Hampshire County Group Insurance
Voluntary Dental Program

PPO $500 Plan (for Medical PPO enrollees)
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. As a PPO Medical enrollee, you will have an additional choice of Dental plans. The attached describes the third plan option, which is the PPO $500.

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

Rates are guaranteed until June 30, 2021.

Benefits of the DentalGuard Plan
Your plan pays the indicated percentages of Usual & Customary fees shown on pages 2 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 PPO $500 plan covers benefits for major services like periodontics (gum treatment), endodontics (root canal therapy), complex oral surgery, removal of impacted teeth, crowns, inlays, dentures, and bridges. This plan provides excellent value from day one of coverage.

Enrollment Process
The effective date of the new Hampshire County Group Insurance Trust voluntary dental program is July 1, 2019. 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.

GUARDIAN®

PPO $500 for
Hampshire County Group Insurance Trust
Group No. 437465

Benefit Maximum:
Per person, per plan year.....$500

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
100%/100%	50%/50%	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 19

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.....No 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 July 1, 2019. 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

July 1, 2019 - June 30, 2021	Rates
Employee	$28.34
Family	$81.09

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.

PPI Benefit Solutions
ACSA Group Insurance Trust

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

B.R. Fox & Associates

Employer Use - *Required Field*
Please fill in the name of your municipality below:

Employer Name ______________________________

____

❑ **Guardian Dental – PPO $500 Plan**

Section 2 – Type of Activity

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

***Date of Hire or Rehire:**

		-			-				

***Effective Date of Coverage:**

		-			-				

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: ❑ M ❑ F	Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Other
Dental: ❑ A ❑ C ❑ R		

SPOUSE:

Last Name	First Name	SS# ___ ___ ___ — ___ ___ — ___ ___ ___ ___
Date of Birth ___ ___ / ___ ___ / ___ ___ ___ ___	Gender: ❑ M ❑ F	
Dental: ❑ A ❑ C ❑ R		

CHILD:

Last Name	First Name	SS# ___ ___ ___ — ___ ___ — ___ ___ ___ ___
Date of Birth ___ ___ / ___ ___ / ___ ___ ___ ___	Gender: ❑ M ❑ F	
Full-time Student? ❑ No ❑ Yes (Complete Section 4)	Handicapped Child? ❑ No ❑ Yes (Separate form may need to be completed)	
Dental: ❑ A ❑ C ❑ R		

CHILD:

Last Name	First Name	SS# ___ ___ ___ — ___ ___ — ___ ___ ___ ___
Date of Birth ___ ___ / ___ ___ / ___ ___ ___ ___	Gender: ❑ M ❑ F	
Full-time Student? ❑ No ❑ Yes (Complete Section 4)	Handicapped Child? ❑ No ❑ Yes (Separate form may need to be completed)	
Dental: ❑ A ❑ C ❑ R		

CHILD:

Last Name	First Name	SS# ___ ___ ___ — ___ ___ — ___ ___ ___ ___
Date of Birth ___ ___ / ___ ___ / ___ ___ ___ ___	Gender: ❑ M ❑ F	
Full-time Student? ❑ No ❑ Yes (Complete Section 4)	Handicapped Child? ❑ No ❑ Yes (Separate form may need to be completed)	
Dental: ❑ A ❑ C ❑ R		

Please use a separate sheet of paper for additional dependents.

Please continue on the reverse side

Section 4 – Student Status Information

Generally, dependents over the age of 18 must be full-time students to be eligible for coverage. Please list below all full-time students from Section 3 and include the name of the school and the student's expected date of graduation. Use a separate sheet of paper for additional students.	
Dependent Name: _____	Dependent Name: _____
Name of School: _____	Name of School: _____
Expected Graduation Date: _____	Expected Graduation Date: _____

Section 5 – Waiver of Coverage (Complete and sign ***ONLY*** if waiving coverage(s) for yourself and/or your dependents)

I hereby certify that I have been given an opportunity to enroll for Group Health Insurance benefits offered by my employer and have decided **NOT** to enroll in the following coverage(s):

❑ Dental ❑ Dependent Dental

I understand that if I delay enrolling more than 31 days after the date I could first become insured, the Dental benefits for myself and my dependents may be limited for a period time as determined by the plan rules.

_____ _____/_____/_____
Employee's Signature Date

Section 6 – Employee Signature

I represent that all the information supplied in this application is true and complete. I have personally designated the beneficiaries shown on this form (if applicable) and hereby request group insurance for myself and for my dependents listed on this form for selected coverages noted in Section 1. I hereby authorize my employer or successor to make deductions from my earnings of the required contributions, if any, to apply toward the insurance costs for the insurance provided for in the policy of group insurance issued to my employer.

I understand that the effective date of insurance for myself or for any of my dependents is subject to my being actively at work on that date and that the effective date of insurance for any of my dependents is also subject to the dependent health condition requirements of the Plan. Further, I understand that any insurance subject to evidence of good health or medical information will not become effective until the carrier gives its written consent.

I understand that, in the event I fail to sign this form within 31 days of the effective date of eligibility or that for any reason the carrier does not receive notice of the Enrollment/Change Request within a reasonable time following the event, my eligibility and my dependent's eligibility may be affected.

Misrepresentations: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

_____ _____/_____/_____
Employee's Signature Date

Section 7 – Employer Verification

Employer's Signature	Title	Date

IMPORTANT Before signing this form, please review it for accuracy and completeness. Incomplete forms will be held pending for missing information resulting in a delay in processing. Should you need assistance, please contact PPI's account service team at (888) 674-0046.