



A Guide to Your VISION BENEFITS

Nebraska Schools BlueVision
Option 63

Schedule of Benefits Summary

Option 63

\$200 Frame Allowance/\$25 Lens Copay/Discounted Fit and Follow Up/FREQ 12/12/12

Insight Network

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Vision Examination		
Exam	\$10 Copay	Up to \$35
Dilation	Included with Exam	N/A
Refraction	Included with Exam	N/A
Frames	80% of Balance over \$200	Up to \$100
Lens		
Single Vision	\$25 Copay	Up to \$25
Bi-focal	\$25 Copay	Up to \$40
Tri-focal	\$25 Copay	Up to \$55
Standard Progressive Lens	\$90 Copay	Up to \$40
Premium Progressive Lens		
• Tier 1	\$110 Copay	
• Tier 2	\$120 Copay	Up to \$40
• Tier 3	\$135 Copay	
• Tier 4	80% of Retail Less \$120 Plus \$90 Copay	
Lenticular	\$25 Copay	Up to \$55
Other Lens Type	80% of Charge	N/A
Lens Options		
Standard Polycarbonate	\$40	N/A
Standard Plastic Scratch Coating	\$15	N/A
Tint	\$15	N/A
UV Treatment	\$15	N/A
Standard Anti-reflective (a/r) Coating	\$45	N/A
Premium Anti-reflective (a/r) Coating		
• Tier 1	\$57	N/A
• Tier 2	\$68	N/A
• Tier 3	80% of Retail	N/A
Photochromatic/Transitions	\$75	N/A
Other Lens Options	80% of Retail	N/A
Contact Lenses		
• Conventional	85% of the Balance Over \$200	Up to \$160
• Disposable	100% of the Balance Over \$200	Up to \$160
• Medically Necessary	\$0 Copay	Up to \$200
Fit and Follow-Up Discount		
• Standard	Up to \$40	N/A
• Premium	Discount of 10% Off Retail Price	N/A
Non-Scheduled Items		
• Doctor Misc. Materials	80% of Charge	N/A
LASIK or PRK Vision Correction	85% of the Retail Price or 95% of a Promotional Price	N/A
Benefit Frequency		
Contact Lenses or Lens Exam	Once Every Calendar Year	
Frame	Once Every Calendar Year	
Shades of Blue Base Plan Included		



**PREFERRED PROVIDER ORGANIZATION
MASTER GROUP
LIMITED BENEFIT CONTRACT
FOR EMPLOYERS AND ASSOCIATIONS**



This Contract is a Preferred Provider limited benefit plan offered by Blue Cross and Blue Shield of Nebraska, Inc. (BCBSNE), a domestic insurance company, licensed by the State of Nebraska. This Contract is made in and governed by the laws of the State of Nebraska. Defined terms are capitalized throughout this Contract.

This Contract is underwritten and administered by Us. The Contract provides In-network benefits for specific health Services provided to Covered Persons by In-network Physicians, Hospitals and other health care providers. These providers have agreed to furnish Services to Covered Persons in a manner reasonably expected to effectively manage health care costs. This Contract also provides Out-of-network benefits for health care Services performed by Out-of-network Providers.

We agree to make payment for the health Services described, defined and limited herein during the term of this Contract. This Contract is effective beginning 12:01 a.m. on the effective date stated in the Master Group Application, in consideration of the payment of premiums, charges or as provided in the Master Group Application or attachments thereto.

This entire Contract consists of the Master Group Application, the enrollment information, this document and any addenda, attachments or endorsements thereto. Only We can approve a change to this Contract and that change must be in writing. Any change will affect all Covered Persons and no agent may change the Contract in any way.

The Group, as the agent representing the group health plan, binds all Subscribers and their covered Eligible Dependents who are beneficiaries of such plan, to the terms and conditions of this Contract.

BLUE CROSS AND BLUE SHIELD OF NEBRASKA

A handwritten signature in blue ink, appearing to read "Jeff Russell".

**Jeff Russell, President and
Chief Executive Officer**

Blue Cross and Blue Shield of Nebraska
1919 Aksarben Drive
Omaha, NE 68180
(402) 982-7000

THIS POLICY IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

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EFFECTIVE DATES

Effective Date of Insured's Insurance. The Insured's insurance will be effective as follows:

1. if the Policyholder does not require the Insured to contribute toward the premium for this coverage, the Insured's insurance will be effective on the date the Insured becomes eligible;
2. if the Policyholder requires the Insured to contribute toward the premium for this coverage, the Insured's insurance will be effective on the date the Insured becomes eligible, provided;
 - a. the Insured has given the Company the Insured's enrollment form (if required) on, prior to, or within 30 days of the date the Insured becomes eligible; and
 - b. the Insured has agreed to pay the required premium contributions; and
3. if the Insured fails to meet the requirements of 2 a) and 2 b) within 30 days after becoming eligible, the Insured's coverage will not become effective until the Company has verified that the Insured has met these requirements. The Insured will then be advised of the Insured's effective date.

Effective Date of Dependents' Insurance. Coverage for Dependents becomes effective on the later of:

1. the date Dependent coverage is first included in the Insured's coverage; or
2. the premium due date on or after the date the person first qualifies as the Insured's Dependent. If an enrollment form is required, the Insured must provide such form and agree to pay any premium contribution that may be required prior to coverage becoming effective.

If the Insured and the Insured's spouse are both Insureds, one Insured may request to be a Dependent spouse of the other. A Dependent child may not be covered by more than one Insured.

Newborn Children. A Dependent child born while the Insured's coverage is in force will be covered from the moment of birth for 31 days or a greater number of days, if elected by the Policyholder. To continue coverage beyond this period, the Insured must provide notice to the Company and agree to pay any premium contribution that may be required within this period.

Adopted Children. If a Dependent child is placed with the Insured for adoption while the Insured's coverage is in force, this child will be covered from the date of placement for 31 days or a greater number of days, if elected by the Policyholder. To continue coverage beyond this period, the Insured must provide notice to the Company and agree to pay any premium contribution that may be required within this period. If proper notice has been given, coverage will continue unless the placement is disrupted prior to legal adoption and the child is removed from placement.}

BENEFITS

Benefits are payable for each Insured Person as shown in the Schedule of Benefits for expenses incurred while this insurance is in force.

In-Network Provider Benefits. The Insured Person must pay any Copayment or any cost above the Allowance shown in the Schedule of Benefits at the time the covered service is provided. Benefits will be paid to the In-Network Provider who will file a claim with the Company on behalf of the Insured Person.

Out-of-Network Provider Benefits. The Insured Person must pay the Out-of-Network Provider the full cost at the time the covered service is provided and file a claim with the Company,

unless the Out-of-Network Provider allows assignment of benefits. The Company will pay the Out-of-Network benefits up to the maximum dollar amount shown in the Schedule of Benefits.

LIMITATIONS

Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy.

Allowances provide no remaining balance for future use within the same Benefit Frequency.

EXCLUSIONS

No benefits will be paid for services or materials connected with or charges arising from:

1. medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures;
2. services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
3. orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
4. any Vision Examination or any corrective Vision Materials required by an employer as a condition of employment;
5. safety eyewear;
6. solutions, cleaning products or frame cases;
7. non-prescription sunglasses;
8. plano (non-prescription) lenses
9. plano (non-prescription) contact lenses;
10. two pair of glasses in lieu of bifocals;
11. electronic vision devices,
12. services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or
13. lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available.

TERMINATION OF INSURANCE

The Policyholder or the Company may terminate or cancel the Policy as shown in the Policy.

For All Insureds. The Insureds' insurance will cease on the earlier of:

1. the date the Policy ends;
2. the end of the last period for which any required premium contribution agreed to in writing has been made; or
3. the date the Insured is no longer eligible for insurance.

For Dependents. A Dependent's insurance will cease on the earlier of:

1. the date the Insured's coverage ends;
2. the date the Dependent ceases to be an eligible Dependent as defined in the Policyholder's application; or
3. the end of the last period for which any required premium contribution has been made.

A Dependent child will not cease to be a Dependent solely because of age if the child is:

1. not capable of self-sustaining employment due to mental incapacity or physical handicap that began before the age limit was reached; and
2. mainly dependent on the Insured for support.

The Company may ask for proof of the eligible Dependent child's incapacity and dependency two months prior to the date the Dependent child would otherwise cease to be covered.

The Company may require the same proof again, but will not request it more than once a year after this coverage has been continued for two years. This continued coverage will end on the earlier of:

1. on the date the Policy ends;
2. on the date the incapacity or dependency ends;
3. on the end of the last period for which any required premium contribution for the Dependent child has been made; or

PREMIUMS

The Company provides insurance coverage in return for premium payment. Premiums are payable to the Company by the Policyholder on behalf of the Insured Person. The Insured Person's first premium is due on the Insured Person's Effective Date. Premiums must be paid to the Company on or before the due date. The initial premium rates are shown in the Policyholder's application.

Premium Changes. The Company has the right to change the premium rates on any premium due date as allowed in the Policy. The Company will provide written notice to the Policyholder at least 31 days before the date of the change. The premium rates also may be changed at any time the terms of the Policy are changed.

Grace Period. The Policy has a 31-day grace period for the payment of each premium due after the first premium. Coverage will continue in force during the grace period. Coverage will terminate at the end of the grace period if all premiums due are not paid. The Company will require payment of all premiums for the period this coverage continues in force, including the premiums for the grace period. The grace period will not apply if the Company receives written notice of the Policyholder's or the Insured's intent to terminate coverage.

Unpaid Premium. When a claim is paid during the grace period, any premium due and unpaid for the Insured Person will be deducted from the claim payment.

CLAIMS

Notice of Claim. Written notice of claim must be given to the Company within 30 days after the occurrence or commencement of any loss covered by the Policy, or as soon as is reasonably possible. Notice given by or for the Insured Person to the Company at the Company's home office, to the Company's authorized administrator or to any of the Company's authorized agents with sufficient information to identify the Insured Person will be deemed as notice to the Company.

Claim Forms. The Company will furnish claim forms to the Insured Person within 15 days after notice of claim is received. If the Company does not provide the forms within that time, the Insured Person may send written proof of the occurrence, character and extent of loss for which the claim is made within the time stated in the Policy for filing proof of loss.

Proof of Loss. Written proof of loss must be furnished to the Company at the Company's home office within 90 days after the date of the loss. Failure to furnish proof within the time required

will not invalidate or reduce any claim if it was not reasonably possible to give proof within that time, if the proof is furnished as soon as reasonably possible. In no event, except in the absence of legal capacity, will proof of loss be accepted later than one year from the time proof is required.

Time Payment of Claims. Any benefit payable under the Policy will be paid immediately, but not more than 30 days, upon receipt of due written proof of loss.

Payment of Claims. All claims will be paid to the Insured, unless assigned. Any benefits payable on or after the Insured's death will be paid to the Insured's estate. Assignment. Benefits under the Policy may be assigned.

Right of Recovery. If payment for claims exceeds the amount for which the Insured Person is eligible under any benefit provision or rider of the Policy, the Company has the right to recover the excess of such payment from the Provider or the Insured. The Company must notify the Insured Person or Provider within six months of such overpayment and must recover such overpayment within three years.

Legal Actions. No Insured Person can bring an action at law or in equity to recover on the Policy until more than 60 days after the date written proof of loss has been furnished according to the Policy. No such action may be brought after the expiration of three years after the time written proof of loss is required to be furnished. If the time limit of the Policy is less than allowed by the laws of the state where the Insured Person resides, the limit is extended to meet the minimum time allowed by such law.

GENERAL PROVISIONS

Clerical Error. Clerical errors or delays in keeping records for the Policy will not deny insurance that would otherwise have been granted, nor extend insurance that otherwise would have ceased, and call for a fair adjustment of premium and benefits to correct the error.

Conformity with State and Federal Law. Any provision of the Policy which, on its effective date, is in conflict with the law of the federal government or the state in which the Insured Person resides on such date, is amended to conform with the laws of that state.

Entire Contract. The Policy, including any endorsements and riders, the Certificate, the Policyholder's application, which is attached to the Policy when issued, the Insured's individual enrollment form, if any, and the eligibility file, if any, are the entire contract between the parties. A copy of the Policy may be examined at the office of the Policyholder during normal business hours. All statements made by the Policyholder or an Insured will, in the absence of fraud, be deemed representations and not warranties, and no such statement will be used in defense to a claim hereunder unless it is contained in a written instrument signed by the Policyholder, the Insured, the Insured's beneficiary or personal representative, a copy of which has been furnished to the Policyholder, the Insured, the Insured's beneficiary or personal representative.

Amendments and Changes. No agent is authorized to alter or amend the Policy, or to waive any conditions or restrictions herein, or to extend the time for paying any premium. The Policy and the Certificate may be amended at any time by mutual agreement between the Policyholder and the Company without the consent of the Insured, but without prejudice to any loss incurred prior to the effective date of the amendment. No person except an Officer of the Company has authority on behalf of the Company to modify the Policy or to waive or lapse any of the Company's rights or requirements.

Incontestability. After the Policy has been in force for two years from the date of issue, it can only be contested for nonpayment of premiums. No statement made by an Insured Person in the enrollment form can be used in a contest after the Insured Person's insurance has been in force for two years during the Insured Person's lifetime. No statement an Insured Person makes in the enrollment form can be used in a contest unless it is in writing and signed by the Insured Person.

Insurance Data. The Policyholder must give the Company the names and ages of all individuals initially insured. The names of persons who later become eligible (whether or not the person becomes insured), and the names of those who cease to be eligible must also be given. The eligibility dates and any other necessary data must be given to the Company so that the premium can be determined.

The Company has the right to audit the Policyholder's books and records as the books and records relate to this insurance. The Company may authorize someone else to perform this audit. Any such inspection may be done at any reasonable time.

Workers' Compensation. The Policy is not a Workers' Compensation policy. The Policy does not satisfy any requirement for coverage by Workers' Compensation Insurance.

DEFINITIONS

Allowance: The benefit amount shown in the Schedule of Benefits that is the maximum amount payable by the Company, subject to the expenses incurred. The Insured Person is responsible for any amounts due above the Allowance. The Allowance cannot be used to satisfy a Copayment.

Benefit Frequency: The period of time in which a benefit is payable as shown in the Schedule of Benefits. The Benefit Frequency begins on Month Day. Each new Benefit Frequency begins at the expiration of the previous Benefit Frequency.

Copayment or Copay: The designated amount, if any, shown in the Schedule of Benefits each Insured Person must pay to a Provider before benefits are payable for a covered Vision Examination or Vision Materials per Benefit Frequency.

Comprehensive Eye Examination: A general evaluation of the complete visual system. The examination includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields, basic sensorimotor examination and Refraction. It always includes initiation of diagnostic and treatment programs. It may include biomicroscopy, examination with cycloplegia or mydriasis and tonometry, as determined by the Provider. These services may be performed at different sessions, but comprise only one Comprehensive Eye Examination.

Dependent: Any of the following persons whose coverage under the Policy is in force and has not ended:

1. the Insured's lawful spouse or Domestic Partner;
2. each child of the Insured or the Insured's spouse who is under 26 years of age;
3. Each unmarried child at least 26 years of age who is primarily dependent upon the Insured or the Insured's spouse for support and maintenance because the child is incapable of self-sustaining employment by reason of mental incapacity or physical handicap.

Dependent includes a step-child, foster child, legally adopted child, child for whom the Insured is a party to a suit for adoption, child who has been placed in the Insured's home for adoption and child under the Insured's legal guardianship, if such child depends primarily on the Insured for support. Dependent will also include a child for whom the Insured is legally required to support due to court order or divorce decree.

An extension of coverage request must be received within 31 days of the end of the month in which the child reaches age 26 and after that, as required (but not more often than yearly after two years of such disability). Determination of eligibility under this provision will be made by Us, subject to meeting the requirements of a.,b. and c. above, and meeting the disability standards and criteria stated in this paragraph 3. Any extended coverage under this paragraph will be subject to all other provisions of this Contract.

Physical or intellectual disability means a severe disability of a person which: a) is attributed to a physical or mental impairment or combination of physical or mental impairments; b) is manifested before the person attains age 26; c) is likely to continue indefinitely; and d) results in incapability of performing self-sustaining employment.

Severe disability means substantial functional limitations in three (3) or more of the following areas of major life activities: a) self-care; b) receptive and expressive language; c) learning; d) mobility; e) self-direction; or f) capacity for independent living; and reflects the person's need for treatment or other services which are of an indefinite duration and are individually planned and coordinated.

A Physician's statement may be required.

A determination of eligibility to continue a dependent child's coverage under this provision will be made within 45 days. A Subscriber has a right to appeal an adverse benefit determination (denial) regarding an extension of coverage due to disability. An appeal request must be submitted to Us in writing within 180 days of the determination. The Subscriber has a right to have access to, and request copies of the documentation relevant to the adverse benefit determination. Written notification of the appeal decision will be provided within 45 days after receipt of the request.

Domestic Partner: A same-sex or an opposite-sex adult who is in a committed relationship with the Insured and the Insured and the Domestic Partner are mutually responsible for one another financially and otherwise. The term "spouse," wherever used, will include a Domestic Partner.

Formulary: A list, provided by the Company, of Vision Materials by tier, that are covered under the Policy as shown in the Schedule of Benefits.

Insured: A Member of the Policyholder who meets the eligibility requirements as shown in the Policyholder's application, and whose coverage under the Policy is in force and has not ended.

Insured Person: The Insured. Insured Person will also include the Insured's Dependents, if enrolled.

In-Network Provider: A Provider who has signed a Preferred Provider Agreement with the PPO.

Medically Necessary Contact Lenses: Adequate functional vision correction cannot be achieved with spectacles but can be achieved with contact lenses. Conditions that qualify for Medically Necessary Contact Lenses are:

1. Anisometropia of 3D in meridian powers;
2. High Ametropia exceeding -12D or +12D in meridian powers;
3. Keratoconus when vision is not correctable to 20/25 in either eye or both eyes using standard spectacle lenses; or
4. vision impairments, other than Keratoconus, when vision can be improved by two lines on the visual acuity chart when compared to best corrected standard spectacle lenses.

Member: A person who meets the eligibility requirements shown in the Policyholder's application.

Out-of-Network Provider: A Provider, located within the PPO Service Area, but is not an In-Network Provider.

Policy: The Vision Insurance Policy issued to the Policyholder. Policyholder means the group named as the Policyholder in the face page of the Policy.

PPO Service Area: The geographical area where the PPO is located.

Preferred Provider Agreement: The agreement between the PPO and a Provider who agrees to become an In-Network Provider. The Preferred Provider Agreement contains the rates and reimbursement methods for services and supplies furnished by an In-Network Provider.

Preferred Provider Organization ("PPO"): A network of Providers and retail chain stores within the PPO Service Area that have signed a Preferred Provider Agreement.

Provider: A licensed physician or optometrist who is operating within the scope of his or her license. Provider also includes a dispensing optician.

Vision Examination: Any eye or visual examination covered under the Policy and shown in the Schedule of Benefits.

Vision Materials: Those materials provided for visual health and welfare shown in the Schedule of Benefits.

ENDORSEMENT

THIS IS AN ENDORSEMENT TO YOUR CONTRACT. PLEASE READ IT CAREFULLY. THIS ENDORSEMENT BECOMES A PART OF YOUR CONTRACT AND SHOULD BE ATTACHED TO IT.

This Endorsement applies to:

Diabetic Eye Care Benefit (BlueVision)

BLUE CROSS AND BLUE SHIELD OF NEBRASKA



Jeff Russell, President and
Chief Executive Officer

The Contract to which this Endorsement is attached is amended as follows:

The BlueVision Diabetic Eye Care benefit is designed to help detect and minimize vision-related complications by providing access to more frequent and in-depth eye care. The Diabetic Eye Care benefit includes the following;

- Coverage for Eligible Dependents with Type 1 or Type 2 diabetes;
- An office visit and diagnostic testing once every six months (separate from a comprehensive eye exam); or
- Diagnostic testing, including gonioscopy, extended ophthalmoscopy, fundus photography, and scanning laser (offered at the provider's discretion).

Exclusions and Limitations

BlueVision Diabetic Eye Care benefit includes diabetic eye care evaluation services only. Exclusions and limitations under this provision include, but are not limited to;

- Costs associated with securing frames, lenses, or any other materials;
- Orthoptics or vision training and any associated supplemental testing;
- Surgical procedures, including laser or any other form of refractive surgery and any pre or post operative Services;
- Pathological treatment of any type for any condition;
- Any eye examination required by an employer as a condition of employment;
- Insulin or any medication or supplies of any type;
- Services and/or materials not included in this endorsement or otherwise identified as covered;

ENDORSEMENT

THIS IS AN ENDORSEMENT TO YOUR CONTRACT. PLEASE READ IT CAREFULLY. THIS ENDORSEMENT BECOMES A PART OF YOUR CONTRACT AND SHOULD BE ATTACHED TO IT.

This Endorsement applies to:

Shades of Blue (BlueVision)

BLUE CROSS AND BLUE SHIELD OF NEBRASKA



Jeff Russell, President and
Chief Executive Officer

The Contract to which this Endorsement is attached is amended to include;

BlueVision Shades of Blue benefit provision provides the Subscriber and their covered spouse with one (1) free pair of non-prescription sunglasses every other year or every other benefit period, whichever is later, after you have completed a qualifying eye examination and that exam has been processed, approved, and paid for under the plan.

The free sunglasses may only be selected from the eligible sunglasses provided under the plan. The sunglasses must be ordered via the designated website, shadesofbluesunglasses.com. The sunglasses available to you will vary by the manufacturer's suggested retail price. Refer to your Schedule of Benefits Summary to determine if you have the Shades of Blue Base Plan or Buy Up option. Shipping and handling fees for standard ground shipping are also included as part of this provision. In the event you do not use the sunglass benefit during the eligible benefit period, you will be eligible to use the benefit during the next eligible benefit period, provided the benefit remains in force.

Limitations

BlueVision Shades of Blue is limited to the following;

- One pair of free non-prescription sunglasses for the Subscriber and their covered spouse every other year or every other benefit period, whichever comes later;
- Redemption or claim of the benefit must be made within 90 days of receiving the redemption code by mail at the address we have on file;
- Subscribers and their covered spouse that are continuously enrolled in the plan and during the alternating eligible benefit year or benefit period;
- Redemption of the benefit only through the designated website, shadesofbluesunglasses.com; and
- The sunglasses have been pre-selected for the plan and are available.

Exclusions

BlueVision Shades of Blue excludes benefits for the following;

- Covered persons that are not the Subscriber and their covered spouse;
- Eye exams that are denied, in whole or in part, under this plan;
- Eye exams paid for by another plan or carriers. Exceptions may be made by Us. To apply for an exception, contact the Member Services Department at (844) 201-0763.
- Prescription or non-prescription lenses, fittings, or any other materials or services not identified as covered in this endorsement or under the plan;
- Claims made after 90 days of you receiving the redemption code and the corresponding instructions;
- Redemption made outside of the designated website shadesofbluesunglasses.com, unless an approved exception is made by Us; and
- Any sunglasses not included in the Shades of Blue benefit or otherwise covered under the plan.



NebraskaBlue.com

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