SANGAMON COUNTY VISION INDEMNITY PROGRAM

Coverage Highlights

1. Included with your medical benefits
2. No deductible
3. Reimbursement based on the following schedule:

Vision Exam	$32 per exam
Single Vision Lenses	$28 per pair
Bifocal Lenses	$50 per pair
Trifocal Lenses	$70 per pair
Lenticular Lenses	$140 per pair
Contact Lenses (permanent or disposal)	$140 per pair or per year for disposable
Frames	$28 per frame

Frequency limitation:

- one vision exam per twelve consecutive months
- one pair of lenses per twelve consecutive months
- one set of frames per 24 consecutive months

NOTE: Additional benefits will be provided within the benefit period if a prescription change is required from previous lenses covered by the BCBSIL Vision Plan.

Eligible providers: Ophthalmologists, Optometrists, and Opticians

Follow these three easy steps:

1. Visit any provider to receive reimbursement on the schedule listed above. Maximize your benefits by using the discounts available through EyeMed Vision Care providers on the Blue Cross Blue Shield of IL Discount Plan. See attached flier for discounts available. For a list of EyeMed providers, go to https://eyemedvisioncare.com/locator to complete a search.
2. Pay for your exam, lenses or contacts, and submit your receipt to BCBSIL along with a completed claim form (attached).
3. Receive the reimbursement noted above directly from Blue Cross.

BlueCross BlueShield of Illinois

Blue365®
Because health is a big deal℠

Blue365®
EyeMed Vision Discount Program



Blue Cross and Blue Shield of Illinois (BCBSIL) is pleased to offer you a vision discount program through EyeMed Vision Care.

What?
The EyeMed Vision Discount through Blue365 offers savings on eyeglasses, contact lenses, eye exams, accessories and laser vision correction. See the back page for a full list of discounts.

Who?
The EyeMed network consists of major national and regional retail locations, such as LENSCRAFTERS®, PEARLE VISION®, Target Optical®, Sears Optical® and JCPenney Optical, as well as independent ophthalmologists and optometrists. Additionally, you may go online to in-network providers at contactsdirect.com.

Where?
Visit eyemedexchange.com/blue365, click Find a Provider and begin your search. Be sure the Advantage network is selected.

For more information about Blue365, log in to Blue Access for Members℠ (BAM) at bcbsil.com. Click the My Coverage tab at the top, and then click the Discounts link on the left.

Referral?
You don't need a referral. Simply visit any EyeMed provider and show your BCBSIL medical ID card.

Program Features
- Discounts on vision care services and materials
- No limit to the number of times the member can receive discounts on purchases
- Access to large provider network
- Convenient evening and weekend hours

Note: This in not insurance. When contacting EyeMed or any retailer or provider in the Eyemed Advantage network, be sure to refer to the discount program.

See all the Blue365 deals and learn more at **blue365deals.com/BCBSIL**.

EyeMed Vision Discounts



For more information, visit eyemedexchange.com/blue365 or call EyeMed's automated help line at 866-273-0813.

Vision Care Services	Cost
Exam with dilation as necessary:	$50 routine exam $10 off contact lens fit and follow-up
Complete Pair of Glasses Purchase: frame, standard plastic lenses, and lens options must be purchased in the same transaction to receive full discount	
Frames*	
Any frame available at provider location	35% off retail price
Standard Plastic Lenses*	
Single-vision	$50
Bifocal	$70
Trifocal	$105
Lenticular	$105
Standard Progressive	$135
Premium Progressive	30% off retail price
Lens Options*	
UV Coating	$12
Tint (Solid and Gradient)	$12
Standard Scratch-resistance	$12
Standard Polycarbonate	$35
Standard Anti-reflective	$40
Other Add-ons and Services	30% off retail price
* Items purchased separately will be discounted 20% off of the retail price.	
Contact Lens Materials (applied to materials only)	
Conventional	15% off retail price
Laser Vision Correction	
Lasik or PRK	15% off retail price or 5% off promotional price
Frequency	
Examination	Unlimited
Frame	Unlimited
Lenses	Unlimited
Contact Lenses	Unlimited

Discounts are only available through participating vendors.

The relationships between Blue Cross and Blue Shield of Illinois (BCBSIL) and EyeMed are that of independent contractors.

Blue365 is a discount program available to BCBSIL members. This is NOT insurance. Some of the services offered through Blue365 may be covered under your health plan. Please refer to your benefit booklet or call the Customer Service number on the back of your ID card for specific benefit information under your health plan. Use of Blue365 does not affect your premium, nor do costs of Blue365's services or products count toward any maximums and/or plan deductibles.

BCBSIL does not guarantee or make any claims or recommendations regarding the services or products offered under Blue365. You may want to consult with your physician prior to use of these services and products. Services and products are subject to availability by location. BCBSIL reserves the right to discontinue or change this discount program at any time without notice.

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

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VISION CLAIM FORM

FAX No.: (855) 831-3249

3 HEALTH INSURANCE CLAIM FORM
Send Completed Claim Form To:
Blue Cross and Blue Shield of Illinois
P.O. Box 805107
CHICAGO, IL 60680-4112

NOTICE TO ALL PARTIES COMPLETING THIS FORM. It is fraudulent to fill out this form with information you know to be false or to omit important facts. Criminal and/or civil penalties can result from such acts.

PLEASE PRINT OR TYPE CLEARLY

ID NUMBER - Copy this from your Blue Cross and Blue Shield Identification Card.

GROUP NUMBER:	IDENTIFICATION NUMBER:

PATIENT INFORMATION - A separate claim form must be completed for each family member.

PATIENT'S FULL LEGAL NAME (Last, First, Middle Initial)	SEX: ☐ Male ☐ Female	SOCIAL SECURITY NUMBER (optional):	DATE OF BIRTH Month / Day / Year

PATIENT IS: ☐ Member ☐ Spouse ☐ Child ☐ Other, please explain relationship

IF CLAIM IS FOR CHILD 19 OR OLDER - IS CHILD: A full time student? ☐ Yes ☐ No Handicapped? ☐ Yes ☐ No

PAYEE:

☐ MAKE PAYMENT TO THE PROVIDER (hospital, doctor, etc.), OR

☐ MAKE PAYMENT TO MEMBER, the provider has been paid

MEMBER INFORMATION:

MEMBER (POLICY HOLDER) NAME: (As shown on your Blue Cross and Blue Shield ID card)	SOCIAL SECURITY NUMBER (optional):	DATE OF BIRTH Month / Day / Year

CURRENT ADDRESS:	HOME PHONE:
IF COVERAGE IS THRU YOUR EMPLOYER, PROVIDE: GROUP (EMPLOYER) NAME	WORK PHONE:

CLAIM INFORMATION:

IS CLAIM FOR AN ACCIDENTAL INJURY? ☐ Yes ☐ No	IS THIS A WORKERS COMPENSATION CLAIM? ☐ Yes ☐ No	DATE OF ACCIDENT:

BRIEFLY DESCRIBE INJURY:

COMPLETE BELOW IF NON-ACCIDENTAL INJURY OR ILLNESS

DATE FIRST TREATED:	BRIEFLY DESCRIBE THE CONDITION(S) FOR WHICH THE PATIENT RECEIVED THESE SERVICES: (You can usually copy the diagnosis or description of service from the provider bill.)

OTHER INSURANCE INFORMATION

Are there any OTHER medical benefits available to you, your spouse, or your dependents from OTHER Group Insurance, including OTHER Blue Cross and Blue Shield policies, OTHER Employer, Labor or Professional Organizations, School, etc? ☐ Yes, (provide below ☐ No

POLICY HOLDER NAME:	SOCIAL SECURITY NUMBER (optional):

POLICY HOLDER IS: ☐ Member ☐ Spouse ☐ Child ☐ Other, please explain relationship

INSURANCE CARRIER NAME:	POLICY NUMBER	EFFECTIVE DATE:
ADDRESS:		PHONE NUMBER

RELEASE OF INFORMATION: I certify that the above information is correct and that the bills attached were incurred by the patient listed above. I understand that Blue Cross and Blue Shield's use or disclosure of individually identifiable health information, whether furnished by me or obtained from other sources such as medical providers, shall be in accordance with the federal privacy regulations under HIPPA (Health Insurance Portability and Accountability Act of 1996).

Sign Here _____ Date _____

Signature of Member