



Local Government Health Plan

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.

Vision Care Services

Exam With Dilation as Necessary

Frames

Standard Plastic Lenses

Single Vision
Bifocal
Trifocal
Lenticular
Standard Progressive Lens
Premium Progressive Lens

Lens Options (paid by the member in addition to the price of the lenses)

UV Treatment
Tint (Solid and Gradient)
Standard Plastic Scratch Coating
Standard Polycarbonate
Standard Anti-Reflective Coating
Polarized
Other Add-Ons and Services

Contact Lenses (Any remaining balance for contact lenses may be used within the same Benefit Frequency.)

Conventional

Disposable

Low Vision (subject to prior approval by insurance carrier)

Supplementary Testing
Vision Aides

Laser Vision Correction

LASIK or PRK from U.S. Laser Network

Additional Pairs Discount

Frequency

Examination
Lenses or Contact Lenses
Frame
Low Vision Supplementary Testing
Low Vision Aides

In-Network Member Cost

\$25 Copayment

\$25 Copayment; Up to \$175 retail frame cost; member responsible for balance over \$175

\$25 Copayment
\$25 Copayment
\$25 Copayment
\$25 Copayment
\$90
\$90, 80% of Charge less \$120 Allowance

\$15
\$15
\$15
\$40
\$45
20% off retail price
20% off retail price

\$0 Copayment, \$120 Allowance, member responsible for balance over \$120

\$0 Copayment, \$120 Allowance, member responsible for balance over \$120

\$10 Copayment, Covered in Full
100% Coverage after 25% Copayment with a \$1,000 maximum Allowance

15% off the retail price or 5% off the promotional price

Members also receive a 40% discount off complete pair eyeglass purchase and 15% off conventional contact lenses once the funded benefit has been used.

Once every 12 months
Once every 12 months
Once every 24 months
Once every 12 months
Once every 24 months

Out-of-Network Reimbursement

Up to \$30 Allowance

Up to \$70 Allowance

Up to \$50 Allowance
Up to \$80 Allowance
Up to \$80 Allowance
Up to \$80 Allowance
Up to \$80 Allowance
Up to \$80 Allowance

N/A
N/A
N/A
N/A
N/A
N/A
N/A

Up to \$120 Allowance

Up to \$120 Allowance

Up to \$125 Allowance
100% Coverage after 25% Copayment with a \$1,000 maximum Allowance

N/A

N/A

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.

eyeSM
Med

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 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. 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.

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[®]

