Limitations & Exclusions

LIMITATIONS

Covered Services paid up to the Schedule of Benefits:

We may limit benefits, as shown in the Schedule of Benefits, for:

1. Contact lenses, except as specifically provided;
2. Contact lens fitting, except as specifically provided;
3. Eyewear when there is no prescription change, except when benefits are otherwise available;
4. Non-standard lenses or lens options including, but not limited to polycarbonate, progressive, photochromic, polarized, high-index, occupational, beveled, faceted, coated (i.e., anti-reflective, scratch, mirrored and UV), oversized exceeding the allowance for covered lenses or such custom lens options;
5. Tints, other than pink or rose #1 or #2, except as specifically provided;
6. New patient intermediate (follow-up) examinations: You should see the same doctor for both the comprehensive and intermediate (follow-up) examinations in order to receive the maximum benefit and to optimize continuity of care. When You elect to have a comprehensive examination and You are eligible for an intermediate examination or select a different provider to perform the intermediate (follow-up) examination, You will be responsible for the difference between the intermediate (follow-up) examination allowance and the comprehensive examination allowance; and
7. Non-prescription (plano) eyewear.

EXCLUSIONS

Non-Covered Services

We will not pay benefits for:

1. Any eye examination required by an employer as a condition of employment;
2. Care or treatment of a condition for which You are entitled to or eligible for benefits under any Workers' Compensation Act or similar law.
3. Replacement contact lens insurance offered by providers, care kits or frame cases;
4. Covered services which began prior to the insured's effective date, or after the benefit has terminated;
5. Covered Services for which You are not legally obligated to pay;
6. Covered Services required by any government agency or program, (federal, state or subdivision thereof);
7. Covered Services performed by a close relative or by an individual who ordinarily resides in the insured's home;
8. Orthoptics, vision training or subnormal vision aids;
9. Services that are Experimental or Investigational in nature;
10. Any services provided in connection with war or any act of war, whether declared or undeclared, or condition contracted or accident occurring while on full-time active duty in the armed forces of any country or combination of countries.
11. Procedures that are not included in the Schedule of Benefits.
12. Any charge for services that the appropriate regulatory board determines were provided as a result of a referral prohibited by State Law.
13. Medical or surgical treatment of the eyes.
14. Any Covered Services provided by another vision policy; and
15. Replacement of lenses or frames which are lost, stolen or broken, except when benefits are otherwise available.

Notice to MA consumers: This program is not insurance coverage and does not meet the minimum creditable coverage requirements under M.G.L. c. 111M and 956 CMR 5.00.