

# VSP Signature Plan® Proposal

Prepared for 2017 proposal



Our Member Promise guarantees that employees are completely satisfied with their eyecare and eyewear from VSP network providers or we'll make it right. This includes satisfaction with out-of-pocket costs, consumer's #1 priority in a vision plan.

| Benefit  | VSP Network<br>subject to applicable copays <sup>1</sup>   | Out-of-Network<br>subject to applicable copays <sup>1</sup>                       |
|--|--|---|
| <b>WellVision Exam</b>   | Covered-in-full after copay<br>Routine retinal screening covered after an up to \$39 copay <sup>2</sup>  | Reimbursed up to \$50   |
| <b>Contact Lens Exam - Fitting and Evaluation</b> (when choosing contacts) | <b>Standard and premium fit:</b> covered in full after copay - 15% off contact lens exam services <sup>2</sup> ; copay will never exceed \$60  | See elective contact lenses   |
| <b>Single Vision Lenses</b>  | Covered-in-full after copay  | Reimbursed up to \$50   |
| <b>Lined Bifocal Lenses</b>  | Covered-in-full after copay  | Reimbursed up to \$75   |
| <b>Lined Trifocal Lenses</b>   | Covered-in-full after copay  | Reimbursed up to \$100  |
| <b>Lenticular Lenses</b>   | Covered-in-full after copay  | Reimbursed up to \$125  |
| <b>Frame</b>   | Covered-in-full after copay up to \$130 allowance (\$50 wholesale)<br>20% off any amount above retail frame allowance <sup>2</sup><br>Members who select a featured frame brand including Ann Klein, bebe®, Calvin Klein, Flexon, Lacoste, Nike, Nine West, and more will receive an extra \$20 toward their frame allowance. <sup>3</sup> | Reimbursed up to \$70   |
| <b>Elective Contact Lenses</b>   | Covered-in-full up to \$130 (instead of lenses and frames)<br>Mail-in rebate savings <sup>4</sup> on eligible Bausch & Lomb contacts   | Reimbursed up to \$105 <sup>5</sup><br>(includes contact lens exam and materials) |
| <b>Necessary Contact Lenses<sup>6</sup></b>                                | Covered-in-full after copay (instead of lenses and frames)   | Reimbursed up to \$210  |

| Benefit                                       | Benefit Highlights   |                               |            |                              |               |                             |                 |                                |                 |  |            |                      |            |               |            |   |            |                      |  |  |  |                                  |            |                             |  |
|---|--|-------------------------------|------------|------------------------------|---------------|-----------------------------|-----------------|--------------------------------|-----------------|--|------------|----------------------|------------|---------------|------------|---|------------|----------------------|--|--|--|----------------------------------|------------|-----------------------------|--|
| <b>Lens Enhancements</b>                      | <p>Covered after a copay, saving our members an average of 35-40%. Maximum copay on some of our popular lens enhancements:</p> <table border="0"> <tr> <td>Standard Progressives Plastic</td> <td>\$50 copay</td> </tr> <tr> <td>Premium Progressives Plastic</td> <td>\$80-90 copay</td> </tr> <tr> <td>Custom Progressives Plastic</td> <td>\$120-160 copay</td> </tr> <tr> <td>Solid Tints &amp; Dyes (Pink I&amp;II)</td> <td>Covered-in-full</td> </tr> <tr> <td>Solid Plastic Dye (except Pink I &amp; II)</td> <td>\$13 copay</td> </tr> <tr> <td>Plastic Gradient Dye</td> <td>\$15 copay</td> </tr> <tr> <td>UV Protection</td> <td>\$14 copay</td> </tr> <tr> <td>Factory Applied Scratch-resistant Coating</td> <td>\$15 copay</td> </tr> <tr> <td>Polycarbonate Lenses</td> <td>Covered-in-full for dependent children</td> </tr> <tr> <td></td> <td>\$23 single vision or \$28 multi-focal copay</td> </tr> <tr> <td>Standard Anti-reflective Coating</td> <td>\$37 copay</td> </tr> <tr> <td>Photochromic Lenses Plastic</td> <td>\$62 single vision or \$76 multi-focal copay</td> </tr> </table> | Standard Progressives Plastic | \$50 copay | Premium Progressives Plastic | \$80-90 copay | Custom Progressives Plastic | \$120-160 copay | Solid Tints & Dyes (Pink I&II) | Covered-in-full | Solid Plastic Dye (except Pink I & II) | \$13 copay | Plastic Gradient Dye | \$15 copay | UV Protection | \$14 copay | Factory Applied Scratch-resistant Coating | \$15 copay | Polycarbonate Lenses | Covered-in-full for dependent children |  | \$23 single vision or \$28 multi-focal copay | Standard Anti-reflective Coating | \$37 copay | Photochromic Lenses Plastic | \$62 single vision or \$76 multi-focal copay |
| Standard Progressives Plastic                 | \$50 copay   |                               |            |                              |               |                             |                 |                                |                 |  |            |                      |            |               |            |   |            |                      |  |  |  |                                  |            |                             |  |
| Premium Progressives Plastic                  | \$80-90 copay  |                               |            |                              |               |                             |                 |                                |                 |  |            |                      |            |               |            |   |            |                      |  |  |  |                                  |            |                             |  |
| Custom Progressives Plastic                   | \$120-160 copay  |                               |            |                              |               |                             |                 |                                |                 |  |            |                      |            |               |            |   |            |                      |  |  |  |                                  |            |                             |  |
| Solid Tints & Dyes (Pink I&II)                | Covered-in-full  |                               |            |                              |               |                             |                 |                                |                 |  |            |                      |            |               |            |   |            |                      |  |  |  |                                  |            |                             |  |
| Solid Plastic Dye (except Pink I & II)        | \$13 copay   |                               |            |                              |               |                             |                 |                                |                 |  |            |                      |            |               |            |   |            |                      |  |  |  |                                  |            |                             |  |
| Plastic Gradient Dye                          | \$15 copay   |                               |            |                              |               |                             |                 |                                |                 |  |            |                      |            |               |            |   |            |                      |  |  |  |                                  |            |                             |  |
| UV Protection                                 | \$14 copay   |                               |            |                              |               |                             |                 |                                |                 |  |            |                      |            |               |            |   |            |                      |  |  |  |                                  |            |                             |  |
| Factory Applied Scratch-resistant Coating     | \$15 copay   |                               |            |                              |               |                             |                 |                                |                 |  |            |                      |            |               |            |   |            |                      |  |  |  |                                  |            |                             |  |
| Polycarbonate Lenses                          | Covered-in-full for dependent children   |                               |            |                              |               |                             |                 |                                |                 |  |            |                      |            |               |            |   |            |                      |  |  |  |                                  |            |                             |  |
|   | \$23 single vision or \$28 multi-focal copay   |                               |            |                              |               |                             |                 |                                |                 |  |            |                      |            |               |            |   |            |                      |  |  |  |                                  |            |                             |  |
| Standard Anti-reflective Coating              | \$37 copay   |                               |            |                              |               |                             |                 |                                |                 |  |            |                      |            |               |            |   |            |                      |  |  |  |                                  |            |                             |  |
| Photochromic Lenses Plastic                   | \$62 single vision or \$76 multi-focal copay   |                               |            |                              |               |                             |                 |                                |                 |  |            |                      |            |               |            |   |            |                      |  |  |  |                                  |            |                             |  |
| <b>Primary EyeCare Plan<sup>SM</sup></b>      | Supplemental coverage for non-surgical medical eye conditions, such as pink eye and other urgent eyecare - \$20 copay per visit  |                               |            |                              |               |                             |                 |                                |                 |  |            |                      |            |               |            |   |            |                      |  |  |  |                                  |            |                             |  |
| <b>Low Vision</b>                             | Supplemental testing covered every two years<br>75% of the cost for approved low vision aids, \$1,000 maximum (less any amount paid for testing)   |                               |            |                              |               |                             |                 |                                |                 |  |            |                      |            |               |            |   |            |                      |  |  |  |                                  |            |                             |  |
| <b>Additional Glasses</b>                     | 30% off <sup>2</sup> unlimited additional complete pairs of prescription and non-prescription glasses (includes sunglasses) <sup>7</sup>   |                               |            |                              |               |                             |                 |                                |                 |  |            |                      |            |               |            |   |            |                      |  |  |  |                                  |            |                             |  |
| <b>Laser VisionCare Program</b>               | 15% average discount or 5% off promotional price for PRK, LASIK, and Custom LASIK <sup>8</sup><br>Members who've had LVC surgery can use their frame benefit for non-prescription sunglasses   |                               |            |                              |               |                             |                 |                                |                 |  |            |                      |            |               |            |   |            |                      |  |  |  |                                  |            |                             |  |
| <b>Exclusions and Limitations<sup>9</sup></b> | There may be some materials and services with either limited or no coverage under this plan<br>Please contact your VSP representative for more information   |                               |            |                              |               |                             |                 |                                |                 |  |            |                      |            |               |            |   |            |                      |  |  |  |                                  |            |                             |  |

<sup>1</sup> When covered-in-full services are obtained from a VSP network provider, the patient will have no out-of-pocket expense other than any applicable copays. Services and eyewear obtained through out-of-network providers are subject to the same copay and limitations. Please refer to rate page.  
<sup>2</sup> Based on applicable laws, benefits may vary by location.

*Our proposal is based on the scope of the obligations that VSP agrees to undertake. VSP will comply with state and/or federal rules and regulations as they pertain to pre-paid vision plans with a defined benefit*

<sup>3</sup> Reflects current promotion, evaluated annually. Promotion/featured frame brands are subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.

<sup>4</sup> Rebates subject to change.

<sup>5</sup> If \$100 allowance is purchased, Out-of-network providers will reimburse up to \$85.

<sup>6</sup> Necessary contact lenses and fitting and evaluation are covered-in-full for members who have specific conditions for which contact lenses provide better visual correction.

<sup>7</sup> 30% off applies to glasses purchased the same day as the member's eye exam from the same VSP network provider who provided the exam. Members will also receive 20% off unlimited additional pairs of glasses valid through any VSP network provider within 12 months of the last covered eye exam.

<sup>8</sup> Custom LASIK coverage only available using wavefront technology with the microkeratome surgical device. Other LASIK procedures may be performed at an additional cost to the member. LaserVision Care discounts are only available from VSP-contracted facilities.

<sup>9</sup> Coverage shall be governed solely by the terms of your VSP contract.

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