



Hale Area Schools

Plan Year 10.1.2016-09.30.2017

Self Funded Vision Benefit Plan	
	Provided Once Per Benefit Period
EYE EXAM	VSP Participating Physician \$5.00 co-pay
	Provided Once Per Benefit Period
LENSES Single Vision Bifocal Trifocal Lenticular Lenses	No Copay Covered up to \$60 Allowance (Maximum per pair of Lenses) Covered up to \$86 Allowance (Maximum per pair of Lenses) Covered up to \$112 Allowance (Maximum per pair of Lenses) Covered up to \$140 Allowance (Maximum per pair of Lenses) <i>NOTE: Lens options, which enhance the appearance, durability & function are available at VSP member preferred discount pricing.</i>
	Provided Once Per Benefit Period
CONTACT LENSES Medically Necessary Elective Contact lenses	Covered up to \$80 Allowance (Maximum per pair of Lenses) Covered up to \$80 Allowance (Maximum per pair of Lenses) <i>NOTE: Allowance applies to the cost of your Contact Lense, Exam and the Contact Lenses themselves.</i>
	Provided Once Per Benefit Period
STANDARD FRAMES	Covered up to \$65 Allowance (Maximum Allowance) <i>NOTE: If you choose a frame valued more than the allowance, you will be able to purchase them at the VSP member preferred discount pricing on your out-of-pocket cost of the frame at VSP participating providers</i>