DELTA DENTAL®

DeltaVision[1] Plan and Rates – California

	DeltaVision Easy Options	
Copays	$10 exam / $25 materials (lenses and/or frames)	
Exam	Once every 12 months	
Lenses	Once every 12 months	
Frame	Once every 12 months	
Frame allowance:	$150 /$230*	
Elective contact lens allowance (in lieu of prescription glasses):	$150 /$230*	
Visually necessary contact lenses (in lieu of prescription glasses)	Covered in full after materials copay	
DeltaVision provider		
Examination	Covered in full after exam copay	
Contact lens exam (fitting & evaluation)	(15% savings on the contact lens exam) Covered in full after copay up to $60	
Lenses		
Single vision	Covered in full after materials copay	
Lined bifocal	Covered in full after materials copay	
Lined trifocal	Covered in full after materials copay	
Lenticular	Covered in full after materials copay	
Lens Enhancements[2,3]		
Copayment amount for:	**Single vision**	**Multifocal**
Anti-reflective coating	$41	$41
Polycarbonate lenses (for children)	Covered in full	Covered in full
Polycarbonate lenses (for all)	$31	$35
Standard progressive lenses	N/A	Covered in full
Premium progressive lenses	N/A	$95 - $105
Custom progressive lenses	N/A	$150 - $175
Photochromic lenses	$75	$75
Scratch-resistant coating	$17	$17

* Members may choose to upgrade to one of the following: higher frame or contact lens allowance ($230), premium progressive lens coverage at no additional cost, anti-reflective coating, or photochromic lens coverage at no additional cost.

Out-of-network maximum allowance	
Examination	$45
Frames	$70
Lenses	
Single vision	$30
Bifocal	$50
Trifocal	$65
Lenticular	$100
Progressive	$50
Elective contact lenses	$105
Necessary contact lenses	$210

Proposed contract effective dates 1/1/2024 through 12/1/2024

Employer paid rates		DeltaVision Easy Options
3 tier	Enrollee only	$13.42
	Enrollee + 1 dependent	$26.82
	Enrollee + 2 or more dependents	$53.15
4 tier	Enrollee only	$13.42
	Enrollee + spouse	$26.82
	Enrollee + child(ren)	$34.88
	Family	$54.42

Voluntary rates		DeltaVision Easy Options
3 tier	Enrollee only	$15.74
	Enrollee + 1 dependent	$31.46
	Enrollee + 2 or more dependents	$62.35
4 tier	Enrollee only	$15.74
	Enrollee + spouse	$31.46
	Enrollee + child(ren)	$40.92
	Family	$63.84

[1] In California, DeltaVision is underwritten by Delta Dental of California. In Alabama, Delaware, District of Columbia, Florida, Georgia, Louisiana, Maryland, Mississippi, Montana, Nevada, New York, Pennsylvania, Texas, Utah and West Virginia. Benefits are subject to the terms of the Contract including limitations and exclusions. DeltaVision is underwritten by Delta Dental Insurance Company. DeltaVision is administered by Vision Service Plan (VSP).

[2] Listed pricing applies to standard enhancement level. Progressive pricing lists all levels.

[3] Enhancements with "copays" or "covered in full" covers all enhancement levels.

DELTA DENTAL®

DeltaVision[1] Plan and Rates – California

	DeltaVision Deluxe	
Copays	$10 exam / $10 materials (lenses and/or frames)	
Exam	Once every 12 months	
Lenses	Once every 12 months	
Frame	Once every 12 months	
Frame allowance:	$200	
Elective contact lens allowance (in lieu of prescription glasses):	$200	
Visually necessary contact lenses (in lieu of prescription glasses)	Covered in full after materials copay	
DeltaVision provider		
Examination	Covered in full after exam copay	
Contact lens exam (fitting & evaluation)	(15% savings on the contact lens exam) Covered in full after copay up to $60	
Lenses		
Single vision	Covered in full after materials copay	
Lined bifocal	Covered in full after materials copay	
Lined trifocal	Covered in full after materials copay	
Lenticular	Covered in full after materials copay	
Lens Enhancements[2,3]		
Copayment amount for:	**Single vision**	**Multifocal**
Anti-reflective coating	$41	$41
Polycarbonate lenses (for children)	Covered in full	Covered in full
Polycarbonate lenses (for all)	$31	$35
Standard progressive lenses	N/A	Covered in full
Premium progressive lenses	N/A	$95 - $105
Custom progressive lenses	N/A	$150 - $175
Photochromic lenses	$75	$75
Scratch-resistant coating	$17	$17

Out-of-network maximum allowance	
Examination	$45
Frames	$70
Lenses	
Single vision	$30
Bifocal	$50
Trifocal	$65
Lenticular	$100
Progressive	$50
Elective contact lenses	$105
Necessary contact lenses	$210

Proposed contract effective dates 1/1/2024 through 12/1/2024

Employer paid rates		DeltaVision Deluxe
3 tier	Enrollee only	$9.99
	Enrollee + 1 dependent	$19.96
	Enrollee + 2 or more dependents	$39.57
4 tier	Enrollee only	$9.99
	Enrollee + spouse	$19.96
	Enrollee + child(ren)	$25.97
	Family	$40.51

Voluntary rates		DeltaVision Deluxe
3 tier	Enrollee only	$11.68
	Enrollee + 1 dependent	$23.35
	Enrollee + 2 or more dependents	$46.27
4 tier	Enrollee only	$11.68
	Enrollee + spouse	$23.35
	Enrollee + child(ren)	$30.37
	Family	$47.38

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DELTA DENTAL®

DeltaVision[1] Plan and Rates – California

	DeltaVision Advantage	
Copays	$10 exam / $25 materials (lenses and/or frames)	
Exam	Once every 12 months	
Lenses	Once every 12 months	
Frame	Once every 12 months	
Frame allowance:	$150	
Elective contact lens allowance (in lieu of prescription glasses):	$150	
Visually necessary contact lenses (in lieu of prescription glasses)	Covered in full after materials copay	
DeltaVision provider		
Examination	Covered in full after exam copay	
Contact lens exam (fitting & evaluation)	(15% savings on the contact lens exam) Covered in full after copay up to $60	
Lenses		
Single vision	Covered in full after materials copay	
Lined bifocal	Covered in full after materials copay	
Lined trifocal	Covered in full after materials copay	
Lenticular	Covered in full after materials copay	
Lens Enhancements[2,3]		
Copayment amount for:	**Single vision**	**Multifocal**
Anti-reflective coating	$41	$41
Polycarbonate lenses (for children)	Covered in full	Covered in full
Polycarbonate lenses (for all)	$31	$35
Standard progressive lenses	N/A	Covered in full
Premium progressive lenses	N/A	$95 - $105
Custom progressive lenses	N/A	$150 - $175
Photochromic lenses	$75	$75
Scratch-resistant coating	$17	$17

Out-of-network maximum allowance	
Examination	$45
Frames	$70
Lenses	
Single vision	$30
Bifocal	$50
Trifocal	$65
Lenticular	$100
Progressive	$50
Elective contact lenses	$105
Necessary contact lenses	$210

Proposed contract effective dates 1/1/2024 through 12/1/2024

Employer paid rates		DeltaVision Advantage
3 tier	Enrollee only	$7.73
	Enrollee + 1 dependent	$15.45
	Enrollee + 2 or more dependents	$30.62
4 tier	Enrollee only	$7.73
	Enrollee + spouse	$15.45
	Enrollee + child(ren)	$20.09
	Family	$31.35

Voluntary rates		DeltaVision Advantage
3 tier	Enrollee only	$9.01
	Enrollee + 1 dependent	$18.00
	Enrollee + 2 or more dependents	$35.68
4 tier	Enrollee only	$9.01
	Enrollee + spouse	$18.00
	Enrollee + child(ren)	$23.42
	Family	$36.53

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DELTA DENTAL®

DeltaVision[1] Plan and Rates – California

	DeltaVision Core	
Copays	$10 exam / $25 materials (lenses and/or frames)	
Exam	Once every 12 months	
Lenses	Once every 12 months	
Frame	Once every 24 months	
Frame allowance:	$150	
Elective contact lens allowance (in lieu of prescription glasses):	$150	
Visually necessary contact lenses (in lieu of prescription glasses)	Covered in full after materials copay	
DeltaVision provider		
Examination	Covered in full after exam copay	
Contact lens exam (fitting & evaluation)	(15% savings on the contact lens exam) Covered in full after copay up to $60	
Lenses		
Single vision	Covered in full after materials copay	
Lined bifocal	Covered in full after materials copay	
Lined trifocal	Covered in full after materials copay	
Lenticular	Covered in full after materials copay	
Lens Enhancements[2,3]		
Copayment amount for:	**Single vision**	**Multifocal**
Anti-reflective coating	$41	$41
Polycarbonate lenses (for children)	Covered in full	Covered in full
Polycarbonate lenses (for all)	$31	$35
Standard progressive lenses	N/A	Covered in full
Premium progressive lenses	N/A	$95 - $105
Custom progressive lenses	N/A	$150 - $175
Photochromic lenses	$75	$75
Scratch-resistant coating	$17	$17

Out-of-network maximum allowance	
Examination	$45
Frames	$70
Lenses	
Single vision	$30
Bifocal	$50
Trifocal	$65
Lenticular	$100
Progressive	$50
Elective contact lenses	$105
Necessary contact lenses	$210

Proposed contract effective dates 1/1/2024 through 12/1/2024

Employer paid rates		DeltaVision Core
3 tier	Enrollee only	$6.27
	Enrollee + 1 dependent	$12.53
	Enrollee + 2 or more dependents	$24.83
4 tier	Enrollee only	$6.27
	Enrollee + spouse	$12.53
	Enrollee + child(ren)	$16.30
	Family	$25.42

Voluntary rates		DeltaVision Core
3 tier	Enrollee only	$7.28
	Enrollee + 1 dependent	$14.55
	Enrollee + 2 or more dependents	$28.83
4 tier	Enrollee only	$7.28
	Enrollee + spouse	$14.55
	Enrollee + child(ren)	$18.92
	Family	$29.52

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DELTA DENTAL®

DeltaVision[1] Plan and Rates – California

	DeltaVision Value	
Copays	$10 exam / $25 materials (lenses and/or frames)	
Exam	Once every 12 months	
Lenses	Once every 12 months	
Frame	Once every 24 months	
Frame allowance:	$130	
Elective contact lens allowance (in lieu of prescription glasses):	$130	
Visually necessary contact lenses (in lieu of prescription glasses)	Covered in full after materials copay	
DeltaVision provider		
Examination	Covered in full after exam copay	
Contact lens exam (fitting & evaluation)	(15% savings on the contact lens exam) Covered in full after copay up to $60	
Lenses		
Single vision	Covered in full after materials copay	
Lined bifocal	Covered in full after materials copay	
Lined trifocal	Covered in full after materials copay	
Lenticular	Covered in full after materials copay	
Lens Enhancements[2,3]		
Copayment amount for:	**Single vision**	**Multifocal**
Anti-reflective coating	$41	$41
Polycarbonate lenses (for children)	Covered in full	Covered in full
Polycarbonate lenses (for all)	$31	$35
Standard progressive lenses	N/A	Covered in full
Premium progressive lenses	N/A	$95 - $105
Custom progressive lenses	N/A	$150 - $175
Photochromic lenses	$75	$75
Scratch-resistant coating	$17	$17

Out-of-network maximum allowance	
Examination	$45
Frames	$70
Lenses	
Single vision	$30
Bifocal	$50
Trifocal	$65
Lenticular	$100
Progressive	$50
Elective contact lenses	$105
Necessary contact lenses	$210

Proposed contract effective dates 1/1/2024 through 12/1/2024

Employer paid rates		DeltaVision Value
3 tier	Enrollee only	$6.16
	Enrollee + 1 dependent	$12.32
	Enrollee + 2 or more dependents	$24.41
4 tier	Enrollee only	$6.16
	Enrollee + spouse	$12.32
	Enrollee + child(ren)	$16.02
	Family	$24.99

Voluntary rates		DeltaVision Value
3 tier	Enrollee only	$7.15
	Enrollee + 1 dependent	$14.29
	Enrollee + 2 or more dependents	$28.33
4 tier	Enrollee only	$7.15
	Enrollee + spouse	$14.29
	Enrollee + child(ren)	$18.59
	Family	$29.01

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