

Group: CareHarmony, Inc.

Group ID: 136376 - 1

Plan Information

Plan Name: Voluntary Vision Insight Supplement Plan 1

This BlueCross BlueShield of Tennessee Supplemental Vision Plan is designed as a supplement to an Essential Health Benefits (EHB) medical plan, which includes pediatric vision benefits.

Members under the age of 19 may not be covered by this supplemental plan unless they are not enrolled in an EHB medical plan.

Member Advantage

- Comprehensive benefits that cover all routine vision care needs and promote member eye health and wellness.
- Savings of up to 40% off retail pricing, and unlimited additional discounts after the funded benefits have been used.
- Supplemental Plans offer the opportunity for single ID cards, which means less confusion for members and providers alike.

Benefits and Eligibility

- This plan is different from the standardized pediatric benefits contained in an EHB medical plan, so it is important to review prior to seeking service.
- Limitations such as allowances and copays are specified in the Schedule of Benefits.
- When a member reaches the age of 19 and is no longer covered by their EHB pediatric vision benefits, he/she is eligible to be added to this plan due to the loss in coverage, which is a qualifying event. As with all qualifying events, subscribers have 31 days to add a newly eligible member to the plan. If the member is not added within 31 days, they must wait until the next open enrollment period.
- Individuals that turn 19 and did not have prior EHB pediatric vision benefits because they were not enrolled in an EHB medical plan, containing pediatric vision benefits, are eligible to add the plan at open enrollment.
- Benefits, eligibility, and claims may be viewed 24/7 using BlueAccess at bcbst.com, or verified by calling the member service number on the ID card.

BlueCross BlueShield
of Tennessee

Independent Licensee of
the BlueCross BlueShield Association

BlueCross BlueShield of Tennessee
1 Cameron Hill Circle, Chattanooga, TN 37402

bcbst.com

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Vision Care Services

Covered Services	Member Cost	Out-of-Network Allowance
Exam		
Exam with Dilation as Necessary	\$10 Copay	up to \$35
Contact Lens Fit and Follow-Up		
Standard	\$40 Copay	Not Covered
Premium	10% off retail	Not Covered
Frames		
Any available frame at provider location	\$0 Copay; \$100 allowance; 20% off remaining balance	up to \$50
Standard Plastic Lenses		
Single Vision	\$25 Copay	up to \$30
Bifocal	\$25 Copay	up to \$45
Trifocal	\$25 Copay	up to \$60
Standard Progressive Lens	Additional \$65 Copay	up to \$45
Premium Progressive Lens	See Fixed Tier Price List	up to \$45
Lens Options		
UV Treatment	\$15	Not Covered
Tint (Solid and Gradient)	\$15	Not Covered
Standard Plastic Scratch Coating	\$15	Not Covered
Standard Polycarbonate	\$40	Not Covered
Standard Anti-Reflective Coating	\$45	Not Covered
Premium Anti-Reflective Coating	See Fixed Tier Price List	Not Covered
Photochromic Lenses	\$75	Not Covered
Polarized Lenses and Other Lens Options	20% off retail	Not Covered
Contact Lenses		
Conventional	\$0 Copay; \$100 allowance; 15% off remaining balance	up to \$80
Disposable	\$0 Copay; \$100 allowance	up to \$80
Medically Necessary	\$0 Copay; Paid-in-full	up to \$200

Covered Services (cont.)	Member Cost	Out-of-Network Allowance
Laser Vision Correction		
Lasik or PRK from U.S. Laser Network	15% off Retail Price or 5% off Promotional Price	N/A
Additional Pairs Benefits		
Additional Pairs Benefits	Members also receive a 40% discount on purchases of complete pairs of eyeglasses and a 15% discount on conventional contact lenses once the funded benefit has been used.	N/A
Frequency		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frames	Once every 24 months	
Diabetic Eye Care (<i>Care and testing for diabetic members</i>)		
Diabetic Eye Care	Up to 2 services per year for each listed service**	
Exam	\$0	Up to \$77
Retinal Imaging	\$0	Up to \$50
Extended Ophthalmoscopy	\$0	Up to \$15
Gonioscopy	\$0	Up to \$15
Scanning Laser	\$0	Up to \$33

**Some or all of the diagnostic services described above will be provided as deemed appropriate, subject to provider determination of service necessity and the benefit frequency limitations referenced above.

- This document serves as a summary of benefits that are contained in the Evidence of Coverage (EOC). Please refer to the EOC for detailed plan information.
- Members receive a 20% discount on items not covered by the plan when a network provider is used. Discounts do not apply to a 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.
- **Diabetic Eye Care included in this plan.**



Price List for Premium Progressive Tiered Lenses and Premium Anti-Reflective Coatings

Effective Apr 1, 2026

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Premium Progressive Tiered Pricing

Tier 1
Tier 2
Tier 3
Tier 4

* In addition to In-network lens copay

Additional Member In-Network Cost*

\$85 Copay*
\$95 Copay*
\$110 Copay*
20% off retail, \$120 allowance, and an additional \$65 copay*

Premium Anti-Reflective Coating

Tier 1
Tier 2
Tier 3

Additional Member In-Network Cost*

\$57
\$68
80%