



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						



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	<input type="radio"/> Y <input type="radio"/> N	Every 12 months	<input type="radio"/> Y <input type="radio"/> N	Every 24 months	<input type="radio"/> Y <input type="radio"/> N	Every 12 months
Eyeglass frames Frequency desired: Every 12 months	<input type="radio"/> Y <input type="radio"/> N	Every 12 months	<input type="radio"/> Y <input type="radio"/> N	Every 12 months	<input type="radio"/> Y <input type="radio"/> N	Every 24 months
Eyeglass lenses Frequency desired: Every 12 months	<input type="radio"/> Y <input type="radio"/> N	Every 12 months	<input type="radio"/> Y <input type="radio"/> N	Every 12 months	<input type="radio"/> Y <input type="radio"/> N	Every 24 months
Contact lenses Frequency desired: Every 12 months	<input type="radio"/> Y <input type="radio"/> N In lieu of frame and lenses? <input type="radio"/> Y <input type="radio"/> N	Every 12 months	<input type="radio"/> Y <input type="radio"/> N In lieu of frame and lenses? Y <input type="radio"/> N	Every 12 months	<input type="radio"/> Y <input type="radio"/> N In lieu of frame and lenses? <input type="radio"/> Y <input type="radio"/> N	Every 12 months
LASIK/PRK	<input type="radio"/> Y <input type="radio"/> N	once	<input type="radio"/> Y <input type="radio"/> N	once*	Y <input type="radio"/> 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.	