VISION SERVICE PLAN (VSP) SIGNATURE PLAN

Benefit Summary 2024-2025

Services	Benefits
Eligibility	Spouse/domestic partner, and dependent children to age 26.
Benefits Renew	January 1 of each year or every other year depending on the plan frequency.
Standard Lenses	Covered in full up to 60mm.
Progressive Lenses	Standard progressives covered in full. See Patient Options below for premium progressive lenses and custom progressive lenses.
Diabetic Eyecare Plus Program	Supplemental Eyecare for patients with Type I and II diabetes. See your vision provider for extended services beyond the initial eye exam. $20 co-pay per visit.
Laser Vision Care (Lasik)	Benefits provided at a discount through VSP approved center. Visit **www.vsp.com** or contact VSP's Customer Service for additional information. **NOTE:** Your health plan does not provide benefits for eye surgery solely for the purpose of correcting refractive defects of the eye.
Polycarbonate Lenses	Covered for dependent children up to age 18
Sunglasses	See Added Value Discounts below
Tinted Lenses	See Patient Options below
Photochromic Lenses (transition)	Covered up to schedule of allowances under Plan C only
Elective Contact Lenses (in lieu of frames and lenses)	$150 paid towards the cost of the contact fitting and evaluation and contact lenses when a member doctor is used.
Medically Necessary Contact Lenses	Covered in full with pre-certification (applies to certain medical conditions).
Warranty	No specified warranty. If the member is unsatisfied with the services rendered, please contact VSP's Customer Service Department at 1-800-877-7195.
Choice of Frames	You will receive a $150 allowance toward any frame of your choice plus 20% off any amount over the allowance.
Provider Network	VSP Signature network includes independent contracted providers nationwide. Member's may also choose to go outside of the network and use the out of network reimbursement. To find a provider, visit **www.vsp.com** and register or search as a guest.
Participating Retail Locations	Participating Retail Locations includes Costco, Visionworks and RxOptical. To find Participating Retail Locations visit **www.vsp.com** or call VSP customer service at 1-800-877-7195.
Added Value Discounts	30% off unlimited additional pairs of prescription glasses and/or non-prescription sunglasses, including lens options (same day as the members eye exam and from the same doctor). Or get 20% off unlimited additional pairs of glasses 12 months from the covered eye exam with any VSP doctor.

Patient Options

Patients who choose to purchase lens options may do so with a **35–40% savings on all non covered lens options**. The patient should check with a VSP participating doctor to verify whether items are covered or are considered options. These cosmetic options are not covered in full by VSP; however, due to our agreements with VSP participating doctors and laboratories, these services are provided at a controlled cost, available only to VSP subscriber.
Examples of options patients may choose include:

- Premium & Custom Progressive lenses
- Blended (seamless) bifocals
- Contact lenses (except as noted)
- Oversize lenses (61mm or greater)
- Fashion and gradient tinting
- Scratch coating
- Laminating of lenses
- A frame that costs more than the plan allowance
- Cosmetic lenses
- Ultra-violet coating
- Polycarbonate lenses for adults age 18 and older
- Tinted lenses

Plan	Examination	Lenses	Frames
A*	Every calendar year	Every other calendar year	Every other calendar year
B*	Every calendar year	Every calendar year	Every other calendar year
C**	Every calendar year	Every calendar year	Every calendar year

** Plans A and B cover tinted pink #1 and #2 only. Basic benefits are the same on Plans A and B with the exception of frequency on lenses.*
*** Plan C covers all tints and photochromic lenses (transition lenses).*

Plan A provides lenses every 24 months, with new lenses available at a 12-month interval if there is a change in prescription.
Districts/Employee Group may offer only one SISC vision plan option and cannot be offered as a dual choice with EyeMed.
Locate a provider at: www.vsp.com

VISION SERVICE PLAN (VSP)—SIGNATURE PLAN—ACTIVE EMPLOYEES ONLY

2024-2025 Monthly Rates

Single Co-pay Plans*			
Exam and Materials Co-pay	$0	$10	$20
PLAN A (Exam every 12 months, lenses and frames every 24 months)			
Single	$7.10	$6.60	$6.00
Two-party	$14.20	$13.20	$12.00
Family	$21.30	$19.80	$18.00
Composite	$15.80	$14.60	$13.30
PLAN B (Exam and lenses every 12 months, frames every 24 months)			
Single	$8.40	$7.80	$7.10
Two-party	$16.80	$15.60	$14.20
Family	$25.20	$23.40	$21.30
Composite	$18.70	$17.30	$15.80
PLAN C (Exam, lenses and frames every 12 months)			
Single	$11.50	$10.60	$9.70
Two-party	$23.00	$21.20	$19.40
Family	$34.50	$31.80	$29.10
Composite	$25.50	$23.60	$21.50

Dual Co-pay Plans*			
Exam Co-pay	$0	$10	$20
Materials Co-pay	$25	$25	$25
PLAN A (Exam every 12 months, lenses and frames every 24 months)			
Single	$6.00	$5.50	$5.00
Two-party	$12.00	$11.00	$10.00
Family	$18.00	$16.50	$15.00
Composite	$13.30	$12.30	$11.20
PLAN B (Exam and lenses every 12 months, frames every 24 months)			
Single	$7.10	$6.60	$6.00
Two-party	$14.20	$13.20	$12.00
Family	$21.30	$19.80	$18.00
Composite	$15.80	$14.60	$13.30
PLAN C (Exam, lenses and frames every 12 months)			
Single	$9.70	$9.00	$8.20
Two-party	$19.40	$18.00	$16.40
Family	$29.10	$27.00	$24.60
Composite	$21.50	$19.90	$18.10

** Your benefit and co-pay amounts renew on January 1.*

Supplemental Benefits (Available with Plan C only)	**2nd Pair of Glasses w/ $20 Deductible** **(subject to annual frame allowance)** **OR** **$150 Annual contact lens allowance**
Single	$1.70
Two-party	$3.40
Family	$5.10
Composite	$3.70

VISION SERVICE PLAN (VSP)—SIGNATURE PLAN—ALL RETIREES UNDER AND OVER AGE 65

2024-2025 Monthly Rates

Single Co-pay Plans*			
Exam and Materials Co-pay	$0	$10	$20
PLAN A (Exam every 12 months, lenses and frames every 24 months)			
Single	$8.90	$8.20	$7.50
Two-party	$17.80	$16.40	$15.00
Family	$26.70	$24.60	$22.50
PLAN B (Exam and lenses every 12 months, frames every 24 months)			
Single	$10.50	$9.70	$8.90
Two-party	$21.00	$19.40	$17.80
Family	$31.50	$29.10	$26.70
PLAN C (Exam, lenses and frames every 12 months)			
Single	$14.30	$13.30	$12.10
Two-party	$28.60	$26.60	$24.20
Family	$42.90	$39.90	$36.30

Dual Co-pay Plans*			
Exam Co-pay	$0	$10	$20
Materials Co-pay	$25	$25	$25
PLAN A (Exam every 12 months, lenses and frames every 24 months)			
Single	$7.50	$6.90	$6.30
Two-party	$15.00	$13.80	$12.60
Family	$22.50	$20.70	$18.90
PLAN B (Exam and lenses every 12 months, frames every 24 months)			
Single	$8.90	$8.20	$7.50
Two-party	$17.80	$16.40	$15.00
Family	$26.70	$24.60	$22.50
PLAN C (Exam, lenses and frames every 12 months)			
Single	$12.10	$11.20	$10.20
Two-party	$24.20	$22.40	$20.40
Family	$36.30	$33.60	$30.60

** Your benefit and co-pay amounts renew on January 1.*

Supplemental Benefits (Available with Plan C only)	2nd Pair of Glasses w/ $20 Deductible (subject to annual frame allowance) OR $150 Annual contact lens allowance
Single Two-party Family	$2.10 $4.20 $6.30