Benefits Manager, Inc

Enrollment Instructions for AMS Health Plans

Here is a checklist of a few things that are commonly overlooked and are mandatory for processing your application.

- ❑ Print all pages of the application including instructions.
- ❑ Complete all questions and sections of the application in blue or black ink.

Don't forget to -

- ❑ Enter your required effective date. Remember you must submit to our office by the 25th of the month in order to qualify for your policy to be effective on the 1st of the following month.
- ❑ Select your preferred billing method.
- ❑ Sign and date the application.
- ❑ If you have requested that your monthly premium be deducted automatically from your checking account, you must sign and date the authorization form, attach a voided check to it, and include a check or money order payable to AMS Health Plans for the first month's premium.

Or

- ❑ If you have chosen 6-month prepayment include a check or money order payable to AMS Health Plans for the first six months' premium with the submission of the application.

- ❑ Mail completed, originally signed application and check if applicable to:

Benefits Manager, Inc
Attn: New Enrollment
1235 W. Stone Creek Ln.
Layton, UT 84041

As an example of one of many of our free services to our clients, Benefits Manager, Inc will review your application for completeness and accuracy before we submit it to AMS Health Plans for approval. This will greatly reduce the approval time because AMS Health Plans does not process unclear or incomplete applications until the missing information has been gathered.

After your application has been reviewed by Benefits Manager it will be submitted to AMS *Health Plans* for processing. If errors are found, please make any necessary charges and re-mail the corrected application to Benefits Manager for processing.

Please contact us if you have any questions regarding the application or enrollment process. You may reach us at (888)310-9623 or e-mail us at mikeoliphant@benefitsmanager.net.

Thank you for giving us this opportunity to serve you. We want to earn the right to have you as one of our Clients for Life.

The Benefits Manager Team

Utah Member Application for Group Insurance

P.O. Box 19032, Green Bay, WI 54307-9032
(920) 661-1111 • (800) 232-5432

❑ New application ❑ Change in Benefits (specify requested date below in Coverage Information)

This application is to be completed by the applicant applying for coverage. For EarlyCare, application is to be completed by the child's parent or legal guardian if child is not of legal age.

Applicant Social Security Number ___ ___ ___ — ___ ___ — ___ ___ ___ ___ **Group No.** ___ ___ ___ ___ — ___ ___ ___ ___ ___ ___

Applicant/Person to be covered for EarlyCare

Last Name				First Name		Initial
❑ Single ❑ Married	Address	City	State	ZIP	County	

Home Phone No.	Best time to Call	Work Phone No. (if applicable)	Gender ❑ M ❑ F	Date of Birth	Height	Weight	Primary Care Physician's Name

Applicant Occupation: ______

Beneficiary Name (for EarlyCare, Payer is automatic beneficiary)	Last	First	Initial	Relationship
Premium Payer Name (for EarlyCare if not Applicant)	Last	First	Initial	Home Phone No.
Premium Payer Billing Address (for EarlyCare if not Applicant)	City	State	ZIP	County

Dependent Information (If more space is needed, attach an additional sheet of paper, sign and date it.)

First Name & M.I. (last name if different)	Gender	Date of Birth	Height/Weight	Social Security No.	Primary Care Physician's Name
Spouse:	❑ M ❑ F		/		
Spouse's Occupation: ______					
Child:	❑ M ❑ F		/		
Child:	❑ M ❑ F		/		
Child:	❑ M ❑ F		/		

Eligibility

❑ Yes ❑ No Are you or any family members covered by Medicare/Medicaid? If yes, list family members and their effective date: ______

❑ Yes ❑ No **Are you or any family members pregnant (including spouse not applying for coverage)?** ______

❑ Yes ❑ No **Are you or any eligible dependent disabled or hospital confined?** ______

❑ Yes ❑ No Do any family members intend to keep other insurance coverage in addition to coverage under this policy? If yes, list family members: ______

List the name of the other insurance company(ies) and the policy number(s): ______

❑ Yes ❑ No Are you or any family members currently eligible for or receiving COBRA or State Continuation benefits? If yes, list names, eligibility dates, and date benefits end: ______

❑ Yes ❑ No Are you a U.S. citizen? If no, list how long in the U.S.: ______ **(Attach copy of valid permanent resident card)**

Coverage Information

Medical: ❑ Applicant ❑ Applicant/Family ❑ Applicant/Spouse ❑ Applicant/Child(ren) ❑ Child only

Requested effective date ______ (Effective date may not be guaranteed)

Network Name ______ Product Name ______

Deductible/Copay ______ Coinsurance ______

Upon signature of this application, I am indicating that I have selected the plan design within the Coverage Information section and that I fully understand the benefit levels of this plan.

❑ I am a HIPAA Eligible Individual under Public Law 104-191 as defined in the Prior coverage section on page 3 of this application and I choose to apply for: HIPAA Eligible medical plan selected ______

❑ I am a HIPAA Eligible Individual under Public Law 104-191 as defined in the Prior coverage section on page 3 of this application but I choose to apply for a Non-HIPAA Eligible medical plan selected. I understand there is no guarantee of policy issuance and that the pre-existing condition limitations of the selected plan will apply regardless of my status as a HIPAA Eligible person. ______

Benefit Options: (Only available with medical coverage)

❑ Yes ❑ No Supplemental Accident Benefit

❑ Yes ❑ No Term Life/AD&D Insurance (If applicable)

❑ Yes ❑ No Dependent Life (If applicable)

❑ Yes ❑ No Optional Term Life and AD&D Insurance Benefit

($10,000 min. - $300,000 max.) Indicate amount: ______

❑ Yes ❑ No Optional Dental Plan

Plan Selected: ______

Prescription Drug: ______

❑ Yes ❑ No ❑ Other ______

Home Office Use Only

Depending upon state law, this information may be submitted as evidence of insurability.

MEDICAL HISTORY

A. ❑ Yes ❑ No Have you or any eligible dependent ever been declined, postponed, ridered, rescinded, or rated up for medical, disability, or life insurance with another insurance carrier? If yes, explain:__________

B. ❑ Yes ❑ No In the past five years, have you or any person to be insured received treatment, received therapy, taken medication, or consulted a health care provider for symptoms? If yes, explain: __________

C. ❑ Yes ❑ No Are you or any person to be insured currently taking any prescription medication, over-the counter medication, or vitamin therapy? Please indicate the reason for use:__________

D. ❑ Yes ❑ No In the past five years, have you or any person to be insured been advised to have a test or treatment, been advised to obtain equipment or service or been advised of a condition that may require attention or treatment? If yes, explain: __________

E. ❑ Yes ❑ No Has any person to be insured ever been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex by a physician or member of the medical profession, or tested positive for HIV? If yes, list names: __________

F. ❑ Yes ❑ No Has anyone to be insured used tobacco products during the previous 12 months? If yes, list names: __________

G. Within the past five years, has any person to be insured ever had any symptoms that would cause an ordinarily prudent person to seek medical care; had any conditions, diagnosis, consultation, routine follow-up, treatment, therapy, been prescribed any medication, been monitored, or received counseling for any of following?… (Provide details to "Yes" answers below.)

1. Abnormal Test Results ❑ Yes ❑ No
2. Acne ❑ Yes ❑ No
3. Alcoholism/Alcohol Abuse ❑ Yes ❑ No
4. Allergies ❑ Yes ❑ No
5. Arthritis/Pain Disorder ❑ Yes ❑ No
6. Asthma/Respiratory/Sleep Apnea ❑ Yes ❑ No
7. Back/Muscle/Joints ❑ Yes ❑ No
8. Blood Abnormality ❑ Yes ❑ No
9. Bone Disease/Deformity ❑ Yes ❑ No
10. Breast Condition/Implants/Fibrocystic Breast Disease ❑ Yes ❑ No
11. Cancer/Leukemia/Hodgkin's/Lymphoma ❑ Yes ❑ No
12. Cholesterol, elevated ❑ Yes ❑ No
13. Colitis/Spastic Colon/Polyps ❑ Yes ❑ No
14. Congenital Abnormality ❑ Yes ❑ No
15. Cystic Fibrosis ❑ Yes ❑ No
16. Diabetes/Pancreas ❑ Yes ❑ No
17. Digestive System ❑ Yes ❑ No
18. Drug or Substance Addiction/Illicit Use ❑ Yes ❑ No
19. Ear/Throat/Mouth ❑ Yes ❑ No
20. Eating Disorder-Anorexia, Bulimia, Other ❑ Yes ❑ No
21. Emphysema/Lung/COPD/Tuberculosis ❑ Yes ❑ No
22. Endocrine System or Hormonal Disorder ❑ Yes ❑ No
23. Epilepsy/Seizure ❑ Yes ❑ No
24. Eye or Cataracts ❑ Yes ❑ No
25. Esophageal Disorder/Gastric Reflux ❑ Yes ❑ No
26. Fracture/Dislocation/Internal Fixation ❑ Yes ❑ No
27. Gallbladder ❑ Yes ❑ No
28. Headaches/Migraines ❑ Yes ❑ No
29. Heart/Murmur/Palpitations ❑ Yes ❑ No
30. Heart Valve/Mitral Valve Prolapse ❑ Yes ❑ No
31. Hepatitis/Liver ❑ Yes ❑ No
32. Hernia ❑ Yes ❑ No
33. High Blood Pressure/Hypertension ❑ Yes ❑ No
34. Infertility Testing/Treatment ❑ Yes ❑ No
35. Lupus/Systemic or Discoid ❑ Yes ❑ No
36. Lymphadenopathy/Immune System ❑ Yes ❑ No
37. Menstrual Disorder ❑ Yes ❑ No
38. Mental/Nervous/Psychological ❑ Yes ❑ No
39. Mental Retardation/Down's Syndrome ❑ Yes ❑ No
40. Multiple Sclerosis ❑ Yes ❑ No
41. Muscular Dystrophy/Cerebral Palsy ❑ Yes ❑ No
42. Neurological Disease/Disorder/Impairment ❑ Yes ❑ No
43. Osteoporosis/Osteopenia/Bone-Thinning ❑ Yes ❑ No
44. Ovarian Cysts ❑ Yes ❑ No
45. Pap Smear, abnormal ❑ Yes ❑ No
46. Paralysis ❑ Yes ❑ No
47. Prostate ❑ Yes ❑ No
48. Rectum Colitis/Irritable Bowel/Other Intestinal Disorder ❑ Yes ❑ No
49. Reproductive Organs ❑ Yes ❑ No
50. Sexually Transmitted Diseases ❑ Yes ❑ No
51. Sinus ❑ Yes ❑ No
52. Skin/Growth/Lesion/Abnormality ❑ Yes ❑ No
53. Spinal Disorder ❑ Yes ❑ No
54. Stroke ❑ Yes ❑ No
55. Systemic Infection ❑ Yes ❑ No
56. Thyroid/Goiter ❑ Yes ❑ No
57. Transplants ❑ Yes ❑ No
58. Tuberculosis ❑ Yes ❑ No
59. Tumors/Growths/Cysts/Fibroids/Lesions ❑ Yes ❑ No
60. Ulcerative Colitis/Crohn's/Regional Ileitis ❑ Yes ❑ No
61. Ulcers-Digestive/Skin/Other ❑ Yes ❑ No
62. Urinary Tract/Bladder/Kidney ❑ Yes ❑ No
63. Uterine Fibroids ❑ Yes ❑ No
64. Vascular Abnormality/Poor Circulation ❑ Yes ❑ No

Provide details to "YES" answers (If more space is needed, attach an additional sheet of paper, sign and date it.)

Question Letter/No.	Name	Illness/Impairment	Dates Treated	Medications/Treatment/Surgery/Physician's Name & Address

Prior Coverage

Prior Coverage Information for HIPAA Guaranteed Issue Plans

Do you meet the requirements of a Federally Eligible Individual under HIPAA legislation (P.L. 104-191)?

Please indicate yes or no or N/A to the following:

❑ Yes ❑ No 1. Have you or your dependents had a total of 18 or more months of prior creditable health coverage, the most recent being an employer sponsored plan?

❑ Yes ❑ No ❑ N/A 2. Are you or your dependents ineligible for coverage under a group plan, Medicare Part A or B, or Medicaid, and do not have any health coverage now in force?

❑ Yes ❑ No ❑ N/A 3. Was your or your dependents most recent employer sponsored health insurance plan coverage terminated for reasons other than fraud, nonpayment of premiums on your behalf, or intentional misrepresentation of material fact?

❑ Yes ❑ No ❑ N/A 4. If offered to you and your dependents, did you elect to continue your prior employer sponsored insurance plan coverage under COBRA or a similar state continuation law?

❑ Yes ❑ No ❑ N/A 5. If you or your dependents elected COBRA or state continuation, has that coverage, or will it soon be, exhausted?

❑ Yes ❑ No ❑ N/A 6. Have you or your dependents had less than a 63-day break in coverage from the most recent employer sponsored plan?

If you answered **No** to **ANY** of the above questions, the pre-existing condition limitation **MAY** apply to you and any dependents. If you answered **Yes** to **ALL** of the above requirements you or your dependents qualify as a HIPAA eligible person; as a result: 1) we **MAY** waive the pre-existing condition limitation for you and your dependents as allowed by state law, and we will advise you accordingly; or 2) you or your dependents may qualify for a state-sponsored plan. If (2) applies in your or your dependents state, we will advise you or your dependents on how to enroll in the state plan. IF YOU ANSWERED YES TO ALL OF THE ABOVE REQUIREMENTS PLEASE ATTACH A CERTIFICATE OF CREDITABLE COVERAGE FROM THE PRIOR PLAN, OR ANY OTHER DOCUMENTS TO PROVE THAT YOU OR YOUR DEPENDENTS HAD PRIOR COVERAGE.

❑ Yes ❑ No 7. Are you or your dependents buying this insurance to replace prior **group health** coverage? If no, the pre-existing condition limitation will apply. If yes, according to state law: 1) we may waive the pre-existing condition limitation for you and any dependents; or 2) you may qualify for a state-sponsored plan. If 2) applies in your state, we will advise you on how to enroll in the state plan. If yes, you must also attach a Certificate of Creditable Coverage from the prior plan and complete all of the following:

Prior employer sponsored coverage effective date:________________________

Prior employer sponsored coverage termination date:____________________ Reason for prior coverage termination: ____________________

Who was covered?____

Prior coverage was provided by: ❑ your employer sponsored plan ❑ spouse's employer sponsored plan

Give name of prior insurance company, policy/certificate number, address, and phone number: ____

____

____

❑ Yes ❑ No 8. If prior coverage was in effect for less than 18 months, did you or your dependents have any preceding health coverage?
If yes, was the coverage provided by:

❑ your employer group plan ❑ spouse's employer group plan ❑ individual policy you purchased for yourself ❑ other: ________________

Give name of insurance company and policy/certificate number: ____

Who was covered?____

Terms and Conditions of Insurance

The Applicant shall furnish to American Medical Security Life Insurance Company (AMS) any information required for AMS to underwrite and administer the Insurance. The Applicant shall have records available for AMS to inspect at any time while insurance is in force, and for up to the earlier of three years after termination date, or final adjustment and settlement of claims is made. AMS reserves the right to waive or change any of the above requirements at any time.

AMS UNDERWRITING REQUIREMENTS

The Applicant is required to submit an Application for Insurance for self and/or for all eligible Dependents to be insured. **Insurance for any person is not effective until the date specified by AMS.** Depending upon the law, AMS may have the right to decline the Application for any person for whom information has been submitted in the Application. AMS will waive the pre-existing limitation for conditions disclosed on this application, but AMS may place an exclusion rider on certain condition(s).

TERMINATION OF INSURANCE

You may terminate insurance at any time by providing AMS written notice prior to the requested termination date. The termination date will be the first of the month. Insurance will terminate at 12:01 a.m. Central Standard Time on the termination date. AMS will terminate insurance if the Applicant fails to pay premium on the due date, except that coverage continues for a grace period of 31 days after the premium due date. The Applicant may be responsible to pay premium for the grace period coverage. If before any premium due date the Applicant provides advance written notice to AMS of request to cancel, then the grace period coverage does not apply. In addition to reasons for termination that are specified in the group insurance Policy, AMS may also reform or rescind for fraud or material misrepresentation. AMS will provide the Applicant with a minimum of 31 days advance written notice of termination date (unless due to nonpayment of premium, fraud or misrepresentation). Termination will not prejudice a valid claim existing on the termination date, unless due to nonpayment of premium, fraud or misrepresentation.

Upon termination, Applicant may request reinstatement of coverage by paying all applicable premium, plus a nonrefundable reinstatement fee when allowed by state law. AMS will deposit payment during review of Applicant's request. Depositing Applicant's check does not mean acceptance and does not guarantee reinstatement. AMS can approve or decline reinstatement request and will notify Applicant in writing.

To be a valid application, your signature and the date you sign it are required.
Signature Required-Applicant Agreement

I understand that the above answers will be relied upon by AMS in the issuance of a certificate of insurance. I declare all statements contained in this entire form about me and my dependents to be insured are true and correct to the best of my knowledge and that no material information has been withheld or omitted. I understand and agree that AMS is not bound by any statement made by or to any agent unless written herein. **I agree that no insurance will be effective until the date specified by AMS in the certificate of insurance. The actual effective date may not be the requested effective date.**

To assist with determining my creditable coverage, I authorize any insurance company, third-party administrator, plan administrator, or other carrier or provider of health benefits to release to AMS certificates of creditable coverage and all such information.

State law may require a group health plan to follow rules for use of medical history, rating, renewability, and replacement of prior coverage when the plan is issued to a self-employed individual, a sole proprietor, an independent contractor, a partner, or a sole employee of a Subchapter S or Chapter C Corporation. If such law applies to my state of residence, the agent has advised me about the law and I hereby certify that I do not qualify for such group health plan.

Any person who, knowingly and with intent to defraud any insurance company, submits an application or files a claim containing any materially false information may be found guilty of insurance fraud, which is a crime, in a court of law and may be subject to fines and confinement in prison. This will not be considered as a complete application unless all pages are attached and completed.

- I also hereby acknowledge receipt of the "Protecting Your Privacy" and "Protecting Your Health Information" notices. I understand that I may request an additional copy of these notices at any time.
- I understand this policy will not pay benefits during the first 12 months after the effective date for a disease or physical condition I now have or have had in the past that has not been disclosed on this application.

Applicant Signature X ______________________________ Date ____________
(If applicant for EarlyCare is not of legal age, signature must be the child's parent or legal guardian.)

If signed by a representative of applicant, please indicate the representative's authority to act on behalf of applicant. ____________________

Spouse Signature X ______________________________ Date ____________
(If spouse is to be insured)

Regional Office ______________________________

Agent Name______________________________

Address ______________________________

Phone ____________________ Fax ____________________ Identification Number ____________

I certify that I delivered the "Protecting Your Privacy" and the "Protecting Your Health Information" notices to this applicant, as required by law.

Licensed Agent Signature X ______________________________

Signature Required/Authorization To Release Medical Information For Underwriting

Please clearly print all information.

I hereby authorize those physicians, medical practitioners, hospitals, clinics, veterans administration facilities, medical information services, urgent care facilities, and other medical or medically related entities, insurance or reinsurance companies, and consumer reporting agencies that have information available as to the present or former physical health condition, including drug or alcohol abuse, and/or treatment of me or my dependents to release any and all such information, including, but not limited to, medical records, health-care provider notes, laboratory tests and results, diagnoses, treatment, and prognoses. I understand the information obtained by use of this authorization may be used to determine eligibility for issuance of health coverage and eligibility for benefits under an existing policy/certificate of insurance for me and my dependents. This authorization is not applicable to psychotherapy notes.

I agree that a photographic copy of this authorization shall be as valid as the original and that this authorization shall expire 15 months after the termination of any coverage I obtain. I understand that I may request a copy of this authorization. I understand that I may revoke this authorization at any time in writing unless action has been taken in reliance on my authorization. Because this authorization is given as a condition of obtaining insurance coverage, my revocation will not prevent American Medical Security Life Insurance Company (AMS) from the right to contest a claim under the policy if another law so allows. Should me or my dependents refuse to sign this authorization, I understand it may affect my enrollment in the benefit plan. All pages must be attached and complete, including this authorization for the application to be considered complete. Incomplete applications may be rejected.

Customer Signature X ______________________________ Date ____________
(For EarlyCare, signature must be the child's parent or legal guardian if customer is not of legal age.)

If signed by a representative of applicant, please indicate the representative's authority to act on behalf of applicant.

____

Spouse Signature X ______________________________ Date ____________
(If spouse is covered)

Signature of Each Covered Dependent Age 18 and over:

X ______________________ Date __________ X ______________________ Date __________

X ______________________ Date __________ X ______________________ Date __________

MEDONE PLUS FEATURES	PPO BENEFIT PLAN 100% OPTION	PPO BENEFIT PLAN 80% OPTION
Lifetime Maximum Per insured	$5 Million	$5 Million
Office Visit Copay Options *A fixed fee that you pay toward office visit charges.*	$30 $40 None	$30 $40 None
Deductible Options *The amount of covered expenses you pay each calendar year before benefits are paid under the Policy.*	**Network** | **Non-network** $ 1,000 | $ 2,000 $ 1,500 | $ 3,000 $ 2,500 | $ 5,000 $ 5,000 | $10,000 $ 7,500 | $15,000† $10,000 | $20,000† † Not available with $30 copay	**Network** | **Non-network** $ 500 | $ 1,000 $ 750 | $ 1,500 $1,000 | $ 2,000 $1,500 | $ 3,000 $2,500 | $ 5,000 $5,000 | $10,000
Coinsurance Options *The level of coverage provided by the insurance plan after the calendar year deductible is satisfied. Once the maximum has been met the insurer pays 100% of covered expenses for the remainder of the calendar year.*	100% | 75%	80% | 55%
Coinsurance Limit *A shared percentage paid by you and the Policy.*	$0 | $16,000	$10,000 | $8,888
Individual Out-of-Pocket Maximum Plus deductible *The maximum amount you pay per calendar year for covered expenses.*	$0 | $4,000	$2,000 | $4,000
Physician Office Visit If no copay is selected, charges for the office visit are payable after deductible then coinsurance.	**Network**: Copay then 100% **Non-network**: Deductible then 75% coinsurance	
Wellness Benefit If no copay is selected, charges for the office visit are also payable after deductible then coinsurance.	**Network Office Visit**: Copay then 100% **Network x-ray/lab**: Deductible then coinsurance *lab, PSA, pap smear, and mammogram* **Non-network**: Deductible then coinsurance	
Pathology (lab) Test	Deductible then coinsurance	
Radiology (x-ray) Test	Deductible then coinsurance	
Surgery and Anesthesiology Fee	Deductible then coinsurance	
Routine Vision Exam	**Vision Benefit Network Provider:** $10 copay, then 100% **Vision Benefit Non-network Provider:** Payable to a maximum of $38	
Inpatient and Outpatient Facility Charges	Deductible then coinsurance	
Physician Inpatient Hospital Visit	Deductible then coinsurance	
Emergency Room Charges Copay is waived if immediately confined	$100 copay, then deductible then coinsurance	
Ambulance Air or ground	Deductible then coinsurance	
Prescription Drug ***Drug Discount Program is not an insurance benefit***	Drug discount program See page 6 for buy-up options	

Insurance plans provide only limited benefits for non-network providers. Benefits received from non-network providers are subject to a separate non-network deductible and coinsurance limit. The Classic Benefit plan (Non-PPO) is available, please see your agent for details.

OPTIONAL MEDONE DENTAL INSURANCE PLAN BENEFITS

SERVICES	BENEFITS	WAITING PERIOD
Optional Benefits are available at an additional cost.		
Calendar Year Deductible	$50 per person (3 per family maximum)	N/A
Calendar Year Maximum	$750 per person	N/A
Preventive *Oral evaluations and cleanings (twice per calendar year). Topical fluoride treatments (for dependent children up to age 16)*	80% of eligible expenses (after deductible)	No waiting period
Basic Services *X-rays; sealants for dependent children (up to age 16); nonsurgical extractions; simple restorative services; stainless steel crowns on primary teeth; repair of crowns, inlays, bridgework, or dentures*	60% of eligible expenses (after deductible)	6-month waiting period
Major Services *Endodontics; periodontics; crowns, inlays, onlays, and veneers; oral surgery; dentures, bridges, and partials*	50% of eligible expenses (after deductible)	18-month waiting period

MEDONE DENTAL INSURANCE PLAN

An option for sale at time of application with MedOne Plus medical insurance plans.

Combining MedOne Dental insurance with your MedOne Plus health insurance plan gives you a more comprehensive coverage package. When elected, MedOne Dental replaces the CAREINGTON International Discount Dental Program. (See page 9).

MedOne Dental delivers some of the same coverages as employer-based dental programs. Coverages like coinsurance and maximum benefit protection for major services (crowns, dentures, and root canals) are part of your insurance plan. And MedOne Dental allows you to see the dentist of your choice. You'll also have coverage for preventive care, including oral evaluations and cleanings, without any waiting periods.

Product Details

Coverage Information:

- Coverage type or dental insurance (applicant/spouse, applicant/family, etc.) needs to match the coverage type elected for health insurance.
- Dental coverage is an optional benefit available with MedOne Plus medical coverage and cannot be continued or moved to another insurance plan if medical coverage is terminated.
- MedOne Dental coverage is available only at the time a MedOne Plus health insurance plan is applied for. Dental coverage is not available for MedOne medical insurance plans that are currently in-force.

Waiting Period Information:

- Waiting periods apply from the original effective date of MedOne Dental coverage. (See chart above). Credit for coverage with a prior carrier is not applicable to the waiting periods. A waiting period is the period of time before the insured is eligible for benefits under the Policy.