BlueVision Premium
SCHEDULE OF BENEFITS

Heart of America Medical Center
273564
January 1, 2022

The Schedule of Benefits lists the vision care services and vision care materials to which the Covered Persons are entitled, subject to applicable Copayments and other conditions, limitations and/or exclusions stated herein. If Plan Benefits are available for Non-Member Provider services as indicated by the reimbursement provisions below, vision care services and materials may be received from any licensed Optometrist, Ophthalmologist, or dispensing Optician, whether Member Doctors or Non-Member Providers.

Member Doctors are those doctors who have agreed to participate in VSP's Signature Network.

When Plan Benefits are received from Member Doctors, benefits appearing in the first column below are applicable subject to applicable Copayments as stated below. When Plan Benefits are available and received from Non-Member Providers, a Covered Person is reimbursed for benefits according to the schedule in the second column below less any applicable Copayment.

The Claims Administrator shall determine the interpretation and application of the Covered Services in each and every situation.

PLAN BENEFITS	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Vision Care Services		
• **Vision Examinations**	Once every calendar year Covered In Full	Up to $60.00
Vision Care Materials		
• **Lenses**	Once every calendar year	
Single Vision	Covered In Full	Up to $50.00
Bifocal	Covered In Full	Up to $75.00
Trifocal	Covered In Full	Up to $100.00
Lenticular	Covered In Full	Up to $125.00
Progressives	Covered In Full	Up to $75.00

15% discount applies to Member Doctor's usual and customary professional fees for contact lens evaluation and fitting.

PLAN BENEFITS	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
• **Frames**	Once every other calendar year Covered up to $150.00	Up to $98.00
Contact Lenses		
• **Necessary**		
Professional Fees and Materials	Covered In Full	Up to $320.00
• **Elective**	Elective contact lens fitting** and evaluation services are covered in full once every Benefit Plan year, after a maximum $60.00 Copayment.	
Materials	Covered up to $150.00	
Professional Fees and Materials		Up to $135.00

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by a Covered Person's Member Doctor or Non-Member Provider. Prior review and approval by VSP are not required for a Covered Person to be eligible for Necessary Contact Lenses.

Contact lenses are available under this Benefit Plan in lieu of all other lens and frame benefits described herein for the current Benefit Period.

15% discount applies to Member Doctor's usual and customary professional fees for contact lens evaluation and fitting.