



**Summary of Benefits**  
 USD #229 – Blue Valley  
 Group #01698-0-1-0  
 EFFECTIVE FOR JANUARY 1, 2023

	Vision Care Services	In-Network Member Costs	Out-of-Network Allowances
<b>This plan utilizes the Access Network.</b>	<b>Exam With Dilation as Necessary</b>	\$10 Copay	Up to \$35 Reimbursement
	<b>Retinal Imaging</b>	\$39	Not Covered
<b>FREQUENCY:</b>	<b>Frames</b>	\$130 Allowance, 20% off balance	Up to \$65 Reimbursement
Exams: <b>Once every Calendar Year</b>  Frames: <b>Once every 2 Calendar Years</b>  Lenses or Contact Lenses: <b>Once every Calendar Year</b>	<b>Standard Plastic Lenses</b>		
	Single Vision	\$25 Copay	Up to \$25 Reimbursement
	Bifocal	\$25 Copay	Up to \$40 Reimbursement
	Trifocal	\$25 Copay	Up to \$55 Reimbursement
	Lenticular	\$25 Copay	Up to \$55 Reimbursement
	<b>Lens Options</b>		
	Standard polycarbonate	Adults: \$40 Dependents under 19: \$0	Up to \$25 Reimbursement Up to \$25 Reimbursement
	UV Coating	\$15	Not Covered
	Tint (Solid and Gradient)	\$15	Not Covered
	Standard Scratch-Resistance	\$15	Not Covered
<b>ADDITIONAL DISCOUNTS:</b>  <b>40% off</b> - Additional pair of eyeglasses or sunglasses (both frames & lenses)  <b>20% off</b> - Non covered items such as cleaning cloths and solution  <b>15% off</b> - Retail price of LASIK Vision Correction  <b>20% off</b> - Remaining balance beyond plan coverage.  <b>40% off</b> - Hearing Discount: hearing exams and a low price guarantee on discounted hearing aids	Standard Anti-Reflective Coating	\$45	Not Covered
	Standard Progressive (includes Copay amount)	\$90 Copay	Up to \$40 Reimbursement
	Premium Progressive (includes Copay amount)	\$90 Copay, \$120 Allowance, 20% off balance	Up to \$40 Reimbursement
	<b>Contact Lens Fit &amp; Follow-Up</b> <small>(Contact lens fit and 2 follow-up visits are available once a comprehensive eye exam has been completed.)</small>		
	<b>Standard</b> - spherical clear contact lenses in conventional wear and planned replacement (Examples include but not limited to disposable, frequent	\$0 Copay, Paid-in-full fit and two follow-up visits	Up to \$40 Reimbursement
<b>Premium</b> - all lens designs, materials and specialty fittings other than Standard Contact Lenses (Examples include toric, multifocal, etc.)	\$55 Allowance	Up to \$40 Reimbursement	
<b>Contacts Lenses</b> <small>(Contact lens allowance includes materials only)</small>			
Conventional	\$130 Allowance, 15% off balance over Allowance	Up to \$100 Reimbursement	
Disposable	\$130 Allowance	Up to \$100 Reimbursement	
Medically Necessary	\$0 Copay	Up to \$200 Reimbursement	

**SEE SECTION ON PLAN LIMITATIONS/EXCLUSIONS ON THE NEXT PAGE**

This is a Summary of Benefits only, and various limitations and exceptions 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.

# WHO IS SURENCY VISION?

Surency Vision offers flexible, straightforward plans with multiple features to meet your employees' needs. Plans include comprehensive eye exams and convenient access to vision care 7 days a week as well as multiple allowances, copay, and frequency options for exams, lenses, and frame. Members also receive savings on eye care and eyewear year-round.



## RETAIL AND ONLINE VISION OPTIONS

Surency Vision offers several in-network online shopping options to go with the thousands of in-network store locations. Retail options include Target Optical, LensCrafters and Pearl Vision. Our online options include ContactDirect.com, Glasses.com, Rayban.com/insurance and more.



## SURENCY VISION MOBILE APP

Download the free Surency Vision Mobile App today to take control of your vision benefits. With the app, you can:

- Find a doctor
- Check eligibility
- Check claim status
- Order replacement contact lenses
- And more



## DEPENDENT CHILD AGE

A child is eligible for coverage under the Plan if the child is under the age of 27.

## PLAN LIMITATIONS/EXCLUSIONS:

- Allowances are one-time use benefits; no remaining balance.
- If eyeglass lenses are elected, contact lens allowance may not be available; coverage specific to vision benefit plan.
- 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 twenty percent (20%) discount).
- Services or materials provided by major medical coverage under any other group benefit providing for vision care.
- Two (2) 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.