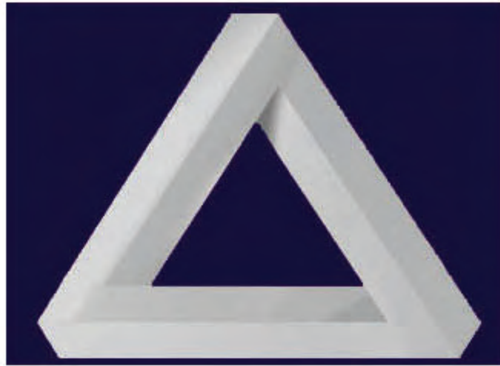
TripleChoicePlan

Exclusive Dental Packages by AmeriChoice



DENTAL • VISION • ORTHODONTIA

BENEFITS INFORMATION

Dear Broker:

Thank you for allowing *TripleChoicePlan* the opportunity to present multiple plan. We welcome the chance to show you how we can meet and exceed your client's expectations with our complete dental benefit solutions.

Our prepaid dental plans, offered through Dental Health Services or California Benefits Dental Plan, allow your client to take advantage of incredible savings on their dental benefits, while affording them access to a network of Quality Assured participating dentists. In combination with the DHMO Carriers, *TripleChoicePlan* offers three different PPO Carriers selections as follows:

- **Madison National Life (MNL)** — provides a large network and expanded dentist choice through the "First Dental Health" network.
- **Security Life (SLICA)**— provides a large network and expanded dentist choice through the "PPO USA" network.
- **Sun Life Financial (SLF)**— provides a large network and expanded dentist choice through the "First Dental Health" network.

The carriers above offer your client PPO, EPO and DHMO combinations as well as Dental, Vision and Orthodontia, hence the name "TripleChoicePlan".

If you have any questions or would like additional information, please feel free to contact me at (310) 470-2343 x150 or lkent@triplechoiceplan.com. I look forward to discussing the enclosed material at your convenience.

Sincerely,

Lawrence V. Kent

Lawrence V. Kent
President & Founder

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TripleChoicePlan

DHMO (Prepaid)
Plan Options, Designs and Features

Dental Health Services
DHMO Plan Options

	GOLD PLAN with orthodontia		SILVER PLAN with orthodontia		BRONZE PLAN with orthodontia	
	Without Vision	With Vision	Without Vision	With Vision	Without Vision	With Vision
Single	13.70	17.95	11.70	15.95	8.85	13.10
Couple	28.45	32.70	22.70	26.95	18.60	22.85
Single + Child(ren)	27.05	31.30	21.60	25.85	17.60	21.85
Family	39.65	43.90	32.45	36.70	26.80	31.05

- Rates are guaranteed 24 months from the proposed effective date of the proposed effective date.
- Plans only available in the State of California.
- Rates are subject to revision if this proposal is not accepted by the proposed effective date, or if actual enrollment varies more than 10% from the census data submitted and no longer meets underwriting expectations

Covered services and copayments

The following list includes a sampling of the most commonly used covered services and their copayments, when performed by a Dental Health Services general dentist. A complete list is included with this proposal.

Procedure	Gold Plan	Silver Plan	Bronze Plan
Office visits	4.00	4.00	4.00
Emergency treatment - palliative	25.00	25.00	10.00
Comprehensive oral evaluation	None	None	None
Full mouth x-rays, including bitewings	None	None	None
Teeth cleaning, with topical fluoride	None	None	5.00
Sealant - per tooth	None	None	5.00
Amalgam filling - two surfaces	None	14.00	23.00
Resin-based composite restoration - two surfaces, anterior	None	18.00	25.00
Porcelain crown fused to base metal	85.00	145.00	230.00
Root canal therapy - anterior	55.00	90.00	145.00
Periodontal scaling and root planing - per quadrant	2.00	15.00	40.00
Extraction of an erupted tooth or exposed root	None	15.00	25.00
Surgical removal of an erupted tooth	5.00	35.00	75.00
Specialty coverage	Yes	Yes	Yes*

* Increased copayments may apply for specialty procedures

Detailed benefit summaries available upon request

California Benefits Dental Plan

California Benefits Dental Plan
DHMO Plan Options

	GOLD PLAN with orthodontia		SILVER PLAN with orthodontia		BRONZE PLAN with orthodontia	
	Without Vision	With Vision	Without Vision	With Vision	Without Vision	With Vision
Single	13.70	17.95	11.70	15.95	8.85	13.10
Couple	28.45	32.70	22.70	26.95	18.60	22.85
Single + Child(ren)	27.05	31.30	21.60	25.85	17.60	21.85
Family	39.65	43.90	32.45	36.70	26.80	31.05

- Rates are guaranteed 24 months from the proposed effective date of the proposed effective date.
- Plans only available in the State of California.
- Rates are subject to revision if this proposal is not accepted by the proposed effective date, or if actual enrollment varies more than 10% from the census data submitted and no longer meets underwriting expectations

Covered services and copayments

The following list includes a sampling of the most commonly used covered services and their copayments, when performed by a California Benefits Dental Plan general dentist. A complete list is included with this proposal.

Procedure	**Gold Plan**	**Silver Plan**	**Bronze Plan**
Initial Office visit (One time only)	5.00	8.00	5.00
Emergency oral examination	6.00	None	10.00
Periodic oral evaluation	None	None	None
Full mouth x-rays, including bitewings	None	None	None
Teeth cleaning, with topical fluoride	None	None	None
Sealant - per tooth	5.00	None	10.00
Amalgam filling - two surfaces, primary	None	5.00	18.00
Resin-based composite restoration - two surfaces, anterior	20.00	28.00	28.00
Crown - Porcelain fused to metal (not for molars)	150.00	156.00	165.00
Root canal therapy - one canal (excluding final restoration)	55.00	80.00	100.00
Periodontal scaling and root planing - per quadrant	50.00	60.00	38.00
Extraction - Single tooth (includes local anesthesia)	5.00	10.00	15.00
Extraction - Surgical (includes local anesthesia)	15.00	30.00	40.00
Emergency office visit - after regularly scheduled hours	20.00	20.00	15.00

Detailed benefit summaries available upon request

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PPO / EPO
Plan Options, Designs and Features

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Madison National - EPO/PPO Plan Options

EPO Plans

	Plan Option A	Plan Option B	Plan Option C
	In-Network	In-Network	In-Network
Preventive	100%	100%	100%
Diagnostic	100%	100%	100%
Basic	90%	80%	80%
Major	60%	50%	50%
Deductible	$50 *	$50 *	$50
Annual Maximum	$2,000	$1,500	$1,000

* Waived for preventive and diagnostic services

PPO Plans

	Plan Option 1		Plan Option 2		Plan Option 3	
	In-Network	Out-Of-Network	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Preventive	100%	100%	100%	100%	100%	80%
Diagnostic	100%	100%	100%	100%	100%	80%
Basic	90%	80%	80%	80%	80%	80%
Major	60%	50%	50%	50%	50%	50%
Deductible	$50 *	$50 *	$50 *	$50 *	$50 *	$100 *
Annual Maximum	$2,000	$2,000	$1,500	$1,500	$1,000	$1,000

* Waived for preventive and diagnostic services

- Endo and Perio (Prophylaxis Scaling) are paid as Basic Benefits on all PPO and EPO Plans.
- In-Network Benefits available when using the “First Dental Health” PPO and EPO Networks
- Out-Of-Network Benefits Paid at the 80th Percentile on PPO Plans 1, 2 and 3.
- A minimum of 5 employees are required to enroll on the PPO and/or EPO plans when combined with our DHMO products..
- Choice of one PPO and/or one EPO combination alongside any or all of the DHMO offerings.

(For Groups of 15 or more CA eligible employees)

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Security Life - PPO Plan Options

"In-Network" PPO Plans

	Plan Option A	Plan Option B	Plan Option C
	In-Network	In-Network	In-Network
Preventive	100%	100%	100%
Diagnostic	100%	100%	100%
Basic	90%	80%	80%
Major	60%	50%	50%
Deductible	$50 *	$50 *	$50
Annual Maximum	$2,000	$1,500	$1,000

* Waived for preventive and diagnostic services

"In & Out-of-Network" PPO Plans

	Plan Option 1		Plan Option 2		Plan Option 3	
	In-Network	Out-Of-Network	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Preventive	100%	100%	100%	100%	100%	80%
Diagnostic	100%	100%	100%	100%	100%	80%
Basic	90%	80%	80%	80%	80%	80%
Major	60%	50%	50%	50%	50%	50%
Deductible	$50 *	$50 *	$50 *	$50 *	$50 *	$100 *
Annual Maximum	$2,000	$2,000	$1,500	$1,500	$1,000	$1,000

* Waived for preventive and diagnostic services

- Endo and Perio (Prophylaxis Scaling) are paid as Basic Benefits on all PPO Plans.
- Out-Of-Network Benefits Paid at the 80th Percentile on PPO Plans 1, 2 and 3v.
- A minimum of 5 employees are required to enroll on the "In-Network" PPO and/or the "In & Out-of-Network" PPO plans when combined with our DHMO products..
- Choice of one "In-Network" PPO and/or one "In & Out-of-Network" PPO combination alongside any or all of the DHMO offerings.

(For Groups of 10 or more eligible employees)

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Sun Life Financial - PPO Plan Options

“In-Network” PPO Plans

	Plan Option A	Plan Option B	Plan Option C
	In-Network	In-Network	In-Network
Preventive	100%	100%	100%
Diagnostic	100%	100%	100%
Basic	90%	80%	80%
Major	60%	50%	50%
Deductible	$50 *	$50 *	$50
Annual Maximum	$2,000	$1,500	$1,000

* Waived for preventive and diagnostic services

“In & Out-of-Network” PPO Plans

	Plan Option 1		Plan Option 2		Plan Option 3	
	In-Network	Out-Of-Network	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Preventive	100%	100%	100%	100%	100%	80%
Diagnostic	100%	100%	100%	100%	100%	80%
Basic	90%	80%	80%	80%	80%	80%
Major	60%	50%	50%	50%	50%	50%
Deductible	$50 *	$50 *	$50 *	$50 *	$50 *	$100 *
Annual Maximum	$2,000	$2,000	$1,500	$1,500	$1,000	$1,000

* Waived for preventive and diagnostic services

- Endodontics and Periodontics are paid as Basic Benefits on all PPO Plans.
- Out-Of-Network Benefits Paid at the 80th Percentile on PPO Plans 1, 2 and 3.
- A minimum of 5 employees are required to enroll on the “In-Network” PPO and/or the “In & Out-of-Network” PPO plans when combined with our DHMO products..
- Choice of one “In-Network” PPO and/or one “In & Out-of-Network” PPO combination alongside any or all of the DHMO offerings.

(For Groups of 10 or more eligible employees)

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PPO / EPO Benefit Plans (Covered Procedures)

Preventive and Diagnostic Care

- Routine exams (once per 6 months)
- Teeth Cleaning (once per 6 months)
- Fluoride treatments
- Bitewing x-rays (on set every six months)
- Full mouth/panoramic x-rays (once every 48 months)
- Sealants

Basic Care

- Emergency exams (subject to Routine exam frequency limit)
- Fillings and stainless steel crowns
- Simple oral surgery
- Complex oral surgery (includes extraction of impacted teeth)
- General anesthesia
- Periodontal prophylaxis (following active periodontal treatment; subject to teeth cleaning frequency limit)
- Endodontics (root canal therapy)
- Non-surgical periodontics, including scaling and root planning (once every 24 months per quadrant).

Major Care

- Surgical periodontics (once every 36 months per quadrant):
- Inlays, onlays, crowns, including replacement (once per tooth every 60 months)
- Full and partial dentures, including replacement (coverd only if at least 120 months have elapsed since last placement)
- Bridgework, including replacement (covered once per 120 months)

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PPO Orthodontia
Plan Option, Design and Limitations

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PPO Ortho Plan

- Benefit covers 50% of the cost of orthodontic procedures
- Members have the option of visiting any orthodontist they choose
- No Deductible
- Lifetime Maximum available in $1000, $1500, and $2000 options
- Annual Maximum is 50% of Lifetime Maximum*

*This amount may be reduced for members who have had previous orthodontic coverage. Ask for more details.

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DHMO Orthodontia
Plan Option, Design and Limitations

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Exclusive Dental Packages

DENTAL HEALTH SERVICES

Orthodontia Coverage
(Included with the DHMO Dental and may be selected as an option for the PPO/EPO Dental)

	Member Pays
Consultation Fee -- Adults & Children	$25.00
Full banded/Full treatment (Adults, Age 19 and over) (Not including x-rays or models)	$1975.00
Full banded/Full treatment (Children up through age 18)	$1775.00
Retentions (after ortho)	$180.00
Broken Appointments (without 24-hour notice)	$25.00

Please call Dental Health Services for referral to an associated orthodontist nearest you.

LIMITATIONS: (The following are subject to additional charges)

A. CEPHALOMETRIC x-rays, dental x-rays.
B. TRACINGS and photographs.
C. STUDY models.
D. REPLACEMENT of lost or broken appliances.
E. CHANGES in treatment necessitated by an accident of any kind.
F. MALOCCLUSIONS so severe or mutilated which are not amenable to ideal orthodontic therapy.
G. RETREATMENT of orthodontic cases.
H. ANY dental procedures considered to be within the field of general dentistry including but not limited to:
   1. MYOFUNCTIONAL therapy.
   2. GENERAL anesthetics including intravenous and inhalation sedation.
   3. DENTAL services of any nature performed in a hospital.

EXCLUSIONS:

A. TREATMENT of a case in progress at inception of eligibility.
B. SURGICAL procedures (including extraction of teeth) incidental to orthodontic treatment.
C. SURGICAL procedures related to cleft palate, micrognathia or macrognathia.
D. TREATMENT related to temporomandibular joint disturbances and/or hormonal imbalances.

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Exclusive Dental Packages

California Benefits Dental Plan

CALIFORNIA BENEFITS DENTAL PLAN

Orthodontia Coverage

(Included with the DHMO Dental and may be selected as an option for the PPO/EPO Dental)

	Member Pays
Twenty-Four Month Orthodontic Treatment Plan	$2,195.00
Single Arch Case	$1,100.00
Treatment beyond twenty-four months (per month)	UCR*

Orthodontic treatment must be provided by an orthodontic provider contracted with California Benefits Dental Plan to perform orthodontia.

Diagnosis & Orthodontic Records (x-rays, study models, etc.)	$200.00
Missed appointments (without 24 hour notice)	$25.00
Extractions	UCR*
Lost Bands	UCR*
Lost or broken headgear	UCR*
Retainers (Child) each	$150.00
Retainers (Adult) each	$175.00
Lost or non-repairable retainers	UCR*

* UCR = Usual, Customary and Reasonable Fees

- There is no benefit for orthodontic treatment that began prior to the member's effective date in the Orthodontic Plan.
- There are no benefits for lost or stolen appliances
- The orthodontist may charge additional fees for:
  - Care Required in excess of twenty-four months,
  - Gross non-cooperation,
  - Accidents occurring during the period of orthodontic treatment,
  - Cases involving surgical orthodontics,
  - Cases involving myofunctional therapy.

- Benefits cease if a member relocates to an area outside of the California Benefits Dental Plan orthodontic service area.
- Choice of orthodontist, initially, after treatment begins or member change of residence is limited to orthodontists participating in this program who accept the copayments outlined.

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Vision Plan Option
Description of Benefits / Co-payments

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Exclusive Dental Packages

VISION PLAN OF AMERICA

M-Plus - Description of Benefits / Co-payment

(Unlimited Usage)

Member Services	Members Pays
Preventive Eye Care Analysis	**No Charge**
Cataract Analysis	**No Charge**
Glaucoma Test (IOP Measurement)	**No Charge**
Frame Repairs - screw, nose pad replacement	**No Charge**
Frame Adjustments	**No Charge**
Tint #1, (solid color) plastic lenses	**No Charge**
Computerized vision analysis (Where available)	**No Charge**
Frames	25% Off UCR
Refraction* (see Note # 1) (Determines Glasses Prescription)	$36
Lenses (CR-39)	**(See Note #2 & #3)**
Single Vision Lenses	$42
Bifocal Lenses (Rnd. 22 – FT 22-28)	$55
Trifocal Lenses (FT 7X22)	$79
Progressive (Generic)	$139
Progressive (Premium)	20% Off UCR
Lenticular Lenses (S.V.)	$180
Lenticular Lenses (B.F.)	$240
Lens Extras: (Add to lens cost)	
Oversize (over 58mm E.D.)	$15
Fashion Tints (each color, CR-39)	
Single gradient	$15
Double gradient	$25
Photoxtra (S/V)	20% Off UCR
Photoxtra (B/F)	20% Off UCR
Photoxtra (Progressive)	20% Off UCR
Photochromic (i.e. transitions, sun sensor, etc.)	20% Off UCR
Scratchcote (Plastic lenses)	$20
Polycarbonate	$39
Thin Lens (other than polycarbonate)	20% Off UCR
UV Coating	$10
Rimless (Edge Groove or Drill Mount)	20% Off UCR
Prism	$4.00 per Diopter

Member Services	Member Pays
Contact Lenses (see Note #4)	
Contact Lens Evaluation & Fitting	25% Off UCR
Contact Lens Service Agreement	**Normal Retail Price**
Contact Lens Care Kits	**Normal Retail Price**
Additional C.L. Visits (each)	$10
Hard Lenses (PMMA)	$85
R.G.P. (Sphere)	$145
Soft (Daily):	
Bausch & Lomb (or similar)	$90
Cooper (or similar)	$99
Soft (Extended Wear):	
Bausch & Lomb (or similar)	$90
Ciba (or similar)	$99
Toric Contact Lenses:	
Soft…Hard…R.G.P.	20% off UCR
Soft Custom Colors for Cosmetic Eye Color Changes	20% off UCR
Disposable (1st 3 months supply only)	20% off UCR
Custom Contact Lenses (see note #5)	20% off UCR
(Orthokeratology, CRT)	**Not Covered**
Multifocal Contact Lenses (Soft Disposable 1st 3 months supply only)	10% off UCR

All LENS PRICES ARE PER PAIR

ANY PROCEDURE OR LENS NOT LISTED AND PROVIDED BY THE SELECTED OPTOMETRIST IS AVAILABLE ON A FEE-FOR-SERVICE BASIS.

*** See Vision Examination**

Note # 1- Refraction determines the need for prescription. The $36 co-payment must be paid directly to the doctor at the time of service. These benefits are part of and used in conjunction with your HMO package.
Note # 2- Cost of lenses may have an additional charge when power of lenses exceeds ±6.00 D SPH or when combined with ±2.00 D CYL.
Note # 3- Any multifocal add of +3.25 or more may be charged a laboratory per pair. SEGS larger than 28mm may be charged an added laboratory fee per pair. Glass lenses may have an additional charge.
Note # 4- When purchasing contact lenses you may require a contact lens evaluation in addition to a refraction.
Note # 5- Contact lens powers over ±6.25 SPH and/or ± 2.0 D CYL (combined) are considered custom, and will be charged extra. Medically necessary contact lenses may be considered custom; however, require prior authorization.

LASIK VISION - VPA is now providing members ACCESS TO a Laser Vision Correction preferred pricing program included at no additional cost! Savings from 40-55% off the national average charge. Experienced Board Certified Ophthalmologists. Flexible financing available.