Vision Plan

Administered by EyeMed Vision Care

PREMIUMS	24 PAY PERIODS	12 PAY PERIODS
Employee	$3.19	$6.38
Employee + spouse	$6.38	$12.76
Employee + child(ren)	$5.40	$10.80
Family	$8.91	$17.82

Along with the one eye exam covered annually on your health plan, you have the option of electing vision coverage to help pay for an additional eye exam, as well as frames, lenses, contacts, and more.

- You can see any vision care doctor you choose, but you may pay less at in-network providers. To find in-network care, visit eyemedvisioncare.com/sosd, select *Provider Locator*, enter your zip code, and choose the network *Insight*.
- If your vision care provider is out of network, you may be eligible to be partially reimbursed for care. Visit https://bhr.sd.gov/benefits/flexible-benefits/vision/ to read instructions and download an out-of-network claim form. The completed form must be mailed in or uploaded within 15 months of the date of service.
- Your eligibility for services resets on July 1 of each year.
- Premiums are paid with pre-tax deductions.

Questions? Call EyeMed at 1.888.626.6334.

VISION PLAN CARE & SERVICES		IN NETWORK You will pay ...	OUT OF NETWORK The plan will reimburse you ...
Exam, including dilation, once every plan year		$10 copay	Up to $45
Frames, once every plan year		$0 copay, $130 allowance, 20% off balance over $130	up to $70
Lenses Once every plan year	Single vision	$25 copay	Up to $30
	Bifocal		Up to $50
	Trifocal		Up to $65
	Lenticular		Up to $100
Lenses (progressive) Once every plan year	Standard	$80 copay	Up to $50
	Premium tiers 1-3	$100-125 copay	
	Premium tier 4	$80 copay; 20% off retail price over $120 allowance	
Lenses (materials and options) Once every plan year	Standard polycarbonate Age 19 and over	$40	N/A
	Anti-reflective coating tiers 1 & 2	$45-$68	
	Anti-reflective coating tier 3	20% off retail price	
	Photochromic	$75	
	Standard polycarbonate Under age 19	$0 copay	Up to $5
	UV treatment		
	Standard plastic scratch coating		
	Tint Solid and gradient		
All other lens options Once every plan year		20% off retail price	N/A
Contact lenses, in place of glasses lenses Once every plan year	Elective disposable	$0 copay; up to $130 allowance	Up to $105
	Elective conventional	$0 copay; 15% off balance over $130 allowance	Up to $105
	Medically necessary	$0 copay; covered in full	Up to $210
Contact lenses, fit and follow-up appointment Once every plan year after a comprehensive eye exam has been completed	Standard	$40	N/A
	Premium	10% off retail price	
Retinal imaging Once every plan year		Up to $39	N/A

NETWORK ADEQUACY REIMBURSEMENT

No in-network provider near you? Unable to schedule an in-network appointment when you need it? In these situations, your vision benefits allow you to schedule out-of-network care and get reimbursed as if you visited an in-network provider.

You may take advantage of this benefit if:

- You are unable to locate a participating provider within a 10-mile radius in an urban/suburban area.
- You are unable to locate a participating provider within a 20-mile radius in a rural area.
- You are unable to schedule a visit within two weeks with a participating provider.

To get reimbursed, after your appointment, go to https://bhr.sd.gov/benefits/flexible-benefits/vision/ to download and complete an out-of-network claim form, including the Network Adequacy section on page 4. The completed form must be submitted within 15 months of the date of service.