Summary of Vision Benefits

Group Name: Kesser Group, LLC

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exams		
Exam with dilation as necessary	$10 copay	Up to $50
Retinal Imaging	Up to $39	N/A
Frequency		
Examination	Once every calendar year	
Lenses or contact lenses	Once every calendar year	
Frame	Once every 2 calendar years	
Exam options		
Contact lens fit and follow-up	Up to $40 for standard; 10% off retail price for premium	N/A
Frames		
Any available frame at provider location	$0 copay, $130 allowance, 20% off balance over $130	Up to $65
Standard Lenses		
Single vision	$25 copay	Up to $48
Bifocal	$25 copay	Up to $67
Trifocal	$25 copay	Up to $86
Lenticular	$25 copay	Up to $86
Standard progressive lens	$90 copay	Up to $67
Premium progressive lens (tiers 1-3)	See table on page 2.	Up to $67
Lens Options		
Ultraviolet coating	$15	N/A
Tint (solid and gradient)	$15	N/A
Scratch resistant coating	$15	N/A
Polycarbonate lenses – adults	$40	N/A
Polycarbonate lenses – kids under 19	$0	Up to $20
Standard Anti-reflective coating	See table on page 2.	N/A
Polarized lenses	20% off retail	N/A
Photochromic/transitions plastic	$75	N/A
Premium Anti-reflective coating	See table on page 2.	N/A
Contact Lenses (in lieu of spectacle lenses)		
Conventional	$0 copay, $130 allowance, 15% off balance	Up to $105
Disposable	$0 copay, $130 allowance, plus balance over $130	Up to $105
Medically necessary	$0 copay, paid-in-full	Up to $210
Other		
Laser vision correction	15% off retail price or 5% off promotional price	N/A
Additional pairs benefit	40% off purchase of complete pair of eyeglasses and a 15% off conventional contact lenses once the funded benefit has been used	N/A
Amplifon hearing discount	Up to 64% off hearing aids, an extended warranty, free batteries and a low price guarantee	N/A
Other Add-On Services and Materials	20% off retail price	N/A
Monthly Rates		
Employee	$ 5.70	
Employee + spouse	$ 9.60	
Employee + child(ren)	$ 9.80	
Employee + family	$ 15.51	

Eligibility: All active full-time employees as defined by your employer.
Dependent coverage is available to age 26.

Insurance products issued by Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148.

Additional discounts

40% OFF
Complete pair of prescription eyeglasses

20% OFF
Non-prescription sunglasses

20% OFF
Any item not covered by the plan

These discounts are not insured benefits and are for in-network providers only.

Take a sneak peek before enrolling

- For a complete list of in-network providers near you, visit member.eyemedvisioncare.com/bcbsil or call 1.855.362.5539.

  Members with BCBSIL medical and/or dental coverage can also access their vision benefit information in Blue Access for Members℠ (BAM℠) at mybam.bcbsil.com.

- For LASIK providers, call 1.877.5LASER6.

Summary of Benefits Continued

Progressive Price List[2]	Member Cost In-Network
Standard progressive	$90 copay
Premium progressives[3] as follows:	
Tier 1	$110 copay
Tier 2	$120 copay
Tier 3	$135 copay
Tier 4	$90 copay, 80% of charge less $120 allowance

Anti-Reflective Coating Price List[2]	Member Cost In-Network
Standard anti-reflective coating	$45
Premium anti-reflective[3] coatings as follows:	
Tier 1	$57
Tier 2	$68
Tier 3	80% of charge

Other Add-ons Price List	Member Cost In-Network
Photochromic	$75
Polarized	80% of charge

Exclusions

1. Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; aniseikonic lenses
2. Medical and/or surgical treatment of the eye, eyes or supporting structures
3. Any eye or vision examination, or any corrective eyewear required by a policyholder as a condition of employment; safety eyewear
4. 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
5. Plano (non-prescription) lenses and/or contact lenses
6. Non-prescription sunglasses
7. Two pair of glasses in lieu of bifocals
8. 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
9. Services or materials provided by any other group benefit plan providing vision care
10. 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

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[1]Member Reimbursement Out-of-Network will be the lesser of the listed amount or the member's actual cost from the out-of-network provider. In certain states, members may be required to pay the full retail rate. [2]Blue Cross and Blue Shield of Illinois Vision Care reserves the right to make changes to the products on each tier and the member out-of-pocket costs. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. [3]Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Not available in all states. Some provisions, benefits, exclusions or limitations listed herein may vary.

Blue Access for Members℠ (BAM℠) is provided and maintained by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

For employee use. This piece is for illustrative purposes only and is not a contract. It is intended to provide only a brief summary of the type of policy and insurance coverage advertised. The policy provides the actual terms of coverage, including any exclusions, conditions and limitations to coverage.

All plans are based on a 48-month contract term and 48-month rate guarantee. Premium is subject to adjustment even during a rate guarantee period in the event of any of the following events: changes in benefits, employee contributions, the number of eligible employees, or the imposition of any new taxes, fees or assessments by Federal or State regulatory agencies. Benefits may not be combined with any discount, promotional offering or other group benefit plans. Benefit allowance provides no remaining balance for future use with the same benefits year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.

Vision Insurance offered by Dearborn Life Insurance Company located at 701 E. 22nd Street, Lombard, IL 60148. Blue Cross and Blue Shield of Illinois, an Independent Licensee of the Blue Cross and Blue Shield Association. EyeMed Vision Care, LLC and First American Administrators, Inc. are independent companies that offer provider network and administration services on behalf of Dearborn Life Insurance Company.