VOLUNTARY VISION

EyeMed Vision | Insight Network

Services	12/12 Plan	12/24 Plan
Eye Exam Frequency	**Once every 12 Months**	**Once every 12 Months**
Eye Exam Copay	**$10**	**$10**
Eyeglass Lens Frequency	**Once every 12 Months**	**Once every 12 Months**
Eyeglass Lens Copay	**$25 Additional charge for Progressive**	**$25 Additional charge for Progressive**
Eyeglass Frame Frequency	**Once every 12 Months**	**Once every 24 Months**
Eyeglass Frame Allowance	**$180-20% off balance over the $180**	**$150-20% off balance over the $150**
Eyeglass Frame Copay	**$0**	**$0**
Contact Lens Frequency	**Once every 12 Months**	**Once every 12 Months**
Contact Lens Allowance	**$180**	**$150**
Contact Lens Copay	**$0 – 15% off balance over the $180**	**$0 – 15% off balance over the $150**
Network	**EyeMed**	**EyeMed**
Employee Only:	$9.62	$6.30
Employee + Spouse:	$18.28	$11.97
Employee + Child(ren):	$19.24	$12.60
Employee + Family:	$28.28	$18.52

Minimum of 2 employees to offer. Disclaimer: The rates noted on this page may be subject to change. For more information on the plan including OON benefits, please contact sales.quotes@siho.org.