Insurance

Current rates in effect for 2021-2022 are as follows:

	Healthcare Rates	Vision Rates	Employee Contribution Monthly
Single	$833.32	$5.49	$125.82
Employee + Spouse	$1,661.04	$10.99	$250.81
Employee + Children	$1,512.05	$11.27	$228.50
Family	$2,157.67	$16.77	$326.17

The School District purchases a high deductible insurance plan through Anthem Blue Cross Blue Shield Insurance. The plan covers major medical and prescription coverage. The District then funds the employee claims as they occur through a 3rd party administrator: Barrett Benefits.

The current plan has deductibles as follows for inside network:

	Deductible	Max Out of Pocket	Reimbursement Deductible
Single:	$5,000	$1,000	$ 500
Family:	$10,000	$2,000	$1,000

Once the employee reaches the reimbursement deductible, Barrett Benefits reimburses the employee directly 80% of their carrier approved claim cost until they reach the max out of pocket and then Barrett will reimburse 100% of the employee claims. The maximum out of pocket that an employee will pay is Single: $1,000 and Family: $2,000. After the deductible is reached, Berkshire pays 100% towards claims. Out of Network claims are subject to network prices and the out of network deductibles. Co-pays are not applied towards deductibles.

Claims can be processed by Barrett Benefits two ways:

1. You can fax or mail your Explanation of Benefits (EOB) to Barrett at:
   Fax (866) 539-5643
   Mail to: Barrett Benefits
   593 Broadway Ave
   Cleveland OH 44146
   (866) 845-8600 Option 1
   Sharefund@bbginc.net
2. You can complete Anthem Authorization that will allow Barrett Benefits to retrieve your EOBs from the Anthem's website on a weekly basis.

Prescription Drug Reimbursements require that you submit a copy of the pharmacy tag (usually comes stapled to your prescription) and the receipt to Barrett Benefits.

Any questions regarding claims for Barrett Benefits can be emailed to Kathy Salsbury at ksalsbury@bbginc.net or she can be reached by phone at (866) 845-8600 Option 1

The Treasurer's office, once a week, receives a list of claims that will be paid by Barrett Benefits. The Treasurer's office does not see any claim detail, they only see the employee's name and a dollar amount. The Treasurer's office then forwards payment to Barrett Benefits, and they in turn process a check to the employee. Please note Barrett Benefits is a licensed 3rd party administrator through the State of Ohio. Barrett Benefits is subject to strict audit and

bonding requirements from the State of Ohio. Your claims are held in the strictest confidence and actual claims are never seen by staff in the Treasurer's Office.

A copy of the Anthem Blue Cross Blue Shield coverage summary is attached.

Dental Insurance

Dental Insurance is provided through a self-insurance program. Anthem Blue Cross Blue Shield Insurance is the servicing company that pays claims on the District's behalf. Claims are submitted to Anthem Insurance and paid directly to the provider. Anthem provides a list of claims paid on our behalf. The claims are reviewed for accuracy and the money is debited from the District's Dental account on a weekly basis.

A copy of the Anthem Dental coverage summary is attached.

OH2563

Optical Insurance

Optical Insurance is provided by Anthem Blue View Vision. Employees contribution is 15% of the Board's premium. The current plan provides for in network copay amounts and out of network reimbursed amounts.

A copy of the Anthem Vision coverage summary is attached.

Life Insurance

Life insurance coverage is available to employees of the District. Employees should consult their negotiated agreement for coverage amounts.

Important Dates

Medical Insurance Coverage Period:

Coverage Year – January 1 through December 31

Dental Insurance Coverage Period:

Coverage Year – January 1 through December 31

Flexible Savings Account: January 1st through December 31st
With a grace period until March 15

Waiver Deadline: August 25th of the new School Year
Waiver Payment: The First pay date in September of the following year

Your summary of benefits

Anthem

Berkshire Local Schools-Effective 09/01/2021

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Access PPO HSA Option with Essential Formulary on the National R90 Network with Optional Home Delivery

Your Network: Blue Access

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$5,000 person / $10,000 family	$10,000 person / $20,000 family
Out-of-Pocket Limit	$6,600 person / $13,200 family	$20,000 person / $40,000 family
The family deductible and out-of-pocket maximum are non-embedded meaning the cost shares of all family members apply to one shared family deductible and one shared family out-of-pocket maximum. The individual deductible and individual out-of-pocket maximum only apply to individuals enrolled under single coverage.		
Preventive Care / Screening / Immunization	No charge	50% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Specialist Care Visit	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Prenatal and Post-natal Care	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Other Practitioner Visits:		
Medical Chats - *within our mobile app*	20% coinsurance after deductible is met	Not Applicable
Retail Health Clinic	20% coinsurance after deductible is met	50% coinsurance after deductible is met
On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Manipulation Therapy *Coverage is limited to 12 visits per benefit period.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Other Services in an Office:		
Allergy Testing	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Chemo/Radiation Therapy	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Dialysis/Hemodialysis	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Prescription Drugs - *Dispensed in the office*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Diagnostic Services **Lab:**		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
X-Ray:		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Advanced Diagnostic Imaging:		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency Room Facility Services	20% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after deductible is met	Covered as In-Network
Ambulance	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Facility Visit:		
Facility Fees	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):		
Facility Fees	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Human Organ and Tissue Transplants *Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and other services	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Recovery & Rehabilitation **Home Health Care** *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation services: Office *Coverage for Occupational Therapy is limited to 20 visits per benefit period, Physical Therapy is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Limit is combined for rehabilitative and habilitative services.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital *Coverage for Occupational Therapy is limited to 20 visits per benefit period, Physical Therapy is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Limit is combined for rehabilitative and habilitative services.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Cardiac rehabilitation Office *Coverage is limited to 36 visits per benefit period.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital *Coverage is limited to 36 visits per benefit period.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage for Skilled Nursing and Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is limited to 150 days combined per benefit period.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospice	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Durable Medical Equipment	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with Non-Network medical deductible
Pharmacy Out of Pocket	Combined with In-Network medical	Combined with Non-Network medical
Prescription Drug Coverage *National R90 Network with Optional Home Delivery* *Essential Drug List* *This product has a 90-day Retail Pharmacy Network available. No coverage for non-formulary drugs.*		
Tier 1 - Typically Generic *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$10 copay per prescription after deductible is met (retail) and $25 copay per prescription after deductible is met (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$50 copay per prescription after deductible is met (retail) and $125 copay per prescription after deductible is met (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$90 copay per prescription after deductible is met (retail) and $225 copay per prescription after deductible is met (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic) *30 day supply (retail pharmacy). 30 day supply (home delivery).*	30% coinsurance up to $350 per prescription after deductible is met (retail and home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)

Notes:

- Dependent age: to end of the month in which the child attains age 26.
- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
- All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services).
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- If your plan includes out-of-network benefits, In-network and out-of-network deductibles, copayments, coinsurance and out-of-pocket maximum amounts are separate and do not accumulate toward each other.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- Benefit Period-Calendar year

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

Summary of Benefits
Anthem Dental Essential Choice
Berkshire Local School District
Anthem Dental Complete Network

WELCOME TO YOUR DENTAL PLAN!

Regular dental checkups can help find early warning signs of certain health problems, which means you can get the care you need to get healthy. So, don't skimp on your dental care, good oral care can mean better overall health!

Powerful and easily accessible member tools.

- **Ask a Hygienist:** Dental members can simply email their dental questions to a team of licensed dental professionals who in turn will respond in about 24 hours.
- **Dental Health Risk Assessment:** We want our dental members to better understand their oral health and their risk factors for tooth decay, gum disease and oral cancer. This easy to use online tool can help them do this.
- **Dental Care Cost Estimator:** In order to help our dental member better understand the cost of their dental care, we offer access to a user-friendly, web-based tool that provides estimates on common dental procedures and treatments when using a network dentist.
- **More Capabilities:** With our latest mobile application, Anthem Anywhere, members can find a network dentist as well as view their claims. It's available both for Android and Apple phones.

Dentists in your plan network.

- You'll save money when you visit a dentist in your plan network because Anthem and the dentist have agreed on pricing for covered services. Dentists who are not in your plan network have not agreed to pricing, and may bill you for the difference between what Anthem pays them and what the dentist usually charges.

• To find a dentist by name or location, go to anthem.com or call dental customer service at the number listed on the back of your ID card.

Ready to use your dental benefits?

- Choose a dentist from the network
- Make an appointment
- Show the office staff your member ID card
- Pay any deductible or copay that is part of your plan

Need to contact us?
See the back of your ID card for who to call, write or email.

Your dental benefits at a glance

The following benefit summary outlines how your dental plan works and provides you with a quick reference of your dental plan benefits. For complete coverage details, please refer to your policy.

		In-Network	Out-of-Network
Annual Benefit Maximum	Calendar Year		
· Per insured person		**$1,000**	**$1,000**
D&P applies to Annual Maximum		**Yes**	**Yes**
Annual Maximum Carryover / Carry in		**Yes/Yes**	**Yes/Yes**
Orthodontic Lifetime Benefit Maximum			
· Per eligible insured person		**$1,000**	**$1,000**
Annual Deductible (Does not apply to Orthodontic Services)			
· Per insured person/Family maximum	Calendar Year	**$25/3X Individual**	**$25/3X Individual**
Deductible Waived for Diagnostic/Preventive Services		**Yes**	**Yes**
Out-of-Network Reimbursement:		**90th percentile**	

Dental Services		In-Network Anthem Pays:	Out-of-Network Anthem Pays:	Waiting Period
Diagnostic and Preventive Services		100% Coinsurance	100% Coinsurance	No Waiting Period
· Periodic oral exam	2 per 12 months			
· Teeth cleaning (prophylaxis)	2 per 12 months; w/periodontal maintenance			
· Bitewing X-rays:	2 sets per 12 months			
· Full-mouth or Panoramic X-rays:	1 per 36 months			
· Fluoride application:	2 per 12 months; through age 18			
· Sealants	1 per 36 months; through age 18			
Basic Services		80% Coinsurance	80% Coinsurance	No Waiting Period
· Consultation (second opinion)	1 per 12 months			
· Space Maintainer	1 per lifetime through age 18; posterior teeth			
· Amalgam (silver-colored) Filling	1 per tooth per 24 months			
· Composite (tooth-colored) Filling	1 per tooth per 24 months			
posterior (back) fillings covered as composites				
· Brush Biopsy (cancer test)	Not Covered			
Endodontics (Non-Surgical)		80% Coinsurance	80% Coinsurance	No Waiting Period
· Root Canal and retreatments	1 per tooth per lifetime			
Endodontics (Surgical)		80% Coinsurance	80% Coinsurance	No Waiting Period
· Apicoectomy and apexification	1 per tooth per lifetime			
Periodontics (Non-Surgical)		80% Coinsurance	80% Coinsurance	No Waiting Period
· Periodontal Maintenance	4 per 12 months; w/teeth cleaning			
· Scaling and root planing	1 per quadrant per 24 months			
Periodontics (Surgical)	1 per quadrant per 36 months	80% Coinsurance	80% Coinsurance	No Waiting Period
· Periodontal Surgery (osseous, gingivectomy, graft procedures)				
Oral Surgery (Simple)		80% Coinsurance	80% Coinsurance	No Waiting Period
· Simple Extractions	1 per tooth per lifetime			
Oral Surgery (Complex)		80% Coinsurance	80% Coinsurance	No Waiting Period
· Surgical Extractions	1 per tooth per lifetime			
Major (Restorative) Services		50% Coinsurance	50% Coinsurance	No Waiting Period
· Crowns, onlays, veneers	1 per tooth per 60 months			
· Cosmetic teeth whitening	Not Covered			
Prosthodontics		50% Coinsurance	50% Coinsurance	No Waiting Period
· Dentures and bridges	1 per tooth per 60 months			
· Dental Implants	Not Covered			
Prosthodontic Repairs/Adjustments		50% Coinsurance	50% Coinsurance	No Waiting Period
· Crown, denture, bridge repairs	1 per 12 months; 6 months after placement			
· Denture and bridge adjustments:	2 per 12 months; 6 months after placement			
Orthodontic Services				
·Dependent Children Only*		80% Coinsurance	80% Coinsurance	No Waiting Periods

*Child orthodontic runs through age 18. This means that the child must have been banded prior to their 19th birthday in order to receive coverage.

Additional Services and Programs

Anthem Whole Health Connection -Dental

- For members with certain health conditions, additional dental benefits are available without a deductible or waiting periods. Eligible services are paid at 100% and won't reduce your coverage year annual maximum (if applicable)

Accidental Dental Injury Benefit

- Provides members 100% coverage for accidental injuries to teeth up to the coverage year annual maximum (if applicable). No deductibles, member coinsurance, or waiting periods apply

Extension of Benefits

- Following termination of coverage, members are provided up to 60 days to complete treatment started prior to their termination of coverage under the plan and eligible services will be covered

International Emergency Dental Program

- Provides emergency dental benefits while working or traveling abroad from licensed, English-speaking dentists. Eligible covered services will be paid 100% with no deductibles, member coinsurance, or waiting periods and won't reduce the member coverage year annual maximum (if applicable)

Additional Limitations & Exclusions

Below is a partial listing of non-covered services under your dental plan. Please see your policy for a full list.

Services provided before or after the term of this coverage - Services received before your effective date or after your coverage ends, unless otherwise specified in the dental plan certificate

Orthodontics (unless included as part of your dental plan benefits) including orthodontic braces, appliances and all related services

Cosmetic dentistry (unless included as part of your dental plan benefits) provided by dentists solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (cavities) exist

Drugs and medications including intravenous conscious sedation, IV sedation and general anesthesia when performed with nonsurgical dental care

Analgesia, analgesic agents, and anxiolysis nitrous oxide, therapeutic drug injections, medicines or drugs for nonsurgical or surgical dental care except that intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.

Waiting periods for endodontic, periodontic and oral surgery services may differ from other Basic Services or Major Services under the same dental plan.
There is a waiting period of up to 24 months for replacement of congenitally missing teeth or teeth extracted prior to coverage under this plan.

Blue View Vision℠
FS.A.10.20.130.130

Anthem

Welcome to your Blue View Vision plan!

You have many choices when it comes to using your benefits. As a Blue View Vision plan member, you have access to one of the nation's largest vision networks. You may choose from many private practice doctors, local optical stores, and national retail stores including LensCrafters®, Target Optical®, and most Pearle Vision® locations. You may also use your in-network benefits to order eyewear online at Glasses.com and ContactsDirect.com. To locate a participating network eye care doctor or location, log in at **anthem.com**, or from the home page menu under Care, select **Find a Doctor**. You may also call member services for assistance at **1-866-723-0515**.

Out-of-Network – If you choose to, you may instead receive covered benefits outside of the Blue View Vision network. Just pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement up to your maximum out-of-network allowance.

YOUR BLUE VIEW VISION PLAN BENEFITS	IN-NETWORK	OUT-OF-NETWORK	FREQUENCY
Routine Eye Exam			
A comprehensive eye examination	$10 Copay	Reimbursed Up To $42	Once every calendar year
Eyeglass Frames			
One pair of eyeglass frames	$130 Allowance, then 20% off any remaining balance	Reimbursed Up To $45	Once every calendar year
Eyeglass Lenses *(instead of contact lenses)*			
One pair of standard plastic prescription lenses o Single vision lenses o Bifocal lenses o Trifocal lenses	 $20 Copay $20 Copay $20 Copay	 Reimbursed Up To $40 Reimbursed Up To $60 Reimbursed Up To $80	Once every calendar year
Eyeglass Lens Enhancements *When obtaining covered eyewear from a Blue View Vision provider, you may choose to add any of the following lens enhancements at no extra cost*			
o Transitions Lenses (for a child under age 19) o Standard polycarbonate (for a child under age 19) o Factory Scratch Coating	$0 Copay $0 Copay $0 Copay	No allowance when obtained out-of-network	Same as covered eyeglass lenses
Contact Lenses *(instead of eyeglass lenses)* *Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.*			
o Elective conventional (non-disposable) OR	$130 Allowance, then 15% off any remaining balance	Reimbursed Up To $105	Once every calendar year
o Elective disposable OR	$130 Allowance *(no additional discount)*	Reimbursed Up To $105	
o Non-elective (medically necessary)	Covered in full	Reimbursed Up To $210	

This is a primary vision care benefit intended to cover only routine eye examinations and corrective eyewear. Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care doctor from your medical network. Benefits are payable only for expenses incurred while the group and insured person's coverage is in force. This information is intended to be a brief outline of coverage. All terms and conditions of coverage, including benefits and exclusions, are contained in the member's policy, which shall control in the event of a conflict with this overview. This benefit overview is only one piece of your entire enrollment package.

EXCLUSIONS & LIMITATIONS (not a comprehensive list – please refer to the member Certificate of Coverage for a complete list)

Combined Offers. Not to be combined with any offer, coupon, or in-store advertisement.
Excess Amounts. Amounts in excess of covered vision expense.
Sunglasses. Plano sunglasses and accompanying frames.
Safety Glasses. Safety glasses and accompanying frames.
Not Specifically Listed. Services not specifically listed in this plan as covered services.
Lost or Broken Lenses or Frames. Any lost or broken lenses or frames are not eligible for replacement unless the insured person has reached his or her normal service interval as indicated in the plan design.
Non-Prescription Lenses. Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no refractive power.
Orthoptics. Orthoptics or vision training and any associated supplemental testing

OPTIONAL SAVINGS AVAILABLE FROM BLUE VIEW VISION IN-NETWORK PROVIDERS ONLY		In-Network Member Cost (after any applicable copay)
Retinal Imaging – at member's option, can be performed a time of eye exam		Not more than $39

Eyeglass lens upgrades
When obtaining eyewear from a Blue View Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass lens copayment applies.
	○ Transitions lenses (Adults)
	○ Standard Polycarbonate (Adults)
	○ Tint (Solid and Gradient)
	○ UV Coating
	○ Progressive Lenses[1]
	  ○ Standard
	  ○ Premium Tier 1
	  ○ Premium Tier 2
	  ○ Premium Tier 3
	  ○ Premium Tier 4
	○ Anti-Reflective Coating[2]
	  ○ Standard
	  ○ Premium Tier 1
	  ○ Premium Tier 2
	  ○ Premium Tier 3
	○ Other Add-ons
		$75
		$40
		$15
		$15
		
		$55
		$85
		$95
		$110
		$175
		
		$45
		$57
		$68
		$85
		20% off retail price

Additional Pairs of Eyeglasses Anytime from any Blue View Vision network provider	○ Complete Pair ○ Eyeglass materials purchased separately	40% off retail price 20% off retail price
Eyewear Accessories	Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc.	20% off retail
Contact lens fit and follow-up A contact lens fitting and up to two follow-up visits are available to you once a comprehensive eye exam has been completed.	○ Standard contact lens fitting[3] ○ Premium contact lens fitting[4]	Up to $55 10% off retail price
Conventional Contact Lenses	○ Discount applies to materials only	15% off retail price

[1] Please ask your provider for his/her recommendation as well as the available progressive brands by tier.

[2] Please ask your provider for his/her recommendation as well as the available anti-reflective brands by tier.

[3] Standard fitting includes spherical clear lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.

[4] Premium fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

Cannot be combined with any other offer. Discounts are subject to change without notice. Discounts are not covered benefits under your vision plan and will not be listed in your certificate of coverage. Discounts will be offered from in-network providers except where State law prevents discounting of products and services that are not covered benefits under this plan. Discounts on frames will not apply if the manufacturer has imposed a no discount on sales at retail and independent provider locations.

Some of our in-network providers include:

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION TARGET OPTICAL

Online stores:

GLASSES.COM glasses.com | contactsdirect contactsdirect.com | 1800contacts 1800contacts.com | LENSCRAFTERS lenscrafters.com | TARGET OPTICAL targetoptical.com | Ray-Ban ray-ban.com/insurance

ADDITIONAL SAVINGS AVAILABLE THROUGH ANTHEM'S SPECIAL OFFERS PROGRAM

Savings on items like additional eyewear after your benefits have been used, non-prescription sunglasses, hearing aids and even LASIK laser vision correction surgery are available through a variety of vendors. Just log in at **anthem.com**, select discounts, then Vision, Hearing & Dental.

* Discounts cannot be used in conjunction with your covered benefits.

OUT-OF-NETWORK

If you choose to receive covered services or purchase covered eyewear from an out-of-network provider, network discounts will not apply and you will be responsible for payment of services and/or eyewear materials at the time of service. Please complete an out-of-network claim form and submit it along with your itemized receipt to the fax number, email address, or mailing address below. To download a claim form, log in at **anthem.com**, or from the home page menu under Support select Forms, click Change State to choose your state, and then scroll down to Claims and select the Blue View Vision Out-of-Network Claim Form. You may instead call member services at 1-866-723-0515 .to request a claim form.

TO FAX: 866-293-7373
TO EMAIL: ooncclaims@eyewearspecialoffers.com
TO MAIL: Blue View Vision
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111