

Carrier Name	EyeMed Vision CLOSED TO NEW ENROLLMENT				Vision Service Plan	
	Plan D 12/12/24/\$20				Plan B 12/12/24/\$20 (CSVC)	
Plan Name Benefit Summary	In-Network		Out-of-Network		In-Network	Out-of-Network
	General Plan Information					
Copay						
Deductible	\$20		\$20		\$20 applies to exam and prescription glasses	\$20 applies to exam and prescription glasses
Deductible Amount Allowance	\$20		\$20		\$20	\$20
Annual Allowance Amount						
Examination	100%		Up to \$40		100%	up to \$50
Materials					100%	Allowances
Benefit Frequency						
Examination	12 months		12 months		12 months	12 months
Lenses	12 months		12 months		12 months	12 months
Frames	24 months		24 months		24 months	24 months
Contacts	12 months		12 months		12 months	12 months
Covered Services						
Lenses						
Single Vision Lens	100%		Up to \$30		100% up to 61mm	up to \$50
Bifocal Lens	100%		Up to \$50		100%	up to \$75
Lenticular	100%		Up to \$70		100% for aphakic monofocal/multifocal	up to \$125
Basic Progressive	100%		Up to \$50		100%	Up to \$75
Lens Options						
UV Coating	Up to \$15		Not covered		100%	Not covered
Tint (Solid and Gradient)	Up to \$15		Not covered		Not covered	Not covered
Scratch Resistance	Up to \$15		Not covered		Not covered	Not covered
Basic Polycarbonate	Up to \$40, 100% for anyone under 19 years of age		Up to \$20 for anyone under 19 years of age		Not covered, Covered for children	Not covered
Standard Anti-Reflective	\$45 copay		Up to \$23		All Anti-reflective coatings covered after \$35	Not covered
Other Add-Ons and Services	20% off retail price		Not covered		Average 40% discount for all other enhancements	Not covered
Contact Lenses						
Medically Necessary	100%		Up to \$300		100% (in lieu of all other eyewear; requires prior authorization)	up to \$210 (in lieu of all other eyewear)

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