City of Jacksonville - Premier Plan

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 or call 1.866.804.0982.
- For LASIK providers, call 1.800.988.4221.

SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK REIMBURSEMENT
EXAM WITH DILATION AS NECESSARY	$10 Copay	Up to $53
RETINAL IMAGING	Up to $39	N/A
FRAMES	$0 Copay, $130 Allowance, 20% off balance over $130	Up to $70
STANDARD PLASTIC LENSES		
Single Vision	$20 Copay	Up to $50
Bifocal	$20 Copay	Up to $75
Trifocal	$20 Copay	Up to $100
Lenticular	$20 Copay	Up to $125
Standard Progressive Lens	$20 Copay	Up to $75
Premium Progressive Lens	$20 Copay	Up to $75
LENS OPTIONS		
UV Treatment	$0 Copay	Up to $8
Tint (Solid and Gradient)	$0 Copay	Up to $8
Standard Plastic Scratch Coating	$0 Copay	Up to $8
Standard Polycarbonate- Adults	$0 Copay	Up to $20
Standard Polycarbonate – Kids Under 19	$0 Copay	Up to $20
Standard Anti Reflective Coating	$39 Copay	Up to $3
Premium Anti Reflective Coating[Δ]	$51 Copay – $62 Copay	Up to $3
Tier 1	$51 Copay	Up to $3
Tier 2	$62 Copay	Up to $3
Tier 3	80% of charge	Up to $3
Photochromic/Transitions	$75	N/A
Polarized	20% off retail	N/A
Other Add-ons and Services	20% off retail	N/A

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SUMMARY OF BENEFITS		
VISION CARE SERVICES	**IN-NETWORK MEMBER COST**	**OUT-OF-NETWORK REIMBURSEMENT**
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	10% off retail price	N/A
CONTACT LENSES	(Contact lens allowance includes materials only)	
Conventional	$0 Copay, $130 Allowance, 15% off balance over $130	Up to $105
Disposable	$0 Copay, $130 Allowance, plus balance over $130	Up to $105
Medically Necessary	$0 Copay, paid-in-full	Up to $210
LOW VISION		
Supplementary Testing	Covered in Full	Up to $125 Allowance
Low Vision Aides	25% Copayment up to $1,000	25% Copayment up to $1,000 Allowance
LASER VISION CORRECTION		
LASIK or PRK from U.S. Laser Network	15% off retail price or 5% off the promotional price	N/A
FREQUENCY		
Examination	Once every calendar year	
Lenses or Contact Lenses	Once every calendar year	
Frame	Once every two calendar years	
Low Vision Supplementary Testing	Once every two calendar years	
Low Vision Aides	Once every two calendar years	

Benefits are not provided from services or materials arising from: Orthopic 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 within 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, 111 East Wacker Drive, Chicago, IL 60601, except in New York. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer. ΔPremium 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.