

**Belmont University  
Eye Care Plan Highlights (revised)**

**Vision Perfect - Materials Only**

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Deductible

Waived

**SERVICE**

**MAXIMUM COVERED  
EXPENSE**

Frames

65.00

Lenses (Per pair of lens - Patient pays remainder)

Single

40.00

Bifocal

60.00

Trifocal

75.00

No line bifocal or progressive power

80.00

Lenticular

80.00

Contact Lenses

105.00

The patient will be responsible for any cost over the specified plan benefits, as stated above.

When contact lenses are selected they shall be in lieu of any other lens or frame benefit allowed in that benefit period. When lenses and frames are chosen, expenses for contact lenses will not be covered in that benefit period.

**FREQUENCY ALLOWANCE**

Frames

12 Months

Lenses

12 Months

**CLAIM AND BENEFIT QUESTIONS**

Phone

1-800-487-5553

Address

Ameritas  
P. O. Box 82520  
Lincoln, NE 68501

Web Site

[www.ameritasgroup.com](http://www.ameritasgroup.com)