

# Vision



	DISCOUNT PLAN	VALUE PLAN	PREMIER PLAN
Annual Eye Exam	Every 12 months	Every 12 months	Every Plan Year
Eyeglass Lenses	Not Covered	Every 12 months (single, bifocal, progressive)	Every Plan Year (single, bifocal, progressive, polycarbonate, photochromic)
Frames	Not Covered	Every 24 months	Every Plan Year
In-Network Coverage Co-pay			
Annual Eye Exam	Free	\$10.00	\$10.00
Materials	Not Covered	\$25.00	\$25.00
Laser Vision Care (Lasik)	Discounted Services Available	Discounted Services Available	Allowance of up to \$500 per eye
VSP Network Allowances			
Retail Frame Value	20% Discount	\$105.00	\$150.00
Elective Contact Lenses	15% Discount	\$100.00	\$150.00
Non-Network Coverage			
Annual Eye Exam	up to \$35.00	up to \$35.00	up to \$35.00
Single Vision Lenses		up to \$25.00	up to \$25.00
Bifocal Lenses		up to \$40.00	up to \$40.00
Trifocal Lenses		up to \$50.00	up to \$50.00
Frame		up to \$45.00	up to \$45.00
Elective Contact Lenses		up to \$100.00	up to \$100.00
Laser Vision Care (Lasik)	Not Covered	Not Covered	Allowance of up to \$500 per eye

## TIPS: VISION

For a list of in-network providers in your area, call Vision Service Plan (VSP) at 800-821-8130 or go to [www.VSP.com](http://www.VSP.com).

You can use the dollars in your Health Care Flexible Spending Account to cover your co-pays and out-of-pocket expenses; see the *Flexible Spending Accounts* section for more details.