VISION CARE BENEFITS

The Vision Care portion of the Plan helps pay for your eye care needs. The annual maximum benefit is $300 per person for all covered services. There is no maximum for pediatric vision essential services, defining "pediatric" as for a child up to age 18; and, defining "services" as essential services such as vision exams.

While you may go to any qualified provider, the Fund offers you discounted prices on covered services and supplies through the EyeMed Vision Care Network. To find a network provider, call 1-866-723-0514 or visit their website at www.eyemedvisioncare.com.

HOW THE VISION CARE PLAN WORKS

Eye Examinations

Benefits are available for an eye examination that is performed by an ophthalmologist, optometrist, or another physician who is licensed to perform vision examinations and prescribe lenses.

Lasik Surgery

Lasik surgery is covered for you and your spouse up to a lifetime maximum of $1,000 per eye per person. Lasik surgery includes:

- FDA-approved indications and indications accepted by the American Academy of Ophthalmology, refractive surgical procedures, such as radial keratotomy (RK), anterior lens keratotomy (ALK), astigmatic keratotomy (AK), photorefractive keratectomy (PRK), photo astigmatic refractive keratectomy (PARK), laser-assisted in situ keratomileusis (LASIK), keratomileusis, epikeratophakia implementation of intrastromal corneal ring segments and other refractive surgical procedures.

Lenses/Frames or Contact Lenses

Coverage is available for lenses and frames or contact lenses each calendar year up to the annual maximum.

VISION CARE EXPENSES NOT COVERED

In addition to any general Plan exclusions, the following expenses are not covered under the Plan:

- services or supplies payable under any other benefits provided by the Plan;
- sunglasses, plain or prescription. Tinted glasses with a tint above two will be considered sunglasses;

VISION CARE EXPENSES NOT COVERED (continued)

- orthoptics, vision training, or aniseikonia lenses, except as provided otherwise by the Plan;
- any material furnished before the date on which you or your Dependents become eligible for benefits;
- charges for failure to keep a scheduled appointment;
- care or services provided free, or that would have been provided free if this Plan were not available;
- expenses that may be paid under Workers' Compensation, occupational disability, or similar laws; and
- expenses incurred for surgical correction of refractive errors and refractive keratoplasty procedures that are not FDA-approved, including, but not limited to, radial keratotomy (RK) and anterior lens keratotomy (ALK), except as described on page 40.

EXTENDED BENEFITS

If you order frames while you are eligible for benefits under the Plan, but receive them after your coverage terminates, your purchase of frames or lenses will still be covered if they are received within 31 days after coverage ends.

GENERAL EXCLUSIONS

In addition to any exclusions already mentioned, the Fox Valley Laborers Health and Welfare Fund will not cover the following expenses:

- charges that exceed the allowable charge for the services provided or for which payment is not legally required;
- injury or illness that is related to any occupation or employment for wage or profit;
- injury or illness for which you or your Dependent are not under the care of a provider who is recognized by the Fund as an eligible provider;
- injury or illness arising out of war, declared or undeclared, or service in any military or civilian noncombatant unit serving with such forces;
- injury or illness arising out of the voluntary participation in the commission of a felony or involvement in a criminal enterprise except where the injury results from an act of domestic violence or a medical condition (including both physical and mental health condition);
- service or supplies provided by a hospital owned or operated by the United States government or agency, or a physician employed by the United States government or agency if the service or supplies is provided as a result of a service-related illness or injury;
- care or treatment in any penal institution or jail facility or jail ward of any state or political subdivision;
- any care or treatment not specifically covered under the Plan, regardless of whether or not the provider is licensed to perform the treatment;

GENERAL EXCLUSIONS (continued)

- transplants not specifically listed as covered under the Plan;
- complications of non-covered procedures (i.e. removal of breast implants when originally performed as a cosmetic procedure);
- vision therapy (orthoptics) unless it is performed by an optometrist in lieu of a surgical procedure;
- treatment rendered by you or your Dependent's spouse, child, brother, sister, or parent;
- court-ordered care;
- injuries incurred by you or your Dependent caused by the use of or as a result of the influence of an illegal substance as established by the Fund through a review of medical evidence;
- injuries sustained in a motor vehicle accident if you or your Dependent was operating the vehicle and if the Fund is able to establish through medical evidence that you or your Dependent's blood alcohol content at the time of the accident was in excess of twice the legal limit of the jurisdiction in which the accident occurred; or
- any service or supplies provided without charge or paid for by a governmental unit, employer, benefit association, union, or similar group, or for which no charge would be made in the absence of benefits.