

VISION BENEFITS

Please Note: Vision Benefits require a separate benefit election

<u>Payment</u>	<u>Covered Person Copayment</u>	<u>Maximum Plan Payment</u>
Eye Exam	\$10	\$50
Contact Lens Fitting	<i>Not Covered</i>	

Frequency: *Once Per Calendar Year*

Lenses

Single Vision Lenses	\$15	\$40
Lined Bifocal Lenses	\$15	\$55
Lined Trifocal Lenses	\$15	\$70
Lenticular	\$15	\$95

Lens Options

UV Coating & Dyes	\$15	\$50
Scratch Resistant	\$20	\$50
Polycarbonate Lenses	\$35	\$50
Progressive Lenses	\$55	\$100
Photochromic	\$55	\$100
Anti-Reflective Coating	\$55	\$100

Frequency: *Once per two (2) year period*

Frames

Retail Frame Allowance	\$15	\$120
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(Frame Copayment applies only if frames are purchased without lenses)

Frequency: *Once per two (2) year period*

Contact Lenses

Retail Allowance	-0-	\$120
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Frequency: *Once every two (2) year period*