

# T&T TRANSPORTS INC

## Eyetopia Vision Care

### VISION PLAN PACKET

#### Plan Descriptions and Enrollment/Change Forms Enclosed

#### See Price Per Paycheck Below

<u>Coverage Options</u>	<u>120/145 PLAN</u>	<u>150/250 PLAN</u>
Employee Only	\$4.62	\$9.23
Employee + One	\$8.77	\$18.00
Entire Family	\$12.47	\$24.93

*These premiums are deducted pre-tax so you will get the benefit of tax savings to offset the cost of the plan.*

**Coverage is available to full-time employees only. Full-time employees are eligible for coverage on the 1<sup>st</sup> of the month following 60 days of continuous employment.\* Employees are considered full-time if they work at least 30 hours a week.\*\***

\* Employee benefits and/or rates are subject to change or termination at any time.

\*\* 30 hours per week is figured by averaging over a calendar month. If you are enrolled in benefits and you work less than 30 hours per week (averaged in the calendar month), you will be responsible for paying for the full cost of your benefits that month.



## Benefit Descriptions & Comparisons

	Eyetopia	Eyetopia
	Proposed 120/145 Plan	Proposed 150/250 Plan
Exam Co-pay	\$10	\$5
Material option in lieu of Exam	\$10	\$5
Materials Co-pay	\$20	None
Single Vision Lens	Covered	Covered
Bifocal Lens	Covered	Covered
Trifocal Lens	Covered	Covered
Lenticular Lens	Covered	Covered
Progressive Lens	Covered	Covered
Frame Allowance	\$120 retail	\$150 Retail
Polycarbonate Lenses	\$35 co-pay	Covered
Scratch Coating	\$15 co-pay	Covered
UV Protection Coating	\$12 co-pay	Covered
Anti-Reflective Coating	\$45 co-pay	Covered w/ VCDLabs lenses
Tint	\$12 co-pay	12.00 co-pay
Non-Rx Computer Glasses	Covered	Covered
Medically Necessary Spectacles	\$400 allowance	\$400 allowance
Contact Lens Allowance	\$145	\$250
Medically Necessary Contacts	\$400 allowance	\$400 allowance
Contact Lens Co-pay	\$20	\$0
Standard Contact Fitting Fee	Included in Allowance	Included in Allowance
Exam Frequency	1 per 12 months	1 per 12 months
Lens Frequency	1 per 12 months	1 per 12 months
Frame Frequency	1 per 12 months	1 per 12 months
Contact Frequency	1 per 12 months	1 per 12 months
Refractive Surgery	\$350/Eye Allowance (All FDA Procedures)	\$500/Eye Allowance (All FDA Procedures)
<b>Voluntary Rates Monthly</b>		
Employee	<b>\$10.00</b>	<b>\$20.00</b>
Employee + 1	<b>\$19.00</b>	<b>\$39.00</b>
Family	<b>\$27.00</b>	<b>\$54.00</b>



Eyetopia Vision Care Benefits	Co-pay <sup>1</sup>
Eyetopia provides two vision benefits each eligibility period. By coordinating your coverage with your health insurance wellness eye exam you have the opportunity to maximize your Eyetopia benefits.	
<b>BENEFIT ONE<sup>2</sup></b> (choose either one of the following 2 options every 12 months): 1. Refractive Exam-One refraction (CPT Code 92015) or one Routine Vision Exam 2. Warranted Anti-Reflective Coating or any other, tint, treatment, coating, or service of an equal or lesser value.	\$5.00
<b>BENEFIT TWO</b> (choose only one of the following Vision Correction Options): Eyetopia Vision Care Provides you with three (3) options for correcting your vision. You may select one of the following every 12 months:	
<b>1. Prescription Eye Wear (lenses and/or frame)<sup>3,4</sup></b> High Index or Polycarbonate single vision, bifocal or trifocal lenses that also include a standard anti-reflective coating – covered 100%. The VCDLabs Acuity® PAL or upgrade® single vision comes with a premium anti-reflective coating and is covered 100%. <ul style="list-style-type: none"> <li>• Specific to VCDLabs® Premium Lenses Only:</li> <li>• Premium Anti-glare, anti-smudge, anti-scratch with UV Protection</li> <li>• iBlu® Coat</li> <li>• Optimized Manufacturing Technology</li> </ul>	None
<ul style="list-style-type: none"> <li>• Tint (Solid and Gradient)</li> <li>• Transition or Polarized Lenses<sup>2</sup></li> <li>• Warranted Anti-Reflective Coating<sup>2</sup></li> <li>• Premium Anti-Reflective Coating<sup>2</sup></li> </ul>	\$12.00 Note 2 \$65.00 Note 2
<ul style="list-style-type: none"> <li>◆ <b>Frame:</b> The member may select any frame on display. Eyetopia Vision Care provides an allowance of \$150.00 to be applied toward the frame selected. The member pays any amount exceeding the \$150.00 allowance.</li> </ul>	None
<b>2. Contact Lens Option</b> Eyetopia Vision provides a \$250.00 allowance to be applied toward the Participating Provider's usual and customary (U&C) fees toward prescription contact lenses. <ul style="list-style-type: none"> <li>◆ This allowance can be applied toward the contact lens fitting fee and all other charges including follow-up visits and contact lenses.<sup>3,4</sup></li> <li>◆ Medically necessary spectacle or contact lenses - \$400 total allowance</li> </ul>	None
<b>3. Refractive Surgery Option.<sup>6,7</sup></b> You may select refractive surgery instead of spectacles or contact lenses during each plan period. Eyetopia Vision Care provides a \$500.00 per eye allowance toward the fees for refractive surgery, for the following procedures: LASIK, ASA, ICL or RLE. The member pays any amount exceeding the \$500.00 per eye allowance.	None

<sup>1</sup> The co-pay must be paid to the Participating Provider at the time of service.

<sup>2</sup> Special Lens Materials: The member may select special lens materials (transition, ultra light, premium PALs, etc.) provided they pay any amount exceeding the participating provider's U&C fees for the covered lenses.

<sup>3</sup> Non-covered items: Any items not specifically mentioned above, including but not exclusive to rush service, service agreements, special lens materials, oversize and other extras are paid for by the patient at the time of service.

<sup>4</sup> If the contact lens exam or "fitting" is performed and the patient decides against getting contact lenses, the patient is responsible for the cost of the contact lens fitting fee.

<sup>5</sup> The Participating Provider must pre-authorize medical necessity.

<sup>6</sup> Non-covered Items and Exclusions – Facility fees, medications and enhancements or treatments related to complications.

<sup>7</sup> Access to surgeons must come by referral from a Primary Eye Care Provider who provides pre and post-op care and counseling.

## Exclusions & Limitations

**Included Services and/or Eye Wear.** Only those professional vision care services and/or vision correction options specifically referenced herein are included in the Eyetopia Vision Care.

In-Network coverage is available through Participating Providers. Out of network services are not covered.

**Additional Professional Services and/or Vision Corrections.** The member may select professional services and/or vision correction items not specifically referenced as included in Eyetopia Vision Care. However, these services and/or items are the member's responsibility at the Participating Provider's (U&C) charge, payable at the time of service or of ordering.



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# Summary of Benefits for Eyetopia (120/145)



Eyetopia Vision Care Benefits	Co-pay
Eyetopia provides two vision benefits each eligibility period. By coordinating your coverage with your Health Insurance you have the opportunity to maximize your Eyetopia benefits.	
<b>Benefit One</b> <sup>2</sup> (choose either one of the following 2 options every 12 months):	
1. Refractive Exam. One refraction (CPT code 92015) or one routine Vision Exam.	
2. Standard Anti-Reflective Coating or any other material or service of an equal or lesser value.	\$10.00
<b>Benefit Two</b> (choose only one of the following Vision Correction Options): Eyetopia Vision Care provides you with three (3) options for correcting your vision. If your prescription has changed at least ½ diopter or your eye doctor recommends a change of lenses, you may select one of the following every 12 months:	
1. Prescription Eye Wear (lenses and/or frame) <sup>3</sup> <ul style="list-style-type: none"> <li>◆ Standard Prescription Lenses – covered 100%</li> <li>◆ Non-coated CR-39 plastic single vision, bifocal, trifocal or standard Progressive lenses<sup>4</sup>.</li> <li>◆ VCDLabs® Standard single vision or bifocal flat top 28 lenses with premium Anti-Reflective Coating<sup>5</sup>.</li> <li>◆ Child dependents (under age 26) can upgrade to VCDLabs Resolution® polycarbonate lenses<sup>5</sup>.</li> </ul>	\$20.00
<ul style="list-style-type: none"> <li>◆ Basic Anti-Reflective Coating (Ultra Violet Protection &amp; Scratch Resistant Coating)</li> <li>◆ Standard Tints (Gradient and Solid)</li> <li>◆ Polycarbonate upgrade<sup>6</sup></li> <li>◆ Warranted Anti-Reflective Coating</li> <li>◆ VCDLabs high definition Acuity® PAL or upgrade® SV in CR-39 with a premium anti-reflective coating.<sup>5</sup></li> </ul>	\$25.00 \$12.00 \$35.00 \$65.00 \$65.00
◆ Frame: The member may select any frame on display. Eyetopia Vision Care provides an allowance of \$120.00 to be applied toward the frame selected. The member pays any amount exceeding the \$120.00 allowance.	
2. <b>Contact Lens Option:</b> <sup>7</sup> Eyetopia Vision provides a \$145.00 allowance to be applied toward the Participating Provider's usual and customary (U&C) fees toward prescription contact lenses. <ul style="list-style-type: none"> <li>◆ This allowance can be applied toward the contact lens fitting fee and all other charges including follow-up visits and contact lenses.</li> </ul>	\$20.00
◆ Medically necessary spectacle or contact lenses - \$400 total allowance. <sup>8</sup>	
3. <b>Refractive Surgery Option.</b> <sup>9</sup> You may select refractive surgery instead of spectacles or contact lenses during each plan period. Eyetopia Vision Care provides a \$350 per eye allowance for in-network surgeons and a \$75 per eye allowance for out-of-network surgeons toward the fees for the following procedures: LASIK, ASA, ICL or RLE. The member pays any amount exceeding the per eye allowance.	None

<sup>1</sup> The co-pay must be paid to the Participating Provider at the time of service.

<sup>2</sup> When Health Insurance Carriers offer an annual wellness eye exam it creates an overlap in benefits for Eyetopia Members. If this occurs, the Member may choose another option under Benefit One as described, a \$10.00 co-pay is still required to exercise these other options.

<sup>3</sup> Special Lens Materials and Non-covered Items: Transition, ultra light, premium PALs, rush service, service agreements, other special lens materials, oversize, other extras and any items not specifically mentioned above may be substituted provided the Member pays any amount exceeding the price of the covered benefit and the Participating Provider's usual and customary fees for the upgrade at the time of service.

<sup>4</sup> Standard Progressive Lenses are defined as any brand of PAL offered by the Participating Provider with up to a \$130.00 retail value.

<sup>5</sup> Members can upgrade from standard non-coated lens to the VCDLabs premium coated lenses at no charge. They can upgrade to the VCDLabs high definition Acuity® PAL or upgrade® single vision in CR-39 plastic for an additional \$65.00.

<sup>6</sup> Child Dependents not being prescribed Resolution® polycarbonate lenses, Members (employees) and Dependent Spouses are charged a polycarbonate upgrade fee.

<sup>7</sup> If the contact lens exam or "fitting" is performed and the patient decides against getting contact lenses, the patient is responsible for the cost of the contact lens fitting fee.

<sup>8</sup> The Participating Provider must pre-authorize medical necessity.

<sup>9</sup> Non-covered Items and Exclusions – Facility fees, medications and enhancements or treatments related to complications. Access to surgeons must come by referral from a Primary Eye Care Provider who provides pre and post-op care and counseling.

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