THE COMPANION LIFE DENTAL PLAN FOR MINNESOTA

Voluntary and 75% Participation Group Dental Plans

DUAL OPTION

CHOOSE YOUR OWN DENTIST

FOR EMPLOYERS 3-100

UNDERWRITTEN BY

Companion Life

ADMINISTERED BY

MERITAIN℠ HEALTH

DENTAL NETWORK

PREMIER DENTAL GROUP®

MARKETED BY

DIRECT BENEFITS INC.

Voluntary and 75% Participation Group Dental Plans

COVERED SERVICES

This plan reimburses covered dental expenses up to a contract year maximum of $1,000.

The rates are guaranteed for 12 months from the effective date of the Master Policy.

Companion Life allows you to choose any dentist. Payment is based upon allowable charges in the area in which the service is rendered. Or you can pick from one of our Premier Dental Providers for lower out-of-pocket costs. You can access the Premier Dental Network at www.premier-dental.com to search for a provider in your area.

CLASS I – DIAGNOSTIC AND 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 of bitewing X-rays per 12 months**

CLASS II – BASIC SERVICES

- **Fillings**
- **Space Maintainers – children under age 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 and up)**

	PPO	CHOOSE ANY DENTIST	
	Co-Insurance Network Provider	Co-Insurance Non-Network Provider	Lifetime Deductible (Combined)
CLASS I	100%	100%	$100
CLASS II	90%	80%	$100
CLASS III	60%	50%	$100

Participation Requirements

Minimum of three full-time enrolled employees

Waiting Period for Class III

A 12-month waiting period will be applied to all covered procedures.

Takeover Credit
Participants listed on the prior carrier's last monthly billing statement will be given credit for waiting periods. A copy of the last plan and billing statement must be included in the enrollment materials to receive takeover credit.

$100 Lifetime Deductible
Applies to preventive, basic and major services combined per person.

Optional $50/$150 Annual Deductible
You can choose to replace the $100 lifetime deductible for a $50/$150 contract year deductible per person/family that applies to Class II and III services for a 13% rate increase.

Optional $1,500, $2,000 or $2,500 Maximum Benefit
You can choose to increase the contract year maximum benefit for this plan to $1,500, $2,000 or $2,500. There is a 10% increase to the base rate for $1,500, 15% for $2,000 and 20% for $2,500.

Optional Endo/Perio/Oral Surgery to Class II
You can choose to have Endodontics, Periodontics and Oral Surgery covered under Class II services for a 15% increase.

Optional Orthodontic Services
These are available for an additional premium for employers with three or more enrolled employees. Orthodontic care for the proper alignment of teeth is provided for dependent children. Coverage is reimbursed at 50% after the first 12 months with a lifetime maximum benefit of $1,000.

VOLUNTARY GROUP DENTAL PLAN		
	ZIP CODE AREA	ZIP CODE AREA
3-9 EMPLOYEES	**556-569**	**550-555**
Employee only	29.89	32.49
Employee +1	56.79	61.73
Family	89.37	97.14
10-100 EMPLOYEES	**556-569**	**550-555**
Employee only	26.90	29.24
Employee +1	51.11	55.56
Family	80.43	87.43

75% PARTICIPATION GROUP DENTAL PLAN		
	ZIP CODE AREA	ZIP CODE AREA
3-9 EMPLOYEES	**556-569**	**550-555**
Employee only	27.20	29.56
Employee +1	51.68	56.17
Family	81.33	88.40
10-100 EMPLOYEES	**556-569**	**550-555**
Employee only	24.48	26.61
Employee +1	46.51	50.56
Family	73.19	79.56

Rates effective 08/01/2010 – 02/01/2011

Orthodontia Rates ($1,000 lifetime maximum for dependent children) Orthodontia can be added to any of the above plans by adding $4.65 to all dependent rates: Employee +1 and Family

PLAN OPTIONS	MULTIPLY RATES BY
$50/$150 Contract Year Deductible (Class II & III)	1.13
$1,500 Contract Year Maximum	1.10
$2,000 Contract Year Maximum	1.15
$2,500 Contract Year Maximum	1.20
Endo/Perio/OS to Basic (Class II)	1.15

INDUSTRY FACTORS

Excluded Industries
Dentists and Dental Labs

Rated Industries (20% Load)
Schools
Government
Legal/Law Firms

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.

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 which 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 which 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 19.
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 Worker's Compensation.
13. For services which are not recommended by a dentist or which 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.
18. No benefit will be provided for implants or implant services where loss of the tooth was prior to the Insured's effective date of coverage under this dental plan.

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.

Companion Life

P.O. Box 100102
Columbia, SC 29202-3102
800-753-0404
C.life@companiongroup.com
www.CompanionLife.com

DIRECT BENEFITS INC.

325 Cedar Street, Suite 800
Saint Paul, MN 55101
651.649.3503 · 800.620.5010
www.directbenefits.com

Companion Life Dental Plan for Minnesota/Wisconsin

Employer (Applicant) Information (Please Print or Type)

EMPLOYER INFORMATION

1. Full legal name of applicant (As it should appear in policy) Telephone Number ( )

2. Applicant's Federal Tax ID Number

3. Address Street Post Office Box ZIP

City County State ZIP

4. Administrative Correspondence with the Applicant should be addressed to:
   Name Title

5. Nature of Business

6. Requested Effective Date:

7. Are there subsidiary businesses covered under this plan? If YES, please state name and nature of each subsidiary or affiliate.
   ☐ Yes ☐ No

   Are separate billings required? If YES, please provide billing instructions.
   ☐ Yes ☐ No

8. Type of Administration: ☐ Home Office Administered ☐ Self Administered

EMPLOYEE ELIGIBILITY

9. The normal work week for full-time employees must be at least 30 hours unless otherwise approved by Companion Life.

10. Current eligible employees are to be covered:
   ☐ Immediately on the requested effective date.
   ☐ After _____ days of continuous employment.
   ☐ First of the month following ____ days of continuous employment.

11. Employees hired after the plan effective dates are to be covered:
   ☐ Immediately.
   ☐ After _____ days of continuous employment.
   ☐ First of the month following ____ days of continuous employment.

12. Coverage following completion of the waiting period selected will be effective the first of the month following completion of the waiting period or the next billing date.

13. Number of Eligible Employees: _____ 14. Number of Enrolled Employees: _____

PLAN SELECTION: WE ELECT TO OFFER THE FOLLOWING COVERAGES TO OUR EMPLOYEES:

15. ☐ Dental Insurance: 75% Participation _____ Voluntary _____

16. Lifetime Deductible: $100 (Standard) ☐ **or** Annual Deductible: $50/$150 ☐

17. Annual Maximum: ☐ $1,000 (Standard) ☐ $1,500 ☐ $2,000 ☐ $2,500

18. Endo/Perio/OS to Basic: ☐ Yes ☐ No (Standard) Child(ren) Orthodontia: ☐ Yes ☐ No

19. Plan Rates: Employee: $_____ Employee + One: $_____ Family: $_____

20. The following documentation is required when prior insurance credit is requested. Your current dental plan must have been in effect continuously for at least 12 months prior to effective date.
   - A copy of the most recent bill which includes a listing of all covered employees.
   - A list of the covered employees with the prior carrier which includes the employee's effective dates of coverage.
   - A copy of the inforce dental plan which may be a contract, certificate, or booklet.

EMPLOYER'S SIGNATURE

FRAUD WARNING (Not Applicable in AZ, FL, MD, OR, VA): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits (in TX, may be committing) a fraudulent insurance act, which is a crime and subjects (in KS, which may be determined by a court of law to be a crime which subjects) such person to criminal and civil penalties.

FRAUD WARNING (FL only): Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Administrative Fee: A monthly administrative fee of $15.00 will be included for the empoyer group. The $15.00 fee will be waived if the employer is paying by ACH bank draft.

Dated at _____ this _____ day of _____, 20 _____
City/State

_____ _____ _____
Signature of Employer | Title | Witness

AGENT'S REPORT

21. Initial Deposit (Minimum first month's premium is required.)
$

22. Agent/Broker Name (Please Print) Telephone Number ( )

23. Address Post Office Box

City County State ZIP

24. Are there other group insurance plans which duplicate any of the benefits applied for with this application that will remain in force or be placed concurrently with this plan(s)?
☐ Yes ☐ No If YES, please describe the benefit amounts and purposes of these plans:

25. Is Agent or Broker licensed and appointed by Companion for the types of insurance solicited where this group is located?
☐ Yes ☐ No Agent Code Number _____ State License_____

26. Signature of Agent/Broker _____ Date _____

Companion Life

Companion Life Insurance Company
PO Box 100102
Columbia, South Carolina 29202-3102
1-800-753-0404 • FAX (803) 735-0736

www.CompanionLife.com

Marketed by: DIRECT BENEFITS INC.

Administered by: MERITAIN HEALTH

Companion Life

Companion Life Insurance Company

P.O. Box 100102 • Columbia, S.C. 29202
800-753-0404 (Phone) • 800-836-5433 (Fax)

GROUP INSURANCE ENROLLMENT FORM AND CHANGE REQUEST

☐ New Employee
☐ Add/Increase Coverage
☐ Change Beneficiary
☐ COBRA
☐ Change Address
☐ Change Dependent Coverage
☐ Change Class or Status
☐ Terminate Coverage

Companion Use Only
Approved: ☐ Declined: ☐
Date:_____
By:_____

TO BE COMPLETED BY EMPLOYER

Name of Employer (Use Name from Group Billing Notice or Master Application)

Group No. (10 digit #)

DEPT/DIV (3 digit #)

CLASS

TO BE COMPLETED BY EMPLOYEES

Social Security Number	Effective Date	Date Employed Full Time	Date of Birth	Hours Worked Per Week
	Month Day Year	Month Day Year	Month Day Year	

Your Name Last First M.I.

Sex ☐ Female ☐ Male

☐ Weekly ☐ Monthly ☐ Annually (Do not include overtime or bonuses.)
Earnings $_____

Marital Status ☐ Single ☐ Married

Occupation

Your Home Address City State Zip Code

COMPLETE FOR DENTAL AND/OR VISION

Coverage Requested:
☐ Dental For Employee Only
☐ Vision For Employee Only
☐ Dental For Employee and Dependents
☐ Vision For Employee and Dependents

Is your spouse to be covered? ☐ **Yes** ☐ **No**

Dental and/or Vision Coverage Is For (Check Box Below):
☐ Employee ☐ Employee plus Spouse ☐ Employee plus Child(ren) ☐ Family

Are you or any of your dependents covered for dental insurance under another policy? ☐ Yes ☐ No

Complete for Dependent Coverage Spouse Name (Last) (First) (Middle Initial)		**Full-time Student Y/N**	**Date of Birth**	**Gender M or F**	**Do any of your dependents have any other dental coverage?**	**If Yes, Name of Carrier**
			/ /		☐ Yes ☐ No	
CHILDREN	1		/ /		☐ Yes ☐ No	
	2		/ /		☐ Yes ☐ No	
	3		/ /		☐ Yes ☐ No	
	4		/ /		☐ Yes ☐ No	

REFUSAL OF GROUP INSURANCE

I have been offered this insurance coverage and decline to purchase it at this time. I understand that in the event I desire such insurance at a later date, I will be required to furnish evidence of insurability at my own expense, and the company will have the right to refuse any request.

Coverage Refused (Check All That Apply): ☐ Dental ☐ Voluntary Dental

FRAUD WARNING (Not Applicable in AZ, FL, GA, MD, OR, VA): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits (in TX, may be committing) a fraudulent insurance act, which is a crime and subjects (in KS, which may be determined by a court of law to be a crime which subjects) such person to criminal and civil penalties.

FRAUD WARNING (FL only): Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Date	Your Signature
	X

NOTICE TO PROPOSED INSURED – DETACH AND GIVE TO PROPOSED INSURED

In connection with your application for insurance as part of our normal underwriting procedure, an investigative consumer report may be obtained, including, if applicable, information as to character, general reputation, personal characteristics and mode of living. This information is obtained through personal interviews with your friends, neighbors and associates. Upon written request, received within a reasonable time, additional, detailed information concerning the nature and scope of this investigation will be provided.

MERITAIN HEALTH

DIRECT DEBIT AUTHORIZATION AGREEMENT

I (we) hereby authorize Meritain Health, to make debit entries, and if necessary, to initiate credit entries and adjustments for any debit entries in error to the account indicated below and the Financial Institution named below, hereinafter called FINANCIAL INSTITUTION, to debit (and credit, if necessary) it to such account. I (we) acknowledge the origination of ACH transactions to said account must comply with the provisions of U.S. law.

Financial Institution Name	Routing Number (9-digit)	Account Number

Financial Institution Address	City	State	ZIP	Phone

If your participation in this arrangement is to be terminated, Meritain Health requests 30 days written notice to be sent to Meritain Health, Attention: Accounting, 9201 Watson Road, St. Louis, Missouri 63126.

Type of Account: ___ Checking ___ Savings

Attach Voided Check Here

For the purpose of paying premiums on the policy listed below:

Policy or contract Number:_____

Name of Group Insured: _____

Address: _____

City/State/Zip: _____

_____

Print Name of Bank Depositor/Account Holder

Signature_____Date_____Title_____

For questions, please contact the Meritain Health Customer Service Department at 800-548-2042.

DDA1

Companion Life

NEW BUSINESS CHECKLIST

DENTAL

Please confirm that the following is submitted with all new cases.

- ☐ Completed Employer Application
- ☐ Completed Employee Enrollments
- ☐ First Month Premium (payable to Companion Life) along with the $15 monthly billing fee. $15 is waived if paying by ACH Bankdraft.
- ☐ Producer Licensing Forms (if not previously contracted)
- ☐ Online Agent-generated Proposal (www.directbenefits.com/dental)

TAKEOVER BENEFIT COVERAGE

Please confirm that all of the following documentation is provided prior to coverage on takeover cases:

- ☐ Copy of Prior Carrier's certificate, booklet or schedule of benefits
- ☐ Copy of Prior Carrier's most recent billing statement

After all of the information listed above is completed and signed, send all original forms to:

Direct Benefits, Inc.
325 Cedar Street, Suite 800
Saint Paul, MN 55101
651.649.3503 • 800.620.5010
Fax: 651.649.3502

Submission Date:

New Group Information should be postmarked no later than the end of the month to be effective by the first of the following month.