



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

Marketed by:


INSURANCE
COORDINATORS
OF MONTANA INC.™

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

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 <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%	Basic Procedures (6 month waiting period) <u>Restorative:</u> Amalgam fillings. <u>Other:</u> Space maintainers, recementation of crowns.
	0%	40%	50%	Major Procedures (12 month waiting period) <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%	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.



Vision Benefits

- No deductible
- No waiting period
- Your choice of eye care providers
- In- and Out-of-Network benefits
- Laser eye surgery benefits through the Laser Vision Network of America (LVNA)
- Network Providers include Private Practice Doctors and Retail Chain Providers
- A vision examination each 12 months
- One set of frames each 24 months
- One pair of standard lenses or contact lenses each 12 months

In-Network Benefits

- A comprehensive vision examination annually with only a \$10.00 copayment.
- Lenses: If prescribed, a pair of single vision or standard lined multi-focal lenses every 12 months with only a \$20.00 co-pay.
- In lieu of lenses and a frame (\$20.00 co-payment applies), you may select from Spectera’s wide variety of covered contact lenses when obtained from a network provider. A \$105.00 credit will be applied toward any fitting fees, and the purchase of non-covered contact lenses once every 12 months.
- There is a \$210 allowance for “necessary” contacts. (When your vision cannot be corrected to better than 70/20 with standard lenses.)
- One pair of frames (each 24 months) from a wide selection of high quality men’s, women’s and children’s frames and a set of lined single/bifocal/trifocal lenses (each 12 months) for a \$20.00 co-pay. If you select a frame from outside the covered selection, you will pay the wholesale cost minus a \$50.00 frame allowance. In the case of retail chain provider locations, due to their pricing structures, the participant will receive a minimum \$130 frame allowance for frames purchased at retail chain providers. Please consult with the specific provider in your area.
- **Patient Options:** Should you select items not covered by the program, such as progressive lenses, tints, coatings, ect., there will be an additional charge. These charges, however, are below usual retail costs. (Standard Scratch coating is covered in full at no cost to the insured.)
- To locate an In-Network Provider call 800-839-3242 or use Spectera’s web site www.spectera.com (Click on provider locator, enter zip code, enter social security number or [any 9 digit number], enter birth date and click submit.)

Out-of-Network Benefits

(Out-of-Network – Reimbursement up to the following amounts once in a 12-month period – frames once in a 24-month period)

Annual Vision Examination	\$40.00
Single Vision Lenses	\$40.00
Bifocal	\$60.00
Trifocal	\$80.00
Frames	\$50.00
Elective Contacts	\$105.00
Necessary Contacts	\$210.00

Monthly Premiums Vision

Area	Member	Plus One	Family
4	\$9.88	\$17.12	\$28.88

Vision Rate Areas

Price Area 4	Montana
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Important Information About Out-of-Network Benefits

Spectera will accept receipts and reimburse you once each 12 months (frames each 24 months) (from date of service) when you use an “out -of-network” provider. While you can file for reimbursement anytime after you receive your exam and eyewear, in order to maximize your “out-of-network” benefits, itemized receipts should be collected (i.e. several purchases of contact lenses) until they total (at least) the maximum reimbursement amounts. Be sure to include with the receipts the participant’s social security number and patient’s date of birth. MAIL TO: Spectera Claims Department
P.O. Box 30978
Salt Lake City, UT 84130

When scheduling your appointment, be sure to say that you are covered under the MorganWhiteGroup / Spectera Vision Plan so that the provider can confirm your eligibility and benefits prior to the appointment.

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.

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 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.

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

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

See Dental Price Areas on the insert page.

Dental and Vision for Everyone

Dental Price Areas

Premier/Price Areas

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/Price Areas

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

Benefits Association Enrollment Form: (Signature Required)

Social Security No.	Primary Enrollee:			Sex
	Last Name	First	Initial	<input type="checkbox"/> M <input type="checkbox"/> 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:

Date _____

Sign Here

For additional information email Insurance Coordinators of Montana, Inc. at wecare4u@icmont.com or call 1-866-449-9777

Dental For Everyone Enrollment Card

Please choose: Delta Dental Premier® Delta Dental PPO

MODE OF PAYMENT

Social Security No.	Primary Enrollee: Last Name	First	Initial	Birthdate	Sex <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Annually <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly <input type="checkbox"/> Bankdraft <input type="checkbox"/> Visa <input type="checkbox"/> 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.
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				<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	

Credit Card #: _____

Exp. Date ____/____/____

"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."

Association Member's Signature _____ Date _____

AGENT NAME (if applicable): _____

BCBSMT Agent #: _____

Forward enrollment form to: Insurance Coordinators of Montana, Inc. • 101 N. Last Chance Gulch, Suite A, Helena, MT 59601

Optional Vision Coverage – Please check one:

- YES**, please enroll everyone listed on the dental application in the vision plan. *Note: Vision plan is not available unless you enroll in the dental plan.*
- No, I would not like to purchase vision benefits