## FREQUENCY OF SERVICE:

<table>
<thead>
<tr>
<th></th>
<th>Employee</th>
<th>Spouse</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision Exam</td>
<td>12 Months</td>
<td>12 Months</td>
<td>12 Months</td>
</tr>
<tr>
<td>Lenses</td>
<td>12 Months</td>
<td>12 Months</td>
<td>12 Months</td>
</tr>
<tr>
<td>Frames</td>
<td>24 Months</td>
<td>24 Months</td>
<td>24 Months</td>
</tr>
</tbody>
</table>

**DEPENDE NT AGE: 26 (EOBM)**

## BENEFITS: Employee can select either:

<table>
<thead>
<tr>
<th>Vision Exam (Glasses or Contacts)</th>
<th>100%</th>
<th>$40</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clear Standard Lenses (Pair):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Vision</td>
<td>100%</td>
<td>$40</td>
</tr>
<tr>
<td>Bifocal</td>
<td>100%</td>
<td>$50</td>
</tr>
<tr>
<td>Blended Bifocal</td>
<td>100%</td>
<td>$50</td>
</tr>
<tr>
<td>Trifocal</td>
<td>100%</td>
<td>$75</td>
</tr>
<tr>
<td>Progressives</td>
<td>Partially Covered&lt;sup&gt;A&lt;/sup&gt;</td>
<td>$75</td>
</tr>
<tr>
<td>Lenticular</td>
<td>100%</td>
<td>$100</td>
</tr>
<tr>
<td>Polycarbonate</td>
<td>100%&lt;sup&gt;B&lt;/sup&gt;</td>
<td>N/A</td>
</tr>
<tr>
<td>Scratch Coat-1 Yr</td>
<td>100%</td>
<td>N/A</td>
</tr>
<tr>
<td>Frame</td>
<td>100%&lt;sup&gt;C&lt;/sup&gt;</td>
<td>$50</td>
</tr>
</tbody>
</table>

**VBA Participating Provider Amount Covered/Benefit**

**Non-Participating Provider Amount Reimbursed**

(Zero Copayment)

### Elective Contacts (in lieu of eyeglass benefits)

- Material Allowance: $160<sup>D</sup>
- Fitting Fee: 15% off UCR<sup>A</sup>

### Medically Necessary Contacts

- Low Vision Aids (Per 24 Months, No Lifetime Max): $650

A Participation may vary by location. Check with your Provider for details.

B Available In-Network at no charge for children under age 19.

C Up to the program’s $50 wholesale allowance.

D The allowance is applied to all services/materials associated with contact lenses, including, but not limited to, contact fitting, dispensing, cost of the lenses, etc. No guarantee the allowance will cover the entire cost of services and materials.

E Requires prior approval. May only be selected in lieu of all other material benefits listed herein.
Limitations

This plan is designed to cover your visual needs rather than cosmetic options.

ADDITIONAL CHARGES

You may incur out-of-pocket charges when selecting any of the following:

- Tinted Lenses
- Photochromic/Polarized Lenses
- Polycarbonate (covered under age 19)
- Hi-index Lenses
- Progressive (available starting at $45)
- The coating of the lenses or lenses (except 1 year scratch protection)
- A frame that costs more than the plan allowance
- Rimless Frames
- Anti-Reflective/Backside UV/Optifog

Additionally, costs for contact lenses/services in excess of the plan’s scheduled reimbursement allowances are the responsibility of the patient.

NOT COVERED

The contract gives VBA the right to waive any of the plan limitations if, in the opinion of our optometric consultants, it is necessary for the patient’s welfare. VBA provides no benefit for professional services or materials connected with the following:

- Orthoptics or vision training
- Non-prescription lenses
- Two pair of glasses in lieu of bifocals
- Medical or surgical treatment of the eyes
- Any eye examination, or corrective eyewear, required by an employer as a condition of employment
- Services or materials provided as a result of any Worker’s Compensation Law or similar legislation
- Glasses and contacts during the same eligibility period

Lenses and frames furnished under this program which are lost or broken will not be replaced except at the normal intervals when services are otherwise available.