

Plan Benefits	Eye Med through Ameritas	
	In-Network	Out-of-Network
General Plan Information		
• Exam	\$10 copay	N/A
• Materials	\$25 copay Glass Lenses	N/A
Benefit Frequency		
• Exam	12 months	12 months
• Lenses	12 months	12 months
• Frames	24 months	24 months
• Contacts	24 months	24 months
Covered Services		
• Examination	100% after exam copay	Reimbursed up to \$35
• Single Vision Lens	Covered after copay	Reimbursed up to \$25
• Bifocal Lens	Covered after copay	Reimbursed up to \$40
• Trifocal Lenses	Covered after copay	Reimbursed up to \$55
• Lenticular	20% discount	No benefit
• Standard Progressive	Standard: Up to \$65 max copay (after materials copay)	Not covered
Lens Options		
• UV Coating	\$15 copay	No benefit
• Scratch Resistant Coating	\$15	No benefit
• Anti-Reflective Coating	\$45	No benefit
• Other Add-Ons and Services	Discounts available	Not covered
Contact Lenses		
• Medically Necessary	Covered after copay	Reimbursed up to \$200
• Elective	Up to \$130 allowance	Reimbursed up to \$104
Frames	Up to \$130 allowance	Reimbursed up to \$65
Other Services		
• Corrective Vision Services (Laser Surgery)	Average discount of 15% off retail price or 5% off promotional price at US Laser Network participating providers	Not covered
• Second Pair of Glasses	Discount available	Not covered

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.