SAN YSIDRO HEALTH

SYHealth Vision Benefits Information Miniguide

May 1, 2024-April 30, 2025

Your Experience, Your Rewards

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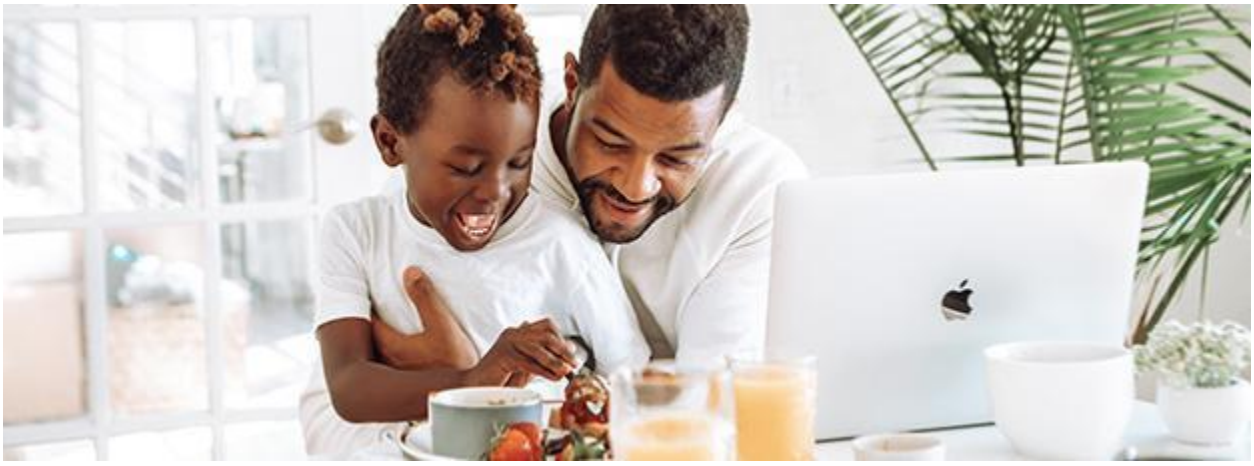

Eligibility

Benefit Eligible Employees

Employees working **20** hours or more per week are eligible to participate in the benefit program.

Eligible Dependents

Your eligible dependents include:

- Your spouse (unless you are legally separated)
- Your registered domestic partner
- Your dependent children, up to age 26 regardless of their student or marital status
- Adopted, foster or domestic partner's children
- Your dependent children, if they are incapable of self-support due to physical or mental disability

Coverage may be available for a mentally or physically disabled child who is age 26 or older. Requirements for such coverage and documentation of disability depend on the insurance carrier. Please contact benefits@syhealth.org if you believe this applies to your family.

When You Can Enroll

New Hires/Newly Eligible for Benefits

You are eligible for benefits on the first day of the month after 30 days worked. **You have 30 days from the date of your hire to enroll in benefits.** After your initial enrollment, you will have the opportunity to re-enroll in the benefits program each year during the Annual Open Enrollment period, unless you have a Qualifying Life Event. Be prepared to show documentation for qualifying event, such as marriage license, birth certificate or divorce decree.

Qualifying Life Event Change

During the annual open enrollment period, you will have the opportunity to make any changes in your coverage(s) for the next plan year.

Please keep in mind that you will have 30 days from the event date to make any changes and notify the Benefits Team of any changes.

Plan year begins May 1, 2024 and is in effect through April 30, 2025.

After the annual enrollment period, you will only be able to change your coverage if you have a qualifying life event. Qualifying life events include, but are not limited to:

- Change in your employment status (commencement, termination, reduction in hours from full-time of 20 hours/week to part-time 19 hours or less or vice versa) or change to per diem employment
- Change in marital status (marriage, death of spouse, divorce, legal separation)
- Change in dependents (birth, death, adoption, and child support order)
- Special enrollment rights under Health Insurance Portability Accountability Act (“HIPAA”)
- Medicare or Medicaid entitlement for you, your spouse, or dependent (60 days)

When Coverage Ends

If your employment at San Ysidro Health ends, your medical, dental, and vision coverage will end on the last day of the month of your termination date. Other circumstances which may result in termination of coverage for you and/or your dependents include: reduction in regular hours, divorce/legal separation, and dependent children who reach age 26. Your FSA will terminate on the date of termination.

Vision Benefits – EyeMed

Vision coverage is offered through EyeMed as a Preferred Provider Organization (PPO) plan.

As with a traditional PPO, you may take advantage of the highest level of benefit by receiving services from in-network vision providers and doctors. You would be responsible for a copayment at the time of your service. However, if you receive services from an out-of-network doctor, you pay all expenses at the time of service and submit a claim for reimbursement up to the allowed amount. Any questions pertaining to your vision coverage can be directed to EyeMed by calling 866.804.0982 or visiting their website, www.eyemed.com (choose INSIGHT Network).

Summary of Benefits

The below is an overview of services covered; please see the full Summary of Benefits Coverage (SBC) from EyeMed on the HR Intranet.

Plan Highlights	EyeMed Vision PPO – Insight Network	
	In-Network	Out-of-Network
Frequency		
Exam / Lenses / Contacts / Frames	Once Every 12 Months	
Exam		
Per Exam	$10 Copay	Up to $40 Reimbursement
Lenses		
Single	$25 Copay	Up to $30 Reimbursement
Bifocal	$25 Copay	Up to $50 Reimbursement
Trifocal	$25 Copay	Up to $70 Reimbursement
Frames		
Per Pair	Up to $130 Allowance + 20% off over allowance	Up to $91 Retail Reimbursement
Contacts (instead of glasses)		
Medically Necessary (not common)	No Copay	Up to $210 Reimbursement
Conventional / Cosmetic (hard contacts)	Up to $130 Allowance + 15% off over allowance	Up to $130 Reimbursement

SYHealth

SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES		
Exam	$10 copay	Up to $40
Retinal Imaging	Up to $39	Not covered
CONTACT LENS FIT AND FOLLOW-UP		
Fit and Follow-up - Standard	Up to $40; contact lens fit and two follow-up visits	Not covered
Fit and Follow-up - Premium	10% off retail price	Not covered
FRAME		
Frame	$0 copay; 20% off balance over $130 allowance	Up to $91
STANDARD PLASTIC LENSES		
Single Vision	$25 copay	Up to $30
Bifocal	$25 copay	Up to $50
Trifocal	$25 copay	Up to $70
Lenticular	$25 copay	Up to $70
Progressive - Standard	$90 copay	Up to $50
Progressive - Premium Tier 1 - 3	$110 - 135 copay	Up to $50
Progressive - Premium Tier 4	$90 copay; 20% off retail price less $120 allowance	Up to $50
LENS OPTIONS		
Anti Reflective Coating - Standard	$45	Not covered
Anti Reflective Coating - Premium Tier 1 - 2	$57 - 68	Not covered
Anti Reflective Coating - Premium Tier 3	20% off retail price	Not covered
Photochromic - Non-Glass	$75	Not covered
Polycarbonate - Standard	$40	Not covered
Polycarbonate - Standard < 19 years of age	$40	Not covered
Scratch Coating - Standard Plastic	$15	Not covered
Tint - Solid or Gradient	$15	Not covered
UV Treatment	$15	Not covered
All Other Lens Options	20% off retail price	Not covered
CONTACT LENSES		
Contacts - Conventional	$0 copay; 15% off balance over $130 allowance	Up to $130
Contacts - Disposable	$0 copay; 100% of balance over $130 allowance	Up to $130
Contacts - Medically Necessary	$0 copay; paid in full	Up to $210
OTHER		
Hearing Care from Amplifon Network	Discounts on hearing exam and aids; call 1.877.203.0675	Not covered
LASIK or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered

FREQUENCY	ALLOWED FREQUENCY - ADULTS	ALLOWED FREQUENCY - KIDS
Exam	Once every 12 months from the date of service	Once every 12 months from the date of service
Frame	Once every 12 months from the date of service	Once every 12 months from the date of service
Lenses	Once every 12 months from the date of service	Once every 12 months from the date of service
Contact Lenses	Once every 12 months from the date of service	Once every 12 months from the date of service

(Plan allows member to receive either contacts and frame, or frames and lens services)

The Cost of Coverage for Employees Working 20+ Hours per Week

The rates below are effective May 1, 2024 – April 30, 2025.

Coverage	Total Monthly Cost	San Ysidro Health Monthly Contribution	Employee Monthly Cost	Payroll Deductions (24 pay periods/yr)
EyeMed Vision PPO				
Employee Only	$6.95	$6.95	$0.00	$0.00
Employee and Spouse / DP	$13.21	$7.57	$5.64	$2.82
Employee and Child(ren)	$13.91	$7.64	$6.27	$3.14
Employee and Family	$20.45	$8.29	$12.16	$6.08

Vision Benefits Directory and Resources

CARRIER	PHONE/FAX/EMAIL	WEBSITE
EyeMed (Vision) *Group #: 1000083*	800.988.4221	www.eyemed.com
Benefits broker for all benefits except medical: Marsh & McLennan Insurance Agency, LLC	Alicia Phan / alicia.phan@marshmma.com Julia Wood / Julia.Wood@marshmma.com Catherine Botello/ catherine.botello@marshmma.com	www.mma-west.com
San Ysidro Health HR Contact: Benefit Team	P: 619.662.4100 Email: benefits@syhealth.org	HR Intranet