

Ready to live your best EyeMed life?

There's so much more to your vision benefits than copays and coverage. Get ready to see the good stuff for yourself.

40% OFF additional complete pairs of prescription eyeglasses*

30% OFF non-prescription sunglasses*

Your network is the place to start

See who you want, when you want. You have thousands of providers to choose from—Independent eye doctors, your favorite retail stores, even online options.

Keep your eyes open for extra discounts¹

Members already realize savings of 76% versus retail using their EyeMed benefits,² but our long list of special offers takes benefits even further.

Remember, you're never alone

We're always here to help you use your benefits like a pro. Stay in-the-know with text alerts or healthy vision resources from the experts. If it can make benefits easier for you, we do it.

*These discounts are not insured benefits and are valid at participating in-network providers.

¹Discounts are not insured benefits. ²EyeMed internal book of business analysis, 2022.



**eye
MED**

Create a member account at eyemed.com

Everything is right there in one spot. Check claims and benefits, see special offers and find an eye doctor—search for one with the hours, location and brands you want. For maximum mobility, try the EyeMed App (Google Play or App Store).



INDEPENDENT
PROVIDER
NETWORK



LENSCRAFTERS[®]

PEARLE
VISION^{EST. 1961}

OPTICAL[®]

Find an eye doctor

(Advantage Network)

- eyemed.com/aon-benx
- EyeMed App
- For LASIK, call 1.800.988.4221

Heads up

Plan allows members to receive either a complete pair of prescription glasses, or prescription contact lenses. Log into eyemed.com/member to see the details of your vision plan benefits.

AON BENEFIT EXPERIENCE SUMMARY OF BENEFITS						
Vision Care Services Advantage Network	GOLD VISION BENEFITS PLAN		SILVER VISION BENEFITS PLAN		BRONZE VISION** BENEFITS PLAN	
	In-Network Member Cost	Out-of-Network Reimbursement	In-Network Member Cost	Out-of-Network Reimbursement	In-Network Member Cost	Out-of-Network Reimbursement
EXAM SERVICES						
Exam	\$0 copay	Up to \$45	\$10 copay	Up to \$45	\$0 copay	Up to \$45
CONTACT LENS FIT AND FOLLOW-UP						
Fit and Follow-Up – Standard	\$10 copay, paid-in-full fit and two follow-up visits	Up to \$15	\$20 copay, paid-in-full fit and two follow-up visits	Up to \$10	Not covered	Not covered
Fit and Follow-Up – Premium	\$10 copay, 10% off retail price, then apply \$40 allowance	Up to \$15	\$20 copay, 10% off retail price, then apply \$40 allowance	Up to \$10	Not covered	Not covered
FRAME						
Any available frame at provider location	\$0 copay; \$200 allowance, 20% off balance over \$200	Up to \$100	\$0 copay; \$150 allowance, 20% off balance over \$150	Up to \$75	35% off retail price	Not covered
STANDARD PLASTIC LENSES						
Single Vision	\$10 copay	Up to \$30	\$20 copay	Up to \$30	\$50	Not covered
Bifocal	\$10 copay	Up to \$45	\$20 copay	Up to \$45	\$70	Not covered
Trifocal	\$10 copay	Up to \$55	\$20 copay	Up to \$55	\$105	Not covered
Lenticular	\$10 copay	Up to \$90	\$20 copay	Up to \$90	30% off retail price	Not covered
Progressive – Standard	\$10 copay	Up to \$45	\$20 copay	Up to \$45	\$135	Not covered
Progressive – Premium	\$10 copay, 70% of charge less \$110 allowance	Up to \$45	\$20 copay, 70% of charge less \$110 allowance	Up to \$45	30% off retail price	Not covered

Vision Care Services Advantage Network	GOLD VISION BENEFITS PLAN		SILVER VISION BENEFITS PLAN		BRONZE VISION** BENEFITS PLAN	
	In-Network Member Cost	Out-of-Network Reimbursement	In-Network Member Cost	Out-of-Network Reimbursement	In-Network Member Cost	Out-of-Network Reimbursement
LENS OPTIONS						
Anti Reflective Coating – Standard	\$45	Not covered	\$45	Not covered	\$45	Not covered
Polycarbonate – Standard	\$15 copay	Up to \$10	\$40	Not covered	\$40	Not covered
Polycarbonate – Standard – Dependent Children	\$0 copay	Up to \$18	\$0 copay	Up to \$18	\$40	Not covered
Scratch Coating – Standard Plastic	\$15	Not covered	\$15	Not covered	\$15	Not covered
Tint – Solid and Gradient	\$15	Not covered	\$15	Not covered	\$15	Not covered
UV Treatment	\$15	Not covered	\$15	Not covered	\$15	Not covered
All Other Lens Options	30% off retail price	Not covered	30% off retail price	Not covered	30% off retail price	Not covered
CONTACT LENSES						
Contacts – Conventional	\$0 copay; \$200 allowance, 15% off balance over \$200	Up to \$100	\$0 copay; \$150 allowance, 15% off balance over \$150	Up to \$75	Not covered	Not covered
Contacts – Disposable	\$0 copay; \$200 allowance, plus balance over \$200	Up to \$100	\$0 copay; \$150 allowance, plus balance over \$150	Up to \$75	Not covered	Not covered
Contacts – Medically Necessary	\$10 copay	Up to \$300	\$20 copay	Up to \$300	Not covered	Not covered
FREQUENCY						
Exam	Once per plan year	–	Once per plan year	–	Once per plan year	–
Frame and Lenses or Contact Lenses	Once per plan year	–	Once per plan year	–	Unlimited	–



Member Reimbursement for Out-of-Network varies by state. Plan allows the member to receive either contacts, or frame and lens services. 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 a 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 supplement 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 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. 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. 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. Underwritten by Fidelity Security Life Insurance Company® of Kansas City, Missouri, Policy number VC-145/VC-146, form number M-9184/M-9191; in New York underwritten by Fidelity Security Life Insurance Company® of New York, Policy Number VCN-19, form number MN-28. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer. **Bronze vision plan is not available in the state of New Mexico. Since frame and contact lenses are not a covered service.