# SCHEDULE OF VISION BENEFITS

| | Participating Provider | Non-Participating Provider |
|---|---|---|
| **ROUTINE EXAM**<br>(for glasses)<br>Once every 24 months*** | Covered 100%* | Reimbursement Amt.<br>Up to $ 32 |
| **LENSES**<br>Once every 24 months***<br>Single Vision<br>Bifocal<br>Trifocal<br>Lenticular<br>Polycarbonate (for children under age 19)<br>1 Yr. Scratch Protection | Standard Glass or Plastic Covered*<br>100%<br>100%<br>100%<br>100%<br>100%<br>100% | <br><br>Up to $ 18<br>Up to $ 27<br>Up to $ 35<br>Up to $ 55<br>N/A<br>N/A |
| **FRAME**<br>Once every 24 months | Covered 100%* if within the plan's wholesale allowance | Up to $ 18 |
| **- OR -**<br><br>**CONTACT LENSES**<br>Once every 24 months***<br><br>Elective Contact Lenses<br><br>Medically Necessary (requires prior authorization from **VBA**) | <br><br>In lieu of all other materials/services**<br><br>Up to $ 68<br><br>UCR (usual, customary, reasonable) | <br><br>In lieu of all other materials/services**<br><br>Up to $ 68<br><br>Up to $ 68 |

* Less $10 Copayment on exam and $20 Copayment on materials.

** The contact allowance is applied to all services/materials associated with contact lenses. This includes, but is not limited to, contact exam, fitting, dispensing, cost of lenses, etc. There is no guarantee that the contact allowance will cover the entire cost.

*** Once every 12 months for children up to age 19.



Vision Benefits of America

*Clearly Managed. Clearly Focused.*

Vision Benefits of America (**VBA**) maintains a network of more than 15,000 Participating Optometrists, Ophthalmologists and Retail Locations nationwide to provide professional vision care for persons covered under this plan.

# HOW YOUR VISION CARE PROGRAM WORKS

- *Select a **VBA** Participating Provider in your area. When scheduling an appointment, please notify the **VBA** Participating Provider that your vision coverage is administered by **VBA**. A list of Participating Providers is available on our website at www.visionbenefits.com. The provider selected will contact **VBA** to verify eligibility via on-line system and will process services received electronically.*

To verify your benefit eligibility prior to visiting your eye care provider, please visit our website at www.visionbenefits.com or contact **VBA**'s Customer Service Department toll-free at 1-800-432-4966.

**ELIGIBILITY (from the last date of service)**:
**EXAM**: Adults/Dependents (over age 19)--Once every 24 months
Children (up to age 19)--Once every 12 months
**LENSES**: Adults/Dependents (over age 19)--Once every 24 months
Children (up to age 19)--Once every 12 months
**FRAMES**: Adults/Dependents/Children--Once every 24 months

**--OR--**

**CONTACT LENSES (in lieu of all other benefits for the benefit period):**
Adults/Dependents (over age 19)--Once every 24 months
Children (up to age 19)--Once every 12 months

**CUSTOMER SERVICE:** To verify eligibility/dependent age, locate a Participating Provider or receive answers to all your vision care related inquiries, please call **VBA**'s Customer Service Department at 1-800-432-4966/option 5.

**Vision Benefits of America**
**300 Weyman Road, Suite 400, Pittsburgh, PA 15236 •1-800-432-4966**

## PARTICIPATING PROVIDER COVERAGE

**VISION EXAMINATION:** A complete analysis of the eyes and related structures to determine the presence of any vision problems.

**SPECTACLE LENSES:** Your program provides the finest quality lenses fabricated to **VBA**'s exacting standards. A **VBA** Participating Provider will order the proper lenses and verify their accuracy when finished.

**FRAMES:** **VBA** plans offer a wide selection of fully covered designer frames; however, if you choose a frame which costs more than the amount allowed by your plan, you will be responsible for any additional controlled charges.

**-OR-**

**CONTACTS SELECTED IN LIEU OF GLASSES:** When contact lenses are selected in lieu of glasses, your plan will provide a total allowance of up to **$68.00** toward their cost. **THIS IS IN LIEU OF ALL OTHER BENEFITS FOR THE BENEFIT PERIOD.** You will not receive any additional monies for contact lenses and/or contact lens exam costs that are more than the **$68.00** allowance.

**MEDICALLY NECESSARY CONTACT LENSES:** Contact lenses are fully covered on a UCR (Usual, Customary, Reasonable as determined by **VBA**) basis when a **VBA** Participating Provider receives prior approval for one of the following services related to eye disease or injury such as, following cataract surgery, visual acuity problems not correctable with spectacle lenses, anisometropia of 4 diopters or greater and keratoconus.

**PLAN ALLOWANCES:** When you choose to obtain services from a **VBA** Participating Provider, this plan covers the benefits described herein (examination, professional services, lenses and frames) at no expense to you, if the materials selected fall within your plan's allowance. **NOTE: A $10 copayment applies to the vision exam and a $20 copayment applies to the total cost of the lenses and/or frames selected through a VBA Participating Provider only, however the copayments do not apply to the contacts.**

**EXCLUSIONS/LIMITATIONS:** There are no benefits for professional services or materials connected with vision training / subnormal vision aids / non-prescription lenses / lost or broken lenses or frames / medical or surgical treatment of the eyes / two pairs of glasses in lieu of bifocals / services or materials provided as a result of any Workers' Compensation Law or similar legislation or any eye exam required by an employer as a condition of employment.

**LASIK:** All **VBA** covered subscribers are eligible to receive a significant discount at hundreds of provider locations nationwide. For more information regarding this benefit, please visit our website or call **VBA**'s Customer Service at 1-800-432-4966/option 5.

**OPTIONAL VISION MATERIALS AT A CONTROLLED PRICE:** This plan is designed to fully cover your visual needs rather than cosmetic lens and frame options. There will be extra controlled costs involved if you select any of the following: Rimless frames / a frame costing more than your plan's allowance / Elective contact lenses (in excess of your plan's allowance) / Polycarbonate lens material for adults (covered if under 19) / Progressive lenses (available starting at $45.00) / Photo-Sensitive lenses / Tinted lenses or Coated lenses (except 1 Yr. Scratch Protection is covered through a VBA Participating Provider only).

## NON-PARTICIPATING PROVIDERS

If you choose to see a Non-Participating Provider, make an appointment and pay the provider their full fee. Obtain an itemized receipt which must contain the following information: patient's name, date services began, services and/or materials received and type of lenses (single vision, bifocal, etc.). There is no assurance the Non-Participating Reimbursement Schedule will cover the entire cost of the examination, glasses or contacts.

Mail your receipts along with a **VBA** out-of-network reimbursement Form (which can be printed on-line at www.visionbenefits.com) to:

**Vision Benefits of America**
**300 Weyman Road, Suite 400**
**Pittsburgh, PA 15236-1588**