Egyptian Area Schools Employee Benefit Trust Plan Design Summary
High Dental Plan

Annual Deductible Deductible applies to Basic and Major services	$50/ person; $150/ family
Annual Maximum	$1500/ person
To Go[SM] Carryover Feature	Not Included
Enhanced Benefits Program	Your plan provides additional cleanings and/or applications of topical fluoride to people with specific health conditions that put them at risk for oral health disease. The costs of the additional cleanings and fluoride treatments will be applied to your annual maximum.
Lifetime Orthodontic Maximum **Dependent Children to Age 19** **Adults are not eligible for coverage**	$1000/ person

	Delta Dental PPO Network Dentist*	Delta Dental Premier Network Dentist**	Non-Network Dentist***
PREVENTIVE/DIAGNOSTIC SERVICES (no waiting period) • Routine exams (two per benefit year) • Cleanings (two per benefit year) • X-rays (bitewings -2 per benefit year; full mouth-1 per 3 years) • Fluoride treatments (twice per benefit year to age 19)	100%	100%	100%
BASIC SERVICES (no waiting period) • Space maintainers (to age 19) • Sealants (to age 19) • Emergency exams and palliative (pain relief) treatment • Fillings (silver (amalgam) and tooth colored (composite) on front teeth) • Posterior composites (tooth colored fillings on back teeth) • Oral surgery (simple extractions) • Oral surgery (surgical extractions including general anesthesia) • Oral surgery (all other) • Prefabricated stainless steel or resin crowns	80%	80%	80%
MAJOR RESTORATIVE SERVICES (no waiting period) • Non-surgical Periodontic (gum) maintenance • Surgical Periodontic (gum) maintenance • Endodontics (root canals and pulpal therapy) • Repairs and recements to crowns, bridges, inlays and onlays • Crowns, onlays, and other ceramic restorations to permanent teeth • Partial/full dentures • Denture (repair, reline, rebase and adjustments) • Fixed/removable bridges • Implants	50%	50%	50%
ORTHODONTICS (no waiting period) Dependent Children to Age 26; Adults are not eligible for coverage	50%	50%	50%

v. 7/q. 10241

*Delta Dental PPO dentists accept payment based on the lesser of the submitted fee or the PPO fee schedule, which is established at a level that typically delivers a 15 – 40% discount off of average billed charges nationally.

**Delta Dental Premier dentists accept payment based on the lesser of the submitted fee or Delta Dental's maximum plan allowance (MPA), which is established at a level that typically delivers discounts of 25% - 30% off of average billed charges nationally.

***Non-network (non-Delta Dental PPO/non-Delta Dental Premier) dentists are reimbursed at the 90th percentile of "reasonable and customary" charges.

Delta Dental PPO and Premier dentists cannot balance bill the enrollee for the difference between Delta Dental's allowed fee and the dentist's submitted charge.

Monthly Premium Payment	
Employee	$45.14
Employee + 1 Dependent	$93.82
Employee + 2 or more Dependents	$132.44

Rates effective September 1, 2026 - August 31, 2028

DELTA DENTAL

Delta Dental of Illinois

Dental Benefit Highlight Sheet

Egyptian Area Schools Eb Trust, Group #11695

Delta Dental of Illinois is pleased to be your dental benefits carrier. Your group plan offers you the dental benefits program: Delta Dental PPO Plus Delta Dental Premier.

Delta Dental PPO Plus Premier

On the reverse side of this sheet is a summary of your plan coverage*. Please also see the sheet, "How You Can Save with a Delta Dental Network Dentist," which provides an example of your out-of-pockets costs with network dentists and a non-network dentist. With Delta Dental PPO Plus Premier:

- You can go to any licensed general or specialty dentist.
- **You will maximize your benefits by receiving care from a Delta Dental PPO or Delta Dental Premier network dentist.**
- Delta Dental's network dentists have agreed to reduced fees as payment in full, which means you will likely save money by going to a Delta Dental PPO or Delta Dental Premier network dentist. Non-network dentists have not agreed to accept our reduced fees as payment in full, which means they may bill you for any charges over our allowed fees.
- You are charged only the patient's share** at the time of treatment. Delta Dental pays its portion directly to network dentists.

Finding a Dentist

Visit our web site at www.deltadentalil.com and click on Provider Search. Please see the "How to Find a Network Dentist" sheet for more details.

Example of Your Copayment with Delta Dental Network Dentists and Non-Network Dentists

- Delta Dental PPO: Lowest out-of-pocket costs and network protection.
- Delta Dental Premier: Higher out-of-pocket costs than PPO, but may be lower than non-network and network protection.
- Non-network: You may have the highest out-of-pocket costs.

Delta Dental PPO Plus Premier Plan Features

Your Delta Dental PPO Plus Premier plan includes the following features (please see pieces for more information):

- **Enhanced Benefit Program** offers additional coverage for individuals who have specific health conditions (including pregnancy, diabetes, high-risk cardiac conditions, suppressed immune systems, and special needs) that can be positively affected by additional oral health care.

Customer Service

The Member Connection sheet explains how to register on Delta Dental of Illinois' website, www.deltadentalil.com. Once registered, you can **get real time benefit information, check claim status, sign up for electronic Explanation of Benefits and print a temporary ID card.**

Call 1-800-323-1743 to access our automated phone system or speak to a customer service representative from 7 am to 7 pm Monday through Thursday and 7 am to 6 pm Friday, Central Time. Our automated phone system is available 24 hours a day, seven days a week, and offers dentist listings and claim information.

You can also connect with us through our mobile app, Facebook, Twitter, our blog and more. See the enclosed sheets on connecting with us.

Learn More

You can learn more about your Delta Dental of Illinois dental plan by reading the information included in your enrollment kit.

***The information on the reverse side of this sheet is a brief summary of your dental plan and the services it covers. There are some limitations on the expenses for which your dental plan pays If you have specific questions regarding benefit coverage, limitations, exclusions, or non-covered services, please refer to your certificate of coverage/dental benefit booklet or contact Delta Dental of Illinois.

**Patient's share is the coinsurance/copayment, any remaining deductible any amount over the annual maximum and any services your plan does not cover.

Note: Delta Dental imposes no restrictions on the method of diagnosis or treatment by a treating dentist. A benefit determination relates only to the level of payment that your group dental plan is required to make.

PPOPREF

Egyptian Area Schools Employee Benefit Trust Plan Design Summary
Low Dental Plan

Annual Deductible Deductible applies to Basic and Major services	$50/ person; $150/ family
Annual Maximum	$750/ person
To Go[SM] Carryover Feature	Not Included
Enhanced Benefits Program	Your plan provides additional cleanings and/or applications of topical fluoride to people with specific health conditions that put them at risk for oral health disease. The costs of the additional cleanings and fluoride treatments will be applied to your annual maximum.

	Delta Dental PPO Network Dentist*	Delta Dental Premier Network Dentist**	Non-Network Dentist***
PREVENTIVE/DIAGNOSTIC SERVICES (no waiting period) • Routine exams (two per benefit year) • Cleanings (two per benefit year) • X-rays (bitewings -2 per benefit year; full mouth-1 per 3 years) • Fluoride treatments (twice per benefit year to age 19)	80%	80%	80%
BASIC SERVICES (no waiting period) • Space maintainers (to age 19) • Sealants (to age 19) • Emergency exams and palliative (pain relief) treatment • Fillings (silver (amalgam) and tooth colored (composite) on front teeth) • Posterior composites (tooth colored fillings on back teeth) • Non-surgical Periodontic (gum) maintenance • Oral surgery (simple extractions) • Oral surgery (surgical extractions including general anesthesia) • Oral surgery (all other) • Prefabricated stainless steel or resin crowns • Endodontics (root canals and pulpal therapy)	70%	70%	70%
MAJOR RESTORATIVE SERVICES (no waiting period) • Crowns, onlays, and other ceramic restorations to permanent teeth • Partial/full dentures • Denture (repair, reline, rebase and adjustments) • Fixed/removable bridges • Implants	0%	0%	0%
ORTHODONTICS (no waiting period)	Not Included	Not Included	Not Included

v. 5/q. 10145

*Delta Dental PPO dentists accept payment based on the lesser of the submitted fee or the PPO fee schedule, which is established at a level that typically delivers a 15 – 40% discount off of average billed charges nationally.

**Delta Dental Premier dentists accept payment based on the lesser of the submitted fee or Delta Dental's maximum plan allowance (MPA), which is established at a level that typically delivers discounts of 25% - 30% off of average billed charges nationally.

***Non-network (non-Delta Dental PPO/non-Delta Dental Premier) dentists are reimbursed at the 90th percentile of "reasonable and customary" charges.

Delta Dental PPO and Premier dentists cannot balance bill the enrollee for the difference between Delta Dental's allowed fee and the dentist's submitted charge.

Monthly Premium Payment	
Employee	$19.64
Employee + 1 Dependent	$39.12
Employee + 2 or more Dependents	$74.44

Rates Effective September 1, 2026 - August 31, 2028

DELTA DENTAL

Delta Dental of Illinois

DeltaVision® Benefit Highlight Insight Network

See premiums on the back.

Egyptian Area Schools EB Trust

DeltaVision® is provided by ProTec Insurance Company, a wholly-owned subsidiary of Delta Dental of Illinois, in association with EyeMed Vision Care networks. DeltaVision offers members vision care benefits that combine choice, value and wellness. Your DeltaVision program provides vision care insurance to you (and your family, if applicable) according to the following information.

Vision Care Services	Insight Network Member Cost (Complete)	Out-of-Network Allowance
Exam with Dilation as Necessary:	$10 Copay	$35
Contact Lens Fit & Follow-up: (Available once a comprehensive eye exam has been completed)		
Standard*	Member pays up to $40 for fit and two follow-up visits	$0
Premium**	10% off retail price	$0
Frames: (Any available frame at provider location)	$130 allowance, 20% off balance over allowance	$65
Standard Plastic Lenses:		
Single Vision	$10 Copay	$25
Bifocal	$10 Copay	$40
Trifocal	$10 Copay	$55
Lens Options:		
UV Coating	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Scratch-Resistance	$15	N/A
Standard Polycarbonate	$40	N/A
Standard Progressive (in addition to to Bifocal copay)	$65	$40
Premium Progressive – (in addition to Bifocal copay)	Tier 1 - $95, Tier 2 - $105, Tier 3- $120, Tier 4 - $75, 80% of retail, less $120 allowance	$40
Standard Anti-Reflective Coating	$45	N/A
Premium Anti –Reflective Coating	Tier 1 - $57, Tier 2 - $68, Tier 3 – 80% of charge	N/A
Photocromatic/Transition Plastic	$75	N/A
Polarized	80% of charge	N/A
Other Add-Ons and Services	20% discount off retail price	N/A
Contact Lenses: (Contact lens allowance covers materials only)		
Conventional	$0 Copay, $130 allowance, 15% off balance over $130	$104
Disposable	$0 Copay, $130 allowance, plus balance over $130	$104
Visually Required	$0 Copay, Paid-in-Full	$200
Frequency:		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frames	Once every 24 months	

*Standard Contact Lens Fitting - spherical clear contact lenses in conventional wear and planned replacement (Examples include, but are not limited to, disposable and frequent replacement)

**Premium Contact Lens Fitting - all lens designs, materials and specialty fittings, other than Standard Contact Lenses (Examples include toric and multifocal)

Additional Discounts

Member will receive a 20% discount at in-network providers on items not covered by the program. This discount may not be combined with any other discounts or promotional offers and the discount does not apply to contact lenses or an in-network provider's professional services. Retail prices may vary by location.

Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses at in-network providers 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 deltadentalil.com/deltavision. The contact lens benefit allowance is not applicable to this service.

LASIK or PRK: DeltaVision enrollees can receive a discount of 15% off retail price or 5% off promotional price from select providers. Please contact us at www.deltadentalil.com/deltavision or 866-723-0513 for a current list of LASIK/PRK providers.

Network Information

You may choose to go to any licensed optometrist, ophthalmologist and/or dispensing optician whenever you need vision care. However, there may be significant cost advantages when you receive treatment from an in-network provider.

We offer two easy ways to locate an in-network provider 7 days a week, 24 hours a day. You can either:

- search our online Provider directory at www.deltadentalil.com/deltavision; or
- use the automated phone system by calling 1-866-723-0513

Using Your Vision Program

1. Have your DeltaVision information card available when scheduling and visiting an in-network provider. An in-network provider is one who participates in the EyeMed Vision Care Provider network. It's very important that you know which network your benefit plan utilizes (your plan uses the **Insight** network). You will only receive in-network benefits from Insight network providers. Please note: the network provider will need the primary enrollee's name and date of birth to verify eligibility.

2. Pay your copayment and any other charges not covered at the time of service. No paperwork is required. You continue to save on additional eyewear purchases any time you present your card to an in-network provider.

3.If you select a provider who is not in the network, you do not receive preferred pricing and you may be asked to provide full payment to your out-of-network provider at the time of service. To receive benefit reimbursement, submit a completed claim form (available on our website), along with itemized receipts from your provider and your prescription to:

DeltaVision Claims Processing
c/o EyeMed Vision Care
P.O. Box 8504
Mason, OH 45040-7111

DeltaVision® is provided by ProTec Insurance Company, a wholly-owned subsidiary of Delta Dental of Illinois, in association with EyeMed Vision Care networks.

Exclusions

In no event will coverage exceed the lesser of:
1. the actual cost of Covered Services or Materials or
2. the limits of the Policy, shown in the Schedule.

Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next benefit period.

Benefits may not be combined with any discount, promotional offering or other group benefit programs.

Benefit allowances provide no remaining balance for future use within the same benefit period.

There is no coverage for professional services or materials connected with:

1. Orthoptic or vision training, sub-normal vision aids and any associated supplemental testing;
2. Aniseikonic lenses;
3. Medical and/or surgical treatment of the eye, eyes or supporting structures;
4. Corrective eyewear required by an employer as a condition of employment and safety eyewear unless specifically covered under this program;
5. Services provided as a result of any Workers' Compensation law;
6. Plano lenses (lenses that have no refractive power), non-prescription lenses and non-prescription sunglasses (except for 20% discount);
7. Two pair of glasses in lieu of bifocals.

*The preceding information is a brief summary of **Egyptian Area Schools Eb Trust** Complete Vision Program and the services it covers.*

If you have specific questions regarding benefit coverage, limitations or exclusions, contact our customer service department at 1-866-723-0513.

DELTA DENTAL

Delta Dental of Illinois
111 Shuman Blvd
Naperville, IL 60563
800-335-8215
www.deltadentalil.com/deltavision

Monthly Premium Payment	
Employee	$ 5.48
Employee + 1 Dependent	$10.74
Employee + 2 or more Dependents	$16.08

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