

SUMMARY OF VISION BENEFITS Plan 703

	VSP Provider	Out-of-Network Provider Reimbursement
Copayments per Person Exam Lenses and Frames	\$20 \$40	\$20 \$40
Benefits Exam Frames* Lenses Single Vision Bifocal Trifocal Lenticular Lens Options Contacts (instead of glasses)**	Covered in full \$120 Covered in full Covered in full Covered in full Covered in full Photochromic and tints Up to \$120 allowance	Up to \$45 Up to \$47 Up to \$45 Up to \$65 Up to \$85 Up to \$125 \$5 total Up to \$105 allowance
Allowable Frequency Exam Frames Lenses Contacts (instead of glasses)	Every 12 months Every 12 months Every 12 months Every 12 months	Every 12 months Every 12 months Every 12 months Every 12 months

*A variety of frames are covered in full. If your frame exceeds the allowable cost, you will receive a 20% discount on your out-of-pocket costs for the frame

**Your plan includes a 15% discount off the cost of your contact lens exam (fitting and evaluation) when obtained from a VSP doctor. The Contact Lens allowance at non-VSP doctors includes both the cost of the exam and the cost of the contact lenses. Medically necessary contact lenses will be covered in full when provided by a VSP provider, or covered up to \$125 per lens when provided by a non-VSP provider. Medically necessary contacts are contact lenses furnished in situations where vision cannot be satisfactorily corrected using spectacle lenses. Prior approval from VSP is required in this case.