



Vision Care Services	In-Network Member Costs	Out-of-Network Allowances
This plan utilizes the Insight Network.	Exam With Dilation as Necessary	\$10 Copay Up to \$35 Reimbursement
	Retinal Imaging	\$39 Not Covered
FREQUENCY:	Frames	\$130 Allowance, 20% off balance Up to \$65 Reimbursement
	Standard Plastic Lenses	
Exams: Once every Calendar Year	Single Vision	\$25 Copay Up to \$25 Reimbursement
	Bifocal	\$25 Copay Up to \$40 Reimbursement
	Trifocal	\$25 Copay Up to \$55 Reimbursement
	Lenticular	\$25 Copay Up to \$55 Reimbursement
Frames: Once every Calendar Year	Lens Options	
	Standard polycarbonate	Adults: \$40 Dependents under 19: \$0 Up to \$25 Reimbursement
	UV Coating	\$15 Not Covered
	Tint (Solid and Gradient)	\$15 Not Covered
Lenses or Contact Lenses: Once every Calendar Year	Standard Scratch-Resistance	\$15 Not Covered
	Standard Anti-Reflective Coating	\$45 Not Covered
	Standard Progressive (includes Copay amount)	\$90 Copay Up to \$40 Reimbursement
	Premium Progressive (includes Copay amount)	Tier 1 – \$110 Copay Tier 2 – \$120 Copay Tier 3 – \$135 Copay Tier 4 – \$90 Copay, \$120 Allowance, and 20% off balance Up to \$40 Reimbursement
ADDITIONAL DISCOUNTS:	40% off - Additional pair of eyeglasses or sunglasses (both frames & lenses)	
	20% off - Non covered items such as cleaning cloths and solution	
	15% off - Retail price of LASIK Vision Correction	
40% off - Hearing Discount: hearing exams and a low price guarantee on discounted hearing aids	Contact Lens Fit & Follow-Up (Contact lens fit and 2 follow-up visits are available once a comprehensive eye exam has been completed.)	
	Standard – spherical clear contact lenses in conventional wear and planned replacement (Examples include but not limited to disposable, frequent	\$40 Copay, Paid-in-full fit and two follow-up visits Not Covered
	Premium – all lens designs, materials and specialty fittings other than Standard Contact Lenses (Examples include toric, multifocal, etc.)	10% off balance Not Covered
	Contacts Lenses (Contact lens allowance includes materials only)	
	Conventional	\$130 Allowance, 15% off balance over Allowance Up to \$100 Reimbursement
	Disposable	\$130 Allowance Up to \$100 Reimbursement
	Medically Necessary	\$0 Copay Up to \$200 Reimbursement

SEE SECTION ON PLAN LIMITATIONS/EXCLUSIONS ON THE NEXT PAGE

This is a Summary of Benefits only, and various limitations and exceptions may apply. Your actual coverage is described in the Agreement which is binding on all of the parties and supersedes all other written or oral communications.

WHO IS SURENCY VISION?

Surency Vision offers flexible, straightforward plans with multiple features to meet your employees' needs. Plans include comprehensive eye exams and convenient access to vision care 7 days a week as well as multiple allowances, copay, and frequency options for exams, lenses, and frame. Members also receive savings on eye care and eyewear year-round.



RETAIL AND ONLINE VISION OPTIONS

Surency Vision offers several in-network online shopping options to go with the thousands of in-network store locations. Retail options include Target Optical, LensCrafters and Pearl Vision. Our online options include ContactsDirect.com, Glasses.com, Rayban.com/insurance and more.

INDEPENDENT
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NETWORK



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SURENCY VISION MOBILE APP

Download the free Surency Vision Mobile App today to take control of your vision benefits. With the app, you can:

- Find a doctor
- Check eligibility
- Check claim status
- Order replacement contact lenses
- And more



PLAN LIMITATIONS/EXCLUSIONS:

- Allowances are one-time use benefits; no remaining balance.
- If eyeglass lenses are elected, contact lens allowance may not be available; coverage specific to vision benefit plan.
- Orthoptic or vision training, subnormal vision aids and any associated supplemental testing.
- Medical and/or surgical treatment of the eye, eyes or supporting structures.
- Services provided as a result of any Worker's Compensation law.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.
- Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under plan.
- Plano lenses and non-prescription sunglasses (except for twenty percent (20%) discount).
- Services or materials provided by major medical coverage under any other group benefit providing for vision care.
- Two (2) pair of glasses in lieu of bifocals.
- Aniseikonic lenses.
- Discounts do not apply for benefits provided by other group benefit plans.
- Lost or broken materials are not covered.