BENEFITS AT A GLANCE

SET Self-Funded Vision Plan 3

Owosso Public Schools
Non Union

There is no network for this plan. You may select any vision provider that you wish to use. Your benefit levels remain the same with any provider.

Examinations, frames, and one set of corrective lenses (regular glasses, photochromic lenses or contact lenses) will be provided once in a 12-month period, defined as July 1 to June 30 of the following year, for each eligible member.

$80 combined allowance for tint, color coating, sun tint, gradient, photochromatic, polaroid, transitions, oversized lenses, rimless and blended bifocal is payable on this plan.

Covered services and amounts listed below will be paid toward items and services incurred in connection with the subscriber's appointment; **the remaining balance is the subscriber's responsibility**.

If this plan is elected, refer to the self-funded vision participation agreement for applicable administrative and setup fees.

Examination	100% after $6.50 deductible covered once every 12 months
Regular Lenses*	$60.00 covered once every 12 months
Bifocal Lenses*	$80.00 covered once every 12 months
Trifocal Lenses*	$120.00 covered once every 12 months
Progressive Lenses*	$144.00 covered once every 12 months
Frame Allowance*	$65 covered once every 12 months
Cosmetic Contact Lenses including exam	$90.00 covered once every 12 months
Medically Necessary Contacts including exam	$250.00 covered once every 12 months

*$18.00 deductible for lenses and frames