

## What's Included in the Texas 2016-2017 Pediatric Vision Program for Student Health?

Blue Cross and Blue Shield of Texas (BCBSTX) is pleased to provide BCBSTX student members pediatric vision benefits administered by EyeMed Vision Care, a leading national provider of routine vision care programs. This benefit is included with the student member's medical plan for covered members and dependents up to age 19<sup>1</sup>.

### Benefits Include:

- Exams
- Standard lenses
- Pediatric frame collection

### How It Works:

The EyeMed Vision Care network consists of major national and regional retail locations such as LensCrafters®, Pearle Vision, Sears® Optical, Target Optical® and JCPenney Optical, as well as independent optometrists and ophthalmologists.

Members who use an EyeMed Vision Care contracted provider for products and services can receive an eye exam at no additional charge, and discounted prices on select frames, lenses and contacts by presenting their BCBSTX member ID card.

For a list of EyeMed Vision Care contracted providers, visit [eyemedvisioncare.com/bcbstx](http://eyemedvisioncare.com/bcbstx) and use their **Enhanced Provider Search tool**.



For more information,  
call **855-267-0214**.

# Eye exam and vision hardware discount fee schedule

Members<sup>1</sup> can receive the following benefits:

## In-Network Benefits<sup>2</sup>

| Benefit  | Once every                    |                               |                                  |
|--|-------------------------------|-------------------------------|----------------------------------|
| Eye Examination (inclusive of dilation when professionally indicated)  | 12 Months                     |                               |                                  |
| Spectacle Lenses   | 12 Months                     |                               |                                  |
| Frame  | 12 Months                     |                               |                                  |
| Contact Lens (CL) Evaluation, Fitting and Follow-Up Care   | 12 Months                     |                               |                                  |
| Contact Lenses (instead of eyeglasses)   | 12 Months                     |                               |                                  |
| Examinations   | Member Cost                   |                               |                                  |
| Eye Examination  | Included                      |                               |                                  |
| Eyeglass Benefit - Frame   | Member Cost                   |                               |                                  |
| Pediatric Frame Selection  | Included                      |                               |                                  |
| Eyeglass Benefit - Spectacle Lenses  | Member Cost                   |                               |                                  |
| Clear Plastic Single-Vision, Lined Bifocal, Trifocal or Lenticular Lenses (any prescription)                 | Included                      |                               |                                  |
| Oversize Lenses  | Included                      |                               |                                  |
| Tinting of Plastic Lenses  | Included                      |                               |                                  |
| Scratch-Resistant Coating  | Included                      |                               |                                  |
| Polycarbonate Lenses   | Included                      |                               |                                  |
| Ultraviolet Coating  | Included                      |                               |                                  |
| Standard Anti-Reflective (AR) Coating  | \$35                          |                               |                                  |
| Premium AR Coating   | \$48                          |                               |                                  |
| Ultra AR Coating   | \$60                          |                               |                                  |
| Standard Progressive Lenses  | Included                      |                               |                                  |
| Select Progressives  | \$70                          |                               |                                  |
| Premium Progressives (Varilux®, etc.)  | \$90                          |                               |                                  |
| Ultra Progressives (category includes digital free-form progressive lenses)                                  | \$195                         |                               |                                  |
| Intermediate-Vision Lenses   | \$30                          |                               |                                  |
| Blended-Segment Lenses   | \$20                          |                               |                                  |
| High-Index Lenses  | \$55                          |                               |                                  |
| Polarized Lenses   | \$75                          |                               |                                  |
| Photochromic Glass Lenses  | \$20                          |                               |                                  |
| Plastic Photosensitive Lenses  | Included                      |                               |                                  |
| Scratch Protection Plan: Single Vision   Multifocal Lenses   | \$20*   \$40*                 |                               |                                  |
| Contact Lens Benefit (instead of eyeglasses)   |                               |                               |                                  |
| Pediatric Contact Lens Selection (\$150 allowance)   | Included                      |                               |                                  |
| Medically Necessary Contact Lenses (with prior approval) – Materials, Evaluation, Fitting and Follow-Up Care | Included                      |                               |                                  |
| Out-of-Network Reimbursement Schedule (Maximum Reimbursement)  |                               |                               |                                  |
| Eye Examination: \$30  | Collection Frames: up to \$30 | Single Vision Lenses: \$25    | Bifocal/Progressive Lenses: \$35 |
| Trifocal Lenses: \$45  | Lenticular Lenses: \$45       | Elective Contact Lenses: \$75 | Medically Necessary CL: \$225    |

<sup>1</sup>The benefit ends the last day of the month in which the member turns 19.

<sup>2</sup>This document does not contain a complete listing of the benefits, exclusions, limitations and conditions that apply to the benefits shown. For more information, please contact BCBSTX at 855-267-0214.

\*All lenses include scratch resistant coating with no additional copayment.

Third party brands are the property of their respective owners.

BCBSTX does not guarantee or make any claims or recommendations regarding these services or products. Members may want to consult with their physicians or an eye care professional prior to use of these services and products. Services and products are subject to availability by location. BCBSTX reserves the right to discontinue or change this program at any time without notice.

For out-of-network coverage, please contact the EyeMed Customer Care Center at 844-684-2254.