Companion Life Insurance Company and

Total Plan Services, Inc. introduce

TotalMed America

GROUP COMPREHENSIVE MAJOR MEDICAL PROGRAM

Companion Life

Group Insurance Program
Underwritten by:
Companion Life Insurance Company
Rated A+ Superior by A.M. Best

*This rating represents an independent opinion from a leading provider of insurance ratings of a company's financial strength and ability to meet its obligations to policyholders.

Administered by:

Total Plan Services, Inc.

14001 Dallas Parkway, Suite 700
Dallas, Texas 75240
800.969.5238 / 469.791.5900
www.totalplan.com

Companion Life Insurance Company and Total Plan Services, Inc.

TotalMed America Group Insurance Program

5 Million Lifetime Max

Calendar Year Deductible Options

4th Quarter Carry Forward Option

Select separate, same or double calendar year deductible. Calendar year deductible applies for covered charges in or out of network.

Individual	$300 / $500 / $750 / $1000 / $1500 / $2000 / $2500 / $5000
Family	3 Individuals per calendar year

Co-Insurance Options

PPO/NON-PPO	70/50 or 80/60 or 80/50 or 90/70 or 90/60

Stop Loss Options

Individual	$5000 / $10,000 / $15,000 Family 3 Individuals per calendar year

Office Visit Co-Pay Options

Available only on specific deductible and co-insurance options.
Non-PPO office visit are subject to deductible and co-insurance.

Co-Pays	$15 / $20 / $25 / $35 / $50
PCP-Specialist	$15/$30 or $20/$40 or $25/$50 or $35/$70 or $50/$100

Prescription Drug Card Options

Drug card Deductible	$50 or $100 or $200
3 Tier Drug Card	$8/$35/$70 or $10/$20/$30 or $10/$40/$80 or $15/$25/$35 or $15/$20/$20 or $15/$30/$50 or $15/$50/$100

Drug Options

Drugs same as any other (SAAO) once deductible is met

Drugs SAAO with Mail Service Program ($15/$25/$40 co-pay)

Drug Co-pay + 20% or 50% on brand and non- formulary

Drug deductible on all levels of co-pays or deductible can be waived on the Generic

Drug Card is Optional

Prescription Drugs are covered SAAO after the deductible is satisfied when the drug card is not selected. Mail order (Extended Supply Network) is available for a 90-day supply.

Preventative

$200 or $300 or $500

ER Co-Pay Options

$75 or $100 or $150 with $1000 benefit

Supplemental Accident

Available on the $300 & $500 deductible plans

Hospital Admit Co-Pays

$0/$300 or $150/$500 or $300/$500 or $500/$750

PLAN INCLUDES

	In-Network PPO	Out of Network Non-PPO
Out Patient Benefits		
Preventive Benefits Any combination of routine physical exams, well-baby exams, x-ray and lab pap smears, mammograms, immunizations, gynecological exams.	100% up to $200, $300 or $500 per calendar year	Not covered
Hospital Emergency Room 3 co-pay options: $75 or $100 or $150 Co-pay applies per visit and is waived if admitted as in-patient.	After co-pay 100% up to $1,000, then subject to deductible and co-insurance.	Subject to co-insurance and deductible.
In-Patient Benefits		
4 Hospital In-patient deductible options: per confinement and in addition to the calendar year deductible and co-insurance limits.	Option 1 $0 Option 2 $150 Option 3 $300 Option 4 $500	$300 $500 $500 $750
Limited Benefits		
Organ/Tissue Transplant Program	Inside Lifetime Maximum Benefit of $500,000 for all covered charges for or in connection with, or as a consequence of covered transplant.	
Treatment for Mental Disorder Covered mental disorders	(SAAO) Same as any other illness	(SAAO) Same as any other illness
Other Covered Services		
Hospice Program $5,000 Lifetime Maximum Benefit	100%	80%
Surgical, Anesthesiology, Services & Supplies	Subject to Deductible and Co-insurance	
Manipulative Therapy of Spine & Soft Tissue	Subject to Deductible and Coinsurance with benefit limitations of: $25 per visit (all combined services) and limited to 2 visits per 7 consecutive days. Maximum of 52 visits per calendar year.	
Home Health Care	Up to $75 per visit for Skilled Nursing; Maximum of 60 visits per calendar year for all services of combined Agencies.	
Skilled Nursing Facility	Up to 90 days per calendar year.	

Out of network claims are based on the UCR or reasonable or allowable charge in the geographic area where the service is received.

Important Plan Features and Additional Options

Special Deductibles Feature: When the deductible is satisfied in the last 90 days of a calendar it will carry over and also be used in the next calendar year. A premium discount is available to groups that do not select this feature.

Special Premium Discount Option: A premium discount of up to 2% may be available for employer groups that drug screen all their employees and applicants prior to hiring.

Maternity covered as any other illness for employees and covered spouses.

Utilization Review (UR) is required. Failure to comply with UR requirements can result in a substantial reduction or loss in benefits. Refer to the Certificate for details.

Initial 12 month rate guarantee.

Optional dental benefit and Optional orthodontia benefit is available.

Optional vision benefit is available.

Optional 24-hour coverage for sole proprietors, owners, partners, and corporate officers when legally eligible not to participate in worker's compensation.

Optional 2 tier Physician's Office Copay with premium discount is available.

$10,000 Life and A D & D included on all employees. Higher amounts available.

Optional voluntary life and Optional dependent life is available.

Optional COBRA and HIPAA administration is available.

LIMITATIONS AND EXCLUSIONS SUMMARY

(see the certificate for details)

Prescription Drug Exclusions: drugs or medicines which are not medically necessary for covered conditions • items used to prevent or terminate pregnancy except for oral prescription contraceptives • growth hormones in excess of $5,000 per calendar year • non-legend drugs other than insulin • administration or injection of any drug • therapeutic devices or appliances, hypodermic needles, syringes (unless for insulin), and non-medicinal substances • prescriptions an eligible person is entitled to at no charge by any other drug or medical services • investigational or experimental drugs • infertility drugs, immunization agents, biological sera, blood or blood plasma • medication while a patient is in a facility which dispenses pharmaceuticals • refills in excess of the number specified by the practitioner, or dispensed after one year from practitioner's order • Retin-A except up to age 25 years • smoking deterrents • drug to stimulate hair growth • cosmetic drugs, health and beauty aids, cosmetics, anorexiants, and dietary supplements • any covered drug consumed at time and place of prescription order.

Limits on covered Charges: covered charges for room, board, and general nursing care other than intensive care, are limited to average semi-private • covered charges for dental treatment are limited unless optional dental benefits are issued • covered charges for an assistant surgeon are limited to 25% of the covered charges for the surgeon • covered charges for treatment of sleep disorders are limited • covered charges for physical, occupational, or speech therapy are limited

Medical Care Benefit Exclusions: **No benefit shall be paid under the policy for care, services, or supplies** • not medically necessary for treatment of injury, illness, or other conditions specifically covered by the policy • not recommended and approved by the attending practitioner or which are furnished by a practitioner outside the scope of his licenses • furnished by or on behalf of a practitioner not personally performed by or under the personal supervision and in the presence of that practitioner • provided by a hospital on behalf of a practitioner for inpatient medical or surgical care • of medical personnel on standby status • incurred while an inpatient which are not consistent with the diagnosis of record • made by you, a close relative, or any person who lives in your home • for injury due to taking part in a riot or insurrection or to committing or attempting to commit an assault or a felony • provided outside the United States of America, except for emergency medical treatment • incurred while coverage under the policy is not in effect for the covered person except as may be specifically provided in the policy • of any illness covered under any worker's compensation law, occupational disease law, or similar law; or any injury arising out of, or in the course of, doing any work for pay, profit, or gain, whether on the covered person's job or any other job • for which the covered person does not legally have to pay, except when payment of such benefits is required by law and then only to the extent required by law • which would not have been made if the covered person were not insured under the policy • for, in connection with, or as a consequence of treatment, care, services, or supplies deemed in the sole judgment of the company to be experimental, investigational, or unproven with respect to the patient's diagnosed injury or illness • for custodial, convalescent, or sanatorium care or other care for the purpose of meeting personal needs (help in walking, bathing, dressing, eating, taking medicine, etc.), except for limited home health aide services through a home health agency or hospice program as specifically provided under the MAJOR MEDICAL EXPENSE BENEFITS provision • for travel, rest cures, supervision in protected settings, or other therapy which is primarily to change or control environment • for treatment of an intentionally self-inflicted bodily injury • for, in connection with, or as consequence of transplants or implants of human, animal, or artificial organs,

tissues, or cells, in whole or in part, as specifically provided under the MAJOR MEDICAL EXPENSE BENEFITS provision • for, in connection with, or as a consequence of solid organ transplants where the diagnosis illness or injury arises from alcoholism, drug addiction, or other chemical dependency, including but not limited to drug overdoses or alcoholic cirrhosis • for refractive keratoplasty (including radial keratotomy), routine eye examinations, eye glasses, contact lenses or their fitting (unless for initial replacement of the lens of the eye), eye exercises, visual therapy, fusion therapy, visual aids or orthoptics, or any related examinations • hearing aids or their fitting • for treatment of the teeth or gums except as specifically provided in the policy • for sex transformation • due to or for plastic surgery, cosmetic surgery or reconstructive surgery, except as covered in the MAJOR MEDICAL EXPENSE BENEFITS provision • due to pre-existing condition • for vitamins or food supplements • for routine care of a newborn child except as specifically provided under the limits on covered charges provision • for surgery to restore fertility when infertility is due to elective surgery • for, in connection with, or as a result of, surgery and services to correct obesity; and, for or in connection with, weight loss programs • for treatment of temporomandibular joint (TMJ) or craniomandibular dysfunction, regardless of cause, except as specifically provided under the MAJOR MEDICAL EXPENSE BENEFITS provision, but only if certified in advance through the Utilization Review Program • for treatment of sleep disorders except as specifically provided under the MAJOR MEDICAL EXPENSE BENEFIT provision • for or due to the prevention of pregnancy in an employee or dependent spouse, except for prescription contraceptives as specifically provided under the MAJOR MEDICAL EXPENSE BENEFITS (other covered charges) provision and the PRESCRIPTION DRUG EXPENSE BENEFIT provision • for or due to the prevention of pregnancy in a dependent child • for or due to any induced termination of pregnancy in an employee or dependent spouse • due to pregnancy or complication of pregnancy, or for or due to any induced termination of pregnancy in a dependent child • for treatment and care of weak or flat feet, fallen or high arches, foot instability or imbalance, metatarsalgia, bunions, corns, calluses, toenails, or hallux valgus • for treatment to reduce or stop use of tobacco nicotine, or caffeine • for private duty skilled nursing services except through a home health agency or as part of a hospice program, as specifically provided under the MAJOR MEDICAL EXPENSE BENEFITS provision • for prescription drugs, except (a) those provided by a covered facility and consumed or otherwise used during treatment on the facility property and (b) as specifically provided under the PRESCRIPTION DRUG EXPENSE BENEFITS provision • for treatment of infertility or sexual dysfunction regardless of cause • for first aid supplies • furnished by a governmental plan or facility, unless the covered person is legally obligated to pay • for treatment due to the covered person riding in or on an vehicle or a motorized vehicle of any type designed primarily used for racing, speed tests or hazardous exhibition purposes • for treatment due to injury resulting from travel, flight in, or descent from any aircraft owed or leased by the covered person or being in any aircraft used for test or experimental purposes, speed test, exhibition or stunt flying, crop dusting, seeding, hunting, herding or herd thinning, fire fighting or rescue • for marriage counseling or any therapy or counseling for sexual dysfunction • for exercise equipment or programs regardless of their intended purpose • for the purchase of home based artificial kidney equipment • for failure to keep an appointment or to complete claim forms • for acupuncture, acupressure, massage therapy, chelation therapy (except in the case of metal poisoning) or orthomolecular medicine • for biofeedback services • for inpatient physical therapy, rehabilitation, diagnostic x-rays and laboratory services or other diagnostic studies, except when such services cannot be rendered on an outpatient basis • for treatment arising from the voluntary taking of any gas or poison or the voluntary taking of any drug, sedative or narcotic, unless prescribed dosage • injury caused by, contributed to, or resulting from the Covered Person's use of alcohol, intoxicants, hallucinogenics, illegal drugs, or any drugs or medicines that are not taken in the recommended dosage or for the purpose prescribed by the Covered Person's Practitioner • related to complications arising from treatment, care, services, or supplies otherwise excluded under the Policy.

Important Notice

1) Actual Benefits may vary by state
2) This brochure briefly describes the insurance coverages offered. It does not include all the benefits, limitations, and exclusions of the contract. The complete terms of the participants covered will be determined by the group policy issued to the employer. Certificates of coverage outlining the benefits in more detail will be provided to each employee.

Companion Life Insurance Company and Total Plan Services, Inc.

TotalMed America Group Insurance Program

HSA Qualified Plan Designs

Calendar Year Deductible Options	Individual	$1,250 / $1,750 / $2,500 / $5,000
Calendar year deductible applies for covered charges in or out of network. See below for package options.	Family	$2,500 / $3,500 / $5,000 / $10,000
Co-Insurance Options	PPO/Non-PPO 100/70, 70/50	
Office Visit Co-Pay Options	Deductible and Co-Insurance for in and out-of-network benefits	
Prescription Drug Card	Deductible and Co-Insurance for in and out-of-network benefits	
Preventive - Optional	$200, $300, or $500 Benefit	

Stop Loss Options

Co-Insurance Options 70/50

Deductible Ind. / Family	Maximum Out-of Pocket Ind. / Family
$1,250/$2,500 In-Network $1,250/$2,500 Out-of-Network	$3,750/$7,500 In-Network $8,750/$17,500 Out-of-Network
$1,750/$3,500 In-Network $1,750/$3,500 Out-of-Network	$3,250/$6,500 In-Network $8,250/$16,500 Out-of-Network
$2,500/$5,000 In-Network $2,500/$5,000 Out-of-Network	$2,500/$5,000 In-Network $7,500/$15,000 Out-of-Network

Co-Insurance Options 100/70

Deductible Ind. / Family	Maximum Out-of Pocket Ind. / Family
$1,250/$2,500 In-Network $1,250/$2,500 Out-of-Network	$0/$0 In-Network $8,750/$17,500 Out-of-Network
$1,750/$3,500 In-Network $1,750/$3,500 Out-of-Network	$0/$0 In-Network $8,250/$16,500 Out-of-Network
$2,500/$5,000 In-Network $2,500/$5,000 Out-of-Network	$0/$0 In-Network $7,500/$15,000 Out-of-Network
$5,000/$10,000 In-Network $5,000/$10,000 Out-of-Network	$0/$0 In-Network $5,000/$10,000 Out-of-Network

For Agent Use Only

This is not for dissemination to or solicitation of the public. Contact us for costs and further details of the coverage, including exclusions, any reductions or limitations and the terms under which the policy may be continued in force.

Companion Life Insurance Company and Total Plan Services, Inc.

TotalMed America Group Insurance Program

Dental Care Expense Coverage

This optional benefits plan may be selected by the employer, for additional premium, in conjunction with the TotalMed America Group Medical Insurance.
This product is not available as a stand alone product.

Dental Plan Highlights

Eligible charges incurred during each calendar year are covered as follows:
After the calendar year deductible (3 individual deductibles per family maximum) is met the following services will be paid at the percentage designated:

100% **Preventive Services**	**80%** **Basic Services**	**50%*** **Major Services**
Cleanings (2 per calendar year)	Extractions	Crowns
Routine Oral Exams	Endodontics	Inlay
Fluoride Treatments (under age 19, once per year)	Fillings	Onlays
Space Maintainers (under age 16)	Denture Repairs	Bridgework
(Covers initial appliance only)		Dentures
X-rays, bitewings once per 6 months)		Gold Fillings
Full mouth (panoramic) once per 36 months		Periodontics
Non-routine exams		Oral Surgery
Sealants		Root Canal Therapy

Up to a Maximum Benefit of $1,000 per calendar year
*A person must be continuously covered on the current employer's dental plan for one year before major services are covered.

Group Options

Benefits in the section are Employer choice options to be selected by the Employer for the entire group.

Calendar year deductible of $50 or $100 per person.

Preventive services may be paid at 80% instead of 100%

Orthodontia Benefit: Available only to groups of 10 or more. If elected, pays 50% orthodontic treatment of a dependent child under age 19, subject to a separate $100 deductible and a $1000 lifetime benefit. Treatment must begin prior to the child's 18th birthday and while the patient is covered under this plan.

Special TMJ Benefit: Provides coverage for treatment of Temporomandibular Joint Dysfunction (TMJ) at 50%. Subject to calendar year deductible. Orthodontic procedures (as determined by us) for treatment of TMJ are covered only under the Orthodontia Benefit and only when the Orthodontia Benefit is in effect.

Pre-Determination of Benefits: When dental treatment is expected to exceed $200, a claim form may be submitted before the actual work is done for a pre-determination of benefits. This procedure reduces a misunderstanding of benefits and allows the patient to make financial arrangements with the dentist. NOTE: A pre-determination of benefits is not a guarantee of benefits.

Alternative Benefits: When two or more procedures are considered equally customary treatment for a given dental condition, benefits will be based on the treatment with the lowest usual and customary charge.

Late Entrants: Eligible employees or dependents who enroll later than 31 days after first becoming eligible, will be covered only for Preventive Services and emergency dental care of accidental dental injuries during the first year of coverage. On plans, which include orthodontia benefits, late entrants must be insured for two full years before being eligible for orthodontia benefits.

LIMITATIONS AND EXCLUSIONS SUMMARY

(See the Certificate for details)

No dental benefits will be paid for the following:

A) Dental services and supplies covered in whole or part by any other plan or benefits or service provided by your employer.
B) Treatment by other than a dentist, except for scaling and cleaning of the teeth and topical applications of fluoride by a licensed Dental Hygienist under the guidance of a Dentist.
C) Porcelain or other veneer facings on crowns or pontics placed on or replacing teeth, except for the ten upper and lower anterior teeth;
D) Services of a cosmetic nature, including personalization and characterization of dentures
E) Replacement of a bridge or denture within five years of the original installation, except for the replacement necessary because of the placement of a full opposing denture or the extraction of natural teeth. This does not apply to a bridge or denture in the oral cavity that is damaged beyond repair as a result of injury.
F) Replacement of, lost missing or stolen prosthetic devices
G) Duplicate prosthetics devices or any other duplication of appliances
H) Oral hygiene, plaque control program and dietary instruction
I) Any service, treatment or supply furnished by the U.S. government or any of its agencies, except when there is a legal obligation to pay. Any services, treatment or supply furnished by a state, providence or political subdivision, except when there is a legal obligation to pay.
J) Dentures during the first 12 months of coverage
K) Treatment started before this insurance is in force as to the Covered Person
L) Treatment considered experimental in nature or implantology
M) Orthodontic treatment or appliances, (except as shown).
N) Diagnosis or treatment of Temporomandibular Joint Dysfunction (TMJ), except as shown.
O) Any service, treatment or supply as the result of any occupational injury or sickness;
P) Prosthetic Appliances when initial work begins prior to the effective date of insurance
Q) Missed office appointment

Important Notice

Benefits may vary by State. The information contained herein, is only a brief description of the benefit plans available and the applicable limitations and exclusions. It is not a contract of insurance or benefits and will not be used to determine any benefits payable. The exact provisions governing insurance coverage are contained in the Certificate issued to each insured employee.

Companion Life Insurance Company and Total Plan Services, Inc.

TotalMed America
Group Insurance Program
Vision Care Expense Coverage

If you or one of your Dependents undergoes a Complete Visual Analysis or purchases any of the listed vision aids, we will pay the provider's charges to the Maximum Payment Limits as described in Certificate.

Vision Care

Benefits Payable

- 100% of charges, but not more than the Max Payment Limit shown for each examination or vision aid.

	Maximum Payment Limit
Complete Visual Analysis (one per 12-month period)	$50.00
Frames (one set per 24-month period)	$100.00
• Single Vision Lenses (pair)	$50.00
• Bifocal Lenses (pair)	$75.00
• Trifocal Lenses (pair)	$100.00
• Lenticular Lenses (pair)	$150.00

- Contact Lenses (in lieu of lens and frame benefit):

  The maximum payment for a pair of contact lenses will be $100. If the lenses are prescribed after cataract surgery or if vision in the better eye can be corrected to 20/70 or better only by use of contact lenses.

  If the contact lenses are chosen for reasons other than stated above, the maximum payment for Single Vision Lenses, not to exceed the following:

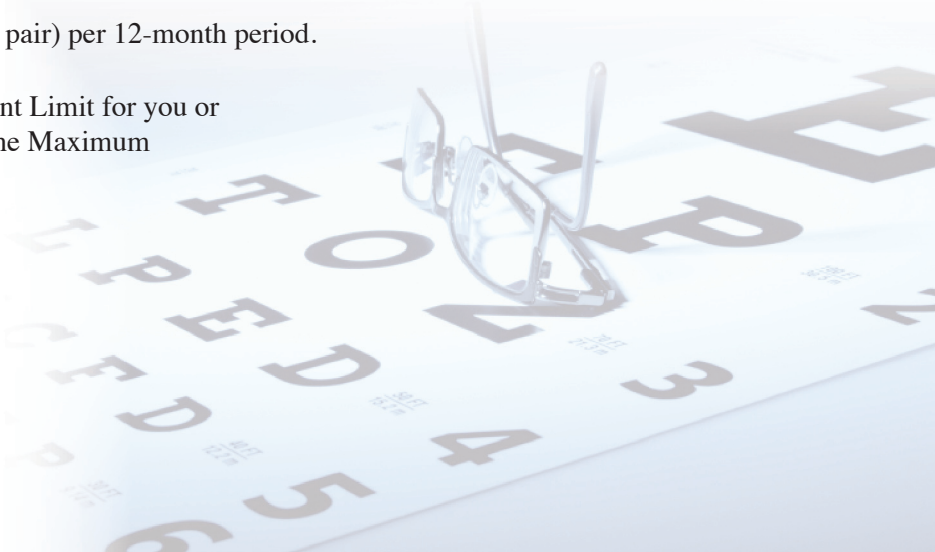
  Single Vision Lenses ($50.00): Two lenses payable once in any period of 12 consecutive months; plus

  Frames ($100.00): One set of frames in any period of 24 consecutive months.

  In determining the maximum payment for contact lenses as described above, the Single Vision lenses amount will be included only as of each 24-month period.

- Not more than two lenses (one pair) per 12-month period.

The Vision Care Maximum Payment Limit for you or your Dependents will not exceed the Maximum Payment Limits shown above.



Definitions

"Complete Visual Analysis" includes:

- Case history and professional consultation; and
- Examination for disease or abnormalities; and
- Determination of the ranges of clear single vision; and
- Measurement of refraction, eye muscle coordination, and balance; and
- Special working distance analysis

"Optometrist" means a person who is licensed to practice optometry.

LIMITATIONS AND EXCLUSIONS SUMMARY

(See the Certificate for details.)

No vision care expense benefits will be paid for the following:

A. A visual analysis or vision aids that are not for Medically Necessary Care; or
B. Any part of a charge for a visual analysis or visions aids that exceeds Prevailing Charges; or
C. A visual analysis performed by other than a Physician or Optometrist; or
D. Vision aids not prescribed by a Physician or Optometrist; or
E. A visual analysis or vision aids provided by a person in the Member's or Dependent's Immediate Family; or
F. Sunglasses (prescribed or not); or
G. Duplication or replacement of a vision aid that is broken, lost, or stolen; or
H. More than one Complete Visual Analysis in any period of 12 consecutive months; or
I. More than two lenses (one pair) in any period of 12 consecutive months or one set of frames in any period of 24 consecutive months; or
J. A visual analysis or vision aids for which the Member or Dependent has no financial liability or that would be provided at no charge in the absence of insurance; or
K. A visual analysis or vision aids paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law) unless such charges are imposed against the person for such visual analysis or vision aids; or
L. A visual analysis or vision aids provided as the result of a sickness or injury that is due to war or act of war; or
M. A visual or vision aids provided as a result of a sickness or injury that is due to participation in criminal activities; or
N. A visual analysis or vision aids provided as the result of: (1)An injury arising out of or in the course of any employment for wage or profit, if the Member or Dependent is eligible to be covered under a Workers' Compensation Act or other similar law; except this limitation will not apply to: partners, proprietors, or corporate officers who are not covered by a Workers' Compensation Act or other similar law Worker' Compensation Act or other similar law; or
O. A visual analysis or vision aids covered by medical;(1) or A sickness covered by insurance issued under this Group Policy; or
P. A visual analysis or vision aids provided outside the United States, unless the Member or Dependent is temporarily outside the United States for a period of six months or less for one of the following reasons: (1)Travel, provided the travel is for a reason other than securing vision care diagnosis or treatment; (2)or A business assignment; (3)or Full-Time Students status, and is either: (4)Enrolled and attending an accredited school in a foreign country; (5)or Participating in an academic program in a foreign country, for which the institution of higher learning at which the student is enrolled in the U.S. grants academic credit.

Important Notice

Benefits may vary by State. The information contained herein, is only a brief description of the benefit plans available and the applicable limitations and exclusions. It is not a contract of insurance or benefits and will not be used to determine any benefits payable. The exact provisions governing insurance coverage are contained in the Certificate issued to each insured employee.

Notes

Administered by:

TOTAL PLAN SERVICES, INC.

14001 Dallas Parkway, Suite 700
Dallas, Texas 75240
800.969.5238 / 469.791.5900
www.totalplan.com