VSP VISION PLAN

BENEFITS	
Network/Plan	VSP Vision
Copay (Exams/Materials)	$10/$25
SERVICE FREQUENCIES	
Eye Exams	Once Every 12 months
Lenses Benefit	Once Every 12 months
Contact Lenses	Once Every 12 months
Frames	Once Every 24 months

REIMBURSEMENT SCHEDULE	In-Network (Copay)	Out-of-Network (Before Copay)
Eye Exams	$10	$50 max
Lenses Benefit		
Single Vision	$25	$48 max
Bifocal	$25	$67 max
Trifocal	$25	$86 max
Lenticular	$25	$126 max
Contact Lenses Benefit		
Medically Necessary	Covered (Copay Waived)	$210 max
Elective Materials	$150 max + 15% off	$105 max
Frames Benefit	$150 retail max + 20% off	$48 max

VSP VISION PLAN

Member Only	Member & Spouse	Member & Child	Member & Family
$14.95	**$28.95**	**$27.95**	**$42.95**

PROVIDER LOOKUP

Visit: https://www.vsp.com/eye-doctor
Search by Location, Office Name, or Doctor Name

The benefits outlined above are a summary of the quoted plan design. Full details on the plan of benefits and applicable policy provi-sions, including limitations and exclusions, are provided in the group contract.