NAVY YARD ASSOCIATION OF MARE ISLAND

PREPAID DENTAL PROGRAM

AVAILABLE TO ASSOCIATION MEMBERS ONLY

This Prepaid Dental Plan provides its members with a plan that is comprehensive in its coverage, simple in its operation, and competitively cost-effective.

All forms of conventional care and treatment are provided, plus a strong diagnostic and preventative maintenance program designed to control future occurrence of dental disease.

Care is provided at conveniently located dental health centers staffed by qualified, licensed dentists.

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

ADVANTAGES OF THE PLAN

Excellent benefit coverage per contribution dollar. Minimal "out of pocket" expense to members. Modern equipment for diagnosis, treatment and well equipped, professional dental facilities. There are convenient office hours for the plan members.

NO

- **Upper Dollar Limit on Dental Care**
- **Deductible**
- **Claim Forms**

PREPAID DENTAL PLAN

PROVIDES COMPREHENSIVE DENTAL SERVICES

1. **DIAGNOSTIC:**
   Provides all necessary procedures to assist the Dentist in evaluating required dental treatment.
2. **ORAL SURGERY:**
   Provides for extractions and other oral surgery, including pre-and post-operative care.
3. **RESTORATIVE DENTISTRY:**
   Provides amalgam, synthetic porcelain and composite restorations (fillings), crowns and jackets when teeth cannot be restored with filling material.
4. **ENDODONTICS:**
   Includes procedures necessary for the treatment of non-vital teeth, pulpal therapy and root canal fillings.
5. **PERIDONTICS:**
   Includes procedures necessary for the treatment of diseases of the gums and bone supporting the teeth.
6. **PROSTHODONTICS:**
   Includes bridges, partial and complete dentures, crowns and space maintainers. Replacement only after five (5) years of placement.
7. **ORTHODONTICS:**
   Treatment is available to members/dependents through a Panel provider using a discount.

ELIGIBILITY

Any active or retired Federal Employee or surviving spouse, and dependent children to age 19 (or to age 23, if a full-time student) are eligible.

REMEMBER: It is the member's responsibility to furnish to your administrator proof of full-time student status.

MONTHLY CONTRIBUTION with ASSOCIATION DUES

Subject to change.

Member Only	$25.00
Member and Dependents	$44.25

PLAN EFFECTIVE DATE

The eligible member and any enrolled dependents are effective the first of the month following the receipt of their first contribution.

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 is a brief description of the benefits provided. For any procedure not listed, contact either the Administrator or the NYA office for complete details. Some Dental Centers do not provide all services such as Periodontics, Endodontics, Oral Surgery, etc. therefore, please refer to the plan Referral Offices for specialty care or call the administrators office. Dental services set forth in the Schedule of Dental Benefits shall be provided by a participating Dental provider only, except for Emergency services while the member is more than 50 miles from their assigned Dental Service Center. Such emergency treatment will be limited to reimbursement of $25.00.

GENERAL PRACTITIONER CO-PAYMENT SCHEDULE

ALL CO-PAYMENTS SHOWN BELOW ARE TO BE PAID
TO THE DENTAL OFFICE AT THE TIME OF SERVICE.
THERE IS A $4.00 CO-PAYMENT PER VISIT IN ADDITION TO CO-PAYMENTS LISTED BELOW.

DIAGNOSTIC & PREVENTIVE CO-PAYMENT

Oral Examination	No Charge
Full Mouth X-Rays (Every 3 yrs)	$10.00
2-Bite Wing X-Rays	$6.50
4-Bite Wing X-Rays	$8.50
Single X-Ray	No Charge
Each Additional X-Rays	No Charge
Emergency, Pallative	
During Office Hours	$20.00
After Office Hours	$30.00
Vitality Test	No Charge
Topical Fluoride	No Charge
Oral Hygiene	No Charge

PERIDONTICS (By General Practitioner)

Prophylaxis (Teeth Cleaning)	
Up To Age 14	No Charge
Adult	No Charge
Subgingival curettage per quadrant	$35.00
Gingivectomy, per quadrant	$95.00

CROWN AND BRIDGE (By General Practitioner)

*Porcelain Fused to Metal, Crown or Pontic	$515.00
*Full Veneer Crown or Pontic	$448.00
*Only or 3/4 Crown or Pontic	$432.00
Re-cement Crown, Bridge, Inlays	No Charge

* When semi-precious metal or gold is deemed to be necessary in the opinion of the provider, the fee is determined by adding the lab cost onto the copayment.

ORAL SURGERY (By General Practitioner)

Alveolectomy edentulous per quadrant	$36.00
Alveolectomy & ridge extension per arch	$23.00
Palatal Torus	By Report
Mandibular Torus	By Report
Simple extractions, local anesthesia	$12.00
Analgesic inhalation	$20.00
Local Anesthetics	No Charge

RESTORATIONS

Primary Teeth:	
Amalgam, 1 surface	$10.00
Amalgam, 2 surface	$17.00
Amalgam, 3 surface	$24.00
Permanent Teeth:	
Amalgam, 1 surface	$15.00
Amalgam, 2 surface	$24.00
Amalgam, 3 surface	$38.00
Pin Build Up	$24.00
Composite	$38.00
Fixed Spacer, band type	By Report
Removable Spacer	$71.00
Temporary Fillings and CaOH	No Charge
Stainless Steel Crown	
Primary	$36.00
Permanent	$36.00

PROSTHETICS

Maxillary Denture	$605.00
Mandibular Denture	$605.00
Partial Denture	
cast frame	$605.00
base free	No Charge
Acrylic partial, cast clasps	$185.00
Teeth and Clasp per unit	$26.00
Stress Breaker per unit	No Charge
Stay Plate (Laboratory costs)	By Report
Denture Adjustment	No Charge
Office Reline, cold cure	$82.00
Laboratory Reline	
Laboratory cost	By Report
Repair Broken Denture	
Laboratory cost	By Report
Missed Appointment or 24–Hour Cancellation	$13.00

ENDODONTICS (By General Practitioner)

Vitalometer Test	No Charge
Pulp Capping	No Charge
Vital Pulpotomy	No Charge
Culture Canal	No Charge
Single Root Canal	$278.00
Bi-Root Canal	$313.00
Tri-Root Canal	$408.00
Apicoectomy and Fill Canal	$178.00
Apicoectomy, separate appt	$72.00

PRINCIPAL EXCLUSIONS

All dental care services and/or dental procedures within any of the following classifications are excluded from coverage under the Schedule of Dental Benefits and this Agreement.

1. Services for injuries, or conditions, which are covered under Worker's compensation or Employer's Liability Laws, services which are provided without cost by any governmental agency, except Medi-Cal benefits.
2. Services which, in the opinion of the Dental Panel Provider, are not necessary for the Dental health of the patient.
3. Cosmetic, elective or aesthetic dentistry.
4. Oral Surgery requiring the setting of fractures or dislocations.
5. Treatment of malignancies, cysts, or neoplasms, alveolar, or gingival reconstruction.
6. Dispensing of drugs.
7. Congenital defects.
8. In the event a patient requires hospitalization for any dental procedure, the cost, including all services, will be born by the patient.
9. Services reimbursable by insurance or other health plans shall be coordinated.
10. Replacement due to loss or theft of dentures or bridgework.
11. General or intravenous anesthesia and work done thereunder, except by a specialist.
12. Examinations required for obtaining or continuing employment or government licensing or to obtain personal insurance.
13. Temporary stay plate used for cosmetic purposes Is excluded.
14. Procedure to increase vertical dimension or to restore occlusion.
15. Services with respect to teeth missing or replacement of dentures, crowns or bridgework at the time coverage begins will be included only after twelve continuous months of coverage.
16. Prophylaxes (cleanings) are limited to once every 6 months.
17. Work started by not completed at time of eligibility under the plan.

LIMITATIONS

Neither the Dental Health Plan nor the Dental Panel Provider shall be obligated to render services in the following occurrences:
1) Major Disaster or epidemic;
2) Complete or partial destruction of facilities, war, riot, civil insurrection, labor disputes, or when a dispute between Provider and Patient exists. Patients may then choose another Dental Provider or file a formal complaint for review by the Trustees of the plan.

THIRD PARTY LIABILITY

If the services rendered hereunder are required due to injury caused by the negligence of a third-party, and if you receive other insurance benefits, the plan shall be entitled to charge the usual and customary prevailing rates for dental services. Upon settlement of your claim against the negligent party, you shall pay, or cause to be paid on the Plan, any amount the Plan paid.

GENERAL PRACTIONER DENTAL OFFICES

1. **NORTH BAY DENTAL** 475 REDWOOD ST #30 VALLEJO, CA 94590 **707.643.1714**	6. **GOLDEN STATE SMILE** 15301 WASHINGTON AVE. SAN LEANDRO, CA 94579 **510.351.6820**
2. **DEOCAMPO & ASSOCIATES** 634 WEBSTER, SUITE A FAIRFIELD, CA 945333 **707.399.8569**	19. **SORRENTO VALLEY DENTAL** 11230 SORRENTO VALLEY SAN DIEGO, CA 92121 **858.458.9126**

PLAN REFERRAL OFFICES

PERIODONTICS:
JOHN BRUNS, DDS
2121 REDWOOD STREET #C
VALLEJO, CA 94590
707.648.3600

Pre-authorization is required by Integrity Administrators, Inc., when being referred to a specialist.
There is a two-month waiting period for specialty care eligibility.
When referred to a specialist, fees are different than shown for general practitioners.

REQUESTS MAILED TO:

Integrity Administrators, Inc.
Re: Termination of Benefits
PO Box 13128
Sacramento, CA 95813-3128

EMAIL REQUESTS TO:

admin@integrityadmin.com

FAX REQUESTS TO:

Integrity Administrators, Inc.
RE: Termination of Benefits
(916) 921-3383

ENROLLMENT FORM FOR PREPAID DENTAL PLAN SERVICES

Write the number of the General Practitioner's office # you desire in the appropriate space below.

LAST NAME:	FIRST NAME:	DOB:	SOCIAL SECURITY #:
ADDRESS:		EMAIL ADDRESS:	
CITY, STATE, ZIP:		HOME PHONE:	WORK PHONE:
I hereby apply for Dental Health Plan membership for myself, and my family dependents listed hereon, and agree that we shall abide by the provision of the Dental Service Agreement and Health Plan Regulations.			
I certify that the dependents listed hereon are supported by me and reside in my household, or are otherwise eligible as defined in the Service Agreement.			

General Practitioner's Office #:

MINIMUM ENROLLMENT PERIOD

Each subscriber must agree to remain on the program a minimum of 1 year and 1 year periods thereafter.

Members must request cancelation, in writing, 30 days prior to the requested termination date.

ELIGIBLE DEPENDENTS

LAST NAME:	FIRST NAME:	RELATION:	DOB:
LAST NAME:	FIRST NAME:	RELATION:	DOB:
LAST NAME:	FIRST NAME:	RELATION:	DOB:
SIGNATURE:			

Administrator's Use Only

Mail this enrollment form along with your Automated Clearing House form.

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 contributions for the Prepaid Dental Plan coverage.
(PLEASE CHECK APPLICABLE BOX)

☐ Member only - $25.00 ☐ Member and Dependents - $44.25

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 Prepaid Enrollment form to:

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