SUMMARY OF FASHION ADVANTAGE OPTION I BENEFITS

BENEFIT	NETWORK	OUT-OF-NETWORK(1)
FREQUENCY(2)		
Eye examination (with dilation as professionally indicated)	Once every 12 months under age 19/Once every 24 months age 19 or old	
Eyeglass lenses	Once every 12 months under age 19/C	Ince every 24 months age 19 or olde
Frames	Once every	24 months
Contact lenses (in lieu of eyeglass lenses)	Once every 12 months under age 19/C	ince every 24 months age 19 or olde
EYE EXAMINATION (with dilation as professionally indicated)	Covered In Full	Plan pays up to \$32
FRAMES		
Fashion level frames from "The Collection"	Covered In Full	
Designer level frames from "The Collection"	Member pays \$20	
Premier level frames from "The Collection"	Member pays \$40	
Retail allowance towards a provider's frame	Plan pays up to \$60	Plan pays up to \$30
STANDARD EYEGLASS LENSES(3) (per pair)		a payo up to 400
Single vision	Covered In Full	Plan pays up to \$25
Bifocal	Covered In Full	Plan pays up to \$36
Trifocal	Covered In Full	Plan pays up to \$46
Lenticular	Covered In Full	Plan pays up to \$72
OPTIONAL EYEGLASS LENSES (per pair)	Jovered III all	Trail pays up to \$72
Standard progressive lenses(4)	Member pays \$50	Not Covered
Premium progressive lenses(4)	Member pays \$90	Not Covered Not Covered
Glass Grey #3 prescription sunglasses	Member pays \$90 Member pays \$11	Not Covered Not Covered
Polycarbonate lenses	ivienibei pays \$11	Not Covered
Adult(5)	Marshan and COO	N 10
	Member pays \$30	Not Covered
Dependent children		
Single vision Polycarbonate (in lieu of single vision	Covered In Full	Not Covered
eyeglass lenses)	A	
Bifocal Polycarbonate (in lieu of bifocal eyeglass lenses)	Covered In Full	Not Covered
Trifocal Polycarbonate (in lieu of trifocal eyeglass lenses)	Covered In Full	Not Covered
Blended segment lenses	Member pays \$20	Not Covered
Intermediate vision lenses	Member pays \$30	Not Covered
Glass photochromic lenses	Member pays \$20	Not Covered
Plastic photosensitive lenses	Member pays \$65	Not Covered
High-index (thinner and lighter) lenses	Member pays \$55	Not Covered
Polarized lenses	Member pays \$75	Not Covered
OPTIONAL EYEGLASS LENS COATINGS/TREATMENTS		
Fashion, sun or gradient tinted plastic lenses	Member pays \$11	Not Covered
Ultraviolet Coating	Member pays \$12	Not Covered
Scratch-resistant coating	Member pays \$20	Not Covered
Standard ARC (anti-reflective coating)	Member pays \$35	Not Covered
Premium ARC (anti-reflective coating)	Member pays \$48	Not Covered
Ultra ARC (anti-reflective coating)	Member pays \$60	Not Covered
CONTACT LENSES(6) (in lieu of eyeglass lenses—per pair or	monitor pays 455	THOI GOVERGE
initial supply of disposable contact lenses)		
Contact lens evaluation and fitting		
Daily wear	Covered in full when the performing	Not Covered
Daily Woal	provider dispenses formulary contact	Not Covered
	1	
Extended wear	lenses	N 10
Exteriued wear	Covered in full when the performing	Not Covered
	provider dispenses formulary contact	
	lenses	
Chandard dally years and at laws	Formulary(7)/Nonformulary	
Standard daily wear contact lenses	Covered In Full/ Plan pays up to	Plan pays up to \$85
	\$85(8)	
Specialty contact lenses	Covered In Full/ Plan pays up to	Plan pays up to \$85
	\$85(8)	
Disposable contact lenses	Covered In Full/ Plan pays up to	Plan pays up to \$85
	\$85(8)	
Medically necessary contact lenses (prior approval required)	Covered In Full	Plan pays up to \$225
OW VISION SERVICES		
Evaluation – one visit every 5 years (prior approval required)	Plan pays up to \$300 per visit	
follow-up visits—up to four follow-up visits every 5 years	Plan pays up to \$300 per visit	
ow vision aids	Plan pays up to \$600 per aid/\$1,200 lifetime maximum	
If you choose an out-of-network provider, you must pay the provider directly for al	L ran pays up to \$000 per alo	γψι, ευυ incurie maximum

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

⁽²⁾ Eligibility will be determined from the date of the last similar service paid under this program, or any other Highmark vision program for this group.

⁽²⁾ Eligibility will be determined from the date of the last similar service paid under this program, or any other Highmark vision program for this group.
(3) Includes glass, plastic or oversized lenses.
(4) Progressive 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 lenses. However, the member's payment towards the progressive upgrade will not be refunded.
(5) Member payment is waived for monocular patients and patients with prescriptions +/- 6.00 diopters or greater.
(6) 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 eyeglasses.
(7) Disposable contact lens wearers will receive four multi-packs of lenses. Planned replacement contact lens wearers will receive two multi-packs of lenses.
(8) The Plan's payment is applied towards the cost of contact lenses and may or may not apply to the evaluation/fitting. Member is responsible for any remaining balance.

SUMMARY OF FASHION ADVANTAGE OPTION V BENEFITS

BENEFIT EPECUENCY(s)	NETWORK	OUT-OF-NETWORK(1)
FREQUENCY(2)		40
Eye examination (with dilation as professionally indicated)	Once every	
Eyeglass lenses	Once every 12 months	
Frames	Once every	
Contact lenses (in lieu of eyeglass lenses)	Once every	
EYE EXAMINATION (with dilation as professionally indicated)	Covered In Full	Plan pays up to \$32
FRAMES		
Fashion level frames from "The Collection"	Covered In Full	
Designer level frames from "The Collection"	Member pays \$20	
Premier level frames from "The Collection"	Member pays \$40	-
Retail allowance towards a provider's frame	Plan pays up to \$60	Plan pays up to \$30
STANDARD EYEGLASS LENSES(3) (per pair)		
Single vision	Covered In Full	Plan pays up to \$25
Bifocal	Covered In Full	Plan pays up to \$36
Trifocal	Covered In Full	Plan pays up to \$46
enticular	Covered In Full	Plan pays up to \$72
OPTIONAL EYEGLASS LENSES (per pair)		
Standard progressive lenses(4)	Member pays \$50	Not Covered
Premium progressive lenses(4)	Member pays \$90	Not Covered
Glass Grey #3 prescription sunglasses	Member pays \$11	Not Covered
Polycarbonate lenses		
Adult(5)	Member pays \$30	Not Covered
Dependent children		
Single vision Polycarbonate (in lieu of single vision	Covered In Full	Not Covered
eyeglass lenses)		
Bifocal Polycarbonate (in lieu of bifocal eyeglass lenses)	Covered In Full	Not Covered
Trifocal Polycarbonate (in lieu of trifocal eyeglass lenses)	Covered In Full	Not Covered
Blended segment lenses	Member pays \$20	Not Covered
ntermediate vision lenses	Member pays \$30	Not Covered
Glass photochromic lenses	Member pays \$20	Not Covered
Plastic photosensitive lenses	Member pays \$65	Not Covered
High-index (thinner and lighter) lenses	Member pays \$55	Not Covered
Polarized lenses	Member pays \$75	Not Covered
OPTIONAL EYEGLASS LENS COATINGS/TREATMENTS	mormon pays tro	140t Govered
ashion, sun or gradient tinted plastic lenses	Member pays \$11	Not Covered
Jitraviolet Coating	Member pays \$12	Not Covered
Scratch-resistant coating	Member pays \$20	Not Covered Not Covered
Standard ARC (anti-reflective coating)	Member pays \$35	Not Covered
Premium ARC (anti-reflective coating)	Member pays \$48	Not Covered Not Covered
Jitra ARC (anti-reflective coating)	Member pays \$60	Not Covered
CONTACT LENSES(6) (in lieu of eyeglass lenses—per pair or	Weitiber pays \$60	Not Covered
nitial supply of disposable contact lenses)		
Contact lens evaluation and fitting		
Daily wear	Covered in full when the norfermine	Not Coursed
Daily Wool	Covered in full when the performing	Not Covered
	provider dispenses formulary contact	
Extended wear	lenses Covered in full when the performing	Not Course
Extended wear		Not Covered
	provider dispenses formulary contact	
	lenses	
	Formulani/7\/Nonformulani	
Standard daily wear contact lenses	Formulary(7)/Nonformulary	Dien
numum dany wear contact lenses	Covered In Full/ Plan pays up to	Plan pays up to \$85
Specialty contact langue	\$85(8)	Diameter and the state
pecialty contact lenses	Covered In Full/ Plan pays up to	Plan pays up to \$85
Nisnosahla contact lancos	\$85(8)	Diam
Disposable contact lenses	Covered in Full/ Plan pays up to	Plan pays up to \$85
Andically passages contact leaves (arise	\$85(8)	Pag.
Medically necessary contact lenses (prior approval required)	Covered In Full	Plan pays up to \$225
OW VISION SERVICES	-	***
valuation – one visit every 5 years (prior approval required)	Plan pays up to \$300 per visit	
ollow-up visits—up to four follow-up visits every 5 years	Plan pays up to \$100 per visit	
ow vision aids	Plan pays up to \$600 per aid/\$1,200 lifetime maximum charges and then submit a claim for reimbursement.	

⁽¹⁾ If you choose an out-of-network provider, you must pay the provider directly for all charges and then submit a claim for reimbursement.

⁽²⁾ Eligibility will be determined from the date of the last similar service paid under this program, or any other Highmark vision program for this group.

⁽³⁾ Includes glass, plastic or oversized lenses.

⁽⁴⁾ Progressive 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 lenses. However, (4) Progressive multifocats can be worn by most people. Conventional billocals will be supplied at no additional charge for anyone who is unable to adapt to progressive the member's payment towards the progressive upgrade will not be refunded.

(5) Member payment is waived for monocular patients and patients with prescriptions +/- 6.00 diopters or greater.

(6) 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 eyeglasses.

(7) Disposable contact lens wearers will receive four multi-packs of lenses. Planned replacement contact lens wearers will receive two multi-packs of lenses.

(8) The Plan's payment is applied towards the cost of contact lenses and may or may not apply to the evaluation/fitting. Member is responsible for any remaining balance.

SUMMARY OF FASHION ADVANTAGE GOLD OPTION LIBENFEITS

SUMINARY OF FASHION ADVANT		SMINERIO
BENEFIT	NETWORK	OUT-OF-NETWORK(1)
FREQUENCY(2)		
Eye examination (with dilation as professionally indicated)	Once every 12 months under age 19/0	Once every 24 months age 19 or olde
Eyeglass lenses	Once every 12 months under age 19/0	Once every 24 months age 19 or olde
Frames	Once every	24 months
Contact lenses (in lieu of eyeglass lenses)	Once every 12 months under age 19/0	Once every 24 months age 19 or olde
EYE EXAMINATION (with dilation as professionally indicated)	Covered In Full	Plan pays up to \$40
FRAMES		
Fashion level frames from "The Collection"	Covered In Full	
Designer level frames from "The Collection"	Member pays \$20	
Premier level frames from "The Collection"	Member pays \$40	
Retail allowance towards a provider's frame	Plan pays up to \$100	Plan pays up to \$64
STANDARD EYEGLASS LENSES(3) (per pair)		1 ian pays up to 404
Single vision	Covered In Full	Plan pays up to \$30
Bifocal	Covered In Full	Plan pays up to \$40
Trifocal	Covered in Full	Plan pays up to \$60
Lenticular	Covered In Full	Plan pays up to \$80
OPTIONAL EYEGLASS LENSES (per pair)	COVERCE III T dii	Fiail pays up to \$60
Standard progressive lenses(4) (in lieu of bifocal/trifocal	Covered In Full	Diam mayor you to \$400
lenses)	Covered in Full	Plan pays up to \$130
Premium progressive lenses(4)	Member nove \$40	NI-t O
Glass Grey #3 prescription sunglasses	Member pays \$40 Member pays \$11	Not Covered
Polycarbonate lenses	wember pays \$11	Not Covered
Adult(5)	Member nove \$20	NI-4 O
Dependent children	Member pays \$30	Not Covered
Single vision Polycarbonate (in lieu of single vision	Covered In Full	D)
eyeglass lenses)	Covered in Full	Plan pays up to \$70
Bifocal Polycarbonate (in lieu of bifocal eyeglass lenses)		
	Covered In Full	Plan pays up to \$80
Trifocal Polycarbonate (in lieu of trifocal eyeglass lenses)	Covered In Full	Plan pays up to \$95
Blended segment lenses	Member pays \$20	Not Covered
Intermediate vision lenses	Member pays \$30	Not Covered
Glass photochromic lenses	Member pays \$20	Not Covered
Plastic photosensitive lenses	Member pays \$65	Not Covered
High-index (thinner and lighter) lenses	Member pays \$55	Not Covered
Polarized lenses	Member pays \$75	Not Covered
OPTIONAL EYEGLASS LENS COATINGS/TREATMENTS		
Fashion, sun or gradient tinted plastic lenses	Member pays \$11	Not Covered
Ultraviolet Coating	Member pays \$12	Not Covered
Scratch-resistant coating	Member pays \$20	Not Covered
Standard ARC (anti-reflective coating)	Member pays \$35	Not Covered
Premium ARC (anti-reflective coating)	Member pays \$48	Not Covered
Ultra ARC (anti-reflective coating)	Member pays \$60	Not Covered
CONTACT LENSES(6) (in lieu of eyeglass lenses—per pair or		
initial supply of disposable contact lenses)		
Contact lens evaluation and fitting		
Daily wear	Covered in full when the performing	Not Covered
•	provider dispenses formulary contact	Not Covered
	lenses	
Extended wear	Covered in full when the performing	Not Covered
	provider dispenses formulary contact	Not Covered
	lenses	
	1011303	
	Formulary(7)/Nonformulary	
Standard daily wear contact lenses	Covered In Full/Plan pays up to	Dian nava to 0445
a aming from contact totals	\$130(8)	Plan pays up to \$115
Specialty contact lenses	Covered in Full/Plan pays up to	Dian same to date
aparamy serious renous		Plan pays up to \$115
Disposable contact lenses	\$130(8)	Discourse
Piobogapio gottage ielises	Covered In Full/Plan pays up to	Plan pays up to \$115
Medically necessary contact lenses (prior approval and its all	\$130(8)	PAL
Medically necessary contact lenses (prior approval required) LOW VISION SERVICES	Covered In Full	Plan pays up to \$225

Evaluation – one visit every 5 years (prior approval required)	Plan pays up to \$300 per visit	
Follow-up visits—up to four follow-up visits every 5 years Low vision aids	Plan pays up to \$100 per visit	
	Plan pays up to \$600 per aid/\$1,200 lifetime maximum	
If you choose an out-of-network provider, you must pay the provider directly for al	charges and then submit a claim for reimbursement.	

⁽¹⁾ If you choose an out-of-network provider, you must pay the provider directly for all charges and then submit a claim for reimbursement.

⁽²⁾ Eligibility will be determined from the date of the last similar service paid under this program, or any other Highmark vision program for this group.
(3) Includes glass, plastic or oversized lenses.

⁽³⁾ Includes glass, plastic or oversized lenses.

(4) Progressive 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 lenses. However, the member's payment towards the progressive upgrade will not be refunded.

(5) Member payment is waived for monocular patients and patients with prescriptions +/- 6.00 diopters or greater.

(6) 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 eyeglasses.

(7) Disposable contact lens wearers will receive four multi-packs of lenses. Planned replacement contact lens wearers will receive two multi-packs of lenses.

(8) The Plan's payment is applied towards the cost of contact lenses and may or may not apply to the evaluation/fitting. Member is responsible for any remaining balance.

SUMMARY OF FASHION ADVANTAGE GOLD OPTION V BENEFITS

BENEFIT	NETWORK	OUT-OF-NETWORK(1)
FREQUENCY(2)		
Eye examination (with dilation as professionally indicated)	Once every 12 months	
Eyeglass lenses	Once every 12 months	
Frames	Once every 12 months	
Contact lenses (in lieu of eyeglass lenses)	Once every	
EYE EXAMINATION (with dilation as professionally indicated)	Covered In Full	Plan pays up to \$40
RAMES		
Fashion level frames from "The Collection"	Covered In Full	
Designer level frames from "The Collection"	Member pays \$20	
Premier level frames from "The Collection"	Member pays \$40	
Retail allowance towards a provider's frame	Plan pays up to \$100	Plan pays up to \$64
STANDARD EYEGLASS LENSES(3) (per pair)		
Single vision	Covered In Full	Plan pays up to \$30
Bifocal	Covered In Full	Plan pays up to \$40
rifocal	Covered In Full	Plan pays up to \$60
enticular	Covered In Full	Plan pays up to \$80
PTIONAL EYEGLASS LENSES (per pair)		
standard progressive lenses(4) (in lieu of bifocal/trifocal	Covered In Full	Plan pays up to \$130
enses)		
Premium progressive lenses(4)	Member pays \$40	Not Covered
Glass Grey #3 prescription sunglasses	Member pays \$11	Not Covered
olycarbonate lenses		
Adult(5)	Member pays \$30	Not Covered
Dependent children		
Single vision Polycarbonate (in lieu of single vision	Covered In Full	Plan pays up to \$70
eyeglass lenses)		
Bifocal Polycarbonate (in lieu of bifocal eyeglass lenses)	Covered In Full	Plan pays up to \$80
Trifocal Polycarbonate (in lieu of trifocal eyeglass lenses)	Covered In Full	Plan pays up to \$95
llended segment lenses	Member pays \$20	Not Covered
ntermediate vision lenses	Member pays \$30	Not Covered
Blass photochromic lenses	Member pays \$20	Not Covered
Plastic photosensitive lenses	Member pays \$65	Not Covered
High-index (thinner and lighter) lenses	Member pays \$55	Not Covered
Polarized lenses	Member pays \$75	Not Covered
OPTIONAL EYEGLASS LENS COATINGS/TREATMENTS		
Fashion, sun or gradient tinted plastic lenses	Member pays \$11	Not Covered
Jitraviolet Coating	Member pays \$12	Not Covered
Scratch-resistant coating	Member pays \$20	Not Covered
Standard ARC (anti-reflective coating)	Member pays \$35	Not Covered
Premium ARC (anti-reflective coating)	Member pays \$48	Not Covered
Iltra ARC (anti-reflective coating)	Member pays \$60	Not Covered
CONTACT LENSES(6) (in lieu of eyeglass lenses—per pair or		
nitial supply of disposable contact lenses)		
Contact lens evaluation and fitting		
Daily wear	Covered in full when the performing	Not Covered
•	provider dispenses formulary contact	
	lenses	
Extended wear	Covered in full when the performing	Not Covered
	provider dispenses formulary contact	
	lenses	
	Formulary(7)/Nonformulary	
tandard daily wear contact lenses	Covered In Full/Plan pays up to	Plan pays up to \$115
•	\$130(8)	, A
pecialty contact lenses	Covered In Full/Plan pays up to	Plan pays up to \$115
·	\$130(8)	F-)
isposable contact lenses	Covered in Full/Plan pays up to	Plan pays up to \$115
•	\$130(8)	pajo ap 10 w 10
fedically necessary contact lenses (prior approval required)	Covered In Full	Plan pays up to \$225
OW VISION SERVICES	The state of the s	· ion payo up to wall
valuation – one visit every 5 years (prior approval required)	Plan pays up to \$300 per visit	
ollow-up visits—up to four follow-up visits every 5 years	Plan pays up to \$100 per visit	
	Plan pays up to \$600 per aid/\$1 200 lifetime maximum	
onow-up visits—up to four follow-up visits every 5 years ow vision aids If you choose an out-of-network provider, you must pay the provider directly for a	Plan pays up to \$600 per aid/\$1,200 lifetime maximum	

⁽¹⁾ If you choose an out-of-network provider, you must pay the provider directly for all charges and then submit a claim for reimbursement.
(2) Eligibility will be determined from the date of the last similar service paid under this program, or any other Highmark vision program for this group.
(3) Includes glass, plastic or oversized lenses.

⁽³⁾ includes glass, plastic or oversized lenses.

(4) Progressive 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 lenses. However, the member's payment towards the progressive upgrade will not be refunded.

(5) Member payment is waived for monocular patients and patients with prescriptions +/- 6.00 diopters or greater.

(6) 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 eyeglasses.

⁽⁷⁾Disposable contact lens wearers will receive four multi-packs of lenses. Planned replacement contact lens wearers will receive two multi-packs of lenses.

⁽⁸⁾The Plan's payment is applied towards the cost of contact lenses and may or may not apply to the evaluation/fitting. Member is responsible for any remaining balance.

How do I receive services from a provider in the network?

- Call the network provider of your choice and schedule an appointment.
- Identify yourself as a Highmark member, or eligible dependent, in a vision plan administered by Davis Vision.
- Provide the office with your identification (ID) number (located on your Highmark ID card), and the name and birth date of the covered dependent receiving services.

It's that easy! The provider's office will verify your eligibility for services. No claim forms are required!

Who are the network providers?

The Davis Vision provider network is being used for this vision product through a contractual arrangement between Davis Vision and Highmark. Davis Vision is an independent company that manages a network of licensed vision providers in both private practice and retail locations. Network providers are reviewed and credentialed to ensure that standards for quality service are maintained. To find a network provider, you can call Member Service toll-free at 1-800-223-4795 and access the Interactive Voice Response (IVR) Unit or access the Vision Provider Directory online at www.highmarkbcbs.com.

What about retail locations?

In order to provide you with the greatest amount of flexibility and convenience, the network includes a number of retail establishments. Benefits at the retail locations may vary slightly from other locations, as noted in this benefit description. However, your value is comparable.

Or, call Member Service at 1-800-223-4795 (TTY users call 1-800-523-2847) to:

- Find a participating provider
- Verify eligibility for yourself or your dependents
- Request an out-of-network provider reimbursement form

Member Service Representatives are available:

• Monday through Friday, 8:00 a.m. to 5:00 p.m., Eastern Standard Time (EST)

Information about Low Vision Services:

You and your covered dependents are entitled to a comprehensive low vision evaluation once every five years and low vision aids up to the plan maximum. Up to four follow-up care visits will be covered during the five-year period.

Are there any exclusions?

This vision program excludes coverage for certain items and services, including:

- Medical treatment of eye disease or injury
- Vision therapy
- Special lens designs or coatings, other than those previously described
- Replacement of lost eyewear
- Non-prescription (plano) lenses
- Services not performed by licensed personnel

For information prior to enrolling, call 1-800-223-4795.