VISION BENEFITS

Covered Vision Expenses	Benefit
Eye exam, per person, each calendar year	$20 copay per eye exam then 100%
Frame-type lenses, per pair, each calendar year – Single Vision **Frame-type lenses, per pair, each calendar year – Bi-focal** **Frame-type lenses, per pair, each calendar year – Tri-focal** **Frame-type lenses, per pair, each calendar year – Lenticular** **Frames, per pair, each calendar year** **Contact Lenses each calendar year**	100% paid up to a combined maximum of $300 paid per Calendar Year.
NOTE: Frames, lenses, and contact lenses are limited to a combined maximum	***of $300 paid per Calendar Year.***

Vision Covered Expenses

Subject to the limits in the Summary of Benefits, the Plan pays the Maximum Allowable Charge for vision care services, as follows:

Eye Refractions. Eye refractions, eyeglasses, contact lenses, or the vision examination for prescribing or fitting eyeglasses or contact lenses.

Recommended. Recommended and approved by a Physician or optometrist.

Vision Exclusions and Limitations

The following Exclusions and limitations are in addition to those set forth in the sections entitled "General Limitations and Exclusions," and "Summary of Benefits":

Consultations. Consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form. Charges for consultations will be covered if they are related to a life-threatening situation or condition. They will also be covered at the Plan's discretion.

Enrolled in a Training Program. Services performed by a Physician or other Provider enrolled in an education or training program when such services are related to the education or training program, except as specifically provided herein.

Eyeglasses. Two pairs of eyeglasses in lieu of bifocals.

Greater Coverage. Any charges that are covered under a medical or health plan that reimburses a greater amount than this Plan.

Lost or Broken. Replacement of frames and/or lenses that are lost or broken. Replacements will be allowed at the normal Plan intervals for frames and/or lenses. (e.g. once per Plan Year);

Non Prescription Lenses. Charges for lenses ordered without a prescription or lenses that do not require a prescription.

Orthoptics. Charges for orthoptics (eye muscle exercises).

Prior to Plan Coverage. Care, treatment or supplies for which a charge was Incurred before or after a person was covered under this Plan;

Radial Keratotomy. Radial keratotomy or other plastic surgeries on the cornea in lieu of eyeglasses.

Safety Goggles or Sunglasses. Charges for eyewear not meant to address any medical purpose including but not limited to plain safety glasses or goggles. This Exclusion shall also apply to sunglasses, including prescription type.

Surgical Treatment. Medical or surgical treatment to the eye;

Vision Training. Charges for vision training or subnormal vision aids.

Workers' Compensation. Eye exams or corrective eyeglasses or contact lenses required by the Participant's Employer as a condition of employment, unless previously approved by the Employer and not considered eligible under workers' compensation.