11. medical or surgical treatment of the eyes.

12. any service or supply not shown on the Schedule of Eye Care Procedures.

13. coated lenses; oversize lenses (exceeding 71 mm); photo-gray lenses; polished edges; UV-400 coating and facets, and tints other than solid.

14. prescription or non-prescription sunglasses.

SCHEDULE OF EYE CARE SERVICES

The following is a complete list of eye care services for which benefits are payable. No benefits are payable for a service which is not listed.

SERVICE	MAXIMUM COVERED EXPENSE
Vision Examination May consist of, but not limited to, the following: case history; external examination of the eye and adnexa; ophthalmoscopic examination; determination of refractive status; binocular balance testing; tonometry test for glaucoma, when indicated; gross visual fields, when indicated; color vision testing when indicated; summary finding; prescribing of lenses.	Up to $ 35.00
Frame	Up to $100.00
Lenses	
Single Vision	Up to $100.00
Bifocal	Up to $115.00
Trifocal	Up to $125.00
No line bifocal or progressive power	Up to $125.00
Lenticular	Up to $125.00
Contact Lenses	Up to $150.00