Anthem Blue Cross
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GSHIP (University of California Graduates)
BLUE VIEW VISION PLAN DESIGN (using the Insight Network)

VISION CARE SERVICES		IN-NETWORK	OUT-OF-NETWORK
Routine eye exam *(once every 12 months)*		$10 copayment	$49 allowance
Eyeglass frames 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	$50 allowance
Eyeglass lenses *(Standard)* *Factory scratch coating included. Polycarbonate lenses included for children under 19 years old.* Transitions *lenses included for children under 19 years old.* You may receive any one of the following lenses *(once every 12 months)*:			
• Standard plastic single vision lenses *(1 pair)*		$25 copay, then covered in full	$35 allowance
• Standard plastic bifocal lenses *(1 pair)*		$25 copay, then covered in full	$49 allowance
• Standard plastic trifocal lenses *(1 pair)*		$25 copay, then covered in full	$74 allowance
Eyeglass lens upgrades 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.	**Lens Options**	**Member cost for upgrades**	Discounts on lens upgrades are not available out-of-network
	• UV Coating	$15	
	• Tint (Solid and Gradient)	$15	
	• Standard Polycarbonate	$40	
	• Transitions lenses	$75	
	• Other Photochromics	$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 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	$120 allowance then 15% off the remaining balance	$92 allowance
	• Elective Disposable Lenses	$120 allowance *(no additional discount)*	$92 allowance
	• Non-Elective Contact Lenses	Covered in full	$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.			
Contact lenses fitting and follow-up A contact lens fitting and two follow-up visits are available to you once a comprehensive eye exam has been completed.	• Standard contact fitting*	Member cost up to $55	Discounts not available out-of-network
	• Premium contact lens fitting**	10% off retail price	

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.

OUT-OF-NETWORK

If you choose an out-of-network provider, please complete the out-of-network claim form and submit it along with your itemized receipt to the below fax number, email address or mailing address. When visiting an out-of-network provider, you are responsible for payment of services and/or eyewear materials at the time of service.

To Fax: 866-293-7373
To Email: oonclaims@eyewearspecialoffers.com
To Mail: Blue View Vision
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

ADDITIONAL SAVINGS	Member Savings
Additional Pair of Complete Eyeglasses	40% discount off retail*
Contact Lenses – Conventional (Materials only)	15% discount off retail
Eyewear Accessories	20% discount off retail

Includes some non-prescription sunglasses, lens cleaning supplies, contact lens solutions and eyeglass cases, etc.
*Items purchased separately are discounted 20% off the retail price.
Blue View Vision's Additional Savings Program is subject to change without notice.

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 Blue Cross Blue Shield. This information is intended to be a brief outline of some plan benefits. The most detailed description of benefits, exclusions, and restrictions can be found in your Certificate of Coverage.