dearborn national
POWERED BY eyemed

Group Vision Insurance Benefit Summary

Eligibility: Class 1 - All Active Full-Time Employees Working 40 Hours or More Per Week

Dependent Definition: To age 26, and to age 26 if a full time student

Vision Plan: 12/12/24 $150

Vision Care Service	Member Cost In-Network	Out of Network Reimbursement
Exam with Dilation as Necessary	$10 Copay	Up to $30
Frequency:		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 24 months	
Exam Options:		
Standard Contact Lens Fit and Follow Up:	Up to $40 for Standard; 10% off retail price for Premium	N/A
Frames:		
Any available frame at provider location	$0 Copay; **$150** Allowance, 20% off balance over $150	Up to $75
Standard Plastic Lenses		
Single Vision	$10 Copay	Up to $25
Bifocal	$10 Copay	Up to $40
Trifocal	$10 Copay	Up to $55
Lenticular	$10 Copay	Up to $55
Standard Progressive Lens	$75 Copay	Up to $40
Premium Progressive Lens	See table on page 2	Up to $40
Lens Options		
UV treatment	$15	N/A
Tint (solid and gradient)	$15	N/A
Standard Plastic Scratch Coating	$0	Up to $5
Standard Polycarbonate – Adults	$40	N/A
Standard Polycarbonate – Kids under 19	$0	Up to $5
Standard Anti-Reflective Coating	$45	N/A
Polarized	20% off retail price	N/A
Photocromatic/Transitions Plastic	$75	N/A
Premium Anti-reflective	See Below Table	N/A
Contact Lenses (Contact lens allowance includes materials only)		
Conventional	$0 Copay; $150 allowance, 15% off balance over $150	Up to $120
Disposable	$0 Copay; $150 allowance, plus balance over $150	Up to $120
Medically Necessary	$0 Copay, Paid in full	Up to $210
Laser Vision Correction		
Lasik or PRK from U.S. Laser Network	15% off Retail Price or 5% off Promotional Price	N/A
Additional Pairs Benefit:	Members also receive a 40% discount off complete pair eyeglass purchase and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A

Group Vision Insurance Benefit Summary *continued*

Progressive Price List*	Member Cost In-Network
Standard Progressive	$75 Copay
Premium Progressives as Follows:	
Tier 1	$95 Copay
Tier 2	$105 Copay
Tier 3	$120 Copay
Tier 4	$75 Copay, 80% of charge less $120 Allowance
Anti-Reflective Coating Price List*	**Member Cost In-Network**
Standard Anti-Reflective Coating	$45
Premium Anti-Reflective Coatings as Follows:	
Tier 1	$57
Tier 2	$68
Tier 3	80% of charge
Other Add-ons Price List	**Member cost In-Network**
Photochromic (plastic)	$75
Polarized	80% of charge

Dearborn National 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

For a current listing of brands by tier, go to:
www.eyemedvisioncare.com/theme/pdf/miccrosite-template/eyemedlenslist.pdf