DELTA DENTAL

Delta Dental of Tennessee
DeltaVision® 175 Declaration Page

Group Name:	Etsell, Inc.
Group Number:	V8641
Group Address:	139 Fox Rd Ste 105
City, State, Zip Code:	Knoxville, TN 37922-3472
Contract Effective Date:	December 1, 2025
Contract Renewal Date:	December 1, 2027
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 the first day of the month following 30 days of continuous employment.
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 - $9.70 per month per Subscriber
Subscriber and spouse - $19.40 per month per Subscriber
Subscriber and child(ren) - $20.75 per month per Subscriber
Subscriber, spouse and child(ren) - $33.17 per month per Subscriber

These Rates are contingent upon the enrollment of a minimum of 35% of the eligible Enrollee of the defined group and their 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 every 12 months*	Comprehensive eye exam to ensure overall visual wellness	
Prescription Glasses		**$10 Copay**
Frames *Once every 12months*	**$175** allowance for wide selection of frames **20%** savings on amount over allowance **$95** Costco frame allowance	Included in Prescription Glasses Copay
Lenses *Once every 12 months*	Single vision, lined bifocal and lined trifocal lenses	Included in Prescription Glasses Copay
Covered Lens Enhancements	Polycarbonate lenses for children Standard Progressive Lenses Standard Anti-Reflective Coating	$0 $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 every 12 months*	**$175** allowance for contacts; copay does not apply Contact lens exam (fitting and evaluation)	up to $60
Extra Savings		
Featured Frames	**$195** 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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