



Viewing as: **James Irving** In group: **1041195**

My Benefits

To view all dependents visit [My Profile \(/cigna/en/private/my-profile\)](#). Dependents over the age of 18 must register or sign in to their own account.

Routine Additional Purchase

SERVICE ELIGIBILITY

| Service | Am I Eligible? | Eligible as of Date | Frequency |
|--------------------------------|----------------|---------------------|--------------------------|
| Routine | | | |
| Exam | Yes | 07/01/2024 | Once every calendar year |
| Lenses | Yes | 07/01/2024 | Once every calendar year |
| Frame | Yes | 07/01/2024 | Once every calendar year |
| Contact Lenses | Yes | 07/01/2024 | Once every calendar year |
| Contact Lens Fit and Follow-up | Yes | 07/01/2024 | Once every calendar year |

Restrictions

Close (-)

In Network Restrictions:

Plan allows the member to receive either contacts or frame and lens services.

BALANCES

Declining Balance Packages

Total balance can be used fully in-network or fully out-of-network.

| Declining Balance Package | Starting Balance | Remaining Balance |
|---|------------------|-------------------|
| In Network | | |
| Contact Lenses and Contacts Fit and Follow Up | \$150 | \$150 |

| Declining Balance Package | Starting Balance | Remaining Balance |
|---|------------------|-------------------|
| Contact Lenses and Contacts Fit and Follow Up | \$120 | \$120 |

BENEFITS

| | | |
|--|--|--|
| Vision Care Services | In-Network Member Cost | Out-of-Network Member Reimbursement |
| Exam Services | | |
| Exam | \$10 copay | Up to \$45 |
| Retinal Imaging | Up to \$39 | Not covered |
| Contact Lens Fit and Follow-Up | | |
| Fit and Follow-up - Standard | \$40 applied to remaining balance | 100% of retail price up to remaining balance |
| Fit and Follow-up - Premium | 90% of retail price applied to remaining balance | 100% of retail price up to remaining balance |
| Frame | | |
| Frame - Retail | \$0 copay; 20% off balance over \$150 allowance | Up to \$98 |
| Frame - Wholesale* | \$0 copay; 100% of balance over \$100 allowance | Up to \$98 |
| Lenses | | |
| Single Vision | \$25 copay | Up to \$32 |
| Bifocal | \$25 copay | Up to \$55 |
| Trifocal | \$25 copay | Up to \$65 |
| Lenticular | \$25 copay | Up to \$80 |
| Progressive - Standard | \$0 copay | Up to \$55 |
| Progressive - Premium | \$25 copay | Up to \$65 |
| Lens Options | | |
| Anti Reflective Coating - Standard | \$45 | Not covered |
| Anti Reflective Coating - Premium Tier 1 | \$57 | Not covered |
| Anti Reflective Coating - Premium Tier 2 | \$68 | Not covered |
| Anti Reflective Coating - Premium Tier 3 | 20% off retail price | Not covered |
| Photochromic - Non-Glass | \$75 | Not covered |
| Polycarbonate - Standard - age 19 and over | \$40 | Not covered |
| Polycarbonate - Standard - under age 19 | \$0 copay | Not covered |

| | | |
|---------------------------|---|--|
| Tint - Solid and Gradient | \$15 | Not covered |
| UV Treatment | \$15 | Not covered |
| Glass | \$0 copay | Not covered |
| Oversize Lens | \$0 copay | Not covered |
| Prism | \$0 copay | Not covered |
| All Other Lens Options | 20% off retail price | Not covered |
| Contact Lenses | | |
| Contacts - Conventional | 85% of retail price applied to remaining balance | 100% of retail price up to remaining balance |
| Contacts - Disposable | 100% of retail price applied to remaining balance | 100% of retail price up to remaining balance |
| Contacts - Therapeutic | \$0 copay | Up to \$210 |

Limitations, Exclusions and Discounts

Limitations

*Available at wholesale providers, such as Costco Optical; discounts do not apply. View the provider locator to find wholesale providers.

Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy.

Allowances provide no remaining balance for future use within the same Benefit Frequency, except for the following Allowance, for which any remaining balance may be used within the same Benefit Frequency:

Vision Materials Allowance.

Where the Insured Person previously utilized an In-Network Provider, the remaining balance must be used with the same or any other In-Network Provider. Where the Insured Person previously utilized an Out-of-Network Provider, the remaining balance must be used with the same or any other Out-of-Network Provider.

Declining balance will be applied to provider's contracted rate. Amounts may vary by provider. Confirm at time of service.

Some provisions, benefits, exclusions or limitations listed herein may vary by state.

Exclusions

- Orthoptic or vision training and any associated supplemental testing
- Medical or surgical treatment of the eyes
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment
- Any injury or illness when paid or payable by Workers' Compensation or similar law, or which is work-related
- Charges in excess of the usual and customary charge for the Service or Materials

- Experimental or non-conventional treatment or device
- Magnification or low vision aids not shown as covered in the Schedule of Vision Coverage
- Any non-prescription (minimum Rx required) eyeglasses, includes frame, lenses, or contact lenses
- Spectacle lens treatments, "add-ons" or lens coatings not show as covered in the Schedule of Vision Coverage.
- Prescription sunglasses "add-ons" or lens coatings not shown as covered in the Schedule of Vision Coverage
- Two pair of glasses, in lieu of bifocals or trifocals
- Safety glasses or lenses required for employment not shown as covered in the Schedule of Vision Coverage
- VDT (video display terminal)/computer eyeglass benefit
- Claims submitted and received in excess of twelve (12) months from the original Date of Service

Plan Discounts

Member receives a 20% discount on items not covered by the plan at In-Network locations. Discount does not apply to Provider's professional services or contact lenses.

Plan discounts cannot be combined with any other discounts or promotional offers.

In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see the online provider locator to determine which participating providers have agreed to the discounted rate.

Discounts on vision materials may not be applicable to certain manufacturers' products.

The Plan reserves the right to make changes to the products on each tier and to the member out-of-pocket costs. Fixed tier pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels.

Services and amounts listed above are subject to change at any time.

Discounts are not insured benefits.

Benefits are based upon the member receiving service for this provider and date of service.

Benefits are underwritten or administered by Connecticut General Life Insurance Company or Cigna Health and Life Insurance Company. Any benefit information is intended as a summary of benefits only. It does not describe all the terms, provisions and limitations of your plan. For costs and complete details of coverage, please refer to your plan document. If the event of any disagreement between the information communicated on this site and the plan document, the plan document will control. Participating providers are independent contractors solely responsible for your routine vision examinations and products.