



At Anthem Blue Cross Life and Health Insurance Company, we understand that vision benefits are essential to maintaining your overall health and well-being. After all, more than 65 percent of today's workforce wears eyeglasses or contact lenses. That is approximately 147 million people nation-wide, and the demand grows with each and every day.

Blue View VisionSM, our vision program, provides a cost-effective, comprehensive vision plan that includes eye exams and eyewear available through a broad range of eye care providers and locations. The plan is easy to use and offers savings beyond basic coverage. Blue View Vision provides you with an innovative vision program to meet your unique needs and improve your overall wellness.

Finding a Blue View Vision Provider

Blue View Vision has an extensive network of participating providers contracted under a unique agreement with EyeMed Vision Care. You can easily find a provider conveniently located near you. We contract with approximately 4,600 independent optometrists and ophthalmologists as well as retail locations such as LensCrafters, Target Optical, Sears Optical, & most Pearle Vision locations.

Using a Participating Provider

By using a participating provider, you minimize your out-of-pocket expenses and receive the benefits of not having to hassle with paperwork, since the participating provider verifies your eligibility and obtains all the necessary information. You simply pay your copayment and any remaining balance at the time of your appointment.

Blue View providers offer you discount pricing, which is significantly below retail. You receive substantial savings (15%-40% or more) on additional eyewear pair purchases, contact lenses, lens treatments, specialized lenses and various sundry items.

Using a Non-Participating Provider

If you choose to go to a non-participating (non-network) provider, you must pay the provider directly at the time of service for exams and materials. Out-of-network claims must be submitted by you. Simply submit a claim for reimbursement. When using a non-participating provider, your coverage may be limited and your out-of-pocket expenses may be greater.

Covered Services	Blue View Vision Providers: Insured Persons Copay Amount	Non-Blue View Providers Reimbursement ¹
Vision Examination (<i>Availability: Once every 12 months²</i>)	\$10	Up to \$49
Lenses (<i>Availability: Once every 12 months²</i>)		
➤ Single Vision Lenses	\$10	Up to \$35
➤ Bifocal Lenses (<i>pair</i>)	\$10	Up to \$49
➤ Progressive Lenses (<i>pair</i>)	\$10 plus \$65	Up to \$49
➤ Trifocal Lenses (<i>pair</i>)	\$10	Up to \$74
Frames (<i>Availability: Once every 12 months²</i>)	No copay, up to \$130 retail value ³	Up to \$50
Contact Lenses⁴ (<i>Availability: Once every 12 months²</i>)		
➤ Elective contact lenses (<i>In lieu of frame & lens benefits</i>)	No copay, up to \$130 retail value	Up to \$92
- Conventional contact lenses ⁵		
- Disposable contact lenses ⁵		
➤ Non-elective contact lenses	No copay	Up to \$250

¹ Represents Plan's allowance towards eligible benefits and may not cover all charges.

² From last date of service

³ Maximum allowable amount is for frames purchased from Blue View Provider. Insured person receives 20% off balance over plan allowance.

⁴ See Certificate of Insurance (Certificate) for definitions of elective and medically necessary contact lenses.

⁵ If the insured person chooses conventional contact lenses greater than the plan allowance, the insured person will receive a 15% discount toward the difference. If the insured person chooses disposable lenses greater than the plan allowance the insured person is responsible for the balance.

This Summary of Benefits is a brief review of benefits. Once enrolled, insured persons will receive the Certificate, which explains the exclusions and limitations, as well as the full range of covered services of the plan, in detail.

Blue View 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.

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 for treatment of illness or injury arising from such release of nuclear energy.

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.

Cosmetic Options. Blended lenses/no line, oversize lenses, progressive multifocal lenses, photochromatic lenses, tinted lenses, coated lenses, cosmetic lenses or processes, and UV-protected lenses.

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

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