# Grainger Deluxe Plan

**40% OFF**
additional complete pair of prescription eyeglasses

**20% OFF**
non-covered items, including non-prescription sunglasses

## Find an eye doctor
(Select Network)

- eyemed.com
- EyeMed Members App
- For LASIK, call 1.800.988.4221

## Heads up
You may have additional benefits. Log into **eyemed.com/member** to see all plans included with your benefits.

## SUMMARY OF BENEFITS

| VISION CARE SERVICES | IN-NETWORK MEMBER COST | OUT-OF-NETWORK MEMBER REIMBURSEMENT |
|---|---|---|
| **EXAM SERVICES** | | |
| Exam | $0 copay | Up to $30 |
| Retinal Imaging | Up to $39 | Not covered |
| **CONTACT LENS FIT AND FOLLOW-UP†** | | |
| Fit and Follow-Up – Standard | $0 copay; paid in full fit and two follow-up visits | Up to $40 |
| Fit and Follow-Up – Premium | $0 copay; 10% off balance over $40 allowance | Up to $40 |
| **FRAME** | | |
| Any available frame at provider location | $0 copay; 20% off balance over $175 allowance | Up to $45 |
| **STANDARD PLASTIC LENSES** | | |
| Single Vision | $10 copay | Up to $40 |
| Bifocal | $10 copay | Up to $60 |
| Trifocal | $10 copay | Up to $80 |
| Lenticular | $10 copay | Up to $80 |
| Progressive – Standard | $10 copay | Up to $60 |
| Progressive – Premium | $10 copay; 20% off retail price less $120 allowance | Up to $60 |
| **LENS OPTIONS** | | |
| Anti Reflective Coating – Standard | $45 | Not covered |
| Polycarbonate – Standard | $0 copay | Up to $5 |
| Polycarbonate – Standard < 19 years of age | $0 copay | Up to $5 |
| Scratch Coating – Standard Plastic | $0 copay | Up to $5 |
| Tint – Solid or Gradient | $0 copay | Up to $5 |
| UV Treatment | $0 copay | Up to $5 |
| All Other Lens Options | 20% off retail price | Not covered |
| **CONTACT LENSES** | | |
| Contacts – Conventional | $0 copay; 15% off balance over $150 allowance | Up to $115 |
| Contacts – Disposable | $0 copay; 100% of balance over $150 allowance | Up to $115 |
| Contacts – Medically Necessary | $0 copay; paid in full | Up to $210 |
| **OTHER** | | |
| Hearing Care from Amplifon Network | Discounts on hearing exam and 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 | Not covered |
| **FREQUENCY** | | |
| Exam | Once every 12 months | |
| Frames | Once every 12 months | |
| Lenses | Once every 12 months | |
| Contact Lenses | Once every 12 months | |

(Plan allows member to receive either contacts and frame, or frames and lens services)

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. Allowances provide no remaining balance for future use within the same Benefit Frequency. Some provisions, benefits, exclusions or limitations listed herein may vary by state. 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. Allowances provide no remaining balance for future use within the same Benefit Frequency. Some provisions, benefits, exclusions or limitations listed herein may vary by state. Plan 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. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, Policy number VC-19, form number M-9083, or Policy number VC-146, form number M-9184, in New York underwritten by Fidelity Security Life Insurance Company of New York, Policy Number VCN-1, form number MN-1, or Policy Number VCN-19, form number MN-28. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.

# Ready to live your best EyeMed life?

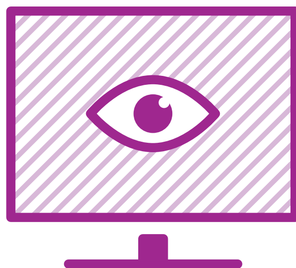
With thousands of providers to choose from, special offers and vision resources from the experts, we're dedicated to helping you see clearly.

## Benefits snapshot

| SERVICE | WITH EYEMED | OUT-OF-NETWORK REIMBURSEMENT |
|---|---|---|
| **Exam (once every 12 months)** | $0 | Up to $30 |
| **Frame (once every 24 months)** | $0 copay, $175 allowance; 20% off balance over $175 | Up to $45 |
| **Single Vision Lenses (once every 24 months)** | $0 | Up to $40 |
| or | | |
| **Contacts (once every 24 months)** | $0 copay, $150 allowance; plus balance over $150 | Up to $115 |

## Choose a plan option that works best for you: Standard or Deluxe

| SERVICE | AVERAGE MEMBER RETAIL COST | STANDARD PLAN - MEMBER RESPONSIBILITY | DELUXE PLAN - MEMBER RESPONSIBILITY | MEMBER SAVINGS - STANDARD VS. DELUXE | MEMBER SAVINGS BROKEN OUT MONTHLY |
|---|---|---|---|---|---|
| **Contact Lens Fit / Follow-up** | $63 | $40 | $0 | $40 | $3.33 |
| **Standard Progressive** | $212 | $75 | $10 | $65 | $5.42 |
| **Premium Progressive** | $266 | $75 and 80% of charge less $120 allowance | $10 and 80% of charge less $120 allowance | $65 | $5.42 |
| **Polycarbonate** | $57 | $40 | $0 | $40 | $3.33 |



## Create a member account at eyemed.com

Everything is right there in one spot. Check claims and benefits, see special offers and find an eye doctor – search for one with the hours, location and brands you want. For maximum mobility, try the EyeMed Members App (Google Play or App Store).

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