DELTA DENTAL®

DeltaVision® Voluntary Plans

Access Network Vision Plans for Delta Dental of Iowa

In-Network	DeltaVision Enhanced	DeltaVision Preferred	DeltaVision Standard	Materials Only
Vision Exam (every 12 months)	$10 copay	$10 copay	$10 copay	N/A
Contact Lens Fit & Follow-up Exam	$0 copay	$0 copay	$0 copay	N/A
Frames (every 24 months)	$150 allowance; 20% discount off the balance	$130 allowance; 20% discount off the balance	$100 allowance; 20% discount off the balance	$130 allowance; 20% discount off the balance
Lens (every 12 months) Standard Plastic Lens Single Vision, Standard Bifocal, Standard Trifocal and Standard Lenticular	Choice of $10 or $25 copay	Choice of $10 or $25 copay	Choice of $10 or $25 copay	$10 copay
Standard Progressive Lens	$75 or $90 copay	$75 or $90 copay	$75 or $90 copay	$75
Premium Progressive Lens	$75 or $90 copay, plus 80% of charge less $120	$75 or $90 copay, plus 80% of charge less $120	$75 or $90 copay, plus 80% of charge less $120	$75 copay, plus 80% of charge less $120
Lens Option Standard Progressive, Tint, UV Coating, Standard Polycarbonate	Various copayments per lens option – approximately equivalent to a 20% discount			
Premium Anti-Reflective Coating	80% of charge	80% of charge	80% of charge	80% of charge
Contact Lenses (every 12 months) Conventional	$150 allowance; 15% discount off the balance	$130 allowance; 15% discount off the balance	$100 allowance; 15% discount off the balance	$130 allowance; 15% discount off the balance
Disposable	$150 allowance	$130 allowance	$100 allowance	$130 allowance
Medically Necessary	Paid in full	Paid in full	Paid in full	Paid in full
Lasik and PRK Benefit	15% off retail price or 5% off promotional price			

Voluntary Monthly Rates*	DeltaVision Enhanced		DeltaVision Preferred		DeltaVision Standard		Materials Only
Lens Copay	$10	$25	$10	$25	$10	$25	$10
Four-Tier Single	$9.76	$9.00	$9.04	$8.30	$7.98	$7.24	$5.90
Employee/Spouse	$18.50	$17.08	$17.18	$15.78	$15.14	$13.78	$11.22
Employee/Child(ren)	$20.94	$19.32	$19.44	$17.84	$17.14	$15.60	$12.70
Family	$27.66	$25.54	$25.68	$23.56	$22.62	$20.60	$16.78
Three-Tier Single	$9.76	$9.00	$9.04	$8.30	$7.98	$7.24	$5.90
Two Person	$18.50	$17.08	$17.18	$15.78	$15.14	$13.78	$11.22
Family	$27.26	$25.16	$25.32	$23.22	$22.32	$20.30	$16.52
Two-Tier Single	$9.76	$9.00	$9.04	$8.30	$7.98	$7.24	$5.90
Family	$24.84	$22.92	$23.04	$21.16	$20.32	$18.48	$15.06

*Four-tier rates are not available for groups with less than ten eligible employees. Rates are effective until December 31, 2019. Voluntary plans are subject to underwriting guidelines. Please see plan for details. DeltaVision is underwritten by Veratrus Benefit Solutions, Inc., a wholly owned subsidiary of Delta Dental of Iowa, utilizing the EyeMed Vision Care Access network.

DELTA DENTAL®

DeltaVision® Contributory Plans

Access Network Vision Plans for Delta Dental of Iowa

In-Network	DeltaVision Enhanced	DeltaVision Preferred	DeltaVision Standard	Materials Only
Vision Exam (every 12 months)	$10 copay	$10 copay	$10 copay	N/A
Contact Lens Fit & Follow-up Exam	$0 copay	$0 copay	$0 copay	N/A
Frames (every 24 months)	$150 allowance; 20% discount off the balance	$130 allowance; 20% discount off the balance	$100 allowance; 20% discount off the balance	$130 allowance; 20% discount off the balance
Lens (every 12 months) Standard Plastic Lens Single Vision, Standard Bifocal, Standard Trifocal and Standard Lenticular	Choice of $10 or $25 copay	Choice of $10 or $25 copay	Choice of $10 or $25 copay	$10 copay
Standard Progressive Lens	$75 or $90 copay	$75 or $90 copay	$75 or $90 copay	$75
Premium Progressive Lens	$75 or $90 copay, plus 80% of charge less $120	$75 or $90 copay, plus 80% of charge less $120	$75 or $90 copay, plus 80% of charge less $120	$75 copay, plus 80% of charge less $120
Lens Option Standard Progressive, Tint, UV Coating, Standard Polycarbonate	Various copayments per lens option – approximately equivalent to a 20% discount			
Premium Anti-Reflective Coating	80% of charge	80% of charge	80% of charge	80% of charge
Contact Lenses (every 12 months) Conventional	$150 allowance; 15% discount off the balance	$130 allowance; 15% discount off the balance	$100 allowance; 15% discount off the balance	$130 allowance; 15% discount off the balance
Disposable	$150 allowance	$130 allowance	$100 allowance	$130 allowance
Medically Necessary	Paid in full	Paid in full	Paid in full	Paid in full
Lasik and PRK Benefit	15% off retail price or 5% off promotional price			

Contributory Monthly Rates*	DeltaVision Enhanced		DeltaVision Preferred		DeltaVision Standard		Materials Only
Lens Copay	$10	$25	$10	$25	$10	$25	$10
Four-Tier Single	$7.24	$6.64	$6.72	$6.12	$5.94	$5.34	$4.42
Employee/Spouse	$13.78	$12.58	$12.78	$11.64	$11.28	$10.16	$8.34
Employee/Child(ren)	$15.60	$14.22	$14.42	$13.16	$12.78	$11.50	$9.46
Family	$20.60	$18.80	$19.08	$17.38	$16.88	$15.20	$12.46
Three-Tier Single	$7.24	$6.64	$6.72	$6.12	$5.94	$5.34	$4.42
Two Person	$13.78	$12.58	$12.78	$11.64	$11.28	$10.16	$8.34
Family	$20.30	$18.52	$18.80	$17.12	$16.62	$14.98	$12.28
Two-Tier Single	$7.24	$6.64	$6.72	$6.12	$5.94	$5.34	$4.42
Family	$18.48	$16.88	$17.12	$15.60	$15.14	$13.66	$11.20

*Four-tier rates are not available for groups with less than ten eligible employees. Rates are effective until December 31, 2019. Contributory plans are subject to underwriting guidelines and require 50 percent participation. Please see plan for details. DeltaVision is underwritten by Veratrus Benefit Solutions, Inc., a wholly owned subsidiary of Delta Dental of Iowa, utilizing the EyeMed Vision Care Access network.