Voluntary Vision Benefit Rates	
Effective Date: 12/01/2018	
Monthly Rates	
Employee	$9.72
Employee & Spouse	$20.75
Employee & Child(ren)	$22.24
Family	$36.41

Your Coverage with a VSP Preferred Provider		
Covered Charges	**Benefit**	**Frequency**
Exams	$10 copay	1 per 12 Months
Prescription Glasses	$25 copay	
Lenses	Single vision, lined bifocal, lined trifocal and lenticular lenses; polycarbonate lenses for dependent children under age 18	1 per 12 Months*
Frames	$150 allowance for a wide selection of frames; 20% off amount over allowance	1 per 24 Months
Contacts	Up to $60 copay for your contact lens exam (fitting and evaluation)	1 per 12 Months
	$150 allowance for contacts	Contacts are instead of frames and lenses

Additional Savings **		
	Glasses and Sunglasses	Lens enhancements are covered after a copay, saving members an average of 20-

	25% off additional glasses and sunglasses, including lens options from any VSP doctor within 12 months of your last covered vision exam
Contacts	15% off cost of contact lens exam (fitting and evaluation)
Laser Vision Correction	Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities

Your Coverage with Other Providers (Non-Network)

Covered Charges	Scheduled Benefit Amount	Frequency
Vision Exams	Up to $45	1 per 12 Months
Single Vision lenses	Up to $30	1 per 12 Months*
Lined bifocal lenses	Up to $50	1 per 12 Months*
Lined trifocal lenses	Up to $65	1 per 12 Months*
Lenticular lenses	Up to $100	1 per 12 Months*
Frames	Up to $70	1 per 24 Months
Contacts	Up to $105	Contacts are instead of frames and lenses

* per pair