Vision Plan

- The Vision Plan is now provided by EyeMed Vision Care, LLC.
- Your eligibility for services will reset on July 1 of each year.
- You can see the vision care doctor of your choice, but you may pay the lowest out-of-pocket cost if you visit an in-network provider.
- You can find an in-network provider by visiting enroll.eyemed.com, clicking on 'Find a Provider', entering your zip code, and choosing the network, Insight. Walmart is also an in-network provider.

Coverage Level	Premiums 24 Pay Periods	Premiums 12 Pay Periods
Employee	$3.54	$7.08
Employee + Spouse	$7.09	$14.18
Employee + Child(ren)	$6.00	$12.00
Employee + Family	$9.90	$19.80
Premiums for coverage under the Vision Care Plan are made on a pretax basis.		

- No in-network provider within 20 miles of where you live? Complete the Network Adequacy part of the out-of-network claim form, and be reimbursed as if you visited an in-network provider. If you visit an out-of-network provider for your eye exam because there are no providers within 20 miles of where you live, you will be charged the retail price at point of sale. If you were charged $100 for your eye exam, EyeMed would reimburse you $90 (because the in-network copay is $10), if you complete the Network Adequacy part of the out-of-network claim form.

Call EyeMed at 888.626.6334 to answer any benefit questions and confirm your provider options.

Service	In-Network Coverage	Out-of-Network Reimbursement	Frequency
Exam, with dilation as necessary	$10 copay	up to $45	Once every plan year
Frames[1]	$0 copay, $130 allowance, 20% off balance over $130	up to $70	Once every plan year
Lenses (in place of contact lenses)			
Single Vision	$25 copay	up to $30	Once every plan year
Bifocal	$25 copay	up to $50	Once every plan year
Trifocal	$25 copay	up to $65	Once every plan year
Lenticular	$25 copay	up to $100	Once every plan year
Standard Progressive Premium Progressive Tiers 1-3[2]	$80 copay $100-125 copay	up to $50 up to $50	Once every plan year
Standard Lens Options UV Treatment Standard Polycarbonate (under age 19) Standard Plastic Scratch Coating Tint (Solid & Gradient)	 $0 copay $0 copay $0 copay $0 copay	 up to $5 up to $5 up to $5 up to $5	 Once every plan year Once every plan year Once every plan year Once every plan year
Standard Polycarbonate (age 19 & over) Anti-Reflective Coating[3] Photochromic (Plastic)	$40 $45-$68 $75	N/A N/A N/A	Once every plan year
Standard Contact Lens Fit and Follow-Up Premium Contact Lens Fit and Follow-Up	$40 10% off retail price	N/A N/A	Contact lens fit and two follow-up visits are available every plan year (once a comprehensive eye exam has been completed)
Elective Contact Lenses (in place of eyeglass lenses	up to $130 allowance	up to $105	Once every plan year
Medically Necessary Contact Lenses (in place of eyeglass lenses)	$0 copay, covered in full	up to $210	Once every plan year
Retinal Imaging Benefit	up to $39	N/A	Once every plan year

[1]20% off the balance when patients choose a frame that exceeds the allowance. Available from all in-network providers.

[2] & [3] Discuss your lens options with your in-network provider.