

Your summary of benefits



Anthem® Blue Cross

WSWHE

Your Plan: Anthem Blue Access PPO with HRA- Aggregate

Your Network: Blue Access

Annual HRA Contribution - \$1,000 person / \$2,000 family

100% Employer HRA Contribution if initial enrollment in the HRA is between 7/1 - 1/31

50% Employer HRA Contribution if initial enrollment in the HRA is between 2/1 - 6/30

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	10% coinsurance after deductible is met
Mental Health & Substance Use Disorder Services	10% coinsurance after deductible is met
Specialist care	10% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	\$1,500 person / \$3,000 family	\$1,500 person / \$3,000 family
Overall Out-of-Pocket Limit	\$3,425 person / \$6,850 family	\$7,500 person / \$15,000 family
The family deductible and out-of-pocket limit are non-embedded, meaning the cost shares of all family members apply to one family deductible and one family out-of-pocket limit. The per person deductible and per person out-of-pocket limit apply to individuals enrolled under single-only coverage. All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit. In-Network does not apply to Out-of-Network, but Out-of-Network applies to In-Network for both deductible and out-of-pocket maximum.		
Doctor Visits (virtual and office) <i>You are encouraged to select a Primary Care Physician (PCP).</i>		
Primary Care (PCP) and Mental Health and Substance Use Disorder Services <i>virtual and office</i>	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Specialist Care <i>virtual and office</i>	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Other Practitioner Visits		
Maternity Doctor services (prenatal/postnatal care and delivery)	10% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i>	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Chiropractic Services	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Acupuncture	10% coinsurance after deductible is met	30% coinsurance after deductible is met
<u>Other Services in an Office</u>		
Allergy Testing	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Prescription Drugs <i>Dispensed in the office</i>	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Surgery	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	30% coinsurance after deductible is met
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	20% coinsurance after deductible is met
<u>Diagnostic Services</u>		
Lab		
Office	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Lab/Reference Lab	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	30% coinsurance after deductible is met
X-Ray		
Office	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i>		
Office	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	30% coinsurance after deductible is met
<u>Emergency and Urgent Care</u>		
Urgent Care	10% coinsurance after deductible is met	Covered as In-Network
Emergency Room Facility Services	10% coinsurance after deductible is met	Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Emergency Room Doctor and Other Services	10% coinsurance after deductible is met	Covered as In-Network
Ambulance	10% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor Services	10% coinsurance after deductible is met	30% coinsurance after deductible is met
<u>Outpatient Surgery</u>		
Facility Fees		
Hospital	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Ambulatory Surgical Center	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Physician and other services including surgeon fees		
Hospital	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Ambulatory Surgical Center	10% coinsurance after deductible is met	30% coinsurance after deductible is met
<u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u>		
Facility Fees		
<i>Coverage for Inpatient Rehabilitation is limited to 90 days per benefit period.</i>	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Physician and other services including surgeon fees	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Home Health Care		
<i>Coverage is limited to 200 visits per benefit period.</i>	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Rehabilitation and Habilitation services including physical, occupational, vision and speech therapies. Coverage for physical therapy is limited to 90 visits per benefit period. Coverage for speech therapy, occupational & vision is limited to 30 visits per benefit period. OON covered at 30% coinsurance after deductible is met.		
Office	10% coinsurance after deductible is met	Covered
Outpatient Hospital	10% coinsurance after deductible is met	Covered
Pulmonary rehabilitation office and outpatient hospital	10% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Cardiac rehabilitation <i>office and outpatient hospital</i>	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Dialysis/Hemodialysis <i>office and outpatient hospital</i>	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Chemo/Radiation Therapy <i>office and outpatient hospital</i>	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Skilled Nursing Care (facility) <i>Coverage is limited to 120 days per benefit period.</i>	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Inpatient Hospice	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Durable Medical Equipment	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Prosthetic Devices <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Routine Vision Benefits through Blue View Vision Must use the BVV -Insight Network <i>(Every 24 months)</i>	\$5 copay for exam \$115 allowance for frames \$10 copay for lenses \$75 allowance for contact lenses	Up to \$30 reimbursement for exams Up to \$64 reimbursement for frames Up to \$25 reimbursement for Single vision lenses, \$35 for bifocal lenses, and \$45 for trifocal lenses. Up to \$75 reimbursement for Contact lenses.
Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible	Combined with In-Network medical deductible	Not covered
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Not covered
Prescription Drug Coverage Network: Base Network Drug List: National		
Preventive Drugs <i>The deductible does not apply to prescription drugs on the PreventiveRX Plus drug list when you use an In-Network Pharmacy.</i>		

Day Supply Limits:**Retail Pharmacy** 30 day supply (cost shares noted below)**Retail Maintenance****Home Delivery Pharmacy** 90 day supply (maximum cost shares noted below). Maintenance medications are available through our home delivery pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.**Specialty Pharmacy** 30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.

Tier 1 - Typically Generic	\$10 copay per prescription after deductible is met (retail) and \$20 copay per prescription after deductible is met (home delivery)	Not covered
Tier 2 - Typically Preferred Brand	\$20 copay per prescription after deductible is met (retail) and \$40 copay per prescription after deductible is met (home delivery)	Not covered
Tier 3 - Typically Non-Preferred Brand/Specialty Drugs	\$40 copay per prescription after deductible is met (retail) and \$80 copay per prescription after deductible is met (home delivery)	Not covered

Notes:

- 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.
- Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, 3D mammography, breast ultrasounds and MRIs are covered in full as required by state mandate.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.
- Covered Infertility services: lab and radiology tests, cryopreservation, fertility drugs, surgical treatments such as: Artificial Insemination, In-vitro fertilization (IVF), GIFT, ZIFT. Cost share will be applied based on service and setting. Lifetime Maximum: IVF limited to 3 cycles.

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.

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 anthembluecross.com, or the Sydney app. You may also call member services for assistance at **1-877-635-6403**.

Out-of-Network – If you choose to, you may instead receive covered benefits outside of the Blue View Vision Insight. 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 vision plan includes coverage for routine eye exams and prescription eyewear from your choice of eye care providers.

YOUR BLUE VIEW VISION PLAN BENEFITS	IN-NETWORK	OUT-OF-NETWORK	FREQUENCY
Routine Eye Exam			
A comprehensive eye examination	\$5 Copay	Reimbursed Up To \$30	Once every 24 months
Eyeglass Frames			
One pair of eyeglass frames	\$115 Allowance, then 20% off any remaining balance	Reimbursed Up To \$64	Once every 24 months
Eyeglass Lenses (instead of contact lenses)			
One pair of standard plastic prescription lenses			
- Single vision lenses - Bifocal lenses - Trifocal lenses	\$10 Copay \$10 Copay \$10 Copay	Reimbursed Up To \$25 Reimbursed Up To \$35 Reimbursed Up To \$45	Once every 24 months
Eyeglass Lens Enhancements			
<i>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</i>			
- Transitions Lenses (for a child under age 19) - Standard polycarbonate (for a child under age 19) - 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)			
<i>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.</i>			
- Elective conventional (non-disposable) OR - Elective disposable OR - Non-elective (medically necessary)	\$75 Allowance, then 15% off any remaining balance \$75 Allowance (no additional discount) Covered in full	Reimbursed Up To \$75 Reimbursed Up To \$75 Reimbursed Up To \$999	Once every 24 months

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 (Discounts are not covered benefits under your vision plan and will not be listed in your certificate of coverage.)		In-Network Member Cost (after any applicable copay)
Retinal Imaging - at member's option, can be performed at 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 Lenses¹ - Standard - Premium Tier 1 - Premium Tier 2 - Premium Tier 3 - Anti-Reflective Coating² - Standard - Premium Tier 1 - Premium Tier 2 - Other Add-ons (i.e. high index lenses, anti-fog coating)	\$75 \$40 \$15 \$15 \$65 \$85 \$95 \$110 \$45 \$57 \$68 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
Conventional Contact Lenses (non-disposable type)	Discount applies to materials only	15% off retail price
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 fitting³ - Premium contact lens fitting⁴	Up to \$55 10% 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

OPTICAL

GLASSES.COM

contactsdirect

1800contacts

Ray-Ban

befitting

OAKLEY

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 anthembluecross.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 anthembluecross.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 1-877-635-6403 to request a claim form.

TO FAX: 866-293-7373
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 Attn: OON Claims
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