VSP Plan Illustration

Ohio Provider Resource Association

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

	2017 Voluntary Plan Offering	
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[1]		
Materials Copay:	**$20**	**$20**
Lens Coverage:		
Single vision, lined bifocal, lined trifocal & lenticular lenses in glass or plastic	Covered in full	Covered in full
Lens Enhancements:		
Progressive Lenses (Standard, Premium & Custom)	$55-$175	$55-$175
Anti-reflective Coatings	$41-$85	$41-$85
Polycarbonate Lenses for Children	***Covered in full***	***Covered in full***
Polycarbonate Lenses for Adults	$31-$35	$31-$35
Scratch-resistant Coatings	$17-$33	$17-$33
Other Lens Enhancements	Average 20-25% savings	Average 20-25% savings
Frame Coverage:		
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 both Standard Fit & Premium Fit patients:	**15% discount on fitting & evaluation fee**	**15% discount on fitting & evaluation fee**
Benefits Out-of-Network		
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.

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By: _____

Title: _____

Date: _____

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