Delta Dental of Tennessee
DeltaVision® 130 Declaration Page

Group Name:	Vanderbilt University
Group Number:	V7831
Group Address:	PMB 407704 2301 Vanderbilt Place
City, State, Zip Code:	Nashville, TN 37240-0001
Contract Effective Date:	January 1, 2021
Contract Renewal Date:	January 1, 2024
Benefit Year:	January 1 through December 31
Provider Network:	VSP Choice Network

Eligibility Requirements

All permanent, full time EMPLOYEES who work a minimum of 30 hours per week who are hired on or prior to the EFFECTIVE DATE are eligible for enrollment on the EFFECTIVE DATE or when they have met the GROUP's eligibility requirements.

Employees are eligible on date of hire.
The benefit termination date is the last day of the respective pay period.

The Dependent Age Limit under this Contract is to age: 26

Monthly Premiums

Subscriber only - $6.36 per month per Subscriber
Subscriber and spouse - $12.72 per month per Subscriber
Subscriber and child(ren) - $13.61 per month per Subscriber
Subscriber, spouse and child(ren) - $21.75 per month per Subscriber

These rates are contingent upon the enrollment of a minimum of 35 percent of the eligible members of the defined group and their eligible dependents with the full cost paid by the member.

This plan requires a minimum of 2 enrolled primary Subscribers. The GROUP will be billed for the greater of the actual number of Subscribers or the minimum number of Subscribers.

Premiums will be deemed delinquent if not paid as billed and received by the 5th of each month.

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Plan Description

WellVision Exam			$10 Copay
Exams *Once per calendar year*	Comprehensive eye exam to ensure overall visual wellness		
Prescription Glasses			$25 Copay
Frames *Once every two calendar years*	$130	allowance for wide selection of frames	Included in Prescription Glasses Copay
	20%	savings on amount over allowance	
	$70	Costco frame allowance	
Lenses *Once per calendar year*	Single vision, lined bifocal and lined trifocal lenses		Included in Prescription Glasses Copay
Covered Lens Enhancements	Polycarbonate lenses for children Standard Progressive Lenses		$0 $0
Optional Lens Enhancements *Average savings of 20-25% on other lens enhancements*	Premium Progressive Lenses Custom Progressive Lenses Tints/Photochromic Adaptive Lenses Scratch Resistant Coating		Copay Ranges $95 - $105 $150 - $175 $15 - $17 $17
Contact Lenses - Instead of Glasses			
Contacts *Once per calendar year*	$130	allowance for contacts; copay does not apply	up to $60
	Contact lens exam (fitting and evaluation)		
Extra Savings			
Featured Frames	$150	allowance on featured frame brands. Check vsp.com for current offers.	
Glasses and Sunglasses	20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam		
Retinal Screening	No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
Value Added Programs			
Included	Primary Eyecare, Eye Health Management (including Diabetic Exam Reminder Letters)		

Your coverage with Out-of-Network Providers Allowances		
• 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

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