BENEFITS COMPARISON

EyeMed

LVBCH℠
Employers for Healthcare Value Since 1980

Extra savings

Great benefit plans, plus additional savings, such as:

40% OFF additional complete pairs of prescription eyeglasses[1, 2]

20% OFF items not covered by plans[2]

15% OFF retail price of LASIK or PRK Vision Correction at U.S Laser Network. For LASIK providers call 1.877.5LASER6[2]

	OPTION 1	OPTION 2	OPTION 3	OPTION 4	OPTION 5	OPTION 6	OPTION 7	OPTION 8
	Member Cost In-Network	Member Cost In-Network	Member Cost In-Network	Member Cost In-Network	Member Cost In-Network	Member Cost In-Network	Member Cost In-Network	Member Cost In-Network
VISION EXAM								
Exam with Dilation	$10 Copay	$10 Copay	$10 Copay	$10 Copay	$10 Copay	$10 Copay	$10 Copay	$10 Copay
Retinal Imaging Benefit	Up to $39	Up to $39	Up to $39	Up to $39	Up to $39	Up to $39	Up to $39	Up to $39
Standard Contact Lens Fit & Follow-Up	$40	$40	$40	$40	$40	$40	$40	$40
Premium Contact Lens Fit & Follow-Up	10% off retail price	10% off retail price	10% off retail price	10% off retail price	10% off retail price	10% off retail price	10% off retail price	10% off retail price
FRAMES								
Any available frame at provider location	$0 Copay; $130 allowance, 20% off balance over $130	$0 Copay; $130 allowance, 20% off balance over $130	$0 Copay; $130 allowance, 20% off balance over $130	$0 Copay; $130 allowance, 20% off balance over $130	$0 Copay; $150 allowance, 20% off balance over $150	$0 Copay; $150 allowance, 20% off balance over $150	$0 Copay; $150 allowance, 20% off balance over $150	$0 Copay; $150 allowance, 20% off balance over $150
STANDARD PLASTIC LENSES								
Single, Bifocal, Trifocal & Lenticular Vision	$25 Copay	$25 Copay	$25 Copay	$25 Copay	$10 Copay	$10 Copay	$10 Copay	$10 Copay
Standard Progressive	$25 Copay	$25 Copay	$25 Copay	$25 Copay	$10 Copay	$10 Copay	$10 Copay	$10 Copay
Premium Progressives	Tier 1: $110; Tier 2: $120; Tier 3: $135; Tier 4: $200	Tier 1: $110; Tier 2: $120; Tier 3: $135; Tier 4: $200	Tier 1: $110; Tier 2: $120; Tier 3: $135; Tier 4: $200	Tier 1: $110; Tier 2: $120; Tier 3: $135; Tier 4: $200	Tier 1: $95; Tier 2: $105; Tier 3: $120; Tier 4: $185	Tier 1: $95; Tier 2: $105; Tier 3: $120; Tier 4: $185	Tier 1: $95; Tier 2: $105; Tier 3: $120; Tier 4: $185	Tier 1: $95; Tier 2: $105; Tier 3: $120; Tier 4: $185
LENS OPTIONS								
UV Treatment & Tint	$15	$15	$15	$15	$15	$15	$15	$15
Standard Plastic Scratch Coating	$15	$15	$15	$15	$15	$15	$15	$15
Standard Polycarbonate - Adults	$40	$40	$40	$40	$40	$40	$40	$40
Standard Polycarbonate - Child	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Standard Anti-Reflective Coating	$45 Copay	$45 Copay	$45 Copay	$45 Copay	$45 Copay	$45 Copay	$45 Copay	$45 Copay
Premium Anti-Reflective Coating	Tier 1: $57; Tier 2: $68; Tier 3: $85	Tier 1: $57; Tier 2: $68; Tier 3: $85	Tier 1: $57; Tier 2: $68; Tier 3: $85	Tier 1: $57; Tier 2: $68; Tier 3: $85	Tier 1: $57; Tier 2: $68; Tier 3: $85	Tier 1: $57; Tier 2: $68; Tier 3: $85	Tier 1: $57; Tier 2: $68; Tier 3: $85	Tier 1: $57; Tier 2: $68; Tier 3: $85
CONTACT LENSES								
Conventional	$0 Copay; $130 allowance, 15% off balance over $130	$0 Copay; $130 allowance, 15% off balance over $130	$0 Copay; $130 allowance, 15% off balance over $130	$0 Copay; $130 allowance, 15% off balance over $130	$0 Copay; $150 allowance, 15% off balance over $150	$0 Copay; $150 allowance, 15% off balance over $150	$0 Copay; $150 allowance, 15% off balance over $150	$0 Copay; $150 allowance, 15% off balance over $150
Disposable	$0 Copay; $130 allowance, plus balance over $130	$0 Copay; $130 allowance, plus balance over $130	$0 Copay; $130 allowance, plus balance over $130	$0 Copay; $130 allowance, plus balance over $130	$0 Copay; $150 allowance, plus balance over $150	$0 Copay; $150 allowance, plus balance over $150	$0 Copay; $150 allowance, plus balance over $150	$0 Copay; $150 allowance, plus balance over $150
Medically Necessary	$0 Copay; Paid-in-Full	$0 Copay; Paid-in-Full	$0 Copay; Paid-in-Full	$0 Copay; Paid-in-Full	$0 Copay; Paid-in-Full	$0 Copay; Paid-in-Full	$0 Copay; Paid-in-Full	$0 Copay; Paid-in-Full
MONTHLY RATES	VOLUNTARY	NON-VOLUNTARY	VOLUNTARY	NON-VOLUNTARY	VOLUNTARY	NON-VOLUNTARY	VOLUNTARY	NON-VOLUNTARY
Subscriber	$6.66	$5.10	$7.52	$5.75	$7.86	$6.13	$9.05	$6.87
Subscriber + Spouse	$12.67	$9.68	$14.29	$10.93	$14.93	$11.64	$17.19	$13.06
Subscriber + Child(ren)	$13.33	$10.19	$15.04	$11.50	$15.72	$12.26	$18.10	$13.75
Subscriber + Family	$19.60	$14.98	$22.11	$16.91	$23.10	$18.02	$26.61	$20.21
FREQUENCY	12, 12, 24	12, 12, 24	12, 12, 12	12, 12, 12	12, 12, 24	12, 12, 24	12, 12, 12	12, 12, 12

1 Complete Pair Eyeglasses Purchase Discounts: Frame, lenses, and lens options must be purchased in same transaction to receive full discount. 2 Discounts are available at participating in-network providers only. Not all in-network providers offer all discounts so please confirm your provider offers discounts prior to your appointment. Discounts are not insured benefits and do not apply to EyeMed Provider's professional services, certain brand name Vision Materials in which the manufacturer imposes a no-discount practice, or contact lenses. Discounts cannot be combined with any other discounts or promotional offers.

Plan Limitations and Exclusions: No benefits will be paid for services or materials connected with or changes 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 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. Fees charged by a provider for services other than a covered benefit must be paid in full by the insured person to the provider. Such fees or materials are not covered under the policy. 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, Policy Number VC-19, Policy Form Number M-9083. S-1908-CB-713