Vision Coverage

We partner with Delta Vision to offer the plan. You will have access to Eyemed access nationwide network of providers. Please see below for a brief summary of your benefits.

Your Vision Plan Costs

Employee Weekly Rates	
Employee	$1.37
Employee + Spouse	$2.68
Employee + Child(ren)	$2.60
Family	$4.06

Delta Vision	
	In Network You Pay:
Exam	$10
Lenses *Single Lenses* *Bifocals* *Trifocals* *Frames*	$25 copay $25 copay $25 copay $130 allowance, then 20% off balance
Contacts *(in lieu of Frames / Lenses)* *Contacts - Medically Necessary* *Contacts - Elective*	$0 after copay $130 Allowance
Benefit Frequency *Exams* *Lenses* *Frames* *Contacts*	Once every 12 months *Frame and Contact allowance are one-time-use benefits during the frequencies shown

DELTA DENTAL®

DeltaVision®

Underwritten by Red Tree Insurance, Inc.,
a Northeast Delta Dental Company.

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Outline of Coverage
MAINE BUSINESS SERVICES DBA MANPOWER
961119-33700

Read Your Policy Carefully – This outline of coverage provides a very brief description of the important features of coverage. This is not the insurance contract, and only the actual policy provisions will control. The policy, also referred to as the Vision Plan Description, sets forth in detail the rights and obligations of both you and the insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

Brief Description of Your Benefits: Your policy provides coverage of certain vision services and products as described below. Your DeltaVision benefit plan is administered through EyeMed Vision Care one of the nation's leading vision providers.

This outline of coverage does not cover all plan details. Please review your Policy as it provides a thorough explanation of your vision plan, including any limitation or exclusions that might apply. Further, if there are any discrepancies between information found here and the group contract, the group contract shall govern.

Frame Allowance (Materials)	$130
Contact Lenses Allowance (Materials)	$130
Copay Amount Exam and Lenses	$10 / $25

	Network Benefit	Non-Network Reimbursement
Exam with Dilation as Necessary	Member co-pay $10, plan pays balance	Up to $35
Contact Lens Fit and Follow-up		
Standard *- Includes spherical clear contact lenses in conventional wear and planned replacement (Examples include, but are not limited to, disposable, frequent replacement, etc.)*	Member pays up to $55.00	None
Premium *- Includes all lens designs, materials and specialty fittings other than Standard Contact Lenses (Examples include toric, multifocal, etc.)*	10% discount off retail	None
Frames --*Any available frame at provider location.*	$130 allowance, then 20% off balance	Up to $65
Standard Plastic Lenses		
Single vision / Bifocal / Trifocal	Member co-pay $25, plan pays balance	Up to $25 / $40 / $55
Lens Options		
UV coating / Tint / Standard scratch resistance	Member co-pay $15 each	None
Standard polycarbonate	Member co-pay $40	None
Standard anti-reflective coating	Member co-pay $45	None
Standard progressive (Add-on to Bifocal)	Member co-pay $90	None
Premium progressive	$90 co-pay, 80% of charge less $120 allowance	None
Other add-ons and services	20% off retail price	None
Contact Lenses – *Contact lens allowance covers materials only.*		
Conventional	$130 allowance, then 15% off balance	Up to $104
Disposable	$130 allowance, member pays balance	Up to $104
Medically necessary	Paid in full	Up to $200
Laser Vision Correction - Lasik or PRK	15% off retail price or 5% off promotional price	None
Frequency - Exams / Lenses or Contact Lenses / Frames	12/12/24 months	

Additional in-network discounts

- Members receive a 20% discount on items not covered by the plan at network providers, which may not be combined with any other discounts or promotional offers. The discount does not apply to EyeMed provider's professional services or to contact lenses. Retail prices may vary by location.
- Members also receive a 40% discount off complete eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.
- After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com. The contact lens benefit allowance is not applicable to this service.
- Discounts do not apply for benefits provided by other group benefit plans.

Policy Provisions which Qualify Payments:

Exclusions: The following are not Benefits under your DeltaVision Plan:

- Services or products received prior to the Effective Date of the Subscriber's or Dependent's coverage or after the termination date of such coverage.
- Any service or product to treat injuries or conditions compensable under worker's compensation or employer's liability laws.
- Any services or products not specifically provided as a Benefit in the Outline of Coverage under the Group Contract.
- Corrective eyewear required as a condition of employment and safety eyewear unless specifically covered under this plan.
- Plano (clear) non-prescription lenses and non-prescription sunglasses.
- Charges for consultations and for completion of forms.
- Orthoptic or vision training, subnormal vision aids and any associated testing.
- Aniseikonic lenses (for unequal size retinas).
- Medical and/or surgical treatment of the eye, eyes or supporting structures.
- Lost or broken products.

Limitations: The following limitations apply to your DeltaVision Benefits:

- Discount benefits do not apply to a Network Provider's professional services which are covered as Benefits or to contact lenses.
- For products received from a Network Provider but not covered as Benefits, the discount specified in this Outline of Coverage will apply; however, the discount may not be combined with any other discounts or promotional offers.
- Lasik or PRK vision correction is an elective procedure performed by specially trained providers who are not located in all areas. The discount available for such procedures may not be available in your immediate location.
- Discounts do not apply to benefits provided by other group benefit plans.
- The Benefit for frames will not be available for certain brands of frames for which the manufacturer imposes a no-discount policy.
- Benefits will not be provided for two (2) pair of eyeglasses in lieu of one pair of bifocals. If two separate pairs of eyeglasses are chosen rather than one pair of bifocals, the first pair will be covered by the Plan as a Benefit and the second pair will receive a 40% discount.

Renewability: Your vision plan will be renewed annually unless your employer elects to terminate the policy or you do not pay your required premiums. Premiums are subject to change annually in accordance with advance notice given to you. Eligibility to be a dependent under this policy is limited by age and other factors. In the event you or a dependent may lose coverage under this group policy, federal or state continuation of coverage rights may apply for a limited time.