

# 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>5</sup>	Not Covered	\$65 Copay <sup>5</sup>	Not Covered	\$65 Copay <sup>5</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

Carrier	VSP® Vision Care <sup>2,3,4,6</sup>					
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
<b>Eye Examination</b>	\$20 <sup>1</sup> Copay	Up to \$45	\$10 Copay	Up to \$45	\$10 Copay	Up to \$45
<b>Frames</b>	\$180 Allowance	Up to \$70	\$180 Allowance	Up to \$70	\$180 Allowance	Up to \$70
<b>Standard Lenses</b>						
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
<b>Contact Lenses</b> (in lieu of lenses & frames)	\$150 Allowance	Up to \$105	\$150 Allowance	Up to \$105	\$150 Allowance	Up to \$105
<b>Benefit Frequency*</b>	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 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.