



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a **summary**. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-499-1275 or visit our website at www.excellusbcbs.com. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at www.cciio.cms.gov or <https://www.healthcare.gov/sbc-glossary> or call 1-800-499-1275 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	For in-network providers and out-of-network providers combined: \$50/ individual or \$150/ family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. Other than office visits, rehabilitation/habilitation services and durable medical equipment , all other services described in this document are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	Medical (includes deductible and coinsurance maximum): \$450/individual or \$1,350/family Prescription drugs : \$2,000/individual or \$6,000/family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Costs for penalties for failure to obtain preauthorization for services, premiums , balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.excellusbcbs.com or call 1-800-499-1275 for a list network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use a out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral.



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	20% coinsurance	None
	Specialist visit	20% coinsurance	20% coinsurance	None
	Preventive care/screening/immunization	Adult physical: No charge Adult Immunizations: No charge Well Child visit: No charge Deductible does not apply	Adult physical: No charge Adult Immunizations: No charge Well Child visit: No charge Deductible does not apply	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge Deductible does not apply	No charge Deductible does not apply	None
	Imaging (CT/PET scans, MRIs)	No charge Deductible does not apply	No charge Deductible does not apply	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.excellusbcbs.com/rxlist	Generic drugs (Tier 1)	\$15 copay /prescription (retail) \$30 copay /prescription (mail order) Deductible does not apply	Not covered	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). Certain prescription drugs require preauthorization . If you don't get preauthorization , your prescription drug will not be covered. The plan requires pharmacies to dispense generic drugs, when available. If you or your provider chooses a higher cost drug instead of the generic equivalent, you will be required to pay the applicable cost-sharing for the higher cost drug, plus the cost-difference between the generic
	Preferred brand drugs (Tier 2)	\$30 copay /prescription (retail) \$60 copay /prescription (mail order) Deductible does not apply	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Non-preferred brand drugs (Tier 3)	\$45 copay /prescription (retail) \$90 copay /prescription (mail order) Deductible does not apply	Not covered	drug and the higher cost drug. This cost difference will not apply to your out-of-pocket limit .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge Deductible does not apply	No charge Deductible does not apply	None
	Physician/surgeon fees	No charge Deductible does not apply	No charge Deductible does not apply	None
If you need immediate medical attention	Emergency room care	No charge Deductible does not apply	No charge Deductible does not apply	None
	Emergency medical transportation	No charge Deductible does not apply	No charge Deductible does not apply	
	Urgent care	No charge Deductible does not apply	No charge Deductible does not apply	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge Deductible does not apply	No charge Deductible does not apply	None
	Physician/surgeon fees	No charge Deductible does not apply	No charge Deductible does not apply	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge Deductible does not apply	No charge Deductible does not apply	None
	Inpatient services	No charge Deductible does not apply	No charge Deductible does not apply	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge Deductible does not apply	No charge Deductible does not apply	None
	Childbirth/delivery professional services	No charge Deductible does not apply	No charge Deductible does not apply	
	Childbirth/delivery facility services	No charge Deductible does not apply	No charge Deductible does not apply	
If you need help recovering or have other special health needs	Home health care	No charge Deductible does not apply	No charge Deductible does not apply	None
	Rehabilitation services	20% coinsurance	20% coinsurance	Limited to 100 visits per plan year
	Habilitation services	20% coinsurance	20% coinsurance	
	Skilled nursing care	No charge Deductible does not apply	No charge Deductible does not apply	None
	Durable medical equipment	20% coinsurance	20% coinsurance	None
	Hospice services	No charge Deductible does not apply	No charge Deductible does not apply	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)			
- Acupuncture - Cosmetic surgery - Dental care (Adult)	- Dental care (Child) - Hearing aids - Long-term care	- Routine eye care (Adult) - Routine eye care (Child) - Routine foot care - Weight loss programs	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: the Department of Labor's Employee Benefit Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact the New York State Department of Financial Services Consumer Assistance Unit at 1-800-342-3736 or www.dfs.ny.gov. Additionally, a consumer assistance program can help you file your [appeal](#). Contact Community Service Society of New York, Community Health Advocates, 633 Third Avenue, 10th floor, New York, NY 10017, (888) 614-5400, <http://www.communityhealthadvocates.org/> (website), cha@cssny.org (email). A list of states with Consumer Assistance Programs is available at: www.dol.gov/ebsa/healthreform and <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>.

Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$50
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
---------------------------	-----------------

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$10
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$70

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$50
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$50
Copayments	\$300
Coinsurance	\$400
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$770

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$50
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic test](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$50
Copayments	\$10
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$260

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Notice of Nondiscrimination

Our Health Plan complies with federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, please refer to the enclosed document for ways to reach us.

If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Advocacy Department
Attn: Civil Rights Coordinator
PO Box 4717
Syracuse, NY 13221
Telephone number: 1-800-614-6575
TTY number: 1-800-421-1220
Fax: 315-671-6656

You can file a grievance in person or by mail or fax. If you need help filing a grievance, the Health Plan's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Attention: If you speak English free language help is available to you. Please refer to the enclosed document for ways to reach us.

Atención: Si habla español, contamos con ayuda gratuita de idiomas disponible para usted. Consulte el documento adjunto para ver las formas en que puede comunicarse con nosotros.

注意: 如果您说中文, 我们可为您提供免费的语言协助。
请参见随附的文件以获取我们的联系方式。

Внимание! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. В приложенном документе содержится информация о том, как ими воспользоваться.

Atansyon: Si ou pale Kreyòl Ayisyen gen èd gratis nan lang ki disponib pou ou. Tanpri gade dokiman ki nan anvlòp la pou jwenn fason pou kontakte nou.

주목해 주세요: 한국어를 사용하시는 경우, 무료 언어 지원을 받으실 수 있습니다. 연락 방법은 동봉된 문서를 참조하시기 바랍니다.

Attenzione: Se la vostra lingua parlata è l'italiano, potete usufruire di assistenza linguistica gratuita. Per sapere come ottenerla, consultate il documento allegato.

אויפמערקזאם: אויב איר רעדט אידיש, איז אומזיסטע שפראך הילף אוועילעבל פאר אייך ביטע רעפערירט צום בייגעלייגטן דאקומענט צו זען אפנים זיך צו פארבינדן מיט אונז.

নজর দিন: যদি আপনি বাংলা ভাষায় কথা বলেন তাহলে আপনার জন্য সহায়তা উপলভ্য রয়েছে। আমাদের সঙ্গে যোগাযোগ করার জন্য অনুগ্রহ করে সংযুক্ত নথি পড়ুন।

Uwaga: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Patrz załączony dokument w celu uzyskania informacji na temat sposobów kontaktu z nami.

تنبيه: إذا كنت تتحدث اللغة العربية، فإن المساعدة اللغوية المجانية متاحة لك. يرجى الرجوع إلى الوثيقة المرفقة لمعرفة كيفية الوصول إلينا.

Remarque : si vous parlez français, une assistance linguistique gratuite vous est proposée. Consultez le document ci-joint pour savoir comment nous joindre.

نوٹ: اگر آپ اردو بولتے ہیں تو آپ کے لیے زبان کی مفت مدد دستیاب ہے۔ ہم سے رابطہ کرنے کے طریقوں کے لیے منسلک دستاویز ملاحظہ کریں۔

Paunawa: Kung nagsasalita ka ng Tagalog, may maaari kang kuning libreng tulong sa wika. Mangyaring sumangguni sa nakalakip na dokumento para sa mga paraan ng pakikipag-ugnayan sa amin.

Προσοχή: Αν μιλάτε Ελληνικά μπορούμε να σας προσφέρουμε βοήθεια στη γλώσσα σας δωρεάν. Δείτε το έγγραφο που εσωκλείεται για πληροφορίες σχετικά με τους διαθέσιμους τρόπους επικοινωνίας μαζί μας.

Kujdes: Nëse flisni shqip, ju ofrohet ndihmë gjuhësore falas. Drejtojuni dokumentit bashkëlidhur për mënyra se si të na kontaktoni.

FUSION combines dental and eye care benefits into one easy-to-administer plan. This plan combines the annual maximum between the dental and vision plans.

For the maximum:

The member can use up to \$1,000 toward any covered dental expense.

The member can use up to \$150 toward any covered eye care expense.

Total benefits paid between the two coverages will not exceed \$1,000.

Dental Plan Benefits *subject to FUSION plan design listed above*

Networks: Classic & Plus

Type 1 Preventive No Waiting Period	100%
Routine Exam (2 per 12 months) Bitewing X-rays (1 per 12 months) Cleaning (4 per 12 months) Fluoride for Children 15 and under (2 per 12 months) Sealants 15 and under (1 in 3 years permanent molars)	
Type 2 Basic No Waiting Period	100%
Surgical Extractions Simple Extractions Restorative Amalgams Restorative Composites Endodontics (nonsurgical) Periodontics (nonsurgical) Endodontics (surgical) Periodontics (surgical)	
Type 3 Major No Waiting Period	50%
Crowns (1 in 5 years per tooth) Prosthodontics (Bridges, Dentures) (1 in 5 years) Implants (1 in 5 years)	

Deductible*

Type 1, 2 and 3	\$0
-----------------	-----

Benefit Year Maximum

Type 2 and 3 (per person, per calendar year)	\$1,000
---	---------

Orthodontia Benefits (children under age 19)

No waiting period	
Plan Benefit	50%
Lifetime Deductible	\$0
Lifetime Maximum (per person)	\$1,500

Claims Allowance

Type 1, 2 and 3	90th U&C
-----------------	----------

In network allowance is discounted fee

Monthly Rates

Employee only	\$58.64
Employee & Dependents	\$189.04

Rates are effective from 9/1/2025 to 9/1/2026.

Vision Plan Benefits *subject to FUSION plan design listed above*

Allowances		Frequencies Based on date of service**	
Exam	Subject to Maximum	Exam	None
Lenses (per pair)		Lenses	None
Single	Subject to Maximum	Frames	None
Bifocal	Subject to Maximum		
Trifocal	Subject to Maximum		
Lenticular	Subject to Maximum	Maximum	\$150
Progressive	Subject to Maximum	Deductibles (Lifetime deductible)	\$0
Contacts			
Elective/Medically Necessary	Subject to Maximum		
Frames	Subject to Maximum		

*Deductible applies to the first service received

**Please submit claims within 90 days of the date of service so that the plan can consider benefits (subject to State requirements).

Open Enrollment

If you do not elect to participate when initially eligible, you may elect to participate at the policyholder's next enrollment period, which normally coincides with the policy anniversary date.

Dental Rewards

Your dental plan includes Dental Rewards as a way to grow your annual maximum benefit. Simply by visiting a dental provider each year and submitting a claim, you can increase your annual maximum benefit over time. After your initial benefit is used, accumulated rewards are there to help pay for more expensive procedures, such as root canals or crowns.

Here's how it works. For each year, you submit at least one dental claim and your total dental benefits paid for the year are at or under \$500 you qualify to carry over \$250 in rewards to the following year. When your dental visit is to an Ameritas network provider, you earn an extra \$100 PPO Bonus. You may accumulate rewards up to the maximum amount of \$1000. Please note, if you do not submit a dental claim during the year, no rewards are earned and accumulated rewards are reset to zero. However, you can start qualifying for rewards again the very next year.

Provider Flexibility and Network Savings

Members aren't limited to one particular dentist, or a small group of providers, who may or may not be taking new patients. Each plan member is free to visit any provider they choose, including your current dentist, regardless if they are in- or out-of-network. And family members do not have to see the same dentist. When you visit an in-network dentist there are no claim forms to complete. For a list of network dentists in your area, go to Find A Provider at Ameritas.com.



The Ameritas Dental Network is one of the nation's largest.

Network providers have agreed to charge **25-50% less** than their regular rates which can lower your out-of-pocket costs.

Late Entrant

We strongly encourage you and/or your dependents to sign up for coverage when you are initially eligible. If you choose to enroll after initially declined, you and/or your eligible dependents will be considered a Late Entrant. Covered expenses will not include and benefits will not be payable in the first 12 months that a person is insured if the person is a Late Entrant; except for evaluations, prophylaxis (cleanings), and fluoride application. After 12 months, you will have access to all of the plan's benefits.

Member Savings

Prescription savings

Just for participating in our dental, vision or hearing care plans, members can save big on prescription medications through one of the world's largest retailers. **No additional cost. Only savings.**

Extra Value

Our plan members, their covered dependents can **save on prescription medications at over 60,000 pharmacies across the nation** including CVS, Walgreens, Rite Aid and Walmart. This Rx discount is offered at no additional cost, and it is not insurance.

Participating pharmacies will give Ameritas plan members their normal health care pharmacy benefit, or the prescription discount, whichever saves them more. Even if the employees already have health insurance pharmacy benefits, they are welcome to check out this Rx discount.

Find a pharmacy near you - <http://www.emsmed.com/vendors/pharmacy.aspx>

Look up a price - <http://www.emsmed.com/vendors/rxpricing.aspx?groupid=Ameritas>

Rx Savings

Members can receive up to 65% savings on generic prescriptions, and overall average savings of 40% across brand name and generic prescription combined.



Save on frames and lenses

Save up to 10% off eyewear frames and lenses purchased at any Walmart Vision Center nationwide. This is available to you without any additional cost to your plan premium.

You may receive savings on the following vision care products at Walmart Vision Centers:



- **top quality frames** for the entire family including today's most popular brands.



- wide selection of **lens options**; all lenses come with scratch resistant coating for no additional charge.



- **safety eyewear.**

Guarantees

Walmart Vision Centers stand behind their products and workmanship by offering:

- 60-day frame and lens satisfaction guarantee.
- 12-month replacement guarantee on broken or damaged frames or lenses.
- lifetime adjustments and cleanings.

Customer Service

Customer Connections **800-659-5556** www.Ameritas.com

Monday - Thursday 7am-12am CST, Friday 7am-6:30pm CST

This document is a highlight of plan benefits provided by Ameritas Life Insurance Corp. of New York as selected by your employer. It is not a certificate of insurance and does not include exclusions and limitations. For exclusions and limitations, or a complete list of covered procedures, contact your benefits administrator.



Welcome to Davis Vision!

We are pleased to provide you with information on your vision benefit to help you care for your vision and eye health - a key part of overall health and wellness!

If you are not currently enrolled, please visit our member site at davisvision.com and enter client code 4523 or call 1.800.999.5431 to locate providers or for additional information.

Using your benefits is easy! Just log on to our Member site at davisvision.com and click "Find a Provider," or call us at 1.800.999.5431.

Make an appointment. Tell your provider you are a Davis Vision member with coverage through Onondaga Central School District. Provide your member ID number, name and date of birth, and do the same for your covered dependents seeking vision services. Your provider will take care of the rest!

Your Davis Vision Designer Plan Benefits



Benefit	Frequency Once every -	In-network Copay	In-network Coverage
Eye Examination	12 months	\$10	After copay, covered in full. <i>Includes dilation when professionally indicated.</i>
Spectacle Lenses	12 months	\$25	After copay, clear glass or plastic lenses in any single vision, bifocal, trifocal or lenticular prescription. (See below for additional lens options and coatings.)
Frame	12 months	\$0	Covered in Full Frames: Any Fashion or Designer level frame from Davis Vision's Collection ² (retail value, up to \$160). OR, Frame Allowance: \$130 toward any frame from provider plus 20% off any balance. ¹ No copay required.
Contact Lens Evaluation, Fitting & Follow Up Care	12 months	\$25	Davis Vision Collection Contacts: Standard, Soft Contacts: After copay, covered in full. Specialty Contacts³: \$60 allowance less copay plus 15% off balance ¹ .
Contact Lenses (in lieu of eyeglasses)	12 months	\$0	Covered in Full Contacts: From Davis Vision's Collection ² , up to: Planned Replacement Disposable Four boxes/multi-packs* Eight boxes/multi-packs* OR, Contact Lens Allowance: \$130 allowance toward any contacts from provider's supply plus 15% off balance. ¹ No copay required. OR, Visually Required Contacts: Covered in full with prior approval. *Number of contact lens boxes may vary based on manufacturer's packaging.

Significant savings on optional frames, lens types and coatings!

Member Price

Davis Vision Collection Frames: Premier	\$25
Tinting of Plastic Lenses or Glass Grey #3 Lenses.....	\$0
Scratch Resistant Coating.....	\$0
Premium Scratch Resistant Coating.....	\$30
Ultraviolet Coating	\$12
Anti-Reflective Coating: Standard Premium Ultra Ultimate	\$35 \$48 \$60 \$85
Polycarbonate Lenses	\$0 ⁴ -\$30
High-index Lenses 1.67 1.74	\$55 \$120
Progressive Lenses: Standard Premium Ultra Ultimate	\$50 \$90 \$140 \$175
Polarized Lenses	\$75
Photochromic Lenses (i.e. Transitions®, etc.) ⁵ : Plastic Glass	\$65 \$20
Digital Single Lenses.....	\$30
Blended Segment Lenses	\$20
Scratch Protection Plan: Single Vision Lenses Multifocal Lenses.....	\$20 \$40
Trivex Lenses	\$50
Blue Light Filtering.....	\$15

Additional Savings!

Retinal Imaging.....	\$39
----------------------	------

^{1/} Some limitations apply to additional discounts, discounts not applicable at all in-network providers.
^{2/} The Davis Vision Collection is available at most participating independent provider locations. Collection is subject to change. Collection is inclusive of select toric and multifocal contacts.
^{3/} Including, but not limited to toric, multifocal and gas permeable contact lenses.
^{4/} For dependent children, monocular patients and patients with prescriptions of +/- 6.00 diopters or greater.
^{5/} Transitions® is a registered trademark of Transitions Optical Inc. .

Please note: Your provider reserves the right to not dispense materials until all applicable member costs, fees and copayments have been collected. Contact lenses: Routine eye examinations do not include professional services for contact lens evaluations. Any applicable fees are the responsibility of the member. If contact lenses are selected and fitted, they may not be exchanged for eyeglasses. Progressive lenses: If you are unable to adapt to progressive addition lenses you have purchased, conventional bifocals will be supplied at no additional cost; however, your copayment is nonrefundable. May not be combined with other discounts or offers.

Frequently Asked Questions

How can I contact Member Services?

Call 1.800.999.5431 for automated help 24/7.
(TTY services: 1.800.523.2847.)

What frames are in Davis Vision's Collection?

Our Collection offers a great selection of fashionable and designer frames, most of which are covered in full. No wonder 8 out of 10 members select a Collection frame. Log on to our member Web site at davisvision.com and take a look!

When will I receive my eyewear?

Your eyewear will be delivered to your network provider generally within five business days of order receipt. Special prescriptions, lens coatings, provider frames or out-of-stock frames may delay the standard turnaround time.

Do I need a claim form?

Claim forms are only required if you visit an out-of-network provider. Claim forms are available on our member Web site.

Can I split my benefits?

You may split your benefits by receiving your eye examination, spectacle lenses and a frame or contact lenses on different dates or through different provider locations. To maximize your benefit value we recommend that all services be obtained from a network provider.

Can I use an out-of-network provider?

Yes; however, you receive the greatest value by staying in-network. If you go out-of-network, pay the provider at the time of service, then submit a claim to Davis Vision for reimbursement, up to the following amounts: eye exam - \$40 | single vision lenses - \$40 | bifocal/progressive - \$60 | trifocal - \$80 | lenticular - \$100 | frame - \$50 | elective contacts - \$105 | visually required contacts - \$225.

Are there any exclusions to the vision benefits?

Your vision plan does not cover medical treatment of eye disease or injury; vision therapy; special lens designs or coatings, other than those described herein; replacement of lost eyewear; non-prescription (plano) lenses; contact lenses and eyeglasses in the same benefit cycle; services not performed by licensed personnel; two pair of eyeglasses in lieu of bifocals.

DAVIS VISION EXTRAS!

One Year Breakage Warranty Repair or replacement of your plan covered spectacle lenses, Collection frame or frame from a network retail location where the Collection is not displayed.

Additional Savings Members will receive 50% off of additional complete pairs of eyeglasses and sunglasses at Visionworks and 30% off at other participating providers on the same transaction. Otherwise, a 20% discount off the provider's usual and customary rate is available. Contact lenses are available at a 10% discount.⁶

Laser Vision Correction Davis Vision provides you and your eligible dependents with the opportunity to receive discounted laser vision correction, often referred to as LASIK. For more information, visit www.davisvision.com.

Low Vision Services Comprehensive low vision evaluation once every five years and low vision aids up to the plan maximum. Covers up to four follow-up visits in five years.

Eye Health & Wellness Log on and learn more about your eyes, health and wellness; common eye conditions that can impair vision; and what you can do to ensure healthy eyes and a healthier life.

For more details... about your vision benefits, patient rights and responsibilities, or more information about Davis Vision, please log on to our member Web site or contact us at 1.800.999.5431.

Davis Vision has made every effort to correctly summarize your vision plan features herein. In the event of a conflict between this information and your organization's contract with Davis Vision, the terms of the contract will prevail.

⁶ Some limitations apply to additional discounts, discounts not applicable at all in-network providers.

Benefits administered by Davis Vision, Inc.
Underwritten by Metropolitan Life Insurance Company, New York, NY