Vision Care RR Donnelley EyeMed

SELECT Network

Contact 1-866-299-1358 with any additional questions

The innovation of EyePrefer allows employees to choose from two plan designs to maximize their household's benefit dollar.

Vision Care Services	ESSENTIAL		ENHANCED	
	Member Cost	**Out-of-Network Reimbursement**	**Member Cost**	**Out-of-Network Reimbursement**
Exam with Dilation as Necessary	$10 Copay	Up to $35	$0 Copay	Up to $35
Exam Options				
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 price, then apply $40 Allowance	Up to $40
Frames	$0 Copay; $130 Allowance, 20% off balance over $130	Up to $60	$0 Copay; $160 Allowance, 20% off balance over $160	Up to $80
Standard Plastic Lenses				
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
Lens Options				
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
Photocromatic/Transitions Plastic	$75	N/A	$75	N/A
Premium Anti-Reflective	See fixed premium price list below:	N/A	See fixed premium price list below:	Up to $5
Other Add-Ons	20% off Retail Price	N/A	20% off Retail Price	N/A
Contact Lenses				
Contact lens allowance includes materials only				
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
Laser Vision Correction				
For Lasik Providers call 1-877-5LASER6 or visit eyemedlasik.com.	15% off Retail Price or 5% off promotional price	N/A	15% off Retail Price or 5% off promotional price	N/A
Amplifon Hearing Health Care	Members receive a 40% discount off hearing exams and a low price guarantee on discounted hearing aids.	N/A	Members receive a 40% discount off hearing exams and a low price guarantee on discounted hearing aids.	N/A
Additional Pairs Benefit	Members also receive a 40% discount off complete pair eyeglass purchases.	N/A	Members also receive a 40% discount off complete pair eyeglass purchases.	N/A
Member Cost Schedules				
Progressive Lenses - Standard	$85 Copay	Up to $40	$10 Copay	Up to $55
Progressive Lenses - Tier 1-3	$105 Copay - $130 Copay	Up to $40	$30 Copay - $55 Copay	Up to $55
Progressive Lenses - Tier 4	$85 Copay, 80% of charge less $120 allowance	Up to $40	$10 Copay, 80% of charge less $120 allowance	Up to $55
Anti-Reflective Coating - Standard	$45	N/A	$0 Copay	Up to $5
Anti-Reflective Coating - Tier 1-2	$57 - $68	N/A	$12 Copay - $23 Copay	Up to $5
Anti-Reflective Coating - Tier 3	80% of charge	N/A	$0 Copay, 80% of charge less $45 allowance	Up to $5
Frequency			***Frequency***	
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. 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.