More for less

Great benefit plans, plus additional savings, such as:

40% OFF additional complete pairs of prescription eyeglasses[1,2]

30% OFF items not covered by plan[2]

15% OFF retail price of LASIK or PRK Vision Correction at U.S. Laser Network. For LASIK providers call 1.877.5LASER6[2]

Vision Care Services–Advantage Network	Bright Vision Benefits Plan		Bold Vision Benefits Plan		Healthy Vision Benefits Plan	
	In-Network Member Cost	Out-of-Network Reimbursement[3]	In-Network Member Cost	Out-of-Network Reimbursement[3]	In-Network Member Cost	Out-of-Network Reimbursement[3]
EXAM WITH DILATION AS NECESSARY	$10 copay	$30	$10 copay	$30	$0 copay	$30
RETINAL IMAGING BENEFIT	Up to $39	N/A	Up to $39	N/A	Up to $39	N/A
FRAMES *(Any available frame at provider location)*	$0 copay; $200 allowance, 20% off balance over $200	$100	$0 copay; $130 allowance, 20% off balance over $130	$65	35% off retail price	N/A
STANDARD NON-GLASS LENSES						
Single Vision	$20 copay	$25	$20 copay	$25	$55	N/A
Bifocal	$20 copay	$40	$20 copay	$40	$75	N/A
Trifocal	$20 copay	$55	$20 copay	$55	$85	N/A
Standard Progressive Lens	$20 copay	$70	$80 copay	$40	$135	N/A
Premium Progressive Lens	$20 copay, 70% of charge less $110 allowance	$70	$80 copay, 70% of charge less $110 allowance	$40	30% off retail price	N/A
LENS OPTIONS						
UV Treatment	$0 copay	$9	$0 copay	$9	$12	N/A
Tint (Solid and Gradient)	$0 copay	$9	$0 copay	$9	$12	N/A
Standard Non-Glass Scratch Coating	$0 copay	$9	$0 copay	$9	$12	N/A
Standard Polycarbonate – Adults	$0 copay	$25	$35	N/A	$35	N/A
Standard Polycarbonate – Kids under 19	$0 copay	$25	$0 copay	$25	$35	N/A
Standard Anti-Reflective Coating	$0 copay	$28	$40	N/A	$40	N/A
Other Add-Ons and Services	30% off retail price	N/A	30% off retail price	N/A	30% off retail price	N/A
CONTACT LENS FIT AND FOLLOW-UP *(Available once a comprehensive eye exam has been completed)*						
Standard Contact Lens Fit and Follow-Up	Up to $40	N/A	Up to $40	N/A	N/A	N/A
Premium Contact Lens Fit and Follow-Up	10% off retail price	N/A	10% off retail price	N/A	N/A	N/A
CONTACT LENSES *(Allowance includes materials only)*						
Conventional	$0 copay; $200 allowance, 15% off balance over $200	$160	$0 copay; $130 allowance, 15% off balance over $130	$104	15% off retail price	N/A
Disposable	$0 copay; $200 allowance, plus balance over $200	$160	$0 copay; $130 allowance, plus balance over $130	$104	N/A	N/A
Medically Necessary	$210 allowance	$210	$210 allowance	$210	N/A	N/A
FREQUENCY						
Examination	Once per plan year		Once per plan year		Once per plan year	
Lenses or Contact Lenses	Once per plan year		Once per plan year		Unlimited	
Frames	Once per plan year		Once per plan year		Unlimited	

DISCOUNTS: [1]Complete Pair Eyeglasses Purchase Discounts: Frame, lenses, and lens options must be purchased in same transaction to receive full discount. [2]Discounts are available at participating in-network providers only. Not all in-network providers offer all discounts so please confirm your provider offers discounts prior to your appointment. Discounts are not insured benefits and do not apply to EyeMed Provider's professional services, certain brand name Vision Materials in which the manufacturer imposes a no-discount practice, or contact lenses. Discounts cannot be combined with any other discounts or promotional offers. **OUT-OF-NETWORK REIMBURSEMENT:** [3]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 provider locator to determine which participating providers have agreed to the discounted rate. **LIMITATIONS & EXCLUSIONS:** 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, pathological, and/or surgical treatment of the eye, eyes or supporting structures; **Any Vision Materials (Healthy Plan only);** Any Vision Examination, or any corrective eyewear required 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; Non-prescription sunglasses; or Two pair of glasses in lieu of bifocals (Bold & Bright Plans only).** Any sales tax charged by the Provider as part of the transaction for covered services are not covered under this Policy. Fees charged by a Provider for services other than those covered under the Policy must be paid in full by the insured person to the Provider. Such fees or materials are not covered under this policy. Out-of-Network Provider expenses do not apply toward In-Network Provider expenses and In-Network Provider expenses do not apply toward Out-of-Network Provider expenses. All providers are not required to carry all brands at all levels. **TERMINATION OF COVERAGE:** Your vision coverage will continue until the last day for which you paid premium, subject to the grace period. Coverage will end on any premium due date the Company elects to non-renew the policy or on any date you provide a written request to cancel coverage. Any dependents covered will terminate on the same date your coverage ends; at the end of the policy year in which your dependent ceases to be eligible; or on the last day for which premium was paid, subject to the grace period. If an act of fraud is committed against the insurance company, all coverage will end on the date such determination is made by a court of law. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, administered by First American Administrators and InsuranceTPA.com, and marketed & serviced by EyeMed. Telephone selling performed by SASid, Inc. Policy VC-133; form M-9157/M-9159. (PDF-1503-I-243-MOST STATES) **ADV-VC133-05012020vM**