SERVICE FREQUENCY

Service Type	Allowed Frequency - Adults	Allowed Frequency - Kids	Allowed Frequency - Seniors
Exam	Once every 12 months from the date of service	Once every 12 months from the date of service	Once every 12 months from the date of service
Contact Lens Fit and Follow-up	Unlimited	Unlimited	Unlimited
Frame	Once every 24 months from the date of service	Once every 24 months from the date of service	Once every 24 months from the date of service
Lenses	Once every 12 months from the date of service	Once every 12 months from the date of service	Once every 12 months from the date of service
Contact Lenses	Once every 12 months from the date of service	Once every 12 months from the date of service	Once every 12 months from the date of service

Date of Service benefits will not be available again until the same date in the following year(s) when a member has active coverage.

Restrictions

Plan allows the member to receive either contacts and frame, or frame and lens services.

BENEFITS

Vision Care Services	In-Network Member Cost	Out-of-Network Member Reimbursement
Exam Services		
Exam	$10 copay	Up to $50
Retinal Imaging	Up to $39	Not covered
Contact Lens Fit and Follow-Up		
Fit and Follow-up - Standard	Up to $55	Not covered
Fit and Follow-up - Premium	10% off retail price	Not covered
Frame		
Frame	$0 copay; 20% off balance over $150 allowance	Up to $120
Lenses		
Single Vision	$25 copay	Up to $50
Bifocal	$25 copay	Up to $70

Trifocal	$25 copay	Up to $100
Lenticular	$25 copay	Up to $125
Progressive - Standard	$90 copay	Up to $125
Progressive - Premium	$90 copay; 20% off retail price less $120 allowance	Up to $125
Lens Options		
Anti Reflective Coating - Standard	$0 copay	Up to $5
Anti Reflective Coating - Premium	20% off retail price	Not covered
Polycarbonate - Standard	$0 copay	Up to $5
Scratch Coating - Standard Plastic	$0 copay	Up to $5
Tint - Solid and Gradient	$15	Not covered
UV Treatment	$15	Not covered
All Other Lens Options	20% off retail price	Not covered
Contact Lenses		
Contacts - Conventional	$0 copay; 15% off balance over $150 allowance	Up to $150
Contacts - Disposable	$0 copay; 100% of balance over $150 allowance	Up to $150
Contacts - Medically Necessary	$0 copay	Up to $300

Limitations, Exclusions and Discounts

Limitations

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.

Exclusions

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;
lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available.
This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.

Plan Discounts

Member receives a 20% discount on items not covered by the plan at In-Network locations. Discount does not apply to Provider's professional services or contact lenses.
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 the online provider locator to determine which participating providers have agreed to the discounted rate.
Discounts on vision materials may not be applicable to certain manufacturers' products.
The Plan reserves the right to make changes to the products on each tier and to the member out-of-pocket costs. Fixed tier pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels.
Services and amounts listed above are subject to change at any time.
Discounts are not insured benefits.
Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, Policy number VC-19, form number M-9083, or Policy number VC-146, form number M-9184, in New York underwritten by Fidelity Security Life Insurance Company of New York, Policy Number VCN-1, form number MN-1, or Policy Number VCN-19, form number MN-28.