NAVY YARD ASSOCIATION OF MARE ISLAND

DENTASSURE DENTAL PLAN

This product is available exclusively through the Naval Yard Association and administered by

Integrity Administrators, Inc.

1787 Tribute Rd., Suite E, Sacramento, CA 95815
PO Box 13128, Sacramento, CA 95813-3128
Toll-free: 800.562.9383 Phone: 916.921.3388 Fax: 916.921.3383
admin@integrityadmin.com

AUGUST 2019

ELIGIBILITY

Members: Any member in good standing of the Navy Yard Association of Mare Island is eligible to enroll.
Dependents: The spouse of an eligible member and unmarried children to age twenty-six (26) are eligible on the same date the member becomes eligible.

EFFECTIVE DATE OF COVERAGE

Application and payment or Automated Clearing House authorization must be received prior to the 5th of a month for coverage to be effective the first of the following month.

HOW TO ENROLL

Fill out a DentAssure application and an Automated Clearing House form to set up payments.

CONTRIBUTIONS

Monthly contributions include
Association Dues (effective October 1, 2019)

Member only	$ 65.92
Member plus Spouse	$ 127.42
Member plus Child(ren)	$ 139.38
Member plus Family	$ 203.70

TERMINATION OF BENEFITS

Coverage for you and/or your dependents terminates at 12:01am, Pacific Standard Time, at the end of the last period for which contributions are paid.
REMEMBER: Members are required to request termination of dental plan participation, in writing. Termination must be requested 30 days, or more, prior to the requested termination date.

This folder represents a summary of the plan and is not a contract. A subscriber will receive an Evidence of Coverage booklet after enrollment.

BENEFIT COORDINATION

The benefits of this plan will be coordinated with the benefits of any other group plan benefits to which the individual is entitled.

Third Party Liability

Through the fault of another person (third party), Benefits of this plan are not applicable, unless the covered person agrees to reimburse **DentAssure** for benefits provided for treatment of injury from any damages for bodily injury which may be collected.

Arbitration of Disputes

If a person covered, or claiming coverage, or benefits from **DentAssure,** has a dispute or disagreement of any nature with **DentAssure**, the dispute or disagreement shall be resolved entirely by arbitration.

If course of Treatment is to exceed $500, prior review is requested.

DEDUCTIBLE & WAITING PERIOD CREDITS

For insured individuals who were covered under a prior dental plan, without any lapse in coverage:

- Credit will be given from the prior dental plan for whole or partial satisfaction of the applicable dental deductible amount under this plan.
- Credit will be given from the prior dental plan for whole or partial satisfaction of the 12 month waiting period applicable to Type III Major Services.
- The calendar year maximum under this plan will be reduced by the amount of benefits the insured person received under the prior dental plan during the same benefit period.
- Type III major services are subject to a 12-month waiting period and will be waived to the extent each employee was covered under the prior plan.

USUAL, CUSTOMARY & REASONABLE (UCR) DENTAL PLAN

$50 per person, calendar year deductible
$1500 calendar year benefit maximum payment

<table>
<tr><th colspan="2">PREVENTATIVE 100% COVERAGE - DEDUCTIBLE WAIVED</th></tr>
<tr><td>CLINICAL ORAL
Limit 2 exams per calendar year</td><td>SPACE MAINTAINERS
Covered Dependent and Children</td></tr>
<tr><td>BITEWING X-RAYS
No less than 6 months apart</td><td rowspan="2">SEALANTS FOR CHILDREN
Only 1 treatment per tooth [permanent posterior only] or quadrant during a 36 month consecutive period for dependents under age 14</td></tr>
<tr><td>PROPHYLAXIS
Limit 3 cleanings per calendar year</td></tr>
<tr><td>TOPICAL FLUORIDE TREATMENT
Covered Dependent—1 per calendar year</td><td>EMERGENCY TREATMENT
If no other service was rendered except x-rays</td></tr>
<tr><th colspan="2">BASIC 80% COVERAGE - AFTER DEDUCTIBLE</th></tr>
<tr><td>EXTRACTION
Non-Orthodontic</td><td>ENDODONTICS TREATMENT
Pulp capping, pulpotomy, & root canal treatment</td></tr>
<tr><td>ORAL SURGERY</td><td>PERIODONTICS TREATMENT</td></tr>
<tr><td>RESTORATIVE TYPE FILLINGS</td><td>GENERAL ANESTHESIA
When administered with oral surgery</td></tr>
<tr><th colspan="2">MAJOR 50% COVERAGE - AFTER DEDUCTIBLE
SERVICES MAY BE SUBJECT TO 12 MONTH WAITING PERIOD</th></tr>
<tr><td>CROWNS
Single Restorations</td><td>INLAYS / ONLAYS
Single Restorations</td></tr>
<tr><td>INSTALLATION PROSTHODONTICS
Bridges & Dentures</td><td>MAINTENANCE PROSTHODONTICS
Adjustments within 6 months of Installation</td></tr>
</table>

PROVIDER NETWORK

For Provider Network information, go to Premier-dental.com or call (800) 392-3112

OPEN ENROLLMENT

Annually there is an open enrollment period. Contact Integrity Administrators, Inc for an enrollment form.

LIMITATIONS & EXCLUSIONS

The following are not covered under the Group Policy:

1. Services and treatment not prescribed by or under the direct supervision of a Dentist;
2. Services and treatment which are experimental or investigational;
3. Services and treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, VA hospital or similar person or group;
4. Services and treatment performed prior to the Covered Individual's effective date of coverage under the Group Policy;
5. Services and treatment incurred after the termination date of the Covered Individual's coverage unless otherwise indicated;
6. Services and treatment which are not Dentally Necessary or which do not meet generally accepted standards of dental practice;
7. Services and treatment resulting from the Covered Individual's failure to comply with professionally prescribed treatment;
8. Telephone consultations;
9. Any charges for failure to keep a scheduled appointment;
10. Any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
11. Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD);
12. Services or treatment provided as a result of intentionally self-inflicted injury or illness;
13. Services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
14. Office infection control charges;
15. Charges for copies of the Covered Individual's records, charts or x-rays, or any costs associated with forwarding/mailing copies of the Covered Individual's records, charts or x-rays;
16. State, federal, or territorial taxes on Dental services performed;
17. Those charges submitted by a Dentist, which is for the same services performed on the same date for the same Covered Individual by another Dentist;
18. Those Dental services provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
19. Those Dental services for which the Covered Individual would have no obligation to pay in the absence of this or any similar coverage;
20. Those Dental services which are for specialized procedures and techniques;
21. Those Dental services performed by a Dentist who is compensated by a facility for similar covered services performed for the Covered Individual;
22. Duplicate, provisional and temporary devices, appliances, and services;
23. Plaque control programs, oral hygiene instruction, and dietary instructions;
24. Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to: (a) equilibration; (b) periodontal splinting; (c) full mouth rehabilitation; and (d) restoration for misalignment of teeth;
25. Gold foil restorations;
26. Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or Group Policy of motor vehicle insurance, including a certified self-insurance plan;
27. Treatment of services for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization;

LIMITATIONS & EXCLUSIONS (cont.)

28. Hospital costs or any additional fees that the Dentist or hospital charges for treatment at the hospital (inpatient or outpatient);
29. Charges by the provider for completing dental forms;
30. Adjustment of a denture or bridgework which is made within six (6) months after installation by the same Dentist who installed it;
31. Use of material or home health aids to prevent decay, such as: (a) toothpaste; (b) fluoride gels; (c) dental floss; and (d) teeth whiteners;
32. Sealants for teeth other than permanent molars;
33. Precision attachments, personalization, precious metal bases and other specialized techniques;
34. Replacement of dentures that have been: (a) lost; (b) stolen; or (c) misplaced;
35. Repair of damaged orthodontic appliances;
36. Replacement of lost or missing appliances;
37. Fabrication of athletic mouth guard;
38. Internal bleaching;
39. Nitrous oxide;
40. Oral sedation;
41. Topical Medicament Carrier;
42. Bone grafts when done in connection with: (a) extractions; (b) apicoetomies; or (c) non-covered/ non eligible implants;
43. When two or more dental services are submitted and the dental services are considered part of the same service to one another, the Group Policy will pay the most comprehensive service (the service that includes the other non-benefited service);
44. When two or more dental services are submitted on the same day and the dental services are considered mutually exclusive (when one service contradicts the need for the other service), the Group Policy will pay for the service that represents the final treatment; or
45. All Out-of-Network services are subject to the Maximum Plan Allowance as defined in Section 1. The Covered Individual is responsible for all remaining charges that exceed the Allowed Amount.
46. Services and treatments not covered if performed outside U.S, Canada or Mexico.

DentAssure Dental Plans Employee Enrollment Form	For Company Use Only					
	ER #	5358	Loc. #		Eff. Date	

PLEASE PRINT IN SPACE PROVIDED ☐ Active ☐ COBRA ☐ Cal COBRA

EMPLOYER INFORMATION

EMPLOYER NAME	LOCATION	GROUP NO.
NAONE		5358

EMPLOYEE APPLICANT

LAST NAME	FIRST NAME	M.I.

STREET ADDRESS	CITY	STATE	ZIP

SOCIAL SECURITY NUMBER	TELEPHONE NUMBER	BIRTH DATE
- -	( ) -	/ /

SEX		FULL TIME EMPLOYMENT DATE	MARITAL STATUS		OCCUPATION / TITLE	EMPLOYMENT STATUS	
MALE	FEMALE		SINGLE	MARRIED		ACTIVE	INACTIVE
☐	☐	/ /	☐	☐		☐	☐

COVERAGE – Check Those That Apply

☐ EMPLOYEE ☐ SPOUSE ☐ CHILDREN ☐ MY FAMILY REQUESTED EFFECTIVE DATE: / /

DEPENDENT INFORMATION

	Last Name	First Name	MI	Date of Birth	Age	Sex	
Spouse				/ /			
Child				/ /			
Child				/ /			
Child				/ /			
Child				/ /			

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

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Fraud Notice: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

REFUSAL/WAIVER – Complete Only If You Are Declining Coverage For Yourself Or Any Dependent

I DECLINE COVERAGE FOR: ☐ MYSELF ☐ MY SPOUSE ☐ MY CHILDREN ☐ MY FAMILY
REASON FOR REFUSAL: _____

ACKNOWLEDGMENT AND AUTHORIZATION

By my signature below, I hereby request coverage as outlined above under the group dental plan offered by my employer and authorize my employer to deduct from my earnings, including any future adjustments, any required contributions. I reserve the right to revoke or change this authorization by written notice and understand that if I have declined any coverage on myself or eligible dependent and wish to enroll at a later date, coverage will be deferred in accordance with the plan provisions. I certify I have read the Fraud Notice above. Typing your name is the equivalent to an electronic signature

DATE	SIGNATURE
/ /	X /s/

Underwritten by:	*Administered by:*
TruAssure Insurance Company *111 Shuman Blvd* *Naperville, IL 60563*	*Integrity Administrators, Inc.* *P.O. Box 13128, Sacramento, CA 95813-3128* *Phone: (800) 562-9383 • Fax (916) 921-3383*

AUTOMATED CLEARING HOUSE Form

ADDRESS AND BANK CHANGES:

Please notify Integrity Administrators of any change in your home address, bank, bank account number, or bank routing number to avoid disruption in your coverage.

PAYMENT AUTHORIZATION:

Complete the authorization form below and we will deduct your contribution automatically from your account on or before the 10th of the month preceding your coverage month.

PLEASE RETURN THIS PORTION WITH YOUR ENROLLMENT FORM

I authorize the following amount to be withdrawn from my bank checking or savings account listed below to pay my monthly premiums for the DentAssure Dental Plan coverage.
(PLEASE CHECK APPLICABLE BOX)

☐ Member only	$ 65.92	☐ Member plus Child(ren)	$139.38
☐ Member plus Spouse	$ 127.42	☐ Member plus Family	$203.70

BANK NAME _____ **ACCT #** _____

BANK ROUTING # _____
(Routing number is usually located at the bottom of your check just before the account number. If unsure, please send a "**VOIDED**" check with this form.)

NAME (print): _____ **Signature** _____

Mail this payment authorization form along with your DentAssure Enrollment form to:

INTEGRITY ADMINISTRATORS, INC.
P O Box 13128
Sacramento, CA 95813-3128

Contact Integrity Administrators at 800.562.9383
for a current DentAssure Enrollment form.

Blue Shield & DentAssure are both "premiums"
The Pre-Paid Plan is "contributions"