You must join AAIC (American Association of Independent Contractors) for $2 per month to get access to BrightIdea Dental and Vision

Rates apply to DenteMax Plus/MESVision networks only. You will incur larger out-of-pocket expense if you visit an out-of-network provider.

Dental and Vision Underwritten by First Continental Life and Accident

Dental Network provided through DenteMax Plus

Vision Network provided through MESVision

Submitted by the 25th
EFFECTIVE DATE: 1st of the following month

DENTAL NOT AVAILABLE IN MINNESOTA

Enroll Today!
(800) 750-7581

Distributed by:

GREENWAY INSURANCE AND FINANCIAL

"For all the things you value most."

1410 Triad Center Dr.
St. Peters, MO 63376
(636) 922-4617 Office

BID/V 10/17

BrightIdea

BrightIdea Dental & Vision Plans

All plans contain the following services

Preventive

Coverage 100%

Includes exams, cleanings, bitewing x-rays and fluoride treatments.

Basic

Coverage 80%

Includes full mouth x-rays, restorative amalgams & composites, simple extractions and sealants.

Major

Coverage 50%

Includes endodontics, all periodontics, dentures, crowns, complex extraction, local anesthesia, onlays and implants.

*12 month waiting period on Major services

Waiting period for Major services can be waived with proof of prior coverage. Proof of prior coverage will only be accepted from the prior carrier and showing 12 months of continuous fully insured coverage with no lapse. DHMO, discount, or scheduled plan coverage will not be accepted.

BrightIdea DENTAL

Guaranteed Acceptance

Includes Implant & Denture Coverage

$25 copay per visit

No Waiting Period for Preventive and Basic Services

Pricing

BrightIdea 1500

$1,500 annual max per person

• Single Member:	$39* month
• Member + Spouse:	$79* month
• Member + Children:	$87* month
• Family:	$126* month

BrightIdea 3000

$3,000 annual max per person

• Single Member:	$49* month
• Member + Spouse:	$94* month
• Member + Children:	$104* month
• Family:	$138* month

BrightIdea 5000

$5,000 annual max per person

• Single Member:	$59* month
• Member + Spouse:	$109* month
• Member + Children:	$119* month
• Family:	$169* month

*Includes $2.00 Association Fee

For a complete listing of benefits, exclusions and limitations, please refer to your Policy. In the event of discrepancies contained in this brochure, the terms and conditions contained in the Policy documents shall govern. The information contained herein is accurate at the time of publication. This brochure provides only summary information.

BrightIdea VISION

Lens Options

Progressive Lenses
The member is responsible for the difference between the Covered Allowance and the Progressive Lens charge.

Additional Lens Options

- Photochromatic: glass/plastic: pays up to $30
- Progressive Lenses: Plan pays up to $89.50
- Polycarbonate Lenses: Plan pays up to $85
- Tints: Pink & Rose Covered in full

Copays

$10 EXAMS • $25 EYE GLASSES (Lenses or Frames)

Lenses (per pair) Coverage
Single Vision; Bi-focal; Tri-focal; Lenticular: 100%
Progressive: See Lens Options

Contact Lenses

Elective:	Up to $150
Medically necessary:	100% covered

Frequencies (months)
Exam/Lens/Frames: 12/24/24 *based on date of service

Member Rates

• Single Member:	$14* month
• Member + Spouse:	$25* month
• Member + Children:	$22* month
• Family:	$29* month

*Includes $2.00 Association Fee

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