



Reta ... A Catholic Healthcare Trust



**Diocese of Oakland
Group Number 6100200
Vision Summary of Benefit Coverage**

CLAIMS ADMINISTERED BY:

Healthsmart Benefit Solutions

Please make sure your group number is indicated on the claim form and mail it to:

**Healthsmart
Attn: Claims – Group 6100200
P.O. Box 93670
Lubbock, TX 79493-3670**

Annual Calendar Year Deductible

\$0 per covered person

How Benefits Are Paid:

- Vision Examination
- Frames
- Lenses

The Plan considers eligible charges (subject to usual and customary fees) as follows:

- For Vision Examinations, the Plan pays up to \$50 for one exam per 12 month period
 - For Frames, the Plan pays up to \$45 for one set per 24 month period
- For Lenses, the Plan pays for one pair of lenses per 12 month period as follows:
- Single Vision \$50 per pair
 - Bifocal \$70 per pair
 - Trifocal \$90 per pair
 - Contact Lenses \$100 per paid

Important Note

Lenses may contain a tint (1 or 2), but sunglasses are not covered. See *Your Vision Plan* insert for additional information regarding benefits.

Benefit, Claim and Eligibility Questions

**Healthsmart
1-800-877-7474**

Claim forms are available from your employer

YOUR VISION PLAN

To encourage you to take good care of your eyesight, your Vision Plan (Plan) provides special vision care benefits. To obtain vision care benefits, you have your choice of any licensed optometrist or ophthalmologist. For more specific information about eligibility, amount of coverage and when coverage begins, refer to your **Summary of Coverage**.

COVERED EXPENSES

VISION EXAMINATION

A vision examination is a complete analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities. Routine examinations, such as those required for employment or by governmental authority, are not covered under this plan.

VISION MATERIAL

The Plan covers a portion of the cost of eyeglass frames and prescription lenses. See your **Summary of Coverage** for specific amounts of coverage.

VISION EXCLUSIONS & LIMITATIONS

Expenses and services not specifically listed are not covered. In addition, the following services are specifically excluded:

- Eye examinations and services which you receive before coverage under this Plan begins.
- Any eye examination or any corrective eyewear required by an employer as a condition of employment.
- Non-prescription lenses.
- Corrective vision surgery or therapy such as, but not limited to Lasik, Radial Keratotomy (RK), Photorefractive Keratotomy (PRK) and Astigmatic Keratotomy (AK).
- Prescriptions which a Covered Person is entitled to receive without charge under any Workers' Compensation law, or any municipal state or federal program.
- Medical or surgical treatment for the eye.
- Safety glasses or safety goggles.
- Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals, as indicated in your **Summary of Coverage**, when services are otherwise available.