Texas Association of Counties Health and Employee Benefits Pool

PY2027 New Vision Benefit Plan Election

Group Name: Atascosa County **Group Number:** _____

Effective Date *(select one)*:

- ☑ October 1, form must be received by June 26, 2026.
- ☐ November 1, form must be received by August 12, 2026.
- ☐ December 1, form must be received by September 09, 2026.
- ☐ January 1, form must be received by October 07, 2026.

This document is for adding **new** vision benefit plan selection. Please indicate which vision plan(s) your county or district will provide in the upcoming plan year and fill out the contribution schedule according to your group's funding arrangements. Return the completed form to your Employee Benefits Specialist or fax it to (512) 481-8481 before the effective date, making sure it is submitted by the **required deadline** listed above. If you have any questions, please contact your assigned Employee Benefit Specialist by email or call 1-800-456-5974.

VISION PLANS		
☑ Vision Premium Plan **Frequency:** 12/12/12 **Examination:** 1 every 12 months **Lenses or Contact Lenses:** 1 every 12 months **Frames:** 1 every 12 months, $0 Copay, $180 Allowance, 20% off balance over $180 **Exam with Dilation:** $0 Copay	☐ Vision Value Plan **Frequency:** 12/12/24 **Examination:** 1 every 12 months **Lenses or Contact Lenses:** 1 every 12 months **Frames:** 1 every 24 months, $0 Copay, $130 Allowance, 20% off balance over $130 **Exam with Dilation:** $10 Copay	☐ Vision Base Plan **Frequency:** 12/12/24 **Examination:** 1 every 12 months **Lenses or Contact Lenses:** 1 every 12 months **Frames:** 1 every 24 months, $0 Copay, $100 Allowance, 20% off balance over $100 **Exam with Dilation:** $10 Copay

Your payroll deductions for vision benefits are:	☑ Pre-Tax ☐ Post-Tax	
Are retirees allowed on the vision plan?	☐ Yes ☑ No *If yes,* ☐ Pre-65 ☐ Post-65	
Does your group have a broker or consultant?	Broker: ☐ Yes ☐ No | Consultant: ☐ Yes ■ No	
Broker/consultant's name, if applicable:	N/A	Broker Comm.: N/A

Tier	Monthly Rates*	Amount Employer Pays	Amount Employee Pays	Amount Retiree Pays
Employee Only	N/A	$0.00	$7.86	$0.00
Employee + Spouse	N/A	$0.00	$14.98	$0.00
Employee + Child(ren)	N/A	$0.00	$15.78	$0.00
Employee + Family	N/A	$0.00	$23.22	$0.00

*Note: Rates shown do not include a broker commission unless specified above.

Signature (County Judge or Contracting Authority)

June 24, 2026
Date

Weldon P. Cude
Print Name and Title

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PROPOSED VISION PLANS AND RATES

Monthly Premium*	Premium Plan	Value Plan	Base Plan
Employee Only Tier	$7.86	$4.58	$3.96
Employee + Spouse Tier	$14.98	$8.72	$7.56
Employee + Child(ren) Tier	$15.78	$9.18	$7.94
Employee + Family Tier	$23.22	$13.52	$11.70

*Rates shown do not include a broker commission. Contact your Employee Benefits Consultant if you would like to include broker commission.

PLAN HIGHLIGHTS

	Premium Plan	Value Plan	Base Plan
Frequency			
Examination	Once every 12 months	Once every 12 months	Once every 12 months
Lenses or contact lenses	Once every 12 months	Once every 12 months	Once every 12 months
Frames	Once every 12 months	Once every 24 months	Once every 24 months
Vision Care Services - In-Network Member Cost			
Exam with dilation as necessary	$0 copay	$10 copay	$10 copay
Contact lens fit and follow-up	Up to $40 for standard; 10% off retail price for premium		
Frames			
Any available frame at provider location	$0 copay, $180 allowance, 20% off balance over $180	$0 copay, $130 allowance, 20% off balance over $130	$0 copay, $100 allowance, 20% off balance over $100
Standard Lenses			
Single vision	$10 copay	$15 copay	$25 copay
Bifocal / Trifocal / Lenticular	$10 copay	$15 copay	$25 copay
Standard progressive lens	$65 copay	$70 copay	$80 copay
Lens Options			
Tint (solid and gradient)		$15	
Scratch resistant coating		$0	
Ultraviolet coating		$15	
Polycarbonate lenses		$0 kids; $40 adults	
High index or Polarized lenses		20% off retail	
Contact Lenses (in lieu of spectacle lenses)			
Conventional	$0 copay, $180 allowance, 15% off balance over $180	$0 copay, $130 allowance, 15% off balance over $130	$0 copay, $100 allowance, 15% off balance over $100
Disposable	$0 copay, $180 allowance, plus balance over $180	$0 copay, $130 allowance, plus balance over $130	$0 copay, $100 allowance, plus balance over $100
Other			
Laser vision correction	15% off retail price or 5% off promotional price		
Additional pairs benefit	40% off purchase of complete pair of eyeglasses and 15% off conventional contact lenses once the funded benefit has been used		
Amplifon hearing discount	40% off hearing exams and low-price guarantee on discounted hearing aids		

**This is a summary of the most commonly used vision benefits. Ask your TAC Employee Benefits Consultant for more coverage details.*

Proprietary and Confidential

BlueCross BlueShield of Texas

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

Insurance products issued by Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148.