Vision Care Benefits Summary

Vision Care benefits will be provided for services or supplies listed below when rendered, recommended or approved by a licensed physician or optometrist up to the actual charge for said service or supply or the amount listed for said service or supply.

COVERED BENEFIT AND MAXIMUM BENEFITS

Services and Supply	**Maximum Benefit**
Examination	$42.00
Lenses, per pair- Maximum:	
Single Vision	$42.00
Bi-focal	$56.00
Tri-focal	$70.00
Frames	$28.00

1) Lenticular lenses are prescribed for the Subscriber:
   a) Where visual acuity is not correctable to 20/40 in the better eye except by the use of contact lenses;
   b) As a requirement following cataract surgery; or
   c) When such person is being treated for a condition, and contact lenses are customarily prescribed as part of treatment $84.00
2) If otherwise prescribed, and, at the subscriber's option in lieu of lenses/frames, for the Subscriber…. $56.00.

Restrictions

Benefits will be provided for not more than:
1) One (1) complete eye examination for the Subscriber in any period of twenty-four (24) months;
2) Two (2) lenses for the Subscriber in any period of twenty –four (24) months when prescribed for the first time or required because of a change in prescription ; and
3) One (1) set of frames for the Subscriber in any period of twenty –four (24) months, provided benefits are payable for lenses under the plan.

Limitations

Expenses incurred for lenses and frames within thirty (30) days of termination of the individual's coverage will be considered covered benefits if a complete eye examination , including refraction, was performed during the thirty (30) day period immediately preceding the termination of coverage and the examination resulted in lenses being prescribed.

Exclusions

1. Services or supplies for which full or partial benefits are provided under any Workers' Compensation law or any other law of similar purpose.
2. Services or supplies determined by the City to be special or unusual including, but not limited to orthotics, vision training, nonprescription sunglasses or low vision aids.
3. Charges for anti-reflective coating.
4. Charges for tinting, prescription sunglasses, and light-sensitive lenses in excess of the maximum benefit payable.
5. Examinations, required by the employer as a condition for employment, or which an employer is required to provide under a labor agreement, or which is required by any law of government.
6. Charges for the replacement of lost, stolen or broken frames and lenses.
7. Services or supplies received while the individual is not covered, including charges for lenses and frames that are furnished or ordered as a result of an eye examination that occurred prior to the effective date of coverage.
8. Charges for duplicate or spare eyeglasses, lenses and frames.
9. Services or supplies not prescribed as medically necessary by a licensed physician, optometrist or ophthalmologist.
10. Services or supplies furnished without cost by any government body.
11. Services or supplies which are included as a covered benefit under any other benefit section included in this plan, or under any other medical or vision care benefit plan carried or sponsored by the City of Charleston , whether partial or full benefits are payable.

Plan Benefit Highlights for: City of Charleston
Group No: 18635 **Effective Date:** 01/01/2017

DELTA DENTAL PPO[SM] BENEFIT HIGHLIGHTS

Eligibility	Primary enrollee, spouse and eligible dependent children to the end of the month dependent turns age 19 or to the end of the month dependent turns age 26 if dependent is full-time student
Deductibles	**Standard Plan:** $25 per person / $75 per family each calendar year **Enhanced Plan:** $50 per person / $150 per family each calendar year
Deductibles waived for Diagnostic & Preventive (D & P) and Orthodontics?	Yes
Maximums	**Standard Plan:** $1,200 per person each calendar year **Enhanced Plan:** $2,000 per person each calendar year
D & P counts toward maximum?	No

Waiting Period(s)	Basic Benefits	Major Benefits	Prosthodontics	Orthodontics
	None	None	None	None

	Standard Plan		Enhanced Plan	
Benefits and Covered Services**	**Delta Dental PPO dentists†**	**Non-Delta Dental PPO dentists†**	**Delta Dental PPO dentists†**	**Non-Delta Dental PPO dentists†**
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays and sealants	100 %	100 %	100 %	100 %
Basic Services Fillings	80 %	80 %	90 %	90 %
Endodontics (root canals) Covered Under Basic Services	80 %	80 %	90 %	90 %
Periodontics (gum treatment) Covered Under Basic Services	80 %	80 %	90 %	90 %
Oral Surgery Covered Under Basic Services	80 %	80 %	90 %	90 %
Major Services Crowns, inlays, onlays and cast restorations	50 %	50 %	60 %	60 %
Prosthodontics Bridges, dentures and implants	50 %	50 %	60 %	60 %
Orthodontic Benefits Dependent children	50 %	50 %	50 %	50 %
Orthodontic Maximums	$1,200 Lifetime	$1,200 Lifetime	$2,000 Lifetime	$2,000 Lifetime

** Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental contract allowances and not necessarily each dentist's actual fees.

† Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

Delta Dental of West Virginia
One Delta Drive
Mechanicsburg, PA 17055

Customer Service
800-932-0783

Claims Address
P.O. Box 2105
Mechanicsburg, PA 17055-6999

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.