

Vision

Employees have the option to elect vision benefits for themselves and dependents, through Aetna Vision.

- The County of El Paso provides the option to enroll in Vision coverage provided by Aetna
- In-Network, annual exam is covered at 100%.
- Employees can use their FSA and HSA to purchase glasses and contacts.

Summary of Benefits for County of El Paso		
	In Network	Out of Network*
Exam		
Use your Exam Coverage once every Calendar Year		
Eye Exam with Dilation as Necessary	\$0 Copay	\$30 Reimbursement
Retinal Imaging	Member pays discounted fee of \$39	Not Covered
Standard Contact Lens Fit /Follow Up ¹	Member pays discounted fee of \$40	Not Covered
Premium Contact Lens Fit /Follow Up	Member pays 90% of retail	Not Covered
Frames		
Use your Frame Coverage once every Calendar Year		
Any Frame available, including frames for prescription sunglasses	\$0 Copay; \$100 Allowance**, 20% off balance over allowance	\$70 Reimbursement
Standard Plastic Lenses		
Use your Lens/Lens Option Coverage once every Calendar Year to purchase 1 pair of eyeglass lenses OR 1 order of contact lenses		
Single Vision	\$0 Copay	\$25 Reimbursement
Bifocal	\$0 Copay	\$35 Reimbursement
Trifocal	\$0 Copay	\$45 Reimbursement
Lenticular	\$0 Copay	\$80 Reimbursement
Standard Progressive Lens	\$65 Copay	\$35 Reimbursement
Premium Progressive Lens ²	\$65 Copay; 80% of Charge less \$120 allowance**	\$35 Reimbursement
Lens Options		
UV Treatment	Member pays discounted fee of \$15	Not Covered
Tint (Solid And Gradient)	Member pays discounted fee of \$15	Not Covered
Standard Plastic Scratch Coating	Member pays discounted fee of \$15	Not Covered
Polycarbonate Lenses - Adult	Member pays discounted fee of \$40	Not Covered
Polycarbonate Lenses - Children to age 19	\$0 Copay	\$7 Reimbursement
Standard Anti-Reflective Coating	Member pays discounted fee of \$45	Not Covered
Photochromic/Transitions Plastic - Adult	20% off Retail	Not Covered
Photochromic/Transitions Plastic - Child to age 19	20% off Retail	Not Covered
Other Add-Ons	20% off Retail Price	Not Covered
Contact Lenses		
Use your Contact Lens Coverage once every Calendar Year to purchase 1 pair of eyeglass lenses OR 1 order of contact lenses		
Conventional	\$0 Copay; \$135 Allowance**, 15% off balance over allowance	\$100 Reimbursement
Disposable	\$0 Copay; \$135 Allowance	\$100 Reimbursement
Medically Necessary	Covered in Full	\$200 Reimbursement
In Network Discounts		
Discounts cannot be combined with any other discounts or promotional offers and may not be available on all brands		
Additional pairs of eyeglasses or prescription sunglasses ³	Up to a 40% discount	
Non-covered Items ⁴	20% discount	
Lasik Laser vision correction or PRK from U.S. Laser Network ⁵ only. Call 1-800-422-6600	15% discount off retail or 5% discount off promotional price	

Plan Name	Employee Only	Employee +1	Employee & Family
Vision	\$3.00	\$4.80	\$7.80