DELTA DENTAL®

DeltaVision®

Platinum Plan (Insight Network)
Summary of Benefits
For Group# 22155V-1000, 9901000
Roosevelt School District #66

Benefits are subject to all provisions, terms and conditions of the Vision Certificate, including this Summary of Benefits and the Group Vision Contract.

Please note: The date of service is the date the procedure was performed unless otherwise noted below.

Control Plan – Delta Dental of Arizona

Benefit Year – January 1 through December 31

Child Age Limit – To age 26

Student Age Limit – To age 26

Covered Services –

Vision Care Services	In-Network	Out-of-Network
Exam with Dilation as Necessary	$10 Copay	$30
Retinal Imaging Benefit	Up to $39	Not Covered
Exam Options		
Standard Contact Lens Fit and Follow-Up	Up to $40	Not Covered
Premium Contact Lens Fit and Follow-Up	10% off Retail Price	Not Covered
Frames		
Any available frame at provider location	$0 Copay; $150 allowance, 20% off balance over $150	$75
Standard Plastic Lenses		
Single Vision	$10 Copay	$25
Bifocal	$10 Copay	$40
Trifocal	$10 Copay	$55
Lenticular	$10 Copay	$55
Standard Progressive*	$75 Copay	$40
Premium Progressive*		
Tier 1	$95 Copay	$40
Tier 2	$105 Copay	$40
Tier 3	$120 Copay	$40
Tier 4	$75 Copay, 80% of charge less $120 Allowance	$40
Lens Options		
UV Treatment	$15 Copay	Not Covered
Tint (Solid and Gradient)	$15 Copay	Not Covered
Standard Plastic Scratch Coating	$15 Copay	Not Covered
Standard Polycarbonate - Adults	$40 Copay	Not Covered
Standard Polycarbonate - Kids under 19	$40 Copay	Not Covered
Standard Anti-Reflective Coating*	$45 Copay	Not Covered
Polarized	20% off Retail Price	Not Covered

Photocromatic/Transitions Plastic	$75	Not Covered
Premium Anti-Reflective*		
Tier 1	$57 Copay	Not Covered
Tier 2	$68 Copay	Not Covered
Tier 3	20% off Retail Price	Not Covered
Other Add-Ons	20% off Retail Price	Not Covered
Contact Lenses *(Contact lens allowance includes materials only)*		
Conventional	$0 Copay; $150 allowance, 15% off balance over $150	$120
Disposable	$0 Copay; $150 allowance, plus balance over $150	$120
Medically Necessary	$0 Copay, Paid-in-Full	$200
Laser Vision Correction Lasik or PRK from U.S. Laser Network	15% off Retail Price or 5% off promotional price	Not Covered
Amplifon Hearing Health Care	Hearing Health Care from Amplifon Hearing Health Care Network - Members receive a 40% discount off hearing exams and a low price guarantee on discounted hearing aids	Not Covered
Additional Pairs Benefit	Members also receive a 40% discount off complete pair prescription eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used	Not Covered
Frequency		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 12 months	

*DDAZ reserves the right to make changes to the products on each tier and the member out-of-pocket costs. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels.

Additional Discounts – Member receives a 20% discount on items not covered by the plan at network Providers, which cannot be combined with any other discounts or promotional offers. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision.

Members also receive a 40% discount off complete pair prescription eyeglass purchases and a 15% discount off conventional contact lenses 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.eyemedvisioncare.com. The contact lens benefit allowance is not applicable to this service. Rates are valid for groups domiciled in the State of AZ.

Plan Exclusions –

1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures; 3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear; 4) 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; 5) Plano (non-prescription) lenses and/or contact lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals; 8) Services or materials provided by any other group benefit plan providing vision care; 9) Certain brand name Vision Materials in which the manufacturer imposes a no-

discount policy; 10) 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. 11) 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.

Diabetic Services Rider –

Diabetic Care Services	Member Cost	Frequency	Out-of-Network Reimbursement
Office Service Visit *(Medical Follow-up Exam)* Type 1 and Type 2 diabetics	Covered 100% $0 copay	Up to 2 services per benefit year	$77
Fundus Photography** Type 1 and Type 2 diabetics	Covered 100% $0 copay	Up to 2 services per benefit year	$50
Extended Ophthalmoscopy** Type 1 and Type 2 diabetics	Covered 100% $0 copay	Up to 2 services per benefit year	$15
Gonioscopy Type 1 and Type 2 diabetics	Covered 100% $0 copay	Up to 2 services per benefit year	$15
Scanning Laser Type 1 and Type 2 diabetics	Covered 100% $0 copay	Up to 2 services per benefit year	$33

**Not covered if extended ophthalmoscopy is provided within 6 months.

Definitions –

Office Service Visit (Medical Follow-up Exam) is the office visit for the evaluation and management of an established patient. The office visit includes patient history, follow-up examination services as deemed appropriate by the provider, and medical decision making. Some or all of the diagnostic services described below will be provided as deemed appropriate, subject to provider determination of service necessity and the benefit frequency limitations referenced above. More comprehensive descriptions of these services are available in the Certificate of Insurance.

- **Fundus Photography** with interpretation and report. Fundus photography is a process using optical imaging equipment to photograph structures of the eye.
- **Extended Ophthalmoscopy** with retinal drawing and interpretation and report. A serious retinal condition must exist or be suspected (based on results of routine ophthalmoscopy) which requires further detailed study.
- **Gonioscopy** procedure to look at the anterior chamber structures of the eye between the cornea and the iris. Gonioscopy can be used in detection or treatment of conditions that can be more prevalent in diabetics such as glaucoma or neovascularization of the angle.
- **Scanning.** Laser Scanning computerized ophthalmic diagnostic imaging, posterior segment with interpretation and report.

Exclusions and Limitations – The Diabetic Benefit covers diabetic eye care evaluation services only. The following services and benefits are excluded:

1) Costs associated with securing frames, lenses, or any other materials.
2) Orthoptics or vision training and any associated supplemental testing.
3) Surgical procedures, including laser or any other form of refractive surgery, and any pre or post-operative services.
4) Pathological treatment of any type for any condition.
5) Any eye examination required by an employer as a condition of employment.
6) Insulin or any medications or supplies of any type.
7) Services and/or materials not included above.