

# *Group Vision Care Policy*



**Group Name:** CONSUMER CHOICE ASSOCIATION  
**Group Number:** 12300897  
**Effective Date:** JANUARY 1, 2007

## **EVIDENCE OF COVERAGE**

Provided by:

### **VISION SERVICE PLAN INSURANCE COMPANY**

3333 Quality Drive, Rancho Cordova, CA 95670  
(916) 851-5000 (800) 877-7195

*VSP's Signature Choice Plan offered through CCA is an insurance plan  
regulated under the state of Missouri laws*

To be filled in by group in the event this document is used to develop a Summary Plan Description:

NAME OF : Consumer Choice Association  
NAME OF PLAN: Signature Choice for Individuals and Families  
PRINCIPAL ADDRESS: 16476 Chesterfield Airport Road  
Chesterfield, Missouri 63017

GROUP #: 12300897

PLAN ADMINISTRATOR: Careington International Corporation  
ADDRESS: 7400 Gaylord Parkway  
Frisco, Texas 75034

PHONE NUMBER: 1-800-785-0699

Benefits are furnished under a vision care Policy purchased by the Group and provided by VISION SERVICE PLAN INSURANCE COMPANY (VSP) under which VSP is financially responsible for the payment of claims.

This Evidence of Coverage is a summary of the Policy provisions and is presented as a matter of general information only. It is not a substitute for the provisions of the Policy itself. A copy of the Policy will be furnished on request.

**DEFINITIONS:**

**ADDITIONAL BENEFITS RIDER** The document attached as Exhibit C to the Group Policy maintained by your Group Administrator, which lists selected vision care services and vision care materials that a Covered Person is entitled to receive by virtue of the Plan.

**BENEFIT AUTHORIZATION** Authorization issued by VSP identifying the individual named as a Covered Person of VSP, and identifying those Plan Benefits to which a Covered Person is entitled.

**COPAYMENTS** Those amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered, and which are payable at the time services are rendered or materials provided.

**COVERED PERSON** An Enrollee or Eligible Dependent who meets VSP's eligibility criteria and on whose behalf premiums have been paid to VSP, and who is covered under the Policy.

**ELIGIBLE DEPENDENT** Any legal dependent of an Enrollee of Group who meets the eligibility criteria established by Group and approved by VSP under Section VI. ELIGIBILITY FOR COVERAGE of the Policy under which such Enrollee is covered.

**EMERGENCY CONDITION** A condition, with sudden onset and acute symptoms, that requires the Covered Person to obtain immediate medical care, or an unforeseen occurrence requiring immediate, non-medical action.

**ENROLLEE** An employee or member of the Group who meets the eligibility criteria specified under Section VI. ELIGIBILITY FOR COVERAGE of the Policy.

**EXPERIMENTAL NATURE** A procedure or lens that is neither used universally nor accepted by the vision care profession, as determined by VSP.

**GROUP** An employer or other entity that contracts with VSP for coverage under this Policy in order to provide vision care coverage to its Enrollees and their Eligible Dependents.

<b>VSP NETWORK DOCTOR</b>	An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to provide vision care services and/or vision care materials on behalf of Covered Persons of VSP.
<b>NON-VSP PROVIDER</b>	An optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to Covered Persons of VSP.
<b>PLAN or PLAN BENEFITS</b>	The vision care services and vision care materials that a Covered Person is entitled to receive by virtue of coverage under the Policy, as defined on the attached Schedule of Benefits and Additional Benefit Rider (if applicable).
<b>POLICY</b>	The contract between VSP and Group upon which this Plan is based.
<b>PREMIUMS</b>	The Payments made to VSP by or on behalf of a Covered Person to entitle him/her to Plan Benefits, as stated in the Schedule of Premiums attached as Exhibit B to the Group Policy document maintained by your Group Administrator.
<b>RENEWAL DATE</b>	The date on which the Policy shall renew or terminate if proper notice is given.
<b>SCHEDULE OF BENEFITS</b>	The document attached as Exhibit A to the Group Policy maintained by your Group Administrator, that lists the vision care services and vision care materials that a Covered Person is entitled to receive by virtue of the Plan.
<b>SCHEDULE OF PREMIUMS</b>	The document attached as Exhibit B to the Group Policy maintained by your Group Administrator, which states the payments to be made to VSP by or on behalf of a Covered Person to entitle him/her to Plan Benefits.
<b>VISUALLY NECESSARY or APPROPRIATE</b>	Services and materials medically or visually necessary to restore or maintain a patient's visual acuity and health and for which there is no less expensive professionally acceptable alternative.

**ELIGIBILITY FOR COVERAGE**

Enrollees: To be covered, a person must currently be an employee or member of the Group and meet the established coverage criteria mutually agreed upon by Group and VSP.

Eligible Dependents: If dependent coverage is provided, the persons eligible are indicated on the attached Schedule of Benefits and Additional Benefit Rider (if applicable).

**PREMIUMS**

Group is responsible for payments of the periodic charges for coverage. Group will notify Covered Person of Covered Person's share of the charges, if any. The entire cost of the program is paid to VSP by Group.

**PROCEDURE FOR USING THE PLAN**

1. When you want to receive Plan Benefits, contact VSP or a VSP Network Doctor. A list of names, addresses and phone numbers of VSP Network Doctors in your area can be obtained from your Group, Plan Administrator or VSP. If this list does not cover the area in which you desire to seek services, call or write the VSP office nearest you to find one that does.
2. If you are eligible for Plan Benefits, VSP will provide Benefit Authorization directly to the VSP Network Doctor. If you contact the VSP Network Doctor directly, you must identify yourself as a VSP member so the doctor can obtain Benefit Authorization from VSP.

3. When such Benefit Authorization is provided by VSP, and services are performed prior to the expiration date of the Benefit Authorization, this will constitute a claim against the Policy, in spite of your termination of coverage or the termination of the Policy. Should you receive services from a VSP Network Doctor without such Benefit Authorization or obtain services from a Non-VSP Provider, you are responsible for payment in full to the provider.
4. You pay the Copayment (if any), amounts which exceed the Plan Allowances, and any amounts for non-covered services or materials to the VSP Network Doctor for services under this Policy. VSP will pay the VSP Network Doctor directly according to its agreement with the doctor.

**Note:** If you are eligible for and obtain Plan Benefits from an Non-VSP Provider, you should pay the provider's full fee. You will be reimbursed by VSP in accordance with the Non-VSP Provider reimbursement schedule shown on the enclosed Schedule of Benefits and Additional Benefit Rider (if applicable), less any applicable Copayments. You are not required to submit a claim form to request the reimbursement. Send us your original receipts, invoices or other proof of loss (be sure to retain a copy for your records) and sufficient information about yourself so we may identify you (name, address, Social Security Number). Mail your claim to the address shown on the cover page of this Evidence of Coverage.

5. In emergency conditions, when immediate vision care of a medical nature, such as for bodily trauma or disease is necessary, Covered Person can obtain covered services by contacting a VSP Network Doctor (or Non-VSP Provider if the attached Schedule of Benefits and, if applicable, Additional Benefits Rider, indicates Covered Person's Plan includes such coverage). No prior approval from VSP is required for Covered Person to obtain vision care for Emergency Conditions of a medical nature. However, services for medical conditions, including emergencies, are covered by VSP only under the Acute EyeCare and Supplemental Primary EyeCare Plans. If there is no Additional Benefit Rider for one of these plans attached to this Evidence of Coverage, Covered Person is not covered by VSP for medical services and should contact a physician under Covered Person's medical insurance plan for care. For emergency conditions of a non-medical nature, such as lost, broken or stolen glasses, the Covered Person should contact VSP's Customer Service Department for assistance.

Emergency vision care is subject to the same benefit frequencies, plan allowances, Copayments and exclusions stated herein. Reimbursement to VSP Network Doctors will be made in accordance with their agreement with VSP.

6. In the event of termination of a VSP Network Doctor's membership in VSP, VSP will be liable to the VSP Network Doctor for services rendered to you at the time of termination and permit the VSP Network Doctor to continue to provide you with Plan Benefits until the services are completed, or until VSP makes reasonable and appropriate arrangements for the provision of such services by another VSP Network Doctor.

## **BENEFIT AUTHORIZATION PROCESS**

VSP authorizes Plan Benefits according to the latest eligibility information furnished to VSP by Covered Person's Group and the level of coverage (i.e. service frequencies, covered materials, reimbursement amounts, limitations, and exclusions) purchased for Covered Person by Group under this Plan. When Covered Person requests services under this Plan, Covered Person's prior utilization of Plan Benefits will be reviewed by VSP to determine if Covered Person is eligible for new services based upon Covered Person's Plan's level of coverage. Please refer to the attached Schedule of Benefits and Additional Benefit Rider (if applicable) for a summary of the level of coverage provided to Covered Person by Group.

## **PRIOR AUTHORIZATION**

Certain Plan Benefits require VSP's prior authorization before such Plan Benefits are covered. VSP's prior authorization determinations are based upon criteria developed by optometric and ophthalmic consultants and approved by VSP's Utilization Management Committee and Board of Directors.

1. **Initial Determination:** VSP will approve or deny requests for prior authorization of services within fifteen (15) calendar days of receipt of the request from the Covered Person's doctor. In the event that a prior authorization cannot be resolved within the time indicated, VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.
2. **Appeals:** If VSP denies the doctor's request for prior authorization, the doctor, Covered Person or the Covered Person's authorized representative may request an appeal of the denial. Please refer to the section on Requests for Appeals, below, for details on how to request an appeal. VSP shall provide the requestor with a final review determination within thirty (30) calendar days from the date the request is received. A second level appeal, and other remedies as described below, are also available. VSP shall resolve any second level appeal within thirty (30) calendar days. Covered Person may designate any person as Covered Person's authorized representative. Where Covered Person does not designate an authorized representative, the doctor will be deemed to be the authorized representative.

For more information regarding VSP's criteria for authorizing or denying Plan Benefits, please contact VSP's Customer Service Department.

## **BENEFITS AND COVERAGES**

Through its VSP Network Doctors, VSP provides Plan Benefits to Covered Persons as may be Visually Necessary or Appropriate, subject to the limitations, exclusions and Copayment(s) described herein. When you wish to obtain Plan Benefits from a VSP Network Doctor, you should contact the VSP Network Doctor of your choice, identify yourself as a VSP member, and schedule an appointment. If you are eligible for Plan Benefits, VSP will provide Benefit Authorization for you directly to the VSP Network Doctor prior to your appointment.

Specific benefits for which you are covered are described on the attached Schedule of Benefits and Additional Benefit Rider (if applicable).

## **COPAYMENT**

The benefits described herein are available to you subject to your payment of any applicable Copayments as described in this Evidence of Coverage, the Schedule of Benefits and Additional Benefit Riders (if applicable). Amounts that exceed plan allowances, annual maximum benefits, options reimbursements, or any other stated Plan limitations are not considered Copayments but are also the responsibility of the Covered Person.

ANY ADDITIONAL CARE, SERVICE AND/OR MATERIALS NOT COVERED BY THIS PLAN MAY BE ARRANGED BETWEEN YOU AND THE DOCTOR.

## **EXCLUSIONS AND LIMITATIONS OF BENEFITS**

This vision service plan is designed to cover *visual needs* rather than *cosmetic materials*. If you select certain options, as listed in the PATIENT OPTIONS section of the attached Schedule of Benefits and Additional Benefit Rider (if applicable), the Plan will pay the basic cost of the allowed lenses, and you will be responsible for the options' extra cost.

Some professional services and/or materials are not covered under this Plan. Please refer to the NOT COVERED section of the attached Schedule of Benefits and Additional Benefit Rider (if applicable) for details.

VSP may, at its discretion, waive any of the Plan limitations if, in the opinion of our Optometric Consultants, this is necessary for the visual welfare of the Covered Person.

#### **LIABILITY IN EVENT OF NON-PAYMENT**

IN THE EVENT VSP FAILS TO PAY THE PROVIDER, YOU SHALL NOT BE HELD LIABLE FOR ANY SUMS OWED BY VSP OTHER THAN THOSE NOT COVERED BY THE PLAN.

#### **COMPLAINTS AND GRIEVANCES:**

If Covered Person ever has a question or problem, Covered Person's first step is to call VSP's Customer Service Department. The Customer Service Department will make every effort to answer Covered Person's question and/or resolve the matter informally. If a matter is not initially resolved to the satisfaction of a Covered Person, the Covered Person may communicate a complaint or grievance to VSP in writing by using the complaint form that may be obtained upon request from the Customer Service Department. Complaints and grievances include disagreements regarding access to care, or the quality of care, treatment or service. Covered Persons also have the right to submit written comments or supporting documentation concerning a complaint or grievance to assist in VSP's review. VSP will resolve the complaint or grievance within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (30) days, a letter will be sent to the Covered Person to indicate VSP's expected resolution date. Upon final resolution, the Covered Person will be notified of the outcome in writing.

#### **CLAIMS PAYMENTS AND DENIALS**

**Initial Determination:** VSP will pay or deny claims within thirty (30) calendar days of the receipt of the claim from the Covered Person or Covered Person's authorized representative. In the event that a claim cannot be resolved within the time indicated, VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.

**Request for Appeals:** If a Covered Person's claim for benefits is denied by VSP in whole or in part, VSP will notify the Covered Person in writing of the reason or reasons for the denial. Within one hundred eighty (180) days after receipt of such notice of denial of a claim, Covered Person may make a verbal or written request to VSP for a full review of such denial. The request should contain sufficient information to identify the Covered Person for whom a claim for benefits was denied, including the name of the VSP Enrollee, Member Identification Number of the VSP Enrollee, the Covered Person's name and date of birth, the name of the provider of services and the claim number. The Covered Person may state the reasons the Covered Person believes that the claim denial was in error. The Covered Person may also provide any pertinent documents to be reviewed. VSP will review the claim and give the Covered Person the opportunity to review pertinent documents, submit any statements, documents or written arguments in support of the claim, and appear personally to present materials or arguments. Covered Person's authorized representative should submit all requests for appeals to:

VSP  
Member Appeals  
3333 Quality Drive  
Rancho Cordova, CA 95670  
(800) 877-7195

VSP's determination, including specific reasons for the decision, shall be provided and communicated to the Covered Person within thirty (30) calendar days after receipt of a request for appeal from the Covered Person or Covered Person's authorized representative.

If Covered Person disagrees with VSP's determination, he/she may request a second level appeal within sixty (60) calendar days from the date of the determination. VSP shall resolve any second level appeal within thirty (30) calendar days.

When Covered Person has completed all appeals mandated by the Employee Retirement Income Security Act of 1974 ("ERISA"), additional voluntary alternative dispute resolution options may be available, including mediation and arbitration. Covered Person should contact the U. S. Department of Labor or the state insurance regulatory agency for details. Additionally, under ERISA (Section 502(a)(1)(B)) [29 U.S.C. 1132(a)(1)(B)], Covered Person has the right to bring a civil (court) action when all available levels of review of denied claims, including the appeals process, have been completed, the claims were not approved in whole or in part, and Covered Person disagrees with the outcome.

**TERMINATION OF BENEFITS**

After the Policy Term, this Policy will continue on a month-to-month basis or until terminated by either party giving the other party sixty (60) days notice. Policy Benefits will cease on the date of cancellation of this Policy whether the cancellation is by your Group or by VSP due to nonpayment of Premium.

If Covered Person is receiving service as of the termination date of the Policy, such service shall be continued to completion, but in no event beyond six (6) months after the termination date of the Policy.

**INDIVIDUAL CONTINUATION OF BENEFITS**

This program is available to groups of a minimum of ten (10) employees and is, therefore, not available on an individual basis. When a Group terminates its coverage, individual coverage is not available for Enrollees who may desire to retain same.

**THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)**

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that, under certain circumstances, health plan benefits available to an eligible Enrollee and his or her Eligible Dependents be made available for purchase by said persons upon the occurrence of a COBRA-qualifying event. If, and only to the extent, COBRA applies, VSP shall make the statutorily-required continuation coverage available for purchase in accordance with COBRA.

## EXHIBIT A

### SCHEDULE OF BENEFITS Plan C

#### GENERAL

This Schedule lists the vision care benefits to which Covered Persons of VISION SERVICE PLAN INSURANCE COMPANY ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. If Plan Benefits are available for Non-VSP Provider services, as indicated by the reimbursement provisions below, vision care benefits may be received from any licensed eye care provider whether VSP Network Doctors or Non-VSP Providers. This Schedule forms a part of the Policy or Evidence of Coverage to which it is attached.

When Plan Benefits are received from VSP Network Doctors, benefits appearing in the VSP Network Doctor Benefit column below are applicable subject to any applicable Copayments and other conditions, limitations and/or exclusions as stated below. When Plan Benefits are received from Non-VSP Providers, the Covered Person is reimbursed for such benefits according to the schedule in the Non-VSP Provider Benefit column below, less any applicable Copayment. The Covered Person pays the provider the full fee at the time of service and submits an itemized bill to VSP for reimbursement. Discounts do not apply for vision care benefits obtained from Non-VSP Providers.

#### ELIGIBILITY

The following are Covered Persons under this Policy:

- Enrollee.
- The legal spouse of Enrollee.
- Any unmarried child of Enrollee, including any natural child from the date of birth, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.

Unmarried dependent children are covered up to age 19 or to age 25 if full-time students.

A dependent, unmarried child over the limiting age may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical disability, and chiefly dependent upon Enrollee for support and maintenance.

The waiting period of vision care is the same as for any other health benefits.

See schedule below for Plan Benefits, payments and/or reimbursement subject to any Copayment(s) as stated:

#### COPAYMENT

The benefits herein are available to each Covered Person subject only to payment of the applicable Copayment by the Covered Person. Plan Benefits received from VSP Network Doctors and Non-VSP Providers require Copayments. Covered Persons must also follow Benefit Authorization procedures.

There shall be no Copayment payable by the Covered Person to the VSP Network Doctor or the Non-VSP Provider at the time services are rendered.

**PLAN BENEFITS**

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
EYE EXAMINATION	Covered in full*	Up to \$ 43.00*	Available once each 12 months**
Complete initial vision analysis: includes appropriate examination of visual functions and prescription of corrective eyewear where indicated.			
*Less any applicable Copayment. **Beginning with the first date of Service.			

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
LENSES			Available once each 12 months**
Single Vision	Covered in full *	Up to \$ 26.00*	
Bifocal	Covered in full *	Up to \$ 43.00*	
Trifocal	Covered in full *	Up to \$ 60.00*	
Lenticular	Covered in full *	Up to \$ 100.00*	
Plan Benefits for lenses are per complete set, not per lens.			
*Less any applicable Copayment. **Beginning with the first date of Service.			

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
FRAMES	Covered up to Plan Allowance*	Up to \$ 40.00*	Available once each 12 months**
Benefits for lenses and frames include reimbursement for the following necessary professional services:			
<ol style="list-style-type: none"> <li>1. Prescribing and ordering proper lenses;</li> <li>2. Assisting in frame selection;</li> <li>3. Verifying accuracy of finished lenses;</li> <li>4. Proper fitting and adjustments of frames;</li> <li>5. Subsequent adjustments to frames to maintain comfort and efficiency;</li> <li>6. Progress or follow-up work as necessary.</li> </ol>			
*Less any applicable Copayment. **Beginning with the first date of Service.			

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
CONTACT LENSES			
Visually Necessary			Available once each 12 months**
Professional Fees/Materials	Covered in full *	Up to \$ 210.00	
Elective			Available once each 12 months**
Professional Fees/Materials***	Up to \$ 120.00	Up to \$ 100.00	
<p>*Less any applicable Copayment.  **Beginning with the first date of Service.  ***Additional Discount applies to VSP Network Doctor's usual and customary professional fees for contact lens evaluation and fitting.</p> <p><b>Visually Necessary or Elective Contact Lenses are provided in lieu of all other lens and frame benefits available herein.</b></p> <p>When contact lenses are obtained, the Covered Person shall not be eligible for lenses again for 12 months and frames for 12 months.</p>			

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
<b>LOW VISION</b>			
Professional services, as necessary, for severe visual problems not correctable with regular lenses, including:			
<b>Supplemental Testing</b>	Covered in full (Includes evaluation, diagnosis and prescription of vision aids where indicated.)	Up to \$125.00	*
<b>Supplemental Aids</b>	75% of approved amount up to \$1000.00*	75% of approved amount up to \$1000.00*	*
<p>*Maximum benefit for all Low Vision services and materials is \$1000.00 every two (2) Benefit Periods.</p> <p>All Low Vision services are subject to prior approval by VSP's Optometric Consultants.</p> <p>Low Vision benefits secured from Non-VSP Providers (if covered) are subject to the same time and Copayment provisions described above for VSP Network Doctors. The Covered Person should pay the Non-VSP Provider's full fee at the time of service. If Low Vision services are approved, Covered Person will be reimbursed an amount not to exceed what VSP would pay a VSP Network Doctor for the same services and/or materials.</p> <p><b>THERE IS NO ASSURANCE THAT THE AMOUNT REIMBURSED WILL COVER 75% OF THE PROVIDER'S FULL FEE.</b></p>			

## **ADDITIONAL DISCOUNT**

Each Covered Person shall be entitled to receive a discount of twenty percent (20%) toward the purchase of additional complete pairs of prescription glasses (lenses, lens options, and frames) from a VSP Network Doctor. Additional pairs are those purchased beyond the benefit frequency allowed under this Plan.

Also, Covered Persons shall be entitled to receive a discount of fifteen percent (15%) off VSP Network Doctor professional fees for elective contact lens evaluations and fittings. The Covered Person pays the VSP Network Doctor the difference between the Plan Benefit Allowance and the VSP Network Doctor's discounted usual and customary fees, plus any Copayments and charges for services or materials not covered under this Plan. Contact lens materials are provided at the doctor's usual and customary charges.

Discounts are applied to the VSP Network Doctor's usual and customary fees for such services and are available within twelve (12) months of the covered eye examination from the VSP Network Doctor who provided the covered eye examination.

Additional discounts noted on this schedule are subject to change as deemed appropriate by VSP with prior notification to the Group.

DISCOUNTS DO NOT APPLY TO VISION CARE BENEFITS OBTAINED FROM NON-VSP PROVIDERS.

## **EXCLUSIONS AND LIMITATIONS OF BENEFITS**

### **PATIENT OPTIONS**

This Plan is designed to cover visual needs rather than cosmetic materials. When a Covered Person selects any of the following extras, the Plan will pay the basic cost of the allowed lenses, and the Covered Person will pay the additional costs for the options.

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.
- Certain limitations on low vision care.

### **NOT COVERED**

There are no benefits for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing.
- Plano lenses (less than a  $\pm .50$  diopter power).
- Two pair of glasses in lieu of bifocals.
- Replacement of lenses and frames furnished under this Policy that are lost or broken, except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes.
- Corrective vision treatment of an Experimental Nature.
- Costs for services and/or materials above Plan Benefit allowances.
- Services and/or materials not indicated on this Schedule as covered Plan Benefits.