Franchise March 2020 Vision Plan Options

	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 Premium: 10% off Retail	No Benefit
March 1, 2020 Monthly Rates	**2 Yr Rate Guarantee**		**2 Yr Rate Guarantee**	
Employee	**$10.77**		**$9.60**	
Employee + 1 Dependent	**$19.50**		**$17.90**	
Employee + 2 Dependents	**$28.76**		**$26.51**	

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