



# Voluntary Option 1 Enhanced Plan Dental Insurance

## The LSU System's Dental Plan

Underwritten by Ameritas Life Insurance Corp. — Group Dental Division

Offering the freedom to choose any licensed dentist.

Employees who choose to participate pay 100% of the premium through payroll deduction.

During the annual enrollment period for July 1 effective dates, all eligible employees may select the Option 1 Enhanced Plan or Option 2 Basic Plan, or waive coverage. The employee must remain in the plan chosen until the next annual election period, at which time employees may switch plans without penalty.

If an employee waives dental coverage when first eligible, he or she will not be allowed to sign up until the next annual enrollment period.

### FEATURES INCLUDE:

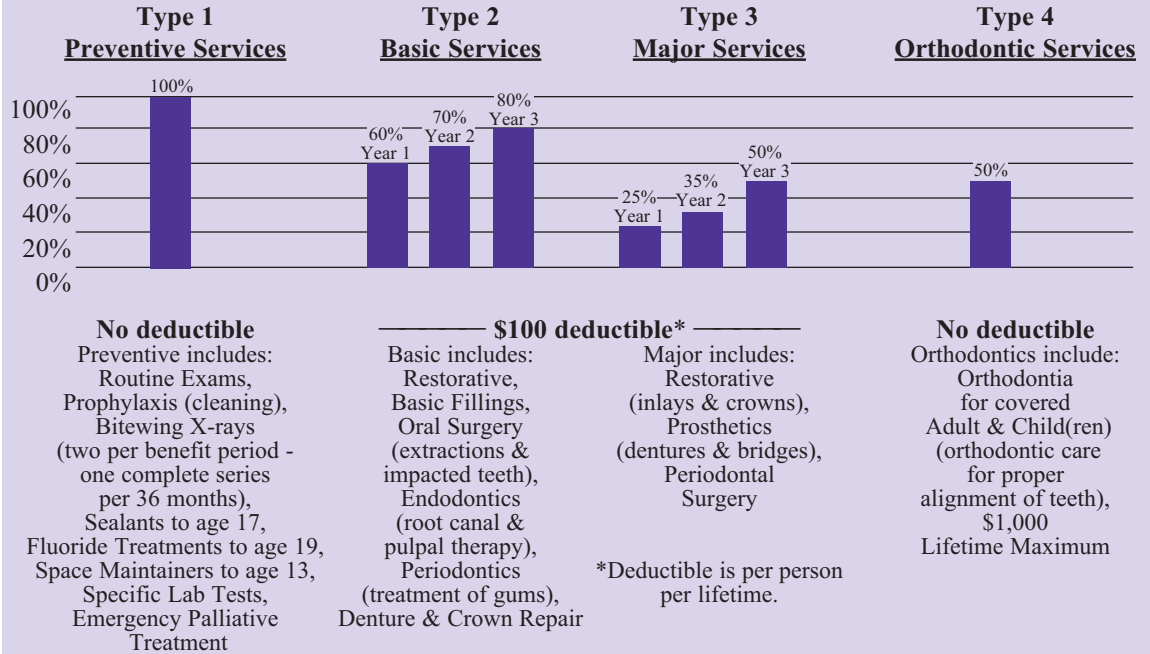
- Immediate coverage, no benefit waiting periods
- No deductible for Preventive and Orthodontic services
- Lifetime deductible for Basic and Major services
- Dental Rewards® (information on back)

### Monthly\* Rates for LSU System Employees:

- \$28.08 Employee only
- \$55.20 Employee plus spouse
- \$67.16 Employee plus child(ren)
- \$94.28 Employee plus family

\*Rates based on 12 pay periods per year.

**BENEFITS PAYABLE** • Plan pays benefits for Type 1, Type 2 and Type 3 up to the \$1,250 annual maximum. Orthodontic benefits have a \$1,000 lifetime maximum.



**GROUP DENTAL ENROLLMENT CARD • OPTION 1 ENHANCED PLAN**

Name of Employer <b>LOUISIANA STATE UNIVERSITY SYSTEM</b>		Group No.	
Employee Name (Last, First MI)		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security No.
Home Address (Street, City, State, Zip)		Date of Birth / /	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced
Date of Hire / /	Occupation	Status: <input type="checkbox"/> Active <input type="checkbox"/> Retired	<input type="checkbox"/> COBRA Continue Qualifying Event _____ Date of Event _____
Group Coverage Requested: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee and Child(ren) <input type="checkbox"/> Employee and Spouse <input type="checkbox"/> Employee and Family		Waiver Statement: <input type="checkbox"/> I have been given the opportunity to apply for group Dental Insurance, but do not wish this coverage	
List Name, Sex and Date of Birth of each dependent you wish to insure.			
Name	Sex	Date of Birth	Name
Spouse		3.	
Children		4.	
2.		5.	
I authorize my employer to deduct from my earnings the amount to cover the cost of the coverage I have requested.		Spouse's Dental Carrier (if any):	
Signature		Date	Monthly Premium
			Annual Premium
Office Use	Campus	HRM Rpt	Pay Type
		Effective Date	P/R Rpt
		Payroll Deduction	Date Processed

This form is for informational purposes only. To enroll, cancel or make any other changes, please use the LSU System Voluntary Benefits ENROLLMENT or CHANGE/CANCELLATION form.

## Contract Provisions

### When and How to Enroll

You may enroll on or within 30 days after the effective date of the Policy, or on or within 30 days of your employment or completion of any employer requested probationary period (if you are employed after the effective date of the policy). Complete the dental enrollment card and return it to the Human Resources Department. If an employee waives dental coverage when first eligible, he or she will not be allowed to sign up until the next annual enrollment period.

### Benefits Payable

The LSU System's Dental Plan (Plan) is designed to provide benefits up to the Usual and Customary fee allowance (U&C). The Plan's U&C fee allowance is defined as the charge falling below the 90th percentile of the customary fee charged for dental services in a certain geographical area, determined by ZIP Code. The plan pays the Percent Payable after deductible of covered expenses incurred during each calendar year, up to the Maximum Benefit.

When the Plan disallows a portion of the charge from your dentist, it means that your dentist's fee is above the U&C fee allowance, a very rare occurrence. Most dentists accept the Plan's fee schedule, but they are free to charge a higher fee, so you may be responsible for charges above the U&C rate.

The LSU System's Dental Plan gives you the freedom to choose any provider. However, choosing a dentist who participates in the Ameritas Participating Provider Network assures you that you will not pay more than the U&C fee allowance. In some cases, you may pay less.

### Who is Eligible?

You are eligible if you are a full-time employee and are regularly scheduled to work at least 30 hours per week (75% of full time) with an appointment extending beyond 120 days. Eligible dependents are your married spouse who is not legally separated from you; your unmarried children and grandchildren who are under age 21; or age 21 but under age 24 if attending school full time and dependent upon you for more than half of their support. No one can be insured as a dependent if eligible for the insurance as an employee. However, if you and your spouse can be insured as employees, one of you may insure your spouse and eligible child(ren).

It is not intended for benefits to exceed your dental bills. If you or your family members are eligible to receive benefits under another Plan, benefits under this Policy will be coordinated with the benefits from the other Plan(s), so that not more than 100% of the Allowable Expenses incurred during a calendar year will be paid by the Policy and other Plan(s).

***PLEASE RETURN COMPLETED ENROLLMENT FORMS TO YOUR LOCAL HUMAN RESOURCES DEPARTMENT.***

**This is not a certificate of insurance.** It is a brief description only. The Group Policy alone determines all rights and benefits.

## Freedom to Choose Any Provider

With this plan, you have the freedom to choose any provider you wish without penalty. However, a significant number of dentists have agreed to provide services to LSU System employees at lower rates. These dentists are members of the Ameritas Participating Provider Network. Should you select one of these dentists, your out-of-pocket expenses may be reduced. In addition, before dental work begins, we recommend asking your dental provider to submit a pretreatment estimate on our dental claim form (it's free of charge).

## Dental Rewards

This plan includes another wonderful benefit — Dental Rewards. Insured members who care for their teeth and use only a portion of their annual maximum benefit are rewarded! With its increasing annual maximum feature, each insured employee and dependent earns additional money toward his/her next year's annual maximum.

After the first Benefit Period following the effective date of this plan, the Maximum Amount per member may be increased by the carry-over amount of \$250 if:

- a) The insured person has submitted a claim for dental expenses incurred the preceding benefit period, and
- b) The benefits paid for dental expenses incurred in the preceding benefit period did not exceed the benefit threshold of \$500.

In each succeeding Benefit Period in which the total dental expense benefits paid do not exceed the Benefit Threshold, the insured person will be eligible for the Carry-over Amount. The Carry-over Amount can be accumulated from one Benefit Period to the next up to the Maximum Carry-over amount of \$1,000, unless:

- a) During any Benefit Period dental expense benefits are paid in excess of the Benefit Threshold. In this instance, there will be no additional Carry-over Amount for that Benefit Period, or
- b) During any Benefit Period no claims for dental expenses incurred during the preceding Benefit Period are submitted. In this instance, there will be no Carry-over Amount for that Benefit Period and any accumulated Carry-over Amounts from previous Benefit Periods will be forfeited.

Eligibility for the Carry-over Amount will be established or reestablished at the time the first claim in a Benefit Period is received for dental expenses incurred during that Benefit Period. To properly calculate the Carry-over Amount, claims should be submitted timely in accordance with the Proof of Loss provision found within the General Provisions Section of the Certificate of Insurance. You have the right to request review of prior Carry-over Amount calculations. The request for review must be made within 24 months from the date the Carry-over Amount was established.

Group Dental Claim Office  
P.O. Box 81889  
Lincoln, NE 68501-1889  
**800.598.8018**  
[www.ameritasgroup.com](http://www.ameritasgroup.com)