ITHACA CITY SCHOOL DISTRICT

12/12/12

VISION SERVICES	AMERITAS DUAL VSP		EYEMED	
Standard Exam Copay	$0		$0	
Materials Copay	$0		$0	
Child Age Limit	26		26	
Network	VSP		EyeMed	
Eye Exams:	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Frequency	Once in 12 months		Once in 12 months	
	Covered in full after copay	Up to $45 Reimbursement after copay	Covered in full after copay	Up to $35 Reimbursement after copay
Lenses:	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Frequency	Once in 12 months		Once in 12 months	
Single Vision	Covered in full after copay	Up to $30 Reimbursement after copay	Covered in full after copay	Up to $25 Reimbursement after copay
Lined Bifocal	Covered in full after copay	Up to $50 Reimbursement after copay	Covered in full after copay	Up to $40 Reimbursement after copay
Lined Trifocal	Covered in full after copay	Up to $65 Reimbursement after copay	Covered in full after copay	Up to $55 Reimbursement after copay
Lenticular	Covered in full after copay	Up to $100 Reimbursement after copay	20% discount	No benefit
Frames:	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Frequency	Once in 12 months		Once in 12 months	
	Up to $130 allowance after copay. Plus 20% off any amount above the retail allowance	Up to $70 Reimbursement after copay	Up to $130 allowance after copay	Up to $65 Reimbursement after copay
Savings on Second Pair Glasses	Included - 20% Discount		Included - 40% Discount	
Contact Lenses:	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Frequency	Once in 12 months		Once in 12 months	
Elective	Up to $130 allowance after copay. Evaluation, Fitting and Follow Up Care Member cost $60	Up to $105 Reimbursement	Up to $130 allowance after copay. Evaluation, Fitting and Follow Up Care Member cost $55 for Standard; Premium: 10% off of retail	Up to $104 Reimbursement; No benefit for Evaluation, Fitting and Follow up Care
Medically Necessary	Covered in full after copay	Up to $210 Reimbursement	Covered in full after copay	Up to $210 Reimbursement

Employee Monthly Rates (for either VSP or EyeMed Plan):

Single- $0.00

Family- $11.68

If you are enrolled in dental, you will automatically be enrolled in single VSP vision. If you would like to elect EyeMed or add family members, you will need to fill out an enrollment form.

Once you enroll in vision coverage, you may not make any changes to your coverage for two years.