Independence

Vision Benefit Highlights

Vision Care 100: 12/12/24

Covered Services (Calendar Year)	Your Costs (You pay)	
Exam	**In-Network**	**Out-of-Network**
Routine Eye Exam at Davis Participating Providers (1 exam/year)[1]	$10	$40 Reimbursement
Retinal Imaging	$39	Not covered
Lenses (1 pair/year)[1]	**In-Network**	**Out-of-Network[2]**
Single Vision Lenses	$25	$40 Reimbursement
Bifocal Lenses	$25	$60 Reimbursement
Trifocal Lenses	$25	$80 Reimbursement
Lenticular Lenses	$25	$100 Reimbursement
Lens Options	**In-Network**	**Out-of-Network**
Progressive Lenses - Standard/Premium/Ultra/ Ultimate	$65/$105/$140/$175	$60 Reimbursement
Polycarbonate Lenses - Single/Multifocal[3]	$35	Not covered
Digital/Intermediate Lenses	$30	Not covered
Photochromic Lenses - Single/Multifocal	No charge	Not covered
Photosensitive Lenses - Single/Multifocal	$70	Not covered
High-Index 1.67 / High-Index 1.74 Lenses	$60/$120	Not covered
Blue Light Lenses	$15	Not covered
Polarized Lenses	$75	Not covered
Lens Coatings		
Tinted Plastic Lenses	$15	Not covered
UV-Coated Lenses	No charge	Not covered
Scratch-Resistant Coating - Single/Multifocal	No charge	Not covered
Scratch-Protection Plan - Single/Multifocal	$20/$40	Not covered
Anti-Reflective Coating - Standard/Premium/ Ultra/Ultimate	$40/$55/$69/$85	Not covered
Frames (1 pair/Every 24 Months)[1]	**In-Network**	**Out-of-Network**
Collection Fashion Frames	No charge	Not covered
Collection Designer Frames	$15	Not covered
Collection Premier Frames	$40	Not covered
Non-Collection Frames	Up to $100 Allowance (plus a 20% discount on overage)[4]	$50 Reimbursement
Visionworks Frames Option	Up to $150 Allowance (plus a 20% discount on overage)[4]	Not covered

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Contact Lenses (in lieu of glasses) (1 pair/ year)[1]	In-Network	Out-of-Network
Collection Contact Lenses Evaluation, Fitting & Follow-Up Care	Not covered	Not covered
Collection Contact Lenses	Not covered	Not covered
Non-Collection Standard Contact Lenses Evaluation, Fitting & Follow-Up Care	Not covered	Not covered
Non-Collection Specialty & Disposable Contact Lenses Evaluation, Fitting & Follow-Up Care	Not covered	Not covered
Non-Collection Contact Lenses	Up to $100 Allowance[4]	$80 Reimbursement
Medically-Necessary Contact Lenses[5]	No charge	$225 Reimbursement

1 Combined in and out-of-network.

2 Lens Options are subject to out-of-network base lens reimbursement. See your benefit booklet for reimbursement amounts.

3 Polycarbonate lenses for dependent children, monocular patients, and patients with prescriptions greater than or equal to +/6.00 diopters are covered at no cost.

4 Member is responsible for balance. Additional discounts not applicable at Walmart, Costco, or Sam's Club locations.

5 Covered with prior approval.

This summary represents only a partial listing of benefits of the Vision Care Program described in this summary. If your employer purchases another program, the benefits may differ. Also, benefits may be further defined by the vision policy. As a result, this vision plan may not cover all of your vision or health care expenses. Read your contract/member benefit booklet carefully for a complete listing of terms and limitations of the program. For more information about your coverage, or to get a copy of the complete terms of coverage, visit **www.ibx.com/LGBooklet** or call **1-800-ASK-BLUE** (TTY: 711).

Benefits may be changed by Independence Blue Cross to comply with applicable federal/state laws and regulations.

Administered by Davis Vision, an Independent Company.

Benefits underwritten or administered by QCC Insurance Company, a subsidiary of Independence Blue Cross - Independent licensees of the Blue Cross and Blue Shield Association. **www.ibx.com**

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