

VSP VISION BENEFIT OPTIONS

PLAN	EYE EXAM CO-PAY		EYEGLASS FRAMES CO-PAY		EYEGLASS LENSES CO-PAY		CONTACT LENSES CO-PAY		THERAPUTIC CONTACT LENS CO-PAY	
	In- Network	Out-of- Network	In- Network	Out-of- Network	In- Network	Out-of- Network	In- Network	Out-of- Network	In- Network	Out-of- Network
VSP 12 (Once every 12 months)	\$5	\$5 co-pay reimbursement up to \$35	\$10	\$10 co-pay reimbursement up to \$46	\$10	Reimbursement up to predetermined amount based on lense type after co-pay	Covered up to \$120	Covered up to \$120	\$10	Reimbursement up to \$210 after a \$10 co-pay
VSP 24 (Once every 12 months)	\$5	\$5 co-pay Reimbursement up to \$35	\$10	\$10 co-pay Reimbursement up to \$46	\$10	Reimbursement up to predetermined amount based on lens type after co-pay	Covered up to \$120	Covered up to \$120	\$10	Reimbursement up to \$210 after a \$10 co-pay

NOTE: Definitions of services outlined on Benefits-at-a-Glance.

VSP PLAN

Based on frequency limits, covered benefits generally include regular eye examinations, corrective lenses, a frame, or contact lenses (in lieu of glasses).

NOTE: This is only a broad overview of the covered benefits. Please refer to a plan certificate for more precise coverage information.

