

VISION INSURANCE



Vision Care Services		
	In-Network	Out-of-Network
Routine Eye Exam Once every 12 months	\$10 / \$15	N/A
Eyeglass Frames Once every 24 months	\$50 Wholesale frame allowance	\$59 retail allowance
Eyeglass Lenses Once every 12 months		
Single	100% after copay	\$26 allowance
Bifocal	100% after copay	\$40 allowance
Trifocal	100% after copay	\$60 allowance
Contact Lenses		
Elective (conventional and disposable)	\$150 allowance	\$150 allowance
Medically Necessary	100%	\$300 allowance
Frequency (based on date of service)		
Examinations	Once every 12 months	Once every 12 months
Lenses or Contact Lenses	Once every 12 months	Once every 12 months
Frames	Once every 24 months	Once every 24 months
*Please note when seeing an Out-of-Network physician you will need to pay in full at the time of service and obtain an itemized receipt, and file a claim for reimbursement.		

Your Bi-Weekly Premium (24 per year)	
Employee	\$ 3.96
Employee + Spouse	\$ 7.92
Employee + Child(ren)	\$ 7.52
Family	\$11.82

To locate a network provider in your area go to:
www.humanavision.com