

Blue View Vision – Full Service Option # 11

DNR/ISEP

Effective Date: July 1, 2013

At Anthem Blue Cross and Blue Shield, we understand that vision benefits are essential to maintaining your overall health and well-being. After all, a slight miscorrection in eyesight can reduce productivity by 10% and work accuracy by nearly 40%. Computer eyestrain can reduce productivity between 10 and 50%.¹

Blue View Vision, our vision program, provides a cost-effective vision plan that includes 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 national network of participating providers contracted under a vendor agreement with EyeMed Vision Care. You can easily find a provider conveniently located near you. Nationally, we contract with independent optometrists and ophthalmologists as well as retail locations such as LensCrafters®, Target Optical, Sears Optical, JCPenney Optical, and most Pearle Vision locations. Please call Blue View Vision at (866) 723-0515 if you have questions about your vision benefits or need to locate a provider.

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 Vision providers offer you discount pricing, which is significantly below retail. You receive substantial savings (15%-40% or more) on most additional eyewear pair purchases, conventional 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. 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 Benefits	Member Benefit From Blue View Vision Network Provider	Non-Network Reimbursement
Vision Examination including dilation and refraction as needed. Covered once every Calendar Year	\$0 copayment	Up to \$40
Prescription Lenses (Pair) Standard plastic lenses up to 55 mm; and all ranges of prescriptions Covered once every Calendar Year	\$0 copayment	
<ul style="list-style-type: none"> ● Single Vision Lenses (pair) ● Bifocal Lenses (pair) ● Progressive Lenses (pair) ● Trifocal Lenses (pair) 	*see discount information below	<ul style="list-style-type: none"> Up to \$29 Up to \$46 Up to \$46 Up to \$63
Frames Covered once every Calendar Year	\$0 copayment, up to \$130 retail value	Up to \$40
Contact Lenses (in lieu of frame and lens benefits) Covered once every Calendar Year		
<ul style="list-style-type: none"> ● Contact Lenses (Elective) ● Contact Lenses (Non-Elective) 	<ul style="list-style-type: none"> \$0 copayment, up to \$105 retail value \$0 copayment up to \$250 retail value 	<ul style="list-style-type: none"> Up to \$100 Up to \$250
Lens Options	Member Cost for Upgrades	
UV Coating	\$15	Discounts on lens option upgrades are not available out-of-network.
Tint (<i>Solid & Gradient</i>)	\$15	
Standard Scratch-Resistance	\$15	
Standard Polycarbonate	\$40	
Standard Progressive (<i>Add-on to bifocal cost</i>)*	\$65	
Standard Anti-Reflective Coating	\$45	
Other Add-ons and Services	20% off retail	

Jan. '04 issue of Optometry: Journal of the AOA

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Blue View Vision Exclusions & Limitations

Low Vision Benefits	Member Benefit From Blue View Vision Network Provider	Non-Network Reimbursement
<p>Subject to a maximum allowance of \$1,100 per member each benefit period.</p> <p>Supplemental testing includes, but is not limited to: Automated Visual Fields, Contract Sensitivity testing, Glare testing, Color vision testing, Visually Evoked Potential (VEP) testing, Electroretinogram (ERG) testing, and Electro-oculogram (EOG) testing.</p> <p>Comprehensive Low Vision Exam \$150 exam maximum allowance each benefit period.</p> <p>Optical/Non-optical aids \$950 optical/non-optical aids maximum allowance each benefit period; not more than \$150 of this maximum allowance may be used for supplemental testing.</p> <p>Supplemental testing each benefit period Any supplemental testing is considered part of the optical/non-optical aids total maximum allowance described above.</p>	<p>20% co-payment up to the maximum allowance.</p>	<p>40% co-payment reimbursed up to 50% of the maximum allowance.</p>

This is a primary vision care benefit and is intended to cover only eye examinations and corrective eyewear. Materials and any items not covered above may be purchased at discount pricing from a Blue View provider. In addition, benefits are payable only for expenses incurred while the group and insured person's coverage is in force.

- The schedule above represents the plan allowance toward eligible benefits and may not cover all charges.
- The next frequency of the eligible benefits are based upon last date of service.
- The lens option discount program is listed above for informational purposes only. It is subject to change without notice and is not included in the Certificate of Insurance.
- Insured members receive 20% off the balance over the plan allowance for frames and 15% off the balance for conventional contact lenses.
- See the Certificate of Insurance (Certificate) for definitions of elective and non-elective contact lenses.

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.

Vision Exams or Tests. Any routine examinations required by an employer in connection with your 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.

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

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

Authorized group signature

Date