Employer Sponsored Vision Service Plans

Benefit Comparison and Rates for 3-500 employees

VSP Vision care for life

NORTH RANCH BENEFITS TRUST
POWERED BY WARNER PACIFIC

BENEFIT SUMMARY								
	VSP Choice Vision Plans		VSP Signature Vision Plans					
	Plan A $0 12/24/24	Plan B $0 12/12/24	Plan A $10 12/24/24	Plan A $25 12/24/24	Plan B $10 12/12/24	Plan B $25 12/12/24	Plan C $10 12/12/12	Plan C $25 12/12/12
BENEFIT FREQUENCY								
EXAM	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months
LENSES	Once every 24 months	Once every 12 months	Once every 24 months	Once every 24 months	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months
FRAMES	Once every 24 months	Once every 24 months	Once every 24 months	Once every 24 months	Once every 24 months	Once every 24 months	Once every 12 months	Once every 12 months
BENEFITS								
COPAYS	Exam or Materials: $0	Exam or Materials: $0	Exam or Materials: $10	Exam or Materials: $25	Exam or Materials: $10	Exam or Materials: $25	Exam or Materials: $10	Exam or Materials: $25
NETWORK	PPO	Out of Network [1]	PPO			Out of Network [1]		
EXAM	100% covered	$45 max. reimbursed	100% covered			$50 max. reimbursed		
LENSES AND FRAMES								
NETWORK	PPO	Out of Network [1]	PPO			Out of Network [1]		
SINGLE	100% covered	$30 max. reimbursed	100% covered			$50 max. reimbursed		
BIFOCALS	100% covered	$50 max. reimbursed	100% covered			$75 max. reimbursed		
TRIFOCALS	100% covered	$65 max. reimbursed	100% covered			$100 max. reimbursed		
LENTICULAR	100% covered	$100 max. reimbursed	100% covered			$125 max. reimbursed		
FRAMES	$160 allowance [3]	$70 max. reimbursed	$160 allowance [3]			$70 max. reimbursed		
CONTACT LENSES (In lieu of frames and lenses) [2, 3]								
ELECTIVE	Contact lens exam (fitting & evaluation): $60 copay		Contact lens exam (fitting & evaluation): $60 copay					
	$130 allowance	$105 max. reimbursed	$150 allowance			$105 max. reimbursed		
MEDICALLY NECESSARY	Up to 100%	$210 max. reimbursed	Up to 100%			$210 max. reimbursed		

[1] If the member chooses to have services provided by a non-participating (out of network) provider, the member must file a claim and the claim will be processed based on the reimbursement amount only.

[2] The member will have a $60 copay for the contact lens exam (fitting & evaluation) when elective contact lenses are chosen in lieu of frames and lenses.

[3] Extra discounts and savings of up to 20-25% on glasses, up to 15% on contacts, and between 5-15% off laser vision correction are available from your VSP provider. Please review the plan summary for details.

EMPLOYER SPONSORED VISION	Effective January 1, 2018 through December 31, 2018 [5,6]		
A $15 monthly administration fee applies to all groups.	Employee Only	Employee + 1 or Employee + Children	Family
Choice A $0 – 12/24/24	$7.93	$13.03	$20.97
Choice B $0 – 12/12/24	$11.12	$16.92	$27.28
Signature A $25 12/24/24	$8.68	$13.18	$21.28
Signature B $25 12/12/24	$10.86	$16.52	$26.61
Signature C $25 12/12/12	$13.27	$20.18	$32.50
Signature A $10 12/24/24	$11.03	$16.55	$26.67
Signature B $10 12/12/24	$13.75	$20.68	$33.32
Signature C $10 12/12/12	$16.79	$25.24	$40.65

[5] All groups receive a renewal each January where rates and/or benefits are subject to change.

[6] Rates include the ACA Tax. Visit www.irs.gov and search Affordable Care Act (ACA) Tax Provisions for more information.

VSP plans are available to groups headquartered in any of the following states: CA, CO, GA, IA, IL, IN, KS, MI, MN, MO, NC, NJ, NV, OH, OK, SC, TN, TX and WV. The group's employees can live in any of the 50 states.

The employer must choose one of the following participation options:

1. VSP participation and contribution matches employer-sponsored medical plan participation exactly **OR**
2. VSP participation and contribution matches employer-sponsored dental plan participation exactly **OR**
3. VSP participation is 100% employer paid and all eligible employees and all eligible dependents are enrolled **OR**
4. VSP participation is 100% employer paid and all eligible employees and no dependents are enrolled

The summary above is meant to be a brief description of plan benefits and rates only. This is not a policy. For a complete description of benefits, exclusions, limitations and participation requirements, please consult the contract and/or evidence of coverage and disclosure brochure. Either of these is available upon request. The accuracy of this summary is not guaranteed and the information herein is subject to change without notice. This is not an offer of coverage.

North Ranch Benefits Trust
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