VISION PLAN

The Vision Plan provides you and your covered dependents with vision care services, such as eye exams, eyeglasses and contact lenses. Choose between Basic and Premier plan options, both of which are in the Vision Service Plan Choice Network. Diabetic eye care is included with all Ohio State vision coverage.

USING THIS BENEFIT

- The Vision Plan offers you a choice of network or non-network coverage when you seek vision services. You can perform a provider search by accessing Vision Service Plan’s (VSP) website via hr.osu.edu/benefits/hb_vision
- If you use a VSP Choice Network Provider
  - Tell the provider’s office that you are covered by VSP when making an appointment, or at the time of service.
  - No claim forms are necessary for network vision services. Your vision provider should file claims directly with VSP, although you will be required to pay for your portion of the expenses at the time of service.
  - The Ohio State University Optometry Clinic is in the VSP Choice network.
- If you use a non-network provider
  - The plan pays less for covered services than it does when you use a network provider.
  - Your provider may require you to pay for services in full and be reimbursed from VSP by filing a claim.
  - If the condition is medical in nature, vision coverage will be coordinated with your medical plan.

VISION PLAN SUMMARY AND COMPARISON—2016 PLAN YEAR

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Basic</th>
<th>Premier</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network Providers</td>
<td>Choice Network</td>
<td>Choice Network</td>
<td></td>
</tr>
<tr>
<td>Annual Deductible</td>
<td>$25 per person, applies to materials only (lenses and frames)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision Examination</td>
<td>100% paid; no deductible</td>
<td>100% paid; no deductible</td>
<td>Maximum of $45 paid; no deductible</td>
</tr>
<tr>
<td>Frequency</td>
<td>Every calendar year</td>
<td>Every calendar year</td>
<td>Every calendar year</td>
</tr>
<tr>
<td>Frames</td>
<td>Maximum of $155 paid, after annual deductible, 20% discount off any amount over $155. Maximum of $175 paid on featured frame brands, after annual deductible; 20% discount off any amount over $175.</td>
<td>Maximum of $200 paid, after annual deductible; 20% discount off any amount over $200. Maximum of $220 paid on featured frame brands, after annual deductible; 20% discount off any amount over $220.</td>
<td>Maximum of $70 paid, after annual deductible.</td>
</tr>
<tr>
<td>Frequency</td>
<td>Every other calendar year</td>
<td>Every calendar year</td>
<td>Basic: Every other calendar year; Premier: Every calendar year</td>
</tr>
<tr>
<td>Lenses</td>
<td>100% paid, after annual deductible, for: Single Vision Lenses; Lined Bifocal Lenses; Lined Trifocal Lenses; Lenticular Lenses; Polycarbonate Lenses for Children</td>
<td>100% paid, after annual deductible, for: Single Vision Lenses; Lined Bifocal Lenses; Lined Trifocal Lenses; Lenticular Lenses; Polycarbonate Lenses for Children</td>
<td>Maximum paid as indicated, after annual deductible, for: Single Vision Lenses: $30; Any Bifocal Lenses: $50; Any Trifocal Lenses: $65; Lenticular Lenses: $100</td>
</tr>
<tr>
<td>or Contact Lenses (including disposables)</td>
<td>Up to $60 copay for our contact lens exam (fitting and evaluation). Maximum of $130 allowance paid toward contact lenses; no deductible.</td>
<td>Up to $60 copay for our contact lens exam (fitting and evaluation). Maximum of $200 allowance paid toward contact lenses; no deductible.</td>
<td>Maximum of $105 paid, no deductible.</td>
</tr>
<tr>
<td>Frequency</td>
<td>Every calendar year</td>
<td>Every calendar year</td>
<td>Every calendar year</td>
</tr>
</tbody>
</table>

BIWEEKLY FULL TIME (75-100 PERCENT FTE) AND PART TIME (74-50 PERCENT FTE)

<table>
<thead>
<tr>
<th>Basic Vision Plan</th>
<th>Premier Vision Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee only</td>
<td>Employee only</td>
</tr>
<tr>
<td>Employee + Children</td>
<td>Employee + Children</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>Employee + Spouse</td>
</tr>
<tr>
<td>Family</td>
<td>Family</td>
</tr>
<tr>
<td>$0.47</td>
<td>$0.47</td>
</tr>
<tr>
<td>$2.65</td>
<td>$3.82</td>
</tr>
<tr>
<td>$3.90</td>
<td>$8.33</td>
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<tr>
<td>$7.34</td>
<td>$10.92</td>
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<td>$18.04</td>
<td>$18.04</td>
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</tbody>
</table>

MONTHLY FULL TIME (75-100 PERCENT FTE) AND PART TIME (74-50 PERCENT FTE)

<table>
<thead>
<tr>
<th>Basic Vision Plan</th>
<th>Premier Vision Plan</th>
</tr>
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<tbody>
<tr>
<td>Employee only</td>
<td>Employee only</td>
</tr>
<tr>
<td>Employee + Children</td>
<td>Employee + Children</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>Employee + Spouse</td>
</tr>
<tr>
<td>Family</td>
<td>Family</td>
</tr>
<tr>
<td>$0.94</td>
<td>$0.94</td>
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<tr>
<td>$5.30</td>
<td>$7.63</td>
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<tr>
<td>$7.80</td>
<td>$16.66</td>
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<td>$14.68</td>
<td>$21.84</td>
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<tr>
<td>$36.07</td>
<td>$36.07</td>
</tr>
</tbody>
</table>

1. Brands/Promotions subject to change.
2. Blended (seamless) lenses are available at VSP preferred member pricing. The plan does not pay for any additional charges above the cost of lined lenses.
3. Contact lenses are in lieu of lenses only.
4. Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Member Doctor or Non-Member Provider.