MISSISSIPPI PUBLIC RETIREES DENTAL AND VISION OPTION

OFFERED BY: SOUTHERN ADMINISTRATORS AND BENEFIT CONSULTANTS, INC.

SOUTHERN ADMINISTRATORS AND BENEFITS CONSULTANTS, INC.
PO BOX 2449*MADISON, MS 39130
601-856-9933 WWW.SABCFLEX.COM

SABC
PO BOX 2449
MADISON, MS 39130
601-856-9933
WWW.SABCFLEX.COM

DELTA DENTAL
800-521-2651
WWW.DELTADENTALINS.COM

DAVIS VISION
800-999-5431
WWW.DAVISVISION.COM

MORGAN WHITE GROUP
PO BOX 14067
JACKSON, MS 39236
888-859-3795

Southern Administrators and Benefit Consultants Inc. (SABC) is offering a dental and vision plan for retired public employees, which gives each retiree and their dependents an affordable choice. These plans offer:

- No limits on how long you can keep the coverage
- Two dental options to choose from

A. **In network coverage only**
This option provides great benefits at a lower cost. You can choose from any of Delta Dental's large list of network providers, and eliminate balance billing

B. **Dual choice plan (In and out of network coverage)**
This option allows both in and out of network coverage, so you can go to the dentist of your choice. *Keep in mind if you do not go to a network dentist, you may be billed for services that exceed usual and customary charges.*

- Great vision plan with Davis vision's large network of providers

- You can enroll your spouse and/or dependent children (under the age of 26).

Your premiums will be auto-drafted from your checking or savings account each month. The Morgan White Group will administer the billing and auto-draft.

Therefore, you will have to complete the bank draft authorization to sign up for coverage. You may sign up by completing the included application or by going online to www.sabcflex.com/retirees. If you have any questions, please feel free to contact us at 601-856-9933.

Important: Your first payment will be deducted immediately from your account. Future deductions will occur around the 20th of the month, for next month's coverage.

Group: Mississippi Public Retiree Dental Option
Plan: **IN NETWORK COVERAGE ONLY**
Full Contract term: 01/01/2024 to 12/31/2024

Initial contract term: 01/01/2024 to 12/31/2024		
		
Enrollee Only	**Enrollee & 1 Dependent**	**Enrollee & Family**
$32.54	$70.83	$112.94

The above rates are not valid unless accompanied by the provisions in the attached pages.

TO LOCATE A NETWORK DENTIST NEAR YOU, GO TO: DELTADENTALINS.COM AND SELECT *FIND A DENTIST OR CLICK HERE:* ***FIND A DENTIST***

Coinsurances	PPO Network	Premier Network	Non-Delta Dental
Diagnostic and preventive services[1, 2] Exams, X-Rays, Prophylaxis, Fluoride, Space Maintainers, Consultation	100%	100%	100%
Basic services Minor Restorative, Stainless Steel Crowns, Denture Repair/Reline/Rebase, Palliative Treatment	80%	80%	80%
Major services Endodontics, Periodontics Surgical, Periodontics Non-Surgical, Periodontal Maintenance, Extractions, Surgical Extractions, Other Oral Surgery, IV sedation & Anesthesia, Major Restorative, Prosthodontics Removable, Prosthodontics Fixed, Implants Surgical, Implants Non-Surgical	50%	50%	50%
Orthodontic services	Not Covered	Not Covered	Not Covered
Additional services Sealants, Temporomandibular joint dysfunction (TMJ)	Not Covered	Not Covered	Not Covered

Deductibles	PPO Network	Premier Network	Non-Delta Dental
Annual deductible Per individual/family per calendar year	$50/$150	$50/$150	$50/$150
Orthodontic deductible Per individual per lifetime	Not Covered	Not Covered	Not Covered

Maximums	PPO Network	Premier Network	Non-Delta Dental
Annual maximum Per individual per calendar year	$1,250	$1,250	$1,250
Orthodontic maximum Per individual per lifetime	Not Covered	Not Covered	Not Covered

[1] Annual deductible is waived for diagnostic & preventive services.
[2] Annual maximum is waived for diagnostic & preventive services.

Assumptions and guidelines

Maximum Contract Allowance

With this policy you are required to see a Contracted dentist which are paid directly by Delta Dental and by agreement cannot bill the enrollee more than their contracted fee. There are no benefits if you go to a non-contracted provider.

Reimbursement is based on the PPO contracted fees for PPO dentists, the Premier contracted fees for Premier dentists and the PPO contracted fees for non-Delta Dental dentists.

Benefit payments for services rendered by non-contracted dentists are sent directly to the enrollee. It is the enrollee's responsibility to pay the non-contracted dentist.

Fully Insured Non-Retention Contract

Any profit or loss remaining at the end of the contract period will be absorbed by Delta Dental. The client assumes no liability in a loss situation.

Rate Guarantee

Rates are valid if purchased by the proposed effective date of 1/1/2024. Delta Dental recommends 90 days advance notice for implementation.

Limitations and Exclusions

The proposed plan designs are based on the current limitations and exclusions, processing policies, and contract specifications.

Single Dental Carrier

It is assumed that Delta Dental is to be the only dental carrier and that all primary enrollees (and their dependent enrollees) will be covered under our plan(s).

Additional Benefits for Pregnancy

Pregnant enrollees are eligible for a benefit enhancement consisting of one additional oral evaluation and either one additional prophylaxis or one periodontal scaling/root planing procedure.

Missing Teeth

Restorative treatment and replacement of teeth extracted prior to the effective date are covered benefits.

Posterior Composites

Posterior Composites covered.

Group: Mississippi Public Retiree Dental Option
Plan: **Delta Dental Dual Choice (In or out of Network Coverage ™**
Full Contract term: 01/01/2024 to 12/31/2024

Initial contract term: 01/01/2024 to 12/31/2024		
		
Enrollee Only	**Enrollee & 1 Dependent**	**Enrollee & Family**
$40.18	$87.46	$139.46

The above rates are not valid unless accompanied by the provisions in the attached pages.

Coinsurances	PPO Network	Premier Network	Non-Delta Dental
Diagnostic and preventive services[1, 2] Exams, X-Rays, Prophylaxis, Fluoride, Space Maintainers, Consultation	100%	100%	100%
Basic services Minor Restorative, Stainless Steel Crowns, Denture Repair/Reline/Rebase, Palliative Treatment	80%	80%	80%
Major services Endodontics, Periodontics Surgical, Periodontics Non-Surgical, Periodontal Maintenance, Extractions, Surgical Extractions, Other Oral Surgery, IV sedation & Anesthesia, Major Restorative, Prosthodontics Removable, Prosthodontics Fixed, Implants Surgical, Implants Non-Surgical	50%	50%	50%
Orthodontic services	Not Covered	Not Covered	Not Covered
Additional services Sealants, Temporomandibular joint dysfunction (TMJ)	Not Covered	Not Covered	Not Covered

Deductibles	PPO Network	Premier Network	Non-Delta Dental
Annual deductible Per individual/family per calendar year	$50/$150	$50/$150	$50/$150
Orthodontic deductible Per individual per lifetime	Not Covered	Not Covered	Not Covered

Maximums	PPO Network	Premier Network	Non-Delta Dental
Annual maximum Per individual per calendar year	$1,250	$1,250	$1,250
Orthodontic maximum Per individual per lifetime	Not Covered	Not Covered	Not Covered

[1] Annual deductible is waived for diagnostic & preventive services.
[2] Annual maximum is waived for diagnostic & preventive services.

Assumptions and guidelines

Maximum Contract Allowance

Contracted dentists are paid directly by Delta Dental and by agreement cannot bill the enrollee more than their contracted fee. Non-contracted dentists may not always accept Delta Dental's program allowance as payment in full. The enrollee is responsible for paying up to the non-contracted dentist's submitted charge.

Reimbursement is based on the PPO contracted fees for PPO dentists, the Premier contracted fees for Premier dentists and the 80th Percentile for non-Delta Dental dentists.

Benefit payments for services rendered by non-contracted dentists are sent directly to the enrollee. It is the enrollee's responsibility to pay the non-contracted dentist.

Fully Insured Non-Retention Contract

Any profit or loss remaining at the end of the contract period will be absorbed by Delta Dental. The client assumes no liability in a loss situation.

Rate Guarantee

Rates are valid if purchased by the proposed effective date of 1/1/2024. Delta Dental recommends 90 days advance notice for implementation.

Limitations and Exclusions

The proposed plan designs are based on the current limitations and exclusions, processing policies, and contract specifications.

Deductibles and Maximums

Deductible and maximum amounts for in network and out-of-network are inclusive of each other and not in addition to.

Single Dental Carrier

It is assumed that Delta Dental is to be the only dental carrier and that all primary enrollees (and their dependent enrollees) will be covered under our plan(s).

Additional Benefits for Pregnancy

Pregnant enrollees are eligible for a benefit enhancement consisting of one additional oral evaluation and either one additional prophylaxis or one periodontal scaling/root planing procedure.

Missing Teeth

Restorative treatment and replacement of teeth extracted prior to the effective date are covered benefits.

Posterior Composites

Posterior Composites covered.

MISSISSIPPI PUBLIC RETIREE
Dental and Vision Application

Please complete the following information:					
Social Security No.	Last Name		First	MI	Date of Birth / /
Home Address			Phone ( )		Sex M ☐ F ☐
City	State	ZIP Code	Email Address		Effective Date
Previous Public Employer					
I would like (check all that apply) Dental ☐ Vision ☐					

PLEASE CHECK COVERAGE TYPE FOR EACH DEPENDENT YOU LIST BELOW				
First MI Last	Coverage.	Sex	Birth Date	
Spouse:	☐ Dental ☐ Vision	M ☐ F ☐	/ /	
Child:	☐ Dental ☐ Vision	M ☐ F ☐	/ /	
Child:	☐ Dental ☐ Vision	M ☐ F ☐	/ /	

PLEASE CHECK YOUR CHOICE(S)	**DELTA DENTAL ☐** ***In Network Only Plan**	**DELTA DENTAL ☐** **In or out of Network Plan**	**DAVIS VISION**	
Monthly Rates	Delta Dental		**Davis Vision**	
Employee Only	$32.54 ☐	$40.18 ☐	**Employee Only**	$11.05 ☐
Employee + 1 Dependent	$70.83 ☐	$87.46 ☐	**Employee + 1 Dependent**	$18.07 ☐
Employee + Family	$112.94 ☐	$139.46 ☐	**Employee + Family**	$27.25 ☐

By my signature below, I authorize Southern Administrators and Benefit Consultants, Inc. (SABC) or their agent MWG, to initiate monthly electronic debits to my account listed below. The authority remains in effect unless SABC receives a new form from me or I terminate the coverage.

Name on account: _____

Financial Institution Name: _____

Financial Institution City and State: _____

Financial Institution Routing/Transit Number (9 digits) _____

Financial Institution Account Number: _____

Account Type Checking ☐ Savings ☐

Signature: _____ **Date:** _____

MAIL THIS APPLICATION TO: SABC RETIREE* PO BOX 2449*MADISON, MS 39130