



Vision Covered Services

Roman Catholic Diocese of Owensboro

Group Number: 061523092ARO

Policy Effective Date: 1/1/2026

\$10/\$25 - \$150 12/12/24

This document provides a general overview of the covered vision services included in the policy. For a complete and official summary of benefits, benefit provisions, exclusions, and limitations, please refer to the plan booklet and certificate of coverage. These documents will be made available at www.insuringsmiles.com following policy onboarding by HRI, on or around the group effective date of 1/1/2026.

VISION SERVICES & MATERIALS

EXAMS	once every plan year	IN-NETWORK - Member Cost	OUT-OF-NETWORK - Reimbursement
-------	----------------------	--------------------------	--------------------------------

Comprehensive eye examination		\$10 Copay	\$40
-------------------------------	--	------------	------

FRAMES	once every two plan years	IN-NETWORK - Member Cost	OUT-OF-NETWORK - Reimbursement
--------	---------------------------	--------------------------	--------------------------------

\$150 Allowance		\$0 Copay	\$66
-----------------	--	-----------	------

Allowance is on any available frame at provider location. Also included is 20% off balance over the \$150 allowance.

LENSES	once every plan year	IN-NETWORK - Member Cost	OUT-OF-NETWORK - Reimbursement
--------	----------------------	--------------------------	--------------------------------

Single BiFocal TriFocal Lenticular		\$25 Copay all	\$40 \$60 \$80 \$80
Progressive Std:		\$90 Copay	\$60 All Tiers
Progressive Prem: Tiers 1 2 3 4*		\$110 \$120 \$135 \$90* Copay	\$60 All Tiers

*20% off charge less \$120 allowance on Tier 4

CONTACTS*	once every plan year	IN-NETWORK - Member Cost	OUT-OF-NETWORK - Reimbursement
-----------	----------------------	--------------------------	--------------------------------

\$150 Allowance - Conventional		\$0 Copay	\$120
\$150 Allowance - Disposable		\$0 Copay	\$120
Fit and Follow-up Visit - Standard		\$40 MOOP	N/A
Fit and Follow-up Visit - Premium		10% off Retail	N/A
Contacts - Medically Necessary		\$0 Copay	\$210

*Contacts benefit in lieu of lenses

ADDITIONAL BENEFITS	IN-NETWORK - Member Cost	OUT-OF-NETWORK - Reimbursement
---------------------	--------------------------	--------------------------------

Retinal Imaging Exam	\$39 MOOP	N/A
Photochromatic - Non Glass	\$75	N/A
Polycarbonate Lens Option Adult	\$40	N/A
Polycarbonate Lens Option Child	\$0	\$32
Scratch Coating Standard Plastic	\$0	\$12
Tint - Solid or Gradient	\$15	N/A
UV Treatment	\$15	N/A
Other Lens Options	20% of Retail	N/A

LASIK or PRK Vision Correction -15% Discount @ over 6000 locations nationwide using U.S. Laser Network



Hearing care through Ampliphon, up to 66% off hearing aids



Vision Plan benefits are available through EyeMed's Insight Network which features many of your favorite independent local providers along with complete care at major vision retailers.



Thru an exclusive partnership with EyeMed, HRI Vision includes [Walmart's Vision Centers](#) and [Sam's Club Optical Centers](#) as a part of our In-Network family for vision materials, along with many of their providers. Locations and providers in your area can be located by checking <https://eyedoclocator.eyemedvisioncare.com/hri/en-us>