

Franchise Vision Options Effective on January 1, 2024

	VSP Option		Eyemed Option	
Plan Name	VSP Choice Network + Affiliates		Eyemed Insight Network	
Waiting Period for Services	No Waiting Periods for all Covered Services		No Waiting Periods for all Covered Services	
Services	In Network	Out of Network	In Network	Out of Network
Eye Exam Copayment	\$10		\$10	None
Frame & Lense Deductible	\$25		\$25	None
Annual Eye Exam	In Network	Out of Network	In Network	Out of Network
Exam w Optometrist	Covered in Full	Up to \$45 Allowance	Covered in Full	Up to \$35
Annual Lenses	In Network	Out of Network	In Network	Out of Network
Single Vision	Covered In Full	Up to \$30	Covered In Full	Up to \$25
Bifocal	Covered in Full	Up to \$50	Covered In Full	Up to \$40
Trifocal	Covered In Full	Up to \$65	Covered In Full	Up to \$55
Lenticular	Covered In Full	Up to \$100	Covered In Full	No Benefit
Progressive	Covers Line Bifocal	Covers Lined Bifocal	See Below	No Benefit
Standard			\$90	No Benefit
Tier 1			\$110	No Benefit
Tier 2			\$120	No Benefit
Tier 3			\$135	No Benefit
Tier 4			\$65 plus 80% of charge less \$120 Allowance	No Benefit
Annual Frames	Subject to Deductible	Subject to Deductible	Subject to Deductible	Subject to Deductible
Allowance	\$130	Up to \$70	\$130	Up to \$65
Annual Contact Lenses	Subject to Deductible	Subject to Deductible	Subject to Deductible	Subject to Deductible
Fit & Follow Up Exams	Member Cost up to \$60	No Benefit	Standard: Member cost up to \$40	No Benefit
			Premium: 10% off Retail	
January 1, 2024 Monthly Rates				
Employee	\$11.23		\$10.03	
Employee + 1 Dependent	\$20.32		\$18.71	
Employee + 2 Dependents	\$29.98		\$27.68	

Note: See Benefit Service Contract for a complete set of services and fees