CarePlus
Dental Plans

Transition Health Benefits

2019-2020 Dental Offering

Agent Enrollment Instructions

Enrollment Packets are Available at:
www.careplusdentalplans.com/transition-health-benefits

Review and complete the following steps:

1. Review the two (2) plan options with your client.
2. Complete the Enrollment Form and Plan Selection Sheet.
3. Complete the "Payment Method Form" if needed.
4. If replacing coverage, please provide proof of prior dental coverage.
5. Submit all completed enrollment materials in one of the following manners:

   Fax: 262-821-0508 (Transition Health Benefits)

   Email: info@thbwi.com

   US Mail: Transition Health Benefits 17040 W Greenfield Ave Ste #1, Brookfield, WI 53005

Option 1 - $1,500 Annual Maximum

(Orthodontia not included)

Please write your name on the form and put a check mark next to the plan selected.

Applicant Name: _____

Agent Name and Phone Number: _____

Premium Payment Options

Annual Automatic Withdrawal:
(Required if no prior coverage)

_____ Member Only: $435.56
_____ Member + 1: 866.12
_____ Families: $1,318.76

Direct Quarterly Invoice:

_____ Member Only: $117.64
_____ Member + 1: $225.28
_____ Families: $338.44

Monthly Automatic Withdrawal:

_____ Member Only: $37.88
_____ Member + 1: $ 73.76
_____ Families: $111.48

Monthly automatic withdrawal rates include a $2 per month administrative fee. Quarterly direct invoices include a $10 per invoice administrative fee. Annual automatic withdrawal rates include a $5 administrative fee.

To Enroll: See Agent Enrollment Instruction Section.

The above rates are subject to change October 1, 2020. If you have any questions regarding your application or the plan benefits, please call Transition Health Benefits at 262-784-7344.

Waiting Periods: There are no waiting periods on any services. Individuals who have had at least 12 months of dental coverage within the last 63 days can take advantage of all available billing options. All others will be required to pay the first year's annual premium in full. You will need to submit proof of prior dental coverage and dates of coverage with your application if you want to take advantage of the expanded billing options. See below for premium rates and billing options.

Option 2 - $1,250 Annual Maximum

(Includes $1,250 Lifetime Orthodontia Maximum)

Please write your name on the form and put a check mark next to the plan selected.

Applicant Name: _____

Agent Name and Phone Number: _____

Premium Payment Options

Annual Automatic Withdrawal:
(Required if no prior coverage)

_____ Member Only: $473
_____ Member + 1: $941
_____ Families: $1,433

Direct Quarterly Invoice:

_____ Member Only: $127
_____ Member + 1: $244
_____ Families: $367

Monthly Automatic Withdrawal:

_____ Member Only: $41
_____ Member + 1: $80
_____ Families: $121

Monthly automatic withdrawal rates include a $2 per month administrative fee. Quarterly direct invoices include a $10 per invoice administrative fee. Annual automatic withdrawal rates include a $5 administrative fee.

To Enroll: See Agent Enrollment Instruction Section.

The above rates are subject to change October 1, 2020. If you have any questions regarding your application or the plan benefits, please call Transition Health Benefits at 262-784-7344.

Waiting Periods: There are no waiting periods on any services. Individuals who have had at least 12 months of dental coverage within the last 63 days can take advantage of all available billing options. All others will be required to pay the first year's annual premium in full. You will need to submit proof of prior dental coverage and dates of coverage with your application if you want to take advantage of the expanded billing options. See below for premium rates and billing options.

Payment Method Form

Transition Health Benefits — CarePlus Dental Plans Insurance Program

Name: _____ **Agent:** Transition Health Benefits

Email: _____

Have you had dental insurance in the last 63 days? Y N If yes, be sure to submit proof of prior coverage with your application.

Direct Invoice (Premium must accompany application.)
$10 administration fee per invoice

☐ Send quarterly invoice to home address on application.

Monthly Automatic Withdrawal (EFT) (Initial and future premium will be drafted. Do not send payment.)
$2 administration fee

☐ Monthly Automatic Bank Draft (Please include a void check.)
Initial premium will be drafted on the 4th — 6th of the month you are effective to pay for your first month of premium. Premium will also be drafted on the 20th of the month you are effective to pay for your second month of coverage. Thereafter, premium will be drafted on the 20th of each month prior to the month you are paying for.

By my signature below I authorize Transition Health Benefits to instruct my financial institution to deduct premium payments from my account designated below. I authorize my financial institution to debit the amount of my premium from my designated account. This authorization will remain in effect until I notify Transition Health Benefits of its termination. My notification must afford Transition Health Benefits and my financial institution reasonable opportunity to act on it.

☐ Checking Account (Please include a void check) ☐ Savings Account

Transit Number: _____ Account Number: _____

_____ _____
Signature Date

Annual Automatic Withdrawal (EFT) This is your only payment option if you do not have current dental coverage. You will not have any waiting periods on your dental plan.
$5 admin fee

☐ Annual Automatic Bank Draft (Please include a void check)
Annual (12 months) premium will be drafted on the 4th — 6th of the month your dental plan becomes effective. Upon the annual October renewal date, additional premium may be required.

By my signature below I authorize Transition Health Benefits to instruct my financial institution to deduct premium payments from my account designated below. I authorize my financial institution to debit the amount of my premium from my designated account. This authorization will remain in effect until I notify Transition Health Benefits of its termination. My notification must afford Transition Health Benefits and my financial institution reasonable opportunity to act on it.

☐ Checking Account (Please include a void check) ☐ Savings Account

Transit Number: _____ Account Number: _____

_____ _____
Signature Date

Dental Enrollment Form

CarePlus Dental Plans

DENTAL ENROLLMENT FORM

INSTRUCTIONS

1) Fill out completely
2) Choose a Dental Office
3) Print Firmly & Legibly
4) Sign and Date this Form
5) Read Terms and Conditions

REQUESTED EFFECTIVE DATE OF BENEFITS		
MO.	DAY.	YEAR.

Transition Health Benefits	Contract Desired ☐ Single ☐ Couple ☐ Family

	Last Name	First Name	Middle Initial	Sex	Date of Birth Mo.	Day	Year	Social Security No.
Enrollee								
Spouse								
Dependent Children								

Home Address			Primary Phone
City	State	Zip	Secondary Phone

Select a Dental Center

- ☐ **Appleton** 4660 W. College Ave.
- ☐ **Appleton-North** 2115 E. Evergreen Dr.
- ☐ **Fond du Lac** 545 E. Johnson St.
- ☐ **Franklin** 6855 S. 27th St.
- ☐ **Green Bay** 430 Main St.
- ☐ **Green Bay - Howard** 2340 Duck Creek Pkwy.
- ☐ **Greenville** N1737 Lily of the Valley Dr.
- ☐ **Kenosha** 7117 Green Bay Rd.
- ☐ **Milwaukee - Beerline B** 220 E. Pleasant St.
- ☐ **Milwaukee - Downtown** 205 E. Wisconsin Ave.
- ☐ **Milwaukee - Miller Park Way** 2100 Miller Park Way
- ☐ **Sturtevant** 10155 Washington Ave.
- ☐ **Waukesha** 1211 Dolphin Ct.
- ☐ **Wauwatosa** 11711 W. Burleigh St.

I HEREBY APPLY FOR ENROLLMENT SUBJECT TO THE TERMS AND CONDITIONS

SIGNATURE **X** _____ DATE SIGNED _____

TERMS AND CONDITIONS

1. All statements and answers in this application are representations made by the member on behalf of himself/herself and other persons named in the application, if any, to induce the insurance of the dental contract applied for.
2. The Applicant, on behalf of himself/herself and other persons named in the application, if any, consents, authorizes and directs any physician, dentist, consultant, hospital or other person or corporation by whom or in which any diagnosis, medical, surgical or dental treatment or advice is being, shall be or shall have been rendered to furnish and make available to Care-Plus Dental Plans, Inc., all such medical, surgical and dental reports, records and other information as they may request, at no cost to them.
3. The contract applied for will become effective only upon the acceptance of this application by Care-Plus Dental Plans, Inc. to be evidenced by the insurance of Identification Card(s) which will be delivered to the Group or to the Member designated herein as the Applicant.

Transition Health Benefits Plan Benefit Design

ANNUAL MAXIMUM	**$1,500**
DEDUCTIBLE	**$0**
DIAGNOSTIC Oral Exams, X-rays	**100%**
PREVENTIVE Cleanings, Fluoride Treatments, Sealants, Space Maintainers	**100%**
RESTORATIVE Amalgam & Composite Fillings	**80%**
CROWNS	**50%**
PROSTHODONTICS Full and Partial Dentures, Denture Relines and Repair, Fixed Bridgework	**50%**
ENDODONTICS Root Canals/Therapy	**50%**
PERIODONTICS* Scaling and Root Planning, Gingivectomy	**50%**
ORAL SURGERY* Surgical Extractions	**50%**
IMPLANTS	**50%**
PREMIUM COST (Monthly	
Single	**$35.88**
Couple	**$71.76**
Family	**$109.48**

*Does not duplicate medical coverage.
Missing Tooth Exclusion: None.
Waiting Period. None.
Network dentist will provide an electronic toothbrush following the member's first cleaning appointment.

CARE-PLUS DENTAL PLANS, INC.

CarePlus Dental Plans

Exclusions and Limitation

Benefits shall not include:

- Dental services not specifically described in the master Contract as a benefit.
- Dental services with respect to congenital malformations or which are primarily for cosmetic or aesthetic purposes, except congenitally missing teeth.
- Any duplicate prosthetic device or any other duplicate appliance, except as otherwise provided.
- The replacement of lost or stolen prosthetic devices or appliances, except as otherwise provided.
- The replacement of an orthodontic appliance, except as otherwise provided.
- Treatment of temporomandibular joint (TMJ) dysfunction.
- Gold foil, gold or other precious metal restorations, except when used as a necessary functional material.
- Transplants, Orthodontics
- Dental Service or Emergency Service: (a) That would be furnished, without charge, to the Participant by any person or entity other than Care-Plus; (b) That the Participant would be entitled to have furnished or paid for, fully or partially, under any law, regulation or agency of any government; (c) That the Participant is entitled or would be entitled if he were enrolled, to have furnished or paid for under any voluntary medical or dental insurance plan established by any government if the master Contract were not in effect; (d) To the extent that Medicare is the Participant's primary payor, which it is, except where Medicare is secondary by law. Where Medicare is primary payor, no Benefits are available to the extent the Participant would have been entitled to Medicare benefits had the Participant enrolled in Medicare or complied with Medicare requirements; (e) For, or resulting from injuries, disease or conditions for which the Participant receives, or is the subject of, any award or settlement under a Worker's Compensation Act or any Employer Liability Law; (f) Rendered or furnished after the date the Participant ceases to be covered under this Contract, except for: (i) Procedures (other than prosthetic services) commenced prior to, and completed in one visit within thirty-one (31) days following termination of coverage; and (ii) Prosthetic devices that are ordered and fitted prior to, and completed within sixty (60) days following termination of coverage; or (g) Provided at a location other than the offices of the Primary Provider except for Emergency Service.
- Hospital or physician services of any kind whether or not related to covered Dental Services.
- Dental Service and Emergency Service resulting from diseases contracted or injuries sustained as a result of war, declared or undeclared, enemy action or action of the Armed Forces of the United States, or its allies, or while serving in the Armed Forces of any country; or any illness or injury occurring after the effective date of the master Contract and caused by atomic explosion whether or not the result of the war.
- Reimbursement to the Participant or any dental office for the cost of Dental Services provided by Dentists, other than the Primary Provider, unless expressly authorized in writing by the Primary Provider or due to an emergency.
- Out of Area Services, unless due to an Emergency and then covered only to the extent of the Emergency Service benefit.
- Dental Service and Emergency Service received from a dental or medical department maintained on behalf of an employer, a mutual benefit association, a labor union, academic institution, trustee or similar person or group.
- Replacement of an existing removable partial denture, full denture, crown or fixed bridge by a new removable partial denture, full denture, crown or a fixed bridge if the existing appliance was provided in the previous five years. The five-year period will be measured from the date on which the existing appliance was last supplied, whether under the master Contract or under any other dental coverage.
- If a satisfactory result can be achieved by a conventional removable partial denture in the case of bilateral edentulous areas, but the Participant selects a more complicated treatment (precision attachments or fixed bridgework), Benefits shall be limited to the appropriate procedures necessary to eliminate oral disease and restore missing teeth. The balance of the cost for the more elaborate selected procedure will be the responsibility of the Participant.
- Services or supplies for personalization or characterization of dentures or bridges.
- Crowns to restore diseased or broken teeth when the tooth can be restored by a conventional type filling.
- Any expense arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which: (a) Benefits are provided or payable under any Workers' Compensation, Employer Liability Law or Occupational Disease Act or Law; or (b) the Participant would have been eligible for benefits under any Workers' Compensation, Employer Liability Law, or Occupational Disease Act or Law had such coverage been applied for.
- Any service related to: (a) Altering vertical dimension; (b) Restoration of occlusion; (c) Splinting teeth including multiple abutments or any service to stabilize periodontally weakened teeth; (d) Replacing tooth structures as a result of abrasions, attrition, or erosion; or (e) Bite registration or bite analysis.
- Missed appointment charges.
- Removal of asymptomatic third molars (wisdom teeth)
- Procedures done in conjunction with fixed complex implant retainer prosthetics.

Transition Health Benefits Plan Benefit Design

ANNUAL MAXIMUM	**$1,250**
DEDUCTIBLE	**$0**
DIAGNOSTIC Oral Exams, X-rays	**100%**
PREVENTIVE Cleanings, Fluoride Treatments, Sealants, Space Maintainers	**100%**
RESTORATIVE Amalgam & Composite Fillings	**80%**
CROWNS	**70%**
PROSTHODONTICS Full and Partial Dentures, Denture Relines and Repair, Fixed Bridgework	**70%**
ENDODONTICS Root Canals/Therapy	**70%**
PERIODONTICS* Scaling and Root Planning, Gingivectomy	**70%**
ORAL SURGERY* Surgical Extractions	**70%**
IMPLANTS	**50%**
ORTHODONTICS	
Lifetime Maximum	**$1,250**
Benefit	**50%**
To Age 19	
PREMIUM COST (Monthly	
Single	**$39.00**
Couple	**$78.00**
Family	**$119.00**

*Does not duplicate medical coverage.
Missing Tooth Exclusion: None.
Waiting Period. None.
Network dentist will provide an electronic toothbrush following the member's first cleaning appointment.

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CarePlus Dental Plans

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Benefits shall not include:

- Dental services not specifically described in the master Contract as a benefit.
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- The replacement of lost or stolen prosthetic devices or appliances, except as otherwise provided.
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- Treatment of temporomandibular joint (TMJ) dysfunction.
- Gold foil, gold or other precious metal restorations, except when used as a necessary functional material.
- Transplants, Orthodontics
- Dental Service or Emergency Service: (a) That would be furnished, without charge, to the Participant by any person or entity other than Care-Plus; (b) That the Participant would be entitled to have furnished or paid for, fully or partially, under any law, regulation or agency of any government; (c) That the Participant is entitled or would be entitled if he were enrolled, to have furnished or paid for under any voluntary medical or dental insurance plan established by any government if the master Contract were not in effect; (d) To the extent that Medicare is the Participant's primary payor, which it is, except where Medicare is secondary by law. Where Medicare is primary payor, no Benefits are available to the extent the Participant would have been entitled to Medicare benefits had the Participant enrolled in Medicare or complied with Medicare requirements; (e) For, or resulting from injuries, disease or conditions for which the Participant receives, or is the subject of, any award or settlement under a Worker's Compensation Act or any Employer Liability Law; (f) Rendered or furnished after the date the Participant ceases to be covered under this Contract, except for: (i) Procedures (other than prosthetic services) commenced prior to, and completed in one visit within thirty-one (31) days following termination of coverage; and (ii) Prosthetic devices that are ordered and fitted prior to, and completed within sixty (60) days following termination of coverage; or (g) Provided at a location other than the offices of the Primary Provider except for Emergency Service.
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- Reimbursement to the Participant or any dental office for the cost of Dental Services provided by Dentists, other than the Primary Provider, unless expressly authorized in writing by the Primary Provider or due to an emergency.
- Out of Area Services, unless due to an Emergency and then covered only to the extent of the Emergency Service benefit.
- Dental Service and Emergency Service received from a dental or medical department maintained on behalf of an employer, a mutual benefit association, a labor union, academic institution, trustee or similar person or group.
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