

Check out our plan design

Feature	In-Network Co-payments and Coverage Options	Out-of-Network Reimbursement Schedule
Eye Examination	\$10 co-pay	Up to \$50
Exam Options: Standard Contact Lens Fit & Follow-Up Premium Contact Lens Fit & Follow-Up	Covered in full 10% off Retail, then apply \$40 allowance	\$40 \$40
Frame	\$0 Co-pay, \$130 Allowance, 20% off balance over \$130*	Up to \$90
Standard Plastic Lenses: Single Vision Bifocal Trifocal Lenticular Standard Progressive Premium Progressive	\$15 Co-pay \$15 Co-pay \$15 Co-pay \$15 Co-pay \$15 Co-pay \$15 Co-Pay, \$120 allowance, 20% off remaining balance	Up to \$50 Up to \$70 Up to \$100 Up to \$100 Up to \$70 Up to \$70
Contact Lenses (in lieu of eyeglass lenses): Conventional Disposable Medically Necessary	\$0 Co-pay, \$150 Allowance , 15% off balance over \$150 \$0 Co-pay, \$150 Allowance , plus balance over \$150 \$0 Co-pay, Paid-in-Full	Up to \$150 Up to \$150 Up to \$210
Frequency Exam Lenses or Contact Lenses Frame	Once every 12 months per plan year Once every 12 months per plan year Once every 24 months per plan year	