Vision Plan

PROVIDED THROUGH AMERITAS

BENEFIT	EyeMed Access Network	Out of Network	Frequency
Vision Exam	$10 Copayment	Up to $35	Once every 12 months
Standard Fit & Follow Up Exam	Member Cost Up to $55	Not Covered	
Premium Fit & Follow Up Exam	10% Off Retail	Not Covered	
Contact Lenses	**Allowance**	**Max Amount**	Once every 12 months
Conventional	Up to $115	Up to $92	
Disposables	Up to $115	Up to $92	
Medically Necessary	$0 Copayment; Covered in Full	Up to $200	
Standard Plastic Lenses	**Co-Payment**	**Max Amount**	Once every 12 months
Single Vision	$25	Up to $25	
Bifocal	$25	Up to $40	
Trifocal	$25	Up to $55	
Lenticular	20% Discount	Not Covered	
Frames	$100 Allowance	Up to $45	Once every 24 months
Progressive Lenses			Once every 12 months
Standard	$65 Allowance + $25 lens deductible	Not Covered	
Premium	Lens Cost – 20% discount – $120 allowance + Standard Progressive cost	Not Covered	

***Please note: This plan covers either contact lenses or lenses for your glasses once every 12 months.**

Eligibility: Dependents are covered until age 26 irrespective of student status.

You're on the **EyeMed ACCESS** network. For a complete list of providers near you, use our Provider Locator on www.eyemed.com and choose the **ACCESS** network or call 1-866-723-0596.

Vision Rates	Monthly Cost
Employee Only	$ 8.40
Employee + Spouse	$ 16.24
Employee + Child(ren)	$ 13.96
Family	$ 21.76