Earnhardt Management Company

Additional discounts

40% OFF
Complete pair of prescription eyeglasses

20% OFF
Non-prescription sunglasses

20% OFF
Remaining balance beyond plan coverage

These discounts are for in-network providers only

Take a sneak peek before enrolling

- You're on the SELECT Network
- For a complete list of **in-network** providers near you, use our **Enhanced** Provider Locator on www.eyemed.com or call **1-866-299-1358**.
- 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 $35
Frames	$120 allowance; 80% of balance over $120	Up to $48
Standard Plastic Lenses		
Single Vision	$25 Co-pay	Up to $25
Bifocal	$25 Co-pay	Up to $40
Trifocal	$25 Co-pay	Up to $60
Standard Progressive Lens	$25, 80% of charge less $55 allowance	Up to $40
Premium Progressive Lens	$25, 80% of charge less $55 allowance	Up to $40
Lens Options (paid by the member and added to the base price of the lens)		
UV Treatment	20% off retail	N/A
Tint (Solid and Gradient)	20% off retail	N/A
Standard Plastic Scratch Coating	20% off retail	N/A
Standard Polycarbonate	20% off retail	N/A
Standard Anti-Reflective Coating	20% off retail	N/A
Other Add-Ons and Services	20% off retail price	N/A
Contact Lens Fit and Follow-Up (Contact lens fit and two 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		
Conventional	$135 allowance; 85% of charge over $135	Up to $95
Disposable	$135 allowance; plus balance over $135	Up to $95
Medically Necessary	$0 Co-pay; Paid-in-Full	Up to $200
Laser Vision Correction		
Lasik or PRK from U.S. Laser Network	15% off the retail price or 5% off the promotional price	N/A
Frequency		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 24 months	

Benefits are not provided from services or materials arising from: 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; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals; 8) Services or materials provided by any other group benefit plan providing vision care 9) 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. 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. 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. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York. The Certificate of Insurance is on file with your employer. Benefit allowance provides no remaining balance for future use within the same benefit year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered.

BLM2015

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 12 months)	**$10 Co-pay**	Up to $35
Frames (Once every 24 months)	**$120 allowance; 80% of balance over $120**	Up to $48
Single Vision Lenses (Once every 12 months)	**$25 Co-pay**	Up to $25
Or		
Contacts (Once every 12 months)	**$135 allowance; plus balance over $135**	Up to $95

Download the EyeMed Members App

It's the easy way to view your ID card, see benefit details and find a provider near you.

INDEPENDENT PROVIDER NETWORK + LensCrafters Pearle Vision Optical sears Optical JCPenney | optical

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