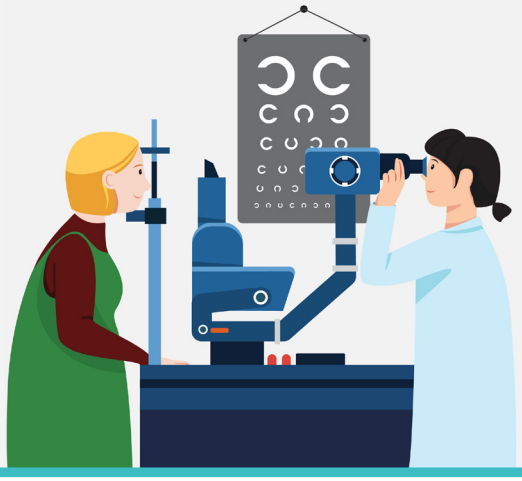
Vision Insurance
EyeMed

ABOUT VISION

Vision insurance provides coverage for routine eye examinations and can help with covering some of the costs for eyeglass frames, lenses or contact lenses.

For full plan details, please visit your benefit website:
www.mybenefitshub.com/laketravisisd



Schedule of Benefits		
VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES		
Exam	*$10 copay*	*Up to $40*
Retinal Imaging	*Up to $39*	*Not Covered*
CONTACT LENS FIT AND FOLLOW-UP		
Fit and Follow-up- Standard	*Up to $40; contact lens fit and two follow-up visits*	*Not covered*
Fit and Follow-up- Premium	*10% off retail price*	*Not covered*
FRAME		
Frame	*$0 copay; 20% off balance over $130 allowance*	*Up to $65*
STANDARD PLASTIC LENSES		
Single Vision	*$25 copay*	*Up to $30*
Bifocal	*$25 copay*	*Up to $50*
Trifocal / Lenticular	*$25 copay*	*Up to $70*
Progressive- Standard	*$80 copay*	*Up to $50*
Progressive- Premium Tier 1- 4	*$110 - 240*	*Up to $50*
LENS OPTIONS		
Anti Reflective Coating- Standard	*$45 copay*	*Up to $23*
Anti Reflective Coating- Premium Tier 1- 3	*$57 - 100*	*Up to $23*
Photochromic- Non-Glass	*$75*	*Not covered*

INDEPENDENT PROVIDER NETWORK + OPTICAL PEARLE VISION LENSCRAFTERS

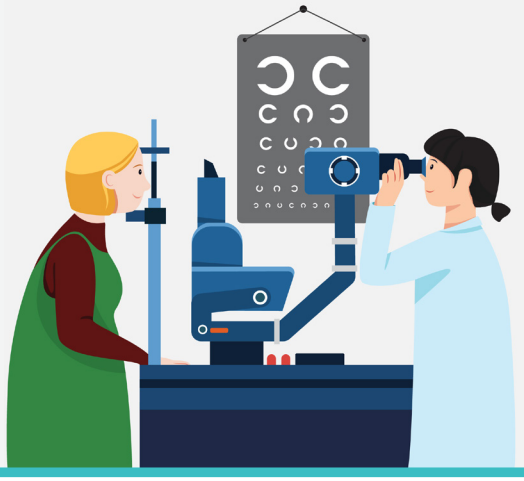
Vision Insurance
EyeMed

EMPLOYEE BENEFITS

ABOUT VISION

Vision insurance provides coverage for routine eye examinations and can help with covering some of the costs for eyeglass frames, lenses or contact lenses.

For full plan details, please visit your benefit website:
www.mybenefitshub.com/laketravisisd



Schedule of Benefits		
Polycarbonate- Standard	*$40*	*Not covered*
Polycarbonate- Std < 19 years of age	*$0 copay*	*Up to $20*
Scratch Coating	*$15*	*Not covered*
Tint	*$0 copay*	*Up to $8*
UV Treatment	*$15*	*Not covered*
All Other Lens Options	*20% off retail price*	*Not covered*
CONTACT LENSES		*Up to $65*
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*
OTHER		
Hearing Care from Amplifon Network	*Discounts on hearing 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*

40% OFF
additional complete pair of prescrption eyeglasses

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

Vision	Monthly Premium
Employee Only	$5.91
Employee and Spouse	$11.23
Employee and Child(ren)	$11.82
Employee and Family	$17.40

Frequency

Exam
once every plan year

Frame
once every plan year

Lens
once every plan year

Contact Lens
once every plan year

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