



AcademicBlueSM 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, 2026 – July 31, 2027.

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 - <i>Tier 1</i>	\$85 Copay	Up to \$60
Premium Progressive Lens - <i>Tier 2</i>	\$95 Copay	Up to \$60
Premium Progressive Lens - <i>Tier 3</i>	\$110 Copay	Up to \$60
Premium Progressive Lens - <i>Tier 4</i>	\$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 – <i>Tier 1</i>	\$57 Copay	
Premium Anti-Reflective Coating – <i>Tier 2</i>	\$68 Copay	
Premium Anti-Reflective Coating – <i>Tier 3</i>	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/mailling 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.

Non-Discrimination Notice

Health Care Coverage Is Important For Everyone

We do not discriminate on the basis of race, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation). We provide people with disabilities with reasonable modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.

To receive reasonable modifications, communication aids or language assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, you can file a grievance with:

Office of Civil Rights Coordinator
Attn: 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
Email: civilrightscoordinator@bcbsil.com

You can file a grievance by mail, fax or email. If you need help filing a grievance, please call the toll-free phone number listed on the back of your ID card (TTY: 711).

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

US Dept of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201

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

This notice is available on our website at bcbstx.com/legal-and-privacy/non-discrimination-notice

ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 855-710-6984 (TTY: 711) or speak to your provider.

Español Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 855-710-6984 (TTY: 711) o hable con su proveedor.
العربية Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 855-710-6984 (TTY: 711) أو تحدث إلى مقدم الخدمة.



中文 Chinese	注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 855-710-6984（文本电话：711）或咨询您的服务提供商。
Français French	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 855-710-6984 (TTY : 711) ou parlez à votre fournisseur.
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 855-710-6984 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.
ગુજરાતી Gujarati	ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઓક્સિડેલરી સહાય અને એક્સેસિબલ ફોર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કોલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
हिंदी Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 855-710-6984 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
Italiano Italian	ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'855-710-6984 (tty: 711) o parla con il tuo fornitore.
한국어 Korean	주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 855-710-6984(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.
Diné Navajo	SHOOH: Diné bee yáníłt'igogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hólq. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóo bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'í' ahoot'í'ígíí éí t'áá jiik'eh hólq. Kohji' 855-710-6984 (TTY: 711) hodíilnih doodago nika'análwo'í bich'í' hanidziih.
فارسی Farsi	توجه: اگر فارسی صحبت می کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب های قابل دسترس، به طور رایگان موجود می باشند. با شماره 855-710-6984 (تله تایپ: 711) تماس بگیرید یا با ارائه دهنده خود صحبت کنید.
Polski Polish	UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 855-710-6984 (TTY: 711) lub porozmawiaj ze swoim dostawcą.
РУССКИЙ Russian	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 855-710-6984 (TTY: 711) или обратитесь к своему поставщику услуг.
Tagalog Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 855-710-6984 (TTY: 711) o makipag-usap sa iyong provider.
اردو Urdu	توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ 855-710-6984 (TTY: 711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
Việt Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 855-710-6984 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.