



**Ameritas Vision PPO INDIVIDUAL  
Benefit and Rate Sheet**



Available in All States  
excluding CA and CO

**PPO INDIVIDUAL VSP VISION PLANS**

| Plan Name   | <b>CHOICE A<br/>\$10/\$25/\$150<br/>0031</b> | <b>CHOICE B<br/>\$10/\$25/\$160<br/>0032</b> | <b>CHOICE B<br/>\$0/\$180<br/>0033</b> | <b>CHOICE C<br/>\$10/\$10/\$180<br/>0034</b> | <b>CHOICE C<br/>\$20/\$200<br/>EASYOPTIONS<sup>1</sup><br/>LIGHTCARE<sup>TM2</sup><br/>0035</b> |
|---|--|--|--|--|---|
| Network   | CHOICE PPO<br>IN-NETWORK                     | CHOICE PPO<br>IN-NETWORK                     | CHOICE PPO<br>IN-NETWORK               | CHOICE PPO<br>IN-NETWORK                     | CHOICE PPO<br>IN-NETWORK  |
| <b>Benefit Frequency</b>  |  |  |  |  |   |
| Exam/Lens/Frame   | Every 12/24/24<br>months                     | Every 12/12/24<br>months                     | Every 12/12/24<br>months               | Every 12/12/12<br>months                     | Every 12/12/12<br>months  |
| <b>Deductible/Copay</b>   |  |  |  |  |   |
| Exam  | \$10   | \$10   | \$0                                    | \$10   | \$20  |
| Lens/Frame  | \$25   | \$25   |  | \$10   |   |
| <b>Benefits (After Deductible/Copay)</b>  |  |  |  |  |   |
| <b>Exam</b>   | 100%   | 100%   | 100%                                   | 100%   | 100%  |
| <b>Lenses - Single</b>  | 100%   | 100%   | 100%                                   | 100%   | 100%  |
| <b>Lenses - Bifocal</b>   | 100%   | 100%   | 100%                                   | 100%   | 100%  |
| <b>Lenses - Trifocal</b>  | 100%   | 100%   | 100%                                   | 100%   | 100%  |
| <b>Lenses - Enhancements</b>  | Subject to copays                            | Subject to copay                             | Subject to copay                       | Subject to copay                             | Subject to copay  |
| <b>Frame</b>  | \$150 <sup>3</sup>                           | \$160 <sup>3</sup>                           | \$180 <sup>3</sup>                     | \$180 <sup>3</sup>                           | \$200 <sup>3</sup>  |
| <b>Contacts - Elective<br/>(in lieu of glasses)</b>   | \$150 allowance                              | \$160 allowance                              | \$180 allowance                        | \$180 allowance                              | \$180 allowance   |
| <b>Fit &amp; Follow-up Exam</b>   | Up to \$60 copay                             | Up to \$60 copay                             | Up to \$60 copay                       | Up to \$60 copay                             | Up to \$60 copay  |
| <b>Medically Necessary</b>  | 100%   | 100%   | 100%                                   | 100%   | 100%  |
| <b>Rates for 2024 Effective Dates - \$5 administration fee applies to each monthly invoice.</b> |  |  |  |  |   |
| Member Only   | \$7.60                                       | \$9.18                                       | \$10.58                                | \$11.02                                      | \$13.22   |
| Member + Spouse/DP  | \$12.66                                      | \$15.84                                      | \$18.63                                | \$19.53                                      | \$23.91   |
| Member + 1 Child  | \$12.66                                      | \$15.84                                      | \$18.63                                | \$19.53                                      | \$23.91   |
| Member + Children   | \$13.38                                      | \$16.77                                      | \$19.76                                | \$20.72                                      | \$25.40   |
| Member + Family   | \$19.87                                      | \$25.28                                      | \$30.05                                | \$31.60                                      | \$39.09   |
| Rate Guarantee  | 2 years                                      | 2 years                                      | 2 years                                | 2 years                                      | 2 years   |

1 EasyOptions - Choose your upgrade - \$260 Frame Allowance, or Anti-glare Lenses, or Progressive Lenses, or Light-reactive Lenses, or in lieu of glasses a \$260 Contact Lens allowance. VSP EasyOptions plan benefits are not available at retail chains such as Walmart®, Sam's Club®, or Costco.

2 LightCare - You can use your frame and lens benefit to get non-prescription (ready-to-wear) eyewear from your VSP network doctor. Such as non-prescription sunglasses or blue light filtering glasses.

3 Coverage with a retail chain, Walmart®, Sam's Club®, or Costco may be different or not apply; such as \$90 Frame Allowance at retail chain. Before seeking services, contact VSP to find a VSP provider or a retail chain to discuss their allowances.