Vision Benefit Election Form

Name of Employee _____

Social Security Number _____

Employer Name ***Johnson Employer Support Services***

☐ Please begin payroll deduction for the premium for the following coverage:
VSP Vision Care Plan B $10/$20 Co-Payments

☐ Employee Only $13.53 per Month

☐ Family Coverage $29.08 per Month

I hereby authorize you to retain from my salary and pay to the insurance company, the deduction amounts due, whether initial or renewal for the insurance for which I am applying. These authorized deductions may be made at intervals mutually agreed upon by my employer and the company and are to be paid when due. I understand that if coverage is elected and I continue employment with Johnson Employer Support Services I must continue coverage for 24 months. Subject to Section 125 plan rules and qualifying events.

Signed _____ Date _____

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Monthly VSP Vision Benefits & Costs

VSP Plan B

A. Employee Only	$13.53
B. Employee & Family	$29.08

Benefit	Frequency[1]	Co-Pay	VSP Doctor	Other Provider
Examination	12 Months	$10.00	Covered	Up to $36.00
Basic Lenses[2]- Single Vision, Bifocal, Trifocal, Lenticular	12 Months	$20.00	Covered[3]	Up to $28.- $80[4]
Contacts- (In lieu of Lenses & Frames)	12 Months			
Medically Necessary[5]		$20.00	Covered	Up to $210.00
Elective[6]			Covered to $105.00	Up to $105.00
Frames[2,7]-	24 Months	$20.00	Covered[3]	Up to $45.00
Laser Vision Correction[8]			Discounted	None

1. Based on your last date of service. **2**. Plan provides a 20% discount on non-covered complete pairs of prescription glasses provided by VSP doctor. **3**. Fully covered up to policy limit for frame or for type of lens. May not cover 100% of certain special lenses and frames. **4**. Other Provider Lenses Limit: Single Vision $28, Bifocal $45, Trifocal $56, Lenticular $80. **5**. Medically necessary contact lenses must be prescribed for certain conditions that prevent the wearing of glasses and must be pre-approved by VSP. **6**. The plan includes a 15% discount off the cost of your contact lens exam (fitting & evaluation) when you receive contact lenses through from a VSP doctor. **7**. If you elect contact lenses, you will be eligible for frames 24 months after the last date of obtaining contact lenses. **8**. Laser vision correction (PRK & LASIK) is available through contracted laser centers. Program availability may vary based on location and regulatory approval.

Vision Plan Carrier: Vision Service Plan
Provided through Educational Benefits, Inc., a subsidiary of USAble Life,
and is a member of Blue Cross & Blue Shield Enterprise.

For more information and a list of VSP participating Doctors visit www.vsp.com or our website at www.peoamerica.net or call VSP @ 800-877-7195.