Dearborn National
POWERED BY EyeMed

Group Vision Insurance Benefit Summary for City of El Paso

Eligibility: Class 1 - All Active Full-Time

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

Vision Plan: 12/12/12 $75

Vision Care Service	Member Cost In-Network	Out of Network Reimbursement
Exam with Dilation as Necessary	$15 Copay	$35
Frequency:		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 12 months	
Exam Options:		
Retinal Imaging:	Up to $39	N/A
Standard Contact Lens Fit and Follow Up:	Up to $40	N/A
Premium Contact Lens Fit and Follow Up:	10% off Retail Price	N/A
Frames:		
Any available frame at provider location	$0 Copay; $75 Allowance, 20% off balance over $75	$45
Standard Plastic Lenses		
Single Vision	$0 Copay	$25
Bifocal	$0 Copay	$40
Trifocal	$0 Copay	$45
Lenticular	$0 Copay	$80
Standard Progressive Lens	$65 Copay	$45
Premium Progressive Lens	See attached Fixed Premium Progressive price list	$45
Lens Options		
UV treatment	$15	N/A
Tint (solid and gradient)	$15	N/A
Standard Plastic Scratch Coating	$15	N/A
Standard Polycarbonate – Adults	$40	N/A
Standard Polycarbonate – Kids under 19	$40	N/A
Standard Anti-Reflective Coating	$45	N/A
Polarized	20% off Retail Price	N/A
Photochromic/Transitions Plastic	$75	N/A
Premium Anti-reflective	See attached Fixed Premium Anti-Reflective Coating list	N/A
Contact Lenses (Contact lens allowance includes materials only)		
Conventional	$0 Copay; $100 allowance, 15% off balance over $100	$55
Disposable	$0 Copay; $100 allowance, plus balance over $100	$55
Medically Necessary	$0 Copay, Paid-in-Full	$150
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 purchases 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	$65 Copay
Premium Progressives as Follows:	
Tier 1	$85 Copay
Tier 2	$95 Copay
Tier 3	$110 Copay
Tier 4	$65 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

Rates Per Pay Period:

Employee Only	$ 2.37
Employee + 1	$ 4.15
Employee + Fam	$ 6.17