WYOMING CHAMBER GROUP HEALTH PLAN
Plan Design Summary

Eye Exam, Lenses, Frames, Frequencies **Proposed Effective Date: 7/1/2024**

	Plan 1: Balanced Care Vision I	
	VSP Choice Network + Affiliates	**Out of Network**
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
Frame Allowance	$150**	Up to $75
Frequencies		
Exam/Lens/Frames	12/12/24 Based on date of service	12/12/24 Based on date of service

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

Deductible, Maximum

Deductibles	$10 Exam $25 Eye Glass Lenses or Frames*	$10 Exam $25 Eye Glass Lenses or Frames
Maximum per benefit period	None	None

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

Contact Lenses

Fit & Follow Up Exams	Participant cost up to $60	No benefit
Contacts		
Elective	Up to $150	Up to $120
Medically Necessary	Covered in full	Up to $210

Monthly Rates

Employee (EE)	$7.12
EE + Spouse	$14.24
EE + Children	$15.24
EE + Spouse & Children	$24.40

Rates are guaranteed for 12 months following the effective date listed above.
Rates include: eServices discounts.
This benefit and cost summary expires on 7/1/2024 unless replaced, withdrawn or amended by The Standard.

Employee Participation Requirements **Eligible Employees: 179**

	The greater of 60% or 10 lives Contributory

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Lens Options (participant cost)*

	Plan 1: Balanced Care Vision I	
	VSP Choice Network + Affiliates (Other than Costco)	**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	No benefit
Scratch Resistant Coating	$17-$33	No benefit
Anti-Reflective Coating	$43-$85	No benefit
Ultraviolet Coating	$16	No benefit

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

Additional Balanced Care Vision I Choice Network Features (In Network)

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.
Lens Options (Participant Cost)*	$15 - Solid Plastic Dye (Except Pink I & II) $17 - Plastic Gradient Dye $31-$82 - Photochromatic Lenses (Glass & Plastic) Lens Option member cost vary by prescription and option chosen.
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.