DeltaVision Plan Summary

DeltaVision®

	Network Benefit
Exam – comprehensive, with dilation as necessary (Comprehensive Spectacle Exam)	Member pays copay; plan pays balance
Contact Lens Fit and Follow-up: Standard Lenses	Member pays up to $55
Contact Lens Fit and Follow-up: Premium Lenses	10% off the retail price
Frames – Any available frame at provider location.	Plan pays frame allowance amount, then 20% off balance
Standard Plastic Lenses	
Single Vision	Member pays copay; plan pays balance
Bifocal	Member pays copay; plan pays balance
Trifocal	Member pays copay; plan pays balance
Lens Options	
UV Coating / Tint / Standard scratch resistance	Member pays $15 for each
Standard polycarbonate	Member pays $40
Standard anti-reflective coating	Member pays $45
Standard progressive (add-on to bifocal)	Member pays $65
Other add-ons and services	20% off retail price
Contact Lenses – In lieu of spectacle lenses (contact lens allowance covers materials only)	
Conventional	Plan pays contact lens allowance amount, then 15% off balance
Disposable	Plan pays contact lens allowance, member pays balance
Medically Necessary	Paid in full
Laser Vision Correction – Lasik or PRK For a location near you, and the discount authorization, please call 1-877-5LASER6.	15% off retail price or 5% off promotional price

Non-Network Reimbursement

Exam	Up to $35
Single Vision Lens	Up to $25
Lined Bifocal	Up to $40
Lined Trifocal	Up to $55
Frame*	Up to $75
Contacts*	Up to $120

*Varies depending upon your In-Network Allowance.

Vision Benefits*	$130 Plans			$150 Plans		
Allowances:						
Frames	$ 130			$ 150		
Contacts	$ 130			$ 150		
Frequency (in months)						
Examination	12			12		
Lenses or Contact Lenses	12			12		
Frame	24			24		
Copayments:						
Exams	$ 10	$ 10	$ 20	$ 10	$ 10	$ 20
Lenses	$ 10	$ 25	$ 20	$ 10	$ 25	$ 20
	VOLUNTARY - Employer contributes 0% – 49% of total premium					
3-Tier - Monthly Rates						
Employee Only	$ 7.67	$ 6.97	$ 6.56	$ 8.81	$ 8.04	$ 7.62
Employee + One Dependent	$ 13.16	$ 11.97	$ 11.25	$ 15.11	$ 13.79	$ 13.07
Family	$ 23.55	$ 21.41	$ 20.13	$ 27.03	$ 24.68	$ 23.39
4-Tier - Monthly Rates						
Employee Only	$ 7.67	$ 6.97	$ 6.56	$ 8.81	$ 8.04	$ 7.62
Employee & Spouse	$ 14.98	$ 13.62	$ 12.80	$ 17.19	$ 15.69	$ 14.88
Employee & Child(ren)	$ 14.53	$ 13.21	$ 12.41	$ 16.67	$ 15.22	$ 14.43
Family	$ 22.70	$ 20.63	$ 19.40	$ 26.05	$ 23.78	$ 22.54
	NON-VOLUNTARY - Employer contributes 50% – 100% of total premium					
3-Tier - Monthly Rates						
Employee Only	$ 5.04	$ 4.50	$ 4.24	$ 6.42	$ 5.75	$ 5.48
Employee + One Dependent	$ 8.65	$ 7.72	$ 7.27	$ 11.01	$ 9.87	$ 9.39
Family	$ 15.47	$ 13.81	$ 13.01	$ 19.70	$ 17.66	$ 16.81
4-Tier - Monthly Rates						
Employee Only	$ 5.04	$ 4.50	$ 4.24	$ 6.42	$ 5.75	$ 5.48
Employee & Spouse	$ 9.84	$ 8.78	$ 8.27	$ 12.53	$ 11.23	$ 10.69
Employee & Child(ren)	$ 9.54	$ 8.52	$ 8.02	$ 12.15	$ 10.89	$ 10.37
Family	$ 14.91	$ 13.31	$ 12.53	$ 18.98	$ 17.02	$ 16.20

* These plans reflect the most popular plans. Contact your producer or Northeast Delta Dental marketing representative to see other plans.

RATES ARE VALID FOR INITIAL EFFECTIVE DATES APRIL 2014 THROUGH DECEMBER 2014, AND ARE GUARANTEED FOR UP TO 24 MONTHS. SEE PRODUCT BROCHURE FOR DETAILS.