



Vision plan benefits for Stanton ISD

You may choose from two plans: high plan or low plan

Benefits through Superior Select Southwest network



[superiorvision.com](https://www.superiorvision.com)

(800) 507-3800

Benefits

Exam
Frames
Lenses (standard) per pair
Single vision
Bifocal
Trifocal
Progressive
Contact lenses⁴
Medically necessary contact lenses
Laser vision correction⁵

| High Plan | |
|---------------------------|-----------|
| Copays | |
| Exam ¹ | \$5 |
| Eyewear ² | \$0 |
| Monthly premiums | |
| Emp. only | \$10.87 |
| Emp. + 1 dependent | \$21.20 |
| Emp. + family | \$29.35 |
| Services/frequency | |
| Exam | 12 months |
| Frames | 12 months |
| Lenses | 12 months |
| Contact lenses | 12 months |

| In-network | Out-of-network |
|------------------------------|----------------|
| Covered in full | Up to \$35 |
| \$150 retail allowance | Up to \$70 |
| Covered in full | Up to \$25 |
| Covered in full | Up to \$40 |
| Covered in full | Up to \$45 |
| See description ³ | Up to \$45 |
| \$225 retail allowance | Up to \$80 |
| Covered in full | Up to \$150 |
| \$200 retail allowance | |

Co-pays apply to in-network benefits; co-pays for out-of-network visits are deducted from reimbursements

¹ Eye exam copay is a single payment due to the provider at the time of service.

² Eyewear copay applies to eyeglass lenses / frame and contact lenses. Eyewear copay is a single payment that applies to the entire purchase of eyeglasses (frame and lenses)

³ Covered to provider's in-office standard retail lined trifocal amount; member pays difference between progressive and standard retail lined trifocal, plus applicable co-pay

⁴ Contact lenses and related professional services (fitting, evaluation and follow-up) are covered in lieu of eyeglass lenses and frames benefit

⁵ Lasik Vision Correction is in lieu of eyewear benefit, subject to routine regulatory filings and certain exclusions and limitations.

| Low Plan | |
|---------------------------|-----------|
| Copays | |
| Exam ¹ | \$10 |
| Eyewear ² | \$20 |
| Monthly premiums | |
| Emp. only | \$7.42 |
| Emp. + 1 dependent | \$14.47 |
| Emp. + family | \$20.03 |
| Services/frequency | |
| Exam | 12 months |
| Frames | 12 months |
| Lenses | 12 months |
| Contact lenses | 12 months |

| In-network | Out-of-network |
|------------------------------|----------------|
| Covered in full | Up to \$35 |
| \$120 retail allowance | Up to \$70 |
| Covered in full | Up to \$25 |
| Covered in full | Up to \$40 |
| Covered in full | Up to \$45 |
| See description ³ | Up to \$45 |
| \$145 retail allowance | Up to \$80 |
| Covered in full | Up to \$150 |
| \$200 retail allowance | |