Notice to Client: In the event this document is used to develop a Summary Plan Description, complete the information below, as applicable.

This Evidence of Coverage is a summary of the Policy provisions and is presented as a matter of general

HOW TO USE THIS PLAN

EXCLUSIONS AND LIMITATIONS OF BENEFITS

URGENT VISION CARE

DEFINITIONS:

ADDITIONAL BENEFIT RIDER

ASSIGNMENT OF BENEFITS

CLIENT

COPAYMENTS

COVERED PERSON

ENROLLEE

PLAN OR PLAN BENEFITS

OPEN ACCESS PROVIDER

PLAN ADMINISTRATOR

POLICY

SCHEDULE OF BENEFITS

EXHIBIT A

SCHEDULE OF BENEFITS
VSP Choice Plan®

GENERAL

BENEFIT PERIOD

ELIGIBILITY

PLAN BENEFITS
VSP PREFERRED PROVIDERS

COPAYMENT

COVERED SERVICES AND MATERIALS

EYE EXAMINATION- Covered in full* once every 12 months**

LENSES - Covered in full* once every 12 months**

FRAMES -

CONTACT LENSES

ELECTIVE

NECESSARY

LOW VISION

Supplemental Testing: Covered in full*.

-Includes evaluation, diagnosis and prescription of vision aids where indicated.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

NOT COVERED

REIMBURSEMENT SCHEDULE
OPEN ACCESS PROVIDERS

COPAYMENT

COVERED SERVICES AND MATERIALS

EYE EXAMINATION: Up to $ 45.00* once every 12 months**

SPECTACLE LENSES

FRAMES: Covered up to $ 70.00* once every 24 months**

CONTACT LENSES

ELECTIVE

NECESSARY

LOW VISION

Supplemental Testing: Up to $125.00*.

-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of Open Access Provider's fee, up to $1,000.00*

EXCLUSIONS AND LIMITATIONS OF BENEFITS
OPEN ACCESS PROVIDERS

EXHIBIT C

ADDITIONAL BENEFIT RIDER
SUPPLEMENTAL ESSENTIAL MEDICAL EYE CARE

GENERAL

Summary of Benefits and Coverage
VSP Choice Plan

Prepared for: John Carroll University
Group ID: 30017808
Effective Date: JANUARY 1, 2024

Common Medical Event	Services You May Need	Your cost if you use an		Limitations and Exceptions
		In-Network Provider	Out-of-Network Provider	

Your Grievance and Appeals Rights: