MICHIGAN OFFICE OF RETIREMENT SERVICES
Big Plans. Small Steps.

EyeMed

2023 Michigan Public School Employees' Retirement System Vision Benefits

Service	Member Cost Share	
Service Provided:	**In-Network:**	**Out-of-Network:**
Comprehensive Eye Exam	$10 copay	All costs that exceed $40
Retinal Imaging	Up to $39	All costs
Contact Lens Exam - Standard Fit and Follow Up	Up to $55	All costs
Frames	$0 copay, up to $120 plan allowance	All costs over $23
Standard Plastic or Glass Lenses		
Single Vision	$25 copay	All costs over $16
Bifocal	$25 copay	All costs over $23
Trifocal	$25 copay	All costs over $27
Lenticular	$25 copay	All costs over $75
Progressive Plastic Lenses		
Standard	$80 copay	All costs over $23
Premium Tier I	$110 copay	All costs over $23
Premium Tier II	$120 copay	All costs over $23
Premium Tier III	$135 copay	All costs over $23
Premium Tier IV	$90 copay, plus 80% coinsurance minus $120 plan allowance	All costs over $23
Contact Lenses		
Medically Necessary	$25 copay	All costs over $96
Conventional or Disposable	$25 copay, up to $120 plan allowance	All costs over $35

Service	Frequency
Comprehensive Examination	Once every 24 months
Frame and Lenses (in Lieu of Contact Lenses)	Once every 24 months
Contact Lenses (in Lieu of Frames and Lenses)	Once every 24 months

Payment Examples:

Comprehensive Eye Exam		Member Cost Share		
	Charge	**Copay**	**Additional Cost**	**Net Amount You Pay**
ACCESS Network Provider	**$110**	**$10**	**NONE**	**$10**
Out of Network	**$110**	**$0**	**$70** $110 minus $40 exam reimbursement	**$70**
			Save $60 by using an in-network provider.	

Frames With Single Vision Lens		Member Cost Share		
	Charge	**Copay**	**Additional Cost**	**Net Amount You Pay**
ACCESS Network Provider	**$271** $182 frames + $89 lenses	**$25** lenses	**$49.60** $182 minus $120 frames allowance, less 20% discount off balance	**$74.60** $25 lens copay + $49.60 frames balance
Out of Network	**$271** $182 frames + $89 lenses	**$0**	**$232** Balance after reimbursements, $23 for frames and $16 for lenses	**$232**
			Save $157.40 by using an in-network provider.	

Note: *The payment examples above are for illustration purposes only. Fees and reimbursements can vary by location and provider.*

Payment Examples Continued:

Frames With Standard Progressive Lens		Member Cost Share		
	Charge	**Copay**	**Additional Cost**	**Net Amount You Pay**
ACCESS Network Provider	**$403** $182 frames + $221 lenses	**$80** lenses	**$49.60** $182 minus $120 frames allowance, less 20% discount off balance	**$129.60** $80 lens copay + $49.60 frames balance
Out of Network	**$403** $182 frames + $221 lenses	**$0**	**$357** Balance after reimbursements, $23 for frames and $23 for lenses	**$357**
			Save $227.40 by using an in-network provider.	

Frame With Standard Progressive and Add-Ons		Member Cost Share		
	Charge	**Copay**	**Additional Cost**	**Net Amount You Pay**
ACCESS Network Provider	**$521** $182 frames + $221 lenses + $80 A/R coat + $38 scratch coat	**$140** $80 lenses + $45 A/R + $15 scratch coat	**$49.60** $182 minus $120 frames allowance, less 20% discount off balance	**$189.60** $140 copay + $49.60 frames balance
Out of Network	**$521** $182 frames + $221 lenses + $80 A/R coat + $38 scratch coat	**$0**	**$475** Balance after reimbursements $23 for frames and $23 for lenses	**$475**
			Save $285.40 by using an in-network provider.	

Note: *The payment examples above are for illustration purposes only. Fees and reimbursements can vary by location and prov*

Additional Discounts Offered by EyeMed:

Service	Member Cost Share	
Service Type:	**In-Network:**	**Out-of-Network:**
Contact Lens Exam – Premium Fit and Follow Up	90% Coinsurance	All costs
Frames Discount	80% coinsurance for costs over the $120 plan allowance	All costs over $23
Cosmetic Lens Options:		
UV Coating	$15 copay	All costs
Tint (Solid and Gradient)	$15 copay	All costs
Standard Scratch Resistance	$15 copay	All costs
Standard Polycarbonate	$40 copay	All costs
Standard Anti-Reflective Coating	$45 copay	All costs
Premium Anti-Reflective Coating Tier 1	$57 copay	All costs
Premium Anti-Reflective Coating Tier 2	$68 copay	All costs
Premium Anti-Reflective Coating Tier 3	80% coinsurance	All costs
Polarized	80% coinsurance	All costs
Other Add-Ons and Services	80% coinsurance	All costs
Contact Lenses – Conventional	85% coinsurance on costs over $120 plan allowance	All costs over $35
LASIK or PRK from US Laser Network	Lesser of 85% coinsurance on retail price or 95% coinsurance on promotional price	

Other Important EyeMed Vision Plan Information:

You Are On The ACCESS Network:

If you have benefit questions or need assistance locating an in-network provider near you, call 1-866-248-2028. You may also find a provider and review eligibility and claims information by visiting **eyemed.com/mpsers**.

Exclusions and Limitations:

Benefits are not provided from 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 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.

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.

$^{\Delta}$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. Additional limitations and exclusions may apply.