

Leidos Benefits Summary Plan Description

Vision Plans

Comparing the Vision Plans

	VSP Basic		VSP Plus	
	VSP Provider	Non-VSP Provider	VSP Provider	Non-VSP Provider
Examination – One (1) per calendar year				
Routine Well Vision Exam	\$20 Copay for exam and glasses	Plan reimburses up to \$45	\$20 Copay for exam and glasses	Plan reimburses up to \$45
Contact Lens Exam (fitting and evaluation)	Up to \$60 Copay	N/A	Up to \$60 Copay	N/A
Lenses – per calendar year				
Single Vision Lenses	Included	Plan reimburses up to \$30	Included	Plan reimburses up to \$30
Lined Bifocal Lenses	Included	Plan reimburses up to \$50	Included	Plan reimburses up to \$50
Lined Trifocal Lenses	Included	Plan reimburses up to \$65	Included	Plan reimburses up to \$65
Lenticular	Included	Plan reimburses up to \$100	Included	Plan reimburses up to \$100
Frames – per calendar year				
Wide selection of frames	\$150 Allowance	Plan reimburses up to \$70	\$150 Allowance	Plan reimburses up to \$70
Featured frame brands	\$200 Allowance	Plan reimburses up to \$70	\$200 Allowance	Plan reimburses up to \$70
Walmart / Sam's Club / Costco	\$150 Allowance	Plan reimburses up to \$70	\$150 Allowance	Plan reimburses up to \$70
Savings on the amount over your allowance	20% off overage	Plan reimburses up to \$70	20% off overage	Plan reimburses up to \$70



	VSP Basic		VSP Plus	
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Contact Lenses (in lieu of glasses) – per calendar year				
Elective Contact Lenses	\$150 Allowance	Plan reimburses up to \$105	\$150 Allowance	Plan reimburses up to \$105
Medical Necessary Contact Lenses	Included	Plan reimburses up to \$210	Included	Plan reimburses up to \$210
VSP EasyOptions – per calendar year				
	N/A	N/A	Each covered plan member may select one of the following enhancements when purchasing their eyewear: <ul style="list-style-type: none"> • Additional \$100 frame allowance • Additional \$100 contact lens allowance • Fully-covered premium or custom progressive lenses • Fully-covered anti-reflective coating • Fully-covered light-reactive lenses 	N/A
Covered Lens Enhancements				
Standard Progressive Lenses	Covered	Reimbursed up to \$50	Covered	Reimbursed up to \$50
Polycarbonate for children	Covered	N/A	Covered	N/A

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Non-Covered Lens Enhancements				
Other Add-Ons & Services	Average of 20-25% discount off of regular price	N/A	Average of 20-25% discount off of regular price	N/A
Diabetic Eyecare Plus Program				
Retinal screening for members with diabetes	\$0 Copay	N/A	\$0 Copay	N/A
Additional exams and services for members with diabetic eye disease, glaucoma, or age-related macular degeneration	\$20 Copay per exam	N/A	\$20 Copay per exam	N/A
Laser VisionCare Preferred Program – per lifetime				
Custom LASIK, Custom PRK, Bladeless LASIK, LASIK, or PRK	\$100 allowance per eye up to \$200 lifetime maximum. Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities.	Plan reimburses up to \$100 per eye up to \$200 lifetime maximum	\$100 allowance per eye up to \$200 lifetime maximum. Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities.	Plan reimburses up to \$100 per eye up to \$200 lifetime maximum