VSP by DELTA VISION
BENEFIT SUMMARY

RATES			
EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	FAMILY
$9.95	$19.90	$20.90	$34.85

BENEFITS	
Network/Plan	VSP Choice
Exam/lens/frame frequency (months)	12/12/24
Contacts (in lieu of glasses)	12
IN-NETWORK COVERAGE	
Eye Exam Copay	$10
Materials Copay	$25
Frame allowance	$130 | $70 Walmart/Sam's Club/Costco frame allowance
Elective contact lens allowance	$130
Necessary contact lenses	Covered in full after copay
Contact lens fit/evaluation copay	$60
Both frames and contacts in same year	No; allows contacts in lieu of frames
OUT-OF-NETWORK COVERAGE	
Examination, up to:	$45
Single vision lenses, up to:	$30
Bifocal lenses, up to:	$50
Trifocal lenses, up to:	$65
Progressive lenses, up to:	$50
Lenticular lenses, up to:	$100
Frames, up to:	$70
Elective contact lenses, up to:	$105
Necessary contact lenses, up to:	$210
LENS ENHANCEMENTS (MEMBER COST)*	
Anti-glare coating	$41 single/$41 multifocal
Impact - resistant lenses - adult	$31 single/$35 multifocal (covered for children)
Progressive lenses	Standard progressive lenses are covered
Light-reactive lenses	$75 single vision/$75 multifocal
Scratch resistant coating	$17 single vision/$17 multifocal

*Prices shown reflect the standard plastic price for each respective category. Premium lens enhancement prices may vary. Prices may vary and are valid only through VSP Choice Network and are subject to change without notice.

VISION PROVIDER LOOKUP

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

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