

Benefits overview¹

Exam/lens/frame frequency (months)	12/12/24
Contacts (instead of glasses) frequency (months)	12

In-network coverage

Exam copay	\$10
Materials copay	\$25
Single vision, lined bifocal, lined trifocal or lenticular lenses	Covered-in-full after copay
Frame allowance <i>Costco frame allowance will be \$70</i>	\$130
Elective contact lenses allowance	\$130
Necessary contact lenses	Covered-in-full after copay
Contact lens fit evaluation copay	Up to \$60

20% on frame overages, Promotions, and Featured Frame Brands do not apply at Walmart, Sam's Club and Costco Optical

DeltaVision®
130 Standard

Out-of-network allowances

Exam	Up to \$45
Single vision lenses	Up to \$30
Bifocal lenses	Up to \$50
Trifocal lenses	Up to \$65
Progressive lenses	Up to \$50
Lenticular lenses	Up to \$100
Frames	Up to \$70
Elective contact lenses	Up to \$105
Necessary contact lenses	Up to \$210

Most popular lens enhancements (member cost)²

Lens enhancements are available at the following flat rates, saving members 30% on average

	Single	Multifocal
Standard anti-glare coating	\$41	\$41
Premium anti-glare coating	\$68	\$68
Custom anti-glare coating	\$85	\$85
Impact-resistant lenses—adult	\$35	\$35
Impact-resistant lenses—child	Covered-in-full	Covered-in-full
Standard progressive lenses	N/A	Covered-in-full
Premium progressive lenses	N/A	\$95 - \$105
Custom progressive lenses	N/A	\$150 - \$175
Light-adaptive lenses (plastic)	\$75	\$75
Scratch-resistant coating	\$17	\$17

Additional savings³

Frames discount over allowance	An extra \$20 allowance on Featured Frame Brands ⁵ . 20% savings on any amount above the retail allowance.
Additional pair	20% savings on unlimited additional pairs of prescription glasses and/or nonprescription sunglasses from any VSP network provider within 12 months of exam.
LASIK	Average 15% off the regular price. Discounts only available from contracted facilities.
Retinal imaging	Routine retinal screening covered for a maximum fee of \$39.
Essential Medical Eye Care	Retinal imaging for members with diabetes covered-in-full. Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma and more. Coordination with your medical coverage may apply. Ask your VSP network doctor for details.
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®	Shop in-network using your vision benefits at eyeconic.com .
TruHearing®	Save up to 60% on digital hearing aids with TruHearing. Visit vsp.com/offers/special-offers/hearing-aids for details. ⁴

DeltaVision plans are administered by VSP®, which performs certain services, including claims processing, customer service and provider network administration for DeltaVision products.

DeltaVision is a registered trademark of the Delta Dental Plans Association.

Michigan DeltaVision insurance plans are underwritten by Renaissance Life & Health Insurance Company of America in partnership with VSP, which performs claims processing, customer service and provider network administration for DeltaVision products.

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5. Frame brands and promotion subject to change. Only available to VSP members with applicable plan benefits. Only available at in-network locations. Members who participate in a Medicaid/state-funded plan are not eligible. For Spanish translations and footnote information, please scan the QR code or visit deltadentalmi.com/DeltaVision-footnotes

Summary of Vision Plan Benefits

For Group #V1692-0001, 0003, 0093, 0099

Continental Services

This Summary of Vision Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your plan. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to the allowance for each service and it may vary due to the Provider's network participation.*

Control Plan – Delta Dental of Michigan

Benefit Year – January 1 through December 31

We will provide vision care Benefits according to the Schedule listed below. This Summary lists the vision care Benefits to which Members are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein.

Administrative Services for the adjudication of Claims and the payment of Benefits under This Plan will be provided by Vision Service Plan Insurance Company ("VSP"), using a VSP network of Providers. VSP is sometimes referred to as the claims administrator for This Plan. If Benefits are available for Out-of-Network Provider services, as indicated by the reimbursement provisions below, Benefits may be received from any licensed eye care provider whether an In-Network or Out-of-Network Provider. This Summary forms a part of the Certificate to which it is attached.

In-Network Providers are those Providers who have agreed to participate in the VSP Choice Network. When Benefits are received from In-Network Providers, Benefits appearing in the In-Network Benefit column below are applicable, subject to any applicable Copayments and other conditions, limitations and/or exclusions as stated below.

When Benefits are received from Out-of-Network Providers, the Member is reimbursed for such Benefits according to the schedule in the Out-of-Network Provider Benefit column below, less any applicable Copayment. The Member pays the Provider the full fee at the time of service and submits an itemized bill to the claims administrator for reimbursement. Discounts do not apply for Benefits obtained from Out-of-Network Providers.

COVERED SERVICES -

COVERED SERVICE OR MATERIAL	IN-NETWORK PROVIDER BENEFIT	OUT-OF-NETWORK PROVIDER BENEFIT	FREQUENCY
EXAMS			
Eye Examination	Covered in full*	Up to \$45.00*	Available once every 12 months**
Retinal Screening	Covered for a maximum fee of \$39.00	Not Covered	Available once every 12 months**
Complete initial vision analysis: includes appropriate examination of visual functions and prescription of corrective eyewear where indicated.			
*Less any applicable Copayment as set forth below.			
**Beginning with the first date of service.			

COVERED SERVICE OR MATERIAL	IN-NETWORK PROVIDER BENEFIT	OUT-OF-NETWORK PROVIDER BENEFIT	FREQUENCY
LENSES			Available once every 12 months**
Single Vision	Covered in full*	Up to \$30.00*	
Lined Bifocal	Covered in full*	Up to \$50.00*	
Lined Trifocal	Covered in full*	Up to \$65.00*	
Lenticular	Covered in full*	Up to \$100.00*	

Benefits for lenses are per complete set, not per lens.

Polycarbonate lenses are covered in full for dependent children up to age 26.

Standard Progressive Lenses are covered in full.

*Less any applicable Copayment as set forth below.

**Beginning with the first date of service.

COVERED SERVICE OR MATERIAL	IN-NETWORK PROVIDER BENEFIT	OUT-OF-NETWORK PROVIDER BENEFIT	FREQUENCY
FRAMES	Covered up to Plan Allowance of \$130.00*	Up to \$70.00*	Available once every 24 months**

Benefits for lenses and frames include reimbursement for the following necessary professional services:

1. Prescribing and ordering proper lenses;
2. Assisting in frame selection;
3. Verifying accuracy of finished lenses;
4. Proper fitting and adjustments of frames;
5. Subsequent adjustments to frames to maintain comfort and efficiency;
6. Progress or follow-up work as necessary.

*Less any applicable Copayment as set forth below.

**Beginning with the first date of service.

COVERED SERVICE OR MATERIAL	IN-NETWORK PROVIDER BENEFIT	OUT-OF-NETWORK PROVIDER BENEFIT	FREQUENCY
CONTACT LENSES			
Necessary	Professional Fees/Materials: Covered in full*	Professional Fees/Materials: Up to \$210.00*	Available once every 12 months**
Elective	Materials: Up to \$130.00 Elective Contact Lens fitting and evaluation services are covered in full once every 12 months**, after a maximum \$60.00 Copayment.	Professional Fees/Materials: Up to \$105.00	Available once every 12 months**

*Less any applicable Copayment as set forth below.

**Beginning with the first date of service.

Necessary Contact Lenses are a Covered Service when specific Benefit criteria are satisfied and when prescribed by the Member's In-Network Provider or Out-of-Network Provider. Review and approval by claims administrator is not required for Members to be eligible for Necessary Contact Lenses.

Contact Lenses are provided in lieu of all other lens and frame Benefits available herein.

When contact lenses are obtained, the Member shall not be eligible for lenses and frames again for 12 months.

COVERED SERVICE OR MATERIAL	IN-NETWORK PROVIDER BENEFIT	OUT-OF-NETWORK PROVIDER BENEFIT	FREQUENCY
LOW VISION Professional services for severe visual problems not correctable with regular lenses, including:			

Supplemental Testing (Includes evaluation, diagnosis and prescription of vision aids where indicated.)	Covered in full	Up to \$125.00	*
Supplemental Aids	75% of amount up to \$1000.00*	75% of amount up to \$1000.00*	*
*Maximum Benefit for all Low Vision services and materials is \$1000.00 (excluding Copayment) every two years. Low Vision Benefits secured from Out-of-Network Providers (if covered) are subject to the same time and Copayment provisions described above for In-Network Providers. The Member should pay the Out-of-Network Provider's full fee at the time of service. The Member will be reimbursed an amount not to exceed what would be paid to an In-Network Provider for the same services and/or materials. THERE IS NO ASSURANCE THAT THE AMOUNT REIMBURSED WILL COVER 75% OF THE PROVIDER'S FULL FEE.			

EXCLUSIONS AND LIMITATIONS

Some brands of frames and lenses may be unavailable for purchase as Benefits, or may be subject to additional limitations. Members may obtain details regarding frame and lens brand availability from their In-Network Provider or by calling the Member Services Department at 800-877-7195.

PATIENT LENS ENHANCEMENTS

This Plan is designed to cover visual needs rather than cosmetic materials. When the Member selects any of the following extras, the Plan will pay the basic cost of the allowed lenses or frames, and the Member will pay the additional costs for the enhancements.

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Polycarbonate lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Premium and custom progressive multifocal lenses.
- UV (ultraviolet) protected lenses.
- Certain limitations on low vision care.

NOT COVERED

There are no Benefits for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing.
- Plano lenses (less than a $\pm .50$ diopter power).
- Two pair of glasses in lieu of bifocals.
- Replacement of lenses and frames furnished under This Plan that are lost or broken, except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes.
- Corrective vision treatment of an Experimental Nature.
- Costs for services and/or materials above stated allowances.
- Services and/or materials not indicated on this Summary as covered Plan Benefits.
- Contact lens modification, polishing or cleaning.

- Local, state and/or federal taxes, except where we or its claims administrator is required by law to pay.
- Replacement of lost or damaged contact lenses, except at the normal intervals when services are otherwise available.

Copayment - Benefits received from In-Network Providers and Out-of-Network Providers may require Copayments.

There shall be a Copayment of \$10 for the examination payable by the Member at the time services are rendered. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be an additional \$25 Copayment payable at the time materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

Lens Enhancements, if covered under This Plan, may have a separate Copayment. Please refer to COVERED SERVICES AND MATERIALS above.

Eligible People – All full-time non-union employees working at least 35 hours per week and all full-time union employees working at least 30 hours per week who choose the vision plan: Continental Services (0001), Cuyahoga (0003) and COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) enrollees: Cuyahoga (0093), Continental Services (0099).

Also eligible are your Spouse and your Children to the end of the calendar year in which they turn 26, including your Children who are married, who no longer live with you, who are not your Dependents for Federal income tax purposes, and/or who are not permanently disabled.

Covered Persons choosing this vision plan are required to remain enrolled for a period of 12 months. Should a Covered Person choose to drop coverage after that time, he or she may not re-enroll prior to the date on which 12 months have elapsed. An election may be revoked or changed at any time if the change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

Waiting Period – Covered Persons who are eligible for Benefits are covered on the first day of the month following 30 days of full-time employment for newly hired employees.

Coordination of Benefits – If you and your Spouse are both eligible to enroll in This Plan as Enrollees, you may be enrolled together on one application or separately on individual applications, but not both. Your Dependent Children may only be enrolled on one application. We will not coordinate Benefits between your coverage and your Spouse's coverage if you and your Spouse are both covered as Enrollees under This Plan.

Benefits will cease on the last day of the month in which your employment is terminated.