ChoiceBuilder®

VISION BENEFIT SUMMARY

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
Eye Examination	$10 Copay	Up to $25	$10 Copay	Up to $25	100%	Up to $25
Frames	$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
Standard Lenses						
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[1]	Not Covered	$65 Copay[1]	Not Covered	$65 Copay[1]	Not Covered
Contact Lenses (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
Benefit Frequency*	12/12/12	12/12/12	12/12/12	12/12/12	12/12/12	12/12/12

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

* Benefit Frequency - Exams/lenses/frames

1 Premium Progressive in-network are discounted.

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