Group Dental and Vision Insurance

Available 2-Year Rate Guarantee Option
Orthodontic Option for Groups as Few as 2
Employees 2-99
Choose Any Provider
Employer-Paid or Voluntary
$1,000 to Unlimited Annual Maximums

DentalSelect

DirectBenefits

Dental Plans available in ALL STATES except OH, OK, MA, MT, NY, NC, WA

Effective 07/01/19

MAGNUM

You No Longer Have to Search the Galaxy for Group Dental and Vision Insurance

We are your shining star and will lead the way when you need new or replacement coverage for groups of 2-99 eligible employees.

Direct Benefits provides full-service, one-stop dental and vision benefits consulting nationwide. The magnum plans are exclusively marketed through Direct Benefits and Dental Select and underwritten by ACE American Insurance Company, a member insurer of the Chubb Group of Companies. ACE American Insurance Company is rated A++ (Superior) by A.M. Best*. Together, the signature Magnum plans offer a solid balance that puts flexible and affordable group dental and vision plans within your reach.

Unique Dental MaxRewards Program

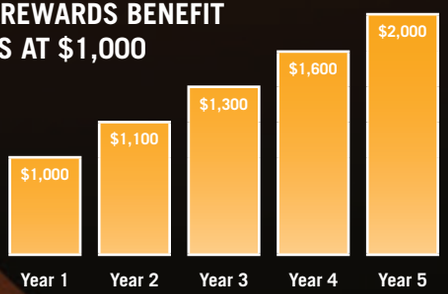
The Magnum plans' MaxRewards program is a continuous benefit that rewards employees and their families by annually increasing maximum benefit amounts incrementally up to $2,000. This simple standard program rewards loyal employees and their families from the time they enroll.

Employees start coverage at the base maximum set by the Employer and enjoy yearly maximum increases up to $2,000. Dependents are also allowed the same full maximum amount and increases, regardless of when they are enrolled. The increases are determined by the initial starting maximum and are generally illustrated below.

Employers can choose the standard initial maximum of $1,000 or enhance the maximums and choose from either $1,250 or $1,500 for the first year. The sample chart below illustrates how the program works with a $1,000 initial maximum.

IF YOUR MAXREWARDS BENEFIT STARTS AT $1,000

Year 1 – Original
Year 2 – add $100
Year 3 – add $200
Year 4 – add $300
Year 5 – add $400



Employee starts with $1,000 max and enjoys increases over 5 years when they reach $2,000 max.

* A.M. Best rating ranges from A++ to D. This rating is an indication of a company's financial strength and ability to meet obligation to its insureds.

Universal Network Savings

Committed to providing our members access to dental care where they live and work, the Magnum plans offer nationwide networks. Members can visit any dentist they choose but the out-of-pocket savings are best when visiting an in-network provider. All network providers have agreed to accept a contracted fee, which results in lower claims costs and affordable premiums for groups and their members.

Magnum vision plans utilize the networks of EyeMed Vision Care. EyeMed offers access to more than 75,000 independent practitioners and optical retail providers at more than 27,000 locations nationwide, such as: LensCrafters, Pearle Vision, JCPenney, Sears Optical, and Target Optical.

Simple Administration

Seamless transition and the ability to accommodate maximum and deductible take-over make the Magnum dental plan an easy choice. Add vision and receive a single invoice for all your products, which will increase the value of the Magnum plan by simplifying the administration of your benefits. Members can also enjoy freedom from having to submit claims paperwork for in-network services. We coordinate with your provider for all network claims, so there is nothing more you need to do.

Customize Your Benefits

Dental

- Available 2-year rate guarantee option
- Graduating MaxRewards benefits
- Customize your benefit options
- 100% preventive care in-network with no waiting periods*
- Benefit waiting periods from 0-12 months
- Orthodontic coverage option for groups with as few as 2 enrolled employees
- Low deductible options available
- Teeth whitening included (not available in UT or IL)

Vision

- Access to more than 75,000 independent practitioners and optical retail providers at more than 27,000 locations nationwide
- Many locations open 7 days/wk, including evenings
- Competitively-priced vision benefit
- Available as a stand-alone product
- 12-month rate guarantee

*Members who receive services from out-of-network providers may be balance billed for amounts not reimbursed under the plan. For the best possible experience we encourage all members to verify a provider's network status prior to service being rendered.

Stellar Service

Performance is the key to both Direct Benefits' and Dental Select's commitment to serving every client as we guide you through each process and answer your questions with our highly trained and knowledgeable staff.

Direct Benefits will put you at ease with their focus on pre-enrollment, employee communications, online and/or paper enrollments, clarification of contract benefits and identification of participating network providers.

Enjoy effective and efficient administration of your dental plan with simple billing, quick claims turnaround, expert call center staffing and the ability to provide each client and member that small-town, personal service with big city corporate benefits.

DentalSelect

DirectBenefits

CHUBB

Learn more about your Magnum Dental Plan
Call Direct Benefits at 651-649-3503 or 800-620-5010 (press option 5)
or visit **DIRECTBENEFITS.COM**.

Group dental and vision plans are just within your reach.

MAGNUM DENTAL

Summary of Benefits

Magnum Dental Plans

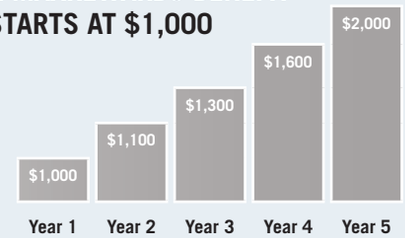
		Magnum I PPO/R&C		Magnum II PPO/MAC
		PPO Contracted	R&C Non-Contracted**	Contracted & Non-Contracted**
Preventive No Waiting Period	Routine exams and cleanings - 2 per calendar year (in conjunction with all other cleanings), Fluoride - 2 per calendar year, Bitewing x-rays - 8 total per year (ages 2 and over), Periapical x-rays, FMX/Panoramic	100%	100%	100%
Basic No Waiting Period	Sealants, Space maintainers, Fillings, Composite, Oral Surgery	90%	80%	80%
Major 12-Month Waiting Period	Endodontics, Periodontics, Dentures, Implant alternate††, Inlays, Onlays, and Crowns	60%	50%	50%
Deductible	Per individual/family, per calendar year Applies to basic & major services	$50/150	$50/150	$50/150
Annual Maximum Rewards	Per member; calendar year Applies to preventative, basic & major services	$1,000 Maximums Increase Yearly	$1,000 Maximums Increase Yearly	$1,000 Maximums Increase Yearly

MaxRewards Plan Standard Benefit

Per person/per calendar year. Available starting maximums of $1,000, $1,250 & $1,500.
MaxRewards℠ standard benefit example for groups 2+. Customized maximums are available.

IF YOUR MAXREWARDS BENEFIT STARTS AT $1,000

Year 1 – Original
Year 2 – add $100
Year 3 – add $200
Year 4 – add $300
Year 5 – add $400



Employee starts with $1,000 Max and enjoys increases over 5 years when they reach $2,000 Max.

How it Works
Increases are automatically applied each year incrementally based on consecutive coverage & the original maximum benefit set by the group, until the maximum benefit reaches $2,000.

Orthodontic Option

12-Month Waiting Period

Magnum I & Magnum II
50%
$1,000 Lifetime Maximum

Additional Maximums Available
Orthodontic coverage for adults, and children ages 8-18 available for groups of 2-4 or 5+ enrolled.

Static Annual Maximum Option

Per member, calendar year

Magnum I & Magnum II
$2,000, $3,000, $4,000, $5000 or Unlimited Static Maximum*

Applies to preventive, basic & major services

Annual Deductible Options For Basic & Major Only

Standard plan assumes $50/150 deductible. Additional available options include:

$0 Deductible	$25/$75 Deductible

The plan will allow up to the reasonable and customary or maximum allowable charge for the dental procedures and services after the required deductible amount as shown, including:

Magnum I & II: In-network – Providers accept the contracted fee schedule as payment in full. Out-of-network – Payments are based on R&C (Magnum I) or Fee Schedule (Magnum II). Member is responsible for the difference between the Provider's fee and the plan payment.
†† Alternate Implant benefit
*Unlimited Maximums are available in the following states: AK, AZ, AR, CA, CO, CK, CT, FL, GA, HI, ID, IL, IA, KS, KY, LA, MN, MS, MO, NV, ND, OR, PA, TX, UT, WI, WY. Please contact your account manager for details or updates.
**Certain states limit the difference between in-network and out-of-network benefits. Please contact your account manager for details.
Claim payments are subject to review. We strongly recommend a pre-estimate for implants & all major services. This is a summary only. For complete details, refer to your dental policy.

MAXIMUM CARE PPO

Connection DENTAL

Networks available starting Jan 1, 2018

For more information please contact us at: 651-649-3503 or 800-620-5010 (press option 5)
Visit www.directbenefits.com for a complete listing of Limitations and Exclusions

DentalSelect

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All plans of insurance are marketed by Dental Select, an insurance agency, and underwritten by ACE American Insurance Company, a member insurer of the Chubb Group of Companies.

2018 MAG.03.9000306 05/19

Group Dental Plan Base Rate

(Voluntary rates and policies effective July 1, 2019 - June 30, 2020)

DentalSelect

DirectBenefits

Toll Free: 800-620-5010
agent@directbenefits.com

Estimate your group rate:

Plans Without Orthodontics

Magnum I

$1,000 Maximum Benefit, $50/150 Deductible Base	Group Size 2 to 4	5 to 9	10+
Employee Only	$33.74	$31.86	$28.76
Employee + Spouse	$71.76	$67.76	$61.17
Employee + Child (ren)	$78.00	$73.65	$66.49
Family	$111.96	$105.71	$95.43

Magnum II

$1,000 Maximum Benefit, $50/150 Deductible Base	Group Size 2 to 4	5 to 9	10+
Employee Only	$24.35	$23.00	$20.76
Employee + Spouse	$51.80	$48.91	$44.15
Employee + Child (ren)	$56.31	$53.17	$48.00
Family	$80.81	$76.31	$68.89

Plans With Orthodontics

Magnum I

$1,000 Maximum Benefit, $50/150 Deductible Base	Group Size 2 to 4	5 to 9	10+
Employee Only	$33.74	$31.86	$28.76
Employee + Spouse	$75.87	$71.63	$64.67
Employee + Child (ren)	$82.47	$77.87	$70.30
Family	$118.36	$111.76	$100.89

Magnum II

$1,000 Maximum Benefit, $50/150 Deductible Base	Group Size 2 to 4	5 to 9	10+
Employee Only	$24.35	$23.00	$20.76
Employee + Spouse	$54.76	$51.71	$46.68
Employee + Child (ren)	$59.53	$56.21	$50.74
Family	$85.44	$80.67	$72.83

Area Multiplier Table - By GeoZip

Zip	Mult.	Zip	Mult.	Zip	Mult.	Zip	Mult.	Zip	Mult.	Zip	Mult.	Zip	Mult.
028-029	1.137	227-229	1.226	346	0.902	479	1.110	583-584	1.206	803	1.277	919	1.364
030-033	1.463	230-236	1.158	347	1.074	480	1.263	585-586	1.277	804	1.206	920-921	1.532
034	1.381	237-239	1.092	349	0.956	481-483	1.339	587	1.206	805	1.138	922-923	1.445
035-038	1.463	240	1.158	350-352	0.913	484-485	1.263	588	1.138	806	1.074	924	1.287
039	1.348	241	1.226	354-355	0.967	486-487	1.124	600-601	1.277	807	1.277	925-926	1.532
040-041	1.273	242-244	1.158	356	0.913	488	1.263	602-603	1.138	808	1.138	927	1.364
042	1.200	245-246	1.031	357-358	0.967	489	1.192	604-606	1.277	809	1.206	928	1.532
043	1.134	247	1.794	359-363	0.913	490-491	1.263	607-629	1.138	810	1.074	930	1.445
044	1.200	248	1.900	364	0.967	492	1.192	630-633	1.092	811	1.138	931	1.364
045-048	1.273	249-251	1.794	365-366	0.913	493	1.263	634-639	1.031	812-813	1.074	932	1.445
049	1.200	252	1.900	367-368	0.967	494	1.192	640-641	1.092	814	1.138	933	1.364
050-051	1.259	253-254	1.794	369	1.025	495	1.124	644-658	1.031	815	1.074	934	1.445
052-053	1.188	255-256	1.900	370-372	1.104	496	1.192	660	0.967	816	1.277	935-937	1.364
054-055	1.259	257-262	1.794	373	1.042	497-498	1.263	661	0.861	820-831	1.001	939	1.532
056-057	1.188	263-264	1.900	374-375	0.983	499	1.192	662	0.967	832	1.004	940	1.622
058-059	1.259	265-268	1.794	376-385	1.042	500	1.036	664-666	0.913	833	1.064	941	1.821
060-061	1.354	290-291	1.001	386-387	0.922	501	1.097	667	0.861	834	1.004	942-943	2.046
062	1.434	292	1.061	388	0.870	502-503	1.036	668	0.913	835	1.128	944	1.930
063	1.277	293	1.001	389	0.922	504-505	0.977	669	0.967	836	1.064	945	1.720
064	1.434	294	1.061	390	0.870	506	1.036	670	1.025	837-838	1.128	946	1.622
065-067	1.354	295-297	1.001	391	0.922	507	0.922	671-672	0.967	840-849	1.196	947	1.287
068	1.434	298-299	1.061	392	0.870	508	1.036	673	0.861	835	1.128	948-949	1.821
069	1.354	300-303	1.138	393	0.922	509-510	1.097	674	0.967	836	1.064	950	1.720
070-089	1.375	304	1.206	394	0.870	511-512	1.036	675	1.025	837-838	1.128	951	1.532
150-151	0.956	305	1.138	395	0.922	513	1.097	676-679	0.967	840-849	1.196	952	1.364
152	1.074	306-309	1.206	396-397	0.922	514	1.036	680	1.004	850-853	1.090	953	1.445
153-189	0.956	310	1.138	398	1.138	515	0.977	681	0.947	855-856	1.224	954	1.364
190-191	1.074	311-319	1.206	400	0.952	516	1.036	683-686	1.064	857	1.090	955	1.821
193-196	0.956	320	1.074	401	0.899	520-522	0.977	687	1.128	859-865	1.224	956	1.445
197-198	2.462	321	1.013	402-403	0.952	523	1.036	688	1.004	870-884	0.993	957	1.622
199	2.323	322	1.074	404	0.899	524-526	0.977	689-693	1.128	890-891	1.147	958	1.532
200	1.606	323	1.013	405	0.952	527	1.036	700-708	0.977	893	1.366	959	1.445
201	1.547	324	1.206	406-409	0.899	528	0.977	710	1.036	894-895	1.147	960	1.364
202-205	1.606	325-326	1.074	410	0.952	550	1.277	711	0.922	897-898	1.366	961	1.821
206	1.354	327	1.013	411-427	0.899	551-554	1.352	712-713	0.977	900	1.720	967-968	1.239
207	1.277	328	1.074	460-463	1.110	556-557	1.205	714	1.036	901-903	1.622	970	1.481
208	1.206	329	1.013	464	0.988	558	1.137	716-717	0.822	904	1.287	971	1.399
209-210	1.138	330	1.074	465	1.047	559-560	1.205	718	0.871	905	1.364	972-974	1.481
211	1.206	331-332	1.277	466	0.988	561-566	1.137	719	0.822	906	1.445	975	1.399
212	1.138	333	1.013	467	1.110	567	1.205	720-721	0.871	907	1.364	976-977	1.481
214	1.074	334	1.074	468	1.047	570	0.956	722	0.924	908	1.445	978-979	1.399
215-216	1.277	335	1.013	469-471	1.110	571	1.013	723	0.822	910	1.622	995-998	1.556
217-219	1.206	336-337	0.956	472	0.988	572	0.956	724-726	0.871	911	1.287	999	1.468
220-222	1.300	338-339	1.074	473	1.110	573-577	1.013	727	0.979	912-914	1.532		
223-224	1.377	341	0.956	474	1.047	580	1.206	728	0.924	915-916	1.287		
225	1.300	342	1.138	475-476	1.110	581	1.277	729	0.871	917	1.532		

Rates shown are trended monthly and are estimations only and meant to provide general guidelines. Actual rates may vary based on proposal issued.

Group Dental Plan Factors

DentalSelect

DirectBenefits

Toll Free: 800-620-5010 **agent@directbenefits.com**

Dental Plan Factors	Rate Impact
☐ $0 Deductible	1.030
☐ $25 Deductible	1.012
☐ $1250 Annual Max	1.047
☐ $1500 Annual Max	1.094
☐ $2000 Annual Max	1.138
☐ $3000 Annual Max	1.195
☐ $4000 Annual Max	1.225
☐ $5000 Annual Max	1.256
☐ Unlimited Annual Max*	1.266
☐ Endo/Perio to Basic	1.060
☐ 90% R&C	1.060
☐ Remove Major Waiting Periods	Request a Quote
☐ Implant Factors $1000	1.033
☐ Implant Factors $1250	1.039
☐ Implant Factors $1500	1.045
☐ Implant Factors $2000	1.061
☐ Implant Factors $3000	1.091
☐ Implant Factors $4000	1.123
☐ Implant Factors $5000	1.157
☐ Unlimited	1.174
☐ Employer Contribution - 75% participation, 50% single premium	0.930
☐ 2-Year Rate Guarantee	1.033

Industry Codes That Require a Load	Rate Impact
☐ Industry codes and rate impact applies to both dental and orthodontic factors.	
☐ 2411-2611 Logging, Sawmills, Lumber & Wood Products, Furniture, Pulp Mills	0.95
☐ 3011-3199 Rubber & Misc Plastic, Leather Tanning, Leather & Leather Products	0.925
☐ 5611-5736 Retail - Apparel, Furniture	1.075
☐ 6011-6289 Financial Institutions	1.075
☐ 6311-6411 Insurance Companies & Agencies	1.075
☐ 7221-7389 Personal Services, Business Services	1.05
☐ 7911-7999 Amusement & Recreation, Movies	1.05
☐ 8000-8399 Health Services, Legal Services, Educational Services, Social Services	1.125
☐ 8711-8748 Engineering, Accounting, Research, Management, Related Services	1.05
☐ 9111 - 9721 Public Administration	1.05

We Do Not Provide Coverage To:

- Dental offices and dental-related industries
- Vision provider offices and vision-related industries

Orthodontic Add On Rates

*Orthodontics should be added to the rate after all other plan factors have been calculated.

Child Only Ortho

	Group Size		
	2 to 4	5 to 9	10+
Employee + Child(ren)	$10.59	$10.00	$9.09
Family	$12.69	$11.98	$10.89

Adult + Child Ortho

	Group Size		
	2 to 4	5 to 9	10+
Employee Only	$2.86	$2.70	$2.45
Employee + Spouse	$5.72	$5.40	$4.91
Employee + Child (ren)	$13.45	$12.70	$11.54
Family	$18.40	$17.38	$15.80

Orthodontic Area Multiplier Table - By State

AK	0.86	DE	1.62	KS	0.85	ND	1.00	RI	0.89	WV	1.67								
AL	0.85	FL	1.00	KY	0.94	NE	1.05	SC	0.88	WI	0.88								
AR	0.86	GA	1.00	LA	0.91	NH	1.02	SD	0.84	WY	0.83								
AZ	1.14	HI	0.97	MD	1.00	NJ	1.14	TN	0.97										
CA	1.27	IA	0.91	ME	0.94	NM	0.85	TX	1.00										
CO	1.00	ID	1.05	MO	0.96	NV	1.20	UT	1.42										
CT	1.00	IL	1.00	MN	1.05	OR	1.16	VA	0.96										
DC	1.12	IN	0.92	MS	0.81	PA	1.00	VT	0.93										

Orthodontic Plan Add On Factors	Rate Impact
☐ $1500 Lifetime Max	1.440
☐ $2000 Lifetime Max	1.830
☐ Employer Contribution	0.930
☐ 2-Year Rate Guarantee	1.033

There is an additional Network Access Fee of $0.62 per subscriber in TX and $0.69 per subscriber in all other states. For rate questions, please contact Direct Benefits (800) 620-5010 (press option 5).

*Unlimited Maximums are available in the following states: AK, AZ, AR, CA, CO, CK, CT, FL, GA, HI, ID, IL, IA, KS, KY, LA, MN, MS, MO, NV, ND, OR, PA, TX, UT, WI, WY. Please contact your account manager for details or updates.

The same effective date will apply to both dental and vision plans when either the 1 or 2-year rate guarantee is applied.

Magnum Dental is offered exclusively by Direct Benefits Inc. and Dental Select.

CHUBB®

All plans of insurance are marketed by Dental Select, an insurance agency, and underwritten by ACE American Insurance Company, a member insurer of the Chubb Group of Companies.

2018 MAG.03.9000306 07/19

MAGNUM VISION

LensCrafters · JCPenney · Pearle Vision · Optical · Sears Optical · GLASSES.COM · contactsdirect

Visit Eyemedvisioncare.com and choose your network to find a provider in your area.

EyeMed Insured Vision

From The Nation's Leading Vision Care Organization

EyeMed

- EyeMed's Insight and Select Networks give you access to more than 75,000 independent practitioners and optical retail providers at more than 27,000 locations nationwide.
- Many locations open 7 days/wk, including evenings
- Innovative services and products
- Competitively-priced vision benefit
- Comprehensive eye health program
- Available as a stand alone product

Options	**Vis 6**		**Vis 8**		**Vis 12**		**Vis 21**	
Insight AND Select Networks	**Contracted Copayment**	**Non-Contracted Reimbursement**	**Contracted Copayment**	**Non-Contracted Reimbursement**	**Contracted Copayment**	**Non-Contracted Reimbursement**	**Contracted Copayment**	**Non-Contracted Reimbursement**
Exam with Dilation as Necessary:	$10	Up to $35	$0	Up to $35	$10	Up to $35	$10	Up to $45
Standard Contact Lens fit & follow-up:	Up to $55	N/A	Up to $55	N/A	Up to $55	N/A	Up to $55	N/A
Premium Contact Lens fit & follow-up:	10% off Retail*	N/A	10% off Retail*	N/A	10% off Retail*	N/A	10% off Retail*	N/A
Standard Plastic Lenses:								
Single Vision	$10	Up to $25	$0	Up to $25	$10	Up to $25	$25	Up to $40
Bifocal	$10	Up to $40	$0	Up to $40	$10	Up to $40	$25	Up to $60
Trifocal	$10	Up to $55	$0	Up to $55	$10	Up to $55	$25	Up to $80
Standard Progressive	$75	Up to $40	$65	Up to $40	$75	Up to $40	$25	Up to $60
Frames:	$0 CoPay, $100 allowance; 20% off* balance over $100	Up to $50	$0 CoPay, $100 allowance; 20% off* balance over $100	Up to $50	$0 Co-pay, $100 allowance; 20% off* balance over $100	Up to $50	$0 CoPay, $130 allowance; 20% off* balance over $130	Up to $45
Lens Options:								
UV Coating	$15		$15		$15		$15	
Tint (Solid & Gradient)	$15		$15		$15		$15	
Standard Scratch-Resistance	$15	N/A	$15	N/A	$15	N/A	$15	N/A
Standard Polycarbonate	$40		$40		$40		$40	
Standard Anti-Reflective Coating	$45		$45		$45		$45	
Other Add-ons & Services	20% Discount*		20% Discount*		20% Discount*		20% Discount*	
Contact Lens Materials:	Declining balance allowance (may be used on multiple purchases within the benefit period up to the maximum allowable)							
Conventional	$0 CoPay: $115 allowance; 15% off* balance over $115	Up to $100	$0 CoPay: $200 allowance; 15% off* balance over $200	Up to $160	$0 CoPay: $120 allowance; 15% off* balance over $120	Up to $80	$0 CoPay: $150 allowance; 15% off* balance over $150	Up to $150
Disposable	$0 CoPay: $115 allowance	Up to $100	$0 CoPay: $200 allowance	Up to $160	$0 CoPay: $120 allowance	Up to $80	$0 CoPay: $150 allowance	Up to $150
Medically Necessary	$0 CoPay: Paid-in-Full	Up to $200	$0 CoPay: Paid-in-Full	Up to $200	$0 CoPay: Paid-in-Full	Up to $200	$0 CoPay: Paid-in-Full	Up to $210
Frequency:								
Examination	Once every 12 Months		Once every 12 Months		Once every 12 Months		Once every 12 Months	
Frame	Once every 24 Months		Once every 12 Months		Once every 12 Months		Once every 12 Months	
Lenses	Lenses OR Contacts every 12 Months		Lenses AND Contacts every 12 Months		Lenses AND Contacts every 12 Months		Lenses OR Contacts every 12 Months	
Laser Vision Correction: Lasik or PRK	15% off retail price* –or– 5% off promotional price* (In-network only)							

*** Discounts on products and services are not insured benefits and not underwritten by ACE American Insurance Company.**
Vision plan options available in the following states: Everywhere but MA, MT, NJ, NY, NC, VA and WA.
For more information please contact us at: 651-649-3503 or 800-620-5010.

DentalSelect

DirectBenefits

CHUBB

All plans of insurance are marketed by Dental Select, an insurance agency, and underwritten by ACE American Insurance Company, a member insurer of the Chubb Group of Companies.

IMPORTANT NOTICE: This information is a brief description of the important features of this insurance plan. It is not an insurance contract. Insurance benefits are underwritten by ACE American Insurance Company. Coverage may not be available in all states or certain terms may be different where required by state law. Chubb NA is the U.S.-based operating division of the Chubb Group of Companies, headed by Chubb Ltd. (NYSE: CB) Insurance products and services are provided by Chubb Insurance underwriting companies and not by the parent company itself.

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MAGNUM DENTAL

Group Vision Plan Rate Range
Group Size 2-99

(Rates effective July 1, 2019)

Minimum & Maximum Rates by State

DentalSelect

DirectBenefits

Toll Free: 800-620-5010
agent@directbenefits.com

Contributory

		Insight Network	Select Network
Vis 6	Employee	$4.79 - $6.83	$4.39 - $5.76
	Employee + Spouse	$7.92 - $11.66	$7.16 - $9.60
	Employee + Child(ren)	$8.27 - $12.20	$7.47 - $10.02
	Family	$12.79 - $19.18	$11.46 - $15.56
Vis 8	Employee	$8.55 - $11.97	$8.31 - $11.08
	Employee + Spouse	$15.06 - $21.43	$14.60 - $19.70
	Employee + Child(ren)	$15.78 - $22.48	$15.29 - $20.66
	Family	$25.19 - $36.15	$24.38 - $33.11
Vis 12	Employee	$5.11 - $7.25	$4.74 - $6.26
	Employee + Spouse	$8.52 - $12.47	$7.82 - $10.54
	Employee + Child(ren)	$8.90 - $13.05	$8.17 - $11.02
	Family	$13.83 - $20.59	$12.62 - $17.20
Vis 21	Employee	$6.02 - $8.65	$5.61 - $7.59
	Employee + Spouse	$10.25 - $15.11	$9.48 - $13.08
	Employee + Child(ren)	$10.72 - $15.83	$9.91 - $13.69
	Family	$16.83 - $25.18	$15.50 - $21.61

Voluntary

		Insight Network	Select Network
Vis 6	Employee	$5.37 - $7.72	$4.90 - $6.47
	Employee + Spouse	$9.02 - $13.37	$8.13 - $10.95
	Employee + Child(ren)	$9.43 - $13.99	$8.49 - $11.44
	Family	$14.70 - $22.14	$13.16 - $17.91
Vis 8	Employee	$9.76 - $13.72	$9.47 - $12.68
	Employee + Spouse	$17.35 - $24.76	$16.81 - $22.73
	Employee + Child(ren)	$18.20 - $25.99	$17.63 - $23.85
	Family	$29.17 - $41.93	$28.23 - $38.38
Vis 12	Employee	$5.74 - $8.22	$5.31 - $7.05
	Employee + Spouse	$9.72 - $14.31	$8.91 - $12.05
	Employee + Child(ren)	$10.16 - $14.98	$9.31 - $12.61
	Family	$15.91 - $23.78	$14.50 - $19.82
Vis 21	Employee	$6.80 - $9.84	$6.33 - $8.61
	Employee + Spouse	$11.74 - $17.39	$10.85 - $15.01
	Employee + Child(ren)	$12.28 - $18.23	$11.35 - $15.72
	Family	$19.41 - $29.13	$17.87 - $24.96

Rates shown are illustrative only and meant to provide general guidelines. Actual rates may vary based on proposal issued.

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Participation Guidelines
Magnum Plan

DentalSelect
DirectBenefits

Toll Free: 800-620-5010 **agent@directbenefits.com**

Group Dental Participation Guidelines - Participation guidelines apply based on the number of employees enrolling.

Outside of open enrollment period, a person must have a qualifying event to gain coverage.

Voluntary Coverage

Co-Insurance (PPO R&C & PPO MAC)

- 2-20 eligible: 25% of eligible persons must enroll with a minimum of 2.
- 21+ eligible: Requires a minimum of 5 eligible persons to enroll.
- Adult and Child Orthodontics options available.
- Requires a minimum of 2 enrolled.

Contributory Coverage

Co-Insurance (PPO R&C & PPO MAC)

- A minimum of 2 eligible persons and 75% of all eligible must enroll.
- The employer must contribute 50% of the single premium to qualify.
- Dual option plans require a minimum of 4 total employees to enroll with a minimum of 2 employees on each plan.
- Adult and Child Orthodontics options available.
- Requires a minimum of 2 enrolled.

Groups which have not offered a dental program within the last 12 months will include waiting periods unless otherwise requested and approved.

Dental Plan Notes

PPO R&C Plans

- CONTRACTED: All payments made to contracted General Dentists and Specialists are based on the contracted dental fee schedule and are accepted as payment in full after the required deductible amount, as shown. Members may receive a discount on orthodontic services from contracted orthodontists.
- NON-CONTRACTED: Dental Select will allow up to the Reasonable & Customary amount for dental procedures and services after the required deductible amount, as shown. Charges above the plan payment are the patient's responsibility.

PPO MAC Plans

- CONTRACTED: All payments made to contracted General Dentists and Specialists are based on the contracted dental fee schedule and are accepted as payment in full after the required deductible amount, as shown. Members may receive a discount on orthodontic services from contracted orthodontists.
- NON-CONTRACTED: Dental Select will allow up to the contracted dental fee schedule amount for dental procedures and services after the required deductible amount, as shown. Charges above the plan payment are the patient's responsibility. .

Administration fee of $15.00 is added to all fully-insured plans except when: (1) enrollment is 50+, or (2) if the group elects EFT.

Waiting Periods and Take-over Provision (if applicable)

With proof of coverage and effective dates from the employer's prior dental carrier, the employee's waiting period, if any, will be reduced by the number of months the employee was covered by the prior plan. Proof of prior coverage must accompany the application in order to reduce waiting periods.

All other services and coverage relating to any other take-over provision will be based on the certificate issued under the Dental Select policy.

To qualify for waiting period waiver or take-over consideration the group must submit, within 45 days of the employee's effective date on the Magnum plan:

a. Certificate, Booklet or Summary of Benefits
b. Most Recent Billing Statement

If this information is not timely received, benefit waiting periods will not be waived and the employee is subject to waiting periods. Coverage under the plan must not have lapsed for more than 60 days. Other restrictions may apply.

Eligible Employee Participation Requirements

Eligibility

- Eligible employees must be considered full time and work at least 30 hours per week for a contributory plan, and 20 hours for a voluntary plan.
- All employees and dependents must enroll within 30 days from the time the employee becomes eligible for their respective employer benefits program as determined by said employer.
- If an eligible employee drops coverage, he/she may not re-enroll at anytime unless a qualifying event occurs or annual open enrollment.
- Full-time employees on a seasonal or temporary basis are not eligible.

Eligible Dependents

- Spouses of eligible employees.
- Unmarried children are eligible for coverage according to state mandated guidelines.
- Dependent children of any age who are disabled are eligible for coverage.
- Eligible dependents are covered up to age 26.

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Eligible Employee Participation Requirements - Continued

Husband and Wife – Both employees of the same employer group

- A husband and wife who are both employees of the same employer may each enroll in only one contract.
- Neither spouse may be enrolled on both an individual and a family or employee plus spouse contract.
- Both are eligible to be enrolled on separate individual "employee-only" contracts.
- Dependent children can be enrolled on only one contract.

Domestic Partners

- Groups of any size may request domestic partner coverage—same sex only—as required by the state specific statute. The Domestic Partner form is available upon request.

Eligible Retirees

- Retirees are eligible for coverage providing they had comparable coverage with another carrier in a take-over situation at the time of retirement and elected to continue coverage.

Retirees are not covered in the following situations:

- If the retiree was not covered at the time of retirement, or they were not already covered as a retiree by another carrier in a take-over situation.
- If the retiree drops their coverage, they may not re-enroll at a later date.
- Retirees may not add dependents to their coverage that were not covered on the retiree's employee plan at the time of the employee's retirement.

Underwriting Guidelines

- If coverage is waived, a qualifying event must occur to gain coverage outside of open enrollment.
- Dual option plan offerings are available upon request. Submit quote request to agent@directbenefits.com
- Dual option plans require a minimum of 2 employees on each plan. General plan participation guidelines apply.
- Rates will be determined by geographical area (by employer). Groups with 50% or more of eligible employees residing outside of the approved state are subject to underwriting review.
- If an eligible employee drops coverage, he/she may not re-enroll at anytime unless a qualifying event occurs or annual open enrollment.
- Standard coordination of benefits applies.
- If the group has less than 2 employees enrolled at the time of renewal, the group will be terminated.
- Deductibles and annual maximums are on a calendar-year basis (January through December). When take-over applies, both the maximum and deductible will be reviewed for take-over together.
- No off-contract changes are allowed.
- Dental offices and dental related industries are not eligible for coverage. The following Industries are subject to industry load: Logging/Saw Mills/Lumber & Wood Products/Furniture/Pulp Mills, Rubber & Misc Plastic/ Leather Tanning/ Leather & Leather Products, Retail Apparel & Furniture, Financial Institutions, Insurance Companies & Agencies, Personal & Business Services, Amusement & Recreation/Movies, Health/Legal/Educational/Social Services, Engineering/Accounting/Research/Management Related Services, and Public Administration.
- If 5 or more employees are eligible, but less than 5 are enrolling, we calculate rates according to 2-4 eligible employees group size. Participation guidelines apply according to the number of employees enrolling.
- For MS and TX residents, in and out of network benefits must be equal.
- For groups with 100% related employees:
  - Tax wage statement — employees listed
  - Business License

Orthodontics – Optional Add On

- Orthodontic option available.
- 12-month waiting period for new groups and new employees/enrollees without prior comparable orthodontic coverage.
- Coverage for dependent children through age 18. Adult orthodontic option also available.
- Coverage for limited, interceptive, and comprehensive orthodontic treatment.
- 50% coverage up to $1,000 lifetime maximum.
- Additional maximum amounts are also available for quote.

Teeth Whitening

In-office cosmetic teeth whitening is a covered service for adults and children 16 and older (not including UT and IL). The plan will pay up to $100 once every 24 months.
Retail over-the-counter (OTC) kits are not included.

Vision Participation Guidelines
Magnum Plan

DentalSelect
DirectBenefits

Toll Free: 800-620-5010
agent@directbenefits.com

Group Vision Participation Requirements - Participation guidelines also apply for Stand-Alone Vision

Outside of open enrollment period, a member must have a qualifying event to gain coverage.

Contributory Coverage

- The employer must contribute 50% of the single premium to qualify. 60% of eligible employees must enroll on the plan.

Voluntary Coverage

- A minimum of 2 employees must be enrolled on the plan.

Eligibility

- This quote assumes eligible employees. If enrollment on the plan differs by more than 10%, Dental Select reserves the right to re-quote. Eligible employees must be considered full time and work at least 30 hours per week for a contributory plan, and 20 hours for a voluntary plan.
- All employees and dependents must enroll within 30 days from the time the employee becomes eligible for their respective employer benefits program as determined by said employer.

Dependent Eligibility

- Eligible dependents are covered up to age 26.

VISION PLAN NOTES

Premium Progressive Lenses

- Members receive a discount on Premium Progressive lenses at certain locations or when using a contracted vision provider.*

Allowances

- Allowances are one-time use benefits; no remaining balance except for contact lens materials, when applicable. Lost or broken materials are not covered.

Discounts

- Members will receive a 20% discount on items not covered by the plan when using contracted providers.
- This discount may not be combined with any other discounts or promotional offers and does not apply to EyeMed Provider's professional services or contact lenses.
- Retail prices may vary by location.
- Discounts do not apply to benefits provided by other group benefit plans.
- When enrolled on the vision plans, Members receive a 40% discount off complete eyeglass purchases and a 15% discount off conventional contact lenses at unlimited frequency after the initial benefit has been used. After initial purchase, replacement contact lenses may be obtained via the internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com. The contact lens benefit allowance is not applicable to this service.

Lasik & PRK

- Since Lasik or PRK vision correction is an elective procedure, performed by specially trained providers, this discount may not always be available from a provider in your immediate location. For a location near you and the discount authorization, please call 1-877-5LASER6

* **Discounts on products and Services are not insured benefits and not underwritten by ACE American Insurance Company.**

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Expenses Not Covered

Toll Free: 800-620-5010 **agent@directbenefits.com**

DENTAL PLAN LIMITATIONS & EXCLUSIONS – No benefits will be paid for expenses incurred:

DENTAL PLAN LIMITATIONS

The services covered by our co-insurance dental plans are subject to limitations and exclusions. A partial list of these limitations and exclusions is shown below. For a complete list of your plan's specific covered services, and the limitations and exclusions that apply to those services, refer to your Policy or contact Us.

(1) Routine exams and cleanings – two per year (in conjunction with all other exams).
(2) Topical Fluoride - up to age 14 - two per calendar year (in conjunction with all other exams).
(3) Panoramic (age 6 and older) or full mouth series x-rays – limited to one every 60 months.
(4) Bitewing x-rays – 8 total per year (ages 2 and over).
(5) Occlusal x-ray – 1 every 24 months.
(6) Sealants – repair/ replacement is not covered within 36 months of application. Limited to permanent molars without decay or restorations for children up to age 15.
(7) Space maintainers – to preserve space between teeth for premature loss of a primary baby tooth. This does not include use for orthodontic treatment. Up to age 15.
(8) Fillings – Repair or replacement is not covered within 24 months of initial placement.
(9) Full mouth debridement – limited services available on same date of service. Limited to one per lifetime.
(10) Periodontal scaling/root planing – limited to once per quadrant in any 24 month period.
(11) Periodontal maintenance – 3 months after surgery, then every 6 months.
(12) Stainless steel crowns (age 18 and under) – 1 every 2 years.
(13) Occlusal guards for bruxism – one every year.
(14) Crowns, bridges, onlays, and dentures – every 60 months (age restrictions may apply; additional lab fee may be charged by provider for higher metals and porcelain that is not covered by the plan).
(15) Dentures – relining or rebasing of removable dentures – once per year.
(16) General anesthesia, including intravenous sedation – Age 7 & under: Once per calendar year up to $150; Age 8 & older: for the extraction of impacted teeth, based on necessity and not for anxiety management, up to $150 per year.

Orthodontia Services Limitations (only included if indicated on Summary of Benefits)

No coverage or limited coverage for orthodontic treatment which began prior to the effective date of coverage.

Alternate Benefit

If a less expensive, alternate procedure, service, or course of treatment can be performed in place of the proposed treatment to correct a dental condition, and the alternative treatment will produce a professionally satisfactory result, then the maximum allowed will be the charge for the less expensive treatment.

DENTAL PLAN EXCLUSIONS

Limitations and Exclusions may vary by state. Refer to your Policy or contact Us

1. For services and supplies not listed in the Coverage Schedule, not recognized as essential for the treatment of the condition according to accepted standards of practice or considered experimental.
2. For services related to, performed in conjunction with, or resulting from a non-covered procedure.
3. For charges in excess of the contracted Fee-for-Service schedule or the Usual and Customary rate, whichever applies.
4. For any treatment program which began prior to the date the Insured is covered under the Policy.
5. For crowns, inlays and onlays on teeth that can be restored by direct placement materials.
6. For the replacement of crowns, bridges, dentures, inlays or onlays that can be restored to normal function.
7. For the replacement of crowns, bridges, inlays, onlays or prosthetic appliance within 5 years from the date of last placement.
8. For service or supplies payable under any medical expense plan.
9. For any condition covered under any Worker's Compensation Act or similar law.
10. For services applied without cost by any municipality, county or other political subdivision or for which there would be no charge in the absence or insurance.
11. During any Waiting Period We require. This exclusion applies to employer-sponsored adult coverage only. When You voluntarily end Your insurance without a Qualifying Event and re-enroll at a later date, Your Waiting Period is 2 years and begins on the date Your coverage first ended.
12. For services that are applied toward the satisfaction of a Deductible, if any.
13. For services subject to a Waiting Period that were incurred during the Waiting Period.
14. For charges resulting from changing from one provider to another while receiving treatment, or from receiving treatment from more than one provider for one dental procedure to the extent that the total charges billed exceed the amount incurred if one provider had performed all services.
15. For hospital facility charges for any dental procedure, including but not limited to: emergency room charges, surgical facility charges, hospital confinement.
16. For drugs or the dispensing of drugs.
17. For oral hygiene instruction; plaque control; acid etch; prescription or take-home fluoride; broken appointments; completion of a claim form; OSHA/Sterilization fees (Occupational Safety & Health Agency); or diagnostic photographs (except for orthodontic purposes).
18. For orthodontia, unless included within the Coverage Schedule.
19. For cosmetic procedures, including but not limited to veneers and procedures performed primarily for cosmetic reasons.
20. For implants (unless included in the Covered Services); myofunctional therapy; athletic mouthguards; precision or semi-precision attachments; treatment of fractures, cysts, tumors, or lesions; maxillofacial prosthesis; orthognathic surgery; TMJ dysfunction; cleft palate; or anodontia.
21. For services to replace teeth that were missing (extracted or congenitally) prior to the effective date of coverage on Our Plan. This limitation ends after 36 months of continuous coverage on the Plan. Abutment teeth will be reviewed for eligibility of prosthetic benefits.

DENTAL PLAN LIMITATIONS & EXCLUSIONS – No benefits will be paid for expenses incurred:

22. For composite, resin, or white fillings on posterior primary teeth. Benefits will be reduced to that of an amalgam or silver filling.
23. For the replacement of a filling within 24 months of placement, unless for specific health reasons.
24. For the replacement of retainers.
25. For sealants not applied to a permanent bicuspid or molar; applied at age 15 or older; applied 3 years from a previous sealant application; applied to a decayed tooth.
26. For lab fees for higher metals or porcelain crowns, bridges, inlays, or onlays.
27. During travel or activity outside the United States.
28. To replace lost or stolen appliances.
29. For any procedure begun after the Policy terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's coverage terminates.
30. For appliances, restorations, or procedures to: (a) alter vertical dimension; (b) restore or maintain occlusion; or (c) splint or replace tooth structure lost as a result of abrasion or attrition.
31. For initial placement of any prosthetic crown, appliance, or fixed partial denture unless such placement is needed because of the extraction of one or more teeth while the Insured is covered under this Policy. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such prosthetic crown, appliance, or fixed partial denture must include the replacement of the extracted tooth or teeth.

Valid Through: June 30, 2020
Plans available in ALL STATES except: OH, OK, MA, MT, NY, NC, WA. Exclusions may vary by state. Please see Group Certificate for specific state.
This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit Us from providing insurance including, but not limited to, the payment of claims.

The services covered by our co-insurance dental plans are subject to limitations and exclusions. A partial list of these limitations and exclusions is shown above. For a complete list of your plan's specific covered services, and the limitations and exclusions that apply to those services, refer to your Policy or contact Us. In addition, actual services as listed above may vary based on state requirements, please refer to your Policy or Contact Us.

VISION PLAN EXCLUSIONS – We will not cover:

1. Orthoptic or vision training, subnormal vision aids and any associated supplemental testing.
2. Aniseikonic lenses.
3. Plano (non-prescription) lenses.
4. Non-prescription sunglasses.
5. Two pair of glasses, in lieu of bifocals or trifocals.
6. Medical or surgical treatment of the eye, eyes or supporting structures.
7. Any eye examination, or any corrective eyewear, required by an employer as a condition of employment; safety eyewear, unless specifically covered under the Plan.
8. Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof.
9. Sub-normal vision aids or non-prescription lenses.
10. Services rendered or Materials purchased outside the U.S. or Canada, unless:
a) the Insured resides in the U.S. or Canada; and
b) the charges are incurred while on a business or pleasure trip.
11. Charges incurred after:
a) the Policy ends; or
b) the Insured's coverage under the Policy ends, except as stated in the Policy.
12. Experimental or non-conventional treatment or device.
13. Certain name brand vision Materials for which the manufacturer maintains a no-discount practice.
14. Lost or broken Materials, except when replaced at normal intervals when Services are available.
15. Photorefractive Keratectomy (PRK) surgery or Laser-assisted in Situ Keratomileusis (LASIK)
16. Charges in excess of the Reasonable and Customary Charge for the Services or Materials.
17. Services or Materials provided by any other group benefit providing for vision care.

Valid Through: June 30, 2020
Exclusions may vary by state. Please see Group Certificate for specific state.
This insurance does not apply to the extent that trade or economic sanctions or other laws or regulations prohibit Us from providing insurance, including, but not limited to, the payment of claims.

New Group Checklist

DentalSelect

DirectBenefits

Toll Free: 800-620-5010 **agent@directbenefits.com**

All required information must be postmarked by the last day of the month in order for coverage to be effective the first day of the following month.

Required New Group Information - Please confirm that the following documents are submitted for seamless service.	
☐	**Completed Group Plan Application**
	Including:
☐	Group Information with Requested Effective Date and All Signatures
☐	Plan Design Selections
☐	Plan Rates
☐	**Completed Employee Enrollment Forms**
☐	Waivers, when applicable
☐	**Payment Options**
☐	Binder Check – *Include the $15 monthly billing fee with your* ***check payable to Dental Select.***
☐	EFT Bankdraft – *$15 monthly billing is waived.*
☐	**Producer Licensing Forms** (if not previously contracted with Dental Select)

Required Take-Over Benefit Information - Please confirm that the following documents are submitted for seamless service.	
☐	**Copy of Prior Carrier's:**
☐	Certificate, Booklet or Summary of Benefits
☐	Most Recent Billing Statement

Submit all completed and signed original forms to:

Direct Benefits
55 E. 5th Street, Suite 500
Saint Paul, MN 55101

800-620-5010 (press option 5) 651-649-3503
agent@directbenefits.com
info@directbenefits.com

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Group Plan Application

DentalSelect

DirectBenefits

Toll Free: 800-620-5010 **agent@directbenefits.com**

Group Information

Group Name			**Billing Address**		
SIC Code or Industry	**Requested Effective Date**		**City**	**State**	**Zip Code**
Street Address			**HR Contact & Title**		
City	**State**	**Zip Code**	**Phone #**	**Email**	
Phone #	**Fax #**		**Billing Contact & Title**		
Nature of Business			**Phone #**	**Email**	

Dental General Participation - A minimum of 2 Employees must enroll

Number of Eligible Employees: _____

Number of Employees Enrolling: _____

Number Not Enrolling Due to Other Coverage: _____

All Group Sizes – Your current Employees and any new hires may enroll at the time of your Group's initial application, upon experiencing a qualifying event, or at your Group's annual open enrollment.

Dental New Hire Waiting Periods

How long must a new hire be employed before being offered dental insurance? Benefits are available the first day of the month following:

☐ Date of Hire ☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ Other: _____

Select when applicable:

☐ Waive at Initial Enrollment Only

Is the new hire waiting period different for any class of Employees (i.e. hourly/salary/management/non-management)? If yes, please identify below.

Class:	**New Hire Waiting Period Days:**

Comparable Dental Plans

Does the Group now have a comparable dental plan which has been in force for the past 12 consecutive months?

☐ **Yes** ☐ **No**

If Yes:

Name of carrier: _____ **Length of coverage:** _____

The waiting periods for Basic, Major and Orthodontic services may be waived (in part or in their entirety) for those Employees and Dependents covered on the Group's prior comparable dental plan. To qualify for a waiver, a copy of the prior carrier's Summary of Benefits and the most recent billing statement listing Employees enrolled on the plan must accompany this application. Waiting periods are not waived for Employees/Dependents who enroll for coverage after the initial Magnum plan effective date.

DentalSelect

DirectBenefits Inc.

CHUBB

Group Plan Application
(Continued)

DentalSelect
DirectBenefits

Toll Free: 800-620-5010 **agent@directbenefits.com**

Design Your Plan

☐ **Dental Only** ☐ **Dental & Vision** ☐ **Vision Only**

Select a Dental Plan

☐ **Magnum I** (PPO/R&C) ☐ **Magnum II** (PPO/MAC)

Select Your Options

All Magnum dental plans have a standard $50/150 deductible per person. If you would prefer a different deductible, please indicate below.

Annual - Applies to Basic and Major Services only
- ☐ $0/$0 Single/Family
- ☐ $25/$75 Single/Family

Add Periodontics & Endodontics to Basic
- ☐ Yes
- ☐ No

Additional Factor Options
- ☐ 90% R&C
- ☐ Dental 2 year rate guarantee
- ☐ Vision 2 year rate guarantee

Dental and Vision must be sold with the same effective date in order to receive the 2 year rate guarantee.

Select Your Annual Maximum (*MaxRewards not available for Static Maximums.) † Available in: AK, AZ, AR, CA, CO, CT, FL, GA, HI, ID, IL, IA, KS, KY, LA, MN, MS, MO, NV, ND, OR, PA, TX, UT, WY

- ☐ $ 1,000 MaxRewards
- ☐ $ 1,250 MaxRewards
- ☐ $ 1,500 MaxRewards
- ☐ $2,000 Static Maximum*
- ☐ $3,000 Static Maximum*
- ☐ $4,000 Static Maximum*
- ☐ $5,000 Static Maximum*
- ☐ Unlimited Static Maximum* †

Dental Plan Type - Select one

☐ **Contributory Plan** (At least 75% of Eligible Employees enrolled.) ☐ **Voluntary Plan** (Less than 75% of Eligible Employees enrolled.)

Do You Want Orthodontia Benefits?

☐ Yes - Child Only ☐ Yes - Adult & Child ☐ No ☐ 2-4 Enrolled Employees ☐ 5 + Enrolled Employees

Does the prior dental plan have orthodontic coverage? ☐ Yes ☐ No

Please note: If you are adding orthodontics and the previous dental plan did not have orthodontic coverage, there will be a 12-month waiting period for orthodontic benefits under the Magnum Plan.

Select a Vision Plan

☐ **Vis 6** ☐ **Vis 8** ☐ **Vis 12** ☐ **Vis 21** **Network:** ☐ **Insight** ☐ **Select**

Vision General Participation - A minimum of 2 Employees must enroll

Number of Eligible Employees: _____ **Number of Employees Enrolling:** _____ **Number Not Enrolling Due to Vision Other Coverage:** _____

Vision Plan Type - Select one

☐ **Contributory Plan** (At least 60% of Eligible Employees enrolled.)
☐ **Voluntary Plan** (Less than 60% of Eligible Employees enrolled.)

Calculate Your Rates – Based on plan design, complete rates below

	Magnum I Rates	Magnum II Rates	Vision Rates	Other
Single:	_____	_____	_____	_____
Employee/Spouse:	_____	_____	_____	_____
Employee/Child(ren):	_____	_____	_____	_____
Family	_____	_____	_____	_____

Monthly Group Administrative Fee of $15.00 is waived for groups paying via EFT (Electronic Funds Transfer)

Groups not using EFT, must include a binder check with this application made payable to Dental Select for the first month's premium.

Group Plan Application
(Continued)

DentalSelect
DirectBenefits

Toll Free: 800-620-5010 **agent@directbenefits.com**

Terms & Conditions

By signing below, company officer or authorized person:

- understands that the In-Network plan providers are not agents, representatives, nor employees of Dental Select.
- represents that all information on this application and any attachment is correct and complete to the best of his/her knowledge and belief.
- understands that no insurance will become effective until approved by the Insurance Company.
- understands that no agent has the authority to modify or waive any conditions of this application or the policy nor to bind the Insurance Company by making any promise of representation.
- agrees to maintain and furnish any records necessary to administer the policy.
- understands that only those employees who meet eligibility requirements are to be covered under the policy and that participation requirements must be met before the policy will become effective and that such requirements must be maintained while the policy is in force to prevent termination of the policy.
- understands that coverage under the policy can be terminated in accordance with its terms and conditions.
- understands that the employer is the plan sponsor and plan administrator and that neither Dental Select or ACE American Insurance Company, nor any insurance agent is a plan administrator nor fiduciary, as those terms are defined under the Employee Retirement Income Security Act of 1974 (ERISA) with respect to participating employer's plan of the groups insurance, and the questions regarding the tax or legal effects of the plan are to be resolved by the employer with advice of their own counsel.

The applicant hereby requests insurance for eligible persons based on the above statements and representations, and where applicable, agrees to be bound by the terms and conditions of any trust agreement establishing a trustee as policyholder. Insurance will not go into effect until the required premium is paid for the plan of benefits selected by the applicant.

WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

Fraud Warning for Kentucky Applicants:
WARNING: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

Signature - Company Officer or Authorized Person	Printed Name	Date

How To Submit Your Information

A binder check for the first month's premium must accompany this application. Thereafter, Dental Select must receive the premium by the first day of each month.

1. Complete Group Plan Application. Retain a copy for your files.
2. Have each Employee complete and sign an Employee Enrollment Form.
3. Submit Electronic Enrollment (834 file format) for groups of 50+ Employees Enrolled (ongoing).
4. Send the original Group Plan Application, completed Employee Enrollment Forms, and the first month of premium made **payable to Dental Select,** to:

Direct Benefits
55 E. 5th Street, Suite 500
Saint Paul, MN 55101
Fax: 651-649-3502

Any questions? Call 800-620-5010.

Please Select Payment Option:

☐ **EFT Electronic Funds Transfer** – EFT Authorization Form must be completed and submitted with original Group Plan Application.

☐ **Monthly Billing Invoice** – Include first month's premium, made **payable to Dental Select.**

Agent / Broker Information

Agent Name	**Email**		
Agency Name	**Agent Phone #**		
GA (if applicable)	**Agent ID #**		
Agent Signature	**Date**		
Agent Address	**City**	**State**	**Zip Code**

NOTE: Please keep a copy of this form for your records.

Dental Select Office Use Only

Approved by	**Date Approved**	**Title**	
Effective Date		**Group #**	**Subgroup #**

DentalSelect

DirectBenefits Inc.

CHUBB

All plans of insurance are marketed by Dental Select, an insurance agency, and underwritten by ACE American Insurance Company, a member insurer of the Chubb Group of Companies.

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Electronic Funds Transfer (EFT) Authorization Form

DentalSelect
DirectBenefits

Toll Free: 800-620-5010 **agent@directbenefits.com**

FOR GROUP PREMIUM ONLY

☐ NEW ☐ CHANGE	Company Name:	Group #:

Payment Options – Choose one of the following options and complete this section in its entirety.

☐ **Checking Account**
(Complete only if using a Checking Account for EFT)

Name on Account (Printed):		
Joint Name on Account - if applicable (Printed):		
Exact Account Name (Please Print):		
Bank Name:	Bank Address:	
Account Number:	Routing #/ ABA #/ or other Bank Code(s):	
Company Contact Person(s):		
Company Contact Phone #:	Company Contact Fax #:	Company Contact Email:

Signature Authorization

As a duly authorized check signer on the financial institution account identified above, I authorize Dental Select to perform scheduled or periodic electronic funds transfer debits and/ or credits from said account in the amounts equal to each invoice, or when applicable, apply electronic funds transfer credits to the same. Charges will appear as "Dental Select" on account statement. I understand that the dollar amount of such debit and/ or credit transactions can and may vary according to the amount of each invoice. Furthermore, if any such electronic debit(s) should be returned by my financial institution as Non-Sufficient Funds (NSF), I authorize Dental Select and/or ACI to collect a returned item fee of Twenty Five Dollars ($25.00) per item by electronic debit from said account. This authorization shall remain in full force and effect, unless terminated sooner by Dental Select, until receipt by Dental Select of written notice from me of its revocation in such a manner as to afford Dental Select and my financial institution a reasonable opportunity to act on it. I understand and authorize all of the above as evidenced by my signature below.

Authorized Signature: Date Signed (MM/DD/YYYY):

Please fax completed form to 801-290-5099
(For your protection, EFT authorization forms are not accepted by email)

Dental Select
75 W Towne Ridge Parkway
Tower 2, Suite 500
Sandy, Utah 84070
800-999-9789

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Enrollment Instructions

DentalSelect

DirectBenefits

Toll Free: 800-620-5010 **agent@directbenefits.com**

General Instructions

Review Employee Enrollment/Change Form to ensure the employee has provided complete, accurate and legible information.

- Verify the Group number and any applicable Subgroup numbers are included on the form.
- Verify that the Effective Date and Date of Hire are included.
- When reporting effective dates use contractual start and stop guidelines as defined in your contract.
- Dental Select generally completes enrollment requests within five business days of receipt.

Reason/Status Change

Check one reason for enrollment and provide requested information including coverage effective date.

- **New Group** – Employee is enrolling at the time of the group's initial enrollment. Note: For a new group enrolling a COBRA participant, complete the COBRA category. Provide original date of qualifying event. If information is not provided, participant will not be enrolled and billed properly.
- **Open Enrollment** – Employee is enrolling during group's open enrollment periods.
- **New Hire** – Enroll newly hired employee. If probationary period applies, coverage effective date is after the probationary period.
- **Rehire** – Former employee was rehired.
- **Loss/Gain of Coverage** – Employee/dependent involuntarily lost other coverage and is now eligible to enroll.
- **Employee Part to Full Time** – Employee's employment status changed and employee is now eligible for dental benefits.
- **Other** – Select reason for a change in status.
    - **Previously Waived Coverage** – Outside of open enrollment period, a member must have a qualifying event or provide proof of prior coverage within 45 days to gain coverage or waive waiting periods. If coverage was waived at initial enrollment, employee is subject to waiting periods.
- **COBRA** – Employee status change to be eligible for COBRA. Mark the appropriate time frame and include the effective and cancel dates.

Authorization of Coverage

- **Waive Coverage** - If choosing to waive coverage, check the appropriate reason.
- **Sign & Date** – Enrollment is not valid without signed authorization of coverage.

Submit all completed and signed original forms to:

Direct Benefits
55 E. 5th Street, Suite 500
Saint Paul, MN 55101

800-620-5010 (press option 5) 651-649-3503
agent@directbenefits.com
info@directbenefits.com

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Employee Enrollment Form

DirectBenefits Inc. DentalSelect

Toll Free: 800-620-5010 **agent@directbenefits.com**

Must be completed in FULL – PLEASE PRINT – Enrollment is not valid without signature at the bottom of this page.

Use the Employee Enrollment Form to collect first time employee and dependent information. for existing member changes, please use the Employee Change Form.

First Name	**Last Name**		
Address			
City	**State**	**Zip Code**	
Phone ☐ Okay to Text	**Date of Birth** (MM/DD/YYYY)		
Email Address			
SSN	**Marital Status** ☐ Married ☐ Single	**Gender** ☐ Male ☐ Female	
Effective Date (MM/DD/YY)	**Date of Hire (Required)** (MM/DD/YY)		

Group Number	**Subgroup/Dept. #**
Name of Emplyer	
Employer's Address	

Coverage Selection
- Confirm available options with your employer. Check all that apply.

Dental Plan

☐ Magnum I
☐ Magnum II

Vision Plan

☐ Add Insured Vision

Individuals Covered
- List individuals for whom you are enrolling and select plan option.

☐ Dental ☐ Vision	**Spouse Name -** (Last, First, MI)	**Gender** ☐ Male ☐ Female	**SSN**	**Date of Birth** - (MM/DD/YYYY)
☐ Dental ☐ Vision	**Dependent Name -** (Last, First, MI)	**Gender** ☐ Male ☐ Female	**SSN**	**Date of Birth** - (MM/DD/YYYY)
☐ Dental ☐ Vision	**Dependent Name -** (Last, First, MI)	**Gender** ☐ Male ☐ Female	**SSN**	**Date of Birth** - (MM/DD/YYYY)
☐ Dental ☐ Vision	**Dependent Name -** (Last, First, MI)	**Gender** ☐ Male ☐ Female	**SSN**	**Date of Birth** - (MM/DD/YYYY)
☐ Dental ☐ Vision	**Dependent Name -** (Last, First, MI)	**Gender** ☐ Male ☐ Female	**SSN**	**Date of Birth** - (MM/DD/YYYY)

For additional dependents include the Dependent Enrollment Form

☐ I am eligible for waiting periods to be waived and have met the necessary requirements.

Waiver Requirements:

- Require CCL (Credible Coverage Letter) within 45 days
- Less than 60 day lapse in coverage from a prior dental plan
- Prior comparable plan summary (submitted within 45 days)
- Orthodontic services may not be eligible (unless prior coverage included Orthodontic services)

Authorization of Coverage

Authorization ☐ Check here to waive if no coverage is desired ☐ Check here to waive if you have additional coverage through another policy

I understand my information is protected by privacy laws and will be released only in accordance with these laws. The only people who have access to this information are employees of the Insurance Company who service my policy or claims and other third parties authorized by the Insurance Company. Information may be disclosed to those who have an insurance-related regulatory or legal need for the information. In other situations, We will ask you for written authorization to disclose information about you.

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I agree and understand that if my employer is contributing towards the cost of any of the insurance products I have chosen to decline, I will not be entitled to any compensation for my non-participation.

Signature (Required) ______________________________ Date ______________

CHUBB® All plans of insurance are marketed by Dental Select, an insurance agency, and underwritten by ACE American Insurance Company, a member insurer of the Chubb Group of Companies.

Dental Select 75 W Towne Ridge Parkway Tower 2, Suite 500 Sandy, Utah 84070 800-999-9789

Formulario de Inscripción

Toll Free: 800-620-5010 **agent@directbenefits.com**

Se debe completar EN SU TOTALIDAD – POR FAVOR, ESCRIBA CON LETRA DE MOLDE LEGIBLE — El presente formulario no será válido sin las firmas correspondientes en la página 2, y se devolverá si no está completo.

Utilice el formulario de inscripción de empleado para obtener información del empleado y personas a cargo nuevos. Para realizar cambios de miembros actuales, utilice el formulario de cambio de empleado.

Nombre	**Apellido**			
Dirección de Envío				
Ciudad	**Estado**	**Código Postal**		
Número de Teléfono Residencial	**Fecha de Nacimiento (DD/MM/AAAA)**			
Número de Seguro Social		**Estado Civil** ☐ Casado/a ☐ Soltero/a	**Sexo** ☐ Masculino ☐ Femenino	
Fecha de Vigencia (DD/MM/AA)	**Fecha de Contratación (Obligatorio) (DD/MM/AA)**			

Número de Grupo	**Número de Departamento/Subgrupo**
Nombre Completo del Empleador	
Dirección del Empleador	

Selección de Cobertura – Confirmar las opciones disponibles con su empleador. Marque las que correspondan.

Plan de Atención Dental

☐ Magnum I
☐ Magnum II

Planes para el Cuidado de la Vista

☐ Añadir la Visión Asegurado

Personas Cubiertas - Enliste las personas a quienes usted desea inscribir, cambiar y/o terminar.

☐ Dental ☐ Vista	**Nombre del Cónyuge -** (Apellido, Nombre, Inicial del 2do nombre)	**Sexo** ☐ Masculino ☐ Femenino	**Número de Seguro Social**	**Fecha de Nacimiento (DD/MM/AAAA)**
☐ Dental ☐ Vista	**Nombre del Dependiente -** (Apellido, Nombre, Inicial del 2do nombre)	**Sexo** ☐ Masculino ☐ Femenino	**Número de Seguro Social**	**Fecha de Nacimiento (DD/MM/AAAA)**
☐ Dental ☐ Vista	**Nombre del Dependiente -** (Apellido, Nombre, Inicial del 2do nombre)	**Sexo** ☐ Masculino ☐ Femenino	**Número de Seguro Social**	**Fecha de Nacimiento (DD/MM/AAAA)**
☐ Dental ☐ Vista	**Nombre del Dependiente -** (Apellido, Nombre, Inicial del 2do nombre)	**Sexo** ☐ Masculino ☐ Femenino	**Número de Seguro Social**	**Fecha de Nacimiento (DD/MM/AAAA)**
☐ Dental ☐ Vista	**Nombre del Dependiente -** (Apellido, Nombre, Inicial del 2do nombre)	**Sexo** ☐ Masculino ☐ Femenino	**Número de Seguro Social**	**Fecha de Nacimiento (DD/MM/AAAA)**

For additional dependents include the Dependent Enrollment Form

☐ Soy elegible para los periodos de esperea, para renuciar y cumplí con todos los requisitos necesarios.

Requistos para la renuncia

- Se requiere una carta de cobertura creíble (Credible Coverage Letter, CCL) dentro de un período de 45 días.
- Un lapso menor a 60 días de la cobertura de un plan de Dental select previo.
- Resumen comparable del plan anterior enviado dentro de un período de 45 días.
- Los servicios de ortodoncia no son elegibles.

Autorización de Cobertura/Cambio

Autorización: ☐ A continuación, marque la opción que corresponda si no desea alguna cobertura. ☐ A continuación, marque la opción que corresponda si desea renunciar a la cobertura, si ya cuenta con una cobertura adicional por medio de otra póliza.

Entiendo que las leyes de privacidad protegerán mi información personal, y la divulgarán únicamente de acuerdo a sus disposiciones. Las únicas personas que tendrán acceso a esta información son los trabajadores de la compañía de seguros que administran mi póliza de seguro o reclamaciones, así como otros terceros autorizados por la compañía de seguros. Además, la información puede darse a conocer a aquellos que tengan una necesidad relacionada con seguros reglamentarios o jurídicos para dicha información. En otras situaciones, le pediremos a usted una autorización por escrito para divulgar su información personal.

ADVERTENCIA: ES UN DELITO PROPORCIONAR, A SABIENDAS, INFORMACIÓN FALSA O FRAUDULENTA A LA COMPAÑÍA DE SEGUROS O CUALQUIER OTRA PERSONA. LAS SANCIONES INCLUYEN ENCARCELAMIENTO Y/O MULTAS. ADEMÁS, UNA COMPAÑÍA DE SEGUROS PUEDE NEGAR CUALQUIER BENEFICIO DE COBERTURA SI EL SOLICITANTE PRESENTA INFORMACIÓN FALSA RELACIONADA ESENCIALMENTE CON UNA RECLAMACIÓN.

Advertencia de fraude para los solicitantes en Kentucky:
ADVERTENCIA: TODA PERSONA QUE, A SABIENDAS Y CON INTENCIÓN DE COMETER FRAUDE CONTRA CUALQUIER COMPAÑÍA DE SEGUROS U OTRA PERSONA, PRESENTE UNA SOLICITUD DE SEGURO QUE CONTENGA INFORMACIÓN ESENCIALMENTE FALSA O QUE CON FINES ENGAÑOSOS OCULTE INFORMACIÓN PERTINENTE A ALGÚN HECHO MATERIAL EN LA MISMA, INCURRIRÁ EN UN ACTO FRAUDULENTO CONTRA LA LEY DE SEGURO, LO CUAL CONSTITUYE UN DELITO.

Entiendo y acepto que si mi empleador contribuye al costo de cualquiera de los productos de seguros que he decidido rechazar, no tendré derecho a indemnización alguna por mi falta de participación.

Firma del Empleador (Obligatorio) ______________________ **Fecha (DD/MM/AAAA)** ______________

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Dental Select 75 W Towne Ridge Parkway Tower 2, Suite 500 Sandy, Utah 84070 800-999-9789

MAGNUM

Employee Change Form

DirectBenefits DentalSelect

Toll Free: 800-999-9789 **Toll Free Fax:** 888-998-8704

Must be completed in FULL – PLEASE PRINT – Change Form is not valid without signature(s)

Employer's Full Name	Employer's Address	
Group Number	**Subgroup/Dept. #**	**Effective Date** (MM/DD/YY)
Subscriber's Name		**SSN/Member #**

Personal Information Selection - Change of name and/or Address.

Previous Employee Name	New Employee Name			
New Address	**City**	**State**	**Zip Code**	**Phone #**

Coverage Selection - Confirm available options with your employer. Check all that apply. Please note that changes may result in premium adjustments.

Requested Dental Plan	Requested Vision Plan
☐ Magnum I ☐ Magnum II	☐ Add Vision Plan ☐ Remove Vision Plan

Reason/Status - (Required for all requested changes - Notice must be given to Dental Select within 30 days)

☐ **Open Enrollment**
Effective Date:_____/_____/______

☐ **Rehire**
Date of Layoff:_____/_____/______ Rehire Date:_____/_____/______

☐ **Loss/Gain of Coverage** - Employee and/or Dependent
Date of Change:_____/_____/______ Effective Date:_____/_____/_____

☐ **Employee Part to Full Time**
Date of Change:_____/_____/______ Effective Date:_____/_____/_____

☐ **Other** - Mark One
☐ Marriage ☐ Termination ☐ Death
☐ Divorce ☐ Birth ☐ Address Change
☐ Leave of Absence ☐ Adoption ☐ Name Change
Date of Change:_____/_____/_____ Effective Date:_____/_____/_____

☐ **COBRA** - Mark One
☐ 18 months - Termination ☐ 36 months - Divorce. Loss of Subscriber, Etc.
Effective Date:_____/_____/_____ Cancel Date:_____/_____/_____

(Cancel as indicated)
☐ Entire Policy
☐ Dependent (as indicated below)
☐ Dental
☐ Insured Vision
☐ COBRA
☐ Cancel Date:_____/_____/______

Individuals Covered - List individuals for whom you are changing and/or terminating.

☐ Add ☐ Terminate ☐ Change	☐ Dental ☐ Vision ☐ COBRA	**Spouse Name -** (Last, First, MI)	**Gender** ☐ Male ☐ Female	**SSN**	**Date of Birth** - (MM/DD/YYYY)
☐ Add ☐ Terminate ☐ Change	☐ Dental ☐ Vision ☐ COBRA	**Dependent Name -** (Last, First, MI)	**Gender** ☐ Male ☐ Female	**SSN**	**Date of Birth** - (MM/DD/YYYY)
☐ Add ☐ Terminate ☐ Change	☐ Dental ☐ Vision ☐ COBRA	**Dependent Name -** (Last, First, MI)	**Gender** ☐ Male ☐ Female	**SSN**	**Date of Birth** - (MM/DD/YYYY)
☐ Add ☐ Terminate ☐ Change	☐ Dental ☐ Vision ☐ COBRA	**Dependent Name -** (Last, First, MI)	**Gender** ☐ Male ☐ Female	**SSN**	**Date of Birth** - (MM/DD/YYYY)

Authorization of Change - (Required for all requested changes - Notice must be given to Dental Select within 30 days)

Employer Signature (Required) **Title** **Date Signed (MM/DD/YYYY)**

Subscriber's Signature **Date Signed (MM/DD/YYYY)**

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In the event there is a discrepancy regarding any information contained in this form, documentation will be required.

Mail: Dental Select (Attn: Eligibility) 75 W Towne Ridge Parkway Tower 2, Suite 500 Sandy, Utah 84070 800-999-9789 Fax: (801) 290-5101 Toll Free Fax: (888) 998-8704

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