

# Plan Comparison from VSP®



Base Plan*		EasyOptions Plan*
<b>Copay</b>	\$15 Exam / \$25 Materials	\$15 Exam / \$25 Materials
<b>Exam</b>	Every 12 months	Every 12 months
<b>Lenses</b>	Every 12 months	Every 12 months
<b>Frame</b>	Every 12 months	Every 12 months
VSP Provider		
<b>WellVision Exam®</b>	Covered after \$15 copay	Covered after \$15 copay
<b>Contact Lens Exam</b>	15% savings on contact lens exam	15% savings on a contact lens exam
<b>Lenses:</b> Single Vision Lined Bifocal Lined Trifocal Lenticular	Covered after \$25 materials copay	Covered after \$25 materials copay
<b>Impact-resistant (polycarbonate) Lenses for Children</b>	Covered with no copay	Covered with no copay
<b>Maximum Copay on Lens Enhancements</b>	Average savings of 20-25% on other lens enhancements	Average savings of 20-25% on other lens enhancements
<b>Anti-glare Coating</b>	\$41-\$85 copay	\$41-\$85 copay
<b>Impact-resistant (polycarbonate) Lenses</b>	\$31-\$35 copay	\$31-\$35 copay
<b>Progressive Lenses</b> (no-line bi/trifocals, ranging from standard to custom)	\$0-\$175 copay	\$0-\$175 copay
<b>Light-to-dark Lens Tinting</b> (photochromic adaptive lenses)	\$70-\$82 copay	\$70-\$82 copay
<b>Scratch-resistant Coating</b>	\$17-\$33 copay	\$17-\$33 copay
<b>Frames</b>	\$150 allowance every 12 months OR \$170 allowance on a featured frame brand	\$150 allowance every 12 months OR \$170 allowance on a featured frame brand
<b>Elective Contact Lenses*</b>	\$150 allowance every 12 months	\$150 allowance every 12 months
<b>Necessary Contact Lenses*</b>	N/A	N/A
	*Contact lenses are in lieu of spectacle lenses and frames once every 12 months	*Contact lenses are in lieu of spectacle lenses and frames once every 12 months
<b>EasyOptions Upgrades</b> Members can choose from one of the following upgrades as part of their plan coverage	N/A	Fully covered custom or premium progressive lenses Fully covered light-to-dark lens tinting Increased frame allowance to \$230 Increased contact lens allowance to \$230
Non-VSP Provider (OUT-OF-NETWORK) Reimbursement Amount		
<b>Examination</b>	Up to \$45	Up to \$45
<b>Lenses:</b> Single Lined Bifocal Lined Trifocal Lenticular	Up to \$30 Up to \$50 Up to \$65 Up to \$100	Up to \$30 Up to \$50 Up to \$65 Up to \$100
<b>Progressive Lenses</b> (no-line bi/trifocals, ranging from standard to custom)	Up to \$50	Up to \$50
<b>Frames</b>	Up to \$70	Up to \$70
<b>Elective Contact Lenses*</b>	Up to \$105	Up to \$105
<b>Necessary Contact Lenses*</b>	N/A	N/A
	*Contact lenses are in lieu of spectacle lenses and frames once every 12 months	*Contact lenses are in lieu of spectacle lenses and frames once every 12 months
Fully-Insured Program		
Member Only Member + One Member + Family	Annual or Monthly	Annual or Monthly
<b>Contract Term</b>	12 months	12 months
<b>Healthy Vision Association</b>	\$18 annual enrollment fee where applicable, every 12 months	\$18 annual enrollment fee where applicable, every 12 months
<b>Plan Availability</b>	Available in all states except Florida, New York, Oregon, and Washington.	Available in all states except Florida.

\*Plans have exclusions and limitations. For complete details of the coverage please talk to your broker.

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