CompBenefits Insurance Company

Elite Preferred 720

The network plan that offers maximum coverage with the cost advantages on a traditional indemnity plan.

➢ **FREEDOM TO CHOOSE ANY DENTIST**
Participants are free to select from a panel of participating dentists or seek care from any non-participating dentist.

➢ **VALUABLE SAVINGS FROM NETWORK DENTISTS**
Network dentists offer savings by agreeing to charge you based on negotiated maximum allowable contracted fee schedule. If you go to a non-participating dentist, the charged amount may be above that charged by a Participating Dentist.

➢ **NO BALANCE BILLING**
A participating dentist has agreed not to charge you any amount for services above the negotiated maximum allowable fee amount. When utilizing a non-participating dentist, you will be responsible for any extra amount charged by the dentist over the CompBenefits negotiated maximum and the customary charge of the dentist.

➢ **EXTENSIVE NETWORK OF PARTICIPATING DENTISTS**
Refer to your Provider Directory for a listing of participating dentists that offer services on a guaranteed-negotiated fee schedule.

➢ **ACCESS TO INFORMATION**
Our toll-free customer service number at 1-(800)-342-5209 has Member Services Representatives who can provide the answers you need quickly and thoroughly.

Any way you add it up, CompBenefits really is the benefits company of choice!

This brochure contains a brief description of the plan. A complete description of the coverage, including limitations on certain procedures, is found in the Schedule of Benefits and Certificate of Group Dental Insurance.

*Coverage based on Preferred Provider schedule of discounted fees

**Time served on the employer's immediately preceding group dental plan may be credited towards this plan's waiting periods, subject to Underwriting approval.

***Maximum of 3 per family.

CompBenefits Family of Companies

CompBenefits Company • CompDent • CompBenefits Insurance Company
CompBenefits Dental, Inc. • American Dental Plan of North Carolina, Inc.
National Dental Plans, Inc.• OHS of Alabama, Inc.
American Dental Plan of Georgia, Inc. • Texas Dental Plans, Inc.
Ultimate Optical, Inc. • VisionCare Plan • Primary Plus

SUMMARY OF BENEFITS

Partial Listing of Covered Services	In-Network Reimbursements	Out-of-Network Reimbursements
Type I Diagnostic & Preventive	**100%**	**100%**
Oral Examination (once per six months)		
Prophylaxis (cleaning, once per six months)		
Topical Fluoride (children under 16, once per 12 months)		
X-Rays (limitations may apply)		
Sealants (once per 3 years for children under age 16, for non carious molars only)		
Space Maintainers (for children under age 16)		
Type II Basic Services	**80%**	**80%**
Simple Restorative (amalgam, synthetic, or composite fillings)		
Emergency Palliative Treatment		
Tooth Extraction		
Endodontics (root canals)		
Type III Major Services (12 month waiting period**)	**50%**	**50%**
Major Restorative (crowns/inlays/onlays)		
Periodontics (includes treatment of diseases of the gums		
Bridge, Denture Repair		
Prosthetics (bridges and dentures)		

MAXIMUM BENEFITS

	Insured Individual and Dependents
Lifetime	
Type I, II, III	Unlimited / Unlimited
Calendar Year	
Type I, II, III	$1,000 / $1,000
Deductible* **	
Type I	None / None
Type II, III	$50 / $50

Passive PPO True Group Std

MAJOR RESTORATIVE LIMITATIONS

The charges for Major Restorative services will be Covered Dental Expenses subject to the following:

1. the denture or partial denture must replace a Natural Tooth extracted while insured for Dental Benefits under this policy;

2. the fixed bridge (including a resin bonded fixed bridge) must replace a Natural Tooth extracted while insured for Dental Benefits under this policy;

3. the replacement of a partial denture, full denture, or fixed partial denture (including a resin bonded bridge), or the addition of teeth to a partial denture if: (a) replacement occurs at least five years after the initial date of insertion of the current full or partial denture or resin bonded bridge; (b) replacement occurs at least five years after the initial date of insertion of an existing implant or fixed bridge; (c) replacement prosthesis or the addition of a tooth to a partial denture is required by the necessary extraction of a Functioning Natural Tooth while insured for Dental Benefits under this policy; or (d) replacement is made necessary by a Covered Dental Injury to a partial denture, full denture, or fixed partial denture (including a resin bonded bridge) provided the replacement is completed within 12 months of the injury;

4. the replacement of crowns, cast restorations, inlays, onlays or other laboratory prepared restorations if: (a) replacement occurs at least five years after the initial date of insertion; and (b) they are not serviceable and cannot be restored to function;

5. the replacement of an existing partial denture with fixed bridgework, only if upgrading to fixed bridgework is essential to the correction of the person's dental condition; and

6. the replacement of teeth up to the normal complement of 32.

EXCLUSIONS

Benefits will not be paid for:

1. procedures which are not included in the Schedule of Benefits; which are not medically necessary; which do not have uniform professional endorsement; are experimental or investigational in nature; for which the patient has no legal obligation to pay; or for which a charge would not have been made in the absence of insurance;

2. any procedure, service, or supply which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least three years, as determined by CompBenefits Insurance Company;

3. crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth which may be restored with an amalgam or composite resin filling;

4. appliances, inlays, cast restorations or other laboratory prepared restorations used primarily for the purpose of splinting;

5. any procedure, service, supply or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension; the alteration or restoration of occlusion including occlusal adjustment, bite registration, or bite analysis;

6. pulp caps, adult fluoride treatments, athletic mouthguards; myofunctional therapy; infection control; precision or semi-precision attachments; denture duplication; oral hygiene instruction; separate charges for acid etch; broken appointments; treatment of jaw fractures; orthognathic surgery; completion of claim forms; exams required by third party; personal supplies (e.g. water pik, toothbrush, floss holder, etc.); or replacement of lost or stolen appliances;

7. charges for travel time; transportation costs; or professional advice given on the phone;

8. procedures performed by a Dentist who is a member of Your immediate family;

9. any charges, including ancillary charges, made by a hospital, ambulatory surgical center, or similar facility;

10. charges for treatment rendered: (a) in a clinic, dental or medical facility sponsored or maintained by the employer of any member of Your family; or (b) by an employee of the employer of any member of Your family;

11. any procedure, service or supply required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joints or their associated structures;

12. charges for treatment performed outside of the United States other than for emergency treatment. Benefits for emergency treatment which is performed outside of the United States are limited to a maximum of $100 (US dollars) per year;

13. the care or treatment of an injury or sickness due to war or an act of war, declared or undeclared;

14. treatment for cosmetic purposes. Facings on crowns or bridge units on molar teeth will always be considered cosmetic;

15. any services or supplies which do not meet the standards set by the American Dental Association or which are not reasonably necessary, or customarily used, for dental care;

16. procedures that are a covered expense under any other medical plan (established by the employer) which provides group hospital, surgical, or medical benefits whether or not on an insured basis;

17. a sickness for which the patient can receive benefits under a workers' compensation act or similar law;

18. an injury that arises out of or in the course of a job or employment for pay or profit;

19. charges to the extent that they are more than the Prevailing Fee. If the amount of the Prevailing Fee for a service cannot be determined due to the unusual nature of the service, CompBenefits Insurance Company will determine the amount. CompBenefits Insurance Company will take into account: (a) the complexity involved; (b) the degree of professional skill required; and (c) other pertinent factors; or

20. orthodontic plan benefits for persons 19 years of age or older.

PREDETERMINATION

If Covered Dental Expenses for a procedure are expected to be more than $200 it is recommended that you send a Dental Treatment Plan in prior to beginning treatment, send preauthorization to CompBenefits, P.O. Box 8236 Chicago, IL 60680–8236. You and/or your dentist will be notified of the benefits payable based upon the Dental Treatment Plan.

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