Vision Services and Frequency	In-Network Plan Coverage**	In-Network Member Cost***	Out-of-Network Reimbursement
Exam and Professional Services:			
Frequency*: once per **12 month**			
Eye Exam	100% after Copay	$10 Copay	Up to $45 Allowance
Retinal Screening	Not Covered	Up to $39	Not Covered
Standard Contact Lens Fit & Follow-up	$0	Up to $40[1]	Not Covered[1]
Premium Contact Lens Fit & Follow-up	$0	90% of Retail[1]	Not Covered[1]
Standard Eyeglass Lenses Allowances:			
Frequency*: one pair per **12 month**			
Lenses:			
Single Vision	100% after Copay	$25 Copay	Up to $32 Allowance
Lined Bifocal	100% after Copay	$25 Copay	Up to $55 Allowance
Lined Trifocal	100% after Copay	$25 Copay	Up to $65 Allowance
Lenticular	100% after Copay	$25 Copay	Up to $80 Allowance
Lens Enhancements / Options			
Oversize lenses	100%	$0	Not Covered
Rose #1 and #2 Solid Tints	100%	$0	Not Covered
Polycarbonate Lenses <19 years of age	100%	$0	Not Covered
Polycarbonate Lenses	$0	$40	Not Covered
Standard Progressives+	$0	$65[2]	Not Covered[2]
Premium Progressives+	$0	Tier 1: $85[2] Tier 2: $95[2] Tier 3: $110[2] Tier 4: $65 plus 20% off retail Less $120 allowance[2]	Not Covered[2]
Plastic Dye Tints	$0	$15	Not Covered
Photochromic – Glass or Plastic	$0	$75	Not Covered
Standard Scratch Coating	$0	$15	Not Covered
Standard Ultraviolet (UV)	$0	$15	Not Covered
Standard Anti-Reflective (AR) Coating+	$0	$45	Not Covered
Premium Anti-Reflective Coating+	$0	Tier 1: $57 Tier 2: $68 Tier 3: 20% off Retail	Not Covered
Hi-Index Lenses	$0	20% off retail	Not Covered
All other lens options	$0	20% off retail	Not Covered
Contact Lenses Retail Allowance:			
Frequency*: one pair or single purchase per 12 month			
Elective – Conventional	100% up to $130 Retail Allowance; Additional 15% off balance over allowance	Balance over $130 Allowance	Up to $105 Allowance
Elective – Disposable	100% up to $130 Retail Allowance		
Therapeutic	100%	$0	Up to $210 Allowance
Frame Allowance			
Frequency*: one per **12** month			
Retail	100% up to $130 Allowance	20% off balance over Allowance	Up to $71 Allowance
Costco	100% up to $80 Allowance	Balance over Allowance	

* Your Frequency Period begins on the 1st of your plan renewal month (Contract year basis)

+Changes to the products in each tier and member out-of-pocket amounts are subject to change; All providers are not required to carry all brands at all levels. Check with your in-network provider for details.

[1]May be applied to Contact Lens Allowance.

[2]Member out-of-pocket includes Lined Bifocal copay. Out-of-network reimbursement based on Lined Bifocal allowance.

**Coverage may vary at participating discount retail and membership club optical locations, please contact Customer Service for specific coverage information.

***Provider participation is 100% voluntary and subject to applicable law, please check with your Eye Care Professional for any offered discounts; stated Customer Cost, up to maximums, are subject to change without notice.