DELTA DENTAL®

Created specifically for:
Alliance OF ARIZONA NONPROFITS

Affordable Dental & Vision Plans

Benefit Year: January 1, 2022 - December 31, 2022[1]

Delta Dental of Arizona is pleased to offer dental and vision plans to organizations in the Alliance of Arizona Nonprofits:

1. Choose a dental plan option (A or B). Alliance of Arizona Nonprofits members receive exclusive pricing on our PPO plans.
2. Decide if you want to purchase the vision option as well.
3. Contact Stephanie Waldrop at Employee Benefits International.

DENTAL

Your employees can choose the high or low plan. Minimum participation requirements may apply.[2]

	OPTION A	OPTION B	
Covered Services[3]	Single Option PPO[2]	High/Low PPO	
		High[2]	Low[2]
Preventive Services	100%	100%	100%
Basic Services	80%	80%	80%
Major Services	50%	50%	50%
Orthodontia	50%	50%	50%
Individual Deductible[5]	$50	$50	$50
Family Deductible[5]	$150	$150	$150
Annual Maximum Benefit	$1,500	$2,000	$1,000
Lifetime Orthodontia Maximum	Child $1,500	Adult & Child $1,500	Child $1,000
Is Patient Responsible for Dentist's Total Billed Charges?	Only when seeing an out-of-network dentist		
Plan Name	Delta Dental PPO Plus Premier™, 4		
Monthly Rates			
Employee	$36.51	$38.07	$31.44
Employee + Spouse	$78.68	$79.91	$66.03
Employee + Child(ren)	$87.77	$90.55	$74.33
Employee + Family	$134.52	$139.13	$114.23

[1]Groups starting coverage mid-year will receive benefits through December 31 and renew for a new benefit year. Renewal rates may be subject to change.
[2]The minimum plan enrollment is the greater of 25% of the eligible employees or 2 enrolled employees.
[3]Chart shows coverage for in-network services. Coverage for out-of-network services may be available. Refer to plan booklet for coverage specifics.
[4]Delta Dental PPO Plus Premier is underwritten and administered in Arizona by Arizona Dental Insurance Service, Inc. dba Delta Dental of Arizona.
[5]Deductible applies to basic and major services.

VISION

Minimum participation requirements may apply.[6]

DeltaVision® - Insight Network[7]

Covered Services[8]	Platinum Plan
Vision Exam With Dilation (As necessary)	$10 copay
Retinal Imaging	Up to $39
Contact Lens Fit & Follow-up	
Standard Fit & Follow-up	Up to $55
Premium Fit & Follow-up	10% off retail price
Frames	$0 copay; $150 allowance, 20% off balance over $150
Standard Plastic Lenses	
Single Vision	$10 copay
Bifocal	$10 copay
Trifocal	$10 copay
Lenticular	$10 copay
Standard Progressive Lens[9]	$75 copay
Premium Progressive Lens[9]	**Tier 1:** $95 copay **Tier 2:** $105 copay **Tier 3:** $120 copay **Tier 4:** $75 copay, 80% of charge less $120 allowance
Lens Options	
UV Coating	$15
Tint (Solid and gradient)	$15
Standard Scratch-Resistance	$15
Standard Polycarbonate	$40
Standard Anti-Reflective[9]	$45
Polarized	20% off retail price
Photocromatic/Transitions Plastic[9]	$75
Premium Anti-reflective	**Tier 1:** $57 **Tier 2:** $68 **Tier 3:** 80% of charge
Other Add-Ons and Services	20% off retail price
Contact Lenses[10]	
Conventional	$0 copay; $150 allowance, 15% off balance over $150
Disposable	$0 copay; $150 allowance, plus balance over $150
Medically Necessary	$0 copay, paid-in-full
Lasik and PRK Benefit	15% off retail price or 5% off promotional price
Diabetic Care Services[11]	
Office Service Visit (Medical follow-up exam)	Covered 100%, $0 copay
Fundus Photography[12]	
Extended Opthamaloscopy[13]	
Gonioscopy	
Scanning Laser	
Frequency	
Examination	Once every 12 months
Lenses or Contact Lenses	Once every 12 months
Frame	Once every 12 months
Diabetic Care Services	Up to 2 services per benefit year

Monthly Rates	
Employee	$8.04
Employee + Spouse	$16.09
Employee + Child(ren)	$15.69
Employee + Family	$24.54

Quoted vision rates only available when bundled with dental.

READY TO BUY?

YOUR BROKER IS:

Broker Name: Stephanie Waldrop

Phone: 602.800.5075

Email: swaldrop@ebint.com

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[6]The minimum plan enrollment is the greater of 25% of the eligible employees or 2 enrolled employees.
[7]DeltaVision vision plans are administered by EyeMed Vision Care LLC.
[8]Chart shows coverage for in-network services. Coverage for out-of-network services may be available. Refer to plan details for coverage specifics.
[9]Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. EyeMed reserves the right to make changes to the products on each tier and the member out-of-pocket costs. Contact EyeMed for a current listing of brands by tier.
[10]Contact lens allowance includes materials only.
[11]Diabetic care services cover diabetic eyecare evaluation services only for members with Type 1 or Type 2 diabetes. Exclusions and limitations may apply. Refer to plan details for coverage specifics.
[12]Not covered if extended ophthalmoscopy is provided within 6 months.
[13]Not covered if fundus photography is provided within 6 months.