The Lincoln Electric Company
SELECT NETWORK

Frequency	Allowed Frequency - Adults	Allowed Frequency - Kids
Exam	Once every 12 months from the date of service	Once every 12 months from the date of service
Lenses	Once every 12 months from the date of service	Once every 12 months from the date of service
Frame	Once every 12 months from the date of service	Once every 12 months from the date of service
Contact Lenses	Once every 12 months from the date of service	Once every 12 months from the date of service
(Plan allows the member to receive either contacts and frame, or frame and lens services.)		

Vision Care Services	In-Network Member Cost at PLUS Provider	In-Network Member Cost	Out-of-Network Member Reimbursement
Exam Services			
Exam	**$0 copay**	$10 copay	Up to $30
Retinal Imaging	Up to $39	Up to $39	Not covered
Contact Lens Fit and Follow-Up			
Fit and Follow-up - Standard	Up to $40	Up to $40	Not covered
Fit and Follow-up - Premium	10% off retail price	10% off retail price	Not covered
Frame			
Frame	**$0 copay; 20% off balance over $200 allowance**	$0 copay; 20% off balance over $150 allowance	Up to $75
Lenses			
Single Vision	$10 copay	$10 copay	Up to $25
Bifocal	$10 copay	$10 copay	Up to $40
Trifocal	$10 copay	$10 copay	Up to $60
Lenticular	$10 copay	$10 copay	Up to $60
Progressive - Standard	$75 copay	$75 copay	Up to $40
Progressive - Premium Tier 1 - 4	$75 copay; 20% off retail price less $120 allowance	$75 copay; 20% off retail price less $120 allowance	Up to $40
Lens Options			
Anti Reflective Coating - Standard	$45	$45	Not covered
Anti Reflective Coating - Premium Tier 1 - 4	20% off retail price	20% off retail price	Not covered
Polycarbonate - Standard	$40	$40	Not covered
Scratch Coating - Standard Plastic	$15	$15	Not covered
Tint - Solid and Gradient	$15	$15	Not covered
UV Treatment	$15	$15	Not covered
All Other Lens Options	20% off retail price	20% off retail price	Not covered
Contact Lenses			
Contacts - Conventional	$0 copay; 15% off balance over $150 allowance	$0 copay; 15% off balance over $150 allowance	Up to $120
Contacts - Disposable	$0 copay; 100% of balance over $150 allowance	$0 copay; 100% of balance over $150 allowance	Up to $120
Contacts - Medically Necessary	$0 copay	$0 copay	Up to $200
Other			
Hearing Care from Amplifon Network	Up to 66% off hearing aids; call 1-877-203-0675	Up to 66% off hearing aids; call 1-877-203-0675	Not covered
LASIK or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered

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Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy. Allowances provide no remaining balance for future use within the same Benefit Frequency. Some provisions, benefits, exclusions or limitations listed herein may vary by state. No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures; Refraction, when not provided as part of a Comprehensive Eye Examination; services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment; safety eyewear; solutions, cleaning products or frame cases; non-prescription sunglasses; plano (non-prescription) lenses; plano (non-prescription) contact lenses; two pair of glasses in lieu of bifocals; electronic vision devices; services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer. Member receives a 20% discount on items not covered by the plan at In-Network locations. Discount does not apply to Provider's professional services or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see the online provider locator to determine which participating providers have agreed to the discounted rate. Discounts on vision materials may not be applicable to certain manufacturers' products. The Plan reserves the right to make changes to the products on each tier and to the member out-of-pocket costs. Fixed tier pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Services and amounts listed above are subject to change at any time. Discounts are not insured benefits. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, Policy number VC-19, form number M-9083, or Policy number VC-146, form number M-9184, in New York underwritten by Fidelity Security Life Insurance Company of New York, Policy Number VCN-1, form number MN-1, or Policy Number VCN-19, form number MN-28.