



2017

**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)
<b>Plan ID</b>	VA01	VA02	VA03	VA09	VA10
<b>Copay</b>	\$20	\$20	\$20	N/A	N/A
<b>Frequency</b>					
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
<b>In-Network Benefits</b>					
<b>Vision Care Services</b>					
Vision examination	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
<b>Vision Care Materials</b>					
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
<b>Contact Lenses</b>					
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 <small>15% professional fees discount applies to member doctor's usual and customary professional fees for contact lens evaluation and fitting</small>	Up to \$120 <small>15% professional fees discount applies to member doctor's usual and customary professional fees for contact lens evaluation and fitting</small>	Up to \$120 <small>15% professional fees discount applies to member doctor's usual and customary professional fees for contact lens evaluation and fitting</small>	N/A	Professional fees covered in full, limited materials
<b>Out-of-Network Benefits</b>					
<b>Vision Care Services</b>					
Vision examination	Up to \$45	Up to \$45	Up to \$45	Up to \$45	N/A
<b>Vision Care Materials</b>					
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
<b>Contact Lenses</b>					
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
<b>Value-Added Discounts</b>					
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.