Blue View Vision plans

The Blue View Vision Bundled plan can only be purchased with a medical and/or dental plan. All other Blue View Vision plans listed on these pages can be purchased with or without a medical and/or dental plan.

	Blue View Vision Bundled		Blue View Vision Enhanced		Blue View Vision Plus		Blue View Vision Value	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Eye exam (with dilation as needed)	$20 copay	$30 Reimbursement	$10 copay	$30 Reimbursement	$10 copay	$30 Reimbursement	$20 copay	$30 Reimbursement
Frequency	Once every 12 months	Once every 12 months	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year
Standard plastic (CR39) lenses								
Single vision	$20 copay	$25 Reimbursement	$10 copay	$25 Reimbursement	$20 copay	$25 Reimbursement	$20 copay	$25 Reimbursement
Bifocal	$20 copay	$40 Reimbursement	$10 copay	$40 Reimbursement	$20 copay	$40 Reimbursement	$20 copay	$40 Reimbursement
Trifocal	$20 copay	$55 Reimbursement	$10 copay	$55 Reimbursement	$20 copay	$55 Reimbursement	$20 copay	$55 Reimbursement
Frequency	Once every 24 months	Once every 24 months	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year
Lens add-ons								
Factory Scratch	$0 copay	Not covered	$0 copay	Not covered	$0 copay	Not covered	$0 copay	Not covered
Tint	$15 copay	Not covered	$15 copay	Not covered	$15 copay	Not covered	$15 copay	Not covered
Standard anti-reflective coating	$45 copay	Not covered	$45 copay	Not covered	$45 copay	Not covered	$45 copay	Not covered
Standard progressive lens *The copay is in addition to bifocal copay.*	$65 copay	$40 Reimbursement	$65 copay	$40 Reimbursement	$65 copay	$40 Reimbursement	$65 copay	$40 Reimbursement
Polycarbonate								
Members under age 19	$0 copay	Not covered	$0 copay	Not covered	$0 copay	Not covered	$0 copay	Not covered
Members age 19 and over	$40 copay	Not covered	$40 copay	Not covered	$40 copay	Not covered	$40 copay	Not covered
Transitions								
Members under age 19	$0 copay	Not covered	$0 copay	Not covered	$0 copay	Not covered	$0 copay	Not covered
Members age 19 and over	$75 copay	Not covered	$75 copay	Not covered	$75 copay	Not covered	$75 copay	Not covered
Frequency	Once every 24 months	Once every 24 months	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year
Frames	$130 allowance	$45 Reimbursement	$150 allowance	$45 Reimbursement	$130 allowance	$45 Reimbursement	$130 allowance	$45 Reimbursement
Frequency	Once every 24 months	Once every 24 months	Once every calendar year	Once every calendar year	Once every other calendar year	Once every other calendar year	Once every other calendar year	Once every other calendar year
Contact lenses Contact 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.								
Elective (conventional and disposable)	$80 allowance	$60 Reimbursement	$150 allowance	$60 Reimbursement	$130 allowance	$60 Reimbursement	$80 allowance	$60 Reimbursement
Nonelective	$0 copay	$210 Reimbursement	$0 copay	$210 Reimbursement	$0 copay	$210 Reimbursement	$0 copay	$210 Reimbursement
Frequency	Once every 24 months	Once every 24 months	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year

1 NetMinder data, May 2020.
2 Laws in some states may prohibit in-network providers from discounting products and services that are not covered benefits.

Blue View Vision plans

The Blue View Vision Bundled plan can only be purchased with a medical and/or dental plan. All other Blue View Vision plans listed on these pages can be purchased with or without a medical and/or dental plan.

	Blue View Progressive Preferred		Blue View Progressive Select		Blue View Vision Basic		Blue View Vision Premier	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Eye exam (with dilation as needed)	$10 copay	$30 Reimbursement	$10 copay	$30 Reimbursement	$20 copay	$30 Reimbursement	$10 copay	$30 Reimbursement
Frequency	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year
Standard plastic (CR39) lenses								
Single vision	$10 copay	$25 Reimbursement	$20 copay	$25 Reimbursement	$20 copay	$25 Reimbursement	$20 copay	$25 Reimbursement
Bifocal	$10 copay	$40 Reimbursement	$20 copay	$40 Reimbursement	$20 copay	$40 Reimbursement	$20 copay	$40 Reimbursement
Trifocal	$10 copay	$55 Reimbursement	$20 copay	$55 Reimbursement	$20 copay	$55 Reimbursement	$20 copay	$55 Reimbursement
Frequency	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year
Lens add-ons								
Factory Scratch	$0 copay	Not covered	$0 copay	Not covered	$0 copay	Not covered	$0 copay	Not covered
Tint	$5 copay	Not covered	$5 copay	Not covered	$15 copay	Not covered	$5 copay	Not covered
Standard anti-reflective coating	$15 copay	Not covered	$15 copay	Not covered	$15 copay	Not covered	$15 copay	Not covered
Standard progressive lens *The copay is in addition to bifocal copay.*	$30 copay	$40 Reimbursement	$30 copay	$40 Reimbursement	$65 copay	$40 Reimbursement	$65 copay	$40 Reimbursement
Polycarbonate								
Members under age 19	$40 copay	Not covered	$40 copay	Not covered	$40 copay	Not covered	$40 copay	Not covered
Members age 19 and over	$10 copay	Not covered	$10 copay	Not covered	$10 copay	Not covered	$10 copay	Not covered
Transitions								
Members under age 19	$65 copay	Not covered	$65 copay	Not covered	$65 copay	Not covered	$65 copay	Not covered
Members age 19 and over	$20 copay	Not covered	$20 copay	Not covered	$20 copay	Not covered	$20 copay	Not covered
Frequency	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year
Frames	$150 allowance	$45 Reimbursement	$130 allowance	$45 Reimbursement	$150 allowance	$45 Reimbursement	$180 allowance	$45 Reimbursement
Frequency	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year
Contact lenses Contact 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.								
Elective (conventional and disposable)	$150 allowance	$60 Reimbursement	$130 allowance	$60 Reimbursement	$150 allowance	$60 Reimbursement	$180 allowance	$60 Reimbursement
Nonelective	$0 copay	$210 Reimbursement	$0 copay	$210 Reimbursement	$0 copay	$210 Reimbursement	$0 copay	$210 Reimbursement
Frequency	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year

1 NetMinder data, May 2020.
2 Laws in some states may prohibit in-network providers from discounting products and services that are not covered benefits.

Blue View Vision plans

The Blue View Vision Bundled plan can only be purchased with a medical and/or dental plan. All other Blue View Vision plans listed on these pages can be purchased with or without a medical and/or dental plan.

	Blue View Vision Ultra	
	In-network	**Out-of-network**
Eye exam (with dilation as needed)	$10 copay	$30 Reimbursement
Frequency	Once every calendar year	Once every calendar year
Standard plastic (CR39) lenses		
Single vision	$10 copay	$25 Reimbursement
Bifocal	$10 copay	$40 Reimbursement
Trifocal	$10 copay	$55 Reimbursement
Frequency	Once every calendar year	Once every calendar year
Lens add-ons		
Factory Scratch	$0 copay	Not covered
Tint	$5 copay	Not covered
Standard anti-reflective coating	$15 copay	Not covered
Standard progressive lens *The copay is in addition to bifocal copay.*	$65 copay	$40 Reimbursement
Polycarbonate		
Members under age 19	$40 copay	Not covered
Members age 19 and over	$10 copay	Not covered
Transitions		
Members under age 19	$65 copay	Not covered
Members age 19 and over	$20 copay	Not covered
Frequency	Once every calendar year	Once every calendar year
Frames	$200 allowance	$45 Reimbursement
Frequency	Once every calendar year	Once every calendar year
Contact lenses Contact 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.		
Elective (conventional and disposable)	$200 allowance	$60 Reimbursement
Nonelective	$0 copay	$210 Reimbursement
Frequency	Once every calendar year	Once every calendar year

1 NetMinder data, May 2020.
2 Laws in some states may prohibit in-network providers from discounting products and services that are not covered benefits.