

VISION – EMPLOYER SPONSORED or VOLUNTARY

Carrier	EyeMed (Provided by Ameritas Group)					
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
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	Madison National Life					
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 \$40	\$10 Copay	Up to \$40	100%	Up to \$40
Frames	\$25 Copay \$130 Allowance, 20% off balance over \$130	Up to \$45	\$10 Copay \$130 Allowance, 20% off balance over \$130	Up to \$45	100% \$130 Allowance, 20% off balance over \$130	Up to \$45
Standard Lenses						
Single Vision	Included	Up to \$40	Included	Up to \$40	Included	Up to \$40
Lined Bifocal	Included	Up to \$60	Included	Up to \$60	Included	Up to \$60
Lined Trifocal	Included	Up to \$80	Included	Up to \$80	Included	Up to \$80
Contact Lenses (in lieu of lenses & frames)	\$25 Copay \$130 Allowance, 15% off balance over \$130	Up to \$105	\$25 Copay \$130 Allowance, 15% off balance over \$130	Up to \$105	\$25 Copay \$130 Allowance, 15% off balance over \$130	Up to \$105
Benefit Frequency*	12/12/24	12/12/24	12/12/24	12/12/24	12/12/12	12/12/12

Carrier	VSP ^{2,3,4}					
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	\$150 Allowance	Up to \$70	\$150 Allowance	Up to \$70	\$150 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
Contact Lenses (in lieu of lenses & frames)	\$150 Allowance	Up to \$105	\$150 Allowance	Up to \$105	\$150 Allowance	Up to \$105
Benefit Frequency*	12/24/24	12/24/24	12/12/24	12/12/24	12/12/12	12/12/12

* Benefit Frequency - Exams/lenses/frames

¹ The \$20 Copay applies to exam and/or materials once in an eligibility period

² Average 35%-40% savings on non-covered lens options

³ 20% off additional glasses and sunglasses, including lens options, from any VSP doctor within 12 months of your last WellVision Exam

⁴ Includes \$250 per eye laser surgery benefit (in-network)