DELTA DENTAL®

DeltaVision® administered by EyeMed

POPULAR PLAN OPTIONS - INSIGHT NETWORK

In-Network	Platinum	Gold	Silver
Vision Exam With Dilation (As necessary)	$10 copay	$10 copay	$10 copay
Retinal Imaging	Up to $39	Up to $39	Up to $39
Contact Lens Fit & Follow-up			
Standard Fit & Follow-up	Up to $55	Up to $55	Up to $55
Premium Fit & Follow-up	10% off retail price	10% off retail price	10% off retail price
Frames	$0 copay; $150 allowance, 20% off balance over $150	$0 copay; $120 allowance, 20% off balance over $120	$0 copay; $120 allowance, 20% off balance over $120
Standard Plastic Lenses			
Single Vision	$10 copay	$10 copay	$10 copay
Bifocal	$10 copay	$10 copay	$10 copay
Trifocal	$10 copay	$10 copay	$10 copay
Lenticular	$10 copay	$10 copay	$10 copay
Standard Progressive Lens[1]	$75 copay	$75 copay	$75 copay
Premium Progressive Lens[1]	**Tier 1:** $95 copay **Tier 2:** $105 copay **Tier 3:** $120 copay **Tier 4:** $75 copay, 80% of charge less $120 allowance	**Tier 1:** $95 copay **Tier 2:** $105 copay **Tier 3:** $120 copay **Tier 4:** $75 copay, 80% of charge less $120 allowance	**Tier 1:** $95 copay **Tier 2:** $105 copay **Tier 3:** $120 copay **Tier 4:** $75 copay, 80% of charge less $120 allowance
Lens Options			
UV Coating	$15	$15	$15
Tint (Solid and gradient)	$15	$15	$15
Standard Scratch-Resistance	$15	$15	$15
Standard Polycarbonate	$40	$40	$40
Standard Anti-Reflective[1]	$45	$45	$45
Polarized	20% off retail price	20% off retail price	20% off retail price
Photocromatic/Transitions Plastic[1]	$75	$75	$75
Premium Anti-reflective	**Tier 1:** $57 **Tier 2:** $68 **Tier 3:** 80% of charge	**Tier 1:** $57 **Tier 2:** $68 **Tier 3:** 80% of charge	**Tier 1:** $57 **Tier 2:** $68 **Tier 3:** 80% of charge
Other Add-Ons and Services	20% off retail price	20% off retail price	20% off retail price
Contact Lenses[2]			
Conventional	$0 copay; $150 allowance, 15% off balance over $150	$0 copay; $80 allowance, 15% off balance over $80	$0 copay; $80 allowance, 15% off balance over $80
Disposable	$0 copay; $150 allowance, plus balance over $150	$0 copay; $80 allowance, plus balance over $80	$0 copay; $80 allowance, plus balance over $80
Medically Necessary	$0 copay, paid-in-full	$0 copay, paid-in-full	$0 copay, paid-in-full
Lasik and PRK Benefit	15% off retail price or 5% off promotional price		
Diabetic Care Services[3]	Covered 100%, $0 copay		
Office Service Visit (Medical follow-up exam)			
Fundus Photography[4]			
Extended Opthamaloscopy[5]			
Gonioscopy			
Scanning Laser			
Frequency			
Examination	Once every 12 months	Once every 12 months	Once every 12 months
Lenses or Contact Lenses	Once every 12 months	Once every 12 months	Once every 12 months
Frame	Once every 12 months	Once every 12 months	Once every 24 months
Diabetic Care Services	Up to 2 services per benefit year		

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Monthly Rates When bundled with dental[6,7,8]	Platinum	Gold	Silver
2-tier			
Employee	$8.04	$6.06	$5.90
Employee + Family	$19.79	$14.92	$14.52
3-tier			
Employee	$8.04	$6.06	$5.90
Employee + 1	$16.49	$12.43	$12.10
Employee + 2 or more	$23.73	$17.89	$17.41
4-tier			
Employee	$8.04	$6.06	$5.90
Employee + Spouse	$16.09	$12.13	$11.81
Employee + Child(ren)	$15.69	$11.83	$11.51
Employee + Family	$24.54	$18.50	$18.01

Monthly Rates When purchased as stand-alone[7,8]	Platinum	Gold	Silver
2-tier			
Employee	$10.76	$8.16	$7.65
Employee + Family	$26.48	$20.07	$18.81
3-tier			
Employee	$10.76	$8.16	$7.65
Employee + 1	$22.07	$16.73	$15.68
Employee + 2 or more	$31.75	$24.07	$22.56
4-tier			
Employee	$10.76	$8.16	$7.65
Employee + Spouse	$21.53	$16.32	$15.29
Employee + Child(ren)	$20.99	$15.91	$14.91
Employee + Family	$32.83	$24.88	$23.32

[1]Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. EyeMed reserves the right to make changes to the products on each tier and the member out-of-pocket costs. Contact EyeMed for a current listing of brands by tier.

[2]Contact lens allowance includes materials only.

[3]Diabetic care services cover diabetic eyecare evaluation services only for members with Type 1 or Type 2 diabetes. Exclusions and limitations may apply. Refer to plan details for coverage specifics.

[4]Not covered if extended ophthalmoscopy is provided within 6 months.

[5]Not covered if fundus photography is provided within 6 months.

[6]Vision plans bundled with dental require a minimum of 2 enrolled employees. Employer contribution is not required.

[7]Vision plans purchased as a stand-alone benefit require a minimum of 2 enrolled employees. Employer contribution is not required. If employer contribution is 80% or higher, the bundled rates may be offered.

[8]Rates valid for effective dates through 07/01/2018 for groups sized 2-500. Contact your broker or Delta Dental of Arizona representative for large group rates.

The Insight network consists of:

EyeMed | INDEPENDENT PROVIDER NETWORK + LensCrafters, Pearle Vision, Target Optical, Sears Optical, JCPenney optical

QUESTIONS?

Additional plans are available. Contact your broker or a Delta Dental of Arizona representative.
You can also visit deltadentalaz.com/vision for more information.