VISION PLANS | VSP Vision Care - vsp.com • 1.800.877.7195

Your vision benefits are provided through **VSP Vision Care**. Use providers in the VSP network to obtain the highest level of benefits. Visit vsp.com to find or confirm in-network providers.

Members are permitted services based upon the plan year of July 1 to June 30. Effective July 1 of each plan year, members have the ability to schedule eligible services.

This chart is an overview of the vision coverage. Visit vsp.com for a detailed description of the Vision Care plan benefits.

VSP does not provide identification cards. In-network providers automatically submit electronic claims on your behalf.

VISION PRICE TAGS

EMPLOYEE STATUS		VISION CARE BASIC	VISION CARE ENHANCED
EMPLOYEE	Annual	$77.04	$155.88
	Biweekly	$2.96	$6.00
EMPLOYEE PLUS CHILD(REN)	Annual	$165.24	$334.68
	Biweekly	$6.36	$12.87
EMPLOYEE PLUS SPOUSE	Annual	$153.96	$311.76
	Biweekly	$5.92	$11.99
FAMILY	Annual	$264.36	$534.60
	Biweekly	$10.17	$20.56

SUMMARY OF BENEFITS	VISION CARE - BASIC		VISION CARE - ENHANCED	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
WellVision Exam	Once every plan year: $0 copay	Up to $45 reimbursement	Once every plan year: $20 copay	Up to $45 reimbursement
Routine Retinal Screening	Up to $39 copay	NA	Up to $39 copay	NA
PRESCRIPTION LENS				
Single Vision, Lined Bifocal and Lined Trifocal. Impact Resistant Glasses for dependent children.	Copay combined with exam covered in full every plan year	Single Vision - up to $30 Lined Bifocal - up to $50 Lined Trifocal - up to $65	Copay combined with exam covered in full every plan year	Single Vision - up to $30 Lined Bifocal - up to $50 Lined Trifocal - up to $65
Standard Progressive	Covered in full every plan year	Up to $50 reimbursement	Covered in full every plan year	Up to $50 reimbursement
Premium Progressive	$95 to $105	Up to $50 reimbursement	$20	Up to $50 reimbursement
Custom Progressive	$150 to $175	Up to $50 reimbursement	$20	Up to $50 reimbursement
Tints/Photochromic	NA	NA	Covered in full	NA
Scratch Resistant Coating	NA	NA	Covered in full	NA
FRAMES	Once EVERY OTHER plan year	Once EVERY OTHER plan year	Once EVERY plan year	Once EVERY plan year
Frames	$130 frame allowance	Up to $70 reimbursement	$170 frame allowance	Up to $70 reimbursement
Featured Frame Brands	$180 frame allowance	NA	$220 frame allowance	NA
VisionWorks	$180 frame allowance	NA	$220 frame allowance	NA
Costco	$70 frame allowance	NA	$95 frame allowance	NA
Additional Frame Savings	20% off amount over allowance	NA	20% off amount over allowance	NA
Additional Pairs of Glasses/Sunglasses	20% savings, including lens enhancements, extra $50 to spend on featured brands	NA	20% savings, including lens enhancements, extra $50 to spend on featured brands	NA
	CONTACT LENSES ARE IN LIEU OF LENSES AND FRAMES		ENHANCED PLAN MEMBERS MAY RECEIVE CONTACT EXAM AND LENSES EVERY PLAN YEAR	
Contact Lenses Exam (Fitting and Evaluation)	Copay not to exceed $60	Up to $105 reimbursement for Contacts	Copay not to exceed $60	Up to $105 reimbursement for Contacts
Contact Lenses	$130 allowance		$170 allowance	
Medically Necessary Contact Lenses	$0 Copay	Up to $210 reimbursement	$20 Copay	Up to $210 reimbursement
PRIMARY EYE CARE				
Retinal Screening for Diabetic Members*	$0 Copay *Limitations and coordination with medical coverage may apply	NA	$0 Copay*Limitations and coordination with medical coverage may apply	NA
Additional exams/services for members with diabetes, glaucoma, age-related macular degeneration*	$20 per exam*Limitations and coordination with medical coverage may apply	NA	$20 per exam*Limitations and coordination with medical coverage may apply	NA
Treatment/Diagnosis of eye conditions, including pink eye, vision loss and cataracts*	$20 per exam*Limitations and coordination with medical coverage may apply	NA	$20 per exam*Limitations and coordination with medical coverage may apply	NA
Laser VisionCare Correction	Average 15% off the regular price or 5% off the promotional price available from contracted facilities.			