

STANDARD VISION COVERAGE



EYE EXAM

Once Every **12** Months

\$10 Co-Pay for WellVision Eye Exam

\$39 Co-Pay for Digital Retinal Scan

MATERIALS

Once Every **12** Months

\$25 Deductible

LENSES

Once Every **12** Months

Free After **Deductible** for Single Vision

Free After **Deductible** for Lined Bi-Focals

Free After **Deductible** for Lined Tri-Focals

Free After **Deductible** for Standard Progressives (No-Lines)

\$80-\$90 Co-Pay for Premium Progressives (No-Lines)

\$120-\$160 Co-Pay for Custom Progressives (No-Lines)

40% Average **Discount** for High Index Lenses

40% Average **Discount** for Polarized Lenses

40% Average **Discount** for Impact-Resistant Lenses

LENS CUSTOMIZATIONS

Free for Polycarbonates for Children

40% Average **Discount** for Polycarbonates for Adults

40% Average **Discount** for Transitional (Photochromic)

40% Average **Discount** for Tinting

40% Average **Discount** for Scratch-Resistant Coating

40% Average **Discount** for Anti-Reflective Coating

40% Average **Discount** for UV Coating

40% Average **Discount** for Other Lens Customizations

FRAMES

Once Every **24** Months

\$120 Allowance or

\$140 Allowance for Featured Brands

20% Discount for Coverage After Allowance



MONTHLY RATES

\$ **6.28** Member

\$ **5.82** Child

\$ **5.82** Children

\$ **5.50** Spouse

\$ **14.92** Spouse & Child

\$ **14.92** Spouse & Children



LEARN MORE

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2025-2026 PLAN YEAR
JULY 1, 2025 TO JUNE 30, 2026



OPEH&W Health Plan
Making Healthy Cheaper

EXTRA SAVINGS

20% Discount for Additional Pair of Glasses

20% Discount for Additional Pair of Sunglasses

20% Discount for Blue-Light Filtering Glasses

CONTACT LENSES (Instead of Lenses and/or Frames)

Once Every **12** Months

\$120 Allowance

Free After **Deductible** for Medically Necessary Contacts

15% Discount for Fitting & Evaluation Exam

LASER VISION SURGERY

Discounted

ESSENTIAL MEDICAL EYE CARE

\$20 Co-Pay

HEARING

Once Every **12** Months

Up to **60% Discount** for TruHearing Digital Hearing Aids

Free Online Hearing Test

\$39 for **120** Hearing Aid Batteries

OUT-OF-NETWORK COVERAGE

Up to **\$150** Reimbursement for Eye Exam

Up to **\$170** Reimbursement for Frames

Up to **\$150** Reimbursement for Single Vision Lenses

Up to **\$175** Reimbursement for Bifocal Lenses

Up to **\$100** Reimbursement for Trifocal Lenses

Up to **\$175** Reimbursement for Progressive Lenses

Up to **\$125** Reimbursement for Lenticular Lenses

Up to **\$105** Reimbursement for Contacts

Up to **\$210** Reimbursement for Medically Necessary Contacts

Visit www.vsp.com or call **800.877.7195** for information about vision coverage and exclusive savings and promotions from VSP.

Coverage with a participating retail chain may be different. Once your benefit is effective, visit www.vsp.com for details. Based on applicable laws, benefits may vary by location. Savings based on network doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Available only through VSP network doctors to VSP members with applicable plan benefits. Ask your VSP network doctor for details. VSP, VSP Vision care for life, and WellVision Exam are registered trademarks, and "Life is better in focus." is a trademark of Vision Service Plan.