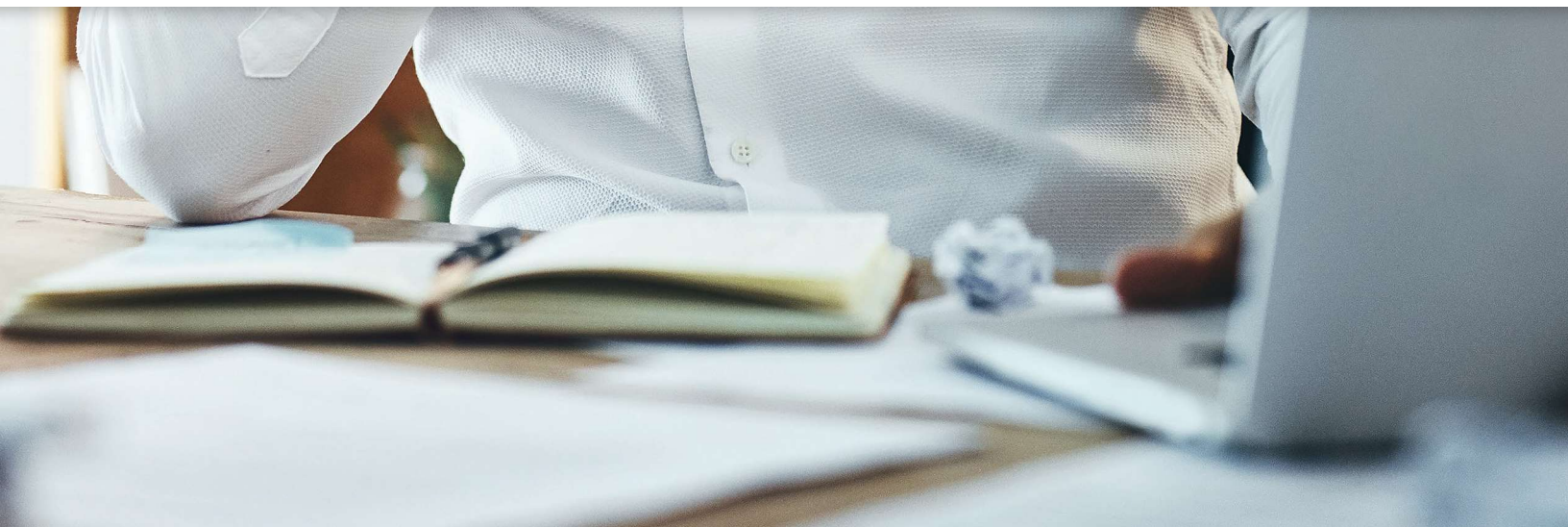
BlueCross BlueShield of North Carolina

Blue20/20℠

Benefit Highlights

Town of Valdese

Effective Date: 06/2025



Blue20/20℠

Benefit Highlights - Blue 20/20 Exam Plus

Benefits	In-Network Copayment or Allowance	Out-of-Network Reimbursement
Routine Eye Exam	$10 Copayment	Provider's billed charge or $39, whichever is less
Frames	$200 Allowance	Provider's billed charge, or 50% of your In-Network Allowance, whichever is less
Lenses * *See plan highlight for additional lens options/copayment **Or** **Contact Lenses**** Progressive lenses may have additional costs outside your regular vision benefit plan. Contact lenses include both conventional and disposable contact lenses. ****Allowance amount is for materials only and does not include fittings for contact lenses or follow-up services**	$25 Copayment $200 Allowance	Provider's billed charge or single vision $25, bi-focal $39, tri-focal and lenticular $63,whichever is less Provider's billed charge, or 80% of your In-Network Allowance for Contact Lenses, whichever is less
Medically required contact lenses* *Subject to eligibility review	$0 Copayment	Provider's billed charge or $200, whichever is less
Frequency Exam	1 per 12 months (Exam)	
Lenses or Contact Lenses / Frames	1 per 12 months (Lenses or Contact Lenses) 1 per 12 months (Frames)	
Voluntary or Non Voluntary	Non-Voluntary	

Please Note:
Additional discounts may be offered at participating retail and provider locations. Please check provider locator for participation.

Plan Exclusions:
1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; structures;
2) Medical and/or surgical treatment of the eye, eyes or supporting structures
3) Any eye or vision examination, or any corrective eyewear required by a Policyholder as a condition of employment i.e. Safety eyewear
4) Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof.
5) Cosmetic (non-prescription) lenses and/or contact lenses;
6) Non-prescription sunglasses;
7) Two pair of glasses in lieu of bifocals;
8) Services or materials provided by any other group benefit plan providing vision care;
9) Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order.
10) Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.
11) Certain brand name vision materials in which the manufacturer imposes a no-discount practice
12) Fees charged by a provider for services other than a covered benefit must be paid-in-full by the insured person; such fees or materials are not covered under the policy.

Plan code: EB01201
Facets code: VIS-B2001921 (base)
Billing arrangement: ee, ee+spouse, ee+children, fam