**VISION INSURANCE**

**IN-NETWORK COVERAGE COMPARISON (2021-2022)**

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| **Network Summary** | **VSP** | **Davis** |
| Eye Exam | $10 copay | |
| Provider Frames | $130 allowance + 20% off balance | $135 allowance + 20% off balance |
| Standard Vision Lenses | $25 copay | |
| Elective Contacts | $130 allowance | $135 allowance + 15% off balance |
| Medically Necessary Contacts | Covered in full after copay | Covered in full with prior approval copay does not apply |
| Dependent Age Limit | To age 26 | |
| Vision Frequency |  | |
| * Eye Exam | Once every 12 months | |
| * Frames | Once every 24 months | |
| * Lenses or Contact Lenses\*\* | Once every 12 months | |
| **Payroll Deductions** |  |  |
| Employee | $5.13 | $3.66 |
| Family | $11.04 | $7.87 |

\*Allowance amount based off lens type \*\*Benefit includes coverage for glasses or contacts, not both