DELTA DENTAL

Delta Dental of Illinois
Dental Benefit Highlight Sheet

Labor Benefits Association, Group #11696

Delta Dental of Illinois is pleased to be your dental benefits carrier. Your plan offers you the dental benefits program: Delta Dental PPO Plus Delta Dental Premier.

Delta Dental PPO Plus Premier

With Delta Dental PPO Plus Premier:

- You can go to any licensed general or specialty dentist.
- **You will maximize your benefits by receiving care from a Delta Dental PPO or Delta Dental Premier network dentist.**
- Delta Dental's network dentists have agreed to reduced fees as payment in full, which means you will likely save money by going to a Delta Dental PPO or Delta Dental Premier network dentist. Non-network dentists have not agreed to accept our reduced fees as payment in full, which means they may bill you for any charges over our allowed fees.
- You are charged only the patient's share** at the time of treatment. Delta Dental pays its portion directly to network dentists.

Finding a Dentist

Visit our web site at www.deltadentalil.com and click on Provider Search.

Example of Your Copayment with Delta Dental Network Dentists and Non-Network Dentists

- Delta Dental PPO: Lowest out-of-pocket costs and network protection.
- Delta Dental Premier: Higher out-of-pocket costs than PPO, but may be lower than non-network and network protection.
- Non-network: You may have the highest out-of-pocket costs.

Delta Dental PPO Plus Premier Plan Features

Your Delta Dental PPO Plus Premier plan includes the following features:

- **Enhanced Benefit Program** offers additional coverage for individuals who have specific health conditions (including pregnancy, diabetes, high-risk cardiac conditions, suppressed immune systems, and special needs) that can be positively affected by additional oral health care.

Customer Service

Please register on Delta Dental of Illinois' website, www.deltadentalil.com. Once registered, you can **get real time benefit information, check claim status, sign up for electronic Explanation of Benefits and print a temporary ID card.**

Call 1-800-323-1743 to access our automated phone system or speak to a customer service representative from 7 am to 7 pm Monday through Thursday and 7 am to 6 pm Friday, Central Time. Our automated phone system is available 24 hours a day, seven days a week, and offers dentist listings and claim information.

You can also connect with us through our mobile app, Facebook, Twitter, our blog and more. See the enclosed sheets on connecting with us.

Welcome to Delta Dental of Illinois!

*There are some limitations on the expenses for which your dental plan pays If you have specific questions regarding benefit coverage, limitations, exclusions, or non-covered services, please refer to your certificate of coverage/dental benefit booklet or contact Delta Dental of Illinois.

**Patient's share is the coinsurance/copayment, any remaining deductible any amount over the annual maximum and any services your plan does not cover.

Note: Delta Dental imposes no restrictions on the method of diagnosis or treatment by a treating dentist. A benefit determination relates only to the level of payment that your group dental plan is required to make.

PPOPREF

Labor Benefits Association Plan Design Summary

Annual Deductible Deductible applies to Basic and Major services	$50/ person; $150/ family
Annual Maximum	$2000/ 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)	100%	100%	100%
• Cleanings (two per benefit year)	100%	100%	100%
• X-rays (bitewings -2 per benefit year; full mouth-1 per 3 years)	100%	100%	100%
• Fluoride treatments (twice per benefit year to age 19)	100%	100%	100%
• Space maintainers (to age 14)	100%	100%	100%
• Sealants (to age 16)	100%	100%	100%
• Emergency exams and palliative (pain relief) treatment	100%	100%	100%
BASIC SERVICES (no waiting period)			
• Fillings (silver (amalgam) and tooth colored (composite) on front teeth)	80%	80%	80%
• Posterior composites (tooth colored fillings on back teeth)	80%	80%	80%
• Non-surgical Periodontic (gum) maintenance	80%	80%	80%
• Surgical Periodontic (gum) maintenance	80%	80%	80%
• Oral surgery (simple extractions)	80%	80%	80%
• Oral surgery (surgical extractions including general anesthesia)	80%	80%	80%
• Oral surgery (all other)	80%	80%	80%
• Endodontics (root canals and pulpal therapy)	80%	80%	80%
MAJOR RESTORATIVE SERVICES (6 month waiting period)			
• Sedative fillings	50%	50%	50%
• Crowns, onlays, and other ceramic restorations to permanent teeth	50%	50%	50%
• Partial/full dentures	50%	50%	50%
• Denture (repair, reline, rebase and adjustments)	50%	50%	50%
• Fixed/removable bridges	50%	50%	50%
• Implants	50%	50%	50%
ORTHODONTICS (no waiting period)	Not Included	Not Included	Not Included

v. 3/q. 10713

This plan is a Maximum Allowable Charge (MAC) plan. With a MAC plan, benefit reimbursement for all dentists is based on the Delta Dental PPO allowed network fees, which are established at a level that typically delivers a 15% - 35% discount off of dentists' average billed charges nationally. Delta Dental PPO network dentists accept our allowed PPO fee as payment in full, and as such, Delta Dental PPO dentists cannot bill more than the allowed PPO fee. However, Delta Dental Premier dentists agree to our Maximum Plan Allowance (MPA) as payment in full and as a result, Delta Dental Premier dentists can bill for the difference between the allowed PPO fee and the MPA. The MPA is established a level that typically delivers a 5% - 20% discount off of average billed charges nationally. Non-network dentists do not agree to any discounted network fees and therefore can bill for amounts over the allowed PPO fee (i.e. the difference between their usual fee and the Delta Dental PPO allowed fee).

DELTA DENTAL

Delta Dental of Illinois
DeltaVision® Benefit Highlight – Select Network
Labor Benefits Association

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. Active, members are eligible for coverage.

Vision Care Services	Select Network Member Cost	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*	$40 Copay, Paid-in-full fit and two follow-up visits	NA
Premium**	10% off retail price	NA
Frames: (Any available frame at provider location)	$150 allowance, 20% off balance over allowance	$75
Standard Plastic Lenses:		
Single Vision	$25 Copay	$25
Bifocal	$25Copay	$40
Trifocal	$25 Copay	$55
Standard Progressive (in addition to lens)	$65 Copay	$40
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 (Add-on to Bifocal)	$65	N/A
Premium Progressive – (in addition to lens)	$65, 20% off retail price, then apply $120 allowance	$40
Standard Anti-Reflective Coating	$45	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, $150 allowance, 15% off balance over allowance	$120
Disposable	$0 Copay, $150 allowance, plus balance over allowance	$120
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.

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 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 Select network).** You will only receive in-network benefits from Select 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

DeltaVision is administered by

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 The Group Name 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®

DeltaVision® is provided by ProTec Insurance Company, a wholly-owned subsidiary of Delta Dental of Illinois, in association with EyeMed Vision Care networks.
111 Shuman Blvd
Naperville, IL 60563
800-335-8215
www.deltadentalil.com/deltavision

ENROLLMENT/ CHANGE OF STATUS WAIVER FORM

Please keep a copy for your records

Labor Benefits Association

Delta Dental Group Number 11696
Group Contact Doyle Rowe LTD 866-201-2524
www.doylerowe.com

All Enrollees Must Complete the Following Sections
Please check one or both plans and coverage type:

☐ I would like to enroll in the Delta Dental Plan (monthly cost listed below)

Coverage Type (Choose one)

- ☐ Individual $57.37
- ☐ Member + 1 $110.56
- ☐ Family $195.07

AND/OR

☐ I would like to enroll in the Delta Vision Plan (monthly cost listed below)

Coverage Type (Choose one)

- ☐ Individual $5.95
- ☐ Member + 1 $11.62
- ☐ Family $17.41

Last Name First Name M.I. Gender

Date of Birth MM/DD/YYYY Marital Status Street

City State Zip

Phone Effective Date MM/DD/YYYY

Social Security Number

Does spouse have a dental and/or vision plan?___ Yes ___ No Are dependents covered by spouse's plan? ___Yes ___ No

Spouse's Employer _____Spouse's Carrier_____

Coverage will be effective on the first of the month following receipt of your application if received by the 25th of the month.

Please list all eligible dependents to be covered

	FIRST NAME	LAST NAME (if different)	BIRTHDATE	GENDER(M/F)
Spouse				
Child				
Child				
Child				
Child				

Signature of applicant Date

DRL
Doyle Rowe LTD

Premium Payment Option and Authorization

Last Name _____ First Name _____ Middle Initial _____

Street Address _____ City/State/Zip _____

Phone _____ Fax _____ Email Address _____

Financial Institution Debit Authorization - membership premium deducted from bank account:
Monthly Electronic Fund Transfer Type: Checking ☐ Savings ☐

Account Holder Name: _____

Bank Name: _____

Bank Account Number: _____

Bank Routing Number: _____

Account Owner Signature: _____
(if different than applicant)

I hereby authorize Doyle Rowe LTD to accept payment by monthly bank draft for the plan(s) I have chosen to enroll in using a separate enrollment form. This authority will remain in effect for a period of not less than one year from the effective date of coverage and thereafter until canceled by written notice to Doyle Rowe LTD from me.

Signature _____ Date _____