



**EyeMed Vision Insurance
Summary of Costs and Benefits
January 1, 2025 to December 31, 2025**

Rates Per Pay Period (20 Paydates)	
Enhanced Vision Plan	
Employee Only	\$5.27
Employee + Spouse	\$10.01
Employee + Child(ren)	\$10.54
Employee + Family	\$15.49

Plan Details	In-Network Benefits
Exam Copay and Frequency	\$10 Copay Once Every 12 Months
Lenses Copay and Frequency (In Lieu of Contacts)	
Single	\$25 Copay Once Every 12 Months
Bifocal	\$25 Copay Once Every 12 Months
Trifocal	\$25 Copay Once Every 12 Months
Progressive - Standard	\$25 Copay Once Every 12 Months
Progressive - Premium	\$25 Copay Plus 20% Retail Price Less \$120 Allowance, Once Every 12 Months
Frame Allowance and Frequency	\$150 Allowance Once Every 12 Months
Elective Contact Allowance and Frequency (In Lieu of Glasses)	
Conventional	\$150 Allowance Once Every 12 Months
Disposable	\$150 Allowance Once Every 12 Months
Medically Necessary	\$0 Copay; Paid in Full Once Every 12 Months