



Bloomington School District 271

More,
for less...

40% OFF

Complete pair
of prescription
eyeglasses

20% OFF

Non-prescription
sunglasses

20% OFF

Remaining balance
beyond plan coverage

These discounts are for
in-network providers only

Hello,
Neighbor

- You're on the SELECT Network
- For a complete list of providers near you, use our Provider Locator on www.eyemed.com and choose the SELECT network or call 1-866-299-1358.
- For Lasik providers, call 1-877-5LASER6 or visit eyemedlasik.com.

| Vision Care Services | In-Network Member Cost | Out-of-Network Reimbursement |
|--|---|------------------------------|
| Exam With Dilation as Necessary | \$10 Copay | Up to \$35 |
| Contact Lens Fit and Follow-Up (Contact lens fit and two follow up visits are available once a comprehensive eye exam has been completed) | | |
| Standard Contact Lens Fit & Follow-Up | Up to \$40 | N/A |
| Premium Contact Lens Fit & Follow-Up | 10% off retail | N/A |
| Frames | \$0 Copay; \$120 allowance; 80% of charge over \$120 | Up to \$50 |
| Standard Plastic Lenses | | |
| Single Vision | \$10 Copay | Up to \$25 |
| Bifocal | \$10 Copay | Up to \$40 |
| Trifocal | \$10 Copay | Up to \$50 |
| Standard Progressive Lens | \$10 Copay | Up to \$40 |
| Premium Progressive Lens | \$10, 80% of charge less \$120 Allowance | Up to \$40 |
| Lenticular | \$10 Copay | Up to \$50 |
| Lens Options (paid by the member and added to the base price of the lens) | | |
| UV Treatment | \$15 | N/A |
| Tint (Solid and Gradient) | \$15 | N/A |
| Standard Plastic Scratch Coating | \$0 | Up to \$5 |
| Standard Polycarbonate | \$40 | N/A |
| Standard Polycarbonate - Kids under 19 | \$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 | | |
| Conventional | \$0 Copay; \$120 allowance; 15% off retail price over \$120 | Up to \$100 |
| Disposable | \$0 Copay; \$120 allowance; plus balance over \$120 | Up to \$100 |
| Medically Necessary | \$0 Copay, Paid in Full | Up to \$210 |
| Laser Vision Correction | | |
| Lasik or PRK from U.S. Laser Network | 15% off the retail price or 5% off the promotional price | N/A |
| Frequency | | |
| Examination | Once every 12 months | |
| Lenses or Contact Lenses | Once every 12 months | |
| Frame | Once every 12 months | |



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 Snapshot | With Us | Out-of-Network Reimbursement |
|---|--|------------------------------|
| Exam with dilation as necessary (Once every 12 months) | \$10 Copay | Up to \$35 |
| Frames (Once every 12 months) | \$0 Copay; \$120 allowance; 80% of charge over \$120 | Up to \$50 |
| Single Vision Lenses (Once every 12 months) | \$10 Copay | Up to \$25 |
| Or | | |
| Contacts (Once every 12 months) | \$0 Copay; \$120 allowance; plus balance over \$120 | Up to \$100 |

And now it's time for the breakdown . . .

Here's an example of what you might pay for a pair of glasses vs. what you'd pay without vision coverage. So, let's say you get an eye exam and choose a frame that costs \$163 with single vision lenses that have UV and scratch protection. Now let's see the difference . . .

**83%
SAVINGS
with us**

| | With Us | Without Insurance** |
|--------------|--|---|
| Exam | \$10 Copay | Exam \$106 |
| Frame | \$163 <u>-\$120 allowance</u> \$43 <u>-\$8.60 (20% discount off balance)</u> \$34.40 | Frame \$163 |
| Lens | \$10 Copay \$15 UV treatment add-on <u>+\$0 Scratch coating add-on</u> \$25 | Lens \$78 \$23 UV treatment add-on <u>+\$25 Scratch coating add-on</u> \$126 |
| Total | \$69.40 | Total \$395 |

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 Combined Insurance Company of America, 5050 Broadway, Chicago, IL 60640, except in New York. CICA Form # VN P63007 0801. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer. Benefit allowance provides no remaining balance for future use within the same benefit year. **Based on industry averages.



LENSCRAFTERS

