

Vision Plan Benefit Summary

Effective January 1 – December 31, 2012

Covered Services	Network	Non-Network
Annual Deductible	\$15 per person, applies to materials only (lenses and frames)	
Vision Examination	100% paid; no deductible	Maximum of \$30 paid; no deductible
Frequency	Once per plan year	
Frames	Maximum of \$155 paid, after annual deductible; 20% discount off any amount over \$155	Maximum of \$60 paid, after annual deductible
Frequency	Once every other plan year	
Lenses	100% paid, after annual deductible, for: <ul style="list-style-type: none"> • Single Vision Lenses • Lined Bifocal Lenses¹ • Lined Trifocal Lenses¹ • Lenticular Lenses¹ 	Maximum paid as indicated, after annual deductible, for: <ul style="list-style-type: none"> • Single Vision Lenses: \$45 • Any Bifocal Lenses: \$70 • Any Trifocal Lenses: \$70 • Lenticular Lenses: \$100
Contact Lenses (includes disposables)	Maximum of \$130 paid; no deductible; 15% discount off the contact lens fitting fee ²	Maximum of \$105 paid; no deductible
Frequency	Only one lens benefit (either glasses or contact lenses) is payable each plan year	

¹ Blended (seamless) lenses are available at Vision Service Plan's (VSP) preferred member pricing; however, the plan does not pay for any additional charges above the cost of lined lenses.

² If an eligible medical condition (keratoconus, significant anisometropia, aphasic condition) exists, VSP pays for this service in full.

Note: This document is intended to be a short summary of program provisions. Plan limitations and exclusions are not included. For greater details about the Vision Plan, refer to the Vision Plan – Specific Plan Details document, available online at hr.osu.edu/hrpubs/ben/visionspd.pdf. If the information in this summary differs from the online information, the online information will govern.