

**SECTION VI: APPENDIX B  
SCHEDULE OF VISION BENEFITS**

**Policy Effective Date:**           **January 1, 2008**

**Policyholder:**                   **The Covenant Church**

**Group Policy Number:**       **20066**

Eligibility Waiting Period: The Eligibility Waiting Period for a person who becomes eligible after the effective date of the employer's benefit plan is: the first day of employment.

Termination: Coverage for an Employee who ceases to meet the definition of eligible person is terminated on the day immediately following: the last day of the calendar month in which such person ceases to meet the definition of eligible person.

Limiting Age: Dependent children means those children under 19 years of age, or under 25 years of age if enrolled as a full-time student in an accredited school, college or university.

**COMPLETE VISION CARE PLAN**

Covered Services and Materials	Your Cost for Treatment from an In-Network Provider	Out-of-Network Reimbursement
<b>Vision Examination:</b>		
Exam with Dilation as Necessary	\$20 Copay	\$35
Each covered person is entitled to a Vision Examination once every 12 months.		
<b>Contact Lens Fit and Follow-up Visits (available once a comprehensive eye exam has been completed):</b>		
Standard*	\$0 Copay, Paid-in-full fit and two follow-up visits	\$40
Premium**	\$0 Copay, 10% off retail price, then apply \$55 allowance	\$40
<b>Materials:</b>		
Frames (any available frame at Provider location)	\$100 allowance, 20% off balance over \$100	\$50
Each covered person is entitled to Frames once every 24 months.		
Standard Plastic Lenses: Single Vision Bifocal Trifocal	\$20 Copay \$20 Copay \$20 Copay	\$25 \$40 \$55

Covered Services and Materials	Your Cost for Treatment from an In-Network Provider	Out-of-Network Reimbursement
Lens Options:		
UV Coating	\$15	N/A
Tint (Solid and Gradient)	\$15	N/A
Standard Scratch-Resistance	\$15	N/A
Standard Polycarbonate	\$40	N/A
Standard Progressive – (add-on to Bifocal)	\$65	N/A
Standard Anti-Reflective	\$45	N/A
Other Add-Ons and Services	20% off retail price	N/A
<b>Contact Lenses (materials only):</b>		
Conventional	\$0 Copay, \$80 allowance, 15% off balance over \$80	\$64
Disposable	\$0 Copay, \$80 allowance, plus balance over \$80	\$64
Visually Required	\$0 Copay, Paid-in-Full	\$200
Each covered person is entitled to Lenses or Contact Lenses once every 12 months.		

\*Standard contact lens fitting – spherical clear contact lenses in conventional wear and planned replacement. Examples include, but are not limited to, disposable and frequent replacement.

\*\*Premium contact lens fitting – all lens designs, materials and specialty fittings other than Standard contact lenses. Examples include, but are not limited to, toric and multifocal.

#### **Additional Discounts:**

Enrollees receiving services from an In-Network Provider will receive a 20% discount on items not covered by the program; the discount does not apply to the In-Network Provider’s professional services or contact lenses. Retail prices may vary by location. This discount may not be combined with any other discounts or promotional offers.

This vision program also provides a 40% discount off the purchase of a complete pair of eyeglasses (frames and lenses) and a 15% discount off the purchase of conventional contact lenses at In-Network Providers after the initial benefit has been used.

**LASIK or PRK:** TruAssure members can receive a discount of 15% off retail price or 5% off promotional price from select providers. Please contact us at [www.TruAssure.com](http://www.TruAssure.com) or 866-723-0513 for a current list of LASIK/PRK providers.