ELIGIBILITY AND ENROLLMENT

To qualify as an Eligible Employee under this Summary Plan Description, a person must be and remain a full-time employee of a Participating School District who regularly works at least 30 hours per week and is paid on a regular, periodic basis through the school district's payroll system. Pre-65 retirees may also be eligible.
(see the Summary Plan Description for additional Eligibility and Enrollment provisions)

PROBATIONARY PERIOD

The Participating School District will determine if there are certain probationary periods that must be satisfied before a new Eligible Employee can qualify for coverage under this Summary Plan Description.

HEALTHY SIGHT FOCUS $130 (CIII)
VISION CARE BENEFITS (VCSV)
BENEFITS OUTLINE

Visit our Website at www.bcidaho.com to locate a Participating Provider.
*The Participating Provider is responsible for verifying benefits with the VCSV prior to rendering services. A Participant must provide the Participating Provider sufficient information to verify eligibility. Failure of the Participant to provide sufficient information may delay services and may affect benefit payment under the Plan.

For Covered Providers and Services **Copayment**	Participant pays $0 per eye exam and/or $25 per Frame and Lenses or Medically Necessary Contact Lenses
Service Frequency Limitations	Participant may receive: • one (1) eye exam every twelve (12) months. • one (1) pair of Lenses or an annual supply of Medically Necessary Contact Lenses (in lieu of eyeglasses) or up to the allowance towards an annual supply of Elective Contact Lenses (in lieu of eyeglasses) every twelve (12) months. • one (1) Frame every twelve (12) months.

IN-NETWORK SERVICES (*PARTICIPATING PROVIDERS)
Payment For Services Rendered and Allowances:

Exam—Participant pays Copayment, as applicable, then Plan pays 100% of Maximum Allowance.

Prescription Glasses—Participant pays Copayment, as applicable, then Plan pays 100% of Maximum Allowance for Basic Lenses and Medically Necessary Contact Lenses (in lieu of glasses). Includes Frame allowance of $130.

Elective Contact Lenses—Includes a Contact Lens fitting and evaluation and $130 allowance for materials in place of benefits for Prescribed Lenses and Frame.

OUT-OF-NETWORK SERVICES (NONPARTICIPATING PROVIDER) Reimbursement Allowances:
Professional Fees Eye Exam: Plan pays up to $45 **Materials—Lenses per pair** Frame: Plan pays up to $47 Single Vision Lenses: Plan pays $45 Lined Bifocals Lenses: Plan pays up to $65 Lined Trifocals Lenses: Plan pays up to $85 Progressives Lenses: Plan pays up to $85 **Contact Lenses per pair:** $105 **Medically Necessary, up to Maximum Allowance:** $210 **Elective Contact Lenses**—includes a Contact Lens fitting and evaluation and an allowance for materials in place of benefits for Prescribed Lenses and Frame.

Benefits for Covered Services received from a Participating Provider will be paid in full, after any required Copayment, up to the Maximum Allowance for standard lenses and/or frames.