

Columbia County School District
 Eye Care Highlight Sheet
 Policy #752268



Plan 1: Balanced Care Vision I Plan Summary

	VSP Network	Out of Network
Deductibles		
	\$10 Exam	\$10 Exam
	\$10 Eye Glass Lenses or Frames*	\$10 Eye Glass Lenses or Frames
	Covered in full	Up to \$52
Annual Eye Exam		
Lenses (per pair)		
Single Vision	Covered in full	Up to \$55
Bifocal	Covered in full	Up to \$75
Trifocal	Covered in full	Up to \$95
Lenticular	Covered in full	Up to \$125
Progressive	See lens options	NA
Contacts		
Fit & Follow Up Exams	Participant cost up to \$60	No benefit
Elective	Up to \$130	Up to \$105
Medically Necessary	Covered in full	Up to \$210
Frames	\$130	Up to \$70
Frequencies (months)		
Exam/Lens/Frame	12/12/24	12/12/24
	Based on date of service	Based on date of service

*Deductible applies to a complete pair of glasses or to frames, whichever is selected.

Lens Options (participant cost)*

	VSP Network	Out of Network
Progressive Lenses	Up to provider's contracted fee for Lined Trifocal Lenses. The patient is responsible for the difference between the base lens and the Progressive Lens charge.	Up to Lined Trifocal allowance.
Std. Polycarbonate	Covered in full for dependent children	No benefit
	\$25 adults	
Solid Plastic Dye	\$13	No benefit
	(except Pink I & II)	
Plastic Gradient Dye	\$15	No benefit
Photochromatic Lenses	\$27-\$76	No benefit
(Glass & Plastic)		
Scratch Resistant Coating	\$15-\$29	No benefit
Anti-Reflective Coating	\$39-\$75	No benefit
Ultraviolet Coating	\$14	No benefit

*Lens Option participant costs vary by prescription, option chosen and retail locations.

Monthly Rates

Employee Only (EE)	\$7.82
EE + Spouse	\$14.16
EE + Children	\$14.72
EE + Spouse & Children	\$23.24



Additional Balanced Care Vision I Features

Contact Lenses Elective	Allowance can be applied to disposables, but the dollar amount must be used all at once (provider will order 3 or 6 month supply). Applies when contacts are chosen in lieu of glasses. For plans without a separate contact lens fit & follow up exam allowance, the cost of the fitting and evaluation is deducted from the contact allowance.
Additional Glasses	20% discount off the retail price on additional pairs of prescription glasses (complete pair).
Frame Discount	VSP offers a 20% discount off the remaining balance in excess of the frame allowance.
Laser VisionCare	VSP offers an average discount of 15% on LASIK and PRK. The maximum out-of-pocket per eye for participants is \$1,800 for LASIK and \$2,300 for custom LASIK using Wavefront technology, and \$1,500 for PRK. In order to receive the benefit, a VSP provider must coordinate the procedure.
Low Vision	With prior authorization, 75% of approved amount (up to \$1,000 is covered every two years).

Eye Care Plan Participant Service

Balanced Care Vision I eye care from The Standard features the money-saving eye care network of VSP. Customer service is available to plan participants through VSP's well-trained and helpful service representatives. Call or go online to locate the nearest VSP network provider, view plan benefit information and more.

VSP Call Center: 1-800-877-7195

- Service representative hours: 5 a.m. to 7 p.m. PST Monday through Friday, 6 a.m. to 2:30 p.m. PST Saturday
- Interactive Voice Response available 24/7

Locate a VSP provider at: standard.com/services

View plan benefit information at: vsp.com

This form is a benefit highlight, not a certificate of insurance.