VISION PLAN BENEFIT SUMMARY

Effective Jan. 1 – Dec. 31, 2017

Covered Services	Basic	Premier	Out-of-Network
Network Providers	Choice Network		
Annual Deductible	$25 per person, applies to materials only (lenses and frames)		
Vision Examination	100% paid; no deductible	100% paid; no deductible	Maximum of $45 paid; no deductible
Frequency	Every calendar year	Every calendar year	Every calendar year
Frames	Maximum of $155 paid, after annual deductible; 20% discount off any amount over $155 Maximum of $175 paid on featured frame brands1, after annual deductible; 20% discount off any amount over $175	Maximum of $200 paid, after annual deductible; 20% discount off any amount over $200 Maximum of $220 paid on featured frame brands1, after annual deductible; 20% discount off any amount over $220	Maximum of $70 paid, after annual deductible
Frequency	Every other calendar year	Every calendar year	Basic: Every other calendar year Premier: Every calendar year
Lenses	100% paid, after annual deductible, for: • Single Vision Lenses • Lined Bifocal Lenses2 • Lined Trifocal Lenses2 • Lenticular Lenses2 • Polycarbonate Lenses for Children	100% paid, after annual deductible, for: • Single Vision Lenses • Lined Bifocal Lenses[2] • Lined Trifocal Lenses[2] • Lenticular Lenses[2] • 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[3], [4] (includes disposables)	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 $150 allowance paid toward contact lenses; no deductible	Maximum of $105 paid; no deductible
Frequency	Every calendar year	Every calendar year	Every calendar year
Easy Options Enhancements		You and each member on your plan may choose one of these enhanced eyewear options in lieu of one base option above: • $250 frame allowance or • $200 contact lens allowance or • Fully covered progressive lenses or • Fully covered photochromic lenses or • Fully covered anti-reflective coating	

1 Visit vsp.com for more information on VSP's featured frame brands, as the brands may 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.

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/oe**. If the information in this summary differs from the online information, the online information will govern.