

A Dental Plan Designed Exclusively for Federal Employees

As a Rhode Island federal employee or retiree, you are eligible to join an affordable, quality dental plan available through Delta Dental of Rhode Island.

This voluntary plan provides you with comprehensive dental benefits that include routine exams and cleanings, fillings, restorative services (crowns and bridges), student coverage up to the age of 23, orthodontics and a \$1,500 calendar year maximum, per member.

As a Delta Dental PPO Plus Premier member, you have access to the nation's largest dental networks: 119,000 dental offices in our PPO program and 198,000 locations nationwide with Delta Dental Premier. In Rhode Island, nine out of ten dentists participate with Delta Dental so chances are your dentist is already in our network. With Delta Dental, you enjoy instant recognition and acceptance of your ID card and the dentist will file claims directly on your behalf.

Once you enroll, we encourage you to visit the "Members" section of our website, which will provide you with detailed information about your plan, including:

BenefitCheckSM – View your personal benefit and eligibility details, the status of your deductible and x-ray information.

Claims LookUpSM – Check the status of a submitted claim, as well as review all your claims activity for the past 18 months.

Online ID Card – Print a copy of your Delta Dental ID card instantly from the website.

Find A Dentist – Search for a dentist anywhere in the country, as well as print maps and driving directions to the dental office.

To learn more about Delta Dental, visit our website at www.deltadentalri.com.

How to Enroll

Complete and sign the enclosed enrollment form and mail it to:

Delta Dental of Rhode Island
PO Box 1517
Providence, RI 02901-1517

Payment Options

Delta Dental offers two convenient payment options: payment by credit card or direct withdrawal from your checking or savings account. Your credit card will be charged/your bank account will be debited no more than ten (10) days prior to the start of coverage, and on a monthly basis thereafter.

FEDERAL EMPLOYEE VOLUNTARY DENTAL PLAN

BENEFIT HIGHLIGHTS

The information listed here is not a guarantee of payment. Payment is based on the Delta Dental allowance for each procedure. To be covered, services must be dentally necessary and in accordance with Delta Dental's treatment guidelines. All services must be performed in a dental office. These benefits are listed according to the level of coverage (i.e. 100%, 80%). Coverage for benefits with time limitations (i.e. 6, 12, 24, 36 or 60 months) is calculated to the exact day.

The annual maximum is: \$1,500.00 per member, per calendar year

The annual deductible is: \$0.00

The maximum lifetime cap: Unlimited

Pretreatment estimates are recommended for underlined procedures.

Plan pays 100%; Member Coinsurance 0%

- One oral exam per calendar year
- Two cleanings per calendar year
- Fluoride treatment for children under age 19 once per calendar year
- One set of bitewing x-rays per calendar year
- One complete x-ray series or panoramic film every 60 months
- Single x-rays as required
- Sealants for children under age 14, once per unrestored permanent molar every 24 months

Plan pays 80%; Member Coinsurance 20%

- Palliative treatment (minor procedures necessary to relieve acute pain) twice per calendar year
- Amalgam (silver) fillings. Composite (white) fillings on front teeth only. For composite fillings on back teeth, the plan pays up to what would have been paid for an amalgam filling. The patient is responsible for the balance up to the dentist's charge.
- Space maintainers for lost deciduous (baby) teeth, replacement limited to once every 60 months
- Extractions and other routine oral surgery not covered by a patient's medical plan
- General anesthesia or intravenous (I.V.) sedation for certain complex surgical procedures
- Root canal therapy
- Repairs to existing partial or complete dentures once per calendar year
- Recementing crowns or bridges
- Rebasing or relining of partial or complete dentures once every 60 months
- Periodontal maintenance following active therapy - two per year
- Root planing and scaling once per quadrant every 24 months

Plan pays 50%; Member Coinsurance 50%

- Surgical placement of endosteal implant, abutment and crown once per tooth per lifetime
- Crowns over natural teeth, build ups, posts and cores - replacement limited to once every 60 months
- Osseous (bone) surgery once per quadrant every 24 months
- Gingivectomies once per site every 24 months
- Soft tissue grafts once per site every 60 months
- Crown lengthening once per site every 60 months
- Bridges, build ups, posts and cores - replacement limited to once every 60 months
- Partial and complete dentures - replacement limited to once every 60 months
- Guided tissue regeneration and bone replacement graft; once per site every 24 months

Orthodontics:

Plan pays 50%; Member Coinsurance 50%; a 12-month waiting period applies*

- Braces and related services for dependent children under the age of 19

Lifetime maximum (orthodontics only) is \$1,200.00

Dependent Coverage - Dependent children who are full-time students over age 19 are covered as long as they stay in school or up until the end of the year that they turn age 23.

* The 12-month waiting period for orthodontic benefits only applies to new enrollees effective on or after 1/1/2007.

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Personal Information Please fill out this form entirely. Incomplete forms will delay your application.

Effective Date	Social Security No.	Are you currently: <small>(from box checked above)</small>	<input type="checkbox"/> Active <input type="checkbox"/> Retiree
First Name		Last Name	
Street Address / P.O. Box Number		Date of Birth (MM/DD/YYYY)	
City	State	Zip Code	
Business Tel. No. () —	Home Tel. No. () —		
Email Address		New Hire/Date of Hire	

Coverage Type & Premium Rates Please select a coverage type: Individual, Two-Person or Family. Rates effective thru 12/31/10.

Monthly Premium _____ Individual \$37.61 _____ Two-Person \$75.21 _____ Family \$124.10

Family Information If you've selected Two-Person or Family Coverage, fill in the appropriate information.

Spouse _____ / _____ <small>first name only date of birth</small>	Child _____ / _____ <small>first name only date of birth</small>
Child _____ / _____ <small>first name only date of birth</small>	Child _____ / _____ <small>first name only date of birth</small>

Coverage Action Please select one: New Enrollee Add/Remove Family Member End Coverage Change Name/Address/Billing
 Please select one of the following reasons when changing family coverage: Marriage Birth/Adoption Divorce Loss of Coverage

Coordination of Benefits (Additional Dental and Medical Coverage)

Are you or any of your family members covered by another dental plan? <input type="checkbox"/> YES <input type="checkbox"/> NO Is this an Individual <input type="checkbox"/> or Family <input type="checkbox"/> Plan? (Check one.)	
Other Dental Insurance Name: _____	Other Dental Insurance Address: _____
Policy Holder Name: _____	Policy Number: _____
Are you or any of your family members covered by a medical plan? <input type="checkbox"/> YES <input type="checkbox"/> NO Is this an Individual <input type="checkbox"/> or Family <input type="checkbox"/> Plan? (Check one.)	
Other Medical Insurance Name: _____	Other Medical Insurance Address: _____
Policy Holder Name: _____	Policy Number: _____

Method of Payment (See back for details.)

Please check a payment type and fill in the appropriate information.

A. Monthly Direct Withdrawal from Bank Account: Type: Checking Savings

Name on Bank Account: _____

Bank Name: _____ Bank Address: _____

Routing Number: _____ Bank Account Number: _____

B. Monthly Payment from Credit Card:

Name: (exactly as it appears on Credit Card) _____

Credit Card Type: MasterCard Visa Credit Card Number: _____ Expiration Date: _____

Authorizing Signature:

I certify that all information is true and correct to the best of my knowledge. I understand that the start date and cancellation date of my insurance coverage will be determined by Delta Dental of Rhode Island. I authorize Delta Dental to withdraw funds from my bank account no more than ten (10) days prior to the start of coverage, and on a monthly basis thereafter. I understand that if funds are not available or payment is not otherwise timely made, I will no longer be eligible for coverage. I have read and understand the information on both the front and back of this form.

Your signature (Form will not be processed without signature.) Date

Please attach a separate sheet for additional notes and remarks, including the name and date of birth of any additional family members.
 Please send form to: Delta Dental of Rhode Island, PO Box 1517, Providence, RI 02901-1517

FEDERAL EMPLOYEE VOLUNTARY DENTAL PLAN

Please read the following information regarding the plan's eligibility, coverage and payment guidelines.

Eligibility Information

You must be a Rhode Island federal employee, a Rhode Island postal employee, or a retiree from any Rhode Island federal agency to qualify and remain eligible for coverage. If you suspend your employment or membership with this association, your dental coverage is subject to termination.

Coverage Type and Premium

Delta Dental offers Individual, Two-Person and Family Coverage. Enrollment in this program occurs during the annual open enrollment period each November. Rates are guaranteed for the entire coverage period. Prior to the end of a coverage period, Delta Dental will mail a notification to you indicating any change in rates.

Enrollment and payment of premium is not a guarantee of claim payment. To be covered, services must be dentally necessary and in accordance with Delta Dental's treatment guidelines. All services must be performed in a dental office and the patient must be covered by a Delta Dental contract on the day services are completed. **Dependent children are not covered for orthodontic services until you have been enrolled in the program for 12 months.** There are no refunds of premium dollars for this coverage.

Renewal of Coverage

Your coverage is automatically renewed at the end of your coverage period. Your coverage period is from your coverage start date until the end of the calendar year, unless otherwise noted.

If you choose to end your coverage, you must notify us in writing. Cancellation of coverage is effective on the last day of your most recent payment period. **Please Note: If you cancel coverage, you must wait 12 months to reapply. If your new application is accepted, your coverage will begin on January 1 of the following year.** Delta Dental reserves the right to cancel coverage after appropriate notification due to non-payment of premium.

Family Information

If you are electing Family Coverage, please provide the first name and date of birth for each family member to be covered by this plan. List your spouse first (if applicable) and then list your children. Dependent children are covered up until the end of the month that they turn age 19. Dependent children who are full-time students over age 19 are covered as long as they stay in school or up until the end of the month in which they turn age 23.

Coordination of Benefits (Additional Medical and Dental Coverage)

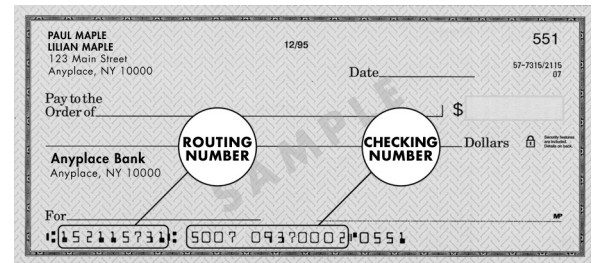
Please provide Delta Dental with any other medical or dental plan that covers you or your family member(s).

Method of Payment

This is a pre-paid dental insurance plan. Delta Dental offers two convenient payment options.

A.) Direct Withdrawal from Bank Account – You may elect to have funds withdrawn from your bank account monthly. Funds will be withdrawn no more than ten (10) days prior to the start of coverage, and on a monthly basis thereafter. Please use this sample check as a guide when selecting direct withdrawal from your checking account. **Please Note: Transaction that are returned for insufficient funds are subject to a \$25 processing fee.**

B.) Credit Card – You may opt for Delta Dental to charge your credit card monthly. Your credit card will be charged no more than ten (10) days prior to the start of coverage, and on a monthly basis thereafter. **Please Note: Transaction that are declined are subject to a \$25 processing fee.**



Authorizing Statement

Please read the authorizing statement on the front of this enrollment form, and sign/date it. Delta Dental cannot process forms without an authorizing signature. You will receive your Subscriber ID card and benefit literature approximately 15 days before your coverage begins.

Please mail this form to Delta Dental of Rhode Island, PO Box 1517 Providence, RI 02901-1517.