



Vision Insurance

- **VSP Vision Care is our NAPEBT Vision Plan Provider**

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For more information please visit these resources:

[VSP Vision Care website](#)

visionbenefits.vsp.com

[CCASD Vision Benefit Information and Rates](#)

Contact Information:

Network Provider Directory and Member Services: 800.877.7195

	Buy-Up Plan In-Network	Exam Only (Core) Plan In-Network
Eye Exam Once every 12 months		\$15.00 Copay Eligibility is for dependents up to age 26
Prescription Lenses Once every 12 months	\$25 Material Copay Lenses and/or Frames Lens Options: Tints, Scratch Coating	
Frames Once every 24 months	\$25 Material Copay Lenses and/or Frames \$150 Allowance Marchon Frame Benefit: Extra \$20 for members to spend on featured frame brands; 20% off additional costs	20% Discount on a complete pair of prescription glasses
Contacts Instead of Glasses (every 12 months)	15% Discount off lens exam (not to exceed \$60) \$130 Allowance for contacts	15% Discount on Contact Lens Exam
Diabetic Eye Care Diabetic eye disease for type 1 & 2, glaucoma or age-related macular degeneration	Additional Coverage: \$20 Copay	N/A
Tru Hearing	Access program for members offering a savings of up to \$2,400 per pair of digital hearing aids	
Laser VisionCare Program	Average 15% off regular price or 5% off the promotional price; discounts only available from contracted facilities	

VSP
Vision Insurance
FY20

Plan	Total Cost	Employer Portion	Employee Portion
Core Benefit			
Employee only	\$0.78	\$0.78	\$0.00
Employee + Family	\$1.80	\$0.78	\$1.02
Buy Up			
Employee only	\$7.18	\$0.78	\$6.40
Employee + Family	\$16.02	\$0.78	\$15.24



Vision Plan
ENROLLMENT/CHANGE FORM
NAPEBT - 12239817

- Add
- Change
- Cancel

EFFECTIVE DATE: _____ EMPLOYEE'S SSN: _____

EMPLOYEE'S NAME: _____

EMPLOYEE'S DATE OF BIRTH: _____

- I WOULD LIKE TO ENROLL IN THE VSP EXAM PLUS PROGRAM.
- I WOULD LIKE TO ENROLL IN THE BUY UP PROGRAM AND THE TYPE OF COVERAGE REQUESTED IS:
 - C EE Only
 - A EE+Family

PLEASE LIST ALL ELIGIBLE DEPENDENTS YOU WISH TO COVER:

SPOUSE: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	DOB _____
CHILD: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	DOB _____
CHILD: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	DOB _____
CHILD: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	DOB _____
CHILD: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	DOB _____
CHILD: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	DOB _____
CHILD: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	DOB _____
CHILD: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	DOB _____
CHILD: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	DOB _____
CHILD: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	DOB _____

Signature _____ Date _____

Please return to your Benefits Department
Do Not Return to Vision Service Plan