

**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 VisionSM

Exam Only Plan for The Claremont Colleges

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®, Sears OpticalSM, Target Optical®, JCPenney® Optical and most Pearle Vision® locations. Best of all – when you receive care from a Blue View Vision participating provider, you can maximize your benefits and money-saving discounts. Members may call Blue View Vision toll-free at (866) 723-0515 with questions about vision benefits or provider locations.

YOUR BLUE VIEW VISION PLAN AT-A-GLANCE

VISION CARE SERVICES

Routine eye exam – once every 12 months

IN-NETWORK

\$10 copay

OUT-OF-NETWORK

\$79 allowance

USING YOUR BLUE VIEW VISION PLAN

Just make an appointment for a comprehensive eye exam with your choice of any of the Blue View Vision participating eye care doctors. Your Blue View Vision plan provides services for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care physician from your medical network.

ADDITIONAL SAVINGS ON EYEWEAR AND MORE

As a Blue View Vision member, you can take advantage of valuable discounts through our Additional Savings program. See page 2 for further details.

OUT-OF-NETWORK

If you choose an out-of-network provider, please complete an out-of-network claim form and submit it along with your itemized receipt to the fax number, email address, or mailing address below. When visiting an out-of-network provider, discounts do not apply and you are responsible for payment 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

anthem.com

This is a primary vision care benefit intended to cover only routine eye examinations. Benefits are payable only for expenses incurred while the group and insured person’s coverage is in force.

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. This benefit overview is only one piece of your entire enrollment package.

OPTIONAL SAVINGS AVAILABLE FROM IN-NETWORK PROVIDERS ONLY		In-network Member Cost
Retinal Imaging	<ul style="list-style-type: none"> At member's option can be performed at time of eye exam 	Not more than \$39
Eyeglass Frame	<ul style="list-style-type: none"> When purchased as part of a complete pair of eyeglasses* 	35% off retail price
Eyeglass Lenses Standard plastic material	<ul style="list-style-type: none"> When purchased as part of a complete pair of eyeglasses*: <ul style="list-style-type: none"> Single Vision \$50 Bifocal \$70 Trifocal \$105 	
Eyeglass Lens Options and Upgrades When purchasing a complete pair of eyeglasses (frame and lenses), you may choose to upgrade your new eyeglass lenses at a discounted cost. Member costs shown are in addition to the member cost of the standard plastic eyeglass lenses.	<ul style="list-style-type: none"> Standard Scratch-Resistant Coating \$15 Tint (Solid and Gradient) \$15 Ultraviolet (UV) Coating \$15 Standard Polycarbonate Lenses \$40 Standard Progressive Lenses (add on to bifocal) \$65 Standard Anti-Reflective Coating \$45 	
Accessories and Materials Purchased Separately Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc., and eyeglass materials if purchased separately	<ul style="list-style-type: none"> As many as you like; as often as you like 	20% off retail price
Conventional Contact Lenses (non-disposable type)	<ul style="list-style-type: none"> Discount applies to materials only 	15% off retail price
SOME OF THE ADDITIONAL SAVINGS AVAILABLE THROUGH OUR SPECIAL OFFERS PROGRAM		
	<ul style="list-style-type: none"> For this and other great offers, login to member services, select discounts, then Vision, Hearing & Dental 	Save \$20 on orders of \$100 or more and get free shipping
LASIK laser vision correction surgery	<ul style="list-style-type: none"> For this offer and more like it, login to member services, select discounts, then Vision, Hearing & Dental 	Discount per eye

* If frames, lenses or lens options are purchased separately, members will receive a 20% discount instead.

Cannot be combined with any other offer. Discounts on frames do not apply in the event the manufacturer has imposed a no discount policy on the frame. Discount on frames and special member pricing apply when complete pairs of eyeglasses are purchased together. If purchased separately, members receive a 20% discount off the retail price.

Discounts referenced are not covered benefits under the vision plan and therefore are not included in the member's policy. Discounts are subject to change without notice.

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Blue View VisionSM BVMO Custom Plan The Claremont Colleges

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 1-800-CONTACTS, LensCrafters®, Target® Optical, JCPenney Optical, Sears Optical and Pearle Vision® locations. Best of all – when you receive care from a Blue View Vision participating provider, you can maximize your benefits and money-saving discounts. Members may call Blue View Vision toll-free at (866) 723-0515 with questions about vision benefits or provider locations.

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 services and you pay the rest. (In-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

Eyeglass frames

Once every 12 months you may select any eyeglass frame and receive the following allowance toward the purchase price:

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.

Once every 12 months you may receive any one of the following lens options:

- Standard plastic single vision lenses (1 pair)
- Standard plastic bifocal lenses (1 pair)
- Standard plastic trifocal lenses (1 pair)
- Standard plastic lenticular lenses (1 pair)

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 copayment applies.

Lens Options

- UV Coating
- Tint (Solid and Gradient)
- Standard Polycarbonate
- Transitions® lenses
- Other Photochromics
- Progressive Lenses¹
 - Standard
 - Premium Tier 1
 - Premium Tier 2
 - Premium Tier 3
- Standard Anti-Reflective Coating²
- Premium Tier 1 Anti-Reflective Coating²
- Premium Tier 2 Anti-Reflective Coating²
- Other Add-ons and Services

¹ Please ask your provider for his/her recommendation as well as the progressive brands by tier.

² Please ask your provider for his/her recommendation as well as the coating brands by tier.

Contact lenses – Once every 12 months

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. *Your contact lens allowance must be used at the time of initial service.*

- Elective Conventional Lenses
- Elective Disposable Lenses
- Non-Elective Contact Lenses
No amount over the allowance may be carried forward to subsequent materials in the same or the following calendar year.

IN-NETWORK

\$130 allowance then 20% off remaining balance

\$15 copay, then covered in full
\$15 copay, then covered in full
\$15 copay, then covered in full
\$15 copay, then covered in full

Member cost for upgrades

- \$15
- \$15
- \$40
- \$75
- \$75
- \$65
- \$85
- \$95
- \$110

\$45
\$57
\$68
20% off retail price

\$130 allowance then 15% off the remaining balance

\$130 allowance
(no additional discount)

Covered in full

OUT-OF-NETWORK

\$100 allowance

\$36 allowance
\$60 allowance
\$79 allowance
\$97 allowance

Discounts on lens upgrades are not available out-of-network

\$115 allowance

\$115 allowance

\$330 allowance

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VISION CARE SERVICES

Contact lens 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*
- Premium contact lens fitting**

*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.

IN-NETWORK Member Cost
 Fitting and follow up visits up to \$55
 10% off retail price

OUT-OF NETWORK
 Discounts not available out-of-network

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, conventional contact lenses, and eyewear accessories courtesy of Blue View Vision network providers.

<p>BLUE VIEW VISION ADDITIONAL SAVINGS</p> <p>Additional Pair of Complete Eyeglasses</p> <p>Contact Lenses - Conventional <i>(Discount applied to materials only)</i></p> <p>Eyewear Accessories Includes some non-prescription sunglasses, lens cleaning supplies, contact lens solutions and eyeglass cases, etc.</p> <p><small>*Items purchased separately are discounted 20% off the retail price. Blue View Vision's Additional Savings Program is subject to change without notice.</small></p>	<p>MEMBER SAVINGS</p> <p>40% discount off retail*</p> <p>15% off retail price</p> <p>20% off retail price</p>	<p>LASER VISION CORRECTION SURGERY Glasses or contacts may not be the answer for everyone. 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 anthem.com and select vision care.</p> <p>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.</p> <p>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.</p> <p>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</p>
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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.
- Disclaimer**
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.

This benefit overview insert is only one piece of your entire enrollment package. Exclusions and limitations are listed in the enrollment brochure.