# Cornell University Student Vision Plan Summary and Cost of Coverage

Help lower your and your family's out-of-pocket costs on eye exams, glasses, lenses and more with MetLife Vision Insurance. With affordable co-payments and nationwide access to discounts, you'll be seeing your way to clear savings in no time.[1]

## Eligibility

All Weill Cornell Medicine Students are eligible. As a Weill Cornell Medicine Student, you can also add your spouse/ domestic partner or unmarried, dependent children under age 26.

## Open Enrollment

July 1, 2025 – August 31, 2025

## Coverage Dates

July 1, 2025 – June 1, 2026

## Summary of Covered Services VSP Choice Plan

| | **In-Network Coverage** (Using a Network Provider) | **Out-of-Network Coverage** (Using a Non-Network Provider) |
|---|---|---|
| **Eye Examination** | | |
| **Comprehensive exam of visual functions and prescription of corrective eyewear.** | $10 copay | $45 allowance |
| **Retinal Imaging** This screening is used to take pictures of the inside of the eye particularly the retina to look for possible changes. | Up to $39 copay | Applied to the exam allowance |
| **Materials / Eyewear** (Either Glasses or Contacts) | | |
| **Standard Corrective Lenses** | | |
| **Single vision** | $0 copay | $30 allowance |
| **Lined bifocal** | $0 copay | $50 allowance |
| **Lined trifocal** | $0 copay | $65 allowance |
| **Lenticular** | $0 copay | $100 allowance |
| **Standard Lens Enhancement** | | |
| **Ultraviolet coating** | Covered in full | Applied to the allowance for the applicable corrective lens |

| | | |
|---|---|---|
| **Polycarbonate (child up to age 18)** | Covered in full | Applied to the allowance for the applicable corrective lens |
| **Additional Lens Enhancements**[4] | | |
| **Progressive Standard** | Covered in full | $50 allowance |
| **Progressive Premium/Custom** | Premium: $95 – $105 copay<br>Custom: $150 – $175 copay | $50 allowance |
| **Polycarbonate (adult)** | Single Vision: Up to $31 copay<br>Multifocal: Up to $35 copay | Applied to the allowance for the applicable corrective lens |
| **Scratch-resistant coating (variable by type)** | Up to $17 – $33 copay | Applied to the allowance for the applicable corrective lens |
| **Tints (variable by type)** | Pink I & II: $0 copay<br>Solid Plastic: $15 Copay<br>Plastic Gradient Dye: $17 Copay | Applied to the allowance for the applicable corrective lens |
| **Anti-reflective coating (variable by type)** | Up to$ 41 – $85 copay | Applied to the allowance for the applicable corrective lens |
| **Photochromic (variable by type)** | Covered in full $47 – $82 copay | Applied to the allowance for the applicable corrective lens |
| **Blue Light Filtering** | Up to $15 | Applied to the allowance for the applicable corrective lens |
| **Frame** | | |
| **Allowance** | $120 allowance<br>$140 allowance on featured frames | $55 allowance |
| **Costco, Walmart and Sam's Club** | $65 allowance | $55 allowance |
| You will receive an additional 20% off any amount that you pay over your allowance. This offer is available from all participating (in-network) locations except Costco, Walmart and Sam's Club. | | |
| **Contact Lenses** (instead of eyeglasses) | | |
| **Elective** | $120 allowance | $105 allowance |
| **Necessary** | Covered in full after eyewear copay | $210 allowance |
| **Contact Fitting and Evaluation** | Standard or Premium fit: with a maximum copay of $60 | Applied to the contact lens allowance |
| **Frequency** (Glasses or Contacts) | | |
| **Eye Examination** | 1 per 12 Months | 1 per 12 Months |

| | | |
|---|---|---|
| **Standard Corrective Lenses** | 1 per 12 Months | 1 per 12 Months |
| **Frame** | 1 per 12 Months | 1 per 12 Months |
| **Contact Lenses** | 1 per 12 Months | 1 per 12 Months |

| **In-Network Value Added Features** | |
|---|---|
| **Additional lens enhancements** | In addition to standard lens enhancements, enjoy an average 20-25% savings on all other lens enhancements.[4] |
| **Additional Savings on Glasses and Sunglasses** | Get 20% off the cost for additional pairs of prescription glasses and non-prescription sunglasses, including lens enhancements.[4] At times, other promotional offers may also be available. |
| **Laser Vision correction[5]** | Savings averaging 15% off the regular price or 5% off a promotional offer for laser surgery including PRK, LASIK and Custom LASIK. Offer is only available at MetLife participating locations. |

## Coverage Cost

The following annual costs are effective **July 1 30, 2025 through June 30, 2026.**

| | |
|---|---|
| Student Only | $55.80 ($4.65/mo.) |
| Student + Family | $153.96 ($12.83/mo.) |

## Exclusions

This plan does not cover the following services, materials and treatments:

**Services and Eyewear**

- Services and/or materials not specifically included in the Summary of Benefits as covered Plan Benefits.
- Any portion of a charge in excess of the Maximum Benefit Allowance or reimbursement indicated in the Summary of Benefits.
- Any eye examination or corrective eyewear required as a condition of employment.
- Services and supplies received by you or your dependent before the Vision Insurance starts.
- Missed appointments.
- Services or materials resulting from or in the course of a Covered Person's regular occupation for pay or profit for which the Covered Person is entitled to benefits under any Worker's Compensation Law, Employer's Liability Law or similar law. You must promptly claim and notify the Company of all such benefits.
- Local, state, and/or federal taxes, except where MetLife is required by law to pay.

- Services or materials received as a result of disease, defect, or injury due to war or an act of war (declared or undeclared), taking part in a riot or insurrection, or committing or attempting to commit a felony.
- Services and materials obtained while outside the United States, except for emergency vision care.
- Services, procedures, or materials for which a charge would not have been made in the absence of insurance.
- Services: (a) for which the employer of the person receiving such services is required to pay; or (b) received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.
- Services, to the extent such services, or benefits for such services, are available under a Government Plan. This exclusion will apply whether or not the person receiving the services is enrolled for the Government Plan. We will not exclude payment of benefits for such services if the Government Plan requires that Vision Insurance under the Group Policy be paid first. Government Plan means any plan, program, or coverage which is established under the laws or regulations of any government. The term does not include any plan, program, or coverage provided by a government as an employer or Medicare.
- Plano lenses (lenses with refractive correction of less than ± 0.50 diopter).
- Two pairs of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses, furnished under this Plan which are lost, stolen, or damaged, except at the normal intervals when Plan Benefits are otherwise available.
- Contact lens insurance policies and service agreements.
- Refitting of contact lenses after the initial (90 day) fitting period.
- Contact lens modification, polishing, and cleaning.

**Treatments**

- Orthoptics or vision training and any associated supplemental testing.
- Medical and surgical treatment of the eye(s).

**Medications**

- Prescription and non-prescription medications.

1. Your actual savings from enrolling in a vision plan will depend on various factors, including the plan chosen, plan premiums, number of visits to an eye care professional by your family per year, and the cost of services and materials received. Be sure to review the Schedule of Benefits for your plan's specific benefits and other important details.
2. You must be enrolled at Cornell University, Cornell Tech or Weill Medical student to qualify for this insurance plan.
3. Refers to your unmarried, dependent children through age 26.
4. Lens enhancements are available at participating private practices. Pricing is subject to change without notice. Please check with your provider for details and availability prior to receiving services. Additional discounts may not be available in certain states or at certain retail locations.
5. The VSP Choice network allows you to access discounted laser correction services. May not be available in all states or regions. Custom LASIK coverage only available using wavefront technology with the microkeratome surgical device. Other LASIK procedures may be performed at an additional cost to the member. Additional savings on laser vision care is only available at participating locations. Not everyone will qualify for LASIK surgery. Results will vary. Please discuss outcomes with your eyecare provider.

Rates may be changed on the entire plan or on a class basis and on any premium due date on which benefits are changed. A class is a group of people defined in the policy. Benefits are subject to change upon agreement between Metropolitan Life Insurance Company and the participating organization.

Vision insurance is provided by Metropolitan Life Insurance Company (MetLife), New York, NY. Certain claim and network administration services are provided through Vision Service Plan (VSP), Rancho Cordova, CA. VSP is not affiliated with MetLife or its affiliates.

Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, reductions, limitations, waiting periods, and terms for keeping them in force. Please Member Benefits your plan administrator at 1-800-282-for costs and complete details.

VSP is a registered trademark of Vision Service Plan.

Policy number 234782-1-G

**Metropolitan Life Insurance Company** | 200 Park Avenue | New York, NY 10166
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