Blue20/20

Benefit Highlights - Blue 20/20 Exam Plus

Vision Care Services	In-Network Member Copay & Allowance	Out-of-Network Allowance
Routine Vision Exam	$25 copayment	$39 reimbursement
Frames, Lens & Options Package: Any frame, lens and lens options available at provider location plus 20% off balance over Allowance	**Allowance** $150	**Allowance** Variable*
Contact Lenses	**Allowance**	**Allowance**
Conventional: Members responsibility if over specified allowance is 80%	$25	80% of allowance
Disposable: Members responsibility if over specified allowance is 80%	$25	80% of allowance
Medically Necessary**	$0 Copay (Paid-in-Full)	Variable*
Laser Vision Correction Lasik or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	N/A
Frequency		
Exam	1 per 12 months	
Frame / Lenses and/or Contact Lenses	1 per 12 months (Lens) 1 per 24 months (Frames)	
Voluntary or Non Voluntary	Non-Voluntary	

*Reimbursements may vary. Please reference Benefit Booklet for details.

**Subject to approval. Please reference Benefit Booklet for details.

Please Note:
Members receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision.
Additional discounts may be offered at participating retail and provider locations. Please check provider locator for participation.
After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com/bcbsnc. The contact lens benefit allowance is not applicable to this service.
Benefit Allowances provide no remaining balance for future use within the same Benefit Frequency.
Certain brand name vision materials in which the manufacturer imposes a no-discount practice are excluded.

Plan Exclusions:
1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; structures;
2) Medical and/or surgical treatment of the eye, eyes or supporting structures
3) Any eye or vision examination, or any corrective eyewear required by a Policyholder as a condition of employment i.e. Safety eyewear
4) Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof.
5) Cosmetic (non-prescription) lenses and/or contact lenses;
6) Non-prescription sunglasses;
7) Two pair of glasses in lieu of bifocals;
8) Services or materials provided by any other group benefit plan providing vision care;
9) Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order.
10) Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

Plan code: EB00110
Facets code: VIS-B2001019
Billing arrangement: ee, ee+spouse, ee+children, fam

Blue20/20™

EXAM PLUS PLAN

Group Employer Paid Vision Plan

Vision Care Service	In-Network Member Cost	Out-of-Network Reimbursement
COMPREHENSIVE EYE EXAM	$25 copay	Up to $39
FRAMES [1,2]	Up to $150 allowance, then member pays 80% of balance	Up to $75
STANDARD PLASTIC LENSES [1,2]		
Single vision	$25 copay	Up to $25
Bifocal	$25 copay	Up to $39
Trifocal	$25 copay	Up to $63
Lenticular	$25 copay	Up to $63
Standard progressive lens	$25 copay plus $65	Up to $39
Premium progressive lens	$25 copay plus $85 – $110	
Tier 1	$85	Up to $39
Tier 2	$95	Up to $39
Tier 3	$110	Up to $39
Tier 4	$90, 80% of charge	Up to $39
LENS OPTIONS [1,2] Standard polycarbonate for covered dependents under age 19	$0	Up to $28
CONTACT LENSES [2]		
Conventional	Up to $150 allowance, then member pays 85% of balance	Up to $120
Disposable	Up to $150 allowance, then member pays 100% of balance	Up to $120
Medically necessary	$0	Up to $200
LASER VISION CORRECTION LASIK or PRK from U.S. Laser Network	15% off the retail price or 5% off the promotional price	Not covered
FREQUENCY		
Exam	Once every 12 months	
Lenses or contact lenses	Once every 12 months	
Frames	Once every 24 months	
RATES For groups with 51+ employees, rates apply to plans with a 2019 effective start date and for a period of 24 months from the 2019 effective start date.	Subscriber $5.89 Subscriber + spouse $11.19 Subscriber + children $11.78 Subscriber + family $17.32	

1 Additional discounts: 40% off additional complete pairs of prescription eyeglasses; 20% off non-prescription sunglasses. These discounts are not insured benefits and are for in-network providers only.

2 Benefit allowances provide no remaining balance for future use within the same benefit frequency. Certain brand name vision materials in which the manufacturer imposes a no-discount practice are excluded.

Rates are valid for groups domiciled in the state of North Carolina. At least 25% employer contribution and 75% employee participation required.

Plan Exclusions:

+ Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
+ Medical and/or surgical treatment of the eye, eyes or supporting structures;
+ Any eye or vision examination, or any corrective eyewear required by a policyholder as a condition of employment; safety eyewear;
+ Services provided as a result of any workers' compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
+ Plano (non-prescription) lenses and/or contact lenses;
+ Non-prescription sunglasses;
+ Two pair of glasses in lieu of bifocals;
+ Services rendered after the date an insured person ceases to be covered under the policy, except when vision materials ordered before coverage ended are delivered, and the services rendered to the insured person are within 31 days from the date of such order;
+ Services or materials provided by any other group benefit plan providing vision care;
+ Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next benefit frequency when vision materials would next become available.

VIS-EP, 6/18; U13585k, 7/18