Dear PFRO Member,

When it comes to dental and vision care, most PFRO members want to save money for their families and get the best possible coverage.

Does that sound like you?

Our members tell me there is no better way to protect their health than with the benefits they get from the PFRO Dental Plan and the PFRO Vision Plan. With pensions and benefits under attack for public sector employees, PFRO promotes retirement security for all.

Think about it: with group rates you can get the preventative care you need to help keep you healthy for a lifetime.

If you ever have to deal with something major – like a root canal – you can feel good knowing you've got coverage.

But don't wait too long…

Open enrollment ends soon. After that, it's too late. And you'll miss out.

Please, review all the information we've enclosed and return your enrollment form back to us today.

You'll be glad you did.

Sincerely,

Gary L Monto

Gary Monto
PFRO President

Limitations & Exclusions

Covered Expenses will not include and no benefits will be payable for expenses incurred:

- for any treatment which is for cosmetic purposes, except as specifically listed in the Table of Dental Procedures.
- to replace any prosthetic appliance, crown, inlay or onlay restoration, or fixed partial denture within five years of the date of the last placement of these items. However, if a replacement is required because of an accidental bodily injury sustained while the plan member is covered under the dental expense benefit, it will be a Covered Expense.
- for initial placement of any dental prosthesis or prosthetic crown unless such placement is needed because of the extraction of one or more teeth while the plan member is covered under the dental expense benefit. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such dental prosthesis or prosthetic crown must include the replacement of the extracted tooth or teeth.
- for any procedure begun before the plan member was covered under the dental expense benefit.
- for any procedure begun after the member's insurance under the dental expense benefit terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the member's insurance under the dental expense benefit terminates.
- to replace lost or stolen appliances.
- for appliances, restorations, or procedures to:
  - alter vertical dimension;
  - restore or maintain occlusion;
  - splint or replace tooth structure lost because of abrasion or attrition
- for any procedure which is not shown on the Table of Dental Procedures.
- for orthodontic treatment (unless otherwise specified in this contract.)
- for which the plan member is entitled to benefits under any workmen's compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.
- for charges for which the plan member is not liable or which would not have been made had no insurance been in force.
- for services which are not required for necessary care and treatment or are not within the generally accepted parameters of care.
- because of war or any act of war, declared or not.

Your Smile is About to Get a Whole Lot Brighter

OPEN ENROLLMENT

You want a healthy smile, but the financial burden of dental expenses keeps getting heavier on everyone's budget. So many plans don't let you choose your own dentist, and many have long waiting periods before you get coverage. Here's the good news: we've fixed all of that.

GET THESE ADVANTAGES:

- **The Dentist You Want –** You get to choose the provider you like best. You are not required to stay inside a specific network.
- **Save 20-40% –** If you pick a dentist within the Ameritas Dental Network. Visit www.findproviders.net or call Ameritas at 888-239-3336.
- **No Waiting Periods –** You get your benefits with *no waiting periods* for covered services – when you enroll during open enrollment.
- **Access Providers Nationwide –** Whether you are at home or traveling the U.S., the Ameritas Dental Network has over 400,000 providers to serve your needs.
- **High Calendar Year Maximum –** With Dental Rewards® you can carry over a portion of your unused maximum to the next benefit period.
- **Guaranteed Rates –** All the way through September 2020.

Platinum Plan Highlights:

Enjoy rich coverage both in network, and at most out of network dentists!

Type 1 Services: 100% coverage for*
- Routine Oral Exams
- Routine Cleanings
- Bitewing X-rays

Type 2 Services: 80% coverage for*
- Panoramic X-rays
- Fillings
- Denture Repair
- General Anesthesia

Type 3 Services: 50% coverage for*
- Crowns
- Endodontics (root canals)
- Periodontics (gum disease)
- Onlays
- Simple and Complex Extractions

Monthly Rates

• Member Only:	**$41.16**
• Member & Spouse or Dependent:	**$82.97**
• Member & Family:	**$139.10**

Plan Details

• Plan Year Deductible:	**$75 person per year** (waived for Type 1 services)
• Plan Year Maximum Benefit:	**$1,500 per person**

Gold Plan Highlights:

Receive higher coverage when you stay with a dentist that's in network.

Type 1 Services*: 100% in network**
- Routine Oral Exams
- Routine Cleanings
- Bitewing X-rays

Type 2 Services*: 80% in network**
- Panoramic X-rays
- Fillings
- Denture Repair
- General Anesthesia

Type 3 Services*: 50% in network**
- Crowns
- Endodontics (root canals)
- Periodontics (gum disease)
- Onlays
- Simple and Complex Extractions

** **Out of Network**: Type 1 - 80%, Type 2 - 60%, Type 3 - 50%.

Monthly Rates

• Member Only:	**$31.35**
• Member & Spouse or Dependent:	**$63.18**
• Member & Family:	**$105.89**

Plan Details

• Plan Year Deductible:	**$75 person per year** (waived for Type 1 services)
• Plan Year Maximum Benefit:	**$1,500 per person**

*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 Ohio.

This information is provided by Ameritas Life Insurance Corp. (Ameritas Life). Group dental, vision and hearing care products (9000 Rev. 03-16, dates may vary by state) and individual dental and vision products (Indiv. 9000 Rev. 07-16, dates may vary by state) are issued by Ameritas Life. Some plan designs are not available in all areas. In Texas, our dental network and plans are referred to as the Ameritas Dental Network. Some states require that producers be appointed with Ameritas Life before soliciting its products. To become appointed with Ameritas Life, please call 800-659-2223.

Endorsed by:
Police & Fire Retirees of Ohio

Underwritten by:
Ameritas Life Insurance Corp.
888-239-3336

Plans Marketed by:
Association Member Benefits Advisors
Austin, TX 78730

Your Vision and Your Good Health

Your eye health is essential to your happiness and well-being. That's why we ensure you can count on your PFRO Vision Plan for superior coverage at affordable rates.

This plan emphasizes eye health by featuring experienced, independent private practice eye doctors and contracted retail chains.

Just look at all your plan entitles you to:

Nationwide Choice Network of Experienced Doctors – Most of our members live within 10 miles of the doctor they choose. That's because we have thousands of doctors located in rural and metropolitan areas throughout the United States. You can even visit your local Walmart for all your vision needs!

One-Stop Convenience – Our network of doctors provides eye exams and eyewear to take care of all your vision needs. You can find a VSP doctor by visiting **pfro.vspforme.com** or call 800-877-7195.

Low Monthly Rates –

Member Only:	$11.94
Member & Spouse or Dependent:	$20.94
Member & Family:	$26.05

Great Benefits and Low Copays – For the services you need, including:

WellVision Exam: (Covered once every 12 months) $15 copay

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 up to your allowance once every 12 months)

- Single vision, lined bifocal, and lined trifocal lenses
- 100% coverage on Standard Progressive lenses
- 20-25% saving on non-covered lens enhancements such as anti-reflective and UV coating

Contact Lens Exam: (Covered 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.

Extra Discounts and Savings – You'll get 20% savings on additional glasses and sunglasses.

Imagine how much you'll save with your PFRO vision plan. Without a vision plan, the average exam and glasses typically cost over $450. But your member-only savings has you covered.

Out-of-Network Reimbursement Amounts – If the provider of your choice is outside the network, no problem. Here are the reimbursement amounts you can expect:

- Exam: up to $45
- Frame: up to $70
- Single Vision Lenses: up to $30
- Lined Bifocal Lenses: up to $50
- Lined Trifocal Lenses: up to $65
- Progressive Lenses: up to $50
- Contacts: up to $105

Let Us Help You Pay for the Care That is So Vital to Your Good Health.

Join Us to Get Your PFRO Member-Only Vision Plan Benefits Today!

VSP

Police & Fire Retirees of Ohio
VSP Choice Plan
800-877-7195

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.

DENTAL & VISION ENROLLMENT FORM for PFRO Members Only

Open enrollment

AMBA ASSOCIATION MEMBER BENEFITS ADVISORS

Ameritas fulfilling life.

Here's all you do to enroll:
1) Complete the information below
2) Select your plan(s) choice
3) Choose your payment type
4) Your coverage will begin on the 1st of the following month

STEP 1: TELL US ABOUT YOURSELF

Full Name: _____ **Address:** _____ **City/State/Zip:** _____	**Gender:** ☐ Male ☐ Female	**Date of Birth:** ____ /____ /_____ MM DD YYYY	**Social Security Number** (Required)**:**
Phone Number: (_____) _____-_____	**Email Address:**	**Have you had continuous Dental coverage for the past 12 months with less than a 60 day gap in coverage?** ☐ Yes ☐ No	
If yes, Name of Your Carrier:	Effective Date:	Termination Date:	

STEP 2: SELECT YOUR COVERAGE

	MONTHLY RATE	MONTHLY RATE	MONTHLY RATE
Dental (Gold)	☐ Member Only $31.35	☐ Member +1 $63.18	☐ Family $105.89
Dental (Platinum)	☐ Member Only $41.76	☐ Member +1 $82.97	☐ Family $139.10
Vision	☐ Member Only $11.94	☐ Member +1 $20.94	☐ Family $26.05

STEP 3: SPOUSE OR DEPENDENT COVERAGE INFORMATION

Dependent children up to age 26 are eligible for coverage.

First Name: _____ **Last Name:** _____	**Gender:** ☐ Male ☐ Female	**Date of Birth:** ____ /____ /_____ MM DD YYYY	**Disabled:** ☐ Yes ☐ No	**Social Security #** (Required)**:**

STEP 4: PAYMENT CHOICE: *(Please select one)*

☐ Convenient Monthly Bank Draft – Include a VOIDED CHECK from the account you wish to pay from. Your initial premium and $20 application fee will be drafted on or after your effective date of coverage.

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: Submit your application to begin coverage on the effective date. You will then receive an invoice for the $20 application fee and your premium balance (through the end of this plan year).

PFRO Dental and Vision 30 Day Review Period

Review your dental and vision plan(s) for a full 30 days. Then if you decide these plans are not for you and you have not filed a claim, simply let us know and we'll promptly refund your payment.

Eff Date: _____ **ACH Date:** _____ **Entered:** _____ **MA:** _____ **R:** _____ **App ID:** ASN _____

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- for services which are not required for necessary care and treatment or are not within the generally accepted parameters of care.
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