

# VISION PLAN PREMIUMS AND COVERAGE – 2026

YOUR SHARE OF THE PREMIUM		
	<i>per pay period</i>	<i>annual</i>
Employee	\$2.30	\$59.80
Employee + 1	\$4.38	\$113.88
Family	\$6.42	\$166.92

YOUR COST FOR NETWORK SERVICES – INSIGHT NETWORK	
Comprehensive eye exam – once every 12 months	\$10 copayment
<b>Eyeglasses – once every 12 months, except frames</b>	
Frames – once every 24 months	\$0 copayment, up to the \$130 allowance; 20% off balance over \$130
Standard plastic lenses single vision, bifocal or trifocal	\$25 copayment
<b>Additional costs for lens treatments</b>	
Standard polycarbonate lenses – adult	\$40 copayment
Standard polycarbonate lenses – child under 19	\$0 copayment
UV treatment	\$15 copayment
Tint (solid or gradient)	\$15 copayment
Standard plastic scratch coating	\$15 copayment
Standard progressive lenses (add on to bifocal)	\$25 copayment
<b>Contact lenses in lieu of eyeglass lenses – once every 12 months</b>	
Conventional	\$0 copayment, up to the \$130 allowance; 15% off balance over \$130
Disposable	\$0 copayment, up to the \$130 allowance
Medically necessary	\$0 copayment; paid in full by the plan
<b>Additional service discounts</b>	
Laser vision correction	15% off retail price or 5% off promotional price through U.S. Laser Network
Hearing care	40% off hearing exams through Amplifon Hearing Network

