Dental and Vision for Everyone

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

*For Benefits Association, Inc. 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. 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 up to $1,000 per calendar year**
- **Benefits increase after the first and second years**
- **Keep your dental plan regardless of age**
- **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	Procedures Covered
$50 per enrollee 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 SM (PPO)

- **Benefits up to $1,500 per calendar year (including ortho benefits)**
- **Benefits increase after the first and second years**
- **Ortho benefits for dependent children included at no extra charge**
- **Keep your dental plan regardless of age**
- **$100 lifetime deductible on ortho**
- **Freedom to choose any dentist**
- **6 month waiting period basic**
- **12 month waiting period for major and ortho**

Your Deductible	Plan Pays 1st Year	Plan Pays 2nd Year	Plan Pays 3rd Year	Procedures Covered
$50 per enrollee 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 per dependent	0%	40%	50%	**Orthodontia Procedures (12 month waiting period)** ($350 calendar year maximum per enrollee) ($1000 lifetime maximum per enrollee for this benefit) Orthodontic benefits are only available for eligible dependent children.

Dental for Everyone DIAMOND PLANS

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

- **Benefits up to $2,000 per calendar year (including ortho benefits)**
- **Benefits increase after the first and second years**
- **Ortho benefits for dependent children included at no extra charge**
- **Keep your dental plan regardless of age**
- **$150 lifetime deductible on ortho**
- **Freedom to choose any dentist**
- **6 month waiting period basic**
- **12 month waiting period for major and ortho**

Your Deductible	Plan Pays 1st Year	Plan Pays 2nd Year	Plan Pays 3rd Year	Procedures Covered
$25 copay per person per visit	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.
$150 lifetime per dependent	0%	40%	50%	**Orthodontia Procedures (12 month waiting period)** ($450 calendar year maximum per enrollee) ($1,500 lifetime maximum per enrollee for this benefit) Orthodontic benefits are only available for eligible dependent children.

® is a Registered Mark of Delta Dental Plans Association and SM is a Service Mark of Delta Dental Plans Association.

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

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) an inlay/onlay instead of an amalgam restoration;
(c) a composite/resin restoration instead of an amalgam restoration on posterior teeth.

If you receive 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. You 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

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

** 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

Vision Monthly Rates

	Choice Plan	Exam Plus
Member	~~$8.99~~ 9.96	$3.00
Member + 1	~~$18.00~~ 19.39	$6.00
Member + Family	~~$28.99~~ 31.23	$9.00

Dental Plan Price Areas

Premier Plan Price Areas
(Gold, Platinum, & Diamond)

States	Zip Code (first 3 digits)	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 Plan Price Areas
(Gold, Platinum, & Diamond)

States	Zip Code (first 3 digits)	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

Dental and Vision for Everyone

Dental Monthly Rates

Premier Plan Rates

Premier rates are based on use of the Premier network. Premier dentists are reimbursed based on the Premier Maximum Contract Allowance. Non-Delta Dental Dentists may balance bill up to their normal fees. Locate Premier Providers at 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

Area	Member	Plus One	Family
1	$32.51	$58.65	$84.78
2	$35.54	$64.54	$93.56
3	$38.89	$71.10	$103.29
4	$42.62	$78.37	$114.11
5	$46.76	$86.44	$126.11
6	$51.36	$95.39	$139.43
7	$56.46	$105.34	$154.22

Platinum Plan

Area	Member	Plus One	Family
1	$40.77	$74.74	$108.72
2	$44.70	$82.41	$120.14
3	$49.06	$90.93	$132.80
4	$53.91	$100.38	$146.86
5	$59.29	$110.87	$162.45
6	$65.27	$122.52	$179.78
7	$71.90	$135.45	$199.00

Diamond Plan

Area	Member	Plus One	Family
1	$43.85	$80.76	$117.67
2	$48.12	$89.09	$130.06
3	$52.86	$98.35	$143.81
4	$58.13	$108.61	$159.09
5	$63.98	$120.01	$176.03
6	$70.47	$132.65	$194.85
7	$77.67	$146.70	$215.73

PPO Plan Rates

Gold Plan

Area	Member	Plus One	Family
1	$26.46	$46.84	$67.23
2	$28.82	$51.45	$74.07
3	$31.44	$56.55	$81.67
4	$34.34	$62.23	$90.10
5	$37.57	$68.52	$99.47
6	$41.16	$75.51	$109.86
7	$45.14	$83.26	$121.39
8	$49.55	$91.87	$134.20

Platinum Plan

Area	Member	Plus One	Family
1	$32.90	$59.39	$85.90
2	$35.96	$65.39	$94.80
3	$39.38	$72.02	$104.67
4	$43.15	$79.41	$115.65
5	$47.35	$87.59	$127.82
6	$52.01	$96.67	$141.33
7	$57.18	$106.75	$156.32
8	$62.92	$117.94	$172.96

Diamond Plan

Area	Member	Plus One	Family
1	$35.30	$64.09	$92.88
2	$38.63	$70.59	$102.54
3	$42.34	$77.80	$113.28
4	$46.44	$85.82	$125.19
5	$51.00	$94.71	$138.41
6	$56.07	$104.57	$153.09
7	$61.68	$115.52	$169.37
8	$67.92	$127.68	$187.45

PPO rates are based on use of the PPO network. Payment to all dentists is based on Delta Dental's PPO fee schedule. PPO and Premier Dentists will file the claim with Delta Dental. Premier dentists may charge an amount above the PPO fee schedule up to their Premier fee schedule. Non-Delta Dental dentists may balance bill up to their normal fees. Locate PPO Providers at 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.

Fill out Step 1, Step 2, (sign both places), write in payment info and Fax to 800-901-1699

Application Step 1

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 monthly membership fee is $1.00 and is included in the monthly rates."

Member Signature:

X _____

Date _____

Sign Here

For additional information, email **marketing@morganwhite.com** or call **1-877-759-5728.**

Application Step 2 Dental For Everyone Enrollment Card

Plan Selection: ❑ **Diamond Plan** ❑ **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** ❑ **Choice Plan**

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., 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 Number

Exp. Date _____/_____
MM YY

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

Total Amount Paid:_____

"I understand and agree that (1) the insurance shall not take effect unless the enrollment has been aceepted and approved (2) the agent does not have the authority to make or alter any contract or waive any other rights or requirements associated with this plan(s)."

Association Member's Signature X _____ Date _____

For Agent Use Only

AGENT NAME (if applicable): F. Hyman

AGENT # (Your state license #): 550511