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	Out of Network[1]	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	
	$180 allowance	$105 max. reimbursed	$180 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.

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