



CompBenefits

CompBenefits Corporation • CompDent •
CompBenefits Insurance Company • Oral
Health Services Inc. • National Dental Plans Inc.
• OHS of Alabama • Texas Dental Plans Inc.

If you're looking for a dental plan that offers preventive care—such as cleanings and x-rays—with a small copayment and that provides up to **75 percent savings** for other procedures, CompBenefits C550 is for you.

CompBenefits' C550 plan provides you with a network of more than 14,000 participating dentists nationwide. And at any time, you can change participating dentists. Just use the provider locator at compbenefitsdirect.com to choose your new dentist and to notify us of the change.

With your CompBenefits C550 plan, you'll get:

- √ 100% coverage for many preventive procedures
- √ Freedom from hidden costs, claim forms, deductibles, waiting periods, and benefit maximums
- √ Pre-existing conditions covered right from the start
- √ 25 percent discount off procedures not listed in your schedule of benefits when you see one of our participating dentists
- √ 25 percent discount off treatment from our participating specialists

In this packet, you will find the information you need to begin receiving the savings the CompBenefits C550 plan can bring you. If you have any questions, please send us an e-mail at mgutierrez@compbenefits.com or feel free to call us at 866-820-3003.

We're looking forward to hearing from you and to giving you a way to stretch your health care dollars!



CompBenefits

Georgia

MDP02

Social Security No.
 Last Name
 First Name
 M.I.
 Birthdate: MO Day Year

Home Address
 Area Code
 Home Phone
 Sex: F M

City
 State
 ZIP Code
 Area Code
 Business Phone

List All Your Eligible Dependents Below If They Are To Be Covered.

(Eligible dependents include your spouse and/or unmarried children from birth to age 23 if a child is both a full-time student and dependent on you for primary support.)

First	Middle	Last (If Different)	Dental Facility #	Date of Birth
2. Spouse				<input type="checkbox"/> F <input type="checkbox"/> M / /
3. Child				<input type="checkbox"/> F <input type="checkbox"/> M / /
4. Child				<input type="checkbox"/> F <input type="checkbox"/> M / /
5. Child				<input type="checkbox"/> F <input type="checkbox"/> M / /
6. Child				<input type="checkbox"/> F <input type="checkbox"/> M / /
7. Child				<input type="checkbox"/> F <input type="checkbox"/> M / /
8. Child				<input type="checkbox"/> F <input type="checkbox"/> M / /

Coverage Effective Date:	Dental Facility #	Agent Code #
Plan Code #	# Dependents Covered	Contribution Amount \$
		For Office Use Only Amount Paid \$
		Non-Refundable Enrollment Fee \$

I wish to enroll in the Plan. I understand that this is a MINIMUM ONE (1) YEAR CONTRACT and that all necessary dental services will be provided as described in the schedule of benefits which I have received and understand.

Date: _____

Applicant's

Signature: X _____

Agent Signature: _____

Enrollment Instructions:

- Complete the attached application. (Be sure to list all family members to be included.)
- Select your payment mode:
 - If MONTHLY, complete the authorization for deduction with full bank information and sign the lower portion. (Be sure to enclose the first month's payment and a blank, voided check plus the non-refundable \$35 enrollment fee.)
 - If annual, choose VISA, MASTERCARD, DISCOVER, AMEX, or payment by check. Fill out the bank card section and send no money, or enclose your check for the full annual payment plus the non-refundable \$35 enrollment fee.
- Monthly Bank Draft:

	Monthly	Annually
Pre-Authorized Bank Draft		Visa/MasterCard/Discover
Admin. Fee	\$1.00	Amex/Check/M.O. \$0.00

Make check payable to **CompBenefits Corporation**. Place all information and check (if applicable) inside. Completed applications with correct payments and received by CompBenefits by the 15th of the month will become effective on the 1st of the following month.

Authorization for Deduction—Signature Required

Name _____ Social Security # _____
Last First M.I.

I authorize _____
Financial Institution

To make a Monthly Bank Draft (drafted on the 15th)

Deductions of \$ _____ + \$1.00 Administrative fee = \$ _____
Contribution

My checking account # _____ (Monthly Only)

and to remit the amounts deducted to **CompBenefits (CB)** upon instructions from **CB**. The amount of deduction indicated above is approximate and may be corrected as instructed by **CB**. This authorization shall cease (a) upon my giving written cancellation to you; (b) automatically upon my termination as an employee, member or depositor, as the case may be, of the above-named organization; (d) automatically upon termination of my checking, savings or share account number above as this authorization relates to such an account; or (d) upon discontinuance of the deduction and remittance arrangements between the above-named organization and **CB**. I understand this authorization does not waive or change any of the payment provisions of any policy issued to me by **CB** and if this authorization terminates for any reason, any further payments required under said policy(ies) shall be made as provided in the policies. I agree that the above-named organization is acting gratuitously and for my sole accommodation and not as an agent for **CB**.

Date _____ Signature X _____

Bank Card Selection

For Your Convenience

Fill in card number

MasterCard Visa Discover AMEX
Check One

Expiration Date
Mo. Yr.

Amount Charged

(Enrollment fee + the annual contribution \$ _____)

I hereby authorize charging my bank card.

Cardholder's Signature _____ Date _____

X _____

TO: THE FINANCIAL OR OTHER ORGANIZATION NAMED ON THE REVERSE SIDE.

In consideration of your paying checks and drafts drawn or purported to be drawn by the undersigned on the checking account of any of your depositors, undersigned hereby agrees that:

- (1) It will indemnify you against and hold you harmless from any and all liability, loss, damage and expense which may be incurred by your because of your payment or dishonor of any such checks so drawn or purported to be drawn whether the payment or dishonor was intentional or through inadvertence, and will further indemnify and hold you harmless from any liability to any persons making claims under any Agreement with respect to which checks are drawn. We will refund you any amount erroneously paid by you on any such check;
- (2) It will refund to you any amount erroneously paid by your to undersigned on any such check if claim is made therefore by you within 3 months from the date of payment; and
- (3) Either you or undersigned may terminate this agreement by ten (10) days prior written notice by either to the other or the agreement will be immediately terminated on the closing of the depositor's account or by the revocation by the depositor of authorization, but any such termination shall not affect undersigned's obligations and liabilities hereunder with respect to any such checks or dishonored by your prior to termination.

CompBenefits Corporation

Secretary *Lamita*

Contribution Rates			+	Monthly Bank Draft (if applicable)	+	One-Time Non-Refundable Enrollment Fee
1 member	Monthly \$15.00	Annually \$180.00		\$1.00 administrative fee monthly for pre-authorized bank draft (waived if paying annually)		\$35.00
2 members	\$25.62	\$307.44				
3 members	\$34.73	\$416.76				
4 members	\$43.67	\$524.04				
5+ members	\$51.95	\$623.40				
<p>Send your completed application with payment to:</p> <p>CompBenefits Enrollment Services 100 Mansell Court East Suite 400 Roswell, GA 30076</p>						
<p>First month's payment must include monthly or annual contribution plus enrollment fee. Payment is drafted during the month prior to the month of coverage. Please be sure include a BLANK, VOIDED CHECK if you would like to have your payment deducted from your bank account.</p>						



CompBenefits C550 DHMO Plan

Comprehensive Benefits at a Reasonable Price

CompBenefits' C550 DHMO plan gives you what you need, when you need it—without emptying your pocketbook.

We know what you expect from your dental plan, and the C550 plan has it:

- √ 100% coverage for many preventive procedures
- √ Freedom from hidden costs
- √ Freedom from claim forms
- √ Freedom from deductibles
- √ Freedom from waiting periods
- √ Freedom from benefit maximums

Here are examples of the savings you'll receive¹:

<u>You Need</u>	<u>With CompBenefits</u>	<u>Without CompBenefits</u>	<u>You'll Save</u>
Cleaning	No charge	\$69.68	\$69.68
Sealant	\$20.00	\$40.17	\$20.17
Filling	\$30.00	\$103.73	\$73.73
Crown	\$370.00	\$966.01	\$596.01
Root Canal	\$450.00	\$988.16	\$538.16

Your schedule of benefits lists your copayments for most common procedures. There is no limit to the number of visits. And pre-existing conditions are covered right from the start. If a procedure is not listed in your schedule of benefits, you'll get a 25 percent discount when you see one of our participating dentists.

And you'll also get a 25 percent discount when you see one of our participating specialists.

All you have to do to start taking advantage of your benefits is choose a dentist who participates in our extensive network and let us know. Then, just make your appointment, and show your dentist your ID card. There's nothing else for you to do!

¹ Dental plan savings are based on CompBenefits C550 plan compared with your state's average from M&R guidelines. Prices for crowns do not include lab charges. The savings listed are examples. Actual savings may vary. C550AL



Schedule of Benefits and Subscriber Copayments

ADA CODE	PROCEDURE	PATIENT PAYS
APPOINTMENTS		
9310	Consultation (diagnostic service provided by dentist other than practitioner providing treatment)	\$30.00
9430	Office Visit (normal hours)	\$10.00
9440	Office Visit (after regularly scheduled hours)	\$35.00
9999	Emergency visit during regularly scheduled hours, by report	\$20.00
9999	Broken appointments (without 24 hr notice, per 15 min)	Maximum \$40 per broken appointment. No charge will be made due to emergencies.
		\$10.00

ADA CODE	PROCEDURE	PATIENT PAYS
DIAGNOSTIC		
120	Periodic oral evaluation	NO CHARGE
140/150/160	Limited/Comprehensive oral evaluation	NO CHARGE
180	Comprehensive periodontal evaluation	\$25.00
210	X-Ray Intraoral - complete series including bitewings	NO CHARGE
220	X-Ray Intraoral - periapical - first film	NO CHARGE
230	X-Ray Intraoral - periapical - each additional film	NO CHARGE
270	X-Ray Bitewing - single film	NO CHARGE
272	X-Ray Bitewings - two films	NO CHARGE
274	Bitewings - four films	NO CHARGE
330	Panoramic film	NO CHARGE
460	Pulp vitality tests	NO CHARGE
470	Diagnostic casts	NO CHARGE

ADA CODE	PROCEDURE	PATIENT PAYS
PREVENTIVE CARE		
1110/1120	Prophylaxis-adult/child-routine(once every 6 months)	NO CHARGE
1110/1120	Prophylaxis-adult/child-(additional)	\$35.00
1201	Topical application of fluoride (including prophylaxis) child (up to 16 years of age)	NO CHARGE
1203	Topical application of fluoride (not including prophylaxis) child (up to 16 years of age)	NO CHARGE
1330	Oral hygiene instruction	NO CHARGE
1351	Sealant - per tooth	\$20.00
1510	Space Maintainer - fixed - unilateral	\$65.00 + LAB
1515	Space Maintainer - fixed - bilateral	\$65.00 + LAB
1520	Space Maintainer - removable - unilateral	\$105.00 + LAB
1525	Space Maintainer - removable - bilateral	\$105.00 + LAB
1550	Recementation of space maintainer	\$20.00

ADA CODE	PROCEDURE	PATIENT PAYS
RESTORATIVE		
2140	Amalgam - one surface, primary or permanent	\$30.00
2150	Amalgam - two surfaces, primary or permanent	\$35.00
2160	Amalgam - three surfaces, primary or permanent	\$40.00
2161	Amalgam - four or more surfaces, primary or permanent	\$50.00
2940	Sedative filling	\$30.00
2999	Sedative base (under fillings), by report	NO CHARGE

ADA CODE	PROCEDURE	PATIENT PAYS
RESIN RESTORATION		
2330	Resin - one surface, anterior	\$50.00
2331	Resin - two surfaces, anterior	\$55.00
2332	Resin - three surfaces, anterior	\$65.00
2391	Resin-based composite - one surface, posterior	\$90.00
2392	Resin-based composite - two surfaces, posterior	\$110.00
2393	Resin-based composite - three surfaces, posterior	\$130.00
2394	Resin-based composite - four or more surfaces, posterior	\$150.00
2510	Inlay - metallic - one surface	\$155.00
2520	Inlay - metallic - two surfaces	\$165.00
2530	Inlay - metallic - three or more surfaces	\$190.00

ADA CODE	PROCEDURE	PATIENT PAYS
CROWN & BRIDGE		
2740	Crown - porcelain/ceramic substrate	\$370 + LAB
2750*	Crown - porcelain fused to high noble metal	\$370.00
2751	Crown - porcelain fused to predominantly base metal	\$370.00
2752*	Crown - porcelain fused to noble metal	\$370.00
2790*	Crown - full cast high noble metal	\$370.00
2791	Crown - full cast predominantly base metal	\$370.00
2792*	Crown - full cast noble metal	\$370.00
2910	Recement inlay	\$30.00

ADA CODE	PROCEDURE	PATIENT PAYS
2920	Recement crown	\$30.00
2930	Prefabricated stainless steel crown - primary tooth	\$120.00
2950	Core buildup, including any pins	\$60.00
2951	Pin retention - per tooth	\$30.00
2952	Cast post and core in addition to crown	\$120.00 + LAB
2953	Each additional cast post - same tooth	\$120.00 + LAB
2954	Prefabricated post and core in addition to crown	\$120.00
2962	Labial veneer (porcelain laminate) - laboratory	\$370 + LAB

ADA CODE	PROCEDURE	PATIENT PAYS
ENDODONTICS		
3220	Therapeutic pulpotomy	\$50.00
3221	Pulpal debridement, primary and permanent teeth	\$130.00
3310	Root canal therapy - anterior (excluding final restoration)	\$250.00
3320	Root canal therapy - bicuspid (excluding final restoration)	\$350.00
3330	Root canal therapy - molar (excluding final restoration)	\$450.00
3410	Apicoectomy/periradicular surgery - anterior	\$200.00

ADA CODE	PROCEDURE	PATIENT PAYS
PERIODONTICS (Gum treatment)		
4210	Gingivectomy/gingivoplasty - 4+ teeth per quad	\$200.00
4211	Gingivectomy/gingivoplasty - 1-3 teeth per quad	\$55.00
4341	Periodontal scaling and root planning 4+ teeth per quad	\$65.00
4342	Periodontal scaling and root planing 1-3 teeth per quad	\$65.00
4355	Full mouth debridement to enable eval and diagnosis	\$60.00
4381	Localized delivery of chemotherapeutic agents (per tooth)	\$60.00
4910	Periodontal maintenance	\$65.00

ADA CODE	PROCEDURE	PATIENT PAYS
PROSTHODONTICS		
5110	Complete denture - maxillary	\$375.00 + LAB
5120	Complete denture - mandibular	\$375.00 + LAB
5130	Immediate denture - maxillary	\$375.00 + LAB
5140	Immediate denture - mandibular	\$375.00 + LAB
5211	Maxillary partial denture - resin base	\$375.00 + LAB
5212	Mandibular partial denture - resin base	\$375.00 + LAB
5213	Maxillary partial denture - cast metal framework, resin denture bases	\$375.00 + LAB
5214	Mandibular partial denture - cast metal framework, resin denture bases	\$375.00 + LAB
5410	Adjust complete denture - maxillary	\$30.00
5411	Adjust complete denture - mandibular	\$30.00
5421	Adjust partial denture - maxillary	\$30.00
5422	Adjust partial denture - mandibular	\$30.00

ADA CODE	PROCEDURE	PATIENT PAYS
REPAIRS TO PROSTHETICS		
5510	Repair broken complete denture base	\$30.00 + LAB
5520	Replace missing or broken teeth - complete denture (each tooth)	\$30.00 + LAB
5610	Repair resin denture base	\$30.00 + LAB
5630	Repair or replace broken clasp	\$30.00 + LAB
5640	Replace broken teeth - per tooth	\$30.00 + LAB
5650	Add tooth to existing partial denture	\$45.00 + LAB
5730	Reline complete maxillary denture (chairside)	\$65.00
5731	Reline complete mandibular denture (chairside)	\$65.00
5740	Reline maxillary partial denture (chairside)	\$65.00
5741	Reline mandibular partial denture (chairside)	\$65.00
5750	Reline complete maxillary denture (laboratory)	\$50.00 + LAB
5751	Reline complete mandibular denture (laboratory)	\$50.00 + LAB
5760	Reline maxillary partial denture (laboratory)	\$50.00 + LAB
5761	Reline mandibular partial denture (laboratory)	\$50.00 + LAB
5850	Tissue conditioning - maxillary	\$45.00
5851	Tissue conditioning - mandibular	\$45.00

ADA CODE	PROCEDURE	PATIENT PAYS
PROSTHODONTICS (Fixed)		
6210*	Pontic - cast high noble metal	\$370.00
6211	Pontic - cast predominantly base metal.....	\$370.00
6212*	Pontic - cast noble metal	\$370.00
6240*	Pontic - porcelain fused to high noble metal	\$370.00
6241	Pontic - porcelain fused to predominantly base metal.....	\$370.00
6242*	Pontic - porcelain fused to noble metal	\$370.00
6750*	Crown - porcelain fused to high noble metal	\$370.00
6751	Crown - porcelain fused to predominantly base metal	\$370.00
6752*	Crown - porcelain fused to noble metal	\$370.00 ¹
6790*	Crown - full cast high noble metal	\$370.00
6791	Crown - full cast predominantly base metal	\$370.00
6792*	Crown - full cast noble metal	\$370.00
6930	Recement fixed partial denture (per unit)	\$25.00

EXTRACTIONS/ORAL AND MAXILLOFACIAL SURGERY

7111	Coronal remnants, deciduous tooth.....	\$35.00
7140	Extraction, erupted tooth or exposed root	\$35.00
7210	Surgical removal of erupted tooth	\$55.00
7220	Removal of impacted tooth - soft tissue	\$100.00
7230	Removal of impacted tooth - partially bony	\$125.00
7240	Removal of impacted tooth - completely bony	\$150.00
7250	Surgical removal of residual tooth roots	\$65.00
7310	Alveoloplasty in conjunction with extractions - per quadrant	\$65.00
7320	Alveoloplasty not in conjunction with extractions - per quadrant.....	\$100.00
7510	Incision and drainage of abscess - intraoral	\$40.00

ADJUNCTIVE GENERAL SERVICES

9215	Local anesthesia	NO CHARGE
9230	Analgesia (nitrous oxide - per 15 minutes)	\$30.00
9450	Case presentation, detailed and extensive treatment planning	NO CHARGE
9951	Occlusal adjustment - limited.....	\$40.00
9952	Occlusal adjustment - complete	\$225.00

* THE ABOVE COPAYMENTS DO NOT INCLUDE THE ADDITIONAL COST OF PRECIOUS (HIGH NOBLE) AND SEMI-PRECIOUS (NOBLE) METAL. THE ADDITIONAL COST OF PRECIOUS METAL SHALL NOT EXCEED \$125 PER UNIT AND \$75 PER UNIT FOR SEMI-PRECIOUS METAL.

NOTE:

1. NOT ALL PARTICIPATING DENTISTS PERFORM ALL LISTED PROCEDURES, INCLUDING AMALGAMS. PLEASE CONSULT YOUR DENTIST PRIOR TO TREATMENT FOR AVAILABILITY OF SERVICES.

2. UNLISTED PROCEDURES ARE AT THE DENTIST'S USUAL FEE LESS 25%.

3. WHEN CROWN AND/OR BRIDGEWORK EXCEEDS SIX UNITS IN THE SAME TREATMENT PLAN, THE PATIENT MAY BE CHARGED AN ADDITIONAL \$50.00 PER UNIT.

SPECIALIST SERVICES

Should you need a specialist, (i.e., Endodontist, Orthodontist, Oral Surgeon, Periodontist, Pediatric Dentist), you may be referred by your Participating General Dentist, or you may refer yourself to any Participating Specialist. Upon identification of yourself as a CompBenefits member, you will receive a 25% reduction from usual and customary fees for services performed. Specialist services are available only in areas where the dental plan has a Participating Specialist.

COMPBENEFITS FAMILY OF COMPANIES

CompDent • CompBenefits Insurance Company • American Dental Plan, Inc.
Oral Health Services, Inc. • DentiCare (Texas) •
American Dental Plan of North Carolina, Inc. • National Dental Plans, Inc.
Texas Dental Plans, Inc. • Vision Care, Inc. • Ultimate Optical, Inc.

Limitations and Exclusions

1. No service of any dentist other than a Participating General Dentist or Participating Specialist will be covered by Company, except out-of-area emergency care as provided in Section VIII, Paragraph C of the Certificate.
2. Whenever any Contributions or Copayments are delinquent, Member will not be entitled to receive Benefits, transfer Dental Facilities, or enjoy any of the other privileges of a Member in good standing.
3. Company does not provide coverage for the following services:
 - a) Cost of hospitalization and pharmaceuticals, drugs or medications.
 - b) Services which in the opinion of the Participating General Dentist or Participating Specialist are not Necessary Treatment to establish and/or maintain the Member's oral health.
 - c) Any service that is not consistent with the normal and/or usual services provided by the Participating General Dentist or Participating Specialist or which in the opinion of the Participating General Dentist or Participating Specialist would endanger the health of the Member.
 - d) Any service or procedure which the Participating General Dentist or Participating Specialist is unable to perform because of the general health or physical limitations of the Member.
 - e) Any dental treatment started prior to the Member's effective date for eligibility of benefits.
 - f) Services for injuries and conditions which are paid or payable under Workers' Compensation or Employers' Liability laws.
 - g) Treatment for cysts, neoplasms and malignancies.
 - h) General anesthesia.