

EyeMed Vision Care Plan

You and your dependents are eligible to participate in the EyeMed Vision Care Plan

The EyeMed network consists of private practice optometrists, ophthalmologists, and opticians who deliver high quality patient care. In addition to these eye care professionals, EyeMed also offers services through the country's leading optical retailers such as LensCrafters and most Sears Optical, Target Optical and most Pearle Vision locations.

VISION CARE SERVICES	MEMBER COST	OUT-OF-NETWORK REIMBURSEMENT
Exam with Dilation as Necessary	\$20 Co-Pay	Up to \$40
Exam Options		
Standard Contact Lens Fit & Follow-Up*	Up to \$55	N/A
Premium Contact Lens Fit & Follow-Up**	10% off retail price	N/A
Frames:	\$100 Allowance; 20% off Balance over \$100	Up to \$50
Standard Plastic Lenses:		
Single Vision	\$20 Co-Pay	Up to \$25
Bifocal	\$20 Co-Pay	Up to \$40
Trifocal	\$20 Co-Pay	Up to \$65
Standard Progressive (add-on to bifocal)	\$20 Co-Pay	Up to \$55
Lens Options (paid by the member and added to the base price of the lens):		
Tint (Solid & Gradient)	\$15 fee	N/A
UV Coating	\$15 fee	N/A
Standard Scratch-Resistance	\$15 fee	N/A
Standard Polycarbonate	\$40 fee	N/A
Standard Anti-Reflective	\$45 fee	N/A
Other Add-ons and Services	20% off retail price	N/A
Contact Lenses: (covers materials only; in lieu of standard plastic lenses):		
Conventional	\$115 allowance; 15% off balance over \$115	Up to \$92
Disposables	\$115 allowance; plus balance over \$115	Up to \$92
Medically Necessary	Paid in Full	Up to \$200
**LASIK and PRK Vision Correction	15% off retail price OR 5% off promotional pricing	
Frequency:		
Examination	Once every 12 months	
Frames	Once every 12 months	
Lenses <u>or</u> Contact Lenses	Once every 12 months	

Additional Purchases and Out-of-Pocket Discount

Member will receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses after initial benefit is exhausted. 20% discounts on items not covered by the plan at network Providers (does not apply to professional services or contact lenses)

MONTHLY FEE

Employee Only	\$9.00
Employee & One (Spouse or Child)	\$16.50
Employee & Family	\$24.50

SEE MORE INFORMATION ON REVERSE SIDE

**LASIK AND PRK **LASIK and PRK correction procedures are provided by the U.S. Laser Network, owned by LCA-Vision. Members must first call 1-877-5LASER6 for the nearest facility and to receive authorization for the discount. Discounts do not apply for benefits provided by other group plan. Allowances are one-time use of benefits; no remaining balance.

The Benefit Alliance Plan

 Leslie & Associates, Inc.

Network Providers

The EyeMed Vision Care network is national, with over 40,000 providers including private practice optometrists, ophthalmologists, opticians and LensCrafters, most Pearle Vision Centers, most Sears Optical and Target Optical locations throughout the country. You may call toll-free 1-866-723-0513 or visit www.eyemedvisioncare.com for the nearest EyeMed Provider.

Claim Forms

With EyeMed Vision Care, you do not need to obtain a claim form, so receiving your benefit is as easy as visiting the nearest participating eye care provider.

Referrals

Your vision care benefit can be accessed directly, without obtaining a referral from your primary care physician. If the optical provider detects a condition that requires further examination by your primary care physician, the provider will recommend that you see your primary care physician.

Exam Options - Contact Lens Fit and Follow-Up

Your plan gives every participant the opportunity to receive a frame and spectacle lenses or contact lenses. If you wear or would like to wear contact lenses, your eye care professional will perform additional services including contact lens fitting and follow-up care. *Standard Contact Lens Fitting - spherical clear contact lenses in conventional wear and planned replacement (i.e, disposables, frequent replacement). **Premium Contact Lenses Fitting - all lens designs, materials and speciality fittings other than standard contact lenses (i.e, toric, multifocal, etc.). Please refer to your benefit description to review the details for coverage for contact lenses.

Contact Lens Allowance

Your contact lens allowance applies to contact lens materials only. For conventional contact lenses, you will receive an additional 15% off the amount that exceeds the allowance. Please be advised that any balance resulting from the purchase of contact lenses are the responsibility of the member.

Coverage For An Out-of-Network Provider

Your vision care plan is designed to provide the best care at the most affordable cost to employees. It is for this reason that coverage for an exam, applies only to the services and products received from an EyeMed provider. If you choose to visit a doctor not in the EyeMed network, you may still receive eyeglass material from an EyeMed provider and apply them to your vision benefit. If you choose contact lenses, the EyeMed provider will perform additional services related to the purchases of contacts. You are responsible for any remaining balance related to these services.

Dependent Coverage

This plan covers both you and your dependents, if you choose that particular option when you enroll.

Benefit Descriptions And Exclusions

Lenses are single vision, bifocal (ST-25, 28 & 35), trifocals (7x28 & 7x35), and progressive, standard plastic, all powers, all sizes. Benefits shown can not be combined with any other promotional offers.

The following services are not included in your vision care benefit

- Orthoptic or vision training
- Aniseikonic lenses
- Plano non-prescription lenses (except for 20% discount)
- Two pairs of glasses instead of bifocals
- Free replacement or repair of lost or broken lenses or frames
- Medical or surgical treatment
- Services or materials covered under Workers' Compensation
- Services or materials provided by any other group benefit providing for vision care
- Eye examinations and material required as a condition of employment

A SAMPLE OF YOUR SAVINGS

Service	Average Retail	You Pay	You Save
Comprehensive Exam	\$64.00	\$20.00	\$44.00
\$100 Frame of your choice	\$100.00	\$0	\$100.00
Pair of Single Vision Lenses	\$70.00	\$20.00	\$50.00
UV Coating	\$20.00	\$15.00	\$5.00
Tint	<u>\$20.00</u>	\$15.00	<u>\$5.00</u>
Annual Premium for Employee Only		<u>\$96.00</u>	
TOTAL	\$274.00	\$166.00	\$108.00
Total Average Retail Cost	\$274.00		
Your Total Cost		\$166.00	
Your Total SAVINGS of 40%			\$108.00