Vision

Vision coverage is provided at no cost to all members enrolled in a State health plan and is administered by EyeMed. All enrolled members and dependents receive the same vision coverage regardless of the health plan selected.

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

* Vision Lenses: Member pays all optional lens enhancement charges. In-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.

Additional Vision Benefits

EyeMed offers additional coverage for Progressive Lenses, Premium Anti-Reflective Coating, and coverage for Photochromic and Polarized lenses. For more information on this program visit eyemedvisioncare.com/stil or contact EyeMed at 1-866-723-0512