AcademicBlue^{SM} Vision Plan 1B

REQUIRED OUTLINE OF COVERAGE

Read your Policy carefully — This outline of coverage provides only a very brief description of the important features of your Policy. This is not the Policy, and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and Blue Cross and Blue Shield of Oklahoma (herein called BCBSOK). It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

The AcademicBlue^{SM} Student Vision Policy is of a limited nature and, as such, is not required to meet the minimum standards for accident and sickness insurance prescribed by law.

You have the right to return the Policy for any reason within 10 days of its delivery to you and have any paid Premium refunded to you. If you return the Policy, BCBSOK will have no liability for any Benefits for vision care or services you received.

SCHEDULE OF BENEFITS

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.	

ELIGIBILITY

All enrolled Students and their Dependents are eligible for coverage under this Policy

YOUR VISION PLAN

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 The Policy describes the Benefits available to Covered Persons. If after reading it, you still have questions, please contact EyeMed Customer Service for BCBSOK Student Vision Policy Members.

RENEWAL

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

NOTICE

This Policy may not fully cover all of your vision costs.

EXCLUSIONS AND LIMITATIONS

This Student Vision Policy does not cover services or materials connected with or charges arising from:

- any vision service, treatment or materials not specifically listed as a Covered Service;
- services or materials which are rendered prior to Your Effective Date of Coverage;
- services and materials incurred after the termination date of Your coverage unless otherwise indicated;
- more than one examination in each successive 12-month Benefit Period;
- services and materials not meeting accepted standards of optometric practice;
- services and materials resulting from Your failure to comply with professionally prescribed treatment;
- telephone consultations;
- any charges for failure to keep a scheduled appointment;
- any 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;
- services or materials provided as a result of intentionally self-inflicted injury or illness;

- services or 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;
- services not performed by licensed personnel;
- prosthetic devices and services; and
- insurance of contact lenses.

Please contact Customer Service if You have any questions.

BlueCross BlueShield of Oklahoma

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	Phone:	855-664-7270 (voicemail)
300 E. Randolph St., 35th Floor	TTY/TDD:	855-661-6965
Chicago, IL 60601	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	Phone:	800-368-1019
200 Independence Avenue SW	TTY/TDD:	800-537-7697
Room 509F, HHH Building 1019	Complaint Portal:	https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
Washington, DC 20201	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.