

2015-2018 VLCT Vision Plans Comparison

Agenda Item III.4

Revised 2/28/2017; pg. 1 of 1



Rates for 1/1/15 - 12/31/18		Option 5: Packaged Plan	Option 6: Voluntary Standard Plan	Option 7: Voluntary Enhanced Plan
Monthly Premiums	Single	\$4.61	\$6.74	\$9.06
	2-Person	\$8.70	\$12.75	\$17.16
	Family	\$12.76	\$18.69	\$25.17
In-Network Provider Benefits (See Access Network provider directory at www.eyemedvisioncare.com .)				
EXAMINATION		Covered in full after \$10 co-pay	Covered in full after \$10 co-pay	Covered in full after \$10 co-pay
EYEGLASSES CO-PAY		One \$20 co-pay for lenses. No co-pay for frame.	One \$25 co-pay for lenses. No co-pay for frame.	One \$25 co-pay for lenses. No co-pay for frame.
EYEGLASS LENSES	Single Vision	Covered in full	Covered in full	Covered in full
	Bifocal	Covered in full	Covered in full	Covered in full
	Trifocal	Covered in full	Covered in full	Covered in full
	Lenticular	Covered in full	Covered in full	Covered in full
	Standard Progressive	\$85	\$90	Covered in full
	Premium Progressive	\$85, 80% of charge less \$120 allowance.	\$90, 80% of charge less \$120 allowance.	\$25, 80% of charge less \$120 allowance.
EYEGLASS FRAME		\$130 retail 20% off bal. over \$130.	\$130 retail. 20% off bal. over \$130.	\$140 retail. 20% off bal. over \$140.
CONTACT LENS Fit and Follow-Up Visits (Separate from materials cost)		Up to \$55 for fitting and up to two follow-ups.	Up to \$55 for fitting and up to two follow-ups.	Up to \$55 for fitting and up to two follow-ups.
CONTACT LENSES (Materials)	Elective	First \$130 and 15% off remaining.	First \$130 and 15% off remaining.	First \$130 and 15% off remaining.
	Medically Necessary	Covered in full	Covered in full	Covered in full
LOW VISION BENEFIT	Supplemental Testing	Covered in full	Covered in full	Covered in full
	Low Vision Aids	25% co-pay to \$1,000	25% co-pay to \$1,000	25% co-pay to \$1,000
	Benefit Period	24 months	24 months	24 months
PLAN FREQUENCIES	Examination	12 months	12 months	12 months
	Lenses OR Contacts	12 months	12 months	12 months
	Frames	24 months	24 months	12 months
Out-of-Network Provider Benefits				
EXAMINATION		\$50.00	\$50.00	\$50.00
EYEGLASS LENSES	Single Vision	\$50	\$50	\$50
	Bifocal	\$70	\$70	\$70
	Trifocal	\$100	\$100	\$100
	Lenticular	\$125	\$125	\$125
	Anti-Reflective	\$5	\$5	\$5
	Polycarb	\$5	\$5	\$5
	Standard Progressive	\$125	\$125	\$125
	Premium Progressive	\$125	\$125	\$125
CONTACT LENSES (Materials)	Elective	\$130	\$130	\$130
	Medically Necessary	\$200	\$200	\$200
LOW VISION BENEFIT	Supplemental Testing	Up to \$125	Up to \$125	Up to \$125
	Low Vision Aids	25% co-pay to \$1,000	25% co-pay to \$1,000	25% co-pay to \$1,000
	Benefit Period	24 months	24 months	24 months
FRAME		\$100.00	\$100.00	\$100.00



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¹ Association Between Vision and Hearing Impairments and Their Combined Effects on Quality of Life, October 1, 2006, Vol 124, No. 10, <http://archophth.jamanetwork.com/article.aspx?articleid=418658>

² AmplifonUSA.com/hearing-loss-information

³ Health Day, U.S. News: <http://health.usnews.com/health-news/news/articles/2012/11/16/hearing-loss-tied-to-diabetes-in-study>