

State of Connecticut partnership plan 2.0 — vision



Effective dates: July 01, 2026 – June 30, 2027

This is a summary of benefits for your vision plan.

Vision services and frequency	In-network plan coverage**	In-network member cost***	Out-of-network reimbursement
Exam and professional services: Frequency* : once per 12 month			
Eye exam	100% after \$15 copay	100% after \$15 copay	Up to \$45 allowance
Retinal screening	\$0	Up to \$39	Not covered
Standard eyeglass lenses allowances: Frequency* : one pair per 12 month			
Lenses	Copay: \$0		
Single vision	100%	\$0 copay	Up to \$40 allowance
Lined bifocal	100%	\$0 copay	Up to \$65 allowance
Lined trifocal	100%	\$0 copay	Up to \$75 allowance
Lenticular	100%	\$0 copay	Up to \$100 allowance
Lens enhancements / options:			
Oversize lenses	100%	\$0	Not covered
Rose #1 and #2 solid tints	100%	\$0	Not covered
Polycarbonate lenses <19 years of age standard	100%	\$0	Not covered
Polycarbonate lenses	\$0	\$40	Not covered
Standard progressives	\$0	\$65	\$65
Plastic dye tints	\$0	\$15	Not covered
Photochromic – glass or plastic	\$0	\$75	Not covered
Standard scratch coating	\$0	\$15	Not covered
Standard ultraviolet (UV) coating	\$0	\$15	Not covered
Standard anti-reflective (AR) coating	\$0	\$45	Not covered
Hi-index lenses	\$0	20% off retail	Not covered
All other lens options, including premium tiers	\$0	20% off retail	Not covered
Contact lenses retail allowance: Frequency* : one pair or single purchase per 12 month			
Elective	100% up to \$360 retail Allowance	Balance over \$360 Allowance	Up to \$345 allowance
Therapeutic	100%	\$0	Up to \$345 allowance
Frame retail allowance Frequency* : one per 12 month	100% up to \$175 retail Allowance	20% off balance over \$175 allowance	Up to \$126 allowance

* Your frequency period begins the day after your last visit (date of service basis)

Definitions:

Copay: the amount you pay towards your exam and/or materials, lenses and/or frames

Coinsurance: the percentage of charges Cigna Healthcare® will pay. Customer is financially responsible for the balance

Allowance: the maximum amount Cigna Healthcare will pay. Customer is financially responsible for any amount over the allowance

Cost per employee per month

Employee only:	\$8.11
Employee + 1:	\$15.03
Employee + family:	\$24.50



In-Network Benefits Include:

One pair of prescription plastic or glass lenses, all ranges of prescriptions (powers and prisms)

Lens Options:

- Standard Polycarbonate: covered for under 18 years of age; min. 20% save, \$40 out-of-pocket max. for adults
- Oversize lenses: covered under plan
- Rose Tints: #1 and #2 — covered under plan
- Solid Tints: min. 20% save, \$15 out-of-pocket max.
- Gradient Tints: \$20 out-of-pocket max.
- Standard photochromic: 20% save, \$78 out-of-pocket max.
- Standard anti-reflective coating: min. 20% save, \$45 out-of-pocket max.
- Standard scratch/UV coating: min. 20% save, \$17 out-of-pocket max.
- Progressive lenses: covered up to bifocal lens amount with 20% savings on the difference; \$81 out-of-pocket max. for standard lens

One frame of choice covered up to retail plan allowance, plus a 20% savings on amount that exceeds frame allowance.

One pair or a single purchase supply of contact lenses - in lieu of lenses and frame benefit, (may not receive contact lenses and frames in same benefit year). Allowance applied towards cost of supplemental contact lens professional services (including the fitting and evaluation), and contact lens materials.

Vision Network Savings Program:

- Minimum 20% savings on additional purchases of frames and/or lenses, including lens options, with a valid prescription; offered savings does not apply to contact lens materials. Check with your Cigna Healthcare Vision Network Provider for details.



To Locate a Vision Provider:

- Visit [Cigna.com](https://www.cigna.com) and select **Find a Doctor, Dentist, or Facility** at the top of the page.
- Then, scroll to the **Additional Directories** section, choose **Cigna Healthcare Vision serviced by EyeMed Directory** from the dropdown menu, and search for a participating provider near you.

** Coverage may vary at participating discount retail and membership club optical locations, please contact Customer Service for specific coverage information.

*** Provider participation is 100% voluntary; please check with your Eye Care Professional for any offered discounts.

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