

Benefits are subject to all provisions, terms and conditions of the group contract.

Dental Plans Benefit Overview	Plan 1 \$500 MAX	Plan 2 \$1,000 MAX	Plan 3 \$1,500 MAX	Plan 4 \$2,500 MAX
Network	MAC PPO	MAC PPO	MAC PPO	PPO + Premier
Deductible (Individual/Family)	\$50 / \$150	\$50 / \$150	\$50 / \$150	\$50 / \$150
Deductible Applies	Basic & Major	Basic & Major	Basic & Major	Basic & Major
Annual Maximum Per person per benefit year	\$500	\$1,000	\$1,500	\$2,500
Services				
Preventive & Diagnostic	100%	100%	100%	100%
Basic	50%	70%	80%	80%
Major	25%	40%	50%	50%
Benefit Highlights				
Endodontics (root canal therapy)	25%	40%	80%	80%
Periodontics (treatment of gum disease)	25%	40%	80%	80%
Simple Extractions	25%	40%	80%	80%
Oral Surgery	25%	40%	50%	50%
CheckUp Plus™	Yes	Yes	Yes	Yes
Composite Fillings on All Teeth	No	No	Yes	Yes
Implants	25%	40%	50%	50%
Orthodontia	N/A	N/A	Child Only	Child Only
Orthodontia Coverage	N/A	N/A	50%	50%
Orthodontia Lifetime Maximum	N/A	N/A	\$1,000	\$1,500

Vision Plans In-Network	Gold Plan 1	Platinum Plan 2	Diamond Plan 3
Vision Exam with Dilatation (as needed)	\$10 copay	\$10 copay	\$10 copay
Frames	\$0 copay; \$125 allowance , 20% off balance over \$125	\$0 copay; \$150 allowance , 20% off balance over \$150	\$0 copay; \$175 allowance , 20% off balance over \$175
Standard Plastic Lenses			
Single Vision	\$10 copay	\$10 copay	\$10 copay
Bifocal	\$10 copay	\$10 copay	\$10 copay
Trifocal	\$10 copay	\$10 copay	\$10 copay
Lenticular	\$10 copay	\$10 copay	\$10 copay
Standard Progressive Lens ¹	\$75 copay	\$75 copay	\$75 copay
Premium Progressive Lens ¹	Tier 1: \$95 copay Tier 2: \$105 copay Tier 3: \$120 copay Tier 4: \$75 copay, 80% of charge less \$120 allowance	Tier 1: \$95 copay Tier 2: \$105 copay Tier 3: \$120 copay Tier 4: \$75 copay, 80% of charge less \$120 allowance	Tier 1: \$95 copay Tier 2: \$105 copay Tier 3: \$120 copay Tier 4: \$75 copay, 80% of charge less \$120 allowance
Contact Lenses			
Disposable	\$0 copay; \$125 allowance	\$0 copay; \$150 allowance	\$0 copay; \$175 allowance
Frequency			
Examination	Once every 12 months	Once every 12 months	Once every 12 months
Lenses or Contact Lenses	Once every 12 months	Once every 12 months	Once every 12 months
Frame	Once every 12 months	Once every 12 months	Once every 12 months
One & Sun (employee & spouse only)	Included*	Included*	Included*

*With the One & Sun™ add-on, eligible DeltaVision® members can claim a free pair of non-prescription designer sunglasses, including Ray-Ban® or Oakley®, after their annual eye exam. This benefit is available every other year and is exclusively for covered employees and their spouses, not dependent children. **Learn more at oneandsun.com.**

¹Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. EyeMed reserves the right to make changes to the products on each tier and the member out-of-pocket costs. Contact EyeMed for a current listing of brands by tier.

DENTIST PAYMENTS PER NETWORK

If the network for your dental plan selection is MAC PPO

- Payment for a PPO dentist is based on the PPO dentist's allowable fee or the submitted fee charges, whichever is less.
- Payment for a Premier dentist is based on the PPO dentist's allowable fee. Members are responsible for the difference between the Premier Maximum Reimbursable Amount (MRA) and the PPO fee.
- Payment for a non-participating dentist is based on the PPO dentist's allowable fee. Members are responsible for the difference between the PPO Allowance and the full submitted fee charged by the dentist.

If the network for your dental plan selection is PPO plus Premier²

- Payment for a PPO dentist is based on the PPO dentist's allowable fee or the submitted fee charges, whichever is less.
- Payment for a Premier dentist is based on the Premier Maximum Reimbursable Amount (MRA) or the submitted fee charges, whichever is less.
- Payment for a non-participating dentist is based on the non-participating table of allowance. Members are responsible for the difference between the non-participating table of allowance and the full fee charged by the dentist.

Dental Plan Benefits and Limitations

	Plan 1 \$500 MAX	Plan 2 \$1,000 MAX	Plan 3 \$1,500 MAX	Plan 4 \$2,500 MAX
Preventive and Diagnostic Services				
Exams, evaluations or consultations: 2 in a benefit year.	✓	✓	✓	✓
Bitewing X-rays are allowed 2 times per benefit year.	✓	✓	✓	✓
Full-mouth series or panoramic X-rays are allowed 1 time every 3 years from last date of service.	✓	✓	✓	✓
Routine Cleanings: 2 per benefit year. <small>One difficult cleaning may be exchanged for one routine cleaning. However, the difficult cleaning is limited to once in a 5-year period.</small>	✓	✓	✓	✓
Fluoride treatment is allowed 2 times per benefit year to age 18.	✓	✓	✓	✓
Sealants for children up to age 19 once in a 2 year period for permanent molars and bicuspid.	✓	✓	✓	✓
Space maintainer for missing posterior primary (baby) teeth up to age 14	✓	✓	✓	✓
Basic & Major Services³				
Fillings: Silver amalgam and synthetic tooth color filling on front teeth only. One per surface every 2 years.	✓	✓	✓	✓
Composite Fillings on All Teeth			✓	✓
Periodontics: Treatment of gum disease - Non-surgical Once every 2 years. Surgical once every 3 years.	✓	✓	✓	✓
Periodontal Maintenance: Limited to 2 in a benefit year, interchangeable with routine cleanings.	✓	✓	✓	✓
Endodontics: Root canal treatment (permanent teeth). Pulpotomy primary (baby) teeth.	✓	✓	✓	✓
Prosthodontics: Bridges, partial dentures, complete dentures - 5-year waiting period for replacement last performed.	✓	✓	✓	✓
Bridge and Denture Repair: Repair of such appliances to their original condition including relining of dentures.	✓	✓	✓	✓
Oral Surgery: Simple & surgical extractions.	✓	✓	✓	✓
Implants are only a benefit to replace a single missing tooth once in a 5-year interval from the date the procedure was last performed.	✓	✓	✓	✓
Orthodontic Services				
Benefit for children ages 8-19. Children must be banded prior to age 17. The ortho max is separate from the annual max.			✓	✓

²Members may incur higher out-of-pocket costs when seeing a Premier or non-participating dentist.

³Deductible applies to these services.

Benefits are subject to all provisions, terms and conditions of the group contract.

Vision Plan Limitations and Exclusions

LIMITATIONS

Fees charged by a Provider for services other than a covered benefit must be paid in full by the Insured Person to the Provider. Such fees or materials are not covered under the Policy. Benefit allowances provide no remaining balance for future use within the same Benefit Frequency. Capitalize terms are defined in the plan document.

EXCLUSIONS

No benefits will be paid for services or materials connected with or charges arising from:

- Services or materials provided by any other group benefit plan providing vision care.
- Certain brand name Vision Materials in which the manufacturer imposes a no-discount policy medical and/or surgical treatment of the eye, eyes or supporting structures.
- Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof.
- Orthoptic or vision training, subnormal vision aids and any associated supplemental testing.
- Aniseikonic lenses.
- Any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment.
- Safety eyewear.
- Non-prescription sunglasses except as allowed under One & Sun Rider, if applicable.
- Plano (non-prescription) lenses and/or contact lenses.
- Two pair of glasses in lieu of bifocals.
- Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order.
- Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

Capitalized terms are as defined in the Plan documents

Benefits are subject to all provisions, terms and conditions of the group contract.