

**DeltaVision Plans by Delta Dental of Kentucky**  
administered by VSP

1/1/2023 - 12/31/2023 Rates

	DeltaVision 130	DeltaVision 150	DeltaVision 150+	DeltaVision 175
<b>BENEFIT FREQUENCY</b>				
WellVision Exam Every:	12 Months	12 Months	12 Months	12 Months
Lenses Every:	12 Months	12 Months	12 Months	12 Months
Frames Every:	24 Months	24 Months	24 Months	12 Months
Contacts (in lieu of glasses):	12 Months	12 Months	12 Months	12 Months

<b>CO-PAYMENTS</b>				
WellVision Exam:	\$10	\$10	\$10	\$10
Materials:	\$25	\$10	\$10	\$10
Contact Lens Exam (fitting and evaluation):	Up to \$60	Up to \$60	Up to \$60	Up to \$60

<b>IN NETWORK ALLOWANCES</b>				
Retail Frame Value:	\$130	\$150	\$150	\$175
Elective Contact Lenses:	\$130	\$150	\$150	\$175
Covered Lens Options:	<ul style="list-style-type: none"> <li>Polycarbonate for Children</li> <li>Standard Progressive Lenses</li> </ul>	<ul style="list-style-type: none"> <li>Polycarbonate for Children</li> <li>Standard Progressive Lenses</li> </ul>	<ul style="list-style-type: none"> <li>Polycarbonate for Children</li> <li>Polycarbonate for Adults</li> <li>Standard Progressive Lenses</li> <li>Anti-Reflective Coating</li> <li>Scratch Resistant Coating</li> <li>UV Screening</li> <li>Solid or Gradient Tint</li> </ul>	<ul style="list-style-type: none"> <li>Polycarbonate for Children</li> <li>Standard Progressive Lenses</li> <li>Anti-Reflective Coating</li> </ul>

<b>EXTRA DISCOUNTS AND SAVINGS</b>	
Lens Enhancements:	Average Savings of 30%
Additional Pairs of Glasses:	20% off
Sunglasses:	20% off
Laser Vision Correction:	Average 15%-20% discount

<b>VALUE ADDED PROGRAMS</b>
Primary Eyecare, Eye Health Management, & Diabetic Exam Reminder Letters

<b>Your coverage with Out-of-Network Providers</b>		
Exam - up to \$45 Frame - up to \$70 Single Vision Lenses - up to \$30	Lined Bifocal Lenses - up to \$50 Lined Trifocal Lenses - up to \$65 Lenticular Lenses - up to \$100	Progressive Lenses - up to \$50 Contacts - up to \$105 Necessary Contact Lenses - up to \$210

**MONTHLY RATES** (Employer Paid / Voluntary)

	DeltaVision 130	DeltaVision 150	DeltaVision 150+	DeltaVision 175
Employee Only:	\$5.36 / \$6.30	\$6.31 / \$7.43	\$7.35 / \$8.67	\$9.87 / \$11.67
Employee + Spouse:	\$10.72 / \$12.60	\$12.62 / \$14.86	\$14.70 / \$17.33	\$19.73 / \$23.34
Employee + Child(ren):	\$11.47 / \$13.49	\$13.50 / \$15.90	\$15.20 / \$18.01	\$21.11 / \$24.98
Family:	\$18.33 / \$21.55	\$21.58 / \$25.42	\$24.29 / \$28.79	\$33.74 / \$39.91