NORTH RANCH BENEFITS TRUST

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North Ranch Benefits Trust

Employer Guide

Dental

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Table of Contents

NRBT Carrier Partner Offerings Overview

NRBT Carrier Partner	Product Type	Plan Offering	Group or Individual	Min. Par.	State Sold in	Participants Reside	Open Enrollment Avail?	Waiting Periods
Ameritas	Voluntary Dental	PPO	Group or Individual	1	Groups must be headquartered in AZ, CA, NV, and UT.	PPO: Participants can live any of the 50 states.	Yes, January 1 only	12 months Major Services
Delta Dental	Voluntary Dental	DHMO PPO	Group Only	3 3 3	Groups must be headquartered in California	DHMO: Participants must reside in CA. PPO & Premier: Participants can live any of the 50 states.	Yes, Jan 1 or matching medical open enrollment, but not both.	12 months Major Services on PPO & Premier plans only
Humana	Voluntary Dental	DHMO PPO	Group Only	2 2	Groups must be headquartered in California.	DHMO: Participants must reside in CA. PPO: Participants can live any of the 50 states.	Yes, January 1 only	12 months Major Services, PPO plan only

Contact Information

Billing and Eligibility Questions

HealthSmart
Phone: 1-800-786-6525
Customer Service Hours: 8 am to 5 pm MT.
Email: nrbt@healthsmart.com

Remit payments to:
HealthSmart Benefit Solutions, Inc.
P.O. Box 17768
Denver, CO 80217-0768

Plan Changes, Renewal, and Information

North Ranch Benefits Trust
32110 Agoura Road
Westlake Village, CA 91361-4026
Phone: 888-833-9220
Customer Service Hours: 8 am to 5 pm PT.
Email: service@nrbt.com
Website: www.nrbt.com

Benefits and Claims Questions

Ameritas
Customer Service: (800) 487-5553
Customer Service Hours: Mon – Thurs: 5am to 10pm PT. Fri: 5am to 4:30 pm PT.
New Claims Fax: (402) 467-7336
Website: www.ameritas.com

Delta Dental
PPO Customer Service: (800) 765-6003 and website: www.deltadentalins.com
Customer Service Hours: Mon – Fri: 5am to 5pm PT.

DHMO Customer Service: (800) 422-4234 and website: www.deltadentalins.com
Customer Service Hours: Mon – Fri: 5am to 6pm PT.

Humana
PPO Member Services: (800) 233-4013
Customer Service Hours: 5am to 2pm PT.

DHMO Member Services: (877) 873-2241
Customer Service Hours: 5am to 2pm PT.
Website: www.humana.com

Employer Eligibility

Employer *Eligibility* Waiting Periods
The employer selects the period of time that must pass between the employee's date of hire and the employee's eligible date to enroll or decline participation in the employer's benefit plan. Otherwise known as the eligibility waiting period. Employers can choose one of the following eligibility waiting periods:

First of the month following:
- Date of hire (DOH)
- 30 days
- 60 days
- 90 days

Important Note: Employers can only change their eligibility waiting period once in a 12 month period. This change must be requested in writing from Group Administrator, Company Owner or Officer, or their Broker of Record.

Dental *Benefit* Waiting periods
There is a 12 month waiting period on Major services with each NRBT dental carrier partner – Ameritas, Delta Dental, and Humana. In other words, a member cannot access these services (e.g. crowns, inlays, onlays) until 12 months have passed from the member's enrollment effective date. Ameritas, Delta Dental, and Humana will waive the 12 month waiting period on Major Services if each member can provide proof of 12 months of continuous prior dental coverage. Waiving the Major Services waiting period is available for initial enrollees only.

Employer Contribution Requirements

<u>Voluntary Dental</u>
There is no minimum contribution on the voluntary plans. Employers can contribute 0% - 100%.

Carrier and Participation Requirements

Each carrier has its own minimum participation requirements, plan offerings, and locations that groups and members can reside. Below is an overview of these requirements followed by a bit more detail of each carrier.

Chart Overview

NRBT Carrier Partner	Product Type	Group or Individual	Minimum Enrollment
Voluntary			
Ameritas Dental	PPO	Group and Individual	1
Delta Dental	DHMO[1] PPO	Group only	3
Humana Dental	DHMO PPO	Group only	2

Voluntary Ameritas Dental

- ONE or more employees are required to be enrolled at all times.
- This plan is available to groups headquartered in AZ, CA, NV, and UT. Employees can live in any State.
- Ameritas will waive the 12-month Major Services waiting period, if proof of 12-months of continued prior dental coverage is provided. A prior carrier bill or the enrollees ID card are required. Available for initial enrollees only.

Voluntary Delta Dental

- THREE or more employees are required to be enrolled at all times.
- This plan is available to groups headquartered in CA. Employees can live in any State for PPO, CA only for DHMO.
- The DeltaCare DHMO can be dual optioned with one PPO plan. PPO residents may live in any state. DHMO members must reside in CA. A minimum of THREE employees enrolled is required under each elected option.
- Delta Dental will waive the 12-month Major Services waiting period, if proof of 12-months of continued prior dental coverage is provided. A prior carrier bill or the enrollees ID card are required. Available for initial enrollees only.

Voluntary Humana Dental

- TWO or more employees are required to be enrolled at all times.
- Group can elect up to all four dental plans.
- This plan is available to groups headquartered in CA. Employees can live in any State for PPO, CA only for DHMO.
- Humana will waive the 12-month Major Services waiting period, if proof of 12-months of continued prior dental coverage is provided. A prior carrier bill or the enrollees ID card are required. Available for initial enrollees only.

Enrollee Enrollment Guidelines

Eligibility and Enrolling

Eligible Employee
An eligible employee is an active, full-time employee who meets the participation requirements stated in the "Carrier and Participation" section, is working at least 30 hours per week, and is paid a salary, wages, or earnings from which federal and state tax and Social Security deductions are made. Partners and proprietors actively engaged in the business on a full-time basis and who meet the carrier and participation requirements are eligible. If the employer wishes to cover part-time employees who work at least 20 hours per week, he or she may do so, but only as long as the group meets the carrier and participation requirements outlined in this guide.

Enrolling New Employees

Please use Employee Enrollment Form

To enroll a new employee: A new employee must complete an Employee Enrollment Application. The Administrator must receive the fully completed application after the employee's date of hire and no more than 45 days after the employee's eligibility date. The eligibility date is the first of the month following the group's imposed waiting period.

Late enrollee: A late enrollee is an employee and/or their dependent(s) who has submitted their Enrollment Application more than 45 days after their eligibility date. These employee's and/or dependent(s) must have a qualifying event to enroll at a later date and provide proof of the qualifying event. Otherwise, the employee will not be eligible for coverage until the group's open enrollment period. (See Qualifying Events or Open Enrollment guidelines later in this document.)

Incomplete applications: Applications with missing information are considered incomplete and will be returned to the agent or group administrator that submitted it to gather all the required information. In these cases, we will use the date that we receive the fully completed application to determine the coverage effective date. HealthSmart must receive the fully completed application no more than 45 days after the employee's eligibility date. The eligibility date is the first of the month following the group's imposed waiting period or else late enrollment rules will apply as stated above.

Tip: We recommend submitting an application immediately after hiring an eligible employee. Coverage will not begin before the group's elected waiting period is over.

Enrolling Rehired Employees

If an enrolled employee's employment ends and the employee is later rehired, certain restrictions apply.

If the employee is rehired within 30 days of termination date, coverage will resume with no lapse upon our receipt of a written request from the employer group administrator. The group is responsible for notifying us immediately if an employee is rehired and will be continuing coverage.

If the employee is rehired more than 30 days after the termination date, the employee is considered a new employee, subject to applicable group-imposed waiting periods and must complete a new Employee Enrollment Application.

Coverage effective dates for new employees
We will determine the coverage effective date for new employees based on:

- The date of hire.
- An employer-imposed waiting period.
- The date we receive the fully completed application.

Effective Dates

1st of the month following receipt of application, waiting period, or qualifying event. Completed applications should be submitted to HealthSmart within 60 days of qualifying event, 45 days if new hire.

- Example 1: If the date of hire is on the 1st day of the month (and if the group has a 30 day waiting period for new hires) and if the fully completed application is received within time frame.

Example 1	
Group's waiting period is the first of the month following one month (30 days).	Date of hire is 1st day of the month. Employee submits application before eligibility date and/or within 45 days of eligibility date
Hire date	4/1/2016
Eligibility Date	5/1/2016
Date completed application received	4/1/2016 – 6/15/2016
Effective date	5/1/2016

- Example 2: If the date of hire is on the 1st day of the month (and if the group has a zero day waiting period) and if fully completed application is received within time frame.

Example 2	
Group's waiting period is the first of the month following date of hire.	Date of hire is 1st day of the month. Employee submits application before eligibility date and/or within 45 days of eligibility date
Hire date	4/1/2016
Eligibility Date	4/1/2016
Date completed application received	4/1/2016 – 5/15/2016
Effective date	4/1/2016

- Example 3: If the date of hire is a date during the month (and if the group has a 30 day waiting period for new hires) and if fully completed application is received before the employee's waiting period is over, the effective date will be first day of the month following receipt of completed application and after waiting period met.

Example 3	
Group's waiting period is the first of the month following one month (30 days).	Employee submits application before eligibility date
Hire date	4/10/2016
Eligibility Date	6/1/2016
Date completed application received	4/10/2016 – 7/15/2016
Effective date	6/1/2016

- Example 4: If the date of hire is a date during the month (and if the group has a 30 day waiting period for new hires) and if fully completed application is received after the employee's eligibility date, but within 45 days of the eligibility date, the effective date will be the first of the month following the completion of the group-imposed waiting period.

Example 4	
Group's waiting period is the first of the month following one month (30 days).	Employee submits application after eligibility date but with 45 days of eligibility date
Hire date	4/10/2016
Eligibility Date	6/1/2016
Date completed application received	6/1/2016 - 7/15/2016
Effective date	6/1/2016

- Example 5: If the date of hire is a date during the month (and if the group has a 30 day waiting period for new hires) and if fully completed application is received more than 45 days after the employee's eligibility date; the applicant will be considered a late enrollee. The effective date will be delayed until the group's open enrollment or upon the first of the month following an approved qualifying event in the future. A new fully completed enrollment form will be required at open enrollment to enroll, if open enrollment is more than 60 days in the future from signature date of currently received application.

Example 5	
Group's waiting period is the first of the month following one month (30 days).	Employee submits application more than 45 days after eligibility date
Hire date	4/10/2016
Eligibility Date	6/1/2016
Date completed application received	7/16/2016 or later
Effective date	Group's next open enrollment date or upon first of the month following approved qualifying event date (A new, more currently dated application may be required at open enrollment, if open enrollment is more than 60 days past signature date.)

Important Note: Applications with missing information are considered incomplete and will be returned for completion. We must receive a fully completed application within the eligibility period.

Group Eligibility Waiting Periods

A group can only change their eligibility waiting period once in a 12 month period. This change must be requested in writing from Group Administrator, Company Owner or Officer, or their Broker of Record. Refer to the waiting period section for further detail.

Declinations/Waivers

New employees or dependents who do not elect coverage or existing employees who choose to end coverage must have (and provide proof of) a qualifying event to enroll at later date or wait until the group's open enrollment period.

Eligible Dependents

An eligible employee may enroll his/her eligible dependents. Dependent coverage is available to:

a. Lawful spouse
b. Registered domestic partner
c. An employee's, spouses or registered domestic partner's child under age 26.
    - Natural child
    - Newborn child (must be enrolled by age 2 or 4, depending on carrier. See chart below for details.)
    - Stepchild
    - Legally adopted child
    - Ward of a permanent Legal guardian
d. Disabled dependent child who, at the time of becoming age 26, is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition, and is chiefly dependent on the subscriber for support and maintenance (a disabled dependent may be eligible for benefits beyond his or her 26th birthday). The employee is required to submit certification by a physician of the dependent child's condition.

To be eligible for coverage as a dependent, that individual must be listed on the employee's enrollment form. It is the employee's responsibility to inform the group administrator of any change in status of his/her dependents. Eligible dependents also must meet the participation requirements as outlined in this guide. If the enrolling employee does not elect to cover their dependents, then dependents may not enroll later unless there is a qualifying event. Dependent children may remain on this plan to age 26.

The application for coverage for a dependent must be submitted and received by the billing administrator within 60 days of the eligibility date. Coverage will be effective beginning on the 1st of the month following the qualifying event.

Enrolling Eligible Dependents Chart Overview

Type of dependent	**Application for coverage or declining coverage must be received:**	**And must include (if requesting coverage):**
New spouse or new domestic partner		
Coverage will begin on the 1st of the month following the qualifying event date.	Within 60 days of new marriage or new domestic partner registration	Employee Enrollment Form or Employee Change Form
Newborn child		
Coverage will begin on the 1st of the month following receipt of application and within child's first years of life. Newborn children can enroll at any time between the ages of birth through the following age for each carrier: Ameritas Dental by 2 years old. Delta Dental by 4 years old. (After 30 days of birth, can only add Jan.1) Humana Dental by 2 years old.	Newborn children can enroll at any time between the ages of birth and: Ameritas Dental by 2 years old. Delta Dental by 4 years old. Humana Dental by 2 years old.	Employee Enrollment Form or Employee Change Form
Adopted child		
Coverage will begin on the 1st of the month following receipt of application.	Within 60 days of date of adoption.	Employee Enrollment Form or Employee Change Form; and Legal evidence of authority to control the health care needs of the child
Stepchild		
A child of subscriber's spouse or registered domestic partner.	Within 60 days of marriage or domestic partnership registration.	Employee Enrollment Form
Ward of a permanent legal guardian		
A dependent child of employee or the employee's enrolled spouse/domestic partner who is named the permanent legal guardian by a final court decree or order will be considered an eligible dependent child, subject to all rules and age limitations that apply to an eligible dependent child.	Within 60 days of issuance of the final court decree or order of legal guardianship (or, if specified, within the time frame indicated in such court decree or order)	Employee Enrollment Form and Letter of Guardianship form from the court, showing the filing date and court seal

Focal Renewal and Open Enrollment

Please use applicable Employee Enrollment Form, Change Form, or Termination Form

Rule for Focal Renewal: All of the NRBT carriers, Ameritas Dental, Delta Dental, and Humana Dental renew January 1 of every year. This is called a Focal Renewal. Renewal letters are sent out 60-90 days before January 1 of every year. Renewal letters, with any applicable benefit or rate changes, will always be effective January 1, regardless of a group's original effective date/anniversary date, or when their open enrollment is held. (No exceptions)

Rule for Focal Renewal Open Enrollment: All of the NRBT carriers, Ameritas Dental, Delta Dental, and Humana Dental allow groups to have an open enrollment during Focal Renewal to be effective January 1 of every year. Note: Groups are allowed only one open enrollment in a twelve month period.

Exception for Open Enrollment: Groups that have Delta Dental through NRBT are allowed to have an open enrollment period outside of Focal Renewal if the date matches their medical open enrollment date. The group must provide proof of their medical open enrollment date upon submitting their open enrollment request. (See requirements below.)

Note: Groups are allowed only one open enrollment in a twelve month period. Therefore, groups that elect to have an open enrollment outside of Focal Renewal cannot have another one at Focal renewal unless more than twelve months have passed since their last one. Also, renewal letters, with any applicable benefit or rate changes, will always be effective January 1, regardless of a group's original effective date/anniversary date, or when their open enrollment is held.

Open Enrollment: This is the time for Employer's to make plan changes and/or allow all employees and/or their eligible dependents that previously enrolled or waived coverage to now waive or enroll in coverage, or update information.

Requirements include:

1) A cover letter from the Employer stating the requested effective date of the group's Open Enrollment Period and that date will be noted in billing administration system.
2) Employee Enrollment Form – for new member enrollments
3) Termination Form – for members or dependents waiving coverage
4) Change Request Form – to update any contact information or dependent information

These forms should accompany the Employer's cover letter and each form should be clearly marked as "Open Enrollment" for their Qualifying Event.

During Open Enrollment, a group can submit their cover letter and forms up to 30 days prior to their requested open enrollment date and the 30 days after. For example, if a group elects to have an Open Enrollment on January 1, 2017, they can submit their cover letter and applicable forms between December 1, 2016 and January 31, 2017, to be effective 1/1/17.

For new dental enrollments, proof of twelve months of prior coverage, along with effective date and end date of prior coverage, is required to waive any major waiting periods. Carriers require no lapse between coverages and enrolling members and their enrolling dependents must have been covered continuously for the prior twelve months.

Eligibility Changes

Change of Name, Address, Email, Phone, or Contact Person
Employers, who have a company name change, relocate or have a change of billing or physical address, change of phone number or contact person; must notify via email by the Group Administrator, Company Owner or Officer, or their Broker of Record.

Change of Employee and/or Dependent Status
Employees wishing to add dependents may do so, provided that the participation requirements outlined in this guide are met. Employees must complete the NRBT Change Form and submit it to HealthSmart.

Terminating Members

Employees who terminate employment are contractually entitled to coverage through the last day of the month in which they last worked on a full-time basis. For example, an employee who terminates employment on June 5th is entitled to coverage through June 30th. Premiums are to be paid for the last month of coverage for any such employee.

Please complete NRBT Termination Form

Rule for Terminating Members: Request to term a member and/or dependent must be received within 30 days of termination. Terminations dates will be effective as of the last day of the month following termination date and receipt date of termination notification. For example, all terminations dates will be effective the last day of current month or immediate prior month. NRBT will not allow a premium credit for more than one month's premium. Terminations will appear on the following month's invoice.

Important Note: Submit completed NRBT Termination Form directly to the administrator and not with the premium payment. If you do, terminations may not be processed because they will go the premium payment lockbox, not directly to administrator.

Employee termination dates examples	Example 1	Example 2
Last day worked	4/3/2016	4/3/2016
Requested date of employee/dependent cancellation	5/1/2016	5/1/2016
Request to cancel received at HealthSmart	4/3/2016 - 5/31/16	6/1/2016 or later
Effective date of cancellation	4/30/2016	Last day of month of which term is received

Important Note: Terminating an active employee is permitted only if the employer continues to maintain the minimum participation requirements outlined in the section entitled "Carrier and Participation" Requirements.

COBRA and State Continuation of Benefits Participation

The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires employers with 20 or more employees to offer certain employees and dependents Federal continuation of benefits beyond normal coverage termination dates. Employers with 2 to 19 employees may be similarly required to offer employees coverage under their State's law for continuation of benefits coverage.

Generally, covered employees and their covered dependents may become eligible for continuation coverage under COBRA or State guidelines due to such qualifying events as a reduction of work hours, termination of employment, divorce, legal separation, death, loss of dependent status, or Medicare eligibility. There are certain actions employers must take in order to comply with continuation of benefits coverage, as applicable.

Timely notification of terminations is required to ensure that coverage does not extend beyond the month when the termination occurred and to comply with Federal COBRA notification requirements or State Continuation

notifications, as applicable. When notification is delayed, we are unable to cancel coverage in a timely manner, which results in continued coverage for ineligible employees and dependents.

If your group is Federal COBRA eligible, employees who elect to continue coverage under COBRA must still be canceled from the plan via a termination form. It is the employer's responsibility to notify the employees of their termination of coverage and of any rights to continue coverage. If the employee elects COBRA, a newly completed change form is required to get them properly enrolled as a COBRA member. These members will billed on the employer's invoice.

If your group is State Continuation (or State COBRA) eligible, and if your state guidelines require that the employer is responsible for employee notifications, employees must still be canceled from the plan via a termination form. It is the employer's responsibility to notify the employees of their termination of coverage and of any rights to continue coverage. If the employee elects State Continuation (or State COBRA), a newly completed change form is required to get them properly enrolled as a State Continuation (or State COBRA) member. These members will invoiced on the employer's bill.

If your group is State Continuation (or State COBRA) eligible, and if your state guidelines require that the carrier/administrator is responsible for employee notifications, employees must still be canceled from the plan via a termination form. On the termination form, if the "State" box is checked, HealthSmart will send out a State Continuation (or State COBRA) offer to employees residing in any of the applicable states. The State Continuation (or State COBRA) notification will be sent directly to the employee's last known address or the address on the termination form if provided. These members will be billed directly at their home address.

Employees enrolled in the plan who choose to end coverage for themselves and/or their dependent(s) must have a qualifying event (and provide proof of it) or wait until the group's open enrollment to re-enroll in coverage at a later date.

Employees who worked on the first of the month are eligible for coverage through the end of that month.

Terminating a Group

Request to terminate a group must be received by the administrator within 30 days of requested termination effective date. The request to terminate a group's coverage can be made via email and must be submitted by the Group Administrator, Company Owner or Officer, or their Broker of Record. All terminations dates are as of the last day of the month.

Groups are subject to cancellation for non-payment if premium is not received by the last day of the month it is due.

Billing Cycle, Premiums, Fees, and Payment Options

Billing Cycle
You will receive a monthly invoice from HealthSmart that includes the due date, total premium due, past due amounts, any applicable fees, listing of those enrolled in the plan(s), enrollment tier, and a listing of any adjustments (e.g. eligibility changes, new hires, terminations).

Bills are generated in advance for the following month and payments are due the 1st of the month. Employees are not eligible for benefits until the premium due is received and processed by the administrator. Payments and/or eligibility changes received after the 5th of the prior month will not appear on the invoice. A late fee will be added if payment is not received by the 15th of the billed month. (For example, payment for the March premium is due March 1st and a late fee will be assessed if payment is not received by March 15th. Coverage is subject to cancellation if premium is not received by the March 31st.) It is the employer's responsibility to make payment regardless of whether or not you receive a bill.

Important Note: The group is responsible for checking the accuracy of each invoice and for notifying the billing administrator immediately of any discrepancies. It is important that the group pay the full amount of the premium listed on the invoice.

Payment Options
Premiums payments can be made via Check or Auto-draft (ACH). Many of NRBT groups pay via ACH since it is faster processing and more efficient than reconciling checks. This prevents potential late fees, keeps processing and administrative fees low, and reduces the amount of paper and time.

If paying by check, please remit payment to address identified on the invoice. Please allow at least five business days for mailing time when making your monthly payment. All checks must include the Billing Division number as it appears on the billing statement. Payment is delayed when the group number is not listed on the check.

To sign up for ACH or Auto-draft, please complete the ACH Authorization form posted at www.nrbt.com.

Important note: Subject to the grace period, the billing administrator must receive your group's payment on or before the due date shown on the invoice, or the premium will be considered late. Subject to the grace period, your group policy is subject to termination if your premium is considered late. Please allow at least five days for mailing time when making your monthly payment.

Fees
The employer is responsible for the payment of any fees that appear on the monthly invoice. The administration fee (if applicable) appears on each invoice and covers; including, but not limited to: the cost of billing, premium collection and reconciliation, insurance record maintenance, and more.

Late Payment
Premiums are considered late if they are not received by the billing administrator by the 15th of the current month. A Late Fee will be charged for late remittance of premium.

Not-Negotiable Checks
Checks returned by the bank for insufficient funds, stop-payment, missing signature, or any other reason for which the bank would deem a check not-negotiable. This will be treated as though no premium payment was received. A handling fee will be charged for all not-negotiable checks.

Non-payment of premiums due may result in cancellation of coverage
If premium payment is not remitted on time, your policy may be terminated, effective as of the last day through which premiums have been paid. Failure to make your premium payment does not meet the notification requirements for canceling your coverage. You are required to pay premiums during your group's final month of coverage.

Important Note: Please allow at least five business days for mailing time when making your monthly payment.

Billing Division Number vs. Carrier Group Number

Billing Division Number
Your division number is your billing reference number with NRBT's Third Party Billing Administrator, HealthSmart. It is only used for billing purposes and the carriers will not recognize it. The division number is listed on each invoice.

Carrier Group Number
Your NRBT Carrier (Ameritas, Delta Dental, or Humana) group number is the identifier for your coverage with that NRBT carrier partner. When contacting your NRBT carrier about your benefits or claims, please reference the NRBT carrier's group number.

Benefit Summaries, Certificates, and ID Cards

Benefit Summaries and Certificates of Coverage
Initial Enrollment
At inception, enrolled employees will receive a Certificate of Coverage and Benefit Summary. This is distributed to the group administrator at initial enrollment for distribution to enrollees. Benefits Summaries and Certificates of Coverage are located at www.nrbt.com.

Ongoing
Should any changes take place, updated benefit summaries and Certificates of Coverage will be distributed to the Group Administrator for employee distribution. Benefits Summaries and Certificates of Coverage are located at www.nrbt.com.

ID Cards
Each carrier approaches providing their members' access to care via ID cards and/or providing members direct access to their system. Here is how each carrier handles ID cards:

NRBT Carrier Partner	Provides Paper ID Cards?	In Lieu of ID Cards
Ameritas	Yes	Members and providers may call to verify eligibility and benefits.
Delta Dental HMO	Yes	Members and providers can call customer service to verify benefits. Members can register online at member portal to access and print digital ID card.
Delta Dental PPO	No	Providers have direct carrier system access to verify benefits. Members can print from member portal.
Humana	No	Members can print from member portal.

Forms and Supplies
You can view or print forms from our website at www.nrbt.com. All forms, carrier materials, and benefit related documents are maintained at www.nrbt.com. Please access this site for all NRBT related materials.