

Inshore Benefits Trust
 Voluntary Vision Service Plans
 Effective January 1, 2022 - December 31, 2022



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 \$10 / \$20 12/12/24	PLAN C \$10 / \$20 12/12/12	PLAN C \$25 12/12/12	
Benefit Frequency				
Exam	Every 12 months	Every 12 months	Every 12 months	Every 12 months
Lenses	Every 24 months	Every 12 months	Every 12 months	Every 12 months
Frames	Every 24 months	Every 24 months	Every 12 months	Every 12 months
Copays	Exam: \$15 Materials: \$30	Exam: \$10 Materials: \$20	Exam: \$10 Materials: \$20	Exam and Materials: \$25

Lenses and Frames (after applicable copay)				
Network	IN NETWORK	IN NETWORK	IN NETWORK	IN NETWORK
Exam	100%	100%	100%	100%
Single	100%	100%	100%	100%
Bifocals				
Trifocals				
Lenticular				
Frames	\$180 allowance ³ (\$100 allowance at Walmart®/ Sam's Club®/Costco®)	\$180 allowance ³ (\$100 allowance at Walmart®/ Sam's Club®/Costco®)	\$180 allowance ³ (\$100 allowance at Walmart®/ Sam's Club®/Costco®)	\$180 allowance ³ (\$100 allowance at Walmart®/ Sam's Club®/Costco®)

Contact Lenses (In lieu of frames and lenses) ^{2,3}				
Network	IN NETWORK	IN NETWORK	IN NETWORK	IN NETWORK
Elective	Contact lens exam (fitting & evaluation): Up to \$60 copay	Contact lens exam (fitting & evaluation): Up to \$60 copay	Contact lens exam (fitting & evaluation): Up to \$60 copay	Contact lens exam (fitting & evaluation): Up to \$60 copay
	\$180 allowance ³	\$180 allowance ³	\$180 allowance ³	\$180 allowance ³
Medically Necessary	100%	100%	100%	100%

Voluntary Vision Rates			
A \$15 monthly administration fee applies to all groups.	Employee Only	Employee + 1 or Employee + Child(ren)	Family
Choice A \$15 / \$30 12/24/24	\$8.55	\$13.34	\$20.87
Choice B \$10 / \$20 12/12/24	\$11.12	\$19.42	\$29.54
Choice C \$10 / \$20 12/12/12	\$13.28	\$23.75	\$36.50
Signature C \$25 12/12/12	\$15.57	\$28.33	\$43.87

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.

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.