Receiving Out-of-Network Benefits

While we highly recommend visiting our in-network providers for your vision care needs, we realize that circumstances may require visiting a doctor who is not part of our network. For those times, please use the following instructions to receive your Optilegra benefits.

Note that the Optilegra **20% Discount** and Optilegra **LASIK Discount** plans do not have an out-of-network benefit.

Directions for Out-of-Network Claims

After visiting your eyecare clinic, you must pay them in full for the services and materials. Then simply fill out the following claim form and submit it, along with a copy of your receipt, to one of the following:

Optilegra
PO Box 91437
Sioux Falls, SD 57109

- or -

admin@optilegra.com

Once we've received your claim, reimbursement will be sent to you within 45 days. This reimbursement will be issued directly from Optilegra. Please note that claims that are not submitted within 45 days of the date of service may be denied.

Optilegra will pay for the services and materials reported up to the annual out-of-network allowance for the member reporting the services. Costs beyond this allowance are the responsibility of the member. Benefits renew one (or two) years from the time they are used. **Out-of-Network benefits are not available for members with a 20% Discount or LASIK Discount plan.**

Note that your materials benefit can be used toward either glasses or contacts, but not both.

Comparison of In-Network and Out-of-Network Benefits

In-Network Benefits	
Eye Exam (after copay)	100%
Contact Lenses (elective)	$105–$200
Contact Lenses (medically necessary*)	$250
Single Vision Lenses (after copay)	100%
Bifocal Lenses (after copay)	100%
Trifocal Lenses (after copay)	100%
Lenticular Lenses (after copay)	100%
Progressive Lenses (Gold/Silver plans)	You pay copay, plus difference between progressive retail and bifocal
Progressive Lenses (Platinum plan)	$180 minus copay
Frame (any brand or style)	$100–$200

Out-of-Network Benefits	
Eye Exam	$40
Contact Lenses (elective)	$80
Contact Lenses (medically necessary*)	$80
Single Vision Lenses	$30
Bifocal Lenses	$45
Trifocal Lenses	$55
Lenticular Lenses	$75
Progressive Lenses (Gold/Silver plans)	$60
Progressive Lenses (Platinum plan)	$144
Frame (any brand or style)	$35

*requires a doctor's diagnosis of keratoconus, aphakia, or anisometropia

Optilegra™

Claim Form for Out-of-Network Services and Materials

PRIMARY MEMBER (EMPLOYEE) INFORMATION			
FIRST NAME	MIDDLE	LAST	
ADDRESS			
CITY		STATE	ZIP
DATE OF BIRTH		DAYTIME PHONE	

PATIENT INFORMATION			
FIRST NAME	MIDDLE	LAST	
DATE OF BIRTH		RELATIONSHIP TO PRIMARY ◯ Self ◯ Spouse ◯ Child ◯ Other	

PROVIDER (DOCTOR) INFORMATION			
PROVIDER NAME		PHONE	
ADDRESS			
CITY		STATE	ZIP

SUMMARY OF CHARGES			
DATE OF SERVICE	**AMOUNT CHARGED (remember to include itemized receipts)**		
EXAM $	FRAME $	LENSES $	CONTACTS $
TYPE OF LENS (please select lens type purchased—does not apply to contact lenses) ☐ Single Vision ☐ Bifocal ☐ Trifocal ☐ Lenticular ☐ Progressive (no-line bi/trifocals)			

Patient or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process this claim. By signing below, I acknowledge that the above information is accurate to the best of my knowledge.

Signed _____ Date _____

Please send this completed claim form and copies of all receipts to one of the following:

Optilegra
PO Box 91437
Sioux Falls, SD 57109

- or -

admin@optilegra.com