



Vision Plan Announcement

Both you and your covered dependents will be eligible to enroll in one of three comprehensive EyeMed Premier plans to replace any current vision plan you are enrolled in through SBPEA.

You may purchase one of these Premier plans via payroll deduction. **Enrollment is optional.**

You and your covered dependents may only cancel enrollment each year during COUNTY Open Enrollment period in June. An exception may be made for a change in status by speaking with SBPEA's Insurance Division at (909) 889-8377 ext 234.

A complete description of the three comprehensive Premier vision plans (EM 2, EM 3, and Dependent Only) is attached. To enroll in one of the optional comprehensive Premier vision plans, please do the following:

Select the plan that best suits your needs. EM 2 is designed for members who are currently enrolled in a medical plan that already covers an eye exam. EM 3 is designed for members whose health plan does not cover exams or materials. Dependent Only is for County members who are covered by County Vision Insurance and wish to have their dependents covered with vision insurance. Compare the EyeMed benefit plans with any current SBPEA vision plan you are enrolled in for potential savings.

Complete the enrollment card below, detach and send to SBPEA. Payroll deductions will begin in the first pay period of the month following enrollment. Your Premier benefits will be available the first day of the month following payroll deduction.

Question about your vision care plan should be directed to SBPEA's Insurance Division at (909)889-8377 ext 234. To learn more about EyeMed or the Eyemed Provider Network, visit www.enrollwiththeyemed.com or call EyeMed Member Services at 1-877-226-1115.



SBPEA Enrollment Card SBPEA Fax (909)888-7429

(NEW/UPDATE)

**PLEASE RETURN THIS FORM
TO SBPEA
P.O BOX 432,
San Bernardino, CA 92402**

YOU: Social Security No. _____ Employee No. _____

Name: _____
Last First MI

Address: _____

City: _____ State: _____ Zip: _____

Sex: F M Date of Birth (mo/day/yr) _____ Work Phone _____

DEPENDENTS

Last Name First Name MI SEX (M/F) D.O.B. (mo/day/yr)

Your spouse: _____

Each child: _____

Your Authorization:

Please check the benefit of your choice
SEMI-MONTHLY RATES

EM 2 (Materials)

- Employee Only \$ 2.70
- Employee + one \$ 4.46
- Employee + family \$ 6.21

EM 3 (Exam and Materials)

- Employee Only \$ 4.41
- Employee + one \$ 7.70
- Employee + family \$ 11.01

Dependent Only

- (Exam and Materials)
- \$ 6.77

Date: _____ Signature: _____

SAN BERNARDINO PEA has selected EyeMed as your vision wellness program. This plan allows you to improve your health through a routine eye exam, while saving you money on your eye care purchases. The plan is available through thousands of provider locations participating on the EyeMed SELECT network.

To see a list of participating providers near you, go to www.eyemedvisioncare.com and choose SELECT from the provider locator drop-down box. You can also call 1-866-299-1358.

Enroll today to take advantage of an affordable way to help ensure a lifetime of healthy vision.

Vision Care Services	Member Cost	Out-of-Network Reimbursement
Exam with Dilatation as Necessary	\$0 Copay	Up to \$48
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 \$40	N/A
Premium Contact Lens Fit & Follow-Up	10% off retail	N/A
Frames	\$0 Copay, \$120 Allowance, 20% off balance over \$120	Up to \$47
Standard Plastic Lenses		
Single Vision	\$0 Copay	Up to \$40
Bifocal	\$0 Copay	Up to \$55
Trifocal	\$0 Copay	Up to \$75
Lenticular	\$0 Copay	Up to \$125
Standard Progressive Lens	\$65	Up to \$70
Premium Progressive Lens	\$65, 80% of Charge less \$120 Allowance	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 - Adults	\$20 Copay	Up to \$14
Standard Polycarbonate - Kids under 19	\$20 Copay	Up to \$14
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 Lenses (Contact lens allowance includes materials only)		
Conventional	\$0 Copay, \$120 Allowance, 85% of balance over \$120	Up to \$85
Disposables	\$0 Copay, \$120 Allowance, plus balance over \$120	Up to \$85
Medically Necessary	\$0 Copay, Paid-in-Full	Up to \$250
Laser Vision Correction		
LASIK or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	N/A
Additional Pairs Discount	Members also receive a 40% discount off complete pair eyeglass purchases and a 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	

Additional Purchases and Out-of-Pocket Discount:

Member will receive a 20% discount on remaining balance at Participating Providers beyond plan coverage; the discount does not apply to EyeMed's Providers' professional services or disposable contact lenses

Benefits are not provided for 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 eye or 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 and/or contact 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, Certain brand name Vision Materials in which the manufacturer imposes a no-discount policy; or 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.

Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York. Fidelity Security Life Policy number VC-19/VC-20, form number M9083. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.



LENSCRAFTERS



Value Added Features:

In addition to the health benefits your EyeMed program offers, members also enjoy additional, value-added features including:

- **Eye Care Supplies** - Receive 20% off retail price for eye care supplies like cleaning cloths and solutions purchased at network providers (not valid on doctor's services or contact lenses).
- **Laser Vision Correction** - Save 15% off the retail price or 5% off the promotional price for LASIK or PRK procedures.
- **Replacement Contact Lens Purchases** - Visit www.eyemedcontacts.com to order replacement contact lenses for shipment to your home at less than retail price.

SAN BERNARDINO PEA has selected EyeMed as your vision wellness program. This plan saves you money on your eye care purchases and is available through thousands of provider locations participating on the EyeMed SELECT network.

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Vision Care Services	Member Cost	Out-of-Network Reimbursement
Frames	\$0 Copay, \$120 Allowance; 20% off balance over \$120	Up to \$60
Standard Plastic Lenses		
Single Vision	\$10 Copay	Up to \$35
Bifocal	\$10 Copay	Up to \$49
Trifocal	\$10 Copay	Up to \$74
Lenticular	\$10 Copay	Up to \$74
Standard Progressive	\$10 Copay	Up to \$95
Premium Progressive	\$10, 80% of charge less \$120 Allowance	Up to \$95
Lens Options (paid by the member and added to the base price of the lens)		
Tint (Solid and Gradient)	\$15	N/A
UV Coating	\$15	N/A
Standard Scratch-Resistance	\$15	N/A
Standard Polycarbonate	\$20	Up to \$14
Standard Polycarbonate for Children under 19	\$20	Up to \$14
Standard Anti-Reflective	\$45	N/A
Polarized	20% off retail price	N/A
Other Add-Ons and Services	20% off retail price	N/A
Contact Lenses (allowance includes materials only; in lieu of Standard Plastic Lenses)		
Conventional	\$0 Copay, \$120 Allowance, 15% off balance over \$120	Up to \$96
Disposables	\$0 Copay, \$120 Allowance; balance over \$120	Up to \$96
Medically Necessary	\$0 Copay, Paid in Full	Up to \$200
Laser Vision Correction		
LASIK or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	N/A
Additional Pairs Discount	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used	N/A
Frequency		
Frames	Once every 12 months	
Standard Plastic Lenses or Contact Lenses	Once every 12 months	

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Premium Progressive Lens	\$0, 80% of Charge less \$120 Allowance	Up to \$95
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Tint (Solid and Gradient)	\$15	N/A
Standard Plastic Scratch Coating	\$15	N/A
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