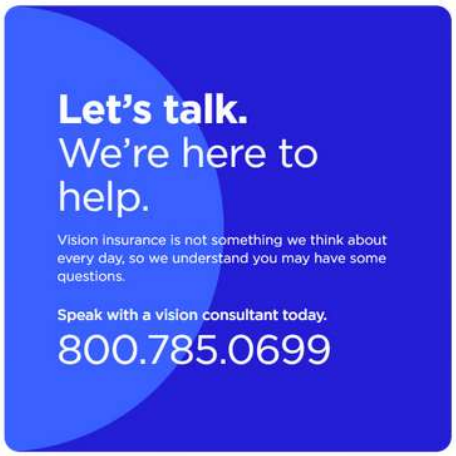
INDIANA PACKERS CORPORATION

# VISION COVERAGE

AFFORDABLE FOR YOUR WHOLE FAMILY

## VISION INSURANCE FOR VSP MEMBERS




As a VSP member, you have access to comprehensive vision coverage through the VSP network of eye care professionals. Our vision insurance plan includes:

- Annual Eye Exams: Routine eye exams are covered once a year to help you maintain optimal eye health and vision.
- Eyewear Allowance: Receive an allowance for glasses or contact lenses, ensuring you have the flexibility to choose the eyewear that best fits your needs.
- Discounts on Lens Enhancements: Enjoy discounts on lens enhancements such as anti-glare coatings, transitions lenses, and progressive lenses.
- Extensive Network: Access a wide network of VSP providers nationwide, making it easy to find a participating eye doctor near you.

Take advantage of these benefits to keep your vision sharp and your eyes healthy!

vsp vision care

| Benefits | | | | |
|---|---|---|---|---|
| | **Plan A - Premier** | | **Plan B - Value** | |
| Benefit and Services | In-Network | Out-of-Network (Plan Pays) | In-Network | Out-of-Network (Plan Pays) |
| **WellVision Exam** | $10 copay | Up to $45 | $10 copay | Up to $45 |
| **Frames Allowances** | $250; $270 for feautured frame brands (every year) | Up to $70 | $200; $220 for feutured frame brands (every other year) | Up to $70 |
| **Lightcare** | $250 (every year) | ~ | $200 (every other year) | ~ |
| **Contacts Allowances** | $250 | Up to $105 | $200 | Up to $105 |
| **Kids Care** | Additional lenses fully covered, minimum prescription change required | Additional lenses fully covered, minimum prescription change required | Not Available | Not Available |

| **Safety Glasses Coverage Included With Your Current Coverage (Coverage is valid for team members only)** | | |
|---|---|---|
| Safety glasses coverage has a $65 frame allowance and polycarbonate lenses are covered in full. | | |
| Benefit | **VSP Preferred Providers** Subject to applicable copay | **Other Providers** Subject to applicable copay |
| Single Vision Lenses | Covered in Full | Reimbursed up to $30 |
| Lined Bifocal Lenses | Covered in Full | Reimbursed up to $50 |
| Lined Trifocal Lenses | Covered in Full | Reimbursed up to $65 |
| Polycarbonate Lenses | Covered in Full | Reimbursed up to $25 |
| When covered-in-full services are obtained from a VSP Preferred Provider, the patient will have no out-of-pocket expense other than any applicable copays. Services obtained through other providers are subject to the same copayments and limitations. Please refer to rate page. | | |

| **Plan A Contributions** | | |
|---|---|---|
| Vison (VSP) | **Plan A - Premier Plan (Weekly)** | **Plan A - Premier Plan (Monthly)** |
| **Single/Individual** | $2.61 | $11.29 |
| **Employee + 1** | $4.92 | $21.31 |
| **Family** | $7.73 | $33.50 |

| **Plan B Contributions** | | |
|---|---|---|
| Vison (VSP) | **Plan B - Value Plan (Weekly)** | **Plan B - Value Plan (Monthly)** |
| **Single/Individual** | $1.45 | $6.28 |
| **Employee + 1** | $2.60 | $11.28 |
| **Family** | $4.01 | $17.36 |

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