Summary of Vision Benefits

NOVOMATIC AMERICAS SALES, LLC- F025371

PLAN 10: 12/12/12/$150		MS 300 V
Frequency		
Examination	Once every 12 months	
Lenses or contact lenses	Once every 12 months	
Frame	Once every 12 months	
Contact lens eval/fitting	N/A	

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement*
Exam with dilation as necessary	$10 copay	Up to $30
Contact lens fit and follow-up	Up to $40 for standard; 10% off retail price for premium	N/A
Frames		
Any available frame at provider location	$0 copay, $150 allowance, 20% off balance over $150	Up to $75
Standard Lenses		
Single vision	$25 copay	Up to $25
Bifocal	$25 copay	Up to $40
Trifocal	$25 copay	Up to $55
Lenticular	$25 copay	Up to $55
Standard progressive lens	$90 copay	Up to $40
Premium progressive lens	See table on page 2.	Up to $40
Lens Options		
Tint (solid and gradient)	$15	N/A
Scratch resistant coating	$0	Up to $5
Polycarbonate lenses	$0 kids; $40 adults	Up to $5 kids
Ultraviolet coating	$15	N/A
Anti-reflective coating	See table on page 2.	N/A
High index lenses	20% off retail	N/A
Polarized lenses	20% off retail	N/A
Photochromic/transitions plastic	$75	N/A
Contact Lenses (in lieu of spectacle lenses)		
Conventional	$0 copay, $150 allowance, 15% off balance over $150	Up to $120
Disposable	$0 copay, $150 allowance, plus balance over $150	Up to $120
Medically necessary	$0 copay, paid-in-full	Up to $210
Other		
Laser vision correction	15% retail price or 5% off promotional price	N/A
Additional pairs benefit	40% off purchase of complete pair of eyeglasses and a 15% off conventional contact lenses once the funded benefit has been used	N/A
Amplifon hearing discount	40% off hearing exams and low price guarantee on discounted hearing aids	N/A
Additional discounts	20% off non-covered items with limitations	N/A

Monthly Premium	
Employee	$9.47
Employee + spouse	$17.99
Employee + child(ren)	$18.93
Employee + family	$27.83

Eligibility: All active full-time employees as defined by your employer.
Dependent coverage is available to age 26.



Additional discounts

40% OFF
Complete pair of prescription eyeglasses

20% OFF
Non-prescription sunglasses

20% OFF
Remaining balance beyond plan coverage

These discounts are not insured benefits and are for in-network providers only.

Take a sneak peek before enrolling

- For a complete list of in-network providers near you, visit eyemedvisioncare.com/bcbsilvis or call 1.855.362.5539.
- For LASIK providers, call 1.877.5LASER6.

BlueCross BlueShield of Illinois

Vision Care

Insurance products issued by Dearborn Life Insurance Company,
701 E. 22nd St. Suite 300, Lombard, IL 60148.

Summary of Benefits Continued

Progressive Price List[1]	Member Cost In-Network
Standard progressive	$90 copay

Premium progressives[2] as follows:	
Tier 1	$110 copay
Tier 2	$120 copay
Tier 3	$135 copay
Tier 4	$90 copay 80% of charge less $120 allowance

Anti-Reflective Coating Price List[1]	Member Cost In-Network
Standard anti-reflective coating	$45

Premium anti-reflective[2] coatings as follows:	
Tier 1	$57
Tier 2	$68
Tier 3	80% of charge

Other Add-ons Price List	Member Cost In-Network
Photochromic	$75
Polarized	80% of charge

Plan Exclusions

1. Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; aniseikonic lenses
2. Medical and/or surgical treatment of the eye, eyes or supporting structures
3. Any eye or vision examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear
4. 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
5. Plano (non-prescription) lenses and/or contact lenses
6. Non-prescription sunglasses
7. Two pair of glasses in lieu of bifocals
8. 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
9. Services or materials provided by any other group benefit plan providing vision care
10. Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next benefit frequency when vision materials would next become available

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[1]Member Reimbursement Out-of-Network will be the lesser of the listed amount or the member's actual cost from the out-of-network provider. In certain states, members may be required to pay the full retail rate. [2]Blue Cross Blue Shield of Illinois reserves the right to make changes to the products on each tier and the member 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. [3]Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Not available in all states. Some provisions, benefits, exclusions or limitations listed herein may vary. For employee use. This piece is for illustrative purposes only and is not a contract. It is intended to provide only a brief summary of the type of policy and insurance coverage advertised. The policy provides the actual terms of coverage, including any exclusions, conditions and limitations to coverage.

All plans are based on a 48-month contract term and 48-month rate guarantee. Premium is subject to adjustment even during a rate guarantee period in the event of any of the following events: changes in benefits, employee contributions, the number of eligible employees, or the imposition of any new taxes, fees or assessments by Federal or State regulatory agencies. Benefits may not be combined with any discount, promotional offering or other group benefit plans. Benefit allowance provides no remaining balance for future use with the same benefits year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.

Benefits are available from the EyeMed Vision Care, LLC provider network and are administered by First American Administrators, Inc., independent companies that offer benefits on behalf of Blue Cross and Blue Shield of Illinois. Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

Blue Cross and Blue Shield of Illinois is the trade name of Dearborn Life Insurance Company, an independent licensee of Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

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