

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	OUT¹	IN	OUT¹		IN	OUT¹
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 allowance³	\$70 max. reimbursed	\$180 allowance³	\$70 max. reimbursed		\$180 allowance³	\$70 max. reimbursed
Contact Lenses (In lieu of frames and lenses)²,³							
Network	IN	OUT¹	IN	OUT¹		IN	OUT¹
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	

¹If 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.

²The 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.

³Extra 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.

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. VSP and VSP Vision Care for Life are registered trademarks of VSP.