



Voluntary Vision Insurance

FOR EMPLOYEES OF GARAGE DOOR REPAIR COMPANY LLC

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES

Eligibility Requirement	You must be actively working a minimum of 30 hours per week to be eligible for coverage.
Dependent Eligibility Requirement	To be eligible for coverage, any dependent child(ren) must be under 26. In order for your spouse and/or children to be eligible for coverage, you must elect coverage for yourself.
Premium Payment	The premiums for this insurance are paid in full by you.

BENEFITS	MEMBER COST IN-NETWORK	OUT-OF-NETWORK REIMBURSEMENT*
Exam with Dilation as Necessary	\$10 copay	Up to \$37
Exam Options: <ul style="list-style-type: none"> • Retinal Imaging • Standard Contact Lens Fit & Follow-up • Premium Contact Lens Fit & Follow-up 	<ul style="list-style-type: none"> • Up to \$39 • Up to \$40 • 10% off retail price 	<ul style="list-style-type: none"> • Not Applicable
Frames <ul style="list-style-type: none"> • Any available frame at provider location 	<ul style="list-style-type: none"> • \$0 copay, \$130 allowance plus 20% off balance over allowance 	<ul style="list-style-type: none"> • Up to \$58
Standard Plastic Lenses: <ul style="list-style-type: none"> • Single Vision • Bifocal • Trifocal • Lenticular • Standard Progressive Lenses (add on to bifocal copay) • Premium Progressive Lenses (add on to bifocal copay) <ul style="list-style-type: none"> Tier 1 Tier 2 Tier 3 Tier 4 	<ul style="list-style-type: none"> • \$25 copay • \$25 copay • \$25 copay • \$25 copay • \$65 copay • \$85 copay • \$95 copay • \$110 copay • \$65 copay plus 80% of charge less \$120 allowance 	<ul style="list-style-type: none"> • Up to \$20 • Up to \$36 • Up to \$64 • Up to \$64 • Up to \$36 • Up to \$36 • Up to \$36 • Up to \$36
Lens Options: <ul style="list-style-type: none"> • UV Coating • Tint (Solid and Gradient) • Standard Scratch Coating • Standard Polycarbonate (Adults) • Standard Polycarbonate (Children under 19) • Standard Anti-Reflective • Premium Anti-Reflective <ul style="list-style-type: none"> Tier 1 Tier 2 Tier 3 • Photochromic – Transitions • Other Add-ons 	<ul style="list-style-type: none"> • \$15 • \$15 • \$15 • \$40 • \$40 • \$45 • \$57 • \$68 • 20% off retail price • \$75 • 20% off retail price 	<ul style="list-style-type: none"> • Not Applicable

Contact Lenses: (Contact lens allowance includes materials only) <ul style="list-style-type: none"> • Conventional • Disposable • Medically Necessary 	<ul style="list-style-type: none"> • \$0 copay, \$130 allowance plus 15% off balance over allowance • \$0 copay, \$130 allowance • \$0 copay, paid in full 	<ul style="list-style-type: none"> • Up to \$89 • Up to \$104 • Up to \$210
Laser Vision Correction: <ul style="list-style-type: none"> • LASIK or PRK from U.S. Laser Network 	<ul style="list-style-type: none"> • 15% off retail price or 5% off promotional price 	
Additional Pair of Glasses or Contacts	40% discount off of complete pair of eyeglasses and 15% off conventional contact lenses once the funded benefit has been used	

FREQUENCY

Exams	Once every 12 months
Lenses or Contact Lenses	Once every 12 months
Frames	Once every 12 months

*Out-of-Network Reimbursement will be the lesser of the listed amount of the member's actual cost from the out-of-network provider. 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 the online provider locator to determine which participating providers have agreed to the discounted rate.

EXCLUSIONS

We will not pay benefits for any services or materials connected with or changes arising from:

- orthoptic or vision training, subnormal vision aides and any associated supplemental testing;
- Aniseikonic lenses;
- medical or surgical treatment of the eye, eyes or supporting structures;
- any eye or vision examination, or any corrective eyewear required by the policyholder as a condition of employment;
- safety eyewear;
- services or materials provided or paid for in whole or in part by a state or federal government or its agencies;
- services or materials provided or paid for in whole or in part as a result of any workers' compensation or occupational disease law or as required by any federal or state governmental agency or program;
- Plano (non-prescription) lenses or contract lenses;
- non-prescription sunglasses;
- two pair of glasses in lieu of bifocals;
- services or materials provided or paid for in whole or in part by any other group benefit plan providing vision benefits;
- certain name brand vision materials for which the manufacturer maintains a no-discount practice;
- services rendered after the date an insured person ceases to be covered under the policy; or
- lost, stolen, or broken lenses, frames, glasses, or contact lenses until the next benefit frequency when vision materials would next become available.

SERVICES

Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.