# VISION COVERAGE

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Under the vision plan, you are covered for an annual eye exam and may purchase your eyeglasses and contacts from an eye care provider of your choice. When you use a Delta Vision network provider, you receive the highest level of plan benefits and have the lowest out-of-pocket costs.

| Vision Care Services | In-Network | Out-of-Network Reimbursement |
|---|---|---|
| Routine Annual Eye Exam | $10 Copay | Up to $35 |
| Frames | $200 allowance | Up to $100 |
| | **Lenses** | |
| Single Vision | $25 copay, then covered in full | Up to $25 |
| Bifocal | $25 copay, then covered in full | Up to $40 |
| Trifocals | $25 copay, then covered in full | Up to $55 |
| Lenticular | $25 copay, then covered in full | Up to $80 |
| Standard Progressives | $75 copay, then covered in full | Up to $40 |
| Other Lens Type | 80% of Charge | N/A |
| | **Contact Lenses** | |
| Elective | $200 allowance | Up to $160 |
| Medically Necessary | Covered in full | Up to $200 |
| | **Frequency Guidelines** | |
| Exams | Once every calendar year | |
| Frames | Once every calendar year | |
| Lenses or Contact Lenses | Once every calendar year | |

For additional information, visit **deltadentalia.com**.