Three Plan Comparison

For all states except FL, NY, OR and WA

vsp individual vision plans

	STANDARD PLAN*	BASE PLAN*	EASY OPTIONS PLAN*
Copay	$15 Exam/$25 Materials	$15 Exam/$25 Materials	$15 Exam/$25 Materials
Exam	Every 12 months	Every 12 months	Every 12 months
Lenses	Every 12 months	Every 12 months	Every 12 months
Frame	Every 12 months	Every 12 months	Every 12 months
VSP® PROVIDER			
WellVision Exam®	Covered after $15 copay	Covered after $15 copay	Covered after $15 copay
Contact Lens Exam	15% savings on contact lens exam	Fully covered contact lens exam	15% savings on a contact lens exam
Lenses: Single Vision Lined Bifocal Lined Trifocal Lenticular Impact-Resistant Lenses for Dependent Children	Covered after $25 materials copay	Covered after $25 materials copay	Covered after $25 materials copay
Lens Enhancements	Average savings of 30% on other lens enhancements	Average savings of 30% on other lens enhancements	Average savings of 30% on other lens enhancements
Anti-glare Coating	$41 – $85 copay	$41 – $85 copay	$41 – $85 copay
Impact-Resistant Lenses	$35 copay	$35 copay	$35 copay
Progressive Lenses (no-line bi/trifocals, ranging from standard to custom)	$0 – $175 copay	$0 – $175 copay	$0 – $175 copay
Light-Reactive Lenses	$75 copay	$75 copay	$75 copay
Scratch-Resistant Coating	$17 – $33 copay	$17 – $33 copay	$17 – $33 copay
Frames	$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	$150 allowance every 12 months or $170 allowance on a featured frame brand
Elective Contact Lenses**	$150 allowance every 12 months	$150 allowance every 12 months	$150 allowance every 12 months
Medically Necessary Contact Lenses	N/A	N/A	N/A
EasyOptions Upgrades Members can choose from one of the following upgrades as part of their plan coverage	N/A	N/A	An additional $80 frame allowance, or fully covered premium or custom progressive lenses, or fully covered light-reactive lenses, or an additional $80 contact lens allowance
NON-VSP PROVIDER (OUT-OF-NETWORK) REIMBURSEMENT AMOUNT			
Examination	Up to $45	Up to $45	Up to $45
Lenses: Single Vision 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	 Up to $30 Up to $50 Up to $65 Up to $100
Progressive Lenses (no-line bi/trifocals, ranging from standard to custom)	Up to $50	Up to $50	Up to $50
Frames	Up to $70	Up to $70	Up to $70
Elective Contact Lenses**	Up to $105	Up to $105	Up to $105
Medically Necessary Contact Lenses	N/A	N/A	N/A
FULLY-INSURED PROGRAM			
Member Only Member + One Member + Family	Annual Payment or Monthly Installments	Annual Payment or Monthly Installments	Annual Payment or Monthly Installments
Contract Term	12 months	12 months	12 months
Healthy Vision Association	N/A	$18 annual enrollment fee	$18 annual enrollment fee in all states except FL, NY, OR, & WA
Plan Availability	Available in all states	Available in all states except FL, NY, OR, and WA	Available in all states

*Plans have exclusions and limitations.
**Contact lenses are in lieu of spectacle lenses and frames once every 12 months.