Individual Vision

MIB HEALTH INSURANCE

Delta Dental – Monthly Vision Rates

	Brilliance Plan	Essential Plan
Single	$28.88	$16.88
Single & Spouse	$57.76	$33.76
Family 1 Child	$80.64	$47.64

**Each additional child is $22.88 per child.

Provider Search

Provider Search:
https://eyedoclocator.eyemedvisioncare.com/deltaviswi/en?networkSetid=1002&networkDDDisabled=true

Apply Online: https://www2.deltadentalcoversme.com/?agency=172845711O
Broker Name: Select Mike Dietz

Apply

Humana – Monthly Vision Rates

Single	$15.49
Single Plus One	$26.99
Family	$42.99

**One time enrollment fee of $35.00

Provider Search

Provider Search: https://idv.humana.com/humanaonenetwork/search-providers-generic.aspx

Apply online: https://www.humana.com/agent/health-insurance-Agents/AOALanding?SANID=1303798&isMarketpointAgent=false

Apply

DELTA DENTAL DeltaVision® MIB HEALTH INSURANCE

Brilliance Vision Insurance Policy

Vision Care Services	Member Cost In-Network	Member Out-of-Network Reimbursement
Exam with Dilation as Necessary	$0 Copay	$30
Retinal Imaging Benefit	Up to $39	N/A
Contact Lens Fit and Follow-Up: *(Contact lens fit and two follow-up visits are available once a comprehensive eye exam has been completed.)*		
Standard Contact Lens Fit and Follow-Up:	$0 Copay, Paid-in-full fit and two follow-up visits	$40
Premium Contact Lens Fit and Follow-Up:	$0 Copay, 10% off retail prices, then apply $55 allowance	$40
Frames: Any available frame at provider location	$0 Copay; $200 Allowance, 20% off balance over $200	$100
Standard Plastic Lenses:		
Single Vision	$0 Copay	$25
Bifocal	$0 Copay	$40
Trifocal	$0 Copay	$55
Lenticular	$0 Copay	$55
Standard Progressive Lens	$0 Copay	$55
Premium Progressive Lens Tier 1	$20 Copay	$40
Premium Progressive Lens Tier 2	$30 Copay	$40
Premium Progressive Lens Tier 3	$45 Copay	$40
Premium Progressive Lens Tier 4	$0 copay, 80% of charge less $120 Allowance	$40

Vision Care Services (continued)	Member Cost In-Network	Member Out-of-Network Reimbursement
Lens Options:		
UV Treatment	$0 Copay	$5
Tint (Solid and Gradient)	$0 Copay	$5
Standard Plastic Scratch Coating	$0 Copay	$5
Standard Polycarbonate - Adults	$0 Copay	$5
Standard Polycarbonate - Kids under 19	$0 Copay	$5
Standard Anti-Reflective Coating	$0 Copay	$5
Premium Anti-Reflective Tier 1	$12 copay	$5
Premium Anti-Reflective Tier 2	$23 copay	N/A
Premium Anti-Reflective Tier 3	80% of charge	N/A
Polarized	20% off Retail Price	N/A
Photocromatic / Transitions Plastic	$75	N/A
Other Add-Ons	20% off Retail Price	N/A
Contact Lenses: *(Contact lens allowance includes materials only)*		
Conventional	$0 Copay; $200 allowance, 15% off balance over $200	$160
Disposable	$0 Copay; $200 allowance, plus balance over $200	$160
Medically Necessary	$0 Copay, Paid-in-Full	$210
Laser Vision Correction Lasik or PRK from U.S. Laser Network	15% off Retail Price or 5% off promotional price	N/A
Additional Pairs Benefit:	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A
Frequency:		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 12 months	

DELTA DENTAL®

DeltaVision®

MIB HEALTH INSURANCE

Essential Vision Insurance Policy

Vision Care Services	Member Cost In-Network	Member Out-of-Network Reimbursement
Exam with Dilation as Necessary	$10 Copay	$30
Retinal Imaging Benefit	Up to $39	N/A
Exam Options: Standard Contact Lens Fit and Follow-Up: Premium Contact Lens Fit and Follow-Up:	 Up to $40 10% off Retail Price	 N/A N/A
Frames: Any available frame at provider location	$0 Copay; $150 Allowance, 20% off balance over $150	$75
Standard Plastic Lenses: Single Vision Bifocal Trifocal Lenticular Standard Progressive Lens Premium Progressive Lens Tier 1 Premium Progressive Lens Tier 2 Premium Progressive Lens Tier 3 Premium Progressive Lens Tier 4	 $10 Copay $10 Copay $10 Copay $10 Copay $75 Copay $95 Copay $105 Copay $120 Copay $75 copay, 80% of charge less $120 Allowance	 $25 $40 $55 $55 $40 $40 $40 $40 $40

Vision Care Services (continued)	**Member Cost In-Network**	**Member Out-of-Network Reimbursement**
Lens Options:		
UV Treatment	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Plastic Scratch Coating	$15	N/A
Standard Polycarbonate - Adults	$40	N/A
Standard Polycarbonate - Kids under 19	$40	N/A
Standard Anti-Reflective Coating	$45	N/A
Premium Anti-Reflective Tier 1	$57	N/A
Premium Anti-Reflective Tier 2	$68	N/A
Premium Anti-Reflective Tier 3	80% of charge	N/A
Polarized	20% off Retail Price	N/A
Photocromatic / Transitions Plastic	$75	N/A
Other Add-Ons	20% off Retail Price	N/A
Contact Lenses: *(Contact lens allowance includes materials only)*		
Conventional	$0 Copay; $150 allowance, 15% off balance over $150	$120
Disposable	$0 Copay; $150 allowance, plus balance over $150	$120
Medically Necessary	$0 Copay, Paid-in-Full	$210
Laser Vision Correction Lasik or PRK from U.S. Laser Network	15% off Retail Price or 5% off promotional price	N/A
Additional Pairs Benefit:	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A
Frequency:		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 12 months	

Humana Vision

Apply Online - Click HERE (https://www.humana.com/agent/health-insurance-Agents/AOALanding?SANID=1303798&isMarketpointAgent=false)

Vision care services	See a participating provider	See a nonparticipating provider
Exam with dilation as necessary	$15 copay	$30 allowance
Contact lens exam options*		
• Standard contact lens fit and follow-up	$40 copay	Not available
• Premium contact lens fit and follow-up	10% off retail	Not available
Frames		
• Discounts may be available on all frames except when prohibited by the manufacturer.	$150 allowance, 20% off balance over $150	$150 allowance
Standard plastic lenses		
• Single vision	$25 copay	$25 allowance
• Bifocal	$25 copay	$40 allowance
• Trifocal	$25 copay	$55 allowance
Lens options		
• UV coating	$15 copay	Not available
• Tint (solid and gradient)	$15 copay	Not available
• Standard scratch-resistance	$15 copay	Not available
• Standard polycarbonate**	$40 copay	Not available
• Standard anti-reflective coating	$45 copay	Not available
• Standard progressive (add-on to bifocal)	$65 copay	Not available
• Other add-ons and services	20% off retail price	Not available
Contact lenses (applies to materials only)		
• Conventional	$150 allowance, 15% off balance over $150	$92 allowance
• Disposable	$150 allowance	$92 allowance
• Medically necessary	$0 copay, paid in full	$200 allowance
Frequency‡		
• Examination	Once every 12 months	Once every 12 months
• Lenses or contact lenses	Once every 12 months	Once every 12 months
• Frame	Once every 12 months	Once every 12 months

* Standard contact lens fitting: spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.)

* Premium contact lens fitting: all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)

** Standard polycarbonate available at no charge to dependents to 19 years old. All other members pay a fixed charge of $40.

‡ Frequencies are based on date of service.

Find a Doctor: https://idv.humana.com/humanaonenetwork/search-providers-generic.aspx

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MIB HEALTH INSURANCE

EyeMed VISION CARE®

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