SightCare™ Arizona's Premier Vision Plan

Employer Paid Cutom Broad Network 150

Alhambra Elementary School Core #30000

Benefit Frequency				
	Examination	**Spectacle Lenses**	**Frame**	**Contact Lenses**
Benefit Frequency	24 Months	24Months	24 Months	24 Months

Schedule of Benefits	Nationwide Vision Network	SightCare Provider Network	Out-of-Network
Provider Network Options			
Eye Examination Eyeglass or Contact Lens Contact Lens Fitting **Ancillary Testing – Exams** Dilation (If necessary) Visual Field Testing	**Copay: $0** Covered 100% (When used with Contact Lens Benefit) Covered 100% **Copay: $12**	**Copay: $0** See Contact Lens Section Covered 100% 20% Discount*	Up to $35 See Contact Lens Section See Exam Allowance Not Covered
Frame Benefit (Based on Retail Allowance)	**Copay: $0 for Materials** Benefit: Up to $150 then 20% discount	**Copay: $10 for Materials** Benefit: Up to $150 Benefit: Up to $74 Wal-Mart/Sam's Club	Benefit: Up to $45
Standard Lenses (CR39) Standard Lenses (Pair) • Single Vision • Bifocal • Trifocal • Lenticular • Progressive (Standard) • Progressive (All others) Lens Options Polycarbonate (Under 18 yrs.) UV & Tint Other Lens Options	 • 100% Covered • 100% Covered • 100% Covered • 100% Covered • $30 CoPay • $79.99 allowance[1] [1]Then 20% discount 100% Covered 100% Covered 20% Discount	 • 100% Covered • 100% Covered • 100% Covered • 100% Covered • $50 Allowance $50 Allowance [1]Then 20% discount* 20% Discount 20% Discount* 20% Discount	 • Up to $25 • Up to $40 • Up to $50 • Up to $50 • Bifocal Allowance • Bifocal Allowance Not Covered Not Covered Not Covered
In Lieu of Frame & Spectacle Lenses			
Contact Lenses Elective/Cosmetic Medically Necessary	**Copay: $0 for Materials** $150 for Contact Up to $250	**Copay: $10 for Materials** $150 for Contact Lenses & Fitting Fees Up to $250	 $100 Allowance towards Contact Lenses & Fitting Fees Up to $100
Additional Discounts Offered			
Second Pair Purchases **Replacement Contact Lenses** Disposable Conventional	25% Discount 10% Discount 20% Discount	Not Covered Not Covered Not Covered	Not Covered Not Covered Not Covered

Notations:
Provider Network: Nationwide Vision **or** SightCare Provider Network **or** Out of Network Allowance
Out-of-Network Allowance: Member must pay first and submit receipts to SightCare for reimbursement within 6 months from date of service
Elective Contacts: When vision can be corrected by glasses, but contacts are worn
Medically Necessary Contacts: When vision can't be corrected with glasses due to extreme vision problems
***Wal-Mart & Sam's Club: Doesn't** offer any discounts on their already low prices.