WELCOME TO BLUE VIEW VISION!

Good news—your vision plan is flexible and easy to use. This benefit summary outlines the basic components of your plan, including quick answers about what's covered, your discounts, and much more!

Empire BlueCross

Blue View Vision℠ BV D 10.0 130/130

Your Blue View Vision network

Blue View Vision offers you one of the largest vision care networks in the industry, with a wide selection of experienced ophthalmologists, optometrists, and opticians. Blue View Vision's network also includes convenient retail locations, many with evening and weekend hours, including LensCrafters®, TargetOptical®, JCPenney® Optical, Sears Optical℠, Pearle Vision®, and New York based Empire Vision and Davis Vision Centers.

Best of all – when you choose to receive care from a Blue View Vision participating provider, you receive full in-network benefits and money-saving discounts.

YOUR BLUE VIEW VISION PLAN AT-A-GLANCE:

VISION CARE SERVICES		IN-NETWORK	OUT-OF-NETWORK REIMBURSEMENT
Routine eye exam *(once every 24 months)*		$10 copayment	$40 allowance
Eyeglass frames You may select an eyeglass frame and receive the following allowance toward the purchase price *(once every 24 months)*:		$130 allowance then 20% off remaining balance	$45 allowance
Eyeglass lenses *(Standard)* ***Polycarbonate lens upgrade included for children under 19 years old.*** You may receive any one of the following lenses *(once every 24 months)*:			
• Standard plastic single vision lenses *(1 pair)*		$0 copay, then covered in full	$25 allowance
• Standard plastic bifocal lenses *(1 pair)*		$0 copay, then covered in full	$40 allowance
• Standard plastic trifocal lenses *(1 pair)*		$0 copay, then covered in full	$55 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 Scratch-Resistance	• $15	
	• Transitions lenses	• $75	
	• Other Photochromics	• $75	
	• Standard Polycarbonate	• $40	
	• Standard Progressive	• $65	
	• Standard Anti-Reflective Coating	• $45	
	• 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 eyeglasses and receive an allowance toward the cost of a supply of contact lenses. *(once every 24 months)*	• Elective Conventional Lenses	$130 allowance then 15% off the remaining balance	$105 allowance
	• Elective Disposable Lenses	$130 allowance *(no additional discount)*	$105 allowance
	• Non-Elective Contact Lenses	Covered in full	$210 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 lens fitting and follow-up Contact lens fitting and follow-up visits are available to you once a comprehensive eye exam has been completed.		Fitting and two follow up visits up to $55	Discounts not available out-of-network
• Standard contact lens fitting*			
• Premium contact lens fitting**		10% off retail price	

*A standard contact lens fitting includes spherical clear contact lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.

**A premium contact lens fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

USING YOUR BLUE VIEW VISION PLAN

The Blue View Vision network is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care physician from your medical network.

Out-of-network services

Did we mention that we're flexible? We offer you the option to receive care outside of the Blue View Vision network. If you choose an out-of-network provider, you will receive an allowance toward services and you pay the rest. Network benefits and discounts will not apply. When you receive eye care or eyewear from a non-participating provider, you will pay in full at the time of service then file a claim for reimbursement to Blue View Vision, Attn: OON Claims, PO BOX 8504, Mason, OH 45040-7111.

For questions about vision benefits, members may contact Blue View customer service at **866-723-0515**.

DISCOUNTS

Savings on additional eyewear and accessories

After you use your initial frame or contact lens allowance, you can take advantage of discounts on additional prescription eyeglasses, contact lenses, and eyewear accessories courtesy of Blue View Vision network providers.

BLUE VIEW VISION ADDITIONAL SAVINGS

	MEMBER SAVINGS
Additional Pair of Complete Eyeglasses	40% discount off retail*
Contact Lenses - Conventional *(Discount applied to materials only)*	15% off retail price
Eyewear Accessories Includes some non-prescription sunglasses, lens cleaning supplies, contact lens solutions and eyeglass cases, etc.	20% off retail price

*Items purchased separately are discounted 20% off the retail price. Blue View Vision's Additional Savings Program is subject to change without notice.

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. Services or supplies combined with any other offer, coupon or in-store advertisement.

Experimental or Investigative. Any services that are experimental or investigative or related to such, whether incurred prior to, in connection with, or subsequent to the experimental or investigative services or supply, as determined by us, or that are received from a vision or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.

Crime or War. Conditions that result from: (1) For a condition resulting from participation in a felony, riot or insurrection; or (2) for illness or injury that occurs as a result of any act of war, declared or undeclared, or any act of war.

Uninsured. Services received before insured person's effective date or after coverage ends.

Excess Amounts. We will not pay an amount that is more than a Vision Care Provider charged for Covered Vision Services nor that is more than the customary charges, nor will we credit such an amount toward the Copayment.

Routine Exams or Tests. Routine examinations required by an employer in connection with insured person's employment.

Work-Related. For any condition, disease, defect, ailment, or injury arising out of or in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. This exclusion applies if you received the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

Government Treatment. To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

Sunglasses. Sunglasses and accompanying frames.

Safety Glasses. Safety glasses and accompanying frames.

Hospital Care. No benefits are provided for services received in a government or a public benefit corporation Hospital unless we have a participation agreement or special agreement with that Hospital (and then only for the specific services to which the special agreement applies).

Orthoptics. Treatment of eye disease or injury, additional diagnostic testing and special procedures such as orthoptics training are not covered under this Certificate.

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

Bifocals. Two pair of glasses in lieu of bifocals.

Lost or Broken Lenses or Frames. Replacement of lost, stolen, broken or duplicate frames or lenses.

Voluntary Payment. We will not cover any service if it is usually provided without charge.

Missed appointments. We will not reimburse the cost associated with a missed or canceled appointment.

Services of Relatives. For services or supplies prescribed, ordered, referred by, or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, grandparent or self.

Preexisting. Conditions or diseases.

Armed forces. For services or supplies related to service in the Armed Forces or units auxiliary thereto.

Manufacturer Limitations. Frame Allowance and Discounts are not available on certain frame brands in which the manufacturer imposes a no discount policy and excludes from benefit coverage.