## **VSP Plan Illustration**

## **Ohio Provider Resource Association**

Contract Period: January 1, 2017 - December 31, 2020



	2017 Voluntary Plan Offering		
Product Platform	VCD Chaire	VCD Chaire	
Product Platform	VSP Choice	VSP Choice	
Benefit Frequency:			
Exam / Lens / Frames	12 / 12 / 24	12 / 12 / 12	
WellVision® Exam w/ Dilation			
Exam Copay	\$10	\$10	
Retinal Imaging	Not to exceed \$39	Not to exceed \$39	
Diabetic EyeCare Plus Exam	\$20 per visit	\$20 per visit	
Prescription Glasses with VSP Provider <sup>1</sup>			
Materials Copay:	\$20	\$20	
Lens Coverage:			
Single vision, lined bifocal, lined trifocal & lenticular	Covered in full	Covered in full	
lenses in glass or plastic			
Lens Enhancements: Progressive Lenses (Standard, Premium & Custom)	\$55-\$175	\$55-\$175	
Anti-reflective Coatings	\$35-\$175 \$41-\$85		
Polycarbonate Lenses for Children	۶4۱-۶۵۵ <b>Covered in full</b>	\$41-\$85	
Polycarbonate Lenses for Adults	\$31-\$35	Covered in full \$31-\$35	
Scratch-resistant Coatings	\$17-\$33	\$17-\$33	
Other Lens Enhancements	Average 20-25% savings	Average 20-25% savings	
Frame Coverage:	A. 0=	A-0-	
Frame Allowance (retail)	\$165	\$165	
Featured Frame Brand Allowance (Extra \$20)	\$185	\$185	
Frame Discount	20% off amount over allowance	20% off amount over allowance	
Contacts Instead of Glasses with VSP Provider			
Coverage for Contacts:	· ·		
Elective Contact Lens Allowance	\$145	\$145	
Necessary Contact Lens Allowance	Covered after materials copay	Covered after materials copay	
Contact Lens Exam (Fitting & Evaluation):  Cost for <u>both</u> Standard Fit & Premium Fit patients:	15% discount on fitting & evaluation fee	15% discount on fitting & evaluation fee	
Benefits Out-of-Network	13% discount on fitting & evaluation fee	13% discount on fitting & evaluation fee	
Reimbursement Schedule:			
Examination	\$45	\$45	
Single Vision / Bifocal / Trifocal / Lenticular Lenses	\$30 / \$50 / \$65 / \$100	\$30 / \$50 / \$65 / \$100	
Frames	\$70	\$70	
Elective Contact Lenses (in lieu of glasses)	\$105	\$105	
Medically Necessary Contact Lenses	\$210	\$210	
Fully-insured Vision Coverage			
Two-Tier Rates:	\$6.11/ \$14.63		
Three-Tier Rates:	\$6.11/ \$11.06/ \$17.87	\$7.76/ \$14.05/ \$22.62	
Four-Tier Rates:	\$7.11/ \$12.87/ \$13.75/ \$21.97		
Contract Term:	48-Months	48-Months	
	Includes 10% commission		

To accept the above plan designs through VSP, please have the appropriate representative review this information, sign and return this form at your earliest convenience. VSP produces your Plan Policy upon receipt of your confirmation of renewal. Your new Plan Policy may contain some provisions that are changed from those in your current Policy, so you should review the new Policy carefully upon receipt. Please file this Agreement with your VSP contract as it serves as your notice of renewal.

Wendy Vance
VSP, Market Director
9378 Mason Montgomery Rd, #415
Mason, OH 45040
513-265-1997
Fax 916-463-9002
wendy vance@ysp.com

Ву:		
Title:		
Date:		