

BENEFITS AT A GLANCE



SET Self-Funded Vision Plan 3

Owosso Public Schools
Union Support

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.

Additional charges for oversized lenses, blended bifocals, prescription sunglasses or sun tint and scratch or anti-glare coatings are not covered. The contact fitting fee is not covered.

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 \$10.00 deductible covered once every 12 months
Regular Lenses*	\$60.00, with tint \$70.00 covered once every 12 months
Bifocal Lenses*	\$80.00, with tint \$90.00 covered once every 12 months
Trifocal Lenses*	\$120.00, with tint \$130.00 covered once every 12 months
Progressive Lenses*	\$144.00, with tint \$154.00 covered once every 12 months
Frame Allowance*	\$65 covered once every 12 months
Contact Lenses	\$80.00 covered once every 12 months

*\$25.00 deductible for lenses and frames