Local Government Health Plan

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam With Dilation as Necessary	$10 Copayment	Up to $20 Allowance
Frames	$10 Copayment; Up to $90 retail frame cost; member responsible for balance over $90	Up to $20 Allowance
Standard Plastic Lenses		
Single Vision	$10 Copayment	Up to $20 Allownace
Bifocal	$10 Copayment	Up to $30 Allowance
Trifocal	$10 Copayment	Up to $30 Allowance
Lenticular	$10 Copayment	Up to $30 Allowance
Standard Progressive Lens	$75	Up to $30 Allowance
Premium Progressive Lens	$75, 80% of Charge less $120 Allowance	Up to $30 Allowance
Lens Options (paid by the member in addition to the price of the lenses)		
UV Treatment	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Plastic Scratch Coating	$15	N/A
Standard Polycarbonate	$40	N/A
Standard Anti-Reflective Coating	$45	N/A
Polarized	20% off retail price	N/A
Other Add-Ons and Services	20% off retail price	N/A
Contact Lenses (Contact lens allowance includes materials only.)		
Conventional	$50 Copayment	Up to $70 Allowance
Disposable(Declining Balance Allowance)	$0 Copayment, $70 Allowance, member responsible for balance over $70	Up to $70 Allowance
Medically Necessary	$20 Copayment	Up to $70 Allowance
Low Vision (subject to prior approval by insurance carrier)		
Supplementary Testing	$10 Copayment	Up to $125 Allowance
Vision Aides	100% Coverage after 25% Copayment with a $1,000 maximum Allowance	100% Coverage after 25% Copayment with a $1,000 maximum Allowance
Laser Vision Correction		
LASIK or PRK from U.S. Laser Network	15% off the retail price or 5% off the promotional price	N/A
Additional Pairs Discount	Members also receive a 40% discount off complete pair eyeglass purchase and 15% off conventional contact lenses once the funded benefit has been used.	N/A
Frequency		
Examination	Once every 24 months	
Lenses or Contact Lenses	Once every 24 months	
Frame	Once every 24 months	
Low Vision Supplementary Testing	Once every 24 months	
Low Vision Aides	Once every 24 months	

More, for less...

40%
Complete pair of prescription eyeglasses

20%
Non-prescription sunglasses

20%
Remaining balance beyond plan coverage

These discounts are for in-network providers only

Hello, Neighbor

- You're on the ACCESS Network
- To see a list of participating providers near you, go to www.eyemedvisioncare.com/STIL or you can also call 1-866-723-0512.
- For Lasik providers, call 1-877-5LASER6, or visit eyemedlasik.com.

Replacement Contact Lens Purchases - Visit www.eyemedcontacts.com to order replacement contact lenses for shipment to your home at less than retail price. Your core benefit allowance will not apply to the service. Your initial pair of contact lenses must still be purchased from your eye care provider to ensure proper fit and follow-up care.

A new angle on wellness

Vision care isn't just for people who wear glasses or contacts. It's for everyone. Sure, an eye exam can check for vision problems, but it can also detect other health concerns like high blood pressure, diabetes and high cholesterol – just to name a few.
If you've got eyes, we're for you.

eye[SM]
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What's in it for me?

Options. It's simple really. We love our members—that's why we are dedicated to helping you see clearly and we've built a network that gives you lots of choices and flexibility. You can choose from independent doctors and retail providers to find the one that best fits your needs and schedule. No matter which one you choose, our plan is designed to be easy to use and to save you money. Welcome to EyeMed.

eyemed.com

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 anyWorkers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; 5) Plano (non-prescription) lenses and/or contact 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. 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.

LensCrafters