DeltaVision®

SUMMARY OF COVERED SERVICES AND BENEFITS

MATERIALS ONLY / $130 Frame Allowance / $10 Copay – Insight Network

Benefit Frequency		
Contact Lenses or Lens	Once per calendar year.	
Frame	Once per every two calendar years.	
Vision Care Services	**In-Network Member Cost**	**Out-of-Network Reimbursement**
Lens		
Single Vision	$10 Copay	Up to $25
Bi-focal	$10 Copay	Up to $40
Tri-focal	$10 Copay	Up to $55
Standard Progressive Lens	$75	Up to $40
Premium Progressive Lens		Up to $40
Tier 1	$95	N/A
Tier 2	$105	N/A
Tier 3	$120	N/A
Tier 4	80% of Charge less $120, plus $75 Copay	N/A
Lenticular	$10 Copay	Up to $55
Other Lens Type	80% of Charge	N/A
Frame		
Frame	80% of Balance over $130	Up to $65
Lens Options		
Standard Polycarbonate	$40 Copay	N/A
Standard Plastic Scratch Coating	$15 Copay	N/A
Tint	$15 Copay	N/A
UV Treatment	$15 Copay	N/A
Standard Anti-reflective (a/r) Coating	$45 Copay	N/A
Premium Anti-reflective Coating		
Tier 1	$57	N/A
Tier 2	$68	N/A
Tier 3	80% of Retail	N/A
Photochromatic/Transitions	$75	N/A
Other Lens Options	80% of Charge	N/A
Contact Lenses		
Contact Lens — Conventional	85% of Balance over $130	Up to $104
Contact Lens — Disposable	Balance over $130	Up to $104
Medically Necessary Contacts	$0	Up to $200
Non-Scheduled Items		
Doctor Misc. Materials	80% of Charge	N/A
LASIK or PRK Vision Correction	85% of Retail Price or 95% of Promotional Price	N/A

Additional Discounts: Member receives a 20% discount on items not covered by the plan at network Providers, which cannot be combined with any other discounts or promotional offers. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Members also receive 15% off retail price or 5% off promotional price for LASIK or PRK from the US Laser Network, owned and operated by LCA Vision. 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.eyemedvisioncare.com. The contact lens benefit allowance is not applicable to this service.

Plan Exclusions: 1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures; 3) Any eye or Vision Examination, or any corrective eyewear required by an employer as a condition of employment; Safety eyewear; 4) Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; 5) Plano (non-prescription) lenses and/or contact lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals; 8) Services or materials provided by any other group benefit plan providing vision care; 9) Services rendered after the date a member ceases to be covered under the Benefit Certificate, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the member are within 31 days from the date of such order. 10) Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available. 11) Benefit Allowances provide no remaining balance for future use within the same Benefit Frequency. Certain brand name Vision Materials in which the manufacturer imposes a no-discount practice.

DeltaVision is underwritten by Veratrus Benefit Solutions, Inc., a wholly-owned subsidiary of Delta Dental of Iowa, utilizing the EyeMed Vision Care Insight network. The information on this page summarizes your benefits and payment obligations. For a detailed description of specific benefits and benefit limitations, see the IMPORTANT INFORMATION and BENEFITS sections of your Certificate.