



City of Los Angeles

SUMMARY OF BENEFITS

Additional discounts

40% OFF

Complete pair of prescription eyeglasses

20% OFF

Non-prescription sunglasses

20% OFF

Remaining balance beyond plan coverage

These discounts are not insured benefits and are for in-network providers only

Take a sneak peek before enrolling

- You're on the INSIGHT Network
- For a complete list of in-network providers near you, use our Enhanced Provider Locator on eyemed.com/cityofla or call 1.855.695.5418.
- For LASIK providers, call 1.877.5LASER6.

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam With Dilatation as Necessary	\$10 Co-pay	Up to \$45
Retinal Imaging	\$10 Co-pay	Up to \$21
Frames	\$0 Co-pay, \$150 Allowance, 80% of balance over \$150	Up to \$104
Standard Plastic Lenses		
Single Vision	\$10 Co-pay	Up to \$35
Bifocal	\$10 Co-pay	Up to \$50
Trifocal	\$10 Co-pay	Up to \$65
Lenticular	\$10 Co-pay	Up to \$65
Standard Progressive Lens	\$75 Co-pay	Up to \$70
Premium Progressive Lens ^A	\$95 Co-pay - \$120 Co-pay	
Tier 1	\$95 Co-pay	Up to \$70
Tier 2	\$105 Co-pay	Up to \$70
Tier 3	\$120 Co-pay	Up to \$70
Tier 4	\$75 Co-pay, 80% of charge less \$120 Allowance	Up to \$70
Lens Options		
UV Treatment	\$15	N/A
Tint (Solid and Gradient)	\$15	N/A
Standard Plastic Scratch Coating	\$15	N/A
Standard Polycarbonate	\$40	N/A
Standard Polycarbonate-Kids under 19	\$0 Co-pay	Up to \$28
Standard Anti-Reflective Coating	\$45	N/A
Premium Anti-Reflective Coating ^A	\$57 - \$68	N/A
Tier 1	\$57	N/A
Tier 2	\$68	N/A
Tier 3	80% of charge	N/A
Photochromic/Transitions	\$75	N/A
Polarized	80% of retail price	N/A
Other Add-Ons and Services	80% of retail price	N/A
Contact Lens Fit and Follow-Up (Contact lens fit and follow up visits are available once a comprehensive eye exam has been completed)		
Standard Contact Lens Fit & Follow-Up	Up to \$55	N/A
Premium Contact Lens Fit & Follow-Up	90% of retail price	N/A
Contact Lenses (Contact lens allowance includes materials only)		
Conventional	\$0 Co-pay, \$150 Allowance, 85% of balance over \$150	Up to \$120
Disposable	\$0 Co-pay, \$150 Allowance; plus balance over \$150	Up to \$120
Medically Necessary	\$0 Co-pay, paid-in-full	Up to \$210
Frequency		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 12 months	
Additional Discounts:		
Laser Vision Correction		
LASIK or PRK from U.S. Laser Network	85% of retail price or 95% of promotional price	N/A
Hearing Care		
Hearing Health Care from Amplifon Hearing Network	40% off hearing exams and a low price guarantee on discounted hearing aids	N/A

Benefits are not provided from services or materials 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 Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear; 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; Plano (non-prescription) lenses; Non-prescription sunglasses; Two pair of glasses in lieu of bifocals; Services or materials provided by any other group benefit plan providing vision care; 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. 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. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/Premium Progressive lens not covered - fund as a Bifocal lens. Standard Progressive lens covered - fund Premium Progressive as a Standard. Benefit allowance provides no remaining balance for future use with the same benefits year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered. Underwritten by Combined Insurance Company of America, 5050 Broadway, Chicago, IL 60640, except in New York. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer. ^APremium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Not available in all states. Some provisions, benefits, exclusions or limitations listed herein may vary.

What's in it for me?

Options. It's simple really. We're dedicated to helping you see clearly – and that's why we've built a network that gives you lots of choices and flexibility. You can choose from thousands of independent and retail providers to find the one that best fits your needs and schedule. No matter which one you choose, our plan is designed to be easy-to-use and help you access the care you need. Welcome to EyeMed.



Benefits Snapshot	With EyeMed	Out-of-Network Reimbursement
Exam, with dilation as necessary (once every 12 months)	\$10 Co-pay	Up to \$45
Frames (once every 12 months)	\$0 Co-pay, \$150 Allowance; 80% of balance over \$150	Up to \$104
Single Vision Lenses (once every 12 months) or Contacts (once every 12 months)	\$10 Co-pay \$0 Co-pay, \$150 Allowance; plus balance over \$150	Up to \$35 Up to \$120

And now it's time for the breakdown . . .

Here's an example of what you might pay for a pair of glasses with us vs. what you'd pay without vision coverage. So, let's say you get an eye exam and choose a frame that costs \$163 with single vision lenses that have UV and scratch protection. Now let's see the difference...

**85%
SAVINGS
with us***

	With EyeMed	Without Insurance**
Exam	\$10 Co-pay	Exam \$106
Frame	\$163 -\$150 Allowance \$13 -\$2.60 (20% discount off balance) \$10.40	Frame \$163
Lens	\$10 Co-pay \$15 UV treatment add-on +\$15 scratch coating add-on \$40	Lens \$78 \$23 UV treatment add-on +\$25 scratch coating add-on \$126
Total	\$60.40	Total \$395



Download the EyeMed Members App

It's the easy way to view your ID card, see benefit details and find a provider near you.



*This is a snapshot of your benefits. Actual savings will depend on provider, frame and lens selections. **Based on industry averages.



The following table provides a summary of your vision care services. Discuss with your vision provider whether the services you are requesting are covered **before** scheduling an appointment and receiving services.

DESCRIPTION	EYEMED	KAISER	ANTHEM
Routine Eye Exam	Covered with co-pay.	Covered with co-pay.	Not covered.
Eyewear – Frames, Lenses, or Contacts	Up to \$150 allowance* every year (does not roll over if not used).	Not covered (Partial reimbursement available from EyeMed if member files an out-of-network claim).	
Medical Eye Exams (e.g. Screening for medical vision conditions like glaucoma, cataracts, etc.)	May be covered. Check with EyeMed vision provider before seeking ophthalmology related services.	Covered with co-pay.	Covered with co-pay. Primary Care Physician (PCP) referral and/or medical group authorization may be required under HMO plans. Please contact your PCP for information regarding their referral process before seeking care from a specialist.
Treatment of Vision Conditions (e.g. glaucoma, cataracts, etc.)	Not covered.	Covered with co-pay.	Covered with co-pay. Primary Care Physician (PCP) referral and/or medical group authorization may be required under HMO plans. Please contact your PCP for information regarding their referral process before seeking care from a specialist.

*Allowances may vary per specific benefit, based on the type of benefit item purchased, and do not apply to all benefits. See Summary of Benefits in your enrollment guide for more details on which benefits have an annual allowance.

CONTACT INFORMATION

PROVIDER	WEBSITE	PHONE	MEMBER ADVOCATE
EyeMed	www.eyemedvisioncare.com/cityofla	1-855-695-5418 Mon-Sat: 4:30 am to 8:00 pm PST Sun: 8:00 am to 5:00 pm PST	N/A
Kaiser	www.my.kp.org/cityofla	1-800-464-4000 7 days a week, 24 hours a day (Closed holidays)	Tue-Th: 8:00 am to 4:00 pm City Hall, Room 867
Anthem Vivity HMO	www.anthem.com/ca/cityofla	1-844-348-6110 Mon-Fri: 8:00 am to 8:00 pm PST	Mon-Fri: 8:00 am to 4:00 pm City Hall, Room 867
Anthem Select HMO (Narrow), Anthem CACare HMO (Full), Anthem PPO	www.anthem.com/ca/cityofla	1-844-348-6111 Mon-Fri: 8:00 am to 8:00 pm PST	