Vision - Active Employee

Vision Plans

Out-of-Pocket Rates per Month for 2015-2016

PLAN	Employee	Employee & Spouse	Employee & Child(ren)	Employee & Family
Superior **Vision**	$5.90	$9.30	$9.52	$15.10
Superior **Vision Plus**	$9.00	$14.08	$15.08	$21.30

Fully insured Vision Care benefits are offered by Superior Vision Services. You have two vision plan options to choose from:

Superior Vision (Standard Plan)

Superior Vision Plus (Enhanced Plan)

Both plans feature the following copayments:

Exam: $35

RESOURCES

> **Superior Vision Plan Guide**

> **Superior Vision Plus Plan Guide**

> **Superior Vision Plans Video**

> **Find a Vision Provider**

> **Superior Vision Website**

CONTACT

Superior Vision
CUSTOMER SERVICE
(800) 507-3800

CLAIMS ADDRESS
P.O. Box 967
Rancho Cordova, CA
95741-0949

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Materials: $0

Contact Lens Fitting: $35

Plan differences are highlighted in the table below.

VISION PLAN COMPARISON

Services	SUPERIOR VISION (Standard Plan)		SUPERIOR VISION PLUS (Enhanced Plan)	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Exam (MD)	Covered in full[1]	Up to $42	Covered in full[1]	Up to $42
Exam (OD)	Covered in full[1]	Up to $37	Covered in full[1]	Up to $37
Frames	$140 retail allowance	Up to $53	$150 retail allowance	Up to $53
Contact Lens Fitting (standard[2])	Covered in full[1]	Not covered	Covered in full[1]	Not covered
Contact Lens Fitting (specialty[2])	$50 retail allowance[1]	Not covered	$50 retail allowance[1]	Not covered
Lenses (standard) per pair:				
Single Vision	Covered in full	Up to $32	Covered in full	Up to $32
Bifocal	Covered in full	Up to $46	Covered in full	Up to $46
Trifocal	Covered in full	Up to $61	Covered in full	Up to $61
Polycarbonate for dependent children only (up to age 25)	Not Covered	Not Covered	Covered in full	Not Covered
Scratch Coat (factory, single sided)	Not Covered	Not Covered	Covered in full	Not Covered
Ultraviolet Coat	Not Covered	Not Covered	Covered in full	Not Covered
Progressive Lens	See description[3]	Up to $61	$120 retail allowance[5]	Up to $61
Elective Contact Lenses[4]	$125 retail allowance	Up to $100	$150 retail allowance	Up to $100

[1] After co-pays. Co-pays apply to in-network benefits only.

[2] See your benefits materials for definitions of standard and specialty contact lens fittings

[3] Covered at the provider's in-office retail price for a standard lined trifocal; member pays difference between the progressive and the trifocal, plus applicable co-pay

[4] Contact lenses are in lieu of eyeglass lenses and frames benefit

[5] Overages on standard progressive lenses will be the member's responsibility.

Services/Frequency limits for both plans:

Exam: 1 per plan year

Frames: 1 per plan year

Contact Lens Fitting: 1 per plan year

Lenses: 1 per plan year

Contact Lenses: 1 per plan year

Additional discounts are available on LASIK, lens options and upgrades and mail-order contacts.

All costs and allowances are retail; you are responsible for any charges in excess of the retail allowances. All final determinations of benefits, administrative duties, and definitions are governed by the certificate of insurance for your specific benefits.