

vision insurance benefits

Take a look at the two Ameritas vision plan choices selected by Minnesota Service Cooperatives and offered through National Insurance Services.

High Plan Highlights

Plan members choose from over 60,000 VSP Choice network access points nationwide, making it easy to use the following benefits right where they live, work and shop:

- Fully covered eye exam (less \$10 deductible) and significant eye wear savings when you visit a network doctor.
- 20% off additional non-covered complete pair of glasses and sunglasses.
- Up to 20% savings on lens extras such as scratch resistant, anti-reflective coatings and progressive lenses.
- 15% off contact lens fit and follow-up.
- Laser vision correction discounts with VSP and a contracted laser surgery center.
- Personalized, quality eye care from a private practice doctor for a lifetime of good vision.

For the best value, members may find a VSP Choice network doctor at www.vsp.com or call VSP at 800-877-7195. Or, if choosing a non-VSP provider, members receive a schedule of allowances for their eye exam and eye wear.

Low Plan Highlights

- This plan is based on an established schedule of benefits. Members select any eye doctor that best fits their needs.
- Employees pay their eye doctor for all services, then submit a claim to Ameritas for reimbursement.
- Claims are reimbursed based on a schedule of benefits, so your employees know precisely how much is covered ahead of time.
- Includes an optional program with access to network providers who offer eye wear and services at reduced costs.

monthly premium rates

This pricing for plans with effective dates of July 1, 2016, through December 31, 2017, is valid for 2 years from the effective date.

	Low Plan	High Plan
Employee Only	\$6.20	\$9.32
Employee + 1	\$11.32	\$17.40
Employee + 2 or More	\$16.12	\$26.80

vision insurance summary of benefits

BENEFITS	LOW PLAN	HIGH PLAN	
		in-network	out-of-network
Required participation: the greater of three lives or 10 percent enrollment.			
Annual Eye Exam	N/A	100% covered	\$43
Frame	\$100	\$120	\$40
Single Vision Lenses	up to \$40	100% covered	\$26
Bifocal Lenses	up to \$60	100% covered	\$43
Trifocal Lenses	up to \$75	100% covered	\$60
Lenticular Lenses	up to \$80	100% covered	\$91
Contact Lenses* - elective	up to \$140	up to \$105	\$100
Contact Lenses* - medically necessary	up to \$140	100% covered	\$210
Frequency			
Exam	N/A	12 months	12 months
Lenses	12 months	12 months	12 months
Frames	24 months	24 months	24 months
Deductibles			
Exam	N/A	\$10	\$10
Materials	\$10 cal year**	***\$25	\$25

* Contact lenses are in lieu of any other frame or benefit.

** Deductible applies to the first service received.

*** Deductible applies to a complete pair of glasses or to frames, whichever is selected

Limitations and Exclusions

Covered Expenses will not include and no benefits will be payable for expenses incurred for:

Limitations for Low Plan

- Vision examinations.
- Lenses more than the frequency as indicated on the plan summary page.
- Frames more than the frequency as indicated on the plan summary page.
- Contact lenses more than once in any twelve month period. When chosen, contact lenses shall be in lieu of any other lens or frame benefit during the twelve month period. When lenses and frames are chosen, expenses for contact lenses are not Covered Expenses during the twelve month period.
- Examinations performed or frames or lenses ordered before the member was covered under the eye care expense benefits.
- Subject to extension of benefits, any examination performed or frame or lens ordered after the member's coverage under the eye care expense benefits ceases.
- Sub-normal eye care aids; orthoptic or eye care training or any associated testing.
- Non-prescription lenses.
- Replacement or repair of lost or broken lenses or frames except at normal intervals.
- 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.

Limitations for High Plan

- More than one eye exam in the frequency as indicated on the plan summary page.
- More than one pair of lenses in the frequency as indicated on the plan summary page.
- More than one set of frames in 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 fitting 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.

High Plan Note: Some brands of spectacle frames may be unavailable at all locations for purchase as Covered Expenses, or may be subject to additional out-of-pocket expenses. Members may obtain details regarding frame brand availability from their treating provider or by calling VSP's Customer Care Division at (800) 877-7195.

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