

SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST AT PLUS PROVIDERS	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES			
Exam	\$0 copay	\$15 copay	Up to \$40
Retinal imaging	Up to \$39	Up to \$39	Not covered
CONTACTS 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
STANDARD PLASTIC LENSES			
Single Vision	\$25 copay	\$25 copay	Up to \$30
Bifocal	\$25 copay	\$25 copay	Up to \$50
Trifocal/Lenticular	\$25 copay	\$25 copay	Up to \$70
Progressive - Standard	\$25 copay	\$25 copay	Up to \$50
Progressive - Premium Tier 1 - 4	\$110 - 200 copay	\$110 - 200 copay	Up to \$50
LENS OPTIONS			
Anti Reflective Coating - Standard	\$45 copay	\$45 copay	Up to \$23
Anti Reflective Coating - Premium Tier 1 - 2	\$57 - 68	\$57 - 68	Up to \$23
Anti Reflective Coating - Premium Tier 3	\$100 copay	\$100 copay	Up to \$23
Photochromic - Non-Glass	\$75	\$75	Not covered
Polycarbonate - Standard	\$40	\$40	Not covered
Polycarbonate - Std < 19 years of age	\$0 copay	\$0 copay	Up to \$20
Scratch Coating/Tint/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 \$200 allowance	\$0 copay; 15% off balance over \$150 allowance	Up to \$75
Contacts - Disposable	\$0 copay; 100% of balance over \$200 allowance	\$0 copay; 100% of balance over \$150 allowance	Up to \$75
Contacts - Medically Necessary	\$0 copay; paid-in-full	\$0 copay; paid-in-full	Up to \$300
ADDITIONAL GLASSES ALLOWANCE			
Glasses Allowance	40% off retail*; 100% of balance over \$100	40% off retail*; 100% of balance over \$50	Up to \$40
OTHER			
Hearing Care from Amplifon Network	Discounts on hearing aids; call 1.877.203.0675	Discounts on 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

FREQUENCY

Exam
 Frame
 Lens
 Contact Lens
 Additional Glasses Allowance
 Plan allows member to receive frame and lens services or contacts.

ALLOWED FREQUENCY – ADULTS

once every plan year
 once every other plan year
 once every plan year
 once every plan year
 once every other plan year

ALLOWED FREQUENCY – KIDS

once every plan year
 once every other plan year
 once every plan year
 once every plan year
 once every other plan year

*Complete pair (frame & lens with or without lens options) purchase required to receive 40% discount. 20% discount applied if complete pair not purchased. Log into eyemed.com/member to see all plans included with your benefits. EyeMed reserves the right to make changes to the products available on each tier. All providers are not required to carry all brands on all tiers. For current listing of brands by tier, call 866-939-3633. 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; or lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. 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. Some provisions, benefits, exclusions or limitations listed herein may vary by state. 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 online provider locator to determine which participating providers have agreed to the discounted rate. Underwritten by Fidelity Security Life Insurance Company® of Kansas City, Missouri, except in New York. Fidelity Security Life Policy number VC-146, form number M-9184. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.