EyeMed VISION CARE®

Union College

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam With Dilation as Necessary	$0 Copay	Up to $40
Contact Lens Fit and Follow-Up *(Contact lens fit and follow up visits are available once a comprehensive eye exam has been completed)*		
Standard Contact Lens Fit & Follow-Up	Up to $55	N/A
Premium Contact Lens Fit & Follow-Up	10% off retail	N/A
Frames	$0 Copay, $175 Allowance; 20% off balance over $175	Up to $75
Standard Plastic Lenses		
Single Vision	$0 Copay	Up to $50
Bifocal	$0 Copay	Up to $60
Trifocal	$0 Copay	Up to $75
Lenticular	$0 Copay	Up to $70
Standard Progressive Lens	$0 Copay	Up to $75
Premium Progressive Lens	$0, 80% of charge less $120 Allowance	Up to $75
Lens Options *(paid by the member and added to the base price of the lens)*		
UV Treatment	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Plastic Scratch Coating	$15	N/A
Standard Polycarbonate	$40	N/A
Standard Polycarbonate—Kids under 19	$40	N/A
Standard Anti-Reflective Coating	$45	N/A
Photocromatic?Transistions Plastic	$0 Copay	N/A
Polarized	20% off retail price	N/A
Other Add-Ons and Services	20% off retail price	N/A
Contact Lenses (Contact lens allowance includes materials only) [(Any remaining balance for contact lenses may be used within the same Benefit Frequency)]		
Conventional	$0 Copay; $175 Allowance, 15% off balance over $175	Up to $75
Disposable	$0 Copay, $175 Allowance; plus balance over $175	Up to $75
Medically Necessary	$0 Copay, Paid-in-Full	Up to $75
Laser Vision Correction		
LASIK or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	N/A
Additional Pairs Discount	Members also receive a 40% discount off complete pair eyeglass purchase and 15% discount off conventional contact lenses once the funded benefit has been used.	
Frequency		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 24 months	

Want to learn more?

- For a complete list of providers near you, use our Provider Locator on www.eyemedvisioncare.com and choose the ACCESS network or call 1-866-723-0596.
- For Lasik providers, call 1-877-5LASER6.

Additional In-Network Discounts and Features:

- 40% off additional eyewear purchases.
- 20% off non-prescription sunglasses.
- 20% off remaining balance beyond plan coverage.
- Laser vision correction—15% off the retail price or 5% off the promotional price for Lasik or PRK procedures.

LensCrafters Pearle Vision Sears Optical OPTICAL JCPenney Optical Private Practitioners

Use your benefit and see great savings

Cost for glasses with standard single-vision lenses

	With EyeMed	Without Vision Coverage**
Step 1: Get an Eye Exam	$0	$88
Step 2: Pick a Frame (allowance $175)	$0	$100
Selected a $170 frame (20% discount)	$0	$70
Step 3: Pick a Lens	$0	$75
Upgraded to Standard Polycarbonate	$40	$62
Added Tint	$15	$25
Step 4: Total Cost	$55	$420
See the Savings		$365, or a 87% savings

Cost for glasses with standard progressive lenses

	With EyeMed	Without Vision Coverage**
Step 1: Get an Eye Exam	$0	$88
Step 2: Pick a Frame (allowance $175)	$0	$100
Selected a $170 frame (20% discount)	$0	$70
Step 3: Pick a Lens	$0	$194
Upgraded to Standard Polycarbonate	$40	$62
Added Tint	$15	$25
Step 4: Total Cost	$55	$539
See the Savings		$484, or a 90% savings

Cost for disposable contact lenses

	With EyeMed	Without Vision Coverage**
Step 1: Get an Eye Exam	$0	$88
Fit and Follow-Up	$55	$74
Step 2: Purchase Contact Lenses	$200	$200
Allowance	$175	$0
Step 3: Total Cost	$80	$362
See the Savings		$282, or a 78% savings

**Based on industry averages. Retail prices and costs will vary by market and provider type. Premiums not included.

Visit EyeMedVisionCare.com to learn more.

LensCrafters · Pearle Vision · Sears Optical · Target Optical · JCPenney Optical · Private Practitioners

EyeMed Vision Care®

Benefits are not provided from services or materials arising from: Orthopic 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; Any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear; 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; Plano (non-prescription) lenses and/or contact 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; Certain brand name Vision Material in which the manufacturer imposes a no-discount policy; or 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. Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next Benefit Frequency with Vision materials would next become available. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/Premium Progressive lens not covered—fund as a Bifocal lens. Standard Progressive lens covered-fund Premium Progressive as a Standard.