



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

Group Vision Plan

Vision Deluxe 15/25/130

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
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
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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.

Benefits²**Your payment**

	When using a Participating Provider³	When using a Non-Participating Provider⁴
Eye examinations		
Comprehensive exam		
One per Insured every 12 months.		
Ophthalmologic visit	\$15	All charges above \$60
Optometric visit	\$15	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	\$25 plus all charges above \$130	All charges above \$40
One per Insured every 12 months.		
Plano (non-prescription) sunglasses	\$25 plus all charges above \$130	Not covered
One per Insured every 12 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 12 months. Each pair of eyeglass lenses includes pink or rose tint #1 or #2 in the Allowance and up to 61mm in size.		
• Single vision	\$25	All charges above \$43
• Lined bifocal	\$25	All charges above \$60
• Lined trifocal	\$25	All charges above \$75
• 7.25 diopter, or more	\$25	All charges above \$12
• Aphakic monofocal	\$25	All charges above \$120
• Aphakic multifocal	\$25	All charges above \$200
• Lenticular monofocal	\$25	All charges above \$120
• Lenticular multifocal	\$25	All charges above \$200
• Prism 1 1/2 to 4 diopters	\$25	All charges above \$10
• Prism 4 1/2 to 10 diopters	\$25	All charges above \$16
• Slab-off prism (per lens)	\$25	All charges above \$35
• Polycarbonate lenses (for Dependent children only)	\$25 plus all charges above \$100	All charges above \$75

Benefits²**Your payment**

	When using a Participating Provider³	When using a Non-Participating Provider⁴
<ul style="list-style-type: none"> • Polycarbonate photochromic single vision lenses (for Dependent children only) • Premium progressive lenses (no-line bifocals) • Anti-reflective lens coating • Photochromic lenses <ul style="list-style-type: none"> Single vision Lined bifocal Lined trifocal Premium progressive (no-line bifocals) 	\$25 plus all charges above \$160 \$25 plus all charges above \$140 \$25 plus all charges above \$50 \$25 plus all charges above \$115 \$25 plus all charges above \$130 \$25 plus all charges above \$150 \$25 plus all charges above \$200	All charges above \$115 All charges above \$100 All charges above \$35 All charges above \$85 All charges above \$95 All charges above \$110 All charges above \$150
Contact lenses		
<i>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.</i>		
<ul style="list-style-type: none"> • Elective (cosmetic/convenience) - hard or soft • Non-Elective (Medically Necessary) - hard <i>Requires a report from the provider and prior authorization from the VPA.</i> • Non-Elective (Medically Necessary) - soft <i>Requires a report from the provider and prior authorization from the VPA.</i> 	\$25 plus all charges above \$130 \$25 \$25	All charges above \$130 All charges above \$200 All charges above \$250
Other services		
Low-vision testing and equipment	25% plus all charges above \$1,000	Not covered
<i>One per Insured every 12 months by a Participating Provider. Exam must be Medically Necessary, requires a report from the provider and prior authorization from the VPA.</i>		
Diabetes management referral	\$0	Not covered
<i>One per Insured, per Calendar Year to a Participating Provider when you are known to have or be at risk for diabetes.</i>		

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 or warehouse pricing, the maximum frame Allowances are:

- wholesale Allowance: \$84.91.
- warehouse Allowance: \$88.83.

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.