

EYE CARE INSURANCE

If an Insured under this section incurs Covered Expenses, we will pay benefits as stated below.

AMOUNT PAYABLE. The Amount Payable for Covered Expenses shall be the lesser of:

- a. the charge for frames or supplies furnished; or
- b. the Maximum Covered Expense for such services or supplies shown in the Schedule of Eye Care Procedures.

DEDUCTIBLE AMOUNT. The Deductible Amount shown in the Schedule of Benefits is an amount of Covered Expenses for which no benefits are payable. It applies separately to the Covered Expenses incurred by each Insured. Benefits will be paid only for those Covered Expenses that are over the deductible amount.

COVERED EXPENSES. Covered Expenses means the Eye Care expenses incurred by an Insured for the procedures shown in the Schedule of Procedures, up to the Maximum Covered Expense shown for each procedure and the Eye Care Maximum as shown in the Schedule of Benefits, if applicable. But such expenses will be Covered Expenses only to the extent that they are incurred for procedures done by a physician, optometrist, or optician. These expenses are subject to the "Limitations" below.

Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.

EXPENSES INCURRED. An expense is incurred at the time a service is rendered or a supply furnished.

EXTENSION OF BENEFITS. Should an Insured's coverage under this section terminate, we will pay Covered Expenses for frames or lenses which were ordered while coverage was in force, provided such frames or lenses are delivered within 30 days from the date the Insured's coverage ceases.

LIMITATIONS: Covered Expenses will not include and no benefits will be payable for expenses incurred for:

1. vision examinations more than once in any 12 month period.
2. prescribed lenses more than once in any 12 month period.
3. frames more than once in any 24 month period.
4. contact lenses more than once in any 12 month period. When chosen, contact lenses shall be in lieu of any other lenses benefit during the 12 month period and in lieu of any other frame benefit during the 24 month period. When lenses are chosen, expenses for contact lenses are not Covered Expenses during the 12 month period.
5. examinations performed or frames or lenses ordered before the Insured was covered under this section.
6. subject to Extension of Benefits, any examination performed or frame or lens ordered after the Insured's coverage under this section ceases.
7. sub-normal vision aids; orthoptic or vision training or any associated testing.
8. non-prescription lenses.
9. replacement or repair of lost or broken lenses or frames except at normal intervals.

10. any eye examination or corrective eye-wear required by an employer as a condition of employment.
11. medical or surgical treatment of the eyes.
12. any service or supply not shown on the Schedule of Eye Care Services.
13. coated lenses; oversize lenses (exceeding 71 mm); photo-gray lenses; polished edges; UV-400 coating and facets, and tints other than solid.
14. lenses and frames during the first 12 months that a person is insured under this section, when the person is a Late Entrant, as defined.

SCHEDULE OF EYE CARE SERVICES

The following is a complete list of eye care services for which benefits are payable. No benefits are payable for a service which is not listed.

SERVICE	MAXIMUM COVERED EXPENSE
Vision Examination May consist of, but not limited to, the following: case history; external examination of the eye and adnexa; ophthalmoscopic examination; determination of refractive status; binocular balance testing; tonometry test for glaucoma, when indicated; gross visual fields, when indicated; color vision testing when indicated; summary finding; prescribing of lenses.	Up to \$ 75.00
Frame	Up to \$125.00
Lenses	
Single Vision	Up to \$ 60.00
Bifocal	Up to \$ 80.00
Trifocal	Up to \$ 95.00
No line bifocal or progressive power	Up to \$100.00
Lenticular	Up to \$100.00
Contact Lenses	Up to \$185.00