ST. JOSEPH COUNTY ISD VISION BENEFIT PLAN
Vision Schedule of Benefits **Effective January 1, 2015**

Refer to the Plan Document and Summary Plan Description for details of covered services.

VISION COVERAGE	BENEFIT PAYMENT
Calendar Year Vision Deductible	This Vision Plan does not contain a Calendar Year deductible.
Vision Examination	100% of Reasonable & Customary charges following a $6.50 Co-payment. Limited to one (1) examination per Calendar Year.
Spectacle Lenses (Pair) Includes Single Vision, Bifocal, Trifocal and Lenticular.	100% of Reasonable & Customary charges following an $18 Co-payment. Vision benefits are limited to one (1) pair of corrective spectacle lenses and one frame during per Calendar Year. Members may choose between eyeglasses or contact lenses, but not both.
Frames	Covered up to $130
Contact Lenses (Pair)	Covered up to $110
Extra Lense Features	Tinted, Photochromic (Transition), Polarized, Oversize and Blended Lenses, Progressive, Rimless Drill, Anti-Reflective, Ultra-Violet and Scratch Coatings.
Not Covered	Please refer to Vision Plan Document for full list of non-covered vision related exclusions: Non-corrective eyeglasses or contact lenses; Vision therapy or subnormal vision aids; Medical or surgical treatment of the eyes; Lost or broken lenses or frames.

If you should have any questions regarding Benefits/Eligibility please contact:

Preferred Benefit Administrators
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Longwood, FL 32791-6188

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