COSE Benefit Plan

VSP Vision Plan

	Member Pays	
Services	**In-Network**	**Non-Network[1]**
Dependent Age Limit	Same as Medical	Same as Medical
Professional Services (one every calendar year)		
Exam with Dilation	$10 Copayment	$10 Copayment up to $50 Allowed Amount
Frame and Lenses (one frame and one set of uncoated plastic lenses every calendar year)		
Frame	$15 Copayment (Up to $130; 20% off anything over $130)	$15 Copayment up to $70 Allowed Amount
Single Vision	$15 Copayment	$15 Copayment up to $50 Allowed Amount
Bifocal	$15 Copayment	$15 Copayment up to $75 Allowed Amount
Trifocal	$15 Copayment	$15 Copayment up to $100 Allowed Amount
Lenticular	$15 Copayment	$15 Copayment up to $125 Allowed Amount
Lenses		
Scratch-Resistant Coating	$15 Copayment	Not covered
Ultraviolet Coating	$14 Copayment	Not covered
Anti-Reflective Coating	$37 Copayment	Not covered
Polycarbonate Lenses—Child(ren) Covered	$23 Single Vision/$28 Multifocal Copayment for adults	Not covered
Standard Progressive Lenses	$50 Copayment	$15 Copayment up to $75 Allowed Amount
Contact Lenses (instead of glasses)		
Contact Lens Materials	$130 Allowed Amount	$15 Copayment up to $105 Allowed Amount[2]
Contact Lens Fit and Follow-Up		
Standard or Premium	Up to $60	$15 Copayment up to $105 Allowed Amount[2]
Medically Necessary Exam & Materials	$15 Copayment	$15 Copayment (up to $210)

Purchase Options	Premiums	Enrollment
VSP Option 1	100% paid by employer	All employees
VSP Option 2	25% or less paid by the employer	Voluntary

This document is only a partial listing of benefits. This is not a contract of insurance. No person other than an officer of Medical Mutual may agree, orally or in writing, to change the benefits listed here. The contract or certificate will contain the complete listing of covered services.

Allowed amount
The maximum amount allowed for each service listed. The member is responsible for any charges exceeding the amount, in addition to any copayments listed.

Footnotes
1 The non-VSP network maximum is the amount a member receives for covered vision services from a non-network provider

2 $105 covers contact lens fit, follow-up and materials combined

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