Your Anthem Benefits

Porter County Schools Employees' Insurance Trust
Anthem Dental Traditional (group size 100+)
Summary of Benefits, Effective October 1, 2015

This is not a contract; it is a partial listing of benefits and services. All covered services are subject to the conditions, exclusions, qualifications, limitations, terms and provisions of the Dental Certificate.

BENEFITS	MEMBER'S RESPONSIBILITY
Annual Deductible (Single/Family)	$25/$75
Annual Maximum	$2,000
Class I PREVENTIVE Services *(no deductible)*	Covered in Full
Include exams, oral evaluations, x-rays (bitewing and complete series), cleaning and scaling, space maintainers and other selected diagnostic and preventive services *(Limits may apply) Please refer to your certificate for additional information.*	
Class II BASIC SERVICES *(deductible applies)*	
Class II A General Services Include palliative (emergency) treatment, consultations, general anesthesia, intravenous sedation, office visits for observation, amalgam and composite restorations and pin retention procedures. ***Includes crowns & onlays.***	20%
Class II B Specialty Services Include root canal therapy, apexification/recalcification, therapeutic pulpotomy, oral surgery, simple and surgical tooth extractions, periodontic services, gingivectomy, osseous surgery and other selected endodontic, oral surgery and periodontal services. *(Limits may apply) Please refer to your certificate for additional information.*	20%
Class III MAJOR SERVICES *(deductible applies)*	
Prosthodontic Services Include dentures, bridges and repair of dentures and bridgework, implants and other selected periodontal services	50%
Missing Tooth Services for the replacement of teeth (tooth) lost prior to the member's effective date of coverage under this plan. • Removable prosthodontics (partials or dentures) • Fixed prosthodontics (bridges) for the replacement of teeth (or tooth) *A waiting period and/or limits may apply. Please refer to your certificate for additional information.*	Covered
Class IV ORTHODONTIC *(no deductible)*	50% Child
Orthodontic Services **Dependent child to age 23** Include examination, records, minor treatment of tooth guidance, repositioning (straightening) of the teeth, interceptive or comprehensive orthodontic treatment, post-treatment stabilization. *A waiting period and/or limits may apply. Please refer to your certificate for additional information*	
Separate Orthodontic Lifetime Maximum	$2,000

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School Trust High Plan

BLUE VIEW VISION PLAN DESIGN

VISION PLAN BENEFITS		IN-NETWORK	OUT-OF-NETWORK
Routine eye exam once every 12 months		$10 copay, then covered in full	$42 allowance
Eyeglass frames Once every 24 months members may select an eyeglass frame and receive an allowance toward the purchase price		$150 allowance, then 20% off any remaining balance	$45 allowance
Eyeglass lenses *(Standard)* Once every 12 months members may receive any one of the following lens options:			
o Standard plastic single vision lenses *(1 pair)*		$20 copay, then covered in full	$40 allowance
o Standard plastic bifocal lenses *(1 pair)*		$20 copay, then covered in full	$60 allowance
o Standard plastic trifocal lenses *(1 pair)*		$20 copay, then covered in full	$80 allowance
Eyeglass lens enhancements When obtaining covered eyewear from a Blue View Vision provider, members may choose to add any of the following lens enhancements at no extra cost.			
o Transitions lenses (for a child under age 19)		$0 after eyeglass lens copay	No allowance on lens enhancements when obtained out-of-network
o [illegible] (Adults)		$20 after eyeglass lens copay	
o Standard Polycarbonate (for a child under age 19)		$0 after eyeglass lens copay	
o Factory Scratch Coating		$0 after eyeglass lens copay	
Contact lenses once every 12 months Instead of eyeglass lenses, an allowance toward the cost of a supply of contact lenses may be chosen.	o Elective Conventional Lenses; or	$140 allowance, then 15% off any remaining balance	$105 allowance
	o Elective Disposable Lenses; or	$140 allowance *(no additional discount)*	$105 allowance
	o Non-Elective Contact Lenses	Covered in full	$210 allowance

Contact lens allowance can only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases made during the same benefit period, nor can any unused amount be carried over to the following benefit period.

OPTIONAL SAVINGS AVAILABLE FROM IN-NETWORK PROVIDERS		*In-network Member Cost (after any applicable copay)*
Retinal Imaging	o 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, members may choose to upgrade their new eyeglass lenses at a discounted cost. Eyeglass lens copayment applies.	o Standard Polycarbonate (Adults)	$40
	o Tint (Solid and Gradient)	$15
	o UV Coating	$15
	o Progressive Lenses	
	o Standard	$65
	o Premium Tier 1	$85
	o Premium Tier 2	$95
	o Premium Tier 3	$110
	o Anti-Reflective Coating	
	o Standard	$45
	o Premium Tier 1	$57
	o Premium Tier 2	$68
	o Other Add-ons and Services	20% off retail price
Additional Pairs of Eyeglasses Anytime from any Blue View Vision network provider	o Complete Pair	40% off retail price
	o Eyeglass materials purchased separately	20% off retail price
Eyewear Accessories	o Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc.	20% off retail price
Contact lens fit and follow-up Available once a comprehensive eye exam has been completed.	o Standard contact lens fitting	Up to $55
	o Premium contact lens fitting	10% off retail price
Conventional Contact Lenses	o Discount applies to materials only	15% off retail price
Laser vision correction surgery LASIK refractive surgery	o Discount per eye	For more information, go to anthem.com/specialoffers and select vision care.

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