

Types of Providers

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS VISION CARE MAY BE OBTAINED. THE MEANINGS OF WORDS AND PHRASES IN ITALICS ARE DESCRIBED IN THE DEFINITIONS SECTION OF THIS PLAN BOOKLET.

Network Vision Care Providers. Anthem Blue Cross Life and Health has contracted with various Vision Care Providers, including vision clinics on some campuses, to provide a network of "Network Vision Care Providers." These providers are called "network" because they have agreed to participate in our network provider program, which we call Blue View Vision Insight. They have agreed to provide insured persons with vision care at a negotiated fee. The amount of benefits payable under this Plan for Out-of-Network Vision Care Providers will be different from, and may be less than, the amount payable for Network Vision Care Providers.

To find a participating Blue View Vision Insight vision care provider, you may call the Member Services at 866-940-8306 or you may also search for a Network Vision Care Provider using the "Provider Finder" function on our website at myucship.org

Out-of-Network Vision Care Providers. Out-of-Network Vision Care Providers are providers which have not agreed to participate in our network. They have not agreed to the negotiated rates and other provisions. You will be responsible for any amounts they charge which exceed the Vision Care Benefit Maximum.

Summary of Benefits

THE BENEFITS OF THIS PLAN BOOKLET ARE PROVIDED ONLY FOR SERVICES WHICH ARE SPECIFIED IN THIS PLAN BOOKLET AS COVERED SERVICES. THE FACT THAT YOUR VISION CARE PROVIDER PRESCRIBES OR ORDERS THE SERVICE DOES NOT, IN ITSELF, MAKE IT A COVERED SERVICE OR A COVERED VISION EXPENSE.

This summary provides a brief outline of your benefits. Please refer to the entire Plan Booklet for complete information about the benefits, conditions, limitations and exclusions of your Plan.

Benefits	Network	Out-of-Network	Frequency
Routine Eye Exam A comprehensive eye examination	\$10 Copayment	Up to \$49 reimbursement	Once every Benefit Year
Eye Frames One pair of eyeglass frames	\$120 allowance, then 20% off any remaining balance	Up to \$50 reimbursement	Once every Benefit Year
Eyeglass Lenses (instead of contact lenses) One pair of standard plastic prescription lenses:			
• Single Vision lenses	\$25 Copayment	Up to \$35 reimbursement	Once every Benefit Year
• Bifocal lenses	\$25 Copayment	Up to \$49 reimbursement	Once every Benefit Year
• Trifocal lenses	\$25 Copayment	Up to \$74 reimbursement	Once every Benefit Year
Eyeglass Lens Enhancements When obtaining covered eyewear from a Blue View Vision Insight provider, you may add any of the following lens enhancements at no extra cost:			
• Transition lenses (for a child under age 19)	No Copayment	Not Covered	Once every Benefit Year
• Standard polycarbonate (for a child under age 19)	No Copayment	Not Covered	Once every Benefit Year
• Factory scratch coating	No Copayment	Not Covered	Once every Benefit Year

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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) Or	\$120 allowance, then 15% off any remaining balance	Up to \$92 reimbursement	Once every Benefit Year
• Elective disposable Or	\$120 allowance (no additional discount)	Up to \$92 reimbursement	Once every Benefit Year
• Non-elective (medically necessary)	No Copayment or Coinsurance	Up to \$250 reimbursement	Once every Benefit Year
Contact lens fit and follow-up A contact lens fitting and up to two follow-up visits are available to you once a comprehensive eye exam has been completed.			
• Standard contact lens fitting ¹ • Premium contact lens fitting ²	\$0 copay 10% off retail price, then apply \$40 allowance	Up to \$35 allowance Up to \$35 allowance	Once every Benefit Year

¹ Standard fitting includes spherical clear lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.

² 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.

Note: In addition to the Copayment shown above, you will be required to pay any amount in excess of the vision care benefit maximums for vision care services. But, when you go to a Network Vision Care Provider, your cost for vision care services and supplies in excess of the benefit maximum will be at discount prices.

Out-of-Network Vision Care Provider Copayments. There will be no Copayment required for services and supplies provided by an Out-of-Network Vision Care Provider, but, you will be responsible for any billed charge which exceeds the Vision Care Benefit Maximum.

General Information

Anthem Blue Cross Life and Health's Address:

Anthem Blue Cross Life and Health Insurance Company
Group Services
P.O. Box 70000
Van Nuys, California 91470