

BCBS Vision Comparison - Basic Plan

Covered Services	State Basic Plan	BCBS Basic Plan
Routine Eye Exam	\$0 copay	\$10 copay
Retinal Imaging Benefit	none	Up to \$39 copay
Frames	\$50 allowance; 20% discount off \$ above the allowance	\$50 allowance; 20% discount off \$ above the allowance
Eyeglass Lenses (includes plastic or glass) <ul style="list-style-type: none"> • Single, Bifocal, Trifocal, Lenticular • Standard Progressive Lens • Premium Progressive Lens 	\$50 allowance; 20% off balance over \$50	Included as part of the \$50 allowance; 20% off balance over \$50
Eyeglass Lens Options (upgrades) <ul style="list-style-type: none"> • Anti-reflective • Polycarbonate • Photochromic • Scratch resistance coating • UV coating • Tints • Polarized • Premium Anti-Reflective • All other eyeglass lens options 	20% discount off all options	Included as part of the \$50 allowance; 20% off balance over \$50
Exam for Contact Lenses (fitting and evaluation)	15% discount off retail price	Up to \$55, 10% off Retail Price
Contact Lenses [1] <ul style="list-style-type: none"> • Elective <ul style="list-style-type: none"> • Conventional • Disposable • Medically Necessary [2] 	\$50 allowance; 15% off balance over \$50 \$50 allowance \$150 allowance	\$50 allowance; 15% off balance over \$50 \$50 allowance Paid-in-Full
Lasik/Refractive Surgery (for select providers)	15% discount off usual & customary fees	15% discount off usual & customary fees or 5% off promotional price
Out-of-Network Benefits <ul style="list-style-type: none"> • All Eye Exams • Frames • Eyeglass Lenses <ul style="list-style-type: none"> • Single Vision • Lined Bifocal • Lined Trifocal • Elective Contacts (conventional or disposable) • Medically Necessary Contacts [2] 	up to \$30 allowance up to \$50 allowance (frames and lenses combined) \$25 allowance \$75 allowance	up to \$35 allowance up to \$25 allowance (frames and lenses combined) \$40 allowance \$200 allowance
Frequency <ul style="list-style-type: none"> • Eye Exam • Eyeglass Lenses and Contacts • Frames 	Once every calendar year per person Once every calendar year per person Once every two cal. years per person	Once every calendar year per person Once every calendar year per person Once every calendar year per person
WEST TN MONTHLY RATES		
Employee Only	\$3.35	\$3.91
Employee + Spouse	\$6.69	\$7.82
Employee + Child(ren)	\$6.35	\$8.21
Family	\$9.83	\$12.90
Rate Guarantee	1 Year	2 Years

[1] Instead of eyeglass lenses

[2] If medically necessary as first contact lenses following cataract surgery or multiple pairs of rigid contact lenses for treatment of keratoconus

Both plans offers some additional discounts which include:

- > 40% off on additional pairs of eyeglasses at any network location, after the vision benefit has been used
- > 15% off conventional contact lenses after the benefit has been used

BCBS Vision Comparison - Enhanced Plan

Covered Services	State Expanded Plan	BCBS Enhanced Plan
Routine Eye Exam	\$10 copay	\$10 copay
Retinal Imaging Benefit	up to \$39 copay	up to \$39 copay
Frames	\$115 allowance; 20% discount off \$ above the allowance	\$125 allowance; 20% discount off \$ above the allowance
Eyeglass Lenses (includes plastic or glass) <ul style="list-style-type: none"> • Single, Bifocal, Trifocal, Lenticular • Standard Progressive Lens • Premium Progressive Lens 	\$15 copay \$55 copay \$81–\$93 [3]	\$25 copay \$90 \$90, 80% of Charges < \$120 Allowance
Eyeglass Lens Options (upgrades) <ul style="list-style-type: none"> • Anti-reflective • Polycarbonate • Photochromic • Scratch resistance coating • UV coating • Tints • Polarized • Premium Anti-Reflective • All other eyeglass lens options 	maximum copayments: \$45 copay \$30 copay; \$0 for children 18 and under \$70 copay \$15 copay \$10 copay \$25 copay 20% off retail price \$57–\$68 20% discount	maximum copayments: \$45 copay \$40 copay; \$0 for children 19 and under 20% off retail price \$15 copay \$15 copay \$15 copay 20% off retail price 20% off retail price 20% off retail price 20% discount
Exam for Contact Lenses (fitting and evaluation)	up to \$60 copay	up to \$55 copay
Contact Lenses [1] <ul style="list-style-type: none"> • Elective <ul style="list-style-type: none"> • Conventional • Disposable • Medically Necessary [2] 	\$130 allowance; 15% off \$ over \$130 \$130 allowance covered at 100%	\$125 allowance; 15% off \$ over \$125 \$125 allowance plus balance over \$125 covered at 100%
Lasik/Refractive Surgery (for select providers)	15% discount off usual/customary fees	15% discount off usual & customary fees or 5% off promotional price
Out-of-Network Benefits <ul style="list-style-type: none"> • All Eye Exams • Frames • Eyeglass Lenses <ul style="list-style-type: none"> • Single Vision • Lined Bifocal • Lined Trifocal • Elective Contacts (conventional or disposable) • Medically Necessary Contacts [2] 	up to \$45 allowance up to \$70 allowance up to \$30 allowance up to \$50 allowance up to \$65 allowance up to \$50 allowance up to \$100 allowance	up to \$35 allowance up to \$63 allowance up to \$25 allowance up to \$40 allowance up to \$55 allowance up to \$100 allowance up to \$200 allowance
Frequency <ul style="list-style-type: none"> • Eye Exam • Eyeglass Lenses and Contacts • Frames 	Once every calendar year per person Once every calendar year per person Once every two cal. years per person	Once every calendar year per person Once every calendar year per person Once every calendar year per person
WEST TN MONTHLY RATES		
Employee Only	\$5.86	\$5.86
Employee + Spouse	\$11.72	\$11.72
Employee + Child(ren)	\$11.14	\$12.30
Family	\$17.23	\$19.33
Rate Guarantee	1 Year	2 Years

[2] If medically necessary as first contact lenses following cataract surgery or multiple pairs of rigid contact lenses for treatment of keratoconus [3] Copays for premium progressive lens are subject to change

Both plans offers some additional discounts which include:

- > 40% off on additional pairs of eyeglasses at any network location, after the vision benefit has been used
- > 15% off conventional contact lenses after the benefit has been used