Indiana Dental Association Insurance Trust

2021 Blue View Vision Benefit Summary

Benefits	Low Plan		High Plan		Frequency
	Network / Non-Network		*Network / Non-Network*		
Routine Eye Exam: Comprehensive Eye Exam	$10 Copay	Up to $42	$10 Copay	Up to $42	Once every calendar year
Eyeglass Frames:	$130 allowance, then 20% off any balance	Up to $45	$150 allowance, then 20% off any balance	Up to $45	Low Plan: Once every 2 years High Plan: Once every year
Eyeglass Lenses:	$25 Copay	(Allowance amount)	$10 Copay	(Allowance amount)	Once every calendar year
Single Vision Lenses:		Up to $40		Up to $40	
Bifocal Lenses:		Up to $60		Up to $60	
Trifocal Lenses:		Up to $80		Up to $80	
Eyeglass Lens Enhancements:					
***Transition Lenses**	$0 copay	No allowance when obtained out-of-network	$0 copay	No allowance when obtained out-of-network	Same as covered eyeglass lenses
***Standard polycarbonate**					
***Factory scratch coating:**					
Contact Lenses:					
***Elective conventional (non-disposable): OR**	$130 allowance, then 15% off any balance	Up to $105 allowance	$150 allowance, then 15% off any balance	Up to $105 allowance	Once every calendar year
***Elective disposable: OR**	$130 (no addtl. Discount)	Up to $105 allowance	$150 (no addtl. Discount)	Up to $105 allowance	
***Non-Elective (medically necessary)**	Covered in full	Up to $210 allowance	Covered in full	Up to $210 allowance	

The benefit descriptions outlined in this presentation are intended to be a brief outline of coverage and are not intended to be a legal contract. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

10/6/2020

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