BlueCross BlueShield of Tennessee

# Sumner County Government Self Insurance Board

## VisionBlue

**Summary of Benefits** (SL#)

**Vision Option: Preferred**
**Effective Date: July 1, 2020**

| Benefit Category | In-Network | Out-of-Network |
|---|---|---|
| **Exams** (Limited to one exam and one contact lens fitting/follow-up within a 12-month period) | | |
| Comprehensive Eye Exam | $10 Copay | Up to $35 |
| Retinal Imaging | Up to $39 | Not Covered |
| Contact Lens Fitting and Follow-up - Standard | $55 Copay | Not Covered |
| Contact Lens Fitting and Follow-up - Premium | 10% off retail | Not Covered |
| **Vision Materials** | | |
| Standard Plastic Lenses (Limited to one set of standard plastic lenses within a 12-month period) | | |
| Single | $10 Copay | Up to $30 |
| Bifocal | $10 Copay | Up to $45 |
| Trifocal | $10 Copay | Up to $60 |
| Frames (Limited to one pair of frames within a 24-month period) | $0 Copay up to $180 allowance* | Up to $75 |
| Contacts (Limited to one set of lenses within a 12-month period in lieu of eyeglasses) | | |
| Conventional | $0 Copay up to $180 allowance** | Up to $120 |
| Disposable | $0 Copay up to $180 allowance | Up to $120 |
| Medically Necessary | Covered at 100% | Up to $200 |
| Lens Options (Limited to one set of lenses within a 12-month period) | | |
| Standard Polycarbonate | $40 | Not Covered |
| Standared Polycarbonate (For covered dependent children under age 19) | No Copay | Up to $5 |
| UV Treatment | $15 Copay | Not Covered |
| Tint | $15 Copay | Not Covered |
| Standard Plastic Scratch Coating | $15 Copay | Not Covered |
| Standard Progressive Lenses (add on to Bifocal) | $65 Copay | $0 Additional*** |
| Premium Progressive Lenses (add on to Bifocal) | $65 Copay, 20% Discount Off of Retail Price, Less $120 Allowance | $0 Additional*** |
| Standard Anti-reflective Coating | $45 Copay | Not Covered |
| **Diabetic Care Services******** | | |
| Office Service Visit *(Medical Follow-up Exam)* | Covered 100% | $77 |
| Retinal Imaging | Covered 100% | $50 |
| Extended Ophthalmoscopy | Covered 100% | $15 |
| Gonioscopy | Covered 100% | $15 |
| Scanning Laser | Covered 100% | $33 |

Notes

1. This document serves as a summary of the benefits that are detailed in the Evidence of Coverage. These benefits are subject to the Covered Services and Limitations on Covered Services. Exclusions from Covered Services, and Schedule of Benefits Sections of the Evidence of Coverage.
2. When applicable, benefits are paid after the copay listed above and to the allowance listed. Members are responsible for amounts exceeding the allowance.
3. Members may see any vision care provider. However, contracted providers in our network have agreed to limit certain charges and provide additional discounts once the allowance has been reached. Because we have no contract with non-network providers, members are responsicble for all charges that exceed the out-of-network reimbursement.

* 20% off balance over allowance

** 15% off balance over allowance

***$45 maximum reimbursement

****Up to 2 additional per year

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