

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 | Once every 12 months | Once every 12 months | Once every 12 months | |
| LENSES | Once every 24 months | Once every 12 months | Once every 12 months | |
| FRAMES | Once every 24 months | Once every 24 months | Once every 12 months | |
| BENEFITS | | | | |
| COPAYS | Exam: \$15 Materials: \$30 | Exam: \$15 Materials: \$30 | Exam: \$15 Materials: \$30 | |
| NETWORK | PPO Network | | PPO Network | Out of Network ¹ |
| EXAM | 100% | \$45 max. reimbursed | 100% | \$50 max. reimbursed |
| LENSES AND FRAMES | | | | |
| SINGLE | 100% | \$30 max. reimbursed | 100% | \$50 max. reimbursed |
| BIFOCALS | 100% | \$50 max. reimbursed | 100% | \$75 max. reimbursed |
| TRIFOCALS | 100% | \$65 max. reimbursed | 100% | \$100 max. reimbursed |
| LENTICULAR | 100% | \$100 max. reimbursed | 100% | \$125 max. reimbursed |
| FRAMES | \$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 | |
| | \$150 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.

| VOLUNTARY VISION RATES | | Rates effective 1/1/2017 through 12/31/17 | | |
|--|---------------|---|---------|--|
| 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.

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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