VISION INSURANCE

VSP | VSP PPO



VISION COVERAGE	IN-NETWORK	OUT-OF-NETWORK
Eye Exam	$10	$45
Single Vision Lens	$25	$30
Lined Bi-Focal Lens	$25	$50
Lined Tri-Focal Lens	$25	$65
Lenticular Lens	$25	$50
Contact Lens Allowance	$150	$105
Frame Allowance	$150 + 20% off balance	$70
FREQUENCIES		
Exam Frequency	Every 12 months	
Lens Frequency	Every 12 months	
Frame Frequency	Every 12 months	
	Your plan provides the following out-of-network reimbursements:	
PLAN INFORMATION		
Network Name	VSP Choice	
Member Website	myhealthplan.com	
Customer Service Phone Number	800-877-7195	

PREMIUM PER EMPLOYEE PAYCHECK	
Employee Only	$0.00
Employee + Spouse	$2.80
Employee + Child(ren)	$4.18
Family	$6.98

vsp vision care

Plan Explanation

Taking care of your vision is an important part of maintaining your overall health. Our **vision plan** helps make routine eye care more affordable by providing coverage for eye exams and savings on glasses, contact lenses, and other vision care needs.

Disclaimer

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage.