

The City of Crossville  
Vision - \$20 copay

	BCBST Vision Care 2 Current	BCBST VisionBlue Option	Davis Vision Plan B Option	BCBST Voluntary Option
<b>Benefits</b>				
Eye Exam	\$20 copay	\$20 copay	\$20 copay	\$20 copay
** Annual Benefit (12)				
Lenses	100% up to \$85	<b>\$20 copay</b>	\$0 copay	<b>\$20 copay</b>
** Annual Benefit (12)				
Frames	100% up to \$75	\$0 copay	\$0 copay	\$0 copay
** 2 annual benefit period (24)				
<b>Material Allowance</b>				
Lenses	\$85.00			
Frames	\$75.00	<b>\$150.00</b>	<b>\$90.00</b>	<b>\$150.00</b>
Contact Lenses (in lieu of eyeglasses)	\$150.00	\$150.00	<b>\$105.00</b>	\$150.00
<b>Davis</b>				
Employee	\$7.20	\$5.43	5.48	\$7.31
Employee/Spouse	\$15.12	\$10.85	Emp + 1 9.87	\$14.61
Employee/child(red)	\$13.18	\$11.40	Emp +2 10.42	\$15.34
Family	\$21.85	\$17.91	Family 16.45	\$24.11
Monthly Total	\$2,216.71	\$1,743.37	\$1,633.29	\$2,346.83
% Rate Increase		<b>-21%</b>	<b>-26%</b>	<b>6%</b>

**Current Vision Plan with Blue Cross is not available in 2015 - due to ACA changes.**

\*\*BCBST VisionBlue/Voluntary - no max allowance "in network" on lenses - additional lens options/upgrades copays attached also.

\*\*Davis Vision - Lenses/Frames - no set allowance for eyeglass lenses in network; additional lens options/upgrades copays attached please note if Davis Vision frames are not used there is a max allowance of \$ 140.00 for lenses

Frames - select from Davis Tower Collection or use credits towards other collections. - **Cumberland Co Gvt & BOE are on this plan**

Following companies declined to bid: Guardian, Starmark, Humana, and Principal



**BlueCross BlueShield  
of Tennessee**

An Independent Licensee of the BlueCross BlueShield Association

**Group Name:**  
**Group Number:**  
**Effective Date:**

**City of Crossville**  
**109616**  
**01/01/2015**

**VisionBlue**

**Benefit**

**In-Network Member Cost**

**Out-of-Network Reimbursement**

**VISION EXAMINATION**

**Comprehensive Eye Examination**

\$20 Copayment

Up to \$35

One exam within a 12 month period for each member covered under the plan.

**Contact Lenses Fit and Follow-Up**

One exam within a 12 month period for each member covered under the plan.

Standard  
Premium

\$55 Copayment  
10% off retail

Up to \$0  
Up to \$0

**VISION MATERIALS**

**Standard Plastic Lenses**

One set of lenses within a 12 month period for each member covered under the plan.

Single Vision  
Bifocal  
Trifocal

\$20 Copayment  
\$20 Copayment  
\$20 Copayment

Up to \$30  
Up to \$45  
Up to \$60  
Up to \$75

**Frames**

\$0 Copayment up to \$150 allowance, 20% off balance over allowance

One pair of frames within a 24 month period for each member covered under the plan.

One set of lenses within a 12 month period for each member covered under the plan (In lieu of lenses + frames).

**Contacts**

Conventional

\$0 copay up to \$150 allowance, 15% off balance over allowance

Out-of-network up to \$120

Disposable

\$0 copay up to \$150 allowance

Out-of-network up to \$120

Medically Necessary

Paid in Full

Up to \$200

One set of lenses within a 12 month period for each member covered under the plan.

**Lens Options**

Standard Polycarbonate  
Standard Polycarbonate (For covered dependent children under 19 years of age)

\$40 Copayment  
\$0 Copayment

Up to \$0  
Up to \$5

UV Treatment  
Tint

\$15 Copayment  
\$15 Copayment

Up to \$0  
Up to \$0

Standard Plastic Scratch Coating

\$15 Copayment

Up to \$0

Standard Progressive Lenses (add on to Bifocal)

\$65 Additional Copayment

Up to \$45

Premium Progressive Lenses (add on to Bifocal)

\$65 Additional Copayment, 20% off retail price less \$120 allowance

Up to \$45

Standard Anti-Reflective Coating

\$45 Copayment

Up to \$0  
N/A

Other Lens Options

20% off retail

- 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.
- When applicable benefits are paid after the Copayment listed above and to the allowance listed, members are responsible for amounts above the allowance.
- 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 responsible for all charges that exceed the out-of-network reimbursement.