

Vision Plan Comparison

Here's a comparison of the plan options available to you. Having trouble deciding? Call Health Advocate at 866-799-2731 for expert advice.

	VSP Core Plan		VSP Core Plus Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Exam	\$10	Up to \$45	\$0	Up to \$45
Covered Services—Lenses and Frames				
Single Vision	\$25	Up to \$30	\$20	Up to \$30
Bifocals	\$25	Up to \$50	\$20	Up to \$50
Trifocals	\$25	Up to \$65	\$20	Up to \$65
Frames	Amount over \$150 allowance	Up to \$70	Amount over \$200 allowance	Up to \$70
Covered Service—Contacts in Lieu of Frames/Lenses				
Contacts—Medically Necessary	Covered in full	Up to \$210	Covered in full	Up to \$210
Contacts—Elective	Amount over \$120 allowance	Up to \$105	Amount over \$200 allowance	Up to \$105
Benefit Frequency				
Exams	Once every 12 months			
Lenses	Once every 12 months			
Frames	Once every 24 months		Once every 12 months	
Contacts	Once every 12 months			

	EyeMed Core Plan		EyeMed Core Plus Plan	
	You Pay	Reimbursement	You Pay	Reimbursement
Exam	\$10 or \$0 (Plus Providers)	Up to \$45	\$0	Up to \$50
Covered Services – Lenses and Frames				
Single Vision	\$25	Up to \$45	\$20	Up to \$50
Bifocals	\$25	Up to \$65	\$20	Up to \$75
Trifocals	\$25	Up to \$85	\$20	Up to \$100
Frames	Amount over \$150 allowance, or \$200 allowance with Plus Providers	Up to \$105	Amount over \$225 allowance, or \$275 with Plus Providers	Up to \$160
Covered Service—Contacts in Lieu of Frames/Lenses				
Contacts—Medically Necessary	Covered in full	Up to \$210	Covered in full	Up to \$210
Contacts—Elective	Amount over \$120 allowance	Up to \$105	Amount over \$200 allowance	Up to \$105
Benefit Frequency				
Exams	Once every 12 months			
Lenses	Once every 12 months			
Frames	Once every 24 months		Once every 12 months	
Contacts	Once every 12 months			