Vision Options

Active Employees and Retirees

Summary of Benefits: Select Vision/BlueVision Plus

	Select Vision (includes in- & out-of-network benefits) Plan Pays	BlueVision Plus You Pay
Network	Select Vision	Davis Vision*
Routine Eye Exam	100% of Allowed Benefit	No Copay
Frames	$45.00	Plan pays up to $45 or up to $95 at Visionworks (plus 20% discount on balance with all Davis Vision Providers)
Single Vision Lenses	$52.00	No Copay
Bifocal Lenses	$82.00	No Copay for lined bifocals
Trifocal Lenses	$101.00	No Copay for lined trifocals
Contact Lenses (Instead of Glasses—Cosmetic)	$97.00	Plan pays up to $97
Contact Lenses (Medically Indicated**)	$352.00	Plan pays up to $352
ADDITIONAL LENS OPTIONS[1]		
Tinting of Plastic Lenses (Solid/Gradient)	N/A	$15
Scratch-Resistant Coating Polycarbonate Lenses (Children***/Adults)	N/A	Covered $0/$35
Ultraviolet Coating	N/A	$15
Blue Light Filtering	N/A	$15
Anti-Reflective Coating (Standard/Premium/Ultra/ Ultimate)	N/A	$40/$55/$69/$85
Progressive Lenses (Standard/Premium/Ultra/ Ultimate)	N/A	$65/$105/$140/$175
High-Index Lenses (1.67/1.74)	N/A	$60/$120
Polarized Lenses	N/A	$75
Plastic Photochromic Lenses	N/A	$70
Scratch Protection Plan (Single Vision, Multifocal Lenses)	N/A	$20 l $40
Blended Segment Lenses	N/A	$20
Photochromic Lenses	N/A	$20
Oversized Lenses	N/A	Covered

* The Davis Vision Network has 94,000+ providers nationwide including Retailers (Walmart, Sam's Club, Costco, Vision Works, Target, JC Penney, My Eye Dr., Pearle Vision and America's Best), 1-800-CONTACTS and glasses.com.

** Following cataract surgery or when visual acuity is correctable to at least 20/70 in the better eye only by use of contact lenses.

*** Polycarbonate lenses are covered for dependent children, monocular patients and patients with prescriptions +/- 6.00 diopters or greater.

[1] These services or supplies are not considered covered benefits under the Plan. This portion of the Plan is not an insurance product. As of 4/1/14, some providers in Maryland and Virginia may no longer provide these discounts.

BlueVision Plus Exclusions

The following services are excluded from coverage:

1. Diagnostic services, except as listed in What's Covered under the Evidence of Coverage.
2. Medical care or surgery. Covered services related to medical conditions of the eye may be covered under the Evidence of Coverage.
3. Prescription drugs obtained and self-administered by the Member for outpatient use unless the prescription drug is specifically covered under the Evidence of Coverage or a rider or endorsement purchased by your Group and attached to the Evidence of Coverage.
4. Services or supplies not specifically approved by the Vision Care Designee where required in What's Covered under the Evidence of Coverage.
5. Orthoptics, vision training and low vision aids.
6. Replacement, within the same benefit period of frames, lenses or contact lenses that were lost.
7. Non-prescription glasses, sunglasses or contact lenses.
8. Vision Care services for cosmetic use.

Core Davis Vision

In addition to the CareFirst Vision plan, BlueChoice members also have the core BlueVision benefit through Davis Vision under the BlueChoice HMO Open Access and BlueChoice Triple Option Open Access medical plan. These benefits entitle members to an annual eye exam and discounts on glasses or contact lenses at participating Davis Vision providers. Members are responsible for a $10 copay for the eye exam. To locate a participating Davis Vision provider, go to **carefirst.com/aacps** and utilize the "Find a Doctor" feature or call Davis Vision at **800-783-5602** for a list of network providers closest to you. Be sure to ask your provider if he or she participates with the Davis Vision network before you receive care.

When seeing a Davis Vision provider, you may also use the discounted benefit in conjunction with your CareFirst Select Vision plan. The Davis Vision discount will be applied and you will pay the required Davis Vision copay and balance at the point of sale. Then you can submit the balance to CareFirst for any eligible reimbursement under the CareFirst Select Vision plan. A completed CareFirst vision claim form and itemized bill will be required for processing.

Summary of Benefits

(12-month benefit period)

In-Network	You Pay
EYE EXAMINATIONS	
Routine Eye Examination with dilation	$10
FRAMES[1]	
Priced up to $70 retail	$40
Priced above $70 retail	$40, plus 90% of the amount over $70
SPECTACLE LENSES[2]	
Single Vision	$35
Bifocal	$55
Trifocal	$65
Lenticular	$110
Standard Progressive Lenses	$75
CONTACT LENSES[1]	
Contact Lens Evaluation and Fitting	85% of retail price
Conventional	80% of retail price
Disposable/Planned Replacement	90% of retail price
DavisVisionContacts.com Mail Order Contact Lens Replacement Program	Up to 40% off retail prices
LASER VISION CORRECTION[1]	Up to 25% off allowed amount or 95% off any advertised special[2]

[1] CareFirst BlueChoice does not underwrite lenses, frames and contact lenses in this program. This portion of the Plan is not an insurance product.

[2] Please note that some providers have flat fees that are equivalent to these discounts.

These benefits are issued under policies: 13.800 (6/98) • 13.801 (R. 10/99) • 13.802 (R. 10/99) • 13.803 (R. 10/99) • 13.804 (R. 10/99) • 13.805 (R. 10/99) • 13.806 (R. 10/99) • 13.810 (R. 10/99) 13.812 (R. 10/99) • BCBSMD-APPEAL (1/99) • Preferred Dental Amendment (10/00)

Please note: Not all services are covered by your benefits contract. This plan summary is for comparison purposes only and does not create rights not given through the benefit plan. All benefits are subject to the provisions stipulated in the CareFirst BlueCross BlueShield Vision contract. CareFirst BlueCross BlueShield does not warrant the quality of vision services or materials.