Vision Plan Options

TLC Insurance Group & Wealth

Monthly rates	VSP Premier Vision Plan				EyeMed Enhanced Vision Plan			
	All other states	FL, MS	MN	MI, NC	All other states	FL, MS	MN	MI, NC
Policyholder	$15.97	$12.78	$9.52	$11.20	$10.98	$8.78	$6.66	$7.84
Policyholder plus one dependent	$29.38	$23.50	$17.17	$20.20	$20.20	$16.16	$12.41	$14.60
Policyholder plus two or more dependents	$43.91	$35.13	$25.33	$29.80	$30.19	$24.15	$18.29	$21.52

vsp vision care | eyemed

Plan details	VSP Premier Vision Plan No waiting periods. No enrollment fees.		EyeMed Enhanced Vision Plan No waiting periods. No enrollment fees.	
	In-network	Out-of-network	In-network	Out-of-network
Benefit frequencies	*Benefits can be applied to contacts OR frames during the benefit year.*		*Benefits can be applied to contacts AND frames during the benefit year, subject to benefit frequency.*	
Exam	Every 12 months		Every 12 months	
Eyeglass lenses or contacts	Every 12 months		Every 24 months	
Frames	Every 12 months		Every 24 months	
Deductibles				
Per person per year (based on date of service)	$15 exam* $25 eyeglass lenses or frames**		$15 exam* $25 eyeglass lenses or frames**	
Eyeglasses				
Single vision	Covered in full	Up to $30	Covered in full	Up to $50
Bifocal	Covered in full	Up to $50	Covered in full	Up to $75
Trifocal	Covered in full	Up to $65	Covered in full	Up to $100
Lenticular	Covered in full	Up to $100	Covered in full	Up to $75
Frames	Up to $150	Up to $70	Up to $130	Up to $70
Contacts				
Elective	Up to $150	Up to $105	Up to $130	Up to $105
Fit & follow-up exam	Member cost up to $60	No Benefit	Member cost up to $15	Up to $40
Lens options & coatings, member cost				
Standard polycarbonate	$31 - $35	No Benefit	$40	No Benefit
Tints & dyes (except pink I & II)	$34 - $44	No Benefit	$15	No Benefit
Scratch resistant	$17	No Benefit	$15	No Benefit
Anti-reflective	$41	No Benefit	$45	No Benefit
Ultraviolet	$16	No Benefit	$15	No Benefit

How to Enroll:

Our easy enrollment was built with you in mind.

Here are the 4 easy steps to getting enrolled:

1. **Visit**
2. **Choose your preferred plan**
3. **Enter your personal information**
4. **Submit payment**

Minimum info needed:

- ZIP Code
- Do you need dental coverage?
- Do you need vision coverage?
- How many need coverage?

Questions? Contact: **Andrea at EBS**
(833) 443-1942 (or) Contact the
EBS - TLC Retiree Service Center
(833) 469-0515 (Mention IAM when calling)

vsp vision care

VSP Premier Provider Network

VSP offers the nation's largest network of independent providers. Retail chains accepting VSP insurance include Costco, Visionworks, Walmart, and Sam's Club. Browse and buy online at eyeconic.com and get the most current deals on eyewear with network benefits.

Plan Overview

VSP Premier offers enhanced eyeglass and contact benefits. Get an eye exam every 12 months and new glasses or contacts every 12 months! Year-round enrollment available. **VSP contracted provider discounts**. Take advantage of 20% off the remaining frame balance, additional prescription glasses, and non-covered lens options. And receive an extra $20 to spend on featured frame brands. All lens enhancements are covered after a Deductible, saving members an average of 35-40%. Based on applicable laws, benefits may vary by doctor location.

Access Your Benefits

After your coverage begins, create an account at **ameritas.com** to access your benefit information. Claims history can be accessed through a VSP account at **vsp.com**.

VSP Premier Limitations and Exclusions

This plan does not cover:

- Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
- Plano lenses (lenses with refractive correction of less than plus or minus .50 diopter) except as specifically allowed in the frames benefit section below.
- Services or materials that are cosmetic, including Plano contact lenses to change eye color and artistically painted Contact Lenses.
- Two pairs of glasses in lieu of Bifocals.
- Replacement of Spectacle Lenses, Frames, and/or contact lenses furnished under this plan that are lost or damaged, except at the normal intervals when services are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Contact lens modification, polishing or cleaning.
- The refitting of Contact Lenses after the initial 90-day filing period.
- Contact Lens insurance policies or service contracts.
- Additional office visits associated with contact lens pathology.
- Local, state and/or federal taxes, except where law requires us to pay.
- Membership fees for any retail center in which an Affiliate or Open Access provider office may be located. Covered persons may be required to purchase a membership in such entities as a condition of accessing Plan Benefits.

EyeMed

EyeMed Enhanced Provider Network

EyeMed offers one of the largest vision networks in the nation with a mix of independent providers and retail chains. Find EyeMed access network providers at **eyemed.com**.

Plan Overview

Get an eye exam every 12 months and new glasses or contacts every 24 months! Year-round enrollment available.

Access Your Benefits

After your coverage begins, create an account at **ameritas.com** to access your benefit information. Claims history can be accessed through a EyeMed account at **eyemed.com** or the EyeMed app.

Retail Locations: Retail chains accepting EyeMed insurance include LensCrafters, Pearle Vision and Target Optical.

Online Options: Browse and buy eyewear online. Glasses.com and ContactsDirect are in the EyeMed network, and your vision benefits are applied directly to your online order.

EyeMed Provider Discounts: Take advantage of EyeMed provider discounts, including 20% off the remaining frame balance, materials not covered by the plan, and non-prescription sunglasses.

EyeMed Enhanced Limitations and Exclusions

This plan has the following limitations:

- Vision examinations, lenses and frames more than the frequency as indicated on the plan summary page.
- This plan does not cover Medically Necessary Contact Lenses more than once in any 24-month period. The treating provider determines if an Insured meets the coverage criteria for this benefit as listed below. This benefit is in lieu of Elective Contact Lenses. Not covered in Texas.
- For Keratoconus where the patient is not correctable to 20/30 in either or both eyes using standard spectacle lenses.
- Patients whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best standard spectacle lens correction.
- Anisometropia of 3D or more.
- High Ametropia exceeding -10D or +10D in meridian powers.
- This plan does not cover Orthoptics or vision training and any associated testing.
- This plan does not cover Plano Lenses.
- This plan does not cover non-prescribed Lenses or sunglasses.
- This plan does not cover two pairs of glasses in lieu of Bifocals.
- This plan does not cover replacement of Lenses and Frames that are lost or broken outside of the normal coverage intervals.
- This plan does not cover medical or surgical treatment of the eyes or supporting structures.
- This plan does not cover services for claims filed more than one year after completion of the service. An exception is if the Insured shows it was not possible to submit the proof of loss within this period.
- This plan does not cover any procedure not listed on the Schedule of Eye Care Services.

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