Anthem Blue Cross and Blue Shield
Blue View Basic Vision Care Member Certificate

Your vision care benefits are provided through a group insurance policy issued by Anthem Blue Cross and Blue Shield to go along with the health benefits provided by your employer’s self-funded health plan. This member booklet fully explains your vision care benefits and how you can maximize them. Treat it as you treat the owner’s manual for your car - store it in a convenient place and refer to it whenever you have questions about your vision care coverage.

Important phone numbers

Member Services
804-358-1551
in Richmond
800-451-1527
from outside Richmond

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente.

(If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling the customer service number.)

Hours of Operation:
Monday- Friday
8:00 a.m. to 6:00 p.m. ET
Saturday
9:00 a.m. to 1:00 p.m. ET

Visit us on-line at:
www.anthem.com

Key words
There are a few key words you will see repeated throughout this booklet. We’ve highlighted them here to make the booklet easier to understand. In addition, we have included a Definitions section on page 17 that lists the various words referenced. A defined word will be italicized each time it is used.

We, us, our, Anthem
Anthem Blue Cross and Blue Shield.

Covered persons
You and enrolled eligible dependents.

You
The enrolled employee.

Your vision care plan
Anthem vision care plan.

Copayment
The fixed dollar amount you pay for some covered services.
Coinsurance
The percentage of the allowable charge you pay for some covered services.
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How your vision care plan works

Your vision care plan provides vision care services within a special network of vision care providers. You will receive benefits based on where you receive vision care services and the limits stated in the Summary of benefits (see page 2) and related exclusions. This section of your vision care booklet details how to access and make the most of your vision care benefits.

Carry your ID card

Your Anthem Blue Cross and Blue Shield ID card identifies you as a member. When you show your ID card to your vision care providers, they will file your claims for you in most cases. Carrying your card at all times will ensure you always have this member information with you when you need it.

Choose a vision care provider

To receive in-network benefits, you should receive care from a licensed optometrist, ophthalmologist, or optician that participates in the Blue View Vision Network. Refer to your participating provider listing to choose a vision care provider with a location that is convenient for you.

Many participating providers offer complete vision care services while others may offer only partial services such as dispensing eyeglasses or contact lenses. Follow the key in your provider listing to see which services each provider offers.

How to find a vision care provider in the network

There are four ways you can find out if a vision care provider participates in the Blue View Vision Network:

- Refer to your vision care plan’s directory of network providers at www.anthem.com, which lists vision care providers that participate in the Blue View Vision Network.
- Call Anthem’s Member Services.
- Check with your vision care provider.
- Ask your group administrator.

Out-of-network care

Out-of-network care is vision care services received from a provider who does not participate in the Blue View Vision Network. Out-of-network care is covered at a lower level of benefits than in-network care. When you seek care from a licensed optometrist, ophthalmologist, or optician, you will receive a set dollar allowance for covered services as stated in the Summary of benefits (see page 2).
What is covered

To help care for your eyes, your vision care plan includes benefits for one routine eye examination per covered person per calendar year. In order to receive the highest level of benefits, you should seek care from a Blue View Vision participating provider.

Summary of benefits

This chart describes your covered services and payment responsibility for care received in-network and out-of-network. For out-of-network care, you will be responsible for the difference between the allowance and the provider’s charge.

A list of services that are not covered begins on page 3.

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one routine eye examination per calendar year
What is not covered (Exclusions)

This list of services and supplies that are excluded from coverage by your vision care plan will not be covered in any case.

Your coverage does not include benefits for the following vision services:
- vision services or supplies unless needed due to eye surgery and accidental injury;
- routine vision care, except as outlined on page 2 of this booklet;
- experimental/investigative vision procedures or materials, as well as services related to or complications from such procedures;
- services for radial keratotomy and other surgical procedures to correct refractive defects such as nearsightedness, farsightedness and/or astigmatism. This type of surgery includes keratoplasty and Lasik procedure;
- services for vision training and orthoptics;
- sunglasses or safety glasses and accompanying frames of any type;
- any non-prescription lenses, eyeglasses or contacts, or Plano lenses or lenses that have no refractive power;
- any lost or broken lenses or frames;
- any blended lenses (no line), oversize lenses, polycarbonate lenses (for dependents over the age of 19 and adults), progressive multifocal lenses, photochromatic lenses, Transitions lenses (for dependents over the age of 19 and adults), tinted lenses, coated lenses, anti-reflective coating, cosmetic lenses or processes, or UV-protected lenses;
- any frame in which the manufacturer has imposed a no discount policy;
- services needed for employment or given by a medical department, clinic, or similar service provided or maintained by the employer or any government entity; or
- any other vision services not specifically listed as covered.

Your coverage also does not include benefits for services or supplies if they are:
- not listed as covered under your health plan;
- received before the effective date or after a covered person's coverage ends;
- given by a member of the covered person's immediate family;
- provided under federal, state, or local laws and regulations. This includes Medicare and other services available through the Social Security Act of 1965, as amended, except as provided by the Age Discrimination Act. This exclusion applies whether or not you waive your rights under these laws and regulations. It does not apply to laws that make the government program the secondary payor after benefits under this policy have been paid. Anthem will pay for covered services when these program benefits have been exhausted;
- provided under a U. S. government program or a program for which the federal or state government pays all or part of the cost. This exclusion does not apply to health benefits plans for civilian employees or retired civilian employees of the federal or state government;
- received from an employer mutual association, trust, or a labor union's medical department; or
4 - What is not covered

- for diseases contracted or injuries caused because of war, declared or undeclared, voluntary participation in civil disobedience, or other such activities.
Claims and payments

We consider the charge to be incurred on the date a service is provided. This is important because you must be actively enrolled on the date the service is provided. Also, the dates of service will affect your payment allowances and other minimums described in the Summary of benefits and in this section.

How Anthem pays a claim

Blue View Vision participating providers

If you go to a provider that participates with Blue View Vision, we will pay the provider directly.

Non- partcipating providers

If you go to a non-participating provider, we may choose to pay you. We will pay only after we have received an itemized bill and all the information we need to process the claim.

In the event that payment is made directly to you, you have the responsibility to apply this payment to the claim from the non-participating provider. In all cases, our payment relieves Anthem of any further liability for the service.

When you must file a claim

Network providers file claims on your behalf. You may have to file a claim if you receive care from a provider that does not participate in the Blue View Vision Network. To file a claim, follow these 3 steps:

1. Call 804-358-1551 in Richmond or 800-451-1527 to order a claim form or visit our web site at www.anthem.com for a copy of the claim form.

2. Please include the completed and signed claim form and any itemized bills for covered services. Each itemized bill must contain the following:
   - name and address of the person or organization providing services or supplies;
   - name of the patient receiving services or supplies;
   - date services or supplies were provided;
   - the charge for each type of service or supply; and
   - a description of the services or supplies received.

3. Send the completed claim form and any itemized bills for covered services to:
   Blue View Vision, Attn: OON Claims
   P. O. Box 8504
   Mason, OH 45040-7111
Timely filing of claims

Written notice of a claim is to be made within 20 days after the occurrence or commencement of any loss covered by the vision care plan. However, failure to give this notice shall not invalidate or reduce any claim if the notice is given as soon as reasonably possible. Claim forms will be furnished to you if needed within 15 days after this written notice.

Written proof of loss must be furnished within 90 days after the date of service. A proof of loss is not complete unless it is properly filed and contains all information that Anthem needs to process the claim. Failure to furnish the proof of loss within this time frame will not invalidate or reduce any claim if the proof of loss is given as soon as reasonably possible. However, no claim will be paid if we receive the proof of loss more than 15 months after the date of service, except in the absence of legal capacity of the covered person. All benefits payable for a claim will be payable within 60 days after receipt of the proof of loss.

When your claim is processed

In processing your claim, your vision care plan may use protocols, guidelines or criteria to ensure that coverage determinations are consistently applied. Claims filed as outlined in the “When you must file a claim” paragraph of this section will be processed within 30 days of receipt of the claim. We may extend this period for another 15 days if we determine it to be necessary because of matters beyond our control. In the event that this extension is necessary, you will be notified prior to the expiration of the initial 30-day period.

Your vision care plan may deny a claim for benefits if information needed to fully consider the claim is not provided. The denial will describe the additional information needed to process the claim. The claim may be reopened by you or your provider furnishing the additional information. You or your provider must submit the additional information to us within either 15 months of the date of service or 45 days from the date you were notified that the information is needed, whichever is later. Once your claim has been processed by your vision care plan, you will receive written notification of the coverage decision. In the event of an adverse benefit determination, the written notification will include the following:

- the specific reason(s) and the plan provision(s) on which the determination is based;
- a description of any additional material or information necessary to reopen the claim for consideration, along with an explanation of why the requested material or information is needed; and
- a description of your vision care plan’s appeal procedures and applicable time limits.

If all or part of a claim was not covered, you have a right to see, upon request and at no charge, any rule, guideline, protocol or criterion that your vision care plan relied upon in making the coverage decision.
Recovery of overpayment

*Anthem* shall have the right to recover any overpayment of benefits from persons or organizations that we have determined to have realized benefits from the overpayment:

- any person to, or for whom such payments were made;
- any insurance company;
- a facility or provider; or
- any other organization.

*You* will be required to cooperate with us to secure *Anthem’s* right to recover the excess payments made on your behalf, or on behalf of *covered persons* enrolled under your family coverage.
Changing your coverage

Who is eligible for coverage

You are eligible for vision care coverage if you are a participant in your employer's group health plan. Your eligible dependents covered under the group health plan are also eligible for vision care coverage. For more specific information on eligibility, please refer to your group health plan's member booklet.

Ending coverage

When a covered person ceases to be eligible or the required premiums are not paid, the covered person's coverage will end. Unless otherwise agreed to in writing by Anthem, the covered person's coverage ends on the last day of the month for which payment is made. The covered person's coverage ends on the last day of the month during which eligibility ceases.
Important information about your vision care plan

Statement of ERISA rights

As a participant in this plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

You may examine, without charge, at your plan administrator’s office and at other specified locations, all plan documents. These include insurance contracts, copies of all documents filed by the plan with the Department of Labor (such as detailed annual reports), and plan descriptions.

You may obtain copies of all plan documents and other plan information by writing to your plan administrator. The administrator may make a reasonable charge for the copies.

 Helpful tip: ERISA generally does not apply to church plans or to governmental plans (such as plans sponsored by city, county, or state governments, or by public school systems).

Plan "fiduciaries"

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants.

- No one may terminate your employment or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.
- If your claim for a welfare benefit is denied in whole or in part, you may receive a written explanation of the reason for the denial.
- You have the right to have the plan administrator review and reconsider your claim.

Enforcement of ERISA rights

Under ERISA, there are steps to enforce the above rights. For instance:

- If you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials (unless the materials were not sent because of reasons beyond the control of the Administrator).
- If you have a claim for benefits or an appeal of a coverage decision, which is denied or ignored, in whole or in part, you may file suit in a state or federal court.
- If plan fiduciaries misuse the plan’s money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court decides who pays court costs and legal fees.
If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, if, for example, it finds your claim to be frivolous.

**Assistance**

If you have questions about your plan, contact your Plan Administrator. If you have questions about this statement about your rights under ERISA, contact the nearest Area Office of the Employee Benefits Security Administration, Department of Labor, listed in your telephone directory. You may also contact the Division of Technical Assistance and Inquires, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

**Employer premiums**

Your employer is responsible for paying a monthly premium by the first day of the month for which coverage is purchased. We will allow employers a 31 day grace period to pay monthly premiums, except for the first month’s premium. During this grace period, coverage will continue unless we receive a written notice of termination from your employer. We will notify your employer at least 15 days prior to terminating the group policy for non-payment of a monthly premium. Anthem is not responsible for costs you incur during any period (other than the grace period discussed above) when your employer fails to pay full premiums.

**Changes in the vision care plan**

We may amend this vision care plan by giving your employer at least 30 days written notice. Any amendment to the vision plan will change covered services to covered persons on the effective date of the change. Your employer and Anthem may mutually agree to amend or reduce benefits at any time.

**Complaint and appeal process**

In order for your vision care plan to remain responsive to your needs, we’ve established both a complaint process and an appeal process. Should you have a problem or question about your vision care plan, a Member Services representative will assist you. Most problems and questions can be handled in this manner. You may also file a written complaint or appeal with us. Complaints typically involve issues such as dissatisfaction about your vision care plan’s services, quality of care, the choice of and accessibility to your vision care plan’s providers and network adequacy. Appeals typically involve a request to reverse a previous decision made by your vision care plan. Requests regarding claim errors, claim corrections, and claims denied for additional information may be reopened for consideration without having to invoke the appeal process.
Complaint Process

Upon receipt, your complaint will be reviewed and investigated. You will receive a response within 30 calendar days of your vision care plan’s receipt of your complaint. If we are unable to resolve your complaint in 30 calendar days, you will be notified on or before calendar day 30 that more time is required to resolve your complaint. We will then respond to you within an additional 30 calendar days.

Important: Written complaints or any questions concerning your vision care plan may be filed to the following address:

Anthem Blue Cross and Blue Shield
Attention: Member Services
P.O. Box 27401
Richmond, VA 23279

Appeal Process

Your vision care plan is committed to providing a full and fair process for resolving disputes and responding to requests to reconsider coverage decisions you find unacceptable. Types of appeals include:

- internal appeals are requests to reconsider coverage decisions of pre-service or post-service claims. Expedited appeals are made available when the application of the time period for making pre-service or post-service appeal decisions could seriously jeopardize the patient's life, health or ability to regain maximum function, or in the opinion of the patient’s physician, would subject the patient to severe pain that cannot be adequately managed without the care or treatment. Situations in which expedited appeals are available include those involving prescriptions to alleviate cancer pain, when the cancer patient would be subjected to pain; and
- external appeals are requests for an independent, external review of the final coverage decision made by your vision care plan through its internal appeal process. More information about this type of appeal may be found in the “Independent external review of adverse utilization review decisions” paragraph of this section.

How to appeal a coverage decision

To appeal a coverage decision, please send a written explanation of why you feel the coverage decision was incorrect. Alternatively, this information may be provided to a Member Services representative over the phone. This is your opportunity to provide any comments, documents, or information that you feel your vision care plan should consider when reviewing your appeal. Please include with the explanation:

- the patient’s name, address and telephone number;
- your identification and group number (as shown on your identification card); and
Important information about your vision care plan

- the name of the vision care professional or facility that provided the service, including the date and description of the service provided and the charge.

**Important:** You may contact Member Services with your appeal or any questions concerning your vision care plan at the following:

**Address:**
Anthem Blue Cross and Blue Shield
Attention: Corporate Appeals Department
P.O. Box 27401
Richmond, VA 23279

**Telephone:**
804-358-1551
in Richmond
800-451-1527
from outside Richmond

You must file your appeal within either 15 months of the date of service or 180 days of the date you were notified of the adverse benefit determination, whichever is later.

**How your vision care plan will handle your appeal**

In reviewing your appeal, we will take into account all the information you submit, regardless of whether the information was considered at the time the initial coverage decision was made. A new review will be completed, and will not assume the correctness of the original determination. The individual reviewing your appeal will not have participated in the original coverage decision, and will not be a subordinate of the individual who made the original determination. Appeals involving medical necessity will be reviewed by a practitioner who holds a non-restricted license in the Commonwealth of Virginia or under comparable licensing law in the same or similar specialty as typically manages the medical condition, procedure or treatment under review. Any other decision that involves the review of medical information will be made by appropriate clinical staff.

We will promptly acknowledge receipt of your appeal, and will resolve and respond to it as follows:

- For pre-service claims, we will respond in writing within 30 days after receipt of the request to appeal;
- For post-service claims, we will respond in writing within 60 days after receipt of the request to appeal; or
- For expedited appeals, we will respond orally within 1 working day after receipt, from the member or treating provider, of the request to appeal, and will then provide written confirmation of our decision to the member and treating provider within 24 hours thereafter. In no event will the notification be provided later than 72 hours after receipt of the request to appeal.
In the event that the original coverage decision is upheld, the written notification will include the specific reasons and the plan provision(s) on which the determination is based. You will also be entitled to receive, upon request and at no charge, the following:

- reasonable access to, and copies of, all documents, records, and other information relevant to the appeal;
- any rule, guideline, protocol or criterion relied upon in the coverage decision(s);
- the explanation of the scientific or clinical judgement as it relates to the patient’s medical condition if the coverage decision was based on the medical necessity or experimental nature of the care; and
- the identification of medical or vocational experts whose advice was obtained by the plan in connection with the claimant’s adverse decision, whether or not the advice was relied upon.

**Virginia Bureau of Insurance**

If you have been unable to contact or obtain satisfaction from *Anthem*, you may contact the Virginia Bureau of Insurance, 1300 East Main Street, P. O. Box 1157, Richmond, VA 23218, in Richmond (804) 371-9741, from outside Richmond (800) 552-7945.

**The Office of the Managed Care Ombudsman**

If you have any questions regarding an appeal or grievance concerning the vision care services that you have been provided which have not been satisfactorily addressed by *your vision care plan*, you may contact the Office of the Managed Care Ombudsman for assistance at any of the following:

**Address:**  
The Office of the Managed Care Ombudsman  
Bureau of Insurance  
P.O.Box 1157  
Richmond, VA 23218

**Telephone:**  
804- 371-9032  
in Richmond  
877- 310-6560  
from outside Richmond

(Note: This number is separate from the Bureau’s existing toll-free number and is exclusive to The Office of the Managed Care Ombudsman)

**E- Mail:**  
ombudsman@scc.virginia.gov
Web Page:
Information regarding The Office of the Managed Care Ombudsman may be found by accessing the State Corporation Commission's web page at:
http://www.scc.virginia.gov

The Virginia Department of Health Office of Licensure and Certification

If you have any questions regarding a complaint and/or an appeal concerning the vision care services that you have been provided which have not been satisfactorily addressed by us, you may contact the Virginia Department of Health Office of Licensure and Certification for assistance at any of the following:

Address:
Office of Licensure and Certification
Virginia Department of Health
9960 Mayland Drive, Suite 401
Richmond, VA 23233

Telephone:
Complaint Hotline: 800-955-1819
Richmond Metropolitan Area: 804-367-2106

Fax:
804-367-2149

E-Mail:
MCHIP@vdh.virginia.gov

Laws governing this vision care plan

This vision care plan is entered into in, and is subject to the laws of, the Commonwealth of Virginia.

This coverage is a Managed Care Health Insurance Program subject to regulation in the Commonwealth of Virginia by both the Virginia State Corporation Commission's Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1.

Notice in writing

If we change the vision care plan, we will send you written notice. Any notice required under this vision care plan must be in writing. Notice given to your employer will be sent to your employer's address, stated in the group application as provided by the group. Notice given to a covered person will be sent, at our option, to your employer or to your address as it appears on our records. Your employer or a covered person may indicate a new address for giving notice.
Cancellation or termination

We can terminate this vision care plan by giving your employer at least 30 days advance written notice. Your employer may cancel this vision care plan on the last day of any month by giving us at least 30 days written notice.

We can also terminate this vision care plan when your employer:

- does not pay the appropriate premium when due;
- fails to perform any duties required by the vision care plan;
- commits fraud or misrepresentation with respect to the vision care plan. Additionally, a covered person’s coverage under the vision care plan may be terminated for fraud or misrepresentation by the covered person with regard to his or her coverage;
- fails to comply with our underwriting guidelines regarding employer contribution and participation requirements; or
- has no more employees living, residing, or working in our service area.

If we have issued this policy to an association offering coverage to its membership, we may terminate coverage for any subgroup in the association for any of the above occurrences attributable to that subgroup.

Termination of the vision care plan automatically ends your coverage. When the vision care plan is terminated because of an action by your employer, your employer must notify all covered persons of the termination of the coverage. However, coverage will end whether or not the notice is given.

Validity of coverage

Your coverage will not be contested after it has been in effect two years, unless premiums have not been paid. Any statement you make that we may use to contest the validity of your coverage must be written and signed by you.

Time limits on legal action

No legal action may be brought against Anthem within the 60-day period after proof of loss notice is filed or more than three years after the end of the 90-day period that proof of loss was required to be filed (see page 6). This limit applies to matters relating to this vision care plan, to our performance under this vision care plan, or to any statement made by an employee, officer, or director of Anthem concerning this vision care plan or the benefits available to a covered person.

Limitations of damages

In the event a covered person or his representative sues Anthem, or any of its directors, officers, or employees acting in his or her capacity as director, officer, or employee, for a determination of what coverage and/or benefits, if any, exist under this vision care plan, the damages shall be limited to the
amount of the covered person’s claim for benefits. The damages shall not exceed the amount of any claim not properly paid as of the time the lawsuit is filed. Under no circumstances shall this provision be construed to limit or preclude any extra contractual damages that may be available to you or your representative.

**Anthem’s continuing rights**

On occasion, we may not insist on your strict performance of all terms of this vision care plan. This does not mean we waive or give up any future rights we have under this vision care plan.

**Anthem’s relationship to providers**

The choice of a vision care provider is solely the covered person’s. Providers are neither Anthem employees nor agents. We can contract with any appropriate provider to provide services to you. Our inclusion or exclusion of a provider in any network is not an indication of the provider’s quality or skill. We make no guarantees about the health of any providers. We do not furnish covered services but only make payment for them when received by covered persons.

We are not liable for any act or omission of any provider, nor are we responsible for a provider’s failure or refusal to render covered services to a covered person.

**Assignment of payment**

A covered person may not assign the right to receive payment for covered services. Prior payments to anyone, whether or not there has been an assignment of payment, shall not waive or otherwise restrict, Anthem’s right to direct future payments to a covered person or any other entity.

Once covered services are rendered by a provider, Anthem will not honor requests not to pay the claims submitted by the provider. Anthem will have no liability to any person because it rejects the request.
Definitions

Adverse benefit determination
is any denial, reduction of a benefit or failure to provide a benefit, in whole or in part, by the health plan.

Blue View Vision Network
is a network of eye care providers including optometrists, ophthalmologists, and opticians. To receive the highest level of benefits, you should seek care from a provider that participates in the Blue View Vision Network.

Coinsurance
is the percentage of the allowable charge you pay for some covered services.

Copayment
is the fixed dollar amount you pay for some covered services.

Covered persons
are you and enrolled eligible dependents.

Effective date
is the date coverage begins for you and/or your dependents enrolled under the vision care plan.

Group administrator
is the benefits administrator at your employer.

In-network
is care rendered by a Blue View Vision participating provider. In-network benefits are the highest level of benefits available under your vision care plan.

Out-of-network
is care that is not rendered by a Blue View Vision participating provider. Out-of-network care is covered at a lower level of benefits.

Plan administrator
is your group administrator.

Post-service claims
are all claims other than pre-service claims. Post-service claims include claims filed after services are rendered and claims that do not require authorization in advance of the service, even where you request authorization in advance.
Pre-service claims
are claims for a service where the terms of the health plan require the member to obtain approval of the benefit, in whole or in part, in advance of receipt of the service. If you call to receive authorization for a service when authorization in advance is not required, that claim will be considered a post-service claim.

Providers
are licensed eye care professionals including ophthalmologists, optometrists, and opticians.

We, us, our, Anthem
is Anthem Blue Cross and Blue Shield.

You
the enrolled employee.

Your vision care plan
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End of Certificate
Vision discount program

To help you care for your eyes, valuable vision discounts are available to you in addition to the routine vision benefits defined in the What is covered section of this booklet. In order to take advantage of the available discounts, you should seek care from a Blue View Vision participating provider.

Your Eyewear Discounts

When you visit a Blue View Vision participating eye care professional or vision center, you’ll pay the discount price for as many pairs of eyeglasses and/or supplies of conventional (non-disposable) contact lenses as you would like. Discounts are subject to change without notice.

Your eyewear discounts/costs at participating Blue View Vision provider offices are as follows:

<table>
<thead>
<tr>
<th>Service</th>
<th>Member Cost*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frame</td>
<td>35% off retail price</td>
</tr>
<tr>
<td><strong>Standard Plastic Lenses</strong></td>
<td></td>
</tr>
<tr>
<td>Single Vision</td>
<td>$50</td>
</tr>
<tr>
<td>Bifocal</td>
<td>$70</td>
</tr>
<tr>
<td>Trifocal</td>
<td>$105</td>
</tr>
<tr>
<td><strong>Lens Options</strong></td>
<td></td>
</tr>
<tr>
<td>UV Coating</td>
<td>$15</td>
</tr>
<tr>
<td>Tint (Solid and Gradient)</td>
<td>$15</td>
</tr>
<tr>
<td>Standard Scratch-Resistance</td>
<td>$15</td>
</tr>
<tr>
<td>Standard Polycarbonate</td>
<td>$40</td>
</tr>
<tr>
<td>Standard Progressive (Add-on to bifocal)</td>
<td>$65</td>
</tr>
<tr>
<td>Standard Anti-Reflective Coating</td>
<td>$45</td>
</tr>
<tr>
<td>Other Add-ons and Services</td>
<td>20% off retail price</td>
</tr>
<tr>
<td><strong>Contact Lenses</strong></td>
<td></td>
</tr>
<tr>
<td>Conventional (non-disposable) - materials only</td>
<td>15% off retail</td>
</tr>
</tbody>
</table>

*Discounts apply towards a complete pair of eyeglasses. If eyeglass materials are purchased separately, a 20% discount is applied.

Plus, Anthem members have access to discounts on laser vision correction surgery and other vision discounts through SpecialOffers@Anthem.