Proposed Benefits

EyeMed Vision Care in conjunction with Fidelity Security Life Insurance Company

Option 1

Exam & Materials

Insight Network

Fully Insured

Employee Paid

Funded Benefits

Frequency

Examination
Once every plan year

Lenses (in lieu of contacts)
Once every plan year

Contacts (in lieu of lenses)
Once every plan year

Frame
Once every other plan year

Terms

Contract Term
48 months

Rate Guarantee
48 months

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES		
Exam at PLUS Providers	***$0 copay***	Up to $40
Exam	$10 copay	Up to $40
FRAME		
Any available frame at PLUS Providers	***$0 copay; 20% off balance over $180 allowance***	Up to $91
Frame	$0 copay; 20% off balance over $130 allowance	Up to $91
CONTACT LENSES		
(Contact Lens allowance includes materials only)		
Contacts - Conventional	$0 copay; 15% off balance over $130 allowance	Up to $91
Contacts - Disposable	$0 copay; 100% of balance over $130 allowance	Up to $91
Contacts - Medically Necessary	$0 copay; paid-in-full	Up to $300
STANDARD PLASTIC LENSES		
Single Vision	$25 copay	Up to $30
Bifocal	$25 copay	Up to $50
Trifocal	$25 copay	Up to $70
Lenticular	$25 copay	Up to $70
Progressive - Standard	$80 copay	Up to $50
Progressive - Premium Tier 1	$110 copay	Up to $50
Progressive - Premium Tier 2	$120 copay	Up to $50
Progressive - Premium Tier 3	$135 copay	Up to $50
Progressive - Premium Tier 4	$200 copay	Up to $50
LENS OPTIONS		
Anti Reflective Coating - Standard	$45 copay	Up to $23
Anti Reflective Coating - Premium Tier 1	$57 copay	Up to $23
Anti Reflective Coating - Premium Tier 2	$68 copay	Up to $23
Anti Reflective Coating - Premium Tier 3	$85 copay	Up to $23

MONTHLY RATES

Subscriber	$6.37
Subscriber + 1	$12.13
Subscriber + Family	$17.80

Monthly Rate is subject to adjustment even during a rate guarantee period in the event of any of the following events: changes in benefits, employee contributions, the number of eligible employees, or the imposition of any new taxes, fees or assessments by Federal or State regulatory agencies. The Plan 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.

PLAN DETAILS

Quote for group situsedin the State of OH and will be valid until the 10/01/2022 implementation date. Date Quoted 08/09/2022. Rates are valid only when the quoted plan is the sole stand-alone vision plan offered by the group. Percentage discounts are not part of the insurance benefit. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York. Fidelity Security Life Policy number VC-146, form number M-9184.

PLAN EXCLUSIONS/LIMITATIONS

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.

By signing below, the Group agrees to receive all documents and correspondence electronically and that the Group can access the internet or the email address provided. The Group understands that the Group may revoke this authorization or request specific paper documents without revoking this authorization by contacting EyeMed by mail, email, or telephone. If Summit County ESC has chosen this benefit design, attach this document to the group application and sign here

DocuSigned by:
Laurel Young
2CFDB7741FEC414...
Signature

8/29/2022 | 2:33 PM EDT
Date