Lower Colorado River Authority

40%OFF

additional complete pair of prescription eyeglasses

20%OFF

non-covered items, including non-prescription sunglasses

Find an eye doctor

(Insight Network)

- eyemed.com
- EyeMed Members App
- For LASIK, call 1.800.988.4221

Heads up

You may have additional benefits. Log into **eyemed.com/member** to see all plans included with your benefits.

SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES		
Exam	$10 copay	Up to $40
Retinal Imaging	Up to $39	Not covered
CONTACT LENS FIT AND FOLLOW-UP		
Fit & Follow-up - Standard	$20 copay; contact lens fit and two follow-up visits	Up to $40
Fit & Follow-up - Premium	$20 copay; 10% off retail price, then apply $40 allowance	Up to $40
FRAME		
Frame	$0 copay; 20% off balance over $125 allowance	Up to $68
STANDARD PLASTIC LENSES		
Single Vision	$20 copay	Up to $32
Bifocal	$20 copay	Up to $46
Trifocal	$20 copay	Up to $61
Lenticular	$20 copay	Up to $70
Progressive - Standard	$85 copay	Up to $61
Progressive - Premium Tier 1 - 3	$105 - 130 copay	Up to $61
Progressive - Premium Tier 4	$85 copay, 20% off retail price less $120 allowance	Up to $61
LENS OPTIONS		
Anti Reflective Coating - Standard	$45	Not covered
Anti Reflective Coating - Premium Tier 1 - 2	$57 - 68 copay	Not covered
Anti Reflective Coating - Premium Tier 3	20% off retail price	Not covered
Photochromic - Non-Glass	$75	Not covered
Polycarbonate - Standard	$40	Not covered
Scratch Coating - Standard Plastic	$15	Not covered
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 $120 allowance	Up to $100
Contacts - Disposable	$0 copay; 100% of balance over $120 allowance	Up to $100
Contacts - Medically Necessary	$0 copay; paid-in-full	Up to $210
OTHER		
Hearing Care from Amplifon Network	Discounts on hearing exam and aids; call 1.877.203.0675	Not covered
Lasik or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered

FREQUENCY	ALLOWED FREQUENCY – ADULTS	ALLOWED FREQUENCY – KIDS
Exam	Once every 12 months	Once every 12 months
Frame	Once every 24 months	Once every 24 months
Lenses	Once every 12 months	Once every 12 months
Contacts Lenses	Once every 12 months	Once every 12 months

(Plan allows member to receive either contacts and frame, or frame and lens services)

QL-0000061152

EyeMed reserves the right to make changes to the products available on each tier. All providers are not required to carry all brands on all tiers. For current listing of brands by tier, call 866-939-3633. 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; or lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. 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.. 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 online provider locator to determine which participating providers have agreed to the discounted rate.