

VISION PLAN
V85D-10/10-FL

This vision plan includes in- and out-of-network benefits as listed below; if you visit a network provider, you will receive the maximum benefit. If you choose to see an out-of-network provider, you will be reimbursed for services as indicated in the "Out-of-network Coverage" section of this schedule.

Frequency (months)	Exam	Lenses	Frame	Contacts
	12	12	24	12
	In-Network Coverage (Using a Network Provider)		Out-of-Network Coverage (Using a Non-Network Provider)	
Examination	Your Co-payment	\$10	Your Reimbursement	\$35 You are responsible for the provider's usual charge; reimbursement for the amount listed will be paid upon receipt of your claim.
Eyeglasses (lenses & frame)	Your Co-payment	\$10 The co-payment covers standard lenses at 100%: <ul style="list-style-type: none"> • Single Vision • Bifocal (FT-25, FT-28, Round) • Trifocal (7x25, 7x28) • Lenticular • UV Protection • SV Polycarbonate Lenses for members under 18 years If you wish to purchase non-standard lenses (not covered at 100%), you will be responsible for the difference between the credit described below and as little as 80% of provider's usual charge: <ul style="list-style-type: none"> • Single Vision \$35 per pair • Bifocal \$46 per pair • Trifocal \$56 per pair • Lenticular \$125 per pair • Progressive \$56 per pair (in lieu of Trifocals) 	Your Co-payment	\$10 Your Reimbursement <ul style="list-style-type: none"> • Single Vision \$25 per pair • Bifocal \$35 per pair • Trifocal \$45 per pair • Lenticular \$100 per pair • UV Protection \$5 per pair • SV Polycarbonate upgrade for members under 18 years \$10 per pair • Progressive \$45 per pair (in lieu of Trifocals)
Frames	Allowance	\$85	Reimbursement	\$55
Cosmetic/ Elective Contact Lenses	Allowance	\$120 Available in lieu of all other eyewear benefits.	Reimbursement	\$95 Available in lieu of all other eyewear benefits.
Medically Necessary Contact Lenses	Allowance	\$250 per pair Prior authorization by SafeGuard is required.	Reimbursement	\$250 per pair Prior authorization by SafeGuard is required.

Please refer to your Certificate of Insurance for details on the process and administration of your coverage.

Please note:

If you wish to purchase non-standard frames or lenses (see "Exclusions" on the following page), or elective contact lenses from a contracted vision care provider, you will be responsible for the difference between the allowance shown above and as little as 80% of that provider's usual charge for frames and lenses and as little as 85% for contact lenses (excluding disposable and planned replacement contact lenses). SafeGuard will apply the Standard Lenses allowance toward upgraded lens materials. You will be responsible for the amount over the allowance.

If you wish to purchase frames, lenses, or contact lenses from a contracted vision care provider that are not covered under this policy, you will be responsible for 80% of that provider's usual charge for frames and lenses and as little as 85% for contact lenses (excluding disposable and planned replacement contact lenses).

If you purchase frames, lenses, or contact lenses from an out-of-network vision care provider, you will be responsible for the provider's usual charge and will be reimbursed as noted above (less any co-payment).

Except as otherwise provided in the Schedule of Benefits, the following are excluded from coverage:

- Charges for procedures, services or materials that are not included as covered charges.
- Any portion of a charge in excess of the allowance or reimbursement indicated in the Summary of Benefits.
- Expenses for any non-standard corrective lens materials, including but not limited to the following: coated, dyed, glass lens or laminated lenses, progressive, blended, or oversize lenses, occupational or recreational lenses, safety glasses, scratch resistant, anti-reflective, or photochromic/photosensitive.
- Non-prescription lenses.
- Orthoptics, vision training and any associated supplemental testing.
- Medical or surgical treatment of the eye. Coverage limited to laser refractive surgery benefit included as covered charges.
- Prescription or non-prescription medications.
- Any eye examination or any corrective eyewear required as a condition of employment.
- Services or materials that are experimental, cosmetic or not medically necessary.
- Any service or material not prescribed by an ophthalmologist, optometrist or registered dispensing optician.
- Services and materials furnished in conjunction with excluded services and materials.
- Services and materials for repair or replacement of broken, lost or stolen lenses, contact lenses or frames.
- Services and materials that a covered person received during a service interval under any other plan offered by the Company or one of the Company's affiliates.
- Charges incurred before a covered person's effective date of coverage under the Policy or after such coverage terminates.
- Services or materials received as a result of disease, defect, or injury due to war or an act of war (declared or undeclared), taking part in a riot or insurrection, or committing or attempting to commit a felony.
- Services and materials obtained while outside the United States, except for emergency vision care.
- Services or materials resulting from or in the course of a covered person's regular occupation for pay or profit for which the covered person is entitled to benefits under any Workers' Compensation Law, Employer's Liability Law or similar law. You must promptly claim and notify the Company of all such benefits.
- Charges payable or reimbursable by or through a plan or program of any governmental agency, except if the charge is related to a non-military service disability and treatment is provided by a governmental agency of the United States;
- Services, procedures, or materials for which a charge would not have been made in the absence of insurance.