MVP Vision Plans for Individuals & Families

MVP Health Care® vision plans are powered by EyeMed®, which means every doctor in our network is carefully selected to ensure our members have the flexibility to choose from the right mix of independent, national retail, and regional retail providers, including LensCrafters®, Target Optical®, and Pearle Vision®. Plus, we offer online, in-network options through **LensCrafters.com**, **Ray-Ban.com**, **Glasses.com**, and **ContactsDirect.com**. To learn more about MVP vision plans, call **1-800-TALK-MVP** (1-800-825-5687).

Summary of Benefits	MVP Vision 1		MVP Vision 2		MVP Vision 3	
	In-Network Provider (Member Responsibility)	**Out-of-Network Provider** (Reimbursement to Member)	**In-Network Provider** (Member Responsibility)	**Out-of-Network Provider** (Reimbursement to Member)	**In-Network Provider** (Member Responsibility)	**Out-of-Network Provider** (Reimbursement to Member)
Routine Eye Exam One exam every 12 months	$10 co-pay Lenses or contact lenses every 12 months, frames every 12 months	Up to $25	$10 co-pay Lenses or contact lenses every 12 months, frames every 24 months	Up to $25	$10 co-pay Lenses or contact lenses every 12 months, frames every 24 months	Up to $25
Frames	20% off after $170 allowance	Up to $85	20% off after $150 allowance	Up to $75	20% off after $130 allowance	Up to $65
Lenses, Single Pair						
Single Vision	$25 co-pay	Up to $7	$25 co-pay	Up to $7	$25 co-pay	Up to $7
Bifocal	$25 co-pay	Up to $21	$25 co-pay	Up to $21	$25 co-pay	Up to $21
Trifocal	$25 co-pay	Up to $46	$25 co-pay	Up to $46	$25 co-pay	Up to $46
Standard Progressive	$90 co-pay	Up to $21	$90 co-pay	Up to $21	$90 co-pay	Up to $21
Premium Progressive Tier 1/Tier 2/Tier 3/Tier 4	$110/$120/$135/$90 co-pay, then 20% off after $120 allowance	Up to $21	$110/$120/$135/$90 co-pay, then 20% off after $120 allowance	Up to $21	$110/$120/$135/$90 co-pay, then 20% off after $120 allowance	Up to $21
Lens Options, Per Pair						
Standard Polycarbonate Adult/to age 19	$40/$0	Not covered/Up to $28	$40/$0	Not covered/Up to $28	$40/$0	Not covered/Up to $28
Scratch Resistant Coating	$0	Up to $11	$0	Up to $11	$0	Up to $11
UV Coating	$15	Not covered	$15	Not covered	$15	Not covered
Solid or Gradient Tint	$15	Not covered	$15	Not covered	$15	Not covered
Standard Anti-Reflection Coating	$45	Not covered	$45	Not covered	$45	Not covered
Additional Add-Ons and Services	20% off	Not covered	20% off	Not covered	20% off	Not covered
Contact Lenses						
Conventional	15% off after $170 allowance	Up to $136	15% off after $150 allowance	Up to $120	15% off after $130 allowance	Up to $104
Disposable	$170 allowance	Up to $136	$150 allowance	Up to $120	$130 allowance	Up to $104

Rates Effective January 1, 2026–December 31, 2026

Single	$8.01	$6.70	$6.20
Single + Spouse	$15.22	$12.73	$11.78
Single + Child(ren)	$16.02	$13.40	$12.40
Family	$23.55	$19.70	$18.23

No benefits will be paid for services or materials connected with or charges arising from: orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; medical and/or surgical treatment of the eye, eyes or supporting structures; services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear; plano (non-prescription) lenses; non-prescription sunglasses; two pair of glasses in lieu of bifocals; services or materials provided by any other group benefit plan providing vision care; services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available. Member receives a 20% discount on items not covered by the plan at EyeMed In-Network locations. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see EyeMed's online provider locator to determine which participating providers have agreed to the discounted rate. Discounts on vision materials may not be applicable to certain manufacturers' products EyeMed Vision Care reserves the right to make changes to the products on each tier and the member out-of-pocket costs. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Service and amounts listed above are subject to change at any time. Fees charged by a Provider for services other than a covered benefit must be paid in full by the Insured Person to the Provider. Such fees or materials are not covered under the Policy. Benefit allowances provide no remaining balance for future use within the same Benefit Frequency.

These plan overviews are intended to provide a general outline of coverage. In the event of any conflict between this document and your Certificate of Coverage, Schedule, or any applicable Rider(s), your Certificate of Coverage, Schedule, or any applicable Rider(s) will be controlling.

Health benefit plans are issued or administered by MVP Health Plan, Inc.; MVP Health Insurance Company; MVP Select Care, Inc.; and MVP Health Services Corp., operating subsidiaries of MVP Health Care, Inc. Not all plans available in all states and counties.

MVPCOMM0245 (07/2025) ©2025 MVP Health Care