

**VSP VISION – RATES GUARANTEED UNTIL JANUARY 1, 2026** \*See page 30, note 14 for Plan Selections and Combination Guidelines

VISION BENEFITS	Option 1		Option 2	
	In-Network	Non-Network	In-Network	Non-Network
Copay	\$25 for Exam and/or Materials		\$25 for Exam and/or Materials	
Exam	Covered after Copay	Plan pays up to: \$50	Covered after Copay	Plan pays up to: \$50
Lenses				
Single	Covered after Copay	\$50	Covered after Copay	\$50
Bifocal	Covered after Copay	\$75	Covered after Copay	\$75
Trifocal	Covered after Copay	\$100	Covered after Copay	\$100
Frames	\$130 Allowance 20% off amount over allowance	\$70	\$130 Allowance 20% off amount over allowance	\$70
Contact Lenses - Elective	\$130 Allowance	\$105	\$130 Allowance	\$105
Contact Lenses - Medically Necessary	Covered after Copay	\$210	Covered after Copay	\$210
Contact Exam and Fitting	Up to \$60	\$0	Up to \$60	\$0
Frequency of Services				
Eye Examination	12 months		12 months	
Lenses	24 months		12 months	
Frames	24 months		24 months	
Contact Lenses <sup>1</sup>	24 months		12 months	
Rates				
Employee Only	\$6.59		\$7.62	
Employee + 1 Dependent	\$12.77		\$14.83	
Employee + 2 or More Dependents	\$20.19		\$23.48	

<sup>1</sup> Contact lenses are in lieu of spectacle lenses and frames

THIS SUMMARY IS INTENDED TO COMPARE COVERAGE BENEFITS ONLY. THE ACTUAL PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.