



# ***Dental and Vision for Everyone***

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

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*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<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	Procedures Covered
\$50 per enrollee 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	Procedures Covered
\$50 per enrollee 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 per dependent	0%	40%	50%	<b>Orthodontia Procedures (12 month waiting period)</b> (\$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 (PPO)*

- Freedom to choose any dentist
- \$150 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 \$2,000 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	Procedures Covered
\$25 copay per person per visit	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.
\$150 lifetime per dependent	0%	40%	50%	<b>Orthodontia Procedures (12 month waiting period)</b> (\$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 <sup>SM</sup> 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

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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.

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## 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 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 Plan Price Areas

## 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 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](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			
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			
Area	Member	Plus One	Family
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

Diamond Plan			
Area	Member	Plus One	Family
1	\$40.23	\$73.70	\$107.17
2	\$44.10	\$81.25	\$118.40
3	\$48.40	\$89.64	\$130.87
4	\$53.18	\$98.95	\$144.72
5	\$58.48	\$109.28	\$160.09
6	\$64.37	\$120.75	\$177.14
7	\$70.89	\$133.49	\$196.08

### PPO Plan Rates

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](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			
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			
Area	Member	Plus One	Family
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

Diamond Plan			
Area	Member	Plus One	Family
1	\$32.48	\$58.58	\$84.69
2	\$35.50	\$64.48	\$93.45
3	\$38.86	\$71.01	\$103.18
4	\$42.58	\$78.28	\$113.98
5	\$46.71	\$86.35	\$125.97
6	\$51.31	\$95.29	\$139.28
7	\$56.39	\$105.22	\$154.04
8	\$62.05	\$116.24	\$170.44

