

# DeltaVision® by Delta Dental of Kentucky

administered by VSP®

## **DeltaVision 150**

| Benefit                                                                      | Description                                                                                                                                           |                                                                                                            | Сорау                                     |                                                                                |
|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|-------------------------------------------|--------------------------------------------------------------------------------|
| WellVision Exam                                                              |                                                                                                                                                       |                                                                                                            |                                           |                                                                                |
| Exams<br>1 exam every 12 months                                              | Comprehensive eye exam to ensure<br>overall visual wellness                                                                                           |                                                                                                            | \$10                                      |                                                                                |
| Prescription Glasses                                                         |                                                                                                                                                       |                                                                                                            | \$10                                      |                                                                                |
| <b>Frames</b><br>1 pair every 24 months                                      | \$150 allowance for wide selection of frames<br>20% savings on amount over allowance<br>\$80 Costco, Walmart/Sam's Club frame allowance               |                                                                                                            | Included in<br>Prescription Glasses Copay |                                                                                |
| Lenses<br>1 pair every 12 months                                             | Single vision, lined bifocal and lined trifocal lenses<br>Polycarbonate lenses for children                                                           |                                                                                                            | Included in<br>Prescription Glasses Copay |                                                                                |
| Covered<br>Lens Enhancements                                                 | Standard Progressive Lenses                                                                                                                           |                                                                                                            | \$O                                       |                                                                                |
| Optional<br>Lens Enhancements                                                | Standard Anti-Reflective Coating<br>Premium Progressive Lenses<br>Custom Progressive Lenses<br>Average savings of 30% on other lens enhancements      |                                                                                                            | \$41<br>\$95 - \$105<br>\$150 - \$175     |                                                                                |
| Contact Lenses - instead of glasses                                          |                                                                                                                                                       |                                                                                                            |                                           |                                                                                |
| Contacts<br>every 12 months                                                  | \$150 allowance for contacts; copay does not apply<br>Contact lens exam (fitting and evaluation)                                                      |                                                                                                            | up to \$60                                |                                                                                |
| Extra Savings                                                                |                                                                                                                                                       |                                                                                                            |                                           |                                                                                |
| Featured Frames                                                              | \$170 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<br>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<br>WellVision Exam                                                      |                                                                                                            |                                           |                                                                                |
| Laser Vision Correction                                                      | Average 15%-20% discount                                                                                                                              |                                                                                                            |                                           |                                                                                |
| Additional Programs                                                          |                                                                                                                                                       |                                                                                                            |                                           |                                                                                |
| Included                                                                     | Primary Eyecare, Eye Health Management (including Diabetic Exam Reminder Letters)                                                                     |                                                                                                            |                                           |                                                                                |
| Your coverage with Out-of-Network Providers                                  |                                                                                                                                                       |                                                                                                            |                                           |                                                                                |
| Exam - up to \$45<br>Frame - up to \$70<br>Single Vision Lenses - up to \$30 |                                                                                                                                                       | Lined Bifocal Lenses - up to \$50<br>Lined Trifocal Lenses - up to \$65<br>Lenticular Lenses - up to \$100 | Contact                                   | sive Lenses - up to \$50<br>s - up to \$105<br>ry Contact Lenses - up to \$210 |

### **Member Services\***

#### **Delta Dental of Kentucky**

Customer Service 800-955-2030

\*Please contact DDKY for eligibility before contacting VSP Member Services

#### **VSP** Vision

Member Services 800-877-7195 Hearing impaired customers may call 800-428-4833

**VSP Choice Network** 

100,000 Access Points • In-network with Costco, Walmart/Sam's Club