Vision Plans

Product Guide: Standalone Plans

Group Size	2+										
Carrier	**VSP**										
Plan Name	**Plan A $20**	**Plan B $25 ($130)**	**Plan B $25**	**Plan C $25 ($130)**	**Plan B $25**	**Plan C $25**	**Plan B $20/$20**	**Plan B $10/$25**	**Plan C $10/$25**	**Plan C $20/$20**	**Plan C $25**
Network	Choice	Choice	Signature	Choice	Choice	Choice	Choice	Choice	Choice	Choice	Choice
Contribution Type	Employer Paid (ER)	ER Paid	ER Paid	ER Paid	ER Paid	ER Paid	Voluntary	Voluntary	Voluntary	Voluntary	Voluntary
Minimum Participation (Employees/%)	2/100%	2/100%	2/100%	2/100%	2/100%	2/100%	2	2	2	2	2
DE-9C Requirements	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No
Industry Loads	No	No	No	No	No	No	No	No	No	No	No
Ineligible Industries	No	No	No	No	No	No	No	No	No	No	No
Open Enrollment	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Rate Guarantee	2 year	2 year	2 year	2 year	2 year	2 year	2 year	2 year	2 year	2 year	2 year
Administration Fee	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Exam Copay	$20	$25	$25	$25	$25	$25	$20	$10	$10	$20	$25
Materials Copay							$20	$25	$25	$20	
Frequency (months)	12/24/24	12/12/24	12/12/24	12/12/12	12/12/24	12/12/12	12/12/24	12/12/24	12/12/12	12/12/12	12/12/12
Frames Allowance (In/Out)	$150/70*	$130/70*	$150/70*	$130/70*	$150/70*	$150/70*	$150/70*	$180/70*	$200/70*	$200/70*	$150/70*
Contact Lenses Allowance (In/Out)	$150/$105*	$130/$105*	$150/$105*	$130/$105*	$150/$105*	$150/$105*	$150/$105*	$180/$105*	$200/$105*	$200/$105*	$150/$105*
Eye Exam (Out)	$45*	$45*	$50*	$45	$45	$45	$45	$45	$45	$45	$45
Single Vision Lenses (Out)	$30*	$30*	$50*	$30*	$30*	$30*	$30*	$30*	$30*	$30*	$30*
Bifocal Lenses (Out)	$50*	$50*	$75*	$50*	$50*	$50*	$50*	$50*	$50*	$50*	$50*
Trifocal Lenses (Out)	$65*	$65*	$100*	$65*	$65*	$65*	$65*	$65*	$65*	$65*	$65*

Eye Exams, Single Vision Lenses, Bifocal Lenses, Trifocal Lenses are covered in full after copay for In-Network

* Reimbursed up to amount shown

Vision Plans

Product Guide: Standalone Plans

Group Size	2-100						
Carrier	**Anthem****				**UnitedHealthcare**		
Plan Name	**Blue View Vision A6**	**Blue View Vision B6**	**Blue View Vision C8**	**Blue View Vision M05 Materials Only**	**Classic**	**Preferred**	**Elite**
Network	Blue View Vision	Blue View Vision	Blue View Vision	Blue View Vision	United Healthcare	United Healthcare	United Healthcare
Contribution Type	ER Paid or Voluntary (5+)	ER Paid or Voluntary (5+)	ER Paid or Voluntary (5+)	ER Paid or Voluntary (5+)	ER Paid or Voluntary	ER Paid or Voluntary	ER Paid or Voluntary
Minimum Participation (Employees/%)	ER Paid: 2/50%, 2/100% for 100% ER Paid Voluntary: 5				1	1	1
DE-9C Requirements	No	No	No	No	No	No	No
Industry Loads	No	No	No	No	No	No	No
Ineligible Industries	No	No	No	No	No	No	No
Open Enrollment	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Rate Guarantee	2 years	2 years	2 years	2 years	3 years	3 years	3 years
Administration Fee	No	No	No	No	No	No	No
Exam Copay	$10	$10	$10	N/A	$15	$10	$10
Materials Copay	$25	$25	$25	$25	$30	$25	$10
Frequency (months)	12/12/12	12/12/24	12/12/24	NA/12/12	12/12/24	12/12/24	12/12/12
Frames Allowance (In/Out)	$130/$92*	$130/$92*	$130/$92*	$130/$92*	$100/$45*	$130/$45*	$150/$45*
Contact Lenses Allowance (In/Out)	$130/$92*	$130/$92*	$130/$92*	$130/$92*	Up to 4 boxes/$105*	Up to 4 boxes/$105*	Up to 4 boxes/$105*
Eye Exam (Out)	$49*	$49*	$49*	N/A	$40*	$40*	$40*
Single Vision Lenses (Out)	$40*	$40*	$40*	$40*	$40*	$40*	$40*
Bifocal Lenses (Out)	$60*	$60*	$60*	$60*	$60*	$60*	$60*
Trifocal Lenses (Out)	$80*	$80*	$80*	$80*	$80*	$80*	$80*

Eye Exams, Single Vision Lenses, Bifocal Lenses, Trifocal Lenses are covered in full after copay for In-Network. Eye Exams are not covered for Anthem Blue View Vison M05.

* Reimbursed up to amount shown

** The full portfolio of Anthem Blue View vision plans are available. Please refer to Anthem's Small Group Product Guide for details.