

Take a sneak peek before enrolling

- You're on the Insight Network
- For a complete list of in-network providers near you, use our Enhanced Provider Locator on eyemed.com or call 1-866-804-0982
- For LASIK providers, call 1-877-5LASER6

College of the Holy Cross

Vision Care In-Network Out of Network Reimbursement Frames \$0 Copay; \$130 allowance, 20% off balance over \$130 Up to \$104 Standard Plastic Lenses Vision \$25 Copay Up to \$42 Bifocal \$25 Copay Up to \$78 Trifocal \$25 Copay Up to \$130 Lenticular \$25 Copay Up to \$130 Standard Progressive Lens \$75 Copay Up to \$130 Standard Progressive Lens \$75 Copay Up to \$130 Tier 1 \$95 Copay Up to \$130 Tier 2 \$105 Copay Up to \$196 Tier 3 \$120 Copay Up to \$196 Tier 3 \$120 Copay Up to \$196 Tier 3 \$120 Copay Up to \$196 Lens Options (paid by the member and added to the base price of the lens) N/A Lens Options (paid by the member and added to the base price of the lens) N/A Lens Options (paid by the member and added to the base price of the lens) N/A Lens Options (paid by the member and added to the base price of the lens) N/A Lens Options (paid by the member and added to the base price of the len	SUMMARY OF BENEFITS		
Frames \$0 Copay; \$130 allowance, 20% off balance over \$130	Vision Care	In-Network	Out of Network
Standard Plastic Lenses Single Vision \$25 Copay Up to \$42 Bifocal \$25 Copay Up to \$78 Trifocal \$25 Copay Up to \$78 Trifocal \$25 Copay Up to \$130 Up to \$140 Up to \$14	Services	Member Cost	Reimbursement
Single Vision \$25 Copay Up to \$42 Bifocal 15 Copay Up to \$78 Trifocal \$25 Copay Up to \$130 On	Frames	\$0 Copay; \$130 allowance, 20% off balance over \$130	Up to \$104
Bifocal \$25 Copay Up to \$78 Trifocal \$25 Copay Up to \$130 Lenticular \$25 Copay Up to \$130 Standard Progressive Lens \$75 Copay Up to \$140 Premium Progressive Lens ^A \$95 Copay Up to \$196 Tier 1 \$95 Copay Up to \$196 Tier 2 \$105 Copay Up to \$196 Tier 3 \$120 Copay Up to \$196 Tier 4 \$75 Copay, 20% off retail less \$120 Allowance Up to \$196 Lens Options (paid by the member and added to the base price of the lens) W LV Treatment \$15 N/A Tier 4 \$15 N/A VV Treatment \$15 N/A Timit (\$0id and Gradiant) \$15 N/A VV Treatment \$15 N/A Standard Plastic Scratch Coating \$15 N/A Standard Polycarbonate - age 26 and over \$40 N/A Standard Polycarbonate - age 26 and over \$40 N/A Standard Polycarbonate - age 26 and over \$10 N/A <t< td=""><td>Standard Plastic Lenses</td><td></td><td></td></t<>	Standard Plastic Lenses		
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Lenticular	Bifocal	\$25 Copay	Up to \$78
Standard Progressive Lens	Trifocal	\$25 Copay	Up to \$130
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Contacts (in lieu of lenses) Once every 12 months	• •	Once every 12 months	
	Frame	Once every 24 months	

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*Frame, Lens & Lens Option discounts apply only when purchasing a complete pair of eyeglasses, If purchased separately, members receive 20% off the retail price.

Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York. Fidelity Security Life Policy number VC-19/VC-20, form number M-9083. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.

A 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. Benefits are not provided from services or materials arising from: 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 anyWorkers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; 5) Plano (non-prescription) lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals; 8) Services or materials provided by any other group benefit plan providing vision care 9) 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. 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. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/Premium Progressive lens not covered-fund as a Bifocal lens. Standard Progressive lens covered-fund Premium Progressive as a Standard. Benefit allowance provides no remaining balance for future use within the same benefit year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered.