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.

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.

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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.

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