

Schedule of Benefits Summary

Option 63

\$200 Frame Allowance/\$25 Lens Copay/Discounted Fit and Follow Up/FREQ 12/12/12

Insight Network

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Vision Examination		
Exam	\$10 Copay	Up to \$35
Dilation	Included with Exam	N/A
Refraction	Included with Exam	N/A
Frames	80% of Balance over \$200	Up to \$100
Lens		
Single Vision	\$25 Copay	Up to \$25
Bi-focal	\$25 Copay	Up to \$40
Tri-focal	\$25 Copay	Up to \$55
Standard Progressive Lens	\$90 Copay	Up to \$40
Premium Progressive Lens		
• Tier 1	\$110 Copay	
• Tier 2	\$120 Copay	
• Tier 3	\$135 Copay	Up to \$40
• Tier 4	80% of Retail Less \$120 Plus \$90 Copay	
Lenticular	\$25 Copay	Up to \$55
Other Lens Type	80% of Charge	N/A
Lens Options		
Standard Polycarbonate	\$40	N/A
Standard Plastic Scratch Coating	\$15	N/A
Tint	\$15	N/A
UV Treatment	\$15	N/A
Standard Anti-reflective (a/r) Coating	\$45	N/A
Premium Anti-reflective (a/r) Coating		
• Tier 1	\$57	N/A
• Tier 2	\$68	N/A
• Tier 3	80% of Retail	N/A
Photochromatic/Transitions	\$75	N/A
Other Lens Options	80% of Retail	N/A
Contact Lenses		
• Conventional	85% of the Balance Over \$200	Up to \$160
• Disposable	100% of the Balance Over \$200	Up to \$160
• Medically Necessary	\$0 Copay	Up to \$200
Fit and Follow-Up Discount		
• Standard	Up to \$40	N/A
• Premium	Discount of 10% Off Retail Price	N/A
Non-Scheduled Items		
• Doctor Misc. Materials	80% of Charge	N/A
LASIK or PRK Vision Correction	85% of the Retail Price or 95% of a Promotional Price	N/A
Benefit Frequency		
Contact Lenses or Lens Exam	Once Every Calendar Year	
Frame	Once Every Calendar Year	
Shades of Blue Base Plan Included		