

AGC Health Benefit Trust  
Eye Care Highlight Sheet



Plan 2: Balanced Care Vision I Plan Summary

Effective Date: 6/1/2016

	VSP Signature Network	Out of Network
<b>Deductibles</b>		
	\$10 Exam	\$10 Exam
	\$25 Eye Glass Lenses or Frames*	\$25 Eye Glass Lenses or Frames
<b>Annual Eye Exam</b>	Covered in full	Up to \$52
<b>Lenses (per pair)</b>		
<b>Single Vision</b>	Covered in full	Up to \$55
<b>Bifocal</b>	Covered in full	Up to \$75
<b>Trifocal</b>	Covered in full	Up to \$95
<b>Lenticular</b>	Covered in full	Up to \$125
<b>Progressive</b>	See lens options	NA
<b>Contacts</b>		
<b>Fit &amp; Follow Up Exams</b>	15% discount See Additional Balanced Care Vision I Features.	No benefit
<b>Elective</b>	Up to \$120	Up to \$105
<b>Medically Necessary</b>	Covered in full	Up to \$210
<b>Frames</b>	\$120	Up to \$45
<b>Frequencies (months)</b>		
<b>Exam/Lens/Frame</b>	12/12/24 Based on date of service	12/12/24 Based on date of service

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

Lens Options (participant cost)\*

	VSP Signature Network	Out of Network
<b>Progressive Lenses</b>	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.
<b>Std. Polycarbonate</b>	Covered in full for dependent children	No benefit
	\$25 adults	
<b>Solid Plastic Dye</b>	\$13	No benefit
	(except Pink I & II)	
<b>Plastic Gradient Dye</b>	\$15	No benefit
<b>Photochromatic Lenses (Glass &amp; Plastic)</b>	\$27-\$76	No benefit
<b>Scratch Resistant Coating</b>	\$15-\$29	No benefit
<b>Anti-Reflective Coating</b>	\$39-\$75	No benefit
<b>Ultraviolet Coating</b>	\$14	No benefit

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



**Additional Balanced Care Vision I Features**

<b>Contact Lenses Elective</b>	Cost of the fitting and evaluation is deducted from the contact allowance. 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. Applies to plans without separate contact lens fit & follow up exam allowance.
<b>Additional Glasses</b>	20% discount off the retail price on additional pairs of prescription glasses (complete pair).
<b>Frame Discount</b>	VSP offers a 20% discount off the remaining balance in excess of the frame allowance.
<b>Laser VisionCare</b>	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.
<b>Low Vision</b>	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](http://standard.com/services)

**Your VSP Network: Signature Network**

**View plan benefit information at:** [vsp.com](http://vsp.com)

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