



AcademicBlueSM Vision Plan 1B

Outline of Coverage

Your Benefits are highlighted below. However, to fully understand your Benefits, it is very important that you read this entire Policy.

This Policy will pay without regard to any Medicare, Medicare Advantage, or Medicaid coverage.

Benefit Period: Plan Year

The Benefits are subject to the Benefit Period unless otherwise specified.

Term of Contract: Monthly

Vision Care Benefits	EyeMed Provider	Non-Contracting Provider Reimbursement*
Exam with Dilation as Necessary	\$10 Copay	Up to \$30
Frames: Any available frame at Provider location	\$0 Copay, \$130 Allowance, 20% off balance over \$130	Up to \$65
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 and Follow-Up	\$0 Copay, Paid-in-Full, and two follow-up visits	Up to \$40
Premium Contact Lens Fit and Follow-Up	\$0 Copay, 10% off Retail Price, then apply \$40 Allowance	Up to \$40
Standard Plastic Lenses:		
Single Vision	\$20 Copay	Up to \$8
Bifocal	\$20 Copay	Up to \$18
Trifocal	\$20 Copay	Up to \$35
Lenticular	\$20 Copay	Up to \$35
Standard Progressive Lens	\$0 Copay	Up to \$60
Premium Progressive Lens as follows: **		
Premium Progressive Lens -Tier 1	\$85 Copay	Up to \$60
Premium Progressive Lens -Tier 2	\$95 Copay	Up to \$60
Premium Progressive Lens -Tier 3	\$110 Copay	Up to \$60

Premium Progressive Lens -Tier 4	\$85 Copay, 20% off Retail less \$120 Allowance	Up to \$60
Lens Options:		
Standard Plastic Scratch Coating	\$15 Copay	Up to \$8
Standard Polycarbonate - Kids under 19	\$0 Copay	Up to \$20
Contact Lenses: (Contact Lens allowance includes materials only.)		
Conventional	\$0 Copay, \$130 Allowance, 15% off balance over \$130	Up to \$104
Disposable	\$0 Copay, \$130 Allowance, plus balance Over \$130	Up to \$104
Medically Necessary	\$0 Copay, Paid-in-Full	Up to \$210

Vision Care Services**	Member Cost
Retinal Imaging Benefit	Up to \$39
Lens Options	
UV Treatment	\$15 Copay
Tint (Solid and Gradient)	\$15 Copay
Standard Polycarbonate - Adults	\$40 Copay
Standard Anti-Reflective Coating	\$45 Copay
Premium Anti-Reflective Coating – Tier 1	\$57 Copay
Premium Anti-Reflective Coating – Tier 2	\$68 Copay
Premium Anti-Reflective Coating – Tier 3	20% off Retail Price
Polarized	20% off Retail Price
Photochromic (Plastic)	20% off Retail Price
Other Add-Ons	20% off Retail Price
Laser Vision Correction Lasik or PRK from U.S. Laser Network	15% off Retail Price or 5% off promotional price
Additional Pairs Benefit:	Covered Persons 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.
Frequency:	
Examination	Once every 12 months
Lenses or Contact Lenses	Once every 12 months

Frame	Once every 12 months
Premium is subject to adjustment even during a rate guarantee period in the event of any of the following events: change in Benefits or the imposition of any new taxes, fees, or assessments by Federal or State regulatory agencies.	
*Reimbursement for Non-Contracting Provider Vision Services and Materials will be the lesser of the listed amount or the actual cost from the Non-Contracting Provider. In certain states, Covered Persons may be required to pay the full retail price, 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.	
**No insurance Benefit is provided, EyeMed Provider or Non-Contracting Provider. Member cost displayed is a negotiated and agreed-upon discount with Contracted Providers. For Non-Contracting Providers, Member will pay charged amount.	
EyeMed Vision Care reserves the right to make changes to the products on each tier and the 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.	

Required Notice: READ YOUR PLAN CAREFULLY – THIS BENEFITS SCHEDULE PROVIDES A VERY BRIEF DESCRIPTION OF THE IMPORTANT FEATURES OF YOUR PLAN. THIS IS NOT THE INSURANCE POLICY. YOUR FULL RIGHTS AND BENEFITS ARE EXPRESSED IN THE ACTUAL PLAN DOCUMENTS THAT ARE AVAILABLE TO YOU UPON YOUR REQUEST TO US.



Health care coverage is important for everyone.

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984. We provide free communication aids and services for anyone with a disability or who needs language assistance.

We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability. If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St., 35th Floor
Chicago, IL 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>
Complaint Forms: <https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>

To receive language or communication assistance free of charge, please call us at 855-710-6984.

Español	Llámenos al 855-710-6984 para recibir asistencia lingüística o comunicación en otros formatos sin costo.
العربية	لتلقي المساعدة اللغوية أو التواصل مجاناً، يرجى الاتصال بنا على الرقم 855-710-6984.
繁體中文	如欲獲得免費語言或溝通協助，請撥打855-710-6984與我們聯絡。
Français	Pour bénéficier gratuitement d'une assistance linguistique ou d'une aide à la communication, veuillez nous appeler au 855-710-6984.
Deutsch	Um kostenlose Sprach- oder Kommunikationshilfe zu erhalten, rufen Sie uns bitte unter 855-710-6984 an.
ગુજરાતી	ભાષા અથવા સંચાર સહાય મફતમાં મેળવવા માટે, કૃપા કરીને અમને 855-710-6984 પર કોલ કરો.
हिंदी	निःशुल्क भाषा या संचार सहायता प्राप्त करने के लिए, कृपया हमें 855-710-6984 पर कॉल करें।
Italiano	Per assistenza gratuita alla lingua o alla comunicazione, chiami il numero 855-710-6984.
한국어	언어 또는 의사소통 지원을 무료로 받으려면 855-710-6984번으로 전화해 주세요.
Navajo	Niná: Doo bilagáana bizaad dinits'á'góó, shá ata' hodooni nínízingo, t'áájíík'eh bee náhaz'á. 1-866-560-4042 jí' hodíilni.
فارسی	برای دریافت کمک زبانی یا ارتباطی رایگان، لطفاً با شماره 855-710-6984 تماس بگیرید.
Polski	Aby uzyskać bezpłatną pomoc językową lub komunikacyjną, prosimy o kontakt pod numerem 855-710-6984.
Русский	Чтобы бесплатно воспользоваться услугами перевода или получить помощь при общении, звоните нам по телефону 855-710-6984.
Tagalog	Para makatanggap ng tulong sa wika o komunikasyon nang walang bayad, pakitawagan kami sa 855-710-6984.
اردو	مفت میں زبان یا مواصلت کی مدد موصول کرنے کے لیے، براہ کرم ہمیں 855-710-6984 پر کال کریں۔
Tiếng Việt	Để được hỗ trợ ngôn ngữ hoặc giao tiếp miễn phí, vui lòng gọi cho chúng tôi theo số 855-710-6984.