

	100		130 / Materials Only 130		160 / Materials Only 160		200	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
<b>Routine eye exam</b>								
With dilation <sup>1</sup>	\$10	Up to \$30	\$10	Up to \$30	\$10	Up to \$30	\$0	Up to \$30
Retinal imaging <sup>2</sup>	Up to \$39	Not covered	Up to \$39	Not covered	Up to \$39	No covered	Up to \$39	Not covered
<b>Contact lens exam<sup>3</sup></b>								
Standard contact lens fit and follow-up	Up to \$55	Not covered	Up to \$55	Not covered	\$0	Up to \$30	\$0	Up to \$30
Premium contact lens fit and follow-up	10% off retail	Not covered	10% off retail	Not covered	10% off retail less \$55 allowance	Up to \$30	10% off retail less \$55 allowance	Up to \$30
<b>Diabetic eye care<sup>1</sup> (care &amp; testing for diabetic members; up to two services per year for each listed service)</b>								
Exam	\$0	Up to \$77	\$0	Up to \$77	\$0	Up to \$77	\$0	Up to \$77
Retinal imaging	\$0	Up to \$50	\$0	Up to \$50	\$0	Up to \$50	\$0	Up to \$50
Extended ophthalmoscopy	\$0	Up to \$15	\$0	Up to \$15	\$0	Up to \$15	\$0	Up to \$15
Gonioscopy	\$0	Up to \$15	\$0	Up to \$15	\$0	Up to \$15	\$0	Up to \$15
Scanning laser	\$0	Up to \$33	\$0	Up to \$33	\$0	Up to \$33	\$0	Up to \$33
<b>Frames<sup>5</sup></b>								
Discounts may be available on all frames except when prohibited by the manufacturer	\$100 allowance 20% off balance over \$100	\$50 allowance	\$130 allowance 20% off balance over \$130	\$65 allowance	\$160 allowance 20% off balance over \$160	\$80 allowance	\$200 allowance 20% off balance over \$200	\$100 allowance
<b>Standard plastic lenses<sup>4</sup></b>								
Single vision	\$25	Up to \$25	\$15	Up to \$25	\$10	Up to \$25	\$0	Up to \$25
Bifocal	\$25	Up to \$40	\$15	Up to \$40	\$10	Up to \$40	\$0	Up to \$40
Trifocal	\$25	Up to \$60	\$15	Up to \$60	\$10	Up to \$60	\$0	Up to \$60
Lenticular	\$25	Up to \$100	\$15	Up to \$100	\$10	Up to \$100	\$0	Up to \$100

(1) Not covered on Materials Only 130 and 160

(2) Member costs may exceed \$39 with certain providers.

(3) Standard contact lens exam fit and follow up costs and premium contact lens exam discounts up to 10% may vary by participating provider.

(4) Lens option costs may vary by provider.

(5) Plan covers contact lenses or frames, but not both, unless you have the Eye Glass and Contact Lens Rider.

	100		130 / Materials Only 130		160 / Materials Only 160		200	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
<b>Lens options<sup>4</sup></b>								
UV coating	\$15	Not covered	\$15	Not covered	\$15	Not covered	\$15	Not covered
Tint (solid & gradient)	\$15	Not covered	\$15	Not covered	\$15	Not covered	\$15	Not covered
Standard scratch-resistance	\$15	Not covered	\$15	Not covered	\$15	Not covered	\$15	Not covered
Standard polycarbonate	\$40	Not covered	\$40	Not covered	\$40	Not covered	\$40	Not covered
Standard anti-reflective coating	\$45	Not covered	\$45	Not covered	\$10	Up to \$25	\$0	Up to \$25
Premium anti-reflective coating								
• Tier 1	\$57	Not covered	\$57	Not covered	\$22	Up to \$25	\$22	Up to \$25
• Tier 2	\$68	Not covered	\$68	Not covered	\$33	Up to \$25	\$33	Up to \$25
• Tier 3	80% of charge	Not covered	80% of charge	Not covered	80% of charge less \$35 allowance	Up to \$25	80% of charge less \$35 allowance	Up to \$25
Standard progressive (add-on to bifocal)	\$25	Up to \$40	\$15	Up to \$40	\$10	Up to \$40	\$0	Up to \$40
Premium progressive								
• Tier 1	\$110	Not covered	\$110	Not covered	\$45	Up to \$40	\$45	Up to \$40
• Tier 2	\$120	Not covered	\$120	Not covered	\$55	Up to \$40	\$55	Up to \$40
• Tier 3	\$135	Not covered	\$135	Not covered	\$70	Up to \$40	\$70	Up to \$40
• Tier 4	\$90 copay, 80% of charge less \$120 allowance	Not covered	\$90 copay, 80% of charge less \$120 allowance	Not covered	\$25 copay, 80% of charge less \$120 allowance	Up to \$40	\$25 copay, 80% of charge less \$120 allowance	Up to \$40
Photochromatic / plastic transitions	\$75	Not covered	\$75	Not covered	\$75	Not covered	\$75	Not covered
Polarized	20% off retail	Not covered	\$20% off retail	Not covered	20% off retail	Not covered	20% off retail	Not covered

(4) Lens option costs may vary by provider.

	100		130 / Materials Only 130		160 / Materials Only 160		200	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
<b>Contact lenses<sup>5</sup> (materials only)</b>								
Conventional	\$100 allowance 15% off balance over \$100	\$80 allowance	\$130 allowance 15% off balance over \$130	\$104 allowance	\$160 allowance 15% off balance over \$160	\$128 allowance	\$200 allowance 15% off balance over \$200	\$160 allowance
Disposable	\$100 allowance	\$80 allowance	\$130 allowance	\$104 allowance	\$160 allowance	\$128 allowance	\$200 allowance	\$160 allowance
Medically necessary	\$0	\$200 allowance	\$0	\$200 allowance	\$0	\$210 allowance	\$0	\$210 allowance
<b>Frequency</b>								
Exam <sup>1</sup>	Once every 12 months		Once every 12 months		Once every 12 months		Once every 12 months	
Lenses or contact lenses	Once every 12 months		Once every 12 months		Once every 12 months		Once every 12 months	
Frames	Once every 24 months		Once every 24 months		Once every 24 months		Once every 24 months	
<b>Plan options</b>								
12-month frame benefit	Benefit replaces the 24-month frequency of the base plan							
Retinal imaging <sup>1</sup>	\$0 in-network and up to \$20 for out-of-network benefits (does not cross apply)							
LASIK / PRK <sup>1</sup>	\$250 per eye (in- or out-of-network); 12-month waiting period applies							
Eye glass & contact lens benefit	Allows fulfillment of frame plus spectacle lenses in addition to the contact lens benefit of the base plan (not available for groups < 100)							
Polycarbonate lenses for children <19	Provides for standard polycarbonate lens with \$0 copay							

- (1) Not covered on Materials Only 130 and 160
- (2) Member costs may exceed \$39 with certain providers.
- (3) Standard contact lens exam fit and follow up costs and premium contact lens exam discounts up to 10% may vary by participating provider.
- (4) Lens option costs may vary by provider.
- (5) Plan covers contact lenses or frames, but not both, unless you have the Eye Glass and Contact Lens Rider.

Members may contact their participating provider to determine what costs or discounts are available.

## EXAM PLUS

	In-network	Out-of-network
<b>Routine eye exam</b>		
With dilation	\$10	Up to \$30
Retinal imaging <sup>1</sup>	Up to \$39	Not covered
<b>Contact lens exam<sup>2</sup></b>		
Standard contact lens fitting & follow-up	Up to \$55	Not covered
Premium contact lens fitting & follow-up	10% off retail	Not covered
<b>Frames</b>		
Discounts may be available on all frames except when prohibited by the manufacturer	35% off retail	Not covered
<b>Standard plastic lenses<sup>3</sup></b>		
Single vision	\$50	Not covered
Bifocal	\$70	Not covered
Trifocal	\$105	Not covered
Lenticular	20% off retail	Not covered

- (1) Member costs may exceed \$39 with certain providers
- (2) Standard contact lens exam fit and follow up costs and premium contact lens exam discounts up to 10% may vary by participating provider.
- (3) Lens option costs may vary by provider.

Members may contact their participating provider to determine if listed costs are available.

	In-network	Out-of-network
<b>Lens options</b>		
UV coating	\$15	Not covered
Tint (solid & gradient)	\$15	Not covered
Standard scratch-resistance	\$15	Not covered
Standard polycarbonate	\$40	Not covered
Standard anti-reflective coating	\$45	Not covered
Standard progressive (add-on to bifocal)	\$65	Not covered
Polarized	20% off retail	Not covered
Add-on service	20% off retail	Not covered
<b>Contact lenses (materials only)</b>		
Conventional	15% off retail	Not covered
Disposable	Not covered	Not covered
Medically necessary	Not covered	Not covered
<b>Frequency</b>		
Exam	Once every 12 months	
Lenses or contact lenses	Not covered	
Frames	Not covered	

## ADDITIONAL VISION PLAN DISCOUNTS

Type	Discount
<b>Member may receive a 20% discount on items not covered by the plan at network Providers</b>	<ul style="list-style-type: none"> <li>• Members may contact their participating provider to determine what costs or discounts are available.</li> <li>• Discount does not apply to EyeMed Provider's professional services, or contact lenses.</li> <li>• Plan discounts cannot be combined with any other discounts or promotional offers.</li> <li>• Services or materials provided by any other group benefit plan providing vision care may not be covered.</li> <li>• Certain brand name Vision Materials may not be eligible for a discount if the manufacturer imposes a no-discount practice.</li> <li>• Frame, Lens, &amp; Lens Option discounts apply only when purchasing a complete pair of eyeglasses. If purchased separately, members receive 20% off the retail price.</li> </ul>
<b>LASIK &amp; PRK</b>	<ul style="list-style-type: none"> <li>• Members may 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.</li> <li>• Since LASIK or PRK vision correction is an elective procedure, performed by specially trained providers, this discount may not always be available from a provider in your immediate location.</li> </ul>

In NJ and MA, any services received for emergency care will pay at the same level of benefits for preferred and non-preferred providers.