2025 EMPLOYEE BENEFITS

VISION BENEFITS

The vision plan provides coverage for exam services, frames, lenses, and contacts. Your coverage under the vision plan depends on the services you plan to utilize. Below provides an overview of plan benefits. Please refer to the Summary Plan Description for additional information.

Plan Provision	In-Network PLUS Providers	In-Network	Out-of-Network*
EXAMS			
– Annual Eye Exam	$0 copay	$10 copay	Up to $30
– Retinal Imaging	Up to $39	Up to $39	Not covered
FRAMES	20% off balance over	20% off balance over	Up to $75
– Frame Allowance	$200 allowance	$150 allowance	
STANDARD PLASTIC LENSES (*in lieu of contacts*)			
– Single Vision	$25 copay		Up to $25
– Bifocal	$25 copay		Up to $40
– Trifocal/Lenticular	$25 copay		Up to $55
– Progressive – Standard	$25 copay		Up to $55
– Progressive – Premium Tier I, II, or III	$45 - $70 copay		Up to $55
– Progressive – Premium Tier IV	$25 copay; 20% off retail price less $120 allowance		Up to $55
LENS OPTIONS			
– Polycarbonate – Standard <19 years of age	$0 copay		Up to $5
– Polycarbonate – Standard >19 years of age	$40 copay		Not covered
– Scratch Coating – Standard Plastic	$0 copay		Up to $5
– Anti-Reflective Coating – Standard	$45 copay		Not covered
– Anti-Reflective Coating – Premium Tier I	$57 copay		Not covered
– Anti-Reflective Coating – Premium Tier II	$68 copay		Not covered
– Anti-Reflective Coating – Premium Tier III	20% off retail price		Not covered
– Photochromic – Non-Glass	$75 copay		Not covered
– Tint – Solid or Gradient	$15 copay		Not covered
– UV Treatment	$15 copay		Not covered
– All Other Lens Options	20% off retail price		Not covered
CONTACT LENSES			
– Fit & Follow-Up – Standard	Up to $40		Not covered
– Fit & Follow-Up - Premium	10% off retail price		Not covered
– Conventional	15% off balance over $150 allowance		Up to $120
– Disposable	$150 allowance		Up to $120
– Medically Necessary	$0 copay; paid-in-full		Up to $200
FREQUENCIES			
– Exams	Once Every Calendar Year		
– Frames	Once Every Calendar Year		
– Lenses	Once Every Calendar Year		
– Contacts	Once Every Calendar Year		
OTHER			
– Hearing Care from Amplifon Network	Up to 64% off hearing aids; call 1.877.203.0675		Not covered
– LASIK or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221		Not covered

**Out-of-Network benefit shown represents maximum reimbursement amount available. Member will be responsible for out-of-pocket cost & can submit for reimbursement by Eyemed.*

MONTHLY VISION COVERAGE COST

	Full-Time	Part-Time
Employee Only	$9.90	$9.90
Employee + 1	$18.80	$18.80
Family	$27.63	$27.63

EyeMed Website:
member.eyemedvisioncare.com/member/en
Network: Insight Network

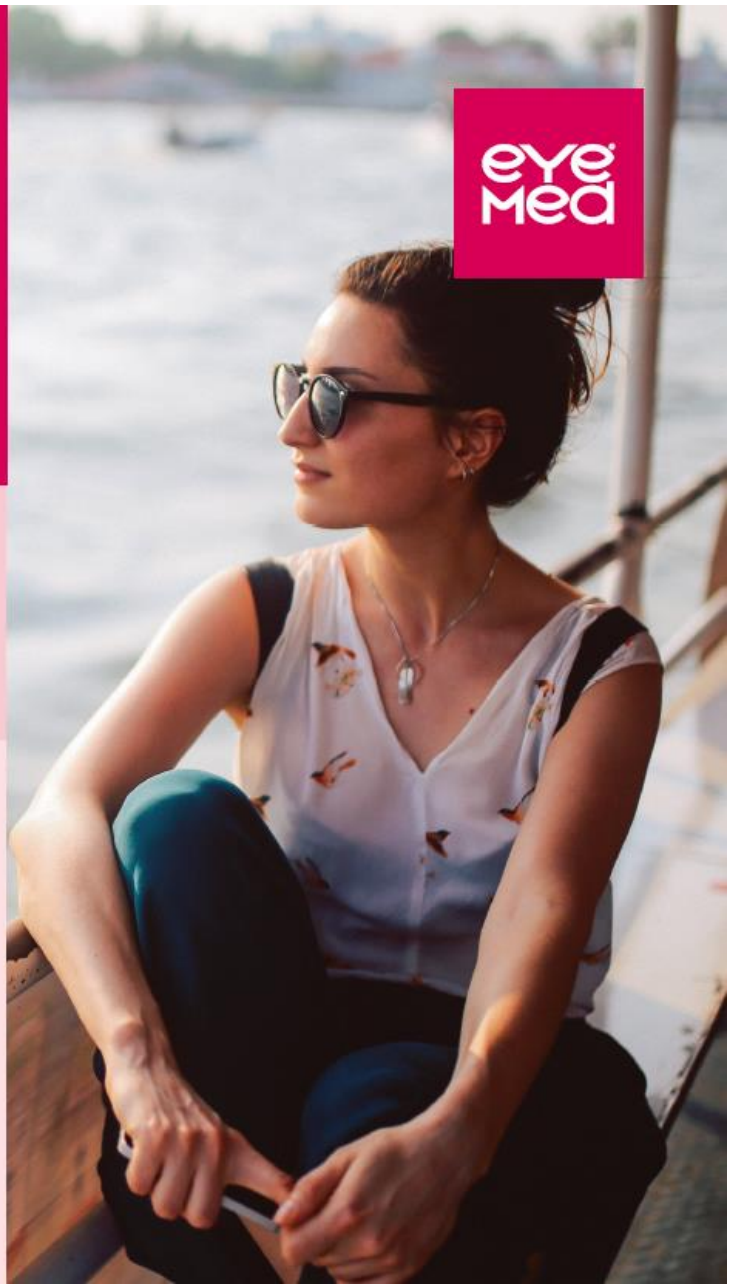
METHODIST

Savings plus convenience plus choice

PLUS Providers add another layer of coverage

$0
Exam copay

$200
Frame allowance



Staying in-network helps you save money on eye exams, frames and lenses. Visiting a PLUS Provider is designed to help you save even more.

And since PLUS Providers are already in our network, the additional perks are built right into your vision benefits. No promo codes, no coupons, no paperwork. The same vision benefits, plus a little more savings.

The choice is yours

Find plenty of in-network eye doctors – including PLUS Providers – on our Provider Locator. Just look for the PLUS.

Need extra assistance? Contact us at 866.804.0982 or visit eyemed.com.

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION OPTICAL