Vision Benefit Summary

MCV Plan 1

This chart provides you a brief summary of the key benefits of the vision coverage available from Principal Life Insurance Company. Following the chart, you will find additional information to answer questions you may have. For a complete list of all your vision coverage benefits and restrictions, please refer to your booklet or contact your employer.

Eligibility	
Job Class	Active

Your Coverage with a VSP Preferred Provider		
Doctor Network	VSP Choice Network	
Covered Charges	**Benefit**	**Frequency**
Exams	$10 copay	One exam every 12 months
Prescription Glasses	$10 copay	
Lenses	Single vision, lined bifocal, lined trifocal and lenticular lenses; polycarbonate lenses for dependent children under age 18	Two lenses (one pair) every 12 months
Frames	$150 allowance for a wide selection of frames; 20% off amount over allowance***	One set every 24 months
Elective Contacts	Up to $60 copay for your elective contact lens exam (fitting and evaluation)	Once every 12 months
	$150 allowance for elective contacts	Contacts are instead of frames and lenses
Necessary Contacts**	$10 copay	Once every 12 months
	Covered in full for members who have specific conditions	Contacts are instead of frames and lenses

Additional Savings ***	
Glasses and Sunglasses	Lens enhancements are covered after a copay, saving members an average of 20-25% off additional glasses and sunglasses, including lens options from any VSP doctor within 12 months of your last covered vision exam
Contacts	15% off cost of contact lens exam (fitting and evaluation)
Laser Vision Correction	Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities

VISION

Your Coverage with Other Providers (Non-Network)		
Covered Charges	**Scheduled Benefit Amount**	**Frequency**
Vision Exams	Up to $45	One per 12 month period
Single Vision lenses	Up to $30	One pair per 12 month period
Lined bifocal lenses	Up to $50	One pair per 12 month period
Lined trifocal lenses	Up to $65	One pair per 12 month period
Lenticular lenses	Up to $100	One pair per 12 month period
Frames	Up to $70	One set per 24 month period
Elective Contacts	Up to $105	In lieu of lenses and frame benefits
Necessary Contacts**	Up to $210	In lieu of lenses and frame benefits

** Necessary contact lenses are prescribed to correct extreme visual problems that cannot be corrected with regular lenses.
*** Based on applicable laws; benefits may vary by doctor location.

There is Coordination of Benefits, which is a procedure for limiting benefits from two or more carriers to 100% of the claimant's covered expenses.

Understanding Your Vision Benefits

Am I Eligible For Coverage?

To be eligible for coverage, you must qualify as an eligible member and be considered actively at work.

You must be enrolled for vision coverage before it can be offered to your dependents. Eligible dependents include your spouse and children. Additional eligibility requirements may apply.

How Do I Find a VSP Provider?

Use the Provider Directory on www.vsp.com to locate nearby VSP providers or to see if your current eye care professional participates in the VSP network. To speak to a representative by phone, please call 800-877-7195.

How Do I Submit A Claim?

When visiting a VSP provider for services, the provider submits the claim for payment. If visiting a non-network provider for services, you are responsible for submitting the claim to VSP. Obtain a claim form by logging on to vsp.com or by calling 800-877-7195. Include a copy of your itemized receipt with your claim form and mail it to the following address.

Vision Service Plan
P.O. Box 997105
Sacramento, CA 95899-7105

What Are The Restrictions Of My Coverage?

This Benefit Summary is a summary only. For a complete list of benefit restrictions, please refer to your booklet.

Late Entrant Waiting Period	Those members enrolling more than 31 days after becoming eligible will be subject to an individual benefit waiting period, subject to coverage guidelines.
Non-Medically Necessary Services	The coverage does not pay for visual analysis or vision aids that are not medically necessary.
Benefit Limitations	The following items are excluded under this coverage: • Two pairs of glasses instead of bifocals • Replacement of lenses, frames or contacts • Medical or surgical treatment • Orthoptics, vision training or supplemental testing • Plano lenses (lenses with refractive correction of less than ± .50 diopter)
Contact Lens Limitations	The following items are not covered under the contact lens coverage: • Insurance policies or service agreements • Artistically painted or non-prescription lenses • Additional office visits for contact lens pathology • Contact lens modification, polishing or cleaning • Refitting of contact lenses after the initial (90 day) fitting period
Other Limitations	There are additional limitations to your coverage. A complete list is included in your booklet.

WE'LL GIVE YOU AN EDGE ®

Principal Life Insurance Company, Des Moines, Iowa 50392-0002, www.principal.com

This is a summary of vision coverage underwritten by or with administrative services provided by Principal Life Insurance Company. This benefit summary is for administrative purposes and is not a complete statement of the rights, benefits, limitations or exclusions of the coverage. You'll receive a benefit booklet with details about your coverage. If there is a discrepancy between this summary and your benefit booklet, the benefit booklet prevails.