STATE VISION PLAN FOR ACTIVE EMPLOYEES

Effective 1.1.2025

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 EMPLOYEES

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 Any available frame at provider location	$150 Allowance, Member pays difference	Reimbursement up to $38.25, Member pays difference
STANDARD PLASTIC OR GLASS LENSES 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
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

* 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 EMPLOYEES

Routine Vision Plan

Vision Care Services	Member In-Network Coverage	Member Out-of-Network Reimbursement*
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
Lasik	Lifetime maximum reimbursement for employee 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][1]	Once every 12 months
Contact Lenses [in lieu of Glasses][1]	Once every 12 months

[1] Members may obtain either eyeglasses or contact lenses, but not both.

* 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. **The lasik reimbursement benefit is limited to a single laser surgical 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 EMPLOYEES

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		
Any available frame at provider location	20% off balance over $150	N/A
STANDARD PLASTIC OR GLASS LENS		
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		
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		
Conventional	15% off balance over $150	N/A
LASER VISION CORRECTION		
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.

STATE VISION PLAN SUMMARY OF BENEFITS FOR EMPLOYEES

Safety Eyewear Plan

The Safety Eyewear Plan is available to State employees who are required to use safety glasses on a full-time basis. Eligible employees must have their HR office complete and submit the Specialty Glasses Employee Certification Form on their behalf. The Safety Eyewear Plan offers savings for safety frames and lenses that meet or exceed ANSI standards.

Vision Care Services	Member In-Network Coverage	Member Out-of-Network Reimbursement
FRAMES		
Any available frame at provider location	$65 Allowance, Member pays difference	N/A
STANDARD PLASTIC LENSES*		
Single vision	100% of EyeMed approved amount, $0 Copay	N/A
Bifocal	100% of EyeMed approved amount, $0 Copay	N/A
Trifocal	100% of EyeMed approved amount, $0 Copay	N/A
Lenticular	100% of EyeMed approved amount, $0 Copay	N/A
Standard Progressive Lens	100% of EyeMed approved amount, $0 Copay	N/A
LENS OPTIONS		
Polycarbonate	100% of EyeMed approved amount, $0 Copay	N/A
Tint (Solid and Gradient)	100% of EyeMed approved amount, $0 Copay	N/A

Vision Care Services	Frequency (In-Network and Out-of Network)
Lenses	Once every 24 months; Once every 12 months if prescription changes
Frame	Once every 24 months; Once every 12 months if prescription changes

*If a member seeks Standard Plastic Lenses in AK, CA, HI, OR, WA, Group Contracted Rate is $15 higher.

Safety: Value added savings

Vision Care Services	Member In-Network Coverage	Member Out-of-Network Reimbursement
FRAMES		
Any available frame at provider location	20% off balance over $65	N/A
STANDARD PLASTIC LENSES		
Premium Progressive Lenses Tiers 1–3	$20–45 Copay	N/A
Premium Progressive Lenses Tier 4	$0 Copay, 80% of charge less $120 Allowance	N/A
LENS OPTIONS		
UV Treatment	$15	N/A
Tint (Photochromic)	$75	N/A
Standard Plastic Scratch Coating	$15	N/A
Standard Anti-Reflective Coating	$45	N/A
Polarized	20% off Retail Price	N/A
Premium Anti-Reflective Tiers 1–2	$57–68	N/A
Premium Anti-Reflective Tiers 3–4	80% of charge	N/A
Other Add-Ons	20% off Retail Price	N/A

Members also receive a 20% discount off additional complete pair eyeglass purchases

Only Employees are eligible for safety eyewear. EyeMed reserves the right to make changes to the products available on each tier. All providers are not required to carry all brands on all tiers. For current listing of brands by tier, call 866.939.3633. No benefits will be paid for services or materials connected with or charges arising from: orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; medical and/or surgical treatment of the eye, eyes or supporting structures; 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; plano (non-prescription) lenses; non-prescription sunglasses; two pair of glasses in lieu of bifocals; services or materials provided by any other group benefit plan providing vision care; services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or 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. Fees charged by a Provider for services other than a covered benefit must be paid in full by the Insured to the Provider. Such fees or materials are not covered under the Policy. Benefit allowances provide no remaining balance for future use within the same Benefit Frequency. Plan discounts cannot be combined with any other discounts or promotional offers. 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 online provider locator to determine which participating providers have agreed to the discounted rate. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.

STATE VISION PLAN SUMMARY OF BENEFITS FOR EMPLOYEES

Computer Glasses (VDT/CRT) Plan

The Computer Glasses (VDT/CRT) Plan is available to State employees who are required to use computers and other digital devices on a full-time basis. The plan includes screening and lenses specifically designed to address the complaints of eye strain and ocular fatigue associated with computer use.

Vision Care Services	Member In-Network Coverage	Member Out-of-Network Reimbursement*
EXAM WITH DILATION AS NECESSARY	100% of EyeMed approved amount, $0 Copay	N/A
FRAMES		
Any available frame at provider location	$150 Allowance, Member pays difference	Reimbursement up to $38.25, $0 Copay, Member pays difference
STANDARD PLASTIC LENSES**		
Single vision	100% of EyeMed approved amount, $0 Copay	Reimbursement up to $17, $0 Copay, Member pays difference
Bifocal	100% of EyeMed approved amount, $0 Copay	Reimbursement up to $30, $0 Copay, Member pays difference
Trifocal	100% of EyeMed approved amount, $0 Copay	Reimbursement up to $43, $0 Copay, Member pays difference
Lenticular	100% of EyeMed approved amount, $0 Copay	Not covered
Standard Progressive Lens	100% of EyeMed approved amount, $0 Copay	Reimbursement up to $30, $0 Copay, Member pays difference
Polycarbonate	100% of EyeMed approved amount, $0 Copay	N/A
Tint (Solid and Gradient)	100% of EyeMed approved amount, $0 Copay	N/A

*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. **If a member seeks Standard Plastic Lenses in AK, CA, HI, OR, WA, Group Contracted Rate is $15 higher.

VDT Plan: Value added savings

Vision Care Services	Frequency (In-Network and Out-of Network)
Examination	Initial eye exam covered if within 12 months of routine eye exam. Subsequent evaluation included with routine eye exam.
Lenses	Once every 12 months; Only covered if prescription is different from prescribed everyday eyewear.
Frame	Once every 12 months; Only covered if prescription is different from prescribed everyday eyewear.

Vision Care Services	Member In-Network Coverage	Member Out-of-Network Reimbursement
FRAME		
Any available frame at provider location	20% off balance over $150	N/A
STANDARD PLASTIC LENSES		
Premium Progressive Lenses Tiers 1-3	$20-45 Copay	Reimbursement up to $30, Member pays difference
Premium Progressive Lenses Tier 4	$0 Copay, 80% of charge less $120 Allowance	Reimbursement up to $30, Member pays difference
LENS OPTIONS		
UV Treatment	$15	N/A
Standard Plastic Scratch Coating	$15	N/A
Standard Anti-Reflective Coating	$45	N/A
Glass	$7.50 Copay	N/A
Polarized	20% off Retail Price	N/A
Premium Anti-Reflective Tiers 1–2	$57–68	N/A
Premium Anti-Reflective Tier 3	80% of charge	N/A
Other Add-Ons	20% off Retail Price	N/A

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