	Buy-Up Plan In-Network	Exam Only (Core) Plan In-Network
Eye Exam Once every 12 months	**$15.00 Copay**	Eligibility is for dependents up to age 26
Prescription Lenses Once every 12 months	$25 Material Copay Lenses and/or Frames **Lens Options:** Tints, Scratch Coating	
Frames Once every 24 months	$25 Material Copay Lenses and/or Frames $150 Allowance **Marchon Frame Benefit:** Extra $20 for members to spend on featured frame brands; 20% off additional costs	20% Discount on a complete pair of prescription glasses
Contacts Instead of Glasses (every 12 months)	15% Discount off lens exam (not to exceed $60) $130 Allowance for contacts	15% Discount on Contact Lens Exam
Diabetic Eye Care Diabetic eye disease for type 1 & 2, glaucoma or age-related macular degeneration	Additional Coverage: $20 Copay	N/A
Tru Hearing	**Access program for members offering a savings of up to $2,400 per pair of digital hearing aids**	
Laser VisionCare Program	**Average 15% off regular price or 5% off the promotional price; discounts only available from contracted facilities**	

VSP

Vision Insurance

FY20

Plan	Total Cost	Employer Portion	Employee Portion
Core Benefit			
Employee only	$0.78	$0.78	$0.00
Employee + Family	$1.80	$0.78	$1.02
Buy Up			
Employee only	$7.18	$0.78	$6.40
Employee + Family	$16.02	$0.78	$15.24

VSP

Vision Plan

ENROLLMENT/CHANGE FORM

NAPEBT – 12239817

☐ Add
☐ Change
☐ Cancel

EFFECTIVE DATE: _____ **EMPLOYEE'S SSN:** _____

EMPLOYEE'S NAME: _____

EMPLOYEE'S DATE OF BIRTH: _____

☐ I WOULD LIKE TO ENROLL IN THE VSP EXAM PLUS PROGRAM.

☐ I WOULD LIKE TO ENROLL IN THE BUY UP PROGRAM AND THE TYPE OF COVERAGE REQUESTED IS:

C ☐ EE Only
A ☐ EE+Family

PLEASE LIST ALL ELIGIBLE DEPENDENTS YOU WISH TO COVER:

SPOUSE: _____ ☐Male ☐Female DOB _____
CHILD: _____ ☐Male ☐Female DOB _____
CHILD: _____ ☐Male ☐Female DOB _____
CHILD: _____ ☐Male ☐Female DOB _____
CHILD: _____ ☐Male ☐Female DOB _____
CHILD: _____ ☐Male ☐Female DOB _____
CHILD: _____ ☐Male ☐Female DOB _____
CHILD: _____ ☐Male ☐Female DOB _____
CHILD: _____ ☐Male ☐Female DOB _____
CHILD: _____ ☐Male ☐Female DOB _____

_____ _____
Signature Date

Please return to your Benefits Department
<u>Do Not Return</u> to Vision Service Plan