



MAPLETON PUBLIC SCHOOLS

July 1, 2026 - June 30, 2027

VSP-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	VSP - Option 2
	In-Network	In-Network
Annual Well-Vision Exam	\$10 Copay	\$10 Copay
Frame	\$175 allowance	\$175 allowance
Enhanced Featured Frame	Additional \$50 for featured frame brands (see www.vsp.com for brands)	
Prescription Lenses Single Vision, Bifocal, Trifocal, Standard Progressive	\$25 Copay	\$25 Copay
Premium Progressive Lenses	\$95 - \$105 Copay	\$95 - \$105 Copay
Custom Progressive Lenses	\$150 - \$175 Copay	\$150 - \$175 Copay
Contacts (instead of glasses)	\$175 allowance	
Contact lens Exam	UP to \$60 Copay (fitting and valuation)	
VSP LightCare	Members can use both their frame and lens benefit towards non-prescription sunglasses or non-prescription blue-light filtering glasses.	
Choose Your Upgrade (Option 2) *	N/A	\$250 Frame Allowance OR/Anti-Reflective Lenses OR/Prem 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 options listed on the Option 2 flyer located on the Benefits Information page on the Mapleton website.

