## VOLUNTARY VISION BENEFITS

The following Deductibles, Copayments, and Benefits are per Plan Participant, per Plan year:

| Vision Benefit Deductible and Benefit Limit Summary: | Amount |
|---|---|
| Annual Deductible per Participant | **$50** |
| Annual Deductible per Family | **$100** |
| Vision Coinsurance | **90% Ninety Percent** |
| Maximum Annual Vision Plan Benefit Limit per Participant | **$600** |

| Vision Expense Benefit Descriptions: | Benefit Limits[27] | Annual Benefit Maximum |
|---|---|---|
| 1 Eye Exam[28], Per Participant | 1 every 12 months | **$100 Maximum** |
| 1 Set of Frame-type Single Vision Lenses | 1 every 12 months | **$120 Maximum** |
| 1 Set of Frame-type Bi-focal Lenses | 1 every 12 months | **$130 Maximum** |
| 1 Set of Frame-type Tri-focal Lenses | 1 every 12 months | **$140 Maximum** |
| 1 Set of Frame-type Lenticular Lenses | 1 every 12 months | **$150 Maximum** |
| 1 Set of Frames | 1 every 24 months | **$130 Maximum** |
| Contact Lenses | Subject to Vision Limit | **90 / 10 to Benefit Limit** |

### 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:

**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.

**Eye Refractions.** Eye refractions, eyeglasses, contact lenses, or the vision examination for prescribing or fitting eyeglasses or contact lenses (except for aphakic patients, and soft lenses or sclera shells intended for use in the treatment of Injury).

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

**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":

**Benefit Limitations.** A Participant can use the benefit to secure either eye glasses with frames or contact lenses, but not both within the same Plan year.

**Glaucoma and Cataracts.** Treatment of glaucoma, cataract surgery and one set of lenses (contacts or frame-type) for these conditions are covered under Medical Benefits.

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

**Missed Consultations.** Missed consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form.

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

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[27] These limits are in addition to all other Plan exclusions, limitations and provisions set forth in this Plan. Please review the entire Plan Document carefully to determine available benefits.

[28] If the member has the major medical plan and the vision program, eligible eye exam expenses will be paid by the medical plan.

**Orthoptics.** Charges for orthoptics (eye muscle exercises).

**Safety Goggles.** Charges for eyewear not meant to address any medical purpose including but not limited to plain safety glasses or goggles.

**Sunglasses.** Charges for sunglasses not meant to address any medical purpose including prescription type.

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