SUMMARY OF BENEFITS

OPTIONAL VISION PLUS BENEFIT

The amounts listed below are the maximum benefits available for all vision exams, lenses, and frames furnished during any 24 consecutive month period. If charges for a service or supply are less than the amount allowed, the benefit will be equal to the actual charge. If only one lens is supplied, the allowance for the lens is 50% of the lens allowance shown below.

SERVICE/SUPPLY	Participating Provider Benefit	Nonparticipating Provider Benefit
Eye Exam	100%	$40
Hardware		
***Lenses** (maximum per pair)		
Single Vision	100%	$56
Bifocal	100%	$84
Trifocal	100%	$116
Lenticular	100%	$236
Progressive	$116	$116
***Frames**	$75	$75
***Contacts** (in place of glasses)	$131	$131

* *Participating Providers discount these services.*

This plan does not cover:

- Special procedures such as orthoptics or vision training.
- Special supplies such as sunglasses (plain or prescription) and subnormal vision aids.
- Tint.
- Plano contact lenses.
- Anti-reflective coatings or scratch resistant coatings.
- Separate charges for contact lens fitting.
- Replacement of lost, stolen, or broken lenses or frames.
- Duplication of spare eyeglasses or any lenses or frames.
- Visual analysis that does not include refraction.
- Services or supplies not listed as covered expenses.
- Charges for services or supplies covered in whole or in part under any other medical or vision benefits provided by the employer.
- Eye exams required as a condition of employment, or required by a labor agreement or government body.
- Expenses covered under any workers' compensation law.
- Services or supplies received before this plan's coverage begins or after it ends.