

## EYEMED VISION CARE BENEFIT

Service Type	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	
Frames	Once every 24 months from the date of service	Once every 24 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	Member Cost In-Network		Out-of-Network Member Reimbursement
<b>Exam Services</b>			
Exam with Dilation as Necessary	\$10 Copay		Up to \$35
Retinal Imaging	Up to \$39		
<b>Contact Lens Fit and Follow-Up</b>			
Fit and Follow-up Standard	Up to \$55		
Fit and Follow-up Prem	10% off Retail Price		
<b>Frames</b>			
Frame	\$0 Copay; 20% off balance over \$130 Allowance		Up to \$65
<b>Lenses</b>			
Single Vision	\$25 Copay		Up to \$25
Bifocal	\$25 Copay		Up to \$40
Trifocal	\$25 Copay		Up to \$60
Lenticular	\$25 Copay		
Progressive Standard	\$90 Copay		Up to \$40
Progressive Prem	\$90 Copay; 20% off Retail Price less \$120 Allowance		Up to \$40
<b>Lens Options</b>			
Anti Reflective Coating Standard	\$45		
Anti Reflective Coating Prem	20% off Retail Price		
Polycarbonate Standard age 19+	\$40		
Polycarbonate Standard under age 19	\$0 Copay		Up to \$5
Scratch Coating Standard Plastic	\$15		
Tint Solid or Gradient	\$15		
UV Treatment	\$15		
All Other Lens Options	20% off Retail Price		
<b>Contact Lenses</b>			
Contacts Conventional	\$0 Copay; 15% off balance over \$130 Allowance		Up to \$104
Contacts Disposable	\$0 Copay; 100% of balance over \$130 Allowance		Up to \$104
Contacts Medically Necessary	\$0 Copay		Up to \$200
<b>Other</b>			
Hearing Care from Amplifon network	Discounts on hearing exam and aids; call 1-844-526-5432		
Lasik or PRK From U.S. Laser Network	15% off retail or 5% off promo price; call 1-800-988-4221		

No benefits will be paid for services or materials connected with or charges arising from: orthoptic or vision training, subnormal vision aids and any associated supplemental testing, Aniseikonic lenses, medical and/or surgical treatment of the eye, eyes or supporting structures; 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; any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear, plano (non-prescription) lenses; non-prescription sunglasses; two pair of glasses in lieu of bifocals; services or materials provided by any other group benefit plan providing vision care; 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 will not be replaced except in the next Benefit Frequency when Vision Materials would next become available. 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 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 the member out-of-pocket costs. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Service and amounts listed above are subject to change at any time. Fees charged by a Provider for services other than a covered benefit must be paid in full by the Insured Person to the Provider. Such fees or materials are not covered under the Policy. Benefit allowances provide no remaining balance for future use within the same Benefit Frequency.