Capital BLUE

BlueCross Vision℠

Vision 12/10 Plus

THIS IS NOT A CONTRACT. This information highlights *some* of the benefits available through this program and is NOT intended to be a complete list or description of available services. Benefits are subject to the exclusions and limitations contained in your Certificate of Coverage (COC). Refer to your COC for benefit details.

HIGHLIGHTS	PLAN ALLOWANCES	
Benefit frequencies are based on date of service	**Participating Providers**	**Nonparticipating Providers**
EXAMINATION Once every 12 months	100% after $10 copay	$32
FRAMES [1] Once every 12 months	$120 plus 30% off the retail balance[2]	$60
EYEGLASS LENSES (per pair)[1 & 3] Once every 12 months		
Single Vision Standard Lenses	100%	$24
Bifocal Standard Lenses	100%	$36
Trifocal Standard Lenses	100%	$46
Aphakic/Lenticular Standard Lenses	100%	$72
Polycarbonate Standard Lenses (under age 19)	100%	Not covered
CONTACT LENSES[1 & 3] Once every 12 months		
Disposable (unlimited boxes)	$115, plus 25% off the retail balance [2 & 4]	$75
Conventional including, but not limited to: Hard/soft daily wear and spherical	$115, plus 25% off the retail balance [2 & 4]	$75
Specialty lenses including but not limited to: Bifocal, toric or gas permeable	$115, plus 25% off the retail balance [2 & 4]	$75
Medically necessary (per pair)	100%	$225
CONTACT LENS FITTING & FOLLOW UP Once every 12 months		
Daily wear	100%	$20
Extended wear	100%	$30
Specialty	$50 copay	Not covered

[1] Walmart/Sam's Club: To maintain comparable values with Walmart's pricing structure, your frame allowance will be 50% of the allowance shown above with no additional retail discounts. Your contact lens allowance will be 75% of the allowance shown above with no additional retail discount. Walmart/Sam's Club stores accept BlueCross Vision for materials, not Lens Options. Doctors affiliated with Walmart/Sam's Club are not Walmart employees; therefore, participation for exams varies.

[2] Discounted amounts may vary and may not be honored at all optical retailers

[3] Payment will be made for either lenses or contact lenses within a benefit period. Payment will not be made for both.

[4] Retail discounts do not apply to Contact Fill.

VALUE ADDED DISCOUNTS[5]

Costs associated with the services and materials listed below are the responsibility of the member. Valid at participating providers only.

LENS OPTIONS AND ADDITIONAL SERVICES	Member Responsibility
Solid Tint	$10
Fashion / Gradient Tint	$12
Standard Scratch-Resistant Coating	$10
Ultraviolet Coating	$12
Standard Anti-reflective Coating	$40
Glass Photogrey	$20 (SV); $30 (bifocal/trifocal)
Polarized	$75
Standard Progressive Lenses [6]	$50
Premium Progressive Lenses [6]	$100
Transitions	$65 (SV);$70 (bifocal/trifocal)
Polycarbonate Standard Lenses (age 19 and older)	$25 (SV); $30 (bifocal/trifocal)
Blended Bifocal (Segment)	$30
Blue Blockers	Standard $40, Premium $60, Ultra $150 or 20% off U&C
High Index	$55
Retinal Imaging	$39
Additional supplies (excluding contact lenses)	20% of retail
LASIK SURGERY	Retail Discount

VALUE ADDED PLUS [5]

Value Added Plus provides discounts on additional purchases during the benefit period after the insured benefits have been exhausted. Costs associated with the services and materials listed below are the responsibility of the member. Valid at participating providers only.

Benefit frequencies are unlimited

SERVICE AND MATERIALS	Member Responsibility
EXAMINATION	Balance after $10 Discount
FRAMES	35% off retail
EYEGLASS LENSES (per pair)	
Single Vision Standard Lenses	$35
Bifocal Standard Lenses	$55
Trifocal Standard Lenses	$70
Aphakic/Lenticular Standard Lenses	$70
CONTACT LENSES[4]	
Disposable (unlimited boxes)	10% off retail
Conventional including, but not limited to: Hard/soft daily wear and spherical	15% off retail
Fitting & Follow up	10% off retail
LENS OPTIONS	
Ultraviolet Coating	$12
Tint (Solid & Gradient)	$12
Scratch-Resistant Coating (Standard)	$15
Polycarbonate (Standard)	$35
Anti-Reflective Coating (Standard)	$45
Polarized	$75
Transitions (Standard)	$65 (Single vision) $70 (bifocal or trifocal)
Blue Blockers	Standard $40, Premium $60, Ultra $150 or 20% off U&C
Standard Progressive Lenses[6]	$50+ Bifocal or trifocal lens charge
Additional supplies	20% off retail

[5]Value Added Discounts & Value Added Plus are not part of the insured benefits. Value Added Discounts & Value Added Plus are a reduced fee-for-service discount program. Members pay a discounted amount for listed services by participating providers. Capital BlueCross does not pay the participating providers for these services. Discounted pricing does not apply at Walmart, Sam's Club and select retailers. Discounted amounts may vary and may not be honored at all participating provider locations. Contact your provider's office to verify their participation in this program.

[6] Fixed discounted pricing is not available on all brands.

Deductibles, coinsurance and copayments under this program are separate from any deductibles, coinsurance and copayments described in your company's other health benefits coverage.

Capital BLUE

BlueCross Dental℠
Dental PPO Basic

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HIGHLIGHTS	MEMBER COST-SHARING
NETWORK: BlueCross Dental PPO	
DEDUCTIBLE	
Per benefit period Deductible waived for diagnostic and preventive.	$50 per member $150 per family
BENEFIT PERIOD PROGRAM MAXIMUM	
When the program maximum is reached, the Member pays 100% until the end of the benefit period.	$1,500 per member per benefit period
DIAGNOSTIC AND PREVENTIVE (Deductible Waived)	
Routine Exams (oral exams limited to twice in twelve months; pregnant women and diabetics may receive one additional oral exam)	Covered in full
X-rays • Periapical X-rays as required • Bitewing X-rays twice in twelve months • Full Mouth or Panoramic X-rays once in three years	Covered in full
Fluoride Treatments (twice in twelve months for dependent children to age 19)	Covered in full
Fluoride Treatments (once in twelve months for adults)	20%
Prophylaxis (twice in twelve months; pregnant women and diabetics may receive one additional cleaning)	Covered in full
Sealants (for dependent children to age 15 on permanent first and second molars; one sealant per tooth in any three year period)	Covered in full
Space Maintainers (for dependent children to age 19)	Covered in full
Palliative Emergency Treatment (acute condition requiring immediate care)	Covered in full
Consultations	Covered in full
BASIC SERVICES	
Basic Restorative (amalgam “silver” fillings and composite “white” fillings)	20%
Endodontics (procedures for pulpal therapy and root canal filling)	20%
Periodontics (treatment to the gums and supporting structures of the teeth; surgical and non-surgical periodontal treatment is covered)	20%
Oral Surgery (extraction and oral surgery procedures, including pre- and post-operative care; general anesthesia is covered when used in conjunction with covered oral surgical procedures)	20%

Participating providers agree to accept our allowed amount as payment in full—often less than their normal charge. If you visit a nonparticipating provider, you are responsible for paying the deductible, coinsurance and the difference between the nonparticipating provider’s charges and the allowed amount.

Deductibles, coinsurance and copayments under this program are separate from any deductibles, coinsurance and copayments described in your company’s other health benefits coverage.

Paper claims may be submitted to the following address: BlueCross Dental; PO Box 1126; Elk Grove Village, IL 60009.

Electronic claims may be submitted using Payor ID CBC01.

Benefits are issued by Capital Advantage Assurance Company®, a subsidiary company of Capital BlueCross. Independent licensee of the BlueCross BlueShield Association. Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.

Capital BLUE

BlueCross Dental℠
Dental PPO Plus

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HIGHLIGHTS	MEMBER COST-SHARING
NETWORK: BlueCross Dental PPO	
DEDUCTIBLE	
Per benefit period	$50 per member
Deductible waived for diagnostic and preventive, and orthodontic treatment	$150 per family
BENEFIT PERIOD PROGRAM MAXIMUM	
When the program maximum is reached, the Member pays 100% until the end of the benefit period	$1,500 per member per benefit period
DIAGNOSTIC AND PREVENTIVE (Deductible Waived)	
Routine Exams (oral exams limited to twice in twelve months; pregnant women and diabetics may receive one additional oral exam)	Covered in full
X-rays • Periapical X-rays as required • Bitewing X-rays twice in twelve months • Full Mouth or Panoramic X-rays once in three years	Covered in full
Fluoride Treatments (twice in twelve months for dependent children to age 19)	Covered in full
Fluoride Treatments (once in twelve months for adults)	20%
Prophylaxis (twice in twelve months; pregnant women and diabetics may receive one additional cleaning)	Covered in full
Sealants (for dependent children to age 15 on permanent first and second molars; one sealant per tooth in any three year period)	Covered in full
Space Maintainers (for dependent children to age 19)	Covered in full
Palliative Emergency Treatment (acute condition requiring immediate care)	Covered in full
Consultations	Covered in full
BASIC SERVICES	
Basic Restorative (amalgam “silver” fillings and composite “white” fillings)	20%
Endodontics (procedures for pulpal therapy and root canal filling)	20%
Periodontics (treatment to the gums and supporting structures of the teeth; surgical and non-surgical periodontal treatment is covered)	20%
Oral Surgery (extraction and oral surgery procedures, including pre- and post-operative care; general anesthesia is covered when used in conjunction with covered oral surgical procedures)	20%
MAJOR SERVICES	
Major Restorative (crowns, inlays, onlays)	50%
Prosthodontics • Procedures for replacement of missing teeth by construction or repair of bridges and partial or complete dentures; prosthetic replacement limited to once in five years • Implant surgical placement and removal; implant supported prosthetics, including repair and recementation	50%
ORTHODONTICS (Deductible Waived)	
Orthodontic Treatment (covered for dependent children to age 19; procedure for straightening teeth)	50%
ORTHODONTICS LIFETIME MAXIMUM	
Lifetime maximum per dependent	$1,000

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