Hampshire County Schools
Dental and Vision Benefits

Humana/CompBenefits
100 Mansell Court East, Ste 400
Roswell, GA 30076-4859
Member Services 800-342-5209
www.compbenefits.com

HUMANA®
Specialty Benefits

CompBenefits Insurance Company

Elite Choice 405 (with ortho)

March

Because we specialize in dental, we can bring you benefits and service that other companies can't match!

- **QUICK CLAIMS TURNAROUND**

CompBenefits' state of the art claims center provides fast reimbursement of your claims.

- **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.

- **TOTAL FREEDOM OF CHOICE**

The plan provides you with total freedom of choice by allowing you to use any licensed dentist for treatment. The plan reimburses a percentage of eligible expenses based on the plan you have chosen.

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 usual, customary and reasonable 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

Coverages*

Type I Diagnostic & Preventive......................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)

Type II Basic Services....................................50%
- Simple Restorative (amalgam, synthetic, or composite fillings)
- Space Maintainers (for children under age 16)
- Non-Surgical Tooth Extractions
- Non-Surgical Periodontics

Type III Major Services....................................50%
(12 month waiting period**)
- Major Restorative (crowns/inlays/onlays)
- Bridge, Denture Repair
- Prosthetics (bridges and dentures)
- Emergency Palliative Treatment
- Endodontics (root canals)
- Surgical Tooth Extractions
- Surgical Periodontics

Type IV Orthodontics 50%
(12 month waiting period**)
- Dependent children 18 years of age or younger

MAXIMUM BENEFITS

	Insured Individual and Dependents
Lifetime	
Type I, II, III	Unlimited
Type IV	$1,000
Calendar Year	
Type I, II, III	$750
Type IV	$500
Deductible* **	
Type I	None
Type II, III, IV	$50

Voluntary+ UCR – Ortho

005EC405X

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.

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.

› Clearly simple: HumanaVision

Vision health impacts overall health

Eye examinations not only help your vision, your doctor can catch major health issues, too. Many diseases can be diagnosed by looking into your eyes including diabetes, hypertension, multiple sclerosis, high blood pressure, osteoporosis, and rheumatoid arthritis.[2]

Focus on healthy eyesight with HumanaVision VCP

Periodic eye examinations are an important part of routine preventive healthcare. Because many eye and vision conditions have no obvious symptoms, you may be unaware of problems. Early diagnosis and treatment are important for maintaining good vision and preventing permanent vision loss.[1]

With HumanaVision VCP options, you get:

- Plans that are easy to use and understand
- Access to one of the largest networks in the United States, with more than 22,500 provider locations including independent optometrists and ophthalmologists
- Wholesale pricing on frames, avoiding high retail markups
- Access to **HumanaVisionCare.com**, where you can view benefits, check eligibility, and use other automated services
- Provider locator services through **HumanaVisionCare.com,** Customer Care, or our automated information line
- Discounts on Lasik and PRK procedures
- Genuine customer service

Preserve and protect your eyesight with a HumanaVision plan.

[1] American Optometric Association
[2] Thompson Media Inc.

HUMANA®
Specialty Benefits

HUMANA
Specialty Benefits

Vision - Exam Plus with ID Card

Hampshire County Schools

Plan Frequencies	**Exam Every**	**12**	**months**
	Lenses Every	**12**	**months**
	Frames Every	**24**	**months**
Co-payments	**Exam**	**$10**	
	Lenses and/ or Frames	**$10**	
Maximum Allowances		**In Network** (after co-payments up to plan limits)	**Out of Network[1]**
Eye Exam		Paid in full	$35
Lenses (per pair)	Single	Paid in full	$26
	Bifocal	Paid in full	$40
	Trifocal	Paid in full	$60
	Lenticular	Paid in full	$100
Contact Lenses[2]	Medically necessary[3]	Paid in full	$210
	Elective (fitting, follow-up & lenses)	$105	$105
Frame	$40 wholesale	$120 retail equivalent[4]	$40 retail
Lasik	Members receive a 10% discount off UCR charges at preferred LASIK provider locations, and pay no more than $1,800 per eye for the Conventional LASIK procedure and $2,300 per eye for CustomLASIK. Members receive benefits where TLC Truvision network providers are available, with the following preferred rates: * Silver Package: $895/eye for Conventional LASIK * Gold Package: $1,295/eye for CustomLASIK * Platinum Package: $1,895/eye for CustomLASIK plus Bladeless LASIK (using Intralase technology).		
Calendar Year Deductible	None, after plan Co-payments		
Calendar Year Maximum Benefit	Up to plan limits		
Lifetime Maximum Benefit	Unlimited		
Waiting Periods	None		

HUMANA®

Specialty Benefits

Benefits Enrollment Form

Group Name: Hampshire County BOE

Please complete the following information:					
Social Security No.	Last Name		First	Middle	Date of Birth
Home Address			Home Phone		Gender
City	State	ZIP Code	Business Phone		Facility Number

List All Your Eligible Dependents That Are To Be Covered			
First MI Last	Facility Number	Sex	Birth Date
Spouse:		M ☐ F ☐	/ /
Child:		M ☐ F ☐	/ /
Child:		M ☐ F ☐	/ /
Child:		M ☐ F ☐	/ /
Child:		M ☐ F ☐	/ /
Child:		M ☐ F ☐	/ /
Child:		M ☐ F ☐	/ /

Effective Date:	Group Number **See Below**	Your E-mail Address	Agent Number **0304075KY**

PLEASE CHECK YOUR CHOICE	☐ **Dental Plan** **CD4380**	☐ **Vision Plan** **VS5113**
Bi-Monthly Rates (24-Pay)	**7/1/10 – 6/30/11**	**7/1/10 – 6/30/12**
Employee Only	☐ **Emplr Pd**	☐ **Emplr Pd**
Employee + One	☐ **$11.94**	☐ **$3.27**
Employee + Family	☐ **$30.78**	☐ **$5.48**

I wish to enroll in the plan indicated above as offered through my employer. I understand that this is a minimum one (1) year contract. I hereby authorize my employer to deduct all applicable contribution amounts from my salary or other compensation for the plan year, and for future renewal period(s). I understand that such contribution rate is subject to change on the anniversary date of the plan.

I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

Signature: X ______________________________ Date: ______________

Subscriber Service Form

Group Name: **Hampshire County Board of Education** Group # ☐ **CD4380** ☐**VS5113**

Subscriber Name: ______________________ **SS#** ______-________-________

A. **CHANGES:**

Name: From: ______________________________

To: ______________________________

Address To: ______________________________

City ______________ State ______ Zip ______

Telephone To: (   ) ______________

Add Dependent:

Name______________________ Birth Date ___/___/___ Male ____ Female ____

Name______________________ Birth Date ___/___/___ Male ____Female____

Name______________________ Birth Date ___/___/___ Male ____ Female ____

Name______________________ Birth Date ___/___/___ Male ____Female____

Delete Dependent:

Name______________________ Effective Date ___/_1_/___ Male ____ Female ____

Name______________________ Effective Date ___/_1_/___ Male ____ Female ____

Name______________________ Effective Date ___/_1_/___ Male ____ Female ____

Name______________________ Effective Date ___/_1_/___ Male ____ Female ____

Effective Date of Change: ___/_1_/___ (DATE MUST BE THE 1ST OF THE TERMINATION MONTH)

B. **Terminate Policy** (Reason) ______________________________

______________________________ Date of Termination ___/_1_/___

C. **Reinstate Policy** (Reason)______________________________

______________________________ Effective Date of Reinstatement ___/_1_/___

D. **Other**(Explain)______________________________

____

Signature ______________________________
Person initiating request (subscriber, administrator, etc.)

********Please be sure your Group # and Effective Date are on all forms before faxing!********