



group dental plan for Associated Credit Union Members

We are happy to announce that you are eligible for CompBenefits coverage. AT LAST, you have the opportunity to receive dental care and save money too! After a small co-payment for an office visit, CompBenefits offers you these excellent benefits:

ROUTINE EXAMS	NO CHARGE
ROUTINE X-RAYS	NO CHARGE
ROUTINE CLEANINGS	NO CHARGE
TOPICAL FLUORIDES (Children Only)	NO CHARGE
SILVER FILLINGS	NO CHARGE
NON-SURGICAL EXTRACTIONS	NO CHARGE
BRACES	SAVE 25%
PLUS SAVINGS UP TO 50% ON OTHER DENTAL PROCEDURES.	

(Please see Schedule of Benefits on the reverse side.)

Notice that many preventive and routine dental services are provided at NO ADDITIONAL COST. Pre-existing conditions are covered. There are no claim forms, no deductibles, no benefit maximums and no waiting periods.

Please see CompBenefits' Provider Directory to locate a participating provider in your area. All facilities are private practices, and all professional services are by appointment. Transfers to another participating provider are allowed.

Associated Credit Union

If you have any questions, call

AA LaRocco & Associates, Inc
(770) 441-2712

Take care of your teeth!

It's a well known fact that dental disease is preventable. Dentists stress regular brushing, flossing and periodic check-ups.

CompBenefits makes preventative care affordable.

CompBenefits will help you take better care of your teeth, and you'll pay less to do it.

You'll get great benefits. You'll save money. You'll help prevent gum disease, which could save your teeth.

No Charge Benefits.

When you see your participating dentist, you'll pay a small co-payment for an office visit, after which you will receive **no charge** services for:

Silver Fillings	Routine X-rays
Routine Cleanings	Oral Exams
Topical Fluoride (children only)	Local Anesthesia

All other dental procedures are covered at substantial savings to you. The Schedule of Benefits shows you the exact amount you pay. **Compare and compute your savings.**

No deductible.

With CompBenefits, you won't be surprised by a hidden deductible. There isn't one. Your dental needs are covered right from the start. And any pre-existing conditions you may have are covered immediately.

No claim forms for you to file.

CompBenefits has taken the confusion out of dental care.

Most routine and preventive care is covered in full. And you'll know exactly how much you'll pay for other procedures by checking your Schedule of Benefits for the pre-negotiated fees.

You don't have to file a claim and then wait to receive your money.

Large, established dental network.

With a large network it is easy to find a participating dentist located near your home or office. Just select your family general dentist from the CompBenefits Provider Directory. Each dentist is appropriately licensed, and CompBenefits carefully reviews the credentials of each dentist in the network before they are selected.

No surprises.

With CompBenefits, you have an easy way to determine how much, if anything, dental services will cost you before they're performed. You just review your Schedule of Benefits with your dentist. You'll always know what to expect. And often, you can expect "No Charge."

Friendly, efficient Customer Care.

CompBenefits Customer Care Representatives are trained to help you with your questions. They are familiar with your benefits and the dentists on the panel. And they'll answer your questions clearly and completely.

Qualified participating CompBenefits dentists.

All participating dentists are appropriately licensed, and as part of our requirement for participation in the CompBenefits network, they undergo periodic reviews by CompBenefits' trained staff of dentists and Professional Service Representatives.

CompBenefits Customer Care
1-800-342-5209

Website
www.compbenefits.com

schedule of benefits and subscriber copayments

ADA CODE	PROCEDURE	PATIENT PAYS	ADA CODE	PROCEDURE	PATIENT PAYS
APPOINTMENTS			PREVENTIVE CARE (cont.)		
9310	Consultation (diagnostic service provided by dentist other than practitioner providing treatment)	\$15.00	1510	Space Maintainer - fixed - unilateral	\$45.00 + LAB
9430	Office Visit (normal hours)	\$5.00	1515	Space Maintainer - fixed - bilateral	\$45.00 + LAB
9440	Office Visit (after regularly scheduled hours)	\$35.00	1520	Space Maintainer - removable - unilateral	\$85.00 + LAB
9999	Emergency visit during regularly scheduled hours, by report	\$20.00	1525	Space Maintainer - removable - bilateral	\$85.00 + LAB
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	1550	Recementation of space maintainer	\$10.00
DIAGNOSTIC			RESTORATIVE		
120	Periodic oral evaluation	NO CHARGE	2140	Amalgam - one surface, primary or permanent	NO CHARGE
140/150/160	Limited/Comprehensive oral evaluation	NO CHARGE	2150	Amalgam - two surfaces, primary or permanent	NO CHARGE
180	Comprehensive periodontal evaluation	\$10.00	2160	Amalgam - three surfaces, primary or permanent	NO CHARGE
210	X-Ray Intraoral - complete series including bitewings	NO CHARGE	2161	Amalgam - four or more surfaces, primary or permanent	NO CHARGE
220	X-Ray Intraoral - periapical - first film	NO CHARGE	2940	Sedative filling	\$15.00
230	X-Ray Intraoral - periapical - each additional film	NO CHARGE	2999	Sedative base (under fillings), by report	NO CHARGE
270	X-Ray Bitewing - single film	NO CHARGE	RESIN RESTORATION		
272	X-Ray Bitewings - two films	NO CHARGE	2330	Resin - one surface, anterior	\$35.00
274	Bitewings - four films	NO CHARGE	2331	Resin - two surfaces, anterior	\$40.00
330	Panoramic film	NO CHARGE	2332	Resin - three surfaces, anterior	\$50.00
460	Pulp vitality tests	NO CHARGE	2391	Resin - based composite - one surface, posterior	\$60.00
470	Diagnostic casts	NO CHARGE	2392	Resin - based composite - two surfaces, posterior	\$80.00
PREVENTIVE CARE			2393	Resin - based composite - three surfaces, posterior	\$100.00
1110/1120	Prophylaxis-adult/child-routine (once every 6 months)	NO CHARGE	2394	Resin - based composite - four or more surfaces, posterior	\$120.00
1110/1120	Prophylaxis-adult/child- (additional)	\$20.00	2510	Inlay - metallic - one surface	\$95.00
1201	Topical application of fluoride (including prophylaxis) child (up to 16 years of age)	NO CHARGE	2520	Inlay - metallic - two surfaces	\$105.00
1203	Topical application of fluoride (not including prophylaxis) child (up to 16 years of age)	NO CHARGE	2530	Inlay - metallic - three or more surfaces	\$130.00
1330	Oral hygiene instruction	NO CHARGE	CROWN & BRIDGE		
1351	Sealant - per tooth	\$10.00	2740	Crown - porcelain/ceramic substrate	\$280 + LAB
			2750*	Crown - porcelain fused to high noble metal	\$280.00
			2751	Crown - porcelain fused to predominantly base metal	\$280.00
			2752*	Crown - porcelain fused to noble metal	\$280.00

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ADA CODE	PROCEDURE	PATIENT PAYS	ADA CODE	PROCEDURE	PATIENT PAYS
CROWN & BRIDGE (cont.)			PROSTHODONTICS		
2790*	Crown - full cast high noble metal	\$280.00	5110	Complete denture - maxillary	\$300.00 + LAB
2791	Crown - full cast predominantly base metal	\$280.00	5120	Complete denture - mandibular	\$300.00 + LAB
2792*	Crown - full cast noble metal	\$280.00	5130	Immediate denture - maxillary	\$300.00 + LAB
2910	Recement inlay	\$15.00	5140	Immediate denture - mandibular	\$300.00 + LAB
2920	Recement crown	\$15.00	5211	Maxillary partial denture - resin base	\$300.00 + LAB
2930	Prefabricated stainless steel crown - primary tooth	\$75.00	5212	Mandibular partial denture - resin base	\$300.00 + LAB
2950	Core buildup, including any pins	\$45.00	5213	Maxillary partial denture - cast metal framework, resin denture bases	\$300.00 + LAB
2951	Pin retention - per tooth	\$15.00	5214	Mandibular partial denture - cast metal framework, resin denture bases	\$300.00 + LAB
2952	Cast post and core in addition to crown	\$90.00 + LAB	5410	Adjust complete denture - maxillary	\$15.00
2953	Each additional cast post - same tooth	\$90.00 + LAB	5411	Adjust complete denture - mandibular	\$15.00
2954	Prefabricated post and core in addition to crown	\$90.00	5421	Adjust partial denture - maxillary	\$15.00
2962	Labial veneer (porcelain laminate) - laboratory	\$280 + LAB	5422	Adjust partial denture - mandibular	\$15.00
ENDODONTICS			REPAIRS TO PROSTHETICS		
3220	Therapeutic pulpotomy	\$35.00	5510	Repair broken complete denture base	\$15.00 + LAB
3221	Pulpal debridement, primary and permanent teeth	\$100.00	5520	Replace missing or broken teeth - complete denture (each tooth)	\$15.00 + LAB
3310	Root canal therapy - anterior (excluding final restoration)	\$100.00	5610	Repair resin denture base	\$15.00 + LAB
3320	Root canal therapy - bicuspid (excluding final restoration)	\$200.00	5630	Repair or replace broken clasp	\$15.00 + LAB
3330	Root canal therapy - molar (excluding final restoration)	\$250.00	5640	Replace broken teeth - per tooth	\$15.00 + LAB
3410	Apicoectomy/periradicular surgery - anterior	\$125.00	5650	Add tooth to existing partial denture	\$30.00 + LAB
PERIODONTICS (Gum treatment)			5730	Reline complete maxillary denture (chairside)	\$50.00
4210	Gingivectomy/gingivoplasty 4+ teeth per quad	\$125.00	5731	Reline complete mandibular denture (chairside)	\$50.00
4211	Gingivectomy/gingivoplasty 1-3 teeth per quad	\$40.00	5740	Reline maxillary partial denture (chairside)	\$50.00
4341	Periodontal scaling and root planing 4+ teeth per quad	\$50.00	5741	Reline mandibular partial denture (chairside)	\$50.00
4342	Periodontal scaling and root planing 1-3 teeth per quad	\$50.00	5750	Reline complete maxillary denture (laboratory)	\$35.00 + LAB
4355	Full mouth debridement to enable eval and diagnosis	\$45.00	5751	Reline complete mandibular denture (laboratory)	\$35.00 + LAB
4381	Localized delivery of chemotherapeutic agents (per tooth)	\$45.00	5760	Reline maxillary partial denture (laboratory)	\$35.00 + LAB
4910	Periodontal maintenance	\$50.00	5761	Reline mandibular partial denture (laboratory)	\$35.00 + LAB
			5850	Tissue conditioning - maxillary	\$30.00
			5851	Tissue conditioning - mandibular	\$30.00

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ADA CODE	PROCEDURE	PATIENT PAYS
PROSTHODONTICS (Fixed)		
6210*	Pontic - cast high noble metal	\$280.00
6211	Pontic - cast predominantly base metal	\$280.00
6212*	Pontic - cast noble metal	\$280.00
6240*	Pontic - porcelain fused to high noble metal	\$280.00
6241	Pontic - porcelain fused to predominantly base metal	\$280.00
6242*	Pontic - porcelain fused to noble metal	\$280.00
6750*	Crown - porcelain fused to high noble metal	\$280.00
6751	Crown - porcelain fused to predominantly base metal	\$280.00
6752*	Crown - porcelain fused to noble metal	\$280.00
6790*	Crown - full cast high noble metal	\$280.00
6791	Crown - full cast predominantly base metal	\$280.00
6792*	Crown - full cast noble metal	\$280.00
6930	Recement fixed partial denture (per unit)	\$10.00

EXTRACTIONS/ORAL AND MAXILLOFACIAL SURGERY

7111	Coronal remnants, deciduous tooth ...	NO CHARGE
7140	Extraction, erupted tooth or exposed root	NO CHARGE
7210	Surgical removal of erupted tooth	\$40.00
7220	Removal of impacted tooth - soft tissue	\$50.00
7230	Removal of impacted tooth - partially bony	\$70.00
7240	Removal of impacted tooth - completely bony	\$85.00
7250	Surgical removal of residual tooth roots	\$35.00
7310	Alveoplasty in conjunction with extractions - per quadrant	\$35.00
7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	\$35.00
7320	Alveoplasty not in conjunction with extractions - per quadrant	\$70.00
7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	\$70.00
7510	Incision and drainage of abscess - intraoral	\$25.00

ADA CODE	PROCEDURE	PATIENT PAYS
ADJUNCTIVE GENERAL SERVICES		
9215	Local anesthesia	NO CHARGE
9230	Analgesia (nitrous oxide - per 15 minutes)	\$15.00
9450	Case presentation, detailed and extensive treatment planning	NO CHARGE
9951	Occlusal adjustment - limited	\$25.00
9952	Occlusal adjustment - complete	\$150.00

* 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.

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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.

Enrollment Change Cancel

Please complete the following information:				
Social Security #	Last Name	First	Birth Date	
Home Phone	Home Address	City, State, Zip	Sex M <input type="checkbox"/> F <input type="checkbox"/>	
List All of your eligible dependents that are to be covered:				
Member:	First Last	Dental Facility Number	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Birth Date / /
Spouse:			M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Child:			M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Child:			M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Child:			M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Child:			M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Effective Date:	Group Number 202532	Premium Amount	Amount Paid	Agent Code 0204222GA

mail today
Enrollment Instructions

1. Complete the application. (Be sure to list all Family Members to be included).
2. Select a dental office from the Provider List and insert the dental facility number on the application
3. Return the completed application to CompBenefits. Deductions from your account will be made in accordance with the procedures established and communicated by CompBenefits

Completed applications, with correct premiums, received by Home Office by the 15th of the month will become effective on the 1st of the following month.

Any person with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

enroll today

Premium Rates Monthly	
Individual	\$ 16.06
Individual and 1	\$ 29.36
Individual and 2 or more dependents	\$ 42.22

Make checks payable to Humana/CompBenefits

Send Applications to:
P.O. Box 769649
Roswell, GA 30076-8225

Authorization for Deduction — Signature Required —

Name _____
(Last) (First) (MI)

Social Security No. _____

I authorize ASSOCIATED CREDIT UNION
(Employer, Financial, or other organization)

To make a monthly deduction of \$ _____ from: My Checking, Savings Account No. _____
check one: () checking () savings

I hereby authorize CompBenefits to deduct monthly and future renewal period(s) my portion of such subscription fee from any funds due me. I understand that enrollments are by group contract and/or my subscription fee is subject to change on the anniversary/renewal date of the Group. I hereby represent to the carrier that all information furnished by me hereon is true and complete to the best of my knowledge. I hereby consent, personally and on behalf of any family member enrolled, to the unrestricted release of my/our dental records maintained by participating dentists to CompBenefits for, but no limited to, verification and quality assessment review, and to any other participating dentist who may be or become involved in my/our dental care.

Date _____ 20 _____ Signature X _____