Lincoln Financial Group®

Group Vision Insurance

SUMMARY OF BENEFITS

Sponsored by: Access Educational HR **Effective Date: August 1, 2014**

- You may choose any provider. However, using providers participating in the network should lower your out-of-pocket expenses.
- A list of participating providers may be accessed at http://lvc.lfg.com or by calling toll-free at 1-800-440-8453.
- Members may purchase mail order contact lenses online at a 10% discount.
- Through Laser Vision Network of America (LVNA), we can provide our members with access to discounted laser vision correction procedures. Members may choose an NCQA-credentialed surgeon from LVNA's nationwide network of more than 400 laser vision correction surgeons.
- Patient options, such as ultraviolet protection and progressive lenses, are offered at a 20% to 40% discount, which results in substantial member savings from the provider's usual and customary charges.

	Network[1]	Out of Network[2]
EXAM COPAY	$20	Not applicable
MATERIAL COPAY	$20	Not applicable

Service Frequencies – based on the last date of service.

Exam:	12 months
Lenses:	12 months
Frames:	12 months

EYE EXAMINATION	100%	Up to $40.00
EYEGLASS LENSES		
Single Lenses	100%	Up to $40.00
Bifocal	100%	Up to $60.00
Trifocal	100%	Up to $80.00
Lenticular	100%	Up to $80.00

As a value-added benefit, standard scratch-resistant coating is provided at no additional charge for all lenses covered in full.

FRAMES[3]	100%	Up to $45.00
ELECTIVE CONTACT LENSES[4]		
Covered Contact Lens Selection (material copay applies)	100%	Up to $125.00
All other elective contact lenses (no copay)	Up to $125.00	Up to $125.00
NECESSARY CONTACT LENSES[5]	100%	Up to $210.00

This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

ELIGIBILITY:

Dependent - Unmarried dependent children may be covered to age 18 or to age 25, if a full-time student.
Employee – A full-time employee actively at work.

BENEFITS:

1. *Network Benefits:* Exam and materials copays and patient options are paid to the network provider by the plan participant.
2. *Out-of-Network Benefits:* The plan participant pays full fee to the provider and the member submits a claim for reimbursement of services rendered up to maximum allowance. There are no copays.
3. *Frame Benefit:* Our generous frame benefit applies to virtually all of the frames on the market today, and most of those are covered-in-full, with no additional cost to the member, other than applicable copay. Plan participants receive a $130.00 retail frame allowance for frames purchased at retail chain providers, and for any frame above $130.00, the member will only pay the difference. A 30% discount is applied in excess of the allowance.
4. *Elective Contact Lenses:* Contact lenses are provided in lieu of eyeglasses (lenses and frame). When purchasing from the Covered Contact Lens Selection, the benefit is covered-in-full (after copay if applicable). This includes:
   - fitting/evaluation fees
   - contacts (including up to 4 boxes of disposables, depending on prescription and plan selected)
   - up to two follow-up visits.

   Coverage for Covered Contact Lens Selection does not apply at Costco Optical, Walmart or Sam's Club locations. Contact lenses purchased with an out-of-network provider or outside of the Covered Contact Lens Selection, the materials copay does not apply, and the allowance is applied toward the fitting/evaluation fees.
5. Necessary contact lenses are determined at the eye care provider's discretion. If an out-of-network provider considers contacts necessary, members should ask their out-of-network provider to contact us concerning the reimbursement that we will make before they purchase such contacts.

EXCLUSIONS:

The following services and materials are excluded from coverage under the Policy:

- Post cataract lenses; Non-prescription items; Medical or surgical treatment for eye disease that requires the services of a physician; Worker's Compensation services or materials; Services or materials that the patient, without cost, obtains from any governmental organization or program; Services or materials that are not specifically covered by the Policy; replacement or repair of lenses and/or frames that have been lost or broken; Cosmetic extras, except as stated in the Policy's Table of Benefits.

OUT-OF-NETWORK CLAIM SUBMISSION:

To file a claim for reimbursement for Services rendered by a non-Network Provider, provide the following information:

- Your itemized receipts; Subscriber name; Subscriber's identification number; Patient name; and Patient date of birth.

Submit a claim by mail to:	Submit a claim by fax to:
Claims Department – *Lincoln VisionConnect*	(248) 733-6060
P.O. Box 30978	
Salt Lake City, UT 84130	

NOTE: This is not intended as a complete description of the insurance coverage offered. While benefit amounts stated in this summary are specific to your coverage, other items may summarize standard product features and not the specific features of your coverage. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describe the benefits in greater detail. Should there be a difference between this summary and the contract, the contract will govern.