

Section XIII - Schedule of Benefits

BENEFIT FREQUENCY	
EXAMS	
Eye Exam	Every calendar year
Contact Lens Fit	Every calendar year
MATERIALS	
Frames	Every other calendar year
Lenses and Lens Options	Every calendar year
Contact Lenses	Every calendar year

	IN NETWORK¹	OUT OF NETWORK REIMBURSEMENT²
EXAMS		
Eye Exam <i>Comprehensive Eye Exam with Dilation</i>	\$10 Copay	Up to \$40
Contact Lens Fit <i>Available once eye exam is completed</i>	\$30 allowance	None
FRAMES		
Frames <i>Any available frame at provider location</i>	\$130 allowance	Up to \$52
LENSES		
Standard (CR-39) Plastic Lens		
Single Vision	\$20 Copay	Up to \$20
Bifocal	\$20 Copay	Up to \$40
Trifocal	\$20 Copay	Up to \$60
Lenticular	\$20 Copay	Up to \$100
Progressive Lenses		
Standard Progressive Lenses ³	\$70 Copay	Up to \$40
Premium Progressive Lenses ³		
Tier 1	\$105 Copay	Up to \$40
Tier 2	\$115 Copay	Up to \$40
Tier 3	\$130 Copay	Up to \$40
Tier 4	\$85 Copay; plus 80% of charge less \$120 Allowance	Up to \$40
Lens Options (available when purchased with standard or progressive lenses; additional copays apply)		
Standard Polycarbonate Lenses <i>(Members under age 20)</i>	\$0 Copay	None
Photochromic Lenses	\$60 Copay	None
CONTACT LENSES Available in lieu of Lenses. Only one of the following may be used.		
Elective Contact Lenses <i>Conventional or Disposable</i>	\$20 Copay; \$130 allowance	Up to \$78
Medically Necessary Contact Lenses	\$20 Copay; \$250 allowance	Up to \$250
DISCOUNTS		
<i>Discount pricing may be available from In-Network Providers for the following services. Member is responsible for paying for the cost of such items. Member may refer to the DeltaVision member portal for more information.</i>		
<ul style="list-style-type: none"> • UV Treatment • Tints and Scratch coating • Standard Polycarbonate • Anti-Reflective Coating • Polarized Lenses 	<ul style="list-style-type: none"> • Retinal Imaging • Discounts off the balance over allowance for certain covered services and materials • Additional pair discount 	<ul style="list-style-type: none"> • Laser Vision Correction (Lasik or PRK) • Hearing Care Services

1. Where 'allowance' is shown, Member is responsible for all charges in excess of the allowance in addition to any applicable copay. Allowances are paid only once during a benefit period and must be fully utilized at time of purchase.
2. Submit Member Reimbursement Request Form and an itemized paid receipt to FAA.
3. Standard and Premium Progressive pricing is reflective of brands at the listed product tier. Providers are not required to carry all brands at all tiers. EyeMed reserves the right to make changes to the brands available on each tier.