Summary of Vision Plan Benefits – Choice Plan
For Group# V10987-0001
Dee Mac Inc.

This Summary of Vision Plan Benefits is part of, and should be read in conjunction with, your Group Vision Certificate. Your Group Vision Certificate will provide you with additional information about your DeltaVision coverage, including information about exclusions and limitations. 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 Delta Dental's 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

Covered Services

We will provide vision care Benefits according to the Schedule listed below. This Summary lists the vision care Benefits to which Covered Persons 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 Contract to which it is attached.

In-Network Providers are those Providers who have agreed to participate in the VSP Choice Network.

When Covered Services are received from In-Network Providers, the Benefit amounts shown 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 Covered Services are received from Out-of-Network Providers, the Covered Person is reimbursed for such Benefits according to the schedule in the Out-of-Network Provider Benefit column below, less any applicable Copayment. The Covered Person 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.

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 Covered Person 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 Policy, may have a separate Copayment. Please refer to COVERED SERVICES AND MATERIALS, below.

BENEFITS – IN-NETWORK AND OUT-OF-NETWORK PROVIDERS

COVERED SERVICE OR MATERIAL	IN-NETWORK PROVIDER BENEFIT	OUT-OF-NETWORK PROVIDER BENEFIT	FREQUENCY
Eye Examination	Covered in full*	Up to $45*	Available once each 12 months**
Retinal Screening	Covered for a maximum fee of $39	Included in exam	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. **Beginning with the first date of service. Coverage for retinal imaging as an enhancement to the eye examination.			

COVERED SERVICE OR MATERIAL	IN-NETWORK PROVIDER BENEFIT	OUT-OF-NETWORK PROVIDER BENEFIT	FREQUENCY
LENSES			Available once each 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 covered in full. *Less any applicable Copayment. **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* Frame Allowance may be applied towards non-prescription sunglasses or blue light filtering glasses, exhausting both frame and lens eligibility. Lab-fabricated plano lenses are not covered.	Up to $70.00* Frame Allowance may be applied towards non-prescription sunglasses or blue light filtering glasses, exhausting both frame and lens eligibility. Lab-fabricated plano lenses are not covered.	Available once each 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.

Frame allowance may be applied towards non-prescription sunglasses for post PRK, LASIK, or Custom LASIK patients.

*Less any applicable Copayment.
**Beginning with the first date of service.

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

*Less any applicable Copayment.
**Beginning with the first date of service.

Necessary Contact Lenses are a Covered Services when specific benefit criteria are satisfied and when prescribed by Covered Person's In-Network Provider or Out-of-Network Provider. Review and approval by Delta Dental's claims administrator is not required for Covered Persons 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 Covered Person 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 (2) 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 Covered Person should pay the Out-of-Network Provider's full fee at the time of service Covered Person 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 OF BENEFITS

Some brands of spectacle frames and lenses may be unavailable for purchase as Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame and lens brand availability from their In-Network Provider or by calling the Member Services Department at 1-800-877-7195.

PATIENT OPTIONS

This Plan is designed to cover visual needs rather than cosmetic materials. When the Covered Person 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.
- 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 ± .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 Schedule as covered Plan Benefits.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where Delta Dental 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.

Eligible (Certificate Holder and Eligible Dependents) – All full-time employees of the Contractor working at least 30 hours per week who choose the vision plan and COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) enrollees, if applicable.

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 60 days of employment.

Coordination of Benefits – If you and your Spouse are both eligible to enroll in This Plan as Covered Persons, you may be enrolled together on one application or separately on individual applications, but not both. We will not coordinate benefits between your coverage and your Spouse's coverage. If you or your Dependents have vision coverage under any other plan, you or your Dependents are not eligible for enrollment in This Plan.

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