

## Welcome to your Blue View Vision plan!

You have many choices when it comes to using your benefits. As a Blue View Vision plan member, you have access to one of the nation's largest vision networks. You may choose from many private practice doctors, local optical stores, and national retail stores including LensCrafters®, Target Optical®, and most Pearle Vision® locations. You may also use your in-network benefits to order eyewear online at Glasses.com and ContactsDirect.com. To locate a participating network eye care doctor or location, log in at [anthem.com](http://anthem.com), or the Sydney app. You may also call member services for assistance at **1-866-723-0515**.

**Out-of-Network** – If you choose to, you may instead receive covered benefits outside of the Blue View Vision. Just pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement up to your maximum out-of-network allowance.

Your vision plan includes coverage for routine eye exams and prescription eyewear from your choice of eye care providers.

Our vision plan includes coverage for routine eye exams and prescription eyewear from your choice of eye care providers.

| YOUR BLUE VIEW VISION PLAN BENEFITS                                                                                                                                                                                                                                                        | IN-NETWORK                                          | OUT-OF-NETWORK                            | FREQUENCY                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|-------------------------------------------|---------------------------------|
| Routine Eye Exam                                                                                                                                                                                                                                                                           |                                                     |                                           |                                 |
| A comprehensive eye examination                                                                                                                                                                                                                                                            | \$20 Copay                                          | Reimbursed Up To \$49                     | Once every 12 months            |
| Eyeglass Frames                                                                                                                                                                                                                                                                            |                                                     |                                           |                                 |
| One pair of eyeglass frames                                                                                                                                                                                                                                                                | \$150 Allowance, then 20% off any remaining balance | Reimbursed Up To \$50                     | Once every 12 months            |
| Eyeglass Lenses (instead of contact lenses)                                                                                                                                                                                                                                                |                                                     |                                           |                                 |
| One pair of standard plastic prescription lenses                                                                                                                                                                                                                                           |                                                     |                                           | Once every 12 months            |
| • Single vision lenses                                                                                                                                                                                                                                                                     | \$20 Copay                                          | Reimbursed Up To \$40                     |                                 |
| • Bifocal lenses                                                                                                                                                                                                                                                                           | \$20 Copay                                          | Reimbursed Up To \$60                     |                                 |
| • Trifocal lenses                                                                                                                                                                                                                                                                          | \$20 Copay                                          | Reimbursed Up To \$80                     |                                 |
| Eyeglass Lens Enhancements                                                                                                                                                                                                                                                                 |                                                     |                                           |                                 |
| When obtaining covered eyewear from a Blue View Vision provider, you may choose to add any of the following lens enhancements at no extra cost                                                                                                                                             |                                                     |                                           |                                 |
| •  Lenses (for a child under age 19)                                                                                                                                                                    | \$0 Copay                                           | No allowance when obtained out-of-network | Same as covered eyeglass lenses |
| • Standard polycarbonate (for a child under age 19)                                                                                                                                                                                                                                        | \$0 Copay                                           |                                           |                                 |
| • Factory Scratch Coating                                                                                                                                                                                                                                                                  | \$0 Copay                                           |                                           |                                 |
| Contact Lenses (instead of eyeglass lenses)                                                                                                                                                                                                                                                |                                                     |                                           |                                 |
| Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period. |                                                     |                                           |                                 |
| • Elective conventional (non-disposable)<br>OR                                                                                                                                                                                                                                             | \$130 Allowance, then 15% off any remaining balance | Reimbursed Up To \$105                    | Once every 12 months            |
| • Elective disposable<br>OR                                                                                                                                                                                                                                                                | \$130 Allowance<br>(no additional discount)         | Reimbursed Up To \$105                    |                                 |
| • Non-elective (medically necessary)                                                                                                                                                                                                                                                       | Covered in full                                     | Reimbursed Up To \$250                    |                                 |

This is a primary vision care benefit intended to cover only routine eye examinations and corrective eyewear. Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care doctor from your medical network. Benefits are payable only for expenses incurred while the group and insured person's coverage is in force. 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 is only one piece of your entire enrollment package.

### EXCLUSIONS & LIMITATIONS (not a comprehensive list – please refer to the member Certificate of Coverage for a complete list)

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

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

**Sunglasses.** Plano sunglasses and accompanying frames.

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

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

**Lost or Broken Lenses or Frames.** Any lost or broken lenses or frames are not eligible for replacement unless the insured person has reached his or her normal service interval as indicated in the plan design.

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

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

| OPTIONAL SAVINGS AVAILABLE FROM BLUE VIEW VISION IN-NETWORK PROVIDERS ONLY<br>(Discounts are not covered benefits under your vision plan and will not be listed in your certificate of coverage.)   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | In-Network Member Cost<br>(after any applicable copay)                                                                         |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|
| <b>Retinal Imaging</b> - at member's option, can be performed at time of eye exam                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Not More Than \$39                                                                                                             |
| <b>Eyeglass lens upgrades</b><br>When obtaining eyewear from a Blue View Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass lens copayment applies. | <ul style="list-style-type: none"> <li>Transitions lenses (Adults)</li> <li>Standard Polycarbonate (Adults)</li> <li>Tint (Solid and Gradient)</li> <li>UV Coating</li> <li>Progressive Lenses<sup>1</sup> <ul style="list-style-type: none"> <li>Standard</li> <li>Premium Tier 1</li> <li>Premium Tier 2</li> <li>Premium Tier 3</li> <li>Premium Tier 4</li> </ul> </li> <li>Anti-Reflective Coating<sup>2</sup> <ul style="list-style-type: none"> <li>Standard</li> <li>Premium Tier 1</li> <li>Premium Tier 2</li> <li>Premium Tier 3</li> </ul> </li> <li>Other Add-ons (i.e. high index lenses, anti-fog coating)</li> </ul> | \$75<br>\$40<br>\$15<br>\$15<br>\$65<br>\$85<br>\$95<br>\$110<br>\$175<br>\$45<br>\$57<br>\$68<br>\$85<br>20% off retail price |
| <b>Additional Pairs of Eyeglasses</b><br>Anytime from any Blue View Vision network provider                                                                                                         | <ul style="list-style-type: none"> <li>Complete Pair</li> <li>Eyeglass materials purchased separately</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 40% off retail price<br>20% off retail price                                                                                   |
| <b>Eyewear Accessories</b>                                                                                                                                                                          | <ul style="list-style-type: none"> <li>Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 20% off retail                                                                                                                 |
| <b>Conventional Contact Lenses (non-disposable type)</b>                                                                                                                                            | <ul style="list-style-type: none"> <li>Discount applies to materials only</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 15% off retail price                                                                                                           |
| <b>Contact lens fit and follow-up</b><br>A contact lens fitting and up to two follow-up visits are available to you once a comprehensive eye exam has been completed.                               | <ul style="list-style-type: none"> <li>Standard contact lens fitting<sup>3</sup></li> <li>Premium contact lens fitting<sup>4</sup></li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Up to \$55<br>10% off retail price                                                                                             |

<sup>1</sup> Please ask your provider for his/her recommendation as well as the available progressive brands by tier.

<sup>2</sup> Please ask your provider for his/her recommendation as well as the available anti-reflective brands by tier.

<sup>3</sup> Standard fitting includes spherical clear lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.

<sup>4</sup> Premium fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

Cannot be combined with any other offer. Discounts are subject to change without notice. Discounts are not covered benefits under your vision plan and will not be listed in your certificate of coverage. Discounts will be offered from in-network providers except where State law prevents discounting of products and services that are not covered benefits under this plan. Discounts on frames will not apply if the manufacturer has imposed a no discount on sales at retail and independent provider locations. Some of our in-network providers include:



LENSCRAFTERS



Online stores:



ray-ban.com/insurance

Savings on items like additional eyewear after your benefits have been used, non-prescription sunglasses, hearing aids and even LASIK laser vision correction surgery are available through a variety of vendors. Just log in at [anthem.com](http://anthem.com), select discounts, then Vision, Hearing & Dental. \* Discounts cannot be used in conjunction with your covered benefits.

#### OUT-OF-NETWORK

If you choose to receive covered services or purchase covered eyewear from an out-of-network provider, network discounts will not apply and you will be responsible for payment of services and/or eyewear materials at the time of service. Please complete an out-of-network claim form and submit it along with your itemized receipt to the fax number, email address, or mailing address below. To download a claim form, log in at [anthem.com](http://anthem.com), or from the home page menu under Support select Forms, click Change State to choose your state, and then scroll down to Claims and select the Blue View Vision Out-of-Network Claim Form. You may instead call member services at 1-866-723-0515 to request a claim form.

**TO FAX:** 866-293-7373  
**TO EMAIL:** [oonclaims@eyewearspecialoffers.com](mailto:oonclaims@eyewearspecialoffers.com)  
**TO MAIL:** Blue View Vision  
 Attn: OON Claims  
 P.O. Box 8504  
 Mason, OH 45040-7111

## Get Help in Your Language

**Curious to know what all this says? We would be too. Here's the English version:**

You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

### Spanish

Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

### Arabic

يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجاناً. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة  
(TTY/TDD: 711)

### Armenian

Դուք իրավունք ունեք ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ ձեր ID քարտի վրա նշված համարով:  
(TTY/TDD: 711)

### Chinese

您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

### Farsi

شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناساییتان درج شده است، تماس بگیرید.(TTY/TDD: 711)

### Hindi

आपके पास यह जानकारी और मदद अपनी भाषा में मुफ्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर कॉल करें।(TTY/TDD: 711)

### Hmong

Koj muaj cai tau txais qhov lus qhia no thiab kev pab hais ua koj hom lus yam tsis xam tus nqi. Hu rau tus nab npawb xov tooj lis Cov Kev Pab Cuam Rau Tswv Cuab nyob rau ntawm koj daim ID txhawm rau thov kev pab. (TTY/TDD: 711)

### Japanese

この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

### Khmer

អ្នកមានសិទ្ធិឮនូវការទទួលព័ត៌មាននេះ និងទទួលជំនួយជាភាសារបស់អ្នកក្នុងរយៈពេលតិចបំផុត។ សូមហៅទូរស័ព្ទទៅលេខសេវាសមាជិកដែលមានលេខប៊ីប៊ីលើ ID របស់អ្នកក្នុងរយៈពេលតិចបំផុត។(TTY/TDD: 711)

### Korean

귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

### Punjabi

ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸੇਵਾ ਸਿੱਖਿੰਗ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ।(TTY/TDD: 711)

**Russian**

Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

**Tagalog**

May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

**Thai**

ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี  
โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ(TTY/TDD: 711)

**Vietnamese**

Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

**It's important we treat you fairly**

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.