Explanation of your vision care benefits

Vision care services	Member cost in-network*	Out-of-network reimbursement*
Exam with dilation as necessary	$0 copay	Up to $30
Exam options†		
Standard contact lens fit and follow up	Up to $55	N/A
Premium contact lens fit and follow up	10% off retail price	N/A
Frames	$20 copay; $120 allowance, 20% off balance over $120	Up to $60
Any available frame at provider location		
Standard plastic lenses		
Single vision	$20 copay	Up to $25
Bifocal	$20 copay	Up to $40
Trifocal	$20 copay	Up to $55
Lenticular	$20 copay	Up to $55
Standard progressive lens	$85 copay	Up to $40
Premium progressive lens$^{\Delta}$	Tier 1 $105	Up to $40
	Tier 2 $115	Up to $40
	Tier 3 $130	Up to $40
	Tier 4 $85 copay; 80% of charge less $120 allowance	Up to $40
Lens options		
UV treatment	$15	N/A
Tint (solid and gradient)	$15	N/A
Standard plastic scratch coating	$15	N/A
Standard polycarbonate – adults	$40	N/A
Standard polycarbonate – kids under 19	$40	N/A
Standard anti-reflective coating	$45	N/A
Polarized	20% off retail price	N/A
Photochromic/transitions plastic	$75	N/A
Premium anti-reflective	Tier 1 $57	N/A
	Tier 2 $68	N/A
Other add ons	20% off retail price	N/A

IU HEALTH Health Plans

POWERED BY EyeMed

EyeMed is an independent vision care program and network of providers utilized by IU Health Plans Medicare Advantage HMO and HMO POS. Indiana University Health Plans is a Medicare Advantage organization with a Medicare contract. Enrollment in Indiana University Health Plans depends on contract renewal. Other pharmacies/physicians/providers are available in our network. Product types include HMO and HMO POS. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or co-payments/co-insurance may change on Jan. 1 of each year. ATTENTION: Our Customer Solutions Center has free language interpreter services available for non-English speakers. Call 800.455.9776 (TTY: 800.743.3333). ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800.455.9776 (TTY: 800.743.3333). 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800.455.9776 (TTY: 800.743.3333). IU Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. IU Health Plans cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. IU Health Plans 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人.

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Explanation of your vision care benefits (continued)

Vision care services	Member cost in-network*	Out-of-network reimbursement*
Contact lenses^ *(Contact lens allowance includes materials only)*		
Conventional	$0 copay; $120 allowance, 15% off balance over $120	Up to $96
Disposable	$0 copay; $120 allowance, plus balance over $120	Up to $96
Medically necessary	$0 copay, paid-in-full	Up to $200
Laser vision correction Lasik or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	N/A
Additional pairs benefit	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A
Frequency		
Examination	Once every calendar year	
Lenses or contact lenses	Once every two calendar years	
Frame	Once every two calendar years	

For a complete list of providers near you, use our Provider Locator on **eyemed.com** or call **844.408.6295**. For Lasik providers, call **877.5LASER6**.

Benefits are not provided from services or materials arising from: Orthopic 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; Any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear; 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; Plano (non-prescription) lenses and/or contact 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. 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. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/ Premium Progressive lens not covered—fund as a Bifocal lens. Standard Progressive lens covered—fund Premium Progressive as a Standard. Benefit allowance provides no remaining balance for future use within the same benefits year. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer. *For the period 1.1.2019 – 12.31.2019. †Standard contact lens exam is funded for members 18 years and younger. Premium fit is covered at 0% off retail less $0 allowance. ^A 12-month supply is defined as the supply required to last 12 months with the patient following the manufacturer's approved wear schedule. ΔPremium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Not available in all states. Some provisions, benefits, exclusions or limitations listed herein may vary.