Metro

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	$15 Copay	Up to $40
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
Retinal Imaging	Up to $39	N/A
Frames	$25 Copay; $130 allowance; 80% of charge over $130	Up to $45
Standard Plastic Lenses		
Single Vision	$25 Copay	Up to $40
Bifocal	$25 Copay	Up to $40
Trifocal	$25 Copay	Up to $60
Standard Progressive Lens	$25 Copay	Up to $80
Premium Progressive Lens	$25, 80% of charge less $120 Allowance	Up to $80
Lenticular	$25 Copay	Up to $80
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	$25 Copay; $130 allowance; 85% of charge over $130	Up to $125
Disposable	$25 Copay; $130 allowance; plus balance over $130	Up to $125
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 24 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)	**$15 Copay**	Up to $40
Frames (Once every 24 months)	**$25 Copay; $130 allowance; 80% of charge over $130**	Up to $45
Single Vision Lenses (Once every 12 months)	**$25 Copay**	Up to $40
Or		
Contacts (Once every 12 months)	**$25 Copay; $130 allowance; plus balance over $130**	Up to $125

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 . . .

73% SAVINGS with us

With Us		Without Insurance**	
Exam	**$15 Copay**	Exam	$106
Frame	**$163** **-$130 allowance** **$33** **-$6.60 (20% discount off balance)** **$26.40 (plus $25 Copay)**	Frame	$163
Lens	**$25 Copay** **$15 UV treatment add-on** **+$0 Scratch coating add-on** **$40**	Lens	$78 $23 UV treatment add-on +$25 Scratch coating add-on $126
Total	**$106.40**	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.

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