



Vision Plan of America

Best Choice Plan

Bundled Individual Vision/Dental Benefits

Dental: no annual deductible

| | <u>Co pays</u> |
|---------------------------|--------------------------------|
| Office Visit | \$5.00 |
| Periodic Exam | No Charge |
| X-rays | No Charge |
| Cleaning (child or adult) | No Charge |
| Fluoride (to age 14) | No Charge |
| 1 or 2 Surface Amalgam | \$10.00 |
| Bi Rooted Canal | \$150.00 (without restoration) |
| Crown (porcelain) | \$275.00 |
| Orthodontia | Covered |
| Specialty Care | Limited Coverage |

Vision: benefits as often as the member chooses

| | <u>Co pays</u> |
|--------------------------|-----------------------|
| Comprehensive Eye Exam | \$25.00 |
| Single Vision Lenses | \$36.00 |
| Bifocal Lenses | \$49.00 |
| Trifocal Lenses | \$79.00 |
| Lenticular Lenses | \$160.00 |
| #1 Tint (plastic lenses) | No Charge |
| Any Frame | 25% off U.C.R. |
| Contact Lenses | Covered |

Rates

| | |
|--------------------------|----------------------|
| Employee | \$12.00/month |
| Employee + 1 | \$18.00/month |
| Employee + Family | \$22.00/month |

Best Choice Plan

The following procedures are covered benefits only when provided by a participating General Dentist:

| <u>ADA CODE</u> | <u>PROCEDURE</u> | <u>MEMBER COPAYMENT</u> | <u>ADA CODE</u> | <u>PROCEDURE</u> | <u>MEMBER COPAYMENT</u> |
|---|---|-------------------------|--|---|-------------------------|
| <u>DIAGNOSTIC</u> | | | <u>ENDODONTICS</u> | | |
| | Office Visit | \$ 5.00 | 3110,20 | Direct or Indirect Pulp Capping w/out Final Restoration | \$ 15.00 |
| 120 | Periodic Oral Exam. | No Charge | 3220 | Therapeutic Pulpotomy, Exclud. Final Restoration | \$ 25.00 |
| 140 | Limited Oral Exam/Problem. Focused | No Charge | Root Canal Therapy, w/ Treatment Plan, Clinical Procedures & Follow Up Care | | |
| 150 | Comprehensive Exam | No Charge | 3310 | One Canal w/out Final Restoration | \$ 125.00 |
| Radiographs | | | 3320 | Two Canals, w/out Final Restoration | \$ 150.00 |
| 210 | Intraoral,Complete Series w/ Bitewings | No Charge | 3330 | Three Canals, w/out Final Restoration | \$ 185.00 |
| 220 | Intraoral,Periapical, First Film | No Charge | Apicoectomy/Periradicular Surgery | | |
| 230 | Intraoral,Periapical,Each Addittional Film | No Charge | 3410,21,25 | Anterior,Bicuspid First Root or Molar First Root | \$ 90.00 |
| 240 | Intraoral,Occlusal Film | No Charge | 3426 | Each Additional Root | \$ 90.00 |
| 270 | Bitewings, Single Film | No Charge | 3430 | Retrograde Filling, Per Tooth | \$ 65.00 |
| 272 | Bitewings, Two Films | No Charge | Other Endodontic Procedures | | |
| 274 | Bitewings, Four Films | No Charge | 3950 | Canal Preparation & Fitting of Pre-Formed Dowel or Post | \$ 70.00 |
| 330 | Panoramic Film | No Charge | <u>PERIODONTICS</u> | | |
| Tests & Laboratory Examinations | | | Surgical Services, w/Usual Post-Operative Services | | |
| 460 | Pulp Vitality Tests | No Charge | 4210 | Gingivectomy or Gingivoplasty, Per Quadrant | \$ 150.00 |
| 470 | Diagnostic Casts-Non-Ortho | \$ 10.00 | 4211 | Gingivectomy or Gigivoplasty, Per Tooth | \$ 20.00 |
| 471 | Diagnostic Photographs | No Charge | 4240 | Gingival Flap Procedure, w/Root Planning Per Quadrant | \$ 150.00 |
| 501 | Histopathologic Examinations | \$ 5.00 | 4261 | Bone Replacement Graft, Single Site w/ Flap Entry & Closure | \$ 300.00 |
| <u>PREVENTIVE</u> | | | Other Periodontal Services | | |
| 1110,20 | Prophylaxis,Child or Adult | No Charge | 4341 | Root Planning, Per Quadrant | \$ 40.00 |
| 1201,03 | Topical Application of Fluoride, Child, w/ or w/ out Prophylaxis | No Charge | 4910 | Periodontic Recall, w/Prophylaxis | \$ 25.00 |
| 1310 | Nutritional Counseling for Control Of Dental Disease | No Charge | 4920 | Unscheduled Dressing Change by Dental Assistant | No Charge |
| 1330 | Oral Hygiene Instruction | No Charge | <u>REMOVABLE PROSTHODONTICS</u> | | |
| <u>RESTORATIVE</u> | | | Complete Dentures, w/ Routine Post-Delivery Care | | |
| Amalgam Restorations, with Polishing | | | 5110,20 | Upper or Lower | \$ 350.00 |
| 2110 | One Surface, Primary | \$ 10.00 | 5130,40 | Immediate Upper or Lower | \$ 350.00 |
| 2120 | Two Surfaces, Primary | \$ 10.00 | Partial Dentures, w/ Routine Post-Delivery Care | | |
| 2130 | Three Surfaces, Primary | \$ 20.00 | 5211,12 | Upper or Lower, Resin Base, Conventional Clasps & Rests | \$ 300.00 |
| 2131 | Four or More Surfaces, Primary | \$ 34.00 | 5213,14 | Upper or Lower, Cast Metal Base w/ Acrylic Saddles | \$ 350.00 |
| 2140 | One Surface, Permanent | \$ 10.00 | Adjustments to Dentures | | |
| 2150 | Two Surfaces, Permanent | \$ 15.00 | 5410,11 | Complete Upper or Lower | \$ 25.00 |
| 2160 | Three Surfaces, Permanent | \$ 20.00 | 5421,22 | Partial Upper or Lower | \$ 20.00 |
| 2161 | Four or More Surfaces, Permanent | \$ 25.00 | Repairs to Complete Dentures | | |
| Resin Restorations, Anterior | | | 5510 | Broken Base | \$ 50.00 |
| 2330, | | | 5520 | Missing or Broken Teeth, Per Tooth | \$ 25.00 |
| 31,32 | One, Two or Three Surfaces | \$ 25.00 | Repairs to Partial Dentures | | |
| 2335 | Four or More Surfaces, or Involving Incisal Angle | \$ 40.00 | 5610,20 | Acrylic Saddle, Base or Cast Framework | \$ 50.00 |
| Crowns, Single Restoration Only # | | | 5630 | Repair or Replace Broken Clasp | \$ 25.00 |
| 2710 | Resin, Laboratory | \$ 145.00 | 5640 | Replace Broken Teeth, Per Tooth | \$ 25.00 |
| 2720,21,22 | Resin with Metal | \$ 175.00 | 5650,60 | Add Tooth or Clasp | \$ 50.00 |
| 2750,51,52 | Porcelain Fused to Metal For Molars | \$ 275.00 | Denture Relines Procedures | | |
| 2790,91,92 | Full Cast Metal | \$ 250.00 | 5730,31 | Complete, Upper or Lower, Chairside | \$ 65.00 |
| 2810 | % Cast Metal | \$ 250.00 | 5740,41 | Partial, Upper or Lower, Chairside | \$ 65.00 |
| Other Restorative Services # | | | 5750,51 | Complete, Upper or Lower, Laboratory | \$ 100.00 |
| 2920 | Recement Crown | \$ 12.00 | 5760,61 | Partial, Upper or Lower, Laboratory | \$ 100.00 |
| 2930 | Prefabricated Stainless Steel Crown, Primary Tooth | \$ 50.00 | <u>FIXED PROSTHODONTICS</u> | | |
| 2931 | Prefabricated Stainless Steel Crown, Permanent tooth, when suggested by Dentist | \$ 45.00 | Bridge Pontics # | | |
| 2940 | Temporary Sedative Filling | \$ 10.00 | 6210,11, | | |
| 2950 | Crown Build-Up w/Any Pins | No Charge | 12 | Cast Metal | \$ 200.00 |
| 2951 | Pin Retention, Per Tooth In Addition to Restoration | \$ 18.00 | 6240,41, | | |
| 2952 | Cast Post & Core In Addition to crown | \$ 75.00 | 42 | Porcelain Fused to Metal | \$ 200.00 |
| 2954 | Prefabricated Post & Core In Addition to Crown | \$ 70.00 | | | |
| 2970 | Temporary Crown, w/Fractured Tooth, When Not Part of Crown Preparation | \$ 20.00 | | | |

| <u>ADA CODE</u> | <u>PROCEDURE</u> | <u>MEMBER COPAYMENT</u> |
|--|---|-------------------------|
| 6250,51,52 | Resin w/ Metal | \$ 175.00 |
| Bridge Retainer-Crowns # | | |
| 6720,21,22 | Resin w/ Metal | \$ 175.00 |
| 6750,51,52 | Porcelain Fused To Metal | \$ 275.00 |
| 6780 | Cast Metal | \$ 200.00 |
| 6790,91,92 | Full Cast Metal | \$ 200.00 |
| Other Fixed Prosthetic Services | | |
| 6930 | Recent Bridge | \$ 25.00 |
| 6970 | Cast Post & Core, In Addition to Bridge Retainer | \$ 75.00 |
| 6971 | Cast Post, As Part of Bridge Retainer | \$ 70.00 |
| 6972 | Prefabricated Post & Core, In Addition to Bridge Retainer | \$ 70.00 |
| 6973 | Core Build-Up for Retainer, Including Any Pins | No Charge |
| 6975 | Coping Metal | No Charge |

ORAL SURGERY

| Extractions, Local Anesthesia, Routine Post-Op Care | | |
|---|---|----------|
| 7110 | Single Tooth | \$ 25.00 |
| 7120 | Each Additional Tooth | \$ 20.00 |
| 7130 | Root Removal, Exposed Roots | \$ 45.00 |
| Surgical Extractions, local Anesthesia Routine Post-Op | | |
| 7210 | Surgical Removal of Erupted Tooth, Requiring Elevation of Mucoperiosteal Flap | \$ 45.00 |
| 7220 | Removal of Impacted Tooth, Soft Tissue | \$ 60.00 |
| 7230 | Removal of Impacted Tooth, Partially Bony | \$ 75.00 |
| 7510 | Surgical Incision w/ Drainage of Abscess, Intraoral Soft Tissue | \$ 40.00 |

ADJUNCTIVE GENERAL SERVICES

| 9110 | Unclassified Treatment, Minor Palliative (Emergency) Treatment of Pain Surgical Procedure | \$ 20.00 No Charge |
|----------------------------|---|-----------------------|
| 9215 | Local Anesthesia | No Charge |
| Professional Visits | | |
| 9430 | Office Visit for Observation, No Other Services Performed | \$ 8.00 |
| 9440 | Office Visit, After Regularly Scheduled Hours | \$ 25.00 |

The member is responsible for the co-payment plus the actual lab cost of gold.

| <u>ADA CODE</u> | <u>PROCEDURE</u> | <u>MEMBER COPAYMENT</u> |
|-------------------------------|--|-------------------------|
| Miscellaneous Services | | |
| 9930 | Treatment of Complication, Post-Surgical Unusual Circumstances | No Charge |
| 9951 | Occlusal Adjustment, Limited | No Charge |

ORTHODONTICS

The following procedures are covered benefits only when provided by a participating Network Orthodontist:

Standard 24 Month Case *

| | |
|--|-------------|
| Full Banded, Upper & Lower, Children to Age 19 | \$ 1,775.00 |
| Full Banded, Upper & Lower Adults | \$ 1,975.00 |
| Banded Upper or Lower, Children & Adults | \$ 1,000.00 |

Retention After Treatment

| | |
|---|--------|
| Full Banded, Children & Adults | UCR*** |
| Banded, Upper or Lower, Children & Adults | UCR*** |

Other Fees

| | |
|--|----------|
| Consultation | \$ 25.00 |
| Diagnosis & Records ** | UCR*** |
| Appliances (Head Gear) | UCR*** |
| Broken Appointments, w/out 24 Hr. Notice | \$ 25.00 |

* Orthodontist may charge members an additional fee for the costs of cases over 24 months, based upon the difference in orthodontists UCR fees for the needed treatment period, less the orthodontists UCR fees for a 24 month treatment period.

** Includes x-rays, tracings, photographs and study models.

*** Means the orthodontist's Usual, Customary & Reasonable Fees.

SPECIALTY REFERRALS

Not all general dentists are capable of performing each of the services listed herein and, based upon the member's condition, certain procedures may not be within the scope of practice or ability of a general dentist. In such cases, the general dentist will refer the member to a Network participating dental specialist, who will give the Member a 25% discount from their regular fees.

The ratio of premium costs to health services paid, for plan contracts with individuals and groups of 25 or fewer members, during the preceding fiscal year was 0%.



Description of Benefits/Co-payments

| <u>Member Services</u> | <u>Member Pays</u> | <u>Member Services</u> | <u>Member Pays</u> |
|--|------------------------------|--|----------------------------|
| Preventive Eye Care Analysis ... | No Charge | Contact Lenses (See Note #4) | |
| Cataract Analysis | No Charge | Contact Lens Evaluation | \$ 38 |
| Glaucoma Test | No Charge | (Determines Lens Type) | |
| Frame Repairs | No Charge | Contact Lens Svc. Agree. | Normal Retail Price |
| Frame Adjustments | No Charge | Contact Lens Care Kits | Normal Retail Price |
| Tint #1, any color (plastic) | No Charge | Additional C.L. visits (ea.)..... | \$ 10 |
| Computerized Vision Analysis . | No Charge | Hard Lenses | \$ 85 |
| (Where Available) | | Gas Permeable | \$145 |
| Frames | -25% Off Normal Retail Price | Soft (Daily): | |
| Refraction* (See Note #1) | \$25 | Bausch & Lomb (or Similar)..... | \$ 50 |
| Determines Eyeglass Prescription | | Am. Hydron (or Similar)..... | \$ 59 |
| Lenses (Plastic) (See Note #2 & #3) | | Cooperthin (or Similar) | \$ 59 |
| Single Vision Lenses | \$ 36 | Soft (Extended Wear): | |
| Bifocal Lenses | \$ 49 | Bausch & Lomb(0 series) (or Similar) | \$ 70 |
| (Rnd. 22 – FT 22-28) | | Hydracurve (Softmate Series) (or Similar) | \$130 |
| Trifocal Lenses | \$ 79 | Toric Contact Lenses: | |
| (FT7X22) | | Soft . . .Hard . . . R.G.P. | 20% Off |
| Progressive (Generic)..... | \$138 | Soft Custom Colors for Cosmetic | |
| Progressive (Premium) | - 20% UCR | Eye Color Changes. | 20% Off |
| Lenticular Lenses..... | \$160/S.V. | Disposable (1 st 3 months Supply Only) | 20% Off |
| Lenticular Lenses | \$210/B.F | Custom Contacts Lenses (See Note #5) | 20% Off |
| Lens Extras: | | (Orthokeratology Not Covered) | |
| Oversize (over 58mm E.D.)..... | \$ 12 | Bifocal Contact Lenses | 20% Off |
| Fashion Tints (ea. color, plastic) | \$ 10 | (Soft Disposable 1 st 3 months Supply Only) | |
| Photoextra (S/V)..... | \$ 20 | | |
| Photoextra (B/F) | \$ 30 | | |
| Photoextra (Progressive) | \$ 50 | | |
| Transitions | - 20% UCR | | |
| Scratchcote (Plastic) | \$ 20 | | |
| Thin Lens (for high Rx) | \$ 35 | | |
| (Polycarbonate) | | | |
| UV Coating | \$ 10 | | |
| Rimless (Edge Groove) | \$ 12 | | |
| Prism | \$4.00 per Diopter | | |

Contact lens fitting may be an additional charge.

*See Vision Examination

ANY PROCEDURE NOT LISTED AND PROVIDED BY THE SELECTED OPTOMETRIST IS AVAILABLE ON A FEE-FOR-SERVICE BASIS.

ALL LENS PRICES ARE PER PAIR

NOTE # 1:

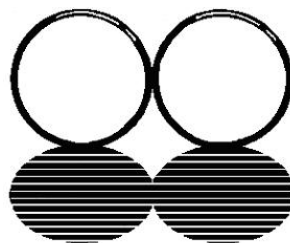
Refraction determines the need for a prescription. The \$25.00 co-payment must be paid directly to the doctor at the time of service. These benefits are part of and used in conjunction with your HMO package.

NOTE #2:

Cost of lenses may have an additional charge when power of lenses exceeds ±6.00 D SPH or when combined with ±2.00 D CYL.

NOTE #5:

Contact lens powers over ±8.00 D SPH and/or ±1.5 D CYL are considered custom, and will be charged extra. Medically necessary contact lenses may be considered custom; however, require prior authorization.



NOTE #3:

Any multifocal add of +3.25 or more may be charged a laboratory fee of \$14.00 per lens. SEGS larger than 28mm may be charged a laboratory fee of \$20.00 BF, \$25.00 TF, per pair. Glass lenses may have an additional charge.

NOTE #4:

When purchasing contact lenses you must have a contact lens evaluation in addition to a refraction.