

Option #1

Plan Highlights

Cosmetic Dentistry Included

No Waiting Periods on any services

Orthodontics (braces) covered for Children and Adults

No Deductibles to satisfy

No Claim Forms to complete

No Age limits for members

No Limit on Visits

No Exclusions for Pre-Existing Conditions

No Yearly Maximum Benefit Level (Use as much as you like each year)

Guaranteed Acceptance

The following fee schedule represents the pre-negotiated discounts we have arranged in advance with the General Dentists who are participating in the plan. Simply pay these amounts directly to your participating dentist at the time services are rendered...its that easy! There are no claim forms to complete.

Beta Health Association, Inc.
Fee Schedule for Group Plan #19
February 1, 2005

ADA CODE	DENTAL PROCEDURE/ADA CODE DESCRIPTION	NORMAL FEE	PLAN #19	YOU SAVE
<i>Diagnostic Services (Exams and X-rays)</i>				
999	ROUTINE OFFICE VISIT	\$ 35	\$ 5	86%
120	PERIODIC ORAL EVALUATION	\$ 47	No Cost	100%
140	LIMITED ORAL EVALUATION-PROBLEM FOCUSED	\$ 69	\$ 13	81%
150	COMPREHENSIVE ORAL EVALUATION-NEW OR ESTABLISHED PATIENT	\$ 85	\$ 11	87%
210	X-RAY INTRAORAL COMPLETE SERIES INC. BITEWINGS	\$ 116	\$ 25	79%
220	X-RAY INTRAORAL-PERAPIICAL-FIRST FILM	\$ 26	\$ 5	79%
230	X-RAY INTRAORAL PERIAPICAL EACH ADDITIONAL FILM	\$ 21	\$ 4	80%
240	X-RAY INTRA ORAL-OCCLUSAL FILM	\$ 42	\$ 4	89%
250	X-RAY EXTRAORAL-FIRST FILM	\$ 66	\$ 4	94%
260	X-RAY EXTRAORAL-EACH ADDITIONAL FILM	\$ 53	\$ 4	92%
270	X-RAY BITEWING-SINGLE FILM	\$ 26	No Cost	100%
272	X-RAY BITEWING-2 FILMS	\$ 41	No Cost	100%
274	X-RAY BITEWING-4 FILMS	\$ 59	No Cost	100%
330	X-RAY PANORAMIC FILM	\$ 101	\$ 43	58%
340	CEPHALOMETRIC FILM	\$ 116	\$ 51	56%
460	PULP VITALITY TEST	\$ 54	No Cost	100%
470	DIAGNOSTIC CASTS	\$ 101	\$ 40	60%
999	EMERGENCY VISIT (SAME DAY)	\$ 90	\$ 25	72%
<i>Preventive Services (Cleanings)</i>				
1110	PROPHYLAXIS-ADULT CLEANING (EVERY 6 MONTHS)	\$ 77	\$ 15	81%
1120	PROPHYLAXIS-CHILD CLEANING (EVERY 6 MONTHS)	\$ 59	\$ 15	75%
1203	TOPICAL APPLICATION OF FLUORIDE NOT INCL/PROPHY-CHILD	\$ 35	\$ 10	71%
1330	ORAL HYGIENE INSTRUCTIONS	\$ 53	No Cost	100%
1351	SEALANT PER TOOTH	\$ 50	\$ 10	79%
1510	SPACE MAINTAINER FIXED UNILATERAL	\$ 307	\$ 157	49%
1515	SPACE MAINTAINER FIXED BILATERAL	\$ 422	\$ 229	46%
1520	SPACE MAINTAINER-REMOVABLE-UNILATERAL	\$ 370	\$ 189	49%
1525	SPACE MAINTAINER-REMOVABLE-BILATERAL	\$ 462	\$ 217	53%
1550	RE-CEMENTATION OF SPACE MAINTAINER	\$ 78	\$ 15	81%
1999	ADDITIONAL PROPHY (FOR PERIO MAINTENANCE)	\$ 77	\$ 33	57%
<i>Restorative Services (Fillings, Crowns, Inlays and Inlays)</i>				
2140	AMALGAM-1 SURFACE (PRIMARY OR PERMANENT)	\$ 122	\$ 27	78%
2150	AMALGAM-2 SURFACES (PRIMARY OR PERMANENT)	\$ 159	\$ 36	77%
2160	AMALGAM-3 SURFACES (PRIMARY OR PERMANENT)	\$ 190	\$ 44	77%
2161	AMALGAM-4 OR MORE SURFACES (PRIMARY OR PERMANENT)	\$ 224	\$ 52	77%
2330	RESIN BASED COMPOSITE 1 SURFACE (ANTERIOR)	\$ 148	\$ 39	73%
2331	RESIN BASED COMPOSITE 2 SURFACES (ANTERIOR)	\$ 181	\$ 50	73%
2332	RESIN BASED COMPOSITE 3 SURFACES (ANTERIOR)	\$ 226	\$ 66	71%
2335	RESIN 4 OR MORE SURFACES OR INVOLVING INCISAL ANGLE (ANTERIOR)	\$ 283	\$ 107	62%
2390	RESIN BASED COMPOSITE CROWN (ANTERIOR)	\$ 423	\$ 233	45%
2391	RESIN BASED COMPOSITE ONE SURFACE (POSTERIOR)	\$ 164	\$ 86	48%
2392	RESIN BASED COMPOSITE TWO SURFACE (POSTERIOR)	\$ 211	\$ 118	44%
2393	RESIN BASED COMPOSITE THREE SURFACE (POSTERIOR)	\$ 265	\$ 149	44%
2394	RESIN BASED COMPOSITE FOUR OR MORE SURFACES (POSTERIOR)	\$ 315	\$ 163	48%
2510	INLAY-METALLIC-ONE SURFACE	\$ 794	\$ 262	67%
2520	INLAY-METALLIC-TWO SURFACE	\$ 796	\$ 262	67%
2530	INLAY-METALLIC-THREE OR MORE SURFACES	\$ 874	\$ 288	67%
2542	ONLAY-METALLIC-TWO SURFACES	\$ 900	\$ 297	67%
2543	ONLAY-METALLIC-THREE SURFACES	\$ 940	\$ 311	67%
2544	ONLAY-METALLIC-FOUR OR MORE SURFACES	\$ 960	\$ 317	67%
2610	INLAY-PORCELAIN/CERAMIC-ONE SURFACE	\$ 829	\$ 273	67%
2650	INLAY-RESIN BASED COMPOSITE-ONE SURFACE	\$ 794	\$ 262	67%
2651	INLAY-RESIN BASED COMPOSITE-TWO SURFACES	\$ 837	\$ 276	67%
2652	INLAY-RESIN BASED COMPOSITE-THREE OR MORE SURFACES	\$ 868	\$ 286	67%
*2710	CROWN-RESIN BASED COMPOSITE (INDIRECT)	\$ 836	\$ 277	67%
*2720	CROWN-RESIN WITH HIGH NOBLE METAL	\$ 960	\$ 316	67%
*2721	CROWN-RESIN WITH PREDOMINANTLY BASE METAL	\$ 901	\$ 297	67%
*2722	CROWN RESIN WITH NOBLE METAL	\$ 925	\$ 306	67%
*2740	CROWN PORCELAIN/CERAMIC SUBSTRATE	\$ 1,032	\$ 341	67%
*2750	CROWN PORCELAIN FUSED TO HIGH NOBLE METAL	\$ 1,005	\$ 331	67%
*2751	CROWN-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	\$ 929	\$ 278	70%
*2752	CROWN-PORCELAIN FUSED TO NOBLE METAL	\$ 965	\$ 327	66%

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Restorative Services (Fillings, Crowns, Inlays and Inlays) Cont.

*2790	CROWN FULL CAST HIGH NOBLE METAL	\$ 986	\$ 312	68%
*2791	CROWN FULL CAST PREDOMINANTLY BASE METAL	\$ 904	\$ 280	69%
*2792	CROWN FULL CAST NOBLE METAL	\$ 949	\$ 310	67%
2910	RECEMENT INLAY, ONLAY, OR PARTIAL COVERAGE RESTORATION	\$ 101	\$ 13	88%
2920	RECEMENT CROWN	\$ 102	\$ 27	73%
2930	PREFAB. STAINLESS STEEL CROWN-PRIMARY	\$ 261	\$ 91	65%
2931	PREFAB STAINLESS STEEL CROWN-PERMANENT	\$ 311	\$ 108	65%
2932	PREFAB. RESIN CROWN	\$ 328	\$ 137	58%
2933	PREFAB. STAINLESS STEEL CROWN WITH RESIN WINDOW	\$ 341	\$ 153	55%
2940	SEDATIVE FILLING	\$ 106	\$ 30	72%
2950	CORE BUILDUP INCLUDING ANY PINS	\$ 257	\$ 73	72%
2951	PIN RETENTION PER TOOTH IN ADD. TO RESTORATION	\$ 69	\$ 20	71%
2952	CAST POST & CORE IN ADDITION TO CROWN	\$ 407	\$ 119	71%
2954	PREFAB POST & CORE IN ADDITION TO CROWN	\$ 314	\$ 92	71%
2955	POST REMOVAL (NOT IN CONJUNCTION WITH ENDODONTIC THERAPY)	\$ 279	\$ 123	56%
2960	LABIAL VENEER RESIN LAMINATE (CHAIRSIDE)	\$ 621	\$ 162	74%
2999	BLEACHING (PER ARCH)	\$ 250	\$ 150	40%
2999	\$125 ADDTL.CHARGE P/UNIT FOR MULTIPLE CROWN UNITS/COMPLEX REHABILITATION			

*These co-payments do not include an allowable \$138 lab fee (per unit). Doctors, please make sure that all members understand what their fees will be and what the savings are from your Usual and Customary fees. Temporary crowns are included with permanent crown preparation.

Endodontic Services (Root Canals)

3110	PULP CAP DIRECT EXCLUDING FINAL RESTORATION	\$ 79	\$ 22	72%
3120	PULP CAP INDIRECT EXCLUDING FINAL RESTORATION	\$ 80	\$ 23	71%
3220	THERAPEUTIC PULPOTOMY EXCLUDING FINAL RESTORATION	\$ 190	\$ 63	67%
3230	PULPAL THERAPY ANTERIOR, PRIMARY TOOTH EXCLUDING REST.	\$ 268	\$ 83	69%
3240	PULPAL THERAPY POSTERIOR, PRIMARY TOOTH EXCLUDING REST	\$ 311	\$ 95	70%
3310	ROOT CANAL THERAPY 1 CANAL (EXCLUDING FINAL RESTORATION)	\$ 650	\$ 230	65%
3320	ROOT CANAL THERAPY 2 CANALS (EXCLUDING FINAL RESTORATION)	\$ 767	\$ 281	63%
3330	ROOT CANAL THERAPY 3 CANALS OR MORE	\$ 931	\$ 352	62%
3410	APICOECTOMY/PERIRADICULAR SURGERY-ANTERIOR	\$ 645	\$ 286	56%
3421	APICOECTOMY/PERIRADICULAR SURGERY-BICUSPID (FIRST ROOT)	\$ 694	\$ 316	55%
3425	APICOECTOMY/PERIRADICULAR SURGERY-MOLAR (FIRST ROOT)	\$ 846	\$ 378	55%
3426	APICOECTOMY/PERIRADICULAR SURGERY-EACH ADDITIONAL ROOT	\$ 387	\$ 138	64%
3430	RETROGRADE FILLING-PER ROOT	\$ 266	\$ 98	63%
3910	SURGICAL PROCEDURE FOR ISOLATION OF TOOTH WITH RUBBER DAM	\$ 241	\$ 56	77%

Periodontic Services (Gum Disease)

4210	GINGIVOPLASY OR GINGIVECTOMY-4+ CONTIGUOUS TEETH	\$ 609	\$ 288	53%
4211	GINGIVECTOMY OR GINGIVOPLASTY-1 TO 3 CONTIGUOUS TEETH	\$ 238	\$ 131	45%
4240	GINGIVAL FLAP PROCEDURE, INCL.ROOT PLNG 4+ CONTIGUOUS TEETH	\$ 713	\$ 306	57%
4260	OSSEOUS SURG. INCL. FLAP ENTRY & CLOSURE-4+ CONTIGUOUS TEETH	\$ 1,005	\$ 460	54%
4320	PROVISIONAL SPLINTING-INTRACORNIAL	\$ 494	\$ 231	53%
4321	PROVISIONAL SPLINTING-EXTRACORNIAL	\$ 455	\$ 213	53%
4341	PERIODONTAL SCALING & ROOT PLNG- 4+ TEETH PER QUAD	\$ 233	\$ 98	58%
4355	FULL MOUTH DEBRIDEMENT TO ENABLE COMP.EVAL. & DIAGNOSIS	\$ 175	\$ 79	55%
4910	PERIODONTAL MAINTENANCE	\$ 132	\$ 51	61%
4999	PERIO SCREENING AND SCORING	\$ 30	\$ 10	67%

Prostodontics (Removable) / Complete Dentures, etc.)

5110	COMPLETE DENTURE-MAXILLARY	\$ 1,587	\$ 470	70%
5120	COMPLETE DENTURE-MANDIBULAR	\$ 1,587	\$ 470	70%
5130	IMMEDIATE DENTURE-MAXILLARY	\$ 1,693	\$ 673	60%
5140	IMMEDIATE DENTURE-MANDIBULAR	\$ 1,693	\$ 673	60%
5211	MAXILLARY PART. DENTURE-RESIN BASE (INCL. CLASPS & TEETH)	\$ 1,244	\$ 390	69%
5212	MANDIBULAR PARTIAL DENTURE-RESIN BASE (INCL. CLASPS & TEETH)	\$ 1,270	\$ 388	69%
5213	MAXILLARY PART. DENT.-CST MTL FRAMEWORK W/RESIN DENT. BASE	\$ 1,639	\$ 475	71%
5214	MANDIBULAR PART. DENT.-CST MTL FRAMEWORK W/RESIN DENT. BASE	\$ 1,635	\$ 472	71%
5410	ADJUST COMPLETE DENTURE-MAXILLARY	\$ 83	\$ 31	63%
5411	ADJUST COMPLETE DENTURE-MANDIBULAR	\$ 83	\$ 31	63%
5421	ADJUST PARTIAL DENTURE-MAXILLARY	\$ 81	\$ 30	63%
5422	ADJUST PARTIAL DENTURE-MANDIBULAR	\$ 83	\$ 31	63%
5510	REPAIR BROKEN COMPLETE DENTURE BASE	\$ 195	\$ 74	62%
5520	REPLACE MISSING OF BROKEN TEETH-COMP.DENTURE-EACH TOOTH	\$ 168	\$ 53	68%
5610	REPAIR RESIN DENTURE BASE	\$ 187	\$ 68	63%
5620	REPAIR CAST FRAMEWORK	\$ 272	\$ 121	56%
5630	REPAIR OR REPLACE BROKEN CLASP	\$ 249	\$ 91	63%
5640	REPLACE BROKEN TEETH-PER TOOTH	\$ 169	\$ 58	66%
5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	\$ 205	\$ 79	62%
5660	ADD CLASP TO EXISTING PARTIAL DENTURE	\$ 255	\$ 105	59%

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Prosthodontics (Removable) / Complete Dentures, etc. Cont.

5710	REBASE COMPLETE MAXILLARY DENTURE	\$ 547	\$ 240	56%
5711	REBASE COMPLETE MANDIBULAR DENTURE	\$ 529	\$ 232	56%
5720	REBASE MAXILLARY PARTIAL DENTURE	\$ 523	\$ 198	62%
5721	REBASE MANDIBULAR PARTIAL DENTURE	\$ 521	\$ 197	62%
5730	RELINE COMPLETE MAXILLARY DENTURE (CHAIRSIDE)	\$ 351	\$ 153	56%
5731	RELINE COMPLETE MANDIBULAR DENTURE (CHAIRSIDE)	\$ 351	\$ 153	56%
5740	RELINE MAXILLARY PARTIAL DENTURE (CHAIRSIDE)	\$ 343	\$ 144	58%
5741	RELINE MANDIBULAR PARTIAL DENTURE (CHAIRSIDE)	\$ 344	\$ 143	58%
5750	RELINE COMPLETE MAXILLARY DENTURE (LABORATORY)	\$ 439	\$ 135	69%
5751	RELINE COMPLETE MANDIBULAR DENTURE (LABORATORY)	\$ 437	\$ 134	69%
5760	RELINE MAXILLARY PARTIAL DENTURE (LABORATORY)	\$ 434	\$ 137	69%
5761	RELINE MANDIBULAR PARTIAL DENTURE (LABORATORY)	\$ 434	\$ 136	69%
5850	TISSUE CONDITIONING MAXILLARY	\$ 196	\$ 56	72%
5851	TISSUE CONDITIONING MANDIBULAR	\$ 196	\$ 55	72%

NOTE: In addition to the fees listed above in section 5000 thru 6000, additional fees may be charged for upgraded teeth and enhanced cosmetics, personalization beyond norm or techniques involving precision dentures.

Prosthodontics (fixed) / Partial Dentures, etc.)

*6210	PONTIC-CAST HIGH NOBLE METAL	\$ 979	\$ 310	68%
*6211	PONTIC-CAST PREDOMINANTLY BASE METAL	\$ 926	\$ 271	71%
*6212	PONTIC-CAST NOBLE METAL	\$ 952	\$ 284	70%
*6240	PONTIC-PORCELAIN FUSED TO HIGH NOBLE METAL	\$ 998	\$ 329	67%
*6241	PONTIC-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	\$ 930	\$ 274	71%
*6242	PONTIC-PORCELAIN FUSED TO NOBLE METAL	\$ 954	\$ 291	69%
*6250	PONTIC-RESIN WITH HIGH NOBLE METAL	\$ 952	\$ 302	68%
*6251	PONTIC-RESIN WITH PREDOMINANTLY BASE METAL	\$ 932	\$ 289	69%
*6252	PONTIC-RESIN WITH NOBLE METAL	\$ 950	\$ 296	69%
*6720	CROWN-RESIN WITH HIGH NOBLE METAL	\$ 979	\$ 323	67%
*6721	CROWN-RESIN WITH PREDOMINANTLY BASE METAL	\$ 921	\$ 304	67%
*6722	CROWN-RESIN WITH NOBLE METAL	\$ 952	\$ 314	67%
*6750	CROWN-PORCELAIN FUSED TO HIGH NOBLE METAL	\$ 1,005	\$ 331	67%
*6751	CROWN-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	\$ 932	\$ 279	70%
*6752	CROWN-PORCELAIN FUSED TO NOBLE METAL	\$ 970	\$ 301	69%
*6790	CROWN-FULL CAST HIGH NOBLE METAL	\$ 990	\$ 314	68%
*6791	CROWN-FULL CAST PREDOMINANTLY BASE METAL	\$ 922	\$ 286	69%
*6792	CROWN-FULL CAST NOBLE METAL	\$ 954	\$ 290	70%
6930	RECEMENT FIXED PARTIAL DENTURE	\$ 159	\$ 59	63%

These co-payments do not include an allowable \$138 lab fee (per unit). Doctors, please make sure that all members understand what their fees will be and what the saving are from your Usual and Customary fees.

Oral Surgery (Extractions, etc.)

7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT	\$ 153	\$ 38	75%
7210	SURGICAL EXT. ERUPTED TOOTH WITH REMOVAL OF BONE	\$ 257	\$ 70	73%
7220	REMOVAL OF IMPACTED TOOTH-SOFT TISSUE	\$ 291	\$ 78	73%
7230	REMOVAL OF IMPACTED TOOTH PARTIALLY BONY	\$ 370	\$ 144	61%
7240	REMOVAL OF IMPACTED TOOTH-COMpletely BONY	\$ 464	\$ 186	60%
7241	REMOVAL OF IMPACTED TOOTH-COMpletely BONY	\$ 547	\$ 213	61%
7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING)	\$ 291	\$ 107	63%
7270	TOOTH REIMPL. AND/OR STAB. OF ACC.EVULSED OR DISPL. TOOTH	\$ 529	\$ 211	60%
7280	SURGICAL ACCESS OF AN UNERUPTED TOOTH	\$ 478	\$ 208	56%
7285	BIOPSY OF ORAL TISSUE-HARD (BONE-TOOTH)	\$ 389	\$ 170	56%
7286	BIOPSY OF ORAL TISSUE-SOFT	\$ 292	\$ 127	56%
7310	ALVEOPLASTY IN CONJ. WITH EXT.- PER QUAD	\$ 275	\$ 105	62%
7320	ALVEOPLASTY NOT IN CONJ WITH EXT- PER QUAD	\$ 423	\$ 156	63%
7510	INCISION AND DRAINAGE ABSCESS- INTRAORAL SOFT TISSUE	\$ 212	\$ 82	61%
7910	SUTURE OF RECENT SMALL WOUNDS UP TO 5CM	\$ 302	No Cost	100%
7960	FRENULECTOMY (FRENECTOMY OR FRENOTOMY)- SEPARATE PRO.	\$ 427	\$ 110	74%
7970	EXCISION OF HYPERPLASTIC TISSUE- PER ARCH	\$ 523	\$ 186	64%

General Miscellaneous Services

9110	EMERGENCY PALATIVE TREATMENT OF DENTAL PAIN	\$ 113	\$ 39	65%
9230	ANALGESIA, ANXIOLYSIS, INHAL. OF NITROUS OXIDE - 1ST 30 MIN.	\$ 74	\$ 21	72%
9310	CONSULTATION (DIAG. SERV. PROV. BY OTHER DENTIST)	\$ 133	No Cost	100%
9910	APPLICATION OF DESSENSITIZING MEDICAMENT	\$ 63	\$ 5	92%
9941	FABRICATION OF ATHLETIC MOUTHGUARD	\$ 265	\$ 90	66%
9951	OCCLUSAL ADJUSTMENT-LIMITED	\$ 185	\$ 67	64%
9952	OCCLUSAL ADJUSTMENT-COMplete	\$ 661	\$ 245	63%
9999	MISSED APPOINTMENT (WITHOUT 24 HOUR NOTICE)	\$ 54	\$ 30	44%

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Orthodontics (Braces) for children & adults

	<u>Monthly Payment</u>			
13 MONTH TREATMENT PLAN	(\$125/MONTH)	\$ 2,852	\$ 2,200	\$ 652
16 MONTH TREATMENT PLAN	(\$125/MONTH)	\$ 3,320	\$ 2,575	\$ 745
19 MONTH TREATMENT PLAN	(\$125/MONTH)	\$ 3,787	\$ 2,950	\$ 837
22 MONTH TREATMENT PLAN	(\$125/MONTH)	\$ 4,218	\$ 3,325	\$ 893
25 MONTH TREATMENT PLAN	(\$125/MONTH)	\$ 4,724	\$ 3,700	\$ 1,024
28 MONTH TREATMENT PLAN	(\$125/MONTH)	\$ 5,192	\$ 4,075	\$ 1,117
31 MONTH TREATMENT PLAN	(\$125/MONTH)	\$ 5,659	\$ 4,450	\$ 1,209
34 MONTH TREATMENT PLAN	(\$125/MONTH)	\$ 6,127	\$ 4,825	\$ 1,302
36 MONTH TREATMENT PLAN	(\$125/MONTH)	\$ 6,439	\$ 5,075	\$ 1,364

Other Orthodontic Guidelines

1. A \$350 charge will apply at the end of treatment (included in the above amounts) to cover all retention office visits (unlimited).
2. Services not listed above will be discounted 30% off of the participating Orthodontist's Usual and Customary fees (except #5 listed below in this "Orthodontic Guidelines" section).
3. Services must only be provided by a contracted Orthodontic Specialist.
4. The amounts listed above also include an initial one-time \$225 charge for all records, mold, x-rays, etc. to determine the Orthodontic Treatment for the patient.
5. Invisalign® procedures are to be discounted 15% off the participating Orthodontist's Usual and Customary fees.

All Plans General Limitations and Exclusions

1. All fees listed above do not include all appropriate lab fees. Member must agree (in writing) to all upgraded materials before treatment is started. See each section for specific details (if applicable).
2. All patients are responsible for paying all fees (as listed above) at the time services are rendered.
3. These fees are for General Dentists only. A participating specialist list is available by calling our office at 303-744-3007 OR 1-800-807-0706.
4. Any procedures not listed will be discounted 20% off the participating General Dentists normal fees.
5. Medical costs associated with any dental procedures are not covered.
6. Dentures or appliances will be replaced only after 3 years have elapsed since such dentures or appliances were provided under any plan program, unless the denture or appliance becomes unserviceable due to illness or other causes not controlled by other means. Replacement of dentures, appliances, or bridgework due to loss or theft are not covered.
7. Any dental treatment started prior to the Member's eligibility to receive services under this plan or started after a Member's termination are not covered.
8. Failure to follow the prescribed treatment or accidents occurring during the course of treatment may result in additional charges by your plan provider.
9. Failure to pay scheduled fees at the time service is rendered may prevent future dental services from being received until all fees have been paid in full.
10. Services provided by non-participating dentists are not covered.
11. Services which, in the opinion of the attending dentist, are not necessary for the patient's dental health, or are contrary to established dental ethics are not covered.
12. Cosmetic dental procedures are covered only if the attending dentist and patient agree on the specific procedure.
13. Services which are compensable under Worker's Compensation or employer liability laws are not covered.
14. General anesthesia and IV sedation are not covered.
15. Myofunctional therapy procedure for training, treating or developing muscles in and around the jaw or mouth including TMJ are not covered except by participating plan specialists.
16. Any dental procedure or service that cannot be performed in the dental office due to general and/or physical limitations of a member are not covered.
17. Expenses incurred for dental procedures initiated prior to member's eligibility or after termination are not covered.
18. Any services that the Participating General Dentist recommends be performed by a specialist are covered only by a plan participating specialist.
19. The liability of Beta Health Association, Inc. is limited to the return of the membership fee's paid for one year by the member.
20. Extractions for asymptomatic third molars (wisdom teeth) are not covered unless causing movement of the teeth. An example of symptomatic include severe decay, and ontogenic cysts, chronic pericoronitis, and infection.
21. The Beta Health Association, Inc. network dental programs do not constitute dental insurance and are considered discount, fee-for-service dental plans.
22. Fee's are subject to change on an as needed basis. Please contact Beta Health Association, Inc. for current fee's

Participating Provider Directory

(For the Alpha Dental Plan)

Administered by Beta Health Association, Inc. - Denver, CO 80203
1-800-807-0706

A NEW APPROACH TO DENTAL CARE

In an age of rising health care costs, we offer an alternative way to provide for you and your families dental care needs economically and conveniently through our contracted, credentialed and caring providers. The Alpha Dental Plan was founded on the principle of delivering quality dental care and preventing dental problems before they start. This plan is a discount, fee-for-service, network dental plan and is not considered an insurance-based program.

We at Beta Health Association, Inc. have contracted with a network of primarily private practice dental offices. A listing of these offices is enclosed. As an enrollee, you are required to select one office from any of these dental offices for you and your family's needs. These network of dental offices are composed of established dental practices. It has been found that most people feel more secure if the same dental office is providing for their entire family's treatment.

◆ PLAN ADVANTAGES

No Claim Forms

The dental location you choose provides all primary dental services. There are no claim forms to complete or percentage of usual charges for you to pay. You pay only the low, pre-negotiated amounts directly to the participating dentist at the time services are rendered.

No Deductibles or Waiting Periods

There are no required deductibles to pay, so your coverage begins immediately. After enrolling you will also have immediate coverage for crowns, dentures, orthodontics (braces) and any other major dentistry you may need.

No Dollar Limit on Dental Services

No annual maximum (unlimited services).

No Restrictions for Pre-Existing Conditions

These conditions are covered as long as work has not been started prior to eligibility.

Plan Saves on Dental Costs

Your out-of-pocket savings are substantial. You know the exact cost prior to treatment and this aids in better fiscal planning for you and your family.

Quality Review of Dental Providers

Our internal credentialing process of all participating dental locations and Dentists insure that all established standards of quality are maintained.

Specialty Services

The Alpha Dental program also offers services in dental specialty areas. These include Periodontics (treatment of diseased gums and bone), Endodontics (root canal therapy) and Oral Surgery procedures. These services are available at approximately 20% off of the contracted specialists normal fees.

Orthodontic Services (braces)

Orthodontic services are covered immediately for both children AND adults. Members will save a minimum of \$652 up to \$1,364 (depending on the length of treatment) off the contracted orthodontists' normal fees.

◆ HOW IT WORKS

When you enroll in the Alpha Dental Plan, you will select a General Dentist from the list in this directory. This location is now the center for your entire dental needs.

After you have enrolled, you will receive a membership card. To receive all necessary dental care covered by the plan, simply call your selected general dentist to make an appointment.

Remember to always contact the dentist you have selected. You may change your dental provider at any time by calling the Beta Health Association, Inc. Administrative Office.

The Alpha Dental program will not cover dental services that are not performed by a participating dental provider.

◆ WHO CAN ENROLL

If you meet your employer's eligibility requirements for dental coverage, you can enroll in the Alpha Dental program. You can also enroll your eligible dependents, which includes your spouse and unmarried children; including stepchildren, legally adopted and foster children with no upper age limits.

◆ SUMMARY OF SERVICES

The Alpha Dental program provides all reasonable and customary dental care (subject to the appropriate schedule of benefits, limitations and exclusions) only if your Participating Plan dentist provides your care. Review your schedule of benefits for specific benefit information.

Would you like your Dentist in our Network?

We have found the best method of contracting with new dentists on the Alpha Dental Plan is through employee referral. Employers should encourage employees to discuss with their own dentist their interest in having the dentist enroll with the plan.

The majority of employees enjoy the broader benefits with lower, predictable dental costs with the Alpha Dental Plan. Experience has shown that some dentists in the community will not want their patients to leave their offices, so they will appreciate hearing about our Dental Plan.

Are you missing your Favorite chair?

Your dentist should be on our list.

If not, please complete this form and fax it to our office at (303) 744-2890.



Questions? Call us at:

(303) 744-3007

or

toll free at

1-800-807-0706

PLEASE PRINT:

YOUR NAME

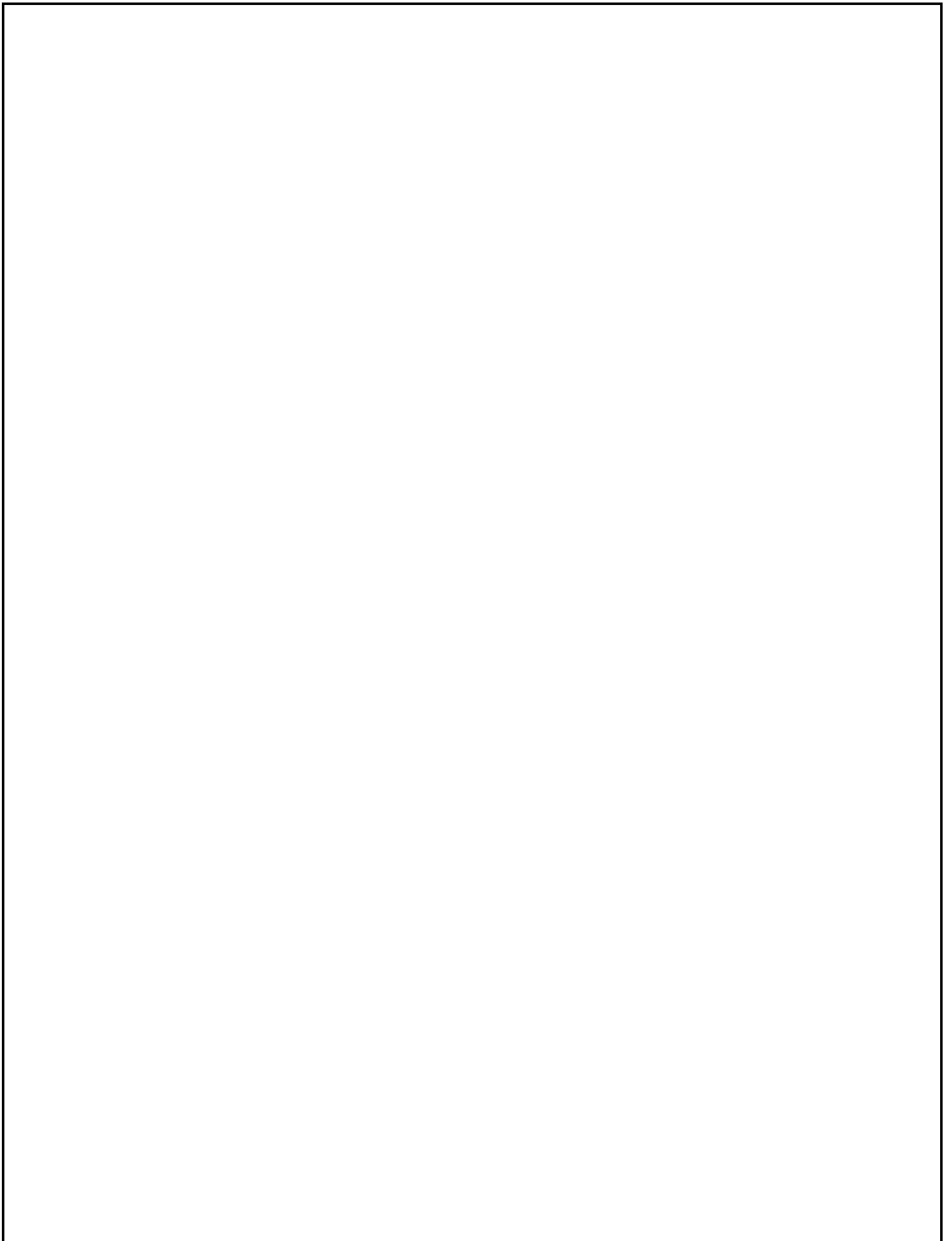
EMPLOYER

DENTIST'S NAME

DENTIST'S ADDRESS

(_____) _____
DENTIST'S PHONE NUMBER

Please call your dentist and ask if they would consider reviewing our provider material.



Alpha Dental Plan

Complete this form to enroll in the Plan #19

SOCIAL SECURITY NUMBER LAST NAME FIRST NAME DATE OF BIRTH HOME PHONE #

HOME ADDRESS CITY STATE ZIP CODE WORK PHONE #

MALE / FEMALE DENTAL OFFICE SELECTED EFFECTIVE DATE GROUP #

NAME AND ADDRESS OF EMPLOYER



I AUTHORIZE PAYROLL DEDUCTION AND AGREE TO REMAIN ON THE PLAN FOR A MINIMUM OF ONE YEAR UNLESS MY EMPLOYMENT TERMINATES.

.....
EMPLOYEE SIGNATURE

.....
DATE

LIST ALL ELIGIBLE DEPENDENTS BELOW WHO YOU WISH TO ENROLL

LAST NAME FIRST NAME SEX (M OR F) BIRTHDATE

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

Complete this form if you are waiving coverage until the next Open Enrollment period

I, _____, have been provided the opportunity to participate in the Dental Plans being offered through my employer. It is my decision:

_____ NOT to cover spouse, children, and myself

_____ NOT to cover my spouse and children

I understand that if my employer is contributing towards this benefit, that I will not be entitled to receive any monies in lieu of non-participation. I further understand that I will not be eligible again until the next open enrollment.

WITNESSED: _____ SIGNED: _____ DATE: _____