

OPTION #2

**COMPANION LIFE DENTAL
INSURANCE PLAN**

SELECT ANY DENTIST



Companion Life

A Dental Plan for Groups of Three or More



Covered Services Description

SELECT ANY DENTIST

Preventive, Basic, and Major services are subject to a combined lifetime deductible of \$100 per covered person. The Companion Life Dental Plan must be offered with one of the Beta Health Association, Inc. Network Dental Plans as an option for all eligible employees. A minimum of three employees must enroll in the Companion Life Dental Plan to start coverage. 30% of all eligible employees must be enrolled between all plans.

Preventive Services

- No waiting periods before benefits begin
- Routine exams, cleanings (one every 6 months)
- Fluoride treatments for dependent children under age 19 (one every 12 months)
- Bitewing x-rays (one every 6 months)
- Emergency exams for dental pain (minor procedures)

Plan Pays Plan A

100%

Basic Services

- No waiting periods before benefits begin
- Periapical x-rays
- Full mouth or panorex x-rays (one every 36 months)
- Simple restorative procedures (fillings)
- Simple extractions
- Palliative treatment for dental pain and local anesthesia

80%

Major Services

- 12 month waiting period before benefits begin (unless takeover applies)
- Replacement of prosthodontics, dentures, crowns, and inlays
- Endodontic procedures (Root canals)
- Periodontic procedures (Gum disease)
- Major restorative procedures (crowns and inlays)
- Prosthetic procedures (bridges and dentures)
- Space maintainers
- Oral surgery procedures (non-simple extractions)
- Denture relines
- General anesthesia (for services dentally necessary)

50%

Plan Maximum Benefit

- Per covered person per calendar year
- Combined between Preventive, Basic, and Major Services only
-

\$1,000

Benefit payments are based upon the allowable charges in the area in which the service is provided. Any Dentist charges above this allowable fee are not an eligible expense. A monthly billing fee of \$1 per covered employee per month (not to exceed \$10 per month) will also apply.

Note: *This a general outline of covered services and does not include all the covered services , limitations and exclusions of the policy. See your certificate for specific details.*

Limitations

Covered expenses will not include and no benefits will be payable for :

1. For major and Orthodontic services in the first 12 months that the Insured is covered, except as may be provided in the Takeover Benefits provision.
2. For any treatment which is for cosmetic purposes or to correct congenital malformations, except for medically necessary care and treatment of congenial cleft lip and palate.
3. To replace any prosthetic appliance, crown, inlay or onlay restoration, or fixed bridge within five years of the date of the last placement of these items, unless required because of an accidental bodily injury sustained while the Insured is covered. Replacement is not covered if the item can be repaired.
4. For initial placement of any prosthetic appliance or fixed bridge unless such placement is needed because of the extraction of natural teeth during the same period of continuous coverage. But the extraction of a third molar (wisdom tooth) will not qualify the item for payment. Any such appliance or fixed bridge must include the replacement of the extracted tooth or teeth. Coverage does not include the part of the cost that applies specifically to replacement of teeth extracted prior to the period of coverage.
5. For the addition of teeth to an existing prosthetic appliance or fixed bridge unless for replacement of natural teeth extracted during the same period of continuous coverage.
6. For any expense incurred or procedure started prior to the Insured's current period of continuous coverage.
7. For any expense incurred or procedure started after the Insured's insurance under this section terminates, except for a prosthetic appliance, fixed bridge, crown, or inlay or onlay restoration for which both (a) the procedure begins before insurance ends and (b) the item's final placement is within 90 days after insurance terminates.
8. To duplicate appliances or replace lost or stolen appliances.
9. For appliances, restorations or procedures to:
 - a. alter vertical dimension;
 - b. restore or maintain occlusion;
 - c. splint or replace tooth structure lost as a result of abrasion or attrition; or
 - d. treat jaw fractures or disturbances of the temporomandibular joint.
10. For education or training in, and supplies used for, dietary or nutritional counseling, personal oral hygiene or dental plaque control.
11. For broken appointments or the completion of claim forms.
12. For orthodontia service or for any services associated with orthodontic therapy when this optional coverage is not elected and the additional premium is not paid.
13. For sealants which are:
 - a. not applied to a permanent molar;
 - b. applied before age 6 or after attaining age 16; or
 - c. reapplied to a molar within three years from the date of a previous sealant application.
14. For sub gingival curettage or root planning (procedure numbers 4220 and 4321) unless both x-rays and depth summaries of each tooth confirm the presence of periodontal disease involved.
15. Because of an Insured's injury arising out of, or in the course of, work for wage or profit.
16. For an Insured's sickness, injury or condition for which he or she is eligible for benefits under any Worker's Compensation Act or similar laws.
17. For charges for which the Insured is not liable or which would not have been made had no insurance been in force.
18. For service which are not recommended by a dentist, not required for necessary care and treatment, or do not have a reasonably favorable prognosis.
19. Because of war or any act of war, declared or not, or while on full-time active duty in the armed forces of any country.
20. To an Insured if payment is not legal where the Insured is living when expenses are incurred.
21. For any services related to: equilibration, bite registration or bite analysis.
22. For crowns for the purpose of periodontal splinting.
23. For charges for: any implants, over dentures, and associated precision or semi-precision attachments and any related Endodontic treatment associated with it; or other customized attachments.
24. For charges for myofunctional therapy, orthognathic surgery or athletic mouth guards.
25. For procedures for which benefits are payable under the employer's medical expense benefit plan for employees and their dependents.
26. Services or supplies provided by a family member or a member of the Insured's household.

Predetermination of Benefits:

As a service to protect the Insured, Companion Life will provide predetermination of benefits for recommended treatment plans that exceed \$300. This predetermination of benefits explains which of the recommended procedures will be covered and at what amount. This benefit helps insured's better understand their coverage. The Insured or Insured's Dentist should submit the treatment plan to Companion Life for review and predetermination of benefits before the service begins.

Designed and Marketed By Beta Health Association, Inc.

9725 East Hampden Avenue, #400, Denver, CO, 80231
303-744-3007 or 1-800-807-0706

Underwritten and Administered by Companion Life Insurance

P.O. Box 100102, Columbia, SC, 29202-3102
1-800-753-0404, Fax 803-735-0736



Companion Life

Companion Life Insurance Company

P.O. Box 100102 • Columbia, S.C. 29202-3102 • (803) 735-1251

- New Employee
- Add Coverage
- Change Dependent Coverage
- Change Beneficiary
- Change Address (Dental)
- Change Class or Status
- Terminate Employee

GROUP INSURANCE ENROLLMENT FORM AND CHANGE REQUEST

Please Type or Print Clearly

TO BE COMPLETED BY EMPLOYER

Name of Employer (Use Name from Group Billing Notice or Master Application)	Group No.	DIV	CLASS

TO BE COMPLETED BY ALL EMPLOYEES

Social Security No.			Effective Date			Date Employed Full Time			Hours Worked Per Week
			Month	Day	Year	Month	Day	Year	
Your Name Last		First		M.I.		Date of Birth			Sex
						Month	Day	Year	<input type="checkbox"/> Female <input type="checkbox"/> Male
Marital Status			Occupation						
<input type="checkbox"/> Single <input type="checkbox"/> Married									

COMPLETE FOR DENTAL

Is your spouse to be covered? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental Coverage Is For (Check Box Below):				Are you covered by other dental insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Employee	<input type="checkbox"/> Employee plus 1 (<input type="checkbox"/> Spouse or <input type="checkbox"/> Child)	<input type="checkbox"/> Employee plus 2 (<input type="checkbox"/> Spouse <input type="checkbox"/> Child or <input type="checkbox"/> 2 Children)	<input type="checkbox"/> Employee plus 3 or more	

Complete for Dependent Coverage				Do any of your dependents have any other dental coverage?	
Spouse Name	(Last)	(First)	(Middle Initial)	Date of Birth	If Yes, Name of Carrier
				/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No
CHILDREN	1			/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No
	2			/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No
	3			/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No

Your Home Address	City	State	Zip Code

FRAUD WARNING (Not Applicable in AZ, FL, MD, OR, VA): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits (in TX, may be committing) a fraudulent insurance act, which is a crime and subjects (in KS, which may be determined by a court of law to be a crime which subjects) such person to criminal and civil penalties.

FRAUD WARNING (FL only): Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

I elect the above coverage which I have checked from those for which I am eligible. If any contribution from me is necessary to pay part of the cost of the insurance, I authorize my employer to deduct the contribution from my wages.

Date	Your Signature
	X

Important Enrollment Announcement!

If you enroll in either the Alpha Dental Plan or the Companion Life Dental Plan at this open enrollment only, then you will receive the following Vision Plan at **NO ADDITIONAL COST!**

Please complete the Vision Plan Enrollment Form and staple it to the appropriate Dental Plan Enrollment Form to receive this special offering