Unitarian Universalist Association

SUMMARY OF BENEFITS

Additional discounts

40%OFF

Complete pair of prescription eyeglasses

20%OFF

Non-prescription sunglasses

These discounts are not insured benefits and are for in-network providers only. For vision plans with qualified materials benefit only. Not applicable for exam only vision plans.

Take a sneak peek before enrolling

- You're on the Insight Network
- For a complete list of in-network providers near you, use our Enhanced Provider Locator on eyemed.com or call 1.866.804.0982
- For LASIK providers, call 1.800.988.4221

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
FRAME		
Any available frame at provider location	$0 copay; 20% off balance over $130 allowance	Up to $104
STANDARD PLASTIC LENSES		
Single Vision	$25 copay	Up to $42
Bifocal	$25 copay	Up to $78
Trifocal	$25 copay	Up to $130
Lenticular	$25 copay	Up to $130
Progressive - Standard	$80 copay	Up to $140
Progressive - Premium Tier 1	$110 copay	Up to $196
Progressive - Premium Tier 2	$120 copay	Up to $196
Progressive - Premium Tier 3	$135 copay	Up to $196
Progressive - Premium Tier 4	$200 copay	Up to $196
LENS OPTIONS		
Anti Reflective Coating - Standard	$45 copay	Up to $36
Anti Reflective Coating - Premium Tier 1	$57 copay	Up to $52
Anti Reflective Coating - Premium Tier 2	$68 copay	Up to $52
Anti Reflective Coating - Premium Tier 3	$85 copay	Up to $52
Photochromic - Non-Glass	$75	Not covered
Polycarbonate - Standard	$40	Not covered
Polycarbonate - Std - Dependent Children	$0 copay	Up to $32
Scratch Coating - Standard Plastic	$15	Not covered
Tint - Solid or Gradient	$15	Not covered
UV Treatment	$15	Not covered
All Other Lens Options	20% off retail price	Not covered
CONTACT LENSES		
Contacts - Conventional	$0 copay; 15% off balance over $130 allowance	Up to $104
Contacts - Disposable	$0 copay; plus balance over $130 allowance	Up to $104
Contacts - Medically Necessary	$0 copay; Paid-In-Full	Up to $210
OTHER		
Hearing Care from Amplifon NetworkCare	Discounts on hearing exam and aids; call 1.877.203.0675	Not covered
Lasik or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered

FREQUENCIES *(Plan allows member to receive either contacts and frame, or frames and lens services)*

Frame	Once every other plan year
Lenses	Once every plan year
Contacts	Once every plan year

QL-0000015076

Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Benefits are not provided from services or materials arising from: 1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures; 3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear; 4) 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; 5) Plano (non-prescription) lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals; 8) Services or materials provided by any other group benefit plan providing vision care 9) 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. 10) 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. 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. Benefit allowance provides no remaining balance for future use within the same benefit year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered.