PO Box 610
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TRAVERSE CITY AREA PUBLIC SCHOOLS Vision Benefits Plan Group # 42234
Non-Instructional

The Plan-at-a-Glance	**Benefit Period – July 1st through June 30th**
Vision Examination	Covered Up to $48
Spectacle Lenses (Pair):	
Single Vision	Covered Up to $63
Bifocal	Covered Up to $72
Trifocal	Covered Up to $90
Lenticular or Progressive	Covered Up to $108
Frames	Covered Up to $27
Contact Lenses (Pair)	
Cosmetic/Elective	Covered Up to $150

Extra Lens Features - None

Limits & Exclusions

1. Plan participants are limited to one vision examination during any benefit year period.
2. Plan participants are limited to one pair of corrective spectacle lenses and one frame or pair of contacts during any benefit year period.
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. Photochromic and Polycarbonate Lenses.
10. Charges for cosmetic (elective) contact lenses that exceed the annual plan allowance

Note: For each benefit period, covered charges for contact lenses are in lieu of all other covered charges during the benefit period each insured person.