Plan Summary For: JOHN DOE

VSP Program: VSP WellVision® Plan Through a VSP Doctor

Benefit	Coverage	Copay	Frequency
Your Coverage with a VSP Doctor			
WellVision® Exam	• Covered after copay.	$10.00	Every year beginning in January.
Description	• Only VSP offers a WellVision Exam, focused on your eyes and overall wellness. Your VSP doctor can see if you have vision problems and signs of other health conditions too.		
Contact Lens Exam	• Covered after copay.	Up to $60.00	Every year beginning in January.
Description	• During your contact lens exam, your VSP doctor ensures your contacts fit properly and tests your vision. This exam is in addition to your WellVision Exam.		
Extra Savings	• 15% off your contact lens exam within 12 months of your eye exam, then your copay applies.		
Retinal Screening	• Covered after copay.	Up to $39.00	As needed.
Description	• A routine retinal screening (digital imaging of the inside of the eye) helps your VSP doctor detect signs of eye disease and chronic health conditions including diabetes, hypertension, and high cholesterol. This is an enhancement to your WellVision Exam.		
Prescription Lenses	• Covered after copay: **Single vision, lined bifocal, lined trifocal.**	$25.00 for lenses and/ or frame	Every year beginning in January.
Fully Covered Lens Enhancements	• Standard Progressive Lenses		

Lens Enhancements Covered with Additional Copay	• Anti-glare coatings	$41.00 - $85.00
	• Custom Progressive Lenses	$150.00 - $175.00
	• Edge Polish	$36.00
	• High Index lenses	$50.00 - $125.00
	• Light Filter	$15.00
	• Light-reactive lenses	$75.00
	• Polarized lenses	$57.00 - $101.00
	• Impact-resistant lenses	$35.00
	• Premium Progressive Lenses	$95.00 - $105.00
	• Scratch-Resistant Coating	$17.00 - $33.00
	• Tinted (colored) lenses	$15.00 - $17.00
	• UV Protection	$16.00

Frame	• You have a $130.00 allowance for frames. • If you choose a featured frame brand, you'll get an extra $20.00 to spend, for a total of $150.00 allowance. • If you choose a bebe, Converse, Dragon or Nike frame brand, you'll get an extra $40.00 to spend, for a total of $170.00 allowance. This offer expires January 31, 2025. • Some frames may be covered at a reduced benefit. Ask your VSP doctor for details. • Plus, you get 20% off any amount over your allowance.	$25.00 for lenses and/ or frame	Every other year beginning in January.
Extra Savings	• 20% savings on additional glasses including lens enhancements, or non-prescription sunglasses or blue light filtering glasses, from any VSP provider within 12 months of your last WellVision Exam.		

Contacts Instead of Glasses	• $130.00 allowance for contacts.	$0	Every year beginning in January.

This information doesn't guarantee your eligibility or coverage. Your VSP doctor will contact VSP to check your eligibility. If there's a conflict between this information and your organization's contract with VSP, the contract will prevail.This benefit information is only for VSP doctors, clients, members and their dependents. Any other use is fraudulent and prohibited. For more information, visit vsp.com.

VSP Program: Specialty Eyecare Services Through a VSP Doctor

Benefit	Coverage	Copay	Frequency

Your Coverage with a VSP Doctor			
Essential Medical Eye Care	• Retinal screening for members with diabetes. Medical eye exams and services to help support optimal vision and eye health.	$20.00 per office visit	As medically necessary.
Description	• Members with diabetes receive a covered-in-full retinal screening (digital imaging of the inside of the eye). Coverage also includes exams and services to treat pink eye and sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. Coordination with your medical coverage may apply. Ask your VSP doctor for details.		

BENEFITS: Routine

Vision Care Services	In-Network Member Cost
Exam Services	
Exam	$10 copay
Retinal Imaging	Up to $39
Contact Lens Fit and Follow-Up	
Fit and Follow-up - Standard	Up to $40
Fit and Follow-up - Premium	10% off retail price
Frame	
Frame	$0 copay; 20% off balance over $150 allowance
Lenses	
Single Vision	$10 copay
Bifocal	$10 copay
Trifocal	$10 copay
Lenticular	$10 copay
Progressive - Standard	$60 copay
Progressive - Premium Tier 1	$80 copay
Progressive - Premium Tier 2	$90 copay
Progressive - Premium Tier 3	$105 copay
Progressive - Premium Tier 4	$60 copay; 20% off retail price less $120 allowance
Lens Options	
Anti Reflective Coating - Standard	$45
Anti Reflective Coating - Premium Tier 1	$57
Anti Reflective Coating - Premium Tier 2	$68
Anti Reflective Coating - Premium Tier 3	20% off retail price
Photochromic - Non-Glass	$75
Polycarbonate - Standard - age 19 and over	$40
Polycarbonate - Standard - under age 19	$0 copay
Scratch Coating - Standard Plastic	$15
Tint - Solid and Gradient	$15
UV Treatment	$15
All Other Lens Options	20% off retail price
Contact Lenses	
Contacts - Conventional	$0 copay; 15% off balance over $150 allowance
Contacts - Disposable	$0 copay; 100% of balance over $150 allowance
Contacts - Medically Necessary	$0 copay

BENEFITS: Additional Purchase

Vision Care Services	In-Network Member Cost
Frame	
Frame	20% off retail price
Lenses	
Lenses	20% off retail price
Lens Options	
Lens Options	20% off retail price
Packages	
Frame, Lens and Lens Options Purchased as Complete Pair	40% off retail price
Contact Lenses	
Contacts - Conventional	15% off retail price

BENEFITS: Hearing

Vision Care Services	In-Network Member Cost
Hearing Care	
Hearing Care from Amplifon network	Up to 66% off hearing aids; call 1-877-203-0675

BENEFITS: LASIK

Vision Care Services	In-Network Member Cost
Exam Services	
Lasik or PRK From U.S. Laser Network	15% off retail or 5% off promo price; call 1-800-988-4221

John Doe (1/1/1999) **Service Date: 10/09/2024**

BENEFIT MESSAGES

*MC = Materials Copay of $20.00
This Plan includes discount features.
Benefit covers glasses or contacts - not both.
Base lens covered in full after copay for single vision, bifocal and trifocal. Progressive lenses covered at trifocal rate.
Specialty Contact Lens fit is covered in lieu of a standard Contact Lens Fit
Unless otherwise indicated basic benefits are covered for all upgrades. Enhanced upgrade benefits will only be covered at the basic upgrade rate.
Polycarbonate Lenses covered for dependents up to age 19.

Plan Covered Benefits

Category	Description	Frequency	Copay Amount	Allowed Per Period	Available	Next Available Date	Allowance Remaining	Auth Required
Exam	Routine Exam	1 per 12 months	$10.00	Covered	Yes	--	$0.00	No
Exam	Contact Lens - Eval Fitting	1 per 12 months	$25.00	Covered	Yes	--	$0.00	No
Exam	Contact Lens Fit Specialty	1 per 12 months	$25.00	$50.00	Yes	--	$50.00	No
ContactLens	Contact Lenses	1 per 12 months	No Copay	$150.00	Yes	--	$150.00	No
Frame	Frame (Non Plan)	1 per 24 months	$20.00	$150.00	Yes	--	$150.00	No
SpectacleLens	Single Vision - Spectacle Lens (Plan)	1 per 12 months	$20.00	Covered	Yes	--	$0.00	No
SpectacleLens	Bifocal - Spectacle Lens (Plan)	1 per 12 months	$20.00	Covered	Yes	--	$0.00	No
SpectacleLens	Trifocal - Spectacle Lens (Plan)	1 per 12 months	$20.00	Covered	Yes	--	$0.00	No

Category	Description	Frequency	Copay Amount	Allowed Per Period	Available	Next Available Date	Allowance Remaining	Auth Required
SpectacleLens	Single Vision - Lenticular	1 per 12 months	$20.00	Covered	Yes	--	$0.00	No
SpectacleLens	Bifocal - Lenticular	1 per 12 months	$20.00	Covered	Yes	--	$0.00	No
SpectacleLens	Trifocal - Lenticular	1 per 12 months	$20.00	Covered	Yes	--	$0.00	No
SpectacleLensOptions	Scratch Resistant Coating Premium	1 per 12 months	$30.00	Covered	Yes	--	$0.00	No
SpectacleLensOptions	Scratch Resistant Coating	1 per 12 months	$15.00	Covered	Yes	--	$0.00	No
SpectacleLensOptions	Tint	1 per 12 months	$15.00	Covered	Yes	--	$0.00	No
SpectacleLensOptions	Tint Gradient	1 per 12 months	$18.00	Covered	Yes	--	$0.00	No
SpectacleLensOptions	UV Coat	1 per 12 months	$12.00	Covered	Yes	--	$0.00	No
SpectacleLensOptions	Blue Light Filtering - EBS	1 per 12 months	$15.00	Covered	Yes	--	$0.00	No
SpectacleLensOptions	Glass - BiFocal	1 per 12 months	$137.00	Covered	Yes	--	$0.00	No
SpectacleLensOptions	Glass - TriFocal	1 per 12 months	$137.00	Covered	Yes	--	$0.00	No
SpectacleLensOptions	Glass - Single Vision	1 per 12 months	$76.00	Covered	Yes	--	$0.00	No
SpectacleLensOptions	Polarized - Single Vision	1 per 12 months	$75.00	Covered	Yes	--	$0.00	No
SpectacleLensOptions	HD Polycarbonate - Multifocal	1 per 12 months	$60.00	Covered	Yes	--	$0.00	No

Category	Description	Frequency	Copay Amount	Allowed Per Period	Available	Next Available Date	Allowance Remaining	Auth Required
ContactLens	Medically Necessary - Contact Lens	1 per 12 months	No Copay	Covered	Yes	--	$0.00	No

Member: JOHN DOE

Date of Birth: 1/1/1999

Subscriber ID: 999333444-00

Product Name: V1100/V1100

Plan Code: F1

Please Note: Member must be eligible at date of service to receive benefit.

In Network Coverage Frequency

Category	Benefit Eligibility	Frequency
Exam	Available on 10/09/2025	1 every 12 month(s)
Maternity Exam	Available	2 every 12 month(s)
Selection Contact Lens Fit	Available	1 every 12 month(s)
Non-Selection Contact Lens Fit	Available	1 every 12 month(s)
Frame	Available	1 every 12 month(s)
Lenses	Available	1 every 12 month(s)
Selection Contact Lenses - Daily/Biweekly Wear[1]	Available	Every 12 month(s)
Selection Contact Lenses - Monthly Wear[1]	Available	Every 12 month(s)
Non-Selection Contact Lenses[1]	Available	Every 12 month(s)
Maternity Replacement Frames	Available on 12/13/2024	1 every 12 month(s)
Maternity Replacement All Lenses	Available on 12/13/2024	1 every 12 month(s)

Dilated Retinal Exam: No known history requiring DRE

[1] Contact Lenses are in Lieu of Eyeglasses

In Network Coverage

Vision Care Services	Patient Responsibility (includes applicable copay)
Professional Services	
Exam	$10.00
Maternity Exam	$10.00
Non-Selection Contact Lens Fit	100% of Billed Charges
Selection Contact Lens Fit	Covered-in-Full
Frames	
Frame	70.00% of Balance over $130.00 Benefit Allowance
Lenses	
Lenses / Blended Bifocals	80% of Billed Charges
Lenses / Free-form SV Lenses	80% of Billed Charges
Lenses / MF Aspheric Lenses	80% of Billed Charges
Lenses / Occupational Double Seg Lenses	80% of Billed Charges
Lenses / Progressive Lenses: Non-Formulary	80% of Billed Charges
Lenses / Progressive Lenses: Tier I	$80.00
Lenses / Progressive Lenses: Tier II	$125.00
Lenses / Progressive Lenses: Tier III	$175.00
Lenses / Progressive Lenses: Tier IV	$225.00

Lenses / Progressive Lenses: Tier V	$275.00
Lenses / Standard Lenses	$25.00
Lenses / SV Aspheric Lenses	80% of Billed Charges

Lens Materials

(Pricing shown is in addition to Patient Responsibility from Lens section above)	
High Index 1.66 - 1.73	$63.00
High Index less than or equal to 1.66	$53.00
High Index, >= 1.74	80% of Billed Charges
Polycarbonate Lenses	Covered-in-Full for Ages 0-18
Polycarbonate Lenses	$33.00 for Ages 19+

Lens Options

Anti-Reflective Coating: Non-Formulary	80% of Billed Charges
Anti-Reflective Coating: Tier I	$30.00
Anti-Reflective Coating: Tier II	$50.00
Anti-Reflective Coating: Tier III	$75.00
Anti-Reflective Coating: Tier IV	$95.00
Chemistrie Clip	100% of Billed Charges
Edge Coating	80% of Billed Charges
Miscellaneous Lens Options	80% of Billed Charges
One Year Scratch Warranty	$10.00
Oversize Lenses	80% of Billed Charges
Photochromic	$67.00
Polarized	80% of Billed Charges
Polished Edges / Roll & Polish	$13.00
Scratch Coating	Covered-in-Full
Tint	$14.00
UV Coating	$16.00

Contact Lenses

Necessary Contact Lenses [1]	$25.00
Non-Selection Contact Lenses[1]	100.00% of Balance over $150.00 Benefit Allowance
Selection Contact Lenses - Daily/Biweekly Wear[1]	$25.00 for up to 6 Boxes
Selection Contact Lenses - Monthly Wear[1]	$25.00 for up to 4 Boxes

Please use the Selection Contact Lenses for Vision Plans Formulary. Contact lenses (including disposable lenses), the fitting/evaluation fees, and up to two follow-up visits are covered-in-full up to the maximum allowed in a benefit year.

[1] Contact Lenses are in Lieu of Eyeglasses

Member : John, Doe : 10/3/2024 12:00:00 PM

Routine:	Member IS NOT ELIGIBLE for Routine Vision exam on 10/3/2024 : Age Restriction
Hardware:	Member IS NOT ELIGIBLE for Routine Hardware on 10/3/2024 : Age Restriction
Member Responsibility:	This members benefit may be subject to a deductible or other cost share. The applicable AMOUNT REMAINING IS: **In-Network:** Individual OOP: $7404.57 Family OOP: $16654.57 Individual Deductible: $6831.66 Family Deductible: $15281.66 Coinsurance: 50%
Benefit: PA2024AX	AMBETTER from PA Health & Wellness ********** In-Network Routine Vision Exam Benefit: Members under the age of 19 may receive 1 routine vision exam every calendar year. Routine vision exams are not covered for members 19 and over. Co-pay: $0 In-Network Routine Material Benefit: Members under the age of 19 may receive 1 pair of prescription eyeglasses per calendar year. Scratch resistant lenses, in CR-39 or polycarbonate materials, with standard anti-reflective coating (e.g., Sharpview) are covered in full. Members under the age of 19 may receive contact lenses in lieu of eyeglasses per calendar year. The initial pair of contact lenses is covered in full. One standard or specialty contact lens fitting is covered in full. Routine material benefits are not covered for members 19 and over. Co-pay: $0 In-Network Medical/Surgical Benefit: COVERED WHEN PROVIDED BY OPTOMETRIST ONLY Specialist copayment (exam only): $90 Deductible: Individual $8450; Family $16900 Coinsurance: 50% Maximum Out of Pocket: Individual $9250; Family $18500 Medical services rendered by Ophthalmologists should be submitted directly to the health plan. In-Network Medically Necessary Hardware Benefit (including post-cataract): COVERED. Out-of-Network services are not covered. Benefits are quoted as a courtesy only. This does not constitute a guarantee of payment. **********
Disclaimer:	Eligibility is based on current information in our system and does not guarantee claims payment. If you have any questions or concerns regarding the information above, please contact Envolve Vision /AECC Total Vision Health Plan of Texas, Inc./Envolve Vision Vision Plan's customer service department.