Keystone Point-of-Service

C2-F3-O1

Keystone HEALTH PLAN EAST
POINT-OF-SERVICE

Archdiocese of Phila

Keystone Point-of-Service lets you maintain freedom of choice by allowing you to select your own doctors and hospitals. You maximize your coverage by having care provided or referred by your primary care physician (PCP). Of course, with Keystone Point-of-Service, you have the freedom to self-refer your care either to a Keystone participating provider or to providers who do not participate in our network; however, higher out-of-pocket costs apply. This program may not cover all your health care services.

To get the most out of your benefits program, below are some key terms that you will need to understand.

- **Referral** - Documentation from your PCP authorizing care at a participating specialist for covered services.
- **Preapproval/Precertification** - Approval from Independence Blue Cross (IBC) for non emergency or elective hospital admissions and procedures prior to the admission or procedure. For in-network (referred) services, your participating provider will contact IBC for authorization. For out-of-network (self-referred) services, you are responsible for obtaining approval for certain services. For more information on the services requiring precertification, please refer to the back page of this summary.
- **Designated site** - PCPs are required to choose one radiology, physical therapy, occupational therapy and laboratory provider where they will send all their Keystone members. You can view the sites selected by your PCP at www.ibx.com.

Your Member Handbook will provide additional details about your benefits program. It will include information about exclusions and benefits limitations. It is important to note that this program may not cover all your health care services. Services may not be covered because they are not included under your benefits contract, not medically necessary, or limited by a benefit maximum (e.g., visit limit). After reviewing this information, please contact our Customer Service department if you have additional questions.

Benefit	Referred	Self-Referred*
BENEFIT PERIOD	Calendar Year[2]	Calendar Year[2]
DEDUCTIBLE		
Individual	$0	$1,000
Family	$0	$2,000
LIFETIME MAXIMUM	Unlimited	Unlimited
OUT-OF-POCKET MAXIMUM[3]		
Individual	$3,000	$6,000[4]
Family	$6,000	$12,000[4]

* Out-of-Network providers may bill you the difference between the plan allowance, which is the amount paid by the plan, and the provider's actual charge. This amount may be significant.

2 A calendar year benefit period begins on January 1 and ends on December 31. The deductible and out-of-pocket maximum amount starts at $0 at the beginning of each calendar year on January 1.

3 In-network out-of-pocket maximum includes copayments, coinsurance and deductible. Out-of-network out-of-pocket maximum includes coinsurance only.

4 Coinsurance and deductible applied to self-referred participating providers will accumulate toward the referred/in-network out-of-pocket maximum.

To receive maximum benefits, services must be provided or referred by your Keystone Primary Care Physician. This is a highlight of benefits available. The benefits and exclusions for Referred Care and Self-Referred Care are not the same. All benefits are provided in accordance with the HMO group contract and self-referred benefit booklet/certificate.

The benefits may be changed by IBC to comply with applicable federal/state laws and regulations

Independence

Referred benefits are underwritten or administered by Keystone Health Plan East;
Self-Referred benefits are underwritten or administered by QCC Insurance Company, subsidiaries of Independence Blue Cross-independent licensees of the Blue Cross and Blue Shield Association.

www.ibx.com

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Benefit	Referred	Self-Referred*
DOCTOR'S OFFICE VISITS		
Primary Care Services	$15 Copayment	70%, after deductible
Specialist Services	$40 Copayment	70%, after deductible
PREVENTIVE CARE FOR ADULTS AND CHILDREN	100%	70%, NO deductible
PEDIATRIC IMMUNIZATIONS	100%	70%, NO deductible
ROUTINE EYE EXAM	$40 Copayment (once every two years)	Not Covered
ROUTINE GYNECOLOGICAL EXAM/PAP 1 per year for women of any age (no referral required)	100%	70%, NO deductible
MAMMOGRAM (no referral required)	100%	70%, NO deductible
NUTRITION COUNSELING FOR WEIGHT MANAGEMENT 6 visits per year	100%	70%, after deductible
OUTPATIENT LABORATORY/PATHOLOGY	100%	70%, after deductible
MATERNITY		
First OB visit	$15 Copayment	70%, after deductible
Hospital	$150/day; maximum of 5 Copayments/ admission***	70%, after deductible[1]
INPATIENT HOSPITAL SERVICES		
Facility	$150/day; maximum of 5 Copayments/ admission***	70%, after deductible[1]
Physician/Surgeon	100%	70%, after deductible
INPATIENT HOSPITAL DAYS	Unlimited	70[1]
OUTPATIENT SURGERY		
Facility	$100 Copayment	70%, after deductible
Physician/Surgeon	100%	70%, after deductible
EMERGENCY ROOM	$150 Copayment (not waived if admitted)	$150 Copayment, NO deductible (not waived if admitted)
URGENT CARE CENTER	$70 Copayment	70%, after deductible
AMBULANCE		
Emergency	100%	100%, NO deductible
Non-Emergency	100%	70%, after deductible
OUTPATIENT X-RAY/RADIOLOGY**		
Routine Radiology/Diagnostic	$50 Copayment	70%, after deductible
MRI/MRA, CT/CTA Scan, PET Scan	$100 Copayment	70%, after deductible
THERAPY SERVICES		
Physical and Occupational 30 total visits per year for PT/OT combined	$40 Copayment	70%, after deductible
Cardiac Rehabilitation 36 visits per year	$40 Copayment	70%, after deductible
Pulmonary Rehabilitation 36 visits per year	$40 Copayment	70%, after deductible
Speech 20 visits per year	$40 Copayment	70%, after deductible
Orthoptic/Pleoptic 8 session lifetime maximum	$40 Copayment	70%, after deductible
SPINAL MANIPULATIONS 20 visits per year	$40 Copayment	70%, after deductible
ALLERGY INJECTIONS (Office visit copayment waived if no office visit is charged)	100%, NO deductible	70%, after deductible
INJECTABLE MEDICATIONS		
Standard Injectables**	100%	70%, after deductible
Biotech/Specialty Injectables	$75 Copayment	70%, after deductible
CHEMO/RADIATION/DIALYSIS	100%	70%, after deductible

* Out-of-Network providers may bill you the difference between the plan allowance, which is the amount paid by the plan, and the provider's actual charge. This amount may be significant.

** Office visit subject to copayment.

*** Copayment waived if readmitted within 10 days of discharge for any condition.

**** Copayment not applicable when service performed in Emergency Room or office setting.

1 Inpatient hospital day limit combined for all self-referred inpatient medical, maternity, mental health, serious mental illness, substance abuse and detoxification services.

To receive maximum benefits, services must be provided or referred by your Keystone Primary Care Physician. This is a highlight of benefits available. The benefits and exclusions for Referred Care and Self-Referred Care are not the same. All benefits are provided in accordance with the HMO group contract and self-referred benefit booklet/certificate.

The benefits may be changed by IBC to comply with applicable federal/state laws and regulations

Benefit	Referred	Self-Referred*
OUTPATIENT PRIVATE DUTY NURSING 360 hours per year	85%	70%, after deductible
SKILLED NURSING FACILITY	$75/day; maximum of 5 Copayments/ admission*** 120 days per year	70%, after deductible 60 days per year
HOSPICE AND HOME HEALTH CARE	100%	70%, after deductible
DURABLE MEDICAL EQUIPMENT	50%	50%, after deductible
PROSTHETICS	50%	50%, after deductible
MENTAL HEALTH CARE		
Outpatient	$40 Copayment	70%, after deductible
Inpatient	$150/day; maximum of 5 Copayments/ admission***	70%, after deductible[1]
SERIOUS MENTAL ILLNESS CARE		
Outpatient	$40 Copayment	70%, after deductible
Inpatient	$150/day; maximum of 5 Copayments/ admission***	70%, after deductible[1]
SUBSTANCE ABUSE TREATMENT		
Outpatient/Partial Facility Visits	$40 Copayment	70%, after deductible
Inpatient Rehabilitation	$150/day; maximum of 5 Copayments/ admission***	70%, after deductible[1]
Detoxification	$150/day; maximum of 5 Copayments/ admission***	70%, after deductible[1]

* Out-of-Network providers may bill you the difference between the plan allowance, which is the amount paid by the plan, and the provider's actual charge. This amount may be significant.

*** Copayment waived if readmitted within 10 days of discharge for any condition.

1 Inpatient hospital day limit combined for all self-referred inpatient medical, maternity, mental health, serious mental illness, substance abuse and detoxification services.

To receive maximum benefits, services must be provided or referred by your Keystone Primary Care Physician. This is a highlight of benefits available. The benefits and exclusions for Referred Care and Self-Referred Care are not the same. All benefits are provided in accordance with the HMO group contract and self-referred benefit booklet/certificate.

The benefits may be changed by IBC to comply with applicable federal/state laws and regulations

What Is Not Covered?

- Services not medically necessary
- Service or supplies that are experimental or investigative, except routine costs associated with qualifying clinical trials and when approved by Keystone Health Plan East
- Hearing aids, hearing examinations/tests for the prescription/fitting of hearing aids, and cochlear electromagnetic hearing devices
- Assisted fertilization techniques, such as in-vitro fertilization, GIFT, and ZIFT
- Reversal of voluntary sterilization
- Expenses related to organ donation for non-member recipients
- Acupuncture
- Dental care, including dental implants and nonsurgical treatment of temporomandibular joint syndrome (TMJ)
- Music therapy, equestrian therapy, and hippotherapy
- Treatment of sexual dysfunction not related to organic disease, except for sexual dysfunction resulting from an injury
- Routine foot care, unless medically necessary or associated with the treatment of diabetes
- Foot orthotics, except for orthotics and podiatric appliances required for the prevention of complications associated with diabetes
- Cranial prostheses, including wigs intended to replace hair
- Routine physical exams for non-preventive purposes such as insurance or employment applications, college, or premarital examinations
- Contraceptives
- Immunizations for travel or employment
- Services or supplies payable under Workers' Compensation, Motor Vehicle Insurance, or other legislation of similar purpose
- Cosmetic services/supplies
- Self-injectable drugs
- Alternative therapies/complementary medicine
- Abortions, voluntary sterilizations and reversal of voluntary sterilizations

This summary represents only a partial listing of benefits and exclusions of the Keystone Point-of-Service program described in this summary. If your employer purchases another program, the benefits and exclusions may differ. Also, benefits and exclusions may be further defined by medical policy. This managed care plan may not cover all of your health care expenses. Read your HMO group contract/member handbook and self-referred group health benefits booklet/certificate carefully to determine which health care services are covered. If you need more information, please call 215-241-2240 (if calling within Philadelphia) or 1-800-227-3115 (outside Philadelphia).

Services that require preapproval/precertification

INPATIENT SERVICES

- Surgical and nonsurgical inpatient admissions
- Acute Rehabilitation
- Skilled Nursing Facility
- Inpatient Hospice

OUTPATIENT FACILITY/OFFICE SERVICES
(other than inpatient)

- MRI/MRA
- CT/CTA Scan
- PET Scan
- Nuclear Cardiac Studies
- Hyperbaric Oxygen
- Hysterectomy
- Cataract Surgery
- Cochlear implant surgery
- Nasal Surgery for Submucous Resection and Septoplasty
- Transplants (except cornea)
- Pain management procedures (including epidural injections, transforaminal epidural injections, paravertebral facet joint injections)
- Obesity Surgery
- Day Rehabilitation Programs
- Dental services as a result of accidental injury
- Uvulopalatopharyngoplasty
(including laser-assisted)

ALL HOME CARE SERVICES
(including infusion therapy in the home)

INFUSION THEARAPY DRUGS
Administered in an Outpatient Facility or in a Professional Provider's Office
(see list included in your open enrollment packet)

MATERNITY ADMISSION AND BIRTHING CENTER (prenotification requested only)

ELECTIVE (non-emergency) AMBULANCE TRANSPORT

OUTPATIENT PRIVATE DUTY NURSING

PROSTHETICS AND ORTHOTICS
Purchase items over $500, including repairs and replacements (except ostomy supplies)

DURABLE MEDICAL EQUIPMENT
Purchase items $500, inluding repairs and replacements, and ALL rentals (except oxygen, diabetic supplies and unit dose medication for nebulizer)

RECONSTRUCTIVE PROCEDURES AND POTENTIALLY COSMETIC PROCEDURES

- Blepharoplasty/ptsosis repair
- Breast: reconstruction, reduction, augmentation, mammoplasty, mastopexy, insertion and removal of breast implants
- Canthopexy/canthoplasty
- Cervicoplasty
- Chemical Peels
- Dermabrasion
- Excision of excessive skin and/or subcutaneous tissue
- Genetically and bio-engineered skin substitutes for wound care
- Hair transplant
- Injectable dermal fillers
- Keloid Removal
- Labiaplasty
- Lipectomy, liposuction, or any other excess fat removal procedure
- Orthognathic surgery procedures, including but not limited to, bone graft, genioplasty, osteoplasty, mentoplasty, osteotomies
- Otoplasty
- Rhinoplasty
- Rhytidectomy
- Scar Revision
- Skin closures, including skin grafts, skin flaps, tissue grafts
- Sex reassignment surgery
- Surgical treatment of gynecomastia
- Surgery for varicose veins, including perforators and sclerotherapy

MENTAL HEALTH/SERIOUS MENTAL ILLNESS/SUBSTANCE ABUSE

- Mental health and serious mental illness treatment
(Inpatient/partial hospitalization programs/intensive outpatient programs)
- Substance Abuse Treatment
(Inpatient/Outpatient/Partial Hospitalization)

BIOTECHNOLOGY/SPECIALTY INJECTABLE DRUGS (see list included in your open enrollment packet)

SERVICES BY A NON-PARTICIPATING PHYSICIAN/PROVIDER FOR NON-EMERGENCY SERVICES (REFERRED CARE)

Preapproval/precertification is not a determination of eligibility or a guarantee of payment. Coverage and payment are contingent upon, among other things, the patient being eligible, i.e., actively enrolled in the health benefits plan when the preapproval/precertification is issued and when approved services occur. Coverage and payment are also subject to limitations, exclusions, and other specific terms of the health benefits plan that apply to the coverage request. Preapproval/precertification list subject to change annually.

In addition to the preapproval/precertification requirements listed above, you should contact KHPE and provide prenotification for certain categories of treatment so you will know prior to receiving treatment whether it is a covered service. This applies to network providers and members who elect to receive treatment provided by out-of-network providers (for members using self-referred care). The categories of treatment (in any setting) include:

- **Any surgical procedure that may be considered potentially cosmetic; and**
- **Any procedure, treatment, drug, or device that represents 'new or emerging technology;' and**
- **Services that might be considered experimental/investigative.**

Your provider should be able to assist you in determining whether a proposed treatment falls into one of these three categories. You are encouraged to have your provider place the call for you.

PENALTIES:

POS Referred Care: It is the network provider's responsibility to obtain preapproval for the services listed. Members are held harmless from financial penalties if the network provider does not obtain preapproval.

POS Self-Referred Care: It is the member's responsibility to initiate precertification for the services listed. The member will be subject to a 20% reduction in benefits if precertification is not obtained for the inpatient/outpatient treatment services listed above.

Select Drug Program

$15/$35/$60

Keystone HEALTH PLAN EAST

Arch/Parishes & Agencies

The Select Drug Program is a comprehensive benefit that provides coverage for prescription drugs[1] when prescribed by a licensed, practicing physician. The Select Drug Program® is based on an incentive formulary that includes all generic drugs and a defined list of brand drugs that have been evaluated for their medical effectiveness, positive results, and value. Generic drugs are just as effective as brand drugs and result in the lowest cost sharing for you. Ask your physician whether generic drugs are right for you.

Benefit	Coverage
Retail Pharmacy - Member Cost Sharing (Participating Pharmacy)	
Generic Formulary	$15 Copayment
Brand Formulary	$35 Copayment
Non-Formulary Brand	$60 Copayment
Mail Order Pharmacy - Member Cost Sharing (Participating Pharmacy) Available for maintenance drugs	
Generic Formulary	$15 Copayment (1-30 days supply); $37.50 Copayment (31-90 days supply)
Brand Formulary	$35 Copayment (1-30 days supply); $87.50 Copayment (31-90 days supply)
Non-Formulary Brand	$60 Copayment (1-30 days supply); $150 Copayment (31-90 days supply)
Out-of-Network Reimbursement	30% of drugs retail cost for the total amount dispensed. For an emergency, you will only be responsible for the applicable copayments listed above. Member must submit for reimbursement.
Network	FutureScripts® network* includes more than 60,000 retail pharmacies. You can locate a participating pharmacy near you on **www.ibx.com** by selecting the *Find a Participating Pharmacy* feature.
Dispensing Limits	
Retail	Up to 30 days supply
Mail order for maintenance drugs	Up to 90 days supply

* FutureScripts is an independent company providing pharmacy benefit management services.

Independence

www.ibx.com

03/14 - PA - HMO-POS Custom Select RX Rider $15/$35/$60 w/o Contraceptives
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Benefit	Coverage
Formulary	IBC Select Drug Program Formulary. To check the formulary status of a drug or to view a copy of the most recent formulary, log onto **www.ibx.com**.
Covered Prescription Drugs[1]	Self-injectable drugs Compound medications of which at least one ingredient is a prescription drug Prescribed Smoking Cessation Drugs Retin-A through age 35 Insulin Insulin needles and syringes Lancets (no copayment required at participating pharmacies) Glucometers (no copayment required at participating pharmacies) Diabetic supplies (i.e test strips)

1 This summary is intended to highlight the benefits available to you. For a complete program description, including all benefits, limitations, and exclusions, refer to your benefit booklet or group contract.

What is Not Covered?

- Injectable fertility drugs
- Non Federal Legend Drugs
- Weight control drugs
- Contraceptives (e.g. Orals, Devices, Injections, IUD's)
- Devices or supplies except those specifically listed under covered drugs
- Drugs used for cosmetic purposes (e.g., anabolic steroids and minoxidil lotion, Retin-A for aging skin)
- Drugs labeled 'Caution-limited by Federal Law to investigational use', even though a charge is made to an individual
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order
- Experimental drugs
- Immunization agents, biologicals, allergy serums, blood, or blood plasma
- Drugs and supplies that can be purchased over the counter except those covered per mandate (with a doctor's prescription)

Vision Program

Biennial Benefit

Keystone HEALTH PLAN EAST

Arch/Parishes & Agencies

The Keystone Health Plan East $35 HMO/POS Vision Rider program, administered by Davis Vision, offers members corrective eyewear, including eyeglasses or contact lenses. The vision rider program is easy to use. Benefits are maximized by using Davis Vision providers that are conveniently located throughout the area. Paid-in-full benefits for eyeglasses with standard lenses are possible when you choose from a select grouping known as the Davis Collection of Frames.

Benefit	Coverage
Eyeglasses, including spectacle lenses and frames, at participating providers	
Spectacle lenses	Spectacle lenses covered at no extra cost include: all range of prescriptions, oversize lenses, glass or plastic lenses, single vision, bifocal, trifocal or lenticular lenses
Additional lens options	Additional spectacle lens options covered at no cost include: polycarbonate lenses for dependent children, monocular patients, and patients with prescriptions greater than or equal to +/- 6.00 diopters
Frames **Two options** are available for selecting frames:	Choose from participating provider's own frame collection and member receives allowance of $10[1] OR Choose from the Davis Collection of Frames that is available at most participating providers and member pays: Fashion selection: $0 Designer selection: $16 Premier selection: $35
Eyeglasses, including spectacle lenses and frames, at non-participating providers	Eyeglasses (spectacle lenses and frames) are available up to a $35 reimbursement to member[2]
Contact lenses (in lieu of eyeglasses) including standard, specialty and disposable lenses and evaluation and fitting	
Participating providers	Member receives allowance up to $35[1]
Non-participating providers	Up to $35 reimbursement to member[2]
Benefit frequency	Once every two calendar years
Network	Davis Vision Network To locate a participating provider, go to www.ibx.com and click on the 'Find a Doctor' feature.

1 Member is responsible for balance

2 In lieu of participating provider benefit, member is responsible for balance

This summary is intended to highlight the benefits available to you. For a complete description, including benefits and exclusions, refer to your benefit booklet.

Administered by:

DAVISVISION
SEE LIFE

www.ibx.com

Value-added Services*

Spectacle lens options available at most participating providers, MEMBER PAYS fixed discounted prices:

Spectacle Lens Option	Fixed Discounted Price
Glass Grey #3 prescription sunglass lenses	$11
Tinting	$11
Blended invisible bifocals	$10
Ultraviolet (UV) coating	$12
Scratch-resistant coating - single vision	$15
Scratch-resistant coating - multifocal	$25
Intermediate vision lenses	$30
Anti-reflective coating - standard	$33
Anti-reflective coating - premium	$48
Anti-reflective coating - ultra	$60
Progressive additional multifocal lenses - standard	$50
Progressive additional multifocal lenses - premium	$90
Polarized lenses	$60
Polycarbonate[3]	$30
High index	$55
Photochromic glass - single vision	$15
Photochromic glass - multifocal	$25
Photochromic plastic - single vision	$60
Photochromic plastic - multifocal	$70

Warranty - Unconditional one-year breakage warranty to repair or replace frames or lenses purchased at a participating provider for a period of one year. This warranty applies to all spectacle lenses, Davis Vision Collection of Frames and regional/national retailer frames, when the Collection is not available.

Replacement Contact Lenses - Through Lens 123, a free mail order program, member may receive replacement contact lenses offered at guaranteed, discounted prices.

Laser Vision Correction Services - Discount on Laser Vision Correction Services at Davis Vision Participating Laser Vision Correction Providers: Up to 25% off the participating provider's usual and customary fees or 5% off any participating provider's advertised specials, whichever is less.

Additional Eyewear Discount - Members selecting non-covered materials (i.e., second pair of eyeglasses, sunglasses, etc.) will receive up to a 20% courtesy discount and up to a 10% discount on disposable contacts at most participating providers.

* Not available at non-participating providers

3 Polycarbonate lenses for dependent children, monocular patients, and patients with prescriptions greater than or equal to +/- 6.00 diopters are covered at no cost.

Frequently Asked Questions

Below find answers to some frequently asked questions about how your IBC Vision benefit program works.

Who are the participating providers in the IBC Vision network?

Our administrator, Davis Vision, contracts with a national network of providers including ophthalmologists, optometrists and opticians. They are primarily licensed providers in private practice and in some retail locations, such as Wal-Mart Vision Center and For Eyes. Please go to www.ibx.com to locate a participating 'Vision Provider' through the 'Find a Doctor' feature, or once enrolled, call the number on your Identification card.

If a retail location such as Wal-Mart Vision Center is in the network, does that mean the doctor located in that store is in the network?

No. When going to a retail location such as Wal-Mart Vision Center for eyewear purchases, you should always confirm the participation status of the on-site doctor who provides the eye exam, since each provider contracts separately with Davis Vision. Please note: Coverage for routine eye exam, if available, would be included under your medical benefit.

What are the advantages of using a participating provider?

- Quality service standards: all participating providers have been extensively reviewed and credentialed to NCQA standards to ensure that stringent standards for quality service are maintained.
- Paid-in-full benefit available: in addition to their own selection of frames, most participating providers have available the Davis Collection of Frames. This allows you to utilize the paid-in-full benefit available through your IBC Vision Program when frames are selected from the Collection with standard lenses - single, bifocal, trifocal or lenticular.
- Spectacle lens options discount: additional services such as anti-reflective coating and Transitions® lenses (photochromic) are available at a discounted price.
- Eyewear quality and value: most eyewear (lenses, coatings, and frames) is fabricated on site at one of Davis Vision's Regional Fabrication Centers. This allows Davis to monitor quality assurance and costs associated with the fabrication process, thereby creating the most value for you, our member.
- Warranty: Unconditional one-year breakage warranty to repair or replace frames or lenses purchased at a participating provider for a period of one year. This warranty applies to all spectacle lenses, Davis Vision Collection of Frames and regional/national retailer frames, when the Collection is not available.

Will I need a claim form to receive services from a participating provider?

No, you will not need a claim form for in-network services. The process is simple. Here's what to do:

- Call the participating provider of your choice and schedule an appointment.
- Identify yourself as a member of IBC Vision, administered by Davis Vision.
- Provide the office with your ID number located on your Identification card and the name and date of birth of any covered dependent needing services.

It's that easy! The provider's office will verify your eligibility for services, and no claim forms are required!

Will I be able to choose any frame available at a participating provider?

Yes, you may apply the amount of your frame benefit toward any available frame that you choose. You can maximize your benefit by selecting frames from the Davis Collection of Frames, which offers you the ability to have a paid in full pair of frames. The Collection is available at most participating providers. The 'Find a Doctor' feature on www.ibx.com also indicates the participating doctors that have the Davis Collection of Frames available.

What types of frames are included in the Davis Collection of Frames?

The Davis Collection includes frames for men and women, adults and children. The collection includes many notable designer name frames that have passed rigorous inspections, such as Perry Ellis, Steve Madden, Alfred Sung, Converse, Bongo, Club Med, Catherine Deneuve, Scooby-Doo!, Garfield and Harley-Davidson. This frame collection is typically updated twice a year.

How soon will I receive my glasses after they are ordered?

Your provider will advise you when to return to his/her office to pick up your new prescription eyeglasses. Delivery of your new eyeglasses to your participating provider from the fabrication center is generally within two to five business days of the doctor's submission of your order. More delivery time may be needed when out-of-stock frames, ARC (anti-reflective coatings), specialized prescriptions or a participating provider's frame is selected.

What if my vision care provider does not participate in the network?

You may receive covered services from a non-participating provider, although you can receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network. If you choose a non-participating provider, you pay the provider directly for all charges and then submit a Direct Reimbursement Claim Form. Covered services will be paid directly to you based on your out-of-network benefits. You are responsible for any balances.

Where do I send the Direct Reimbursement Claim Form?

Mail your completed Direct Reimbursement Claim Form with receipts attached to:

Vision Care Processing Unit

P. O. Box 1525

Latham, NY 12110

To obtain a claim form, please visit www.ibx.com and click on 'Forms'. The IBC Vision Direct Reimbursement Claim Form is located on this Forms page under the Claims section.

How do I purchase replacement contact lenses through the Lens 123 Program?

Enrolled members who have utilized their covered benefit may call 1-800-LENS 123 (1-800-536-7123) to register and set up your Lens 123 account. The Customer Service Representative will explain to you how to order replacement contact lenses and receive them in the mail. Lens 123 is an easy and convenient way to order replacement contact lenses. For additional information, go to www.lens123.com.