

PrimeStar[®] Basic Vision

Individual vision insurance - Massachusetts, Montana, Rhode Island

• No waiting periods

• No enrollment fees

Plan details

This plan gives policyholders the freedom to use any provider, with no network restrictions.

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|---|-----------------|
| Benefit frequencies | |
| Exam | Every 12 months |
| Eyeglass lenses or contacts | Every 12 months |
| Frames | Every 24 months |
| Deductible* | |
| Exam per person per year (based on date of service) | \$10 |
| Eyeglass materials | \$50 |
| Annual eye exam | Up to \$50 |
| Lenses | |
| Single vision | Up to \$40 |
| Bifocal | Up to \$60 |
| Trifocal | Up to \$70 |
| Lenticular | Up to \$100 |
| Progressive | Up to \$100 |
| Frames | Up to \$65 |
| Contacts | |
| Elective | Up to \$100 |
| Lens options and coatings, member cost | |
| Std. polycarbonate | No benefit |
| Tints & dyes (except pink I & II) | No benefit |
| Photochromatic | No benefit |
| Scratch resistant | No benefit |
| Anti-reflective | No benefit |
| Ultraviolet | No benefit |

Based on applicable laws, reduced cost may vary by doctor location.

* Deductible is a combined \$50 per person per lifetime for frames and lenses (other than contact lenses). A maximum of three (3) individual deductibles per family shall apply to frames deductible.

| Monthly rates | |
|--|---------|
| Policyholder | \$9.66 |
| Policyholder plus one dependent | \$17.77 |
| Policyholder plus two or more dependents | \$26.56 |

Vision limitations and exclusions

What is not covered?

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.
- Examinations performed or frames or lenses ordered before the Insured was covered under this section.
- Any examination performed or frame or lens ordered after the Insured's coverage under this section ceases, subject to Extension of Benefits.
- Sub-normal vision aids; orthoptic or vision 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 Services.
- Coated lenses; oversize lenses (exceeding 71 mm); photo-gray lenses; polished edges; UV-400 coating and facets, and tints other than solid.

This brochure highlights the vision coverage available through Ameritas Life Insurance Corp. Please refer to the Certificate of Insurance for a complete list of covered procedures.



Underwritten by Ameritas Life Insurance Corp. | 5900 O Street Lincoln, NE 68510

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