County Board – Meeting Handouts

October 20, 2016

XV. New Business

B. Finance

1. Adoption of Resolution No. 9762 Approving Employee Insurance Benefits for FY2017

RESOLUTION NO. 9762

RESOLUTION APPROVING EMPLOYEE INSURANCE BENEFITS FOR FY2017

WHEREAS, the Champaign County Board annually determines the employee insurance benefits to be provided in the ensuing fiscal year; and

WHEREAS, the Champaign County Labor Management Health Insurance Committee has recommended to the County Board approval of the recommendations for employee insurance benefits for FY2017; and

WHEREAS, the Champaign County Labor Management Health Insurance Committee recommends to the County Board approval of offering the Health Alliance HMO 2000 Rx1 NS1 Plan for all County Employees for FY2017; and continuing to offer the Delta Dental Plan as a voluntary plan for a 24-month renewal with premiums locked at the first year rate and with an effective date of January 1, 2017; and offering the EyeMed Vision Plan as a voluntary plan for a 48-month renewal with .07% rate of decrease over current rates and with an effective date of January 1, 2017; and

WHEREAS, the Champaign County Labor Management Health Insurance Committee recommends to the County Board approval of Benefit Planning Consultants as the administrator of the County's Flexible Spending Account Plan for the period of January 1, 2017 to December 31, 2017 with no increase over current administrative fees.

NOW, THEREFORE, BE IT AND IT IS HEREBY RESOLVED by the County Board of Champaign County, Illinois that the FY2017 employee insurance benefits as recommended in this Resolution shall be and hereby are approved for FY2017; and

BE IT FURTHER RESOLVED by the County Board of Champaign County, Illinois that a service agreement with Benefit Planning Consultants as the administrator of the County's Flexible Spending Account Plans for the period of January 1,2017 to December 31, 2017 with no change in the monthly administrative fees is hereby approved.

PRESENTED, ADOPTED, APPROVED and RECORDED this 20th day of October, 2016.

_____

Pattsi Petrie, Chair
Champaign County Board

Attest:

_____

Gordy Hulten, County Clerk and *Ex-Officio*
Clerk of the Champaign County Board

Richard S. Snider
County Administrator

Brookens Administrative Center
1776 East Washington Street
Urbana, Illinois 61802

OFFICE OF THE
COUNTY ADMINISTRATOR

19 October 2016

MEMORANDUM

TO: Mr. Chris Alix, County Board Finance Chair; and
Honorable Members of the Champaign County Board

FR: Angela Lusk, Co-Chair, and Rick Snider, Co-Chair, and Members of the Labor Management Health Insurance Committee

RE: Recommendation for Employee Health Insurance and Related Benefit Plans for FY2017

ISSUE

The County Board is to consider the recommendations of the Labor Management Health Insurance Committee (LMHIC) for the selection of insurance plans for medical, dental and vision coverages for the County workforce, and related account administration services.

NARRATIVE

The recommendation for FY2017 was delayed as a result of extended discussions and review of options for the health insurance plan. The committee received an initial proposal from our current carrier that increased our premium by 51% over FY2016 rates. Consequently, the committee worked closely with our broker at Gallagher Benefit Services to solicit and evaluate competitive proposals and consider potential alternatives for employee coverage.

The Champaign County Labor Management Health Insurance Committee submits the following recommendations for employee health insurance and related benefits plans for FY2017:

HEALTH INSURANCE PLAN RECOMMENDATION
The LMHIC recommends the selection of Health Alliance HMO 2000 Rx1 NS1 Plan with a $2000 deductible for FY2017.

The recommended plan is a change from the current plan provided for County employees in FY2016, and this plan covers the FY2017 budget year from January 1, 2017 through December 31, 2017. The net premium cost increase from FY2016 will be 11.6% for single coverage. Earlier in the deliberation process, the committee had tentatively selected a different carrier for FY2017 but the County was unable to reach an agreement with the proposed carrier on payment terms that met the County's financial and audit requirements. The health plan will change from a $5000 deductible

plan coupled with the $1500 HRA, to a flat $2000 deductible. This will simplify benefits processing. The four plan tiers to be offered and the change in cost from FY2016 to FY2017 are documented here:

Plan	FY2016 Monthly Premium	FY2017 Monthly Premium	Increase
Employee Only	$687	$767	$80.00
Employee + Spouse	$908	$1,016	$108.00
Employee + Children	$859	$959	$100.00
Family	$1,479	$1,658	$179.00

Premium contributions for all County employees will be consistent based on their terms of employment and/or respective collective bargaining agreement. The Health Alliance Benefit Plan Summary is attached to this memorandum for your information.

We wish to take a moment to commend the LMHIC members from the FOP and AFSCME bargaining units as well as the management representatives for their hard work to reach this conclusion. Working as a team, we made significant progress in reducing the initial cost proposal through negotiations and a willingness to consider alternatives such as participating in a statewide insurance collaborative and self-insurance. It is not possible for all employees to be involved in the selection of a carrier due to the large volumes of plan information that must be digested, concern for privacy of health claim data to which the committee has access, evaluation of provider networks, ancillary benefits such as wellness programs, premium tiers, financial models, and numerous other factors. We believe that the committee members made great efforts to communicate plan information to employees and to represent employee concerns in a way that balanced the needs for benefit services with insurance affordability for employees and the county government. The value of the teamwork required to achieve this result cannot be overstated.

DENTAL PLAN RECOMMENDATION

For FY2017, Delta Dental proposed a 24-month rate lock, expiring December 31, 2018. The benefit year of January 1, 2017 to December 31, 2017 is the first year of the premium rate lock. This is a voluntary, employee paid insurance benefit plan.

Network Plan	FY2017
Employee	$17.60
Employee + spouse	$35.22
Employee + children	$50.00
Employee + family	$79.64

Premier Plan	FY2017
Employee	$30.50
Employee + spouse	$60.96
Employee + children	$61.42
Employee + family	$113.56

The Delta Dental Insurance Plan Summary is attached to this memorandum for your information.

VISION PLAN RECOMMENDATION

The LMHIC recommends the continued offering of the EyeMed Vision Care Plan. We recommend accepting the EyeMed Direct renewal proposal of a 48-month renewal with .07% rate decrease. The

48-month rate lock is for the period January 1, 2017 to December 31, 2020. This is a voluntary, employee paid insurance benefit plan.

The EyeMed Vision Plan Summary is attached to this memorandum for your information.

FLEXIBLE SPENDING ACCOUNT ADMINISTRATION RECOMMENDATION
The LMHIC recommends the continued relationship with Benefit Planning Consultants for administration of the County's Flexible Spending Account Plans. Benefit Planning Consultants offered a 24-month renewal that began January 1, 2016. This is for the second year of the rate proposal.

Flex Plan Administration	$3.90/per employee/per month in FY 2017

RECOMMENDED ACTIONS

The Labor Management Health Insurance Committee recommends to the County Board approval of offering the Health Alliance HMO 2000 Rx1 NS1 Plan with $2000 deductible for all County employees for FY2017.

The Labor Management Health Insurance Committee recommends to the County Board approval of continuing to offer the Delta Dental Plan as a voluntary plan for a 24-month renewal with premiums locked at the first year rate and with an effective date of January 1, 2017.

The Labor Management Health Insurance Committee recommends to the County Board approval of offering the EyeMed Vision Plan as a voluntary plan for a 48-month renewal with .07% rate of decrease over current rates and with an effective date of January 1, 2017.

The Labor Management Health Insurance Committee recommends to the County Board approval of Benefit Planning Consultants as the administrator of the County's Flexible Spending Account Plan for the period of January 1, 2017 to December 31, 2017 with no increase over current administrative fees.

Thank you for your consideration of this recommendation.

Health Alliance

HMO 2000 Rx1 NS1

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$2,000	Not Applicable
Embedded		Family	$4,000	Not Applicable
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$2,000	Not Applicable
		Family	$4,000	Not Applicable
Contract Year Maximum Benefits				
Cardiac Rehabilitation			36 OP session w/in 6 month of event	
Outpatient Rehabilitation Services			60 visits per condition per plan year	
Home Health			Unlimited with Pre-authorization	
Vision Exam			Once every 12 months	
Ambulatory Patient Services				
Vision Exam			*$40 per exam	Not Covered
Primary Care Physician Office Visits			*$25 per visit^	Not Covered
Specialty Care Physician Office Visits			*$50 per visit^	Not Covered
Spinal Manipulations			*50%	Not Covered
Urgent Care Visits			*$50 per visit^	$50 per visit
Allergy Treatment and Testing			0%	Not Covered
Emergency Services				
Emergency Department Visits			*$200 per visit	In Network Benefit Applies
Emergency Ambulance Transportation			*$100	In Network Benefit Applies
Hospital Services				
Outpatient Surgery/Procedures Facility Fee			0%	Not Covered
Outpatient Surgery/Procedures Physician/Surgeon Services			0%	Not Covered
Inpatient Hospitalization Facility Fees			0%	Not Covered
Inpatient Physician/Surgeon Fees			0%	Not Covered
Rehabilitative and Habilitative Services				
Outpatient Rehabilitation Services			0%	Not Covered
Inpatient Rehabilitation/Skilled Nursing Facility			0%	Not Covered
Home Health			0%	Not Covered
Diagnostic Services				
MRI and CT Scans			0%	Not Covered
Diagnostic Testing			0%	Not Covered
Mental Health/Substance Use Treatment				
Outpatient Office Visits			*$25 per visit^	Not Covered
Inpatient Services			0%	Not Covered
Non-Serious Mental Health Care			See in network outpatient office visit or inpatient services benefit.	Not Covered

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Prescription Drugs		
30 day supply		
Generic - Tier 1	*$7	Not Covered
Brand - Tier 2	*$25	Not Covered
Non-Preferred Brand - Tier 3	*$50	Not Covered
Preferred Specialty Pharmacy/Medical - Tier 4	*$100	Not Covered
Non-Preferred Specialty Pharmacy/Medical - Tier 5	*$150	Not Covered
Non-Formulary Specialty Pharmacy/Medical - Tier 6	*50%	Not Covered
Maternity		
Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.		
Routine Prenatal Care	0%	Not Covered
Maternity Inpatient	0%	Not Covered
Newborn Care	0%	Not Covered
Preventive and Wellness Services		
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate screening & more. Age/frequency schedules apply.		
Wellness Care	*$0	Not Covered
Other Services		
Other services covered within your policy and not otherwise specified on this summary or on the SBC.		
Other Covered Services	0%	Not Covered
Durable Medical Equipment	0%	Not Covered

* Deductible does not apply

^ Additional, other services obtained while in the office may require an additional copayment or coinsurance.

Embedded deductible definition - if there are two or more people on this plan – meaning the family amount(s) apply – you have a separate individual deductible within (or embedded within) the family deductible. This gives each member on the plan a chance to have his or her benefits start before the entire family meets the family deductible.

This is a brief statement of Health Alliance **HMO** benefits, exclusions and limitations which are subject to change. Please refer to the Health Alliance **HMO** Policy booklet for more detail about your health plan. This document is in conjunction with the Summary of Benefits and Coverage (SBC). You can view your SBC online at www.healthalliance.org or request a copy by contacting the customer service number on the back of your ID card.

DELTA DENTAL

COUNTY OF CHAMPAIGN – PREMIER PLAN

Delta Dental PPO Plan Highlights — Group #10981

Introduction
The Delta Dental PPO program allows you to go to any in- or out-of-network general or specialty dentist at the time of treatment. County of Champaign dental enrollees have access to two networks, Delta Dental PPO and Delta Dental Premier managed fee-for-service. When you call your dentist's office to make an appointment, ask if your dentist participates in either Delta Dental PPO or Premier. Your out-of-pocket costs will vary depending on whether he/she participates in Delta Dental PPO, Premier or neither (i.e., "out-of-network"). **You will maximize your benefits by receiving care from a Delta Dental PPO network dentist.** There are 143,000 Delta Dental PPO and 223,000 Delta Dental Premier dentist locations nationwide.

Choosing Your Dentist
Under your Dental Plan, you may go to any in- or out-of-network general or specialty dentist. However, it is to your advantage to choose a Delta Dental PPO or Premier network dentist for the following reasons:

1) Payment to Delta Dental PPO dentists is based on reduced fees; payment to Premier dentists is based on Delta Dental's maximum plan allowance (MPA). In both networks, you only have to pay your deductible and coinsurance – *you will not be "balance billed" for charges that exceed the reduced PPO fee if you receive treatment from a Delta Dental PPO dentist or the MPA if you receive treatment from a Premier dentist.**

For example, if you need a crown, assume the Delta Dental PPO fee allowance is $500 and the MPA is $600. If your plan covers crowns at 50% and your dentist normally charges $700, your out-of-pocket cost (excluding deductible) would be:

Delta Dental PPO Dentist – $250
(50% of the $500 PPO fee allowance)

Delta Dental Premier Dentist – $300
(50% of the $600 MPA)

Out-of-Network Dentist – $400
(50% of the $600 MPA plus $100 difference between the MPA and the dentist's billed charge)

2) Because we reimburse Delta Dental PPO and Premier dentists directly, they agree to charge you no more than your deductible and coinsurance; in other words, *you do not have to pay the whole bill up-front and wait for reimbursement.*

3) Out-of-network dentists do not accept Delta Dental's MPA as payment-in-full. If an out-of-network dentist's charge exceeds the MPA, you must pay the difference plus your deductible and coinsurance. At the dentist's discretion, *you may also have to pay the entire bill in advance.*

4) Claim forms will be completed and submitted at no charge. Out-of-network dentists may require you to complete forms yourself or to pay a service charge.

**If your Delta Dental PPO or Premier dentist inadvertently charges you for amounts payable by Delta Dental, please call our customer service department at 1-800-323-1743.*

Non-Covered Services
There are some limitations on the expenses for which the County of Champaign Dental Plan pays. For further information, refer to your certificate of coverage or call our customer service department.

Finding a Network Dentist
To verify your dentist's participation status, simply ask him/her if he/she is a Delta Dental PPO or Delta Dental Premier network dentist, call our interactive voice response (IVR) phone system, contact our customer service department or visit our Web site.

Visit Delta Dental of Illinois' Web site at
www.deltadentalil.com

The County of Champaign Dental Plan utilizes the Delta Dental PPO and Delta Dental Premier networks. To locate a network dentist, click on Dentist Search in the Subscriber section.

You can search by:
1) City, state and ZIP code
2) Specialty
3) Dentist name (optional)

Summary of Benefits and Covered Services

Annual Maximum		$1,000/person ***TO GO***	
	Enrollees may carryover unused portions of their annual maximums to the new year's annual maximum. Maximum amounts eligible for carryover are subject to limitations.		
Annual Deductible (applies to Basic/Major only)	$50/person; $150/family	$50/person; $150/family	$50/person; $150/family
Lifetime Ortho. Maximum		$1,000	
	Delta Dental PPO	**Delta Dental Premier**	**Out-of-Network**
Preventive/Diagnostic ♦ oral evaluations (two per benefit year) ♦ X-rays (bitewings only - two per benefit year) ♦ prophylaxis (cleaning; two per benefit year) ♦ fluoride treatment (once per benefit year for children under age 19) ♦ space maintainers ♦ sealants	100% of reduced fee*	100% of MPA**	100% of MPA***
Basic ♦ fillings ♦ X-rays (excluding bitewings) ♦ emergency exams and palliative treatment	80% of reduced fee*	80% of MPA**	80% of MPA***
Major ♦ crowns, jackets, cast restorations ♦ fixed/removable bridges ♦ partial/full dentures ♦ simple extractions ♦ surgical & non-surgical periodontics ♦ endodontics ♦ oral surgery ♦ general anesthesia (in conjunction with oral surgery)	50% of reduced fee*	50% of MPA**	50% of MPA***
Orthodontia ♦ for dependent children under age 19	50% of reduced fee* subject to lifetime maximum	50% of dentist's usual fee subject to lifetime maximum	50% of dentist's usual fee subject to lifetime maximum
	*You will not be "balance" billed" for charges exceeding Delta Dental's allowed PPO fee	**You will not be "balance billed" for charges exceeding Delta Dental's maximum plan allowance (MPA)	***You are responsible for charges exceeding Delta Dental's maximum plan allowance (MPA)

The preceding information is a brief summary of the County of Champaign Dental Plan and the services it covers. If you have specific questions regarding benefit coverage, limitations or exclusions, contact Delta Dental at 1-800-323-1743.

Note: Delta Dental imposes no restrictions on the method of diagnosis or treatment by a treating dentist. A benefit determination relates only to the level of payment that your group dental plan is required to make.

DELTA DENTAL

COUNTY OF CHAMPAIGN – NETWORK PLAN

Delta Dental PPO Plan Highlights — Group #10981

Introduction
The Delta Dental PPO program allows you to go to any in- or out-of-network general or specialty dentist at the time of treatment. County of Champaign dental enrollees have access to two networks, Delta Dental PPO and Delta Dental Premier managed fee-for-service. When you call your dentist's office to make an appointment, ask if your dentist participates in either Delta Dental PPO or Premier. Your out-of-pocket costs will vary depending on whether he/she participates in Delta Dental PPO, Premier or neither (i.e., "out-of-network"). **You will maximize your benefits by receiving care from a Delta Dental PPO network dentist.** There are 143,000 Delta Dental PPO and 223,000 Delta Dental Premier dentist locations nationwide.

Choosing Your Dentist
Under your Dental Plan, you may go to any in- or out-of-network general or specialty dentist. However, it is to your advantage to choose a Delta Dental PPO or Premier network dentist for the following reasons:

1) Payment to Delta Dental PPO dentists is based on reduced fees; payment to Premier dentists is based on Delta Dental's maximum plan allowance (MPA). In both networks, you only have to pay your deductible and coinsurance—*you will not be "balance billed" for charges that exceed the reduced PPO fee if you receive treatment from a Delta Dental PPO dentist or the MPA if you receive treatment from a Premier dentist.**

For example, if you need a crown, assume the Delta Dental PPO fee allowance is $500 and the MPA is $600. If your plan covers crowns at 50% and your dentist normally charges $700, your out-of-pocket cost (excluding deductible) would be:

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(50% of the $600 MPA)

Out-of-Network Dentist – $400
(50% of the $600 MPA plus $100 difference between the MPA and the dentist's billed charge)

2) Because we reimburse Delta Dental PPO and Premier dentists directly, they agree to charge you no more than your deductible and coinsurance; in other words, *you do not have to pay the whole bill up-front and wait for reimbursement.*

3) Out-of-network dentists do not accept Delta Dental's MPA as payment-in-full. If an out-of-network dentist's charge exceeds the MPA, you must pay the difference plus your deductible and coinsurance. At the dentist's discretion, *you may also have to pay the entire bill in advance.*

4) Claim forms will be completed and submitted at no charge. Out-of-network dentists may require you to complete forms yourself or to pay a service charge.

**If your Delta Dental PPO or Premier dentist inadvertently charges you for amounts payable by Delta Dental, please call our customer service department at 1-800-323-1743.*

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You can search by:
1) City, state and ZIP code
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Annual Deductible (applies to Basic/Major only)	**$50/person; $150/family**	**$100/person; $300/family**	**$100/person; $300/family**
Lifetime Ortho. Maximum		**$1,000**	
	Delta Dental PPO	**Delta Dental Premier**	**Out-of-Network**
Preventive/Diagnostic ♦ oral evaluations (two per benefit year) ♦ X-rays (bitewings only - two per benefit year) ♦ prophylaxis (cleaning; two per benefit year) ♦ fluoride treatment (once per benefit year for children under age 19) ♦ space maintainers ♦ sealants	**100%***	**70%****	**70%*****
Basic ♦ fillings ♦ X-rays (excluding bitewings) ♦ emergency exams and palliative treatment ♦ non-surgical periodontics	**80%***	**50%****	**50%****
Major ♦ crowns, jackets, cast restorations ♦ fixed/removable bridges ♦ partial/full dentures ♦ simple extractions ♦ surgical periodontics ♦ endodontics ♦ oral surgery ♦ general anesthesia (in conjunction with oral surgery)	**50%***	**50%****	**50%****
Orthodontia ♦ for dependent children under age 19	**50% subject to lifetime maximum**	**50% subject to lifetime maximum**	**50% subject to lifetime maximum**

***Delta Dental PPO dentists accept payment based on the lesser of the submitted fee or the PPO fee schedule, which is established at a level that typically delivers a 15-35% discount off of average billed charges. PPO dentists may not bill you for charges exceeding these fees.**

****Delta Dental Premier dentists accept payment based on the lesser of the submitted fee or Delta Dental's maximum plan allowance. Premier dentists may not bill you for charges exceeding these fees.**

*****Non-network dentists are reimbursed at the lesser of the submitted fee or the 50th percentile Reasonable and Customary (R&C) fee. These dentists may balance bill you for charges in excess of Delta Dental's reimbursement.**

The preceding information is a brief summary of the County of Champaign Dental Plan and the services it covers. If you have specific questions regarding benefit coverage, limitations or exclusions, contact Delta Dental at 1-800-323-1743.

Note: Delta Dental imposes no restrictions on the method of diagnosis or treatment by a treating dentist. A benefit determination relates only to the level of payment that your group dental plan is required to make.

eyeMed

Champaign County

Additional discounts

40% OFF
Complete pair of prescription eyeglasses

20% OFF
Non-prescription sunglasses

20% OFF
Remaining balance beyond plan coverage

These discounts are for in-network providers only

Take a sneak peek before enrolling

- You're on the ACCESS Network
- For a complete list of in-network providers near you, use our Enhanced Provider Locator on www.eyemed.com or call 1-866-723-0596.
- For Lasik providers, call 1-877-5LASER6.

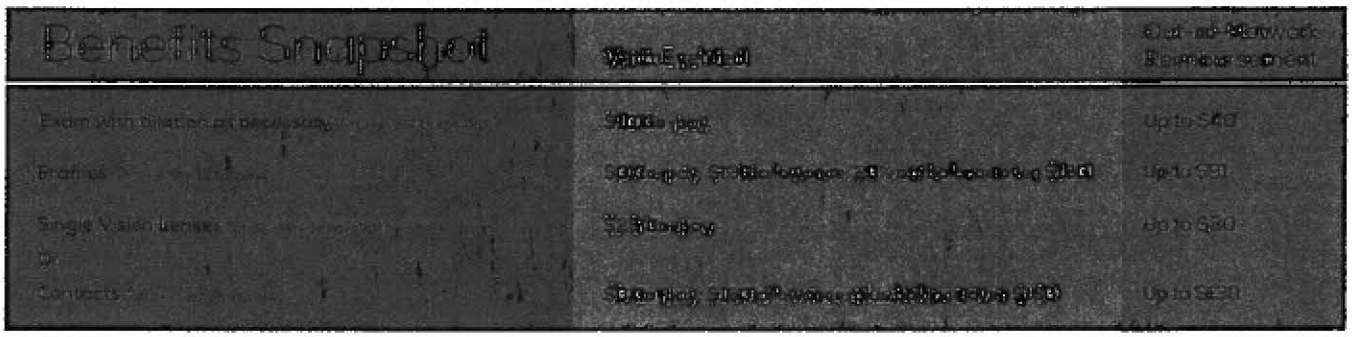
SUMMARY OF BENEFITS

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam With Dilation as Necessary	$10 Co-pay	Up to $40
Retinal Imaging	Up to $39	N/A
Frames	$0 Co-pay. $130 allowance. 20% off balance over $130	Up to $91
Standard Plastic Lenses		
Single Vision	$25 Co-pay	Up to $30
Bifocal	$25 Co-pay	Up to $50
Trifocal	$25 Co-pay	Up to $70
Standard Progressive Lens	$25 Co-pay	Up to $76
Premium Progressive Lens	$25, 80% of charge less $120 allowance	Up to $76
Lenticular	$25 Co-pay	Up to $70
Lens Options (paid by the member and added to the base price of the lens)		
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	Up to $32
Standard Anti-Reflective Coating	$45	N/A
Polarized	20% off retail price	N/A
Other Add-Ons and Services	20% off retail price	N/A
Contact Lens Fit and Follow-Up (Contact lens fit and two 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	N/A
Contact Lenses		
Conventional	$0 Co-pay. $130 allowance: 15% off balance over $130	Up to $130
Disposable	$0 Co-pay. $130 allowance: plus balance over $130	Up to $130
Medically Necessary	$0 Co-pay. Paid-in-Full	Up to $210
Laser Vision Correction		
Lasik or PRK from U.S. Laser Network	15% off the retail price or 5% off the 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
Additional Pairs Benefit	Members also receive a 40% discount off complete pair eyeglass purchase and 15% discount off conventional contact lenses once the funded benefit has been used	N/A
Frequency		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 12 months	

Benefits are not provided from services or materials arising from: 1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses. 2) Medical and/or surgical treatment of the eye, eyes or supporting structures. 3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment. Safety eyewear. 4) 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. 5) Plano (non-prescription) lenses. 6) Non-prescription sunglasses. 7) Two pair of glasses in lieu of bifocals. 8) Services or materials provided by any other group benefit plan providing vision care 9) 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. 10) 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. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York. The Certificate of Insurance is on file with your employer. Benefit allowance provides no remaining balance for future use within the same benefit year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered.

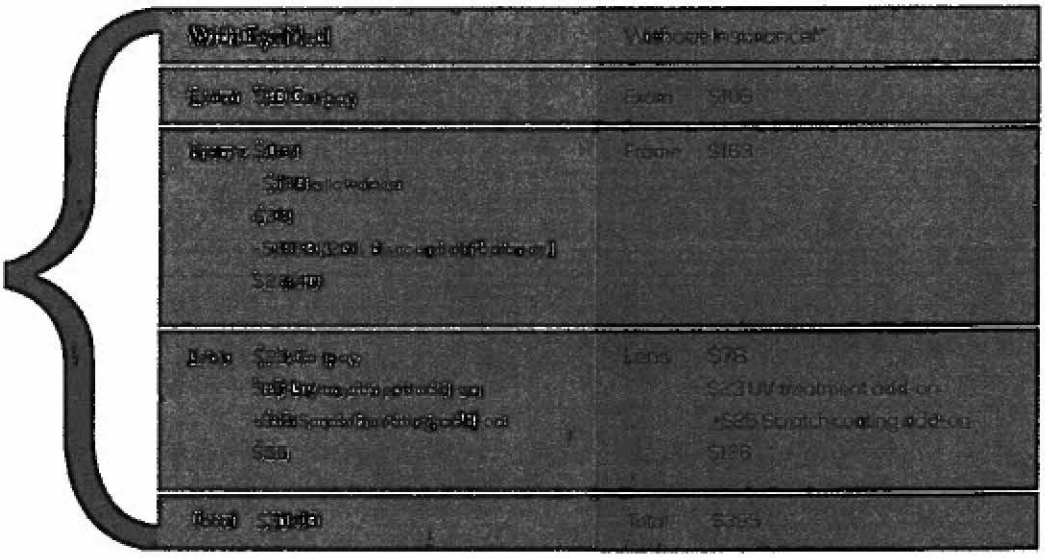
What's in it for me?

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.

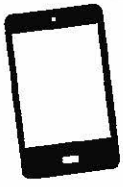


And now it's time for the breakdown . . .

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...



77%
SAVINGS with us*



Download the EyeMed Members App

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

EyeMed | INDEPENDENT PROVIDER NETWORK + LensCrafters · Pearle Vision · Optical · pearle · JCPenney | optical

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