

Santa Clara County Schools' Insurance Group 2027 Vision Plans Comparison



	VSP "Premium" Plan		VSP "High" Plan		VSP "Low" Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Examination	\$5 Copay	<u>Reimbursement</u> Up to \$45	\$15 Copay	<u>Reimbursement</u> Up to \$45	\$25 Copay	<u>Reimbursement</u> Up to \$45
Frequency of Services Exam Lenses Frames Elective Contact Lenses	Every 12 months Every 12 months Every 12 months Every 12 months		Every 12 months Every 12 months Every 24 months Every 12 months		Every 12 months Every 24 months Every 24 months Every 24 months	
Lenses Single Bifocal Trifocal	Covered in Full Covered in Full Covered in Full	<u>Reimbursement</u> Up to \$45 Up to \$65 Up to 85	Covered in Full Covered in Full Covered in Full	<u>Reimbursement</u> Up to \$45 Up to \$65 Up to 85	Covered in Full Covered in Full Covered in Full	<u>Reimbursement</u> Up to \$45 Up to \$65 Up to 85
Frames	<u>Allowance</u> Up to \$210*	<u>Reimbursement</u> Up to \$47	<u>Allowance</u> Up to \$180*	<u>Reimbursement</u> Up to \$47	<u>Allowance</u> Up to \$160*	<u>Reimbursement</u> Up to \$47
Elective Contact Lenses (in lieu of lenses and frames)	Up to \$60 Copay for contact lens exam (fitting/evaluation) <u>Allowance</u> Up to \$210	<u>Reimbursement</u> Up to \$105	Up to \$60 Copay for contact lens exam (fitting/evaluation) <u>Allowance</u> Up to \$180	<u>Reimbursement</u> Up to \$105	Up to \$60 Copay for contact lens exam (fitting/evaluation) <u>Allowance</u> Up to \$160	<u>Reimbursement</u> Up to \$105
2027 RATES						
Employee Only	\$14.68		\$9.70		\$7.09	
Two-Party	\$29.37		\$19.39		\$14.18	
Family	\$55.48		\$36.61		\$26.81	

*Includes Costco, Walmart and Sam's Club

Disclaimer: The information described on this page is only intended to be a summary of your plans benefits. If the information on this page conflicts in any way with the Group Contract Agreement, the contract provisions of the appropriate policy or plan document will prevail.