of Tennessee

Ruby Tuesday

BlueCross Vision *Insight*

Voluntary (Basic Plan)

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement*
Exam with Dilation as Necessary	$10 Copay	$37
Fundus Photography Benefit	Up to $39	N/A
Exam Options:		
Standard Contact Lens Fit and Follow-Up:	Up to $40	N/A
Premium Contact Lens Fit and Follow-Up:	10% off Retail Price	N/A
Frames: Any available frame at provider location	$0 Copay; $150 Allowance, 20% off balance over $150	$40
Standard Plastic Lenses:		
Single Vision	$25 Copay	$37
Bifocal	$25 Copay	$51
Trifocal	$25 Copay	$58
Lenticular	$25 Copay	$58
Standard Progressive Lens (add on to bifocal)	$25 Copay	$51
Premium Progressive Lens (add on to bifocal)	See attached Fixed Premium Progressive price list	$51
Lens Options:		
UV Treatment	$15 Copay	N/A
Tint (Solid and Gradient)	$15 Copay	N/A
Standard Plastic Scratch Coating	$0 Copay	$5
Standard Polycarbonate - Adults	$40 Copay	N/A
Standard Polycarbonate - Kids under 19	$40 Copay	$5
Standard Anti-Reflective Coating	$45 Copay	N/A
Premium Anti-Reflective	See attached Fixed Premium Anti-Reflective Coating list	N/A
Polarized	20% off Retail Price	N/A
Photocromatic / Transitions Plastic	$75 Copay	N/A
Other Add-Ons	20% off Retail Price	N/A
Contact Lenses: *(Contact lens allowance includes materials only)*		
Conventional	$0 Copay; $125 allowance, 15% off balance over $125	$125
Disposable	$0 Copay; $125 allowance, plus balance over $125	$125
Medically Necessary	$0 Copay, Paid-in-Full	$210
Diabetic Care Rider	$0 Copay; See attached Diabetic Care Rider	Varies
Laser Vision Correction Lasik or PRK from U.S. Laser Network	15% off Retail Price or 5% off promotional price	N/A
Additional Pairs Benefit:	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A
Frequency:		
Examination	Once every calendar year	
Lenses or Contact Lenses	Once every calendar year	
Frame	Once every 2 calendar years	

* Member out-of-network reimbursement will be the lesser of the listed amount or the member's actual cost from the out-of-network provider.

Plan is based on a 3-year rate guarantee.

Premium is subject to adjustment even during a rate guarantee period in the event any of the following occur: change in benefits, employee contributions, the number of eligible employees, or the imposition of any new taxes, fees or assessments by Federal or State regulatory agencies.

0% Broker Commission included

Additional Discounts:

Member receives a 20% discount on items not covered by the plan at network Providers. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered.

Members also 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.

The initial purchase of contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.contactsdirect.com. The contact lens benefit allowance *is* 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.

Rates are valid only when the quoted plan is the sole stand-alone vision plan offered by the group.

Rates are valid for groups domiciled in the State of TN.

Fees quoted will be valid until the 1/1/20 plan implementation date. Date quoted: 7/31/2019

Rates assume 100% Employee contribution.

Plan Exclusions:

1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 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; 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) Plano (non-prescription) lenses and/or contact lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals; 8) 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; 9) Services or materials provided by any other group benefit plan providing vision care;

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.

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Fixed Fee Schedule

Progressive Price List*	Member Cost In-Network (Includes Lens Copay)
Standard Progressive	$90 copay
Premium Progressives as Follows:	
Tier 1	$110 Copay
Tier 2	$120 Copay
Tier 3	$135 Copay
Tier 4	$90 Copay, 80% of charge less $120 allowance
Anti-Reflective Coating Price List*	**Member Cost In-Network**
Standard Anti-Reflective Coating	$45 copay
Premium Anti-Reflective Coatings as Follows:	
Tier 1	$57 copay
Tier 2	$68 copay
Tier 3	80% of charge
Other Add-ons Price List	**Member Cost In-Network**
Photochromic (Plastic)	$75
Polarized	80% of charge

EyeMed Vision Care reserves the right to make changes to the products on each tier and the member out-of-pocket costs.

*Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels.

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Diabetic Care Rider

Diabetic Care Services	Member Cost	Frequency	Out-of-Network Reimbursement
Office Service Visit *(Medical Follow-up Exam)* Type 1 and Type 2 diabetics.	Covered 100% $0 copay	Up to (2) services per benefit year	$77
Retinal Imaging * Type 1 and Type 2 diabetics.	Covered 100% $0 copay * *Not covered if Extended Ophthalmoscopy is provided within 6 months*	Up to (2) services per benefit year	$50
Extended Ophthalmoscopy * Type 1 and Type 2 diabetics.	Covered 100% $0 copay *Not covered if Retinal Imaging is provided within 6 months	Up to (2) services per benefit year	$15
Gonioscopy Type 1 and Type 2 diabetics.	Covered 100% $0 copay	Up to (2) services per benefit year	$15
Scanning Laser Type 1 and Type 2 diabetics.	Covered 100% $0 copay	Up to (2) services per benefit year	$33

Definitions:

Office Service Visit *(Medical Follow-up Exam)* Office visit for the evaluation and management of an established patient. The office visit includes patient history, follow-up examination services as deemed appropriate by the provider, and medical decision making.
Some or all of the diagnostic services described below will be proivded as deemed appropriate, subject to provider determination of service necessity and the benefit frequency limitations referenced above. More comprehensive descriptions of these services are available in the Certificate of Insurance.

Retinal Imaging with interpretation and report. Retinal Imaging is a process using optical imaging equipment to photograph structures of the eye.

Extended Ophthalmoscopy with retinal drawing and interpretation and report. A serious retinal condition must exist or be suspected (based on results of routine ophthalmoscopy) which requires further detailed study.

Gonioscopy procedure to look at the anterior chamber structures of the eye between the cornea and the iris. Gonioscopy can be used in detection or treatment of conditions that can be more prevalent in diabetics such as glaucoma or neovascularization of the angle.

Scanning Laser Scanning computerized ophthalmic diagnostic imaging, posterior segment with interpretation and report.

Exclusions and Limitations
The Diabetic Benefit covers diabetic eyecare evaluation services only. The following services and benefits are excluded:
1] Costs associated with securing frames, lenses, or any other materials 2] Orthoptics or vision training and any associated supplemental testing
3] Surgical procedures, including laser or any other form of refractive surgery, and any pre or post-operative services
4] Pathological treatment of any type for any condition
5] Any eye examination required by an employer as a condition of employment 6] Insulin or any medications or supplies of any type
7] Services and/or materials not included in this Rider