

**County Health Pool
Vision Benefit Summary
Effective January 1, 2010**



Covered Benefits	IN-NETWORK
EXAMINATION	<p>\$15 Co-pay</p> <p>A complete exam once every 12 months</p>
EYEGLASS LENSES AND FRAMES	<p>\$15 Co-pay</p> <p>Necessary lenses once every 12 months</p> <p>Frame allowance, once every 24 months (\$120 maximum)</p>
CONTACT LENSES (NECESSARY)	<p>Once every 12 months in lieu of eyeglass lenses</p>
CONTACT LENSES (ELECTIVE)	<p>Once every 12 months in lieu of eyeglass lenses</p> <p>\$120 maximum</p>
COVERED PROVIDERS	<p>Vision Service Plan(VSP) Preferred PPO Consult www.vsp.com or call Customer Service at 1-800-877-7195</p>
EXTRA DISCOUNTS AND SAVINGS	<p>Laser Vision Correction Discounts</p> <p>Prescription Eyeglasses- Up to 20% savings on lens extras such as scratch resistant, anti-reflective coatings and progressives.</p> <p>20% off additional prescription glasses and sunglasses</p> <p>Contacts- 15% off cost of contact lens exam (fitting and evaluation)</p> <p>Available from the same VSP doctor who provided your eye exam within the last 12 months</p>