DELTA DENTAL®

DeltaVision[1] Plan and Rates – California

	EasyOptions*	
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 (instead of prescription glasses):	$150/$230*	
Visually necessary contact lenses (instead of prescription glasses)	Covered in full after materials copay	
DeltaVision provider		
WellVision Exam®	Covered in full after exam copay	
Contact lens exam (fitting & evaluation)	Covered in full after copay up to $60	
Lenses		
Single vision, lined bifocal, lined trifocal, or lenticular	Covered in full after materials copay	
Lens Enhancements		
Copayment amount for:	**Single vision**	**Multifocal**
Anti-reflective coating	$41 - $85	$41 - $85
Polycarbonate lenses (for children)	Covered in full	Covered in full
Polycarbonate lenses (for adults)	$35	$35
Standard progressive lenses	N/A	Covered in full
Premium progressive lenses	N/A	$95 - $105
Custom progressive lenses	N/A	$150 - $175
Light-reactive lenses	$75	$75
Scratch-resistant coating	$17	$17
Additional lens enhancements	Low fixed pricing with an average savings of 30%	
Essential Medical Eye Care		
Retinal imaging for members with diabetes covered-in-full. Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. Copay $20; Coordination with medical coverage may apply.		

[1] 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 light-reactive 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 1/1/2025 through 12/1/2025

Employer paid rates		EasyOptions
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		EasyOptions
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, Montana, Nevada, New York, Pennsylvania, Texas, Utah and West Virginia, DeltaVision is underwritten by Delta Dental Insurance Company. Benefits are subject to the terms of the Contract including limitations and exclusions. DeltaVision is administered by Vision Service Plan (VSP).

The DeltaVision contract renewal will align with dental contract renewals, and run for the same duration as the dental contract(s).

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 (instead of prescription glasses):	$200	
Visually necessary contact lenses (instead of prescription glasses)	Covered in full after materials copay	
DeltaVision provider		
WellVision Exam®	Covered in full after exam copay	
Contact lens exam (fitting & evaluation)	Covered in full after copay up to $60	
Lenses		
Single vision, lined bifocal, lined trifocal, or lenticular	Covered in full after materials copay	
Lens Enhancements		
Copayment amount for:	**Single vision**	**Multifocal**
Anti-reflective coating	$41 - $85	$41 - $85
Polycarbonate lenses (for children)	Covered in full	Covered in full
Polycarbonate lenses (for adults)	$35	$35
Standard progressive lenses	N/A	Covered in full
Premium progressive lenses	N/A	$95 - $105
Custom progressive lenses	N/A	$150 - $175
Light-reactive lenses	$75	$75
Scratch-resistant coating	$17	$17
Additional lens enhancements	Low fixed pricing with an average savings of 30%	
Essential Medical Eye Care		
Retinal imaging for members with diabetes covered-in-full. Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. Copay $20; Coordination with medical coverage may apply.		

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 1/1/2025 through 12/1/2025

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 (instead of prescription glasses):	$150	
Visually necessary contact lenses (instead of prescription glasses)	Covered in full after materials copay	
DeltaVision provider		
WellVision Exam®	Covered in full after exam copay	
Contact lens exam (fitting & evaluation)	Covered in full after copay up to $60	
Lenses		
Single vision, lined bifocal, lined trifocal, or lenticular	Covered in full after materials copay	
Lens Enhancements		
Copayment amount for:	**Single vision**	**Multifocal**
Anti-reflective coating	$41 - $85	$41 - $85
Polycarbonate lenses (for children)	Covered in full	Covered in full
Polycarbonate lenses (for adults)	$35	$35
Standard progressive lenses	N/A	Covered in full
Premium progressive lenses	N/A	$95 - $105
Custom progressive lenses	N/A	$150 - $175
Light-reactive lenses	$75	$75
Scratch-resistant coating	$17	$17
Additional lens enhancements	Low fixed pricing with an average savings of 30%	
Essential Medical Eye Care		
Retinal imaging for members with diabetes covered-in-full. Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. Copay $20; Coordination with medical coverage may apply.		

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 1/1/2025 through 12/1/2025

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 (instead of prescription glasses):	$150	
Visually necessary contact lenses (instead of prescription glasses)	Covered in full after materials copay	
DeltaVision provider		
WellVision Exam®	Covered in full after exam copay	
Contact lens exam (fitting & evaluation)	Covered in full after copay up to $60	
Lenses		
Single vision, lined bifocal, lined trifocal, or lenticular	Covered in full after materials copay	
Lens Enhancements		
Copayment amount for:	**Single vision**	**Multifocal**
Anti-reflective coating	$41 - $85	$41 - $85
Polycarbonate lenses (for children)	Covered in full	Covered in full
Polycarbonate lenses (for adults)	$35	$35
Standard progressive lenses	N/A	Covered in full
Premium progressive lenses	N/A	$95 - $105
Custom progressive lenses	N/A	$150 - $175
Light-reactive lenses	$75	$75
Scratch-resistant coating	$17	$17
Additional lens enhancements	Low fixed pricing with an average savings of 30%	
Essential Medical Eye Care		
Retinal imaging for members with diabetes covered-in-full. Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. Copay $20; Coordination with medical coverage may apply.		

Out-of-network maximum allowance	
Examination	$45
Frames (every other year)	$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 1/1/2025 through 12/1/2025

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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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 (instead of prescription glasses):	$130	
Visually necessary contact lenses (instead of prescription glasses)	Covered in full after materials copay	
DeltaVision provider		
WellVision Exam®	Covered in full after exam copay	
Contact lens exam (fitting & evaluation)	Covered in full after copay up to $60	
Lenses		
Single vision, lined bifocal, lined trifocal, or lenticular	Covered in full after materials copay	
Lens Enhancements		
Copayment amount for:	**Single vision**	**Multifocal**
Anti-reflective coating	$41 - $85	$41 - $85
Polycarbonate lenses (for children)	Covered in full	Covered in full
Polycarbonate lenses (for adults)	$35	$35
Standard progressive lenses	N/A	Covered in full
Premium progressive lenses	N/A	$95 - $105
Custom progressive lenses	N/A	$150 - $175
Light-reactive lenses	$75	$75
Scratch-resistant coating	$17	$17
Additional lens enhancements	Low fixed pricing with an average savings of 30%	
Essential Medical Eye Care		
Retinal imaging for members with diabetes covered-in-full. Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. Copay $20; Coordination with medical coverage may apply.		

Out-of-network maximum allowance	
Examination	$45
Frames (every other year)	$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 1/1/2025 through 12/1/2025

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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