Prairie Meadows Racetrack and Casino Inc

Insight network

SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST AT PLUS PROVIDERS	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES			
Exam	*$0 copay*	*$10 copay*	*Up to $40*
Retinal imaging	*Up to $39*	*Up to $39*	*Not covered*
CONTACTS LENS FIT AND FOLLOW-UP			
Fit and Follow-up - Standard	*Up to $40;*	*Up to $40;*	*Not covered*
Fit and Follow-up - Premium	*10% off retail price*	*10% off retail price*	*Not covered*
FRAME			
Frame	*$0 copay; 20% off balance over $200 allowance*	*$0 copay; 20% off balance over $150 allowance*	*Up to $75*
STANDARD PLASTIC LENSES			
Single Vision	*$0 copay*	*$0 copay*	*Up to $30*
Bifocal	*$0 copay*	*$0 copay*	*Up to $50*
Trifocal/Lenticular	*$0 copay*	*$0 copay*	*Up to $70*
Progressive - Standard	*$65 copay*	*$65 copay*	*Up to $50*
Progressive - Premium Tier 1 - 3	*$85 - 110 copay*	*$85 - 110 copay*	*Up to $50*
Progressive - Premium Tier 4	*$185 copay*	*$185 copay*	*Up to $50*
Progressive - Premium Tier 5	*$225 copay*	*$225 copay*	*Up to $50*
LENS OPTIONS			
Anti Reflective Coating - Standard	*$45 copay*	*$45 copay*	*Up to $23*
Anti Reflective Coating - Premium Tier 1 - 2	*$57 - 68*	*$57 - 68*	*Up to $23*
Anti Reflective Coating - Premium Tier 3	*$85*	*$85*	*Up to $23*
Photochromic - Non-Glass	*$75*	*$75*	*Not covered*
Polycarbonate - Standard	*$40*	*$40*	*Not covered*
Scratch Coating/Tint/UV Treatment	*$15*	*$15*	*Not covered*
All Other Lens Options	*20% off retail price*	*20% off retail price*	*Not covered*
CONTACT LENSES			
Contacts - Conventional	*$0 copay; 15% off balance over $180 allowance*	*$0 copay; 15% off balance over $130 allowance*	*Up to $65*
Contacts - Disposable	*$0 copay; 100% of balance over $180 allowance*	*$0 copay; 100% of balance over $130 allowance*	*Up to $65*
Contacts - Medically Necessary	*$0 copay; paid-in-full*	*$0 copay; paid-in-full*	*Up to $300*
ADDITIONAL GLASSES ALLOWANCE			
Glasses Allowance	*40% off retail*; 100% of balance over $100*	*40% off retail*; 100% of balance over $50*	*Up to $40*
OTHER			
Hearing Care from Amplifon Network	*Discounts on hearing aids; call 1.877.203.0675*	*Discounts on hearing 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*	*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 plan year*	*once every plan year*
Frame	*once every other plan year*	*once every other plan year*
Lens	*once every plan year*	*once every plan year*
Contact Lens	*once every plan year*	*once every plan year*
Additional Glasses Allowance	*once every other plan year*	*once every other plan year*

Plan allows member to receive frame and lens services or contacts.

Employee Rates Per Pay Period

Employee Only	**$1.51**
Employee + Spouse	**$2.76**
Employee + Child(ren)	**$3.39**
Family	**$4.44**

**Complete pair (frame & lens with or without lens options) purchase required to receive 40% discount. 20% discount applied if complete pair not purchased. Log into eyemed.com/member to see all plans included with your benefits. 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.Some provisions, benefits, exclusions or limitations listed herein may vary by statePlan 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.*

Savings plus convenience plus choice

PLUS Providers add another layer of coverage

Staying in-network helps you save money on eye exams, frames and lenses. Visiting a PLUS Provider is designed to help you save even more. And since PLUS Providers are already in our network, the additional perks are built right into your vision benefits.

No promo codes, no coupons, no paperwork. The same vision benefits, plus a little more savings.

The choice is yours

Find plenty of in-network eye doctors – including PLUS Providers – on our Provider Locator. Just look for the PLUS.

Need extra assistance? Contact us at 1.866.939.3633 or visit eyemed.com.

INDEPENDENT PROVIDER NETWORK + LensCrafters® PEARLE VISION EST. 1961 OPTICAL™