Dental and Vision for Everyone

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

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

DELTA DENTAL®

Dental Underwritten by:
Delta Dental Insurance Company

Vision Administered by:

vsp®

Marketed by:

MWG MARKETING

*Dental Insurance Policy benefits and Vision Coverage are provided through different carriers.
These companies are financially responsible for their own products. Dental plan is only available in 16 states.
**Available to small employers with fewer than 5 employees.

Dental for Everyone GOLD PLANS

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

- **Benefits increase after the first and second years**
- **Keep your dental plan regardless of age**
- **Benefits up to $1,000 per calendar year**
- **12 month waiting period for major**
- **6 month waiting period basic**
- **Freedom to choose any dentist**

Your Deductible	Plan Pays 1st Year	Plan Pays 2nd Year	Plan Pays 3rd Year	Services Covered
$50 per person per calendar year	60%	80%	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.
	50%	65%	80%	**Basic Procedures (6 month waiting period)** Restorative: Amalgam fillings. Other: Space maintainers, recementation of crowns.
	0%	30%	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.

Dental for Everyone PLATINUM PLANS

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

- **Freedom to choose any dentist**
- **$100 lifetime deductible on ortho**
- **6 month waiting period basic**
- **12 month waiting period for major and ortho**
- **Benefits increase after the first and second years**
- **Benefits up to $1500 per calendar year (including ortho benefits)**
- **Ortho benefits for dependent children 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.

Vision Benefits Through VSP

Signature Choice Plan

Your Coverage from a VSP Doctor

WellVision Exam® $10 Co-Pay – every 12 months

Prescription Glasses $20 Co-Pay

Lenses: every 12 months

- Single vision, lined bifocal, and lined trifocal lenses
- Polycarbonate lenses for dependent children

Frames: every 24 months

- $130 allowance for frame of your choice
- 20% off the amount over your allowance

***** Or *****

Contacts Lense Care No Co-pay – every 12 months

- $130 allowance for contacts and the contact lens exam (fitting and evaluation). This additional exam ensures proper fit of contacts. If you choose contact lenses you will be eligible for a frame 12 months from the date the contact lenses were obtained. Current soft contact lens wearers may qualify for a special program that includes a contact lens evaluation and initial supply of replacement lenses.

Extra Discounts and Savings

Glasses and Sunglasses

- 20% off lens options like progressives and scratch-resistant and anti-reflective coatings
- 20% off additional glasses and sunglasses, including lens options*

Contacts*

15% off cost of contact lens exam (fitting and evaluation)

Laser Vision Correction

Average 15% off the regular price or 5% off the promotional price from contracted facilities

** Available from any VSP doctor within 12 months of your last eye exam*

You get the best value from your benefit when you see a VSP doctor. If you see a non-VSP provider, you'll typically pay more out-of-pocket. You'll pay the provider in full and have 6 months to submit a claim to VSP for partial reimbursement less copays. Before seeing a non-VSP provider, call us at 800.877.7195.

Out-of-Network Reimbursement Amounts:

Exam ..... Up to $34
Single vision lenses ..... Up to $17
Lined bifocal lenses ..... Up to $30
Lined trifocal lenses ..... Up to $43
Frame ..... Up to $38.25
Contacts ..... Up to $100

Exam Plus Plan

Your Coverage from a VSP Doctor

WellVision Exam® $15 copay – every 12 months

Prescription Glasses Discounts

Lenses: 20% discount when a complete pair of glasses is purchased

Frames: 20% discount when a complete pair of glasses is purchased

Contacts* 15% discount off the contact lens fitting and evaluation exam. This additional exam ensures proper fit of your contacts.

Extra Discounts and Savings

Glasses and Sunglasses

- 20% off lens options like progressives and scratch-resistant and anti-reflective coatings
- 20% off additional glasses and sunglasses, including lens options*

Contacts*

15% off cost of contact lens exam (fitting and evaluation)

Laser Vision Correction

Average 15% off the regular price or 5% off the promotional price from contracted facilities

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You get the best value from your benefit when you see a VSP doctor. If you see a non-VSP provider, you'll typically pay more out-of-pocket. You'll pay the provider in full and have 6 months to submit a claim to VSP for partial reimbursement less copays. Before seeing a non-VSP provider, call us at 800.877.7195.

Out-of-Network Reimbursement Amounts:

Exam: Up to $34

Dental and Vision for Everyone

Premier Plan Price Areas (Gold & Platinum)

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

PPO Plan Price Areas (Gold & Platinum)

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

Dental Monthly Rates

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.

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

Gold Plan Premier Rates

Area	Member	Plus One	Family
1	$29.94	$53.64	$77.34
2	$32.69	$58.99	$85.30
3	$35.73	$64.93	$94.13
4	$39.11	$71.53	$103.94
5	$42.87	$78.84	$114.82
6	$47.04	$86.96	$126.89
7	$51.66	$95.98	$140.31

Platinum Plan Premier Rates

1	$37.43	$68.24	$99.05
2	$41.00	$75.19	$109.40
3	$44.95	$82.92	$120.88
4	$49.35	$91.49	$133.63
5	$54.23	$101.00	$147.77
6	$59.65	$111.56	$163.48
7	$65.66	$123.29	$180.91

Gold Plan PPO Plan Rates

Area	Member	Plus One	Family
1	$24.46	$42.94	$61.43
2	$26.59	$47.12	$67.63
3	$28.98	$51.74	$74.52
4	$31.61	$56.89	$82.17
5	$34.53	$62.60	$90.66
6	$37.79	$68.93	$100.08
7	$41.39	$75.96	$110.54
8	$45.40	$83.77	$122.15

Platinum Plan PPO Plan Rates

1	$30.30	$54.32	$78.36
2	$33.07	$59.76	$86.43
3	$36.17	$65.77	$95.38
4	$39.59	$72.47	$105.33
5	$43.40	$79.89	$116.37
6	$47.63	$88.12	$128.62
7	$52.31	$97.26	$142.21
8	$57.52	$107.41	$157.30

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.

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

There will be a one time non-refundable $35.00 setup fee.

Vision Monthly Rates

	Signature Choice	Exam Plus
Member	$7.54	$3.00
Member + 1	$15.11	$6.00
Member + Family	$24.34	$9.00

Application Step 1

Fill in the form online. Then save it to your computer. You will be able to attach it to an email and email it back to me. My email is getaquote@gmail.com

You can also print it out and fax it back to me at 1-775-254-2881.

Do not worry about signature fields unless you fax it. Then I would like you to sign it. If you have any problems, call me at 800-272-0512.

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**

Application Step 2 Dental For Everyone Enrollment Card

Plan Selection: ☐ **Platinum Plan** ☐ **Gold Plan**
Network Selection: ☐ **Delta Dental Premier®** ☐ **Delta Dental PPO**
Type of Coverage ☐ **Member** ☐ **Member + 1** ☐ **Member + Family**
Optional Vision Coverage: ☐ **Exam Plus** ☐ **Signature Choice**

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

METHOD OF PAYMENT

☐Annually ☐Quarterly ☐Monthly

❑ Bankdraft: This is my authorization for Morgan-White Administrators, Inc., on behalf of Delta Dental Insurance Company to draft payments from my checking account for payment of my insurance premiums. Below is the Routing Number and Checking Account number for the account on which drafts are to be drawn.

Name of Bank:

_____

Name as it appears on Check:

_____

Routing Number (Bottom Left Corner of Check)

_____

Account Number (2nd set of numbers on bottom)

_____

☐Visa ☐Mastercard
Credit Card #:

_____

Exp. Date __

Security Code _____
(3 digit code on back of card)

"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 _____

For Agent Use Only

AGENT NAME (if applicable): Martin Unger

AGENT # (Your state license #): A301602