Crescent Dental

Choice Comprehensive Plan

Underwritten by Companion Life Insurance Company

FEATURES INCLUDE:

- No deductible for Preventive and Orthodontia services
- $50 deductible for Basic and Major services; $150 maximum deductible per family
- $1,250 calendar year maximum
- $1,250 Orthodontia lifetime maximum
- 12 month waiting period for Type III & IV services for timely enrollees
- Late entrants will only have limited Type I services for the first 12 months.

This is not a certificate of insurance. It is a brief description only. The Group Policy alone determines all rights and benefits. Exclusions and limitations apply.

Below are the monthly rates:

Employee
$39.63

Employee + One
$79.34

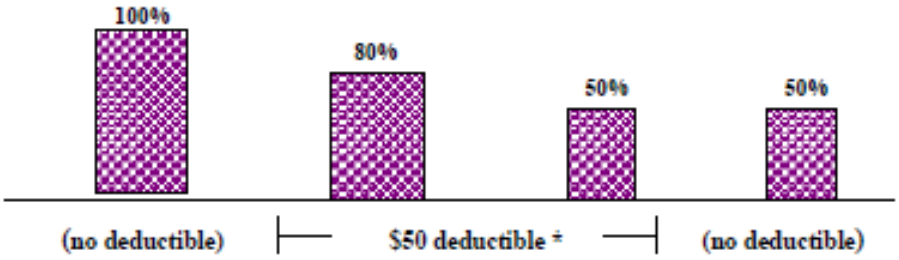
Employee + Family
$118.07

Based on 12 pay periods per year and premiums are guaranteed until the next policy renewal date.

9/2020

COVERED SERVICES

Pays up to $1250 Calendar Year Benefit for Certain Procedures. Percentage payable is based on Allowable Charges for covered procedures.



TYPE I
PREVENTIVE SERVICES
Including
Routine Exams
(2 per 12 months)
Bitewing X-rays
(1 per calendar year)
Routine Cleaning
(1 per 6 months)
Sealants
(ages 6 to16)
Full Mouth & Panoramic X-rays
(1 per 36 months)

TYPE II
BASIC SERVICES
Including
Restorative Basic Fillings
Space Maintainers
Simple Extractions
Periodontics
(treatment of gums including surgery)
Palliative Treatment
Anesthesia
Oral Surgery
(extractions & impacted teeth)

TYPE III
MAJOR SERVICES
Including
Restorative
(inlays & crowns)
Prosthetics
(dentures & bridges)
Endodontics
(root canals, endodontic therapies)
Implants

**Combined deductible For Type 2 and Type 3 Services is per person per calendar year; (3) per family maximum*

TYPE IV
ORTHODONTIA
Including
Orthodontia
(orthodontic care of proper alignment of teeth)
Orthodontia is provided only to dependent children who are under age 19 when treatment is received.

Group Dental Insurance Enrollment Card — Dentemax

Name of Employer
Holmes Community College

Group Number: CR567
Policy N… D4214

Employee Name: First Middle Last

☐ Female ☐ Male

So… ty No.

Complete Home Address (Please include street/PO Box, city, state and zip)

D… h

Marital
☐ Sing… ☐ Married
☐ …d ☐ Divorced

Date of Hire | Effective Date on Dental Plan | Occupati… | …OBI… …tinues p…

…ring Event_____
…ent_____

…s at least 30 hrs per week?
☐ Yes
☐ No

Check One: ☐ Employ… ☐ …nploy…
…ployee …m…

List Nam… …ate of Bi… …f e… …en… …d Wish to Insure:

…me		Date of Birth	Name	Sex	Date of Birth
…se			3.		
Children			4.		
			5.		

☐ …t… …r:

☐ I authorize my employer to deduct from my earnings the amount to cover my share of the contribution for coverage indicated above.

Signature of Employee **Provisions on reverse side accepted** Date Office Use Only