Peoni®
PLANS ADMINISTERED BY VERDEGARD™

Navigator Vision Expense Benefits

These benefits only apply to employees and eligible dependents enrolled for Vision Coverage.

This section describes the Vision Benefits of the Plan. Vision benefits will be paid for the charges for covered vision expenses for covered persons as shown on the Schedule of Benefits. All Covered Benefits are subject to applicable Plan provisions including, but not limited to, any payment limitations, as outlined within the Schedule of Benefits. This plan does not utilize a network. The plan benefits are available to any provider of your choice.

FUNDING STATUS

This plan is a self-funded plan that requires the employer to pay for Covered Vision Services up to the Payment Limits as shown in the Schedule of Benefits. This plan does not carry secondary insurance coverage to pay for the costs of Covered Vision Services, therefore funding the costs of Covered Vision Services is solely the responsibility of the employer.

PAYMENT LIMITS

Charges incurred for Covered Vision Services are reimbursed based on the billed charge(s) up to the Payment Limits, durational or monetary, are shown in the Schedule of Benefits. The plan pays Covered Benefits up to the payment limitation(s); subject to all provisions of the Plan.

VISION PLAN SCHEDULE OF BENEFITS	
Vision Services	**Plan Provisions**
Eye Examination (Including Retinal Imaging)	100% up to $130 per year (Limited to 1 exam every 12 months; includes dilation of eyes)
Frames	100% up to $200 per year (Limited to 1 pair every 24 months)
Eyeglass Lenses Single Vision Lens Lined Bifocal Lens LinedTrifocal Lens Lenticular Lens Progressive Standard Lens Progressive Premium Lens	Single Vision Lens 100% up to $120 per year Lined Bifocal Lens 100% up to $170 per year Lined Trifocal Lens 100% up to $260 per year Lenticular 100% up to $290 per year Progressive Standard 100% up to $290 per year Progressive Premium 100% up to $390 per year Additional Lens Enhancements subject to the allowance for the applicable corrective lens including scratch-resistant coating, tints, anti-reflective coating, and polycarbonate lens. (Limited to 1 pair every 12 months)

Contact Lens Exam (fitting and evaluation)	100% up to $200 per year (Limited to 1 exam every 12 months)
Contacts	100% up to $200 per year (Limited to 1 pair every 12 months; disposables limited to 4 boxes every 12 months)

COVERED VISION SERVICES

Subject to the maximum benefit specified on the Schedule of Benefits, the Plan provides coverage for services, supplies and treatment for the following:

1. Vision Examinations; limited to one vision exam once every twelve (12) months.
2. Standard frames and lenses; including single vision, lined bifocal, lined trifocal, lenticular lenses, progressive standard and progressive premium lenses; limited to one pair every twelve (12) months. If the covered member chooses contact lenses, standard lenses will not be covered for one year from the date the contact lenses are purchased. Polycarbonate lenses are covered, subject to the allowance for the applicable corrective lens.
3. Contact lenses; including hard, rigid gas permeable, soft disposable, 30-day extended wear, daily-wear and planned replacement elective contact lenses. If the covered member chooses contact lenses, standard frames and lenses will not be covered for one year from the date the elective contact lenses are purchased. Contact lenses are limited to one (1) pair every twelve (12) months or four (4) boxes of disposables every twelve (12) months.

VISION EXCLUSIONS

No benefit will be provided under this Plan for vision expenses incurred by a covered member for the following services:

1. Orthoptics or vision training including any associated supplemental testing.
2. Medical or surgical treatment of the eyes.
3. Any vision examination or corrective eyewear required by an employer as a condition of employment.
4. Plano lenses (lenses with less than a +/- .50 diopter power).
5. Two sets of glasses in lieu of bifocals.
6. Replacement of lenses and frames furnished under this Plan which are lost or broken, except at normal intervals when services are otherwise available.
7. Refitting of contact lenses after the initial 90 day fitting period.
8. Routine maintenance of contact lenses such as polishing or cleaning.
9. Corneal refractive therapy (CRT) or Orthokeratology (using contact lenses to change the shape of the cornea in order to reduce myopia).
10. A frame that costs more than the plan allowance.
11. Blended lenses.
12. Oversized lenses.
13. Polycarbonate lenses; except as specified under Covered Vision Services.
14. High index lenses.
15. Laminating of the lens or lenses.
16. UV (ultraviolet) protected lenses.
17. Photochromic lenses and tinted lenses, except for pink #1 and pink #2.
18. Mirror and ski coating of the lens or lenses.
19. Edge treatment.
20. Lasik surgery to correct myopia, hyperopia, and astigmatism.
21. Charges not covered due to these exclusions are not considered eligible for coverage.

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