



**VSP Vision EMPLOYER SPONSORED  
Benefit and Rate Sheet for 2025 Effective Dates**



Available in CA & CO<sup>1</sup>  
Group Size: 3+

Choose One Plan from Page 1 or 2:					
Plan Name	CHOICE A \$0/\$160 0080	CHOICE B \$10/\$25/\$160 0093	CHOICE B \$0/\$160 0081	CHOICE C \$10/\$25/\$160 0094	CHOICE C EASYOPTIONS <sup>2</sup> LIGHTCARE <sup>3</sup> \$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	\$10	\$0	\$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 <sup>4</sup>	\$160 <sup>4</sup>	\$160 <sup>4</sup>	\$160 <sup>4</sup>	\$160 <sup>4</sup>
Contacts - Elective (In lieu of glasses)	\$150 allowance	\$160 allowance	\$150 allowance	\$160 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%
Monthly Rates					
Member Only	\$7.93	\$9.30	\$11.12	\$11.29	\$11.42
Member + Spouse/DP	\$13.03	\$15.89	\$16.92	\$19.89	\$20.34
Member + 1 Child	\$13.03	\$15.89	\$16.92	\$19.89	\$20.34
Member + Children	\$13.03	\$15.89	\$16.92	\$19.89	\$20.34
Member + Family	\$20.97	\$23.94	\$27.28	\$30.37	\$31.20
Rate Guarantee	2 years	2 years	2 years	2 years	2 years
Monthly Admin Fee	\$15				

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.

The employer must choose one of the following participation options on the Employer Application:

- Option 1: VSP participation and contribution matches employer-sponsored medical plan participation exactly.
- Option 2: VSP participation and contribution matches employer-sponsored dental plan participation exactly.
- Option 3: VSP participation is 100% employer paid, and all eligible employees and all eligible dependents are enrolled.
- Option 4: VSP participation is 100% employer paid, and all eligible employees and no dependents are enrolled.

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.



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Plan Name	SIGNATURE B \$10/\$25/\$160 0090	SIGNATURE B \$10/\$160 0001	SIGNATURE C \$10/\$25/\$160 0091	SIGNATURE C \$25/\$160 0069	SIGNATURE C \$10/\$160 0068
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	\$25	\$10
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 <sup>2</sup>	\$160 <sup>2</sup>	\$160 <sup>2</sup>	\$160 <sup>2</sup>	\$160 <sup>2</sup>
Contacts - Elective (In lieu of glasses)	\$160 allowance	\$150 allowance	\$160 allowance	\$150 allowance	\$150 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%
Monthly Rates					
Member Only	\$10.63	\$13.75	\$13.03	\$13.27	\$16.79
Member + Spouse/DP	\$18.56	\$20.68	\$23.36	\$20.18	\$25.24
Member + 1 Child	\$18.56	\$20.68	\$23.36	\$20.18	\$25.24
Member + Children	\$18.56	\$20.68	\$23.36	\$20.18	\$25.24
Member + Family	\$28.25	\$33.32	\$35.96	\$32.50	\$40.65
Rate Guarantee	2 years	2 years	2 years	2 years	2 years
Monthly Admin Fee	\$15				

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