# Vision Plan Benefit Summary


<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Basic</th>
<th>Premier</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Network Providers</strong></td>
<td>Choice Network</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>$25 per person, applies to materials only (lenses and frames)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Vision Examination</strong></td>
<td>100% paid; no deductible</td>
<td>100% paid; no deductible</td>
<td>Maximum of $45 paid; no deductible</td>
</tr>
<tr>
<td><strong>Frequency</strong></td>
<td>Every calendar year</td>
<td>Every calendar year</td>
<td>Every calendar year</td>
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<tr>
<td><strong>Frames</strong></td>
<td>Maximum of $155 paid, after annual deductible; 20% discount off any amount over $155</td>
<td>Maximum of $200 paid, after annual deductible; 20% discount off any amount over $200</td>
<td>Maximum of $70 paid, after annual deductible</td>
</tr>
<tr>
<td><strong>Frequency</strong></td>
<td>Every other calendar year</td>
<td>Every calendar year</td>
<td>Basic: Every other calendar year Premier: Every calendar year</td>
</tr>
</tbody>
</table>
| **Lenses** | 100% paid, after annual deductible, for:  
  • Single Vision Lenses  
  • Lined Bifocal Lenses  
  • Lined Trifocal Lenses  
  • Lenticular Lenses  
  • Polycarbonate Lenses for Children | 100% paid, after annual deductible, for:  
  • Single Vision Lenses  
  • Lined Bifocal Lenses  
  • Lined Trifocal Lenses  
  • Lenticular Lenses  
  • Polycarbonate Lenses for Children | Maximum paid as indicated, after annual deductible, for:  
  • Single Vision Lenses: $30  
  • Any Bifocal Lenses: $50  
  • Any Trifocal Lenses: $65  
  • Lenticular Lenses: $100 |
| **Frequency** | Every calendar year | Every calendar year | Every calendar year |
| **Or Contact Lenses** | Up to $60 copay for your contact lens exam (fitting and evaluation)  
  Maximum of $130 allowance paid toward contact lenses; no deductible | Up to $60 copay for your contact lens exam (fitting and evaluation)  
  Maximum of $200 allowance paid toward contact lenses; no deductible | Maximum of $105 paid; no deductible |
| **Frequency** | Every calendar year | Every calendar year | Every calendar year |

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1. Brands/Promotions subject to change.
2. 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.
3. Contact lenses are in lieu of lenses only. Member can receive frame and contact lenses per eligible frequency.
4. Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Member Doctor or Non-Member Provider. Prior review and approval by VSP are not required for Covered Person to be eligible for Necessary Contact Lenses.

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**Note:** This document is intended to be a short summary of program provisions. Plan limitations and exclusions are not included. The Diabetic Eyecare Plus Program (DEP Plus) covers certain service related to diabetes, subject to a $20 copayment.

For greater details about the DEP Plus and 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.