DENTAL PLAN FEATURES

DELTA DENTAL

Plan Pays	Dental PPO Low Plan	Dental PPO High Plan (Buy-up)
Covered expenses	**In-network***	**In-network***
Calendar Year Maximum (Plan pays)	$2,000	$5,000; does not apply to Class I services
Calendar Year Deductible (You pay)	Individual: $50 **Family: $150**	Individual: $50 **Family: $150**
Class I – Preventive & Diagnostic Care	100%, no deductible	100%, no deductible
Class II – Basic Restorative Care	80% after deductible	80% after deductible
Class III – Major Restorative Care	50% after deductible	50% after deductible
Class IV – Orthodontia (Children/Adults) Orthodontia Lifetime Maximum	Not covered	50% after deductible (lifetime maximum limit of **$2,000**)
Class V – Implants	Not covered	50% after deductible

REMINDER: You do not need a Delta Dental ID card to receive coverage! Present your SSN and policy group number (21412) at time of care.

**Note: If you visit an out-of-network provider, you are responsible for any charges above the usual, customary, and reasonable (UCR) limits.*

VISION PLAN FEATURES

VSP

Vision Coverage	In-network	Out-of-network
Eye Exam (once every 12 months)	$20 copay	Allowance up to $45
Eyeglass Lens Allowance (one pair every 12 months) *Single Vision* *Bifocal* *Trifocal* *Lenticular*	Covered 100 %	Allowance up to $32 Allowance up to $55 Allowance up to $65 Allowance up to $80
Frame Retail Allowance (once every 24 months)	Allowance up to $180	Allowance up to $100
Contact Lens Allowance (one pair or single purchase every 12 months in lieu of lenses and frames) *Elective* *Therapeutic*	Allowance up to $180 Covered 100 %	Allowance up to $105 Allowance up to $210

REMINDER: You do not need a VSP ID card to receive coverage! Provide your SSN at the time of care.