



**SELECT Network**

Contact 1-866-299-1358 or visit [www.eyemedvisioncare.com/rrd](http://www.eyemedvisioncare.com/rrd) with any additional questions

EyeMed Vision Care in conjunction with Fidelity Security Life Insurance Company

Vision Care Services	EyeMed		EyeMed Enhanced	
	Member Cost	Out-of-Network Reimbursement	Member Cost	Out-of-Network Reimbursement
<b>Exam with Dilatation as Necessary</b>	\$10 Copay	Up to \$35	\$0 Copay	Up to \$35
<b>Exam Options</b>				
Standard Contact Lens Fit and Follow-Up	Up to \$40	N/A	\$0 Copay, Paid-in-full fit and two follow-up visits	Up to \$40
Premium Contact Lens Fit and Follow-Up	10% off retail price	N/A	\$0 Copay, 10% off retail prices, then apply \$40 Allowance	Up to \$40
<b>Frames</b>	\$0 Copay; \$130 Allowance, 20% off balance over \$130	Up to \$60	\$0 Copay; \$160 Allowance, 20% off balance over \$160	Up to \$80
<b>Standard Plastic Lenses</b>				
Single Vision	\$20 Copay	Up to \$25	\$10 Copay	Up to \$25
Bifocal	\$20 Copay	Up to \$40	\$10 Copay	Up to \$40
Trifocal	\$20 Copay	Up to \$55	\$10 Copay	Up to \$55
Lenticular	\$20 Copay	Up to \$80	\$10 Copay	Up to \$80
Standard Progressive Lens*	\$85 Copay	Up to \$40	\$10 Copay	Up to \$55
Premium Progressive Lens*	See fixed premium price list below	Up to \$40	See fixed premium price list below	Up to \$55
<b>Lens Options</b>				
UV Treatment	\$15	N/A	\$0 Copay	Up to \$5
Tint (Solid and Gradient)	\$15	N/A	\$0 Copay	Up to \$5
Standard Plastic Scratch Coating	\$0 Copay	Up to \$5	\$0 Copay	Up to \$5
Standard Polycarbonate - Adults	\$40	N/A	\$0 Copay	Up to \$5
Standard Polycarbonate - Kids under 19	\$0 Copay	Up to \$5	\$0 Copay	Up to \$5
Standard Anti-Reflective Coating	\$45	N/A	\$0 Copay	Up to \$5
Polarized	20% off Retail Price	N/A	20% off Retail Price	N/A
Photochromic - Plastic	\$75	N/A	\$75	N/A
<b>Other Add-Ons</b>	20% off Retail Price	N/A	20% off Retail Price	N/A
<b>Contact Lenses</b>				
<i>Contact lens allowance includes materials only</i>				
Conventional	\$0 Copay; \$150 Allowance, 15% off balance over \$150	Up to \$150	\$0 Copay; \$170 Allowance, 15% off balance over \$170	Up to \$150
Disposable	\$0 Copay; \$150 Allowance, plus balance over \$150	Up to \$150	\$0 Copay; \$170 Allowance, plus balance over \$170	Up to \$150
Medically Necessary	\$0 Copay, Paid-in-Full	Up to \$210	\$0 Copay, Paid-in-Full	Up to \$210
<b>Laser Vision Correction</b>				
For Lasik Providers call 1-877-5LASER6 or visit <a href="http://eyemedlasik.com">eyemedlasik.com</a> .	15% off Retail Price or 5% off promotional price	N/A	15% off Retail Price or 5% off promotional price	N/A
<b>Additional Pairs Benefit</b>	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A
<b>Member Cost Schedules</b>				
	<b>Progressive Lenses</b>	<b>Anti-Reflective Coating</b>	<b>Progressive Lenses</b>	<b>Anti-Reflective Coating</b>
Standard	\$85 Copay	\$45	\$10 Copay	\$0 Copay
Tier 1	\$105 Copay	\$57	\$30 Copay	\$12 Copay
Tier 2	\$115 Copay	\$68	\$40 Copay	\$23 Copay
Tier 3	\$130 Copay	80% of charge	\$55 Copay	\$0 Copay, 80% of charge less \$45 allowance
Tier 4	\$85 Copay, 80% of charge less \$120 allowance	N/A	\$10 Copay, 80% of charge less \$120 allowance	N/A
	<b>Frequency</b>		<b>Frequency</b>	
	Examination	Once every 12 months	Examination	Once every 12 months
	Frame	Once every 24 months	Frame	Once every 12 months
	Lenses	Once every 12 months	Lenses	Once every 12 months
	OR		OR	
	Contact Lenses	Once every 12 months	Contact Lenses	Once every 12 months

\* Standard progressive lens covered - fund premium progressive as a standard

**Plan Limitations and Exclusions**  
 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 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.

**Additional Plan Details**  
 Member receives a 20% discount on items not covered by the plan at network Providers. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Benefit Allowances provide no remaining balance for future use within the same Benefit Frequency. Insured Plans are underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York. Policy number VC-19/VC-20, form number M-9083.