MediExcel HEALTH PLAN

VISION PLANS

SUMMARY OF BENEFITS & COVERAGE

In-Network Provider		
	Included in Small Group Plans	Better Value
Benefit	**Pediatric Vision***	**V100**
Eye Exam	**$0 Copay** every 12 months	**$0 Copay** every 12 months
Frame	**$30 allowance** Member pays any amount over allowance, every 24 months.	**$100 allowance** Member pays any amount over allowance, every 24 months.
Standard Lenses	**$0 Copay** Up to 61 mm, single and bifocal.	**$0 Copay** Up to 61 mm, single and bifocal.
Lens Coatings	**$0 Copay** Pink or Rose Tints #1 or #2.	**$0 Copay** Pink or Rose Tints #1 or #2.
Elective/Convenience Contact Lenses	**Not Covered**	**$100 allowance** Member pays any amount over allowance, every 12 months, fit and follow-up additional cost.
LASIK	**Not Covered**	**$900 per eye** 6 month no refraction change Age 20-50 Moderate nearsightedness (-2.25/-5.00 refraction)

Out-of-Network Provider - Not Covered

V100 PLAN UNDERWRITING:

- Requires a minimum of 1 enrolled employee.
- Can be offered as a voluntary plan.
- Group must have active MediExcel Health Plan medical coverage to be eligible for vision coverage.
- Subscribing member must be actively enrolled in MediExcel Health Plan medical coverage.

LIMITATIONS:

- Repeat, follow-up procedures, or refinements are not covered.
- Contact lenses and contact lens fitting, except as specifically provided. In lieu of frames and lenses.
- Eyewear when there is no prescription change, except when benefits are available.
- Lenses or frames which are lost, stolen or broken will not be replaced, except when benefits are available.
- Custom lenses (non-standard) such as no-line, (blended type) progressive, polycarbonate, beveled, faceted, coated or oversize exceeding the Schedule of Allowance.
- Tints, other than pink or rose #1 or #2 except as specifically provided.
- LASIK procedure is only covered at IDOC inside Excel Hospital in Tijuana. In lieu of frame allowance/standard lens and contact lens benefit.

EXCLUSIONS:

- Medical or surgical treatment of the eyes.
- Non-prescription (plano) eyewear.
- Orthoptics, vision training, subnormal or low vision aides.
- Services that are experimental or investigational in nature.

**Included with 2025 Small Group Health Plans Only.*
Please refer to the Plan specific Benefit Summary, along with the Evidence of Coverage for all limitations and exclusions.