△ DELTA DENTAL®



Dental Plan Enrollment Form

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1. 0	Check the appropriate box	for coverage desired:				
		Basic Plan	Core Plan		Premium Plan	
	Member Only	\$23.81	\$31.90		\$56.45	
	Member + 1 Child	\$51.60	\$64.02		\$122.23	
	Member + Spouse	\$48.02	\$61.41		\$115.97	
	Member + Child(ren)	\$51.60	\$64.02		\$122.23	
	Member + 1 Family	\$82.20	\$105.10		\$203.83	
Applications received in the SEANC home office by the 10th of the month will be effective the first of the following month.					Send forms to SEANC office:	
These rates are effective until 12/31/2026.					ax: 1-919-792-3321	
For more information on becoming a member, call 800-222-2758 or visit www.seanc.org or www.deltadentalnc.com. After enrolling, visit www.memberportal.com for provider search, benefits and claims information.					Mail: ATTN: Insurance Department 1621 Midtown Place	
You	must be a member of S	EANC to enroll.			Raleigh, NC 27609	
2. Employee Information (please print clearly):						
	Social Security Number:		SEANC#			

2. E	mployee Infor	mation (plea	ase print clea	arly):	
	Social Security Number:			-	SEANC#
	Your Name:	First Name			Middle Initial Last Name
	Birth Date:	/	/	Gender: • M • F	Marital Status: - Single - Married - Divorced - Widowed - Domestic Partnership
	Address:				
	Home Phone: ()	-		Work Phone: () -
	Cell Phone: ()	-		Personal email address:

st all eligibl	e family members below (if electing depender	nt coverage): Note: Adult dependent children (up to age 26	
	First Name	Last Name	Birth Date	Gender
Spouse			/ /	M F
Child			/ /	M F
Child			/ /	M F
Child			/ /	M F
Child			/ /	M F

Child		/	/	M F
I agree to continue enrollment in the dental plan for a	neriod of 12 months			
☐ I authorize payroll/pension deduction for this insuranc☐ I prefer to have my premiums invoiced		Name of Bank:	Routing Nu	ımber:
I, the undersigned, hereby authorize my employer to deduct pren monthly basis, in such amounts as are currently established pursua be established by SEANC and the provider by contract subseque	ant to the SEANC insurance contract with the	, ,	•	

Date

Your Signature

This authorization shall continue until cancelled by me by written notice to the SEANC Central Office.

State Employees Association of North Carolina

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	Premium Plan	Core Plan	Basic Plan
Annual Maximum Benefit*	\$5,000	In - \$1,500 Out - \$1,250	\$1,250
Orthodontia Lifetime Policy Maximum	\$2,000	Not Covered	Not Covered
Deductible (Individual)	\$50	\$25	\$25
Deductible (Family)	\$150	\$75	\$75
Preventive and Diagnostic Services			
Preventive & Diagnostic Co-Insurance	In - 100% Out - 80%	In - 100% Out - 80%	In - 100% Out - 80%
Oral evaluation Exams (Routine Exam)	2 times per calendar year	2 times per calendar year	2 times per calendar year
Dental Prophylaxis (Teeth Cleaning) *	2 times per calendar year *	2 times per calendar year *	2 times per calendar year *
Fluori de Treatments	2 times per calendar year to age 16	2 times per calendar year to age 16	2 times per calendar year to age 16
Intraoral Radiographs (Full Mouth X-rays)	1 time per 3 year period (complete series and Panorex)	1 time per 3 year period (complete series and Panorex)	1 time per 3 year period (complete series and Panorex)
Bitewing and Extraoral X-rays Adults and child(ren)	Bitewing: 2 per calendar year Extraoral: 2 films per calendar year	Bitewing: 2 per calendar year Extraoral: 2 films per calendar year	Bitewing: 2 per calendar year Extraoral: 2 films per calendar year
Space maintainers	1 per 5 year period for dependent children to age 16.	1 per 5 year period for dependent children to age 16.	1 per 5 year period for dependent children to age 16.
Brush Biopsy	Covered	Covered	Covered
Basic Services			
Basic Co-Insurance	In - 80% Out - 60%	In – 80% Out - 60%	In - 70% Out - 50%
Sealants	Once per first or second permanent molar every 36 months for dependent children to age 16.	Once per first or second permanent molar every 36 months for dependent children to age 16.	Once per first or second permanent molar every 36 months for dependent children to age 16.
Simple Extractions	Covered	Covered	Covered
Restorations (Routine Fillings)	Covered	Covered	Covered
Periodontal maintenance	2 times per calendar year with a documented history of periodontal disease	2 times per calendar year with a documented history of periodontal disease	2 times per calendar year with a documented history of periodontal disease
Palliative Treatment	Covered	Covered	Covered
Major Services			Covered
Major Co-Insurance	In - 50% Out - 25%	In – 50% Out – 25%	0% Not Covered
Endodontics	Covered	Covered	Not Covered
Denture Repairs	12 months after initial insertion, 1 time per 6 months	12 months after initial insertion, 1 time per 6 months	Not Covered
Adjustment to Dentures	12 months after initial insertion, 1 time per 6 months	12 months after initial insertion, 1 time per 6 months	Not Covered
Oral Surgery	Covered	Covered	Not Covered
Periodontal Scaling and Root Planing	One time per quadrant per consecutive 24 months	One time per quadrant per consecutive 24 months	Not Covered
Root Canal Therapy	1 time per tooth per lifetime	1 time per tooth per lifetime	Not Covered
Periodontal Surgery	Once per quadrant or site every consecutive 36 months	Once per quadrant or site every consecutive 36 months	Not Covered
Oral Surgery – Other/Surgical			
	Covered	Covered	
Anesthesia			Not Covered
Anesthesia Bridges/Dentures	Covered Covered as a basic service Full Denture/Partial Denture: 1 per five year period Relining and Rebasing Dentures: 6 months after initial installation and 1 time per consecutive 12 months.	Covered Covered as a basic service Full Denture/Partial Denture: 1 per five year period. Relining and Rebasing Dentures: 6 months after initial installation and 1 time per consecutive 12 months.	
	Covered as a basic service Full Denture/Partial Denture: 1 per five year period Relining and Rebasing Dentures: 6 months after initial installation and 1	Covered as a basic service Full Denture/Partial Denture: 1 per five year period. Relining and Rebasing Dentures: 6 months after initial installation and 1	Not Covered Covered as a basic service
Bridges/Dentures	Covered as a basic service Full Denture/Partial Denture: 1 per five year period Relining and Rebasing Dentures: 6 months after initial installation and 1 time per consecutive 12 months. 1 time per tooth per five year period Crown replacement: 1 time per five year period from initial or	Covered as a basic service Full Denture/Partial Denture: 1 per five year period. Relining and Rebasing Dentures: 6 months after initial installation and 1 time per consecutive 12 months. 1 time per tooth per five year period Crown replacement: 1 time five year period from initial or	Not Covered Covered as a hasic service Not Covered
Bridges/Dentures Crowns/Inlays/Onlays	Covered as a basic service Full Denture/Partial Denture: 1 per five year period Relining and Rebasing Dentures: 6 months after initial installation and 1 time per consecutive 12 months. 1 time per tooth per five year period Crown replacement: 1 time per five year period from initial or supplemental placement.	Covered as a basic service Full Denture/Partial Denture: 1 per five year period. Relining and Rebasing Dentures: 6 months after initial installation and 1 time per consecutive 12 months. 1 time per tooth per five year period Crown replacement: 1 time five year period from initial or supplemental placement.	Not Covered Covered as a basic service Not Covered Not Covered
Bridges/Dentures Crowns/Inlays/Onlays Implants Procedures	Covered as a basic service Full Denture/Partial Denture: 1 per five year period Relining and Rebasing Dentures: 6 months after initial installation and 1 time per consecutive 12 months. 1 time per tooth per five year period Crown replacement: 1 time per five year period from initial or supplemental placement. 6 month waiting period. I time per tooth per five year period Relining and Rebasing Dentures: 6 months after initial installation and 1	Covered as a basic service Full Denture/Partial Denture: 1 per five year period. Relining and Rebasing Dentures: 6 months after initial installation and 1 time per consecutive 12 months. 1 time per tooth per five year period Crown replacement: 1 time five year period from initial or supplemental placement. 6 month waiting period. 1 time per tooth per five year period Relining and Rebasing Dentures: 6 months after initial installation and 1	Not Covered Covered as a basic service Not Covered Not Covered Not Covered Not Covered Not Covered
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^{*}The Annual Maximum Benefit is the maximum amount the plan will pay each calendar year. It is a combined annual maximum for network and out-of- network benefit services.

Please refer to the Delta Dental Certificate of Coverage for a detail description of the plan benefits.

^{*}Women who are pregnant and have gum disease, individuals with diabetes and gum disease, as well as individuals at risk for infective endocarditis, or other at-risk conditions such as renal failure, immune suppressed systems due to chemotherapy and/or radiation, organ transplant, or stem cell transplant may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.

^{*}Out-ofi-network reimbursement has changed firom 90th UCR to the PPO fiee schedule.