

Miami-Dade County Public Schools



	SUMMARY OF BENEFITS		
	VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
	EXAM SERVICES Exam Retinal Imaging	\$10 copay Up to \$39	Up to \$40 Not covered
40%	CONTACT LENS FIT AND FOLLOW-UP Fit and Follow-up - Standard Fit and Follow-up - Premium	Up to \$40 10% off retail price	Not covered Not covered
additional complete pair of prescription eyeglasses	FRAME Frame	\$0 copay; 20% off balance over \$180 allowance	Up to \$45
20%FF non-covered items, including non- prescription sunglasses	STANDARD PLASTIC LENSES Single Vision Bifocal Trifocal Lenticular Progressive - Standard Progressive - Premium Tier 1 Progressive - Premium Tier 2 Progressive - Premium Tier 3 Progressive - Premium Tier 4	\$10 copay \$10 copay \$10 copay \$10 copay \$15 copay \$105 copay \$115 copay \$130 copay \$200 copay	Up to \$40 Up to \$60 Up to \$80 Up to \$80 Up to \$55 Up to \$55 Up to \$55 Up to \$55 Up to \$55
Find an eye doctor (Insight Network) • eyemed.com • EyeMed Members App • For LASIK, call 1.800.988.4221	LENS OPTIONS Anti Reflective Coating - Standard Anti Reflective Coating - Premium Tier 1 Anti Reflective Coating - Premium Tier 2 Anti Reflective Coating - Premium Tier 3 Photochromic - Non-Glass Polycarbonate - Standard Polycarbonate - Standard Polycarbonate - Standard <19 years of age Scratch Coating - Standard Plastic Tint - Solid or Gradient UV Treatment All Other Lens Options	\$45 \$57 \$68 \$85 \$75 \$30 \$0 copay \$0 copay \$12 \$12 20% off retail price	Up to $\$5$ Up to $\$5$ Up to $\$5$ Up to $\$5$ Not covered Up to $\$5$ Up to $\$20$ Up to $\$8$ Up to $\$5$ Up to $\$5$ Not covered
Heads up You may have additional benefits. Log into eyemed.com/member to see all plans included with your benefits.	CONTACT LENSES Contacts - Conventional Contacts - Disposable Contacts - Medically Necessary OTHER Hearing Care from Amplifon network Lasik or PRK From U.S. Laser Network FREQUENCY	\$0 copay; 15% off balance over \$150 allowance \$0 copay; 100% of balance over \$150 allowance \$0 copay; paid in full Discounts on hearing exam and aids; call 1.877.203.0675 15% off retail or 5% off promo price; call 1.800.988.4221	Up to \$105 Up to \$105 Up to \$210 Not covered Not covered
	Exam Frame Lenses Contact Lenses (Plan allows member to receive either contacts of frame, or frames and lens services)	Once every 12 months Once every 12 months Once every 12 months Once every 12 months	

frame, or frames and lens services)

EveMed 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 Dicyholder 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 of the date an Insured Person cases 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. Some Person to the Provider. Such fees, taxes or materials are not covered under the Policy. Allowances provide nor remining balance for future use within the same Benefit Frequency. Some 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 fees, exclusions or limitations listed herein may vary by state. Fees charged by a Provider for services canned the no herein and any local, state or Federal taxes must be paid i

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¹Based on weighted average of sample transactions; EyeMed Insight network/\$10 exam copay/\$10 materials copay/\$120 frame or contact lens allowance.





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LENSCRAFTERS



