

This plan provides coverage for a vision examination, eyeglass lenses or contact lenses and frame and a hearing exam with allowances for hearing aids. Vision benefits are available from an extensive national network of participating providers powered by Eye Med Vision Care. You can easily find a conveniently located provider near you. You have a choice of independent optometrists and ophthalmologists, as well as retail locations such as Lens Crafters, Sears Optical, Target Optical and JC Penney Optical and most Pearle Vision Centers. Members will receive additional savings from Network Providers for lens upgrades and additional pair purchases.

NETWORK PROVIDERS - By using a network provider, you minimize your out-of-pocket costs and receive the benefit of our paperless claims processing. Network Providers verify your eligibility and obtain all the necessary information to validate your level of coverage. You simply pay your copayment and any remaining balance for non-covered services or materials at the time of your appointment. In addition, Network Providers offer you discount pricing which is significantly below retail. You receive substantial savings of 15%-40% or more on most additional pair purchases, conventional contact lenses, lens treatments, specialized lenses and various accessory items. **Out of Network Benefits**** – If you choose to go to a non-network provider, you must pay the provider his or her full charges at the time of service. Members will be responsible for submitting a claim for reimbursement for the amount indicated in the member reimbursement schedule.

Benefits from a Network Provider*		Member Copay	Out-of-Network Benefit Schedule **	
Vision Examination – includes dilation as indicated	Once Every 24 Months*	\$ 0.00	Vision Examination	Up to \$32.00
Eyeglass Lenses - single vision, bifocal, or trifocal in standard/basic plastic w/Standard Scratch Resistance and Tints	Once Every 24 Months*	\$ 0.00	Lenses <ul style="list-style-type: none"> • Single Vision Up to \$30.00 • Bifocal Up to \$45.00 • Trifocal Up to \$75.00 • Standard Scratch Up to \$12.00 • Tints Up to \$12.00 	
Frame – covered in full up to a \$ 130.00 retail value. Members receive 20% off balance for selection costing more than the plan allowance. Glasses available through glasses.com	Once Every 24 Months*	N/A	Frame	Up to \$57.00
Contact Lenses- Contact lenses can be purchased through contactsdirect.com	Not Covered	N/A	Not Covered	N/A

* Vision Benefits are available 24 months from last date of service *In-network services and materials may be subject to a copayment at the time of service.
 Out-of-Network amounts are maximum reimbursable amounts paid to members after the claim is filed. **Co-pays don't apply to the out of network reimbursement

Additional Savings Program				<p>Please contact EPIC to utilize the hearing aid saving plan</p>
Lens Options	Member Pricing	Other Options/Services	Member Pricing	
Tint (solid & gradient) *	Covered	Other Lens Add-Ons and Services	20% off Retail	
UV Coating	\$15.00	Complete Pair Purchases ***	40% off Retail	
Standard Scratch Resistance*	Covered	Conventional Contact Lenses	15% off Retail	
Standard Polycarbonate Adult	\$40.00	Standard Contact Lens Fitting & Follow-up	\$40.00	
Standard Polycarbonate Children	\$40.00	Premium Contact Lens Fitting & Follow-up	10% discount	
Standard Anti-Reflective	\$45.00	EPIC Hearing Savings Plan	Fixed fee schedule on hearing aids	
Standard Progressive Lenses**	\$65.00	Photo chromatic Lenses	20% discount	
Premium Progressive Lenses**	20% off Retail	Retinal Imaging	\$39.00	

*Covered by plan benefit. ** Standard/Premium Progressive lenses are not covered benefits – however when upgrading in conjunction with your funded benefit the bifocal lens amount will be applied. Members are responsible for the lens copayment and any additional charges. (bifocal co-pay + \$65 + 80% of retail less \$120) *** Discount applies on complete pair purchase once funded benefit is used.



Vision Limitations & Exclusions

Fees charged by a provider for services other than a covered benefit must be paid in full by the insured to the provider. Such fees or materials are not covered under the policy. Benefit allowances provide no remaining balance for future use within the same benefit frequency. No benefits will be paid for services or materials connected with/or charges arising from

- Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; medical and/or surgical treatment of the eye, eyes or supporting structures
- Any corrective eyewear, required by a policyholder as a condition of employment, safety eyewear, services provided as a result of any Worker's Compensation law, or similar legislation or required by any governmental agency or program whether federal, state or subdivision thereof
- Plano (non-prescription) lenses; non-prescription sunglasses
- Two pair of glasses in lieu of bifocal
- Services or materials provided by another group benefit plan providing vision care
- Services rendered after the date an insured ceases to be covered under the policy, except when vision materials ordered before coverage ended are delivered and the services rendered to the insured are within 31 days from the date of such order
- 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.
- Certain frame brands in which the manufacturer imposes a no-discount policy
- Covered benefits may not be used in conjunction with coupons or other provider discount offers
- If an Insured and the Insured Spouse are both Insured by the plan, one Insured party may request to be a Dependent spouse of the other. A Dependent child may not be covered by more than one Insured.

Visit the GVS web site to “Locate a Provider” or “View your Benefits” and learn more about our Additional Savings Program

Web Site – www.gvsmd.com - click “Members” to locate a provider or view your benefits

Customer Service and IVR – at 866-265-4626
Call customer service to ask about your benefits or to locate a provider.

Access 7 Days a Week	<u>Call Center Hours</u> 7:30 a.m. to 11:00 p.m. EST-Monday – Saturday 11:00 a.m. to 8:00 p.m. EST - Sunday
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Locating a Provider

Network Providers

1. Find network provider at www.gvsmd.com click on “Providers”.
2. Schedule an exam with the provider of your choice. When scheduling your appointment inform the provider that you are a GVS/EyeMed member and provide your name and date of birth (DOB). The provider will verify your eligibility and plan benefits prior to your appointment.
3. If you have already made an appointment show your ID card at the time of service or provide your name and DOB for quick verification of eligibility and plan coverage.
4. Members will be responsible to pay the provider at the time of service for any applicable copayment /costs that exceed the plan coverage.

Out-of-Network Providers

1. Visit non-network provider
2. Members are required to pay the entire amount for exam and eyewear at the time of service.
3. Members must obtain an OON claim form from the GVS website at www.gvsmd.com. (click “Members”).
4. Members must submit OON claim form and provider receipt to the Claims Address indicated on the form.
5. Member will be reimbursed based on OON benefits indicated in their benefit summary.

Personalized Member Website Access

For Members to Access their Benefits: You must first register on the GVS website – www.gvsmd.com

1. Under the **MEMBER** tab select **VIEW YOUR BENEFITS**
2. Welcome to the GVS Member - Click [here](#) to Login/Register
3. Select [Register for an account](#)
4. When you enter the Member Site to Register for an Account - USE the LAST FOUR DIGITS of your social security number and pick your own user ID.
5. Site will send an Email confirmation and password selection