BCBST

Group Name:	**Lennox Companies, LLC**
Group Number:	**138330**
Effective Date:	**06/01/2019**

VisionBlue

Benefit	In-Network Member Cost	Out-of-Network Reimbursement	
VISION EXAMINATION			
Comprehensive Eye Examination	$10 Copayment	Up to $35	One exam within a 12 month period for each member covered under the plan.
Retinal Imaging	Up to $39	N/A	
Contact Lenses Fit and Follow-Up			
Standard	$55 Copayment	Up to $0	
Premium	10% off retail	Up to $0	

VISION MATERIALS			
Standard Plastic Lenses			One set of lenses within a 12 month period for each member covered under the plan.
Single Vision	$10 Copayment	Up to $30	
Bifocal	$10 Copayment	Up to $45	
Trifocal	$10 Copayment	Up to $60	
Frames	$0 Copayment up to $135 allowance, 20% off balance over allowance	Up to $67.50	One pair of frames within a 24 month period for each member covered under the plan.
Contacts			One set of lenses within a 12 month period for each member covered under the plan (In lieu of lenses + frames).
Conventional	$0 copay up to $135 allowance, 15% off balance over allowance	Out-of-network up to $108	
Disposable	$0 copay up to $135 allowance	Out-of-network up to $108	
Medically Necessary	Paid in Full	Up to $200	
Lens Options			One set of lenses within a 12 month period for each member covered under the plan.
Standard Polycarbonate	$40 Copayment	Up to $0	
Standard Polycarbonate *(For covered dependent children under 19 years of age)*	$0 Copayment	Up to $5	
UV Treatment	$15 Copayment	Up to $0	
Tint	$15 Copayment	Up to $0	
Standard Plastic Scratch Coating	$15 Copayment	Up to $0	
Standard Progressive Lenses (add on to Bifocal)	$65 Additional Copayment	$0 Additional *	
Premium Progressive Lenses (add on to Bifocal)	$65 Additional Copayment, 20% off retail price less $120 allowance	$0 Additional *	
Standard Anti-Reflective Coating	$45 Copayment	Up to $0	
Other Lens Options	20% off retail	N/A	
* $45 maximum reimbursement			

Diabetic Eye Care *(Care and testing for diabetic members)*			Up to 2 services per year for each listed service.**
Exam	$0	Up to $77	
Retinal Imaging	$0	Up to $50	
Extended Ophthalmoscopy	$0	Up to $15	
Gonioscopy	$0	Up to $15	
Scanning Laser	$0	Up to $33	

**Some or all of the diagnostic services described above will be provided as deemed appropriate, subject to provider determination of service necessity and the benefit frequency limitations referenced above.

- This document serves as a summary of the benefits that are detailed in the Evidence of Coverage. These benefits are subject to the Covered Services and Limitations on Covered Services, Exclusions from Covered Services, and Schedule of Benefits sections of the Evidence of Coverage.
- When applicable benefits are paid after the Copayment listed above and to the allowance listed, members are responsible for amounts above the allowance.
- Members may see any vision care provider. However, contracted providers in our network have agreed to limit certain charges and provide additional discounts once the allowance has been reached. Because we have no contract with non-network providers, members are responsible for all charges that exceed the out-of-network reimbursement.