Dental Plan

Administrative Guide

Plan Administered by CompBenefits

www.compbenefits.com

table of contents

Introduction	*2*
Enrollment Procedures	*3-5*
Termination of Coverage	*6-7*
Billing Procedures	*8-9*
Reconciling Your Payment	*10*
Selecting a Dentist	*11*
Claims Administration	*12*
HIPAA Information	*13-16*
Frequently Asked Questions	*17*

introduction

Welcome to the CompBenefits family of clients. We are pleased that you chose CompBenefits to provide and administer dental benefits for your employees. We take our responsibility seriously and will do everything in our power to ensure that service levels meet your expectations.

This guide is designed to assist you in the administration of the benefit program by providing a handy reference to procedures and contacts in our Company. We have kept it as brief as possible to enable you to have a quick reference.

Please note that this guide is for reference and guidance only and may be amended from time to time. All administrative policies are established by CompBenefits and can only be changed with written permission from CompBenefits. **The information in this guide does not in any way change or alter the provisions or benefits contained in the policy, certificates or benefit schedules.**

contact numbers

CompBenefits Home Office
800-633-1262 (770-998-8936)
Fax: 770-998-6871
Address: 100 Mansell Court East, Ste. 400
Roswell, GA 30076-4859

Claims Office Chicago
Fax: 312-427-9665
Address: 200 West Jackson Blvd., 9th Floor
Chicago, IL 60606-6910

Account Services for Group Administrators
800-342-5209

Member Services for Employees
800-342-5209
(or the dedicated number printed on the Employee's I.D. Card)

enrollment procedures

Initial Enrollment

During the initial enrollment process all eligible employees and their eligible dependents may enroll in the plan. The effective date of their coverage will be the effective date of your dental plan.

If your plan is an Indemnity, PPO, Advantage or Access plan, eligible employees may enroll after the initial enrollment period only for the following reasons:

1. New employees upon satisfying eligibility requirements defined by the Employer.
2. Newly acquired dependent(s) [spouse and / or child(ren)]
3. Individuals who become eligible due to a qualifying event.
4. Change of status (divorce, etc.).
5. Annual open enrollment.

If your plan is a prepaid dental plan (DHMO) employees may enroll at any time acceptable to the employer. The effective date shall be the 1st of the month following receipt of application.

Terms of Enrollment

All members must remain enrolled in the plan until an open enrollment period, except in the following situations:

1. The subscriber voluntarily or involuntarily terminates employment with the employer.
2. The subscriber's employment status changes to such an extent that he/she is no longer eligible for benefit coverage as determined by the Employer's eligibility.
3. A dependent child reaches the maximum eligible age for dependent children (please refer to the group policy / certificate for the dependent age limit).
4. Relocation outside of CompBenefits' service area. (DHMO only)
5. Death.

open enrollment

Open enrollment is conducted annually, usually 2-3 months prior to the anniversary date of the Group's Contract. CompBenefits will notify the Group 2-3 months prior to the contract anniversary date of the renewal terms for your Dental Policy. The open enrollment should be held at this time. The following changes are allowed during open enrollment and are effective on the plan's renewal date:

1. New enrollment for eligible employees not previously enrolled.
2. Enrollment for dependents not previously enrolled.
3. Termination of coverage for subscribers and/or their dependents.

employee / subscriber change form

The following actions require completion of an employee / subscriber change form:*

1. Employee name change
2. Add dependent coverage
3. Add dependent child(ren)
4. Terminate dependent spouse
5. Terminate dependent child(ren)
6. Terminate all coverage
7. Address change
8. Changing plans during an open enrollment

* Signature by employee and date required.

Change forms must be submitted to CompBenefits Home Office no later than the 15th day of each month to be effective on the 1st day of the following month. Changes that are made after the 15th of the month will be effective the 1st of the month following thereafter. Example: A change made on the 20th of April would become effective on the 1st of June.

new employees

New employees may be added to the group at any time once they become eligible*. Eligibility will be the agreed upon criteria between CompBenefits and the Employer. Applications received on or before the 15th of the month will be effective the 1st of the following month. Once the employee has been added to the system, he / she will receive a Certificate and I.D. cards (if applicable) at the address indicated on the application.

Mail new enrollment forms to:
CompBenefits, 100 Mansell Court East, Suite 400, Roswell, GA 30076
or to the PO BOX shown on your monthly invoice.

* Indemnity and PPO plans require enrollment within 31 days of eligibility.

renewals

Coverage for employees and their dependents is automatically renewed upon each annual open enrollment period unless a written request for termination is submitted to CompBenefits. I.D. cards are generated at renewal only upon request from the Employer.

enrollment materials

Please contact your local Account Executive for the following materials:

1. Enrollment packets
2. Updated Provider Directories
3. Enrollment Forms
4. Change Status Forms
5. Claim Forms
6. Benefit Plan Design

Enrollment packets are available which include an application, Schedule of Benefits, and updated Provider Directory (for PPO, Access, Advantage and DHMO plans). Requests may be made through your local Account Executive or Regional Sales Office (listed on back of guide).

termination of coverage

Coverage must remain in-force for the full month, with termination being the last day of the month. CompBenefits must be notified of the termination by the 15th of the month for coverage to terminate at the end of the month.

Please refer to the Policy / Certificate to determine benefits for procedures in progress at the time of termination.

consolidated omnibus reconciliation act (COBRA)

CompBenefits will continue benefits in accordance with COBRA requirements as administered by your company.

When the covered employee or employee's covered dependent(s) experience a COBRA qualifying event, the administrator must notify CompBenefits of the date of the qualifying event.

Once COBRA coverage is elected, the Administrator must collect the monthly premiums from the individual and remit to CompBenefits. Upon receipt of the premiums, CompBenefits will reinstate the individual back to the date of termination and continue coverage as stipulated by COBRA requirements. Reinstatement will only be allowed up to 180 days from the date of the qualifying event.

conversion privilege (DHMO only)

Employees whose employment is terminated, either on a voluntary or involuntary basis, may convert their coverage to a direct pay policy with CompBenefits. The following conditions apply:

1. Premiums will be paid on an annual basis to CompBenefits or through a monthly bank draft.
2. CompBenefits will send an annual renewal notification to the Subscriber.
3. Coverage will convert to the Individual Benefits and Co-Payments Schedule.

billing procedures

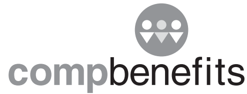
Invoices are mailed no later than the last day of each month. Included will be:

- An original copy of the invoice.
- A remittance coupon.
- A return envelope.

It is important to review the first invoice to confirm the accuracy. Listed below for your convenience is an explanation for each item on the invoice.

1. Your group account number
2. Coverage month for the current invoice
3. Your group's name and address
4. Certificate number for each covered subscriber
5. Names of each covered subscriber
6. Coverage period for each covered subscriber
7. Premium amount for each covered subscriber
8. Type of plan for covered subscriber
9. Original effective date of coverage for each covered subscriber
10. Total premium for current invoice
11. Adjustments made to current invoice, if any
12. Current monthly premium due after adjustments
13. Total premium due. This includes the monthly adjusted premium, past due premium and pending payments
14. Total number of subscribers on your group account
15. Due date for premium payment
16. Mailing address to send the premium remittance

See sample invoice on next page with above numbers referenced.



ABC COMPANY, INC. ❸
ATTN: JOHN MANSELL
4100 SMITH ROAD
FRIENDLY, GEORGIA 30076

invoice

❶	Group Number	3639
	Desk Code	P
❷	For Month of	July, 2003
	Invoice Number	000895136
	Payment Due	06/15/03
	Agent #	99179
	Agent Name	Broker, Julia A.

Cobra	Certificate	Subscriber or Buyer	Cvrg Prd	Prem Amt	Plan	Eff Date
	❹ 000-00-0001	❺ SUBSCRIBER NAME	❻ 7/03	❼ 24.70	❽ PP	❾ 04/97
	000-00-0002	SUBSCRIBER NAME	7/03	10.50	PP	04/97
	000-00-0003	SUBSCRIBER NAME	7/03	10.50	PP	08/97
	000-00-0004	SUBSCRIBER NAME	7/03	10.50	PP	08/98
	000-00-0005	SUBSCRIBER NAME	7/03	24.70	PP	04/98
	000-00-0006	SUBSCRIBER NAME	7/03	18.00	PP	08/97
C	000-00-0007	SUBSCRIBER NAME	7/03	18.00	PP	04/99
	000-00-0008	SUBSCRIBER NAME	7/03	10.50	PP	08/99
	000-00-0009	SUBSCRIBER NAME	7/03	10.50	PP	04/00
	000-00-0010	SUBSCRIBER NAME	7/03	10.50	PP	04/99
	000-00-0011	SUBSCRIBER NAME	7/03	10.50	PP	11/01
	000-00-0012	SUBSCRIBER NAME	7/03	10.50	PP	04/00
	000-00-0013	SUBSCRIBER NAME	7/03	18.00	PP	04/02
C	000-00-0014	SUBSCRIBER NAME	7/03	10.50	PP	04/02
	000-00-0015	SUBSCRIBER NAME	7/03	24.70	PP	04/02
	000-00-0016	SUBSCRIBER NAME	7/03	10.50	PP	04/02
	000-00-0017	SUBSCRIBER NAME	7/03	10.50	PP	11/98

Previous Balance		EE Only	11
Unreconciled Cash		EE+1	3
Balance		Family	3
Current Month Premium	❿ 243.60		
Current Adjustments	⓫	Total ⓮	17
Administrative Fee			
Current Total Due	⓬ 243.60		
Please Pay this amount	⓭ 243.60		

how you can reach us

For benefit questions, please call Member Services at (800) 342-5209.

For billing questions, please call Account Services at (800) 342-5209.

If you have special needs, please call your billing representative, John Doe at (800) 342-5209 ext. 7812.

If no changes, detach and return bottom portion of invoice with your remittance. If changes shown, adjust the total premium and mail this entire form back to CompBenefits with your remittance.
Check here if changes are shown on the back of this form. ☐

ABC COMPANY, INC.
ATTN: JOHN MANSELL
4100 SMITH ROAD
FRIENDLY, GEORGIA 30076

Group Number	3639
Desk Code	P
For Month of	July, 2003
Invoice Number	000895136
Payment Due	06/15/03 ⓯

MAKE CHECK PAYABLE TO:

CompBenefits ⓰
PO Box 769849
Roswell, GA 30076-8230

Check Amount
Check Number

reconciling your payment

To cancel any employee on the invoice:

1. Complete the membership changes section found on the back of page one of your invoice.
2. Strike through the individual's name with a single line.
3. Note the date the certificate is to be cancelled (always on 1st day of month).

To add new subscribers:

1. New applications for the month should be noted in the membership changes section on the back of the invoice. Please include the additional amount in your premium check.

Overpayments and credits should be noted on the invoice when you return it and you will receive credit on the next invoice.

All refund requests must be submitted in writing listing the employee name and premium amount to be refunded.

A copy of the invoice must accompany the premium payment when changes are made in the invoice amount.

selecting a dentist

DHMO and Advantage plans require that the subscriber select a dentist for all care from our directory of Participating Dentists. Advantage plans allow the selection of that dentist to occur at the time of service (the member is not assigned to a specific dentist). Indemnity plans allow the subscriber to choose any licensed dentist. PPO and Access plans offer maximum benefits when using a Participating Dentist but do not require the use of Participating Dentists.

To assist in the selection of a Participating Dentist, the member may:

- Go to our web site www.compbenefits.com and enter their address. The provider search mechanism allows the member to look for a Participating Dentist by city, state or zip code. The mapping system will assist the member in selecting a dentist within the requested radius. The map also lists the dentists and mileage to their offices.
- Refer to one of our Provider Directories handed out during enrollment. The member must contact Member Services to verify the dentist accepts their plan and is accepting new patients. Changes in the network since the directory printing can be verified through Member Services as well.
- The dentist should be listed on the enrollment application. If not when a dentist is selected, DHMO members must contact Member Services (800-342-5209) so that we can assign the selected dentist as their primary dental provider.

how to change selected dentist (DHMO)

Members wishing to change their selected general dentist may do so at any time. (Note: DHMO Participating Dentists cannot be changed if there is an outstanding balance owed to the current dentist). When contacting Member Services for the change, the member will need to provide the name of the current dentist. Changes will be effective the 1st of the following month if the change is received by the 15th.

specialist (DHMO, access and advantage)

The Participating General Dentist may refer a member to a Participating Specialist or the member may self-refer from the Provider Directory.

Prior to treatment with the Participating Specialist, the member will need to confirm that the Specialist accepts the member's specific plan of benefits.

claims administration

Where Should Claims be Submitted
(Does not apply to DHMO)

Claims are processed in our Chicago office located at 200 West Jackson Blvd., 9th Floor Chicago, IL 60606-6910. The applicable PO Box for submitting claims will be displayed on the subscriber's I.D. card.

Generally, the dentist utilizing a standardized claim form files the claim, or the dentist may file the claim electronically. Our payor I.D. is CX021.

Claim forms may be downloaded from our web site at www.compbenefits.com.

questions about the filed claim

If members have questions concerning their claim, our Member Services Department is available to assist the subscriber in answering any questions they may have at 800-342-5209 or the dedicated number listed on the employee's I.D. Card.

Members may go to our web site, www.compbenefits.com, and check claims through our Personal Touch for members.

The member also has the option of contacting our Interactive Voice Response system (IVR) 24 hours per day, 7 days a week at 800-824-0295. The Member must have the following information available when contacting IVR:

- Certificate Number
- Patient's date of birth
- Date of Service

important HIPAA information for groups and benefits administrators

The following information is provided as a courtesy to our groups to address frequently asked questions about HIPAA and is not intended as interpretive or legal advice.

The new privacy protections required by the Health Insurance Portability and Accountability Act ("HIPAA") is changing the way health plans manage, use and disclose an individual's health-related information. These changes will affect the availability and amount of information that groups and group benefits administrators will be able to receive from health carriers, such as CompBenefits. The information provided below will help you better understand what these changes will be and how they may affect you and your ability to receive certain kinds of information.

The HIPAA privacy rule provides the first comprehensive federal protection for the privacy of an individual's health information. You will hear this referred to as the individual's "Protected Health Information" or "PHI". The privacy rule gives individuals more control over their PHI and it sets boundaries on the use and disclosure of their PHI. Additionally, it establishes safeguards that must be achieved to protect the privacy of protected health information and it holds violators accountable with civil and criminal penalties that can be imposed if they violate an individual's privacy rights.

Depending on the type of information you request from us, certain certifications or authorizations may be required under HIPAA before we can release such information to you. As a general rule, when you request information from us that contains an individual's PHI, you will be required to provide us with some type of certification or authorization depending on the type of request. Whether or not your request will require you to provide a certification or authorization will depend upon whether your request is for summary information, plan administration functions, or other type of request.
(NOTE: Information regarding enrollment, disenrollment or participation is not subject to these requirements.)

You may receive “summary information” from us for the purpose of obtaining premium bids or when modifying, amending, or terminating the group health plan, without any type of authorization or certification. HIPAA defines “summary information” as information that summarizes claims history, claims expenses, or types of claims experienced by individuals for whom the plan sponsor has provided health benefits under a group health plan, provided that specified identifiers (i.e. those identifiers that could identify an individual, including, but not limited to, name, address, social security number, etc.) are omitted.

If you request an individual's PHI for the purposes of “plan administration functions” that you perform as the plan sponsor, we can provide you with such PHI without authorization from the individual, if, and only if, you provide us with written certification that your plan documents have been amended as required under HIPAA If you wish to receive an individual’s PHI from us for plan administration functions, your written certification to us must state that your plan documents have been amended to incorporate the following provisions and that you agree to:

a) not use or further disclose PHI other than as permitted or required by the plan documents or as required by law;

b) ensure that any subcontractors or agents to whom the plan sponsor provides PHI agree to the same restrictions;

c) not use or disclose the PHI for employment-related actions;

d) report to group health plan any use or disclosure that is inconsistent with the plan documents or HIPAA regulation;

e) make the individual’s PHI accessible to the individual;

f) allow individuals to amend their information;

g) provide an accounting of its disclosures;

h) make its practices available to the Secretary of HHS for determining compliance;

i) return and destroy all PHI when no longer needed, if feasible; and

j) ensure that firewalls have been established. (Note, the firewalls must identify the employees or classes of employees or other persons under the plan sponsor’s control who will have access to PHI.)

It is important to note that “plan administration functions” are defined by HIPAA to only include quality assurance, claims processing, auditing, monitoring, and management of carve-out plans. Plan administration functions do not include any employment-related functions or functions in connection with any other benefits or

benefit plans, and we are not permitted under HIPAA to disclose information for such purposes absent an authorization from the individual.

All other requests for an individual's PHI will require that you provide us with written authorization from the individual to prior to release of such PHI. This includes instances where the individual has asked you to advocate on his/her behalf in benefit disputes, claims issues and grievances and appeals. In order for an authorization to be a valid authorization, it must be written in plain language and must contain the following core elements:

1) a description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion;
2) the name or other specific identification of the person(s) or class of persons authorized to make the use/disclosure;
3) the name or other specific identification of the person(s) or class of persons to whom the covered entity may make the requested use/disclosure;
4) a description of each purpose of the requested use or disclosure. (The statement "at the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement the purpose."
5) the authorization's expiration date or an expiration event that relates to the individual or to the purpose or use of the requested disclosure;
6) a statement of the individual's right to revoke the authorization in writing and exceptions to the right, along with a description of how the individual may revoke;
7) a statement that information used or disclosed under the authorization may be subject to re-disclosure by the recipient and no longer protected;
8) the signature of the individual and the date signed; and
9) a description of the personal representative's authority to sign, if applicable.

Further, a copy of the signed authorization must be given to the individual. An authorization is not valid if: 1) the expiration date has passed or the expiration event has occurred; 2) the authorization was not filled out completely; 3) the authorization was revoked; 4) the authorization lacks a required element; or 5) any material information in the authorization is known to be false.

We appreciate your business and hope that this information has been helpful in your understanding of the additional measures that are being put into place as part of our commitment to ensuring the privacy and confidentiality of your group members protected health information in compliance with HIPAA requirements.

If you should have any questions, please do not hesitate to contact our Privacy Officer at (770) 998-8936 or e-mail at PrivacyOfficer@CompBenefits.com.

frequently asked questions

Q. *Who do I call about billing or enrollment questions?*
A. Account Services 800-342-5209

Q. *Who do I contact if I need supplies?*
A. Your State's Regional Sales Office
(Florida Groups use Gainesville Office)

Q. *Who does the employee call if they have a claims question?*
A. Member Services 800-342-5209

Q. *Who does the employee call if they would like to change DHMO providers?*
A. Member Services 800-342-5209

Q. *How often can I change my DHMO provider?*
A. Once per month

Q. *Where do I send new enrollment forms?*
A. CompBenefits
100 Mansell Court East, Suite 400
Roswell, GA 30076
or to the PO BOX shown on your monthly invoice.

regional sales offices

Alabama

2204 Lakeshore Dr.
Suite 100
Birmingham, AL 35209-6701
Phone: (205) 879-7374
(888) 879-7374
Fax: (205) 879-5307

Florida

2772 NW 43rd Street, Suite C
Gainesville, FL 32606
Phone: (352) 371-2811
(800) 458-2507
Fax: (352) 371-9055

5775 Blue Lagoon
Miami, FL 33126-2034
Phone: (305) 262-1333
(800) 223-6447
Fax: (305) 262-6119
(305) 269-2106

Citadel International Building
5950 Hazeltine National Dr.
Suite 520
Orlando, FL 32822
Phone: (407) 240-0540
(800) 893-2981
Fax: (407) 240-5452

1511 North Westshore Blvd.
Suite 1000
Tampa, FL 33607-4591
Phone: (813) 289-2020
(800) 749-5855
Fax: (813) 281-0916

Georgia

100 Mansell Court East
Suite 125
Roswell, GA 30076
Phone: (404) 365-0074
(800) 411-6725
Fax: (404) 233-2366

Illinois

200 W. Jackson Boulevard
9th Floor
Chicago, IL 60606
Phone: (312) 261-6200
(800) 837-2341
Fax: (312) 427-9558

Indiana

3850 Priority Way S. Drive
Suite 222
Indianapolis, IN 46240
Phone: (317) 581-7081
(800) 456-1625
Fax: (317) 581-7080

Kansas

7450 West 130th Street
Suite 320, Building 10
Overland Park, KS 66213-2665
Phone: (913) 851-9532
(800) 456-1629
Fax: (913) 851-4563

Kentucky

1951 Bishop Lane
Suite 100
Louisville, KY 40218
Phone: (502) 456-1800
(800) 999-3900
Fax: (502) 456-2772

Missouri

1650 Des Peres Road
Suite 207
St. Louis, MO 63131
Phone: (314) 821-0183
(800) 456-1647
Fax: (314) 821-6548

North Carolina

130 Edinburgh South
Suite 107
Cary, NC 27511
Phone: (919) 380-9267
(800) 542-1146
Fax: (919) 380-1729

Ohio

8180 Corporate Park Drive
Suite 202
Cincinnati, OH 45242
Phone: (513) 489-6550
(800) 456-1635
Fax: (513) 489-7003

Rockside Square Two
6133 Rockside Road
Suite 304
Independence, OH 44131
Phone: (216) 520-1555
(800) 903-1555
Fax: (216) 520-1559

Tennessee

105 Westpark Drive
Suite 450
Brentwood, TN 37027
Phone: (615) 371-5881
(800) 261-5881
Fax: (615) 371-5445

Texas

12870 Hillcrest Road
Suite H200
Dallas, TX 75230
Phone: (972) 726-0092
(800) 275-2584
Fax (972) 726-9986

2929 Briarpark
Suite 314
Houston, TX 77042
Phone: (713) 784-7011
(800) 679-7883
Fax: (713) 784-9440

85 N.E. Loop 410
Koger Atrium Bldg.
Suite 603
San Antonio, TX 78216
Phone: (210) 979-3940
(800) 721-0455
Fax: (210) 979-3982

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