

## SELECT PLUS 150 PLAN

| COVERAGE   | IN-NETWORK BENEFITS  | OUT-OF-NETWORK REIMBURSEMENT*  | BENEFIT FREQUENCY |
|--|--|--|-------------------|
| Comprehensive Eye Examination with dilation                        | <b>Copay TBD</b>   | Reimbursed up to \$40 (less applicable copay)  | Frequency TBD     |
| Eyeglass Lenses (standard plastic)                                 | <p><b>Copay TBD</b> includes:</p> <ul style="list-style-type: none"> <li>- Single</li> <li>- Bifocal</li> <li>- Trifocal</li> <li>- Lenticular</li> </ul> <p>Polycarbonate lenses covered-in-full for members age 19 and younger; \$30 copay over the age of 19.</p> <p>Additional \$50 copay Standard Progressive Lenses.</p> <p>Additional \$60 copay Photochromic Lenses.</p> | <p>Reimbursed (less applicable copay):</p> <ul style="list-style-type: none"> <li>- Single up to \$20</li> <li>- Bifocal up to \$40</li> <li>- Trifocal up to \$60</li> <li>- Lenticular up to \$100</li> </ul> <p>No out-of-network reimbursement available for polycarbonate lenses.</p> <p>No out-of-network reimbursement available for standard progressive lenses.</p> <p>No out-of-network reimbursement available for photochromic lenses.</p> | Frequency TBD     |
| Eyeglass Frames  | <b>Copay TBD</b> (no copay if included with Eyeglass Lenses); paid in full on Special Frame Selection; outside of the Selection, \$150 allowance outside of the selection (less applicable copay).   | Reimbursed up to \$60 (no copay if included with eyeglass lenses).   | Frequency TBD     |
| Contact Lens Examination   | <b>\$40 allowance</b>  | No reimbursement available.  | Frequency TBD     |
| Contact Lenses (in lieu of Eyeglasses)** Conventional / Disposable | <b>\$150 allowance</b> (less applicable copay)   | Reimbursed up to \$80 (less applicable copay)  | Frequency TBD     |
| Contact Lenses (in lieu of Eyeglasses)** Medically necessary***    | <b>\$250 allowance</b> (less applicable copay)   | \$250 allowance (less applicable copay)  | Frequency TBD     |
| Laser Vision Correction (LASIK)                                    | <b>Discount</b> pricing  | No reimbursement available.  |                   |

\* Submit Member Out-Of-Network Reimbursement Form and copy of paid receipt to Advantica EyeCare.

\*\* This benefit is paid only once during the Group's Benefit Period and must be fully utilized at the time of purchase.

\*\*\* Limited to Aphakia, Keratoconus or Severe Anisometropia and requires pre-authorization by Advantica EyeCare.

Plan is qualified under IRS Section 125.  
AEC.SB PDM SP150 07/03

## NATIONAL NETWORK OF INDEPENDENT & RETAIL PROVIDERS.

Advantica EyeCare's national network is comprised of both independent and national retail optical locations. Please visit our website at [www.advanticaeyecare.com](http://www.advanticaeyecare.com) to view our entire network, or contact our Service Center at (866) 425-2323.

When scheduling an appointment, please be sure to inform the provider that you are an Advantica member.







