Superior Dental Care®
A Medical Mutual Company

ENROLLMENT INFORMATION
Boone County Board of Education
Contract Period: 1/1/2023 through 12/31/2023

SUPERIOR SMILES START WITH SUPERIOR DENTAL CARE

Dental coverage through SDC offers financial protection for maintaining oral health ***and*** helps care for general health in the process. Regular oral exams, like those covered by your SDC plan, prevent and detect dental problems before they turn into something serious. A simple routine dental check-up could even save your life, as major health problems can first show symptoms in the mouth. Your employer has selected a **SUPERIOR** dental plan for you to elect – please see the plan details below. Sign up today for your new **SUPERIOR** dental coverage...and let SDC keep you ***smiling for a lifetime!***

	Core Plan #1237		Enhanced Plan #1238	
	In Network	Out of Network	In Network	Out of Network
Preventive *oral exams, x-rays, cleanings, fluoride treatments for children, emergency treatment, sealants for children, space maintainers*	100%	100%	100%	100%
Basic *fillings, root canal therapy, oral surgery, extractions, repairs & recementation*	50%	50%	80%	80%
Major *crowns, onlays, bridges, dentures, periodontal treatment, implants*	50%	50%	50%	50%
Contract Maximum *per member, per contract period; applies to Preventive, Basic & Major services*	$1,000.00	$1,000.00	$1,500.00	$1,500.00
Orthodontia	N/A	N/A	50%	50%
Orthodontia Maximum *lifetime maximum applies to Orthodontic services*	N/A	N/A	$1,000.00	$1,000.00
Deductible *applies to Basic & Major services and follows the contract period*	$50/$150	$50/$150	$50/$150	$50/$150
Copay *applies to Preventive exams*	N/A	N/A	N/A	N/A
Network Access	No Balance Billing	Balance Billing Possible	No Balance Billing	Balance Billing Possible

Any out of network service may be subject to a "balance bill" for any amount that the dentist's charge exceeds SDC's then current allowable amount for an eligible service.

To review the complete List of Covered Services, refer to SDC's Evidence of Coverage or the Schedule of Benefits associated with the plan number above.

Monthly Rates	Core Plan	Enhanced Plan
Employee	$21.88	$32.72
Employee + Spouse	$43.56	$65.08
Employee + Child(ren)	$54.46	$81.36
Family	$78.44	$117.14

Rates listed are valid only for the plans above and for the contract period listed above.

PROTECT YOUR SMILE...AND YOUR MONEY!

SDC's dental plans focus on preventive services like cleanings and exams that can help you avoid major dental procedures and save you money. Without SDC dental coverage, the cost of an emergency dental procedure that wasn't detected and treated early can easily reach thousands of dollars. Additionally, SDC will provide a **Free Second Opinion** by a participating dentist for extensive treatment plans. This is provided at no cost and without utilizing any portion of the individual's Contract Maximum. This benefit is required to be coordinated, in advance, through SDC's Dentist and Member Services team.

OVER HALF A MILLION NETWORK ACCESS POINTS ACROSS THE COUNTRY

NO WAITING PERIODS | NO BALANCE BILLING *(in network)* **| NO CLAIM FORMS** *(in network)* **| NO MISSING TOOTH EXCLUSION**

Notice: Any person obligated for any part of a pre-payment may cancel such agreement within 72-hours after having signed the agreement or offer to enroll. Cancellation occurs when written notice of cancellation is given to SDC or its agents or other representatives.

Warning: If you or your family members are covered by more than one healthcare plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers you or your family.

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SUPERIOR DENTAL CARE
EMPLOYEE ENROLLMENT FORM

LEADING THE WAY IN DENTAL BENEFITS

Company Name: Boone County Board of Education
Effective Date of Action: 1-1-2023

Employee Name:
Group #: Subgroup #:

Address:
☐ Male ☐ Female

City: State: Zip: County:
Home Phone #: Alt Phone #:

Date of Birth: SS#:
E-Mail:

Which dental plan number are you enrolling? (please circle one): #1237 #1238

Reason for the Form:

☐ New Enrollment / ☐ Open Enrollment
☐ Add / ☐ Delete Dependent & Reason:
☐ Subgroup Change
☐ Marriage / ☐ Divorce Date:
☐ COBRA Continuation/Conversion
☐ Enrollee Termination & Reason:
☐ Waive Coverage
☐ Other:

Full Name	*Relationship*	*Gender*	*Birth Date*	*Waive*	*Other Dental Insurance*
				Y / N	Y / N
				Y / N	Y / N
				Y / N	Y / N
				Y / N	Y / N
				Y / N	Y / N
				Y / N	Y / N

Other Dental Coverage (if you circled 'Y' in the Other Dental Insurance section above for any of the dependents listed, please complete this section):

Are you, your spouse, or any dependents also covered under another dental policy? ☐ Yes ☐ No If yes, please complete the following: Policy #:

Employer Name: Insurance Company:
Employer Address: SS #: Birthdate:
City: State: Zip: Individuals covered:

Signatures:

Enrollee Signature: **Date:**
Approved by (Group Administrator): **Date:**

Superior Direct Connect - Once your group is enrolled and effective, go to superiordental.com and sign up to access your account and personal benefit information.

On behalf of myself and any dependents listed above, I hereby apply for coverage under the Master Group Contract/Policy issued to my employer by Superior Dental Care (SDC). I understand the benefits for which I and my dependents are eligible under this Policy. I understand certain services may require a copayment or deductible payable by me or my dependents directly to the provider of services. I authorize my employer to deduct the necessary dental service fees, if any, from my wages or salary, with the understanding that he acts as my agent in all dealings with the plan and that all acts performed by him and all notices given to him in such dealings are binding upon me, as not prohibited by statute or regulation. I waive the dentist-patient privilege and authorize my dentist to give SDC, its agents and representatives, any information concerning any claims for reimbursement for covered services of any person under this coverage. In the absence of fraud, all statements under this application are considered representations and not warranties.

OHIO FRAUD NOTICE: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

KENTUCKY FRAUD NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime.

INDIANA FRAUD NOTICE: Any person who knowingly and with intent to defraud an insurer files an application for insurance containing any false, incomplete, or misleading information commits a felony.

7.3.2019