Vision Service Plan (VSP)

VSP's program provides affordable, quality vision care nationwide. Through VSP's provider network, you'll receive a comprehensive vision examination as well as materials, if needed.

Vision plan features	VSP benefit coverage
Network coverage	VSP Choice network
Examination (once every calendar year)	In-network: Covered in full after $10 copay Out-of-network: Exa, up to $45
Lenses or medically necessary contact lenses (once every calendar year)	In-network: Covered in full after $10 copay Out-of-network: Up to $100, depending on lens type
Frames (once every other calendar year)	In-network: Covered in full up to $50 wholesale retail chain: $130 allowance Out-of-network: Up to $70
Disposable and nondisposable contact lenses Once every calendar year	In-network: Covered up to $120 retail value Out-of-network: Up to $105
Semimonthly vision rates Associate Associate + child(ren) Associate + spouse Family	 $ 2.98 $ 6.39 $ 5.97 $ 10.20

How do I use the VSP vision plan?

1. Find the right VSP Choice Plan doctor for you at vsp.com or call VSP at (800) 877-7195.
2. Call your doctor to make an appointment.
3. When you call, tell the doctor you are covered by the VSP Choice Plan and provide your ID.
4. After you make an appointment, your doctor's office and VSP will handle the rest.
5. If you see an out-of-network provider, VSP will reimburse you up to the amount allowed under the plan's out-of-network provider reimbursement allowance. Be aware that your out-of-network reimbursement allowance does not guarantee full payment. You must file the claim for out-of-network services within six months of seeing the provider. If you are eligible for services from a non-VSP provider, you will be required to pay the provider in full at the time of service.

To ensure a timely reimbursement, send the following information to VSP:

- An itemized receipt listing the services you received
- The name, address and phone number of the non-VSP provider
- The covered member's I.D. number
- The covered member's name, phone number and address
- The name of the organization that provides your VSP coverage
- The patient's name, date of birth, phone number and address
- The patient's relationship to the covered member (such as "self," "spouse," "child")

Please keep a copy of the information and mail the originals to:

VSP
Attn: Out-of-Network Claims
P.O. Box 997105
Sacramento, CA 95899-7105