DRL
Doyle Rowe LTD

PLEASE READ BEFORE COMPLETING YOUR DELTA DENTAL ENROLLMENT FORM

Dear IMRF Retiree:

Thank you for your interest in the IMRF Delta Dental plan. The following will assist you in completing the enrollment materials:

Enrollment Form:

- Fill out all information in the section titled **"ALL ENROLLEES MUST COMPLETE THE FOLLOWING SECTIONS".**
- Check the box for your choice of Delta Dental plan: **STANDARD or HIGH OPTION.**
- Check the box for your choice of Coverage Type (Single, Single +1 or Family). This box appears **directly under your Delta Dental Plan choice**.
- Supply the requested information about yourself.
- Supply the requested information about any dependents for whom you are requesting coverage.
- Sign and date the application.

HEALTH CARE PROGRAM PREMIUM DEDUCTION AUTHORIZATION FORM: Please complete the information at the top of the form and check **Delta Dental of Illinois** for yourself and if applicable, your spouse of family. You must sign the form.

PLEASE NOTE: The Delta Dental plan requires a **one year enrollment** commitment. **Coverage will become effective on the first of the month following receipt of your application (if received before the 25th of the month). The rates listed on the application are guaranteed through December 31, 2027.**

Please complete the Delta Dental Enrollment form and the Health Care Program Premium Deduction Authorization Form and return to: **Doyle Rowe LTD, 1301 W. 22nd St., Suite 101, Oak Brook, IL 60523**. Please contact our office at 1-800-564-7227 with any questions

Sincerely,
Doyle Rowe LTD

DELTA DENTAL®

Illinois Municipal Retirement Fund – Standard Option

Delta Dental PPO Plan Highlights Group #10231

Introduction
Illinois Municipal Retirement Fund dental enrollees have access to two extensive networks, Delta Dental PPO and Delta Dental Premier managed fee-for-service. When you call your dentist to make an appointment, ask if he/she participates in either Delta Dental PPO or Premier. Your out-of-pocket costs will vary depending on whether he/she participates in Delta Dental PPO, Premier or neither (i.e., "out-of-network"). **You will maximize your benefits by receiving care from a Delta Dental PPO network dentist**. There are 165,200 Delta Dental PPO and 247,600 Delta Dental Premier dentist locations nationwide, including 5,650 and 9,340, respectively, in Illinois.

Choosing Your Dentist
You may go to any in- or out-of-network general or specialty dentist at the time of treatment. However, it is to your advantage to choose a Delta Dental PPO or Premier network dentist for the following reasons:

1) Payment to Delta Dental PPO dentists is based on pre-set, reduced fees; payment to Premier dentists is based on Delta Dental's maximum plan allowance (MPA). In both networks, you only have to pay your deductible and coinsurance – *you are not responsible for charges exceeding the reduced PPO fee if you receive treatment from a Delta Dental PPO dentist or the MPA if you receive treatment from a Premier dentist.**

For example, if you need a crown, assume the Delta Dental PPO fee allowance is $600 and the MPA is $900. If your plan covers crowns at 50% and your dentist normally charges $1000, your out-of-pocket cost (excluding deductible) would be:

Delta Dental PPO Dentist – $300
(50% of the $600 PPO fee allowance)

Delta Dental Premier Dentist – $600
(50% of the $600 PPO fee allowance plus $300 difference between PPO fee allowance and MPA)

Out-of-Network Dentist – $700
(50% of the $600 PPO fee allowance plus $400 difference between PPO fee allowance and the dentist's billed charge)

2) Because we reimburse Delta Dental PPO and Premier dentists directly, they agree to charge you no more than your deductible and coinsurance; in other words, *you do not have to pay the whole bill up-front and wait for reimbursement.*

3) Out-of-network dentists do not accept Delta Dental's reduced PPO fee and you will have to pay the difference between Delta's reduced PPO fee and the dentist's billed charge. At the dentist's discretion, *you may also have to pay the entire bill in advance.*

4) Claim forms will be completed and submitted at no charge. Out-of-network dentists may require you to complete forms yourself or to pay a service charge.

**If your Delta Dental PPO or Premier dentist inadvertently charges you for amounts payable by Delta Dental, please call our customer service department at 800-323-1743.*

Non-Covered Services
There are some limitations on the expenses for which the Illinois Municipal Retirement Fund Dental Plan pays. For further information, refer to your certificate of coverage or call our customer service department.

Finding a Network Dentist
To verify your dentist's participation status, simply ask him/her if he/she is a Delta Dental PPO or Delta Dental Premier network dentist, call our interactive voice response system, contact our customer service department or visit our Web site.

Visit Delta Dental of Illinois' Web site at
www.deltadentalil.com

The Illinois Municipal Retirement Fund Dental Plan utilizes the Delta Dental PPO and Delta Dental Premier networks. To locate a network dentist, click on Dentist Search in the Subscriber section.

You can search by:
1) City, state and ZIP code
2) Specialty
3) Dentist name (optional)

Summary of Benefits and Covered Services – Illinois Municipal Retirement Fund – Standard Option

Annual Maximum	$1,000/person	$1,000/person	$1,000/person
Annual Deductible (applies to Basic/Major only)	$50/person; $150/family	$50/person; $150/family	$50/person; $150/family
	Delta Dental PPO Network	**Delta Dental Premier Network**	**Out-of-Network**
Preventive/Diagnostic ♦ Oral evaluations (two per benefit year) ♦ X-rays (bitewings – two per benefit year; full mouth – once every three years) ♦ Prophylaxis (cleaning; two per benefit year) ♦ Fluoride treatment (once per benefit year children to age 19) ♦ Space maintainers ♦ Sealants	100% of reduced fee*	100% of reduced fee**	100% of reduced fee***
Basic ♦ Fillings ♦ Periodontics ♦ Endodontics ♦ Oral surgery ♦ General anesthesia (in conjunction with oral surgery)	50% of reduced fee*	50% of reduced fee**	50% of reduced fee***
Major ♦ Crowns, jackets, cast restorations ♦ Fixed/removable bridges ♦ Partial/full dentures)	50% of reduced fee*	50% of reduced fee**	50% of reduced fee***
	*You will not be "balance" billed" for charges exceeding Delta Dental's allowed PPO fee.	**You will not be "balance billed" for charges exceeding Delta Dental's maximum plan allowance (MPA). However, you are responsible for charges exceeding Delta Dental's allowed PPO fee.	***You are responsible for charges exceeding Delta Dental's allowed PPO fee.

The preceding information is a brief summary of the Illinois Municipal Retirement Fund Dental Plan and the services it covers. If you have specific questions regarding benefit coverage, limitations or exclusions, contact Delta Dental at 800-323-1743.

Note: Delta Dental imposes no restrictions on the method of diagnosis or treatment by a treating dentist. A benefit determination relates only to the level of payment that your group dental plan is required to make.

DELTA DENTAL®

Illinois Municipal Retirement Fund – High Option

Delta Dental PPO Plan Highlights — Group #10231

Introduction
Illinois Municipal Retirement Fund dental enrollees have access to two extensive networks, Delta Dental PPO and Delta Dental Premier managed fee-for-service. When you call your dentist to make an appointment, ask if he/she participates in either Delta Dental PPO or Premier. Your out-of-pocket costs will vary depending on whether he/she participates in Delta Dental PPO, Premier or neither (i.e., "out-of-network"). **You will maximize your benefits by receiving care from a Delta Dental PPO network dentist**. There are 165,200 Delta Dental PPO and 247,600 Delta Dental Premier dentist locations nationwide, including 5,650 and 9,340, respectively, in Illinois.

Choosing Your Dentist
You may go to any in- or out-of-network general or specialty dentist at the time of treatment. However, it is to your advantage to choose a Delta Dental PPO or Premier network dentist for the following reasons:

1) Payment to Delta Dental PPO dentists is based on pre-set, reduced fees; payment to Premier dentists is based on Delta Dental's maximum plan allowance (MPA). In both networks, you only have to pay your deductible and coinsurance – *you are not responsible for charges exceeding the reduced PPO fee if you receive treatment from a Delta Dental PPO dentist or the MPA if you receive treatment from a Premier dentist.**

For example, if you need a crown, assume the Delta Dental PPO fee allowance is $600 and the MPA is $900. If your plan covers crowns at 50% and your dentist normally charges $1000, your out-of-pocket cost (excluding deductible) would be:

Delta Dental PPO Dentist – $300
(50% of the $600 PPO fee allowance)

Delta Dental Premier Dentist – $600
(50% of the $600 PPO fee allowance plus $300 difference between PPO fee allowance and MPA)

Out-of-Network Dentist – $700
(50% of the $600 PPO fee allowance plus $400 difference between PPO fee allowance and the dentist's billed charge)

2) Because we reimburse Delta Dental PPO and Premier dentists directly, they agree to charge you no more than your deductible and coinsurance; in other words, *you do not have to pay the whole bill up-front and wait for reimbursement.*

3) Out-of-network dentists do not accept Delta Dental's reduced PPO fee and you will have to pay the difference between Delta's reduced PPO fee and the dentist's billed charge. At the dentist's discretion, *you may also have to pay the entire bill in advance.*

4) Claim forms will be completed and submitted at no charge. Out-of-network dentists may require you to complete forms yourself or to pay a service charge.

**If your Delta Dental PPO or Premier dentist inadvertently charges you for amounts payable by Delta Dental, please call our customer service department at 800-323-1743.*

Non-Covered Services
There are some limitations on the expenses for which the Illinois Municipal Retirement Fund Dental Plan pays. For further information, refer to your certificate of coverage or call our customer service department.

Finding a Network Dentist
To verify your dentist's participation status, simply ask him/her if he/she is a Delta Dental PPO or Delta Dental Premier network dentist, call our interactive voice response system, contact our customer service department or visit our Web site.

Visit Delta Dental of Illinois' Web site at
www.deltadentalil.com

The Illinois Municipal Retirement Fund Dental Plan utilizes the Delta Dental PPO and Delta Dental Premier networks. To locate a network dentist, click on Dentist Search in the Subscriber section.

You can search by:
1) City, state and ZIP code
2) Specialty
3) Dentist name (optional)

Summary of Benefits and Covered Services – Illinois Municipal Retirement Fund – High Option

Annual Maximum	$2,000/person	$2,000/person	$2,000/person
Annual Deductible (applies to Basic/Major only)	$50/person; $150/family	$50/person; $150/family	$50/person; $150/family
	Delta Dental PPO Network	**Delta Dental Premier Network**	**Out-of-Network**
Preventive/Diagnostic ♦ Oral evaluations (two per benefit year) ♦ X-rays (bitewings – two per benefit year; full mouth – once every three years) ♦ Prophylaxis (cleaning; two per benefit year) ♦ Fluoride treatment (once per benefit year children to age 19) ♦ Space maintainers ♦ Sealants	100% of reduced fee*	100% of reduced fee**	100% of reduced fee***
Basic ♦ Fillings ♦ Posterior composites ♦ Endodontics ♦ Periodontics ♦ Oral surgery ♦ General anesthesia (in conjunction with oral surgery)	80% of reduced fee*	80% of reduced fee**	80% of reduced fee***
Major ♦ Crowns, jackets, cast restorations ♦ Fixed/removable bridges ♦ Partial/full dentures ♦ Implants	50% of reduced fee*	50% of reduced fee**	50% of reduced fee***
	*You will not be "balance" billed" for charges exceeding Delta Dental's allowed PPO fee.	**You will not be "balance billed" for charges exceeding Delta Dental's maximum plan allowance (MPA). However, you are responsible for charges exceeding Delta Dental's allowed PPO fee.	***You are responsible for charges exceeding Delta Dental's allowed PPO fee.

The preceding information is a brief summary of the Illinois Municipal Retirement Fund Dental Plan and the services it covers. If you have specific questions regarding benefit coverage, limitations or exclusions, contact Delta Dental at 800-323-1743.

Note: Delta Dental imposes no restrictions on the method of diagnosis or treatment by a treating dentist. A benefit determination relates only to the level of payment that your group dental plan is required to make.

DELTA DENTAL

Member Connection

Connecting with Delta Dental of Illinois is easy!

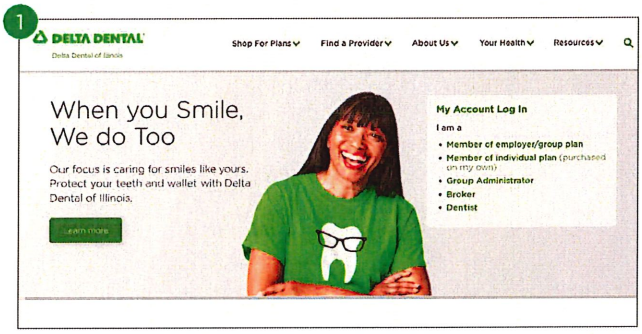
Get real-time benefit and claim information 24 hours a day, seven days a week through the Member Connection at deltadentalil.com or through our automated phone system at 800-323-1743.

With the Member Connection, you can find everything you need to know about your and your covered dependents' benefits, including:

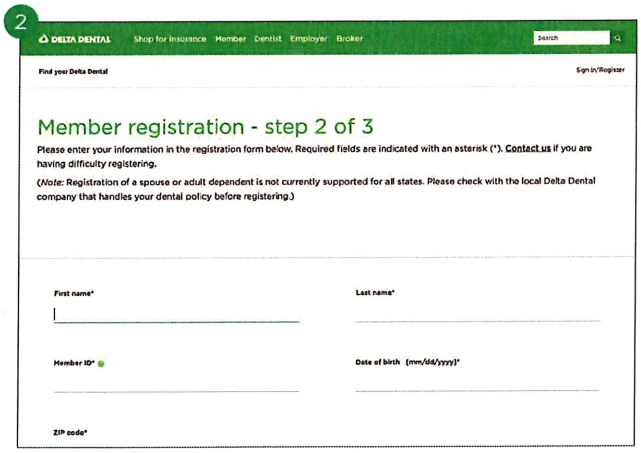
- Claim status
- Eligibility information
- Maximum and deductibles used to date
- Benefit levels
- Frequency and age limits
- Waiting periods
- Preventive history
- Explanation of Benefits (EOBs)

How to Register:

1. Go to deltadentalil.com, select "Member of employer/group plan" in the "My Account Log In" box located on the right side of the homepage. On the next page, click "Don't have an account? Create an account." Select "I am a member or adult dependent and have coverage with Delta Dental" on the next screen.



2. You will need to enter the primary member's first and last name, member ID or Social Security number and date of birth.
   - For name:
     - The name must appear exactly how your employer entered it during enrollment; for example, "Bob" may be "Robert."
     - If you have a suffix before or after your first name – for example, Jr., II or an initial – you may also need to list it; for example, Robert Jr., Robert III or J Robert.
     - There is a 10-character limit for first name and a 15-character limit for last name. For example, if your first name is Christopher, you are limited to Christophe for first name.
   - For member ID: If your member ID is less than 9 digits, you must enter zero's in front of the number; for example, 001234567. You may also use Social Security number with no dashes.
   - For date of birth: You must enter two-digit month, two-digit day and four-digit year with dividers; for example, 03/15/1984.

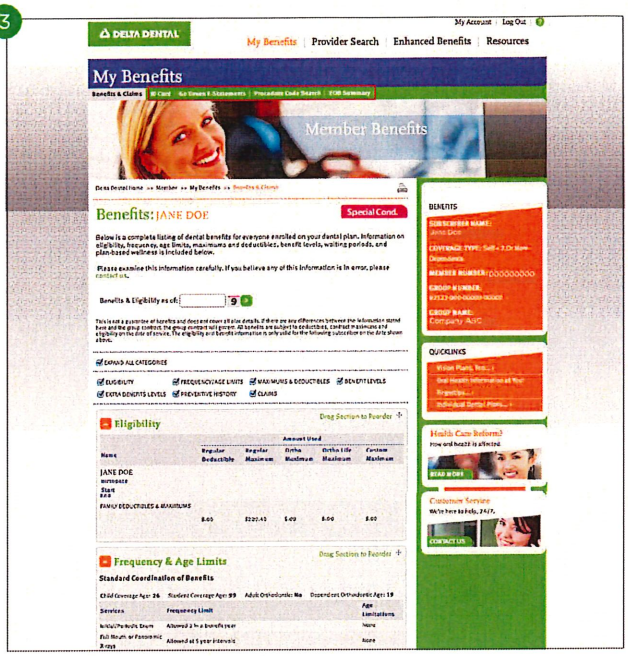


3 Once registered, you can easily access your and your covered dependents' benefits and claims information, print a temporary ID card, sign up to receive electronic EOBs (Go Green E-Statements), conduct a procedure code search and access EOB history.

Automated Phone System. Faster service for you.

You can also call 800-323-1743 to access our automated phone system 24 hours a day, seven days a week or to speak to a customer service representative during normal business hours.

3



ENROLLMENT/ CHANGE OF STATUS WAIVER FORM

Please keep a copy for your records

Delta Dental Group Number 10231 IMRF
Group Contact Doyle Rowe LTD 1-800-564-7227
www.doylerowe.com

All Enrollees Must Complete the Following Sections
Please check one plan and one coverage type:

☐ I would like to enroll in the Standard Option Delta Dental Plan (monthly cost listed below)

Coverage Type (Choose one)

- ☐ Single $36.05
- ☐ Single + 1 $72.14
- ☐ Family $112.37

OR

☐ I would like to enroll in the High Option Delta Dental Plan (monthly cost listed below)

Coverage Type (Choose one)

- ☐ Single $48.41
- ☐ Single + 1 $96.88
- ☐ Family $150.90

Last Name First Name M.I. Gender

Date of Birth MM/DD/YYYY Marital Status Street

City State Zip

Phone Effective Date MM/DD/YYYY

Social Security Number

Does spouse have a dental plan?___ Yes ___ No Are dependents covered by spouse's plan? ___Yes ___ No

Spouse's Employer _____Spouse's Carrier_____

Coverage will be effective on the first of the month following receipt of your application if received by the 25th of the month.

Please list all eligible dependents to be covered

	FIRST NAME	LAST NAME (if different)	BIRTHDATE	GENDER(M/F)
Spouse				
Child				
Child				
Child				
Child				

I wish to enroll in the Delta Dental plan and understand that a one year enrollment in the Delta Dental plan is required.

Signature of applicant Date

Health Care Program Premium Deduction Authorization for IMRF-endorsed Plans

IMRF Form 7.10E (Rev. 08/2013)

- Please indicate which program you are **NEWLY** applying for by checking the appropriate box(es) below.
- Fill out the front page of this form only; the back page will be filled out by the plan administrator.
- **Please note**: All programs except for Sav-Rx **require additional applications**.
- **Return completed form to**: Doyle Rowe Ltd.,1301 W. 22nd Street, Suite 101, Oak Brook, IL 60523.
- **If you have any questions contact Doyle Rowe at 1-800-564-7227 or www.doylerowe.com.**

PLEASE PRINT OR TYPE

MEMBER'S LAST NAME	FIRST NAME	MIDDLE INITIAL	(JR., SR., II, ETC.)

DATE OF BIRTH (MM/DD/YYYY)	IMRF MEMBER ID OR LAST 4 DIGITS OF SSN

(If applicable) SPOUSE'S LAST NAME	FIRST NAME	MIDDLE INITIAL	(JR., SR., II, ETC.)

DATE OF BIRTH (MM/DD/YYYY)	SOCIAL SECURITY NUMBER
	_____ - _____ - _____

HOME STREET (MAILING) ADDRESS

CITY, STATE, AND ZIP	DAYTIME TELEPHONE NUMBER (with Area Code)
	( )

To be completed by applicant. Please note that all programs except Sav-Rx require a separate application form. CHECK ONLY THE PLAN YOU ARE NEWLY ENROLLING IN.

Seniors Choice	☐ Individual	☐ Spouse	**Humana Local PPO**	☐ Individual	☐ Spouse	
United Health Care Medicare Complete	☐ Individual	☐ Spouse	**Humana Regional PPO**	☐ Individual	☐ Spouse	
Health Care Alliance HMO	☐ Individual	☐ Spouse	**Humana Group PDP Plan**	☐ Individual	☐ Spouse	
Health Care Alliance PPO	☐ Individual	☐ Spouse	**Sav-Rx Advantage Card**	☐ Individual	☐ Spouse	
Blue Cross Blue Shield of Illinois	☐ Individual	☐ Spouse	**Delta Dental of Illinois**	☐ Individual	☐ Spouse	☐ Family
Blue Cross Blue Shield of Texas	☐ Individual	☐ Spouse	**United Health Care Vision Plan**	☐ Individual	☐ Spouse	☐ Family

Member Authorization

I authorize and request the Illinois Municipal Retirement Fund (IMRF) to deduct premiums for the selected program(s) from my IMRF benefit payment and to remit the amount deducted to the health care program. I authorize IMRF to release information to the health care program in order to ensure proper handling of premiums. I understand IMRF will adjust deductions in response to changes in the premiums. I further understand that IMRF will cease making any deduction if the premiums exceed my IMRF benefit amount.
This authorization is not an assignment of my right to receive payment. This authorization will remain in effect with IMRF until cancelled by written notice from me or until IMRF is notified that a premium deduction is no longer required.

MEMBER SIGNATURE* _____ DATE (MM/DD/YYYY) _____

SPOUSE'S SIGNATURE _____ DATE (MM/DD/YYYY) _____

***Member signs if member is receiving benefit payment; Spouse signs if spouse is receiving surviving spouse benefit or if spouse is enrolling in the Sav-Rx Advantage Card program.**

FOR IMRF USE ONLY	Date Entered	Date Effective