Alaska Electrical Health and Welfare Fund
SCHEDULE OF BENEFITS
Vision Plan 704

	If You See a VSP Network Provider	If You See a Non-VSP Provider
Copayment		
Exam	$20	$20
Lenses & Frame	$40	$40
Covered Expenses		
Eye Exam	Paid in full	Up to $45
Lenses		
Single Vision	Paid in full*	Up to $45
Lined Bifocal	Paid in full*	Up to $65
Lined Trifocal	Paid in full*	Up to $85
Lenticular	Paid in full*	Up to $125
Frames	Paid up to $120**	Up to $47
Contacts – instead of lenses and frames		
Necessary***	Paid in full*	Up to $250
Cosmetic	Up to $120	Up to $105
Frequency Limits		
Exam	Every 24 months	Every 24 months
Lenses	Every 24 months	Every 24 months
Frames	Every 24 months	Every 24 months
Contacts (instead of glasses)	Every 24 months	Every 24 months

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