- Find out what your plan covers and what it doesn't. DCPG's customer service department can help explain your benefits and plan details.
- Request that your dentist provide a pretreatment review to DCPG when he or she recommends services that exceed $400. This will help you plan for your portion of the expense.
- Know your plan's annual maximum since you will be responsible for costs that exceed this amount.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices ("Notice") applies to Protected Health Information (defined below) associated with Group Health Plans (defined below) provided by Greater Cincinnati Insurance Consortium to its participating Districts' employees, employee's dependents and, as applicable, retired employees. This Notice describes how the Greater Cincinnati Insurance Consortium, collectively we, may use and disclose Protected Health Information to carry out payment and health care operations, and for other purposes that are permitted or required by law.

We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of Protected Health Information and to provide individuals covered under our group health plan with notice of our legal duties and privacy practices concerning Protected Health Information. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all Protected Health Information maintained by us. If we make material changes to our privacy practices, copies of revised notices will be mailed to all policyholders then covered by the Group Health Plan. Copies of our current Notice may be obtained by contacting the Greater Cincinnati Insurance Consortium at the telephone number or address below.

DEFINITIONS

Group Health Plan means, for purposes of this Notice, the following employee benefits that we provide to our employee and dependents: major medical and prescription drug coverage.

Protected Health Information ("PHI") means individually identifiable health information, as defined by HIPAA, that is created or received by us and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

The following categories describe different ways that we use and disclose PHI. For each category of uses and disclosures we will explain what we mean and, where appropriate, provide examples for illustrative purposes. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted or required to use and disclose PHI will fall within one of the categories.

Your Authorization – Except as outlined below, we will not use or disclose your PHI unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing except to the extent that we have taken action in reliance upon the authorization or that the authorization was obtained as a condition of obtaining coverage under the group health plan, and we have the right, under other law, to contest a claim under the coverage or the coverage itself.

Uses and Disclosures for Payment – We may make requests, uses, and disclosures of your PHI as necessary for payment purposes. For example, we may use information regarding your medical procedures and treatment to process and pay claims. We may also disclose your PHI for the payment purposes of a health care provider or a health plan.

Uses and Disclosures for Health Care Operations – We may use and disclose your PHI as necessary for our health care operations. Examples of health care operations include activities relating to the creation, renewal, or replacement of your Group Health Plan coverage, reinsurance, compliance, auditing, rating, business management, quality improvement and assurance, and other functions related to your Group Health Plan.

Family and Friends Involved in Your Care – If you are available and do not object, we may disclose your PHI to your family, friends, and others who are involved in your care or payment of a claim. If you are unavailable or incapacitated and we determine that a limited disclosure is in your best interest, we may share limited PHI with such individuals. For example, we may use our professional judgment to disclose PHI to your spouse concerning the processing of a claim.

Business Associates – At times we use outside persons or organizations to help us provide you with the benefits of your Group Health Plan. Examples of these outside persons and organizations might include vendors that help us process your claims. At times it may be necessary for us to provide certain of your PHI to one or more of these outside persons or organizations.

Other Products and Services – We may contact you to provide information about other health-related products and services that may be of interest to you. For example, we may use and disclose your PHI for the purpose of communicating to you about our health insurance products that could enhance or substitute for existing Group Health Plan coverage, and about health-related products and services that may add value to your Group Health Plan.

Other Uses and Disclosures – We may make certain other uses and disclosures of your PHI without your authorization.

- We may use or disclose your PHI for any purpose required by law. For example, we may be required by law to use or disclose your PHI to respond to a court order.
- We may disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations

- We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.
- We may disclose your PHI if authorized by law to a government oversight agency (e.g., a state insurance department) conducting audits, investigations, or civil or criminal proceedings.
- We may disclose your PHI in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).
- We may disclose your PHI to the proper authorities for law enforcement purposes.
- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for cadaveric organ, eye or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services, and we may also disclose your PHI for other specialized government functions such as national security or intelligence activities.
- We may disclose your PHI to workers' compensation agencies for your workers' compensation benefit determination.
- We will, if required by law, release your PHI to the Secretary of the Department of Health and Human Services for enforcement of HIPAA.

In the event applicable law, other than HIPAA, prohibits or materially limits our uses and disclosures of Protected Health Information, as described above, we will restrict our uses or disclosure of your Protected Health Information in accordance with the more stringent standard.

RIGHTS THAT YOU HAVE

Access to Your PHI – You have the right of access to copy and/or inspect your PHI that we maintain in designated record sets. Certain requests for access to your PHI must be in writing, must state that you want access to your PHI and must be signed by you or your representative (e.g., requests for medical records provided to us directly from your health care provider). Access request forms are available from the Greater Cincinnati Insurance Consortium at the address below. We may charge you a fee for copying and postage.

Amendments to Your PHI – You have the right to request that PHI that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. To be considered, your amendment request must be in writing, must be signed by you or your representative, and must state the reasons for the amendment/correction request. Amendment request forms are available from us at the address below.

Accounting for Disclosures of Your PHI – You have the right to receive an accounting of certain disclosures made by us of your PHI. Examples of disclosures that we are required to account for include those to state insurance departments, pursuant to valid legal process, or for law enforcement purposes. To be considered, your accounting requests must be in writing and signed by you or your representative. Accounting request forms are available from us at the address below. The first accounting in any 12-month period is free; however, we may charge you a fee for each subsequent accounting you request within the same 12-month period.

Restrictions on Use and Disclosure of Your PHI – You have the right to request restrictions on certain of our uses and disclosures of your PHI for insurance payment or health care operations, disclosures made to persons involved in your care, and disclosures for disaster relief purposes. For example, you may request that we not disclose your PHI to your spouse. Your request must describe in detail the restriction you are requesting. We are not required to agree to your request but will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction. You may make a request for a restriction (or termination of an existing restriction) by contacting us at the telephone number or address below.

Request for Confidential Communications – You have the right to request that communications regarding your PHI be made by alternative means or at alternative locations. For example, you may request that messages not be left on voice mail or sent to a particular address. We are required to accommodate reasonable requests if you inform us that disclosure of all or part of your information could place you in danger. Requests for confidential communications must be in writing, signed by you or your representative, and sent to us at the address below.

Right to a Copy of the Notice – You have the right to a paper copy of this Notice upon request by contacting us at the telephone number or address below.

Complaints – If you believe your privacy rights have been violated, you can file a complaint with us in writing at the address below. You may also file a complaint in writing with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C., within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

FOR FURTHER INFORMATION
If you have questions or need further assistance regarding this Notice, you may contact the Greater Cincinnati Insurance Consortium's Privacy Officer by writing to: Mr. Dave Distel, Privacy Official, c/o Hamilton County Educational Service Center, 11083 Hamilton Avenue, Cincinnati, Ohio, 45231; phone number: 513-674-4236.

EFFECTIVE DATE
This Notice is effective for 2016-2017 School Year

Nomination form.

The Dental Care PLUS GROUP
The plus is service.

To determine if your dentist is a participating provider with The Dental Care Plus Group (DCPG), search our online directory at: ***fad.DentalCarePlus.com****. If your dentist is not listed, simply fill out the nomination form below so that we may contact him/her and extend an invitation to begin the process to join our networks. You may also submit the nomination form through the Find a Dentist page (link above).*

Please provide the following:

Your Name **Today's Date**

Employer Name (please do not abbreviate)

Dentist Name

Street Address

City **State** **ZIP Code**

County **Phone**

May we use your name in our recruiting efforts with your dentist? ☐ Yes ☐ No

Please return completed form with your enrollment application:

By email: providerrelations@dentalcareplus.com

By fax: (513) 618-3881, Attn: Provider Relations

By mail: The Dental Care Plus Group, Attn: Provider Relations, 100 Crowne Point Place, Cincinnati, OH 45241

The completion of this form is a request for DCPG to begin the recruitment process with your dentist. This does not guarantee that your dentist will become a participating provider.

For more information, call (800) 367-9466 or visit DentalCarePlus.com.

T H E P L U S I S S E R V I C E

REV. 12-16

The details.

The Dental Care PLUS GROUP
The plus is service.

Welcome to Your Total Vision Services Discount Program

The Dental Care Plus Group is pleased to offer you access to a free vision discount program with your dental benefits plan. You and your eligible dependents will be enrolled in one of two programs offered by Total Vision Services (TVS): the TVS program or the Coast to Coast program. Both programs feature discounts with unlimited usage, no additional paperwork to file and no health restrictions. Your enrollment in the appropriate program is automatic and based on your home ZIP code.

Vision Schedule

TVS contracts with ophthalmologists and optometrists in selected markets across the country to provide you with discounts on eyeglasses, contact lenses, eye exams and surgical procedures (including PRK & LASIK surgery) where available. If your ophthalmologist or optometrist doesn't contract with TVS, you can give their name, address and phone number to a TVS representative and they will be invited to start the process to join the program.

Your program comes with:

- Discounts on frames, lenses and specialty items such as tints, scratch-resistant coatings and ultraviolet protection.
- No limit on the number of times you and your family may use the membership during the year.
- Savings of 10-30 percent on medical eye exams and surgical procedures including refractive surgery (PRK & LASIK).

To locate a participating provider near you, simply call (800) 869-5400 or visit TotalVisionServices.com.

Elective Eye Surgeries

In keeping with the tradition of utilizing both chain and independent providers, TVS contracts with national chains of laser surgery centers to provide discounts on refractive laser surgery. In addition, TVS contracts with independent ophthalmologists who provide discounts on refractive surgery. Payment must be made at the time of service to receive a discount. Call TVS at (513) 921-7500 or (800) 869-5400 for information regarding discounts. Usual and customary charges vary between physicians.

America's Eyewear (Replacement Contacts)

Note: this is only available through the Coast to Coast program.

Members receive greater savings on contact lenses through the TVS mail-order program. Simply call (800) 800-EYES for price quotes and to place an order. Most orders are fulfilled within 7 to 14 days.

- Savings of 10-40 percent through mail-order service.*
- Most types of contact lenses are available including disposables, torics, bifocals and gas permeable lenses.

Some brands available through the mail-order program include:

- **Disposable:** Acuvue, Durasoft, Encore, Freshlook, Biomedic, Soflens 66, Optima FW, Focus
- **Gas Permeable:** Boston, Fluoroperm, SGP, Transaire

How to use the Total Vision Services program

Simply present your Dental Care Plus Group member ID Card at any of the participating provider locations to receive your program discount. If you decide to use your own eye doctor and not take advantage of the reduced examination fees under the TVS program, you may take your prescription to any of the participating provider locations and they will fill it for you at TVS program rates.

How to use the Coast to Coast program

TVS will issue you a Coast to Coast ID Card which you must present prior to service to a participating provider. Tell the provider that you are a member with access to the Coast to Coast vision program. Should you decide to use your own eye doctor and not take advantage of savings on examination fees under the Coast to Coast program, take your prescription to any of the provider locations to receive the Coast to Coast discount on materials (frames and lenses). For the provider locations nearest you, contact the Coast to Coast vision program at (800) 800-EYES or search online at TotalVisionServices.com.

*Mail-order contacts not available in New Jersey.

Total Vision Services Out-of-Pocket Fee Schedule

Eye Examinations

Optometrist Eye Examination (Dilation Included) . . . . . 25% off UCR

Ophthalmologist Eye Examination . . . . . .$69 Flat Fee

Standard Plastic Lenses (CR-39)

Single Vision $39

Bifocals (FT-25, FT-28) $60

Trifocals (FT-7/25, FT-7/28) $70

Progressive Bifocals (Excluding Specialty Designs) $112

Strong Power Charge

Sphere and Cylinder Greater than + or – 4 Diopters . . . . . Add $5/Per Lens

Sphere and Cylinder Greater than + or – 8 Diopters . . . . . Add $15/Per Lens

Lens Options

Standard Tint . . . . . add $15

Tint (Solid or Gradient) . . . . . add $15

Standard Scratch Coating . . . . . add $15

UV Treatment . . . . . add $15

Standard Anti-reflective Coating . . . . . add $40

Polycarbonate – Single Vision . . . . . add $30

Polycarbonate – Bifocal/Trifocal . . . . . add $35

Polycarbonate – Progressive . . . . . add $45

Hi Index 1.60 – Single Vision . . . . . add $35

Hi Index 1.60 – Bifocal/Trifocal . . . . . add $45

Hi Index 1.60 – Progressive . . . . . add $55

Prescription Remake Policy (per pair)

Single Vision Lenses $10

Bifocal Lenses $15

Progressive Lenses $20

Frames

All Frames up to $150 Retail . . . . . 40% off

All Frames over $150 Retail . . . . . 30% off

Any optical products not listed on the fee schedule above will be subject to a 25% discount off the regular retail price. Manufacturers rebates may be used in conjunction with the fee schedule pricing. Prices are subject to change.

Contact Lenses

Professional Services (i.e. fitting fees, follow-up visits, polishes, etc.) are 25% off regular retail prices. All contact lens fitting fees include a follow-up visit and solution.

Note: Provider may require one year minimum order of disposable lenses.

Disposable Contact Lenses

Sphere, Aspheric, Toric, Multifocal and Cosmetic Includes: One Day Disposables, Two-Week Disposables and Silicon Hydrogel . . . . . .10% off Retail

Specialty Soft Lenses – Non-disposable

Toric, Bifocal, Piggyback, Softperm, Cosmetic,Therapeutic, Post-Operative . . . . . .20% off Retail

Rigid Gas Permeable Lenses

Spherical, Front, Back and Bitoric, Bifocal, Keratoconus, Graft, Lenticular and etc. . . . . .20% off Retail

All contact lenses not listed by type or brand name are 20% off regular retail, except for disposable lenses, which are 10% off regular price.

For more information, contact Total Vision Services at (800) 869-5400 or visit TotalVisionServices.com.

T H E P L U S I S S E R V I C E

Dental Care Plus, Inc.
100 Crowne Point Place • Cincinnati, OH 45241
Phone (513) 554-1100 • 1-800-367-9466

ALL SECTIONS MUST BE COMPLETED FOR APPLICATION TO BE PROCESSED.

ENROLLMENT FORM

SOCIAL SECURITY NUMBER ---- ---	GROUP NUMBER	EMPLOYER AND LOCATION

EMPLOYEE LAST NAME	FIRST NAME	MI	EMPLOYEE'S HOME PHONE	
			EMPLOYEE'S EMAIL ADDRESS	

HOME ADDRESS	APT#	GENDER	DATE OF BIRTH

CITY	STATE	ZIP CODE	COUNTY IN WHICH YOU RESIDE

MARITAL STATUS: ☐ SINGLE (01) ☐ MARRIED (02)	EMPLOYMENT DATE	EFFECTIVE DATE

APPLICATION FOR DENTAL COVERAGE (CHECK THOSE THAT APPLY) ☐ EMPLOYEE ☐ SPOUSE ☐ CHILD(REN)

COMPLETE THE FOLLOWING INFORMATION FOR EACH DEPENDENT TO BE COVERED BY THE PLAN

NAME – IF LAST NAME DIFFERENT FROM ABOVE INDICATE LAST NAME	RELATIONSHIP	GENDER	BIRTH DATE
	SPOUSE		

WILL YOU OR ANY DEPENDENT HAVE OTHER DENTAL INSURANCE COVERAGE? _____ IF YES, PLEASE LIST THE NAME OF THE OTHER INSURANCE COMPANY AND PHONE NUMBER:_____

REFUSAL/WAIVER – COMPLETE ONLY IF YOU ARE DECLINING COVERAGE FOR YOURSELF OR ANY DEPENDENT

I DECLINE COVERAGE FOR: ☐ MYSELF ☐ MY SPOUSE ☐ MY CHILDREN

REASON FOR REFUSAL:_____

On behalf of myself and any dependants listed above, I hereby apply for coverage under the Master Group Policy/Contract issued to my employer by Dental Care Plus, Inc. I understand that the benefits for which I (we) will be eligible are in accordance with those described in the Master Group Policy/Contract and any changes provided for therein. I understand that certain services may require copayment or deductible, payable by me (or my dependents) directly to the provider of such services. I authorize my employer to deduct the necessary contributions, if any, from my wages or salary, with the understanding that he acts as my agent in all dealings with the plan, and that all acts performed by him and all notices given to him in such dealings are binding upon me, as not prohibited by statute or regulation.

I hereby waive the dentist-patient privilege and authorize any dentist or other provider of dental services to give Dental Care Plus, Inc., its agents and representatives any information concerning the claims for reimbursement for covered services of any person included under such coverage, including the undersigned, the undersigned's spouse and the undersigned's dependents.

To the best of my knowledge, the above information is complete, true, and correct. In the absence of fraud, however, all statements made by applicants or by an insured person shall be deemed representations and not warranties.

PLEASE SIGN WHETHER YOU ARE ACCEPTING OR DECLINING COVERAGE

EMPLOYEE SIGNATURE _____ **DATE**_____

Fraud Notice - Ohio Residents Only: 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 is guilty of insurance fraud.
Fraud Notice – Kentucky Residents Only: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime.
Fraud Notice – Indiana Residents Only: Any person who knowingly and with intent to defraud an insurer files an application for insurance containing any false, incomplete, or misleading information commits a felony.
Fraud Notice – Tennessee Residents Only: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

The Dental Care PLUS GROUP

The plus is service.

100 Crowne Point Place • Cincinnati, OH 45241
Phone (513) 554-1100 • 1-800-367-9466
Fax (513) 618-3882

CHANGE REQUEST FORM

☐ Name/Address change: fill in Section 1

☐ Add/Terminated dependents: fill in Section 2

☐ Terminate/Reactivate coverage: fill in Section 3

SOCIAL SECURITY NUMBER ___ ___	EMPLOYEE LAST NAME	FIRST NAME	MI
EMPLOYER		GROUP NUMBER	

SECTION 1

ADDRESS CHANGE NEW ADDRESS CITY STATE ZIP CODE

NAME CHANGE THE REASON FOR THE CHANGE IS (CHECK ONE): ☐ MARRIAGE ☐ CORRECTION ☐ DIVORCE ☐ COURT ORDER

CHANGE NAME FROM: **TO:**

SECTION 2

☐ **ADD DEPENDENT(S)**

COMPLETE THE FOLLOWING INFORMATION FOR EACH DEPENDENT TO BE ADDED TO THE PLAN

	NAME(S) OF DEPENDENT(S) TO BE ADDED:	SEX	BIRTH DATE	EFFECTIVE DATE	RELATIONSHIP	REASON
01						
02						
03						
04						

Will you or any dependent be covered under another dental insurance plan while a member of Dental Care Plus Insurance Company?

Yes ☐ No ☐

If yes, name and address of other insurance company _____ Policy # _____

☐ **DELETE DEPENDENT(S)**

COMPLETE THE FOLLOWING INFORMATION FOR EACH DEPENDENT TO BE REMOVED FROM THE PLAN

	NAME(S) OF DEPENDENT(S) TO BE DELETED:	SEX	BIRTH DATE	EFFECTIVE DATE	REASON
01					
02					
03					
04					

SECTION 3

TERMINATE COVERAGE

REASON: ☐ TERMINATED EMPLOYMENT ☐ NO LONGER ELIGIBLE ☐ COBRA ELIGIBILITY ENDED ☐ OPEN ENROLLMENT

DATE COVERAGE ENDS: _____

REACTIVATE COVERAGE

REASON: ☐ TERMINATED IN ERROR ☐ ELECTED COBRA ☐ REHIRED ☐ COURT ORDER

EFFECTIVE DATE: _____

OTHER

STATE CLEARLY THE REQUESTED CHANGE: _____

X **ADMINISTRATOR/EMPLOYEE SIGNATURE** _____ **DATE** _____

Fraud Notice - Ohio Residents Only: 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 is guilty of insurance fraud.
Fraud Notice - Kentucky Residents Only: Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.