

# Routine Vision Plan

Vision Care Services <sup>1</sup>	Member In-Network Coverage	Member Out-of-Network Reimbursement*
<b>EXAM WITH DILATION AS NECESSARY</b>	100% of EyeMed approved amount, \$5 Copay	Reimbursement up to \$34, \$5 Copay, Member pays difference
<b>FRAMES</b>	\$150 Allowance, Member pays difference <sup>2</sup>	Reimbursement up to \$38.25, \$7.50 Copay <sup>1</sup> , Member pays difference <sup>2</sup>
<b>STANDARD PLASTIC OR GLASS LENSES</b>		
Single vision	100% of EyeMed approved amount, \$7.50 Copay	Reimbursement up to \$17, \$7.50 Copay, Member pays difference
Bifocal	100% of EyeMed approved amount, \$7.50 Copay	Reimbursement up to \$30, \$7.50 Copay, Member pays difference
Trifocal	100% of EyeMed approved amount, \$7.50 Copay	Reimbursement up to \$43, \$7.50 Copay, Member pays difference
Lenticular	100% of EyeMed approved amount, \$7.50 Copay	Not covered
Standard Progressive Lens	100% of EyeMed approved amount, \$7.50 Copay	Reimbursement up to \$30, \$7.50 Copay, Member pays difference

<sup>1</sup>State Police Troopers and Sergeants who retired on or after 10/1/87 have In-network coverage of polycarbonate lenses, \$0 copay on frames In and Out-of-Network, \$150 allowance for contact lenses In-Network and \$115 reimbursement for Out-of-Network (conventional or disposable), and are able to receive glasses in lieu of contact lenses or contact lenses in lieu of glasses once every 12 months without the need of a prescription change. This population is also eligible for up to a \$1,000 reimbursement for Lasik surgery (this is a lifetime maximum benefit and applies only to this retiree population and their spouses each; dependent children are not covered). The Lasik reimbursement benefit is limited to a single laser surgical encounter per eye. Follow-up care for enhancements or secondary procedures are excluded from coverage for this retiree population.

<sup>2</sup>One \$7.50 Copay per complete pair of glasses (lenses and frame).

\*Member Reimbursement Out-of-Network will be the lesser of the listed amount or the member's actual cost from the out-of-network provider. 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 EyeMed's online provider locator to determine which participating providers have agreed to the discounted rate.

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<b>LENS OPTIONS</b>		
Tint (Solid and Gradient)	100% of EyeMed approved amount, \$0 Copay	Not covered
Photochromic/Transitions	100% of EyeMed approved amount, \$0 Copay	Not covered
<b>CONTACT LENSES</b>		
<i>Includes fit, follow-up and materials</i>		
Conventional	\$0 Copay; \$130 Allowance <sup>1</sup> , Member pays difference	Reimbursement up to \$100 <sup>1</sup> , \$0 Copay, Member pays difference
Disposable	\$0 Copay; \$130 Allowance, Member pays difference	Reimbursement up to \$100, \$0 Copay, Member pays difference
Medically Necessary	\$7.50 Copay, 100% of EyeMed approved amount	Reimbursement up to \$210, \$7.50 Copay, Member pays difference

Vision Care Services	Frequency (In-Network and Out-of Network)
Examination	Once every 12 months
Glasses [Frame and Lens; in lieu of contact lenses] <sup>1</sup>	Once every 24 months; Once every 12 months if prescription changes <sup>1</sup>
Contact Lenses [in lieu of Glasses] <sup>1</sup>	Once every 24 months; Once every 12 months if prescription changes <sup>1</sup>

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# EyeMed: Value added savings

Vision Care Services	Member In-Network Coverage	Member Out-of-Network Reimbursement*
<b>RETINAL IMAGING BENEFIT</b>		
	Up to \$39	N/A
<b>FRAME</b>		
Any available frame at provider location	20% off balance over \$150	N/A
<b>STANDARD PLASTIC OR GLASS LENS</b>		
Premium Progressive Lens—Tiers 1–3	\$27.50–\$52.50 Copay	Reimbursement up to \$30, \$7.50 Copay, Member pays difference
Premium Progressive Lens—Tier 4	\$7.50 Copay, 80% of charge less \$120 Allowance	Reimbursement up to \$30, \$7.50 Copay, Member pays difference
<b>LENS OPTIONS</b>		
UV Treatment	\$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
Premium Anti-Reflective—Tier 1–2	\$57–\$68	N/A
Premium Anti-Reflective—Tier 3	20% off Retail Price	N/A
Other Add-Ons	20% off Retail Price	N/A
<b>CONTACT LENSES</b>		
Conventional	15% off balance over \$150	N/A
<b>LASER VISION CORRECTION</b>		
Lasik or PRK from U.S. Laser Network	15% off Retail Price or 5% off promotional price	N/A



Members also receive a 40% discount off additional complete pair eyeglass purchases and 20% off non-covered items, including non-prescription sunglasses

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# Disclaimers

**Additional Discounts:** Subject to exclusions, discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision. Benefit Allowances provide no remaining balance for future use within the same Benefit Frequency. Certain brand name Vision Materials in which the manufacturer imposes a no-discount practice are not eligible for discount.

**Plan Exclusions:** 1. Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2. Medical and/or surgical treatment of the eye, eyes or supporting structures; 3. 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; 4. Plano (non-prescription) lenses and/or contact lenses; 5. Non-prescription sunglasses; 6. Two pair of glasses in lieu of bifocals; 7. Services rendered after the date a member ceases to be covered under the Plan, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the member are within 31 days from the date of such order; 8. Services or materials provided by any other group benefit plan providing vision care; 9. 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.