Inshore Benefits Trust

Voluntary Vision Service Plans

Effective January 1, 2020 - December 31, 2020[5,6]

Benefit Comparison and Rates for 1-500 Employees

	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
Copays	Exam: $15 Lenses and/or Frames: $30	Exam: $15 Lenses and/or Frames: $30	Exam: $15 Lenses and/or Frames: $30

Lenses and Frames						
Network	**IN**	**OUT[1]**	**IN**	**OUT[1]**	**IN**	**OUT[1]**
Exam	100%	$45 max. reimbursed	100%	$45 max. reimbursed	100%	$50 max. reimbursed
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]						
Network	**IN**	**OUT[1]**	**IN**	**OUT[1]**	**IN**	**OUT[1]**
Elective	Contact lens exam (fitting & evaluation): $60 copay	$105 max. reimbursed	Contact lens exam (fitting & evaluation): $60 copay	$105 max. reimbursed	Contact lens exam (fitting & evaluation): $60 copay	$105 max. reimbursed
	$180 allowance		$180 allowance		$180 allowance	
Medically Necessary	100%	$210 max. reimbursed	Up to 100%	$210 max. reimbursed	100%	$210 max. reimbursed

Voluntary Vision Rates			
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

[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.

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 state, excluding FL.