WASHTENAW COMMUNITY COLLEGE - VISION BENEFIT PLAN

Section I

Eligibility

Your eligibility and/or your dependent(s) eligibility to participate in this Plan is determined by Washtenaw Community College.

Scope of Coverage

Your Scope of Coverage is determined by Washtenaw Community College. This section of the Vision Benefit Handbook will explain your plan benefit. The following chart indicates what services are covered, how often each covered service can be used, what you can expect to pay when receiving services from an in-network provider and what your reimbursement amounts will be when receiving services from an out-of-network provider.

SERVICES	COVERAGE FREQUENCY	IN-NETWORK COVERAGE	OUT-OF-NETWORK EMPLOYEE REIMBURSEMENT
Comprehensive Eye Exam (Does not apply to Contact Fitting Fees)	Once every 12 months (from date of last exam)	100% Covered, **$10.00 Co-pay**	Reimbursed up to $35.00 [2]
Frames:			
Frames (Ask Provider to identify Frame selection available under your $100 Wholesale Allowance)	Once every 24 months (from date of last purchase)	**$100.00 Wholesale** Frame Allowance Retail equivalent of $100 Wholesale Allowance **will vary** by Provider (estimated $200 – $300 retail equivalent) For frames exceeding the $100 allowance, the member pays twice the difference between the wholesale price of the frame and the $100 wholesale allowance.	Reimbursed up to $40.00
Covered Lenses: (Choice of One)	***Covered Material = Plastic or Glass*** *(Includes Oversized and High Prescription)*		
Single Vision	Once every 24 months (from date of last purchase)	100% Covered, **$25.00 Co-pay**	Reimbursed up to $40.00 [2]
Bifocal		100% Covered, **$25.00 Co-pay**	Reimbursed up to $50.00 [2]
Trifocal		100% Covered, **$25.00 Co-pay**	Reimbursed up to $60.00 [2]
Lenticular		100% Covered, **$25.00 Co-pay**	Reimbursed up to $75.00 [2]
Lens Options and Upgrades			
Progressive "No-Line" Upgrade Upgrade from Covered Lenses (above)	Once every 24 months (from date of last purchase)	A **20% Preferred Pricing Discount** off the provider's standard retail charges will be granted for all eyeglass lens options and upgrades not covered by the plan.	N/A
Other Lens Options/Upgrades: i.e. Thinner Lenses, Tint, Scratch Coating, Anti-Reflective Coating, UV Protection, Transitions, Roll & Polish, etc.			
Contact Lenses: (in lieu of eyeglasses)			
• The Contact Lens Benefit may be applied to **Contact Expenses**, including: Lenses and/or Professional Contact Fitting & Follow-Up Care Fees • The Contact Lens Benefit is in addition to the Comprehensive Eye Exam.			
Elective / Cosmetic [1] Contact Lenses ($115.00 Retail Allowance)	Once every 24 months (from date of last purchase)	**$115.00 Retail Allowance** (Member pays all CL expenses over $115.00)	Reimbursed up to $80.00
Medically Necessary [1] Contact Lenses *Prior Approval Required for Medical Necessity*		100% Covered, **$25.00 Co-pay**	Reimbursed up to $210.00 [2]

[1] You are eligible for contact lenses **OR** eyeglasses, **not both**, in any (24 Month) Plan Year.

[2] Less Applicable Co-payment.