DELTA DENTAL

Delta Dental of Illinois

DeltaVision® Benefit Highlight Insight Network

See premiums on the back.

Egyptian Area Schools EB Trust

Effective September 1, 2024

DeltaVision® is provided by ProTec Insurance Company, a wholly-owned subsidiary of Delta Dental of Illinois, in association with EyeMed Vision Care networks. DeltaVision offers members vision care benefits that combine choice, value and wellness. Your DeltaVision program provides vision care insurance to you (and your family, if applicable) according to the following information.

Vision Care Services	Insight Network Member Cost (Complete)	Out-of-Network Allowance
Exam with Dilation as Necessary:	$10 Copay	$35
Contact Lens Fit & Follow-up: (Available once a comprehensive eye exam has been completed)		
Standard*	Member pays up to $40 for fit and two follow-up visits	$0
Premium**	10% off retail price	$0
Frames: (Any available frame at provider location)	$130 allowance, 20% off balance over allowance	$65
Standard Plastic Lenses:		
Single Vision	$10 Copay	$25
Bifocal	$10 Copay	$40
Trifocal	$10 Copay	$55
Lens Options:		
UV Coating	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Scratch-Resistance	$15	N/A
Standard Polycarbonate	$40	N/A
Standard Progressive (in addition to to Bifocal copay)	$65	$40
Premium Progressive – (in addition to Bifocal copay)	Tier 1 - $95, Tier 2 - $105, Tier 3- $120, Tier 4 - $75, 80% of retail, less $120 allowance	$40
Standard Anti-Reflective Coating	$45	N/A
Premium Anti –Reflective Coating	Tier 1 - $57, Tier 2 - $68, Tier 3 – 80% of charge	N/A
Photocromatic/Transition Plastic	$75	N/A
Polarized	80% of charge	N/A
Other Add-Ons and Services	20% discount off retail price	N/A
Contact Lenses: (Contact lens allowance covers materials only)		
Conventional	$0 Copay, $130 allowance, 15% off balance over $130	$104
Disposable	$0 Copay, $130 allowance, plus balance over $130	$104
Visually Required	$0 Copay, Paid-in-Full	$200
Frequency:		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frames	Once every 24 months	

*Standard Contact Lens Fitting - spherical clear contact lenses in conventional wear and planned replacement (Examples include, but are not limited to, disposable and frequent replacement)

**Premium Contact Lens Fitting - all lens designs, materials and specialty fittings, other than Standard Contact Lenses (Examples include toric and multifocal)

Additional Discounts

Member will receive a 20% discount at in-network providers on items not covered by the program. This discount may not be combined with any other discounts or promotional offers and the discount does not apply to contact lenses or an in-network provider's professional services. Retail prices may vary by location.

Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses at in-network providers once the funded benefit has been used.

After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www deltadentalil.com/deltavision. The contact lens benefit allowance is not applicable to this service.

LASIK or PRK: DeltaVision enrollees can receive a discount of 15% off retail price or 5% off promotional price from select providers. Please contact us at www.deltadentalil.com/deltavision or 866-723-0513 for a current list of LASIK/PRK providers.

Effective September 1, 2024

Egyptian Area Schools Employee Benefit Trust Plan Design Summary
High Dental Plan

Annual Deductible Deductible applies to Basic and Major services	$50/ person; $150/ family
Annual Maximum	$1500/ person
To Go[SM] Carryover Feature	Not Included
Enhanced Benefits Program	Your plan provides additional cleanings and/or applications of topical fluoride to people with specific health conditions that put them at risk for oral health disease. The costs of the additional cleanings and fluoride treatments will be applied to your annual maximum.
Lifetime Orthodontic Maximum **Dependent Children to Age 19** **Adults are not eligible for coverage**	$1000/ person

	Delta Dental PPO Network Dentist*	Delta Dental Premier Network Dentist**	Non-Network Dentist***
PREVENTIVE/DIAGNOSTIC SERVICES (no waiting period) • Routine exams (two per benefit year) • Cleanings (two per benefit year) • X-rays (bitewings -2 per benefit year; full mouth-1 per 3 years) • Fluoride treatments (twice per benefit year to age 19)	100%	100%	100%
BASIC SERVICES (no waiting period) • Space maintainers (to age 19) • Sealants (to age 19) • Emergency exams and palliative (pain relief) treatment • Fillings (silver (amalgam) and tooth colored (composite) on front teeth) • Posterior composites (tooth colored fillings on back teeth) • Oral surgery (simple extractions) • Oral surgery (surgical extractions including general anesthesia) • Oral surgery (all other) • Prefabricated stainless steel or resin crowns	80%	80%	80%
MAJOR RESTORATIVE SERVICES (no waiting period) • Non-surgical Periodontic (gum) maintenance • Surgical Periodontic (gum) maintenance • Endodontics (root canals and pulpal therapy) • Repairs and recements to crowns, bridges, inlays and onlays • Crowns, onlays, and other ceramic restorations to permanent teeth • Partial/full dentures • Denture (repair, reline, rebase and adjustments) • Fixed/removable bridges • Implants	50%	50%	50%
ORTHODONTICS (no waiting period) Dependent Children to Age 26; Adults are not eligible for coverage	50%	50%	50%

v. 7/q. 10241

*Delta Dental PPO dentists accept payment based on the lesser of the submitted fee or the PPO fee schedule, which is established at a level that typically delivers a 15 – 40% discount off of average billed charges nationally.

**Delta Dental Premier dentists accept payment based on the lesser of the submitted fee or Delta Dental's maximum plan allowance (MPA), which is established at a level that typically delivers discounts of 25% - 30% off of average billed charges nationally.

***Non-network (non-Delta Dental PPO/non-Delta Dental Premier) dentists are reimbursed at the 90th percentile of "reasonable and customary" charges.

Delta Dental PPO and Premier dentists cannot balance bill the enrollee for the difference between Delta Dental's allowed fee and the dentist's submitted charge.

Monthly Premium Payment	
Employee	$40.46
Employee + 1 Dependent	$84.08
Employee + 2 or more Dependents	$118.70

Effective September 1, 2024

Egyptian Area Schools Employee Benefit Trust Plan Design Summary
Low Dental Plan

Annual Deductible Deductible applies to Basic and Major services	$50/ person; $150/ family
Annual Maximum	$750/ person
To Go[SM] Carryover Feature	Not Included
Enhanced Benefits Program	Your plan provides additional cleanings and/or applications of topical fluoride to people with specific health conditions that put them at risk for oral health disease. The costs of the additional cleanings and fluoride treatments will be applied to your annual maximum.

	Delta Dental PPO Network Dentist*	Delta Dental Premier Network Dentist**	Non-Network Dentist***
PREVENTIVE/DIAGNOSTIC SERVICES (no waiting period) • Routine exams (two per benefit year) • Cleanings (two per benefit year) • X-rays (bitewings -2 per benefit year; full mouth-1 per 3 years) • Fluoride treatments (twice per benefit year to age 19)	80%	80%	80%
BASIC SERVICES (no waiting period) • Space maintainers (to age 19) • Sealants (to age 19) • Emergency exams and palliative (pain relief) treatment • Fillings (silver (amalgam) and tooth colored (composite) on front teeth) • Posterior composites (tooth colored fillings on back teeth) • Non-surgical Periodontic (gum) maintenance • Oral surgery (simple extractions) • Oral surgery (surgical extractions including general anesthesia) • Oral surgery (all other) • Prefabricated stainless steel or resin crowns • Endodontics (root canals and pulpal therapy)	70%	70%	70%
MAJOR RESTORATIVE SERVICES (no waiting period) • Crowns, onlays, and other ceramic restorations to permanent teeth • Partial/full dentures • Denture (repair, reline, rebase and adjustments) • Fixed/removable bridges • Implants	0%	0%	0%
ORTHODONTICS (no waiting period)	Not Included	Not Included	Not Included

v. 5/q. 10145

*Delta Dental PPO dentists accept payment based on the lesser of the submitted fee or the PPO fee schedule, which is established at a level that typically delivers a 15 – 40% discount off of average billed charges nationally.

**Delta Dental Premier dentists accept payment based on the lesser of the submitted fee or Delta Dental's maximum plan allowance (MPA), which is established at a level that typically delivers discounts of 25% - 30% off of average billed charges nationally.

***Non-network (non-Delta Dental PPO/non-Delta Dental Premier) dentists are reimbursed at the 90th percentile of "reasonable and customary" charges.

Delta Dental PPO and Premier dentists cannot balance bill the enrollee for the difference between Delta Dental's allowed fee and the dentist's submitted charge.

Monthly Premium Payment	
Employee	$17.60
Employee + 1 Dependent	$35.06
Employee + 2 or more Dependents	$66.68

Network Information

You may choose to go to any licensed optometrist, ophthalmologist and/or dispensing optician whenever you need vision care. However, there may be significant cost advantages when you receive treatment from an in-network provider.

We offer two easy ways to locate an in-network provider 7 days a week, 24 hours a day. You can either:

- search our online Provider directory at www.deltadentalil.com/deltavision; or
- use the automated phone system by calling 1-866-723-0513

Using Your Vision Program

1. Have your DeltaVision information card available when scheduling and visiting an in-network provider. An in-network provider is one who participates in the EyeMed Vision Care Provider network. It's very important that you know which network your benefit plan utilizes (your plan uses the **Insight** network). You will only receive in-network benefits from Insight network providers. Please note: the network provider will need the primary enrollee's name and date of birth to verify eligibility.

2. Pay your copayment and any other charges not covered at the time of service. No paperwork is required. You continue to save on additional eyewear purchases any time you present your card to an in-network provider.

3.If you select a provider who is not in the network, you do not receive preferred pricing and you may be asked to provide full payment to your out-of-network provider at the time of service. To receive benefit reimbursement, submit a completed claim form (available on our website), along with itemized receipts from your provider and your prescription to:

DeltaVision Claims Processing
c/o EyeMed Vision Care
P.O. Box 8504
Mason, OH 45040-7111

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Exclusions

In no event will coverage exceed the lesser of:
1. the actual cost of Covered Services or Materials or
2. the limits of the Policy, shown in the Schedule.

Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next benefit period.

Benefits may not be combined with any discount, promotional offering or other group benefit programs.

Benefit allowances provide no remaining balance for future use within the same benefit period.

There is no coverage for professional services or materials connected with:

1. Orthoptic or vision training, sub-normal vision aids and any associated supplemental testing;
2. Aniseikonic lenses;
3. Medical and/or surgical treatment of the eye, eyes or supporting structures;
4. Corrective eyewear required by an employer as a condition of employment and safety eyewear unless specifically covered under this program;
5. Services provided as a result of any Workers' Compensation law;
6. Plano lenses (lenses that have no refractive power), non-prescription lenses and non-prescription sunglasses (except for 20% discount);
7. Two pair of glasses in lieu of bifocals.

*The preceding information is a brief summary of **Egyptian Area Schools Eb Trust** Complete Vision Program and the services it covers.*

If you have specific questions regarding benefit coverage, limitations or exclusions, contact our customer service department at 1-866-723-0513.

DELTA DENTAL

Delta Dental of Illinois
111 Shuman Blvd
Naperville, IL 60563
800-335-8215
www.deltadentalil.com/deltavision

Monthly Premium Payment	
Employee	$ 5.38
Employee + 1 Dependent	$10.52
Employee + 2 or more Dependents	$15.74