

CHELSEA SCHOOL DISTRICT Vision Benefits Plan

Group #9709

The Plan-at-a-Glance **Benefit Year – January 1 through December 31**

Vision Examination Covered at 100% of Reasonable & Customary (R&C)
Following \$6.50 Copay

Spectacle Lenses (Pair):
 Single Vision Covered at 100% of R&C
 Bifocal Following \$9.00 Copay
 Trifocal According to Limits & Exclusions
 Lenticular

Frames Covered up to \$65
Following \$9.00 Copay

Contact Lenses (Pair)
 Cosmetic/Elective Covered Up to \$90
 Medically Necessary Covered at 100% of R&C

Extra Lens Features – Tinted, Polarized, Oversize and Blended Lenses

Limits & Exclusions

1. Plan participants are limited to one vision examination during a benefit year
2. Plan participants are limited to one pair of corrective spectacle lenses and one frame during a benefit year
3. Plan participants may choose between eyeglasses or contact lenses, but not both

No Payments will be made for the following:

1. Non-corrective eyeglass or contact lenses
2. Vision therapy or subnormal vision aids
3. Medical or surgical treatment of the eyes
4. Replacement of lost or broken lenses or frames if benefits applicable to the replacement were previously provided during the benefit year
5. Charges with respect to which benefits are provided under any Workers' Compensation or similar law
6. Vision examination, lenses or frames which would have been furnished without cost in the absence of this insurance or for which an insured person has no legal obligation to pay
7. The cost of frames that exceeds the plan allowance
8. Extra charges for any lens treatments and coatings not listed under Extra Lens Features
9. The additional cost of progressive lenses
10. Charges for cosmetic (elective) contact lenses, including the exam, prescription and fitting fee, that exceed the annual plan allowance

Note: For each benefit year, covered charges for contact lenses are in lieu of all other covered charges during the benefit year for each insured person.