

**VISION – EMPLOYER SPONSORED or VOLUNTARY**

Carrier	EyeMed (Provided by Ameritas)					
Plan Name	Silver		Gold		Platinum	
	In-Network	Out-of-Network Reimbursement	In-Network	Out-of-Network Reimbursement	In-Network	Out-of-Network Reimbursement
<b>Eye Examination</b>	\$10 Copay	Up to \$25	\$10 Copay	Up to \$25	100%	Up to \$25
<b>Frames</b>	\$100 Allowance, 20% off balance over \$100	Up to \$40	\$130 Allowance, 20% off balance over \$130	Up to \$40	\$150 Allowance, 20% off balance over \$150	Up to \$40
<b>Standard Lenses</b>						
Single Vision	\$15 Copay	Up to \$20	\$10 Copay	Up to \$20	100%	Up to \$20
Lined Bifocal	\$15 Copay	Up to \$35	\$10 Copay	Up to \$35	100%	Up to \$35
Lined Trifocal	\$15 Copay	Up to \$60	\$10 Copay	Up to \$60	100%	Up to \$60
Standard Progressive	\$65 Copay <sup>1</sup>	Not Covered	\$65 Copay <sup>1</sup>	Not Covered	\$65 Copay <sup>1</sup>	Not Covered
<b>Contact Lenses</b> (in lieu of lenses & frames)	\$100 Allowance, 15% off balance over \$100	Up to \$65	\$130 Allowance, 15% off balance over \$130	Up to \$65	\$150 Allowance, 15% off balance over \$150	Up to \$65
<b>Benefit Frequency*</b>	12/12/12	12/12/12	12/12/12	12/12/12	12/12/12	12/12/12

\* Benefit Frequency - Exams/lenses/frames

<sup>1</sup> Premium Progressive in-network are discounted.