

A Dental Plan With You In Mind



An Exciting Dental Plan Exclusively For Members Of The Ohio Retired Teachers Association

ORTA has endorsed a group dental insurance plan underwritten by Ameritas Life Insurance Corp. This plan has been heavily negotiated for our membership and we believe it provides many valuable benefits for our members!

While most plans require a twelve month waiting period for certain services, this plan does not. You will enjoy first day benefits for all covered services under the endorsed ORTA dental plan.

How do I locate an Ameritas Network Provider or get additional information about the dental benefits?

Contact Ameritas at 1.888.239.3336, or online at www.ameritasgroup.com/resources/find.asp

Endorsed by:

Ohio Retired Teachers Association

Underwritten by:

Ameritas Life Insurance Corp.



Marketed by:

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



**Reimbursement percentages are based on the usual and customary charges for services in your geographical area. All services are subject to limitations and exclusions.*

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

ORTA <u>GOLD</u> PLAN	
Advantages of Coverage	
<ul style="list-style-type: none"> • Rates guaranteed until January 2009 • Lower monthly premiums • Freedom to use your own dentist. No network required • You may choose an Ameritas Network provider and save up to 20-30% • \$50 Calendar Year deductible per person (limited to a family maximum of \$100 per year) • NO referral required for specialty care • \$1500 Calendar Year Maximum per person • Dental Rewards - may enable your \$1500 Calendar Year Maximum to grow to \$2500 	
Dental Plan Highlights*	
In Network	Out of Network
<ul style="list-style-type: none"> • Preventative Services: 100% Coverage <ul style="list-style-type: none"> ○ Oral Exams ○ Prophylaxis (teeth cleanings) ○ Bitewing x-rays • Basic Services: 60% Coverage <ul style="list-style-type: none"> ○ Fillings ○ X-Rays ○ General Anesthesia ○ Oral Surgery ○ Endodontics (root canals) ○ Periodontics (gum disease) • Major Services: 35% Coverage <ul style="list-style-type: none"> ○ Crowns ○ Crown repair ○ Dentures 	<ul style="list-style-type: none"> 80% Coverage 50% Coverage 25% Coverage
Monthly Plan Rates	
Member	\$ 27.41
Member + 1	\$ 61.94
Family	\$ 76.34

An Eye Care Plan With You In Mind

Exclusively for Members of the
Ohio Retired
Teachers Association



EyeMed Vision Care is one of the leading managed vision care organizations in the industry. With over 18 years in the industry, EyeMed knows and understands the type of program members desire. That is why we offer a vision care program that combines ultimate choice, quality, value and service that over 135 million people count on for their vision care needs.

EyeMed's diverse network gives you a true choice in provider selection, with an extensive choice of private practice optometrists, ophthalmologists, opticians and optical retailers including the nation's leading optical retailers, LensCrafters®, Target Optical®, Sears Optical®, JC Penny Optical®, and most Pearle Vision® Locations.

For additional information, or to locate a provider, call EyeMed at 1.888.239.3336, or visit www.ORTAbenefits.com.

Additional Discounts:

Members will receive a 20% discount on items not covered by the plan at network providers, which may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed provider's professional services, or contact lenses. Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.

Retail prices may vary by location.

Discounts do not apply for benefits provided by other group benefit plans. Allowances are one-time use benefits; no remaining balance. Lost or broken materials are not covered.

Plan Limitations / Exclusions:

- Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing
- Medical and/or surgical treatment of the eye, eyes, or supporting structures
- Services provided as a result of any Worker's Compensation law
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy
- Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under the plan
- Plano non-prescription lenses and non-prescription sunglasses (except for 20% discount)
- Service or materials provided by any other group benefit providing for vision care
- Two pairs of glasses in lieu of bifocals
- Aniseikonic lenses

In-Network Member Benefits (co-pays apply)

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

Prescription Glasses

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

- Progressive lenses, single vision, lined bifocals, and lined trifocal lenses.

Frame.....once every 24 months

- Any frame available up to \$130
- Plus, 20% off balance over \$130

-OR-

Conventional Contact Lenses.....once every 12 months

- Any brand up to \$130
- Plus, 15% off balance over \$130

Standard* contact lens fit and follow-up is the responsibility of the member up to \$55. Premium contact lens fit and follow-up is the responsibility of the member and will be discounted 10%. Once contact lenses are purchased, the lens benefit is subject to the same 12 month frequency limitation as regular eyeglass lenses.

*Standard Contact lens Fitting - spherical clear contact lenses in conventional wear and planned replacement (Examples include but not limited to disposable, frequent replacement, etc.).

**Premium Contact Lens Fitting - all lens designs, materials and specialty fittings other than Standard Contact Lenses (Examples include toric, multi-focal, etc.)

Advantages of Coverage

Without coverage, an exam and prescription glasses can cost around \$300 or more. With EyeMed, your savings average about 40%.

Your Co-Pays

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

Your Monthly Contribution

Member Only.....\$10.24
Member + One.....\$19.88
Family.....\$23.82

Members save more when in-network providers are utilized. If you decide not to see an EyeMed provider, your benefits are lower. Members are responsible for the costs of all services obtained at a non-panel provider. A claim form and receipt should be sent in for any eligible reimbursements.

Out-of-Network Reimbursement Amounts:

Exam.....Up to \$35.00
Lenses:
Single Vision.....Up to \$25.00
Lined Bifocal.....Up to \$40.00
Lined Trifocal.....Up to \$55.00
Frame.....Up to \$65.00
Contacts.....Up to \$104.00

ORTA Group Dental Insurance Plan Frequently Asked Questions

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 may also select one of Ameritas' network dentists who will accept a reduced reimbursement for covered services allowing you to reduce your out of pocket costs.

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, using less than \$750 of their annual benefit. Dental rewards then 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 ability to grow to \$2,500!

Can I use this plan outside of the state of Ohio?

Yes, the plan pays benefits anywhere in the United States.

How can I find out exactly what services are covered?

For more information regarding plan benefits, Ameritas can be reached at 1.888.239.3336.

Can my spouse and children be covered under the ORTA group dental plan?

Yes, your spouse and dependent children up to age 26 are eligible for coverage under your dental policy.

Follow These Easy Steps to Enroll in the ORTA Gold Dental and/or Vision Plan

1. Complete the Enrollment Form.

Complete the form in its entirety. Be sure to sign it, and if adding dependents, include each person's Social Security number and date of birth.

2. Submit your payment.

In order to provide ORTA members with the best rates and service, we offer a convenient 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:

AMBA, 6034 W. Courtyard Dr., Suite 300, Austin, TX 78730



ORTA GOLD Dental & Vision Platinum Plan

Complete this form to enroll in the ORTA Group Dental and/or Vision Plan.
Membership with ORTA is required to enroll in these plans.



Ohio Retired Teachers Association Member Information

Retired From: _____ Retirement Date: _____

Member Name (Last, First) _____ Social Security Number (required) _____

Mailing Address _____

City _____ State _____ Zip _____ Home Phone _____

Date of Birth _____ Gender _____ Email Address: _____

Have You Had Continuous Dental Coverage for the Last 12 Months? Yes No If Yes, Carrier Name: _____
Effective Date: ___/___/_____ Termination Date: ___/___/_____

Monthly Dental Coverage Only:
 Member (\$27.41) Member + 1 (\$61.94) Family (\$76.34) \$ _____

Monthly Vision Coverage Only:
 Member (\$10.24) Member + 1 (\$19.88) Family (\$23.82) \$ _____

Monthly Dental + Vision Coverage:
 Member (\$37.65) Member + 1 (\$81.82) Family (\$100.16) \$ _____

Total: Dental Premium + Vision Premium + \$20 One-Time Enrollment Fee \$ _____

Eligible Dependents to be Covered

Name	DOB	Gender	Student	Disabled	Social Security Number
Spouse					
Child					
Child					

Payment

Convenient Monthly Bank Payment: 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) or the insurance carrier. 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. NOTE: Bank drafts occur on the 2nd business day of each month.

 _____ Date _____
Your signature EXACTLY as it appears on your Bank Records

Office use only: Effective Date: _____ ACH Date: _____ Entered: _____
ID _____ MA _____ R _____