Northeast Delta Dental
One Delta Drive
PO Box 2002
Concord, NH 03302-2002
Customer Service:
1-800-832-5700

Outline of Benefits
AVERY INNS OF VERMONT DBA LAKE MOREY RESORT
Group Number: 71170-904258

For more information on your benefits, please refer to your Dental Plan Description (DPD) or Summary Plan Description (SPD).

Benefit Period: January 1 through December 31

Eligibility Period: Determined by the Employer.

Benefit percentages paid by Northeast Delta Dental after any applicable Waiting Periods and/or Copayments:

Diagnostic & Preventive (Coverage A)	100%
Basic (Coverage B)	80%
Major (Coverage C)	50%
Orthodontics (Coverage D)	50%

Maximum Benefits: $2,000 per person per benefit period excluding Orthodontics.
Orthodontic benefits have a separate lifetime maximum of $1,500 per adult and child

Deductibles: $100/$300 lifetime deductible per person/family (applies to Basic and Major benefits only).

Office Visit Copayments: None

Waiting Periods:
Waiting periods do not apply to eligible enrollees under nineteen (19) years of age, except for orthodontic benefits.
Basic Benefits: Coverage begins on the first day of the month following 6 months of continuous coverage.
Major Benefits: Coverage begins on the first day of the month following 12 months of continuous coverage.
Orthodontic Benefits: Coverage begins on the first day of the month following 12 months of continuous coverage.

Dependent Age Limits:
Dependent Children are covered up to age 26.

Your benefits include Domestic Partner Coverage. Please contact your employer for more details.

Double-Up Max[SM]:

This Northeast Delta Dental Plan allows you to double your calendar year maximum by earning an additional $250 per year for use in future benefit periods. Here is how it works:

- To qualify for the carryover, you must have a claim paid for either an oral exam or a cleaning during a calendar year (a focus on prevention), and your total paid claims cannot exceed $500 during the same calendar year.

- The carryover will accumulate for each year of qualification up to an amount equal to the plan's original calendar year maximum. If, for example, the calendar year maximum is $1,000, enrollees can ultimately achieve an annual maximum of $2,000

- This feature does not apply to orthodontic benefits.

Please note: Groups first effective during July – December will begin qualifying for the carryover the following calendar year for benefit dollars that can be used in the subsequent year.

DELTA DENTAL®

DeltaVision®

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

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Outline of Coverage
AVERY INNS OF VERMONT DBA LAKE MOREY RESORT
907151-904258

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)	$180
Contact Lenses Allowance (Materials)	$180
Copay Amount Exam and Lenses	$10 / $10

	Network Benefit	Non-Network Reimbursement
Exam with Dilation as Necessary	Member copay $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.*	$180 allowance, then 20% off balance	Up to $90
Standard Plastic Lenses		
Single vision / Bifocal / Trifocal	Member copay $10, plan pays balance	Up to $25 / $40 / $55
Lens Options (in addition to copay for Standard Plastic Lenses)		
UV coating / Tint / Standard scratch resistance	Member pays $15 each	None
Standard polycarbonate	Member pays $40	None
Standard anti-reflective coating	Member pays $45	None
Standard progressive (Add-on to Bifocal)	Member pays $65	None
Premium progressive	Member pays $65, 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	$180 allowance, then 15% off balance	Up to $144
Disposable	$180 allowance, member pays balance	Up to $144
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	12/12/12 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.