



Voluntary Vision Member Benefit Summary

Vision Benefits for Rich Township District 227

This plan provides coverage for a vision examination eyeglass lenses and frame or contact lenses. Vision benefits are available from an extensive national network of participating providers contracted through EyeMed Vision Care. You can easily find a conveniently located provider near you. You have a choice of independent optometrists and ophthalmologists, as well as retail locations such as Lens Crafters, Pearle Vision, Sears, Target Optical and JC Penney Optical. Members will receive additional savings from Network Providers for lens upgrades and additional pair purchases.

NETWORK PROVIDERS - By using a network provider, you minimize your out-of-pocket costs and receive the benefit of our paperless claims processing. Network Providers verify your eligibility and obtain all the necessary information to validate your level of coverage. You simply pay your copayment and any remaining balance for non-covered services or materials at the time of your appointment. In addition, Network Providers offer you discount pricing which is significantly below retail. You receive substantial savings of 15%-40% or more on most additional pair purchases, conventional contact lenses, lens treatments, specialized lenses and various accessory items.

Benefits from a Network Provider*		Copayment
Vision Examination	Once every 12 months	\$ 10.00
Eyeglass Lenses - single vision, bifocal, or trifocal in standard/basic plastic w/Standard Scratch Resistance	Once every 12 months	\$ 20.00
Frame –covered in full up to a \$130.00 retail value. Members receive 20% off balance for selection costing more than the plan allowance	Once every 12 months	N/A
Contact Lenses- in lieu of spectacle lenses (does not include fitting and follow-up)	Once every 12 months	N/A
Elective – Disposable or Conventional, covered in full up to \$130 allowance. Conventional lenses: members receive 15% discount off balance over plan allowance.		
Medically Necessary – Covered in full up to \$250		
Standard Contact Lens Fitting & Follow-up	Member Option	\$40.00
Premium Contact Lens Fitting and Follow-up	Member Option	90% of retail

Out of Network Benefits** – If you choose to go to a non-network provider, you must pay the provider his or her full charges at the time of service. Members will be responsible for submitting a claim for reimbursement for the amount indicated in the member reimbursement schedule.

Vision Examination	Up to \$ 30.00
Lenses	
Single Vision	Up to \$ 35.00
Bifocal	Up to \$ 50.00
Trifocal	Up to \$ 75.00
Scratch Resistance	Up to \$11.00
Frame	Up to \$ 50.00
Elective Contact Lenses (in lieu of spectacle lenses)	Up to \$105.00
Medically Necessary Contact Lenses	Up to \$200.00

*In-network services and materials may be subject to a copayment at the time of service. **Out-of-Network amounts are maximum reimbursable amounts paid to members after the claim is filed. Amounts may vary by state.

Additional Savings Program Pricing available in conjunction with funded benefits			
Lens Options	Member Pricing	Other Options/Services	Member Pricing
Tint (solid & gradient)	\$15	Other Lens Add-Ons and Services	20% off Retail
UV Coating	\$15	Additional Complete Pair Purchases ***	40% off Retail
Standard Scratch Resistance*	Covered	Conventional Contact Lenses	15% off Retail
Standard Polycarbonate (Adult/Children)	\$40	Premium Contact Lens Fitting and Follow-up	10% discount
Standard Anti-Reflective	\$45	Standard Contact Lens Fitting and Follow-up	\$40.00
Standard Progressive Lens**	\$65	Premium Progressive Lens**	20% off Retail
* Scratch Coating is covered in by your funded benefit only. ** Standard/Premium Progressive lenses are not covered benefits – however when upgrading in conjunction with your funded benefit the bifocal lens amount will be applied. Members are responsible for the lens copayment and any additional charges. *** Complete Pair Eyeglasses Purchase: Frame, lenses and lens options must be purchased in the same transaction to receive full discount. <ul style="list-style-type: none"> • 20% discount on the balance over the frame allowance • 15% discount on the balance over the conventional lens allowance 			

Monthly Premium	
Employee Only	\$ 4.83
Employee + Spouse	\$ 9.66
Employee + Child(ren)	\$ 10.14
Employee + Family	\$16.42



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Limitations & Exclusions

Fees charged by a provider for services other than a covered benefit must be paid in full by the insured to the provider. Such fees or materials are not covered under the policy. Benefit allowances provide no remaining balance for future use within the same benefit frequency. No benefits will be paid for services or materials connected with/ or charges arising from

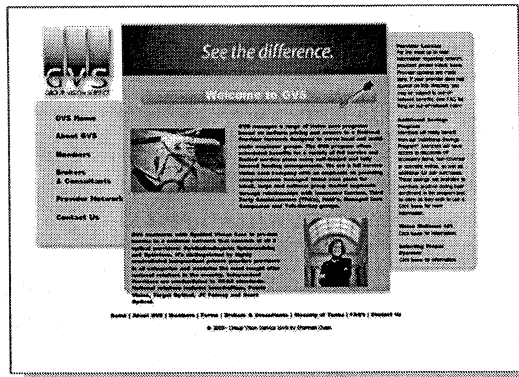
- Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; medical and/or surgical treatment of the eye, eyes or supporting structures
- Any corrective eyewear, required by a policyholder as a condition of employment, safety eyewear, services provided as a result of any Worker's Compensation law, or similar legislation or required by any governmental agency or program whether federal, state or subdivision thereof
- Plano (non-prescription) lenses; non-prescription sunglasses
- Two pair of glasses in lieu of bifocal
- Services or materials provided by another group benefit plan providing vision care
- Services rendered after the date an insured ceases to be covered under the policy, except when vision materials ordered before coverage ended are delivered and the services rendered to the insured 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.

Visit the GVS web site to "Locate a Provider" or "View your Benefits" and learn more about our Additional Savings Program

Web Site – www.gvsmd.com - click "Members" to locate a provider or view your benefits

Customer Service and IVR – at 866-265-4626
Call customer service to ask about your benefits or to locate a provider.

Access 7 Days a Week	Call Center Hours
	8:00am to 11:00pm EST Monday - Saturday 11:00am to 8:00pm EST - Sunday



Locating a Provider

Network Providers

1. Find network provider at www.gvsmd.com click on "Provider Locator".
2. Schedule an exam with the provider of your choice. When scheduling your appointment inform the provider that you are a GVS/EyeMed member and provide your name and date of birth (DOB). The provider will verify your eligibility and plan benefits prior to your appointment.
3. If you have already made an appointment show your ID card at the time of service or provide your name and DOB for quick verification of eligibility and plan coverage.
4. Members will be responsible to pay the provider at the time of service for any applicable copayment /costs that exceed the plan coverage.

Out-of-Network Providers

1. Visit non network provider
2. Members are required to pay the entire amount for exam and eyewear at the time of service.
3. Members must obtain an OON claim form from the GVS website at www.gvsmd.com. (click "Members" click "Forms").
4. Members must submit OON claim form and provider receipt to the Claims Address indicated on the form.
5. Member will be reimbursed based on OON benefits indicated in their benefit summary.