Vision Benefit Summary: This plan provides coverage for a vision examination eyeglass lenses and frame or contact lenses. 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, most Pearle Vision, Sears, Target Optical and JC Penney Optical. 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.

Benefits from a Network Provider*		Copayment
Vision Examination – includes dilation as indicated	**Once Every 12 Months***	**$ 0.00**
Eyeglass Lenses - single vision, bifocal, trifocal or lenticular in standard/basic plastic:**Plus:,tints,UV,standard scratch and polycarbonate**	**Once Every 12 Months***	**$ 0.00**
Frame –covered in full up to a **$ 150.00 retail value**. Members receive 20% off balance for selection costing more than the plan allowance **Frames also available through glasses.com**	**Once Every 24 Months***	**N/A**
Contact Lenses - in lieu of spectacle lenses (does not include fitting and follow-up) • **Elective** – Disposable or Conventional, covered in full up to **$ 120.00 A**llowance. Conventional lenses: members receive 15% discount off balance over plan allowance. **Contacts available through contactsdirect.com** • **Medically Necessary** – Covered in full up to **$ 250.00**	**Once Every 12 Months***	**N/A**
*** Benefits are available 12 or 24 months from last date of service**		

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.

Member Reimbursement for services/materials obtained from an Non-Network Provider	
Vision Examination	**Up to $ 65.00**
Lenses	
Single Vision	**Up to $90.00**
Bifocal	**Up to $110.00**
Trifocal	**Up to $120.00**
Lenticular	**Up to $140.00**
Frame	**Up to $120.00**
Elective Contact Lenses (in lieu of spectacle lenses)	**Up to $120.00**
Medically Necessary Contact Lenses	**Up to $200.00**

*In-network services and materials may be subject to a copayment at the time of amenity. **Out-of-Network amounts are thoroughgoing reimbursable amounts paid to members after the claim is filed. **Co-pay doesn't apply to OON reimbursement.**

Additional Savings Program

Pricing available in conjunction with funded benefits

Lens Options	Member Pricing	Other Options/Services	Member Pricing
Tint (solid & gradient)*	**Covered**	Other Lens Add-Ons and Services	20% off Retail
UV Coating*	**Covered**	Additional Complete Pair Purchases ***	40% off Retail
Standard Scratch Resistance*	**Covered**	Conventional Contact Lenses	15% off Retail
Standard Polycarbonate Adult*	**Covered**	Premium Contact Lens Fitting and Follow-up	10% discount
Children*	**Covered**		
Standard Anti-Reflective	$45.00	Standard Contact Lens Fitting and Follow-up	$40.00
Standard Progressive Lens	$65.00	Retinal Imaging	$39.00
Premium Progressive Lens**	20% off Retail	EPIC Hearing Aid Savings Program	Fixed fee schedule

** 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.

LensCrafters

Sears Optical

Pearle Vision

JCPenney jcp.com

Target Optical

Private Practitioners

To access the Hearing aid savings plan contact:
EPIC Hearing Healthcare at
T: 877-606-3742

EPIC Hearing Healthcare

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

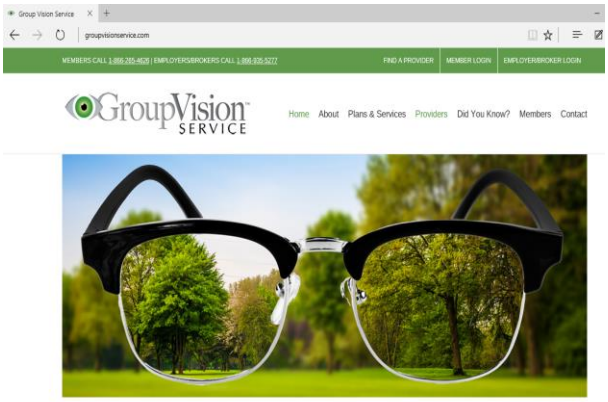
- Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseiikonic lenses; medical and/or surgical treatment of the eye, eyes or supporting structures
- Any corrective eyewear, required by a policyholder as a condition of employment, safety eyewear, services provided 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

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	Call Center Hours 8:00 a.m. to 11:00 p.m. EST-Monday – Saturday 11:-- a.m. to 8:00 p.m. EST - Sunday



Network Providers

1. Find network provider at www.gvsmd.com click on "Provider Locator".
2. Schedule an exam with the provider of your choice. When scheduling your appointment inform the provider that you are a GVS/Eye Med 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.
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.