BlueVision Plus

A plan for healthy eyes, healthy lives

Professional vision services including routine eye examinations, eyeglasses and contact lenses offered by CareFirst BlueCross BlueShield and CareFirst BlueChoice, through the Davis Vision, Inc. national network of providers.

How the plan works

How do I find a provider?

To find a provider, go to **carefirst.com** and utilize the *Find a Provider* 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.

How do I receive care from a network provider?

Simply call your provider and schedule an appointment. Identify yourself as a CareFirst BlueCross BlueShield or CareFirst BlueChoice member and provide the doctor with your identification number, as well as your date of birth. Then go to the provider to receive your service. There are no claim forms to file.

What if I go out-of-network?

Staying in-network gives you the best benefit, but BlueVision Plus does offer an out-of-network allowance schedule as well. In this case, you may see any provider you wish, but you will be responsible for all payments up-front. You will also be responsible for filing the claim with Davis Vision for reimbursement and paying any balances over the allowed benefit to the non-participating provider. You can find the claim form by going to **carefirst.com**, locate *For Members*, then click on *Forms, Vision, Davis Vision*.

Can I get contacts and eyeglasses in the same benefit period?

With BlueVision Plus, the benefit covers one pair of eyeglasses or a supply of contact lenses per benefit period.

Mail order replacement contact lenses

DavisVisionContacts.com offers members the flexibility to shop for replacement contact lenses online after benefits are spent. This website offers a wide array of contact lenses, easy, convenient purchasing online and quick shipping direct to your door.

Need more information? Visit **carefirst.com** or call 800-783-5602.

Summary of Benefits

(24-month benefit period)

In-Network	You Pay
EYE EXAMINATIONS *(once per 12-month benefit period)*	
Routine Eye Examination with dilation (per benefit period)	$10 copay
FRAMES *(once per 24-month benefit period)*	
Davis Vision Frame Collection	No copay for approximately 400 frames
Non-Collection Frame	Plan pays up to $130, you pay balance minus 20% discount[1,2]
SPECTACLE LENSES *(once per 12-month benefit period)*	
Basic Single Vision	$20 copay
Lenticular (post-cataract)	$20 copay
Basic Bifocal	$20 copay
Basic Trifocal	$20 copay
CONTACT LENSES *(initial supply; once per 12-month benefit period, in lieu of spectacle lenses)*	
Medically Necessary Contacts	No copay with prior approval
Davis Vision Contact Lens Collection*	No copay
Other (Non-Collection) Contact Lenses	Plan pays up to $130, you pay balance minus 15% discount[1,2]
CONTACT LENS EVALUATION, FITTING AND FOLLOW-UP CARE *(once per 12-month benefit period)*	
Davis Vision Collection, Standard Contact Lenses and Medically Necessary Contact Lenses	$20 copay
Specialty Contact Lenses that are non-collection, including, but not limited to, toric, multi-focal and gas permeable lenses	Plan pays up to $60, you pay balance minus 15% discount[1,2], plus $20 copay
LENS OPTIONS[2] *(add to spectacle lens prices above)*	
Standard Progressive Lenses	$50
Premium Progressive Lenses (Varilux®, etc.)	$90
Ultra Progressive Lenses (digital)	$140
Polarized Lenses	$75
High Index Lenses	$55
Blended Segment Lenses	$20
Polycarbonate Lenses for children, monocular and high prescription	No copay
Polycarbonate Lenses for all other patients	$30
Transition Lenses	$65
Intermediate Vision Lenses	$30
Photochromic Lenses	$20
Scratch-Resistant Coating	$20
Standard Anti-Reflective (AR) Coating	$35
Premium AR Coating	$48
Ultra AR Coating	$60
Ultraviolet (UV) Coating	$12
Tinting	No copay
Plastic Photosensitive Lenses	$65
Oversized Lenses	No copay

In-Network	You Pay
CONTACT LENSES[1] *(mail order)*	
DavisVisionContacts.com Mail Order Contact Lens Replacement Online	Discounted prices
Laser Vision Correction[2]	Up to 25% off allowed amount or 5% off any advertised special[3]

Out-of-Network	You Pay
Routine Eye Examination with dilation (per benefit period)	Plan pays $45, you pay balance
Contact Lens Evaluation, Fitting & Follow-Up Care	Plan pays $60, you pay balance
Frames	Plan pays $60, you pay balance
Single Lenses	Plan pays $52, you pay balance
Bifocal Lenses	Plan pays $82, you pay balance
Trifocal Lenses	Plan pays $101, you pay balance
Lenticular (post-cataract) Eyeglass Lenses	Plan pays $181, you pay balance
Medically Necessary Contacts	Plan pays $285, you pay balance
Elective Contact Lenses	Plan pays $112, you pay balance
Elective Bifocal Contact Lenses	Plan pays $127, you pay balance

*The Davis Vision contact lens Collection offers a wide variety of covered-in-full contact lenses from today's top manufacturers, including CooperVision® and Vistakon®, in both traditional and silicone hydrogel materials. The Collection is inclusive of disposable, planned replacement and select torics and multifocals. The Collection is updated regularly to reflect industry trends.

[1] Additional discounts not applicable at Walmart or Sam's Club locations.

[2] These discounts 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.

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

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.

Benefits issued under policy form numbers: Non-rider/Freestanding:

MD CFMI: CFMI/51+/GC (R. 7/10) • CFMI/EOC/D-V (R. 10/11) • CFMI/VISION DOCS (R. 10/11) • CFMI/VISION SOB (R. 10/11) • CFMI/ELIG/D-V (7/09) • and any amendments.

MD GHMSI: MD/CF/GC (R. 7/10) • MD/CF/EOC/D-V (R. 10/11) • MD/CF/DOCS-V (R. 10/11) • MD/CF/SOB-V (R. 10/11) • MD/CF/ELIG (R. 1/08) • and any amendments.

Ridered: CFMI/VISION RIDER (10/11) • MD/BCOO/VISION (R. 10/11) • MD/CF/VISION (R. 10/11).

CareFirst
Family of health care plans