Member: WENDY REED

Date of Birth: 11/01/1966

Subscriber ID: 969132041-00

Product: C0756

This benefit summary outlines your eligibility and benefit coverage

Please note: Consult the applicable policy/certificate of coverage for a full description of benefits, including exclusions and limitations. If there are differences in this page description and the Group Policy, the Group Policy is the governing document.

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

In Network Coverage Frequency		
Category	**Benefit Eligibility**	**Frequency**
Exam	Available on 01/01/2018	1 every 1 plan year
Contact Lens Fit	Available	1 every 1 plan year
Frames	Available	1 every 1 plan year
Lenses	Available	1 every 1 plan year
Contact Lenses	Available	1 every 1 plan year
In lieu of eyeglasses		

In Network Coverage	
Vision Care Services	**Patient Responsibility** (includes applicable copay)
Professional Services	
Exam	$10.00
Selection Contact Lens Fit	Covered-in-Full
Non-Selection Contact Lens Fit	100% of Billed Charges
Frames	
Frames	Balance over your $175.00 Benefit Allowance
Your frame allowance is applied toward the retail price of a frame at any network provider. If the frame costs less than the allowance, you have no additional out of pocket expense. If the frame costs more than the allowance, you are only responsible for the difference.	
Lenses (Glass or Plastic)	
Bifocal Lenses	$25.00
Blended Bifocals	80% of Billed Charges
Lenticular Lenses	$25.00
Multifocal Aspheric Lenses	80% of Billed Charges
Progressive Lenses: Tier 1 (Standard)	$95.00
Progressive Lenses: Tier 2 (Deluxe)	$135.00
Progressive Lenses: Tier 3 (Premium)	$175.00
Progressive Lenses: Tier 4 (Platinum)	$275.00
Progressive Lenses: Tier 5 (Non-formulary)	80% of Billed Charges
Single Vision Aspheric Lenses	80% of Billed Charges
Single Vision Lenses	$25.00
Trifocal Lenses	$25.00
Lens Options	
Edge Coating	80% of Billed Charges
High Index 1.67 - 1.73	$63.00

High Index less than or equal to 1.66	$53.00
High Index, >= 1.74	80% of Billed Charges
One Year Scratch Warranty	$10.00
Oversize Lenses	80% of Billed Charges
Photochromic	$67.00
Platinum Anti-Reflective Coating	$90.00
Polarized	80% of Billed Charges
Polished Edges / Roll & Polish	$13.00
Polycarbonate Lenses	Covered-in-Full
Premium Anti-Reflective Coating	$80.00
Scratch Coating	Covered-in-Full
Standard Anti-Reflective Coating	$40.00
Tint	$14.00
UV Coating	$16.00

Additional Lens Options not reflected on this list may be available at a discount, please see your provider for details.

Contact Lenses (In lieu of eyeglasses)

Necessary Contact Lenses	$25.00
Non-Selection Disposable Contact Lenses	Balance over your $175.00 Benefit Allowance
Selection Disposable Contact Lens / Formulary Contacts: Disposable	$25.00 for Boxes 1-6
Selection Planned Replacement Monthly Wear Contact Lens / Formulary Contacts: Monthly Wear	$25.00 for Boxes 1-4

Selection Contacts
Contacts (including disposables), the fitting/evaluation fees, and up to two follow-up visits are covered-in-full up to the maximum allowed in a benefit year. Coverage for Covered Contact Lens Selection does not apply to Costco, Walmart or Sam's Club locations. The allowance for Non-selection Contact Lenses will be applied toward the purchase of all contacts at these locations.

Non-Selection Contacts
Your allowance above is the total amount available per benefit year and is applied toward the purchase of contact lenses. The material copay does not apply. If your contacts are greater than the allowance, then you are only responsible for the difference.

Out of Network Coverage Frequency

(out of network frequency follows your In Network frequency schedule)

Category	Reimbursement Availability
Exam	Available on 01/01/2018
Frames	Available
Lenses	Available
Contact Lenses	Available

Out of Network Coverage

Vision Care Services	Patient Reimbursement
Professional Services	
Exam	Up to $60.00
Frames	
Frames	Up to $70.00
Lenses (Glass or Plastic)	
Bifocal Lenses	Up to $70.00
Lenticular Lenses	Up to $90.00

Progressive Lenses	Up to $70.00
Single Vision Lenses	Up to $50.00
Trifocal Lenses	Up to $90.00
Contact Lenses	
Necessary Contact Lenses	Up to $210.00
OON Contact Lenses	Up to $175.00

Please note: Receipts must be submitted together at the same time for services and materials purchased on different dates to receive reimbursement. We will reimburse you for covered expenses according to the schedule shown above.