Vision Benefit Summary
Individual and Family Plan

ARIZONA

VSP Plus 10-160

Plan Details

Network	VSP Choice Plus
Exam, lenses, frame, and contacts	Every 12 months

	In-Network	Out-of-Network
WellVision Exam	$10 copay	Up to $65
Lenses (Glass or Plastic)		
Single Vision	$10 copay	Up to $30
Lined Bifocal	$10 copay	Up to $50
Lined Trifocal	$10 copay	Up to $65
Progressive (Standard, no-line)	$0 copay	Up to $50
Polycarbonate (children under 18)	$0 copay	Up to $50
Frames		
Frame allowance *$160 at any VSP doctor or $90 at Costco, Sam's Club, or Walmart***	$160 allowance	Up to $80
Contact Lenses (in lieu of frame & lenses)		
Elective contacts *Includes contact lens fitting and evaluation. 15% discount on fitting/evaluation services, excluding materials.*	$160 allowance	Up to $145

Specialty Lens Upgrades (in-network copays)

Lenticular	$10 copay
Premium progressive options	$95–$105 copay
Custom progressive options	$150–$175 copay
Plastic gradient dye	$17 copay
Solid plastic dye	$15 copay
Photochromic lenses	$75 copay
Polycarbonate (adults)	$31 single vision / $35 multifocal

Out-of-network reimbursement for lens options: up to $50 (in lieu of lined bifocal reimbursement).

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Monthly Premium

Subscriber	$11.00
Subscriber +1	$21.40
Subscriber +2 or more	$34.00

Additional Benefits & Discounts

	In-Network	Out-of-Network
Coatings* *Scratch-resistant, anti-reflective, UV protection, other enhancements*	Up to 25% off retail	N/A
Additional pairs of glasses* *Unlimited additional pairs through any VSP Choice provider within 12 months of last covered exam*	20% off retail	N/A
LASIK and refractive surgery* *Discounts average 15–20% off, or 5% off promotional pricing. Includes PRK, LASIK, Custom LASIK, and IntraLase³*	Up to $500 in savings	Not covered

** These are discount programs, not insured benefits.*

**Accepted at thousands of VSP providers nationwide — including Walmart, Costco, Sam's Club, Visionworks, Eyemart Express, and Eyeconic.

Check your plan summary for any exclusions.

Please note:

Plan benefits are available once every 12 months for exam, lenses, frame, and contact lenses.
Contact lenses are provided in lieu of frame and lenses, not in addition.
Out-of-network benefits are reimbursed after the visit; you pay the provider in full and submit a claim for reimbursement up to the listed amounts.
This summary is for reference only. See your vision policy for full coverage details, limitations, and exclusions. Underwritten by EMI Health.