



SafeGuard[®] SCHEDULE OF BENEFITS

Vision Plan

SmileSaver 10

Your selected SafeGuard vision care professional must provide all of the following services in order to be covered under this vision plan.

This document describes the services this vision plan covers, co-payment requirements, and any benefits, and exclusions. (Please refer to your Evidence of Coverage for further details.)

Benefits provided by SafeGuard Health Plans, Inc.

Frequency	Exam	Lens	Frames	Contacts
Months	12	12	12	12

Service	Your Co-payment
EXAM (Visual analysis)	
Eye exam, including refraction and glaucoma testing	\$40
OFFICE VISIT/EMERGENCY	
<ul style="list-style-type: none"> There is a \$0 co-payment for new members who have received an eye exam by an assigned provider within the past year There is a \$20 co-payment for members who have not received an eye exam by an assigned provider for more than one (1) year previously, or for members who have never received an eye exam by the assigned provider 	
Emergency office visits	\$0
Office visits	\$0
LENSES	
Single vision (glass or plastic)	\$45 per pair
Bifocals (glass or plastic)	
<ul style="list-style-type: none"> FT28, round FT35 Executive 	\$65 per pair add \$25 add \$25
Trifocals (glass or plastic)	
<ul style="list-style-type: none"> 7x28 7x35, 8x35 Executive Progressives All others 	\$80 per pair add \$25 add \$30 add \$85 20% discount
Lens additions	
<ul style="list-style-type: none"> Polycarbonate (single vision) Polycarbonate (multifocal) Hi-index (1.57 or less, non-aspheric) Solid tint Gradient tint (single or double) 	add \$35 add \$39 add \$45 add \$15 add \$20

- Scratch coating add \$20
- UV coating add \$20
- Anti-reflective coating add \$59
- Edge polish add \$15
- Photochromic glass (single vision) add \$35
- Photochromic glass (multifocal) add \$39
- Photochromic plastic (single vision) add \$85
- Photochromic plastic (multifocal) add \$89
- All others 20% discount

FRAMES

Any type and size 20% discount

CONTACT LENSES

- *Contact lens powers over -8.00 D Sph, 4.00 D Sph and/or -2.00 D Cyl are considered custom and the member may be charged extra.*
- *When purchasing contact lenses, patients must have a contact lens evaluation which includes 90-day follow-up care in addition to the initial exam.*

Rigid

- Hard lens (PMMA) \$40 per lens
- RGP (DW - Sph) \$60 per lens
- RGP (EW - Sph) \$70 per lens
- Toric/bitopic \$95 per lens
- Bifocal \$130 per lens

Soft Daily Wear

- Regular soft (clear or tinted) \$45 per lens
- Toric (clear or tinted) \$85 per lens
- Opaque/colored (Sph) \$75 per lens
- Bifocal \$115 per lens

Soft Extended Wear

- Regular soft (clear or tinted) \$50 per lens
- Toric (clear or tinted) \$100 per lens
- Opaque/colored (Sph) \$80 per lens
- Bifocal \$130 per lens

Disposable (spherical 1 - day/2 - week) 10% discount

Planned replacements 10% discount

All other types of contact lenses 10% discount

Contact lens solutions 10% discount

Contact lens fitting/evaluation fee
(includes training and starter care kit) 10% discount

ACCESSORIES

- Eyeglass adjustment \$0
- Eyeglass case \$0

PLANO SUNGLASSES 20% discount

Principal Exclusions and Limitations

Limitations

The limitations listed below apply to your vision plan. However, you may elect to have any treatment performed at the vision provider's usual fees:

1. Any procedure not listed on this Schedule of Benefits may be available at the vision provider's usual fees.
2. Follow-up care for contact lenses shall be limited to a period of three (3) months. Additional visits are subject to an office visit charge which is set by the vision provider's usual fees.
3. Benefits are not available if the Member receives such services from a vision provider who is not his/her assigned participating vision care provider.
4. Lenses and frames furnished under this plan which are lost or broken will not be replaced except at the Member's yearly examination.
5. Office visit listed no charge co-payments is defined as any non-medical eye care appointment performed by the assigned participating vision provider in addition to the provided annual eye examination. Examples include difficulty seeing with the new glasses or inability adjusting to the new prescription. Emergency office visit listed at no charge co-payments is defined as any non-medical eye care delivered on an emergency basis by the assigned participating vision provider in addition to the provided annual eye examination. Examples include a sudden change of prescription or a lost contact lens in the eye. The following are NOT considered emergencies: broken glasses, lost contact lens, lost glasses.
6. The initial examination and one corrective device is allowed per membership year, per Member. One corrective device is defined as one pair of glasses, one pair of yearly contact lenses, or one year's supply of disposable/planned replacement contact lenses. The Member may request an additional refraction if he/she desires, at no additional charge. Any subsequent refractions, at the Member's request in the same policy year, may result in an additional charge of \$20 for each refraction. If the Member experiences a change in his or her prescription, the Member is eligible to receive new lenses at the appropriate co-payment.
7. If the participating vision provider determines that a referral to a specialist is appropriate and the Member has medical coverage, the Member is to be advised to seek care through his/her medical coverage. If the Member has no medical coverage or the Member's medical coverage does not cover the needed treatment, then the participating doctor may provide a referral and the Member shall be responsible for the referred care. The participating vision provider must make his/her records available for the specialist to review upon written request from the Member.

Exclusions

The following vision services and procedures are not included in this plan and there is no coverage for these items. However, you may elect to have any treatment performed at the vision provider's usual fees:

1. Orthoptics (process for improvement of visual perception and coordination of the two (2) eyes for binocular vision).

2. Visual training or vision therapy.
3. Contact lenses for Keratoconus and Aphakia.
4. A second pair of glasses in lieu of bifocals.
5. Replacement of lost, stolen, or destroyed lenses and frames.
6. Medical care, surgical treatment, ophthalmologic emergencies, or any hospital or medical charges are excluded. In the event that Member desires to be hospitalized for any ocular procedure, the cost will be borne by the Member.
7. Orthokeratology (a procedure for decreasing refractive error by use of contact lenses).
8. Charges for any treatment, which because of the Member's general health, or mental, emotional, behavioral, or physical limitations, cannot be performed in the assigned participating vision provider's office.
9. Low vision care (the treatment and use of specialized devices to assist those persons who are partially sighted).
10. Prolonged occlusion tests associated with special remedial care or a diagnosis of strabismus or amblyopia.
11. The services of specialized Ophthalmologists or Optometrists are not covered benefits under the plan. If, in the opinion of the assigned participating vision provider, it is in the best interest of the member to be referred to a specialist for such services, the Member shall be responsible for the provider's usual fees for the specialty services rendered. Examples of specialty areas include the care and treatment of refractive surgery, cataract surgery, glaucoma, corneal disorders, binocular vision disorders, dyslexia, and reading disabilities.
12. Any eye examination required by an employer as a condition of employment, unless it is in conjunction with an eye examination for which the Member is otherwise entitled under the plan.
13. This program does not provide coverage for medications other than those that are utilized by the assigned participating vision provider at the Member's visit in the participating vision provider's office.
14. A treatment plan which, in the opinion of the participating vision provider, is not medically necessary, will not produce a beneficial result, or has a poor prognosis.
15. The participating vision provider shall have the right to discontinue further treatment of a Member who continually fails to keep appointments or who fails to follow their prescribed course of treatment.

16. In the event the Member has other vision coverage, benefits will be coordinated as follows: a. If the other coverage is a group or non-group pre-paid program the Member may obtain covered services from a participating vision provider in either program and be subject to the appropriate co-payment specified in the Schedule of Benefits. b. If the other coverage is group or non-group insurance, the participating vision provider will provide covered services to the Member at the co-payment specified in the Schedule of Benefits. The participating vision provider may not collect more, from the insurance payment and Member payment combined than the co-payment specified in the Schedule of Benefits.
17. Care or treatment which is obtained from, or for which payment is made by, any federal, state, county, municipal, or other governmental agency, including any foreign government.
18. Any corrective treatment required as a result of services performed by a non-participating vision provider while this coverage is in effect, and any services started by a non-participating vision provider will not be the responsibility of the participating vision provider's office or the plan for completion or compensation.
19. Procedures which are considered experimental or investigative or which are not widely accepted as proven and effective procedures within the standard vision care community.