



City of Cincinnati

SUMMARY OF BENEFITS

Additional discounts

40% OFF

Complete pair of prescription eyeglasses

20% OFF

Non-prescription sunglasses

20% OFF

Remaining balance beyond plan coverage

These discounts are not insured benefits and are for in-network providers only

Take a sneak peek before enrolling

- You're on the SELECT Network
- For a complete list of in-network providers near you, use our Enhanced Provider Locator on eyemed.com or call 1.844.256.6372.
- For LASIK providers, call 1.877.5LASER6.

Vision Care Services

Exam With Dilation as Necessary

Frames

Standard Plastic Lenses

| | | |
|---------------------------|---|--------------|
| Single Vision | \$0 Co-pay | Up to \$100* |
| Bifocal | \$10 Co-pay | Up to \$100* |
| Trifocal | \$45 Co-pay | Up to \$100* |
| Lenticular | \$45 Co-pay | Up to \$100* |
| Standard Progressive Lens | \$75 Co-pay | Up to \$100* |
| Premium Progressive Lens | \$75, 80% of charge less \$75 Allowance | |

Lens Options

| | | |
|--------------------------------------|----------------|--------------|
| UV Treatment | \$15 | Up to \$100* |
| Tint (Solid and Gradient) | \$15 | Up to \$100* |
| Standard Plastic Scratch Coating | \$15 | Up to \$100* |
| Standard Polycarbonate—Adults | \$40 | Up to \$100* |
| Standard Polycarbonate—Kids under 19 | \$40 | Up to \$100* |
| Standard Anti-Reflective Coating | \$45 | Up to \$100* |
| Polarized | 20% off retail | Up to \$100* |
| Other Add-Ons and Services | 20% off retail | Up to \$100* |

Contact Lens Fit and Follow-Up (Contact lens fit and 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 ¹ | 10% off retail price | N/A |

Contact Lenses (Contact lens allowance includes materials only)

| | | |
|---------------------|---|--------------|
| Conventional | \$0 Co-pay, \$100 Allowance, 15% off balance over \$100 | Up to \$100* |
| Disposable | \$0 Co-pay, \$100 Allowance; plus balance over \$100 | Up to \$100* |
| Medically Necessary | \$0 Co-pay, paid-in-full | Up to \$100* |

Laser Vision Correction

LASIK or PRK from U.S. Laser Network 15% off the retail price or 5% off the promotional price

***In and Out of Network Allowance:** The maximum dollar amount paid for the plan for both in and out-of-network services is \$100 per year per employee and dependent. Members are responsible for expenses exceeding the \$100 plan maximum, however, excess expenses may be discounted if they are received from an EyeMed Network Provider. Members may still go to any vision care provider of their choice. However, all claims for vision expenses from an out-of-network provider must be paid at the time of service and a copy of the receipt and claim form will be submitted to EyeMed for the administration of vision plan benefits. For in-network services, the member is responsible for paying the applicable copay(s) and any cost that exceeds the plan maximum. In-network providers will submit the claim on behalf of the member.

Frequency

| | |
|--------------------------|----------------------|
| Examination | Once every 12 months |
| Lenses or Contact Lenses | Once every 12 months |
| Frame | Once every 12 months |

*Benefits are not provided from services or materials arising from: Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses, medical and/or surgical treatment of the eye, eyes or supporting structures; Any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear; 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; Plano (non-prescription) lenses; Non-prescription sunglasses; Two pair of glasses in lieu of bifocals; Services or materials provided by any other group benefit plan providing vision care; 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. 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 with the same benefits year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, 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. ¹Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Not available in all states. Some provisions, benefits, exclusions or limitations listed herein may vary.

What's in it for me?

Options. It's simple really. We're dedicated to helping you see clearly – and that's why we've built a network that gives you lots of choices and flexibility. You can choose from thousands of independent 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 help you access the care you need. Welcome to EyeMed.



| Benefits Snapshot | With EyeMed | Out-of-Network Reimbursement |
|--|--|------------------------------|
| Exam, with dilation as necessary (Once every 12 months) | \$10 Co-pay | Up to \$100* |
| Frames (Once every 12 months) | \$0 Co-pay, \$50 Allowance; 20% off balance over \$50 | Up to \$100* |
| Single Vision Lenses (Once every 12 months) or Contacts (Once every 12 months) | \$0 Co-pay \$0 Co-pay, \$100 Allowance; plus balance over \$100 | 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 with us 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...

67%
SAVINGS
with us*

| | With EyeMed | Without Insurance** |
|-------|--|--|
| Exam | \$10 Co-pay | Exam \$106 |
| Frame | \$163 -\$50 Allowance \$113 -\$23 (20% discount off balance) \$90 | Frame \$163 |
| Lens | \$0 Co-pay \$15 UV treatment add-on +\$15 scratch coating add-on \$30 | Lens \$78 \$23 UV treatment add-on +\$25 scratch coating add-on \$126 |
| Total | \$130 | Total \$395 |



Download the EyeMed Members App

It's the easy way to view your ID card, see benefit details and find a provider near you.



*This is a snapshot of your benefits. Actual savings will depend on provider, frame and lens selections. **Based on industry averages.