



The following is a summary of the vision benefits for State of Nebraska - Premium
This document is not the Summary Plan Description document.

COVERED VISION SERVICES – EyeMed Access Plan H

I. Examination Benefit

- A. **In-Network Benefit.** A Member is entitled to a paid-in-full comprehensive spectacle eye examination, including dilation, performed by a Participating Provider.
- B. **Out-of-Network Benefit.** A Member is entitled to a comprehensive spectacle eye examination with dilation, up to a \$40.00 retail value. The Member must pay at the point-of-service and will be reimbursed up to \$40.00 toward an eye examination after submitting a complete claim.
- C. **Member Pays.** There is a \$10.00 co-payment for in-network benefit only.
- D. **Fitting and Follow up** – Contact lens fit and two follow-ups are available once a comprehensive eye exam has been completed.
 - 1. **Standard** Contact lens – spherical clear contact lenses in conventional wear and planned replacement. Examples include but not limited to disposable, frequent replacement, etc. **Standard** benefit: member pays up to \$55 of the usual and customary charge.
 - 2. **Premium** Contact Lens – all lens designs, materials and speciality fittings other than Standard Contact Lenses. **Premium** benefit: a 10% discount off of the usual and customary charge.
- E. **Out of Network, Fitting and Follow up** – Contact lens fit and two follow-ups are available once a comprehensive eye exam has been completed.
 - 1. **Standard** Contact lens – Not Available
 - 2. **Premium** Contact Lens – Not Available
- F. **Benefit Frequency.** Once every twelve (12) months from last Date of Service.

II. Contact Lens Benefit

- A. **In-Network Benefit.** In lieu of lenses, all Members are entitled to non-disposable, disposable or medically necessary contact lenses for the amounts below. The Member is responsible for the balance over the allowance amount at the time of service.
 - 1. **Non-disposable**-a \$130.00 allowance applied toward non-disposable contact lenses. The Member is responsible for 85% of the balance amount over \$130.00 at the time of service.
 - 2. **Disposable**-a \$130.00 allowance applied toward disposable contact lenses. The Member is responsible for 100% of the balance over \$130.00 at the time of service.
 - 3. **Medically Necessary**-a paid in full benefit toward medically necessary contact lenses.
- B. **Out-of-Network Benefit.** In lieu of the lenses benefit, 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 be reimbursed up to \$104.00 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 be reimbursed up to \$104.00 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.

4. **Medically Necessary**-a Member is entitled to be reimbursed up to \$200.00 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 co-payment.
- D. **Benefit Frequency**. Once every twelve (12) months from last Date of Service.

III. **Frame Benefit**

- A. **In-Network Benefit**. A Member is entitled to a \$120.00 allowance toward a frame with the purchase of prescription lenses. The Member is responsible for 80% of the balance over the \$120.00 at the time of service.
- B. **Out-of-Network Benefit**. A Member is entitled to a reimbursement of up to \$65.00 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 co-payment.
- D. **Benefit Frequency**. Once every twelve (12) months from last Date of Service.

IV. **Lens Benefits**

- A. **In-Network Benefit**. A Member is entitled to single vision, bifocal, trifocal, and lenticular lenses.
- B. **Member Pays**. There is \$10.00 co-payment.
- C. **Lens Options** A Member is entitled to the following lens options for the additional amounts set forth below:

Ultra Violet Coating	\$15.00
Tint (Solid & Gradient)	\$15.00
Standard Scratch Resistant	\$15.00
Standard Polycarbonate - Adults	\$40.00
Standard Polycarbonate - Kids Under 19	\$ 0.00
Standard Progressive Lens	\$75.00
Premium Progressive Lens	\$75.00, 80% of Charge less than \$120 Allowance
Standard Anti-Reflective	\$45.00
Other Add-Ons	20% discount
- D. **Out-of-Network Benefit**. A Member is entitled to be reimbursed for the following: up to \$25.00 for single vision; up to \$40.00 for bifocal; up to \$55.00 for trifocal; up to \$55.00 for lenticular; up to \$40.00 for Standard and Premium Progressives. 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.
- E. **Benefit Frequency**. Once every twelve (12) months from last Date of Service.

Note: Discounts do not apply for benefits provided by other group benefit plans. Allowances are one-time use benefits, no remaining balance. Lost or broken materials are not covered.

** 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®.*

V. **Laser Vision Benefit**

A Member is entitled to a 15% discount or a 5% discount on promotional pricing on LASIK and PRK treatments through the U.S. Laser Network, including pre-operative and post-operative care. However, if the treatment is performed at a LasikPlus Center, which is part of the U.S. Laser Network, and the Member elects to obtain pre-operative and post-operative care not from the LasikPlus Center provider, the other provider may charge additional fees for the pre-operative and post-operative care which the Member

will be responsible for and such fees are not subject to the 15% discount or the 5% discount on promotional pricing.

Accessing the Benefit

1. To locate the nearest U.S. Laser Network provider, a Member must call 1-877-5LASER6.
2. After the Member has located a U.S. Laser Network provider, the Member should contact the U.S. Laser Network provider and identify himself or herself as an EyeMed Member. The Member should schedule a consultation with a U.S. Laser Network provider to determine if he or she is a good candidate for laser vision correction.
3. If it is determined that the Member is a good candidate for laser vision correction, the Member should schedule a treatment date with a U.S. Laser Network provider.
4. To activate the benefit, the Member must call the U.S. Laser Network again at 1-877-5LASER6 with his or her scheduled treatment date.
5. At the time the treatment is scheduled, the Member will be responsible to remit an initial refundable deposit to U.S. Laser Network. (If the Member should decide not to have the treatment, the deposit will be returned. Otherwise, the deposit will be applied to the total cost of the treatment.)
6. At the time the Member remits the deposit, U.S. Laser Network will issue to the Member an authorization number confirming the EyeMed discount. This authorization number will be sent to the Member's U.S. Laser Network provider prior to treatment.
7. On the day of the treatment, it is the responsibility of the Member to pay or arrange to pay the balance of the fee.
8. After the treatment, the Member should follow all post-operative instructions carefully. In addition, the Member is responsible to schedule any required follow-up visits with a U.S. Laser Network provider to ensure the best results from the laser vision correction.

VI. Additional Purchases and Out-of-Pocket Discount

Member will receive a 20% discount on remaining balance at Participating EyeMed Providers beyond plan coverage, which may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed's Providers professional services, disposable contact lenses or services provided by laser providers. Members are also eligible for additional discounts on eyewear purchases. Once the initial benefit has been used, members are eligible for 40% off the retail price of a complete pair eyeglass purchase and 15% off conventional contact lenses.

VII. 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. Medical and/or surgical treatment of the eye, eyes, or supporting structures. 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). Two pair of glasses in lieu of bifocals.

SAMPLE SAVINGS

The following examples illustrate how your benefit would be applied to the services received at any participating EyeMed 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 \$120:	the member pays \$0.00
One pair of bifocal lenses:	the member pays \$10.00
Ultraviolet coating:	the member pays \$15.00
The total cost to the member is:	\$35.00

If a member chooses to receive:

A comprehensive vision care examination:	the member pays \$10.00
A frame up to a value of \$150:	the member pays \$24.00
A pair of single vision lenses:	the member pays \$10.00
Standard anti-reflective coating:	the member pays \$45.00
The total cost to the member is:	\$89.00

The EyeMed network is always growing, and provider locations are subject to change. Therefore, we recommend calling EyeMed’s Member Services Department 877-861-3459 or using the Provider Locator service through EyeMed’s web site www.eyemedvisioncare.com to locate the EyeMed Provider closest to you.

Note: The benefits are underwritten by Fidelity Security Life. If you have any questions or concerns, please contact EyeMed Vision Care.

Filing Claims

Using your Vision Benefit

Before you go to a participating EyeMed 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 EyeMed Identification Card, if applicable, or if you should forget to take your card be sure to say that you are participating in the State of Nebraska vision care plan so that eligibility can be verified.

EyeMed 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 877-861-3459.

When you receive services at a participating EyeMed 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 any applicable co-payments. You will also owe state tax, if applicable, and the cost of non-covered expenses (for example, vision perception training).

Time Frames for Processing Claims

Health Claim Processing Activity	Post Service Claims
Plan Initial Determination	
<ul style="list-style-type: none"> • Initial Review Decision • Extension Period, including extension for 	30 calendar days 15 calendar days

Missing Information	
Plan Notice of Incomplete Claim <ul style="list-style-type: none"> Missing Information 	Included in Extension Time above
Claimant Time to Complete Claim <ul style="list-style-type: none"> Provide Additional Information Comply with Required Filing Procedure 	45 calendar days 45 calendar days

Time Frames for Responding to Appealed Claims

Activity	Time Frame
Claimant Appeal of Adverse Determination (Denial or Reduction)	180 calendar days
Plan Decision on Appeal	60 calendar days

EyeMed Vision Care has been determined to belong to the post service claims category. If a claim for benefits is denied, EyeMed Vision Care will notify the member in writing of the specific reasons for the denial. The member may request a full review by EyeMed Vision Care within 180 days of the date of a denial. The member's written letter of appeal should include the following:

- The applicable claim number or a copy of the EyeMed Vision Care denial information or Explanation of Benefits, if applicable.
- The item of your vision coverage that the member feels was misinterpreted or inaccurately applied.
- Additional information from the member's eye care provider that will assist EyeMed Vision Care in completing its review of the member's appeal, such as documents, records, questions or comments.

The appeal should be mailed to the following address:

EyeMed Vision Care, L.L.C.
Attn: Quality Assurance Dept.
4000 Luxottica Place
Mason, Ohio 45040

EyeMed Vision Care will review your appeal for benefits and notify you in writing of its decision, as well as the reasons for the decision, with reference to specific plan provisions.

Member Grievance Procedure

If the member is dissatisfied with the services provided by an EyeMed Vision Care Provider, the member should either write to EyeMed at the address indicated above or call the EyeMed Vision Care Member Services toll free telephone number at 877-861-3459. The EyeMed Vision Care Member Services representative will log the telephone call and attempt to reach a resolution to the issues raised by the member. If a resolution cannot be reached during the telephone call, the EyeMed Vision Care Member Services representative will document all of the issues or questions raised. EyeMed Vision Care will use its best efforts to communicate back with the member within four (4) business days with a decision or resolution to the issues or questions raised. If the member is not satisfied with the resolution, the member may file a formal appeal as set forth above related to a denial of benefits.

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.