VSP Vision Care

VSP Choice Plan

SAMPLE

Summary of Benefits

Group Vision Care Plan — VSP Choice Network | Effective: 01/01/2027 | Group #: 0012345 (Sample Company, Inc.)

In-Network Benefits

Service	Your Cost In-Network	Frequency
Comprehensive Eye Exam	$10 copay	Every 12 months
Prescription Lenses (single, bifocal, trifocal, progressive)	$25 copay — progressives covered with no upgrade fee	Every 12 months
Frames	$200 allowance, then 20% off any amount over	Every 24 months
Elective Contact Lenses (in lieu of lenses)	$200 allowance; fitting fee up to $60	Every 12 months
Medically Necessary Contact Lenses	Covered in full	Every 12 months

Out-of-Network Reimbursement

Service	Reimbursement Up To
Eye Exam	$50
Frames	$70
Elective Contact Lenses	$105

Additional Savings

Feature	Detail
Laser Vision Correction	15% off LASIK or PRK from VSP-contracted providers
Additional Glasses	20% off additional pairs of glasses
Lens Upgrades	Up to $40 off lens upgrades (anti-reflective, photochromic)
Premium Contributions	Employer pays 100% of vision premiums for employees and dependents

Limitations and Exclusions

This plan does not cover orthoptics or vision training, non-prescription lenses, replacement of lost or broken lenses or frames outside the normal frequency, or medical or surgical treatment of the eyes. See the certificate of coverage for complete provisions.