

# A Dental Plan With You In Mind



## An Exciting Dental Plan For Members Of The Kansas Association of Retired School Personnel

The KARSP Board of Directors has endorsed a group dental insurance plan underwritten by Ameritas Life Insurance Corp. This plan has been heavily negotiated for our membership.

Most plans require a 12 month waiting period on certain services. However, during this special open enrollment, you can join the group KARSP dental insurance plan and have first day access to all covered services with **no waiting periods!** Your applications must be postmarked by August 15, 2011, for your coverage to become effective September 1, 2011. Late applications postmarked by September 15, 2011, will have an October 1, 2011, effective date.

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

Contact Ameritas at 1-888-239-3336, or online at [www.ameritasgroup.com/resources/find.asp](http://www.ameritasgroup.com/resources/find.asp).

#### Endorsed by:

Kansas Association of Retired School Personnel

#### 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 Kansas.*

### Advantages of Coverage

- Freedom to use your own dentist; NO network required!
- You may choose an Ameritas Network provider and save up to 20-30%
- Your routine cleanings and exams are covered at 100% of the usual and customary rate with no deductible (twice per calendar year)
- \$75 Calendar Year deductible per person (only applies to basic and major services)
- NO referral required for specialty care
- \$1,000 Calendar Year Maximum per person
- Dental Rewards - may enable your \$1,000 Calendar Year Max to grow to \$2,000
- **Rates guaranteed through July 2013!**

### Dental Plan Highlights

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

### Monthly Plan Rates

<b>Member</b>	<b>\$46.76</b>
<b>Member + 1</b>	<b>\$89.96</b>
<b>Member + Family</b>	<b>\$131.76</b>

# An Eyecare Plan With You In Mind



Exclusively for Members of the Kansas Association of Retired School Personnel

**85% of all you experience is through your eyes**

Are you really seeing your best? Or are you simply used to the view? With good vision, your experiences are clearer and sharper!

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 eye-wear, 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/KARSP](http://www.vsp.com/go/KARSP) 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.

### Visit [www.vsp.com/go/KARSP](http://www.vsp.com/go/KARSP)

What's important to you? Do you need an evening appointment? Interested in a doctor who focuses on sports eyewear or children? Want an online savings statement after you visit a VSP doctor?



Searching for information on conditions of the eye? Visit [www.vsp.com/go/KARSP](http://www.vsp.com/go/KARSP). We think you'll like what you see!

### 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**

- Progressive lenses, single vision, lined bifocal, and lined trifocal lenses.
- Polycarbonate lenses for dependent children.

**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. Learn more from your doctor or [www.vsp.com/go/KARSP](http://www.vsp.com/go/KARSP).

### Advantages of Coverage

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

### Your Copays

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

### Extra Discounts and 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.....\$11.89**

**Member + One.....\$21.43**

**Family.....\$27.19**

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 not in the VSP network, 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)

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.



# Questions?

We Have Answers

## 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 \$500 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 \$1,000 calendar year maximum has the potential to grow to \$2,000! 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.

### Can I use This Plan Anywhere?

Yes! The plan pays benefits anywhere in the U.S.

### Can I Pay My Premium by Check Every Month?

We offer a convenient monthly bank draft option or the option to pay annually.

## 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:

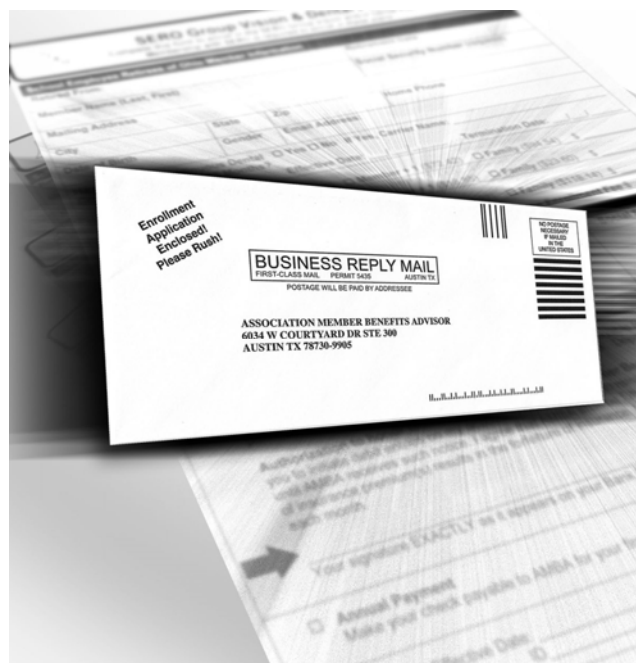
**Monthly Bank Draft:** Enclose a check payable to AMBA for your first month's premium(s) plus the \$20 one-time enrollment fee. You must also sign the bank draft authorization on the bottom of the application, and include a blank check marked "Void" on the account to be drafted.

**Annual Billing:** If you elect to pay your premium(s) annually, enclose a check payable to AMBA for your monthly premium(s) x 12 plus the \$20 one-time enrollment fee.

### 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





# KARSP Group Dental & Vision Plans

Complete this form to enroll in the Group Dental and/or Vision Plans.  
Membership with KARSP 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: _____ Effective date: / / Termination date: / /						
Select Your Coverage Below ▶ <i>MONTHLY</i> Premiums Are Shown						
Dental Coverage Only:		<input type="checkbox"/> Member: \$46.76	<input type="checkbox"/> Member + 1: \$89.96	<input type="checkbox"/> Family: \$131.76		
Vision Coverage Only:		<input type="checkbox"/> Member: \$11.89	<input type="checkbox"/> Member + 1: \$21.43	<input type="checkbox"/> Family: \$27.19		
Dental + Vision Coverage:		<input type="checkbox"/> Member: \$58.65	<input type="checkbox"/> Member + 1: \$111.39	<input type="checkbox"/> Family: \$158.95		
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 Information (Select One)

**Convenient Monthly Bank Payment:** Make your check payable to AMBA for your first month's premium plus the one-time \$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 2<sup>nd</sup> business day of each month.**

\_\_\_\_\_  
Your signature EXACTLY as it appears on your Bank Records

\_\_\_\_\_  
Date

**Annual Payment:** Make your check payable to AMBA for your first month's premium x 12 plus the one-time \$20 enrollment fee.

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

07/11

Office use only: Effective Date: \_\_\_\_\_ ACH Date: \_\_\_\_\_ Entered: \_\_\_\_\_  
MA \_\_\_\_\_ R \_\_\_\_\_