



# Genesee ISD – GIESPA

Group#: 1025642

## SUMMARY OF BENEFITS



### 40% OFF

additional complete pair of prescription eyeglasses

### 20% OFF

non-covered items, including non-prescription sunglasses

### Find an eye doctor (Insight Network)

- 866.804.0982
- eyemed.com
- EyeMed Members App
- For LASIK, call 1.800.988.4221

### Heads Up

You may have additional benefits. Log into [eyemed.com/member](http://eyemed.com/member) to see all plans included with your benefits.

#### VISION CARE SERVICES

##### **EXAM SERVICES**

Exam  
Retinal Imaging

#### IN-NETWORK MEMBER COST

\$0 copay  
Up to \$39

#### OUT-OF-NETWORK MEMBER REIMBURSEMENT

Up to \$40  
Not covered

##### **CONTACT LENS FIT AND FOLLOW-UP**

Fit and Follow-up – Standard  
Fit and Follow-up – Premium

Up to \$40; contact lens fit and two follow-up visits  
10% off retail price

Not covered  
Not covered

##### **FRAME**

Frame

\$0 copay; 20% off balance over \$200 allowance

Up to \$140

##### **STANDARD PLASTIC LENSES**

Single Vision  
Bifocal  
Trifocal  
Lenticular  
Progressive – Standard  
Progressive – Premium Tier 1-4

\$0 copay  
\$0 copay  
\$0 copay  
\$0 copay  
\$0 copay  
\$85 - \$175 copay

Up to \$30  
Up to \$50  
Up to \$70  
Up to \$70  
Up to \$50  
Up to \$50

##### **LENS OPTIONS**

Anti Reflective Coating - Standard  
Anti Reflective Coating – Premium Tier 1-3  
Photochromic – Non-Glass  
Polycarbonate – Standard  
Polycarbonate – Standard < 19 years of age  
Scratch coating – Standard Plastic  
Tint – Solid and Gradient  
UV Treatment  
All Other Lens Options

\$45  
\$57 - 85  
\$75  
\$40  
\$0 copay  
\$0 copay  
\$15  
\$15  
20% off retail price

Up to \$5  
Up to \$5  
Not covered  
Not covered  
Up to \$5  
Up to \$5  
Not covered  
Not covered  
Not covered

##### **CONTACT LENSES**

Contacts – Conventional  
Contacts – Disposable  
Contacts – Medically Necessary

\$0 copay; 15% off balance over \$160 allowance  
\$0 copay; 100% off balance over \$160 allowance  
\$0 copay; paid in full

Up to \$112  
Up to \$112  
Up to \$210

##### **OTHER**

Hearing Care from Amplifon Network  
LASIK or PRK from U.S. Laser Network

Up to 64% off hearing aids; call 1.877.203.0675  
15% off retail or 5% off promo price; call 1.800.988.4221

Not covered  
Not covered

##### **FREQUENCY**

Exam  
Frame  
Lenses  
Contact Lenses

##### **ALLOWED FREQUENCY-ADULTS**

Once every plan year  
Once every plan year  
Once every plan year  
Once every plan year

##### **ALLOWED FREQUENCY-ADULTS**

Once every plan year  
Once every plan year  
Once every plan year  
Once every plan year

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. Allowances provide no remaining balance for future use within the same Benefit Frequency. Some provisions, benefits, exclusions or limitations listed herein may vary by state. Plan 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.