IN-NETWORK SENETION CO-72Y FREQUENCY		TWU LOCAL 100 20	25 VISION B	BENEFIT
Vision Care Exam, with disation when professionally indicated NoLUDED		IN-NE	TWORK	
Price Pric	BENEFIT	DESCRIPTION	CO-PAY	FREQUENCY
FRAME ALLOWANCE	EYE EXAMINATION		INCLUDED	Every 12 Months
Non Collection Allowance \$325 allowance Every 12 Months		Retinal Imaging, when professionally indicated	INCLUDED	
Non Collection Allowance \$325 allowance	FRAME ALLOWANCE	GVS Collection Frame	\$325	Every 12 Months
SPECTACLE LENSES SPECTACLE LENSES Trifocal Trifocal SinCLUDED Trifocal Trifocal SinCLUDED SinCLUDED SinCLUDED SinCLUDED Since Sinc		Non Collection Allowance	\$325 allowance	
SPECTACLE LENSES Tirlocal Standard Progressive INCLUDED INCLUDED	SPECTACLE LENSES	Single Vision	INCLUDED	Every 12 Months
SPECTACLE LENSES Standard Progressive Blended Biffocal Varilux Comfort Progressive or Similar Varilux Comfort Progressive or Similar Plastic Polycarbonate for dependents and adults INCLUDED Polycarbonate for Sep oc-pay Plastic Polocarbonate Included Polycarbonate Standard Coating Anti-reflective Standard Coating Anti-reflective Standard Coating Anti-reflective Standard Coating INCLUDED Cosmetic or Sunglass Tint INCLUDED Cosmetic or Sunglass Tint INCLUDED Scratch Resistant Plastic Photosensitive SV (Transition) Set oc-pay Plastic Photosensitive SV (Transition) Plastic Photosensitive SV (Transition) Polarized - Single Vision Syation Polarized - Single Vision Syation-pay Ultra Anti Glare Coating Set oc-pay Included CONTACT LENSES (In Lieu of Eyeglasses) Plan Contact Lens Evaluation, Fitting & Follow-Up Visits Non-Plan Contact Lens Evaluation, Fitting & Follow-Up Visits Non-Plan Contact Lens Allowance (excluding colored) VALUE ADDED SERVICES VALUE ADDED SERVICES VALUE ADDED SERVICES LASIK Discount benefit included VALUE ADDED SERVICES VALUE ADDED SERVICES LASIK Discount benefit included DUT-OF-NETWORK BENEFIT DESCRIPTION CO-PAY FREQUENCY FREQUENCY SEVENT 25 Months Frames SE0.00 Every 12 Months Frames Second Every 12 Months Frames Second Every 12 Months Frames Second Every 12 Months Every 12 Months Frames Second Every 12 Months Every 12 Months Frames Second Every 12 Months		Bifocal	INCLUDED	
Standard Progressive Blended Bifocal Blended Bifocal Variux Comfort Progressive or Similar Variux Var		Trifocal	INCLUDED	
Varioux Confort Progressive or Similar \$150 co-pay		Standard Progressive	INCLUDED	
Plastic		Blended Bifocal	INCLUDED	
Polycarbonate for dependents and adults INCLUDED HI-Index SV \$75 co-pay Every 12 Months		Varilux Comfort Progressive or Similar	\$150 co-pay	
MATERIALS Hi-Index SIOcal (FT28) \$75 co-pay Hi-Index Hi0cal (FT28) \$75 co-pay Hi-Index Hi0cal (FT28) \$75 co-pay Hi-Index 1.60 BF \$69 co-pay Blue Light Filtering Anti-reflective Standard Coating Anti-reflective Premium Coating INCLUDED Anti-reflective Premium Coating INCLUDED Anti-reflective Premium Coating INCLUDED Cosmetic or Sunglass Tint Ultra Violet Ultra Violet Ultra Violet Plastic Photosensitive SV (Transition) Plastic Photosensitive SV (Transition) Plastic Photosensitive Permium (Progressive (Transition)) Plastic Photosensitive Varilux Progressive (Transition) Plastic Photosensitive Varilux Progressive (Transition) Plastic Photosensitive SV (Transition) Plastic Photosensitive SV (Transition) Plastic Photosensitive Permium (Progressive (Transition)) Plastic Photosensitive Permium (Progressive (Progressive (Transition)) Plastic Photosensitive Permium (Progressive (Progressiv	MATERIALS	Plastic	INCLUDED	
Hi-Index 1.60 SV Hi- Index 1.60 SV Hi- Index 1.60 SV Hi- Index 1.60 BF S68 co-pay Blue Light Filtering INCLUDED Anti-reflective Standard Coating INCLUDED Anti-reflective Premium Coating Cosmetic or Sunglass Tint Ultra Violet Ultra Violet INCLUDED Scratch Resistant Plastic Photosensitive SV (Transition) Polarized - Single Vision Polarized - Single Vision Ultra Anti Glare Coating Services Visits Non-Plan Contact Lens Allowance (excluding Services) VALUE ADDED SERVICES VALUE ADDED SERVICES Prames SPECTACLE LENSES (In Lieu of Eye glasses) Frames Spectacle Lenses Single Vision Vision Care Eye Exam S40.00 Every 12 Months S60 co-pay Every 12 Months INCLUDED Every 12 Months		Polycarbonate for dependents and adults	INCLUDED	
Hi-Index Bifocal (FT28) \$75 co-pay Hi- Index 1.60 SV \$40 co-pay Hi- Index 1.60 BF \$69 co-pay Biue Light Filtering INCLUDED Anti-reflective Standard Coating INCLUDED Anti-reflective Premium Coating INCLUDED Cosmetic or Sunglass Tint INCLUDED Ultra Violet INCLUDED Scratch Resistant INCLUDED Plastic Photosensitive SV (Transition) \$60 co-pay Plastic Photosensitive BF (Transition) \$80 co-pay Plastic Photosensitive Varilux Progressive (Transition) Polarized - Single Vision \$74 co-pay Ultra Anti Glare Coating \$60 co-pay 1 year supply of Basic Disposables INCLUDED Visits Non-Plan Contact Lens Evaluation, Fitting & Follow-Up Visits Non-Plan Contact Lens Allowance (excluding colored) VALUE ADDED SERVICES SERVICES SERVICES DESCRIPTION CO-PAY FREQUENCY EYE EXAMINATION Vision Care Eye Exam \$40.00 Every 12 Months FRAMES Frames \$50.00 Every 12 Months Single Vision \$40.00 Every 12 Months Every 12 Months Every 12 Months FRAMES Frames \$50.00 Every 12 Months FRAMES Frames \$50.00 Every 12 Months		Hi-Index SV	\$75 co-pay	Every 12 Months
HI- Index 1.66 BF \$69 co-pay Blue Light Filtering INCLUDED Anti-reflective Standard Coating INCLUDED Anti-reflective Premium Coating INCLUDED Cosmetic or Sunglass Tint INCLUDED Ultra Violet INCLUDED Ultra Violet INCLUDED Scratch Resistant INCLUDED Plastic Photosensitive SV (Transition) \$60 co-pay Plastic Photosensitive BF (Transition) \$80 co-pay Plastic Photosensitive Varilux Progressive (Transition) \$74 co-pay Ultra Anti Glare Coating \$60 co-pay Included Servery 12 Months Plan Contact Lens Evaluation, Fitting & Follow-Up Visits Non-Plan Contact Lens Evaluation, Fitting & Follow-Up Visits Non-Plan Contact Lens Allowance (excluding colored) 25% discount for members/dependents for over the counter medication i.e. additional eyeglass cases & cleaning cloths Lastik Discount benefit included VALUE ADDED SERVICES EVERY 12 Months 10 CO-PAY FREQUENCY EYE EXAMINATION Vision Care Eye Exam \$40.00 Every 12 Months FRAMES Frames \$50.00 Every 12 Months FRAMES Frames \$50.00 Every 12 Months Lined Bifocal S50.00 Lined Bifocal Progressive Lenses \$50.00 Every 12 Months		Hi-Index Bifocal (FT28)	\$75 co-pay	
Blue Light Filtering INCLUDED Anti-reflective Standard Coating INCLUDED Anti-reflective Standard Coating INCLUDED Cosmetic or Sunglass Tint INCLUDED Ultra Violet INCLUDED Ultra Violet INCLUDED Scratch Resistant INCLUDED Plastic Photosensitive SV (Transition) \$60 co-pay Plastic Photosensitive BF (Transition) \$80 co-pay Plastic Photosensitive Varilux Progressive (Transition) \$74 co-pay Ultra Anti Glare Coating \$60 co-pay Ultra Anti Glare Coating \$60 co-pay Ultra Anti Glare Coating \$60 co-pay Plan Contact Lens Evaluation, Fitting & Follow-Up Visits Non-Plan Contact Lens Evaluation, Fitting & Follow-Up Visits Non-Plan Contact Lens Allowance (excluding 200 allowance colored) VALUE ADDED SERVICES Above Transition Service of the members/dependents for over the counter medication i.e. additional eyeglass cases & cleaning cloths LASIK Discount benefit included VALUE ADDED SERVICES Frames \$50.00 Every 12 Months Single Vision \$40.00 Lined Bifocal \$50.00 Progressive Lenses \$50.00 Every 12 Months Every 12 Months Frequency Frequency Every 12 Months Frequency Frequency Every 12 Months Frequency Frequency Every 12 Months		Hi- Index 1.60 SV	\$40 co-pay	
Anti-reflective Standard Coating INCLUDED Anti-reflective Premium Coating INCLUDED Cosmetic or Sunglass Tint INCLUDED Ultra Violet INCLUDED Ultra Violet INCLUDED Scratch Resistant INCLUDED Plastic Photosensitive SV (Transition) \$60 co-pay Plastic Photosensitive BF (Transition) \$80 co-pay Plastic Photosensitive Varilux Progressive (Transition) Polarized - Single Vision \$74 co-pay Ultra Anti Glare Coating \$60 co-pay Ultra Anti Glare Coating \$60 co-pay 1 year supply of Basic Disposables INCLUDED Plan Contact Lens Evaluation, Fitting & Follow-Up Visits Non-Plan Contact Lens Evaluation, Fitting & Follow-Up Visits Non-Plan Contact Lens Evaluation, Fitting & Follow-Up Visits Non-Plan Contact Lens Allowance (excluding colored) 40% off additional glasses & prescription sunglasses, including lens options not covered for above plan design 25% discount for members/dependents for over the counter medication i.e. additional eyeglass cases & cleaning cloths LASIK Discount benefit included VALUE ADDED SERVICES LASIK Discount benefit included TOUT-OF-NETWORK BENEFIT DESCRIPTION CO-PAY FREQUENCY EYE EXAMINATION Vision Care Eye Exam \$40.00 Every 12 Months FRAMES Frames \$50.00 Every 12 Months Single Vision \$40.00 Lined Biflocal \$50.00 Lined Trifocal \$50.00		Hi- Index 1.66 BF	\$69 co-pay	
Anti-reflective Premium Coating INCLUDED Cosmetic or Sunglass Tint INCLUDED Ultra Violet INCLUDED Scratch Resistant INCLUDED Scratch Resistant INCLUDED Plastic Photosensitive SV (Transition) \$60 co-pay Plastic Photosensitive SV (Transition) \$80 co-pay Plastic Photosensitive Varilux Progressive (Transition) \$74 co-pay Ultra Anti Glare Coating \$80 co-pay Ultra Anti Glare Coating \$60 co-pay 1 year supply of Basic Disposables INCLUDED Plan Contact Lens Evaluation, Fitting & Follow-Up Visits Non-Plan Contact Lens Allowance (excluding colored) VALUE ADDED SERVICES VALUE ADDED SERVICES A0% off additional glasses & prescription sunglasses, including lens options not covered for above plan design 25% discount for members/dependents for over the counter medication i.e. additional eyeglass cases & cleaning cloths LASIK Discount benefit included OUT-OF-NETWORK BENEFIT DESCRIPTION CO-PAY FREQUENCY EYE EXAMINATION Vision Care Eye Exam \$40.00 Every 12 Months Single Vision Single Vision Single Vision Single Vision Lined Bifocal Lined Trifocal Progressive Lenses \$50.00 Every 12 Months Every 12 Months Every 12 Months	COATINGS	Blue Light Filtering	INCLUDED	
COATINGS COATINGS Scratch Resistant Plastic Photosensitive SV (Transition) Plastic Photosensitive BF (Transition) Plastic Photosensitive BF (Transition) Plastic Photosensitive Varilux Progressive (Transition) Polarized - Single Vision Progressive Lenses Polarized - Single Vision Pogressive Lenses Polarized - Single Vision Polarized - Single Vision Polarized - Single Vision Polarized - Si		Anti-reflective Standard Coating	INCLUDED	
COATINGS COATINGS Scratch Resistant INCLUDED Every 12 Months		Anti-reflective Premium Coating	INCLUDED	Every 12 Months
COATINGS Scratch Resistant INCLUDED Every 12 Months Plastic Photosensitive SV (Transition) \$60 co-pay Plastic Photosensitive BF (Transition) \$80 co-pay Plastic Photosensitive Varilux Progressive (Transition) \$210 co-pay (Transition) Polarized - Single Vision \$74 co-pay Ultra Anti Glare Coating \$60 co-pay 1 year supply of Basic Disposables INCLUDED Plan Contact Lens Evaluation, Fitting & Follow-Up Visits Non-Plan Contact Lens Evaluation, Fitting & Follow-Up Visits Non-Plan Contact Lens Allowance (excluding colored) 25% discount for members/dependents for over the counter medication i.e. additional eyeglass cases & cleaning cloths LASIK Discount benefit included Value ADDED SERVICES EVERY 12 Months Value ADDED SERVICES 25% discount for members/dependents for over the counter medication i.e. additional eyeglass cases & cleaning cloths LASIK Discount benefit included Value ADDED SERVICES 25% discount for members/dependents for over the counter medication i.e. additional eyeglass cases & cleaning cloths LASIK Discount benefit included Value ADDED SERVICES 25% discount for members/dependents for over the counter medication i.e. additional eyeglass cases & cleaning cloths LASIK Discount benefit included Value ADDED SERVICES 25% discount for members/dependents for over the counter medication i.e. additional eyeglass cases & cleaning cloths LASIK Discount benefit included 25% discount for members/dependents for over the counter medication i.e. additional eyeglass cases & cleaning cloths LASIK Discount benefit included 25% discount for members/dependents for over the counter medication i.e. additional eyeglass cases & cleaning cloths LASIK Discount benefit included 25% discount for members/dependents for over the counter medication i.e. additional eyeglass cases & cleaning cloths later 25% discount for members/dependents for over the counter medication i.e. additional eyeglass cases & cleaning cloths later		Cosmetic or Sunglass Tint	INCLUDED	
Plastic Photosensitive SV (Transition) \$60 co-pay Plastic Photosensitive BF (Transition) \$80 co-pay Plastic Photosensitive Varilux Progressive (Transition) \$80 co-pay Plastic Photosensitive Varilux Progressive (Transition) \$74 co-pay Ultra Anti Glare Coating \$60 co-pay I year supply of Basic Disposables INCLUDED Plan Contact Lens Evaluation, Fitting & Follow-Up Visits Non-Plan Contact Lens Evaluation, Fitting & Follow-Up Visits Non-Plan Contact Lens Allowance (excluding colored) VALUE ADDED SERVICES VALUE ADDED SERVICES VALUE ADDED SERVICES VALUE ADDED SERVICES VOIT-OF-NETWORK BENEFIT DESCRIPTION CO-PAY FREQUENCY EYE EXAMINATION Vision Care Eye Exam Set 0.00 Every 12 Months FRAMES Frames Single Vision Single Vision Single Vision Single Vision Lined Bifocal Lined Bifocal Lined Trifocal Progressive Lenses S50.00 Every 12 Months		Ultra Violet	INCLUDED	
Plastic Photosensitive SV (Transition) \$60 co-pay Plastic Photosensitive BF (Transition) \$80 co-pay Plastic Photosensitive Varilux Progressive (Transition) \$210 co-pay Plastic Photosensitive Varilux Progressive (Transition) \$74 co-pay Ultra Anti Glare Coating \$60 co-pay 1 year supply of Basic Disposables INCLUDED Plan Contact Lens Evaluation, Fitting & Follow-Up Visits Non-Plan Contact Lens Evaluation, Fitting & Follow-Up Visits Non-Plan Contact Lens Allowance (excluding colored) \$200 allowance VALUE ADDED SERVICES LASIK Discount for members/dependents for over the counter medication i.e. additional eyeglass cases & cleaning cloths LASIK Discount benefit included **TOTAL COLOR OF TRETWORK** **BENEFIT** **DESCRIPTION** **SPECTACLE LENSES** Single Vision Lined Bifocal Lined Bifocal Lined Trifocal Progressive Lenses **SO.00** **So.00** **Every 12 Months*		Scratch Resistant	INCLUDED	
Plastic Photosensitive Varilux Progressive (Transition) Polarized - Single Vision \$74 co-pay Ultra Anti Glare Coating \$60 co-pay 1 year supply of Basic Disposables Plan Contact Lens Evaluation, Fitting & Follow-Up Visits Non-Plan Contact Lens Allowance (excluding colored) VALUE ADDED SERVICES 40% off additional glasses & prescription sunglasses, including lens options not covered for above plan design 25% discount for members/dependents for over the counter medication i.e. additional eyeglass cases & cleaning cloths LASIK Discount benefit included TOPAY FREQUENCY EYE EXAMINATION Vision Care Eye Exam \$40.00 Every 12 Months FRAMES Frames \$50.00 Every 12 Months Every 12 Months Frequency Frequency Every 12 Months Frequency Every 12 Months		Plastic Photosensitive SV (Transition)	\$60 co-pay	
Contact Lenses Included Inc		Plastic Photosensitive BF (Transition)	\$80 co-pay	
CONTACT LENSES (In Lieu of Eyeglasses) VALUE ADDED SERVICES BENEFIT DESCRIPTION Vision Care Eye Exam SUDI-OF-NETWORK EYE EXAMINATION Vision Care Eye Exam Sudiation Single Vision Single Vision Single Vision Lined Bifocal Lined Bifocal Lined Bifocal Lined Bifocal Lined Trifocal Plan Contact Lenses Single Vision Single Vis			\$210 co-pay	
1 year supply of Basic Disposables INCLUDED Plan Contact Lens Evaluation, Fitting & Follow-Up Visits Non-Plan Contact Lens Allowance (excluding colored) \$200 allowance		Polarized - Single Vision	\$74 co-pay	
Plan Contact Lens Evaluation, Fitting & Follow-Up Visits Non-Plan Contact Lens Allowance (excluding colored) \$200 allowance \$25% discount for members/dependents for over the counter medication i.e. additional eyeglass cases & cleaning cloths \$25% discount benefit included \$25% discount benefit i		Ultra Anti Glare Coating	\$60 co-pay	
VALUE ADDED SERVICES Visits Non-Plan Contact Lens Allowance (excluding colored) 40% off additional glasses & prescription sunglasses, including lens options not covered for above plan design 25% discount for members/dependents for over the counter medication i.e. additional eyeglass cases & cleaning cloths LASIK Discount benefit included OUT-OF-NETWORK BENEFIT DESCRIPTION CO-PAY FREQUENCY EYE EXAMINATION Vision Care Eye Exam \$40.00 Every 12 Months FRAMES Frames \$50.00 Every 12 Months		1 year supply of Basic Disposables	INCLUDED	Every 12 Months
Non-Plan Contact Lens Allowance (excluding colored) VALUE ADDED SERVICES 40% off additional glasses & prescription sunglasses, including lens options not covered for above plan design 25% discount for members/dependents for over the counter medication i.e. additional eyeglass cases & cleaning cloths LASIK Discount benefit included OUT-OF-NETWORK BENEFIT DESCRIPTION CO-PAY FREQUENCY EYE EXAMINATION Vision Care Eye Exam \$40.00 Every 12 Months FRAMES Frames \$50.00 Every 12 Months Single Vision \$40.00 Lined Bifocal \$50.00 Lined Bifocal \$50.00 Progressive Lenses \$50.00			INCLUDED	
VALUE ADDED SERVICES 25% discount for members/dependents for over the counter medication i.e. additional eyeglass cases & cleaning cloths LASIK Discount benefit included OUT-OF-NETWORK BENEFIT DESCRIPTION CO-PAY FREQUENCY EYE EXAMINATION Vision Care Eye Exam \$40.00 Every 12 Months FRAMES Frames \$50.00 Every 12 Months Single Vision \$40.00 Lined Bifocal \$50.00 Lined Trifocal \$50.00 Progressive Lenses \$50.00			\$200 allowance	
SERVICES 25% discount for members/dependents for over the counter medication i.e. additional eyeglass cases & cleaning cloths LASIK Discount benefit included OUT-OF-NETWORK BENEFIT DESCRIPTION CO-PAY FREQUENCY EYE EXAMINATION Vision Care Eye Exam \$40.00 Every 12 Months FRAMES Frames \$50.00 Every 12 Months Single Vision \$40.00 Lined Bifocal \$50.00 Lined Trifocal \$50.00 Progressive Lenses \$50.00		25% discount for members/dependents for over the counter medication i.e. additional eyeglass cases & cleaning cloths		
LASIK Discount benefit included				
BENEFIT DESCRIPTION CO-PAY FREQUENCY EYE EXAMINATION Vision Care Eye Exam \$40.00 Every 12 Months FRAMES Frames \$50.00 Every 12 Months Single Vision \$40.00 Every 12 Months Lined Bifocal \$50.00 Every 12 Months Lined Trifocal \$50.00 Every 12 Months				
EYE EXAMINATION Vision Care Eye Exam \$40.00 Every 12 Months FRAMES Frames \$50.00 Every 12 Months Single Vision \$40.00 Every 12 Months Lined Bifocal \$50.00 Every 12 Months Lined Trifocal \$50.00 Every 12 Months		OUT-OF-	NETWORK	
FRAMES Frames \$50.00 Every 12 Months SPECTACLE LENSES Single Vision \$40.00 Lined Bifocal \$50.00 Lined Trifocal \$50.00 Progressive Lenses \$50.00	BENEFIT	DESCRIPTION	CO-PAY	FREQUENCY
Single Vision	EYE EXAMINATION	Vision Care Eye Exam	\$40.00	Every 12 Months
SPECTACLE LENSESLined Bifocal\$50.00Lined Trifocal\$50.00Progressive Lenses\$50.00	FRAMES	Frames	\$50.00	Every 12 Months
SPECTACLE LENSES Lined Trifocal \$50.00 Progressive Lenses \$50.00	SPECTACLE LENSES	<u> </u>	4	Every 12 Months
Lined Trifocal \$50.00 Progressive Lenses \$50.00		Lined Bifocal	\$50.00	
			\$50.00	
CONTACT LENSES Contact Lenses \$100.00 Every 12 Months		Progressive Lenses		
	CONTACT LENSES	Contact Lenses	\$100.00	Every 12 Months