Ameriprise Financial

2024 Vision Plan Fact Sheet

EyeMed
Provider Network: Access
eyemed.com
1.866.639.3633

This fact sheet highlights the services and supplies available under the Vision Care Plan. For provider information, please refer to the website above. Or for additional information you may contact the Member Services Department at the phone number listed above. Please note that out-of-network coverage is based on the carrier's allowable charge for a particular service, as defined under the plan. In the event of a discrepancy between the below information and the actual plan provisions, the actual plan provisions will govern.

Type of Service	Premium	Basic
Exam with dilation as necessary (once every 12 months; does not include contact lens exam or fitting)	$0 copay	$0 copay
Exam Options:		
• Standard Contact Lens Fit and Follow-Up[1]	$0 copay	Up to $55 copay
• Premium Contact Lens Fit and Follow-Up[2]	10% off retail price, then apply $55 allowance	10% off retail price
Standard Plastic Lenses (once every 12 months)		
• Single Vision, Bifocal, Trifocal and lenticular Lenses	$0 copay	$20 copay
• Standard Progressives	$80 copay	$100 copay
• Premium Progressives	$80 copay, 80% of charge, less $120 allowance	$100 copay, 80% of charge, less $120 allowance
Standard Lens Options		
• UV Treatment	$15	$15
• Tint (Solid/Gradient)	$15	$15
• Plastic Scratch	$15	$15
• Polycarbonate	$0	$40
• Standard Anti - Reflective	$45	$45
• Premium Anti-Reflective	20% off retail price	20% off retail price
• Polarized	20% off retail price	20% off retail price
Frame (once every 12 months)		
• Any frame available at provider location	$150 retail allowance, 20% off balance over $150	$110 retail allowance, 20% off balance over $110
Contact Lenses (once every 12 months, in lieu of eyeglass lenses; allowance includes materials only)		
• Conventional	$150 allowance, plus 15% off balance over $150 allowance	$105 allowance, plus 15% off balance over $105 allowance
• Disposables	$150 allowance, plus balance over $150	$105 allowance, plus balance over $105
• Medically Necessary[3]	Paid in full	Paid in full

Additional Discounts[4]

- Member will receive a 20% discount on items not covered by the plan at in-network providers, which may not be combined with other discounts or promotional offers. Discounts do not apply for benefits provided by other group benefit plans or provider professional services. Allowances are one-time use benefits.
- Lost or broken materials are not covered.
- Members receive a 40% discount off unlimited number of complete pair eyeglass purchase and a 15% discount off conventional contact lenses once the funded benefit has been used.
- Members receive 15% off retail price or 5% off promotional price for Lasik or PRK from the U.S. Laser Network, owned and operated by LCA Vision.
- Since Lasik or PRK vision correction is an elective procedure, performed by specially trained providers, this discount may not always be available from a provider in your area. For locations near you and discount authorization call 1.877.5LASER6.

[1] Standard – spherical clear contact lenses in conventional wear and planned replacement.
[2] Premium – all lens designs, materials and specialty fittings other than standard.
[3] The frequency limits include one benefit per plan year, filed on one claim and not exceeding an annual supply, as defined by contact lens manufacturer's replacement guidelines. The benefit may not be expanded due to professional prescriptions that exceed the manufacturer's replacement guidelines.
[4] Due to varying state laws, discounts may not be available at all network providers. Prior to your appointment, you should confirm with your provider that discounts are offered.