

VISION PLANS WITH EYE EXAM

Underwritten by Opticare of Utah, Inc.

UTAH

	10-160B		10-130B		10-100B		
	In Network	Out-of-Network	In Network	Out-of-Network	In Network	Out-of-Network	
Eye Exam							
Eyeglass exam	\$10 Co-pay	◆ \$40 Allowance	\$10 Co-pay	◆ \$40 Allowance	\$10 Co-pay	◆ \$40 Allowance	
Contact exam	\$10 Co-pay	◆ \$40 Allowance	\$10 Co-pay	◆ \$40 Allowance	\$10 Co-pay	◆ \$40 Allowance	
Dilation	Retail	Included above	Retail	Included above	Retail	Included above	
Contact fitting	Retail	Included above	Retail	Included above	Retail	Included above	
Lenses							
Single vision	\$10 Co-pay	◆ \$95 Allowance for lenses, options, and coatings	\$10 Co-pay	◆ \$85 Allowance for lenses, options, and coatings	\$10 Co-pay	◆ \$80 Allowance for lenses, options, and coatings	
Bifocal (FT 28)	\$10 Co-pay		\$10 Co-pay		\$10 Co-pay		
Trifocal (FT 7*28)	\$10 Co-pay		\$10 Co-pay		\$10 Co-pay		
Lens Options							
*Progressive (Standard no-line)	\$50 Co-pay		\$50 Co-pay		\$50 Co-pay		
*Premium Progressive Options	No Discount		No Discount		No Discount		
Glass Lenses	15% Discount		15% Discount		15% Discount		
Polycarbonate	25% Discount		25% Discount		25% Discount		
High Index	25% Discount		25% Discount		25% Discount		
Coatings							
Scratch Resistant Coating	\$10 Co-pay	\$10 Co-pay	\$10 Co-pay				
Ultra Violet protection	\$10 Co-pay	\$10 Co-pay	\$10 Co-pay				
Other Options A/R, edge polish, tints, mirrors, etc.	Up to 25% Discount	Up to 25% Discount	Up to 25% Discount				
Frames							
Allowance Based on Retail Pricing	\$160 Allowance	◆ \$90 Allowance	\$130 Allowance	◆ \$90 Allowance	\$100 Allowance	◆ \$70 Allowance	
**Additional Pairs of Glasses Throughout the Year	Up to 50% Off Retail		Up to 50% Off Retail		Up to 50% Off Retail		
Contacts							
Contact benefits is in lieu Of lens and frame benefit.	\$160 Allowance	◆ \$125 Allowance	\$130 Allowance	◆ \$90 Allowance	\$100 Allowance	◆ \$70 Allowance	
Additional contact purchases: *** Conventional *** Disposables	Retail Retail		Retail Retail		Retail Retail		
Frequency							
Lenses, Frames, Contacts	Every 12 months	Every 12 months	Every 12 months	Every 12 months	Every 12 months	Every 12 months	
Refractive Surgery							
****LASIK	\$250 Off Per Eye	Not covered	\$250 Off Per Eye	Not covered	\$250 Off Per Eye	Not covered	
	CONTRIBUTORY	VOLUNTARY	CONTRIBUTORY	VOLUNTARY	CONTRIBUTORY	VOLUNTARY	
Single	\$7.80	\$11.50	\$6.20	\$9.20	\$5.30	\$7.80	
2 party	\$15.20	\$22.40	\$12.20	\$17.90	\$10.40	\$15.20	
Family	\$24.20	\$35.50	\$19.40	\$28.50	\$16.50	\$24.20	

Discounts

Any item listed as a discount in the benefit outline above is a merchandise discount only and not an insured benefit. Providers may offer additional discounts.

* Co-pays for Progressive lenses may vary. This is a summary of plan benefits. The actual Policy will detail all plan limitations and exclusions.

** 50% discount at Standard Optical locations Only. All other Network discounts vary from 20% - 35%.

*** Must purchase full year supply to receive discounts on select brands. See provider for details.

**** LASIK (Refractive surgery) Standard Optical Locations ONLY.

LASIK services are not an insured benefit - this is a discount only. All pre & post operative care is provided by Standard Optical Only and is based on Standard Optical retail fees.

◆ Out of Network - Allowances are reimbursed at 75% when discounts are applied to merchandise. Promotional items or Online purchases not covered.

emihealth.com

852 EAST ARROWHEAD LANE, MURRAY, UTAH 84107
TOLL FREE 800 662 5850 CORPORATE 801 262 7476
FAX 801 270 3016



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Single	\$5.10	\$7.50	\$4.10	\$6.00	\$3.50	\$5.10
2 party	\$9.90	\$14.50	\$7.90	\$11.60	\$6.70	\$9.90
Family	\$15.70	\$23.10	\$12.60	\$18.50	\$10.70	\$15.70

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