Companion Life®

Dental & Vision Plan

ALL OTHER STATES

Administered by:

TDA
Total Dental Administrators

Marketed by:

DirectBenefits

Voluntary and 75% Participation Group Dental Plans

In & Out of Network Plan
Choose Your Own Dentist for
Employers 2-200
Annual Maximums up to $5,000

Rates Effective 2/1/2019 - 1/31/2020

Voluntary and 75% Participation Group Dental Plans

COVERED SERVICES

This plan includes coverage for both In and Out of Network Benefits.

- In Network Benefits: 100% Class I, 90% Class II and 60% Class III
- Out of Network Beneifts: 100% Class I, 80% Class II and 50% Class III

This plan also includes a $1,000 contract/calendar year maximum and a $100 lifetime deductible that applies to Class I, II, and III covered services for all members, in addition to a 12 month rate guarantee. Out of pocket savings are best when visiting an In Network Provider*. However, members can visit any Provider they choose. Payment is based upon allowable charges in the area in which the services is rendered. Members who receive services from an Out of Network Provider may be balance billed for services. All "Out of Network" service allowances are calculated at 90% of the "Usual and Customary" rates.

*See "Dental Network" section for additional details.

CLASS I
DIAGNOSTIC & PREVENTIVE SERVICES

- Oral Exams - two per 12 months
- Cleanings - two per 12 months
- Fluoride Treatments - one treatment per 12 months to age 16
- Bitewing X-Rays - one set per 12 months

CLASS II
BASIC SERVICES

- Fillings - Composite
- Space Maintainers - children under 16
- Sealants - one per tooth per 36 months (ages 6-16)
- Emergency Care - dental pain (minor procedures)

CLASS III
MAJOR OR PANOREX SERVICES

- Full Mouth or Panorex X-rays - one set per 36 months
- Crowns, Inlays, and Onlays
- Prosthodontics, Dentures, and Bridges
- Endodontics (includes root canals)
- Periodontics
- Oral Surgery and Anesthesia
- Simple Extractions
- X-rays of the Roots of Teeth
- Dental Implants (age 17+)

	Coinsurance In Network Provider	Coinsurance Out of Network Provider	Lifetime Deductible (Combined)
CLASS I	100%	100%	$100
CLASS II	90%	80%	$100
CLASS III	60%	50%	$100

Participation Requirements
Minimum of two full-time enrolled employees for groups with two to nine eligible employees. Minimum of three full-time enrolled employees for groups with 10 or more eligible employees.

Waiting Period for Class III
A 12-month waiting period will be applied to all covered procedures. There is an option to remove waiting periods that apply to Class III services for a 7% rate increase.

Disclaimer: This is a summary of benefits only. Please refer to the policy for comprehensive benefit details. Payment is based upon allowable charges in the area which the service is rendered. Any dentist charge above the allowable charge is not a covered expense.

TAKEOVER CREDIT

If a group has at least 12 continuous months of prior comparable coverage and no gap between that coverage and the Companion Life effective date, all members of the group will receive a waiver of the Companion Life waiting periods. This waiver DOES NOT apply to employees/dependents who join the group or enroll for coverage after the initial Companion Life effective date.

$100 LIFETIME DEDUCTIBLE

Applies to Class I, II, and III services combined, per person. If a group has at least 12 months continuous coverage with a $100 Lifetime deductible on it's prior plan and converts to a Companion Life plan with a $100 Lifetime deductible, members of the group will receive credit for the $100 Lifetime deductible.

OPTIONAL $0/$0, $25/$75, $50/$150 ANNUAL DEDUCTIBLE

The group has the option to change the $100 lifetime deductible to a $0/$0, $25/$75, or $50/$150 contract/calendar deductible per person/family that applies to Class II and III services. There is a 26% rate increase to the base rate for a $0/$0 deductible, 8% for the $25/$75 deductible and 5% for the $50/$150 deductible.

OPTIONAL $1,500, $2,000, $2,500, $3,000 or $5,000 MAX BENEFIT

The group can choose to increase the contract/calendar year maximum benefit for this plan to $1,500, $2,000, $2,500, $3,000 or $5,000. There is a 10% increase to the base rate for $1,500, 15% for $2,000, 20% for $2,500, 25% for $3,000 and 50% for $5,000.

OPTIONAL ENDO/PERIO/ORAL SURGERY TO CLASS II

The group can choose to have endodontics, periodontics and oral surgery covered under Class II services for a 15% increase

OPTIONAL ORTHODONTIC SERVICES

Adult and Child benefits are available for an additional premium for employers with two or more enrolled employees. Coverage is reimbursed at 50% after the first 12 months with a lifetime maximum benefit of $1,000, or $1,500.

MISSING TOOTH PROVISION

There is no missing tooth exclusion with this coverage.

NOTE

A monthly administrative fee of $15 will be included for the employer group. The $15 fee will be waived if the employer is paying by ACH bank draft or Visa/Mastercard.

INDUSTRY FACTORS

Excluded Industries:
Dentists & Dental Labs

RATED INDUSTRIES (20% LOAD)

Schools
Government
Legal/Law Firms

DENTAL NETWORKS - TO FIND A PROVIDER

MN & WI Employees: Premier Network is primary | premier-dental.com
ND, UT & AZ Employees: TDA Network is primary | tdadental.com
All Other State Employees: Dentemax Network is primary | dentemax.com

*DenteMax can be used if provider does not participate in the network specified above.

LIMITATIONS

I. Covered expenses will not include, and no benefits will be payable:

1. For Class III and Class IV Procedures in the first 12 months that a person is insured, except as may be provided in the Takeover Benefits provision.

2. For any treatment that is for cosmetic purposes, or to correct congenital malformations other than medically necessary treatment of congenital cleft in the lip or palate, or both.

3. To replace any prosthetic appliance, crown, inlay or onlay restoration, or fixed bridge within five years of the date of the last placement of these items. Replacement of an existing implant-supported prosthetic device is covered only once every ten (10) years from the placement date of such device and only then if it is unserviceable and cannot be made serviceable. However, if a replacement is required because of an accidental bodily injury sustained while the Insured is covered under this policy it will be a covered expense.

4. For initial placement of any prosthetic appliance, implant or fixed bridge unless such placement is needed because of the extraction of one or more natural teeth while the Insured is covered under this policy. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such appliance or fixed bridge must include the replacement of the extracted tooth or teeth.

5. For any procedure begun before coverage begins or after the Insured's coverage terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's coverage terminates.

6. To replace lost or stolen appliances.

7. For appliances, restorations or procedures to:
    a. alter vertical dimension
    b. restore or maintain occlusion
    c. splint or replace tooth structure lost as a result of abrasion or attrition
    d. treat disturbances of the temporomandibular joint

8. Charges for a missed appointment, consultations or for completion of claim forms.

9. For orthodontia services, when this optional coverage is not elected and the premium not paid. In any event, orthodontia covered charges will not include charges for services:
    a. payable under any other provisions or policy
    b. rendered in the first 12 months the insured person is covered under the policy
    c. incurred by employee or spouse, or incurred by dependent children after reaching the age of 19

10. For sealants that are:
    a. not applied to a permanent molar
    b. applied before age 6 or after attaining age 16
    c. reapplied to a molar within three years from the date of a previous sealant application

11. For application of fluoride after attaining age 16.

12. Because of an injury arising out of, or in the course of, work for wage or profit or for an injury, sickness or condition eligible for benefits under workers' compensation.

13. For services that are not recommended by a dentist or that are not required for necessary care and treatment.

14. For services related to equilibration, bite registration or bite analysis.

15. Crowns for the purpose of periodontal splinting.

16. Charges for any precision or semi-precision attachments, and any endodontic treatment associated with it, or other customized attachments.

17. For procedures not identified on the List of Dental Procedures in the Master Policy.

II. Payment for services shall be limited as follows:

If this plan replaces another plan of similar benefits and as a result offers takeover benefits, we limit what we pay to the lesser of: (a) what the prior plan would have paid, or (b) what this plan would usually pay. We will deduct any benefits actually paid by the prior plan under any extension provision.

Vision Plan

	Vision Select - Exam & Materials		Vision Choice - Materials Only
VISION CARE	In Network	Out of Network	
Exams with Dilation	$10 Co-Pay	$35 allowance	N/A
Contact Lens Fit & follow-up	Contact Lens fit and 2 follow up visits are available once a comprehensive eye exam has been completed		N/A
Standard*	$0 Co-Pay	$40 allowance	N/A
Premium**	$0 Co-Pay, 10% off retail then apply $55 allowance	$40 allowance	N/A

***Standard Contact Lens Fitting:**
spherical clear contact lenses in conventional wear planned replacement (example includes, but not limited to, disposable, frequent replacement, etc.)
****Premium Contact Lens Fitting:**
all lens designs, materials and specialty fittings other than Standard (ex: toric, multifocal, etc.)

Vision Rates are guaranteed for 2 years.

FRAMES	In Network	Out of Network	In Network	Out of Network
Any available frame at provider locations	$130 allowance, 20% off balance over allowance	$72 allowance	$130 allowance, 20% off balance over allowance	$72 allowance
LENSES	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Single	$10 Co-Pay	$25	$10 Co-Pay	$25
Bifocal	$10 Co-Pay	$40	$10 Co-Pay	$40
Trifocal	$10 Co-Pay	$55	$10 Co-Pay	$55
CONTACTS	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Material Only	$0 Co-Pay	$96 allowance	$0 Co-Pay	$104 allowance
Conventional and Disposable	$120 allowance 15% off balance over allowance (conventional only)		$130 allowance 15% off balance over allowance (conventional only)	
Medically Necessary	Paid in Full	$200 allowance	Paid in Full	$200 allowance

+Eyeglass lenses are paid in lieu of the contact lenses benefit. Available once in a 12-month period defined by last date of service.

++The contact lens benefit is paid in lieu of eyeglass lenses. Available once in a 12-month period defined by the last date of service.

You can access the Eyemed Networks at www.eyemedvisioncare.com to search for a provider in your area. (Select "Access" network)

****Eyemed Vision is not available in All States*

Notice: This is not an insurance policy. It is a brief description of some of the provisions of this dental plan. A full explanation of benefits, exceptions, and limitations is contained in the Companion Life Dental Insurance Policy.

Dental Area Factor Table

AZ	
all	A
ID	
all	D

IL	
600-603, 606-608	E
604-605	D
609, 613-618	B
610-611, 627	C
all others	A
MT	
all	A
ND	
581	B
all others	A

NE	
all	A
OR	
all	B
TX	
750-753, 760-761	C
770-773, 786-787	C
790-792	C
all others	A

UT	
all	B
WA	
980-981	D
all others	B
WI	
530-534, 540-549	B
353-536, 538-539	A
537	C