Vision Plan

Contact: **VSP**
1.800.877.7195
www.vsp.com

Cross-eyed from reading this guide, find an in-network provider at **www.vsp.com.**

VSP Vision Plan Coverage		
	Network	**Out-of-network**
Exam Frequency	Once every 12 months	
Exam Copay	$10	Up to $43 reimbursement
Frames Frequency	Once every 24 months	
Frames	$10 up to $130 allowance	Up to $40 reimbursement
Lens Frequency	Once every 12 months	
Single Lenses	$10	Up to $30 reimbursement
Lined Bifocal Lenses	$10	Up to $45 reimbursement
Lined Trifocal Lenses	$10	Up to $62 reimbursement
Contact Frequency (Contacts are in lieu of glasses)	Once every 12 months	
Medical Necessary Contacts	Paid in Full	Up to $100 reimbursement
Elective Contacts	$130 Allowance	Up to $100 reimbursement

To avoid filing a claim...stay in network.