Fayette County Schools

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 INSIGHT Network
- For a complete list of in-network providers near you, use our Enhanced Provider Locator on eyemed.com or call 1.866.804.0982.
- For LASIK providers, call 1.877.5LASER6.

SUMMARY OF BENEFITS

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam With Dilation as Necessary	$10 Co-pay	Up to $45
Retinal Imaging	Up to $39	N/A
Frames	$0 Co-pay, $150 Allowance, 20% off balance over $150	Up to $75
Standard Plastic Lenses		
Single Vision	$10 Co-pay	Up to $40
Bifocal	$10 Co-pay	Up to $60
Trifocal	$10 Co-pay	Up to $80
Lenticular	$10 Co-pay	Up to $80
Standard Progressive Lens	$75 Co-pay	Up to $60
Premium Progressive Lens[Δ]	$95 Co-pay - $120 Co-pay	
Tier 1	$95 Co-pay	Up to $60
Tier 2	$105 Co-pay	Up to $60
Tier 3	$120 Co-pay	Up to $60
Tier 4	$75 Co-pay, 80% of charge less $120 Allowance	Up to $60
Lens Options		
UV Treatment	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Plastic Scratch Coating	$15	N/A
Standard Polycarbonate–Adults	$40	N/A
Standard Polycarbonate–Kids under 19	$0 Co-pay	Up to $30
Standard Anti-Reflective Coating	$45	N/A
Premium Anti-Reflective Coating[Δ]	$57 - $68	N/A
Tier 1	$57	N/A
Tier 2	$68	N/A
Tier 3	80% of charge	N/A
Photochromic/Transitions	$75	N/A
Polarized	20% off retail	N/A
Other Add-Ons and Services	20% off retail	N/A
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	10% off retail price	N/A
Contact Lenses (Contact lens allowance includes materials only.)		
Conventional	$0 Co-pay, $130 Allowance, 15% off balance over $130	Up to $130
Disposable	$0 Co-pay, $130 Allowance; plus balance over $130	Up to $130
Medically Necessary	$0 Co-pay, 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
Hearing Care		
Hearing Health Care from Amplifon Hearing Network	40% off hearing exams and a low price guarantee on discounted hearing aids	N/A
Frequency		
Examination	Once every calendar year	
Lenses or Contact Lenses	Once every calendar year	
Frame	Once every calendar year	
Premiums–Per Pay Period		
Subscriber	$4.82	
Subscriber + Spouse	$8.28	
Subscriber + Children	$9.90	
Subscriber + Family	$12.20	

Benefits are not provided from services or materials arising from: Orthopic 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 Combined Insurance Company of America, 5050 Broadway, Chicago, IL 60640, except in New York. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer. [Δ]Premium 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

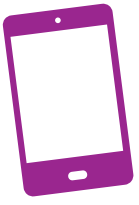
	With EyeMed	Out-of-Network Reimbursement
Exam, with dilation as necessary (Once every calendar year)	$10 Co-pay	Up to $45
Frames (Once every calendar year)	$0 Co-pay, $150 Allowance; 20% off balance over $150	Up to $75
Single Vision Lenses (Once every calendar year)	$10 Co-pay	Up to $40
or **Contacts** (Once every calendar year)	$0 Co-pay, $130 Allowance; plus balance over $130	Up to $130

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...

85% SAVINGS with us*

With EyeMed		Without Insurance**	
Exam	$10 Co-pay	Exam	$106
Frame	$163 -$150 Allowance $13 -$2.60 (20% discount off balance) $10.40	Frame	$163
Lens	$10 Co-pay $15 UV treatment add-on +$15 scratch coating add-on $40	Lens	$78 $23 UV treatment add-on +$25 scratch coating add-on $126
Total	$60.40	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.

EyeMed | INDEPENDENT PROVIDER NETWORK + LensCrafters | Pearle Vision | Target Optical | Sears Optical

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