



Pennsylvania
MEDICAL SOCIETY[®]

PENNSYLVANIA MEDICAL SOCIETY
INSURANCE AGENCY

Fashion Advantage Vision Program Option I

www.pamedinsurance.com

Fashion Advantage Vision Program (Option I)

Highmark Blue Shield Vision Care Plan Benefit Summary

Rates:

\$4.45/Individual

\$12.91/Family

Benefits		
Frequency <ul style="list-style-type: none"> o Eye Examination (including dilation as professionally indicated) o Eyeglass Lenses o Frames o Contact Lenses (in lieu of eyeglass lenses) 	Once every 12 months under age 19/24 months age 19 or older. Once every 12 months under age 19/24 months age 19 or older. Once every 24 months Once every 12 months under age 19/24 months age 19 or older.	
	In-Network (Coverage)	Out-of-Network* (Reimbursement)
Eye Examination <ul style="list-style-type: none"> o Including dilation as professionally indicated 	Included	Up to \$32.00
Frames <ul style="list-style-type: none"> o Fashion level frames from “The Collection” o Designer level frames from “The Collection” o Premier level frames from “The Collection” o Retail allowance towards a network provider’s frame 	Included \$20.00 copayment \$40.00 copayment \$60.00	Up to \$30.00
Standard Eyeglass Lenses (per pair) <ul style="list-style-type: none"> o Single Vision o Bifocal o Trifocal o Lenticular <i>Includes glass, plastic or oversized lenses.</i>	Included Included Included Included	Up to \$25.00 Up to \$36.00 Up to \$46.00 Up to \$72.00
Optional Eyeglass Lenses <ul style="list-style-type: none"> o Standard progressive addition lenses + o Premium progressive addition lenses + o Glass-Grey #3 Prescription Sunglasses o Polycarbonate lenses <ul style="list-style-type: none"> ▪ Adult <ul style="list-style-type: none"> ▪ Dependent children, monocular patients and patients with prescriptions +/- 6.00 diopters or greater. <ul style="list-style-type: none"> ▪ Single Vision Polycarbonate lenses (in lieu of Single Vision Lenses) ▪ Bifocal Polycarbonate lenses (in lieu of Bifocal Lenses) ▪ Trifocal Polycarbonate lenses (in lieu of Trifocal Lenses) o Blended segment lenses o Intermediate vision lenses o Photosensitive glass lenses o Plastic photosensitive lenses o High-index (thinner and lighter) lenses o Polarized lenses <p><i>+ Progressive addition multifocals can be worn by most people. Conventional bifocals will be supplied at no additional charge for anyone who is unable to adapt to progressive addition lenses however the copayment will not be refunded.</i></p>	\$50.00 copayment \$90.00 copayment \$11.00 copayment \$30.00 copayment Included Included Included \$20.00 copayment \$30.00 copayment \$20.00 copayment \$65.00 copayment \$55.00 copayment \$75.00 copayment	NC NC NC NC NC NC NC NC NC NC NC
Optional Eyeglass Lens Coatings/Treatments <ul style="list-style-type: none"> o Fashion, sun or gradient tinted plastic lenses o Ultraviolet coating o Scratch-resistant coating o Standard ARC (anti-reflective coating) o Premium ARC (anti-reflective coating) o Ultra ARC (anti-reflective coating) 	\$11.00 copayment \$12.00 copayment \$20.00 copayment \$35.00 copayment \$48.00 copayment \$60.00 copayment	NC NC NC NC NC NC
Contact Lenses (in lieu of eyeglass lenses – per pair or initial supply of disposable contact lenses) <ul style="list-style-type: none"> o Contact lens evaluation and fitting <ul style="list-style-type: none"> ▪ Daily Wear ▪ Extended Wear o Standard Daily Wear Contact Lenses - Formulary/Non-Formulary o Specialty Contact Lenses - Formulary/Non-Formulary o Disposable Contact Lenses - Formulary/Non-Formulary o Medically Necessary Contact Lenses (prior approval required) <p><i>Please Note: Contact lenses can be worn by most people. Once the contact lens option is selected and the lenses fitted, they may not be exchanged for eyeglass lenses.</i></p> <p>¹ Program allowance applies towards contact lens evaluation, fitting and cost of contact lenses.</p>	Included when formulary contact lenses are prescribed Formulary / Non-Formulary Covered in full / \$85 ¹ Covered in full / \$85 ¹ Covered in full / \$85 ¹ Covered in full	NC Up to \$85.00 Up to \$85.00 Up to \$85.00 Up to \$225.00
Low Vision Services <ul style="list-style-type: none"> o Evaluation – One visit every 5 years o Follow-up visits – Up to four follow-up visits every 5 years o Low vision aids 	\$300 allowance per visit \$100 allowance per visit \$600 per device with \$1,200 lifetime maximum	

* If you choose an out-of-network provider, you must pay the provider directly for all charges and then submit a claim for reimbursement.

This is a summary of vision benefits. Please refer to the group contract for complete benefit information. Should the information in this summary differ from the information contained in the group contract, the terms of the group contract shall govern.