



The following is a summary of the vision benefits for:

**CITY OF SAN JOSE**

This document is **not** the Summary Plan Description document.

**I. Examination Benefit**

- A. In-Network Benefit: A Member is entitled to a paid-in-full comprehensive spectacle or contact lens eye examination with dilation, as necessary, performed by a Participating Provider once the Member has paid the required copayment.
- B. Out-of-Network Benefit: A Member is entitled to a comprehensive spectacle or contact lens eye examination with dilation, as necessary, up to a \$25.00 retail value. The Member must pay at the point-of-service and will be reimbursed up to \$25.00 toward an eye examination after submitting a complete claim.
- C. Member Pays: There is a \$10.00 copayment for the in-network benefit.
- D. Benefit Frequency: Once every twelve (12) months per calendar year.

**II. Contact Lens Exam Options**

- A. In-Network Benefit for Standard Contact Lens Fit and Follow-Up. The member is responsible for the amount up to \$40.00. The member would not be responsible for any remaining amount after \$40.00 for the standard contact lens fit and follow-up. Standard Contact Lens Fitting includes spherical clear contact lenses in conventional wear and planned replacement (Examples include but not limited to disposable, frequent replacement, etc.)
- B. In-Network Benefit for Premium Contact Lens Fit and Follow-Up. The Member will receive a 10% discount off the retail price for premium contact lens fit and follow-up. Premium Contact Lens Fitting includes all lens designs, materials and specialty fittings other than Standard Contact Lenses (Examples include toric, multifocal, etc.)
- C. Member Pays. There is no copayment for the in-network benefit.
- D. Benefit Frequency. Once every twelve (12) months per calendar year.

**III. Frame Benefit**

- A. In-Network Benefit: A Member is entitled to a \$115.00 allowance toward any frame with the purchase of prescription lenses. The Member will receive a 20% discount off the balance over \$115.00.
- B. Out-of-Network Benefit: A Member is entitled to a reimbursement of up to \$45.00 toward any frame purchased from an out-of-network provider. The Member must pay the out-of-network provider at the point-of-service and file a complete claim to receive the reimbursement.
- C. Member Pays: There is no copayment for the in-network benefit.
- D. Benefit Frequency: Once every twelve (12) months per calendar year.

**IV. Lens Benefit**

- A. In-Network Benefit: A Member is entitled to a paid-in-full single vision, bifocal, or trifocal lenses, this includes all powers and sizes once the Member has paid the required copayment.

- B. Out-of-Network Benefit: A Member is entitled to reimbursement up to the following amounts when purchasing lenses: up to \$30.00 for single vision lenses; up to \$50.00 for bifocal lenses; or up to \$60.00 for trifocal lenses. The Member must pay the out-of-network provider in full at the point-of-service and file a complete claim to receive the reimbursement.
- C. Member Pays. There is no copayment for single vision, bifocal, or trifocal lenses when using the in-network benefit.
- D. Benefit Frequency. Once every twelve (12) months per calendar year.

**V. Contact Lens Benefit**

- A. In-Network Benefit: In lieu of the standard plastic lenses, a Member is entitled to non-disposable, disposable or medically necessary contact lenses for the amounts shown below. The contact lens benefit includes materials only.
  - 1. Non-disposable: A \$100.00 allowance applied toward the purchase of non-disposable contact lenses. The Member will receive a 15% discount off the balance over \$100.00.
  - 2. Disposable: A \$100.00 allowance applied toward disposable contact lenses.
  - 3. Medically Necessary:
- B. Out-of-Network Benefit: In lieu of the standard plastic lenses, for contact lenses obtained from an out-of-network provider, a Member is entitled to the following:
  - 1. Non-disposable: A Member is entitled to reimbursement up to \$85.00 for materials. The Member must pay the out-of-network provider at the point-of-service and file a complete claim to receive the reimbursement.
  - 2. Disposable: A Member is entitled to reimbursement up to \$85.00 for materials. The Member must pay the out-of-network provider at the point-of-service and file a complete claim to receive the reimbursement.
  - 3. Medically Necessary: A Member is entitled to reimbursement up to \$250.00 for materials. The Member must pay the out-of-network provider at the point-of-service and file a complete claim to receive the reimbursement.
- C. Member Pays: There is no copayment for the in-network benefit.
- D. Benefit Frequency: Once every twelve (12) months per calendar year.

**VI. Lens Options Discount**

- A. In-Network Lens Options A Member is entitled to lens options for the following additional discounted amounts:

Standard Progressives (add on to bifocal)	\$65.00
Standard Polycarbonate	\$0.00
Ultraviolet Coating	\$15.00
Standard Anti-Reflective Coating	\$45.00
Tint (Solid & Gradient)	\$15.00
Standard Scratch Resistant	\$15.00
Other Add-Ons and Services	20% off retail price

Notes:

- (1) Allowances are one-time use benefits, no remaining balance.
- (2) Lost or broken materials are not covered.
- (3) Discounts do not apply to benefits provided by other group benefit plans.
- (4) \* Standard Progressive Lenses include, but are not limited to the following trade names; Access®, Adaptar®, AF Mini®, Continuous®, Vue®, Freedom®, Sola VIP®, Sola XL® and True Vision®.
- (5) Members are responsible for payment of any applicable sales tax incurred on the purchase of services and/or materials.

**VII. Additional Purchases and Out-of-Pocket Discount**

Member will receive a 20% discount on remaining balance at Participating Providers beyond plan coverage, which may not be combined with any other discounts or promotional offers, and the discount does not apply to Participating Providers professional services or disposable contact lenses.

**VIII. Limitations and Exclusions**

Benefits are not provided for services or materials arising from: Orthoptic or vision training; subnormal vision aids, and any associated supplemental testing. Aniseikonic lenses. Medical and/or surgical treatment of the eyes. Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under the Plan. Services provided as a result of any Worker's Compensation law. Plano non-prescription lenses and non-prescription sunglasses (except for the 20% discount). Services or materials provided by any other group benefit providing for vision care. Benefit allowances provide no remaining balance for future use within same benefit period. Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next benefit period.

The following examples illustrate how your benefit would be applied to the services received at any Participating Provider's office or location:

**If a Member chooses to receive:**

A comprehensive vision care examination:	the Member pays \$10.00
A frame up to a value of \$115:	the Member pays \$0.00
One pair of bifocal lenses:	the Member pays \$0.00
Ultraviolet coating:	the Member pays \$15.00
<b>The total cost to the Member is:</b>	<b>\$25.00</b>

**If a Member chooses to receive:**

A comprehensive vision care examination:	the Member pays \$10.00
A frame up to a value of \$140:	the Member pays \$20.00
A pair of single vision lenses:	the Member pays \$0.00
Standard anti-reflective coating:	the Member pays \$45.00
<b>The total cost to the Member is:</b>	<b>\$75.00</b>

The provider network is always growing, and provider locations are subject to change. Therefore, we recommend calling the Member Services Department 866-723-0513 or using the Provider Locator service through the web site [www.eyemedvisioncare.com](http://www.eyemedvisioncare.com) to locate the Participating Provider closest to you.

**Tips for Filing Claims**

**Providers**

Before you go to a Participating Provider location for an eye exam, glasses or contact lenses, it is recommended that you call ahead for an appointment. When you arrive, show the receptionist or sales associate your Identification Card, or if you should forget to take your card be sure to say that you are participating in the City of San Jose vision care plan so that eligibility can be verified.

When you receive services at a Participating Provider location, you will not have to file a claim form. At the time services are rendered, you will have to pay the cost of any services or eyewear that exceeds any

allowances and your applicable copayments. You will also owe state tax, if applicable, and the cost of non-covered expenses (for example, vision perception training).

The Vision Care Customer Service can be reached seven days a week Monday through Saturday 8:00 am to 11:00 pm and Sunday 11:00 am to 8:00 pm Eastern Time at (800) 334-7591.

If you select an Out-of-Network Provider, you must pay in full at the time services are rendered or materials are purchased. For reimbursements, simply call the Customer Service Center at (800) 334-7591 to verify eligibility and receive a claim form. Then mail a completed claim form with a copy of your bill to:

Cole Vision Services, Inc.  
P.O. Box 8504  
Mason, OH 45040-7111  
Attn: Vision Care Department

If you are not satisfied with the Vision Care Department response and still believe that the claim form was incorrectly paid or denied, you should file a formal (ERISA) appeal to Cole Vision Services, Inc. at the address below or to the Plan Administrator within 60 days after the claim was denied or any other adverse determination. Your written letter of appeal should include the following:

- The provision you feel was misinterpreted or inaccurately applied; and
- Additional information from your eye care provider that will assist the Quality Assurance Department in completing their review of your appeal, such as documents, records, questions or comments.

If you are sending an appeal to Cole Vision Services, Inc., it should be mailed to the following address:

Cole Vision Services, Inc.  
Attn: Quality Assurance Dept.  
4000 Luxottica Place  
Mason, Ohio 45040

The Quality Assurance Department will review your appeal for benefits and notify you in writing of their decision, as well as the reason for the decision, with reference to specific plan provisions. For more information on your rights and how to file a formal appeal under the Employee Retirement Income Security Act of 1974, as amended (ERISA), refer to the appropriate section of your Summary Plan Description.

The benefits are underwritten by **Combined Insurance Company of America**. If you have any questions or concerns regarding your benefit, please contact Cole Vision Services, Inc.