# Current Plan Benefits Summaries

**VSP**

**VOLUNTARY VISION**

**This plan is currently offered for Insurance Class 1**

| PLAN BENEFITS SUMMARY | | | |
|---|---|---|---|
| | **In-Network** | **Out-of-Network** | **Frequency** |
| **Exam Copay** | $20 | $20 | Once per Calendar Year |
| **Exam Allowance** | 100% | $39 | Once per Calendar Year |
| **Materials Copay** | $20 | $20 | |
| **Base Lenses** | | | |
| Single Vision Allowance | 100% | $23 | Once per Calendar Year |
| Bifocal Allowance | 100% | $37 | Once per Calendar Year |
| Trifocal Allowance | 100% | $49 | Once per Calendar Year |
| Lenticular Allowance | 100% | $64 | Once per Calendar Year |
| **Contact Lenses** | | | |
| Elective Allowance | $130 | $100 | Once per Calendar Year |
| Therapeutic Allowance | 100% | $210 | Once per Calendar Year |
| **Frame Retail Allowance** | $130 | $46 | Once per Calendar Year |
| **Materials Allowance** | N/A | N/A | N/A |

The following plan features are for illustrative purposes only. Please verify if a specific feature is applicable by consulting your vision policy contract: