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VSP Vision EMPLOYER SPONSORED Benefit and Rate Sheet

vsp vision care

Available in CA & CO[1]
Group Size: 3+

PPO EMPLOYER SPONSORED VSP VISION PLANS					
Plan Name	**CHOICE A $0/$160 0080**	**CHOICE B $0/$160 0081**	**CHOICE B $10/$25/$160 0093**	**CHOICE C $10/$25/$160 0094**	**CHOICE C EASYOPTIONS[2] LIGHTCARE[3] $10/$25/$160 0095**
Network	CHOICE PPO IN-NETWORK	CHOICE PPO IN-NETWORK	CHOICE PPO IN-NETWORK	CHOICE PPO IN-NETWORK	CHOICE PPO IN-NETWORK
Benefit Frequency					
Exam/Lens/Frame	Every 12/24/24 months	Every 12/12/24 months	Every 12/12/24 months	Every 12/12/12 months	Every 12/12/12 months
Deductible/Copay					
Exam	$0	$0	$10	$10	$10
Lens/Frame			$25	$25	$25
Benefits (After Deductible/Copay)					
Exam	100%	100%	100%	100%	100%
Lenses - Single	100%	100%	100%	100%	100%
Lenses - Bifocal	100%	100%	100%	100%	100%
Lenses - Trifocal	100%	100%	100%	100%	100%
Lenses - Enhancements	Subject to copays	Subject to copays	Subject to copays	Subject to copays	Subject to copays
Frame	$160[4]	$160[4]	$160[4]	$160[4]	$160[4]
Contacts - Elective (In lieu of glasses)	$130 allowance	$130 allowance	$130 allowance	$130 allowance	$160 allowance
Fit & Follow-up Exam	Up to $60 copay	Up to $60 copay	Up to $60 copay	Up to $60 copay	Up to $60 copay
Medically Necessary	100%	100%	100%	100%	100%
Rates for 2024 Effective Dates - $15 administration fee applies to each monthly invoice.					
Member Only	$7.93	$11.12	$9.30	$11.29	$11.42
Member + Spouse/DP	$13.03	$16.92	$15.89	$19.89	$20.34
Member + 1 Child	$13.03	$16.92	$15.89	$19.89	$20.34
Member + Children	$20.97	$27.28	$23.94	$30.37	$31.20
Member + Family	$20.97	$27.28	$23.94	$30.37	$31.20
Rate Guarantee	2 years	2 years	2 years	2 years	2 years

SIC code is required. Certain industries are ineligible to purchase these plans, such as: Dental Offices 8021, Dental Labs 8071, Medical Labs 8072, and Seasonal Employees, Part-time help and groups without an SIC. This is a summary of benefits. For more detailed information, view the carriers Summary of Benefits.

1 VSP Vision plans are available to groups of 3 or more enrolled employees. Group must be headquartered in CA or CO. Employees can reside in any state. Employer Sponsored plans assume employer is paying 50%-100% of the member's premium.

2 EasyOptions - Choose your upgrade - $260 Frame Allowance, or Anti-glare Lenses, or Progressive Lenses, or Light-reactive Lenses, or in lieu of glasses a $260 Contact Lens allowance. VSP EasyOptions plan benefits are not available at retail chains such as Walmart®, Sam's Club®, or Costco.

3 LightCare - You can use your frame and lens benefit to get non-prescription (ready-to-wear) eyewear from your VSP network doctor. Such as non-prescription sunglasses or blue light filtering glasses.

4 Coverage with a retail chain, Walmart®, Sam's Club®, or Costco may be different or not apply; such as $90 Frame Allowance at retail chain. Before seeking services, contact VSP to find a VSP provider or a retail chain to discuss their allowances.

Inshore Benefits is a product portfolio of North Ranch Benefits Trust | Website: InshoreBenefits.com
Inshore Benefits is marketed by Warner Pacific Insurance Services, Inc. | Phone: (800) 801-2300 | Fax: (800) 609-0111 | Email: quoting@warnerpacific.com
Inshore Benefits is administrated by Pathian Administrators | Phone: (800) 786-6525 | Fax: (818) 960-0141 | Email: inshore@pathianadministrators.com

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Plan Name	**SIGNATURE B $10/$160 0001**	**SIGNATURE B $10/$25/$160 0090**	**SIGNATURE C $10/$160 0068**	**SIGNATURE C $10/$25/$160 0091**	**SIGNATURE C $25/$160 0069**
Network	SIGNATURE PPO	SIGNATURE PPO	SIGNATURE PPO	SIGNATURE PPO	SIGNATURE PPO
Benefit Frequency					
Exam/Lens/Frame	Every 12/12/24 months	Every 12/12/24 months	Every 12/12/12 months	Every 12/12/12 months	Every 12/12/12 months
Deductible/Copay					
Exam	$10	$10	$10	$10	$25
Lens/Frame		$25		$25	
Benefits (After Deductible/Copay)					
Exam	100%	100%	100%	100%	100%
Lenses - Single	100%	100%	100%	100%	100%
Lenses - Bifocal	100%	100%	100%	100%	100%
Lenses - Trifocal	100%	100%	100%	100%	100%
Lenses - Enhancements	Subject to copays	Subject to copays	Subject to copays	Subject to copays	Subject to copays
Frame	$160[2]	$160[2]	$160[2]	$160[2]	$160[2]
Contacts - Elective (In lieu of glasses)	$130 allowance	$130 allowance	$130 allowance	$160 allowance	$130 allowance
Fit & Follow-up Exam	Up to $60 copay	Up to $60 copay	Up to $60 copay	Up to $60 copay	Up to $60 copay
Medically Necessary	100%	100%	100%	100%	100%
Rates for 2024 Effective Dates - $15 administration fee applies to each monthly invoice.					
Member Only	$13.75	$10.63	$16.79	$13.03	$13.27
Member + Spouse/DP	$20.68	$18.56	$25.24	$23.36	$20.18
Member + 1 Child	$20.68	$18.56	$25.24	$23.36	$20.18
Member + Children	$33.32	$28.25	$40.65	$35.96	$32.50
Member + Family	$33.32	$28.25	$40.65	$35.96	$32.50
Rate Guarantee	2 years	2 years	2 years	2 years	2 years

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