

Vision Summary

SERVICE	PREFERRED PROVIDER	OUT-OF-NETWORK PLAN REIMBURSEMENT
Eye Exam (once every 12 months)	\$10 copay (Fee waived at Truhlsen Eye Institute.)	Up to \$45
Frames	\$150 allowance, 20% off balance over \$150; \$85 allowance at Costco, Walmart and Sams's Club	Up to \$70
Standard plastic lenses		
Single Vision	Covered in full after \$10 eyewear copay (Fee waived at Truhlsen Eye Institute.)	Up to \$30
Bifocal		Up to \$50
Trifocal		Up to \$65
Lenticular		Up to \$100
Standard Progressive		Up to \$50
Contact lenses (materials; in lieu of standard plastic lenses)		
Conventional	\$0 copay; \$150 allowance; balance over \$150	Up to \$105
Disposable	\$0 copay; \$150 allowance, balance over \$150	Up to \$105
Medically Necessary	Paid in full after \$10 copay	Up to \$210
Fit and follow-up for:		
Standard Contact Lenses	Balance up to \$60	Not Covered

Frequency

- Exams..... **Once every 12 months**
- Frames..... **Once every 12 months**
- Standard plastic lenses or contact lenses **Once every 12 months**

Vision Costs

2025 EMPLOYEE COSTS PER PAY PERIOD (FOR FULL- AND PART-TIME EMPLOYEES)	
Employee Only	\$4.17
Employee/Spouse	\$8.95
Employee/Child(ren)	\$9.34
Family	\$13.04

TOGETHER. EXTRAORDINARY.

