All Savers Vision Plan Offerings 2020

Plan #	Contribution	Exam/Lenses/Frames (months)	Copay	Frame Allowance	Contact Lens Allowance
V1012	Employee Core/Vol Dependents	12/12/24	$10/$25	$130	$105
V1010	Employee Core/Vol Dependents	12/12/12	$10/$25	$130	$105
V1043	Vol	12/12/24	$15/$30	$130	$105
V1008	Vol	12/12/24	$10/$25	$130	$105
V1006	Vol	12/12/12	$10/$25	$130	$105

Employee Core/Voluntary Dependents means Employee coverage = ER paid.
Dependent coverage = Voluntary (no employer contribution for the dependent coverage).

Out-of-Network Reimbursement for All Plans Above:	
Eye Exam	Up to $40
Eyeglass Lenses	
Single Vision	Up to $40
Bifocal	Up to $60
Trifocal	Up to $80
Lenticular	Up to $80
Frames	Up to $45
Elective Contact Lenses	
Covered Contact Lens Selection	Up to $105
All Other Elective Contacts	Up to $105
Medically Necessary Contact Lenses	Up to $210

Employee Participation Requirements for Employee Core/Vol Dependents plans (Vol plans do not have participation requirements): At least 75 percent participation of eligible employees less valid waivers, not to fall below 50 percent of total eligible employees.

Minimum number of eligible is 5 for all Vision plans.