PO Box 610
Southfield, MI 48037
248-901-3705

BAY ARENAC ISD Vision Benefits Plan — Group #10076

The Plan-at-a-Glance	Benefit Year – January 1 through December 31
Vision Examination	Covered Up to $75.00
Spectacle Lenses (Pair):	
Single Vision	Covered Up to $63.00
Bifocal	Covered Up to $80.00
Trifocal	Covered Up to $95.00
Lenticular	Covered Up to $115.00
Frames	Covered Up to $130.00
Contact Lenses (Pair) (includes fitting fees)	Covered Up to $200.00

Extra Lens Features – None

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, polycarbonate and photochromic lenses
10. Charges for contact lenses, including the prescription and fitting fee, that exceed the one-time annual plan allowance

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