OPEN ENROLLMENT

Texas Retired Teachers Association

Endorsed DENTAL PLAN | *For TRTA Members Only*

The Board of Directors has endorsed a group dental insurance plan for our members. The plan is underwritten by the Ameritas Life Insurance Corp and has been heavily negotiated for our members.

During open enrollment, you will enjoy access to all covered services with no waiting periods. Postmark your application by October 22, 2017 and your coverage will be effective November 1, 2017.

How do I locate an Ameritas Network Provider or get additional information about benefits?
Contact Ameritas at 1.888.239.3336, or online at:

www.FindProviders.net

Endorsed by:
Texas Retired Teachers Association

Underwritten by:
Ameritas Life Insurance Corp.

Ameritas
fulfilling life.

Plans Marketed by:
Association Member Benefits Advisors
6034 W. Courtyard Dr., Ste 300
Austin, TX 78730

AMBA
ASSOCIATION MEMBER BENEFITS ADVISORS

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 Type 2 and Type 3 services)
- $1,500 Calendar Year Maximum per person
- Dental Rewards® – enables your $1,500 calendar year max to grow to $2,750!

Dental Plan Highlights

- **Type 1 Services: 100% coverage***
  - Oral Exams
  - Routine Cleanings
- **Type 2 Services: 80% coverage***
  - Fillings
  - X-Rays
  - Crown – Stainless Steel
  - Crown Repair
  - General Anesthesia
- **Type 3 Services: 50% coverage***
  - Endodontics (root canals)
  - Crowns – Porcelain
  - Oral Surgery
  - Dentures
  - Periodontics (gum disease)

Monthly Rates

Rates Guaranteed through July 2018

Member:	**$51.72**
Member+1:	**$103.44**
Family:	**$130.28**

*Reimbursement percentages are based on the maximum plan allowance 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 Texas.

MEMBERS SAVE WITH THE

Texas Retired Teachers Association

VSP Signature Plan

You Can Count on Us to Put Members First
The VSP Signature Plan helps members receive and pay for the eye care they need. Signature plans emphasize eye health featuring experienced, independent private practice VSP eye doctors, and contracted retail chains such as Visionworks and Costco.

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.

Monthly Rates

Member Only:	$10.90
Member + One:	$18.85
Family:	$23.60

No ID Cards, No Claim Forms! Easy As 1, 2, 3!

1. Find a VSP network doctor by visiting www.vsp.com/go/trta 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.

Out-of-Network Reimbursement Amounts
Visit vsp.com for details, if you plan to see a provider other than a VSP network provider.
- Exam: up to $50
- Frame: up to $70
- Single Vision Lenses: up to $50
- Lined Bifocal Lenses: up to $75
- Lined Trifocal Lenses: up to $100
- Progressive Lenses: up to $75
- Contacts: up to $105

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. It is not a certificate of insurance and does not include exclusions and limitations. For exclusions and limitations, or a complete list of covered procedures, contact your benefits administrator.

Advantages of Coverage
Without coverage, an exam and prescription glasses can cost around $450 or more. Take a look below to see how you can save with VSP!

Your Coverage From a VSP Doctor (copays apply)

WellVision Exam - $15 copay
Covered once every 12 months
- Focuses on your eyes and overall wellness

Prescription Eyeglasses - $25 copay
Frames:
Covered up to your allowance once every 24 months
- $150 allowance for a wide selection of frames
- $170 allowance for featured frame brands
- 20% savings on the amount over your allowance

Lenses:
Covered once every 12 months
- Single vision, lined bifocal, and lined trifocal lenses
- Polycarbonate lenses for dependent children
- 35-40% savings on non-covered lens enhancements such as progressives

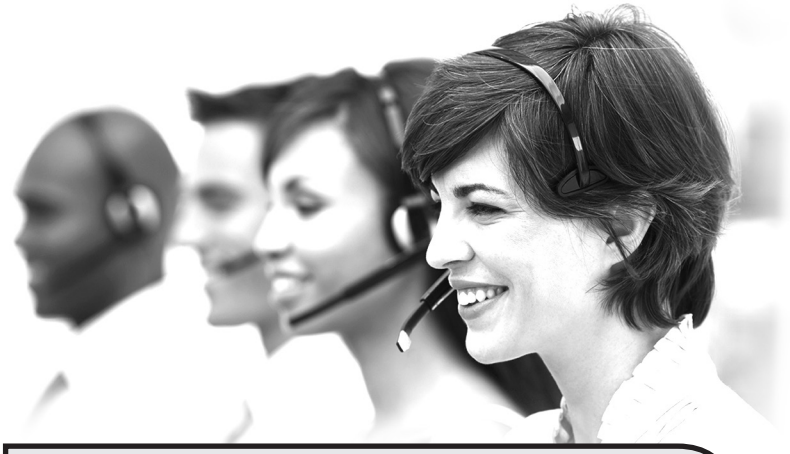
Contact Lens Exam - No copay
Once every 12 months (instead of eyeglasses)
When you choose contacts instead of glasses, your $150 allowance applies to the cost of your contacts and the lens exam (fitting and evaluation). This exam is in addition to your vision exam to ensure proper contact fit. If you choose contact lenses you will be eligible for a frame 12 months from the date the contact lenses were obtained.

Diabetic Eyecare Plus Program - $20 copay
- Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.

Retinal Screening
- No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam Laser Vision Correction
- Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.

Extra Discounts and Savings
Glasses and Sunglasses
Go to vsp.com/specialoffers for details.
- 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.

Dental & Vision Plan
Frequently Asked Questions



How Can I find Out What is Covered and Locate a Network Dentist?
You can call Ameritas at 1.888.239.3336 for coverage information. To locate a network dentist, call Ameritas or visit them at:

www.FindProviders.net

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 to receive the highest benefits. 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 $350 into the next benefit period with a maximum carry over amount of $1,250. Therefore, your $1,500 calendar year maximum has the potential to grow to $2,750! 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 These Plans?
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 or annual payment.

How Do I Enroll?
Enrolling is Easy!

By Mail:

❶ **Complete The Enrollment Form:**
If adding dependents, include each person's Social Security number and date of birth.

❷ **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 Payment: Enclose a check payable to AMBA for your first month's premium plus the $20 one-time enrollment fee. We will invoice you for the remainder of the plan year.

❸ **Mail Your Completed Application To:**
Association Member Benefits Advisors
6034 W. Courtyard Dr., Suite 300
Austin, TX 78730

Dental & Vision Enrollment Form

Complete this form to enroll in this Endorsed Dental & Vision Plan. **Membership with TRTA is required.**

AMBA
ASSOCIATION MEMBER BENEFITS ADVISORS

Have you retired within the last 60 days? ☐Yes ☐No

If Yes, Where: _____ Retirement Date: _____

STEP 1: Tell Us About Yourself

Last Name:	First Name:	MI:	Gender	Social Security Number *(Required)*
			☐M ☐F	- -

Street Address:	City:	State:	Zip:

Date of Birth (MM/DD/YYYY)	Phone Number:	Email Address:
/ /	( ) -	

STEP 2: Prior Coverage Information

Have you had continuous dental coverage for the past 12 months with less than a 60 day gap in coverage? ☐Yes ☐No

If Yes, carrier name:	Effective date:	Termination date:

STEP 3: Select Your Coverage

NOTE: Monthly rates are shown.

Dental Plan:	☐ Member: $51.72	☐ Member + 1: $103.44	☐ Family: $130.28
Vision Coverage:	☐ Member: $10.90	☐ Member + 1: $18.85	☐ Family: $23.60
Dental+Vision Coverage:	☐ Member: $62.62	☐ Member + 1: $122.29	☐ Family: $153.88

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

STEP 4: Dependents to Be Covered

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

Name	First	Last	MM/DD/YYYY Date of Birth	Gender	Student	Disabled	Social Security# (required)
Spouse			/ /	☐M ☐F	☐Y ☐N	☐Y ☐N	
Child			/ /	☐M ☐F	☐Y ☐N	☐Y ☐N	
Child			/ /	☐M ☐F	☐Y ☐N	☐Y ☐N	

STEP 5: Payment

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

Authorization to honor drafts drawn by Association Member Benefits Advisors. 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

☐ **Annual Payment:** Make your check payable to AMBA for your first month's premium plus the $20 one-time enrollment fee. We will invoice you for the remainder of the plan year.

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

Office Use Only: Effective Date: _____ ACH Date: _____ Entered: _____ MA _____ R _____