Bloomington School District 271

More, for less...

40% OFF
Complete pair of prescription eyeglasses

20% OFF
Non-prescription sunglasses

20% OFF
Remaining balance beyond plan coverage

These discounts are for in-network providers only

Hello, Neighbor

- You're on the SELECT Network
- For a complete list of providers near you, use our Provider Locator on www.eyemed.com and choose the SELECT network or call 1-866-299-1358.
- For Lasik providers, call 1-877-5LASER6 or visit eyemedlasik.com.

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam With Dilation as Necessary	$10 Copay	Up to $35
Contact Lens Fit and Follow-Up (Contact lens fit and two follow up visits are available once a comprehensive eye exam has been completed)		
Standard Contact Lens Fit & Follow-Up	Up to $40	N/A
Premium Contact Lens Fit & Follow-Up	10% off retail	N/A
Frames	$0 Copay; $120 allowance; 80% of charge over $120	Up to $50
Standard Plastic Lenses		
Single Vision	$10 Copay	Up to $25
Bifocal	$10 Copay	Up to $40
Trifocal	$10 Copay	Up to $50
Standard Progressive Lens	$10 Copay	Up to $40
Premium Progressive Lens	$10, 80% of charge less $120 Allowance	Up to $40
Lenticular	$10 Copay	Up to $50
Lens Options (paid by the member and added to the base price of the lens)		
UV Treatment	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Plastic Scratch Coating	$0	Up to $5
Standard Polycarbonate	$40	N/A
Standard Polycarbonate - Kids under 19	$40	N/A
Standard Anti-Reflective Coating	$45	N/A
Polarized	20% off retail price	N/A
Other Add-Ons and Services	20% off retail price	N/A
Contact Lenses		
Conventional	$0 Copay; $120 allowance; 15% off retail price over $120	Up to $100
Disposable	$0 Copay; $120 allowance; plus balance over $120	Up to $100
Medically Necessary	$0 Copay, Paid in Full	Up to $210
Laser Vision Correction		
Lasik or PRK from U.S. Laser Network	15% off the retail price or 5% off the promotional price	N/A
Frequency		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 12 months	

	Monthly Premium	Per Paycheck
Single	$ 6.42	$ 3.21
Single + spouse	$12.86	$ 6.43
Single + children	$13.60	$ 6.80
Family	$21.34	$10.67