

## Group Vision Plan

- ✓ **NO WAITING PERIODS**
- ✓ 2 Year Rate Guarantee
- ✓ 24 hour access to your benefit information at [www.healthedgeinc.com](http://www.healthedgeinc.com)

	<b>SILVER Plan# 9657974</b>	<b>GOLD Plan# 9657941</b>	<b>PLATINUM Plan# 9657925</b>
<b>Eye Examination Frequency</b>	Once every 12 Months	Once every 12 Months	Once every 12 Months
<b>Co-pay</b>	\$10	\$10	\$0
<b>Eyeglass Frequency</b>	Once every 24 Months	Once every 12 Months	Once every 12 Months
<b>Co-pay</b>	\$20	\$10	\$0
<b>Frames Frequency</b>	Once every 24 Months	Once every 12 Months	Once every 12 Months
<b>Co-pay</b>	\$0	\$0	\$0
<b>Contact Lenses</b>	Instead of Glasses	Instead of Glasses	Instead of Glasses
<b>Frequency &amp; Co-pay</b>	Same as Glasses	Same as Glasses	Same as Glasses

**Eye Examination:** A routine, complete eye examination, refraction, and prescription for eyeglasses. Contact lens examinations require additional fees. If indicated, your doctor may recommend additional procedures, which are the responsibility of the member.

**Eyeglass Lenses:** Standard uncoated plastic lenses of any size or power.

**Frames:** Any frame up to a regular retail value of \$100. Frames above \$100 retail are available at an additional charge.

**Contact Lenses:** Any pair of contact lenses up to a regular retail price of \$100, obtained from a network provider or the mail order program. Contacts above \$100 are available at an additional charge.

**THIS FORM IS A SUMMARY OF PLAN BENEFITS ONLY**  
**REFER TO THE BENEFIT CERTIFICATE FOR COMPLETE BENEFIT DETAILS**  
**INCLUDING LIMITATIONS AND EXCLUSIONS.**