

# Vision Plan Options



**Blue Cross and Blue Shield  
of New Mexico**

**This is a summary only** that lists member coinsurance amounts and provides a brief description of vision care services. Please see your Vision Care Rider for detailed vision care benefit information.

Vision Care Services	Preferred Plan Benefits		Premier Plan Benefits	
	In-Network member cost or discount (remainder payable by plan up to covered charge <sup>1</sup> )	Out-of-Network allowance (amount payable by plan, not to exceed retail cost <sup>2</sup> )	In-Network member cost or discount (remainder payable by plan up to covered charge <sup>1</sup> )	Out-of-Network allowance (amount payable by plan, not to exceed retail cost <sup>2</sup> )
Exam: With dilation as necessary	\$10 Copay	Up to \$35	\$10 Copay	Up to \$35
Frames: Any frame available at provider location	\$40 charge for the first \$70 then 10% off balance of retail cost over \$70	Not covered	20% off balance of retail cost over \$100	Up to \$45
Frequency: Examination Lenses or contact lenses Frames	Once every 12-month benefit period Unlimited Unlimited		Once every 12-month benefit period Once every 12-month benefit period Once every 24-month benefit period	
Standard plastic or glass spectacle lenses: Single-vision Bifocal Trifocal Lenticular	\$35 Charge \$55 Charge \$65 Charge \$110 Charge	Not covered	\$25 Copay \$25 Copay \$25 Copay \$25 Copay	Up to \$25 Up to \$40 Up to \$55 Up to \$55
Lens Options: Add to lens prices above Plastic lens tinting (solid/gradient) Scratch-resistant coating Glass lenses Polycarbonate lenses Standard progressive (add-on to bifocal) Premium progressive (add-on to bifocal) Standard anti-reflective coating (ARC) Premium/ultra ARC Blended invisible bifocals/Corning™ photochromic Plastic photosensitive lenses High-index lenses Polarized lenses Intermediate vision lenses Glass-Grey #3 prescription sunglass Ultraviolet coating	\$10/\$12 Charge \$15 Charge \$18 Charge \$30 Charge \$60 Charge \$110 Charge \$45 Charge Not covered \$20/\$35 Charge \$65 Charge \$55 Charge \$75 Charge \$30 Charge Not covered \$15 Charge	Not covered	Covered in full \$15 Copay Covered in full \$30 Copay \$45 Copay \$90 Copay \$35 Copay \$48/\$60 Copay \$20 Copay \$65 Copay \$55 Copay \$75 Copay \$30 Copay Covered in full \$12 Copay	Not covered

	Preferred Plan Benefits		Premier Plan Benefits	
Vision Care Services	In-Network member cost or discount (remainder payable by plan up to covered charge <sup>1</sup> )	Out-of-Network allowance (amount payable by plan, not to exceed retail cost <sup>2</sup> )	In-Network member cost or discount (remainder payable by plan up to covered charge <sup>1</sup> )	Out-of-Network allowance (amount payable by plan, not to exceed retail cost <sup>2</sup> )
Contact lenses: Includes fit <sup>4</sup> , follow-up <sup>4</sup> , and materials				
Conventional	20% off retail cost	Not covered	15% off balance of retail cost over \$115	Up to \$100
Disposable	10% off retail cost			
Medically necessary	Not covered <sup>3</sup>			
Value-added features: Laser vision correction: You will receive a discount for traditional LASIK and custom LASIK. <i>Prices/discounts may vary by state and are subject to change without notice.</i> Mail-order contact lens replacement: Lens 1-2-3 <sup>®</sup> Program (visit the Lens 1-2-3 website: <a href="http://www.lens123.com">www.lens123.com</a> ).				

Note: Members receive a 20% discount on additional items **beyond plan coverage** from in-network providers which may not be combined with any other discounts or promotional offers. The discount does not apply to in-network vision care plan providers' professional services or contact lenses.

<sup>1</sup> The "covered charge" is the rate negotiated by the Claims Administrator with in-network providers for a particular covered service.

<sup>2</sup> The Plan pays the lesser of the maximum allowance noted or the retail cost. Retail prices vary by location.

<sup>3</sup> These services may be covered under the member's medical/surgical plan. Premier members submit claims for such services to the vision plan administrator first; any balance remaining may be submitted to the medical/surgical plan for consideration.

<sup>4</sup> Under the Premier Plan, the cost for fit and follow-up may be covered by the \$115 allowance, depending on state regulations or the location's individual administrative policy. Under the Preferred Plan, fit and follow-up is discounted up to 20%.