

# Group Vision Insurance

Help protect your eye health with coverage for exams, glasses and contacts.

This summary of benefits and coverage shows how you and The Standard would share the cost for covered vision care services. NOTE: This is only a summary; for detailed information on coverage, please consult your certificate of coverage.

## Plan 1: Balanced Care Vision I Plan Summary

Effective Date: 10/1/2026

|                       | VSP Choice Network + Affiliates  | Out of Network                  |
|-----------------------|----------------------------------|---------------------------------|
| Deductibles           |                                  |                                 |
|                       | \$10 Exam                        | \$10 Exam                       |
|                       | \$25 Eye Glass Lenses or Frames* | \$25 Eye Glass Lenses or Frames |
| Annual Eye Exam       | Covered in full                  | Up to \$45                      |
| Lenses (per pair)     |                                  |                                 |
| Single Vision         | Covered in full                  | Up to \$30                      |
| Bifocal               | Covered in full                  | Up to \$50                      |
| Trifocal              | Covered in full                  | Up to \$65                      |
| Lenticular            | Covered in full                  | Up to \$100                     |
| Progressive           | See lens options                 | NA                              |
| Contacts              |                                  |                                 |
| Fit & Follow Up Exams | Participant cost up to \$60      | Not covered                     |
|                       |                                  |                                 |
| Elective              | Up to \$150                      | Up to \$120                     |
| Medically Necessary   | Covered in full                  | Up to \$210                     |
| Frame Allowance       | \$150**                          | Up to \$70                      |
| Frequencies (months)  |                                  |                                 |
| Exam/Lens/Frame       | 12/12/12                         | 12/12/12                        |
|                       | Based on date of service         | Based on date of service        |

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

\*\*The Costco and Walmart allowance will be the wholesale equivalent.

## Lens Options (participant cost)\*

|                                            | VSP Choice Network + Affiliates                                                                                                                                | Out of Network                 |
|--------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|
|                                            | (Other than Costco)                                                                                                                                            |                                |
| Progressive Lenses                         |                                                                                                                                                                |                                |
| Standard                                   | \$55                                                                                                                                                           | Up to Lined Bifocal allowance. |
| Premium                                    | Up to provider's contracted fee for Lined Bifocal Lenses. The patient is responsible for the difference between the base lens and the Progressive Lens charge. | Up to Lined Bifocal allowance. |
| Std. Polycarbonate                         | Covered in full for dependent children<br>\$33 adults                                                                                                          | Not covered                    |
| Solid Plastic Dye                          | \$15<br>(except Pink I & II)                                                                                                                                   | Not covered                    |
| Plastic Gradient Dye                       | \$17                                                                                                                                                           | Not covered                    |
| Photochromatic Lenses<br>(Glass & Plastic) | \$31-\$82                                                                                                                                                      | Not covered                    |
| Scratch Resistant Coating                  | \$17-\$33                                                                                                                                                      | Not covered                    |
| Anti-Reflective Coating                    | \$43-\$85                                                                                                                                                      | Not covered                    |
| Ultraviolet Coating                        | \$16                                                                                                                                                           | Not covered                    |

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

| Monthly Rates          |         |
|------------------------|---------|
| Employee Only (EE)     | \$7.12  |
| EE + Spouse            | \$12.14 |
| EE + Children          | \$12.68 |
| EE + Spouse & Children | \$19.28 |

| Additional Balanced Care Vision I Choice Network 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 fitting & evaluation (which includes follow up contact lens exams), the cost of the fitting and evaluation is deducted from the allowance. |
| Additional Glasses                                        | 20% off additional complete pairs of prescription glasses and/or prescription sunglasses.*                                                                                                                                                                                                                                                                              |
| Frame Discount                                            | VSP offers 20% off any amount above the retail allowance.*                                                                                                                                                                                                                                                                                                              |
| Laser VisionCare                                          | VSP offers an average discount of 15% off or 5% off a promotional offer for LASIK Custom 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).                                                                                                                                                                                                                                                                            |

Based on applicable laws, reduced costs may vary by doctor location.



## Vision Plan Participant Service

Balanced Care Vision I 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: 800.877.7195**

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

### **Locate a VSP provider at:**

[www.standard.com/services](http://www.standard.com/services)

## About The Standard

For more than 100 years, we have been dedicated to our core purpose: to help people achieve financial well-being and peace of mind. Headquartered in Portland, Oregon, The Standard is a nationally recognized provider of group employee benefits. To learn more about products from The Standard, visit us at [www.standard.com](http://www.standard.com).

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