

Christian Church  
(Disciples of Christ)  
Health Care  
Benefit Trust

**Churchwide Dental Plan  
for  
Church Employees  
(Clergy and Laity-Employer Paid)**



**Through  
Delta Dental Plan of Indiana**

**Trustee:  
Pension Fund of the Christian Church  
(Disciples of Christ)  
130 E. Washington Street  
Indianapolis, IN 46204-3659  
Ph: 317.634.4504  
Fax: 317.634.4071**

The Christian Church Health Care Benefit Trust is pleased to offer a dental program for employees of the church. This plan requires the employer to be responsible for the payment of 100% of the employee only premiums.

All employees of the church are eligible to participate in this plan. It is not required that you participate in the Churchwide Health Care program to participate in the Dental program.



**DeltaPremier USA  
Benefit Features for  
Pension Fund of the Christian Church  
(Disciples of Christ)**

The following chart indicates the services covered by Delta Dental Plan of Indiana through DeltaPremier USA. It also shows the percentage of coverage of Delta Dental's allowed fee for each category and your co-payment, if any:

	Plan Pays	You Pay
<b><i>Class I</i></b>		
<b>Diagnostic and Preventive Service</b> - Used to diagnose and/or prevent dental abnormalities or disease (includes exams, cleanings and fluoride treatments).	100%	0%
<b>Emergency Palliative Treatment</b> - Used to temporality relieve pain.	100%	0%
<b>Radiographs</b> - X-rays	100%	0%
<b>Sealants</b> - Dental sealants to prevent decay of permanent molars (to age nine on first molars; to age 14 on second molars).	100%	0%
<b><i>Class II</i></b>		
<b>Oral Surgery Services</b> - Extractions and dental surgery, including preoperative and postoperative care.	80%	20%
<b>Minor Restorative Services</b> - Used to repair teeth damaged by disease or injury (for example, amalgam [silver] and resin [white] fillings).	80%	20%
<b>Periodontic Services</b> - Used to treat diseases of the gums and supporting structures of the teeth.	80%	20%
<b>Endodontic Services</b> - Used to treat teeth with diseased or damaged nerves (for example, root canals).	80%	20%
<b>Relines and Repairs</b> - Relines and repairs to bridges and dentures.	50%	50%
<b><i>Class III</i></b>		
<b>Major Restorative Services</b> - Used when teeth can't be restored with another filing material (for example, crowns).	50%	50%
<b>Prosthetic Services</b> - Used to replace missing natural teeth (for example, bridges and dentures).	50%	50%
<b><i>Class IV</i></b>		
<b>Orthodontic Services (to age 19)</b> - Used to correct malposed teeth and/or facial bones (for example, braces).	50%	50%
<b>Maximum Payment</b> - \$1,000 per person total per calendar year for Class I, Class II and Class III Benefits. Delta Dental's payment for Class IV Benefits will not exceed a <b>lifetime</b> maximum of \$1,000 per eligible person.		
<b>Deductible</b> - \$50 deductible per person total per <b>calendar</b> year limited to a maximum deductible of \$150 per family per <b>calendar</b> year on Class II and Class III Benefits. The deductible does not apply to the balance of Class I or Class IV Benefits.		

**Customer Service toll-free number (800) 524-0149  
www.deltadelta.com**

This document is intended as a supplement to your Dental Care Certificate and Summary of Dental Plan Benefits. Please refer to your certificate and summary for policy exclusions and limitations.

**Dental Premium Rates for 2009**  
(Per Month)

	<b>Employee Only</b>	<b>Employee &amp; Spouse</b>	<b>Employee &amp; Child(ren)</b>	<b>Employee &amp; Family</b>
<b>Region I</b>	\$41.95	\$82.64	\$88.91	\$146.69
<b>Region II</b>	\$36.56	\$72.34	\$77.83	\$131.03
<b>Region III</b>	\$31.94	\$63.18	\$67.98	\$114.46
<b>Region IV</b>	\$29.65	\$58.67	\$63.12	\$106.27

Region I rates apply for participants residing in Alaska, California, Colorado, Connecticut, Delaware, Minnesota, New Jersey, New Mexico, Oklahoma, Oregon, Washington.

Region II rates apply for participants residing in Arizona, Florida, Guam, Hawaii, Idaho, Illinois, Maine, Massachusetts, Michigan, Nebraska, Nevada, New Hampshire, New York, Rhode Island, Utah, Vermont, Virgin Islands, Washington D.C. or Wyoming.

Region III rates apply for participants residing in Alabama, Georgia, Kansas, Louisiana, Missouri, Montana, North Dakota, South Carolina, South Dakota, Texas, Virginia, or Wisconsin.

Region IV rates apply for participants residing in Arkansas, Indiana, Iowa, Kentucky, Maryland, Mississippi, North Carolina, Ohio, Pennsylvania, Puerto Rico, Tennessee or West Virginia.

Note: An employee must initially enroll at open enrollment. If an employee declines coverage at open enrollment, he or she may not enroll until the next open enrollment.

Employees and their dependents choosing either dental plan are required to remain enrolled for a minimum of 12 months. Should a dependent choose to drop dental coverage after that time, he or she may not re-enroll prior to the next open enrollment period following 12 months. Dependents may only enroll if the employee is enrolled (excluding COBRA) and must be enrolled in the same plan as the employee. An election may be revoked or changed at any time if said change is the result of a qualifying event as defined under Internal Revenue Code Section 125.



Delta Dental Plan of Indiana

# Eligibility Enrollment/Update

Group Name: \_\_\_\_\_

Group/Subgroup# -

**Subscriber Information** (please complete for all enrollments/updates:) Example: **ABCDEFGHI123456**

Subscriber Name (Last)  (First)  (M.I.)  Sex  Male  Female

Subscriber Social Security Number -- Birth Date -- Status\*  Active  COBRA  Retiree  Surviving Coverage Effective Date --

Street Address   Check here if this is a new address

City  State  ZIP Code -

**Plan Enrollment/Update Information** (please indicate type of update and fill in appropriate information):

Type of Update:  New Enrollment  Reinstatement  Change/Correction to Information  Termination of Benefits

Group Transfer From: Group/Subgroup# - To: Group/Subgroup# - Rate Code Change\* From:  To:  Effective Date of Change --

Change is for:  Subscriber  Dependent

**Enrollment /Corrections to Information** (please fill in for spouse/dependents for first-time enrollment or corrections):

**SPOUSE** Name (Last)  (First)  (M.I.)  Sex  Male  Female

Social Security Number -- Birth Date -- Status\*  Legal  Surviving

**DEPENDENT #1** Name (Last)  (First)  (M.I.)  Sex  Male  Female

Social Security Number -- Birth Date -- Status\*  IRS Dep.  Disabled  Surviving  Sponsored

**DEPENDENT #2** Name (Last)  (First)  (M.I.)  Sex  Male  Female

Social Security Number -- Birth Date -- Status\*  IRS Dep.  Disabled  Surviving  Sponsored

**DEPENDENT #3** Name (Last)  (First)  (M.I.)  Sex  Male  Female

Social Security Number -- Birth Date -- Status\*  IRS Dep.  Disabled  Surviving  Sponsored

**DEPENDENT #4** Name (Last)  (First)  (M.I.)  Sex  Male  Female

Social Security Number -- Birth Date -- Status\*  IRS Dep.  Disabled  Surviving  Sponsored

\*See reverse side for instructions and explanation of codes.

3 Subscriber's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Please read the following information carefully before completing the other side of this form. You should fill out this form if you are enrolling for coverage or changing any information from an earlier enrollment. If you have any questions about filling out this form, your human resources or personnel department can help you.

**Subscriber Information** - This section must be completed for us to process your enrollment or update your records. All information should apply to you, the primary subscriber. Please print clearly or type.

**Effective Date:** The date that Delta Dental coverage takes effect for you and/or your dependents.

**Status Definitions** (Please select only one status):

**Active:** You are a current/active subscriber.

**Retiree:** You are retired and your group continues to provide you with dental benefits.

**COBRA:** You are no longer an active subscriber but you have continued self-paid coverage under COBRA. COBRA requires many employers to offer extended self-paid coverage to certain employees and qualified beneficiaries who lose group medical benefits coverage. **Please check with your human resources or personnel department.**

**Surviving:** The surviving spouse or child of a deceased subscriber.

**Plan Enrollment/Update Information** - This section should only be completed if you are: 1) Enrolling yourself or a family member for the first time, or 2) if your benefits were terminated and are now being reinstated or, 3) if you are making changes to your current enrollment information.

**Enrollment:** Check for first time enrollment for yourself or your dependents.

**Reinstatement:** Check for reinstatement coverage for yourself or your dependents.

**Change/ Corrections:** Check If any changes are being submitted on the form.

**Termination of Benefits:** Check only if you are terminating Delta Dental coverage for yourself or a family member.

**Group Transfers:** When transferring from one group to another, all dependents will transfer unless otherwise Indicated. (This section should also be completed when transferring to COBRA.)

When reporting a change or correction, the Information that is incorrect or has changed should be listed on the line titled "from" and the correct information should be listed on the line titled "to".

When changing a rate code, please refer to the following explanation to select the code that describes who is being covered by your Delta Dental program.

**Rate Codes:**

<b>Rate 1</b>	Employee Only
<b>Rate 2</b>	Employee and spouse
<b>Rate 3</b>	Employee, spouse and children
<b>Rate 5</b>	Employee, one child, no spouse
<b>Rate 6</b>	Employee and more than one child. no spouse

**Enrollment/Corrections To Information** - This section should be completed when: 1) enrolling dependents or, 2) if you have checked Changes/Corrections and are changing information that was previously submitted to Delta Dental. Please include both first and last names of any individuals for whom you are enrolling or submitting a change or correction.

**Dependent Status Definitions:**

**Legal:** Your current spouse

**Surviving:** The surviving spouse or child of a deceased subscriber.

**IRS Dependent:** An individual who is your dependent child according to the U.S. Internal Revenue Code. This could include your unmarried dependent child who is attending a university, college, community college, junior college or trade school on a full-time basis and for whom you provide principal support.

**Disabled:** Your permanently disabled child.

**Sponsored:** A dependent for whom you are legally responsible. Sponsored dependents could include parents, grandparents, and foreign exchange students, but only if specified In your group's contract with Delta Dental.

## **Questions and Answers About DeltaPremier USA**

- 1. Who is Delta Dental?** Delta Dental Plan of Indiana specializes in administering group dental plans. We are a member of the Delta Dental Plans Association, which is the largest and most experienced dental carrier in the United States.
- 2. What is DeltaPremier USA?** DeltaPremier USA is a carefully managed fee-for-service program administered by Delta Dental. "Fee-for-service" means that the dentist charges a fee for each service performed, then sends a claim to Delta Dental. Delta Dental then pays a certain percentage for each covered service, based on your group's contract with Delta Dental.

With DeltaPremier USA, you are likely to lower your out-of-pocket costs by going to a DeltaPremier participating dentist. That is because participating dentists agree to accept their fee or Delta Dental's UCR fee, whichever is less, as full payment for covered services.

More than 108,000 dentists throughout the United States and its territories participate in DeltaPremier USA.

- 3. What are the advantages of going to a participating dentist?** Your out-of-pocket costs are likely to be lower when you go to a participating dentist because participating dentists agree to accept Delta Dental's UCR fee as full payment for covered services. If the dentist's fee is higher than Delta Dental's UCR fee, he or she can not charge you the difference. That means you will pay only your co-payment and deductible, if any, when you go to a participating dentist. Participating dentists will also file your claims for you.
- 4. Do I have to go to a participating dentist?** No. In fact, you can go to any licensed dentist.
- 5. What happens if I do not go to a participating dentist?** If you go to a dentist who does not participate in DeltaPremier USA, you might have to pay more because you will not be protected from "balance billing." In other words, you will be responsible for any difference between Delta Dental's payment and the dentist's fee. You may have to fill out and file your own claim forms as well.
- 6. How can I find a dentist who participates in DeltaPremier?** Chances are good that you already go to a DeltaPremier dentist, since three out of every four practicing dentists nationwide participate in this program.

If not, you can find names of participating dentists near you by checking our Web site at [www.deltadental.com](http://www.deltadental.com). You can also call our Customer and Claims Services department, toll-free at 800.524.0149. Our automated telephone system, called DASI (Delta's Automated Service Inquiry), is available Monday through Saturday, 24 hours a day, and can provide you with the names of participating dentists near you.

- 7. Will I have to fill out and file claim forms?** You will not have to fill out and file your claim forms if you go to a participating dentist - the dentist will do it for you. And because Delta Dental pays participating dentists directly, you do not have to pay the dentist up front and then file for reimbursement if you go to a participating dentist. (You may be responsible for your co-payments and deductibles, if any, when services are rendered.)
- 8. When does my new coverage take effect?** Your new coverage takes effect January 1, 2009.
- 9. Do I need to tell my dentist my coverage has changed?** Yes. It would be helpful to you to tell your dentist that you have DeltaPremier USA coverage through Delta Dental of Indiana.
- 10. Do I need an ID card to receive care?** No. Your dentist can verify your eligibility for coverage through our DASI system. It is not necessary for you to show him or her an ID card.
- 11. What if I have more questions?** If you have additional questions, please call Delta Dental's Customer and Claims services Department at 800.524.0149 or check our Web site at [www.deltadental.com](http://www.deltadental.com).