Set your sight on savings

State Vision Plan

Vision care services	In-network member cost	Out-of-network reimbursement
Exam with dilation as necessary	$10 copay	Up to $35
Retinal imaging	Up to $39	N/A
Frames	$0 copay, $150 allowance, 20% off balance over $150	Up to $75
Standard plastic lenses		
Single vision	$10 copay	Up to $25
Bifocal	$10 copay	Up to $40
Trifocal	$10 copay	Up to $55
Lenticular	$10 copay	Up to $55
Standard progressive lens	$35 copay	Up to $55
Premium progressive lens[1]		
Tier 1	$55	Up to $55
Tier 2	$65	Up to $55
Tier 3	$80	Up to $55
Tier 4	$35 copay, 80% of charge less $120 allowance	Up to $55
Lens options		
UV treatment	$0	Up to $5
Tint (solid and gradient)	$0	Up to $5
Standard plastic scratch coating	$0	Up to $5
Standard polycarbonate – adults	$30 copay	Up to $5
Standard polycarbonate – children under 19	$0	Up to $5
Standard anti-reflective coating	$45	N/A
Premium anti-reflective coating[1]		
Tier 1	$57	N/A
Tier 2	$68	N/A
Tier 3	80% of charge	N/A
Transitions	$60	Up to $5
Photochromic plastic	20% off retail	N/A
Polarized	20% off retail	N/A
Other add-ons and services	20% off retail	N/A

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[1]Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Not available in all states. Some provisions, benefits, exclusions or limitations listed herein may vary.

State Vision Plan

Vision care services	In-network member cost	Out-of-network reimbursement
Contact lens fit and follow-up (contact lens fit and follow-up visits are available once a comprehensive eye exam has been completed)		
Standard contact lens fit & follow-up	$0 copay, paid in full and two follow-up visits	Up to $40
Premium contact lens fit & follow-up	$0 copay, 10% off retail price, then apply $55 allowance	Up to $40
Contact lenses (contact lens allowance includes materials only)		
Conventional	$0 copay, $130 allowance, 15% off balance over $130	Up to $104
Disposable	$0 copay, $130 allowance; plus balance over $130	Up to $104
Medically necessary	$0 copay, paid in full	Up to $200
Laser vision correction		
LASIK or PRK from U.S. laser network	15% off the retail price or 5% off the promotional price	
Frequency		
Examination	Once every year	
Lenses or contact lenses	Once every year	
Frame	Once every year	

Benefits are not provided for services or materials arising from: orthopic 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; any vision examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear; 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 pairs 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. 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. Benefits may not be combined with any discount, promotional offering or other group benefit plans. Standard/Premium Progressive lens not covered — fund as a bifocal lens. Standard Progressive lens covered – fund Premium Progressive as a Standard. Benefit allowance provides no remaining balance for future use within the same benefits year. Fees charged for a non-insured benefit must be paid in full to the provider. Such fees or materials are not covered. This is a snapshot of your benefits.

State Vision Diabetic Plan

Diabetic care services Type 1 and Type 2 diabetics frequency: up to two services per benefit year	In-network member cost	Out-of-network reimbursement
Office service visit (medical follow-up exam)	Covered 100%, $0 copay	Up to $77 per service
Retinal imaging	Covered 100%, $0 copay[2]	Up to $50 per service
Extended ophthalmoscopy	Covered 100%, $0 copay[3]	Up to $15 per service
Gonioscopy	Covered 100%, $0 copay	Up to $15 per service
Scanning laser	Covered 100%, $0 copay	Up to $33 per service

[2]Not covered if extended opthalmoscopy is provided within six months.
[3]Not covered if fundus photography is provided within six months.
Exclusions and limitations:
The diabetic benefit covers diabetic eye care evaluation services only. The following services and benefits are excluded:
1. Costs associated with securing frames, lenses or any other materials
2. Orthoptics or vision training and any associated supplemental testing
3. Surgical procedures, including laser or any other form of refractive surgery, and any pre- or post-operative services
4. Pathological treatment of any type for any condition
5. Any eye examination required by an employer as a condition of employment
6. Insulin or any medications or supplies of any type
7. Services and/or materials not included in this rider

Learn more about vision care benefits at ***www.peba.sc.gov/vision.html****.*