

## Vision Service Plan <sup>1</sup>

### 3 or more employees

	<b>Signature Plan</b>				<b>Choice Plan</b>					
	<b>Access to Standard Network VSP Providers</b>				<b>Access to Choice Network VSP Providers</b>					
	<b>VSP</b>		<b>Non-VSP</b>		<b>VSP</b>		<b>Non-VSP</b>			
<b>PROVIDER</b>										
<b>EXAM &amp; MATERIALS COPAY</b>	\$10 or \$25				\$0					
<b>DIABETIC EYECARE PROGRAM</b>	\$20				N/A					
<b>VISION EXAM</b>	Covered in Full		Up to \$50		Covered in Full		Up to \$45			
<b>LENSES &amp; FRAMES</b>										
<b>Single Vision</b>	Covered in Full		Up to \$50		Covered in Full		Up to \$30			
<b>Lined Bifocals</b>			Up to \$75				Up to \$50			
<b>Lined Trifocals</b>			Up to \$100				Up to \$65			
<b>Lenticular Lenses</b>			Up to \$125				Up to \$100			
<b>Frames</b>	Up to \$130		Up to \$70		Up to \$130		Up to \$70			
<b>CONTACTS (in lieu of all other lens and frame benefits)</b>										
<b>Medically Necessary</b>	Up to 100%		Up to \$210		Up to 100%		Up to \$210			
<b>Elective</b>	Up to \$130		Up to \$105		Up to \$130		Up to \$105			
<b>BENEFIT FREQUENCY</b>	<b>PLAN A</b>		<b>PLAN B</b>		<b>PLAN C</b>		<b>PLAN A</b>		<b>PLAN B</b>	
<b>Examination</b>	Once every 12 months					Once every 12 months				
<b>Lenses</b>	Once every 24 months		Once every 12 months		Once every 12 months		Once every 24 months		Once every 12 months	
<b>Frames</b>	Once every 24 months		Once every 24 months		Once every 12 months		Once every 24 months		Once every 24 months	
<b>PREMIUMS</b>	<b>PLAN A</b>		<b>PLAN B</b>		<b>PLAN C</b>		<b>PLAN A</b>		<b>PLAN B</b>	
<b>Copay Amount</b>	<b>\$10.00</b>	<b>\$25.00</b>	<b>\$10.00</b>	<b>\$25.00</b>	<b>\$10.00</b>	<b>\$25.00</b>	<b>\$0</b>		<b>\$0</b>	
<b>Employee Only</b>	\$9.89	\$7.79	\$12.06	\$9.53	\$15.08	\$11.91	\$5.56		\$7.62	
<b>Employee + 1 Dependent</b>	\$14.55	\$11.60	\$17.76	\$14.18	\$22.19	\$17.73	\$8.93		\$11.34	
<b>Employee + Children</b>	\$14.85	\$11.84	\$18.13	\$14.48	\$22.66	\$18.10	\$9.13		\$11.59	
<b>Family</b>	\$23.94	\$19.10	\$29.23	\$23.34	\$36.52	\$29.17	\$14.69		\$18.67	
<b>MONTHLY ADMINISTRATION FEE</b>	\$15.00					\$15.00				

**Rates are guaranteed through December 2012.**

#### **PARTICIPATION RULES**

The employer must choose one of the following participation options:

1. VSP participation and contribution matches employer-sponsored medical plan participation exactly **OR**
2. VSP participation and contribution matches employer-sponsored dental plan participation exactly **OR**
3. VSP participation is 100% employer paid and all eligible employees and all eligible dependents are enrolled **OR**
4. VSP participation is 100% employer paid and all eligible employees and no dependents are enrolled.

<sup>1</sup> These plans are only available to groups headquartered in the following states: CA, CO, GA, IA, IL, IN, KS, MI, MN, MO, NC, NJ, NV, OH, OK, SC, TN, TX and WV. Employees can live in any of the 50 states.

The summary above is meant to be a brief description of plan benefits and features 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.