

## EXEMPT VISION PLAN

### VISION SERVICE PLAN (VSP)

### EYEMED PLAN

Service

In-Network

Out-Of-Network

In-Network

Out-Of-Network

Network

VSP Signature

Select

Routine Exam/Frame/  
Lens Frequency

1 every 12 months

1 every 12 months

Routine Exam/  
Professional Fees

Plan pays 100%  
after \$10 copay.

You pay \$10 copay, then plan  
pays maximum of \$25.

Plan pays 100%  
after \$5 copay.

The plan reimburses  
a maximum of \$25.

MATERIALS/LENSES

Plan pays 100%  
after \$15 copay.

You pay \$15 copay,  
then plan pays maximum  
benefit of:

Plan pays 100%.

Plan reimburses a  
maximum benefit of:

Single Vision Lenses  
Bifocal Lenses  
Progressive Lenses  
Trifocal Lenses  
Lenticular Lenses  
Polycarbonate Lenses  
(Available to All)

\$25  
\$35  
\$52  
\$52  
\$62  
\$0

\$25  
\$35  
\$55  
\$52  
\$62  
\$0

FRAMES

Plan pays 100% up to  
\$120 retail.

Plan pays maximum  
benefit of \$18.

Plan pays 100% up  
to \$120 retail.

Plan reimburses a  
maximum benefit of \$18.

CONTACT LENSES  
Elective (Instead of  
Lenses & Frames)

Plan pays maximum of \$125  
plus standard eye exam.

Plan pays maximum of \$125  
plus standard eye exam.

Plan pays maximum of \$125  
plus standard eye exam.

Plan reimburses a maximum of  
\$105 plus standard eye exam.

Medically Necessary

Plan pays 100% plus standard  
eye exam.

Plan pays maximum of \$125  
plus standard eye exam.

Plan pays 100% plus  
standard eye exam.

Plan reimburses a maximum of  
\$105 plus standard eye exam.