Select Health

See clearly with vision hardware coverage from EyeMed Vision Care.

Large Employer Eyewear Plans

Choose an eyewear plan and access:

- Over 260 Utah locations, over 130 in Idaho, more than 260 in Nevada, and 29,500 nationwide.
- Private practitioners and leading retailers such as LensCrafters®, Target Optical®, and Pearle Vision®
- Exceptional customer service, available Monday to Saturday, from 6:00 a.m. to 9:00 p.m., and Sundays, from 9:00 a.m. to 6:00 p.m. MST.

Visit **eyedoclocator.eyemedvisioncare.com/selecthealth/en** and select the **Access network.**

Additional discounts

You receive a 20% discount through network providers on items not covered by the plan. This discount cannot be combined with any other discounts or promotional offers. The discount does not apply to EyeMed providers' professional services or contact lenses.

STANDARD PLANS - CHOOSE A PLAN		
PLAN A	**PLAN B**	**PLAN C**
MEMBER COST	**MEMBER COST**	**MEMBER COST**
FRAMES: Covered once every 24 months. Any available frame at provider location		
$0 copay, $100 allowance, 20% off balance over $100 Out-of-Network: $50 allowance	$0 copay, $150 allowance, 20% off balance over $150 Out-of-Network: $75 allowance	$0 copay, $200 allowance, 20% off balance over $200 Out-of-Network: $100 allowance
STANDARD PLASTIC LENSES: Covered once every 12 months. Note: Either eyeglass lenses or contact lenses are covered once every 12 months, not both. Single, Bifocal, Trifocal (Progressive lenses available at higher cost-sharing)		
$10 copay Out-of-Network: $25 allowance	$20 copay Out-of-Network: $25 allowance	$25 copay Out-of-Network: $25 allowance
CONTACT LENSES: Covered once every 12 months. Includes materials only, fitting and follow-up not covered. Lenses May be conventional or disposable lenses. Note: Either eyeglass lenses or contact lenses are covered once every 12 months, not both.		
$115 allowance, 15% off balance over $115 for conventional lenses Out-of-Network: $92 allowance	$150 allowance, 15% off balance over $150 for conventional lenses Out-of-Network: $120 allowance	$200 allowance, 15% off balance over $200 for conventional lenses Out-of-Network: $160 allowance

ALLOWANCE PLANS

PLAN D	PLAN E
MEMBER COST	**MEMBER COST**
FRAMES AND LENSES: Covered once every 12 months. Frame and lens benefit may not be used in the same year as the contact lens benefit. Any available frame at provider location.	
$200 allowance for frames, lenses, and lens options, 20% off balance over $200 Out-of-Network: $100 allowance	$300 allowance for frames, lenses, and lens options, 20% off balance over $300 Out-of-Network: $150 allowance
CONTACT LENSES: Covered once every 12 months. Includes materials only; fitting and follow up are not covered. Contact lens benefit may not be used in the same year as the frame and lens benefit. Conventional or disposable.	
$200 allowance 15% off balance over $200 for conventional lenses Out-of-Network: $160 allowance	$300 allowance 15% off balance over $300 for conventional lenses Out-of-Network: $240 allowance

STANDARD PLANS - CHOOSE A PLAN

PLAN F	PLAN G	PLAN H
MEMBER COST	**MEMBER COST**	**MEMBER COST**
	Eye Exam Included $0 copay once every 12 months	$200 allowance In-Network or Out-of- Network
FRAMES Covered once every 24 months. Any available frame at provider location.		
$0 Copay; $250 allowance, 20% off balance over $250 Out-of-Network: $125 allowance	$0 Copay; $250 allowance, 20% off balance over $250 Out-of-Network: $125 allowance	$0 Copay; $200 allowance, 20% off balance over $200 Out-of-Network: $200 allowance
STANDARD PLASTIC LENSES Covered once every 12 months. Note: Either eyeglass lenses or contact lenses are covered once every 12 months, not both. Single, Bifocal, Trifocal (Progressive lenses available at higher cost-sharing)		
$25 copay Out-of-Network: $25 allowance	$25 copay Out-of-Network: $25 allowance	$25 copay Out-of-Network: $25 allowance
CONTACT LENSES Covered once every 12 months. Includes materials only, fitting and follow-up not covered. Lenses May be conventional or disposable lenses. Note: Either eyeglass lenses or contact lenses are covered once every 12 months, not both.		
$250 allowance, 15% off balance over $250 for conventional lenses Out-of-Network: $125 allowance	$250 allowance, 15% off balance over $250 for conventional lenses Out-of-Network: $125 allowance	$200 allowance, 15% off balance over $200 for conventional lenses Out-of-Network: $200 allowance

PRICING	PLAN A	PLAN B	PLAN C	PLAN D	PLAN E	PLAN F	PLAN G	PLAN H
Contributory								
Single	$4.10	$4.50	$5.30	$6.10	$8.40	$6.00	$7.60	$5.50
Two-Party	$7.80	$8.60	$10.10	$11.60	$16.00	$11.40	$14.50	$10.50
Family	$15.30	$16.70	$19.70	$22.70	$31.20	$22.30	$28.20	$20.50
Voluntary								
Single	$5.40	$6.10	$7.20	$8.30	$11.70	$7.80	$9.90	$7.30
Two-Party	$10.30	$11.60	$13.70	$15.80	$22.30	$14.90	$18.90	$13.90
Family	$20.10	$22.70	$26.80	$30.80	$43.50	$29.00	$36.80	$27.10

*Select Health Eyewear is underwritten by Select Health and administered by EyeMed Vision Care.

Select Health obeys federal civil rights laws. We do not treat you differently because of your race, color, ethnic background or where you come from, age, disability, sex, religion, creed, language, social class, sexual orientation, gender identity or expression, and/or veteran status. This information is available for free in other languages and alternate formats by contacting Select Health Medicare: **855-442-9900** (TTY: 711) / Select Health: **800-538-5038**.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電