Vision Cost and Coverage

Cost	
Employee only	$3.08
Employee + spouse	$6.12
Employee + child(ren)	$6.00
Employee + family	$9.12

Coverage	In Network	Out of Network Reimbursement
Exams (once per calendar year)	$10 copay	Up to $45
Lenses single vision or lined multi-focal lenses (once per calendar year)	$10 copay	Single: up to $45 Bifocal: up to $65 Trifocal: up to $85
Progressive lenses	Standard: $65 copay Premium: $95-$185 copay based on tier	Up to $65
Lens options	Polycarbonate: covered in full for children under 19 All lens options available to members at fixed pricing	Varies based on option
Frames (once per calendar year)	$0 copay $170 allowance 20% off balance over $170	Up to $65
Contact lens fit and follow up	Standard: $25 copay, paid in full (fit) and two follow up visits Premium: $25 copay, 10% off retail price + $55 allowance	Up to $40
Contacts (once per calendar year) Consult with your provider if you believe contact lenses are medically necessary	If contacts are necessary to correct your vision: $0 copay, covered in full If contacts are cosmetic: $0 copay, $170 allowance	If contacts are necessary to correct your vision: up to $210 If contacts are cosmetic: up to $136
Diabetic Care Services (up to two services per calendar year)	$0 copay, includes additional testing such as retinal imaging, extended opthalmpscopy, gonioscopy and scanning laser	Not covered
Laser vision correction	15% of the retail price or 5% off the promotional price	Not covered

Premiums are deducted on a pretax basis.

If you go out of network, you will need to pay for all services and materials in full and then submit your receipt for reimbursement.