

Vision Plan

Vision coverage is provided at no additional cost to members enrolled in any of the State-sponsored health plans. All members and enrolled dependents have the same vision coverage regardless of the health plan selected. Eye exams are covered once every 12 months from the last date the exam benefit was used. All other benefits are available once every 24 months from the last date used. Copayments are required.



Service	Network Provider Benefit	Out-of-Network** Provider Benefit	Benefit Frequency
Eye Exam	\$10 copayment	\$30 allowance	Once every 12 months
Spectacle Lenses* (single, bifocal and trifocal)	\$10 copayment	\$50 allowance for single vision lenses \$80 allowance for bifocal and trifocal lenses	Once every 24 months
Standard Frames	\$10 copayment (up to \$175 retail frame cost; member responsible for balance over \$175)	\$70 allowance	Once every 24 months
Contact Lenses (All contact lenses are in lieu of spectacle lenses)	\$120 allowance	\$120 allowance	Once every 24 months

* Spectacle Lenses: Plan participant pays any and all optional lens enhancement charges. Network providers may offer additional discounts on lens enhancements and multiple pair purchases.

** Out-of-network claims must be filed within one year from the date of service.

 EyeMed Vision Care: (866) 723-0512
 TDD/TTY: (800) 526-0844
 Website: www.eyemedvisioncare.com/stil