

# Learn about your



The enclosed materials explain the Ameritas coverages offered by your employer.

Employee benefits can have huge value; make sure you're taking full advantage of yours.



# GOODWILL OF CENTRAL AND NORTHERN ARIZONA

Policy #: 010-35327 - **HIGH PLAN**



**FUSION** combines dental and eye care benefits into one easy-to-administer plan. This plan combines the annual maximum between the dental and vision plans.

For the maximum:

- The member can use up to \$1,500 toward any covered dental expense.
- The member can use up to \$100 toward any covered eye care expense.
- Total benefits paid between the two coverages will not exceed \$1,500.

## Dental Plan Benefits *subject to FUSION plan design listed above*

Type 1 Preventive No Waiting Period	100%	Routine Exam (1 per 6 months) Bitewing X-rays (1 per 12 months) Cleaning (1 per 6 months)
Type 2 Basic No Waiting Period	80%	Restorative Amalgams Restorative Composites Endodontics (nonsurgical) Periodontics (nonsurgical) Endodontics (surgical) Periodontics (surgical) Simple Extractions
Type 3 Major No Waiting Period	50%	Surgical Extractions Crowns (1 in 10 years per tooth) Prosthodontics (Bridges, Dentures) (1 in 10 years)

## Deductible

Type 1	\$0
Type 2 and 3	\$50 per person, per calendar year
Family Maximum	When 3 family members satisfy their Deductible Amounts for this Calendar Year, no additional Deductibles will apply to any family members for the rest of this Calendar Year.

## Benefit Year Maximum

Type 1, 2, and 3 (per person, per calendar year)	\$1,500
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## Orthodontia Benefits (children under age 19)

No waiting period	
Plan Benefit	50%
Lifetime Deductible	\$0
Lifetime Maximum (per person)	\$1,500

## Claims Allowance

Type 1, 2 and 3 <i>In network allowance is discounted fee</i>	90th U&C
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## Vision Plan Benefits *subject to FUSION plan design listed above*

<i>Allowances</i>		<i>Frequencies Based on date of service**</i>	
Exam	Subject to Maximum	Exam	None
Lenses (per pair)		Lenses	None
Single	Subject to Maximum	Frames	None
Bifocal	Subject to Maximum		
Trifocal	Subject to Maximum		
Lenticular	Subject to Maximum	Maximum	\$100
Progressive	Subject to Maximum	Deductibles (Lifetime deductible)	\$0
Contacts			
Elective/Medically Necessary	Subject to Maximum		
Frames	Subject to Maximum		

\*Deductible applies to the first service received

\*\*Please submit claims within 90 days of the date of service so that the plan can consider benefits (subject to State requirements).

## Member Cost for Vision Discounts *(may vary by prescription, option chosen and retail location)*

Exam	\$5 off routine exam
With dilation as necessary	\$10 off contact lens exam
The following lenses, frame and lens options discounts and fees apply only if a complete pair of glasses is purchased.	
Standard Plastic Lenses	
Single Vision	\$50
Bifocal	\$70
Trifocal	\$105
Frame	35% of retail price
Lens Options	
Standard Progressive	\$65 plus standard plastic lens cost
Premium Progressive	20% discount
Standard Polycarbonate	\$40
Tint (solid or gradient)	\$15
Scratch-Resistant Coating	\$15
Anti-Reflective Coating	\$45
Ultraviolet coating	\$15
Other Add-ons	20% discount
Contact Lenses	
Conventional	15% off retail price (does not apply to fitting) After initial purchase, replacement contacts by mail are offered at substantial savings online through <a href="http://eyemedvisioncare.com">eyemedvisioncare.com</a> .
Lasik or PRK	Average discount of 15% off retail price or 5% off promotional price at US Laser Network participating providers.
Items Not included	See limitations and exclusions

## Limitations and Exclusions

Discounts are not available for the following procedures material or services.

- Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing.
- Medical and/or surgical treatment of the eye, eyes, or supporting structures.
- Corrective eye wear required by your employer as a condition of employment, includes safety eye wear unless specifically covered under your plan.
- Worker's Compensation injury claims (or similar injury laws.)
- Plano non-Prescription lenses and non-prescription sunglasses, but you receive 20% off retail for items purchased separately.
- EyeMed provider professional services, or disposable contact lenses.
- Two pairs of glasses in lieu of bifocals.

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## Open Enrollment

If you do not elect to participate when initially eligible, you may elect to participate at the policyholder's next enrollment period, which normally coincides with the policy anniversary date.

## LASIK Advantage

Your dental plan includes a feature called LASIK Advantage which provides benefits for LASIK and related procedures, including standard LASIK, custom LASIK, LASIK with Wavefront Technology, CustomVue LASIK, LASIK with IntraLase technology and Photorefractive Keratectomy (PRK).

As a participant in the dental plan you earn a lifetime LASIK benefit per eye over time. The benefit amount increases over a four year period, with the highest benefit provided in year four. Benefits are earned for each eye.

If you and/or your eligible dependents are late entrants as described above, you and/or your eligible dependents must wait 12 months from enrollment to be eligible for LASIK coverage; after 12 months the LASIK benefit starts at the year one amount.

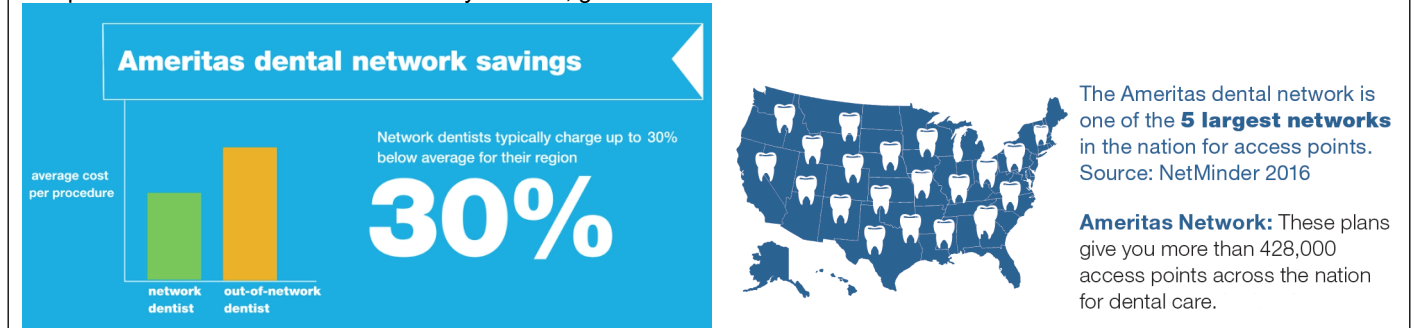
The LASIK Advantage benefit is available to participants age 18 and older.

This benefit offers choice! Any specialist can be chosen, as there is no network tied to this coverage.

Lifetime Benefit Earned per Eye:	Year One	Year Two	Year Three	Year Four
	\$100	\$200	\$300	\$500

## Provider Flexibility and Network Savings

Members aren't limited to one particular dentist, or a small group of providers, who may or may not be taking new patients. Each plan member is free to visit any provider they choose, including your current dentist, regardless if they are in- or out-of-network. And family members do not have to see the same dentist. When you visit an in-network dentist there are no claim forms to complete. For a list of network dentists in your area, go to Find A Provider at [ameritas.com](http://ameritas.com).



## Late Entrant

We strongly encourage you and/or your dependents to sign up for coverage when you are initially eligible. If you choose to enroll after initially declined, you and/or your eligible dependents will be considered a Late Entrant. Covered expenses will not include and benefits will not be payable in the first 12 months that a person is insured if the person is a Late Entrant; except for evaluations, prophylaxis (cleanings), and fluoride application. After 12 months, you will have access to all of the plan's benefits.

## Customer Service

Customer Connections **800-487-5553** [www.Ameritas.com](http://www.Ameritas.com)  
Monday - Thursday 7am-12am CST, Friday 7am-6:30pm CST

This document is a highlight of plan benefits provided by Ameritas Life Insurance Corp. as selected by your employer. 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.

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## Hearing Plan Benefits

Annual Hearing Exam	100%
Hearing Aid	50%
Hearing Aid Maintenance	100%

### Deductible

Annual Hearing Exam	\$0
Hearing Aid	\$0
Hearing Aid Maintenance	\$0

### Benefit Year Maximum

Annual Hearing Exam	Up to \$75
Hearing Aids (per ear)	
Year One	Up to \$100
Year Two	Up to \$300
Year Three	Up to \$400
Hearing Aid Maintenance	Up to \$40

### Late Entrant

We strongly encourage you and/or your dependents to sign up for coverage when you are initially eligible. If you choose to enroll after initially declining, you will be considered a Late Entrant. Late Entrants are eligible for only exams for the first 12 months they are covered.

### Member Savings

#### Prescriptions




Save an average of 40% on generic and brand name prescriptions at over 60,000 pharmacies including CVS, Walgreens, Rite Aid and Walmart. Use your normal health care pharmacy benefit, or the prescription discount, whichever saves you more. This Rx discount is offered at no additional cost, and it is not insurance.

**Access your Ameritas Rx savings card:**

<https://www.ameritas.com/OCM/GetFile?doc=037275>

#### Frames and lenses

Save up to 15% at any Walmart Vision Center:

-  • top quality frames for the entire family including today's most popular brands
-  • wide selection of lens options; all lenses come with scratch resistant coating for no additional charge
-  • safety eyewear

This discount is available to you without any additional cost to your plan premium.

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# GOODWILL OF CENTRAL & NORTHERN ARIZONA

FUSION Highlight Sheet



## CLAIM FORM

PLEASE BE AS THOROUGH AND ACCURATE AS POSSIBLE WHEN COMPLETING THIS FORM. ERRORS OR OMISSIONS MAY DELAY CLAIM PAYMENTS. **Claims Must Be Submitted Within 90 Days from Date of Service.**

### TO BE COMPLETED BY THE CARDHOLDER

1. PATIENT'S NAME (Last, First, Middle)		2. CARDHOLDER'S GROUP # <b>35327</b>		3. CARDHOLDER'S ID#	
4. PATIENT'S BIRTH DATE	5. PATIENT'S SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	6. RELATIONSHIP TO CARDHOLDER <input type="checkbox"/> SELF <input type="checkbox"/> CHILD <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER		7. CARDHOLDER'S NAME (Last, First, Middle)	
8. CARDHOLDER'S ADDRESS (No., Street, City, State and Zip Code)				9. HOME NUMBER (   ) (   )	WORK NUMBER (   ) (   )
10. NAME OF INSURANCE CARRIER <b>Ameritas</b>		11. NAME OF EMPLOYER <b>Goodwill of Central &amp; Northern AZ</b>		12. CARDHOLDER'S STATUS <input type="checkbox"/> ACTIVE <input type="checkbox"/> RETIRED <input type="checkbox"/> HOURLY <input type="checkbox"/> SALARIED	
13. CARDHOLDER'S BIRTH DATE		15. NAME AND ADDRESS OF THE OTHER CARRIER			
14. PATIENT IS COVERED FOR VISION CARE COMPLETE BY ANOTHER PLAN <input type="checkbox"/> YES                      IF YES, PLEASE <input type="checkbox"/> NO                      BOXES 15 THROUGH 16		16. POLICY HOLDER'S NAME			
17. RELATIONSHIP TO CARDHOLDER <input type="checkbox"/> SELF <input type="checkbox"/> CHILD <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER		18. POLICY HOLDERS' DATE OF BIRTH		19. POLICYHOLDER'S S.S. #/GROUP	

SIGNATURE OF CARDHOLDER \_\_\_\_\_ DATE SIGNED \_\_\_\_\_

### PLEASE CHECK ALL ITEMS BELOW THAT APPLY TO THE SERVICES RENDERED BY YOUR EYE CARE PROVIDER

DATE OF SERVICE \_\_\_\_\_

- EXAM
- CONTACT LENS FITTING/EXAM
- CONTACT LENSES
- EYE GLASS LENSES
- SINGLE VISION
  - BIFOCAL
  - TRIFOCAL
  - PROGRESSIVE (NO LINE BIFOCAL)
  - OTHER \_\_\_\_\_
- FRAME

### PLEASE SUBMIT THIS FORM WITH YOUR ITEMIZED RECEIPT (S) TO THE FOLLOWING

Send claims to: Ameritas Group Claim Office P.O. Box 82520 Lincoln, NE 68501 Toll Free (800) 487-5553 <a href="http://www.ameritas.com">www.ameritas.com</a>	<b>\$100 Flat Max</b>
	<input type="checkbox"/> Check to send payment directly to provider.
	Member Signature _____