StaffScapes
Human Resource Solution Center

Dental Insurance

HUMANA DENTAL

Introducing StaffScapes Dental Plans

StaffScapes offers employees a selection between two unique and useful plans which will benefit your entire family. Both plans utilize the widespread Humana network, have no waiting periods, and offer different price points which can best suited for every budget.

Humana PPO Dental Plan

The Humana PPO plan is what most people will think of as traditional dental insurance. The monthly premiums are more, but aside from low deductibles, you will pay less out of pocket at your regular dental appointments. The PPO Plan covers:

- 100% of Preventative Treatments;
- 100% of Basic Services;
- 60% of Major Services;
- $1500 Annual Maximum; and
- After you reach the annual maximum amount, you will receive 30 percent coinsurance on preventive, basic, and major services for the rest of the plan year. (Implants and orthodontia excluded.)

Employee Only:	**Employee & Spouse**	**Employee & Family**
$35.31/month	$75.83/month	$113.38/month

Alpha Dental Discount Plan

The Alpha Dental Plan is a discount plan which utilizes the same wide Humana Network as the PPO plan, but offers a substantial discount off fixed prices. The result is that the monthly premium is less, but there will be fees for services. The Alpha Dental Plan:

- Has no annual maximums;
- Covers many routine dental concerns (including orthodontia); and
- Specialty dental visits offered at a discount of 20% off

Employee Only:	**Employee & Spouse**	**Employee & Family**
$11.75/month	$21.75/month	$31.75/month

For questions or more detailed information, please do not hesitate to contact the StaffScapes Benefits Department at 303-466-7864.

HumanaDental PPO 09

HUMANA Specialty Benefits

COLORADO

StaffScapes

	If you use **IN-NETWORK** provider		If you use **OUT-OF-NETWORK** provider	
Calendar-year deductible (excludes orthodontia services)	**Individual** $50	**Family** $150	**Individual** $50	**Family** $150
Annual maximum (excludes orthodontia services)	$1,500 After you reach the annual maximum amount, you will receive 30 percent coinsurance on preventive, basic, and major services for the rest of the plan year. (Implants and orthodontia excluded.)			
Preventive services • Oral examinations • X-rays • Cleanings • Topical fluoride treatment (through age 14, one per calendar year) • Sealants (through age 14)	100% no deductible		100% no deductible of in-network fee schedule	
Basic services • Space maintainers (through age 14) • Emergency care for pain relief • Basic oral surgery services - basic extractions of erupted tooth or root • Fillings (amalgam, composite for anterior teeth) • Appliances for children (through age 14) • Prefabricated stainless steel crowns	100% after deductible		80% after deductible of in-network fee schedule	
Major services • Crowns • Inlays and onlays • Bridgework • Dentures • Denture relines and rebases • Denture repair and adjustments • Complex surgical extractions - surgical removal of erupted tooth, impacted tooth, and tooth roots • Implant • Periodontics • Endodontics (root canal)	60% after deductible		50% after deductible of in-network fee schedule	
Orthodontia	Orthodontia discount - Members can receive up to a 20 percent discount if they visit an orthodontist from the HumanaDental PPO Network and ask for the discount.			

Non-participating dentists can bill you for charges above the amount covered by your HumanaDental plan. To ensure you do not receive additional charges, visit a participating PPO Network dentist.

Waiting periods

Voluntary funding: 10+ enrolled employees

Enrollment type	Preventive	Basic	Major	Orthodontia
Initial enrollment, open enrollment and timely add-on	No	No	No	Not available
Late applicant [1]	No	12 months	12 months	Not available

[1] Late applicants not allowed with open enrollment option.

HumanaDental PPO 09

HUMANA
Specialty Benefits

Questions?

Simply call 1-800-233-4013 to speak with a friendly, knowledgeable Customer Care specialist, or visit **Humana.com**.

Feel good about choosing a HumanaDental plan

Make regular dental visits a priority

Regular cleanings can help manage problems throughout the body such as heart disease, diabetes, and stroke.* Your HumanaDental PPO plan focuses on prevention and early diagnosis, providing four exams and cleanings every calendar year: two regular and two periodontal.

* www.perio.org

Go to MyDentalIQ.com

Take a health risk assessment that immediately rates your dental health knowledge. You'll receive a personalized action plan with health tips. You can print a copy of your scorecard to discuss with your dentist at your next visit.

Tips to ensure a healthy mouth

- Use a soft-bristled toothbrush
- Choose toothpaste with fluoride
- Brush for at least two minutes twice a day
- Floss daily
- Watch for signs of periodontal disease such as red, swollen, or tender gums
- Visit a dentist regularly for exams and cleanings

Did you know that 74 percent of adult Americans believe an unattractive smile could hurt a person's chances for career success?* HumanaDental helps you feel good about your dental health so you can smile confidently.

* American Academy of Cosmetic Dentistry

Use your HumanaDental benefits

Find a dentist

With HumanaDental' s PPO plan, you can see any dentist. You save an average of 30 percent when you visit a dentist in HumanaDental' s PPO Network. To find a dentist in HumanaDental' s PPO Network, log on to **Humana.com** or call 1-800-233-4013.

Know what your plan covers

The other side of this page provides a summary of HumanaDental benefits. Your plan certificate describes in detail your HumanaDental benefits. You can find it on MyHumana, your personal page at **Humana.com** or call 1-800-233-4013.

See your dentist

Your HumanaDental identification card contains all the information your dentist needs to submit your claims. Be sure to share it with the office staff when you arrive for your appointment. If you don't have your card, you can print proof of coverage at **Humana.com**.

Learn what your plan paid

After HumanaDental processes your dental claim, you will receive an explanation of benefits or claims receipt. It provides detailed information on covered dental services, amounts paid, plus any amount you may owe your dentist. You can also check the status of your claim on MyHumana at **Humana.com** or by calling 1-800-233-4013.

HUMANA
Specialty Benefits

Insured or administered by HumanaDental Insurance Company

Plan summary created on: 4/15/13 14:07

Policy Number: CO-70090-HD 3/08 et.al.

Beta Health Alpha Dental Plan

HUMANA

Colorado

Feel good about choosing a HumanaDental plan

The Beta Health Alpha Dental Plan has you covered for any circumstance. Whether you need routine dental care or unexpected dental treatment, you know what to expect with HumanaDental.

- No waiting periods
- No claims to file
- No annual maximums

Use your HumanaDental benefits

After you enroll in a plan and receive your ID card, you can manage your plan information on your personal home page at **HumanaDental.com**.

- You have the freedom to select any participating general dentist as your primary care dentist. To select a dental provider from our network, simply call 1-800-233-4013 or visit **HumanaDental.com**. Once there, you can get a new or temporary ID card. For benefit information, contact us at 303-744-3007 (if calling from within Denver) or 1-800-807-0706 (if calling from outside of Denver).
- Life without claim forms! With the Beta Health Alpha Dental Plan you pay your dentist directly, when applicable.
- Your primary dentist will provide all of your routine dental care and any copayment or discounted charges will be paid at the time of service.
- If you need a specialty dentist, you'll receive up to a 20 percent discount by using one of the participating specialty dentists from our network.

Questions?

Check out HumanaDental.com

Call 303-744-3007 (if calling from within Denver) or 1-800-807-0706 (if calling from outside of Denver) anytime for the automated information line or 8 a.m. to 6 p.m. for a Customer Care specialist.

Good health starts with a healthy mouth

Make dental visits a priority

One of the first lines of defense in overall health is dental care. Regular dental cleanings can help manage problems throughout the body, such as heart disease, diabetes, and stroke. In fact, a healthy mouth can add 6.4 years to RealAge® life expectancy.[1] The Beta Health Alpha Dental Plan enables you to take better care of your teeth, and you'll pay less for your dental care doing so.

Go to MyDentalIQ.com

Take a health risk assessment that immediately rates your dental health knowledge. You'll receive a personalized action plan with health tips. You can print a copy of your scorecard to discuss with your dentist at your next visit.

Tips to ensure a healthy mouth

- Use a soft-bristled toothbrush
- Choose toothpaste with fluoride
- Brush for at least two minutes twice a day
- Floss daily
- Watch for signs of periodontal disease such as red, swollen, or tender gums
- Visit a dentist regularly for exams and cleanings

[1] Dr. Michael Roizen, RealAge.com

Beta Health Alpha Dental Plan

The Beta Health Alpha Dental Plan focuses on maintaining oral health, prevention and cost-containment. Members may see a primary care dentist as often as necessary. There are no yearly maximums, no deductibles to meet and no waiting periods. Beta Health Alpha plan copayments for listed procedures are applicable at a participating general dentist.

Member costs listed here are for services provided by a chosen participating primary care dentist (PCD) only. A PCD may decide that a member needs to see a contracted dental specialist. No referral is necessary to see a network specialist.

Specialists services: Should members need a specialist, (i.e., endodontist, oral surgeon, periodontist, pediatric dentist), they may be referred by a participating general dentist, or members can self-refer to any participating specialist. Members will receive up to a 20 percent discount by visiting a participating specialist.

Summary of services

Services marked with a single asterisk (*) below also require separate payment of an allowable $151 laboratory fee (per unit). The laboratory charges must be paid to the Plan Dentist in addition to any applicable copayment for the service. Temporary crowns are included with permanent crown preparation.

Diagnostic (Exams and x-rays)		**member pays**
D0999	Routine office visit	$ 5.00
D0120	Periodic oral evaluation	no charge
D0140	Limited oral evaluation—problem focused.	$ 15.00
D0150	Comprehensive oral evaluation—new or established patient	$ 12.00
D0210	X-ray intraoral—complete series including bitewings	$ 29.00
D0220	X-ray intraoral—periapical, first film	$ 6.00
D0230	X-ray intraoral—periapical, each additional film	$ 5.00
D0240	X-rays intraoral—occlusal film	$ 5.00
D0250	X-ray extraoral—first film	$ 5.00
D0260	X-ray extraoral—each additional film	$ 5.00
D0270	X-ray bitewing—single film	no charge
D0272	X-ray bitewings—two films	no charge
D0274	X-ray bitewings—four films.	no charge
D0330	X-ray panoramic film.	$ 49.00
D0340	Cephalometric film	$ 60.00
D0460	Pulp vitality test.	no charge
D0470	Diagnostic casts	$ 49.00
D0999	Emergency visit (same day)	$ 25.00

Preventive (Cleanings)		**member pays**
D1110	Prophylaxis—adult cleaning (every six months)	$ 15.00
D1120	Prophylaxis—child cleaning (every six months).	$ 15.00
D1203	Topical application of fluoride not including prophylaxis—child.	$ 11.00
D1330	Oral hygiene instructions.	no charge
D1351	Sealant—per tooth	$ 12.00
D1510	Space maintainer—fixed, unilateral	$173.00
D1515	Space maintainer—fixed, bilateral	$250.00
D1520	Space maintainer—removable, unilateral.	$213.00
D1525	Space maintainer—removable, bilateral.	$246.00
D1550	Recementation of space maintainer	$ 17.00
D1999	Additional prophy (for perio maintenance)	$ 41.00

Restorative Services (Fillings, crowns, inlays and onlays)		**member pays**
D2140	Amalgam—one surface, primary or permanent	$ 33.00
D2150	Amalgam—two surfaces, primary or permanent	$ 44.00
D2160	Amalgam—three surfaces, primary or permanent	$ 54.00
D2161	Amalgam—four or more surfaces, primary or permanent	$ 63.00
D2330	Resin based composite—one surface, anterior	$ 45.00
D2331	Resin based composite—two surfaces, anterior	$ 58.00
D2332	Resin based composite—three surfaces, anterior	$ 77.00
D2335	Resin based composite—four or more surfaces or involving incisal angle (anterior)	$124.00
D2390	Resin based composite crown, anterior	$262.00
D2391	Resin based composite—one surface, posterior	$ 98.00
D2392	Resin based composite—two surfaces, posterior	$135.00
D2393	Resin based composite—three surfaces, posterior	$172.00
D2394	Resin based composite—four or more surfaces, posterior	$188.00
D2510*	Inlay—metallic, one surface	$299.00
D2520*	Inlay—metallic, two surfaces.	$309.00
D2530*	Inlay—metallic, three or more surfaces	$327.00
D2542*	Onlay—metallic, two surfaces	$332.00
D2543*	Onlay—metallic, three surfaces	$343.00
D2544*	Onlay—metallic, four or more surfaces	$352.00
D2610*	Inlay—porcelain/ceramic, one surface	$318.00
D2650*	Inlay—resin based composite, one surface	$306.00
D2651*	Inlay—resin based composite, two surfaces.	$314.00
D2652*	Inlay—resin based composite, three or more surfaces	$328.00
D2710*	Crown—resin based composite, indirect	$319.00
D2720*	Crown—resin with high noble metal.	$375.00
D2721*	Crown—resin with predominantly base metal	$340.00
D2722*	Crown—resin with noble metal.	$346.00
D2740*	Crown—porcelain/ceramic substrate	$395.00
D2750*	Crown—porcelain fused to high noble metal	$384.00
D2751*	Crown—porcelain fused to predominantly base metal	$315.00
D2752*	Crown—porcelain fused to noble metal	$370.00
D2790*	Crown—full cast high noble metal	$366.00
D2791*	Crown—full cast predominantly base metal	$318.00
D2792*	Crown—full cast noble metal	$345.00
D2910	Recement inlay, onlay, or partial coverage restoration	$ 15.00
D2920	Recement crown.	$ 31.00
D2930	Prefabricated stainless steel crown—primary tooth	$101.00
D2931	Prefabricated stainless steel crown—permanent tooth.	$123.00
D2932	Prefabricated resin crown	$157.00
D2933	Prefabricated stainless steel crown with resin window	$179.00
D2940	Sedative filling	$ 37.00
D2950	Core buildup, including any pins.	$ 82.00
D2951	Pin retention—per tooth, in addition to restoration	$ 23.00
D2952	Cast post and core in addition to crown	$134.00
D2954	Prefabricated post and core in addition to crown	$107.00
D2955	Post removal (not in conjunction with endodontic therapy)	$139.00
D2960	Labial veneer (resin laminate)—chairside	$187.00
D2999	Bleaching (per arch) ($125 additional charge per unit for multiple crown units—complex rehabilitation)	$162.00

Endodontic Services (Root canals)		**member pays**
D3110	Pulp cap—direct (excluding final restoration)	$ 26.00
D3120	Pulp cap—indirect (excluding final restoration)	$ 27.00
D3220	Therapeutic pulpotomy excluding final restoration	$ 72.00
D3230	Pulpal therapy—anterior, primary tooth (excluding restoration)	$102.00
D3240	Pulpal therapy—posterior, primary tooth (excluding restoration)	$113.00
D3310	Root canal therapy—one canal (excluding final restoration)	$275.00
D3320	Root canal therapy—two canals (excluding final restoration)	$320.00
D3330	Root canal therapy—three canals or more	$400.00
D3410	Apicoectomy/periradicular surgery—anterior	$328.00
D3421	Apicoectomy/periradicular surgery—bicuspid (first root)	$366.00
D3425	Apicoectomy/periradicular surgery—molar (first root)	$424.00
D3426	Apicoectomy/periradicular surgery (each additional root)	$161.00
D3430	Retrograde filling—per root	$116.00
D3910	Surgical procedure for isolation of tooth with rubber dam	$64.00

Periodontic Services (Gum disease)		**member pays**
D4210	Gingivoplasty or gigivectomy—four or more contiguous or bounded teeth spaces per quadrant	$333.00
D4211	Gingivoplasty or gigivectomy—one to three contiguous or bounded teeth spaces per quadrant	$178.00
D4240	Gingival flap, including root planing—four or more contiguous or bounded teeth spaces per quadrant	$352.00
D4260	Osseous surgery including flap entry and closure—four or more contiguous or bounded teeth spaces per quadrant	$521.00
D4320	Provisional splinting—intracoronal	$260.00
D4321	Provisional splinting—extracoronal	$246.00
D4341	Periodontal scaling and root planing—four or more teeth per quadrant	$112.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$ 89.00
D4910	Periodontal maintenance	$ 57.00
D4999	Periodontal screening and scoring	$ 10.00

Prosthodontics (Removable/Complete Dentures, etc.)		**member pays**
D5110	Complete denture—maxillary	$533.00
D5120	Complete denture—mandibular	$533.00
D5130	Immediate denture—maxillary	$764.00
D5140	Immediate denture—mandibular	$778.00
D5211	Maxillary partial denture—resin base (including clasps and teeth)	$463.00
D5212	Mandibular partial denture—resin base (including clasps and teeth)	$442.00
D5213	Maxillary partial denture—cast metal framework, resin denture bases (including clasps and teeth)	$547.00
D5214	Mandibular partial denture—cast metal framework, resin denture bases (including clasps and teeth)	$545.00
D5410	Adjust complete denture—maxillary	$ 36.00
D5411	Adjust complete denture—mandibular	$ 36.00
D5421	Adjust partial denture—maxillary	$ 36.00
D5422	Adjust partial denture—mandibular	$ 36.00
D5510	Repair broken complete denture base	$ 88.00
D5520	Replace missing or broken teeth—complete denture (each tooth)	$ 62.00
D5610	Repair resin denture base	$ 82.00
D5620	Repair cast framework	$139.00
D5630	Repair or replace broken clasp	$105.00
D5640	Replace broken teeth—per tooth	$ 68.00
D5650	Add tooth to existing partial denture	$ 93.00
D5660	Add clasp to existing partial denture	$121.00
D5710	Rebase complete maxillary denture	$276.00
D5711	Rebase complete mandibular denture	$276.00
D5720	Rebase maxillary partial denture	$230.00
D5721	Rebase mandibular partial denture	$231.00
D5730	Reline complete mandibular denture (chairside)	$175.00
D5731	Reline complete mandibular denture (chairside)	$175.00
D5740	Reline maxillary partial denture (chairside)	$167.00
D5741	Reline mandibular partial denture (chairside)	$167.00
D5750	Reline complete maxillary denture (laboratory)	$155.00
D5751	Reline complete mandibular denture (laboratory)	$155.00
D5760	Reline maxillary partial denture (laboratory)	$158.00
D5761	Reline mandibular partial denture (laboratory)	$157.00
D5850	Tissue conditioning, maxillary	$ 66.00
D5851	Tissue conditioning, mandibular	$ 65.00

NOTE: In addition to the fees listed above in section 5000 through 6000, additional fees may be charged for upgraded teeth and enhanced cosmetics, personalization beyond norm or techniques involving precision dentures.

Prosthodontics (Fixed/Partial Dentures, etc.)		**member pays**
D6210*	Pontic—cast high noble metal	$359.00
D6211*	Pontic—cast predominantly base metal	$303.00
D6212*	Pontic—cast noble metal	$320.00
D6240*	Pontic—porcelain fused to high noble metal	$383.00
D6241*	Pontic—porcelain fused to predominantly base metal	$312.00
D6242*	Pontic—porcelain fused to noble metal	$331.00
D6750*	Crown—porcelain fused to high noble metal	$345.00
D6251*	Crown—porcelain fused to predominantly base metal	$323.00
D6252*	Pontic—resin with noble metal	$325.00
D6720*	Crown—resin with high noble metal	$380.00
D6721*	Crown—resin with predominantly base metal	$344.00
D6722*	Crown—resin with noble metal	$352.00
D6750*	Crown—porcelain fused to high noble metal	$384.00
D6751*	Crown—porcelain fused to predominantly base metal	$315.00
D6752*	Crown—porcelain fused to noble metal	$335.00
D6790*	Crown—full cast high noble metal	$359.00
D6791*	Crown—full cast predominantly base metal	$323.00
D6792*	Crown—full cast noble metal	$330.00
D6930	Recement fixed partial denture	$ 69.00

Oral Surgery (Extractions, etc.)		**member pays**
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$ 46.00
D7210	Surgical extraction—erupted tooth with removal of bone	$ 81.00
D7220	Removal of impacted tooth—soft tissue	$ 92.00
D7230	Removal of impacted tooth—partially bony	$163.00
D7240	Removal of impacted tooth—completely bony	$210.00
D7241	Removal of impacted tooth—completely bony with unusual surgical complication	$248.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	$118.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$243.00
D7280	Surgical access of an unerupted tooth	$235.00
D7285	Biopsy of oral tissue—hard (bone, tooth)	$217.00
D7286	Biopsy of oral tissue—soft	$150.00
D7310	Alveoloplasty in conjunction with extractions—per quadrant	$126.00
D7320	Alveoloplasty not in conjunction with extractions—per quadrant	$195.00
D7510	Incision and drainage of abscess—intraoral soft tissue	$ 99.00
D7910	Suture of recent small wounds up to 5 cm	no charge
D7960	Frenulectomy (frenectomy or frenotomy)—separate procedure	$128.00
D7970	Excision hyperplastic tissue—per arch	$207.00

General miscellaneous services		**member pays**
D9110	Palliative (emergency) treatment of dental pain—minor procedure	$ 48.00
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide—first 30 minutes	$ 27.00
D9310	Consultation—diagnostic services provided by dentist or physician other than practioner providing treatment	no charge
D9910	Application of desensitizing medicament	$ 6.00
D9941	Fabrication of athletic mouthguard	$107.00
D9951	Occlusal adjustment—limited	$ 77.00
D9952	Occlusal adjustment—complete	$286.00
D9999	Missed appointment (without 24 hour notice)	$ 30.00

Orthodontics (Braces)
for Children & Adults (Monthly Payment) **member pays**

13 month treatment plan ($137/month)	$2,409.00
16 month treatment plan ($137/month)	$2,820.00
19 month treatment plan ($137/month)	$3,231.00
22 month treatment plan ($137/month)	$3,642.00
25 month treatment plan ($137/month)	$4,053.00
28 month treatment plan ($137/month)	$4,464.00
31 month treatment plan ($137/month)	$4,875.00
34 month treatment plan ($137/month)	$5,286.00
36 month treatment plan ($137/month)	$5,560.00

Other Orthodontic Guidelines

1. A $382 charge will apply at the end of treatment (included in the above amounts) to cover all retention office visits (unlimited).
2. Services not listed above will be discounted 30% off of the participating Orthodontist's Usual and Customary fees (except #5 listed below).
3. Services must only be provided by a contracted Orthodontic Specialist.
4. The amounts listed above also include an initial one-time $246 charge for all records, mold, x-rays, etc. to determine the Orthodontic Treatment for the patient.
5. Invisalign® procedures are to be discounted 15% off the participating Orthodontist's Usual and Customary fees.

NOTE:

- Not all participating dentists perform all listed procedures, including amalgams. Please consult your dentist prior to treatment for availability of services.
- Some covered services are typically only offered by a specialist (like many oral surgery procedures)
- Additional exclusions and limitations are listed along with full plan information in your certificate of benefits

All Plans General Limitations and Exclusions

1. All fees listed above do not include all appropriate lab fees. Member must agree (in writing) to all upgraded materials before treatment is started. See each section for specific details (if applicable).
2. All patients are responsible for paying all fees (as listed above) at the time services are rendered.
3. These fees are for General Dentists only. A participating specialist list is available by calling our office at 303-744-3007 or 1-800-807-0706.
4. Any procedures not listed will be discounted 20% off the participating General Dentists normal fees.
5. Medical costs associated with any dental procedures are not covered.
6. Dentures or appliances will be replaced only after 3 years have elapsed since such dentures or appliances were provided under any plan program, unless the denture or appliance becomes unserviceable due to illness or other causes not controlled by other means. Replacement of dentures, appliances, or bridgework due to loss or theft are not covered.
7. Any dental treatment started prior to the Member's eligibility to receive services under this plan or started after a Member's termination are not covered.
8. Failure to follow the prescribed treatment or accidents occurring during the course of treatment may result in additional charges by your plan provider.
9. Failure to pay scheduled fees at the time service is rendered may prevent future dental services from being received until all fees have been paid in full.
10. Services provided by non-participating dentists are not covered.
11. Services which, in the opinion of the attending dentist, are not necessary for the patient's dental health, or are contrary to established dental ethics are not covered.
12. Cosmetic dental procedures are covered only if the attending dentist and patient agree on the specific procedure.
13. Services which are compensable under Worker's Compensation or employer liability laws are not covered.
14. General anesthesia and IV sedation are not covered.
15. Myofunctional therapy procedure for training, treating or developing muscles in and around the jaw or mouth including TMJ are not covered except by participating plan specialists.
16. Any dental procedure or service that cannot be performed in the dental office due to general and/or physical limitations of a member are not covered.
17. Expenses incurred for dental procedures initiated prior to member's eligibility or after termination are not covered.
18. Any services that the Participating General Dentist recommends be performed by a specialist are covered only by a plan participating specialist.
19. The liability of Beta Health Association, Inc. is limited to the return of the membership fees paid for one year by the member.
20. Extractions for asymptomatic third molars (wisdom teeth) are not covered unless causing movement of the teeth. An example of symptomatic include severe decay, and ontogenic cysts, chronic pericoronitis, and infection.
21. The Beta Health Association, Inc. dental programs do not constitute dental insurance and are considered discount, fee-for-service dental plans.
22. Fees are subject to change on an as needed basis. Please contact Beta Health Association, Inc. for current fees.

HUMANA®

BETA HEALTH ASSOCIATION, INC.
"Dental Plan Specialists Since 1990"

Insured or administered by Beta Health Assocation, Inc. CO-52439-HD 11/11

Humana Large Group Employee Enrollment Form

The offering company(ies) listed on the signature page, severally or collectively, as the content may require, are referred to in this application as "Humana". Print clearly and completely fill in each applicable circle.

Company name: StaffScapes, Inc.

Company city

State: CO

Office use only

Qualifying event:
❍ Open Enrollment ❍ Re-hire
❍ New hire ❍ Changed to full time status

Qualifying event date (MM/DD/YYYY) / /

Benefit effective date (MM/DD/YYYY) / /

Employee information

Last name

First name

MI

Social security number – –

Date of birth (MM/DD/YYYY) / /

Area code ( )

Phone number –

Street address

Apt / Suite / PO box number

Gender ❍ Female ❍ Male

Language of choice ❍ English ❍ Spanish

City

State

Zip code

County / Parish

E-mail address

Employment state ❍ Full-time employee ❍ Retiree

Date of full-time hire (MM/DD/YYYY) / /

Are you disabled or unable to perform normal work activities? ❍ No ❍ Yes If yes, indicate reason: _____

Dependent information

Enter information for each covered dependent, including spouse.

1

Dependent last name

First name

MI

Gender ❍ Female ❍ Male

Social security number – –

Date of birth (MM/DD/YYYY) / /

Relationship ❍ Spouse ❍ Child ❍ Other:_____

Dependent status (if applicable): ❍ Full-time student (18 or older) ❍ Disabled If disabled, indicate reason: _____

2

Dependent last name

First name

MI

Gender ❍ Female ❍ Male

Social security number – –

Date of birth (MM/DD/YYYY) / /

Relationship ❍ Spouse ❍ Child ❍ Other:_____

Dependent status (if applicable): ❍ Full-time student (18 or older) ❍ Disabled If disabled, indicate reason: _____

3

Dependent last name

First name

MI

Gender ❍ Female ❍ Male

Social security number – –

Date of birth (MM/DD/YYYY) / /

Relationship ❍ Spouse ❍ Child ❍ Other:_____

Dependent status (if applicable): ❍ Full-time student (18 or older) ❍ Disabled If disabled, indicate reason: _____

Last name: | First name:

4 Dependent last name | First name | MI | Gender ❍ Female ❍ Male

Social security number – – | Date of birth (MM/DD/YYYY) / / | Relationship ❍ Spouse ❍ Child ❍ Other:_____

Dependent status (if applicable): ❍ Full-time student (18 or older) ❍ Disabled If disabled, indicate reason: _____

Use the following alternate address for these dependents: ❍ 1 ❍ 2 ❍ 3 ❍ 4

Street address

Apt / Suite / PO box number

City | State | Zip code | County / Parish

Dental

Coverage type:
❍ Employee only
❍ Employee & spouse
❍ Family
❍ Employee & child(ren)
❍ Other: _____

Office use only
Group # | Benefit # | Class/Div #

If choosing Beta Health Alpha Plan, please indicate Primary Care Dentist # and Name below

Plan name Humana Dental or Beta Health Alpha Plan (Circle One)

- Within the past 12 months, have you or any covered family member had any dental or orthodontia coverage, such as a spouse's dental coverage?

❍ Yes ❍ No If yes, list all: (This section must be completed for Humana to process any dental claims)

Current dental carrier name: | Orthodontia coverage? ❍ Yes ❍ No | Starting date (MM/DD/YYYY) / / | End date, if applicable (MM/DD/YYYY) / /

Covered member (check all that apply) ❍ Employee ❍ Spouse ❍ Child(ren)

Prior dental carrier name: | Orthodontia coverage? ❍ Yes ❍ No | Starting date (MM/DD/YYYY) / / | End date, if applicable (MM/DD/YYYY) / /

Covered member (check all that apply) ❍ Employee ❍ Spouse ❍ Child(ren)

Waiver (refusal of coverage)

I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through my employer. I proclaim that I was not pressured or forced by my employer, the writing agent, or Humana into waiving (declining) coverage. If I have waived any coverage offered to me or my dependents, my signature below is evidence of this action.

I hereby waive coverage for (check all that apply):

Dental for: ❍ Myself ❍ My spouse ❍ My dependent child(ren)

I decline to apply for group coverage because of:
❍ Spousal coverage
❍ Medicare supplement
❍ Individual coverage
❍ Coverage under another carrier's plan provided by my employer
❍ Other: _____

Last name: | First name:

Insuring companies — COLORADO

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in this application as "Humana".
Medical and Life plans insured or administered by Humana Insurance Company.
HMO plans offered by Humana Health Plan, Inc. and insured by Humana Insurance Company.
Dental plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company.
Vision plan insured and administered by CompBenefits Insurance Company.

True and complete acknowledgement

I understand, agree and represent:

- I have read this document or it has been read to me and answers provided are true and complete to the best of my knowledge and belief.
- Neither my employer nor the agent can waive any question, determine coverage or insurability, alter any contract or waive any of Humana's other rights and requirements.
- If this application for coverage is accepted, coverage will be effective on the date specified by Humana on the certificate of coverage/ certificate of insurance. If I have a new dependent as a result of a qualifying event, I may in the future be able to enroll myself or my dependents provided I request enrollment with in 31 days after the qualifying event.
- In the event that I should decide to apply for coverage hereafter, that subsequent application shall be subject to the applicable terms and conditions of the master group contract(s) or plan provisions which may require additional limitations and waiting periods.
- I may be required to furnish, at my own expense, evidence of health status satisfactory to Humana.
- If I am declining coverage for myself or my dependents (including my spouse) because of other coverage, I may in the future be able to enroll myself or my dependents provided that I request enrollment within 31 days after my other coverage ends.
- Humana reserves the right to delay medical coverage and/or deny life or dental coverage with any future application for coverage.
- If any deductions are required for this coverage, I authorize those deductions from my earnings. If selecting the Health Savings Account (HSA), I authorize Humana or its banking partners to provide my account number to my employer for the purposes of depositing any contributions.
- Any misrepresentation contained herein relied on by Humana may be used to reduce or deny a claims or void the contract within the contestable period if such misrepresentation materially affected the acceptance of the risk.
- It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall by reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Authorization

I authorize any third party to have information regarding myself. This includes any medical or non-medical information and to share any and all such information with Humana, its reinsurer or its legal representatives, and its affiliates.

My dependents and I understand and agree:

- The information obtained by use of this authorization may be used by Humana to make claims determinations, determine eligibility for coverage, eligibility for benefits under an existing policy and plan administration.
- Any information obtained will not be released by Humana to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc. or other persons or organizations performing health care operations or business or legal services in connection with an application, claim or as may be otherwise lawfully required, or as I (we) may further authorize. Once personal and health (including medical, dental and pharmacy) information is disclosed pursuant to this authorization, the recipient may redisclose it and the information may not be protected by federal and state privacy requirements.
- A photographic copy of this authorization shall be as valid as the original.
- This authorization shall be valid for two years from the date shown below and I have the right to revoke this authorization at any time by writing to Humana's Privacy office.

This document, together with any supplements, will form part of any contract and be the basis for any certificate of coverage/certificate of insurance issued.

Signature - Please sign below if enrolling or waiving any group coverage

Employee or legal representative signature _____ Date ___ / ___ / ____

Name and relationship of legal representative _____