LEIDOS
2027 Plan Year Benefit Summary

PLAN NAME	**VSP**
PRODUCT NAME	**VSP Choice - Base Plan**
LEIDOS SYSTEMS CODE	VSP
PLAN STATES	Nationwide
CUSTOMER SERVICE PHONE	1-800-877-7195
WEB ADDRESS	www.vsp.com

Benefit	In Network – Employee Pays*	Out of Network – Plan Reimburses
Frequency - Exams	Every calendar year	Every calendar year
Frequency - Lenses	Every calendar year	Every calendar year
Frequency - Frames	Every calendar year	Every calendar year
Copay	$20	$20 (deducted from out-of-network reimbursement)
Vision Exam	Covered in full after copay	Up to $45 for exam services
Routine Retinal Screening	$10	
Lenses	Plan pays 100% for single vision, standard progressive, lined bifocal, lined trifocal, and lenticular lenses. Lens options that enhance appearance, durability and functions of glasses are available with an average 30% discount	Plan reimburses up to: $30 for single vision; $50 for lined bifocal; $65 for lined trifocal; $100 for lenticular
Frames	Plan covers frames up to $150 (featured brands covered up to $200); participants may upgrade frames by paying the difference in cost; 20% discount on any out-of-pocket costs.	Plan reimburses up to $70
Contacts (in lieu of lenses and frames)	Plan pays up to $150 allowance for contact lenses. Contact lens exam (fitting and evaluation) covered in full after a copay not to exceed $60; 15% discount on contact lens exam	Plan reimburses up to $105 for both contact lens fitting and evaluation and contacts
Medically necessary contact lenses (in lieu of lenses and frames)	Plan pays 100% if contact lenses are required for certain medical conditions that prevent a participant from wearing eyeglasses. Medically necessary contact lenses must be approved by VSP.	Plan reimburses up to $210
Laser Vision Correction	Plan pays $100 per eye up to a $200 lifetime maximum, plus plan provides discounts averaging 15% on charges not to exceed: Custom LASIK: $2,300 per eye; LASIK $1,800 per eye; PRK: $1,500 per eye	Plan pays $100 per eye up to a $200 lifetime maximum, no discounts available
LightCare	$20 copay $150 allowance **Not available at Walmart Optical or Sam's Club Optical	Plan reimburses up to $70

***VSP doctors offer additional savings including a 20% discount on non-covered pairs of prescription glasses (lenses and frames). Services must be received within 12 months from the same VSP doctor who provided your last covered eye exam.**

You can also save 15% off the cost of your contact lens exam when you receive contact lens services from VSP.

****Coverage with a retail chain affiliate may be different. Once your benefit is effective, visit vsp.com for details.**

Please refer to the Certificate of Coverage (COC) for terms and conditions of all benefits. Benefits may require pre-certification in order to avoid a reduction in benefits or denial of coverage. The insured should contact the carrier at the phone number indicated on this summary or refer to the COC for further details prior to seeking treatment. If there is any conflict between this benefit summary and the Plan Document/Certificate, the Plan Document/Certificate governs. Contact Plan for limitations, exclusions, and additional costs.