

# Vision Plus Benefit Summary

Get Access to the best in eye care and eyewear with Providence Health Plan and VSP® Vision Care

## Using your VSP benefit is easy.

- **Create an account at [vsp.com](http://vsp.com).** Once your plan is effective, review your benefit information.
- Find an eye doctor who's right for you. The decision is yours to make—choose a VSP network doctor or any out-of-network provider. Visit [ProvidenceHealthPlan.com/findaprovider/](http://ProvidenceHealthPlan.com/findaprovider/) or call **800.877.7195**.
- At your appointment, all you need is your ID number.  
This number is 17-digits composed of your Providence Health Plan member ID + group number. These numbers are available on your Providence member ID card.

### Example:

PHP ID# (10 numeric digits): XXXXXXXX-XX

PHP Group# (6 numeric digits): XXXXXX

VSP ID# (PHP ID# without dash and PHP Group#): XXXXXXXXXXXXXXXXX

**That's it! We'll handle the rest**—there are no claim forms to complete when you see a VSP provider.

## Best Eye Care

You'll get the highest level of care, including a WellVision Exam® under your medical benefit – the most comprehensive exam designed to detect eye and health conditions. Plus, when you see a VSP provider, you'll get the most out of your benefit, have lower out-of-pocket costs, and your satisfaction is guaranteed.

## Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like bebe®, CALVIN KLEIN, Cole Haan, Flexon®, Lacoste, Nike, Nine West, and more. <sup>1</sup>Visit [vsp.com](http://vsp.com) to find a Premier Program location that carries these brands. Plus, save up to 40% on popular lens enhancements. <sup>2</sup>Prefer to shop online? Check out all of the brands at [eyeconic.com](http://eyeconic.com)®, VSP's preferred online eyewear store.

## Important information about your plan

- You do not need to meet any medical health plan deductibles, regardless of your medical plan type, before accessing your vision care benefit.
- Your copays do not apply to your plan's medical out-of-pocket maximums.
- Limitations and exclusions apply to your benefits. See your Member Handbook for further details.

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<sup>1</sup> Brands/Promotion subject to change

<sup>2</sup> Savings based on network doctor's retail price and vary by plan and purchase selection: average savings determined after benefits are applied. Available only through VSP network doctors to VSP members with applicable plan benefits. Ask VSP network doctor for details.

# Vision Plus Benefit Summary

Providence Health Plan and VSP provide you with the highest quality vision coverage for you and your family.

## Plan Information

VSP Provider Network: VSP Choice

## Adult Coverage

Benefit	Description	Copay
WellVision Exam	<ul style="list-style-type: none"> <li>Covered under medical benefit</li> </ul>	See Medical Benefit Summary
<b>Prescription Glasses</b>		
Frame	<ul style="list-style-type: none"> <li>20% savings on the amount over your allowance</li> <li>Every 24 months</li> </ul>	Included in prescription Glasses \$130 allowance; copay does not apply
Lenses	<ul style="list-style-type: none"> <li>Single vision, lined bifocal, lined trifocal, or lenticular lenses</li> <li>Polycarbonate lenses for dependent children</li> <li>Every 12 months</li> </ul>	Included in prescription Glasses \$50 for Progressive Lenses
Contacts (instead of glasses)	<ul style="list-style-type: none"> <li>Contact lens exam (fitting and evaluation)</li> <li>Every 12 months</li> </ul>	\$130 allowance; copay does not apply
Extra Savings	<p><b>Glasses and Sunglasses</b></p> <ul style="list-style-type: none"> <li>Extra \$20 to spend on featured frame brands. Go to <a href="http://vsp.com/special">vsp.com/special</a> offers for details.</li> <li>20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.</li> </ul> <p><b>Retinal Screening</b></p> <ul style="list-style-type: none"> <li>No more than a \$39 copay on routine retinal screening as an enhancement to a WellVision Exam</li> </ul> <p><b>Laser Vision Correction</b></p> <ul style="list-style-type: none"> <li>Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities</li> </ul>	

## Adult Coverage with Out-of-Network Providers

Get the most out of your benefits and greater savings with a VSP network doctor. Your coverage with out-of-network providers will be less or you'll receive a lower level of benefits. Visit [vsp.com](http://vsp.com) for plan details.

**This plan covers up to the amount below. Any remaining balance is member responsibility.**

Exam	See Medical Benefit Summary
Frame	Up to \$70
Single Vision Lenses	Up to \$30
Lined Bifocal Lenses	Up to \$50
Lined Trifocal Lenses	Up to \$70
Contacts	Up to \$105

## Child Coverage - up to 19 years old

Benefit	Description	Copay
WellVision Exam	<ul style="list-style-type: none"> <li>Covered under medical benefit</li> </ul>	See Medical Benefit Summary
<b>Prescription Glasses</b>		
Frame	<ul style="list-style-type: none"> <li>Otis &amp; Piper Frames are Covered in full</li> <li>The equivalent value of \$150 can also be applied to other frame collections</li> <li>Every 12 months</li> </ul>	\$0
Lenses	<ul style="list-style-type: none"> <li>Single vision, lined bifocal, lined trifocal, or lenticular lenses</li> <li>Polycarbonate, scratch, and UV</li> <li>Covered in full</li> <li>Every 12 months</li> </ul>	\$0
Contacts (instead of glasses)	<ul style="list-style-type: none"> <li>Contact lens exam and an annual supply of contact lenses</li> <li>Covered in full</li> <li>Every 12 months</li> </ul>	\$0
Extra Savings	<p><b>Glasses and Sunglasses</b></p> <ul style="list-style-type: none"> <li>20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.</li> </ul> <p><b>Laser Vision Correction</b></p> <ul style="list-style-type: none"> <li>Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities</li> </ul>	

### Child Coverage with Out-of-Network Providers

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**This plan covers up to the amount below. Any remaining balance is member responsibility.**

Exam	See Medical Benefit Summary
Frame	Up to \$70
Single Vision Lenses	Up to \$30
Lined Bifocal Lenses	Up to \$50
Lined Trifocal Lenses	Up to \$70
Contacts	Up to \$105