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!

Blue View Vision℠

BlueCross BlueShield of Georgia

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℠, Target Optical, JCPenney Optical, Sears Optical and most Pearle Vision locations. Best of all – when you receive care from a Blue View Vision participating provider, you receive some of the greatest benefits and money-saving discounts. To locate a provider or for questions on your benefits, please contact customer service at 866-723-0515.

Out-of-network services

Did we mention we're flexible? You can choose to receive care outside of the Blue View Vision network. You simply get an allowance toward the eye exam and you pay the rest. (Network benefits and discounts will not apply.) Just pay in full at the time of service and then file a claim for reimbursement.

YOUR BLUE VIEW VISION PLAN AT-A-GLANCE

VISION CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK
Annual routine eye exam *(once every 12 months)*	$10 copayment	Up to 70% of $50

DISCOUNTS

When you visit a participating Blue View Vision 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. Take advantage of these savings –it means more money in your pocket!

ADDITIONAL SAVINGS PROGRAM DISCOUNTS	MEMBER SAVINGS
Eye Glass Frame*	35% discount off retail*
Contact Lenses** Conventional (non-disposable)	15% off retail price
Standard Plastic Lenses*	
Single Vision	You Pay: $50
Bifocal	You Pay: $70
Trifocal	You Pay: $105
Eyeglass Lens Options/Upgrades* – For those who like to add an extra touch to their eyewear!	
UV Coating	You Pay: $15
Tint (Solid and Gradient)	You Pay: $15
Standard Scratch-Resistance	You Pay: $15
Standard Polycarbonate	You Pay: $40
Standard Progressive (Add-on to bifocal)	You Pay: $65
Standard Anti-Reflective Coating	You Pay: $45
Other Add-ons and Services Includes some non-prescription sunglasses, lens cleaning supplies, contact lens solutions and eyeglass cases, etc.	20% off retail price

Discounts are subject to change without notice.

** If frames, lenses or lens options are purchased separately, members get a 20% discount instead.*
***Discount does not apply to fitting fees or services.*

And – there's more! You also get access to discounts on other vision services through SpecialOffers. Visit bcbsga.com to learn more about these valuable discounts.

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Laser vision correction surgery
Glasses or contacts may not be the answer for every person. That's why we offer further savings with discounts on refractive surgery. Pay a discounted amount per eye for LASIK Vision correction. For more information go to SpecialOffers at bcbsga.com and select Vision Care.

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. Your out-of-pocket expenses related to the vision benefits do not count toward your annual out-of-pocket limit and are never waived, even if your annual out-of-pocket limit is reached.

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

BLUE VIEW VISION LIMITATIONS & EXCLUSIONS

This is a primary vision care benefit and is intended to cover only eye examinations. Materials and other items not covered may be purchased with our Additional Savings Program from a Blue View Vision Network Provider. In addition, benefits are payable only for expenses incurred while the Group and individual Member coverage are in force.

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 for treatment of illness or injury arising from such release of nuclear energy.

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

Excess Amounts. Any amounts in excess of covered vision expense.

Vision Exams or Tests. Any routine examinations required by an employer in connection with your 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 at no additional costs.

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.

Hospital Care. Inpatient or outpatient hospital vision care.

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

Eyewear. Prescription lenses, frames or contact lenses.

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

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.

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The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.