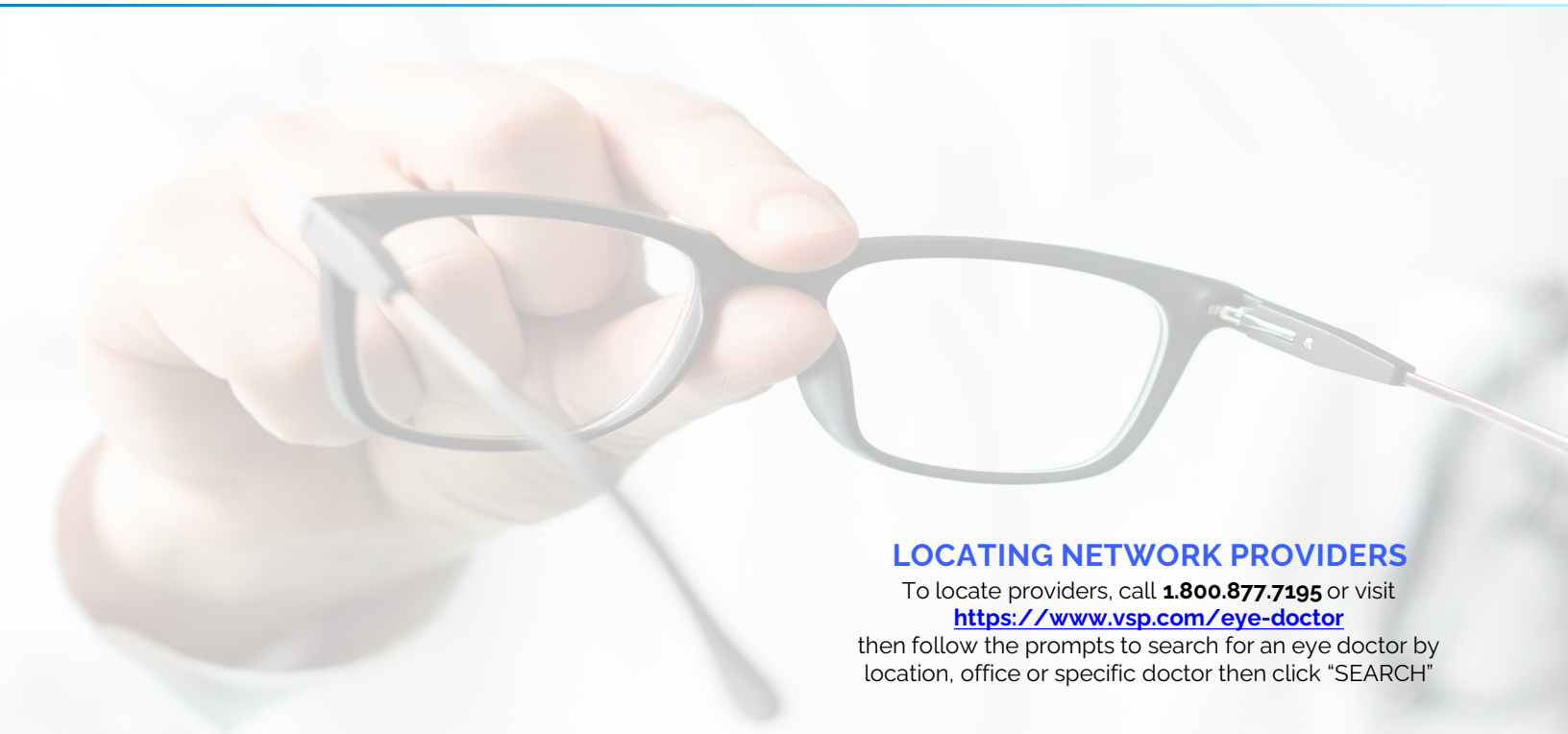
VSP Vision

Coverage Tier	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Monthly Rates	$11.71	$22.25	$23.31	$38.08

Vision Benefits	In Network	Out of Network	Frequency
Comprehensive eye exam	$10 copay	$45 allowance	Once every 12 months
Eyeglass Frames			
One pair of eyeglass frames	$130 allowance ($70 allowance at Walmart / Costco)	$70 allowance	Once every 24 months
Eyeglass Lenses (instead of contacts)			
Single	$25 copay	$30 allowance	Once every 12 months
Bifocal	$25 copay	$50 allowance	Once every 12 months
Trifocal	$25 copay	$65 allowance	Once every 12 months
Contact Lenses (instead of glasses)			
Contact Fitting & Evaluation	Maximum $60 copay	Applied to contact lens allowance	Once every 12 months
Elective disposable	$130 allowance	$105 allowance	Once every 12 months
Non-elective (medically necessary)	Covered 100% after copay	$210 allowance	Once every 12 months

[1]The VSP Vision Essential plan is not available as a standalone product and may only be sold in combination with Delta Dental plan offerings.

[2]Discounts for additional products and services are available in network only. For example, 20% savings on any amount above the retail allowance for frames, and 15% off regular price, or 5% off the promotional price, for LASIK.



LOCATING NETWORK PROVIDERS

To locate providers, call **1.800.877.7195** or visit
https://www.vsp.com/eye-doctor
then follow the prompts to search for an eye doctor by location, office or specific doctor then click "SEARCH"

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. Please contact your SBMA representative for additional information.