Benefit Enrollment Guide
2024

Contact Information

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Customer Service
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Teamworks

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Eligibility & Contributions

To be eligible for Dental, Vision and Ancillary benefits you must be full time working 30+ hours per week.

The spouse of eligible employee may be enrolled on all plans.

Children under the age of 26 may be eligible for coverage regardless of martial status of financial dependency.

Contributions dedpendent on your employer. Please check with Teamworks if you have any questions on the contribution.

TEAMWORKS DENTAL AND VISION PLANS

The proposed dental plans allow members to receive care from any licensed dentist; however, members receive the greatest value and convenience when they receive care from a participating dentist in the Dentemax network. This means that members who receive care from a participating dentist are responsible only for those deductibles and coinsurance amounts that are part of the program design. click to find your dentist - Find a dentist

	Dental Benefits	
	Premier Plan	**Standard Plan**
	DenteMax Network	DenteMax Network
Class I Preventive	100%	100%
Class II Restorative	80%	80%
Class III Major (12 Month Waiting Period)	50%	50%
Class IV Orthodontia (12 Month Waiting Period)	50%	Not Covered
Annual Program Maximum	$1,500	$1,000
Annual Program Deductible	$50/$150(excludes Class I)	$50/$150(excludes Class I)
Lifetime Orthodontic Maximum	$1,000	Not Covered

STANDARD DENTAL PLAN		
Coverage Tier		**Monthly Rate**
Employee	$	33.84
Employee + One	$	81.63
Employee + Two or More	$	122.52

PREMIER DENTAL PLAN		
Coverage Tier		**Monthly Rate**
Employee	$	41.44
Employee + One	$	86.15
Employee + Two or More	$	152.25

VISION PLAN		
Coverage Tier		**Monthly Rate**
Employee	$	9.55
Employee + One	$	18.70
Employee + Two or More	$	28.65

Teamworks Group Dental Plan 2023

Administered By:

Prodegi
Corporate Benefit Services

This material is for informational purposes only and is designed to highlight some of the benefits available under this plan. Consult the plan documents to determine specific terms of coverage relating to your plan. Terms include covered procedures, applicable waiting periods, exclusions and limitations.

Your dental plan allows you to see any licensed dentist, but using an in-network Dentemax dentist may minimize your out-of-pocket expenses.

DENTAL BENEFIT SUMMARY				
Network Options	**Premier Plan**		**Standard Plan**	
Reimbursement Levels	PPO Contracted Amt	MRC	PPO Contracted Amt	MRC
Calendar Year Benefits Maximum Applies to: Class II, III & IX expenses	$1,500		$1,000	
Calendar Year Deductible Individual Family	$50 $150		$50 $150	
Benefit Highlights	***Plan Pays***	***You Pay***	***Plan Pays***	***You Pay***
Class I: Diagnostic & Preventive Oral Evaluations Prophylaxis: routine cleanings X-rays: routine X-rays: non-routine Fluoride Application Sealants: per tooth Space Maintainers: non-orthodontic Emergency Care to Relieve Pain	100% No Deductible	No Charge	100% No Deductible	No Charge
Class II: Basic Restorative Restorative: Fillings Periodontic scaling and root planing Routine Tooth Extractions Non-routine xrays	80% After Deductible	20% After Deductible	80% After Deductible	20% After Deductible
Class III: Major Restorative (One year waiting period applies) Inlays and Onlays Endodontics and Periodontic surgery Crowns: prefabricated stainless steel / resin Crowns: permanent cast and porcelain Bridges and Dentures Repairs: Bridges, Crowns and Inlays Repairs: Dentures Denture Relines, Rebases and Adjustments	50% After Deductible	50% After Deductible	50% After Deductible	50% After Deductible
Class IV: Orthodontia Coverage for Dependents to age 19 (One year waiting period applies)	50% After Deductible Lifetime Max $1,500	50% After Deductible	Not Covered	100%
Class IX: Implants	Not Covered	100%	Not Covered	100%
Benefit Plan Provisions:				
In-Network Reimbursement	For services provided by a Dentemax network dentist, your dental plan will reimburse the dentist according to a Fee Schedule or Discount Schedule.			
Non-Network Reimbursement	For services provided by a non-network dentist, your dental plan will reimburse according to the Maximum Reimbursable Charge. The MRC is calculated at the 90th percentile of all provider submitted amounts in the geographic area. The dentist may balance bill up to their usual fees.			
Cross Accumulation	All deductibles, plan maximums, and service specific maximums cross accumulate between in and out of network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network.			

Calendar Year Benefits Maximum	The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply.
Calendar Year Deductible	This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.
Late Entrant Limitation Provision	Payment will be reduced by 50% for Class III, IV and IX services for 12 months for eligible members that are allowed to enroll in this plan outside of the designated open enrollment period. This provision does not apply to new hires.
Pretreatment Review	Pretreatment review is available on a voluntary basis when dental work in excess of $200 is proposed.
Alternate Benefit Provision	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Prodegi will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.

Benefit Limitations:	
Oral Evaluations/Exams	2 per calendar year.
X-rays (routine)	Bitewings: 2 per calendar year.
X-rays (non-routine)	Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 36 months.
Diagnostic Casts	Payable only in conjunction with orthodontic workup.
Cleanings	2 per calendar year, including periodontal maintenance procedures following active therapy.
Fluoride Application	2 per calendar year for children under age 16.
Sealants (per tooth)	Limited to posterior tooth. 1 treatment per tooth every 24 months for children under age 16.
Space Maintainers	Limited to non-orthodontic treatment for children under age 16.
Inlays, Crowns, Bridges, Dentures and Partials	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
Denture and Bridge Repairs	Reviewed if more than once.
Denture Relines, Rebases and Adjustments	Covered if more than 6 months after installation.
Gold Restoration	The cost of gold restorations in excess of the cost for other fillings will be included only when the teeth must be restored with gold.
Restorative: fillings	Includes composite fillings on molars
Prosthodontics	Includes porcelain crowns on molars

Benefit Exclusions:

Covered Expenses will not include, and no payment will be made for the following:

- Procedures and services not included in the list of covered dental expenses;
- Implants, including any appliances and/or crowns, and the surgical insertion or removal of implants
- Preventive Services: instruction for plaque control, oral hygiene and diet;
- Restorative: veneers of porcelain, ceramic, resin, or acrylic materials on crowns or pontics on or replacing the upper and or lower first, second and/ or third molars;
- Periodontics: bite registrations; splinting;
- Prosthodontic: precision or semi-precision attachments;
- Procedures, appliances or restorations, except full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of dysfunction of the temporomandibular joint (TMJ), stabilize periodontally involved teeth or restore occlusion;
- Athletic mouth guards;
- Services performed primarily for cosmetic reasons;
- Personalization or decoration of any dental device or dental work;
- Replacement of an appliance per benefit guidelines;
- Services that are deemed to be medical in nature;
- Services and supplies received from a hospital;
- Drugs: prescription drugs;
- Charges in excess of the Maximum Reimbursable Charge.

TEAMWORKS GROUP VISION PLAN 2023

Administered By:

Prodegi
Corporate Benefit Services

Frequency	
Exam	Every Plan Year
Frames / Materials	Every Plan Year
Lenses	Ever Plan Year
Contacts	Every Plan Year in Lieu of Glasses

SERVICE OR MATERIALS	IN NETWORK PROVIDER PLAN PAYS	OUT OF NETWORK PROVIDER MAXIMUM PLAN REIMBURSEMENT
Vision Examination	100% after $10 copay	Up to $40
Single-Vision Lenses	100% after $10 copay	Up to $85
Bifocal Lenses	100% after $10 copay	Up to $85
Trifocal Lenses	100% after $10 copay	Up to $85
Lenticular Lenses	100% after $10 copay	Up to $85
Frames	100% Up to $130	Up to $90
Contact Lenses Medically Necessary	100% Up to $130	Up to $90
Contact Lenses Elective	100% Up to $130	Up to $90
Standard Progressive Lenses	100% after $50	Up to $85
Premium Progressive Lenses	Not Covered	Not Covered
Polycarbonate Lenses	25% Discount	25% Discount
Anti-Reflective Lens Coating	25% Discount	25% Discount
Solid Lens Tints	25% Discount	25% Discount
Lasik Surgery	$250 Discount per eye	Not Covered
Polarized Lenses	25% Discount	25% Discount

When services are rendered by a non-network provider, the participant will pay the provider in full and submit a claim to Prodegi for reimbursement as shown in the above table. This document is a high-level summary of your vision benefit.

For benefit details including exclusions and limitations, see Plan Document for complete description of benefits and exclusions to coverage.

Take advantage of your benefits at work.

- Convenient payroll deduction
- Affordable group rates
- Great plans provided by your employer

Have you thought about what would happen if you didn't have the benefits offered to you through your workplace? It's an uncomfortable thought for most people. That's why it's important to take the time to review what coverage options are available to you through your employer that can help meet the needs of you and your family.

Consider all of your benefit options during open enrollment and choose the ones that are right for you!

- Accident Insurance
- Critical Illness Insurance
- Hospital Indemnity Insurance
- Accidental Death & Dismemberment Insurance
- Life Insurance
- Disability Insurance

Review and update your benefits on the **enrollment portal.**
Reach out to us at Benefits@teamworksgroup.com with any questions

The Guardian Life Insurance Company of America
New York, NY

guardianlife.com

2021-127622 (10/23)