DENTAL PLAN

BENEFITS DESCRIPTION

WYOMING COUNTY CHAMBER

11/2017

Dental Pay Plus
100 Corporate Pkwy. Suite 334
Amherst, NY 14226
Phone: 716- 831-8171
Fax: 716-831-8080
Toll-Free: 1-888-683-3682
www.probenefitsadmin.com

GENERAL QUESTIONS & ANSWERS
ABOUT YOUR NEW
DENTAL INSURANCE PROGRAM

Q. **When does the plan start?**
A. The first of the following month that the application is received.

Q. **Who pays for the program?**
A. The plan is a voluntary plan, which means the employee is responsible for all of the premium costs

Q. **How do I enroll?**
A. Fill out the enrollment form included with this package and return it to your Chamber Representative within three working days.

Q. **Can I continue to see my own dentist?**
A. You may use the dentist of your choice. However, you will receive a higher benefit if you use a participating dentist. If you choose to use a participating dentist, it is your responsibility to make sure that your dentist participates in the plan prior to having any services performed. To verify if a dentist is the PPO program, go to www.probenefitsadmin.com

Q. **What if my dentist does not participate?**
A. Fill out the provider request form included with this package and return it to your Human Resource Representative. It is also advisable to contact your dentist to let him/her know that you are now enrolled in Dental Pay Plus and you would appreciate his/her considering joining the program and that they will be contacted directly by Dental Pay Plus.

Q. **How do I submit a claim?**
A. Forms may be obtained from your Human Resource Representative. It is not necessary to submit a claim form if you use a participating dentist. Non-participating dentists will either submit the claim form for you or will instruct you to send the form directly to Dental Pay Plus at the address listed in the top right hand corner of the claim form.

Q. **Will I be receiving an Identification Card?**
A. Each enrolled employee will receive an ID card along with a summary plan booklet detailing the coverage.

Q. **What is the age to which my child will be covered?**
A. Children are covered to the end of the month they turn age 26.

Q. **How does payment work?**
A. For any service that requires a participant co-payment, you will be responsible for such co-payment to the dentist. Please refer to the summary of benefits included in this package or to your summary plan booklet you receive after you enroll in the plan. You will be responsible for the co-payment at the time or service, or will be billed at a later date by your dentist (depending on your particular dentist's practice). You will receive a statement from Dental Pay Plus detailing each claim submitted and processed. The statement will show any participant co-payment required.

Q. **What are In-Network Benefits?**
A. In-Network benefits are those services where you utilize a dentist who participates in the Dental Pay Plus plan. Dentists who participate agree to accept our schedule fees. You are responsible for any applicable co-payment directly to the dentist.

Q. **What are Out-of-Network Benefits?**
A. Out-of-Network benefits are those services where you choose to utilize a dentist who does not participate with Dental Pay Plus. These dentists do not have an agreement to accept our fees, and therefore may charge you the difference between what the plan pays and their charges.

Q. **Who may I call with questions about my plan?**
A. You may contact your Human Resource Representative with general questions regarding your plan, such as when and how to enroll, information on ID cards or booklets. For questions regarding coverage or claims, please contact Dental Pay directly at (716) 831-8171 or toll-free 1-888-683-3682.

SUMMARY OF BENEFITS

BENEFIT	**DENTAL PAY PLUS**	
Plan Summary	**In-Network** plan utilizes participating dentists. **Out-of-Network** allows freedom of choice.	
Dependents covered to end of month age 26	**In-Network**	**Out-of-Network**
Preventative Services: Oral Exams X-rays & Diagnostic Teeth Cleanings (1 every 6 months) Fluoride Treatment Topical Sealant Emergency Treatment	100%	100% OF REASONABLE AND CUSTOMARY
Minor Restorative Services: Fillings Space Maintainers Oral Surgery Extractions Stainless Steel Crowns Occlusion Adjustment Local Anesthesia	80%	80% OF REASONABLE AND CUSTOMARY
Major Restorative Services: Crowns Inlay/Onlay Partial & Full Dentures Fixed Bridgework Endodontics Periodontic Services Repairs to crowns & bridgework	50%	50% OF REASONABLE AND CUSTOMARY
Deductible (waived on preventative)	$50, 3 per family	$50, 3 per family
Annual Maximum	$750	$750
Monthly Premium	Single $ 49.95	Family $132.24

Dental Pay Plus

100 Corporate Parkway, Suite 334
Amherst, New York 14226
(716) 831-8171

WYOMING COUNTY CHAMBER OF COMMERCE

GROUP APPLICATION

EMPLOYER INFORMATION:

Name: _____

Address: _____

Phone: _____ Fax: _____

Person to contact regarding plan: Name: _____ Title: _____

Total number of employees in company: _____ # Single:_____ # Family:_____

Total number of employees eligible for insurance:_____ # Single:_____ # Family:_____

Total number of employees enrolled in prior carrier's plan:_____ # Single:_____ # Family:_____

Is this an Employer paid plan? Yes: _____ No: _____

If Employees contribute towards cost, at what percentage do employees contribute?: _____% Individual_____% Family

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PLAN INFORMATION:

Requested Effective Date of Coverage:_____
(Please allow necessary time for document preparation. It takes approximately 3-6 weeks for completion of enrollment process.)

Is this plan replacing another plan?: Yes: _____ No: _____

(If Yes, please list name of carrier:)_____

Date of Cancellation of Prior Carrier's coverage:_____
(Please note it is the Employer's responsibility to cancel previous coverage. Generally, cancellations must be written and received at least 30 days prior to requested cancellation date.)

COVERAGE INFORMATION:

Group Plan Selected:

Level I: In-Network 100/80/50% of scheduled allowance
Out-of-Network 100/80/50% of R&C
$750 calendar year maximum per person
Annual Deductible In/Out Network; $50 (3 per family) (waived on preventative)
Dependents covered to end of month age 26

_____ _____
Employer Signature Date

_____ _____
WCC Signature Date