Jefferson County Commission Low Plan

Additional discounts

40%OFF

Complete pair of prescription eyeglasses

20%OFF

Non-prescription sunglasses

These discounts are not insured benefits and are for in-network providers only. For vision plans with qualified materials benefit only. Not applicable for exam only vision plans.

Take a sneak peek before enrolling

- You're on the Insight Network
- For a complete list of in-network providers near you, use our Enhanced Provider Locator on eyemed.com or call 1.866.804.0982
- For LASIK providers, call 1.800.988.4221

SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES		
Exam	$10 copay	Up to $30
Retinal Imaging	Up to $39	Not covered
CONTACT LENS FIT AND FOLLOW-UP		
Fit and Follow-up - Standard	$40	Not covered
Fit and Follow-up - Premium	10% off retail price	Not covered
FRAME		
Any available frame at provider location	$0 copay; 20% off balance over $130 allowance	Up to $65
STANDARD PLASTIC LENSES		
Single Vision	$15 copay	Up to $25
Bifocal	$15 copay	Up to $40
Trifocal	$15 copay	Up to $60
Lenticular	$15 copay	Up to $100
Progressive - Standard	$30 copay	Up to $55
Progressive - Premium Tier 1	$110 copay	Up to $55
Progressive - Premium Tier 2	$120 copay	Up to $55
Progressive - Premium Tier 3	$135 copay	Up to $55
Progressive - Premium Tier 4	$90 copay, 80% of charge less $120 allowance	Up to $55
LENS OPTIONS		
Anti Reflective Coating - Standard	$45	Not covered
Anti Reflective Coating - Premium Tier 1	$57	Not covered
Anti Reflective Coating - Premium Tier 2	$68	Not covered
Anti Reflective Coating - Premium Tier 3	20% off retail price	Not covered
Photochromic - Non-Glass	$75	Not covered
Polycarbonate - Standard	$40	Not covered
Scratch Coating - Standard Plastic	$15	Not covered
Tint - Solid or Gradient	$15	Not covered
UV Treatment	$15	Not covered
All Other Lens Options	20% off retail price	Not covered
CONTACT LENSES		
Contacts - Conventional	$0 copay; 15% off balance over $130 allowance	Up to $104
Contacts - Disposable	$0 copay; plus balance over $130 allowance	Up to $104
Contacts - Medically Necessary	$0 copay; Paid-In-Full	Up to $210
OTHER		
Hearing Care from Amplifon NetworkCare	Discounts on hearing exam and aids; call 1.844.526.5432	Not covered
Lasik or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered

FREQUENCIES *(Plan allows member to receive either contacts and frame, or frames and lens services)*

Exam	Once every plan year
Frame	Once every other plan year
Lenses	Once every plan year
Contacts	Once every plan year

QL-0000003645

Premium 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. Benefits are not provided from services or materials arising from: 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) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear; 4) 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; 5) Plano (non-prescription) lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals; 8) Services or materials provided by any other group benefit plan providing vision care 9) 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. 10) 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 benefit year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered.

Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York. Fidelity Security Life Policy number VC-19/VC-20, form number M-9083. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.

Jefferson County Commission High Plan

Additional discounts

40%OFF

Complete pair of prescription eyeglasses

20%OFF

Non-prescription sunglasses

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- For LASIK providers, call 1.800.988.4221

SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES		
Exam	$10 copay	Up to $35
Retinal Imaging	Up to $39	Not covered
CONTACT LENS FIT AND FOLLOW-UP		
Fit and Follow-up - Standard	$40	Not covered
Fit and Follow-up - Premium	10% off retail price	Not covered
FRAME		
Any available frame at provider location	$0 copay; 20% off balance over $200 allowance	Up to $100
STANDARD PLASTIC LENSES		
Single Vision	$15 copay	Up to $40
Bifocal	$15 copay	Up to $60
Trifocal	$15 copay	Up to $80
Lenticular	$15 copay	Up to $100
Progressive - Standard	$30 copay	Up to $60
Progressive - Premium Tier 1	$110 copay	Up to $60
Progressive - Premium Tier 2	$120 copay	Up to $60
Progressive - Premium Tier 3	$135 copay	Up to $60
Progressive - Premium Tier 4	$30 copay, 80% of charge less $120 allowance	Up to $60
LENS OPTIONS		
Anti Reflective Coating - Standard	$45	Not covered
Anti Reflective Coating - Premium Tier 1	$57	Not covered
Anti Reflective Coating - Premium Tier 2	$68	Not covered
Anti Reflective Coating - Premium Tier 3	20% off retail price	Not covered
Photochromic - Non-Glass	$75	Not covered
Polycarbonate - Standard	$40	Not covered
Scratch Coating - Standard Plastic	$15	Not covered
Tint - Solid or Gradient	$15	Not covered
UV Treatment	$15	Not covered
All Other Lens Options	20% off retail price	Not covered
CONTACT LENSES		
Contacts - Conventional	$0 copay; 15% off balance over $200 allowance	Up to $160
Contacts - Disposable	$0 copay; plus balance over $200 allowance	Up to $160
Contacts - Medically Necessary	$0 copay; Paid-In-Full	Up to $210
OTHER		
Hearing Care from Amplifon NetworkCare	Discounts on hearing exam and aids; call 1.844.526.5432	Not covered
Lasik or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered

FREQUENCIES *(Plan allows member to receive either contacts and frame, or frames and lens services)*

Exam	Once every plan year
Frame	Once every other plan year
Lenses	Once every plan year
Contacts	Once every plan year

QL-0000003646

Premium 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. Benefits are not provided from services or materials arising from: 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) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear; 4) 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; 5) Plano (non-prescription) lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals; 8) Services or materials provided by any other group benefit plan providing vision care 9) 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. 10) 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 benefit year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered.

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Get more and see more with EyeMed

72%
AVERAGE SAVINGS

on eye exams and glasses for EyeMed members*

CHOOSE A DOC

EyeMed members choose from the right mix of thousands of providers—independent eye doctors, your favorite retail stores and everything in between. Find your ideal fit at eyemed.com or the EyeMed Members App.

CREATE AN ACCOUNT

Get special offers with an account on eyemed.com. Enter your email, choose a password and sign up for emailed savings. Log in 24/7 to view your benefit details or health and wellness information.

MOBILIZE YOUR BENEFITS

The EyeMed Members App makes your benefits easy to understand—and even easier to use. Find an eye doctor near you, schedule an appointment and manage your vision benefits.

Learn more about enrolling in EyeMed vision benefits at **enroll.eyemed.com** and see more of the good stuff

**Based on a sample transaction on the Insight network with a covered exam and eyewear benefits*

EyeMed | INDEPENDENT PROVIDER NETWORK + LensCrafters | Pearle Vision | Target Optical | Sears Optical | JCPenney optical

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