MAPLETON PUBLIC SCHOOLS
July 1, 2022 - June 30, 2023
VISION INSURANCE RATES

This is only for illustrative and summary purposes. The contents of this summary are subject to the provisions of the policy, which contains all terms, covenants, and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted on the following pages.The benefits in this summary may only be available if required plan procedures are followed (e.g., use of specific providers or facilities).

Summary of Covered Benefits	VSP Option 1 (Vision Service Plan)	VSP Option 2 (Vision Service Plan)
	In-Network	In-Network
Annual Well-Vision Exam	$10 Copay	$10 Copay
Prescription Glasses (frames andlenses included)	$25 Copay	$25 Copay
Standard Progressive Lenses	$55 Copay	$55 Copay
Premium Progressive Lenses	$95 - $105 Copay	$95 - $105 Copay
Custom Progressive Lenses	$150 - $175 Copay	$150 - $175 Copay
Contacts (instead of glasses)	$130 allowance (exam copay does not apply)	$130 allowance (exam copay does not apply)
Contact lens Exam (fitting and valuation)	Up to $60 Copay	Up to $60 Copay
Choose Your Upgrade (Option 2) *	N/A	$230 Frame Allowance OR Anti-reflectiveLenses OR Progressive Lenses OR Photochromic Lenses
Coverage Tier	**Semi-Monthly Premium Paid by Employee**	**Semi-Monthly Premium Paid by Employee**
Employee Only	$5.09	$6.88
Employee + Family	$10.94	$14.78

*Option 2, upgrade option selected during in-network doctor's visit. See the flyer located on the Benefit Information page for additionaldetails.