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[5]	Not Covered	$65 Copay[5]	Not Covered	$65 Copay[5]	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

Carrier	VSP® Vision Care[2,3,4,6,7,8]					
Plan Name	Silver ER Sponsored Only		Gold		Platinum	
	In-Network	Out-of-Network Reimbursement	In-Network	Out-of-Network Reimbursement	In-Network	Out-of-Network Reimbursement
Eye Examination	$20[1] Copay	Up to $45	$10 Copay	Up to $45	$10 Copay	Up to $45
Frames	$180 Allowance	Up to $70	$200 Allowance	Up to $70	$250 Allowance	Up to $70
Standard Lenses						
Single Vision	Covered In Full	Up to $30	$25 Copay	Up to $30	$25 Copay	Up to $30
Lined Bifocal	Covered In Full	Up to $50	$25 Copay	Up to $50	$25 Copay	Up to $50
Lined Trifocal	Covered In Full	Up to $65	$25 Copay	Up to $65	$25 Copay	Up to $65
Standard Progressive	Covered In Full	Up to $50	Covered In Full	Up to $50	Covered In Full	Up to $50
Contact Lenses (in lieu of lenses & frames)	$150 Allowance	Up to $105	$180 Allowance	Up to $105	$200 Allowance	Up to $105
Benefit Frequency*	12/24/24	12/24/24	12/12/24	12/12/24	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 The $20 Copay applies to exam and/or materials once in an eligibility period
2 Average 20%-25% savings on non-covered lens enhancements.
3 20% off additional glasses and sunglasses, including lens options, from any VSP Vision Care doctor within 12 months of your last WellVision Exam
4 Includes $250 per eye laser surgery benefit (in-network)
5 Premium Progressive in-network are discounted.
6 Sun Care included- provides Plano Sunglasses to members who do not have a prescription.
7. Essential Medical Eye Care included – members have access to supplemental coverage for urgent and medical eye care.
8. VSP LightCare™ included – members can use frame and lens benefits to get non-prescription eyewear from a VSP network doctor.