# Werfen

Insight network

## SUMMARY OF BENEFITS

| VISION CARE SERVICES | IN-NETWORK MEMBER COST AT PLUS PROVIDERS | IN-NETWORK MEMBER COST | OUT-OF-NETWORK MEMBER REIMBURSEMENT |
|---|---|---|---|
| **EXAM SERVICES** | | | |
| *Exam* | *$0 copay* | *$10 copay* | *Up to $57* |
| *Retinal imaging* | *Up to $39* | *Up to $39* | *Not covered* |
| **CONTACTS LENS FIT AND FOLLOW-UP** | | | |
| *Fit and Follow-up - Standard* | *Up to $40;* | *Up to $40;* | *Not covered* |
| *Fit and Follow-up - Premium* | *10% off retail price* | *10% off retail price* | *Not covered* |
| **FRAME** | | | |
| *Frame* | *$0 copay; 20% off balance over $200 allowance* | *$0 copay; 20% off balance over $150 allowance* | *Up to $120* |
| **STANDARD PLASTIC LENSES** | | | |
| *Single Vision* | *$25 copay* | *$25 copay* | *Up to $47* |
| *Bifocal* | *$25 copay* | *$25 copay* | *Up to $79* |
| *Trifocal/Lenticular* | *$25 copay* | *$25 copay* | *Up to $113* |
| *Progressive - Standard* | *$80 copay* | *$80 copay* | *Up to $73* |
| *Progressive - Premium Tier 1 - 4* | *$110 - 200 copay* | *$110 - 200 copay* | *Up to $95* |
| **LENS OPTIONS** | | | |
| *Anti Reflective Coating - Standard* | *$45 copay* | *$45 copay* | *Up to $23* |
| *Anti Reflective Coating - Premium Tier 1 - 2* | *$57 - 68* | *$57 - 68* | *Up to $23* |
| *Anti Reflective Coating - Premium Tier 3* | *$100 copay* | *$100 copay* | *Up to $23* |
| *Photochromic - Non-Glass* | *$75* | *$75* | *Not covered* |
| *Polycarbonate - Standard* | *$40* | *$40* | *Not covered* |
| *Polycarbonate - Std < 26 years of age* | *$0 copay* | *$0 copay* | *Up to $22* |
| *Scratch Coating/Tint/UV Treatment* | *$15* | *$15* | *Not covered* |
| *All Other Lens Options* | *20% off retail price* | *20% off retail price* | *Not covered* |
| **CONTACT LENSES** | | | |
| *Contacts - Conventional* | *$0 copay; 15% off balance over $200 allowance* | *$0 copay; 15% off balance over $150 allowance* | *Up to $120* |
| *Contacts - Disposable* | *$0 copay; 100% of balance over $200 allowance* | *$0 copay; 100% of balance over $150 allowance* | *Up to $120* |
| *Contacts - Medically Necessary* | *$0 copay; paid-in-full* | *$0 copay; paid-in-full* | *Up to $300* |
| **OTHER** | | | |
| *Hearing Care from Amplifon Network* | *Discounts on hearing aids; call 1.877.203.0675* | *Discounts on hearing 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* | *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 plan year* | *once every plan year* |
| *Lens* | *once every plan year* | *once every plan year* |
| *Contact Lens* | *once every plan year* | *once every plan year* |

*Plan allows member to receive frame and lens services or contacts.*

*Log into eyemed.com/member to see all plans included with your benefits. 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 (non-prescription) 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.Some provisions, benefits, exclusions or limitations listed herein may vary by statePlan 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.*

# Savings plus convenience plus choice

*PLUS Providers add another layer of coverage*

*Staying in-network helps you save money on eye exams, frames and lenses. Visiting a PLUS Provider is designed to help you save even more. And since PLUS Providers are already in our network, the additional perks are built right into your vision benefits.*

*No promo codes, no coupons, no paperwork. The same vision benefits, plus a little more savings.*




## The choice is yours

*Find plenty of in-network eye doctors – including PLUS Providers – on our Provider Locator. Just look for the PLUS.*

*Need extra assistance? Contact us at 1.866.939.3633 or visit eyemed.com.*

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION OPTICAL