Vision Benefit Plan Summary		
	In-Network	Out-of-Network
Office Copay	$25	$25
Services		
Exams	Once every plan year	Once every plan year
Lenses		
Exam	Covered 100%*	Covered up to $45*
Lenses		
Single Vision		Covered up to $45*
Lined Bifocal	Covered 100%*	Covered up to $65*
Lined Trifocal		Covered up to $85*
Lenticular		Covered up to $125*
Frames	Covered up to $150*	Covered up to $47
Contact Lenses		
Medically Necessary	Covered 100%	Covered up to $210*
Elective	Covered 100% up to $150	Covered up to $105*
*Included in $25 Copay.		

Vision Plan Premiums		
	Weekly	Semi-Monthly
Employee Only	$1.62	$3.50
Employee + Spouse	$3.23	$7.00
Employee + Child(ren)	$3.23	$7.00
Employee + Family	$4.85	$10.50