Dental and Vision for Everyone

Dental and **Vision** Coverage in One Program*

For Association Members including
Individuals, Small Employers, and Senior Citizens

Dental Underwritten by:
Delta Dental Insurance Company

Vision Administered by:

Marketed by:

*Dental Insurance Policy benefits and Vision Coverage are provided through different carriers.
These companies are financially responsible for their own products.

Delta Dental Insurance Company (Delta Dental) Dental Benefits

Two plans to choose from: Delta Dental Premier® (Premier) or Delta Dental PPO (PPO)

- **Free choice of dentist**
- **Benefits up to $1200 per calendar year**
- **6 month waiting period basic**
- **12 month waiting period for major and ortho**
- **Benefits increase after the first and second years**
- **$100 lifetime deductible on ortho**
- **Ortho benefits for dependents included at no extra charge**
- **Keep your dental plan regardless of age**

Your Deductible	Plan Pays 1st Year	Plan Pays 2nd Year	Plan Pays 3rd Year	Services Covered
$50 per person per calendar year	80%	90%	100%	**Diagnostic and Preventive Procedures** Diagnostic: Routine periodic examinations once in a 6 month period. Preventive: Dental prophylaxis (teeth cleaning) once in a 6 month period. Radiography: Bitewing and full mouth x-rays.
	60%	70%	80%	**Basic Procedures (6 month waiting period)** Restorative: Amalgam fillings. Other: Space maintainers, recementation of crowns.
	0%	40%	50%	**Major Procedures (12 month waiting period)** Endodontics: Pulpal therapy and root canals. Periodontics: Treatment of diseases of the gums. Oral Surgery: Extractions and other oral surgery, including pre and post operative care. Prosthetics: Gold restorations, crowns, bridges, partials and complete dentures. Other: Pontics, repair of crowns and bridges, repair of full and partial dentures.
$100 lifetime	0%	40%	50%	**Orthodontia Procedures (12 month waiting period)** ($350 calendar year maximum) ($1000 lifetime maximum per person for this benefit) Orthodontic benefits are only available for eligible dependent children.

OPTIONAL SERVICES

Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services." Optional Services also include the use of specialized techniques instead of standard procedures. For example:

(a) a crown where a filling would restore the tooth;

(b) a precision denture/partial where a standard denture/partial could be used;

(c) an inlay/onlay instead of an amalgam restoration;

(d) a composite/resin restoration instead of an amalgam restoration on posterior teeth.

If a member receives Optional Services, your Benefits will be based on the lower cost of the customary service or standard practice instead of the higher cost of the Optional Service. Member will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard practice.

DENTAL EXCLUSIONS

Delta Dental does not pay Benefits for:

a) Services for injuries or conditions which are compensable under workers' compensation or employers' liability laws; services which are provided to the Enrollee by any federal or state government agency or are provided without cost to the Enrollee by any municipality, county or other political subdivision except as such exclusion may be prohibited by law.

b) Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic surgery or dentistry for purely cosmetic reasons, including but not limited to cleft palate, maxillary and mandibular (upper and lower jaw) malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration) of the teeth, and andontia (congenitally missing teeth), except those services provided to newborn children for congenital defect or birth abnormalities or services that may be provided under Orthodontic Benefits.

c) Services for restoring tooth structure lost from wear, erosion, or abrasion, for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Such services include, but are not limited to: equilibration, periodontal splinting, occlusal adjustment.

d) Any Single Procedure started prior to the date the person became covered for such services under this program.

e) Prescribed drugs, medication or analgesia.

f) Experimental procedures.

g) Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.

h) Charges for anesthesia, other than by a licensed Dentist for administering general anesthesia in connection with covered oral surgery services.

i) Extra oral grafts (grafting of tissues from outside the mouth to oral tissues).

j) Services with respect to any disturbance of the temporomandibular joint (jaw joint).

k) Services performed by any person other than a Dentist or auxiliary personnel legally authorized to perform services under the direct supervision of a Dentist.

l) Replacement of teeth extracted prior to the member's effective date.

The preceding information is a brief description of coverage. Contact Benefits Association for complete details.

Benefits Association

As a member of Benefits Association you receive the following Benefits and Services:

Discount prescription program • Pre-Employment Background Reports • Customized Web Services • Office Supplies
Vitamins & Nutritional Supplements • Auto Rental Discounts • Quest Travel Plan • Global Long Distance Services

Vision Benefits Through EyeMed

The discount plan provides significant savings to you on eye care and eyewear. By showing your Delta Dental ID card to any EyeMed provider, you can obtain your discount. You can choose from a nationwide network of optometrists, ophthalmologists and opticians, as well as the nation's leading optical retailers such as LensCrafters, Sears Optical, Target Optical and most Pearle Vision locations.

Vision Care Services	Member Benefit
Exam with Dilation as Necessary	$5 off comprehensive exam $10 off contact lens exam
Complete Pair Glasses Purchased: **• The following frame, lenses, and lens options discounts & fees apply only if a complete pair is purchased in the same transaction.** **• Items purchased separately will be discounted 20% off the retail price.**	
Frames: Any frame available at provider location	30% off retail price
Standard Plastic Lenses including Standard Scratch: Single Vision Bifocal Trifocal	 $75 $95 $125
Lens Options: UV Coating Tint (Solid and Gradient) Standard Polycarbonate Standard Anti-Reflective Coating Standard Progressive (Add-on to Bifocal)	 $15 $15 $40 $45 $70
Conventional Contact Lenses[1]: (Applied to materials only)	 15% off retail price
Laser Vision Correction: LASIK or PRK	 15% off retail price or 5% off promotional price
Frequency: Exam, Frame, Lenses and Contact Lenses	 Unlimited

1) 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/deltadental.**

Member will receive 20% discount on items purchased at participating Providers not included under the plan coverage. 20% discount may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed provider's professional services, or contact lenses. Retail prices may vary by location.

Plan Limitations/Exlusions

- Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing
- Medical and/or surgical treatment of the eye, or supporting structures
- Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under plan
- Services provided as a result of any Worker's Compensation law
- Plano non-prescription lenses and non-prescription sunglasses (except for 20% discount)

For more information and a list of Providers, visit
www.eyemedvisioncare.com/deltadental or call toll-free: 866-246-9041

Dental and Vision for Everyone

Dental Price Areas

Premier/Price Areas

States	Zip Code	Area
Alabama	350-355, 359 All Others	2 1
California	900-904, 915-918 905 956-958 906-914, 919-927, 930-939, 949, 952, 955, 959-961 All Others	7 6 4 6 6 4
Delaware	All	2
District of Columbia	All	5
Florida	320-322 330-334 All Others	4 5 3
Georgia	300-303 All Others	2 3
Louisiana	712 707-711 All Others	3 2 1
Maryland	207-212 All Others	4 2
Mississippi	390-392 All Others	2 1
Montana	590-591, 599 All Others	1 2
Nevada	893-898 All Others	5 4
New York	100-102 103-114 115-119 120-129 All Others	7 6 5 4 3
Pennsylvania	189, 193-194 190-191 All Others	4 3 2
Texas	754 751-753 756-757, 776-777 All Others	4 3 1 2
Utah	All	5
West Virginia	255-257, 262-265 All Others	2 1

PPO/Price Areas

States	Zip Code	Area
Alabama	350-355, 359 All Others	3 2
California	900-904, 915-918 905 956-958 906-914, 919-927, 930-939, 949, 952, 955, 959-961 All Others	7 6 4 6 6 4
Delaware	All	4
District of Columbia	All	7
Florida	320-322 330-334 All Others	5 4 3
Georgia	300-303 All Others	2 3
Louisiana	712 707-711 All Others	3 2 1
Maryland	207-212 All Others	5 4
Mississippi	390-392 All Others	2 1
Montana	590-591, 599 All Others	1 2
Nevada	893-898 All Others	5 4
New York	100-102 103-114 115-119 120-129 All Others	8 7 7 5 4
Pennsylvania	189, 193-194 190-191 All Others	6 4 3
Texas	754 751-753 756-757, 776-777 All Others	4 3 1 2
Utah	All	5
West Virginia	255-257, 262-265 All Others	4 3

Benefits Association Enrollment Form: *(Signature Required)*

Social Security No.	Primary Enrollee: Last Name / First / Initial	Birthdate	Sex ❑ M ❑ F
Home Phone	Street		
	City / State / Zip		

"I hereby enroll in Benefits Association, Inc. To Purchase the insurance, you must first become a member of Benefits Association Inc. The BAI monthy membership fee is $1.00 and is included in the monthly rates."

Member Signature: ____________________

Date ____________________

Sign Here

For additional information email MorganWhiteGroup at marketing@morganwhite.com or call **1-800-800-1397**

Monthly Rates

Premier Rates

Area	Member	Plus One	Family
1	$36.64	$66.70	$96.76
2	$40.12	$73.48	$106.85
3	$43.98	$81.02	$118.05
4	$48.27	$89.38	$130.49
5	$53.03	$98.66	$144.29
6	$58.32	$108.96	$159.61
7	$64.18	$120.40	$176.62

Includes: $4.00 Billing Fee, $1.00 Association Dues, and 4% Administration Fee

Premier coverage rates are based on Delta Dental's Premier network. Both Premier and Non-Delta Dental dentists are reimbursed on Usual, Reasonable and Customary (UCR) charges. The Premier dentist will file the claim with Delta Dental and will not balance bill. Locate Premier Providers at www.deltadentalins.com.

PPO Plan Rates

Area	Member	Plus One	Family
1	$29.68	$53.12	$76.57
2	$32.39	$58.42	$84.44
3	$35.41	$64.29	$93.18
4	$38.75	$70.82	$102.88
5	$42.46	$78.06	$113.65
6	$46.59	$86.09	$125.60
7	$51.16	$95.01	$138.86
8	$56.24	$104.91	$153.59

Includes: $4.00 Billing Fee, $1.00 Association Dues, and 4% Administration Fee

PPO coverage rates are based on Delta Dental's PPO network. Benefits for all dentists are based on Delta Dental's reduced PPO fee schedule. PPO dentists wil file the claim with Delta Dental. There is no balance billing for PPO dentists. Locate PPO Providers at www.deltadentalins.com.

Dental For Everyone Enrollment Card

Please choose: ❑ Delta Dental Premier® ❑ Delta Dental PPO

Social Security No.	Primary Enrollee: Last Name	First	Initial	Birthdate	Sex ❑ M ❑ F
Home Phone	Street				
	City	State	Zip		
	E-mail address:				

LIST ALL DEPENDENTS TO BE COVERED BELOW

Last Name (if different)	First Name	Initial	Birthdate	Sex
2. Spouse				❑ M ❑ F
3. Dependents				❑ M ❑ F
4.				❑ M ❑ F
5.				❑ M ❑ F
6.				❑ M ❑ F
7.				❑ M ❑ F

MODE OF PAYMENT

❑ Annually ❑ Quarterly

❑ Monthly

❑ Bankdraft

❑ Visa ❑ Mastercard

BANKDRAFT: This is authorization for Morgan-White, on behalf of Delta Dental Insurance Company to draft payments from my checking account for payment of my insurance premiums. Enclosed is a blank voided check on the bank on which drafts are to be drawn.

Credit Card #: ______________________

Exp. Date ______/______

"I understand and agree that (1) the insurance shall not take effect unless the enrollment has been aceepted and approved by Delta Dental Insurance Company and (2) the agent does not have the authority to make or alter any contract or waive any of Delta Dental's other rights or requirements."

Association Member's Signature ____ Date ______________________

AGENT NAME (if applicable): ____

AGENT # (Your state license #): ____

Enroll online at www.dentalforeveryone.com