

Group Name: GIOA Silver Vision Plan
Blue View Vision

| Blue View Vision plan benefits | In-network | Out-of-network | Frequency |
|---|--|---|---------------------------------|
| Routine Eye Exam A comprehensive eye examination | \$30 copay | Up to \$30 reimbursement | Once every calendar year |
| Eyeglass Frames One pair of eyeglass frames | \$100 allowance, then 20% off any balance | Up to \$75 reimbursement | Once every other calendar year |
| Eyeglass Lenses (instead of contact lenses) One pair of standard plastic prescription lenses: | | | |
| <ul style="list-style-type: none"> Single vision lenses Bifocal lenses Trifocal lenses | \$0 copay \$0 copay \$0 copay | Up to \$25 reimbursement Up to \$40 reimbursement Up to \$55 reimbursement | Once every other calendar year |
| Eyeglass Lens Enhancements¹ | | | |
| <ul style="list-style-type: none"> Transitions Lenses (for a child under age 19) Standard polycarbonate (for a child under age 19) Factory scratch coating | \$0 copay \$0 copay \$0 copay | No allowance when obtained out-of-network | Same as covered eyeglass lenses |
| Contact Lenses² (instead of eyeglass lenses) | | | |
| <ul style="list-style-type: none"> Elective conventional (non-disposable); OR Elective disposable; OR Non-elective (medically necessary) | \$100 allowance, then 15% off any balance \$100 allowance (no additional discount) Covered in full | Up to \$100 reimbursement Up to \$100 reimbursement Up to \$210 reimbursement | Once every other calendar year |

¹When obtaining covered eyewear from a Blue View Vision provider, members may choose to add any of the listed lens enhancements at no extra cost.

²Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.

Additional savings available from in-network providers

When obtaining covered eyewear from a Blue View Vision provider, members may choose to upgrade their new eyeglass lenses at a discounted cost. Costs shown are after any applicable eyeglass lens copayment.

| Description | Member cost | Description | Member cost |
|---|--|---|--|
| <ul style="list-style-type: none"> Progressive Lenses <ul style="list-style-type: none"> Standard Premium Tier 1 Premium Tier 2 Premium Tier 3 Premium Tier 4 Anti-Reflective Coating <ul style="list-style-type: none"> Standard Premium Tier 1 Premium Tier 2 Premium Tier 3 | \$55 \$85 \$95 \$110 \$175 \$45 \$57 \$68 \$85 | <ul style="list-style-type: none"> Transitions lenses (Adults) Standard Polycarbonate lenses (Adults) UV Coating Tint (Solid and Gradient) Other lens upgrades and add-ons Retinal Imaging (obtained at same time as covered eye exam) Standard contact lens fitting and follow-up after comprehensive eye exam Premium contact lens fitting and follow-up after comprehensive eye exam Additional supplies of conventional contact lenses after benefits have been used Additional complete pairs of eyeglasses Eyeglass materials purchased separately Other items including most non-prescription sunglasses, eyewear accessories such as lens cleaning supplies, contact lens solutions, eyeglass cases, etc. | \$75 \$40 \$15 \$15 20% off retail price Up to \$39 Up to \$55 10% off retail price 15% off retail price 40% off retail price 20% off retail price 20% off retail price |

Other discount offers on LASIK surgery and much more are available through Anthem's SpecialOffers program.

This information is intended to be a brief outline of plan benefits. The most detailed description of benefits, exclusions, and restrictions can be found in the Certificate of Coverage. Discounts are subject to change without notice. Laws in some states may prohibit network providers from discounting products and services that are not covered benefits under the plan. Discounts will not apply when a manufacturer has imposed a no discount policy on the item.