

Summary of Vision Benefits

Administered By



Benefits:

Comprehensive Vision Examination:	One every 12 months
Lenses	One pair every 12 months
Frame	One frame every 12 months
Contact Lenses	One pair every 12 months

The Policy provides full coverage for Covered Services, when you go to a Participating Provider of The MESVision Network (MES). If Covered Services are provided by a Non-Participating Provider, charges will be paid, but not to exceed the following Schedule of Allowances.

Description of Services	Participating Provider	Non-Participating Provider
Ophthalmologic Examination	Paid-in-Full	Up to \$ 60.00
Optometric Examination	Paid-in-Full	Up to \$ 50.00
Single Vision Lenses	Paid-in-Full	Up to \$ 43.00
Bifocal Lenses	Paid-in-Full	Up to \$ 60.00
Trifocal Lenses	Paid-in-Full	Up to \$ 75.00
Polycarbonate Lenses	Up to \$100.00*	Up to \$ 75.00
Aphakic or Lenticular Monofocal	Paid-in-Full	Up to \$ 120.00
Aphakic or Lenticular Multifocal	Paid-in-Full	Up to \$ 200.00
Frame	Up to \$120.00**	Up to \$ 40.00
Contact Lenses ***		
Medically Necessary Hard	Paid-in-Full	Up to \$ 200.00
Medically Necessary Soft	Paid-in-Full	Up to \$ 250.00
Cosmetic or Convenience	Up to \$120.00	Up to \$ 120.00

* Polycarbonate Lenses for dependent children are covered up to **\$100.00**, after applicable copay, balance is your responsibility.

** Participating Providers allow a selection of frames that retail up to **\$120.00** with lenses that fit an eyesize less than 61 millimeters. If a more expensive frame is selected, you are responsible for the additional cost above **\$120.00**. If the lenses are 61 millimeters or above, the charge for oversize lenses is your responsibility. Retail frame benefits will be converted to wholesale equivalent prices at certain provider locations, see provider directory.

*** This benefit is in addition to the comprehensive vision examination, but in lieu of lenses and frame. If contact lenses are for cosmetic or convenience purposes, the Policy will pay up to **\$120.00** toward the contact lens evaluation, fitting costs and materials. Any balance is your responsibility.

If contact lenses are medically necessary, they are a fully covered benefit. Approval from MES is required. Please refer to your Policy if you require additional information.

A 20% discount is available from selected MES providers for cosmetic extras such as tints, coatings and other add-on charges to standard lenses. The discount may be applied to charges for the frame or contact lenses (except disposable or replacement contact lenses) over the stated allowances. The 20% discount also applies to an additional routine exam or materials when benefits are not otherwise available.

Please visit our website at www.mesvision.com to determine whether your provider offers the 20% discount. Additionally, you may refer to your Participating Provider Directory or call MES at 800/877-6372.

How to Use Your Benefits

Make an appointment with the eyecare specialist of your choice. Participating Provider information and MES Claim Form can be obtained by visiting www.mesvision.com or by contacting your employer or MES.

At the time of your appointment, inform them of your vision coverage and identify yourself as having a MES *Vision* / AIG Vision plan.

If Covered Services are received from a Non-Participating Provider, you are responsible for paying the provider in full. You or the provider must submit and itemized billing and a copy of your prescription with the Claim Form to MES. Reimbursement will be made to the Insured Person up to the Schedule of Allowances shown for Non-Participating Providers.

Exclusions

Benefits will not be payable under the Policy for expenses incurred for:

1. Professional services and/or materials in connection with:
 - a. Plano (non-prescription) lenses;
 - b. Sub-Normal vision aids;
 - c. Blended bifocals, no-line, or progressive addition lenses;
 - d. Compensated or special multi-focal lenses;
 - e. Anti-reflective, scratch, UV400, or any coating or lamination applied to lenses;
 - f. Tints, except as provided;
 - g. Orthoptics, vision training and developmental vision procedures;
 - h. Contact lens insurance or care kits;
 - i. Services that are experimental or investigational in nature;
2. Broken, lost or stolen lenses, contact lenses or frames;
3. Medical or surgical treatment of the eye, unless such treatment is performed during a vision examination, subject to the applicable Vision Examination Maximum Benefit shown in the Benefit Schedule;
4. Services or materials which are payable under any Workers' Compensation Act or similar law or any other public program other than Medicaid;
5. Services or materials rendered by a provider other than Ophthalmologist, Optometrist or Optician acting within the scope of his or her license; or by an Immediate Family Member;
6. Any additional service required outside basic vision analyses for contact lenses, except fitting fees;
7. Vision examination or vision materials that may be required as a condition of employment, including but not limited to, industrial or safety glasses;
8. Services rendered after the date You or Your Covered Dependent(s) ceases to be covered under the Policy, except when vision materials ordered before coverage ended are delivered and the services are rendered to You or Your Covered Dependent(s) within 31 days from the date of such order, and;
9. Services rendered or materials ordered before the date coverage began for an Insured Person under the Policy.

If you have any questions about the vision benefits, please contact Medical Eye Services:

P.O. Box 25209
Santa Ana, CA 92799-5209
714/619-4660
800/877-6372
www.mesvision.com

This is a brief outline of the vision benefits and is not to be accepted or construed as a substitute for provisions of the Policy.

