Group Dental Insurance

Underwritten by Delta Dental of California

Benefits Guide for California Optometric Association Members

Questions?

800.775.2020

Email:

COA.Insurance.service@getamba.com

DELTA DENTAL®

AMBA

Delta Dental PPO℠ – Easy, Friendly, Accessible

We're pleased to be your partner in maintaining great oral health. The Delta Dental PPO† plan makes it easy for you to find a dentist and control your costs when you visit a network dentist. Here are some of the great things you'll need to know about enrolling with Delta Dental:

★ **Save with a PPO dentist.** The PPO network dentists accept reduced fees for covered services, so you'll usually pay the least when you visit a PPO network dentist. Non-Delta Dental dentists may balance bill you the difference between the contracted fee and their usual fee.

★ **Large dentist network.** Since Delta Dental offers access to some of the largest dentist networks in the U.S.,‡ chances are there's a wide choice of PPO dentists near your home or office. Use your desktop or mobile device to search for a dentist at deltadentalins.com.

★ **Visit the dentist of your choice.** Want to visit a non-Delta Dental dentist? No problem. You can visit any licensed dentist, but your costs are usually lowest with a PPO dentist.

★ **Log in to Online Services.** Check benefits, eligibility and claims status, view or print an ID card and use the "Fee Finder" tool to check average costs in your area. You can also change your Profile preference to go paperless. Use your mobile device to access many of these tools on the go; show the dental office your ID card information instead of carrying a printed card.

Visit the *SmileWay®* Wellness section of the Delta Dental website at deltadentalins.com for dental health articles, videos, quizzes and a risk assessment tool. You can also subscribe to the free dental health e-newsletter.

Save with a PPO Dentist

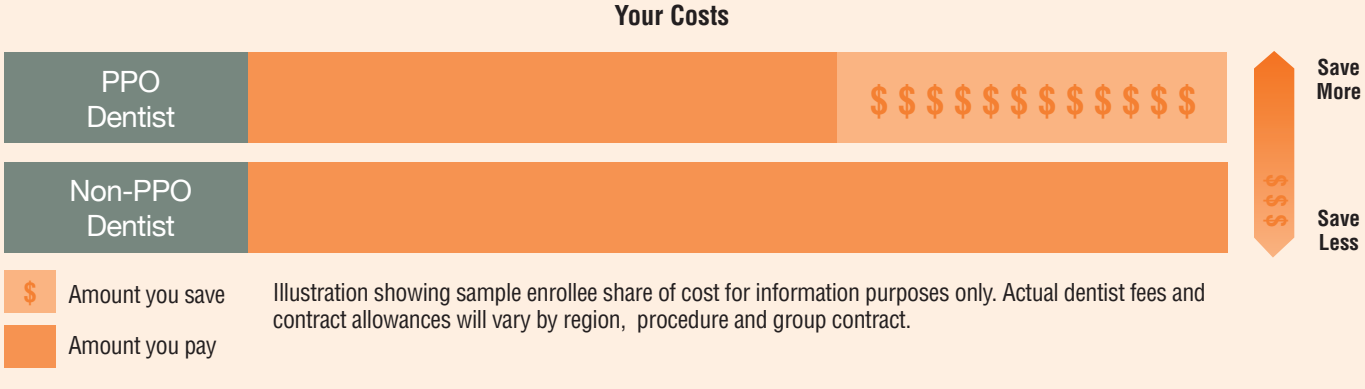

Illustration showing sample enrollee share of cost for information purposes only. Actual dentist fees and contract allowances will vary by region, procedure and group contract.

† In Texas, Delta Dental Insurance Company offers a Dental Provider Organization (DPO) plan

‡ Netminder Dental Network Trend Report, March 2013

Benefit Highlights / Delta Dental PPO℠

Eligibility		
Primary enrollee, spouse (includes domestic partner) and eligible dependent children to age 26		
Deductibles	$50 per person / $150 per family each calendar year	
Deductibles waived for D & P?	Yes	
Maximums	$1,000 per person each calendar year	
Waiting Period(s)	Basic Services None	Major Services None

The Delta Dental PPO℠ Table of Allowance plan provides you great dental benefits at a reasonable cost. With a table of allowance plan, you know in advance exactly how much the plan covers for each dental service. Delta Dental will pay the share specified on your table of allowance; you are responsible for the share of the dentist's fee not covered by the allowance.

Sample Benefits and Covered Services*	**Table Allowance**** (Amount Delta Dental Will Pay)
Diagnostic & Preventive Services (D & P)	D0120 Periodic oral exam – established patient: $22 D0272 Bitewings (two films): $22 D1110 Prophylaxis (cleaning): $47
Basic Services	D2150 Amalgam fillings, two surfaces – primary or permanent: $77 D2160 Amalgam fillings, three surfaces – primary or permanent: $93
Endodontics	D3310 Root canal, (anterior – excluding final restoration): $325
Periodontics	D4341 Periodontal scaling and root planing – four or more teeth per quadrant: $92
Oral Surgery	D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal): $65
Major Services	D2750 Crown; porcelain fused to high noble metal: $474 D5110 Complete denture – maxillary: $637

* Limitations or waiting periods may apply for some benefits; some services may be excluded.

** Allowances specified above represent only a few examples from your plan's table. Please refer to your Benefit Booklet for a full schedule of allowances and for any limitations and exclusions on these benefits.

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

Questions?

Call Toll-Free 1-800-775-2020 • 8:00 AM - 5:00 PM Monday-Friday

If you have any questions about your eligibility, what the plan covers, rates, or how to complete the application, please do not hesitate to call. A Client Advisor will be able to immediately provide you with the information you need. Or you can email us: COA.Insurance.service@getamba.com.

The California Optometric Association incurs costs in connection with this sponsored program. To provide and maintain this valuable membership benefit, it is reimbursed for these costs. The California Optometric Association also receives a fee for the license of its name and logo for use in connection with this plan.

CA Insurance License #0I96562 • Association Member Benefits & Insurance Agency

800-775-2020 • COA.Insurance.service@getamba.com • www.COAMemberInsurance.com

Sponsored by:

Underwritten by: DELTA DENTAL

Program Administered by: AMBA

Association Member Benefits & Insurance Agency
P.O. Box 14555
Des Moines, IA 50306

DELTA DENTAL®

ENROLLMENT/CHANGE FORM - CA

Delta Dental of California

3-454

Delta Dental of California
P.O. Box 429086
San Francisco, CA 94142-9086
www.deltadentalins.com

VERY IMPORTANT - Please Print Legibly

FOR GROUP USE ONLY

Group No.	Division	State
7314	1002	CA

Effective Date / / | Hire Date / /

Name of Employer

Location | Pay Code | Benefit Package

Enrollee/Change Information

- ❑ New Enrollment
- ❑ Marital Status Change
- ❑ Terminate Enrollee Coverage
- ❑ SSN/Enrollee ID Number Correction or previous ID under which benefits are received
- ❑ Add/Delete Dependent
- ❑ Address Change
- ❑ Other _____

Primary Enrollee Information

Social Security Number	Enrollee ID Number (if applicable)	Date of Birth	Gender	Marital Status
		/ /	❑ Male ❑ Female	❑ Single ❑ Married

First Name | Last Name | Middle Initial

Mailing Address (Street) | City | State | Zip Code

E-mail Address (internal use only) | Phone Number ( ) - | Phone Type Cell ❑ Work ❑ Home ❑

Name of Other Dental Carrier | Policy Holder Name (first/last) | Date of Birth / /

Effective Date of Other Policy / / | Policy Holder Street Address | City | State | Zip Code

Enrollee Classification

- ❑ Full-Time ❑ Hourly ❑ Certified
- ❑ Part-Time ❑ Salaried ❑ Classified
- ❑ Retired ❑ Member/Other _____

COBRA (if applicable)

- ❑ Termination
- ❑ Reduction in Hours
- ❑ Divorce/Legal Separation*
- ❑ Widowed/Surviving Dependent*
- ❑ Dependent Child No Longer Eligible*

Indicate qualifying date: _____/_____/_____

*If a dependent is enrolling under his/her social security number, the **SSN currently enrolled under must be provided**.

Dependent Information

Relationship	Dependent First Name (Last only if different from enrollee)	Add / Term	Social Security Number	Date of Birth	Male / Female	Student / Disabled**	Name of School (overage student)**
Spouse/Partner		❑ ❑		/ /	❑ ❑	❑ ❑	
Dependent		❑ ❑		/ /	❑ ❑	❑ ❑	
Dependent		❑ ❑		/ /	❑ ❑	❑ ❑	
Dependent		❑ ❑		/ /	❑ ❑	❑ ❑	
Dependent		❑ ❑		/ /	❑ ❑	❑ ❑	

Please attach a separate sheet for additional dependent information. All dependents listed will be considered enrolled. **Additional documentation will be required for disabled and student status.

❑ I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the above information is true and correct to the best of my knowledge. I understand that changes can only be made if I experience a qualifying family status change, in which case the change must be consistent with that event, or as may otherwise be provided by the group contract.

❑ I decline coverage at this time.

Signature of Enrollee _____ Date _____/_____/_____