Schedule of Benefits
Peak Gold $0 Ded + Adult Dental & Vision Rx Copay
(Who Pays What)
From 01/01/2022 through 12/31/2022

This Schedule of Benefits does not explain all benefits in detail. For a complete explanation of Your benefits, you should read Your entire Policy.

THIS PLAN UTILIZES A PROVIDER NETWORK

This plan uses a Provider Network to provide Covered Health Services to You, which means You will have less out-of-pocket expenses if You receive care from In-Network or Participating Providers.

You can review our provider network online at www.brighthealthcare.com, or You can contact Bright HealthCare Customer Service at (855) 827-4448 to locate a provider or request a paper copy of the provider directory.

Deductible
A Deductible is the amount that a Covered Person must pay before Bright HealthCare pays any benefits for Covered Health Services. The Deductible amount does not include Coinsurance, Copayment, or non-covered charges.

Copayment
Copayments are the charges stated as a set dollar amount that You are required to pay for certain Covered Health Services. Copayment amounts accumulate towards Your Out-of-Pocket Maximum.

Coinsurance
Coinsurance is the percentage of any Allowed Amount that You are required to pay for certain Covered Health Services. Coinsurance amounts accumulate towards Your Out-of-Pocket Maximum.

Out-of-Pocket Maximum
The Out-of-Pocket Maximum is the maximum amount of Deductible, Coinsurance, or Copayments You pay in a calendar year. All Deductible, Copayment and Coinsurance payments for In-Network Covered Health Services will apply to the Out-of-Pocket Maximum. Once the Out-of-Pocket Maximum has been met for a Covered Person, the Covered Person will have no further obligation to pay Deductible, Copayment or Coinsurance amounts for Covered Health Services received from a participating Bright HealthCare Provider for the remainder of the Calendar Year.

For policies with two or more people, each Covered Person's Individual Out-of-Pocket Maximum applies to the Family Out-of-Pocket Maximum. Once a Covered Person has met his or her Out-of-Pocket Maximum, the Covered Person will have no further obligation to pay charges for In-Network Covered Health Services for the remainder of the Calendar Year. Once two (2) or more people's combined Out-of-Pocket expenses reach the Family Out-of-Pocket Maximum, Covered Persons under the Family policy will have no further obligation to pay charges for In-Network Covered Health Services.

Limitations/Exclusions
Some limitations are listed in this Schedule of Benefits. Refer to Your policy for a more comprehensive listing and description of services or items that are limited or excluded from covered by the Plan.

General Cost Share & Features	In Network	Non Network
Deductible: Per Plan Year - Medical	$0/Individual; $0/Family	Not Covered
Out-of-Pocket Maximum: - Per Plan Year	$6,500/Individual; $13,000/Family	Not Covered

Benefit	In Network	Non Network
Allergy Services		
Physician Services	$40 per Visit	Not Covered
Allergy Testing	20%	Not Covered
Allergy Serum	20%	Not Covered

Benefit	In Network	Non Network
Autism Spectrum Disorder Services		
Outpatient Therapy Services *Services require Prior Authorization.*	20%	Not Covered
Autism - Applied Behavioral Analysis *Services require Prior Authorization.*	$0 per Visit	Not Covered

Benefit	In Network	Non Network
Chemotherapy & Radiation Treatment		
Chemotherapy Treatment *Services require Prior Authorization.*	20%	Not Covered
Radiation Treatment *Services require Prior Authorization.*	20%	Not Covered

Benefit	In Network	Non Network
Chiropractic Care		
Spinal Manipulations *Limited to 20 Visit(s) per Year.*	$40 per Visit	Not Covered
Diagnostic X-ray Services	20%	Not Covered

Benefit	In Network	Non Network
Dialysis Services		
Dialysis Treatment *Services require Prior Authorization.*	20%	Not Covered

Benefit	In Network	Non Network
Durable Medical Equipment		
Durable Medical Equipment and Devices *Services require Prior Authorization.*	20%	Not Covered
Diabetic Shoes *Services require Prior Authorization.*	20%	Not Covered
Ostomy Supplies *Services require Prior Authorization.*	20%	Not Covered

Benefit	In Network	Non Network
Equipment for the treatment of Positional Plagiocephaly *Services require Prior Authorization.*	20%	Not Covered

Benefit	In Network	Non Network
Emergency Health Services		
Non-emergent services received in an emergency room are generally not covered. See Your Policy for the definition of Emergency Health Services and/or Emergency Care.		
Emergency Room Facility	$600 per Admission	$600 per Admission
Emergency Room Physician/ Surgeon charges	$50 per Admission	$50 per Admission
Professional Fees	$50 per Admission	$50 per Admission
Anesthesia	$50 per Encounter	$50 per Encounter
Laboratory Services	20%	20%
Radiology Services	20%	20%
High-Tech Imaging (MRI, CT, PET Scan), Nuclear Imaging	20%	20%
Emergency Room Ancillary Charges	$50 per Encounter	$50 per Encounter
Emergency Ambulance Transport (Ground/Air/Water)	20%	20%

Benefit	In Network	Non Network
Genetic Testing and Counseling		
Genetic Testing and Counseling *Services require Prior Authorization.*	20%	Not Covered

Benefit	In Network	Non Network
Hearing Services		
Hearing Screening *Limited to 1 preventive care hearing screening per calendar year to determine the need for hearing correction.*	$0 per Visit	Not Covered
Hearing Exam/Evaluation	$40 per Visit	Not Covered
Hearing Aids *Limited to 1 Item(s) per Benefit Period. Benefit period is 5 years. Services require Prior Authorization.*	20%	Not Covered

Benefit	In Network	Non Network
Home Health Care		
Home Health *Limited to 28 Hours per Week. Limit combined with Private Duty Nursing. Services require Prior Authorization.*	20%	Not Covered
Home Infusion Therapy	20%	Not Covered

Benefit	In Network	Non Network
Hospice Care Services		
Hospice Care	20%	Not Covered
Bereavement Support Services	$0 per Visit	Not Covered

Benefit	In Network	Non Network
Hospital Services & Inpatient Surgery, including Organ & Tissue Transplants, and Gender Dysphoria and Gender Transition Services *All transplants must be performed at a plan-designated Centers of Excellence Facility or transplant center.*		
Inpatient Hospital Facility/Surgery *Services require Prior Authorization.*	20%	Not Covered
Inpatient Habilitation/ Rehabilitation Facility *Services require Prior Authorization.*	20%	Not Covered
Skilled Nursing Facility *Limited to 100 Days per Year. Copay applies per day, up to 2 days.*	20%	Not Covered
Professional Fees	20%	Not Covered
Surgeon Fees *Services require Prior Authorization.*	20%	Not Covered
Anesthesia	20%	Not Covered
Laboratory Services, including pre-admission testing	20%	Not Covered
Radiology Services	20%	Not Covered
High-Tech Imaging (MRI, CT, PET Scan), Nuclear Imaging	20%	Not Covered
Ancillary Services	20%	Not Covered

Benefit	In Network	Non Network
Infertility Services		
Diagnosis and Management *Services require Prior Authorization.*	$40 per Visit	Not Covered
Treatment for Infertility	20%	Not Covered
Artificial Insemination	20%	Not Covered

Benefit	In Network	Non Network
Infusion Therapy		
Infusion Therapy .	20%	Not Covered

Benefit	In Network	Non Network
Lab, X-Ray and Diagnostic Services		
Laboratory Services	20%	Not Covered
Radiology Services	20%	Not Covered
High-tech Imaging (MRI, CT, PET Scan), Nuclear Imaging *Services require Prior Authorization.*	20%	Not Covered

Benefit	In Network	Non Network
Mental Health and Substance Use Services		
Inpatient Mental Health Care *Services require Prior Authorization.*	20%	Not Covered
Outpatient Mental Health Office Visit	$0 per Visit	Not Covered
Inpatient Substance Use Services *Services require Prior Authorization*	20%	Not Covered
Outpatient Substance Use Office Visits	$0 per Visit	Not Covered
Other Outpatient Mental Health and Substance Use Services (non-office visits) *Services require Prior Authorization.*	$0 per Visit	Not Covered

Benefit	In Network	Non Network
Outpatient Surgery		
Outpatient Ambulatory Surgery *Services require Prior Authorization.*	$200 per Encounter	Not Covered
Surgeon Fees *Services require Prior Authorization.*	$50 per Encounter	Not Covered
Professional Fees *Services require Prior Authorization.*	$50 per Encounter	Not Covered
Anesthesia	$50 per Encounter	Not Covered
Laboratory Services, including pre-admission testing	20%	Not Covered
Radiology Services	20%	Not Covered
High-Tech Imaging (MRI, CT, PET Scan), Nuclear Imaging	20%	Not Covered

Benefit	In Network	Non Network
Ancillary Services	$50 per Encounter	Not Covered

Benefit	In Network	Non Network
Outpatient Therapy Services – Rehabilitative and Habilitative		
Rehabilitative Occupational and Rehabilitative Physical Therapy *Limited to 40 Visit(s) per Year. Limited to 20 visits per therapy type per year. Services require Prior Authorization.*	20%	Not Covered
Rehabilitative Speech Therapy *Limited to 20 Visit(s) per Year. Services require Prior Authorization.*	20%	Not Covered
Cardiac Rehabilitation *Services require Prior Authorization.*	20%	Not Covered
Pulmonary Rehabilitation *Services require Prior Authorization.*	20%	Not Covered
Inhalation/Respiratory Therapy *Services require Prior Authorization.*	20%	Not Covered

Benefit	In Network	Non Network
Pediatric Dental Services for Dependent Children (through the end of the month in which they turn age 19)		
Diagnostic and Preventive Services *Limited to 2 Exam(s) per Year.*	$0 per Visit	Not Covered
Basic Services *See Schedule of Benefits for plan limits. Benefits are available up to the end of the month in which the member turns 19.*	50%	Not Covered
Major Services *See Schedule of Benefits for plan limits.*	50%	Not Covered
Medically Necessary Orthodontics and Prosthodontics *Medically necessary Orthodontia only. Benefits are available up to the end of the month in which the member turns 19.*	50%	Not Covered

Benefit	In Network	Non Network
Pediatric Vision Services for Dependent Children (through the end of the month in which they turn age 19)		
Pediatric Routine Eye Exam *Limited to 1 Exam(s) per Year.*	$0 per Visit	Not Covered

Benefit	In Network	Non Network
Eyeglasses for Children *Limited to 1 pair of eyeglasses per calendar year including standard frames and standard lenses up to $110, or contact lenses up to $150.*	$0	Not Covered
Low Vision Exam *Limited to 1 Exam(s) per Year. Includes $130 materials allowance plus discount.*	$10	$45
Low Vision Aids	Not Covered	Not Covered

Benefit	In Network	Non Network
Physician's Office Services		
Primary Care Office Visits	No charge for first 2 visit(s) then $20	Not Covered
Specialist Office Visits	$40 per Visit	Not Covered
Clinic Fees for Office Visits at an Outpatient Clinic (hospital-owned clinic)	20%	Not Covered
Surgeon Fees	$50 per Visit	Not Covered
Anesthesia	$50 per Visit	Not Covered
Injections/Physician Administered Medications (with or without office visit)	20%	Not Covered

Benefit	In Network	Non Network
Pregnancy/ Maternity Services		
Delivery stays exceeding 48 hours for vaginal delivery or 96 hours for a cesarean require pre- authorization. Services for newborn care after the mother's hospital discharge require Prior Authorization.		
Prenatal/Postnatal Care	$0 per Visit	Not Covered
Delivery Facility Fee *Delivery stays exceeding 48 hours for vaginal delivery or 96 hours for cesarean delivery require pre-authorization.*	20%	Not Covered
Professional Fees	20%	Not Covered
Surgeon Fees	20%	Not Covered
Anesthesia	20%	Not Covered
Laboratory Services, including pre-admission testing	20%	Not Covered
Radiology Services, including Ultrasound	20%	Not Covered

Benefit	In Network	Non Network
High-Tech Imaging (MRI, CT, PET Scan), Nuclear Imaging	20%	Not Covered
Ancillary Services	20%	Not Covered

Prescription Drugs		
Retail Pharmacy		
Tier	**In Network**	**Out of Network**
Preventive Medications	$0	Not Covered
Preferred Generics	$0/$10	Not Covered
Preferred Brand and Non-Preferred Generics	$50	Not Covered
Non-Preferred Brand and Non-Preferred Generics	$100	Not Covered
Specialty Medications	$540	Not Covered
Mail Order		
Tier	**In Network**	**Out of Network**
Preventive Medications	$0	Not Covered
Preferred Generics	$0/$25	Not Covered
Preferred Brand and Non-Preferred Generics	$125	Not Covered
Non-Preferred Brand and Non-Preferred Generics	$250	Not Covered
Specialty Medications	$540	Not Covered

Benefit	In Network	Non Network
Preventive and Wellness Services		
Preventive Care Services, Screenings and Immunizations	$0 per Visit	Not Covered
Breast Cancer and Mammography Screening	$0 per Visit	Not Covered
Visit https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations for a list of Preventive and Wellness Services. You may also have additional preventive and wellness services available to you as required by state law.		

Benefit	In Network	Non Network
Prosthetics		
Prosthetic Limbs *Services require Prior Authorization.*	20%	Not Covered
Internally Implanted Prosthetic Devices	20%	Not Covered

Benefit	In Network	Non Network
Services require Prior Authorization.		
All other Prosthetic Devices *Services require Prior Authorization.*	20%	Not Covered
Wigs *Limited to 1 Item per Calendar Year up to $500.*	$0	Not Covered

Benefit	In Network	Non Network
Sleep Studies		
Sleep Studies *Services require Prior Authorization.*	20%	Not Covered

Benefit	In Network	Non Network
Telehealth Virtual Care Services		
Primary Care Telehealth Services	$20 per Visit	Not Covered
Behavioral Health Telehealth Services	$0 per Visit	Not Covered
Urgent Care Telehealth Services	$75 per Visit	$75 per Visit

Benefit	
Travel Expenses	
Travel Expenses (Lodging and Food)	We will reimburse up to the Federal CONUS rate for lodging and food for the city in which services are received.
Mileage for use of a motor vehicle	We will reimburse in accordance with the current IRS allowance per mile for medical travel.
Airfare	We will reimburse airfare limited to the cost of coach round-trip airfare to the facility, unless Medically Necessary to travel in a different capacity.

Benefit	In Network	Non Network
Urgent Care Services		
Urgent Care Facility Fee	$75 per Visit	$75 per Visit
Surgeon Fees	$50 per Visit	$50 per Visit
Anesthesia	$50 per Visit	$50 per Visit
Laboratory Services	20%	20%
Radiology Services	20%	20%
High-Tech Imaging (MRI, CT, PET Scan), Nuclear Imaging	20%	20%
Urgent Care Ancillary Charges	$50 per Encounter	$50 per Encounter

Bright Health Insurance Company
Adult Dental
Individual EPO Plan

BENEFITS HIGHLIGHT SHEET

LIBERTY Dental Plan Corporation
PO Box 26110 Irvine, CA 92799-6110
Member Services: 855-827-4448

	DENTAL EPO PLAN BENEFITS	
CALENDAR YEAR MAXIMUM	$1,000 per person	
CALENDAR YEAR DEDUCTIBLE: Deductible waived for Diagnostic & Preventive Services	$25 Individual/$75 per Family	
COVERED SERVICES	**IN-NETWORK PLAN PAYS**	**OUT-OF-NETWORK PLAN PAYS**
TYPE I, DIAGNOSTIC & PREVENTIVE SERVICES Oral Exams, Cleanings, Fluoride, X-rays (Full Mouth, Panoramic Image Bitewings, and Diagnostic X-rays), Teledentistry	100%	Not Covered
TYPE II, BASIC BENEFITS Fillings (Amalgam, Composite) Protective Restoration, Non-Surgical Periodontal Services (Scaling & Root Planing, Periodontal Maintenance, Full Mouth Debridement), Palliative Treatment, Consultation	70%	Not Covered
TYPE III, MAJOR BENEFITS	Not Covered	Not Covered
TYPE IV, ORTHODONTIA	Not Covered	Not Covered

Fees are based on contracted fees for in-network dentists. Reimbursement is paid on LIBERTY Dental Plan's contract allowances and not necessarily the dentist's actual fees.

Dental deductible and maximums do not accumulate against the health plan

This Adult Dental Individual EPO Plan is offered by Bright Health Insurance Company and administered by Liberty Dental Plan Corporation.

Making members shine, one smile at a time™ www.libertydentalplan.com

Calendar Year Deductible: $25 per person/$75 for family
Calendar Year Maximum: $1,000 per person

✓ Members must visit a LIBERTY Dental Plan contracted dental office to utilize covered benefits. The Member's dental office will initiate a treatment plan or recommend the Member see a specialist if the services are dentally necessary and outside the scope of general dentistry. Members may directly refer to a specialist dentist in the network.

✓ Dental deductible and maximums do not accumulate against the health plan

✓ This Benefit Schedule does not guarantee benefits. All services are subject to eligibility, exclusions and limitations must be determined to be medically necessary at the time you receive the service.

✓ Dental services are limited to the least costly treatment. Dental procedures not listed are available at the dental office's usual and customary fee.

CDT Code	Description	Limitations:
DIAGNOSTIC & PREVENTIVE SERVICES		
D0120	Periodic oral evaluation	2 of (D0120, D0150, D0180) every 12 months
D0140	Limited oral evaluation	2 of (D0140, D0160-D0171) every 12 months
D0150	Comprehensive oral evaluation	2 of (D0120, D0150, D0180) every 12 months
D0160	Oral evaluation, problem focused	2 of (D0140, D0160-D0171) every 12 months
D0170	Re-evaluation, limited, problem focused	
D0171	Re-evaluation, post operative office visit	
D0180	Comprehensive periodontal evaluation	2 of (D0120, D0150, D0180) every 12 months
D0210	Intraoral, complete series of radiographic images	1 of (D0210, D0330) every 36 months
D0220	Intraoral, periapical, first radiographic image	
D0230	Intraoral, periapical, each add 'l radiographic image	
D0240	Intraoral, occlusal radiographic image	
D0250	Extra-oral 2D projection radiographic image, stationary radiation source	
D0270	Bitewing, single radiographic image	1 of (D0270-D0274) every 12 months
D0272	Bitewings, two radiographic images	
D0273	Bitewings, three radiographic images	
D0274	Bitewings, four radiographic images	
D0330	Panoramic radiographic image	1 of (D0210, D0330) every 36 months
D0340	2D cephalometric radiographic image, measurement and analysis	
D0350	2D oral/facial photographic image, intra-orally/extra-orally	
D0351	3D photographic image	
D1110	Prophylaxis, adult	2 of (D1110, D4346) every 12 months
D1206	Topical application of fluoride varnish	1 of (D1206, D1208) every 12 months
D1208	Topical application of fluoride, excluding varnish	
D9995	Teledentistry, synchronous; real-time encounter	2 of (D9995, D9996) every 12 months
D9996	Teledentistry, asynchronous; information stored and forwarded to dentist for subsequent review	
ROUTINE (Basic) SERVICES		
D2140	Amalgam, one surface, primary or permanent	1 of (D2140-D2394) per tooth, per surface, every 12 months
D2150	Amalgam, two surfaces, primary or permanent	
D2160	Amalgam, three surfaces, primary or permanent	
D2161	Amalgam, four or more surfaces, primary or permanent	
D2330	Resin-based composite, one surface, anterior	
D2331	Resin-based composite, two surfaces, anterior	
D2332	Resin-based composite, three surfaces, anterior	
D2335	Resin-based composite, four or more surfaces, involving incisal angle	
D2391	Resin-based composite, one surface, posterior	
D2392	Resin-based composite, two surfaces, posterior	
D2393	Resin-based composite, three surfaces, posterior	
D2394	Resin-based composite, four or more surfaces, posterior	
D2940	Protective restoration	
D4346	Scaling in presence of moderate or severe inflammation, full mouth after evaluation	2 of (D1110, D4346) every 12 months
D4341	Periodontal scaling and root planing, four or more teeth per quadrant	1 of (D4341, D4342) per site/quad every 24 months
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis, subsequent visit	1 (D4355) in a lifetime
D4910	Periodontal maintenance	2 of (D4910) every 12 months
D9110	Palliative (emergency) treatment, minor procedure	
D9310	Consultation, other than requesting dentist	
D9311	Consultation with a medical health care professional	

Important:

If a Member decides to receive Dental Services that are not covered under this Agreement, the contracted dentist may charge the Member his or her usual and customary rate for those services. Prior to providing a Member with Dental Services that are not a Covered Service, the dentist should provide a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. For more information about the Dental Services that are covered under this Agreement, please call customer service at 1-855-827-4448.

This Agreement covers the dental services for Members when they are performed by a licensed dentist and when they are necessary and customary, as determined by the standards of generally accepted dental practice. If there is more than one professionally acceptable treatment for a Member's dental condition, the Plan will cover the least expensive treatment.

Pretreatment Estimate:

A pretreatment estimate is a valuable tool for You and Your Member. It gives You and the Member an idea of what the Member's Out-of-Pocket costs will be. This allows You and Your Member to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontal, prosthetic, or orthodontic care.

The pretreatment estimate is recommended, but not required for a Member to get benefits for Covered Services. A pretreatment estimate does not authorize treatment or determine its Medical Necessity, and does not guarantee benefits. The estimate will be based on a Member's current eligibility and the Agreement benefits in effect at the time the estimate is sent to us. This is an estimate only. Our final payment will be based on the claim that is sent to Us at the time of the completed dental care service(s). Sending in other claims or changes to a Member's eligibility or to the Agreement may affect our final payment.

Members can ask their dentist to send pretreatment estimate on their behalf, or send it directly to Us. Please include the procedure codes for the services to be performed for a Member. Pretreatment estimate requests can be sent to Us. If a Member has questions on where to send the estimate, call Us at the number on the back of their ID card.

Adult Vision Benefit
EyeMed Insight Plan H

Bright HealthCare

Vision Care Services	Member Cost In-Network	Member Out-of-Network Reimbursement* & Group Charge Out-of-Network
Exam with Dilation as Necessary	$10 Copay	$45
Retinal Imaging Benefit	Up to $39	N/A
Frames: Any available frame at provider location	$0 Copay; $130 Allowance, 20% off balance over $130	$60
Standard Plastic Lenses		
Single Vision	$25 Copay	$25
Bifocal	$25 Copay	$39
Trifocal	$25 Copay	$63
Lenticular	$25 Copay	$63
Standard Progressive Lens	$90 Copay	$39
Premium Progressive Lens	See attached Fixed Premium Progressive price list	$39
If a member seeks Standard Plastic Lenses in AK, CA, HI, OR, WA, Group Contracted Rate is $15 higher.		
Lens Options:		
UV Treatment	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Plastic Scratch Coating	$15	N/A
Standard Polycarbonate - Adults	$40	N/A
Standard Polycarbonate - Kids under 19	$40	N/A
Standard Anti-Reflective Coating	$45	N/A
Polarized	20% off Retail Price	N/A
Other Add-Ons	20% off Retail Price	N/A
Contact Lenses *(Contact lens allowance includes materials only)*		
Conventional	$0 Copay; $130 allowance, 15% off balance over $130	$112
Disposable	$0 Copay; $130 allowance, plus balance over $130	$112
Medically Necessary	$0 Copay, Paid-in-Full	$210
Laser Vision Correction Lasik or PRK from U.S. Laser Network	15% off Retail Price or 5% off promotional price	N/A
Amplifon Hearing Health Care	Hearing Health Care from Amplifon Hearing Health Care Network Members receive a 40% discount off hearing exams and a low price guarantee on discounted hearing aids.	N/A
Additional Pairs Benefit:	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A
Frequency:		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 12 months	

Progressive Price List*	Member Cost In-Network (Includes Lens Copay)
Standard Progressive	$90 Copay
Premium Progressives as Follows:	
Tier 1	$110 Copay
Tier 2	$120 Copay
Tier 3	$135 Copay
Tier 4	$90 Copay, 80% of charge less $120 allowance
Anti-Reflective Coating Price List*	**Member Cost In-Network**
Standard Anti-Reflective Coating	$45
Premium Anti-Reflective Coatings as Follows:	
Tier 1	$57
Tier 2	$68
Tier 3	80% of charge
Other Add-ons Price List	**Member Cost In-Network**
Photochromic (Plastic)	$75
Polarized	80% of charge
EyeMed Vision Care reserves the right to make changes to the products on each tier and the member out-of-pocket costs.	
*Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels.	

For a current listing of brands by tier, go to:
http://www.eyemedvisioncare.com/theme/pdf/microsite-template/eyemedlenslist.pdf