2017

Sutter Health Plus
Your Health Plan

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VISION PLANS OFFERED AND CONTRACTED THROUGH VISION SERVICE PLAN (VSP)

Plan Name	VSP Plan A (Voluntary)	VSP Plan B (Voluntary)	VSP Plan C (Voluntary)	Exam Plus** Core (LG Only)	Pediatric Vision Core (I and SG Only)
Plan ID	VA01	VA02	VA03	VA09	VA10
Copay	$20	$20	$20	N/A	N/A
Frequency					
Eye examination	Every 12 months	Every 12 months	Every 12 months	Every 12 Months	Every 12 months
Lenses	Every 24 months	Every 12 months	Every 12 months	N/A	Every 12 months
Frames	Every 24 months	Every 24 months	Every 12 months	N/A	Every 12 months
In-Network Benefits					
Vision Care Services					
Vision examination	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Vision Care Materials					
Lenses: single vision	Covered in full*	Covered in full*	Covered in full*	N/A	Covered in full
Lenses: bifocal	Covered in full*	Covered in full*	Covered in full*	N/A	Covered in full
Lenses: trifocal	Covered in full*	Covered in full*	Covered in full*	N/A	Covered in full
Lenses: lenticular	Covered in full*	Covered in full*	Covered in full*	N/A	Covered in full
Frames	Covered up to plan allowance of $120*	Covered up to plan allowance of $120*	Covered up to plan allowance of $120*	N/A	From collection
Contact Lenses					
Necessary professional fees and materials	Covered in full	Covered in full	Covered in full	N/A	Covered in full
Elective professional fees and materials	Up to $120 15% professional fees discount applies to member doctor's usual and customary professional fees for contact lens evaluation and fitting	Up to $120 15% professional fees discount applies to member doctor's usual and customary professional fees for contact lens evaluation and fitting	Up to $120 15% professional fees discount applies to member doctor's usual and customary professional fees for contact lens evaluation and fitting	N/A	Professional fees covered in full, limited materials
Out-of-Network Benefits					
Vision Care Services					
Vision examination	Up to $45	Up to $45	Up to $45	Up to $45	N/A
Vision Care Materials					
Lenses: single vision	Up to $30*	Up to $30*	Up to $30*	N/A	N/A
Lenses: bifocal	Up to $50*	Up to $50*	Up to $50*	N/A	N/A
Lenses: trifocal	Up to $65*	Up to $65*	Up to $65*	N/A	N/A
Lenses: lenticular	Up to $100*	Up to $100*	Up to $100*	N/A	N/A
Frames	Up to $70*	Up to $70*	Up to $70*	N/A	N/A
Contact Lenses					
Necessary professional fees and materials	Up to $210	Up to $210	Up to $210	N/A	N/A
Elective professional fees and materials	Up to $105	Up to $105	Up to $105	N/A	N/A
Value-Added Discounts					
Glasses	20% off the amount over allowance				N/A
Lens options	20–25% average savings on all non-covered lens options				N/A
Sunglasses	20% discount				N/A
Contacts	15% discount off fitting and evaluation				N/A
TruHearing	25% average discount				N/A
Laser vision care	15% average discount				N/A

*Indicates subject to copayment

**This benefit applies to large employer groups (101+ employees effective 1/1/2017) ONLY. Each covered person shall be entitled to receive a discount of twenty percent (20%) toward the purchase of non-covered materials from any VSP member doctor when a complete pair of glasses is dispensed. Also, covered persons shall be entitled to receive a discount of fifteen percent (15%) off of contact lens examination services from any VSP member doctor.

Note: VSP Plan A, Plan B and Plan C are available for all members of large group plans and adults only (age 19 and up) for members of small group plans.