

Vision Service Plan (VSP)

Includes \$1 Admin Fee



Plan Options	10/01/2021 - 9/30/2025 Rates
Signature Plan B (12/12/24)	
\$5 Total Copay	\$10.44/\$20.72/\$29.30
\$175 In-Network Retail Frame Allowance	
\$150 In-Network Elective Contact Lens Allowance	
Not to Exceed \$60 Copay for Contact Lens Exam	
DEP+ w/\$20 Copay	
Signature Plan C (12/12/12)	
\$5 Total Copay	\$12.58/\$25.22/\$35.76
\$175 In-Network Retail Frame Allowance	
\$150 In-Network Elective Contact Lens Allowance	
Not to Exceed \$60 Copay for Contact Lens Exam	
DEP+ w/\$20 Copay	
Choice Plan B (12/12/24)	
\$5 Total Copay	\$8.44/\$16.54/\$23.30
\$175 In-Network Retail Frame Allowance	
\$150 In-Network Elective Contact Lens Allowance	
Not to Exceed \$60 Copay for Contact Lens Exam	
DEP+ w/\$20 Copay	
Choice Plan C (12/12/12)	
\$5 Total Copay	\$10.10/\$20.00/\$28.28
\$175 In-Network Retail Frame Allowance	
\$150 In-Network Elective Contact Lens Allowance	
Not to Exceed \$60 Copay for Contact Lens Exam	
DEP+ w/\$20 Copay	

DEP = Diabetic Eyecare Plus

E/L/F

Rates illustrated per month

REDWOOD EMPIRE SCHOOLS' INSURANCE GROUP

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