Vision Service Plans

Benefit Comparison and Rates

Individual and Family

North Ranch Benefits Trust
POWERED BY WARNER PACIFIC

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 12/12/12**	**Plan A $15/$30 12/24/24**	**Plan A $15/$30 CVC [4] 12/24/24**	**Plan B $15/$30 12/12/24**	**Plan B $15/$30 CVC [4] 12/12/24**	**Plan B $15 12/12/24**	**Plan B $15 CVC[4] 12/12/24**
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	Once every 12 months
Lenses	Once every 24 months	Once every 12 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 12 months	Once every 24 months	Once every 24 months	Once every 24 months	Once every 24 months	Once every 24 months	Once every 24 months
BENEFITS									
Copays	Exam: $15 Materials: $30	Exam: $15 Materials: $30	Exam or Materials: $15	Exam: $15 Materials: $30	Exam: $15 Materials: $30	Exam: $15 Materials: $30	Exam: $15 Materials: $30	Exam or Materials: $15	Exam or Materials: $15
Network	PPO	Out of Network		PPO			Out of Network		
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	$150 allowance [3]	$70 max. reimbursed		$150 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.

[4] CVC is Computer Vision Care Benefit. $10 copay for frame and lenses, $90 frame allowance.

VOLUNTARY VISION RATES				
A $5 administration fee applies to all individual and family plans monthly invoices.	Member Only	Member + 1	Member + Children	Family
Choice Plans				**Rates effective through 12/31/16**
Plan A $15/$30 - 12/24/24	$ 8.28	$12.65	$12.89	$20.13
Plan B $15/$30 – 12/12/24	$10.99	$17.12	$17.30	$27.27
Plan C $15 – 12/12/12	$19.54	$30.68	$31.32	$49.90
Signature Plans				**Rates effective through 12/31/16**
Exam Plus – 12/0/0	$ 3.18	$ 6.37	$ 6.37	$ 6.38
Plan A $15/$30 – 12/24/24	$ 9.53	$14.64	$14.93	$23.43
Plan A $15/$30 CVC – 12/24/24	$13.84	$18.96	$19.24	$27.75
Plan B $15/$30 – 12/12/24	$12.71	$19.71	$20.11	$31.79
Plan B $15/$30 CVC – 12/12/24	$17.02	$24.02	$24.42	$36.09
Plan B $15 – 12/12/24	$17.82	$27.89	$28.45	$45.25
Plan B $15 CVC – 12/12/24	$22.13	$32.20	$32.76	$49.56

[5] All plans 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.

These **VSP** plans are available to members residing 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. VSP providers are available in all 50 states. To find a provider visit www.VSP.com.

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.

N o r t h R a n c h B e n e f i t s T r u s t

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