

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.