

Montgomery County Government

VisionBlue

Summary of Benefits

Effective Date: 9/1/2024

Benefit Category	In-Network	Out-of-Network
Exams (Limited to one exam and one contact lens fitting/follow-up within a 12-month period)		
Comprehensive Eye Exam	\$10 Copay	Up to \$35
Retinal Imaging	Up to \$39	Not Covered
Contact Lens Fitting and Follow-up - Standard	\$55 Copay	Not Covered
Contact Lens Fitting and Follow-up - Premium	10% off retail	Not Covered
Vision Materials		
Standard Plastic Lenses (Limited to one set of standard plastic lenses within a 12-month period)		
Single	\$25 Copay	Up to \$30
Bifocal	\$25 Copay	Up to \$45
Trifocal	\$25 Copay	Up to \$60
Frames (Limited to one pair of frames within a 12-month period)	\$0 Copay up to \$150 allowance*	Up to \$75
Contacts (Limited to one set of lenses within a 12-month period in lieu of eyeglasses)		
Conventional	\$0 Copay up to \$150 allowance**	Up to \$120
Disposable	\$0 Copay up to \$150 allowance	Up to \$120
Medically Necessary	Covered at 100%	Up to \$200
Lens Options (Limited to one set of lenses within a 12-month period)		
Standard Polycarbonate	\$40	Not Covered
Standard Polycarbonate (For covered dependent children under age 19)	No Copay	Up to \$5
UV Treatment	\$15 Copay	Not Covered
Tint	\$15 Copay	Not Covered
Standard Plastic Scratch Coating	\$15 Copay	Not Covered
Standard Progressive Lenses (add on to Bifocal)	\$65 Copay \$65 Copay, 20% Discount Off of Retail Price, Less \$120 Allowance	\$0 Additional***
Premium Progressive Lenses (add on to Bifocal)		\$0 Additional***
Standard Anti-reflective Coating	\$45 Copay	Not Covered
Diabetic Care Services****		
Office Service Visit (<i>Medical Follow-up Exam</i>)	Covered 100%	\$77
Retinal Imaging	Covered 100%	\$50
Extended Ophthalmoscopy	Covered 100%	\$15
Gonioscopy	Covered 100%	\$15
Scanning Laser	Covered 100%	\$33

Notes

- This document serves as a summary of the benefits that are detailed in the Evidence of Coverage. These benefits are subject to the Covered Services and Limitations on Covered Services, Exclusions from Covered Services, and Schedule of Benefits Sections of the Evidence of Coverage.
- When applicable, benefits are paid after the copay listed above and to the allowance listed. Members are responsible for amounts exceeding the allowance.
- Members may see any vision care provider. However, contracted providers in our network have agreed to limit certain charges and provide additional discounts once the allowance has been reached. Because we have no contract with non-network providers, members are responsible for all charges that exceed the out-of-network reimbursement.

* 20% off balance over allowance

***\$45 maximum reimbursement

****Up to 2 additional per year

** 15% off balance over allowance

Nondiscrimination Notice

BlueCross BlueShield of Tennessee (BlueCross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BlueCross does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

BlueCross:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: (1) qualified interpreters and (2) written information in other formats, such as large print, audio and accessible electronic formats.
- Provides free language services to people whose primary language is not English, such as: (1) qualified interpreters and (2) written information in other languages.

If you need these services, contact a consumer advisor at the number on the back of your Member ID card or call 1-800-565-9140 (TTY: 1-800-848-0298 or 711).

If you believe that BlueCross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance ("Nondiscrimination Grievance"). For help with preparing and submitting your Nondiscrimination Grievance, contact a consumer advisor at the number on the back of your Member ID card or call 1-800-565-9140 (TTY: 1-800-848-0298 or 711). They can provide you with the appropriate form to use in submitting a Nondiscrimination Grievance. You can file a Nondiscrimination Grievance in person or by mail, fax or email. Address your Nondiscrimination Grievance to: Nondiscrimination Compliance Coordinator; c/o Manager, Operations, Member Benefits Administration; 1 Cameron Hill Circle, Suite 0019, Chattanooga, TN 37402-0019; (423) 591-9208 (fax); Nondiscrimination_OfficeGM@bcbst.com (email).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.