ARKANSAS BLUE CROSS VISION
Employer Rates

As an employer, you understand the advantages of providing healthcare benefits for your employees. Arkansas Blue Cross and Blue Shield group vision plans are an important part of any benefits package. Arkansas Blue Cross has joined with VSP to help your employees get vision coverage that's clearly a good choice.

	Silver	Silver II
GROUP		
Employee	$5.39	$5.91
Employee + Spouse	$9.96	$11.86
Employee + Child(ren)	$10.77	$12.69
Employee + Spouse + Child(ren)	$15.34	$20.26
VOLUNTARY		
Employee	$7.73	$8.03
Employee + Spouse	$14.30	$16.03
Employee + Child(ren)	$15.45	$17.17
Employee + Spouse + Child(ren)	$22.02	$27.43

	Gold	Gold II
GROUP		
Employee	$6.26	$7.63
Employee + Spouse	$11.57	$15.26
Employee + Child(ren)	$12.51	$16.34
Employee + Spouse + Child(ren)	$17.84	$26.09
VOLUNTARY		
Employee	$9.00	$10.33
Employee + Spouse	$16.67	$20.67
Employee + Child(ren)	$18.02	$22.10
Employee + Spouse + Child(ren)	$25.67	$35.33

	Platinum	Platinum II
GROUP		
Employee	$9.56	$9.23
Employee + Spouse	$17.67	$18.49
Employee + Child(ren)	$19.10	$19.77
Employee + Spouse + Child(ren)	$27.21	$31.60
VOLUNTARY		
Employee	$13.62	$12.50
Employee + Spouse	$25.20	$25.00
Employee + Child(ren)	$27.23	$26.77
Employee + Spouse + Child(ren)	$38.82	$42.77

Group: Employer must contribute minimum of 50% of employee-only rate.

Voluntary: Employee funds the entire plan.

Guidelines for vision groups

Arkansas Blue Cross Vision plans for groups will require a minimum of:

Group: Greater of five or 50% of eligible employees with a minimum of 50% employer contribution based on the individual rate only.

Voluntary: Two contracts (regardless of group size).

Questions? Contact your Arkansas Blue Cross marketing representative or agent to learn more about our vision plans.

*On behalf of Arkansas Blue Cross and Blue Shield, Vision Service Plan assists in the administration of vision benefits. VSP is an independent company that operates separately from Arkansas Blue Cross and Blue Shield, and contracts with vision care providers and provides lenses, frames and contact lenses.

Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

VSP® Vision Care

MPI 5580.1 8/18

Terms, Conditions, Exclusions and Limitations of the Plan
This is a group insurance product offered through an employer. A group policy is issued in consideration of the employer's application, the employer's covenants and the employer's payment of the premium. The group policy is renewable month to month, by payment of the monthly premium. The premium for the group policy may be adjusted upon thirty (30) days' notice. The group policy is subject to termination according to its terms.

Eligibility for Employees
Employees must be eligible for, and have coverage through, their employer. General requirements for eligibility may include, but are not limited to, employees who work on a full-time basis for the employer; complete the required waiting period, if applicable; be in a class of employees who are included in the plan; and work at least the specified hours per week and the specified weeks per year in the Benefit Certificate. Coverage is provided through form numbers 17-280 and 17-281.

Eligibility for Dependents
Eligible dependents include the employee's spouse and children under age 26 as well as children incapable of self support because of mental retardation or physical disability, provided requirements are met.

Limitations of the Plan
VISION EXAMINATION BENEFIT: A vision examination includes but is not limited to, case history (eye and vision history and medical history); entrance distance acuities; external ocular evaluation including slit lamp examination; internal ocular examination; tonometry; distance refraction (objective and subjective); binocular coordination and ocular motility evaluation; evaluation of papillary function; biomicroscopy; gross visual fields; assessment and planning; vision care counseling; form completion; and dilated fundus examination (DFE) (diagnostic procedure used in the detection and management of diabetes, glaucoma, hypertension and other ocular and/or systemic diseases when professionally indicated).

VISION MATERIALS BENEFIT: If a vision examination results in a covered person needing corrective vision materials for their visual health and welfare, those vision materials prescribed by providers will be covered, subject to the following limitations:

(1) *Spectacle Lenses* – Provided one time in each frequency period;
(2) *Frames* – One frame provided one time in each frequency period;
(3) *Contact Lenses* – Contact lens benefit provided in lieu of frames and/or lenses no more than one time in each frequency period. Participating providers will apply the allowable charge toward a contacts supply.

Necessary Contact Lenses: Necessary contact lenses are subject to prior verification and are limited to one pair of lenses per frequency period unless a subsequent vision examination shows a prescription change that qualifies for another lens or lenses due to medical necessity. You or your attending provider must send a completed request to the company for necessary contact lenses before the lenses are dispensed initially or due to a change in prescription. Any amount due over the allowable charge for such lenses is your responsibility. If you do not obtain prior verification for necessary contact lenses initially or due to a prescription change, the entire charge is your responsibility.

Low Vision Coverage: Subject to prior approval, coverage is provided for low-vision services and optical devices as described below.

1. Complete low vision analysis/diagnosis, which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated. This examination, sometimes called a functional vision assessment, can determine distance and clarity of vision, the size of readable print, the existence of blind spots or tunnel vision, depth perception, eye-hand coordination, problems perceiving contrast and lighting requirements for optimum vision. Services from a non-participating provider are only covered up to $125.00.
2. Maximum low-vision aids as visually necessary or appropriate are covered at 75% of the cost up to maximum of $1,000 every two years for items such as high power spectacles, magnifiers and telescopes. These devices are utilized to maximize use of available vision, reduce problems of glare or increase contrast perception, based on the individual's visual goals and lifestyle needs.

Laser Vision Correction Discounts: A covered person is entitled to savings of up to 10%-20% off the provider's charge, or a 5% discount on any advertised special through our network of physicians and refractive surgery centers (some centers provide a flat fee equating to these discount levels).

Ancillary Product Discount: Most participating providers provide a twenty percent (20%) courtesy discount for items not covered by this Benefit Certificate, e.g. second pair of glasses, sunglasses, etc.

Exclusions of the Plan
No coverage will be provided for: services or supplies collectible under Worker's Compensation or any law providing benefits for dependents of military personnel; services for conditions which treatment is provided by federal or state government or are provided without cost; experimental or investigational services; services provided by an immediate relative; charges for services or supplies for which no charge is made that the covered person is legally obligated to pay; charges for which no charge would be made in the absence of vision coverage; charges for service by other than a provider; charges by a provider to complete forms for benefit determinations; fees charged by a provider for services other than covered vision examination or covered vision materials must be paid in full by the covered person to the provider; benefits for services of materials started prior to the date the covered person was eligible under this Benefit Certificate; orthoptic or vision training, subnormal vision aids and any associated supplemental testing and aniseikonic lenses; medical and/or surgical treatment of the eye, eyes or supporting structures; any vision examination or any corrective eyewear required by an employer as a condition of employment and safety eyewear, unless specifically covered under this Benefit Certificate; Plano (non-prescription) lenses or non-prescription sunglasses; two pair of glasses in lieu of bifocals; lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next frequency period when vision materials would next become available; specialized techniques that entail procedure and process over and above that which is normally adequate – any additional fee is the covered person's responsibility; all other services not specifically listed as benefits herein; contact lens replacement.

Terms
Coverage will terminate if a covered person ceases to be eligible as an employee or dependent for any reason or if premiums are not paid timely by the employer.