



Hampshire County Group Insurance Voluntary Dental Program

Dental Plan Choice

As an industry leader and innovator in the area of voluntary dental benefits, Guardian Insurance Company understands that you demand **choice**. That's why Guardian is offering a voluntary option that allows you to choose between a basic preventative plan and a plan that provides more extensive coverage.

The Dual Option provides you with the freedom to choose a dental plan that best fits your individual needs. Consider the cost and the benefits of each plan and then determine which one is best for you and your family.

Plan Features

- Increased benefits within the DentalGuard Preferred Network
- PPO provider coverage throughout the country
- Underwritten by Guardian Insurance Company
- Fast and accurate claims service
- Employee choice between two excellent dental plans

Rates are guaranteed until April 1, 2017.

Benefits of the DentalGuard Plan

Your plan pays the indicated percentages of Usual & Customary fees shown on pages 2 and 3 for covered services listed and described in your Group Certificate. Benefits are paid after any applicable deductible has been met up to the Annual Maximum. Usual & Customary fees are based on charges of providers in the area where the dental services are performed.

The **Core Plan** offers protection that provides coverage for the most common Preventive and Basic Restorative Services such as exams, cleanings, x-rays, fluorides, fillings, and simple extractions. This program allows you complete freedom to choose any dentist you wish.

The **High Plan** covers all of the same services as the Core Plan and also provides benefits for major services like periodontics (gum treatment), endodontics (root canal therapy), complex oral surgery, removal of impacted teeth, crowns, inlays, dentures, and bridges. The High Plan provides excellent value from day one of coverage. In Year 2, the coverage is 50% for major services. Details about the plan may be found on page 3.

Enrollment Process

The effective date of the new Hampshire County Group Insurance Trust voluntary dental program is **April 1, 2016**. If you would like to enroll in the new dental program, please complete the enclosed enrollment form and return it to your benefits administrator.

If you have further questions regarding the dental plans, Guardian is available to answer your questions by phone. Just call the Guardian Employee Benefit Hot-line at (888) 600-1600 and identify yourself as a Hampshire County Group Insurance Trust employee.



Core DentalGuard Plan for
Hampshire County Group Insurance Trust
Group No. 437465

Benefit Maximum:

Per person, per plan year.....\$1,000

Deductible: In-Network Out-of-Network

Per plan year. Waived for preventive services.

Per person \$50 \$50

(3 individual deductibles per family)

Insured Percent: In-Network Out-of-Network

Preventative 100% 100%

Basic 100% 80%

Preventive Services.....No Waiting Period

- Routine oral examinations- once every 6 mo.
- Routine dental cleanings- once every 6 mo.
- Bitewing x-rays- once every 12 mo.
- Bitewing x-rays- full mouth series every 5 yr.
- Emergency examinations
- Fluoride treatments*- once every 12 mo.
- Sealants*- once per permanent molar every 3 yr.
- Space maintainer- includes adjustments
- Harmful habit appliances- once per person

*Children under age 16

Basic Services.....No Waiting Period

- All other x-rays
- Fillings
- Simple extractions
- Minor periodontics
- General anesthesia-surgical procedures only
- Stainless steel crowns

DentalGuard Limitations and Exclusions

This policy provides dental insurance only. Coverage is limited to those charges that are necessary to prevent, diagnose or treat dental disease, defect, or injury. Deductions apply. The plan does not pay for: oral hygiene services (except as covered under preventive services), orthodontia (unless expressly provided for), cosmetic or experimental treatments, any treatments to the extent benefits are payable by any other payor or for which no charge is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment. The plan limits benefits for diagnostic consultations and for preventive, restorative, endodontic, periodontic, and prosthodontic services. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage.

Contract #GP-1-DG2000 et al.

Other Policy Provisions

Effective Date

The group contract is effective April 1, 2016. Your individual effective date may differ depending on when your enrollment form is received.

Eligibility

Full-time employees, legal spouse, and dependent children to age 26.

Usual & Customary fees

Benefits are based on the usual & customary charges for covered services. The usual & customary charge is based on the general level of charges for similar procedures, services and supplies made by dentists in the area where your dentist practices.

Pre-Determination of Benefits

If the cost of treatment is expected to be \$300 or more, your dentist should submit a pre-determination to Guardian. This will allow you and your dentist to know the amount covered by insurance and the amount you will have to pay, before treatment is started.

Monthly Payroll Deduction

April 1, 2016 - March 31, 2017	Rates
Employee	\$26.72
Employee + 1 Dependent	\$52.72
Family	\$98.54





**High DentalGuard Plan for
Hampshire County Group Insurance Trust
Group No. 437465**

Benefit Maximum:

Per person, per plan year.....\$1,000

Deductible: In-Network Out-of-Network

Per plan year. Waived for preventive services.

Per person \$50 \$50

(3 individual deductibles per family)

Insured Percent:

	Preventive In/Out	Basic In/Out	Major In/Out
1st Yr.	100%/100%	100%/80%	0%/0%
2nd Yr.	100%/100%	100%/80%	50%/50%

Preventive Services.....No Waiting Period

- Routine oral examinations- once every 6 mo.
- Routine dental cleanings- once every 6 mo.
- Bitewing x-rays- once every 12 mo.
- Bitewing x-rays- full mouth series every 5 yr.
- Emergency examinations
- Fluoride treatments*- once every 12 mo.
- Sealants*- once per permanent molar every 3 yr.
- Space maintainer- includes adjustments
- Harmful habit appliances- once per person
*Children under age 16

Basic Services.....No Waiting Period

- All other x-rays
- Fillings
- Simple extractions
- Minor periodontics: scaling & root planing
- General anesthesia-surgical procedures only
- Stainless steel crowns

Major Services

12 Month Waiting Period

- Adjustments and repairs to: dentures, crowns, inlays, onlays, fixed bridgework
- Endodontics
- Denture relines/rebases
- Complex oral surgery
- Major periodontics
- Full or partial dentures
- Crowns, inlays, onlays
- Fixed bridgework

Other Policy Provisions

Effective Date

The group contract is effective April 1, 2016. Your individual effective date may differ depending on when your enrollment form is received.

Eligibility

Full-time employees, legal spouse and dependent children to age 26.

Usual & Customary fees

Benefits are based on the usual & customary charges for covered services. The usual & customary charge is based on the general level of charges for similar procedures, services and supplies made by dentists in the area where your dentist practices.

Pre-Determination of Benefits

If the cost of treatment is expected to be \$300 or more, your dentist should submit a pre-determination to Guardian. This will allow you and your dentist to know the amount covered by insurance and the amount you will have to pay, before treatment is started.

Monthly Payroll Deduction

April 1, 2016 - March 31, 2017	Rates
Employee	\$48.48
Employee + 1 Dependent	\$92.02
Family	\$142.46

DentalGuard Limitations and Exclusions

This policy provides dental insurance only. Coverage is limited to those charges that are necessary to prevent, diagnose or treat dental disease, defect, or injury. Deductions apply. The plan does not pay for: oral hygiene services (except as covered under preventive services), orthodontia (unless expressly provided for), cosmetic or experimental treatments, any treatments to the extent benefits are payable by any other payor or for which no charge is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment. The plan limits benefits for diagnostic consultations and for preventive, restorative, endodontic, periodontic, and prosthodontic services. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract #GP-1-DG2000 et al.



Hampshire County Group Insurance Trust
ENROLLMENT/CHANGE
REQUEST FORM

PPI Employer No. _____

Mailing Address:
10 Research Parkway
Wallingford, CT 06492
Phone: (888) 674-0046
Fax: (203) 793-1210

Section 1 – Plan Options



Employer Use - *Required Field*

Please fill in the name of your municipality below:

Employer Name _____

Select a dental plan option:

Guardian Dental Core Plan

Guardian Dental High Plan

Section 2 – Type of Activity

*Employer **must** complete both of the following if enrolling or changing coverage:

*Date of Hire or Rehire:

		-			-				
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*Effective Date of Coverage:

		-			-				
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1. ENROLL FOR COVERAGE (List all enrollees in Section 3):

- New/Rehire
- Open Enrollment
- Part-time to Full-time status
- Loss of other coverage (HIPAA Cert from prior carrier **required**)

Date of Loss of Coverage: _____

2. CHANGES TO COVERAGE

A. Add Dependents (List Deps in Section 3):

- Birth/Adoption
- Marriage
- Other (**specify**): _____

Date of Event: _____

PLEASE NOTE THE FOLLOWING:

Provider Changes after your initial election must be reported directly to the insurance carrier.

B. Other Changes (Specify on form)

- Open Enrollment Plan Change
- Name Change
- Address Change
- Beneficiary Change

3. REMOVE COVERAGE

A. Cancel Dependents (List Deps in Section 3):

- Loss of Student Status
- Divorce/Separation
- Gained Other Coverage
- Death
- Other (**specify**): _____

Date of Loss: _____

B. Term Employee Coverage

- Reduced Hours
- Gained Other Coverage
- Retirement
- Other (**specify**): _____

Date of Loss: _____

To *Terminate ALL employee coverage*, please use PPI's Employer Change Report.

Section 3 – Individuals Covered (A=Add C=Change R=Remove)

EMPLOYEE:

Last Name				First Name				SS#									
Home Address										City			State		Zip		
Date of Birth				/			/	Gender: <input type="checkbox"/> M <input type="checkbox"/> F		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Other							
Dental: <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> R																	

SPOUSE:

Last Name				First Name				SS#									
Date of Birth				/			/	Gender: <input type="checkbox"/> M <input type="checkbox"/> F									
Dental: <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> R																	

CHILD:

Last Name				First Name				SS#									
Date of Birth				/			/	Gender: <input type="checkbox"/> M <input type="checkbox"/> F									
Full-time Student? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete Section 4)				Handicapped Child? <input type="checkbox"/> No <input type="checkbox"/> Yes (Separate form may need to be completed)													
Dental: <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> R																	

CHILD:

Last Name				First Name				SS#									
Date of Birth				/			/	Gender: <input type="checkbox"/> M <input type="checkbox"/> F									
Full-time Student? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete Section 4)				Handicapped Child? <input type="checkbox"/> No <input type="checkbox"/> Yes (Separate form may need to be completed)													
Dental: <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> R																	

CHILD:

Last Name				First Name				SS#									
Date of Birth				/			/	Gender: <input type="checkbox"/> M <input type="checkbox"/> F									
Full-time Student? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete Section 4)				Handicapped Child? <input type="checkbox"/> No <input type="checkbox"/> Yes (Separate form may need to be completed)													
Dental: <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> R																	

Please use a separate sheet of paper for additional dependents.

Please continue on the reverse side

