$35/mth Family
$20/mth Single

CWA Local 1170 – Frontier Direct Bill
Dental Assistance Plan
Outline of Coverage
Effective July 1, 2021

Class I
Diagnostic & Preventative
- Examinations
- Cleanings
- X-Rays
- Fluoride

Class I

First $125.00 paid at 100%; balance is subject to Lifetime Deductible; then Plan pays 60%

Class II
Basic/Minor Restorative
- Fillings
- Root Canal Therapy
- Extractions
- Gum Surgery
- Denture Repair
- Sealants

Class III
Major Restorative
- Crowns
- Bridgework
- Dentures

Class II Class III

Services are subject to Lifetime Deductible, then Plan pays 60%

Class IV
Orthodontia
- Braces

Class IV

Plan pays 60% up to Annual Lifetime Orthodontia Maximum of $1,500.00

LIFETIME DEDUCTIBLE: $50.00 (applies to Classes I, II and III combined)

ANNUAL MAXIMUM BENEFIT: $600.00 Individual/$1000.00 family
(applies to Classes I, II, and III combined)

The Benefit Year is July 1 - June 30.

You are encouraged to request a Pre-Treatment Estimate for any dental work expected to cost over $300.

Dependent coverage to age 19. Full-time student coverage to age 23.

Health Economics Group, Inc.
1387 Fairport Road
Building 1000, Suite A-1
Fairport, NY 14450
(585) 241-9500 / (800) 666-6690, ext. 501 www.heginc.com

Get the best in eye care and eyewear with CWA, LOCAL 1170 HEALTH & WELFARE and VSP® Vision Care.

VSP Vision care for life

At VSP, we invest in the things you value most—the best care at the lowest out-of-pocket costs. Because we're the only national not-for-profit vision care company, you can trust that we'll always put your wellness first.

You'll like what you see with VSP.

- **Value and Savings.** You'll enjoy more value and the lowest out-of-pocket costs.
- **High Quality Vision Care.** You'll get the best care from a VSP provider, including a WellVision Exam®—the most comprehensive exam designed to detect eye and health conditions. Plus, when you see a VSP provider, your satisfaction is guaranteed.
- **Choice of Providers.** The decision is yours to make—choose a VSP provider or any out-of-network provider.
- **Great Eyewear.** It's easy to find the perfect frame at a price that fits your budget.

Using your VSP benefit is easy.

- **Create an account at vsp.com.** Once your plan is effective, review your benefit information.
- **Find an eye care provider who's right for you.** To find a VSP provider, visit **vsp.com** or call **800.877.7195.**
- **At your appointment, tell them you have VSP.** There's no ID card necessary. If you'd like a card as a reference, you can print one on **vsp.com.**

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP provider.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like bebe®, Calvin Klein, Cole Haan, Flexon®, Lacoste, Nike, Nine West, and more[1]. Visit **vsp.com** to find a Premier Program location that carries these brands. Prefer to shop online? Check out all of the brands at **Eyeconic.com**, VSP's online eyewear store.

DIRECT BILL $8.00/mth

Plan # 04107491-0009

See why we're consumers' #1 choice in vision care[2].

Contact us. **800.877.7195**
vsp.com

C.W.A. LOCAL 1170 DIRECT BILL

VISION SERVICE PLAN EYE CARE APPLICATION

PARTICIPANT'S NAME _____

STREET ADDRESS _____

CITY, STATE & ZIP CODE _____

TELEPHONE # (HM) _____ **(CELL)** _____

EFFECTIVE DATE OF COVERAGE _____ **BIRTH DATE** _____

SOCIAL SECURITY NUMBER _____

EMAIL ADDRESS _____

DEPENDENT INFORMATION

SPOUSE'S FIRST NAME _____ **BIRTH DATE** _____ **SEX** _____

CHILD'S FIRST NAME _____ **BIRTH DATE** _____ **SEX** _____

CHILD'S FIRST NAME _____ **BIRTH DATE** _____ **SEX** _____

CHILD'S FIRST NAME _____ **BIRTH DATE** _____ **SEX** _____

CHILD'S FIRST NAME _____ **BIRTH DATE** _____ **SEX** _____

CHILD'S FIRST NAME _____ **BIRTH DATE** _____ **SEX** _____

CHILD'S FIRST NAME _____ **BIRTH DATE** _____ **SEX** _____

Are you or your dependents presently covered under another eye care insurance plan? ☐ **Yes** ☐ **No**

If yes, please supply the name and group number of the Insurance Carrier.

A. Insurance Carrier _____

B. Group Number _____

I hereby certify that the information furnished is accurate to the best of my knowledge and that any deliberate falsification with regard to the information furnished will result in any disqualification from the Plan, as well as my dependents. I agree to stay a participant in this plan for a minimum of one year. Payment is due on the 1st of each month ($8.00/mth for both single and family plans). Please make your check payable to: CWA Local 1170 Health & Welfare Fund.

Date _____ **Signature** _____

Updated 3/30/2021

C.W.A. LOCAL 1170 DIRECT BILL

DENTAL PLAN APPLICATION

PARTICIPANT'S NAME _____

STREET ADDRESS _____

CITY, STATE & ZIP CODE _____

TELEPHONE # (HM) _____ **(CELL)** _____

EFFECTIVE DATE OF COVERAGE _____ **BIRTH DATE** _____

SOCIAL SECURITY NUMBER _____

EMAIL ADDRESS _____

DEPENDENT INFORMATION

SPOUSE'S FIRST NAME _____ **BIRTH DATE** _____ **SEX** _____

CHILD'S FIRST NAME _____ **BIRTH DATE** _____ **SEX** _____

CHILD'S FIRST NAME _____ **BIRTH DATE** _____ **SEX** _____

CHILD'S FIRST NAME _____ **BIRTH DATE** _____ **SEX** _____

CHILD'S FIRST NAME _____ **BIRTH DATE** _____ **SEX** _____

CHILD'S FIRST NAME _____ **BIRTH DATE** _____ **SEX** _____

CHILD'S FIRST NAME _____ **BIRTH DATE** _____ **SEX** _____

Are you or your dependents presently covered under another dental insurance plan? ☐ **Yes** ☐ **No**

If yes, please supply the name and group number of the Insurance Carrier.

A. Insurance Carrier _____

B. Group Number _____

I hereby certify that the information furnished is accurate to the best of my knowledge and that any deliberate falsification with regard to the information furnished will result in any disqualification from the Plan, as well as my dependents. I agree to stay a participant in this plan for a minimum of one year. Payment is due on the 1st of each month ($20/mth for a single plan & $35/mth for a family plan). Please make your check payable to: CWA Local 1170 Health & Welfare Fund.

Date _____ **Signature** _____