Voluntary Vision Service Plans

Benefit Comparison and Rates for 1-500 employees

BENEFIT SUMMARY						
	VSP Choice Vision Plans				VSP Signature Vision Plans	
	Plan A $15/$30 12/24/24		Plan B $15/$30 12/12/24		Plan C $15/$30 12/ 12/12	
BENEFIT FREQUENCY						
EXAM	Every 12 months		Every 12 months		Every 12 months	
LENSES	Every 24 months		Every 12 months		Every 12 months	
FRAMES	Every 24 months		Every 24 months		Every 12 months	
COPAYS						
EXAM	$15		$15		$15	
LENSES AND/OR FRAMES	$30		$30		$30	
EXAM						
NETWORK	Choice	Out of Network[1]	Choice	Out of Network[1]	Signature	Out of Network[1]
EXAM	100%	$45 max. reimbursed	100%	$45 max. reimbursed	100%	$50 max. reimbursed
LENSES AND FRAMES						
SINGLE	100%	$30 max. reimbursed	100%	$30 max. reimbursed	100%	$50 max. reimbursed
BIFOCALS	100%	$50 max. reimbursed	100%	$50 max. reimbursed	100%	$75 max. reimbursed
TRIFOCALS	100%	$65 max. reimbursed	100%	$65 max. reimbursed	100%	$100 max. reimbursed
LENTICULAR	100%	$100 max. reimbursed	100%	$100 max. reimbursed	100%	$125 max. reimbursed
FRAMES	$180 allowance[3]	$70 max. reimbursed	$180 allowance[3]	$70 max. reimbursed	$180 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	
	$180 allowance	$105 max. reimbursed	$180 allowance	$105 max. reimbursed	$180 allowance	$105 max. reimbursed
MEDICALLY NECESSARY	Up to 100%	$210 max. reimbursed	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.

VOLUNTARY VISION RATES			Rates effective 1/1/18 through 12/31/18
A $15 monthly administration fee applies to all groups.	Employee Only	Employee + 1 or Employee + Children	Family
Choice A $15/$30 12/24/24	$8.55	$13.34	$20.87
Choice B $15/$30 12/12/24	$11.36	$17.91	$28.28
Signature C $15/$30 12/12/12	$17.32	$27.24	$42.94

[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.

North Ranch Benefits Trust

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