Dental Plans

DeltaCare USA DHMO Dental Plan

	STANDARD	ENRICHED
CHOICE OF DENTIST	Limited to providers participating in the DeltaCare USA network.	
MAXIMUM BENEFIT/DEDUCTIBLE	No Maximum, No Deductible	
	STANDARD - YOU PAY	**ENRICHED - YOU PAY**
TYPE I		
1110/20 Prophylaxis	No Charge	No Charge
0120 Periodic Oral Exam	No Charge	No Charge
0150 Comprehensive Oral Evaluation - New Or Established	No Charge	No Charge
1203 Fluoride Treatment (Children Up To The Age 19)	No Charge	No Charge
1351 Sealant - Per Tooth	$5.00	No Charge
1510 Space Maintainers	$30.00	No Charge
TYPE II	**STANDARD**	**ENRICHED**
Fillings: (Silver)		
2140 One Surface	$5.00	No Charge
2150 Two Surfaces	$5.00	No Charge
2160 Three Surfaces	$10.00	No Charge
2161 Four Or More Surfaces	$13.00	No charge
Root Canals		
3310 Anterior	$75.00	$70.00
3320 Bicuspid	$85.00	$80.00
3330 Molar	$150.00	$140.00
3410 Apicoectomy	$100.00	$90.00
Extractions:		
7111 Single Tooth	$10.00	$10.00
7140 Extraction, Erupted Tooth Or Exposed Tooth	$10.00	$10.00
7210 Surgical Extraction Of Erupted Tooth	$30.00	$35.00
Periodontics: (Gum Treatment)		
4210 Gingivectomy/Gingivoplasty - Per Quadrant	$75.00	$60.00
4341 Periodontal Scaling & Root Planing- Per Quadrant	$30.00	$25.00
4910 Periodontal Maintenance Procedures	$15.00 each (Twice every 12 months)	$15 each (Twice every 12 months)
Two Additional Every 12 Months	$60.00 each	$60.00 each
TYPE III	**STANDARD**	**ENRICHED**
Crown & Bridge:		
2751 Crown Porcelain Fused To Base Metal	$180.00	$95.00
2791 Crown Full Cast Predominately Base Metal	$180.00	$95.00
2930 Prefabricated Stainless Steel	$15.00	$10.00
Prosthodontics (Dentures):		
5110 Complete Upper	$190.00	$110.00
5120 Complete Lower	$190.00	$110.00
5213/14 Partial Upper Or Lower - Cast Metal Base	$220.00	$130.00
ORTHODONTIA		
Consultation Evaluation Records 8080 Children - Normal Class II 8090 Adult - Normal Class II 8680 Retention	You pay orthodontia as follows: Comprehensive for dependent children under age 19: $1,500. Adults: $2,800 $200 copayment for pre and post orthodontic records.	You pay orthodontia as follows: Comprehensive for dependent children under age 19: $1,500. Adults: $2,800 $200 copayment for pre and post orthodontic records.

Vision Plans

Davis Vision Plan

The out of-network-benefit allows you to select any out of-network provider and reimburses a fixed dollar amount based on the schedule shown for the out of-network services. The following chart indicates the benefits the plan pays for the services you receive. For more information, see the Davis Covered Vision Services on the following pages.

Vision Plan Rates

	PER PAY PERIOD
BASE PLAN	
Employee Only	$1.91
Employee + One	$3.83
Employee + 2 or more	$7.03
PREMIER PLAN	
Employee Only	$4.59
Employee + One	$9.87
Employee + 2 or more	$19.06

Vision Plans

Covered Vision Services	BASE PLAN COPAY	PREMIER PLAN COPAY
FREQUENCY		
Exam	Once Every Calendar Year	Once Every Calendar Year
Lenses & Lens Upgrades	Once Every Calendar Year	Once Every Calendar Year
Frame	Once Every Other Calendar Year	Once Every Calendar Year
Contacts Evaluation & Fitting	Once Every Calendar Year	Once Every Calendar Year
EXAMS & SERVICES		
Eye Exam	$25	$10
CONTACTS EVALUATION, FITTING:		
Standard Lens & Specialty Lens	15% Discount[1]	15% Discount[1]
GLASSES		
FRAMES		
Other Locations	$100	$160
Visionworks[4]	$150	Covered In Full
Any Overages	Additional 20% Off Any Overage[1]	Additional 20% Off Any Overage[1]
THE EXCLUSIVE COLLECTION:		
Fashion/Designer/Premier	Covered in Full/$15/$40	Covered In Full
LENSES	$25	$0
COPAYS FOR OPTIONS & UPGRADES		
LENS OPTIONS		
Clear Plastic Single-Vision, Bifocal, Trifocal or Lenticular Lenses (any RX)	$0	$0
Oversized Lenses	$0	$0
Plastic Lenses	$0	$0
Polycarbonate Lenses (Children/Adults)	$0/$35	$0/$30
High-Index Lenses	$60	$55
Polarized Lenses	$75	$75
Progressive Lenses (Standard/Premium/Ultra)	$65 / $105 / $140	$0 / $90 / $140
Anti-Reflective (AR) Coating (Standard/Premium/Ultra)	$40 / $55 / $69	$35 / $48 / $60
Ultraviolet Coating	$15	$12
Tinting of Plastic Lenses (Solid / Gradient)	$15	$0
Plastic Photochromic Lenses (Transitions® Signature™)	$70	$65
Scratch-Resistant Coating	$0	$0
Scratch-Protection Plan (Single-Vision | Multifocal)	$20 | $40	$20 | $40
ADDITIONAL SAVINGS		
Retinal Imaging (Member charge)	$39	$39
Additional Pairs of Eyeglasses	30% Discount[1]	30% Discount[1]
CONTACTS[2] IN LIEU OF GLASSES		
Contact Allowance	$100	$120
Any Overages	Additional 15% Off Any Overage[1]	Additional 15% Off Any Overage[1]
THE EXCLUSIVE COLLECTION OF CONTACT LENSES: [3]	N/A	Covered In Full

Vision Plans

Covered Vision Services Continued	BASE PLAN COPAY	PREMIER PLAN COPAY
OUT-OF-NETWORK BENEFITS		
You will receive the greatest value and maximize benefit dollars if you select a provider who participates in the network, however, you may receive services from an out-of-network provider.		
OUT-OF-NETWORK REIMBURSEMENT SCHEDULE (UP TO)		
Eye Examination	$40	$40
Frame	$50	$50
Single-Vision Lenses	$40	$40
Bifocal / Progressive Lenses	$60	$60
Trifocal Lenses	$80	$80
Lenticular Lenses	$116	$116
Elective Contact Lenses	$100	$120
Visually Required Contacts	$210	$210

1. Some limitations apply to additional discounts; Discounts not applicable at all in-network providers.
2. Contact lens coverage varies by product selection. Visually required contacts are covered in full with prior approval.
3. The Davis Vision Exclusive Collection of Contact Lenses is available at participating independent providers. Evaluation, fitting, and follow-up care for Collection contacts are covered in full.
4. Excludes Maui Jim® Eyewear. Davis Vision has done its best to accurately reflect plan coverage herein. If differences exist between this document and the plan contract, the contract will prevail.