

Weakley County Government

VisionBlue

Summary of Benefits

Vision Option: 1

Effective Date: January 1, 2012

Benefit Category	In-Network	Out-of-Network
Exams (Limited to one exam and one contact lens fitting/follow-up within a 12 month period) Comprehensive Eye Exam Contact Lens Fitting and Follow-up – Standard Contact Lens Fitting and Follow-up – Premium	\$10 Copay \$55 Copay 10% off retail	Up to \$35 Not Covered Not Covered
Vision Materials		
Standard Plastic Lenses (Limited to one set of standard plastic lenses within a 12-month period) Single Bifocal Trifocal	\$25 Copay \$25 Copay \$25 Copay	Up to \$30 Up to \$45 Up to \$60
Frames (Limited to one pair of frames within a 24-month period)	\$0 Copay up to \$150 allowance*	Up to \$75
Contacts (Limited to one set of lenses within a 12-month period) Conventional Disposable Medically Necessary	\$0 Copay up to \$150 allowance** \$0 Copay up to \$150 allowance Covered at 100%	Up to \$120 Up to \$120 Up to \$200
Lens Options (Limited to one set of lenses within 12 months) Standard Polycarbonate Standard Polycarbonate (For covered dependent children under age 19) UV Treatment Tint Standard Plastic Scratch Coating Standard Progressive Lenses (add on to Bifocal) Premium Progressive Lenses (add on to Bifocal) Standard Anti-Reflective Coating	\$40 No Copay \$15 Copay \$15 Copay \$15 Copay \$65 Additional Copay \$65 Additional Copay, 20% off of Retail Price, Less \$120 Allowance \$45 Copay	Not Covered Up to \$5 Not Covered Not Covered Not Covered Up to \$45 Up to \$45 Not Covered

RATES:	
Individual:	\$7.15
Employee/Spouse:	\$14.30
Employee/Child:	\$15.02
Family:	\$21.45

Notes:

- 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 copay listed above and to the allowance listed. Members are responsible for amounts exceeding 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.
 - * 20% off balance over allowance
 - ** 15% off balance over allowance