SUMMARY OF BENEFITS & RATES

Principal Vision Plan

PPO Plan · Network: VSP Choice Network

For demonstration purposes only. This document is a fictitious plan summary created for sales training and product demonstrations. It is not an offer of coverage, not an official carrier document, and does not reflect actual carrier rates or plan designs.

PRODUCT	PLAN TYPE	PLAN NAME	NETWORK
Vision	PPO	Principal Vision Plan	VSP Choice Network

BENEFIT FREQUENCIES

COMPREHENSIVE EXAM	EYEGLASS LENSES	FRAMES	CONTACT LENSES
Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months (in lieu of eyeglasses)

EXAM, LENSES & FRAMES

SERVICE	IN-NETWORK (VSP CHOICE NETWORK)	OUT-OF-NETWORK REIMBURSEMENT
Comprehensive Eye Exam	$10 copay	Up to $40
Eyeglasses — Lenses & Frame Copay	$10 copay (lenses and frames combined)	Copays do not apply
Single Vision Lenses	Covered in full after $10 materials copay	Up to $40
Lined Bifocal Lenses	Covered in full after $10 materials copay	Up to $60
Lined Trifocal Lenses	Covered in full after $10 materials copay	Up to $80
Lenticular Lenses	Covered in full after $10 materials copay	Up to $80
Standard Progressive Lenses	Covered in full after $10 materials copay	Up to $60
Premium Progressive Lenses	Covered in full after $10 materials copay	Up to $60
Included Lens Options	Standard scratch-resistant coating and polycarbonate lenses (for dependent children through age 19)	
Frame Allowance	$100 retail frame allowance (private practice or retail chain)	Up to $45
Frame Overage Discount	Additional 30% off overage at most participating in-network providers	

CONTACT LENSES (IN LIEU OF EYEGLASSES)

TYPE	IN-NETWORK	OUT-OF-NETWORK REIMBURSEMENT
Formulary Contacts	Fitting/evaluation fees, contact lenses, and up to two follow-up visits covered in full after $10 copay	Elective: Up to $120
Disposable Contacts	Covered in full after copay — up to 4 boxes from an in-network provider	Elective: Up to $120
Non-Formulary Contacts	$120 allowance (copay waived)	Elective: Up to $120
Medically Necessary Contacts	Covered in full after copay (if applicable)	Up to $210

Additional Contact Lens Discount	20% discount on additional contact lens purchases

INCLUDED PROGRAMS & FEATURES

Children's & Maternity Eye Care

Members age 0–12 and members who are pregnant or breastfeeding are eligible for a 2nd exam per 12 months, and for replacement frames and lenses after a prescription change of 0.5 diopter or more.

Laser Vision Correction (VSP Laser VisionCare)

Average savings of 15% off the regular price or 5% off promotional pricing for laser vision correction (including PRK, LASIK, and Custom LASIK) at VSP Laser VisionCare participating locations.

Additional Materials Discount

20% discount on an additional pair of eyeglasses or contact lenses at a participating in-network provider, after vision benefits have been used.

VSP Exclusive Member Extras

Access to exclusive member-only savings from popular brands (valued at over $3,000/year) through VSP Exclusive Member Extras, including discounts on eyewear accessories, contacts, and wellness products.

MONTHLY PREMIUM RATES — RENEWAL PLAN

COVERAGE TIER	MONTHLY RATE
Employee Only	**$5.39** per month
Employee + Spouse	**$10.75** per month
Employee + Child(ren)	**$10.88** per month
Family	**$17.34** per month

Rate basis: Rates shown are composite monthly premiums per contract. Contributions between employer and employee are determined at the group level.

GENERAL EXCLUSIONS

- Services and materials not specifically included in the Summary of Benefits as covered Plan Benefits.
- Any portion of a charge in excess of the Maximum Benefit Allowance or reimbursement indicated.
- Plano lenses (refractive correction of less than ±0.50 diopter).
- Two pairs of glasses instead of bifocals.
- Replacement of lost, stolen, or damaged lenses, frames, or contact lenses (except at normal frequency).
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Prescription or non-prescription medications.
- Contact lens insurance policies or service agreements.
- Refitting of contact lenses after the initial 90-day fitting period.
- Contact lens modification, polishing, or cleaning.
- Missed appointments.
- Any eye examination required as a condition of employment.
- Services obtained outside the United States (except emergency vision care).
- Services for which a charge would not have been made in the absence of insurance.
- Services covered under Workers' Compensation, employer liability, or other employer-provided coverage.

Notice: This Summary of Benefits is provided for informational purposes and is not an offer of coverage. For a complete listing of coverage, including exclusions and limitations, refer to the Certificate of Coverage. If differences exist between this summary and the Certificate of Coverage, the Certificate of Coverage will govern.

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