



# ***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:



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<sup>SM</sup> (PPO)**

- Benefits increase after the first and second years
- 12 month waiting period for major
- Keep your dental plan regardless of age
- 6 month waiting period basic
- Benefits up to \$1,000 per calendar year
- 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%	<b>Diagnostic and Preventive Procedures</b> <u>Diagnostic:</u> Routine periodic examinations once in a 6 month period. <u>Preventive:</u> Dental prophylaxis (teeth cleaning) once in a 6 month period. <u>Radiography:</u> Bitewing and full mouth x-rays.
	50%	65%	80%	<b>Basic Procedures (6 month waiting period)</b> <u>Restorative:</u> Amalgam fillings. <u>Other:</u> Space maintainers, recementation of crowns.
	0%	30%	50%	<b>Major Procedures (12 month waiting period)</b> <u>Endodontics:</u> Pulpal therapy and root canals. <u>Periodontics:</u> Treatment of diseases of the gums. <u>Oral Surgery:</u> Extractions and other oral surgery, including pre and post operative care. <u>Prosthetics:</u> Gold restorations, crowns, bridges, partials and complete dentures. <u>Other:</u> 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
- Benefits increase after the first and second years
- \$100 lifetime deductible on ortho
- Benefits up to \$1500 per calendar year (including ortho benefits)
- 6 month waiting period basic
- Ortho benefits for dependent children included at no extra charge
- 12 month waiting period for major and ortho
- 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%	<b>Diagnostic and Preventive Procedures</b> <u>Diagnostic:</u> Routine periodic examinations once in a 6 month period. <u>Preventive:</u> Dental prophylaxis (teeth cleaning) once in a 6 month period. <u>Radiography:</u> Bitewing and full mouth x-rays.
	60%	70%	80%	<b>Basic Procedures (6 month waiting period)</b> <u>Restorative:</u> Amalgam fillings. <u>Other:</u> Space maintainers, recementation of crowns.
	0%	40%	50%	<b>Major Procedures (12 month waiting period)</b> <u>Endodontics:</u> Pulpal therapy and root canals. <u>Periodontics:</u> Treatment of diseases of the gums. <u>Oral Surgery:</u> Extractions and other oral surgery, including pre and post operative care. <u>Prosthetics:</u> Gold restorations, crowns, bridges, partials and complete dentures. <u>Other:</u> Pontics, repair of crowns and bridges, repair of full and partial dentures.
\$100 lifetime	0%	40%	50%	<b>Orthodontia Procedures (12 month waiting period)</b> (\$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:*

Prescription Drug Assistance • Online Storage • Auto Rental Discounts • Discounted Hotel Rates • Office Supplies  
Legal Documents • Apparel and Hunting Accessories

# 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 Lens 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

*\* 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

# 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, 952, 955, 959-961	6
	All Others	6
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, 952, 955, 959-961	6
	All Others	6
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](http://www.deltadentalins.com).

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

**There is a one-time, non-refundable, \$35 set up fee charged with the first month's premium.**

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 will file the claim with Delta Dental. There is no balance billing for PPO dentists. Locate PPO Providers at [www.deltadentalins.com](http://www.deltadentalins.com).

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

**There is a one-time, non-refundable, \$35 set up fee charged with the first month's premium.**

# Vision Monthly Rates

	Signature Choice	Exam Plus
<b>Member</b>	\$8.99	\$3.00
<b>Member + 1</b>	\$18.00	\$6.00
<b>Member + Family</b>	\$28.99	\$9.00

## Application Step 1

### Benefits Association Enrollment Form: (Signature Required)

Social Security No.	Primary Enrollee: Last Name	First	Initial	Birthdate	Sex <input type="checkbox"/> M <input type="checkbox"/> F	<p><i>"I hereby enroll in Benefits Association, Inc. To Purchase the insurance, you must first become a member of Benefits Association Inc. The BAI monthly membership fee is \$1.00 and is included in the monthly rates."</i></p> <p><b>Member Signature:</b> _____</p> <p>Date _____</p>
Home Phone	Street	City		State	Zip	

For additional information email MorganWhiteGroup at [marketing@morganwhite.com](mailto:marketing@morganwhite.com) or call 1-800-800-1397

**Sign Here**

## Application Step 2 Dental For Everyone Enrollment Card

<b>Plan Selection:</b> <input type="checkbox"/> Platinum Plan <input type="checkbox"/> Gold Plan <b>Network Selection:</b> <input type="checkbox"/> Delta Dental Premier® <input type="checkbox"/> Delta Dental PPO <b>Type of Coverage</b> <input type="checkbox"/> Member <input type="checkbox"/> Member + 1 <input type="checkbox"/> Member + Family <b>Optional Vision Coverage:</b> <input type="checkbox"/> Exam Plus <input type="checkbox"/> Signature Choice					<b>METHOD OF PAYMENT</b> <input type="checkbox"/> Annually <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly <input type="checkbox"/> 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) _____ <input type="checkbox"/> Visa <input type="checkbox"/> Mastercard Credit Card #: _____ Exp. Date _____ / _____ Security Code _____ (3 digit code on back of card)	
Social Security No.	Primary Enrollee: Last Name	First	Initial	Birthdate	Sex <input type="checkbox"/> M <input type="checkbox"/> F	
Home Phone	Street	City		State	Zip	
	E-mail address:					
<b>LIST ALL DEPENDENTS TO BE COVERED BELOW</b>						
Last Name (if different)	First Name	Initial	Birthdate	Sex		
2. Spouse					<input type="checkbox"/> M <input type="checkbox"/> F	
3. Dependents					<input type="checkbox"/> M <input type="checkbox"/> F	
4.					<input type="checkbox"/> M <input type="checkbox"/> F	
5.					<input type="checkbox"/> M <input type="checkbox"/> F	
6.					<input type="checkbox"/> M <input type="checkbox"/> F	
7.					<input type="checkbox"/> M <input type="checkbox"/> F	
<p>"I understand and agree that (1) the insurance shall not take effect unless the enrollment has been accepted 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."</p> <p>Association Member's Signature _____ Date _____</p>						

**For Agent Use Only** AGENT NAME (if applicable): \_\_\_\_\_

AGENT # (Your state license #): \_\_\_\_\_