ADN ADMINISTRATORS

PO Box 610
Southfield, MI 48037
248-901-3705

NORTHVIEW PUBLIC SCHOOLS Vision Benefits Plan **Group # 40441**
Instructional

The Plan-at-a-Glance **Benefit Year – September 1st through August 31st**

Annual Deductible $50 Individual/$100 Family applies to all services

Vision Examination	Covered Up to $80
Spectacle Lenses (Pair):	
Single Vision	Covered Up to $90
Bifocal	Covered Up to $90
Trifocal	Covered Up to $120
Lenticular or Progressive	Covered Up to $130
Standard Frames	Covered Up to $100
Contact Lenses (Pair)	
Cosmetic/Elective	Covered Up to $160

Extra Lens Features – None

Limits & Exclusions

1. Plan participants are limited to one vision examination during any benefit year period.
2. Plan participants are limited to one pair of corrective spectacle lenses and one frame during any benefit year period.
3. Plan participants may choose between eyeglasses and contact lenses, but not both.

No Payments will be made for the following:

1. Non-corrective eyeglass or contact lenses
2. Vision therapy or subnormal vision aids
3. Medical or surgical treatment of the eyes
4. Replacement of lost or broken lenses or frames if benefits applicable to the replacement were previously provided during the benefit year
5. Charges with respect to which benefits are provided under any Workers' Compensation or similar law
6. Vision examination, lenses or frames which would have been furnished without cost in the absence of this insurance or for which an insured person has no legal obligation to pay
7. The cost of frames that exceeds the plan allowance
8. Extra charges for any lens treatments and coatings not listed under Extra Lens Features
9. Photochromic and Polycarbonate Lenses.
10. Charges for cosmetic (elective) contact lenses that exceed the annual plan allowance

Note: For each benefit period, covered charges for contact lenses are in lieu of all other covered charges except examinations during the benefit period for each insured person.

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NORTHVIEW PUBLIC SCHOOLS Vision Benefits Plan **Group # 40441**
Secretaries

The Plan-at-a-Glance	Benefit Year – July 1st through June 30th
Vision Examination	Covered Up to $32
Spectacle Lenses (Pair):	
Single Vision	Covered Up to $52
Bifocal	Covered Up to $58
Trifocal	Covered Up to $70
Lenticular or Progressive	Covered Up to $82
Standard Frames	Covered Up to $65
Contact Lenses (Pair)	
Cosmetic/Elective	Covered Up to $100

Extra Lens Features – None

Limits & Exclusions

1. Plan participants are limited to one vision examination during any benefit year period.
2. Plan participants are limited to one pair of corrective spectacle lenses and one frame during any benefit year period.
3. Plan participants may choose between eyeglasses and contact lenses, but not both.

No Payments will be made for the following:

1. Non-corrective eyeglass or contact lenses
2. Vision therapy or subnormal vision aids
3. Medical or surgical treatment of the eyes
4. Replacement of lost or broken lenses or frames if benefits applicable to the replacement were previously provided during the benefit year
5. Charges with respect to which benefits are provided under any Workers' Compensation or similar law
6. Vision examination, lenses or frames which would have been furnished without cost in the absence of this insurance or for which an insured person has no legal obligation to pay
7. The cost of frames that exceeds the plan allowance
8. Extra charges for any lens treatments and coatings not listed under Extra Lens Features
9. Photochromic and Polycarbonate Lenses.
10. Charges for cosmetic (elective) contact lenses that exceed the annual plan allowance

Note: For each benefit period, covered charges for contact lenses are in lieu of all other covered charges except examinations during the benefit period for each insured person.

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NORTHVIEW PUBLIC SCHOOLS Vision Benefits Plan **Group # 40441**

Administrators, Administrative Assistants, Central Office, Custodians, Maintenance, Mechanics, Superintendent, 52 Week Employees

The Plan-at-a-Glance	Benefit Year – July 1st through June 30th
Vision Examination	Covered Up to $48
Spectacle Lenses (Pair):	
Single Vision	Covered Up to $78
Bifocal	Covered Up to $87
Trifocal	Covered Up to $105
Lenticular or Progressive	Covered Up to $123
Standard Frames	Covered Up to $90
Contact Lenses (Pair)	
Cosmetic/Elective	Covered Up to $150

Extra Lens Features – None

Limits & Exclusions

1. Plan participants are limited to one vision examination during any benefit year period.
2. Plan participants are limited to one pair of corrective spectacle lenses and one frame during any benefit year period.
3. Plan participants may choose between eyeglasses and contact lenses, but not both.

No Payments will be made for the following:

1. Non-corrective eyeglass or contact lenses
2. Vision therapy or subnormal vision aids
3. Medical or surgical treatment of the eyes
4. Replacement of lost or broken lenses or frames if benefits applicable to the replacement were previously provided during the benefit year
5. Charges with respect to which benefits are provided under any Workers' Compensation or similar law
6. Vision examination, lenses or frames which would have been furnished without cost in the absence of this insurance or for which an insured person has no legal obligation to pay
7. The cost of frames that exceeds the plan allowance
8. Extra charges for any lens treatments and coatings not listed under Extra Lens Features
9. Photochromic and Polycarbonate Lenses.
10. Charges for cosmetic (elective) contact lenses that exceed the annual plan allowance

Note: For each benefit period, covered charges for contact lenses are in lieu of all other covered charges except examinations during the benefit period for each insured person.

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NORTHVIEW PUBLIC SCHOOLS Vision Benefits Plan **Group # 40441**
Daycare, Food Service, Interpreter, Para-Professionals, Transportation

The Plan-at-a-Glance	Benefit Year – July 1st through June 30th
Vision Examination	Covered Up to $32
Spectacle Lenses (Pair):	
Single Vision	Covered Up to $42
Bifocal	Covered Up to $48
Trifocal	Covered Up to $60
Lenticular or Progressive	Covered Up to $72
Standard Frames	Covered Up to $18
Contact Lenses (Pair)	
Cosmetic/Elective (includes Exam)	Covered Up to $100

Extra Lens Features – None

Limits & Exclusions

1. Plan participants are limited to one vision examination during any benefit year period.
2. Plan participants are limited to one pair of corrective spectacle lenses and one frame during any benefit year period.
3. Plan participants may choose between eyeglasses and contact lenses, but not both.

No Payments will be made for the following:

1. Non-corrective eyeglass or contact lenses
2. Vision therapy or subnormal vision aids
3. Medical or surgical treatment of the eyes
4. Replacement of lost or broken lenses or frames if benefits applicable to the replacement were previously provided during the benefit year
5. Charges with respect to which benefits are provided under any Workers' Compensation or similar law
6. Vision examination, lenses or frames which would have been furnished without cost in the absence of this insurance or for which an insured person has no legal obligation to pay
7. The cost of frames that exceeds the plan allowance
8. Extra charges for any lens treatments and coatings not listed under Extra Lens Features
9. Photochromic and Polycarbonate Lenses.
10. Charges for cosmetic (elective) contact lenses, including the examination, that exceed the annual plan allowance

Note: For each benefit period, covered charges for contact lenses are in lieu of all other covered charges during the benefit period for each insured person.