



# Teamsters Local 251 Health Services Safety

## Safety Eyewear Plan

We want to make sure your eyes are well-protected, even on the job. With the EyeMed Safety Program, you may be eligible to get the right prescription glasses for your job.



### SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
<b>FRAME</b>		
Frame	\$0 copay; 20% off balance over \$180 allowance	Not covered
<b>STANDARD PLASTIC LENSES</b>		
Single Vision	\$30 copay	Not covered
Bifocal	\$30 copay	Not covered
Trifocal	\$30 copay	Not covered
Lenticular	\$30 copay	Not covered
Progressive - Standard	\$30 copay	Not covered
Progressive - Premium Tier 1 - 4	\$60 - 205 copay	Not covered
<b>LENS OPTIONS</b>		
Anti Reflective Coating - Standard	\$0 copay	Not covered
Anti Reflective Coating - Premium Tier 1 - 3	\$0 - 85 copay	Not covered
Photochromic - Non-Glass	\$0 copay	Not covered
Polycarbonate - Standard	\$0 copay	Not covered
Scratch Coating - Standard Plastic	\$0 copay	Not covered
Tint - Solid and Gradient	\$0 copay	Not covered
UV Treatment	\$0 copay	Not covered
All Other Lens Options	20% off retail price	Not covered
<b>FREQUENCY</b>		
Frame	<b>ALLOWED FREQUENCY - ADULTS</b>	
Lenses	Once every 12 months	
	Once every 12 months	



# 20% OFF

additional complete pairs of safety eyewear\*

\* Discounts only available at participating in-network providers

Only Employees are eligible for safety eyewear. EyeMed reserves the right to make changes to the products available on each tier. All providers are not required to carry all brands on all tiers. For current listing of brands by tier, call 866.939.3633. No benefits will be paid for services or materials connected with or charges 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; 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; or 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. Fees charged by a Provider for services other than a covered benefit must be paid in full by the Insured to the Provider. Such fees or materials are not covered under the Policy. Benefit allowances provide no remaining balance for future use within the same Benefit Frequency. Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see online provider locator to determine which participating providers have agreed to the discounted rate.

