DeltaVision®

MEREDITH CORP. CONSOLIDATED HEALTH AND WELFARE PLAN

SUMMARY OF COVERED SERVICES AND BENEFITS

$10 LENS COPAY $180 FRAME ALLOWANCE – Insight Network

Benefit Frequency

Contact Lenses or Lens	Once every calendar year.
Exam	Once every calendar year.
Frame	Once every calendar year.

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam		
Exam	$10 Copay	$35
Fundus Photograph Benefit	Up to $39	
Eye Exam Refraction	$0	
Lens		
Single Vision	$10 Copay	$25
Bi-focal	$10 Copay	$40
Tri-focal	$10 Copay	$55
Standard Progressive Lens	$75 Copay	$40
Premium Progressive Lens	Premium Progressive as follows:	$40
Tier 1	$95	
Tier 2	$105	
Tier 3	$120	
Tier 4	80% of Charge less $120, plus $75 Copay	
Lenticular	$10 Copay	$55
Other Lens Type	80% of Charge	
Frame		
Frame	80% of Balance over $180	$90
Lens Options		
Standard Polycarbonate - *Adults*	$40 Copay	$5
Standard Polycarbonate - *Minors under 19*	$0 Copay	
Standard Plastic Scratch Coating	$15 Copay	
Tint	$15 Copay	
UV Treatment	$15 Copay	
Standard Anti-reflective (a/r) Coating	$45 Copay	
Premium Anti-reflective (a/r) Coating	Premium Anti-reflective Coating as follows:	
Tier 1	$57	
Tier 2	$68	
Tier 3	80% of Charge	
Photochromatic/Transitions	$75	
Other Lens Options	80% of Charge	
Contact Lenses		
Contact Lens — Conventional	85% of Balance over $180	$126
Contact Lens — Disposable	Balance over $180	$126
Standard Fit And Follow Up Exam	$0 Copay, paid in full fit and 2 follow up visits	$40
Premium Fit And Follow Up Exam	$0 Copay, 10% off retail price then apply $40 allowance	$40
Medically Necessary Contacts	$0	$210

Delta Dental of Iowa
deltadentalia.com/ deltavision
877-423-3582

DELTA DENTAL®

Non-Scheduled Items Doctor Misc. Materials	80% of Charge	
LASIK or PRK Vision Correction	85% of Retail Price or 95% of Promotional Price	
Second Pair Discount	40% discount off complete pair of eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used	

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.