VISION CARE SERVICES	In-Network Member Cost	Out-of-Network Allowance
Benefit Frequency		
Contact Lenses or Lens Exam	Once every 12 months from last date of service.	
Frame	Once every 24 months from last date of service.	
Exam	$10 copay	Up to $35
Dilation, Eye Exam Refraction	$0	N/A
Frames	80% of Balance over $130	Up to $65
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 Copay	Up to $40
Premium Progressive Lens	$75 copay, 80% of charge less $120	Up to $40
Lenticular	$10 Copay	Up to $55
Other Lens Type	80% of Charge	N/A
Lens Options		
Standard Polycarbonate	$40 Copay	N/A
Standard Plastic Scratch Coating	$15 Copay	N/A
Tint (Solid and Gradient)	$15 Copay	N/A
UV Treatment	$15 Copay	N/A
Standard Anti-reflective (a/r) Coating	$45 Copay	N/A
Other Lens Options	80% of Charge	N/A
Contact Lenses		
Conventional	85% of Balance over $130	Up to $104
Disposable	Balance over $130	Up to $104
Medically Necessary	$0 Copay	Up to $200
Contact Lens Fit & Follow-up Exam		
Standard	$0 Copay	Up to $40
Premium	$0 Copay, 10% off Retail Price then apply $55 Allowance	Up to $40
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

Monthly Rates

Single	$9.40
Employee / Child(ren)	$17.18
Family	$23.92

DeltaVision is underwritten by Veratrus Benefit Solutions, Inc., a wholly-owned subsidiary of Delta Dental of Iowa, utilizing the EyeMed Vision Care Access network. The information on this page summarizes your benefits and payment obligations.

2598-F10213 01/2021