### VISION

Smart benefits.

Clear value.

How important is a vision benefit to your employees? When you consider that two-thirds of them would likely **trade a vacation** day for vision coverage<sup>1</sup>, it's no wonder that offering an eyecare plan is a great way to recruit and retain staff.

DeltaVision provides vision coverage to more than 170,000 members.<sup>2</sup> Here's how we can make eyecare coverage easy for you:

### **SIMPLE**

Coverage is accepted at 154,000+ providers nationwide<sup>3</sup>, including a choice of independent and retail providers.

### **CUSTOMIZABLE**

Choose your:

- Lens copay (\$10 or \$25)
- Frame allowance (\$130, \$150 or \$200)
- Funded or Discounted Fit & Follow-Up Contact Exams
- Or choose to offer a Materials Only plan (\$130, \$150 or \$200 frame allowance)

### **TRUSTED**

We support more than 2,100<sup>4</sup> employers like you with a dedicated, experienced team that manages every part of your program.





# One & Sun™ Plan with **FREE** sunglasses

With our One & Sun Plan, your employees and their covered spouses can score a FREE pair of designer sunglasses ... simply for having a routine eye exam! To learn more about the One & Sun Plan, contact your broker or Delta Dental.

### FOR MORE INFORMATION

Contact your broker | Call 877-423-3582 | Visit deltadentalia.com/deltavision

# Plan options

Insight In-Network	\$10 Lens Copay	\$25 Lens Copay	Materials Only			
Benefit Frequency	Once every calendar year (frames are once every two calendar years)					
Vision Exam	\$10 copay	\$10 copay	N/A			
Standard Contact Lens Fit & Follow-Up Exam Funded Discounted	\$0 copay \$0 copay Up to \$40 Up to \$40		N/A			
Frames (once every two calendar years)	Choice of allowance: \$130/\$150/\$200 20% discount off the balance	Choice of allowance: \$130/\$150/\$200 20% discount off the balance	Choice of allowance: \$130/\$150/\$200 20% discount off the balance			
Standard Plastic Lens Single Vision, Standard Bifocal, Standard Trifocal and Standard Lenticular	\$10 copay	\$25 copay	\$10 copay			
Standard Progressive Lens	\$75 copay	\$90 copay	\$75 copay			
Premium Progressive Lens	Copay for Tiers 1/2/3: \$95/\$105/\$120 Tier 4: \$75 copay, plus 80% of charge less \$120	Copay for Tiers 1/2/3: \$110/\$120/\$135 Tier 4: \$90 copay, plus 80% of charge less \$120	Copay for Tiers 1/2/3: \$95/\$105/\$120 Tier 4: \$75 copay, plus 80% of charge less \$120			
Lens Option Standard Progressive, Tint, UV Coating, Standard Polycarbonate	Various copayments	s per lens option — approximately equivale	nt to a 20% discount			

Copay for Tiers 1/2: \$57/\$68 Copay for Tiers 1/2: \$57/\$68 Copay for Tiers 1/2: \$57/\$68 Premium Anti-Reflective Coating Tier 3: 80% of retail Tier 3: 80% of retail Tier 3: 80% of retail Contact Lenses Choice of Allowance: \$130/\$150/\$200 Choice of Allowance: \$130/\$150/\$200 Choice of Allowance: \$130/\$150/\$200 Conventional 15% discount off the balance 15% discount off the balance 15% discount off the balance Disposable Balance over \$130/\$150/\$200 Balance over \$130/\$150/\$200 Balance over \$130/\$150/\$200

Paid in full

Medically Necessary Lasik and PRK Benefit

15% off retail price or 5% off promotional price

## **Voluntary Vision Plan Rates**

		\$10 Lens Copay			\$25 Lens Copay		Ma	aterials O	nly
Frame Allowance	\$130	\$150	\$200	\$130	\$150	\$200	\$130	\$150	\$200
Fit & Follow-Up	Discounted / Funded								
Single	\$7.90 / \$8.62	\$8.30 / \$9.26	\$9.38 / \$10.30	\$7.10 / \$7.80	\$7.44 / \$8.16	\$8.64 / \$9.40	\$6.10	\$6.48	\$7.64
Employee/Spouse	\$15.00 / \$16.38	\$15.80 / \$17.66	\$17.86 / \$19.62	\$13.54 / \$14.78	\$14.18 / \$15.52	\$16.42 / \$17.92	\$11.50	\$12.26	\$14.40
Employee/Child(ren)	\$17.02 / \$18.48	\$17.92 / \$19.98	\$20.24 / \$22.24	\$15.34 / \$16.76	\$16.06 / \$17.58	\$18.58 / \$20.32	\$13.08	\$13.90	\$16.34
Family	\$22.44 / \$24.42	\$23.68 / \$26.38	\$26.70 / \$29.34	\$20.26 / \$22.14	\$21.20 / \$23.24	\$24.54 / \$26.84	\$17.20	\$18.28	\$21.52

### **Contributory Vision Plan Rates**

		\$10 Lens Copay			\$25 Lens Copay		Ma	aterials Or	ıly
Frame Allowance	\$130	\$150	\$200	\$130	\$150	\$200	\$130	\$150	\$200
Fit & Follow-Up	Discounted / Funded								
Single	\$6.02 / \$6.58	\$6.32 / \$7.08	\$7.16 / \$7.88	\$5.42 / \$5.94	\$5.70 / \$6.22	\$6.60 / \$7.18	\$4.68	\$4.96	\$5.84
Employee/Spouse	\$11.44 / \$12.48	\$12.08 / \$13.46	\$13.64 / \$14.98	\$10.32 / \$11.28	\$10.82 / \$11.86	\$12.54 / \$13.68	\$8.80	\$9.34	\$11.00
Employee/Child(ren)	\$12.98 / \$14.12	\$13.68 / \$15.26	\$15.44 / \$16.98	\$11.70 / \$12.80	\$12.26 / \$13.42	\$14.20 / \$15.50	\$9.98	\$10.60	\$12.46
Family	\$17.14 / \$18.66	\$18.08 / \$20.14	\$20.38 / \$22.40	\$15.46 / \$16.88	\$16.18 / \$17.74	\$18.74 / \$20.48	\$13.14	\$13.96	\$16.42

### One & Sun Vision Plan

	Voluntary	Contributory
Single	\$11.42	\$9.46
Employee/Spouse	\$21.22	\$17.48
Employee/Child(ren)	\$21.04	\$16.80
Family	\$29.10	\$23.48

# FOR MORE INFORMATION

Contact your broker | Call 877-423-3582 | Visit deltadentalia.com/deltavision

These monthly rates are effective January 1, 2026 through December 31, 2026, and are subject to lowa Insurance Division approval. For new groups, rates are good for 24 months from initial enrollment as long as your plan does not change. Contributory plans require employers with 50 or less employees to contribute any amount towards premiums and employers with 51+ employees to have 50 percent participation. For complete details of the coverage, including exclusions, limitations, and out-of-network coverage, call 877-423-3582 or go to deltadentalia.com.

Veratrus Benefit Solutions, Inc. underwrites DeltaVision using the EyeMed Vision Care Insight Network. Veratrus is a wholly owned subsidiary of Delta Dental of Iowa.



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