Alaska Electrical Health and Welfare Fund
SCHEDULE OF BENEFITS
Vision Plan 701

	If You See a VSP Network Provider	If You See a Non-VSP Provider
Copayment		
Exam Lenses & Frame	$10 $20	$10 $20
Covered Expenses		
Eye Exam	Paid in full	Up to $45
Lenses Single Vision Lined Bifocal Lined Trifocal Lenticular	 Paid in full* Paid in full* Paid in full* Paid in full*	 Up to $45 Up to $65 Up to $85 Up to $125
Frames	Paid up to $120**	Up to $47
Contacts – instead of lenses and frames Necessary*** Cosmetic	 Paid in full* Up to $120	 Up to $250 Up to $105
Lens Options Photochromic Lenses Tinted Lenses	 Paid in full* Paid in full*	 Up to $5 total
Frequency Limits		
Exam Lenses Frames Contacts (instead of glasses)	Every 12 months Every 12 months Every 12 months Every 12 months	Every 12 months Every 12 months Every 12 months Every 12 months

* Lenses are paid in full, excluding cosmetic extras. Cosmetic extras include (but are not limited to) oversize lenses, coated lenses, progressive addition or blended lenses.

** A variety of frames are covered in full. If your frame exceeds the allowable cost, you will receive a 20% discount on your out-of-pocket costs for the frame.

*** Medically necessary contact lenses may be prescribed by a provider for certain conditions. Your VSP provider will determine if you qualify for coverage for these types of contacts at the time of service.