



Voluntary Custom Broad Network 150

Alhambra Elementary School Buy-Up#30010

Benefit Frequency				
	Examination	Spectacle Lenses	Frame	Contact Lenses
Benefit Frequency	12 Months	12 Months	12Months	12 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	Copay: \$0 Covered 100% (When used with Contact Lens Benefit)	Copay: \$0 See Contact Lens Section	Up to \$35 See Contact Lens Section
Ancillary Testing – Exams Dilation (If necessary) Visual Field Testing	Covered 100% Copay: \$12	Covered 100% 20% Discount*	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) <u>Standard Lenses (Pair)</u> <ul style="list-style-type: none"> • Single Vision • Bifocal • Trifocal • Lenticular • Progressive (Standard) • Progressive (All others) <u>Lens Options</u> Polycarbonate (Under 18 yrs.) UV & Tint Other Lens Options	<ul style="list-style-type: none"> • 100% Covered • 100% Covered • 100% Covered • 100% Covered • \$30 CoPay • \$79.99 allowance¹ ¹ Then 20% discount 100% Covered 100% Covered 20% Discount	<ul style="list-style-type: none"> • 100% Covered • 100% Covered • 100% Covered • 100% Covered • 100% Covered • \$50 Allowance • \$50 Allowance ¹ Then 20% discount* 20% Discount 20% Discount* 20% Discount	<ul style="list-style-type: none"> • 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.