

EyeMed – Choose from two plans.

EYEMED ACCESS PLAN A

Eye Exam focuses on your eye health and overall wellness

- \$15 co-payevery 12 months

Contact Lens Exam & Fitting
Standard and premium contact lens exam and fitting

- \$15 co-payevery 12 months

Frames

- Up to \$150 frame allowance.....every 12 months

Contacts (in lieu of frames)

- Up to \$150 allowanceevery 12 months

Single/Bifocal/Trifocal or Lenticular Lenses

- \$25 co-payevery 12 months

EYEMED ACCESS PLAN B

Eye Exam focuses on your eye health and overall wellness

- \$15 co-payevery 12 months

Contact Lens Exam & Fitting
Standard and premium contact lens exam and fitting

- \$15 co-payevery 24 months

Frames

- Up to \$150 frame allowance.....every 24 months

Contacts (in lieu of frames)

- Up to \$150 allowanceevery 24 months

Single/Bifocal/Trifocal or Lenticular Lenses

- \$25 co-payevery 24 months

EYEMED DIRECT VISION RATES		
	EyeMed Access Plan A	EyeMed Access Plan B
Individual	\$15.02	\$11.53
Individual +1	\$27.64	\$21.22
Family	\$41.31	\$31.71

Lenses and frames.

- Standard plastic single, bifocal, trifocal or lenticular lenses coverage with discounts available on additional lens options.
- 40% off unlimited additional eyeglasses after initial benefit is exhausted.
- Receive 20% discount on remaining frame balance (once allowance has been applied) and 15% discount on any balance over the conventional contact lens allowance.

Additional benefits at no additional cost.*

- 5-15% savings on LASIK or PRK services through the US Laser Network.

Out-of-network benefits.

Direct Vision also offers out-of-network benefits. Members will realize the biggest benefit savings when they utilize an in-network provider, but our plans reflect the understanding that it is not always possible. When an out-of-network provider is utilized, the member pays the provider the appropriate fees and then requests reimbursement from the plan. The plan will reimburse up to the amounts indicated in the schedule to the right.

ADDITIONAL STANDARD LENS ENHANCEMENTS	SINGLE VISION	MULTIFOCAL VISION
UV Protection Coating	\$15	\$15
Glass Tints	\$15	\$15
Solid Plastic Dye	\$15	\$15
Plastic Gradient Dye	\$15	\$15
Standard Scratch-Resistance	\$15	\$15
Standard Polycarbonate Lens	\$40	\$40
Anti-Reflective Coating	\$45	\$45
Photochromic Lens - Plastic	Retail Discount	Retail Discount
Standard Progressive	\$65	\$65
Other Add-Ons and Services	Retail Discount	Retail Discount

MAXIMUM ALLOWANCE OUT-OF-NETWORK	
Exams	\$50
Frames	\$70
Single Vision Lens	\$50
Bifocal Lens	\$75
Progressive Lens	\$75
Trifocal Lens	\$100
Elective Contact Lenses	\$105
Medically Necessary Contact Lenses	\$250

* These additional discounts and value-added features are not a part of the insurance plan and there is no affiliation or ownership between Security Life and these programs.

The EyeMed Direct Vision Insurance plans are available in all states except: AK, FL, MA, MD, NY, RI, VA, WA and PA counties of Adams, Bradford, Cameron, Forest, Huntington, Mifflin, Montour, Potter, Sullivan, Tioga, and Warren.

NOTICE: This provides a very brief description of some of the important features of the insurance policy. It is not the insurance policy and does not represent it. A full explanation of benefits, exceptions and limitations is contained in Individual Vision Policy Form IP3000 (and any state specific). This policy is renewable at the option of the insured. This product may not be available in all states and is subject to individual state regulations.

For the Outline of Coverage and Replacement Notice, visit www.directvisioninsurance.com.



LIMITATIONS AND EXCLUSIONS

The cost of replacement frames will not be covered, unless the existing frame is not compatible with the replacement lenses.

We will not pay or provide alternate benefits for any of the following:

1. Items, treatments or services: (a.) not listed as an eligible expense; (b.) not prescribed by or performed by or under the direct supervision of a vision provider; (c.) not visually necessary to restore or maintain a patient's visual acuity and health; (d.) not meeting the accepted standards of vision practice; (e.) experimental in nature; or (f.) covered under any other insurance policy providing vision care.
2. Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing; Aniseikonic lenses.
3. Plano lenses and/or contact lenses (less than a $\pm .50$ diopter power).
4. Non-prescription sunglasses.
5. Two pair of glasses in lieu of bifocals or trifocals.
6. Medical and/or surgical treatment of the eye, eyes, or supporting structures.
7. Any eye or vision examination, or any corrective eyewear, required as a condition of employment; Safety eyewear.
8. Replacement of lenses, frames or contacts furnished under this policy that are lost or broken, except at the normal intervals when services are otherwise available.
9. Corneal refractive therapy or orthokeratology.
10. Artistically painted contact lenses.
11. Additional office visits for contact lens pathology.
12. Contact lens modification, polishing or cleaning.
13. 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.
14. 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.
15. Charges for service agreements or insurance policies.
16. Charges for sterilization of equipment; disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies.
17. Telephone consultations, charges for failure to keep a scheduled appointment, or charges for completion of a claim form.
18. Codes that are by report.
19. Ancillary charges, including but not limited to, hospital, ambulatory surgical center or similar facility; or use of provider office space.

BENEFITS ARE LIMITED AS FOLLOWS:

(1) In the event you transfer from the care of one vision provider to that of another during the course of treatment, or if more than one vision provider performs services for one qualifying expense, we shall be liable for not more than the amount we would have been liable for had but one vision provider performed the service.

WHEN WILL MY COVERAGE BEGIN

The Direct Vision Insurance plan provides four options for effective dates. Choose the one that works best for you and your family. You will receive an email confirmation immediately after enrollment to verify this information. Your policy will arrive within 10 business days of enrollment.

IMPORTANT NOTICE: Your enrollment will take 2-3 business days before it becomes accessible in the EyeMed or VSP provider systems. If you have an appointment within several days of your effective date and your provider indicates you are not yet in their system, please call Security Life customer service for assistance. Representatives are available Monday-Friday at 800.300.9566.

Plan includes a one-time non-refundable enrollment fee of \$25. This charge will be made at the time of purchase and may appear as a separate transaction from your vision insurance.