Eyetopia 130/150 (Standard)
Florence ISD Summary of Benefits

Eyetopia Benefits

Eyetopia provides two vision benefits each eligibility period. You may have the opportunity to maximize your Eyetopia benefits by coordinating benefits with your Health Insurance coverage.

BENEFIT ONE [2] (choose either one of the following 2 options every 12 months):	**Allowance**	**Co-pay**[1]
1. Refractive Exam. One routine Vision Exam.	N/A	$10.00
2. Coverage towards a medical eye exam copay or other services or materials. [2]	$45.00	None

BENEFIT TWO (choose only one of the following Vision Correction Options): Eyetopia provides you with 3 options for correcting your vision every 12 months.[3]

	Allowance	**Co-pay**[1]
1. Prescription Lenses [4] CR-39 plastic single vision, bifocal, trifocal lenses.	N/A	$20.00
• CR-39 plastic Progressive (no-line multi-focal) lenses that retail for up to $199.	N/A	$20.00
• CR-39 plastic Progressive (no-line multi-focal) lenses that retail for more than $199.	$200.00	$20.00
• Polycarbonate material upgrade	N/A	$25.00
• Polycarbonate material upgrade for child dependents (under age 26)	Covered	None
• Basic Coating (Ultraviolet Protection & Scratch Resistant Coating)	Covered	None
• Mid-Level Anti-Reflective Coatings that retail up to $99.	Covered	None
• Premium Anti-Reflective Coatings that retail for $100 or more copay not to exceed:	N/A	$130.00
• Premium blue light blocking lenses or premium blue light blocking anti-reflective coating.	N/A	$105.00
• Tint (Solid or Gradient)	N/A	$12.00
• Photochromatic or Polarized Lenses	N/A	$90.00
♦ Medically necessary spectacles for Aniseikonia or Amblyopia.[5]	$400.00	None
♦ Anti-Fatigue lenses.	Covered	$20.00
♦ **Frame:** The member may select any frame on display and is responsible for any amount exceeding the allowance.	$130	None
2. Contact Lens Option: In lieu of spectacles. Allowance to be applied toward prescription contact lenses. ♦ This allowance can be applied toward the contact lens fitting fee and all other charges including follow-up visits and contact lenses.[6]	$150.00	None
♦ Medically necessary contact lenses - $145.00 evaluation allowance and $400.00 contact lens allowance.[7]	$550.00	None
3. Refractive Surgery Option. [8] In lieu of spectacles or contact lenses. A $350.00 per eye allowance with contracted surgeons or a $75.00 per eye allowance with non-contracted surgeons toward the fees for refractive surgery care for the following procedures: LASIK, PRK, ICL or RLE. The member pays any amount exceeding the per eye allowance.	$350/eye $75/eye	None

[1] The co-pay must be paid to the Participating Provider at the time of service.

[2] When Health Insurance Carriers offer a comprehensive medical eye exam it creates an overlap in benefits for Eyetopia Members. If this occurs, the Member may choose another option under Benefit One as described, no co-pay is required to exercise these other options.

[3] If your prescription has changed at least ½ diopter or your eye doctor recommends a change of lenses, you may select one of three vision correction options every 12 months.

[4] Special Lens Materials and Non-covered Items: Ultra-light, premium PALs, rush service, service agreements, other special lens materials, oversize, other extras and any items not specifically mentioned above may be substituted provided the Member pays any amount exceeding the price of the covered benefit and the Participating Provider's usual and customary fees for the upgrade at the time of service.

[5] The Shaw Lens coverage includes a premium anti-reflective coating and an upgraded lens material. .

[6] If the contact lens evaluation, fitting or dispensing service is performed and the Member decides to use their benefit toward an alternative vision correction option, the Member must pay the cost of the contact lens evaluation, fitting or dispensing service before another vision correction benefit option can be used.

[7] Total maximum benefit allowance is $550.00 the Participating Provider must pre-authorize medical necessity.

[8] Non-covered Items and Exclusions – Facility fees, surgical procedures, medications and enhancements or treatments related to medical procedures.

Exclusions & Limitations

Included Services and/or Eye Wear. Only those professional vision care services and/or vision correction options specifically referenced herein are included in the Eyetopia.

In-Network coverage is available through Participating Providers. Out of network services are not covered.

Additional Professional Services and/or Vision Corrections. The member may select professional services and/or vision correction items not specifically referenced as included in Eyetopia. However, these services and/or items are the member's responsibility at the Participating Provider's (U&C) charge, payable at the time of service or of ordering.

Emp - $10
E+1 - $17
Fam - $24

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