DADE ASSOCIATION OF SCHOOL ADMINISTRATORS

SUNSHINE UNITED
INSURANCE SOLUTIONS

Member Benefits Guide

Dental

Because maintaining your smile is important, DASA offers dental coverage through Solstice. DASA member, you have the option of enrolling in one of the following plans: Standard DHMO, High DHMO, Standard PPO & High PPO.

Dental Plan Features: DHMO		
	Standard - S700B Access+	**High - S200B Access+**
Deductibles		
Calendar Year Deductible	Individual: None	Individual: None
	Family: None	Family: None
Calendar Year Annual Maximum	None	None
Lifetime Orthodontia Maximum	N/A	N/A
Services		
Routine Exam(s)	No charge (1 per consecutive 6 months)	No charge (1 per consecutive 6 months)
Cleaning(s)	No charge (1 per consecutive 6 months)	No charge (1 per consecutive 6 months)
Flouride Treatment	$15	$5
Orthodontic Treatment (Adult)	$2,350	$1,950
Orthodontic Treatment (Child)	$2,250	$1,850
Periodontics	$175	$175
Endodontics, Root Canal	$245	$210
Crowns & Bridges	$245	$195
Denture (Complete Upper)	$325	$210

The Summary of Benefits is for informational purposes only and is not an offer of coverage. Please note that the above tableprovides only a brief, general description of coverage and does not constitute a contract.

Dental Plan Features: Standard PPO - Plan 11430		
Calendar Year Deductible	Individual: $50	Individual: $50
	Family: $150	Family: $150
Deductible applies to Class II & III.		
Calendar Year Annual Maximum	$1500	$1500
Lifetime Orthodontia Maximum	$1,000 per person	$1,000 per person
	In-Network (Plan Pays)	**Non-Network(Plan Pays)**
Class I (Diagnostic & Preventive A)		
• Examination • Flouride Treatment for Children • X-rays (Full & Panorex 1 per 36 months) • Bitewing (1 per year) • Routine cleaning (3 x 12 months) • Sealants (1 per 36 months to age 16)	100% MAC	100% MAC
Class II (Basic/Restorative B)		
• Simple Restorations (fillings) • Routine/Simple Extractions • Non-Surgical Periodontics • General Anesthesia	90% of MAC	80% of MAC
Class III (Major C)		
• Endodontics • Surgical Periodontics • Oral Surgery • Extraction - erupted tooth • Inlays/onlays • Dentures • Crown & Bridge • Anesthesia	60% of MAC	50% of MAC
Class IV (Orthodontia D)	50% of MAC	50% of MAC

Dental Plan Features: High PPO - Plan 11429		
Calendar Year Deductible	Individual: $25	Individual: $25
	Family: $75	Family: $75
Deductible applies to Class II & III.		
Calendar Year Annual Maximum	Unlimited per person	Unlimited per person
Lifetime Orthodontia Maximum	$1,500 per person	$1,500 per person
	In-Network (Plan Pays)	**Non-Network (Plan Pays)**
Class I (Diagnostic & Preventive A)		
• Examination • Flouride Treatment for Children • X-rays (Full & Panorex 1 per 36 months) • Bitewing (1 per year) • Routine cleaning (3 x 12 months) • Sealants (1 per 36 months to age 16)	100% MAC	100% MAC
Class II (Basic/Restorative B)		
• Simple Restorations (fillings) • Routine/Simple Extractions • Non-Surgical Periodontics • General Anesthesia	90% of MAC	90% of MAC
Class III (Major C)		
• Endodontics • Surgical Periodontics • Oral Surgery • Extraction - erupted tooth • Inlays/onlays • Dentures • Crown & Bridge • Anesthesia	60% of MAC	60% of MAC
Class IV (Orthodontia D)	50% Adult & children to age 26	

Vision

We are proud to offer vision coverage through Solstice.

Solstice Vision Plan Features		
In-Network Benefits	**Member Co-Payment**	**Frequency**
Eye Exam	$4	One exam every 12 months
Single Lenses	$10	One standard pair (plastic or clear glass)every 12 months 12 Months
Bifocal Lenses	$10	
Trifocal Lenses	$10	
Lens Options *(tint, UV, anti-scratch coat, anti-reflective, progressive, polycarbonate, hi-index, photogray transitions, polaroid)*	20% Discount	None
Frames*	$79.00 Retail allowance after $10 co-payment	Frames every 12 months
Contact Lenses**	$85 allowance	Contact lenses every 12 months
Medically Necessary Contact Lenses	Paid in Full	

*Once a year benefit for either frames or contacts
**Allowance is for exam, fitting, evaluation, follow-up care and materials.

Please refer to your plan summaries for full benefit details.

VSP Vision

The VSP Advantage Plan is a basic full-service plan that offers choice, flexibility, and value through a VSP Advantage Network Provider.

50% OFF additional pairs of prescription glasses at all Visionworks® locations

Standard progressives **covered-in-full**

An **extra $20** to spend on featured frame brands or on any frame at Visionworks*

Benefits through a VSP Network Provider

Exam Services

- Comprehensive WellVision Exam® covered in full*
- Routine retinal screening covered after a no more than $39 copay

Lenses

- Glass or plastic single vision, lined bifocal, lined trifocal, or lenticular lenses arecovered in full*

Lens Enhancements

- Most popular lens enhancements are covered after a copay, saving our members an average of 20-25%

Lens Enhancement	***Single Vision***		***Multifocal***
Anti-reflective coating	$41		$41
Polycarbonate - Adult	$35		$35
Polycarbonate - Children	Covered	Covered	
Standard Progressive Tints	N/A	Covered	
Scratch-resistant coating	Covered	Covered	
	Covered	Covered	

Prices above reflect standard lens enhancement selections; premium or custom lens enhancements may also be available at an additional cost

Frame

- Frames covered in full* up to the retail allowance of **$180**
- Featured frame brands, including bebe, Calvin Klein, Cole Haan, Dragon, Flexon, Longchamp, Nike, and more are covered up to the enhanced featured frame allowance of **$200.**

  Featured frame brands subject to change
- 20% off any amount above the retail allowance
- Members can choose from all frames available on the market today

Additional Pairs of Glasses	• Within 12 months of exam: 20% off unlimited additional pairs of prescription glasses and/or non-prescription sunglasses from any VSP doctor
Elective Contact Lenses	• **Contact lens exam (fitting and evaluation):** Standard and Premium fits are covered infull after copay. Member receives 15% off of contact lens exam services and member's copay will never exceed **$60** • Prescription contact lens materials are covered in full up to the retail allowance of **$180** (inlieu of frame & lenses) • Members can choose from any available prescription contact lens materials
Essential Medical Eye Care	• Supplemental medical coverage for specialty eyecare services and conditions, such aspink eye, and other urgent eyecare needs • $20 exam copay
VSP Laser VisionCare℠ Program	• Discounts average 15-20% off or 5% off a promotional offer for laser surgery, including PRK, Custom PRK, LASIK, Custom LASIK, SMILE, and Contoura *Discounts are only available from VSP-contracted facilities. Also custom LASIK coverage only available using wavefronttechnology, other LASIK procedures may be performed at an additional cost to the member*

Out-of-Network Schedule

We offer a generous reimbursement schedule for services from other providers

Exam	$ 40
Lenses:	
Single vision	$ 30
Lined bifocal	$ 50
Lined trifocal	$ 60
Lenticular	$ 75
Frame	$ 50
Elective contact lenses	$100
(in lieu of lenses and frame) Medically Necessary	$210