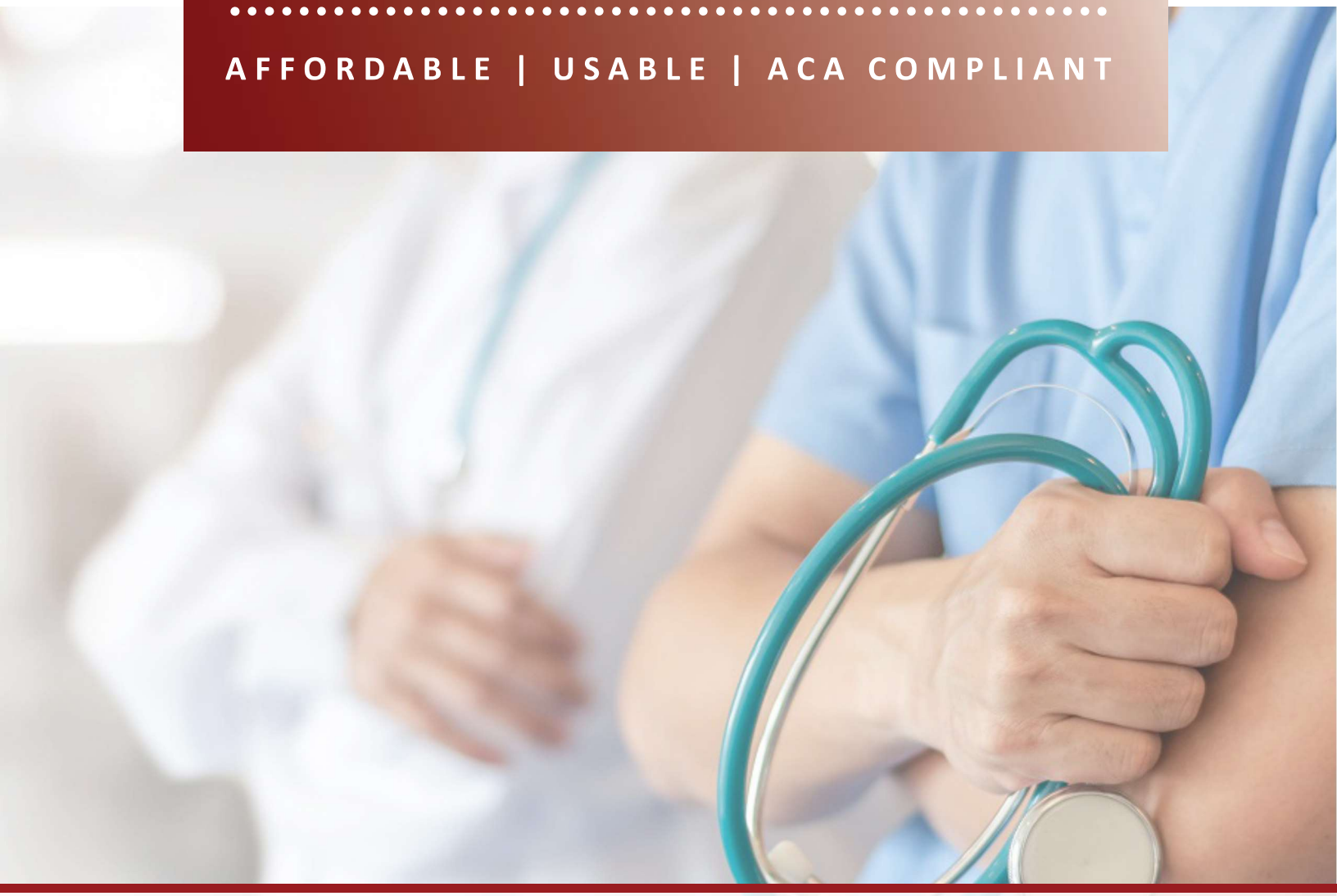
BENEFITS PROPOSAL
CoreCare Planning - by LCG

AFFORDABLE | USABLE | ACA COMPLIANT



optionsplus

COMPREHENSIVE DENTAL

MONTHLY	COMPREHENSIVE DENTAL	
Employee Only	$47.15	
Employee + Spouse	$91.20	
Employee + Child(ren)	$86.47	
Family	$137.99	
DENTAL BENEFITS	In-Network	Out-of-Network
Preventive & Diagnostic Exams; Cleanings; Bitewing X-Rays; Full Mouth X-Rays; Fluoride Treatments (Frequency limitations apply); Space Maintainers	100%	80%
Basic Fillings; Simple Extractions; Oral Surgery; Periodontics; Root Canals (Endodontics); Sealants	80%	50%
Major Crowns & Gold Restorations; Bridgework; Full & Partial Dentures; Repair of Dentures; Implants	50%	50%
Annual Maximum (per person)	$1,500	$1,500
Annual Deductible Per Person Family Maximum	 $50 $150	 $100 $300
Waived For		

DENTAL PROVIDER LOOKUP

Visit: https://www.deltadental.com/us/en/member/find-a-dentist.html
Specialty: Choose one or Choose Any | Your Plan: Delta Dental PPO
Search by Current Location: No, Enter Zip Code | Find Dentists

DELTA DENTAL®

DENTAL PLAN NOTES

Carryover Max℠ from Delta Dental allows you to increase your benefits.

This valuable benefit feature allows you to carry over a portion of your unused standard annual maximum benefit limit into the next year, and beyond. You can accumulate part of your unused benefit dollars from a healthy year and use it for larger, more expensive procedures in the future- such as bridges, crowns, and root canals.

The benefits outlined above are a summary of the quoted plan design. Full details on the plan of benefits and applicable policy provisions, including limitations and exclusions, are provided in the group contract.

VSP by DELTA VISION
BENEFIT SUMMARY

RATES			
EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	FAMILY
$12.95	$22.90	$23.90	$37.85

BENEFITS	
Network/Plan	VSP Choice
Exam/lens/frame frequency (months)	12/12/24
Contacts (in lieu of glasses)	12
IN-NETWORK COVERAGE	
Eye Exam Copay	$10
Materials Copay	$25
Frame allowance	$130 | $70 Walmart/Sam's Club/Costco frame allowance
Elective contact lens allowance	$130
Necessary contact lenses	Covered in full after copay
Contact lens fit/evaluation copay	$60
Both frames and contacts in same year	No; allows contacts in lieu of frames
OUT-OF-NETWORK COVERAGE	
Examination, up to:	$45
Single vision lenses, up to:	$30
Bifocal lenses, up to:	$50
Trifocal lenses, up to:	$65
Progressive lenses, up to:	$50
Lenticular lenses, up to:	$100
Frames, up to:	$70
Elective contact lenses, up to:	$105
Necessary contact lenses, up to:	$210
LENS ENHANCEMENTS (MEMBER COST)*	
Anti-glare coating	$41 single/$41 multifocal
Impact - resistant lenses - adult	$31 single/$35 multifocal (covered for children)
Progressive lenses	Standard progressive lenses are covered
Light-reactive lenses	$75 single vision/$75 multifocal
Scratch resistant coating	$17 single vision/$17 multifocal

*Prices shown reflect the standard plastic price for each respective category. Premium lens enhancement prices may vary. Prices may vary and are valid only through VSP Choice Network and are subject to change without notice.

VISION PROVIDER LOOKUP

Visit: https://www.vsp.com/eye-doctor
Search by Location, Office Name, or Doctor Name

VSP Vision Care | DELTA DENTAL®

DeltaVision® in partnership with VSP®