Anthem REST EASY | SMALL BUSINESS

Georgia | 2020

Blue View Vision plans

(2-50 employees) - standalone, off-exchange

Plan availability: Non-voluntary – groups with two or more enrolled employee / Voluntary – groups with five or more enrolled employees

Plan	Copay[1] eye exam / eyeglass lenses	Allowance[1,2] frames / contact lenses	Eye exam (frequency)	Eyeglass lenses (frequency)	Frames (frequency)	Contact lenses (frequency)
Full service plans						
FS.A.10.0.130.130	$10 / $0	$130 / $130	Once every CY	Once every CY	Once every CY	Once every CY
FS.A.10.0.150.150	$10 / $0	$150 / $150	Once every CY	Once every CY	Once every CY	Once every CY
FS.A.10.0.180.180	$10 / $0	$180 / $180	Once every CY	Once every CY	Once every CY	Once every CY
FS.A.10.10.130.130	$10 / $10	$130 / $130	Once every CY	Once every CY	Once every CY	Once every CY
FS.A.10.10.150.150	$10 / $10	$150 / $150	Once every CY	Once every CY	Once every CY	Once every CY
FS.A.10.20.130.130	$10 / $20	$130 / $130	Once every CY	Once every CY	Once every CY	Once every CY
FS.A.10.25.130.130	$10 / $25	$130 / $130	Once every CY	Once every CY	Once every CY	Once every CY
FS.A.10.25.150.150	$10 / $25	$150 / $150	Once every CY	Once every CY	Once every CY	Once every CY
FS.A.10.25.200.200	$10 / $25	$200 / $200	Once every CY	Once every CY	Once every CY	Once every CY
FS.A.20.20.130.130	$20 / $20	$130 / $130	Once every CY	Once every CY	Once every CY	Once every CY
FS.B.10.0.180.180	$10 / $0	$180 / $180	Once every CY	Once every CY	Once every other CY	Once every CY
FS.B.10.10.130.130	$10 / $10	$130 / $130	Once every CY	Once every CY	Once every other CY	Once every CY
FS.B.10.10.150.150	$10 / $10	$150 / $150	Once every CY	Once every CY	Once every other CY	Once every CY
FS.B.10.20.130.130	$10 / $20	$130 / $130	Once every CY	Once every CY	Once every other CY	Once every CY
FS.B.10.25.130.130	$10 / $25	$130 / $130	Once every CY	Once every CY	Once every other CY	Once every CY
FS.B.10.25.150.150	$10 / $25	$150 / $150	Once every CY	Once every CY	Once every other CY	Once every CY
FS.B.10.25.200.200	$10 / $25	$200 / $200	Once every CY	Once every CY	Once every other CY	Once every CY
FS.B.20.20.130.130	$20 / $20	$130 / $130	Once every CY	Once every CY	Once every other CY	Once every CY
FS.C.10.20.100.100	$10 / $20	$100 / $100	Once every CY	Once every other CY	Once every other CY	Once every other CY
FS.C.10.20.130.130	$10 / $20	$130 / $130	Once every CY	Once every other CY	Once every other CY	Once every other CY
FS.C.20.20.130.80	$20 / $20	$130 / $80	Once every CY	Once every other CY	Once every other CY	Once every other CY
FS.C.20.20.130.130	$20 / $20	$130 / $130	Once every CY	Once every other CY	Once every other CY	Once every other CY
FS.C.20.20.150.150	$20 / $20	$150 / $150	Once every CY	Once every other CY	Once every other CY	Once every other CY
FS.C.25.0.120.115	$25 / $0	$120 / $115	Once every CY	Once every other CY	Once every other CY	Once every other CY
Material only plans						
MO.A.10.130.130	Not covered / $10	$130 / $130	Not applicable	Once every CY	Once every CY	Once every CY
MO.B.10.130.130	Not covered / $10	$130 / $130	Not applicable	Once every CY	Once every other CY	Once every CY
MO.A.10.150.150	Not covered / $10	$150 / $150	Not applicable	Once every CY	Once every CY	Once every CY
MO.B.10.150.150	Not covered / $10	$150 / $150	Not applicable	Once every CY	Once every other CY	Once every CY
MO.A.20.130.130	Not covered / $20	$130 / $130	Not applicable	Once every CY	Once every CY	Once every CY
MO.B.20.130.130	Not covered / $20	$130 / $130	Not applicable	Once every CY	Once every other CY	Once every CY

Benefits include coverage for member's choice of eyeglass lenses or contact lenses, but not both.

1 Above amounts reflect in-network copays and allowances.
2 Non-elective contacts covered in full.

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Exclusions and limitations

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Request a copy of the Evidence of Coverage for comprehensive details on covered services, exclusions and limitations. These exclusions and limitations will apply to all members enrolled in any of the products described in this guide unless otherwise noted.

Vision exclusions

- **Sunglasses.** Sunglass lenses or accompanying frames, unless listed as covered in the Evidence of Coverage.
- **Excess amounts.** Any amounts in excess of the maximum allowable amounts or other allowances and benefit frequencies stated in the Evidence of Coverage.
- **Contact lenses fittings.** [Standard] [and] [Premium] contact lens fitting[s] are not covered. This includes fittings for more complex applications, including toric, bifocal/multifocal, cosmetic color, post-surgical and gas permeable lenses. It also includes extended/overnight wear lenses.
- **Cosmetic options.** Cosmetic lens options not specifically listed in the covered services section of the Evidence of Coverage.
- **Eye surgery/medical or surgical treatments.** Any diagnostic testing or medical or surgical treatment of the eyes, including any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia) and/or astigmatism. We also will not cover any contact lenses or eyeglasses required as a result of this surgery.
- **Lost or broken lenses or frames.** Any lost or broken lenses or frames, unless you have reached a new benefit period.
- **Charges over the maximum allowable amount.** We will not pay charges that are more than the maximum allowable amount under this plan.
- **Uninsured.** Services received before your effective date or after your coverage ends.
- **Voluntary payment.** Services for which you are not legally obligated to pay, for which you are not charged, or for which no charge is made in the absence of insurance coverage.
- **Work-related.** Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation law or similar law, even if you do not claim those benefits. If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those condition pursuant to any workers' compensation law or similar law, we will provide the benefits of this plan for such condition, subject to our right to a lien or other recovery applicable law.
- **Government treatment.** Any services actually given to you by a local, state, or federal government agency, or by a public school system or school district, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if you are not required to pay for them or they are given to you for free.
- **Non-licensed vision care providers.** Treatment or services rendered by non-licensed providers and treatment or services for which the provider of services is not required to be licensed. This includes treatment or services from a non-licensed vision care provider under the supervision of a licensed physician or licensed vision care provider, except as specifically provided or arranged by us.
- **Services of relatives.** Professional services or supplies received from a person who lives in your home or who is related to you by blood or marriage.
- **Hospital care.** Inpatient or outpatient hospital vision care.
- **Orthoptics.** Orthoptics or vision training and any associated supplemental testing.
- **Missed or cancelled appointments.** We will not pay for appointments a member has missed or cancelled.
- **Services or supplies combined with discounts.** We will not pay for services or supplies when combined with any other offer, coupons or in-store advertisement. We will also not pay for certain brands of frames where the manufacturer does not allow discounts.

Vision limitations

Limitations apply to the following benefits, see the benefit grid on the previous page for details:

- Routine eye exam
- Standard plastic lenses
- Frames
- Contact lenses