DeltaVision®

DELTA DENTAL®

DYNAMIC SELECT PLUS 150 ALLOWANCE PLAN

EMPLOYER GROUP: North Central Missouri Mental Health Care

EFFECTIVE DATE: August 1, 2021

QUOTE DATE:

COPAYS[1]	Exam	$10
	Materials	$25

FREQUENCY	Eye Exam	Every 12 Months
	Eyeglass Lenses	Every 12 Months
	Eyeglass Frames	Every 24 Months
	Contact Lenses	Every 12 Months

All Frequencies run on a Calendar Year basis.

COVERAGE	IN-NETWORK	OUT-OF-NETWORK[2]
EXAMS		
Comprehensive Eye Examination *(with dilation)*	Covered in full after copay	Reimbursed up to $40
Contact Lens Fit & Follow-up	$40 allowance (copay does not apply)	Not covered
MATERIALS		
Eyeglasses[3] *(in lieu of contact lenses)*		
Standard Plastic CR-39 Lenses ▪ Single ▪ Bi-focal ▪ Tri-focal ▪ Lenticular	Covered in full after copay	Reimbursed up to: ▪ Single: $20 ▪ Bi-focal: $40 ▪ Tri-focal: $60 ▪ Lenticular: $100
Polycarbonate Lenses *(members age 19 and under)*	Covered in full (copay does not apply)	Not covered
Standard Progressive Lenses	Additional $50 copay	Not covered
Photochromic Lenses	Additional $60 copay	Not covered
Standard Frames	$150 retail allowance	Reimbursed up to $60
Contact Lenses[4] *(in lieu of eyeglass lenses and frames)*		
Elective Contact Lenses	$150 retail allowance	Reimbursed up to $90
Medically Necessary Contact Lenses[5]	$250 retail allowance	Reimbursed up to $250

1. Copays apply to all benefits except where noted. 2. For out-of-network benefits, member is reimbursed up to the amount shown less copay. 3. Single materials copay applies with standard lenses and frames when purchased together. 4. Benefit paid only once during the group's benefit period; must be fully utilized at the time of purchase. 5. Medically Necessary Contact Lenses limited to conditions of aphakia, keratoconus, or severe anisometropia.

DELTAVISION *VALUE* DISCOUNTS

Covered members can take advantage of discounted services and materials at participating discount provider locations.

Polycarbonate Lenses[1] (Members over age 19): $40
Frames: 20% off amount over allowance
Laser Vision Correction: Member discounts up to 50%.

[1]Only applies to single vision lenses.
The discount features are not insurance and may be subject to change without notice. Not all providers participate in DeltaVision Value Discounts. Call your provider or visit our website to confirm if they offer discounts.

RATE GUARANTEE 24 Months

MONTHLY PREMIUMS		Monthly Premiums *With Dental Bundle*
Single		$4.88
Employee & Spouse		$9.15
Employee & Child(ren)		$10.38
Family		$15.13

Rates quoted are based on dependent coverage up to age 26.