PIPESTONE AREA SCHOOLS ISD #2689

Eye Care Highlight Sheet

Ameritas

High Plan: Focus® Plan Summary

	VSP Choice Network	Out of Network
Deductibles		
	$10 Exam	$10 Exam
	$25 Eye Glass Lenses or Frames*	$25 Eye Glass Lenses or Frames
Annual Eye Exam	Covered in full	Up to $43
Lenses (per pair)		
Single Vision	Covered in full	Up to $26
Bifocal	Covered in full	Up to $43
Trifocal	Covered in full	Up to $60
Lenticular	Covered in full	Up to $91
Progressive	See lens options	NA
Contacts		
Fit & Follow Up Exams	15% discount See Additional Focus Features.	No benefit
Elective	Up to $105	Up to $100
Medically Necessary	Covered in full	Up to $210
Frame Allowance	$120	Up to $40
Frequencies (months)		
Exam/Lens/Frame	12/12/24 Based on date of service	12/12/24 Based on date of service

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

Lens Options (member cost)*

	VSP Choice Network	Out of Network
Progressive Lenses	Up to provider's contracted fee for Lined Bifocal Lenses. The patient is responsible for the difference between the base lens and the Progressive Lens charge.	Up to Lined Bifocal allowance.
Std. Polycarbonate	Covered in full for dependent children $33 adults	No benefit
Solid Plastic Dye	$15 (except Pink I & II)	No benefit
Plastic Gradient Dye	$17	No benefit
Photochromatic Lenses (Glass & Plastic)	$31-$82	No benefit
Scratch Resistant Coating	$17-$33	No benefit
Anti-Reflective Coating	$43-$85	No benefit
Ultraviolet Coating	$16	No benefit

**Lens Option member costs vary by prescription, option chosen and retail locations.*

Monthly Rates

Employee Only (EE)	$10.80
EE + 1 Dependent	$18.80
EE + 2 or more Dependents	$25.68