

Ready to live your best EyeMed life?

There's so much more to your vision benefits than copays and coverage. Get ready to see the good stuff for yourself.

Your network is the place to start

See who you want, when you want. You have thousands of providers to choose from – independent eye doctors, your favorite retail stores, even online options.

Keep your eyes open for extra discounts*

Members already save an average 76% off retail using their EyeMed benefits,¹ but our long list of special offers takes benefits even further.

Remember, you're never alone

We're always here to help you use your benefits like a pro. Stay in-the-know with text alerts or healthy vision resources from the experts. If it can make benefits easier for you, we do it.

*Discounts are not insurance. Available at participating providers. ¹Based on weighted average of sample transactions: EyeMed Insight network/\$10 exam copay/\$10 materials copay/\$120 frame or contact lens allowance. 2022 EyeMed Commercial BOB stats.



eye
Med



Create an account at eyemed.com/member

Everything is right there in one spot. Check claims and benefits, see special offers, estimate costs and find an eye doctor – search for one with the hours, location and brands you want. For maximum mobility, try the EyeMed App (Google Play or App Store).

This information is available broadly and is not plan or state specific.

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INDEPENDENT
PROVIDER
NETWORK



LENSCRAFTERS[®]

PEARLE
EST. 1961
VISION[®]

OPTICAL[®]

Summary of benefits

Vision Care Services	In-Network Member Cost	Out-of-Network Member Reimbursement
EXAM SERVICES		
Exam	\$0 copay	Up to \$35
Retinal Imaging	Up to \$39	Not covered
FRAME		
Frame	\$0 copay; 20% off balance over \$150 allowance	Up to \$35
STANDARD PLASTIC LENSES		
Single Vision	\$0 copay	Up to \$35
Bifocal	\$0 copay	Up to \$50
Trifocal	\$0 copay	Up to \$60
Lenticular	\$0 copay	Up to \$90
Standard Progressive	\$55 copay	Up to \$50
Premium Progressive – Tier 1-4	\$85 - \$175 copay	Up to \$50
LENS OPTIONS		
Standard Anti-Reflective Coating	\$45	Up to \$5
Premium Anti-Reflective Coating – Tier 1-3	\$57 - \$85	Up to \$5
Photochromic – Non-Glass	\$75	Not covered
Standard Polycarbonate	\$0	Up to \$5
Standard Plastic Scratch Coating	\$15	Not covered
Tint – Solid and Gradient	\$15	Not covered
UV Treatment	\$15	Not covered
All Other Lens Options	20% off retail price	Not covered

Summary of benefits

Vision Care Services	In-Network Member Cost	Out-of-Network Member Reimbursement
CONTACT LENS FIT AND FOLLOW-UP		
Standard Fit and Follow-Up	Up to \$40; contact lens fit and two follow-up visits	Not covered
Premium Fit and Follow-Up	10% off retail price	Not covered
CONTACT LENSES		
Conventional	\$0 copay; 15% off balance over \$150 allowance	Up to \$90
Disposable	\$0 copay; 100% of balance over \$150 allowance	Up to \$90
Medically Necessary	\$0 copay	Up to \$210
OTHER		
Hearing Care from Amplifon Network	Discounts on hearing exam and aids; call 1.877.203.0675	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
FREQUENCY		
	Allowed Frequency - Adults	Allowed Frequency - Kids
Exam	Once every plan year	Once every plan year
Frame	Once every other plan year	Once every other plan year
Lenses	Once every plan year	Once every plan year
Contact Lenses	Once every plan year	Once every plan year

(Plan allows member to receive either contacts and frame, or frame and lens services).



40% OFF

additional complete pair of prescription eyeglasses*



20% OFF

non-covered items including non-prescription sunglasses*

Summary of benefits

Vision Care Services	In-Network Member Cost	Out-of-Network Member Reimbursement
DIABETIC CARE SERVICES		
<i>For Type 1 or Type 2 Diabetes with Diabetic Retinopathy</i>		
Medical Follow Up Eye Examination	\$0 copay	Up to \$77
Fundus Photography Examination	\$0 copay	Up to \$50
Extended Ophthalmoscopy (initial and subsequent)	\$0 copay	Up to \$15
Gonioscopy	\$0 copay	Up to \$15
Scanning Laser	\$0 copay	Up to \$33

*Benefit Frequency: All Diabetic Care Services are covered once every 6 months**

DEFINITIONS

Medical Follow-Up Examination means an office visit for diabetic vision care after the initial Comprehensive Eye Examination.

Some or all of the diagnostic services described below will be provided as deemed appropriate, subject to provider determination and the benefit frequency limitations referenced above. More comprehensive descriptions of these services are available in the Certificate of Insurance.

Fundus Photography Examination means photographing portion(s) of or the complete retina surface and structures, with interpretation and report. (**The Fundus Photography Examination is not covered if an Extended Ophthalmoscopy was provided within the previous six-month period.*)

Extended Ophthalmoscopy means an examination of the interior of the eye, focusing on the posterior segment of the eye, including the lens, retina, and optic nerve, by direct or indirect ophthalmoscopy, and includes a retinal drawing with interpretation and report. (**The Extended Ophthalmoscopy is not covered if Fundus Photography Examination was provided within the previous six-month period*)

Gonioscopy means an eye examination of the front part of the eye (anterior chamber) to check the angle where the iris meets the cornea with a gonioscope or with a contact prism lens.

Scanning Laser means a computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report.



Diabetes and eye wellness are linked by healthy choices. Full of advice from vision experts, eyesiteonwellness.com is a collection of videos, quizzes, articles, recipes and tools to help you make those choices.

Exclusions: In addition to the Exclusions in the Policy/Certificate, no benefits are payable for services connected with or charges arising from any Vision Materials; orthoptic or vision training, subnormal vision aids and any associated supplemental testing; medical, pathological and/or surgical treatment of the eye, eyes or supporting structures; any Vision Examination required by a Policyholder as a condition of employment; or services, supplies, prescription medication or treatment for diabetes, except as specifically included.



Find an in-network provider

INSIGHT NETWORK

- CALL 866.804.0982
- VISIT eyemed.com/member
- DOWNLOAD the EyeMed Members App
- FOR LASIK call 1.800.988.4221

To learn more about all the benefits available to you under the vision plan, create an account at eyemed.com/member



EyeMed reserves the right to make changes to the products available on each tier. All providers are not required to carry all brands on all tiers. For current listing of brands by tier, call 866-939-3633. No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures; Refraction, when not provided as part of a Comprehensive Eye Examination; 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; orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment; safety eyewear; solutions, cleaning products or frame cases; non-prescription sunglasses; plano (non-prescription) lenses; plano (nonprescription) contact lenses; two pair of glasses in lieu of bifocals; electronic vision devices; 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; or lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy. Allowances provide no remaining balance for future use within the same Benefit Frequency. Some provisions, benefits, exclusions or limitations listed herein may vary by state.. Plan discounts cannot be combined with any other discounts or promotional offers. 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 online provider locator to determine which participating providers have agreed to the discounted rate.