BENEFITS

Washington Elementary School District

Benefits

EE 130/130 4T
Exam & Materials
Insight Network
Fully Insured
Employee Paid

Monthly rates

Subscriber
$5.82

Subscriber + Spouse
$11.64

Subscriber + Child(ren)
$12.22

Subscriber + Family
$13.82

SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES once every plan year		
Exam at PLUS Providers	*$0 copay*	*Up to $40*
Exam	$10 copay	Up to $40
FRAME ***in lieu of contacts*** **once every plan year**		
Any available frame at PLUS Providers	*$0 copay; 20% off balance over $180 allowance*	*Up to $65*
Frame	$0 copay; 20% off balance over $130 allowance	Up to $65
STANDARD PLASTIC LENSES ***in lieu of contacts*** **once every plan year**		
Single Vision	$10 copay	Up to $30
Bifocal	$10 copay	Up to $50
Trifocal/Lenticular	$10 copay	Up to $70
Progressive – Standard	$65 copay	Up to $50
Progressive – Premium Tier I, II, or III	$95, $105, or $120 copay	Up to $50
Progressive – Premium Tier IV	$225 copay	Up to $50
LENS OPTIONS		
Anti Reflective Coating – Standard	$45 copay	Up to $23
Anti Reflective Coating – Premium Tier I, II, or III	$57, $68, or $100 copay	Up to $23
Polycarbonate – Standard	$0 copay	Up to $20
CONTACT LENSES ***in lieu of frame and lenses*** **once every plan year**		
Contacts – Conventional	$0 copay; 15% off balance over $130 allowance	Up to $65
Contacts – Disposable	$0 copay; 100% of balance over $130 allowance	Up to $65
Contacts – Medically Necessary	$0 copay; paid-in-full	Up to $300
ADDITIONAL GLASSES ALLOWANCE once every plan year		
Glasses Allowance at Plus Provider	*40% off retail*; 100% of balance over $100*	*Up to $40*
Glasses Allowance	40% off retail*; 100% of balance over $50	Up to $40

*Complete pair (frame & lens with or without lens options) purchase required to receive 40% discount. 20% discount applied if complete pair not purchased. All plans are based on a 48 month contract and 48 month rate guarantee. Monthly Rate is subject to adjustment even during a rate guarantee period in the event of any of the following events: changes in benefits, employee contributions, the number of eligible employees, or the imposition of any new taxes, fees or assessments by Federal or State regulatory agencies. The Plan reserves the right to make changes to the products available on each tier.

Plan Details

Quote for group situsedin the State of AZ and will be valid until the 07/01/2024 implementation date. Date Quoted 10/30/2023. Rates are valid only when the quoted plan is the sole stand-alone vision plan offered by the group. Percentage discounts are not part of the insurance benefit. Underwritten by Fidelity Security Life Insurance Company® of Kansas City, Missouri, except in New York. Fidelity Security Life Policy number VC-146, form number M-9184. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.

Plan Exclusions/Limitations

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 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.