Anthem. And Its Affiliate HealthKeepers, Inc. REST EASY | SMALL BUSINESS

Virginia | 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.

This document is intended to be a brief summary of coverage and is not intended to be a legal contract. The entire provisions of benefits and exclusions are contained in the Evidence of Coverage; the Evidence of Coverage has exclusions, limitations and terms under which the Evidence of Coverage may be continued in force or discontinued.

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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

We do not provide vision benefits for services, supplies or charges:

- Received from an individual or entity that is not a provider, as defined in the Evidence of Coverage.
- For any condition, disease, defect, aliment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For illness or injury that occurs as a result of any act of war, declared or undeclared.
- For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
- For which you have no legal obligation to pay in the absence of this or like coverage.
- Received from an optical or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
- Prescribed, ordered, referred by, or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- In excess of member reimbursement amount.
- Incurred prior to your effective date.
- Incurred after the termination date of this coverage except as specified elsewhere in the Evidence of Coverage.
- For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
- For sunglasses and accompanying frames.
- For safety glasses and accompanying frames.
- For inpatient or outpatient hospital vision care.
- For orthoptics or vision training and any associated supplemental testing.
- For non-prescription lenses.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes.
- Lost or broken lenses or frames, unless the member has reached his or her normal interval for service when seeking replacements.
- For services or supplies not specifically listed in the Evidence of Coverage.
- Certain brands on which the manufacturer imposes a no discount policy.
- For services or supplies combined with any other offer, coupon or in-store advertisement.

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

This document refers to form number: VABVVGRP 0819.