DeltaVision®
In partnership with VSP®

Essential plan
Vision benefit summary

Plan highlights

Exam/Lens/Frame frequency (months)	12/12/24
Contacts frequency (in lieu of glasses)	12
	In-network coverage
Exam copay	$10
Materials copay	$25
Frame allowance (includes Walmart/Sam's Club)* Frame allowance Costco*	$130 $70
Elective contact lens allowance	$130
Necessary contact lenses	Covered in full after copay
Contact lens fit/eval copayment	Up to $60
Both frames and contacts in same year	No (allows contacts in lieu of frames)

Lens enhancements[1]

Benefits	Member cost
Anti-glare coating	$41 single $41 multifocal
Impact-resistant lenses — adult	$31 single $35 multifocal (covered for children)
Progressive lenses	Standard progressive lenses are covered
Light-reactive lenses	$75 single vision $75 multifocal
Scratch-resistant coating	$17 single vision $17 multifocal

Out-of-network allowances (in addition to in-network copays)

Benefits	Covered up to
Examination	$45
Single vision lenses	$30
Bifocal lenses	$50
Trifocal lenses	$65
Progressive lenses	$50

Benefits	Covered up to
Lenticular lenses	$100
Frame	$70
Elective contact lenses	$105
Necessary contact lenses	$210

Additional savings

Benefits	Plan details
Frames discount over allowance[2]	An extra $20 allowance on featured designer brands for frames. 20% savings on any amount above the retail allowance.
Additional pair[2]	20% savings on unlimited additional pairs of prescription glasses and/or nonprescription sunglasses from any VSP provider within 12 months of exam.
LASIK[2]	Average 15% off the regular price, or 5% off the promotional price; discounts only available from contracted facilities.
Retinal screening[2]	Routine retinal screening covered for a maximum fee of $39.
Lens coverage[2]	Glass or plastic single vision, lined bifocal, lined trifocal, or lenticular lenses are covered in full.[3]
Essential Medical Eye Care	• Retinal imaging for members with diabetes covered-in-full. • Additional exams and services beyond routine care to treat immediate issues such as pink eye or to monitor ongoing conditions like high blood pressure, diabetes, and more. Coordination with your medical coverage may apply. Ask your VSP network doctor for details. Available as needed. $20 per exam.
Low vision	• Pre-approved low vision supplemental testing covered every two years. • 75% coverage for approved low vision aids, up to $1,000 (less any amount paid for supplemental testing) every two years.
Eyeconic®[2]	Go to **Eyeconic.com®** for an easy-to-use, convenient online eyewear option.
TruHearing®[2]	Save up to 60% on hearing aids and batteries. Visit **TruHearing.com/VSP** or call **877.396.7194** for more information.[4]

Need help?

For questions about your vision benefits, please call:
VSP Customer Service at 1-800-877-7195.

Disclaimers and exclusions

Promotions and Featured Frame Brands do not apply at Costco® Optical, Walmart, Sam's Club, and other participating retail chains. *In-network status of the optometrist performing the exam may vary at participating retail chains. Please contact VSP and/or the optometrist at the retail location to verify network participation status before receiving services.

[1]Prices shown reflect the standard plastic price for each respective category. Premium lens enhancement prices may vary. Prices are valid only through VSP Choice Network Providers and are subject to change without notice.

[2]Available in-network only.

[3]Covered in full materials and services are less any applicable copay. Based on applicable laws, benefits, and savings may vary by location. Benefits may also vary at participating retail chains. Promotions like rebates are continually evaluated and subject to change without notice. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

The following items are excluded under this plan: plano lenses (lenses with refractive correction of less than ± .50 diopter); two pairs of glasses instead of bifocals; replacement of lenses, frames, or contacts; medical or surgical treatment; orthoptics; vision training or supplemental testing.

[4]VSP is providing information to its members, but does not offer or provide any discount hearing program. VSP makes no endorsement, representations or warranties regarding any products or services offered by TruHearing, a third-party vendor. TruHearing is not insurance and not subject to state insurance regulations. For additional information, please visit vsp.com/offers/special-offers/hearing-aids/truhearing. For questions, contact TruHearing directly. Not available directly from VSP in the states of Washington and California.

This overview contains a general description of your vision care program for your use as a convenient reference. Complete details of your program appear in the group contract between your plan sponsor and Delta Dental of Connecticut, Inc., which governs the benefits and operation of your program. The group contract would control if there should be any inconsistency or difference between its provisions and the information in this overview. Claims processing, claims service, and provider network administration for DeltaVision are provided under contract by VSP. VSP, Eyeconic, and eyeconic.com are registered trademarks of Vision Service Plan. All other brands or marks are the property of their respective owners.

DeltaVision® and Delta Dental are registered trademarks of the Delta Dental Plans Association. DeltaVision® insurance plans are underwritten by Delta Dental of Connecticut, Inc. VSP, Inc., performs claims processing, customer service and provider network administration for DeltaVision products. In Connecticut, Delta Dental of Connecticut, Inc., is a licensed insurer that markets and sells dental and vision coverage on an insured basis. Its parent company, Delta Dental of New Jersey, Inc., is a licensed third party administrator in Connecticut and administers self-funded dental benefit programs.

DELTA DENTAL®

DeltaVision®
In partnership with VSP®

Brilliance plan
Vision benefit summary

Plan highlights

Exam/Lens/Frame frequency (months)	12/12/12
Contacts frequency (in lieu of glasses)	12
	In-network coverage
Exam copay	$10
Materials copay	$10
Frame allowance (includes Walmart/Sam's Club)* Frame allowance Costco*	$150 $80
Elective contact lens allowance	$150
Necessary contact lenses	Covered in full after copay
Contact lens fit/eval copayment	Up to $60
Both frames and contacts in same year	No (allows contacts in lieu of frames)

Lens enhancements[1]

Benefits	Member cost
Anti-glare coating	$41 single $41 multifocal
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Elective contact lenses	$105
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