

BENEFITS HIGHLIGHT VISION CARE BENEFITS

Benefits. If a Participant receives an eye examination, lenses or frames, the Plan will, subject to the provisions hereafter stated, pay benefits in accordance with the following.

Deductible. Benefits under this Article V are not subject to deductible and are payable at 100%, subject to the maximum benefit limitations under the Schedule of Benefits.

Covered Services. The Plan will pay for:

- a. an eye examination for a participant for determination of necessity of prescription lenses.
- b. lenses if ordered by a doctor or an optometrist on an initial evaluation or if a prescription change so indicates.
- c. subnormal vision aids including contact lenses, telescopic lenses and other similar devices prescribed by an optometrist or doctor as Medically Necessary to improve vision to 20/70 in the better eye, providing conventional lenses fail.
- d. contact lenses, in lieu of glasses.

Schedule of Benefits. Benefits are payable only once in each two (2) calendar year period pursuant to the Schedule of Benefits, with the exception of a prescription change which is payable once each calendar year.

Exclusions and Limitations. The Plan will not provide benefits for:

- a. all services in excess of the Schedule of Benefits.
- b. Experimental Treatment.
- c. services provided by a close relative.
- d. benefits covered under the Worker's Compensation Act.
- e. surgery or medical treatment of the eyes.
- f. replacement of lost stolen or broken lenses and/or frames.
- g. services and supplies for which the Participant or Dependent is not required to pay or which are not listed.
- h. more than one complete eye examination every two (2) calendar years or more than one pair of frames and/or lenses or contact lenses every two (2) calendar years, unless due to a prescription change. In that event, benefits will be payable once in each calendar year.

Vision Care Benefits

Availability of Services

Eye examination, per person	One each two calendar years
Lenses	One each two calendar years
Frames, if required	One each two calendar years
Contact Lenses	One each two calendar years
Materials and exams if prescription	One each calendar year

<u>Covered Expenses</u>	<u>Maximum Benefit</u>
Complete Eye Examination (including refraction)	\$75.00

Lenses, per pair

single	75.00
bifocal	100.00
trifocal	150.00
lenticular	125.00
contacts, telescopic lenses (which are subnormal vision aids)	205.00
contacts for cosmetic purposes including disposable contacts	125.00

Frames	100.00
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Not subject to a deductible

LATE ENTRY RESTRICTIONS: Effective January 1, 1997 for plan participants determined to be late vision entrants. The maximum reimbursement available for the first twelve monthss of continuous coverage would be \$75 toward a complete eye exam.