

# SUMMARY OF BENEFITS



USD #437 - Auburn Washburn, Group # 06402-0-1-0, Effective January 1, 2022

Plan Design #698 – H

VISION CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK	FREQUENCY
<b>Vision Examination with Dilation as Necessary</b> Retinal Imaging	\$10 Copay Up to \$39	\$35 Not Covered	Once every Calendar Year
<b>Contact Lens Fit &amp; Follow-Up:</b> (Contact lens fit and two (2) follow-up visits are available once a comprehensive eye exam has been completed.) <b>Standard</b> – spherical clear contact lenses in conventional wear and planned replacement (Examples include but not limited to disposable, frequent replacement, etc.)  <b>Premium</b> – all lens designs, materials and specialty fittings other than Standard Contact Lenses (Examples include toric, multifocal, etc.)	\$40 Copay, Paid-in-full fit and two follow-up visits  10% off balance	Not Covered  Not Covered	Once every Calendar Year
<b>Frames:</b> Any available frames at provider location	\$130 Allowance, 20% off balance	\$65	Once every Calendar Year
<b>Standard Plastic Lenses:</b> Single Vision Bifocal Trifocal Lenticular	\$25 Copay \$25 Copay \$25 Copay \$25 Copay	\$25 \$40 \$55 \$55	Once every Calendar Year
<b>Lens Options:</b> Standard polycarbonate  UV Coating Tint (Solid and Gradient) Standard Scratch-Resistance Standard Anti-Reflective Coating Standard Progressive (Includes Copay amount) Premium Progressive (Includes Copay amount)	Adults: \$40 Dependents under 19: \$0  \$15 \$15 \$15 \$45 \$90 Copay Tier 1 - \$110 Copay Tier 2 - \$120 Copay Tier 3 - \$135 Copay Tier 4 - \$90 Copay, \$120 Allowance, and 20% off balance	\$25 \$25  Not Covered Not Covered Not Covered Not Covered \$40 \$40	Once every Calendar Year  Once every Calendar Year
Other Add-ons and Services	20% off balance	Not Covered	
<b>Contact Lenses:</b> (Contact lens allowance includes materials only) (Allowance not available if eyeglass lenses are elected)			
Conventional	\$130 Allowance, additional 15% off balance over Allowance	\$100	Once every Calendar Year
Disposable	\$130 Allowance	\$100	
Medically Necessary	\$0 Copay	\$200	
<b>Additional Pairs Benefit</b>	40% discount off complete pair of eyeglass purchase and 15% off conventional contact lenses	N/A	N/A
<b>Laser Vision Correction</b> For Lasik providers call 1-877-5LASER6	15% off retail price or 5% off promotional price	N/A	N/A

Service frequencies are computed by Calendar Year, not date-of-service. This plan utilizes the Insight Network.  
SEE SECTION ON EXCLUSIONS AND LIMITATIONS FOR ADDITIONAL INFORMATION.

This is a Summary of Benefits only, and various exceptions and limitations may apply. Your actual coverage is described in the agreement which is binding on all of the parties and supersedes all other written or oral communications.



Get the convenience you need and the provider choices you want with your Surency Vision plan.



With access to over 100,000 providers nationwide using EyeMed's extensive provider network, finding an in-network provider is easy. Search for a provider by location, provider name, services and more. Locate a provider at [Surency.com](https://www.surency.com) or use the [Surency Vision Mobile App](#).



You have access to your benefit information through the [Surency Vision Mobile App](#) or your [Member Account](#) at [Surency.com](https://www.surency.com).

Questions? Call Surency Customer Service at 866-818-8805.



Surency Vision is underwritten by Surency Life & Health Insurance Company ("Surency").

Surency has been selected by your employer to provide your group vision coverage. We are pleased to bring these important benefits to you and any eligible dependents you have enrolled for coverage.

This Summary of Vision Plan Benefits describes the essential features of your group vision coverage. This Summary of Vision Plan Benefits is a summary of benefits only and does not bind Surency to any coverage. All benefits are paid according to the terms, conditions and provisions of your employer's Agreement with Surency, which is binding on all parties and supersedes all other written or oral communications.

A child is eligible for coverage under the Plan if the child is under the age of 26.

### Additional Value Added Savings:

- Members may receive additional discounts not covered by the plan's in-network providers. Please check with your provider regarding any additional discounts. Discount does not apply to in-network providers' professional services or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Retail prices may vary by location. Services or materials provided by any other group benefit plan providing vision care may not be covered.
- After initial purchase, replacement contact lenses may be obtained via online at substantial savings and mailed directly to the member. Details are available at [Surency.com/Vision/Member-Perks](https://www.surency.com/Vision/Member-Perks). The contact lens benefit allowance is not applicable to this service.

### Plan Limitations/Exclusions:

- Allowances are one-time use benefits; no remaining balance.
- Orthoptic or vision training, subnormal vision aids and any associated supplemental testing.
- Medical and/or surgical treatment of the eye, eyes or supporting structures.
- Services provided as a result of any Worker's Compensation law.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.
- Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under plan.
- Plano lenses and non-prescription sunglasses (except for 20% discount).
- Services or materials provided by major medical coverage under any other group benefit providing vision care.
- Two pair of glasses in lieu of bifocals.
- Aniseikonic lenses.
- Discounts do not apply for benefits provided by other group benefit plans.
- Lost or broken materials are not covered.