Savannah-Chatham CPSS
EyeMed Insight Plan H, Fixed Fee
Voluntary
Option 2
EyeMed Vision Care in conjunction with Combined Insurance Company of America

Version 6

Vision Care Services	Member Cost In-Network	Out-of-Network Reimbursement*
Exam with Dilation as Necessary	$10 Copay	$35
Fundus Photography Benefit	Up to $39	N/A
Exam Options:		
Standard Contact Lens Fit and Follow-Up:	Up to $55	N/A
Premium Contact Lens Fit and Follow-Up:	10% off Retail Price	N/A
Frames: Any available frame at provider location	$0 Copay; $130 Allowance, 20% off balance over $130	$65
Standard Plastic Lenses		
Single Vision	$20 Copay	$25
Bifocal	$20 Copay	$40
Trifocal	$20 Copay	$55
Standard Progressive Lens	$85 Copay	$40
Premium Progressive Lens	See attached Fixed Premium Progressive price list	$40
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	$40	N/A
Standard Anti-Reflective Coating	$45	N/A
Polarized	20% off Retail Price	N/A
Photocromatic / Transitions Plastic	$75	N/A
Premium Anti-Reflective	See attached Fixed Premium Anti-Reflective Coating price list	N/A
Other Add-Ons	20% off Retail Price	N/A
Contact Lenses		
(Contact lens allowance includes materials only)		
Conventional	$0 Copay; $130 allowance, 15% off balance over $130	$104
Disposable	$0 Copay; $130 allowance, plus balance over $130	$104
Medically Necessary	$0 Copay, Paid-in-Full	$210
Laser Vision Correction		
Lasik or PRK from U.S. Laser Network	15% off Retail Price or 5% off promotional price	N/A
Amplifon Hearing Health Care	Hearing Health Care from Amplifon Hearing Health Care Network Members receive a 40% discount off hearing exams and a low price guarantee on discounted hearing aids.	N/A
Additional Pairs Benefit:	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A
Frequency:		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 24 months	
Monthly Rate		
Subscriber	$5.22	
Subscriber + Spouse	$9.70	
Subscriber + Child(ren)	$11.00	
Subscriber + Family	$14.17	

All plans are based on a 48-month contract term and 48-month rate guarantee.
Premium 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

* Member Reimbursement Out-of-Network will be the lesser of the listed amount or the member's actual cost from the out-of-network provider. 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 EyeMed's online provider locator to determine which participating providers have agreed to the discounted rate

Additional Discounts:
Member receives a 20% discount on items not covered by the plan at network Providers. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered.
Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision.
After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com.
The contact lens benefit allowance is not applicable to this service.
Benefit Allowances provide no remaining balance for future use within the same Benefit Frequency.
Certain brand name Vision Materials in which the manufacturer imposes a no-discount practice.
Rates are valid only when the quoted plan is the sole stand-alone vision plan offered by the group
Rates are valid for groups domiciled in the State of GA.
Fees quoted will be valid until the 1/1/2017 plan implementation date. Date quoted: 7/7/2016.
Rates assume Employer contribution of 20% or less for employees and dependents
Insured Plans are underwritten by Combined Insurance Company of America, 5050 Broadway, Chicago, IL 60640, except in New York.

Plan Exclusions:
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 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; 9) Services or materials provided by any other group benefit plan providing vision care;
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.

If Savannah-Chatham CPSS has chosen this benefit design, attach this document to the group application and sign here:

Signature _____ Date _____

Savannah-Chatham CPSS

Option 2

Progressive Price List*	Member Cost In-Network (Includes Lens Copay)
Standard Progressive	$85 copay
Premium Progressives as Follows:	
Tier 1	$105 Copay
Tier 2	$115 Copay
Tier 3	$130 Copay
Tier 4	$85 Copay, 80% of charge less $120 Allowance
Anti-Reflective Coating Price List*	**Member Cost In-Network**
Standard Anti-Reflective Coating	$45
Premium Anti-Reflective Coatings as Follows:	
Tier 1	$57
Tier 2	$68
Tier 3	80% of charge
Other Add-ons Price List	**Member Cost In-Network**
Photochromic (Plastic)	$75
Polarized	80% of charge
EyeMed Vision Care reserves the right to make changes to the products on each tier and the member out-of-pocket costs.	
*Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels.	

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Signature Date

For a current listing of brands by tier, go to:
http://www.eyemedvisioncare.com/theme/pdf/microsite-template/eyemedlenslist.pdf