VISION BENEFITS AT A GLANCE

CITY OF DETROIT RETIREE LOCAL PLAN

PLAN EFFECTIVE 01/01/2025
CLIENT # 4006-00 | GROUP # 1101

SERVICES	NETWORK COVERAGE	OUT OF NETWORK[4,5]
EYE EXAM		
Comprehensive Eye Exam	100% Covered, No Co-Pay	Reimbursed up to $25.00
FRAME		
Frame	$100.00 Retail Allowance Member pays retail frame costs over allowance[2]	Reimbursed up to $30.00
STANDARD LENSES		
Single Vision	100% Covered, No Co-Pay	Reimbursed up to $30.00
Bifocal	100% Covered, No Co-Pay	Reimbursed up to $35.00
Trifocal	100% Covered, No Co-Pay	Reimbursed up to $40.00
Progressive, Standard	100% Covered, $55.00 Co-Pay	Reimbursed up to $40.00
Progressive, Premium	80% of the difference between the standard and premium, $55.00 Co-Pay	Reimbursed up to $40.00
Lens Options		
Anti-Reflective Coating	20% Discount	N/A
Hi-Index	20% Discount	N/A
Mirror Coating	20% Discount	N/A
Photochromic/Transition, Single Vision	20% Discount	N/A
Photochromic/Transition, Multi-Focal	20% Discount	N/A
Polycarbonate, Child	20% Discount	N/A
Polycarbonate, Adult	20% Discount	N/A
Polarization	20% Discount	N/A
Prism	100% Covered, No Co-Pay	N/A
Scratch Coating	100% Covered, No Co-Pay	N/A
Tint, Solid	100% Covered, No Co-Pay	N/A
Tint, Gradient	20% Discount	N/A
UV Coating	20% Discount	N/A
Other Lens Options	20% Discount	N/A
CONTACT LENS SERVICES		
Standard Contact Fitting	$40.00 Max Co-Pay	N/A
Premium Contact Fitting	10% Discount	N/A
Contact Lenses[1]	$45.00 Retail Allowance Member pays retail contact lens costs over allowance, less 10% discount[3]	Reimbursed up to $40.00

Plan Information

Network

Select: Southeast Michigan

Service Frequency[6]

Exam	Every 24 months
Frames	Every 24 months
Lenses	Every 24 months
Contacts	Every 24 months

Dependent Children

Covered to age 26 (EOY)

[1] You are eligible for contact lenses or eyeglasses, not both, in any 24 month period.

[2] Includes 6-month manufacturer's warranty.

[3] Discount may not apply to disposable contact lenses.

[4] If you use the services of an in network provider but take advantage of a sale, coupon, or other in-store special, the provider may require that you pay in full and submit your itemized receipt for reimbursement at the out of network reimbursement rates.

[5] Claims for out of network reimbursement must be filed within six months of service date.

[6] Progressive myopia children (under age 19) may receive new lenses every 12 months with a prescription change of +/- .50 diopters or more.

This is intended as an easy-to-read summary and provides a general overview of your benefits. It is not a contract.

To find a Heritage provider, visit **www.heritagevisionplans.com,** no login required.
Choose **"SELECT NETWORK"** from the dropdown.

Questions? Call **800.252.2053**

Eligibility

Your eligibility to participate in this plan is determined by your employer, group or trust. Contact your benefit manager for eligibility rules.

Limitations

This plan is designed to cover eye examinations and corrective eyewear. It is also designed to cover visual needs rather than cosmetic options. Should you select options that are not covered under your plan, as shown in the vision benefits at a glance, you will pay a discounted fee to the participating provider, when applicable. Benefits are payable only for services received while your coverage is in force.

Exclusions:

- Non-Prescription Lenses
- Medical or surgical treatment of the eyes, including drugs and/or medications
- Replacement of lost or broken lenses or frames
- Vision training
- Services provided as a result of any workers' comp law, or similar legislation, or required by any governmental agency or program whether federal or state
- Two pairs of glasses instead of bifocals
- Parts or repair of frame not covered under manufacturers' warranty
- Services not visually necessary
- Corrective vision services, treatments and materials of an experimental nature
- Safety lenses (3mm) and/or frame with side shields
- Services not specified in scope of coverage
- Services or materials provided by any other group plan providing vision care
- Services rendered after the date an insured person ceases to be covered under the policy, except when materials ordered before coverage ended are delivered
- Benefits cannot be combined with any discount or promotional offering
- Fees charged for non-covered services and materials must be paid in full to the provider

Termination Provisions

Coverage will end on the earliest of: the date the policy ends, or the date you are no longer eligible.

Notes and Disclaimers

- The contact lens allowance may be used all at once, or throughout the plan year as needed, and may be applied toward contact lenses only
- Discounts are not insured benefits
- ID cards are not required for services
- Other disclaimers may apply

Using an Out of Network Provider

Here are the steps to take if you choose to use an out of network provider:

1. Call our Customer Service Center toll free at 800.252.2053 to verify your eligibility.
2. Make an appointment with the provider of your choice.
3. When the examination is complete and you have been fitted for necessary eyeglasses or contact lenses, pay the charges in full.
4. Request an itemized receipt.
5. Complete a Heritage Reimbursement Claim Form that can be accessed on our website, heritagevisionplans.com or by calling our Customer Service Center toll free at 800.252.2053.
6. Submit the completed Heritage Reimbursement Claim Form along with your itemized receipt(s) using one of these methods:

   Mail to:
   Heritage Vision Plans, Inc.
   Attention: Claim Processing
   One Woodward Avenue, Suite 2020
   Detroit, MI 48226
   Fax to: **313.863.1189**
   Email to: **eligibility@heritagevisionplans.com**

7. Out of network benefits are subject to the same eligibility, frequency, limitation and exclusion provisions of the plan, and are in lieu of in network services.

Heritage vision plans