IBEW Local 369
Delta Dental Plan Option

DELTA DENTAL®

What the plan pays: This is partial list of covered services and is not a contract of insurance. Your coverage is subject to the limitations, exclusions, and other terms and conditions of the member certificate of insurance.	Delta Dental PPO™	
	Network *(Percent of Allowable Amount)*	**Out-of-Network** *(Percent of Allowable Amount)*
Preventive & Diagnostic		
► Exams (initial, periodic, and emergency; limited to 2 in a benefit period)	100%	80%
► Bitewing x-rays (limited to 1 in a benefit period)	100%	80%
► Full-mouth or panoramic (limited to 1 in a 5 year period)	100%	80%
► Cleanings (limited to 2 in a benefit period)	100%	80%
► Pulp Vitality Test	100%	80%
► Emergency Treatment (relief of pain)	100%	80%
Minor Services		
► Routine Fillings	80%	60%
► Stainless Steel Crowns	80%	60%
► Sedative Filling (relief of pain)	80%	60%
► Pin Retention	80%	60%
► Crown Repair	80%	60%
► Simple denture repairs to an existing denture or partial	80%	60%
► Oral Surgery	80%	60%
Major Services*		
► Crowns (permanent; limited to once per tooth in 5 years)	50%	50%
► Recement Crown	50%	50%
► Crown Build-up	50%	50%
► Root Canal and Pulp Therapy (excluding final restoration)	50%	50%
► Periodontal Procedures	50%	50%
► Dentures (complete and partial)*	50%	50%
► Denture repairs for adding a tooth or clasp to an existing denture or partial*	50%	50%
► Bridges*	50%	50%
Orthodontics Services*	50%	50%

To enroll, please complete the enrollment form and include payment in the envelope provided.

There is a 12-month waiting period on Major and Orthodontic Services. Replacement of teeth missing prior to the effective date of this plan is not covered.
Deductibles: No deductible for Preventive & Diagnostic Services. $50 individual/$150 family deductible per year for Minor and Major Services.
Plan pays a maximum of $1,000 per member, per year for covered services. Only the services listed above will be covered. Plan pays a lifetime of $1,000 for orthodontic services.
Dependents covered through age 26 (non-orthodontics). Dependents covered through age 19 for orthodontics.
This is not a contract. Covered services are subject to the limitations, exclusions, and other terms and conditions of the member certificate. A complete description of covered services can be found in the member's certificate booklet.

Rev. 9/19

DELTA DENTAL®

vsp® Vision care for life

IBEW DeltaVision®

You'll see the difference with DeltaVision

3 in 4
adults need vision correction.[1]

1 in 4
children need vision correction.[1]

Only 1 in 5
Americans get an annual medical exam.[2]

Personalized Care. DeltaVision members receive quality care that focuses on their eyes and overall wellness. Our eyecare provider will look for vision problems and signs of other health conditions.

Eyewear. Choose eyewear that's right for you and your budget. From classic styles to the latest designer fashions, there are hundreds of options for DeltaVision members.

Value and Savings. DeltaVision members receive great benefits on exams and eyewear at an affordable price.

Enroll Today!

ky.deltadental.com/IBEW | (800)-955-2030

Sources: 1. Vision Council, VisionWatch December 2014; 2. American Journal of Preventative Medicine 2012, 42, Issue 2:164-173.

DELTA DENTAL®

VSP® Vision care for life

DeltaVision® by Delta Dental of Kentucky
administered by VSP

IBEW DeltaVision®

Benefit	Description	Copay
WellVision Exam		
Exams 1 exam every 12 months	Comprehensive eye exam to ensure overall visual wellness	$20
Prescription Glasses		$20
Frames 1 pair every 24 months	$120 allowance for wide selection of frames 20% savings on amount over allowance	Included in Prescription Glasses Copay
Lenses 1 pair every 12 months	Single vision, lined bifocal and lined trifocal lenses Polycarbonate lenses for children	Included in Prescription Glasses Copay
Optional Lens Enhancements	Standard Anti-Reflective Coating Standard, Premium, Custom Progressive Lenses Photochromic Lenses Scratch -resistant coating Average savings of 25-30% on other lens enhancements	$41 $55 - $175 $70 - $82 $17
Contact Lenses - instead of glasses		
Contacts every 12 months	$120 allowance for contacts; copay does not apply Contact lens exam (fitting and evaluation)	up to $60
Extra Savings		
Featured Frames	$140 allowance on featured frame brands. Check vsp.com for current offers.	
Glasses and Sunglasses	20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam	
Retinal Screening	No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam	
Additional Programs		
Included	Primary Eyecare, Eye Health Management (including Diabetic Exam Reminder Letters)	

Your coverage with Out-of-Network Providers		
Exam - up to $45 Frame - up to $70 Single Vision Lenses - up to $30	Lined Bifocal Lenses - up to $50 Lined Trifocal Lenses - up to $65 Lenticular Lenses - up to $100	Progressive Lenses - up to $50 Contacts - up to $105 Necessary Contact Lenses - up to $210

VSP Choice Network
38,000 preferred providers - 91,000 Access Points