blue of california

Blue Shield of California Life & Health Insurance Company
Summary of Benefits

Group Vision Plan

Vision Deluxe 10/25/150

This Summary of Benefits shows the amount you will pay for Covered Services under this Blue Shield of California Life & Health Insurance Company (Blue Shield Life) Plan. It is only a summary and it is included as part of the Certificate of Insurance (COI).[1] Please read both documents carefully for details.

Provider Network:

This Plan uses a contracted network of vision care providers. Providers in this network are called Participating Providers. You pay less for Covered Services when you use a Participating Provider than when you use a Non-Participating Provider. You can find Participating Providers in this network at blueshieldca.com.

Benefit Frequency Limits

This Plan pays up to the Allowance and frequency limits as listed for Covered Services.

Comprehensive exam	One every 12 consecutive months
Eyeglass lenses or contact lenses	Once every 12 consecutive months
Eyeglass frame	One every 12 consecutive months
Low vision testing	One every 12 consecutive months

Waiting Period

A waiting period is the length of time you must be covered under the Plan before Blue Shield Life will pay for Covered Services.

Waiting period	No waiting period

No Deductible

Under this Plan there is no dollar amount an Insured must pay before Blue Shield Life will pay for Covered Services.

No Lifetime Dollar Limit

Under this Plan there is no dollar limit on the total amount Blue Shield Life will pay for Covered Services in an Insured's lifetime.

Benefits[2]	Your payment	
	When using a Participating Provider[3]	**When using a Non-Participating Provider[4]**
Eye examinations		
Comprehensive exam *One per Insured every 12 months.*		
Ophthalmologic visit	$10	All charges above $60
Optometric visit	$10	All charges above $60
Retinal Imaging *One per Insured every 12 months by a Participating Provider.*	$39	Not covered
Standard contact lens fitting and evaluation *One per Insured every 12 months by a Participating Provider.*	Not covered	Not covered
Eyewear/Materials		
Eyeglass frame *One per Insured every 12 months.*	$25 plus all charges above $150	All charges above $100
Plano (non-prescription) sunglasses *One per Insured every 12 months instead of an eyeglass frame when prescribed by a Participating Provider or surgeon after vision correction surgery.*	$25 plus all charges above $150	All charges above $100
Eyeglass lenses and lens treatments *One pair of lenses per Insured every 12 months.*		
• Single vision	$25	All charges above $43
• Lined bifocal	$25	All charges above $60
• Lined trifocal	$25	All charges above $75
• Lenticular	$25	All charges above $200
• Polycarbonate lenses (for Dependent children only)	$25 plus all charges above $100	All charges above $75
• Polycarbonate photochromic single vision lenses (for Dependent children only)	$25 plus all charges above $160	All charges above $115
• Standard progressive lenses (no-line bifocals)	$25	All charges above $75
• Premium progressive lenses (no-line bifocals)	$25 plus all charges above $140	All charges above $100
• Anti-reflective lens coating	$25 plus all charges above $50	All charges above $35
• Photochromic lenses	$25 plus all charges above $200	All charges above $150

Benefits[2]	Your payment	
	When using a Participating Provider[3]	**When using a Non-Participating Provider[4]**
Contact lenses *Elective or Non-Elective Contact Lenses are provided per Insured every 12 months. Benefits are provided instead of eyeglass frames and lenses up to the Allowance.*		
• Elective (cosmetic/convenience)	$25 plus all charges above $150	All charges above $100
• Non-Elective (Medically Necessary) *Requires a report from the provider and prior authorization from the VPA.*	$25	All charges above $250
• Scleral and hybrid lenses *Requires a report from the provider and prior authorization from the VPA.*	All charges above $350	All charges above $350
Other services		
Low-vision testing and equipment *One per Insured every 12 months by a Participating Provider. Exam must be Medically Necessary.*	25% plus all charges above $1,000	Not covered

Notes

1 Certificate of Insurance (COI):

The Certificate of Insurance (COI) describes the Benefits, limitations, and exclusions that apply to coverage under this Plan. Please review the COI for more details of coverage outlined in this Summary of Benefits. You can request a copy of the COI at any time.

Capitalized terms are defined in the COI. Refer to the COI for an explanation of the terms used in this Summary of Benefits.

2 Vision Care Services:

All vision Benefits are provided through Blue Shield Life's Vision Plan Administrator (VPA).

Contact lenses. The Allowance for contact lenses may be used towards the fitting fees. If you receive Elective or Non-Elective Contact Lenses, no Benefits will be available for eyeglass frames and lenses until you satisfy the Benefit frequency.

3 Using Participating Providers:

Participating Providers have a contract to provide vision care services to Insureds. When you receive Covered Services from a Participating Provider, you are responsible for:

- the Copayment, and
- any charges above the stated Allowance, which is the Benefit maximum.

When the Participating Provider uses wholesale pricing, the maximum frame Allowances are:

- wholesale Allowance: $103.64.

Note: This pricing replaces the frame Allowance shown in the Summary of Benefits. If a more expensive frame is selected at a provider location that uses wholesale pricing, the Insured Person is responsible for the additional cost

Notes

above the wholesale Allowance. Participating Providers using wholesale pricing are identified in the directory of Participating Providers at blueshieldca.com.

4 Using Non-Participating Providers:

Non-Participating Providers do not have a contract to provide vision care services to Insureds. When you receive Covered Services from a Non-Participating Provider, you are responsible for:

- any charges above the stated Allowance, which is the Benefit maximum.

Plans may be modified to ensure compliance with State and Federal requirements.

NOTICES AVAILABLE ONLINE

Nondiscrimination and Language Assistance Services

Blue Shield complies with applicable state and federal civil rights laws. We also offer language assistance services at no additional cost.

View our nondiscrimination notice and language assistance notice: **blueshieldca.com/notices**. You can also call for language assistance services: **(866) 346-7198 (TTY: 711)**.

If you are unable to access the website above and would like to receive a copy of the nondiscrimination notice and language assistance notice, please call Customer Care at **(888) 256-3650 (TTY: 711)**.

Servicios de asistencia en idiomas y avisos de no discriminación

Blue Shield cumple con las leyes de derechos civiles federales y estatales aplicables. También, ofrecemos servicios de asistencia en idiomas sin costo adicional.

Vea nuestro aviso de no discriminación y nuestro aviso de asistencia en idiomas en **blueshieldca.com/notices**. Para obtener servicios de asistencia en idiomas, también puede llamar al **(866) 346-7198 (TTY: 711)**.

Si no puede acceder al sitio web que aparece arriba y desea recibir una copia del aviso de no discriminación y del aviso de asistencia en idiomas, llame a Atención al Cliente al **(888) 256-3650 (TTY: 711)**.

非歧視通知和語言協助服務

Blue Shield 遵守適用的州及聯邦政府的民權法。同時，我們免費提供語言協助服務。

如需檢視我司的非歧視通知和語言幫助通知，請造訪 **blueshieldca.com/notices**。您還可致電尋求語言協助服務：**(866) 346-7198 (TTY: 711)**。

如果您無法造訪上述網站，且希望收到一份非歧視通知和語言幫助通知的副本，請致電客戶服務部，電話：**(888) 256-3650 (TTY: 711)**。