

## City of Chattanooga

### Vision

#### Summary of Benefits

**Vision Option: 1**

**Effective Date: January 1, 2024**

Benefit Category	In-Network	Out-of-Network
<b>Exams (Limited to one exam and one contact lens fitting/follow-up within a 12-month period)</b>		
Comprehensive Eye Exam	\$10 Copay	Up to \$35
Retinal Imaging	Up to \$39	Not Covered
Contact Lens Fitting and Follow-up - Standard	\$55 Copay	Not Covered
Contact Lens Fitting and Follow-up - Premium	10% off retail	Not Covered
<b>Vision Materials</b>		
<b>Standard Plastic Lenses (Limited to one set of standard plastic lenses within a 12-month period)</b>		
Single	\$25 Copay	Up to \$30
Bifocal	\$25 Copay	Up to \$45
Trifocal	\$25 Copay	Up to \$60
Frames (Limited to one pair of frames within a 24-month period)	\$0 Copay up to \$150 allowance*	Up to \$75
<b>Contacts (Limited to one set of lenses within a 12-month period in lieu of eyeglasses)</b>		
Conventional	\$0 Copay up to \$150 allowance**	Up to \$120
Disposable	\$0 Copay up to \$150 allowance	Up to \$120
Medically Necessary	Covered at 100%	Up to \$200
<b>Lens Options (Limited to one set of lenses within a 12-month period)</b>		
Standard Polycarbonate	\$40	Not Covered
Standard Polycarbonate (For covered dependent children under age 19)	No Copay	Up to \$5
UV Treatment	\$15 Copay	Not Covered
Tint	\$15 Copay	Not Covered
Standard Plastic Scratch Coating	\$15 Copay	Not Covered
Standard Progressive Lenses (add on to Bifocal)	\$65 Copay	\$0 Additional***
Premium Progressive Lenses (add on to Bifocal)	\$65 Copay, 20% Discount Off of Retail Price, Less \$120 Allowance	\$0 Additional***
Standard Anti-reflective Coating	\$45 Copay	Not Covered
<b>Diabetic Care Services****</b>		
Office Service Visit ( <i>Medical Follow-up Exam</i> )	Covered 100%	\$77
Retinal Imaging	Covered 100%	\$50
Extended Ophthalmoscopy	Covered 100%	\$15
Gonioscopy	Covered 100%	\$15
Scanning Laser	Covered 100%	\$33

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

\*\*\*\$45 maximum reimbursement

\*\*\*\*Up to 2 additional per year

\*\* 15% off balance over allowance

