ALL ABOUT VISION

Vision Plan Coverage Worksheet

Items and Services Desired	Vision plan 1: _____ (name)		Vision plan 2: _____ (name)		Vision plan 3: _____ (name)	
	Is the Item or Service Covered by the Plan?	Frequency Covered by Plan	Is the Item or Service Covered by the Plan?	Frequency Covered by Plan	Is the Item or Service Covered by the Plan?	Frequency Covered by Plan
Eye exam, including dilation Frequency desired: Every ___ months	Y N	Every ___ months	Y N	Every ___ months	Y N	Every ___ months
Eyeglass frames Frequency desired: Every ___ months	Y N	Every ___ months	Y N	Every ___ months	Y N	Every ___ months
Eyeglass lenses Frequency desired: Every ___ months	Y N	Every ___ months	Y N	Every ___ months	Y N	Every ___ months
Contact lenses Frequency desired: Every ___ months	Y N In lieu of frame and lenses? Y N	Every ___ months	Y N In lieu of frame and lenses? Y N	Every ___ months	Y N In lieu of frame and lenses? Y N	Every ___ months
LASIK/PRK	Y N		Y N		Y N	
Other items covered						
Other notes and considerations						

ALL ABOUT VISION

Vision Plan Coverage Worksheet – SAMPLE

Items and Services Desired	Vision plan 1: XYZ Eyecare Plan		Vision plan 2: EyeInsure Plan		Vision plan 3: PostModern Eye Plan	
	Is the Item or Service Covered by the Plan?	Frequency Covered by Plan	Is the Item or Service Covered by the Plan?	Frequency Covered by Plan	Is the Item or Service Covered by the Plan?	Frequency Covered by Plan
Eye exam, including dilation Frequency desired: Every **12** months	(Y) N	Every **12** months	(Y) N	Every **24** months	(Y) N	Every **12** months
Eyeglass frames Frequency desired: Every **12** months	(Y) N	Every **12** months	(Y) N	Every **12** months	(Y) N	Every **24** months
Eyeglass lenses Frequency desired: Every **12** months	(Y) N	Every **12** months	(Y) N	Every **12** months	(Y) N	Every **24** months
Contact lenses Frequency desired: Every **12** months	(Y) N In lieu of frame and lenses? (Y) N	Every **12** months	(Y) N In lieu of frame and lenses? Y (N)	Every **12** months	(Y) N In lieu of frame and lenses? (Y) N	Every **12** months
LASIK/PRK	(Y) N	**once**	(Y) N	**once***	Y (N)	**--**
Other items covered	**Includes free contact lens solutions.**	**as needed**	**--**	**--**	**--**	**--**
Other notes and considerations	**Contact lenses limited to replacement every two weeks or less often. Eye exam requires $10 copay. LASIK/PRK is 15% discount off retail price or 5% off promotional price.**		**Daily disposable contacts covered. Multifocal eyeglass lenses not covered – just single vision. *LASIK/PRK includes one touchup surgery if nec. LASIK/PRK covered to $3,000.**		**Frames are fully covered if you choose from a special collection. Only 35% covered if you choose one of the other frames on the board. But multifocal lenses fully covered.**	