EyeChoice: Vision Benefits With Options

For businesses with 3+ enrolled employees

High value, low cost, employee choice

Ameritas offers affordable vision plans with the two largest vision networks, VSP and EyeMed. Or choose a reimbursement plan with no network. If you have at least 20 employees, consider offering more than one plan, such as one VSP and one EyeMed plan. You get the convenience of one carrier, one enrollment form, and one plan administration process.

Choose the vision coverage that's right for you and your employees.

Three simple steps

1. Select a plan or plans.
   - One plan, or a choice of plans with different network or coverage options.
2. Pick your plan elements.
   - For VSP and EyeMed network plans, choose the frame allowance and benefit frequency.
   - For a reimbursement plan, select a flat maximum or maximum covered expense (MCE) plan.
3. Select 3-tiered or 4-tiered monthly rates.

Compare plans, networks and member savings

VSP network	**EyeMed Insight** network	**No-network** reimbursement
VSP offers the nation's largest network of independent doctors. Retail locations* include: Costco Optical, Walmart, Sam's Club, Visionworks, Pearle Vision In-network online options for purchasing eyewear: eyeconic.com	EyeMed's network includes some of the most recognized names, including: LensCrafters, Pearle Vision, Target Optical In-network online options for purchasing eyewear: contactsdirect.com glasses.com lenscrafters.com ray-ban.com targetoptical.com oakley.com	Members will receive the same benefits no matter which vision provider they choose. Since there is no network, they can take advantage of special pricing offers from any vision provider.
Additional savings		
VSP provider discounts: • 20% off any amount exceeding retail frame allowance • 20-30% off additional prescription glasses and non-prescription sunglasses • 30-40% off lens enhancements • An extra $20-40 to spend on featured frame brands • 15% average off retail for LASIK or PRK laser eye correction, or 5% off promotional price, through a VSP provider	EyeMed provider discounts: • 20% off any amount exceeding retail frame allowance • 40% off complete pair of prescription glasses after plan benefit • 20% off materials not covered by the plan, including non-prescription sunglasses (excludes lens upgrades) • 15% off remaining contact lens balance and additional conventional contacts after plan benefit • 15% average off retail for LASIK or PRK laser eye correction, or 5% off promotional price, with U.S. Laser Network owned by LCA-Vision	Choose a savings program from Walmart or EyeMed. **Walmart eyewear savings:** Plan members can save on eyewear frames and lenses purchased at Walmart Vision Centers nationwide. They must present the savings card. **EyeMed discount overlay:** Plan members can save on exams, frames, eyeglass lenses and contact lenses when visiting EyeMed providers.

Based on applicable laws, reduced costs may vary by doctor location and material type. Costs are subject to change without notice. Eyewear savings are available at no additional cost to the plan premium and are not insurance.

**Not all providers at Costco, Walmart, and Sam's Club locations are VSP network providers. Please verify that your provider is in the VSP network before seeking services. The frame allowance at some retailers may be less due to lower wholesale pricing.*

Ameritas

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VSP network plans

All VSP network plans offer the same benefits for an annual eye exam and lenses. You choose the allowance for frames and contact lenses, the benefit frequency, and either 3-tier or 4-tier rates.

If you are offering more than one plan, make choosing a plan easy for your employees. Pair one VSP plan with either:

- another VSP network plan with higher or lower benefit coverage, OR
- an EyeMed network plan or no-network plan with similar benefit coverage.

Base benefits

Please note: benefits can be applied to contacts OR glasses during the benefit year.

	What the plans pay in-network	What the plans pay out-of-network
Deductible	$10 exam, $25 materials	
Annual eye exam	Covered in full	Up to $45
Lenses		
Single vision	Covered in full	Up to $30
Bifocal	Covered in full	Up to $50
Trifocal	Covered in full	Up to $65
Standard polycarbonate	Covered in full for dependent children	No benefit
Prescription safety glasses	Covered in lieu of regular eyeglasses or contacts; lens and frame allowances apply	

Variable benefits and rates

	Plan 1	Plan 2	Plan 3	Plan 4	Plan 5	Plan 6
Choose an allowance: displayed as in-network / out-of-network						
Frames	$130 / Up to $70		$150 / Up to $70		$180 / Up to $70	
Contacts	$130 / Up to $105		$150 / Up to $120		$180 / Up to $144	
Choose a benefit frequency: displayed in months						
Exam-lens-frames	12-12-24	12-12-12	12-12-24	12-12-12	12-12-24	12-12-12
Choose a monthly rate tier						
3-tier rates	**V20001**	**V20015**	**V20021**	**V23027**	**V20048**	**V23036**
Employee	$8.24	$9.04	$8.56	$9.36	$9.08	$9.92
Employee + 1 dependent	$16.60	$18.08	$17.16	$18.72	$18.16	$19.84
Employee + 2 dependents	$23.32	$25.40	$24.12	$26.36	$25.60	$27.96
4-tier rates						
Employee	$8.24	$9.04	$8.56	$9.36	$9.08	$9.92
Employee + spouse	$17.84	$19.44	$18.48	$20.12	$19.56	$21.40
Employee + child(ren)	$14.44	$15.76	$14.92	$16.36	$15.84	$17.28
Family	$24.04	$26.16	$24.84	$27.12	$26.32	$28.76

All rates are valid for policies with an effective date through January 1, 2027, and are guaranteed for four years, except in the state Florida where plans are guaranteed for 12 months. Voluntary plans may be set to align with the Section 125 plan year.

Limitations

Please refer to the Certificate of Insurance for a complete list of covered procedures. Check for availability in your state. Covered expenses will not include, and no benefits will be payable for:

- In-network contact lens exam – fit & follow-up cost is capped at $60 (except in WA).
- Vision examinations, lenses and frames more than the frequency as indicated on the plan summary page.
- Services and/or materials not specifically included in the Schedule as covered Plan Benefits.
- Plano lenses (lenses with refractive correction of less than plus or minus .50 diopter) except as specifically allowed in the frames benefit section of the Plan Benefits.
- Services or materials that are cosmetic, including plano contact lenses to change eye color and artistically painted contact lenses.
- Two pairs of glasses in lieu of bifocals.
- Replacement of spectacle lenses, frames, and/or contact lenses furnished under this plan that are lost or damaged, except at the normal intervals when services are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Contact lens modification, polishing or cleaning.
- The refitting of contact lenses after the initial 90-day filing period.
- Contact lens insurance policies or service contracts.
- Additional office visits associated with contact lens pathology.
- Local, state and/or federal taxes, except where law requires us to pay.
- Covered persons may be required to purchase a membership at certain retail locations before accessing plan benefits.
- Plans not available in RI.
- Specific plans not listed in this brochure are available for MA and MD.

Consult your sales representative regarding plan availability in the states of MA, WA and MD.

EyeMed network plans

All EyeMed network plans offer the same benefits for an annual eye exam and lenses. You choose the allowance for frames and contact lenses, the benefit frequency, and either 3-tier or 4-tier rates.

If you are offering more than one plan, make choosing a plan easy for your employees. Pair one EyeMed plan with either:

- another EyeMed network plan with higher or lower benefit coverage, OR
- a VSP network plan or no-network plan with similar benefit coverage.

Base benefits

Please note: benefits can be applied to contacts AND frames during the benefit year.

	What the plans pay in-network	What the plans pay out-of-network
Deductible	$10 exam, $25 materials	No deductible
Annual eye exam	Covered in full	Up to $35
Lenses		
Single vision	Covered in full	Up to $25
Bifocal	Covered in full	Up to $40
Trifocal	Covered in full	Up to $55
Standard polycarbonate	See provider for special pricing	
Prescription safety glasses	No benefit	

Variable benefits and rates

	Plan 1	Plan 2	Plan3	Plan 4	Plan 5	Plan 6
Choose an allowance: displayed as in-network / out-of-network						
Frames	$130 / Up to $65		$150 / Up to $75		$180 / Up to $90	
Contacts	$130 / Up to $104		$150 / Up to $120		$180 / Up to $144	
Choose a benefit frequency: displayed in months						
Exam-lens-frames	12-12-24	12-12-12	12-12-24	12-12-12	12-12-24	12-12-12
Choose a monthly rate tier						
3-tier rates	**V01013**	**V1016**	**V1019**	**V01022**	**V01025**	**V1028**
Employee	$7.44	$8.12	$7.76	$8.44	$8.48	$9.24
Employee + 1 dependent	$14.88	$16.28	$15.96	$17.44	$17.56	$19.12
Employee + 2 dependents	$21.00	$22.84	$22.88	$24.96	$25.20	$27.48
4-tiered rates						
Employee	$7.44	$8.12	$7.76	$8.44	$8.48	$9.24
Employee + spouse	$16.04	$17.52	$17.16	$18.72	$18.84	$20.60
Employee + child(ren)	$13.00	$14.16	$13.96	$15.24	$15.36	$16.72
Family	$21.60	$23.56	$23.36	$25.52	$25.72	$28.08

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Limitations

Please refer to the Certificate of Insurance for a complete list of covered procedures. Check for availability in your state. Covered expenses will not include, and no benefits will be payable for:

- Vision examinations, lenses and frames more than the frequency as indicated on the plan summary page.
- Orthoptics or vision training and any associated supplemental testing.
- Plano lenses (lenses with refractive correction of less than plus or minus .50 diopter) except as specifically allowed in the frames benefit section of the Plan Benefits.
- Two pairs of glasses in lieu of bifocals.
- Replacement of spectacle lenses, frames, and/or contact lenses furnished under this plan that are lost or damaged, except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes.
- Plans not available in RI.
- Specific plans not listed in this brochure are available for MA , MT, ME and MD.

Consult your sales representative regarding plan availability in the states of MA, WA and MD.

No-network reimbursement plans

A Flat Max plan provides a maximum annual reimbursement amount for eligible exams, glasses and contacts collectively. You choose the annual maximum amount.

A maximum covered expense (MCE) plan reimburses members based on fixed amounts assigned to vision services and materials. Exam-lens-frame benefit frequencies apply. This plan covers an exam, eyeglass lenses or contacts and a frame once every 12 months.

If you are offering more than one plan, make choosing a plan easy for your employees. Offer a no-network reimbursement plan and a network plan to give your employees options.

Base benefits

	MCE plan	Flat Max plans
Benefit frequencies (months)		
Exam-lens-frames	12-12-12	No frequency limitations
What the plan pays		
Exam	Up to $50	The annual maximum can be used for eligible exams, lenses, contacts, frames and prescription safety glasses collectively.
Lenses		
Single vision	Up to $30	
Bifocal	Up to $50	
Trifocal	Up to $100	
Progressive	Up to $130	
Frames	Up to $80	
Contacts	Up to $110	
Prescription safety glasses	Covered in lieu of regular eyeglasses or contacts; lens and frame allowances apply	

Variable benefits and rates

	Plan 1	Plan 2	Plan 3	Plan 4
Benefit	MCE	$100 flat max	$150 flat max	$200 flat max
Choose a monthly rate tier				
3-tiered rates				
Employee	$5.96	$4.28	$7.04	$9.52
Employee + 1 dependent	$11.92	$8.96	$14.48	$19.64
Employee + 2 dependents	$16.80	$12.88	$20.76	$28.20
4-tiered rates				
Employee	$5.96	$4.28	$7.04	$9.52
Employee + spouse	$12.88	$9.60	$15.56	$21.20
Employee + child(ren)	$10.44	$7.84	$12.68	$17.24
Family	$17.36	$13.16	$21.20	$28.92

All rates are valid for policies with an effective date through January 1, 2027, and are guaranteed for four years, except in the state Florida where plans are guaranteed for 12 months. Voluntary plans may be set to align with the Section 125 plan year.

Limitations

Please refer to the Certificate of Insurance for a complete list of covered procedures. Check for availability in your state. Covered expenses will not include, and no benefits will be payable for:

- Vision examinations, lenses and frames exceeding the set annual benefit amount.
- Examinations performed, or frames or lenses ordered, before the member was covered under the plan.
- Subject to extension of benefits, any examination performed or frame or lens ordered after the coverage under the plan ceases.
- Sub-normal eye care aids; orthoptic or eye care training or any associated testing.
- Non-prescription lenses.
- Any eye examination or corrective eyewear required by an employer as a condition of employment.
- Medical or surgical treatment of the eyes.
- Any service or supply not shown on the Schedule of Eye Care Procedures.
- Coated lenses; oversize lenses (exceeding 71 mm); photo-gray lenses; polished edges; UV-400 coating and facets, and tints other than solid.
- Claims filed more than 90 days after completion of the service (or longer than 90 days in certain states). An exception is if the Insured shows it was not possible to submit the proof of loss within this period.

Consult your sales representative regarding plan availability in the states of WA and MD.

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