AcademicBlue℠ Vision Plan 1B

REQUIRED OUTLINE OF COVERAGE

I. Read Your Policy Carefully. This Outline of Coverage provides a very brief description of some important features of Your Student Vision Policy. This is not the insurance Policy, and only the actual Student Vision Policy provisions will control. The Student Vision Policy itself sets forth, in detail, the rights and obligations of You, Your Vision Care Provider, and Us. It is, therefore, important that You **READ YOUR STUDENT VISION POLICY CAREFULLY!**

Changes in some state or federal law or regulations, or interpretations thereof, may change the terms and conditions of coverage.

II. This Student Vision Policy is designed to provide You with coverage for Vision Services and Vision Materials.

Coverage is provided for the Benefits outlined in Paragraph III. The Benefits described in Paragraph III may be limited by Paragraph IV.

III. Benefits. Your vision care Benefits are highlighted below.

Benefit Period – Your Benefit Period is August 1, 2025 – July 31, 2026.

Under this Student Vision Policy, You may visit any Provider and receive Benefits (as listed on the Schedule of Benefits) for a Vision Examination and Vision Materials.

A Vision Examination is a vision testing exam that includes a determination as to the need for correction of visual acuity and prescribing lenses, if needed, that is performed by a licensed physician, optometrist, therapeutic optometrist or ophthalmologist who is operating within the scope of his or her license. A comprehensive routine eye examination (including dilation, if necessary) includes but is not limited to the following procedures:

- case history, including chief complaint and/or reason for visit, patient medical and eye health history, and record of current medications;
- record of visual acuities with or without present correction, if applicable;
- pupil responses, external exam findings, internal exam findings, screening of visual fields perception;
- present prescription;
- retinoscopy (when applicable), subjective refraction at far and near point;
- binocular and ocular mobility testing;
- test of accommodation and/or near point refraction;
- tonometry, to include pressures, time of day, and type of instrument used (a reasonable attempt at tonometry or equivalent testing will be made unless, in the Provider's professional opinion, tonometry is contraindicated); and
- diagnosis/prognosis and/or specific recommendations.

SCHEDULE OF BENEFITS

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This Policy will pay without regard to any Medicare, Medicare Advantage, or Medicaid Coverage.

Vision Care Benefits	EyeMed Provider	Non-Contracting Provider Reimbursement*
Exam with Dilation as Necessary	$10 Copay	Up to $30
Frames: Any available frame at Provider location	$0 Copay, $130 Allowance, 20% off balance over $130	Up to $65
Contact Lens Fit and Follow-Up (Contact Lens fit and two follow-up visits are available once a comprehensive eye exam has been completed.)		
Standard Contact Lens Fit and Follow-Up	$0 Copay, Paid-in-Full, and two follow-up visits	Up to $40
Premium Contact Lens Fit and Follow-Up	$0 Copay, 10% off Retail Price, then apply $40 Allowance	Up to $40
Standard Plastic Lenses:		
Single Vision	$20 Copay	Up to $8
Bifocal	$20 Copay	Up to $18
Trifocal	$20 Copay	Up to $35
Lenticular	$20 Copay	Up to $35
Standard Progressive Lens	$0 Copay	Up to $60
Premium Progressive Lens as follows: **		
Premium Progressive Lens -*Tier 1*	$85 Copay	Up to $60
Premium Progressive Lens -*Tier 2*	$95 Copay	Up to $60
Premium Progressive Lens -*Tier 3*	$110 Copay	Up to $60
Premium Progressive Lens -*Tier 4*	$85 Copay, 20% off Retail less $120 Allowance	Up to $60
Lens Options:		
Standard Plastic Scratch Coating	$15 Copay	Up to $8
Standard Polycarbonate - Kids under 19	$0 Copay	Up to $20
Contact Lenses: (Contact Lens allowance includes materials only.)		

Conventional	$0 Copay, $130 Allowance, 15% off balance over $130	Up to $104
Disposable	$0 Copay, $130 Allowance, plus balance Over $130	Up to $104
Medically Necessary	$0 Copay, Paid-in-Full	Up to $210
Vision Care Services**	**Member Cost**	
Retinal Imaging Benefit	Up to $39	
Lens Options		
UV Treatment	$15 Copay	
Tint (Solid and Gradient)	$15 Copay	
Standard Polycarbonate - Adults	$40 Copay	
Standard Anti-Reflective Coating	$45 Copay	
Premium Anti-Reflective Coating – *Tier 1*	$57 Copay	
Premium Anti-Reflective Coating – *Tier 2*	$68 Copay	
Premium Anti-Reflective Coating – *Tier 3*	20% off Retail Price	
Polarized	20% off Retail Price	
Photochromic (Plastic)	20% off Retail Price	
Other Add-Ons	20% off Retail Price	
Laser Vision Correction Lasik or PRK from U.S. Laser Network	15% off Retail Price or 5% off promotional price	
Additional Pairs Benefit:	Covered Persons 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.	
Frequency:		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 12 months	
Premium is subject to adjustment even during a rate guarantee period in the event of any of the following events: change in Benefits or the imposition of any new taxes, fees, or assessments by Federal or State regulatory agencies.		
*Reimbursement for Non-Contracting Provider Vision Services and Materials will be the lesser of the listed amount or the actual cost from the Non-Contracting Provider. In certain states, Covered Persons may be required to pay the full retail price, and not the negotiated discount rate with certain participating Providers. Please see EyeMed's online Provider locator to determine which participating Providers have agreed to the discounted rate.		
**No insurance Benefit is provided, EyeMed Provider or Non-Contracting Provider. Member cost displayed is a negotiated and agreed-upon discount with Contracted Providers. For Non-Contracting Providers, Member will pay charged amount.		
EyeMed Vision Care reserves the right to make changes to the products on each tier and the 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.		

IV. Limitations and Exclusions

These general Limitations and Exclusions apply to all services described in this Student Vision Policy. This Student Vision Policy does not cover Vision Services or Vision Materials connected with or arising from:

- any Vision Service, treatment, or Vision Materials not specifically listed as a Covered Service;
- Vision Services or Vision Materials which are rendered prior to Your Effective Date of Coverage;
- Vision Services and Vision Materials incurred after the termination date of Your coverage unless otherwise indicated;
- more than one Vision Examination in each successive 12-month Benefit Period;
- Vision Services and Vision Materials not meeting accepted standards of optometric practice;
- Vision Services and Vision Materials resulting from Your failure to comply with professionally prescribed treatment;
- telephone consultations;
- any charges for failure to keep a scheduled appointment;
- any Vision Services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- any eye or Vision Examination, or any corrective eye wear required by an employer as a condition of employment, and safety eyewear;
- Vision Services or Vision Materials provided as a result of intentionally self-inflicted injury or illness;
- Vision Services or Vision Materials provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
- office infection control charges;
- charges for copies of Your records, charts, or any costs associated with forwarding/mailing copies of Your records or charts;
- state or territorial taxes on Vision Services performed;
- medical treatment of eye disease or injury;
- visual therapy;
- special lens designs or coatings other than those described in this Student Vision Policy;
- replacement of lost/stolen eyewear;
- non-prescription (Plano) lenses;
- two pairs of eyeglasses in lieu of bifocals;
- Vision Services not performed by licensed personnel;
- prosthetic devices and services; or
- insurance of contact lenses.

BCBSTX may, without waiving these Exclusions, elect to provide Benefits for care and services while awaiting the decision of whether or not the care and services fall within the Exclusions listed above. If it is later determined that the care and services are excluded from the Covered Person's coverage, We will be entitled to recover the amount we have allowed for Benefits under this Student Vision Policy. The Covered Person must provide BCBSTX with all documents We need to enforce its rights under this provision.

V. Renewability

The Student Vision Policy renewal date, when the Institution's vision coverage under this Student Vision Policy renews for another academic year, is August 1 of each year.

VI. Termination

A Student's coverage under this Student Vision Policy will end on the earliest of the date:

- this Policy terminates;
- the Student is no longer eligible; or
- the period ends for which Premium is paid.

A Dependent's coverage will end of the earliest of the date:

- he or she is no longer a Dependent;
- the Student's coverage ends;
- the period ends for which the Premium is paid; or
- the Policy terminates.

We may terminate this Policy by giving 31 days written (authorized electronic or telephonic) notice to the Institution. Either We or the Institution may terminate this Policy on any Premium due date by giving 31 days advance written (authorized electronic or telephonic) notice to the other. This Policy may be terminated at any time by mutual written or authorized electronic/telephonic consent of the Institution and Us.

This Policy terminates automatically on the earlier of:

- the Policy termination date;
- the Premium due date if Premiums are not paid when due; or
- the Policy effective date of the renewal of this Policy if a Student decides to renew coverage under this Student Vision Policy, and the Policy effective date of the renewal of this Student Vision Policy becomes effective before this Policy terminates.

VII. Premiums

On or before the Premium due date, You shall remit the required Premium to Your Institution.

1. Only if Your Institution receives Your initial payment, shall You be entitled to vision care services covered hereunder and then only for the Policy Month for which such payment is received. If any required payment is not received by the Premium due date of the Policy Month for You or there is a bank draft failure, then You will be terminated at the end of the grace period. You will be responsible for the cost of services rendered to You during the grace period of the Policy Month in the event that Premium payments made by You.

   Your Institution reserves the right to change the schedule of Premium payments on each anniversary date of this Student Vision Policy upon sixty (60) days written notice.

   When you renew BCBSTX coverage or reenroll by selecting a new product, You will need to be current on Your Premium payments. Any past due Premium payments for coverage We will provide will be due at the beginning of the new plan year in addition to current Premium charges. New coverage will not be effective until such payments are made.

2. A grace period of 31 days, or such other grace period, if any, permitted by applicable law or regulatory guidance, will be granted for the payment of each Premium falling due after the first Premium, during which grace period, this Student Vision Policy shall continue in force. After a grace period of 31 days, coverage under this Student Vision Policy will automatically terminate on the last day of the coverage period for which Premiums have been paid.

BlueCross BlueShield of Texas

Health care coverage is important for everyone.

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984. We provide free communication aids and services for anyone with a disability or who needs language assistance.

We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability. If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St., 35th Floor
Chicago, IL 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
Complaint Forms: https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

	To receive language or communication assistance free of charge, please call us at 855-710-6984.
Español	Llámenos al 855-710-6984 para recibir asistencia lingüística o comunicación en otros formatos sin costo.
العربية	لتلقي المساعدة اللغوية أو التواصل مجانًا، يرجى الاتصال بنا على الرقم 855-710-6984.
繁體中文	如欲獲得免費語言或溝通協助，請撥打855-710-6984與我們聯絡。
Français	Pour bénéficier gratuitement d'une assistance linguistique ou d'une aide à la communication, veuillez nous appeler au 855-710-6984.
Deutsch	Um kostenlose Sprach- oder Kommunikationshilfe zu erhalten, rufen Sie uns bitte unter 855-710-6984 an.
ગુજરાતી	ભાષા અથવા સંચાર સહાય મફતમાં મેળવવા માટે, કૃપા કરીને અમને 855-710-6984 પર કૉલ કરો.
हिंदी	निःशुल्क भाषा या संचार सहायता प्राप्त करने के लिए, कृपया हमें 855-710-6984 पर कॉल करें।
Italiano	Per assistenza gratuita alla lingua o alla comunicazione, chiami il numero 855-710-6984.
한국어	언어 또는 의사소통 지원을 무료로 받으려면 855-710-6984번으로 전화해 주세요.
Navajo	Niná: Doo bilagáana bizaad dinits'á'góó, shá ata' hodooni nínízingo, t'áájíík'eh bee náhaz'á. 1-866-560-4042 jį' hodíilni.
فارسی	برای دریافت کمک زبانی یا ارتباطی رایگان، لطفاً با شماره 855-710-6984 تماس بگیرید.
Polski	Aby uzyskać bezpłatną pomoc językową lub komunikacyjną, prosimy o kontakt pod numerem 855-710-6984.
Русский	Чтобы бесплатно воспользоваться услугами перевода или получить помощь при общении, звоните нам по телефону 855-710-6984.
Tagalog	Para makatanggap ng tulong sa wika o komunikasyon nang walang bayad, pakitawagan kami sa 855-710-6984.
اردو	مفت میں زبان یا مواصلت کی مدد موصول کرنے کے لیے، براہِ کرم ہمیں 855-710-6984 پر کال کریں۔
Tiếng Việt	Để được hỗ trợ ngôn ngữ hoặc giao tiếp miễn phí, vui lòng gọi cho chúng tôi theo số 855-710-6984.