Plan Rules - Regular

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Group: 087 - DOVER CITY OF

General Plan Rules *

What is covered ?

EITHER (1) EYEGLASS EXAM WITH LENSES & FRAME **OR (2)** ALLOWANCE TOWARD CONTACT EXAM & CONTACT LENS MATERIALS

Plan Specifics

Plan Type:	LAST DATE OF SERVICE
Student Age Limit:	25
Child Age Limit:	19

Exam Copay	Lens/Frame Copays
None	$10.00[2]

Plan Benefit Frequency

	Exam	Lens	Frame	Contacts
Child	12 months	12 months	24 months	**- OR -** $90 every 12 months [1]
Adult	24 months	24 months	24 months	**- OR -** $90 every 24 months [1]

[1] Elective contact lens can only be selected in lieu of all other benefits. When selected, your plan will provide a **total allowance of up to $90 toward the cost of the routine eye exam, contact fitting fees and contacts** (if all purchased at the same time and same provider). Any additional cost over the $90 will be the member's responsibility.
Member may be asked to pay the contact fitting fee out of pocket, at some locations.

[2] Exam copay is not paid if the member elects contact lenses and chooses to order contact lenses the day of the exam. Material copays do not apply to contact lenses.

* Contact lens policies and pricing varies by provider. Be sure to check both before receiving services. Your coverage does not provide both glasses and contact lenses in the same eligibility period.

* Benefits may vary at participating retail locations. Members may contact VBA at 412-881-4900 for more information regarding benefits available at participating retail locations.

* Coupons or advertised specials cannot be used in conjunction with your vision coverage.

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In Network Covered Services*

Vision Care Exam(for Glasses)	Covered
Digital Retinal Screening	Non-Covered
Single Vision Lens	Covered
Lined Multifocals	Covered
Lenticular	Covered
Wholesale Frame Allowance	$50.00 [1]
Polycarbonate	Covered
Blended Bifocal	Covered
Medically Necessary Contact Lenses	Covered w/ Authorization
Basic Scratch	Covered
Elective Contact Lens Allowance	$90 [2]

In Network Lens Options **

Option Name	
Premium 3 (V) & 4 (D) Progressive	Partially Covered
Premium 1 (B) & 2 (C) Progressive	Partially Covered
Basic (Z) Progressive	Partially Covered
Standard (A) Progressive	Partially Covered
High Index	Non-Covered
Photochromic	Non-Covered
Polarized	Non-Covered
UV 400	Non-Covered
Plano	Non-Covered
Aspheric & Atoric	Non-Covered
Digital Surfacing, Single Vision	Non-Covered
Solid or Gradient Tint	Non-Covered
Premium Scratch	Non-Covered
Standard A/R 1	Non-Covered
Standard A/R 2	Non-Covered
Premium A/R 1	Non-Covered
Color Coating	Non-Covered
Mirror Coating	Non-Covered
Edge Treatment	Non-Covered
Rimless Mounting	Non-Covered
Mid-Index / Trivex	Non-Covered
Near Variable Focus	Non-Covered
Blue Protection	Non-Covered
Premium A/R 2	Non-Covered

Ultra A/R	Non-Covered

Out of Network Reimbursements (up to)	
Exam:	$30
Single Vision Lens	$25
Bifocal:	$40
Trifocal:	$60
Lenticular	$80
Contacts:	$90 [2]
Medically Necessary Contact Lenses	$200 [3]
Frames:	$30
Progressive:	$60

[1] Amount is based on wholesale frame cost at non-retail locations. Members can contact their provider before requesting services.

[2] Elective contact lens can only be selected in lieu of all other benefits. When selected, your plan will provide a **total allowance of up to $90 toward the cost of the routine eye exam, contact fitting fees and contacts** (if all purchased at the same time and same provider). Any additional cost over the $90 will be the member's responsibility.
Member may be asked to pay the contact fitting fee out of pocket, at some locations.

[3] Authorization of medical condition required.

[4] Price does not include base charge for material (if applicable).

[6] Medical contacts can only be selected in lieu of all other benefits.

* Member may select only one pair of the covered lens options listed below.

* Benefits may vary at participating retail locations. Members may contact VBA at 412-881-4900 for more information regarding benefits available at participating retail locations.

** Benefits may vary where prohibited by state law.

*** Certain plans may specify that no more than 50% of the above benefit may be used per eye.