

<b>Service</b>	<b>Network Provider Benefit</b>	<b>Out-of-Network Provider Benefit***</b>
<b>Eye Exam</b>	\$10 co-payment	\$20 allowance
<b>Spectacle Lenses*</b> (single, bifocal and trifocal)	\$10 co-payment	\$20 allowance for single vision lenses \$30 allowance for bifocal and trifocal lenses
<b>Standard Frames</b>	\$10 co-payment (up to \$90 retail frame cost; member responsible for balance over \$90)	\$20 allowance
<b>Contact Lenses**</b> (All contact lenses are in lieu of standard frames and spectacle lenses)	\$20 co-payment for medically necessary \$50 co-payment for elective contact lenses \$70 allowance for all other lenses not mentioned above	\$70 allowance

\* Spectacle Lenses: Plan participant pays any and all optional lens enhancement charges. Network providers may offer additional discounts on lens enhancements and multiple pair purchases.

\*\* Contact Lenses: The contact lens allowance applies toward the cost of the contact lenses as well as the professional fees for fitting and evaluation services.

\*\*\* Out-of-network claims must be filed within one year from the date of service.



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