blue of california

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

**Group Vision Plan**

## Vision Standard 10/0/100

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 24 consecutive months |
| **Eyeglass frame** | One every 24 consecutive months |
| **Low vision testing** | One every 24 consecutive months |
| **Diabetes management referral** | One every Calendar Year |

### 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.

Blue Shield of California Life & Health Insurance Company is an independent licensee of the Blue Shield Association

| 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 $50 |
| Retinal Imaging | $39 | Not covered |
| *One per Insured every 12 months by a Participating Provider instead of a standard comprehensive exam with dilation.* | | |
| Standard contact lens fitting and evaluation | Not covered | Not covered |
| *One per Insured every 12 months by a Participating Provider if administered at the same time as the comprehensive exam.* | | |
| **Eyewear/Materials** | | |
| Eyeglass frame | All charges above $100 | All charges above $40 |
| *One per Insured every 24 months.* | | |
| Plano (non-prescription) sunglasses | All charges above $100 | Not covered |
| *One per Insured every 24 months instead of an eyeglass frame when prescribed by a Participating Provider or surgeon after vision correction surgery.* | | |
| Eyeglass lenses and lens treatments | | |
| *One pair of lenses per Insured every 24 months or every 12 months if the examination indicates a Prescription Change. Each pair of eyeglass lenses includes pink or rose tint #1 or #2 in the Allowance and up to 61mm in size.* | | |
| • Single vision | $0 | All charges above $43 |
| • Lined bifocal | $0 | All charges above $60 |
| • Lined trifocal | $0 | All charges above $75 |
| • 7.25 diopter, or more | $0 | All charges above $12 |
| • Aphakic monofocal | $0 | All charges above $120 |
| • Aphakic multifocal | $0 | All charges above $200 |
| • Lenticular monofocal | $0 | All charges above $120 |
| • Lenticular multifocal | $0 | All charges above $200 |
| • Prism 1 1/2 to 4 diopters | $0 | All charges above $10 |
| • Prism 4 1/2 to 10 diopters | $0 | All charges above $16 |
| • Slab-off prism (per lens) | $0 | All charges above $35 |
| • Polycarbonate lenses (for Dependent children only) | All charges above $100 | All charges above $75 |
| • Polycarbonate photochromic single vision lenses (for Dependent children only) | Not covered | Not covered |
| • Standard progressive lenses (no-line bifocals) | $0 | All charges above $75 |

| Benefits[2] | Your payment | |
|---|---|---|
| | **When using a Participating Provider[3]** | **When using a Non-Participating Provider[4]** |
| • Anti-reflective lens coating | Not covered | Not covered |
| • Photochromic lenses | | |
| Single vision | Not covered | Not covered |
| Lined bifocal | Not covered | Not covered |
| Lined trifocal | Not covered | Not covered |
| Premium progressive (no-line bifocals) | Not covered | Not covered |
| Contact lenses | | |
| *Elective or Non-Elective Contact Lenses are provided per Insured every 24 months or every 12 months if the examination indicates a Prescription Change. Benefits are provided instead of eyeglass frames and lenses up to the Allowance.* | | |
| • Elective (cosmetic/convenience) - hard or soft | All charges above $120 | All charges above $120 |
| • Non-Elective (Medically Necessary) - hard<br>*Requires a report from the provider and prior authorization from the VPA.* | $0 | All charges above $200 |
| • Non-Elective (Medically Necessary) - soft<br>*Requires a report from the provider and prior authorization from the VPA.* | $0 | All charges above $250 |
| **Other services** | | |
| Low-vision testing and equipment<br>*One per Insured every 24 months by a Participating Provider. Exam must be Medically Necessary, requires a report from the provider and prior authorization from the VPA.* | 25% plus all charges above $1,000 | Not covered |
| Diabetes management referral<br>*One per Insured, per Calendar Year to a Participating Provider when you are known to have or be at risk for diabetes.* | $0 | 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.

## Notes

**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 or warehouse pricing, the maximum frame Allowances are:*

- wholesale Allowance: $66.04.
- warehouse Allowance: $69.09.

**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 or warehouse pricing, the Insured Person is responsible for the additional cost above the wholesale or warehouse Allowance. Participating Providers using wholesale or warehouse pricing are identified in the directory of Participating Providers at blueshieldca.com.

*Participating Providers maintain a selection of frames that retail within the Allowance of this plan with lenses that fit an eye size less than 61 millimeters.*

**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:

- the Copayment, and
- 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)**。

Blue Shield of California is an independent member of the Blue Shield Association