STATE VISION PLAN FOR RETIREES

**Effective 1.1.2027**

# Your EyeMed vision benefit guide

# Vision benefits that cater to you

## Welcome to your State Vision Plan, administered by EyeMed Vision Care, LLC, under the direction of the Michigan Civil Service Commission (MCSC).

The MCSC is responsible for implementing your vision benefits and future changes in benefits. EyeMed provides certain services on behalf of the MCSC through an administrative contract. Your benefits are not insured with EyeMed, but are paid from funds administered by the MCSC.

This document is not a contract. Rather, it is intended to be a summary description of your State Vision Plan benefits. If statements in this description differ from the applicable coverage documents, the terms and conditions of the applicable coverage documents will prevail.

## Your vision is the focus of everything we do

*eyemedvisioncare.com/SOM*

# The value of an eye exam

Think you don't need vision care? Think again. Your eyes can speak pretty clearly. Pay attention and they'll tell you about health problems you may not even know about.

### SPOT HEALTH PROBLEMS SOONER

An eye exam can spot early signs of diabetes, high blood pressure, high cholesterol, heart disease and even cancer. Not to mention cataracts and glaucoma. See it sooner. Treat it sooner.

### STEER CLEAR OF EYE STRAIN

Every day, we spend hours staring at phones, laptops and tablets. These screens put out blue light, which is linked to blurred vision and retinal damage. An eye exam helps you protect those peepers.

### AVOID VISION CREEP

Your eyes are always changing (you probably don't even notice it). But even the smallest changes can be tracked. Your benefits give you access to the sophisticated exam technology that sees it all.

# The support that makes it simple

From the day you enroll to the day you find your favorite frames, we'll be within easy reach. Guiding. Advising. Helping you make the most of your vision benefits.

### GET A HEAD START

We'll mail you a welcome kit with the 8 closest eye doctors and your ID card. (You don't need your card to receive services, but it's nice to know EyeMed is always there.)

### GET 24/7 HELP ON-THE-GO

Visit eyemedvisioncare.com/SOM or download the EyeMed Members App to track claims and payments, find an eye doctor, print ID cards, get special offers, submit an out-of-network claim and much more.

### GET EVERY QUESTION ANSWERED

One of America's highest-rated call centers is standing by 102 hours per week. Live, responsive and prepared to make life easy.

1-833-279-4355
Mon. – Fri. | 7:30 am – 11 pm ET
Sat. | 8 am – 11 pm ET
Sun. | 11 am – 8 pm ET

# Coordination of Benefits (COB)

## HOW COB WORKS

If you are covered by more than one group vision plan, coordination of benefits guidelines determine which carrier pays for covered services first.

The primary plan is the carrier that is responsible for paying first. This plan must provide you with the maximum benefits available to you under that plan.

Your secondary plan is the carrier that is responsible for paying after your primary plan has processed the claim.

## FILING COB CLAIMS

Remember to ask your vision provider to submit claims to your primary carrier first. Note: Your vision benefits cover routine eye care. If your exam is for a medical condition, some charges may be paid through your medical plan. If you have questions about how services will be billed, ask your provider or contact EyeMed directly, 1-833-279-4355.

When you submit claims to EyeMed for reimbursement, please follow these steps:

1. Obtain an Explanation of Benefits (EOB) or payment statement from the primary carrier.

2. Ask your provider for an itemized receipt or a detailed description of the services, including charges for each service.

3. If you made any payments for the service, provide a copy of the receipt you received from the provider.

4. Make sure the provider's name and complete address are on your receipts.

5. Send these items to: First American Administrators, Inc., Attn: OON Claims, P.O.Box 8504, Mason, OH 45040-7111
*Please note: COB claims may not be filed electronically.*

6. Please make copies of all forms and receipts for your own files.

STATE VISION PLAN SUMMARY OF BENEFITS FOR RETIREES

# Routine Vision Plan

| Vision Care Services | Member In-Network Coverage | Member Out-of-Network Reimbursement* |
|---|---|---|
| **EXAM WITH DILATION AS NECESSARY** | 100% of EyeMed approved amount, $5 Copay | Reimbursement up to $34, $5 Copay, Member pays difference |
| **FRAMES**<br>Any available frame at provider location | $150 Allowance, Member pays difference | Reimbursement up to $38.25, Member pays difference |
| **STANDARD PLASTIC OR GLASS LENSES**<br>Single vision | 100% of EyeMed approved amount, $7.50 Copay | Reimbursement up to $17, $7.50 Copay, Member pays difference |
| Bifocal | 100% of EyeMed approved amount, $7.50 Copay | Reimbursement up to $30, $7.50 Copay, Member pays difference |
| Trifocal | 100% of EyeMed approved amount, $7.50 Copay | Reimbursement up to $43, $7.50 Copay, Member pays difference |
| Lenticular | 100% of EyeMed approved amount, $7.50 Copay | Not covered |
| Standard Progressive Lens | 100% of EyeMed approved amount, $7.50 Copay | Reimbursement up to $30, $7.50 Copay, Member pays difference |

*Member Reimbursement Out-of-Network will be the lesser of the listed amount or the member's actual cost from the out-of-network provider. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see EyeMed's online provider locator to determine which participating providers have agreed to the discounted rate.

STATE VISION PLAN SUMMARY OF BENEFITS FOR RETIREES

# Routine Vision Plan

| Vision Care Services | Member In-Network Coverage | Member Out-of-Network Reimbursement* |
|---|---|---|
| **LENS OPTIONS** | | |
| Polycarbonate | 100% of EyeMed approved amount, $0 Copay | Not covered |
| Tint (Solid and Gradient) | 100% of EyeMed approved amount, $0 Copay | Not covered |
| Photochromic/Transitions | 100% of EyeMed approved amount, $0 Copay | Not covered |
| **CONTACT LENSES** | | |
| *Includes fit, follow-up and materials* | | |
| Conventional | $0 Copay; $150 Allowance, Member pays difference | Reimbursement up to $115, $0 Copay, Member pays difference |
| Disposable | $0 Copay; $150 Allowance, Member pays difference | Reimbursement up to $115, $0 Copay, Member pays difference |
| Medically Necessary | $7.50 Copay, 100% of EyeMed approved amount | Reimbursement up to $210, $7.50 Copay, Member pays difference |

| Vision Care Services | |
|---|---|
| Lasik | Lifetime maximum reimbursement for retirees and spouses up to $1,000 each for Lasik surgery; dependent children are not eligible |

| Vision Care Services | Frequency (In-Network and Out-of Network) |
|---|---|
| Examination | Once every 12 months |
| Glasses [Frame and Lens; in lieu of contact lenses] | Once every 12 months |
| Contact Lenses [in lieu of Glasses] | Once every 12 months |

*Member Reimbursement Out-of-Network will be the lesser of the listed amount or the member's actual cost from the out-of-network provider. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see EyeMed's online provider locator to determine which participating providers have agreed to the discounted rate.

**Lasik reimbursement benefit is limited to a single laser surgery encounter per eye. Follow-up care enhancements or secondary procedures are excluded from coverage under the state vision benefit.

STATE VISION PLAN SUMMARY OF BENEFITS FOR RETIREES

# EyeMed: Value added savings

| Vision Care Services | Member In-Network Coverage | Member Out-of-Network Reimbursement* |
|---|---|---|
| **RETINAL IMAGING BENEFIT** | Up to $39 | N/A |
| **FRAME**<br>Any available frame at provider location | 20% off balance over $150 | N/A |
| **STANDARD PLASTIC OR GLASS LENS**<br>Premium Progressive Lens–Tiers 1–3 | $27.50–$52.50 Copay | Reimbursement up to $30, $7.50 Copay, Member pays difference |
| Premium Progressive Lens–Tier 4 | $7.50 Copay, 80% of charge less $120 Allowance | Reimbursement up to $30, $7.50 Copay, Member pays difference |
| **LENS OPTIONS**<br>UV Treatment | $15 | N/A |
| Standard Plastic Scratch Coating | $15 | N/A |
| Standard Anti-Reflective Coating | $45 | N/A |
| Premium Anti-Reflective–Tier 1–2 | $57–$68 | N/A |
| Premium Anti-Reflective–Tier 3 | 20% off Retail Price | N/A |
| Other Add-Ons | 20% off Retail Price | N/A |
| **CONTACT LENSES**<br>Conventional | 15% off balance over $150 | N/A |
| **LASER VISION CORRECTION**<br>Lasik or PRK from U.S. Laser Network | 15% off Retail Price or 5% off promotional price | N/A |

**Members also receive a 40% discount off additional complete pair eyeglass purchases and 20% off non-covered items, including non-prescription sunglasses**

* Member Reimbursement Out-of-Network will be the lesser of the listed amount or the member's actual cost from the out-of-network provider. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see EyeMed's online provider locator to determine which participating providers have agreed to the discounted rate.

# Disclaimers

**Additional Discounts:** Subject to exclusions, discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision. Benefit Allowances provide no remaining balance for future use within the same Benefit Frequency. Certain brand name Vision Materials in which the manufacturer imposes a no-discount practice are not eligible for discount.

**Plan Exclusions:** 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. 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; 4. Plano (non-prescription) lenses and/or contact lenses; 5. Non-prescription sunglasses; 6. Two pair of glasses in lieu of bifocals; 7. Services rendered after the date a member ceases to be covered under the Plan, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the member are within 31 days from the date of such order; 8. Services or materials provided by any other group benefit plan providing vision care; 9. 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.

## YOUR RIGHT TO REVIEW THE PLAN'S DETERMINATION

If you are not satisfied with a benefit determination, you are entitled to a review (appeal). To request a review, you or your authorized representative should submit your request in writing to:

**EyeMed Vision Care**
Attn: Quality Assurance
4000 Luxottica Place
Mason, OH 45040

**Fax:** 513-492-3259

Your request for a review must be submitted within 180 days of the date of the Explanation of Benefits. With your request, you may also submit written comments, documents, records, and other information that you wish to have considered as part of the review. If an internal rule, guideline, or protocol was relied upon in making the benefit determination, it will be provided free of charge upon request by you or your authorized representative. The documents relevant to your claim will be provided free of charge upon request by you or your authorized representative. You will be notified of the final decision upon review in a timely fashion, but no later than 60 calendar days. If you have exhausted the appeal process with EyeMed, you may request an external review by Department of Insurance and Financial Services (DIFS) within 127 days of the date you received our final determination:

**Mail:**
Department of Insurance and Financial Services
Office of Appeals and Market Regulation – Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720

**Fax:** 517-284-8838

**Email:** DIFS-HealthAppeal@michigan.gov

# Get more of what you want

eyemed.com
eyemedvisioncare.com/SOM
1-833-279-4355

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