

A Dental Plan With You In Mind:



An Exciting Dental Plan For Members Of The Indiana Retired Teachers Association



The Indiana Retired Teachers Association Board of Directors has endorsed a group dental insurance plan underwritten by Ameritas Life Insurance Corp.

You will enjoy first day access to all covered services if you have had twelve months of continuous coverage with no more than a 60-day lapse in coverage. If you do not have prior coverage, or a lapse of more than 60-days, you will have first day access to preventative and basic services with only a twelve month waiting period on major services.

To locate an Ameritas network provider:

- By Phone: 1.888.239.3336
- Web: www.AmeritasGroup.com/resources/find.asp

Contact Ameritas to get more information about the dental benefits offered.

Endorsed by:
Indiana Retired Teachers Association

Underwritten by:
Ameritas Life Insurance Corp.



Marketed by:
Association Member Benefits Advisors
6034 W. Courtyard Drive, Suite 300
Austin, TX 78730



Advantages of Coverage

- Rates guaranteed through December 2012!
- Freedom to use your own dentist!
- NO network required! However, a network is available providing savings of 20-30%
- \$75 Calendar Year deductible per person
- \$1500 Calendar Year Maximum per person
- NO referral required for specialty care
- Dental Rewards - may enable your \$1500 Calendar Year Maximum to grow to \$2500

Dental Plan Highlights

- Preventative Services: 100% coverage*
 - Oral Exams
 - Prophylaxis (teeth cleanings)
- Basic Services: 80% coverage*
 - Fillings
 - Crown & Denture Repairs
 - X-Rays
 - General Anesthesia
 - Oral Surgery (Simple)
- Major Services: 50% coverage*
 - Endodontics (root canals)
 - Periodontics (gum disease)
 - Crowns & Dentures

Monthly Plan Rates

Member	\$44.96
Member + 1	\$89.92
Member + Family	\$113.03

Indiana Retired Teachers Association-10/10

**Reimbursement percentages are based on the usual and customary charges for services in your geographical area. All services are subject to limitations and exclusions. Network providers may not be available in all states or geographical areas. The master insurance policy providing coverage is governed by the laws of Indiana.*

An Eye Care Plan With You In Mind



For Members of the Indiana Retired Teachers Association



Besides helping you see better, routine eye exams can detect a number of serious health conditions such as glaucoma, cataracts, diabetes, even cancer.

Convenience for Members

VSP has a network of thousands of doctors, located in rural and metropolitan areas throughout the nation. More than 90% of members have access to a VSP doctor within 10 miles of work and home. VSP doctors provide both eye exams and eyewear, offering a convenient “one-stop” solution for your eyecare needs.

➔ **No ID Cards, No Claim Forms!**

Easy As 1, 2, 3!

1. Find a VSP network doctor at:
www.vsp.com/go/inrta
or call 800.877.7195
2. Make an appointment and tell the doctor you are a VSP member.
3. Your doctor and VSP will handle the rest.

With VSP, you don't have to worry about keeping up with an ID card. Just visit a VSP doctor and they take care of the rest! ➤ No ID Cards! ◀

VSP guarantees service from VSP network doctors only. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.

Your Coverage from a VSP Doctor (co-pays apply)

Exam covered in full.....every 12 months

Prescription Glasses:

Lenses covered in full.....every 12 months

- Single vision, lined bifocal, and lined trifocal lenses.

In addition, you can experience significant savings on lens options such as progressive and transitional lenses.

Frame.....every 24 months

- Frame of your choice covered up to \$ 120.00.
- Plus, 20% off any out-of-pocket costs.

- OR -

Contact Lens Care.....every 12 months

When you choose contacts instead of glasses, your \$120.00 allowance applies to the cost of your contacts and the contact lens exam (fitting and evaluation). This exam is in addition to your vision exam to ensure 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 contact lens program that includes a contact lens evaluation and initial supply of replacement lenses.

Advantages of Coverage

Without coverage, an exam and prescription glasses can cost \$300 or more. With VSP coverage, you'll save.

Your Co-Pays

- Exam.....\$15.00
- Prescription Glasses.....\$25.00
- Contacts.....No co-pay applies

Extra Discounts & Savings

Laser Vision Correction Discounts

Prescription Glasses:

- Up to 20% savings on lens extras such as scratch resistant and antireflective coatings
- 20% off additional prescription glasses and sunglasses*

Contacts*:

- 15% off cost of contact lens exam (fitting and evaluation)
- *Available from the same VSP doctor who provided your eye exam within the last 12 months.

Your Monthly Contribution

Member Only.....\$10.90
Member + One.....\$18.85
Family.....\$23.60

Dollar for dollar you get the best value from your VSP benefit when you visit a VSP network doctor. If you decide not to see a VSP doctor you'll receive fewer benefits and typically pay more out-of-pocket. You are required to pay the provider in full at the time of your appointment and submit a claim to VSP for partial reimbursement. If you decide to see a provider non-network provider, call us first at 800.877.7195.

Out of Network Reimbursement Amounts:

Exam.....Up to \$ 45.00

Lenses:

Single Vision.....Up to \$ 45.00

Lined Bifocal.....Up to \$ 65.00

Lined Trifocal.....Up to \$ 85.00

Frame.....Up to \$ 47.00

Contacts.....Up to \$105.00

(Co-pays apply)

Questions?

We Have Answers



Enrolling is Easy!

1 Complete The Enrollment Form On The Reverse Side Of This Page:

If adding dependents, include each person's Social Security number and date of birth.

2 Submit Your Payment:

In order to provide members with the best rates and service, we offer a monthly bank draft option.

Monthly Bank Draft: Enclose a check payable to AMBA for your first month's premium(s) plus the \$20 one-time enrollment fee. You must also sign the bank draft authorization on the bottom of the application, and include a blank check marked "Void" on the account to be drafted.

3 Mail Your Completed Application To Us In The Enclosed Envelope.

Our address is:

Association Member Benefits Advisors, Ltd.
6034 W. Courtyard Dr., Suite 300
Austin, TX 78730



Frequently Asked Dental Plan Questions:

How Can I find Out Exactly What Services Are Covered?

For more information regarding plan benefits, you may call Ameritas at 1-888-239-3336.

Can I Use My Current Dentist?

Yes! One of the best features of this plan is that you have the freedom to use your current dentist. You also have the option of selecting an Ameritas network dentist whose services are discounted from 20-30%. It's your choice!

How Does The Dental Rewards Feature Work?

This feature rewards members who care for their teeth by filing at least one claim during the plan year, but use less than \$750 of their annual benefit. Dental Rewards rolls over \$250 into the next benefit period with a maximum carry over amount of \$1,000. Therefore, your \$1,500 calendar year maximum has the potential to grow to \$2,500! This feature solves the "use it or lose it" benefit problem many dental insurance plans have. By allowing you to roll over part of your unused benefit, you can accumulate higher plan maximums that could be beneficial if major procedures are needed in the future.

Can My Spouse & Children Be Covered Under This Plan?

Yes! Your spouse and dependent children up to the month they turn age 26 are eligible for coverage.



Indiana Retired Teachers Association Group Dental & Vision Plans

Complete this form to enroll in the Group Dental and/or Vision Plans.

Membership with the Indiana Retired Teachers Association is required.



Member Information

Last Name		First Name		Gender	Social Security Number (Required)	
				M <input type="checkbox"/> F <input type="checkbox"/>		
Street Address			City	State	Zip	
Date of Birth (MM/DD/YYYY)		Phone Number		Email Address		
Prior Coverage Information						
Have you had continuous dental coverage for the past 12 months with less than a 60 day gap in coverage? Yes <input type="checkbox"/> No <input type="checkbox"/>						
If Yes, carrier name: _____ Effective date: _____ Termination date: _____						
Select Your Coverage Below ► MONTHLY Premiums Are Shown						
Dental Coverage Only:		<input type="checkbox"/> Member: \$44.96	<input type="checkbox"/> Member + 1: \$89.92	<input type="checkbox"/> Family: \$113.03		
Vision Coverage Only:		<input type="checkbox"/> Member: \$10.90	<input type="checkbox"/> Member + 1: \$18.85	<input type="checkbox"/> Family: \$23.60		
Dental + Vision Coverage:		<input type="checkbox"/> Member: \$55.86	<input type="checkbox"/> Member + 1: \$108.77	<input type="checkbox"/> Family: \$136.63		
TOTAL: Dental Premium + Vision Premium + \$20 One-Time Enrollment Fee: \$ _____						

Eligible Dependents to Be Covered

Name	Date of Birth MM/DD/YYYY	Gender	Student	Disabled	Social Security Number (Required)
Spouse		M <input type="checkbox"/> F <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Child		M <input type="checkbox"/> F <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Child		M <input type="checkbox"/> F <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	

Payment

Convenient Monthly Bank Payment Option: Make your check payable to AMBA for your first month's premium plus the \$20 enrollment fee and attach a VOIDED check. Deposit slips are not acceptable.

Authorization to honor drafts drawn by Association Member Benefits Advisors (AMBA). I hereby authorize you to initiate debit entries on my account. This authority is to remain in effect until revoked by me in writing and until AMBA receives such notice. I agree that AMBA shall be fully protected in honoring such debit. Non-payment of insurance premium(s) results in the forfeiture of insurance. I authorize future increases and/or decreases in the cost of the plan(s) I selected to be automatically deducted without further authorization from me.

NOTE: Bank drafts occur on the 2nd business day of each month.



Your signature EXACTLY as it appears on your Bank Records

Date

The master policy is governed by the laws of the state of Indiana.

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Office use only: Effective Date: _____ ACH Date: _____ Entered: _____

MA _____ R _____