

Vision Care Service Record  
(This form to be maintained by the provider's office)

NOTE: THIS IS AN AFFORDABLE CARE ACT POLICY. Benefits outlined below may be subject to cost sharing (i.e., Deductible and/or Co-Insurance Expense up to Maximum Out-Of-Pocket for covered services). Details to be provided at enrollment confirmation.

SECTION I - PATIENT/PROVIDER SECTION	
Member Name:	
Member ID No:	
Patient Name:	DOB:
Relationship: (circle one)	Member Child
Provider's Name:	
Provider's No:	

SECTION II - ENROLLMENT CONFIRMATION	
Enrollment Confirmation: BIA	_____
Enrollment Confirmation Date:	
*Patient Responsible for 100% of Benefit Value: (circle one):	Yes No N/A
*Maximum Out-Of-Pocket Met <sup>1</sup> : (circle one)	Yes No N/A
*Deductible Met <sup>2</sup> (circle one):	Yes No N/A
*Co-insurance amount:	N/A

\*Not all portions of cost sharing apply to all plans. Deductible, Co-insurance and Maximum Out-Of-Pocket information provided at time of enrollment confirmation based on most recent information Davis Vision has received from the patient's medical carrier.

### WHO IS ELIGIBLE?

SECTION III: ALLOWABLE SERVICES SECTION			
<b>Examination</b> - routine (including dilation)			
Coverage : This is a Pediatric Benefit - Children are covered to the age of 19	Patient Responsibility <sup>3</sup>	Benefit Value <sup>4</sup>	Provider Fee Schedule
Every January 1	\$10	See Benefit Alert	See Benefit Alert on <a href="http://www.davisvision.com">www.davisvision.com</a>
<b>Frames</b>			
Coverage : Every January 1			
Types : Pediatric Frame Selection			
Fashion Frame from the "Exclusive Davis Vision Collection"	Included	\$23.30	
Designer Frame from the "Exclusive Davis Vision Collection"	Included	\$32.71	
Premier Frame from the "Exclusive Davis Vision Collection"	See Non-Covered Services	See Non-Covered Services	
Non-Selection Frame - *20% discount on balance	Co-insurance + amount over \$130*	\$130 + amount over \$130*	
<b>Spectacle Lenses</b>			
Coverage : Every January 1	\$25.00		
Single Vision	Included	\$59.44	
Bifocal	Included	\$79.08	
Trifocal	Included	\$96.24	
<b>Contact Lenses</b>			
Coverage : Every January 1			
Evaluation/Fitting	\$25.00	\$60.00	
Davis Vision Premium Contact Lens Collection - Plan 2 (circle one): 8 multi-packs of plan supplied Disposable 8 multi-packs of plan supplied Disposable 8 multi-packs of plan supplied Disposable 4 multi-packs of plan supplied Planned Replacement	\$0	\$92.00	
<b>Non Plan</b>			
Evaluation/Fitting (circle one):	\$25.00		
Standard - After copay, covered in full			
Specialty - \$60 allowance less copay plus 15% off balance.			
Provider Supplied - *15% discount on balance	Co-insurance + amount over \$130*	\$130.00*	
Visually Required Contact Lenses (prior approval required) Materials, Evaluation, Fitting & Follow –Up Care	100% of Provider's charge	100% of Provider's charge	

<sup>1</sup> If Maximum Out-Of-Pocket is met, the patient only pays the non-covered services charges. If plan has a Maximum Out-Of-Pocket and the maximum has not been met, the patient is responsible to pay the 'patient responsibility', in addition to non-covered service charges.

<sup>2</sup> If plan is subject to Deductible and the Deductible is not met as of the date of service, the patient is responsible to pay the Benefit Value, in addition to any non-covered service charges. If the Deductible is met, the patient is responsible to pay only the non-covered service charges at the time of their initial visit. Remaining patient responsibility should be collected prior to dispensing eyewear.

<sup>3</sup> The patient responsibility is only applicable when a patient has met Deductibles; these charges should not be collected during the patient's initial visit. They should be collected if and when eyewear is dispensed.

<sup>4</sup> The Benefit Value becomes the patient's responsibility when a plan has a Deductible that has not been met. In the event that a lens enhancement is included as an allowable service, but the patient's Deductible has not been met, the patient is responsible to pay the Benefit Value.

You have specific ERISA appeals rights regarding your vision care benefits. These rights may be obtained in detail by contacting Davis Vision at 1.800.753.3311 or writing to: Quality Assurance Department  
P. O. Box 1525, Latham, NY 12110

Appeals must be made within 180 days of the date of service.

## SECTION IV: NON-COVERED SERVICES

	Patient Responsibility <sup>3</sup>	Additional Dispense
<b>Frames:</b>		
Premier Selection from the "Exclusive Davis Vision Collection"	\$25.00	\$10.00
<b>Lens Options</b>		
Ultraviolet Coating	\$12.00	\$6.00
Scratch-Resistant Coating	Included	N/A
Premium Scratch Resistant Coating	\$30.00	\$5.00
Scratch Protection Plan Single Vision	\$20.00	\$10.00
Scratch Protection Plan Multifocal	\$40.00	\$10.00
Photochromic Lenses	\$20.00	\$10.00
Digital Single Vision Lenses	\$30.00	\$10.00
Standard Progressive Addition Multifocal	\$50.00	\$30.00
Premium Progressive Addition Multifocal	\$90.00	\$30.00
Ultra Progressive Addition Multifocal	\$140.00	\$55.00
Ultimate Progressive Addition Multifocal	\$175.00	\$60.00
Polycarbonate Lenses	\$30.00	\$20.00
Standard ARC (anti-reflective coating)	\$35.00	\$7.00
Premium ARC (anti-reflective coating)	\$48.00	\$7.00
Ultra ARC (anti-reflective coating)	\$60.00	\$10.00
Ultimate ARC (anti-reflective coating)	\$85.00	\$17.00
Polarized Lenses	\$75.00	\$25.00
High Index Lenses 1.67	\$55.00	\$25.00
High Index Lenses 1.74	\$120.00	\$40.00
Trivex Lenses	\$50.00	\$20.00
Blue Light Filtering	\$15.00	\$7.00
Tinted Lenses	Included	N/A
Mirror Coat	\$86.00	\$56.00
Edge Polish	\$22.00	\$14.00
High Luster Edge Polish	\$70.00	\$63.00
Roll & Polish	\$16.00	\$6.00
Roll Edge	\$24.00	\$14.00
Rimless Drill	\$66.00	\$49.00
Slab Off	\$186.00	\$76.00
Specialty Lens (myodisc, lenticular grind, double sided grind)	\$206.00	\$170.00
Plastic Photosensitive Lenses	\$65.00	\$25.00
<b>Contact Lenses:</b>		
Contact lenses Evaluation, Fitting, and Follow-up - 15% discount	85% of Provider's charge	N/A
Provider Supplied - 15% discount	85% of Provider's charge	N/A

## SECTION V: INSTRUCTIONS

1. Confirmation is valid for 21 days. If expired, call 1.800.773.2847 prior to rendering services.
2. Tennessee state law stipulates that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for purposes or defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.