CITY OF ARNOLD

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: 1/1/2024**

	VSP Choice Network	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	15% discount	Not covered
	See Additional Balanced Care Vision I Features.	
Elective	Up to $130	Up to $105
Medically Necessary	Covered in full	Up to $210
Frame Allowance	$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 Choice Network	Out of Network
Progressive Lenses	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 $33 adults	Not covered
Solid Plastic Dye	$15 (except Pink I & II)	Not covered
Plastic Gradient Dye	$17	Not covered
Photochromatic Lenses (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.*

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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.

Section 125

This plan is provided as part of the Policyholder's Section 125 Plan. Each employee has the option under the Section 125 Plan of participating or not participating in this plan. If an employee does not elect to participate when initially eligible, he/she may elect to participate at the Policyholder's next Annual Election Period.

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

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**.

The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of Portland, Oregon, in all states except New York. Product features and availability vary by state and are solely the responsibility of Standard Insurance Company.

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Plan 2: Balanced Care Vision II Plan H Summary **Effective Date: 1/1/2024**

	EyeMed Access Network	Out of Network
Deductibles		
	$10 Exam	No deductible
	$25 Eye Glass Lenses	
Annual Eye Exam	Covered in full	Up to $35
Lenses (per pair)		
Single Vision	Covered in full	Up to $25
Bifocal	Covered in full	Up to $40
Trifocal	Covered in full	Up to $55
Lenticular	20% discount	Not covered
Progressive	See lens options	NA
Contacts		
Fit & Follow Up Exams		
Standard	Standard: Participant cost up to $55	Not covered
Premium (Allowance)	Premium: 10% off of retail	Not covered
Elective	Up to $115	Up to $100
Medically Necessary	Covered in full	Up to $200
Frame Allowance	$110	Up to $45
Frequencies (months)		
Exam/Lens/Frame	12/12/24	12/12/24
	Based on date of service	Based on date of service

Lens Options (participant cost)

	EyeMed Access Network	Out of Network
Progressive Lenses		Not covered
Standard	Standard: $65 + lens deductible	
Premium	Premium: lens cost - 20% discount - $120 allowance + Standard Progressive cost	
Std. Polycarbonate	$40	Not covered
Tint (solid and gradient)	$15	Not covered
Scratch Resistant Coating	$15	Not covered
Anti-Reflective Coating	$45	Not covered
Ultraviolet Coating	$15	Not covered
Lasik or PRK	Average discount of 15% off retail price or 5% off promotional price at US Laser Network participating providers.	Not covered

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Additional Balanced Care Vision II H Features	
EyeMed In-Network Discounts	15% discount off the remaining balance in excess of the conventional contact lens allowance. 20% discount off the remaining balance in excess of the frame allowance. 20% discount on items not covered by the plan at network providers, which may not be combined with any other discounts or promotional offers. This discount does not apply to EyeMed Provider's professional services, or contact lenses.
EyeMed In-Network Secondary Purchase Plan	Participants receive a 40% discount on a complete pair of glasses once the funded benefit has been exhausted. Participants receive a 15% discount off the retail price on conventional contact lenses once the funded benefit has been exhausted. Discount applies to materials only.
Contact Lens Replacement by Mail Program	After exhausting the contact lens benefit, replacement lenses may be obtained at significant discounts on-line. Visit **www.eyemedvisioncare.com** for details.

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

Section 125

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Vision Plan Participant Service

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

EyeMed Customer Care Center: 866.289.0614

- Service representative hours: 8 a.m. to 11 p.m. ET Monday through Saturday, 11 a.m. to 8 p.m. ET Sunday
- Interactive Voice Response available 24/7

Locate an EyeMed provider at:
www.standard.com/services

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This form is a benefit highlight, not a certificate of insurance. This policy has exclusions, limitations, reductions of benefits, and terms under which the policy may be continued in force or terminated. Please contact The Standard or your employer for additional information, including costs and complete details of coverage.

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Plan 3: Balanced Care Vision III Plan Summary **Effective Date: 1/1/2024**

Deductibles	
	$20 Calendar Year Exam, Eye Glass Lenses or Frames*
Maximum	
per benefit period	None
Annual Eye Exam	Up to $50
Lenses (per pair)	
Single Vision	Up to $40
Bifocal	Up to $60
Trifocal	Up to $75
Lenticular	Up to $80
Progressive	Up to $80
Contacts	
Elective/Medically Necessary	Up to $120
Frame Allowance	$80
Frequencies (months)	
Exam/Lens/Frame	12/12/24
	Based on date of service***

**Deductible applies to the first service received*
****Please submit claims within 90 days of the date of service so that the plan can consider benefits (subject to State requirements).*

Section 125

This plan is provided as part of the Policyholder's Section 125 Plan. Each employee has the option under the Section 125 Plan of participating or not participating in this plan. If an employee does not elect to participate when initially eligible, he/she may elect to participate at the Policyholder's next Annual Election Period.

Vision Plan Participant Service

With Balanced Care Vision III plans, there is no network, so participants can select the eye doctor of their choice, pay the doctor for the services provided and submit their claims to The Standard for reimbursement.

Customer Service
Customer service is available to plan participants through our well-trained and helpful service representatives. Call or go online to view plan benefit information and more.

Call Center: 800.547.9515
- Service representative hours are 5 a.m. to 10 p.m. Pacific Monday through Thursday; 5 a.m. to 4:30 p.m. Pacific Friday
- Interactive Voice Response available 24/7

View plan benefit information at:
www.standard.com/services.

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