**WELCOME TO BLUE VIEW VISION!**

Good news—your vision plan is flexible and easy to use. This benefit summary outlines the basic components of your plan, including quick answers about what's covered, your discounts, and much more!

Anthem

# Blue View Vision℠ Plus

**Your Blue View Vision network**

Blue View Vision offers you one of the largest vision care networks in the industry, with a wide selection of experienced ophthalmologists, optometrists, and opticians. Blue View Vision's network also includes convenient retail locations, many with evening and weekend hours, including LensCrafters®, TargetOptical®, JCPenney® Optical, Sears Optical℠ and Pearle Vision® locations.

Best of all – when you choose to receive care from a Blue View Vision participating provider, you receive full in-network benefits and money-saving discounts.

## YOUR BLUE VIEW VISION PLAN AT-A-GLANCE:

| VISION CARE SERVICES | IN-NETWORK | OUT-OF-NETWORK REIMBURSEMENT |
|---|---|---|
| **Routine eye exam** *(once every 12 months)* | $15 copayment | Up to $49 allowance |
| **Eyeglass frames**<br>You may select an eyeglass frame and receive the following allowance toward the purchase price *(once every 12 months)*: | $120 allowance then 20% off remaining balance | Up to $50 allowance |
| **Eyeglass lenses** *(Standard)*<br>Factory scratch coating included<br>Polycarbonate lenses included for children under 19 years old.<br>Transitions lenses included for children under 19 years old.<br>You may receive any one of the following lenses: *(once every 12 months)*: | | |
| • Standard plastic single vision lenses *(1 pair)* | Covered in full | Up to $35 allowance |
| • Standard plastic bifocal lenses *(1 pair)* | Covered in full | Up to $49 allowance |
| • Standard plastic trifocal lenses *(1 pair)* | Covered in full | Up to $74 allowance |
| **Eyeglass lens upgrades**<br>When receiving services from a Blue View Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass lens copayment applies.<br>[1] Please ask your provider for his/her recommendation as well as the progressive brands by tier.<br>[2] Please ask your provider for his/her recommendation as well as the coating brands by tier. | **Lens Options** | **Member Cost for upgrades** |
| • UV Coating | $15 | Discounts on lens upgrades are not available out-of-network |
| • Tint *(Solid and Gradient)* | $15 | |
| • Standard Polycarbonate | $40 | |
| • Transitions lenses | $75 | |
| • Progressive Lenses[1] | | |
| – Standard | $65 | |
| – Premium Tier 1 | $91 | |
| – Premium Tier 2 | $97 | |
| – Premium Tier 3 | $103 | |
| • Standard Anti-Reflective Coating[2] | $45 | |
| • Premium Tier 1 Anti-Reflective Coating[2] | $57 | |
| • Premium Tier 2 Anti-Reflective Coating[2] | $68 | |
| • Other Add-ons and Services | 20% off retail price | |
| **Contact lenses**<br>Prefer contact lenses over glasses? You may choose to receive contact lenses instead of eyeglass lenses and receive an allowance toward the cost of a supply of contact lenses. *(once every 12 months)* | | |
| • Elective Conventional Lenses | $115 allowance then 15% off the remaining balance | Up to $92 allowance |
| • Elective Disposable Lenses | $115 allowance *(no additional discount)* | Up to $92 allowance |
| • Non-Elective Contact Lenses | Covered in full | Up to $250 allowance |
| *Your contact lens allowance must be used at the time of initial service. No amount over the allowance may be carried forward to subsequent materials in the same or the following benefit year. Coverage for this plan includes choice of eyeglass lenses OR contact lenses, not both.* | | |
| **Contact lens fitting and follow-up**<br>Contact lens fitting and follow-up visits are available to you once a comprehensive eye exam has been completed. | Fitting and two follow up visits $55 Member Cost | Discounts not available |
| • Standard contact lens fitting* | 10% off retail price | Discounts not available |
| • Premium contact lens fitting** | | |

*A standard contact lens fitting includes spherical clear contact lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.

**A premium contact lens fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

## USING YOUR BLUE VIEW VISION PLAN

The Blue View Vision network is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care physician from your medical network.

Your out-of-pocket expenses related to the vision benefits do not count toward your annual out of pocket limit and are never waived, even if your annual out-of-pocket limit is reached.

### Out-of-network services

Did we mention that we're flexible? We offer you the option to receive care outside of the Blue View Vision network. If you choose an out-of-network provider, you will receive an allowance toward services and you pay the rest. Network benefits and discounts will not apply. When you receive eye care or eyewear from a non-participating provider, you will pay in full at the time of service then file a claim for reimbursement to Blue View Vision, Attn: OON Claims, PO BOX 8504, Mason, OH 45040-7111.

For questions about vision benefits, members may contact Blue View customer service at **866-723-0515**.

## DISCOUNTS

### Savings on additional eyewear and accessories

After you use your initial frame or contact lens allowance, you can take advantage of discounts on additional prescription eyeglasses, conventional contact lenses, and eyewear accessories courtesy of Blue View Vision network providers.

**BLUE VIEW VISION ADDITIONAL SAVINGS**

| | MEMBER SAVINGS |
|---|---|
| **Additional Pair of Complete Eyeglasses** | 40% discount off retail* |
| **Contact Lenses - Conventional** *(Discount applied to materials only)* | 15% off retail price |
| **Eyewear Accessories** Includes some non-prescription sunglasses, lens cleaning supplies, contact lens solutions and eyeglass cases, etc. | 20% off retail price |

*Items purchased separately are discounted 20% off the retail price. Blue View Vision's Additional Savings Program is subject to change without notice.

## EXCLUSIONS & LIMITATIONS

This is a primary vision care benefit and is intended to cover only eye examinations and corrective eyewear. Covered materials that are lost or broken will be replaced only at normal service intervals indicated in the plan design; however, these materials and any items not covered below may be purchased at preferred pricing from Blue View Vision provider. In addition, benefits are payable only for expenses incurred while the group and insured person's coverage is in force.

**Combined Offers.** Not combined with any offer, coupon, or in-store advertisement.

**Experimental or Investigative.** Any experimental or investigative services or materials.

**Crime or Nuclear Energy.** Conditions that result from: (1) insured person's commission of or attempt to commit a felony; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available

**Uninsured.** Services received before insured person's effective date or after coverage ends.

**Excess Amounts.** Any amounts in excess of covered vision expense.

**Routine Exams or Tests.** Routine examinations required by an employer in connection with insured person's employment.

**Work-Related.** Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if insured person does not claim those benefits.

**Government Treatment.** Any services actually given to the insured person by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if insured person is not required to pay for them or they are given to the insured person for free.

**Services of Relatives.** Professional services or supplies received from a person who lives in insured person's home or who is related to insured person by blood or marriage.

**Voluntary Payment.** Services for which insured person is not legally obligated to pay. Services for which insured person is not charged. Services for which no charge is made in the absence of insurance coverage.

**Not Specifically Listed.** Services not specifically listed in this plan as covered services.

**Private Contracts.** Services or supplies provided pursuant to a private contract between the insured person and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

**Eye Surgery.** Any medical or surgical treatment of the eyes and any diagnostic testing. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

**Sunglasses.** Sunglasses and accompanying frames.

**Safety Glasses.** Safety glasses and accompanying frames.

**Hospital Care.** Inpatient or outpatient hospital vision care.

**Orthoptics.** Orthoptics or vision training and any associated supplemental testing.

**Non-Prescription Lenses.** Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no refractive power.

**Lost or Broken Lenses or Frames.** Any lost or broken lenses or frames, unless insured person has reached a new benefit period.

**Frames:** Discount is not available on certain frame brands in which the manufacturer imposes a no discount policy.

### Disclaimer

This information is intended to be a brief outline of coverage. All terms and conditions of coverage, including benefits and exclusions, are contained in the member's Policy, which shall control in the event of a conflict with this overview.

This benefit overview insert is only one piece of your entire enrollment package. Exclusions and limitations are listed in the enrollment brochure. The in-network providers referred to in this communication are independently contracted providers who exercise independent professional judgment. They are not agents or employees of Anthem.



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