Choosing and using your plan

Your guide to open enrollment and making the most of your benefits

Hancock County Government
2020 Benefit Offerings
Effective January 1, 2020

This guide is for information purposes only. You must enroll in a plan for your benefits to start.
It’s time to choose your plan

Your trusted health partner

Anthem is committed to being your trusted health care partner. We’re developing the technology, solutions, programs and services that give you greater access to care. We also work with doctors to make sure you get affordable, quality health care.

Save this guide

You’ll find tips on how to make the most of your benefits and save on health care costs throughout the year.
It’s time to choose your plan

Let’s get started

This is the perfect time to think about your health — where you are right now and where you want to be tomorrow. It’s your opportunity to check out the benefits, programs and resources that can support your health and well-being all year long.

This guide will help you understand our plans. It’s also full of tips, tools and resources that can help you reach your health and wellness goals when you become a member. So keep it handy to make the most of your benefits throughout the year.

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Choosing your plan

Coinsurance:
Once you’ve met your deductible, you and your health plan share the cost of covered health care services. The coinsurance is your share of the costs, usually a percent of the cost of care. Your plan details show what portion of the cost you’ll pay.

Copay:
A flat fee you pay for covered services like doctor visits.

Out-of-pocket limit:
This is the most you have to pay out of your own pocket each year for covered services. This amount may include your deductible and your percentage of the costs, depending on your plan. And some plans may still have you pay a copay at the time of service.

Premium:
The premium, also called a monthly payment, is what you pay for the plan. It’s the money that comes out of your paycheck. Think of it like a membership fee that’s separate from what you pay when you get care.

Before we dive into the plan details, it may be helpful to review some health benefit basics.

What you pay and what your plan pays

Words that are helpful to know

Deductible:
A set amount you pay each year for covered services before your plan starts to pay for covered health care costs.
You can use your HSA/FSA/HRA toward your deductible.

Copay:
A flat fee you pay for covered services like doctor visits.

Coinsurance:
Once you’ve met your deductible, you and your health plan share the cost of covered health care services. The coinsurance is your share of the costs, usually a percent of the cost of care. Your plan details show what portion of the cost you’ll pay.

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The premium, also called a monthly payment, is what you pay for the plan. It’s the money that comes out of your paycheck. Think of it like a membership fee that’s separate from what you pay when you get care.

Words that are helpful to know

We can help you crack the code of health insurance lingo. Here are the meanings of some common terms:
Here’s the part where you get to look at the plans and find the one that fits. What works best for you and your family?

**PPO**

With a Preferred Provider Organization (PPO), you can go to almost any doctor or hospital and you’re covered — giving you more choices and flexibility. You get special rates for doctors in your plan, which lowers your out-of-pocket costs.

- You can choose a primary care provider (PCP) from the plan for preventive care, like checkups and screenings.
- You don’t need to have a PCP to see a specialist.
- When you want to see a specialist, like an orthopedic doctor or a cardiologist, you don’t need to visit your PCP first to get a referral. This can save you time and a copay.
- You’ll pay less if you use doctors who are part of the PPO.
- You can see providers who aren’t part of the PPO, but you’ll pay more.
- Once you pay your deductible, you’ll pay a percentage of the total cost (also called coinsurance) anytime you get care for a covered service. Your plan will cover the rest.

**Health Savings Account**

An HSA allows you to set aside pre-tax dollars to pay for care when you need it, now or in the future. You can use money in the account to pay for qualified medical expenses like hospital visits, prescription drugs or copays for doctor visit.¹

- Once you pay your deductible, you’ll pay a percentage of the total cost (also called coinsurance) anytime you get care for a covered service. Your plan will cover the rest.
- All the money in your HSA rolls over from year to year, and it’s yours even if you change health plans, jobs or retire.
- The money you put into your HSA, any interest you earn and even the money you take out to pay for health care is all tax-free.
- You can contribute up to $3,550 for individuals and $7,100 for families.¹
- If you’re 55 or older you can contribute an extra $1,000 a year.

Watch our HSA Basics video to learn more.

¹ For a full list of qualified expenses for an individual, visit anthem.com/qme. Veterans who have received medical benefits from the VA, due to a service-connect disability, are eligible to receive or make HSA contributions. Visit the IRS website at irs.gov/irb/2004-33_IRB for more information.
Your pharmacy benefits

What your plan will cover

It’s easy to get what you need, whether you take medicine every day or only once in a while.

Your pharmacy plan includes:

- One or more drugs lists. Be sure to check for your medications – the brand-name drugs and the generics that are included in your plan.

  — You can find out if the drug you take is included on the **National 3-tier Drug List** by visiting [anthem.com/nationaltier3](http://anthem.com/nationaltier3).

How your pharmacy benefits work

You pay your deductible

Your plan options come with a **combined medical and pharmacy deductible**. That means you’ll have to pay the full cost for your covered drugs until you meet 100% of your annual deductible. The cost you pay out of your pocket for covered drugs and covered medical care will go towards meeting your annual deductible. Your plan will start to share the cost of your covered medicine and covered medical care after you reach your deductible.

You and your plan share the costs

After you meet your deductible, your plan will share the cost of medicine. Your options include plans with different ways of sharing the cost:

- **Copays:** You pay a set amount, or copay, for medicine. Your copay will be based on which tier the drug is on. See [Save money with Tier 1 drugs](save-money-with-tier-1-drugs) to learn more.

- **Coinsurance:** You pay a certain percentage of the drug’s cost, which can be different based on the pharmacy you use.
Save money with Tier 1 drugs

Prescription medicines or drugs are listed in groups called tiers. Your cost is based on which tier the drug is in. Tiers 1 and 2 usually include low-cost and generic drugs. You’ll save the most money when you use Tier 1 drugs.

Once you’re a member, you can check the price of a drug at different pharmacies at anthem.com and see if there are lower-cost drugs.

<table>
<thead>
<tr>
<th>Drug type</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 Preferred generic</td>
<td>$</td>
</tr>
<tr>
<td>Tier 2 Preferred brand name and newer, more expensive generic drugs</td>
<td>$$</td>
</tr>
<tr>
<td>Tier 3 Nonpreferred brand name and generic drugs</td>
<td>$$$</td>
</tr>
</tbody>
</table>

Simple ways to save money on medicine

- Use home delivery for drugs you take on a regular basis.
- Find a pharmacy in your plan.
- Talk to your doctor about generic medicines.
- See if an over-the-counter option is available.
How to use your plan

Once you've chosen a plan, explore how to make the most of your benefits. Here you'll learn simple ways to make using your plan easy. Plus, you'll discover tools and resources that can help you reach your health and wellness goals. With Anthem, supporting your healthiest self is all part of the plan!
How to use your plan

Use your ID card right from your phone

Introducing the **Sydney Health** mobile app. With **Sydney Health** you can find everything you need to know about your benefits – all in one place. You’ll have a custom experience that’s based on your plan, your specific health care needs and lots more. And you can quickly access your digital ID card to show it to your doctor or pharmacy. You can even use **Sydney Health** to track your health goals, find care, compare costs, and manage your claims.

Have a question? **Sydney Health** acts like a personal health guide, answering your questions and connecting you to the right resources at the right time. And you can use the chatbot to get answers quickly. **Sydney Health** makes it easier to get things done, so you can spend more time focusing on your health. Get started by downloading the **Sydney Health** mobile app.

Register for online tools and resources

Accessing your health plan on your mobile phone or computer makes life so much easier. Register on the **Sydney Health** mobile app and [anthem.com](http://anthem.com) to get personalized information about your health plan and more. You can:

- Quickly access your digital ID card.
- Find a doctor and estimate your costs before you go.
- Look at your prescription drug benefits, check the price of a drug and find a pharmacy near you that’s in your plan.
- View your claims, see what’s covered and what you may owe for care.
- Check your spending account balances.
- Get support managing your health conditions and tracking your goals.
- Update your email and communication preferences.
How to use your plan

Find a doctor in your plan

The right doctor can make all the difference — and choosing one in your plan can save you money, too. So you’ll be happy to know your plan includes lots of top-notch doctors. If you decide to get care from doctors outside the plan, it'll cost you more and your care might not be covered at all.

It’s easy to find a doctor in your plan. Simply use the Find a Doctor tool on the Sydney Health mobile app or at anthem.com to search for doctors, hospitals, labs and other health care professionals.

Schedule a checkup

Preventive care, like regular checkups and screenings, can help you avoid health problems down the road. Your plan covers these services at little or no extra cost when you see a doctor in your plan:

- Yearly physicals
- Well-child visits
- Flu shot
- Routine shots
- Screenings and tests

Check your plan details on the Sydney Health mobile app or anthem.com to confirm what preventive care is covered.
Make the most of your pharmacy benefits

You can manage your prescriptions and costs at anthem.com. Simply log in and explore the following ways to save:

1. **Search the drug list.** Find out if your drugs are covered and which tier they’re in. Lower-cost drugs and generics are usually in Tiers 1 and 2. You’ll save the most money when you use Tier 1 drugs.

2. **Price a medication.** See how much a medicine costs. You can compare retail drug costs at local pharmacies and see the price of generic options. Results will include the cost of up to a 90-day supply and home delivery pricing.

3. **See if there are generic options.** If you’re taking a brand-name drug, you can find a list of generic options that cost less, or ask your doctor.

4. **Choose a pharmacy that’s in your plan.** You have many retail pharmacies to choose from. Use a pharmacy that is in your plan to get the best price. To find a pharmacy in your plan, visit anthem.com/pharmacyinformation/networks and choose your network list. Your plan uses the National network list of pharmacies.

5. **Sign up for home delivery.** If you take medicines regularly or need them on a long-term basis, you can save time with home delivery. You may also save money. You can get up to a 90-day supply of your maintenance medications delivered to your door. Once you’re a member, visit anthem.com to sign up.

**Questions?**

Call the Pharmacy Member Services phone number on your member ID Card – we’re available 24/7.
Plan extras that support your health

Learn more by registering on the Sydney Health app or at anthem.com.

Your plan comes with great tools and programs to help you reach your health goals and save money on health products and services. Plus, most of them come at no extra cost. Learn more by registering on the Sydney Health app or at anthem.com.

Apps

Introducing the Sydney Health mobile app. With Sydney Health you can find everything you need to know about your benefits – all in one place. You’ll have a custom experience that’s based on your plan, your specific health care needs and lots more. And you can quickly access your digital ID card to show it to your doctor or pharmacy. You can even use Sydney Health to track your health goals, find care, compare costs, and manage your claims.

Have a question? Sydney Health acts like a personal health guide, answering your questions and connecting you to the right resources at the right time. And you can use the chatbot to get answers quickly. Sydney Health makes it easier to get things done, so you can spend more time focusing on your health. Get started by downloading the Sydney Health mobile app.

Where to get care

24/7 NurseLine — You can connect with a registered nurse who’ll answer your health questions wherever you are — anytime, day or night. They can help you decide where to go for care and find providers in your area. All you have to do is call 1-800-337-4770.

ConditionCare — Get support from a dedicated nurse team to manage ongoing conditions like asthma, chronic obstructive pulmonary disorder (COPD), diabetes, heart disease or heart failure. Work with dietitians, health educators and pharmacists who can help you learn about your condition and manage your health.

Future Moms — This program can help you take care of yourself and your baby before, during and after pregnancy. You can talk to registered nurses 24/7 about your pregnancy, newborn care and more. Plus, you’ll have access to dietitians and social workers, as needed. The program also includes breastfeeding support on LiveHealth Online.

Healthy living

MyHealth Advantage — This free service helps you stay healthy and save money. You’ll get reminders when you need to refill a prescription or get a checkup, test or exam. You’ll also get a personalized and confidential MyHealth Note in the mail or on the

Want healthy advice?

Follow our Better Care Blog for helpful information about health benefits, living healthy and the latest member news.
Plan extras that support your health

Learn more by registering on the Sydney Health app or at anthem.com.

Sydney Health mobile app if we see something that can help you.
Hancock County Government  
Blue Access® (PPO)  
Effective January 1, 2020

Please note: As we receive additional guidance and clarification from the U.S. Department of Health and Human Services, we may be required to make additional changes to your benefits.

<table>
<thead>
<tr>
<th>Covered Benefits</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible (Single/Family)</strong></td>
<td>$1,500/$3,000</td>
<td>$2,000/$6,000</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Limit (Single/Family)</strong></td>
<td>$4,000/$8,000</td>
<td>$8,000/$16,000</td>
</tr>
<tr>
<td><strong>Physician Home and Office Services (PCP/SCP)</strong></td>
<td>$40/$40</td>
<td>50%</td>
</tr>
<tr>
<td>Primary Care Physician (PCP)/Specialty Care Physician (SCP)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Including Office Surgeries and allergy serum:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- allergy injections (PCP and SCP)</td>
<td>$5</td>
<td>50%</td>
</tr>
<tr>
<td>- allergy testing</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>- MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds and pharmaceutical products,</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Preventive Care Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services include but are not limited to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations¹, Annual diabetic eye exam, Vision and Hearing screenings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Physician Home and Office Visits (PCP/SCP)</td>
<td>No copayment/coinsurance</td>
<td>50%</td>
</tr>
<tr>
<td>- Other Outpatient Services @ Hospital/Alternative Care Facility</td>
<td>No copayment/coinsurance</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Emergency and Urgent Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Room Services</strong></td>
<td>$200</td>
<td>$200</td>
</tr>
<tr>
<td>- facility/other covered services (copayment waived if admitted)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Urgent Care Center Services</strong></td>
<td>$75</td>
<td></td>
</tr>
<tr>
<td>- MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, and pharmaceutical products</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>- Allergy injections</td>
<td>$5</td>
<td>50%</td>
</tr>
<tr>
<td>- Allergy testing</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Inpatient and Outpatient Professional Services</strong></td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>Include, but are not limited to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Covered Benefits

<table>
<thead>
<tr>
<th>Covered Benefits</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Facility Services</strong> (Network/Non-Network combined) Unlimited days except for:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>- 90 days for skilled nursing facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Surgery Hospital/Alternative Care Facility</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Surgery and administration of general anesthesia</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Other Outpatient Services</strong> (including but not limited to):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Non Surgical Outpatient Services</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Home Care Services (Network/Non-Network combined)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90 visits (excludes IV Therapy)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Durable Medical Equipment and Orthotics (Network/Non-network combined)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(excluding Prosthetic Devices, Limbs and Medical Supplies)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Prosthetic Devices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Prosthetic Limbs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Physical Medicine Therapy Day Rehabilitation programs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Hospice Care</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>- Ambulance Services</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Outpatient Therapy Services</strong> (Combined Network &amp; Non-Network limits apply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Physician Home and Office Visits (PCP/SCP)</td>
<td>$40/$40</td>
<td></td>
</tr>
<tr>
<td>- Other Outpatient Services @ Hospital/Alternative Care Facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limits apply to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Physical therapy: 20 visits</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>- Occupational therapy: 20 visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Manipulation therapy: 12 visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Speech therapy: 20 visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Cardiac Rehabilitation: 36 visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Pulmonary Rehabilitation: 20 visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Accidental Dental: $3,000 limit per occurrence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(network and non-network combined)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copayments/Coinsurance based on setting where covered services are received</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>50%</td>
<td></td>
</tr>
</tbody>
</table>
Your Summary of Benefits

<table>
<thead>
<tr>
<th>Covered Benefits</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Illness and Substance Abuse1:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Inpatient Facility Services</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>o Inpatient Professional Services</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>o Physician Home and Office Visits (PCP/SCP)</td>
<td>$40</td>
<td></td>
</tr>
<tr>
<td>o Other Outpatient Services, Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Human Organ and Tissue Transplants2</td>
<td>No copayment/coinsurance</td>
<td>50%</td>
</tr>
<tr>
<td>o Acquisition and transplant procedures, harvest and storage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription Drug Options:4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Network Tier structure equals 1/2/3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Network Retail Pharmacies: (30-day supply)</td>
<td>$20/$35/$50</td>
<td>50%, min $403</td>
</tr>
<tr>
<td>Includes diabetic test strip</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Anthem Rx Direct Mail Service: (90-day supply)</td>
<td>$20/$70/$120</td>
<td>Not covered</td>
</tr>
<tr>
<td>Includes diabetic test strip</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Member may be responsible for additional cost when not selecting the available generic drug.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare Rx - Wrap</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialty Medications must be obtained via our Specialty Pharmacy network in order to receive network level benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Surgical Treatment of Morbid Obesity</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

Notes:
- 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).
- Deductible(s) apply to covered medical services listed with a percentage (%) coinsurance, including 0%. However, the deductible does not apply to Emergency Room Services where a copayment and coinsurance applies and may not apply to some Behavioral Health services where coinsurance applies.
- Dependent age: to end of the month which the child attains age 26.
- Specialist copayment is applicable to all Specialists excluding General Physicians, Internist, Pediatricians, OB/GYNs and Geriatrics or any other Network Provider as allowed by the plan.
- When allergy injections are rendered with a Physicians Home and Office Visit, only the Office Visit cost share applies. When the Office Visit cost share is a % coinsurance, deductible and coinsurance apply to allergy injections.
- NCS (No Cost Share) means no deductible/copayment/coinsurance up to the maximum allowable amount.
- PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network provider as allowed by the plan.
- SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.
- Live Health Online (LHO) is covered at the PCP costshare.
- Certain diabetic and asthmatic supplies, except diabetic test strips, have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies.
- Benefit period = calendar year
- Prosthetic limbs are unlimited and do not apply to the Plan Lifetime Maximum.
- Mammograms (Diagnostic) are no copayment/coinsurance in Network office and outpatient facility settings.
- Behavioral Health Services: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.
Your Summary of Benefits

- Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits are no deductible/coinsurance up to the maximum allowable amount.
- Private Duty Nursing – limited to 82 visits/Calendar Year and 164 visits/lifetime.
- Elective abortions not covered unless otherwise noted in your Certificate of Coverage.

1 We encourage you to review the Schedule of Benefits for limitations.
2 Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.
3 Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.

Precertification:
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.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Pre-existing Exclusion Period: none

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

This benefit overview is for illustrative purposes and some content may be pending Indiana Department of Insurance approval.
Hancock County Government  
Blue Access® for Health Savings Accounts  
Effective: January 1, 2020

Please note: As we receive additional guidance and clarification from the U.S. Department of Health and Human Services, we may be required to make additional changes to your benefits

<table>
<thead>
<tr>
<th>Covered Benefits</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td>Single: $3,000</td>
<td>Single: $6,000</td>
</tr>
<tr>
<td>Embedded</td>
<td>Family: $6,000</td>
<td>Family: $12,000</td>
</tr>
<tr>
<td>The single deductible applies to the Family deductible.</td>
<td>Once the single deductible has been satisfied, benefits for that member are payable subject to coinsurance.</td>
<td></td>
</tr>
<tr>
<td>Once the family deductible has been satisfied, benefits for the family are payable subject to coinsurance.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Out-of-Pocket Limit</strong></td>
<td>Single: $3,000</td>
<td>Single: $12,000</td>
</tr>
<tr>
<td></td>
<td>Family: $6,000</td>
<td>Family: $24,000</td>
</tr>
<tr>
<td><strong>Physician Home and Office Services</strong></td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td></td>
<td>No copayment/coinsurance</td>
<td>30%</td>
</tr>
<tr>
<td>- Including Office Surgeries, allergy serum, allergy injections and allergy testing</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Preventive Care Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services include but are not limited to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Routine Vision and Hearing exams</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Physician Home and Office Visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Other Outpatient Services @ Hospital/Alternative Care Facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emergency and Urgent Care</strong></td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>- Emergency Room Services (facility/other covered services) (copayment waived if admitted)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Urgent Care Center Services</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient and Outpatient Professional Services</strong></td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>Include but are not limited to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Facility Services</strong> (Network/Non-Network combined) Unlimited days except for:</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>- 60 days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 90 days for skilled nursing facility</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Covered Benefits

#### Outpatient Surgery Hospital/Alternative Care Facility
- Surgery and administration of general anesthesia

<table>
<thead>
<tr>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>30%</td>
</tr>
</tbody>
</table>

#### Other Outpatient Services
(Network/Non-network combined) including but not limited to:
- Non Surgical Outpatient Services
  For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services.
- Home Care Services 90 visits (excludes IV Therapy)
- Durable Medical Equipment and Orthotics
  (excluding Prosthetic Devices, Limbs and Medical Supplies)
- Prosthetic Devices
- Prosthetic Limbs
- Physical Medicine Therapy Day
  Rehabilitation programs
- Hospice Care
- Ambulance Services

<table>
<thead>
<tr>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

#### Accidental Dental Services
$3,000 limit per occurrence (network and non-network combined)

<table>
<thead>
<tr>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>30%</td>
</tr>
</tbody>
</table>

#### Outpatient Therapy Services
(Combined Network & Non-Network limits apply)
- Physician Home and Office Visits
- Other Outpatient Services @ Hospital/Alternative Care Facility

Limits apply to:
- Physical therapy: 20 visits
- Occupational therapy: 20 visits
- Manipulation therapy: 12 visits
- Speech therapy: 20 visits
- Cardiac Rehabilitation: 36 visits
- Pulmonary Rehabilitation: 20 visits

<table>
<thead>
<tr>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>0%</td>
<td>30%</td>
</tr>
</tbody>
</table>

#### Behavioral Health Service
Mental Illness and Substance Abuse:
- Inpatient Facility Services
- Inpatient Professional Services
- Physician Home and Office Visits (PCP/SCP)
- Other Outpatient Services, Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional.

<table>
<thead>
<tr>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>30%</td>
</tr>
</tbody>
</table>

#### Human Organ and Tissue Transplants
- Acquisition and transplant procedures, harvest and storage.

<table>
<thead>
<tr>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>30%</td>
</tr>
</tbody>
</table>
## Covered Benefits

<table>
<thead>
<tr>
<th></th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prescription Drugs - Anthem National Drug List</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o <strong>Network Retail Pharmacies:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o (30-day supply)</td>
<td>0%</td>
<td>30%²</td>
</tr>
<tr>
<td>o Includes diabetic test strip</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o <strong>Anthem Rx Direct Mail Service:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o (90-day supply)</td>
<td>0%</td>
<td>Not covered</td>
</tr>
<tr>
<td>o Includes diabetic test strip</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialty medications are limited up to a 30 day supply regardless of whether they are retail or mail service.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medicare Rx - Wrap</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lifetime Maximum (Combined Network and Non-network)³</strong></td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

### Notes:
- All medical and drug cost shares, deductibles and percentage (%) coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services).
- Deductible(s) apply to covered services listed with a percentage (%) coinsurance, including 0%.
- Deductible applies to all prescription drug expenses for Rx plans. Once the deductible is met the appropriate copayment/coinsurance applies. Copayments/coinsurance accumulate to the Medical OOP max. Once the Medical OOP max is met, no additional cost share applies.
- Once the family deductible is satisfied by either one member or all members collectively, then the additional percentage coinsurance will be required before the family out-of-pocket is satisfied. Does not apply to embedded deductible plans.
- Network and Non-network Deductible, copayments, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- Dependent Age: to end of the month which the child attains age 26.
- 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.
- No Cost Share (NCS): No deductible/copayment/coinsurance up to the maximum allowable amount.
- Live Health Online (LHO) is covered at the PCP cost share.
- Benefit period = calendar year
- Behavioral Health Services: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.
- Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits are covered.
- Private Duty Nursing – limited to 82 visits/Calendar Year and 164 visits/lifetime.
- Elective abortions not covered unless otherwise noted in your Certificate of Coverage.
- Wigs limited to 1 per benefit period.

1. We encourage you to review the Schedule of Benefits for limitations.
2. Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.

### Precertification:
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.

### Pre-existing Exclusion Period: none

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

This benefit overview is for illustrative purposes and some content may be pending Indiana Department of Insurance approval.
WELCOME TO YOUR DENTAL PLAN!
This 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 certificate of coverage.

Dental coverage you can count on
Your Anthem Blue Cross and Blue Shield (Anthem) dental plan lets you visit any licensed dentist or specialist you want – with costs that are normally lower when you choose one within our large network.

Savings beyond your dental plan benefits – you get more for your money.
You pay our negotiated rate for covered services from in-network dentists even if you exceed your annual benefit maximum.

<table>
<thead>
<tr>
<th>YOUR DENTAL PLAN AT A GLANCE</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Benefit Maximum – (Calendar Year)</td>
<td>$1,250</td>
<td>$1,250</td>
</tr>
<tr>
<td>• Per insured person</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Diagnostic &amp; Preventive Services are applied to the Annual Benefit Maximum</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Annual Maximum Carryover</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthodontic Lifetime Benefit Maximum</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>• Per eligible insured child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Deductible – (Calendar Year)</td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td>• Per insured person</td>
<td>3x single member deductible</td>
<td>3x single member deductible</td>
</tr>
<tr>
<td>• Family maximum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductible Waived for Diagnostic/Preventive Services</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Out-of-Network Reimbursement</td>
<td></td>
<td>90th percentile</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dental Services</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>Waiting Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic and Preventive Services</td>
<td>100% coinsurance</td>
<td>100% coinsurance</td>
<td>No waiting period</td>
</tr>
<tr>
<td>• Periodic oral exam</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Teeth cleaning (prophylaxis)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Bitewing X-rays (once in 12 mos. for all ages)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Periapical X-rays</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic Services</td>
<td>90% coinsurance</td>
<td>80% coinsurance</td>
<td>No waiting period</td>
</tr>
<tr>
<td>• Amalgam (silver-colored) filling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Front composite (tooth colored) filling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Back composite (tooth colored) filling, alternated to amalgam allowance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Simple extractions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endodontics</td>
<td>60% coinsurance</td>
<td>50% coinsurance</td>
<td>No waiting period</td>
</tr>
<tr>
<td>• Root canal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Periodontics</td>
<td>60% coinsurance</td>
<td>50% coinsurance</td>
<td>No waiting period</td>
</tr>
<tr>
<td>• Scaling and root planing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>60% coinsurance</td>
<td>50% coinsurance</td>
<td>No waiting period</td>
</tr>
<tr>
<td>• Surgical extractions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major Services</td>
<td>60% coinsurance</td>
<td>50% coinsurance</td>
<td>No waiting period</td>
</tr>
<tr>
<td>• Crowns</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prosthodontics</td>
<td>60% coinsurance</td>
<td>50% coinsurance</td>
<td>No waiting period</td>
</tr>
<tr>
<td>• Dentures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Bridges</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Dental implants (covered)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prosthetic Repairs/Adjustments</td>
<td>60% coinsurance</td>
<td>50% coinsurance</td>
<td>No waiting period</td>
</tr>
<tr>
<td>• Dependent children only*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthodontic Services</td>
<td>50% coinsurance</td>
<td>50% coinsurance</td>
<td>No waiting period</td>
</tr>
</tbody>
</table>

This is not a contract; it is a partial listing of benefits and services. All covered services are subject to the conditions, limitations, exclusions, terms and provisions of your certificate of coverage. In the event of a discrepancy between the information in this summary and the certificate of coverage, the certificate will prevail.

*Child orthodontic coverage begins at age eight and runs through age 18. This means that the child must have been banded between the ages of eight and 19 in order to receive coverage. If children are dependents until age 19, they can continue to receive coverage, but they must have been banded before age 19.
Emergency dental treatment for the international traveler
As an Anthem dental member, you and your eligible, covered dependents automatically have access to the International Emergency Dental Program.* With this program, you may receive emergency dental care from our listing of credentialed dentists while traveling or working nearly anywhere in the world.

* The International Emergency Dental Program is managed by an independent company offering dental-management services to Anthem. To learn more about the program, please visit the International Emergency Dental Web site at www.decredental.com/internationalDentalProgram.do.

Finding a dentist is easy.
To select a dentist by name or location, do one of the following:
- Go to anthem.com/mydentalvision
- Call Anthem dental customer service at the toll-free number listed on the back of your ID card.

TO CONTACT US:

<table>
<thead>
<tr>
<th>Call</th>
<th>Write</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refer to the toll-free number indicated on the back of your plan ID card to speak with a U.S.-based customer service representative during normal business hours. Calling after hours? We may still be able to assist you with our interactive voice-response system.</td>
<td>Refer to the back of your plan ID card for the address.</td>
<td>Go to anthem.com or the website listed on the back of your ID card.</td>
</tr>
</tbody>
</table>

Limitations & Exclusions

Limitations – Below is a partial listing of dental plan limitations when these services are covered under your plan. Please see your certificate of coverage for a full list.

**Diagnostic and Preventive Services**
- Oral evaluations (exam) – Limited to two per Calendar Year
- Teeth cleaning (prophylaxis) – Limited to two per Calendar Year
- Periapical X-rays, single film – Limited to four films per 12-month period
- Complete series X-rays – (panoramic or full-mouth) Limited to once every 36 months
- Topical fluoride application – Limited to once every 12 months for members through age 18
- Sealants – Limited to first and second molars once every 24 months per tooth for members through age 15; sealants may be covered under Diagnostic and Preventive or Basic Services.

**Basic and/or Major Services**
- Fillings – Limited to once per surface per tooth in any 24 months
- Space Maintainers – Limited to extracted primary posterior teeth once per lifetime per tooth for members through age 16; space maintainers may be covered under Diagnostic and Preventive or Basic Services.
- Crowns – Limited to once per tooth in a seven-year period
- Fixed or removable prosthetics – dentures, partials, bridges, tooth implants covered once in any seven-year period; benefits are provided for the replacement of an existing bridge, denture or partial for members age 16 or older if the appliance is seven years old or older and cannot be made serviceable.
- Root canal therapy – Limited to once per lifetime per tooth; coverage is for permanent teeth only.
- Periodontal surgery – Limited to one complex service per single tooth or quadrant in any 36 months, and only if the pocket depth of the tooth is five millimeters or greater
- Periodontal scaling and root planing – Limited to once per quadrant in 36 months, when the tooth pocket has a depth of four millimeters or greater
- Brush biopsy – (Not covered)

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

**ADDITIONAL LIMITATION FOR ORTHODONTIC SERVICES – if Orthodontia is included as a benefit of your dental plan**
- Orthodontia Limited to one course of treatment per member per lifetime

**Exclusions – Below is a partial listing of noncovered services under your dental plan. Please see your certificate of coverage 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) – Orthodontic braces, appliances and all related services
- Cosmetic dentistry – Services 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 – Intravenous conscious sedation, IV sedation and general anesthesia when performed with nonsurgical dental care
- Analgesia, anesthetic agents, amitriptyline; 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.
- Extractions – Surgical removal of third molars (wisdom teeth) that do not exhibit symptoms or impact the oral health of the member

The in-network dental providers mentioned in this communication are independently contracted providers who exercise independent professional judgment. They are not agents or employees of Anthem.

Anthem Blue Cross and Blue Shield is the trade name of: In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Ohio: Community Insurance Company. In Wisconsin: Blue Cross Blue Shield of Wisconsin (“BCBSWI”) underwrites or administrators PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by Compcare Health Services Insurance Corporation (“Compcare”) or Wisconsin Collaborative Insurance Company (“WCIC”); Compcare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are the registered marks of the Blue Cross and Blue Shield Association.
Choice of dentists
While your dental plan lets you choose any dentist, you may end up paying more for a service if you visit an out-of-network dentist.

Here's why...
In-network dentists have agreed to payment rates for various services and cannot charge you more. On the other hand, out-of-network dentists don't have a contract with us and are able to bill you for the difference between the total amount we allow to be paid for a service – called the “maximum allowed amount” – and the amount they usually charge for a service. When they bill you for this difference, it's called “balance billing.”

How Anthem dental decides on maximum allowed amounts
Anthem develops an out-of-network dental fee schedule/rate to determine the maximum allowed amount for services provided by an out-of-network dentist. This schedule may be changed or updated based on such things as reimbursement amounts accepted by dentists contracted with our dental plans, or other industry cost and usage data.

Here's an example of higher costs for out-of-network dental services
This is an example only. Your experience may be different, depending on your insurance plan, the services you receive and the dentist who provides the services.

Say Ted's dental plan allows him 50% coinsurance for either in- or out-of-network services... Ted chooses to get a crown from an out-of-network dentist who charges $1,200 for the service and bills Anthem for that amount. If Anthem’s maximum allowed cost for this dental service is $800, this means there will be a $400 difference. The out-of-network dentist can “balance bill” Ted for that amount.

Ted will also need to pay $400 coinsurance. Therefore, the total he will pay the out-of-network dentist is $800. Here's the math:

- Dentist's charge: $1,200
- Anthem’s maximum allowed cost: $800
- Anthem pays 50%: $400
- Ted pays 50% (coinsurance): $400
- Balance Ted owes the provider: $1,200 - $800 = $400
- Ted's total cost: $400 coinsurance + $400 provider balance = $800

In the example, if Ted had gone to an in-network dentist, his cost would be only $400 for the coinsurance because he would not have been “balance billed” the $400 difference.
WELCOME TO BLUE VIEW VISION!

Good news—your vision plan is flexible and easy to use. This benefit summary outlines the basic components of your plan, including quick answers about what’s covered, your discounts, and much more!

Custom High Summary:
Hancock County Government
Effective Date: January 1, 2020

Blue View Vision

Your Blue View Vision network
Blue View Vision offers you one of the largest vision care networks in the industry, with a wide selection of experienced ophthalmologists, optometrists, and opticians. Blue View Vision’s network also includes convenient retail locations, many with evening and weekend hours, including LensCrafters®, Sears Optical®, Target Optical®, JCPenney® Optical and most Pearle Vision® locations. Best of all – when you receive care from a Blue View Vision participating provider, you can maximize your benefits and money-saving discounts.

Out-of-network: If you choose to, you may 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 of your out-of-network allowance. In-network benefits and discounts will not apply.

YOUR BLUE VIEW VISION PLAN AT-A-GLANCE

VISION PLAN BENEFITS

Routine eye exam once every 12 months

Eyeglass frames
Once every 24 months you may select an eyeglass frame and receive an allowance toward the purchase price

Eyeglass lenses (Standard)
Once every 12 months you may receive any one of the following lens options:

- Standard plastic single vision lenses (1 pair)
- Standard plastic bifocal lenses (1 pair)
- Standard plastic trifocal lenses (1 pair)

Eyeglass lens enhancements
When obtaining covered eyewear from a Blue View Vision provider, you may add any of the following lens enhancements at no extra cost.

- Transitions® Lenses (for a child under age 19)
- Transitions® Lenses (Adults)
- Standard Polycarbonate (for a child under age 19)
- Factory Scratch Coating

Contact lenses – once every 12 months
Prefer contact lenses over glasses? You may choose contact lenses instead of eyeglass lenses and receive an allowance toward the cost of a supply of contact lenses.

- Elective Conventional Lenses; or
- Elective Disposable Lenses; or
- Non-Elective Contact Lenses

IN-NETWORK
OUT-OF-NETWORK

Routine eye exam
$10 copay, then covered in full
$42 allowance

Eyeglass frames
$150 allowance, then 20% off any remaining balance
$45 allowance

Eyeglass lenses (Standard)
$20 copay, then covered in full
$20 copay, then covered in full
$20 copay, then covered in full
$40 allowance

Eyeglass lens enhancements
$0 after eyeglass lens copay
$20 after eyeglass lens copay
$20 after eyeglass lens copay
No allowance on lens enhancements when obtained out-of-network

Contact lenses
$140 allowance, then 15% off any remaining balance
$105 allowance

EXCLUSIONS & LIMITATIONS (not a complete list)

Combined Offers. Not combined with any offer, coupon, or in-store advertisement.

Excess Amounts. Amounts in excess of covered vision expense.

Sunglasses. 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.
<table>
<thead>
<tr>
<th>OPTIONAL SAVINGS AVAILABLE FROM IN-NETWORK PROVIDERS ONLY</th>
<th>In-network Member Cost (after any applicable copay)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retinal Imaging - at member’s option can be performed at time of eye exam</td>
<td>Not more than $39</td>
</tr>
<tr>
<td><strong>Eyeglass lens upgrades</strong>&lt;br&gt;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.</td>
<td></td>
</tr>
<tr>
<td>- Standard Polycarbonate (Adults)</td>
<td>$40</td>
</tr>
<tr>
<td>- Tint (Solid and Gradient)</td>
<td>$15</td>
</tr>
<tr>
<td>- UV Coating</td>
<td>$15</td>
</tr>
<tr>
<td>- Progressive Lenses¹&lt;br&gt;  - Standard</td>
<td>$65</td>
</tr>
<tr>
<td>- Premium Tier 1</td>
<td>$85</td>
</tr>
<tr>
<td>- Premium Tier 2</td>
<td>$95</td>
</tr>
<tr>
<td>- Premium Tier 3</td>
<td>$110</td>
</tr>
<tr>
<td>- Anti-Reflective Coating²&lt;br&gt;  - Standard</td>
<td>$45</td>
</tr>
<tr>
<td>- Premium Tier 1</td>
<td>$57</td>
</tr>
<tr>
<td>- Premium Tier 2</td>
<td>$68</td>
</tr>
<tr>
<td>- Other Add-ons and Services</td>
<td>20% off retail price</td>
</tr>
<tr>
<td><strong>Additional Pairs of Eyeglasses</strong>&lt;br&gt;Anytime from any Blue View Vision network provider</td>
<td>40% off retail price</td>
</tr>
<tr>
<td>- Complete Pair</td>
<td>20% off retail price</td>
</tr>
<tr>
<td>- Eyeglass materials purchased separately</td>
<td>20% off retail price</td>
</tr>
<tr>
<td><strong>Eyewear Accessories</strong></td>
<td></td>
</tr>
<tr>
<td>- Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc.</td>
<td>20% off retail price</td>
</tr>
<tr>
<td><strong>Contact lens fit and follow-up</strong>&lt;br&gt;A contact lens fitting and up to two follow-up visits are available to you once a comprehensive eye exam has been completed.</td>
<td></td>
</tr>
<tr>
<td>- Standard contact lens fitting³</td>
<td>Up to $55</td>
</tr>
<tr>
<td>- Premium contact lens fitting⁴</td>
<td>10% off retail price</td>
</tr>
<tr>
<td><strong>Conventional Contact Lenses</strong></td>
<td></td>
</tr>
<tr>
<td>- Discount applies to materials only</td>
<td>15% off retail price</td>
</tr>
<tr>
<td><strong>Laser vision correction surgery</strong>&lt;br&gt;LASIK refractive surgery</td>
<td></td>
</tr>
<tr>
<td>- Discount per eye</td>
<td>For more information, go to anthem.com/specialoffers and select vision care.</td>
</tr>
</tbody>
</table>

1 Please ask your provider for his/her recommendation as well as the progressive brands by tier.<br>2 Please ask your provider for his/her recommendation as well as the coating brands by tier.<br>3 A standard contact lens fitting includes spherical clear contact lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.<br>4 A premium contact lens fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

**OUT-OF-NETWORK**

If you choose an out-of-network provider, 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. When visiting an out-of-network provider, discounts do not apply and you are responsible for payment of services and/or eyewear materials at the time of service.

To Fax: 866-293-7373<br>To Email: oonclaims@eyewearspecialoffers.com<br>To Mail: Blue View Vision<br>Atn: OON Claims<br>P.O. Box 8504<br>Mason, OH 45040-7111

Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care physician from your medical network. If you have questions about your benefits or need help finding a provider, visit anthem.com or call us at 1-866-723-0515.

This is a primary vision care benefit intended to cover only routine eye examinations and corrective eyewear. 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. Discounts referenced are not covered benefits under this vision plan and therefore are not included in the member’s policy. Frame discounts may not apply to some frames where the manufacturer has imposed a no discount policy on sales at retail and independent provider locations. Discounts are subject to change without notice. This benefit overview is only one piece of your entire enrollment package.

Transitions and the swirl are registered trademarks of Transitions Optical, Inc. Photochromic performance is influenced by temperature, UV exposure and lens material.

Anthem Blue Cross and Blue Shield is the trade name of: In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Missouri (excluding 39 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT). Healthy Alliance Life Insurance Company (HALIC), and HMS Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMS Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Ohio: Community Insurance Company. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), which underwrites or administers the PPO and indemnity policies; CompCare Health Services Insurance Corporation (CompCare), which underwrites or administers the HMO policies; and CompCare and BCBSWI collectively, which underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are the registered marks of the Blue Cross and Blue Shield Association.
You’ve got quick access to your health care!

Register on anthem.com or the Sydney mobile app.* Have your member ID card handy to register

From your computer

1. Go to anthem.com/register
2. Provide the information requested
3. Create a username and password
4. Set your email preferences
5. Follow the prompts to complete your registration

From your mobile device

1. Download the free Sydney mobile app and select Register
2. Confirm your identity
3. Create a username and password
4. Confirm your email preferences
5. Follow the prompts to complete your registration

It’s easy. Everything you need to know about your plan — including medical — in one place. Making your health care journey simple, personal — all about you.

Need help signing up? Call us at 1-866-755-2680.

* You must be 18 years or older to register your own account.
Looking for a doctor?

Finding one online is fast and easy

The right doctor can make all the difference — and choosing one in your plan can save you money, too. Our Find a Doctor tool helps you find doctors, dentists, hospitals, labs and other health care providers in your plan. If you decide to get care from doctors outside the plan, it’ll cost you more and your care might not be covered at all.

Here’s all you need to do to find a doctor near you:

1. Go to anthem.com/find-doctor

You can look for a doctor by using either:
- Search as a member: Log in with a username and password or with the member number on your ID card.
- Search as guest: Select a plan or network,* or search by all plans and networks, to get started.

2. Once you log in, select the Find Care option on the welcome menu.

3. Next, choose who you’d like to see. You can search for a doctor nearby or use the doctor’s name.

4. Select a provider to get details, like:
   - Specialties
   - Gender
   - Languages spoken
   - Training
   - A map of their office location
   - Phone number

Going mobile

Search for doctors, hospitals and more on your smartphone or mobile device.

And don’t forget that going mobile keeps everything you need to know about your plan — including medical, pharmacy, dental, vision, life insurance — in one place. It’s simple, personal and all about you. Simply download the Sydney app to get started.

*If you don’t know the name of the plan or network, check with your human resources department or benefits administrator.

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Digital ID cards —
always current,
always accurate

Make sure we have your email so you can get your digital ID card

Have you ever handed your member ID card to a doctor only to find it’s expired, or it isn’t even the right one? Your digital ID card always has the latest information, so you can be sure you’re giving the right details to your doctor or health care professional.

Your digital ID card can make your life easier

“*No need to wait for your ID card to come in the mail — new ID cards are available faster!

“*It’s easy to use.

— Print a copy any time.

— Email or fax it right from your computer or mobile device.

— Show it to your doctor from your smartphone. Your digital ID card is always there and works just like a printed ID card.

Tip: Download the card to your smartphone, so you’ll always have it even if your cell signal or internet connection goes bad.

Be sure you register at anthem.com

There’s only one thing you have to do to get your digital ID card: register on anthem.com or the Sydney mobile app. While you’re logged in, set your ID card preference to digital.
The ER isn’t your only option

Find the right place to go when you need to see a doctor quickly

Your primary care doctor is usually the best place to start when you need care. After all, they know your story. But you have other options for non-emergency care — even in the middle of the night. Make a plan now, so you’re prepared when you need to choose care in a hurry. And remember, going to the emergency room (ER) or calling 9-1-1 is always best when it’s an emergency.

### Where to go

<table>
<thead>
<tr>
<th>Where to go</th>
<th>What can be treated</th>
<th>Hours</th>
<th>Your cost¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have a video visit with a doctor on LiveHealth Online</td>
<td>Flu and cold symptoms, allergies, pink eye and sinus infections, even if a prescription is needed²</td>
<td>24/7 from your smartphone, tablet or computer with a webcam</td>
<td>$</td>
</tr>
<tr>
<td>Call your doctor's office</td>
<td>Flu and cold symptoms, allergies, chronic health conditions and preventive care like your annual physical</td>
<td>Hours vary, usually best by appointment</td>
<td>$$</td>
</tr>
<tr>
<td>Visit a retail health clinic</td>
<td>Flu and cold symptoms, rashes, minor allergic reactions, pink eye, urinary tract infections and minor cuts and burns</td>
<td>Most can see you nights and weekends, and accept walk-ins</td>
<td>$$</td>
</tr>
<tr>
<td>Go to an urgent care center</td>
<td>Back and joint injuries, flu and cold symptoms, sprains, strains and cuts or when you need X-rays</td>
<td>Usually open extended hours (nights and weekends)</td>
<td>$$$</td>
</tr>
</tbody>
</table>

¹ Costs are ranked according to the member’s estimated out-of-pocket costs and average health plan copays. $ = lower cost and $$$ = higher cost. Care outside of your plan may cost more out of pocket. Call the Member Services number on your ID card if you have questions about your plan.

² Prescription availability is defined by physician judgment.

### Finding care is easy.

Log in at anthem.com or download the Sydney app today. It’s easy and fast to find doctors, retail health clinics and urgent care centers in your plan and compare costs.
What should you do when you need care right away, but it’s not an emergency?

The emergency room (ER) might be your first choice, but you also have options that cost less and are quicker than the ER. Learn more about these choices and how to find care.

First call your primary care doctor

This is the doctor you see for most of your care. When you call your doctor, he or she will tell you if you should make an appointment with the doctor, go to the ER or choose another place to get care. Your doctor may even be able to give you advice on the phone or see you later in the day or on the weekend.

But when you can’t see your doctor or if your doctor’s office is closed, choose an option below. It often takes less time than the ER and costs about the same as a doctor visit. Plus, most are open weeknights and weekends.

Choose an option that could save time and money

Retail health clinic — A clinic staffed by health care experts who give basic health care services to walk-in patients. It’s usually in a major pharmacy or retail store.

Walk-in doctor’s office — A doctor’s office that doesn’t require you to be an existing patient or have an appointment. Can handle routine care and common illnesses.

Urgent care center — A center with doctors who treat conditions that should be looked at right away but aren’t as severe as emergencies. Can often do X-rays, lab tests and stitches.

LiveHealth Online — This online tool lets you video chat with a board-certified doctor who can answer questions and diagnose many common problems, including sore throats, infections and the flu. You can use your computer’s webcam, a smartphone or a tablet without an appointment or waiting. Enroll at livehealthonline.com or on the LiveHealth Online iOS or Android app.

Pick a care facility and call before you go

Ask:

- What are your hours?
- Tell them what has happened (for example, “I have a cut”). Then ask, “Do you have services that I need?”
- What age range do you treat?
- Are you a provider who is part of my health plan network?
- Do you accept my health insurance?

What you pay for a visit

<table>
<thead>
<tr>
<th>Care facility</th>
<th>Cost*</th>
</tr>
</thead>
<tbody>
<tr>
<td>ER</td>
<td>$1200</td>
</tr>
<tr>
<td>Retail health clinic</td>
<td>$85</td>
</tr>
<tr>
<td>Walk-in doctor’s office</td>
<td>$125</td>
</tr>
<tr>
<td>Urgent care center</td>
<td>$190</td>
</tr>
<tr>
<td>LiveHealth Online</td>
<td>$49</td>
</tr>
</tbody>
</table>

*These rates are national averages of the total cost, not what members paid. Your actual cost may vary depending on your plan and where you go for care.

When to use the ER

Always call 911 or go to the ER if you think you could put your health at serious risk by delaying care.

Want to learn more about your options?
Check out the video at www.anthem.com/wheretogetcare
### Deciding where to go

#### Who usually provides care
- Sprains, strains
- Animal bites
- X-rays
- Stitches
- Minor headaches
- Back pain
- Nausea, vomiting, diarrhea
- Minor allergic reactions
- Coughs, sore throat
- Rashes, minor burns
- Minor fevers, colds
- Ear or sinus pain
- Burning with urination
- Eye swelling, irritation, redness or pain
- Vaccinations

#### Cost
- Retail health clinic: $85
- Walk-in doctor’s office: $125
- Urgent care center: $190
- LiveHealth Online: $49

<table>
<thead>
<tr>
<th>Service</th>
<th>Care Provider</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail health clinic</td>
<td>Physician assistant or nurse practitioner</td>
<td>$85</td>
</tr>
<tr>
<td>Walk-in doctor’s office</td>
<td>Family practice doctor</td>
<td>$125</td>
</tr>
<tr>
<td>Urgent care center</td>
<td>Internal medicine, family practice, pediatric and ER doctors</td>
<td>$190</td>
</tr>
<tr>
<td>LiveHealth Online</td>
<td>Board-certified doctor</td>
<td>$49</td>
</tr>
</tbody>
</table>

### When to go to the ER

#### Some examples of ER medical emergencies are:
- Any life-threatening or disabling condition
- Severe shortness of breath
- Cut or wound that won’t stop bleeding
- Sudden or unexplained loss of consciousness
- High fever with stiff neck, mental confusion or difficulty breathing
- Major injuries
- Chest pain; numbness in the face, arm or leg; difficulty speaking
- Coughing up or vomiting blood
- Possible broken bones

### When you need care, the ER doesn’t always have to be your first choice

Here are the top 10 reasons why members go to the ER when it’s usually not necessary:

1. Minor headache
2. Urinary tract infection
3. Flu
4. Common cold
5. Nausea with vomiting
6. Dizziness
7. Migraine
8. Bronchitis
9. Lower-back pain
10. Minor head injury

*Internal claims analysis.

If you get care from a provider that is NOT part of your health plan network, you may have significantly higher out-of-pocket costs.

**Remember, if it’s serious, sudden or severe, go to the ER. If it’s minor, mild or moderate, try an urgent care center, retail health clinic, or walk-in doctor’s office to save time and money. Be ready for whatever comes your way.**

---

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No waiting room, no need to leave home.

Using LiveHealth Online, you can have a private video visit on your smartphone, tablet or computer.

When you’re not feeling well you can get the support you need easily using LiveHealth Online. Whether you have a cold, you’re feeling anxious or need help managing your medication, doctors and mental health professionals are right there, ready to help you feel your best. Using LiveHealth Online you can have a video visit with a board-certified doctor, psychiatrist or licensed therapist from your smartphone, tablet or computer from home or anywhere.

You’ve got access to affordable and convenient care

Your Anthem plan includes benefits for video visits using LiveHealth Online, so you’ll just pay your share of the costs — usually $59 or less for medical doctor visits, and a 45-minute therapy or psychiatry session usually costs the same as an office mental health visit.

On LiveHealth Online, you can:

- **See a board-certified doctor 24/7.** You don’t need an appointment to see a doctor. They’re always available to assess your condition and send a prescription to the pharmacy you choose, if needed. It’s a great option when you have pink eye, a cold, the flu, a fever, allergies, a sinus infection or another common health issue.

- **Visit a licensed therapist in four days or less.** Have a video visit with a therapist to get help with anxiety, depression, grief, panic attacks and more. Schedule your appointment online or call 1-888-548-3432 from 8 a.m. to 8 p.m., seven days a week.

- **Consult a board-certified psychiatrist within two weeks.** If you’re over 18 years old, you can get medication support to help you manage a mental health condition. To schedule your appointment call 1-888-548-3432 from 8 a.m. to 8 p.m., seven days a week.

Sign up for LiveHealth Online today — it’s quick and easy

Go to livehealthonline.com or download the app and register on your phone or tablet.
Skip the drugstore – have your medicine delivered to your home!

Why wait in line at the drugstore if you don’t have to? If you take prescribed medicine on a regular basis, you can get up to a 90-day supply delivered to your door.¹ And depending on your plan, you may save on copays because the cost of a 90-day supply of many drugs is usually less than three 30-day refills. Standard shipping is free, and you can even set up automatic refills and renewals.

Getting set up for home delivery is easy:

Go online to get started.

Go to anthem.com, log in and choose Pharmacy. On your personal pharmacy page, select View Your Prescriptions under Switch to a 90-Day Supply.

For the drugs you want to switch to home delivery, choose Switch to a 90-day Supply and then Select Prescriber. You can also add or update your shipping address, shipping options and payment method on this page.

Pay for your prescription.

We make it easy. You can pay by credit or debit card, flexible spending account, health savings account or electronic funds transfer (EFT).

To set up your payments, select Complete your Profile and Communication Preferences from your personal pharmacy page, then Change Payment Method to choose how you’d like to pay, sign up to pay online or add/update your credit card on file.
A few important things to know

- If your doctor prescribes a brand-name drug, your pharmacy plan may require the home delivery pharmacy to send a generic version instead.
- All prescriptions and refills, including those sent by your doctor, will be filled as soon as the home delivery pharmacy gets them.
- In most cases, your first order will arrive within two weeks. After that, the orders will arrive within one week.
- If you need your medicine sooner, you can call the home delivery pharmacy and ask for overnight delivery. You’ll be charged extra for the faster shipping.
- Your orders will be delivered by the U.S. Postal Service, UPS or FedEx.
- With some drugs, you may need to sign to accept delivery.2

Need help?
Call the home delivery pharmacy at 1-833-236-6196 and we’ll get you started.

1 Supplies vary based on your pharmacy plan design.
2 Drugs that are defined as controlled substances are highly regulated, which requires the home delivery pharmacy to follow special rules for filling these prescriptions.

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Specialty pharmacy
Extra support for your long-term health condition

If you have a long-term health condition and you take complex drugs to treat it, specialty pharmacies are a great help. They’re experts in handling drugs that treat serious illnesses like rheumatoid arthritis, cancer, HIV and hepatitis C.1 Specialty pharmacies have pharmacists, nurses and care managers on staff who are trained to help you get the best health results from your specialty drugs.

Here’s the kind of support you get

- **A care team just for you.** You’ll have 24/7 access to pharmacists and nurses who can tell you more about your condition, how your drugs work and any side effects you could have. They’ll also help you stay on track with your treatment. Care coordinators can answer questions about your health plan, paying for your drugs and getting refills.

- **Easy home delivery.** A specialty pharmacy will send your medicine to your home, and can help you set up automatic refills, too. This not only makes your life simpler, it can also lead to better health. Research shows that having refills on hand helps you stay on track with your drug treatment and can improve your health.2 If your doctor administers your medicine, it’ll be sent to the doctor’s office.

- **Expert storage and handling.** Some specialty drugs need to be refrigerated or handled in a special way. Specialty pharmacies make sure they’re stored and delivered to you safely. You’ll also get any supplies you need to give yourself the medicine.

A specialty pharmacy helps you get the best health results from the drugs you take.

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1 This is not a complete listing of conditions treated by specialty drugs.
Which specialty pharmacy should you use?
The specialty pharmacy you use is based on how your health plan covers your specialty drug. Depending on the drug you take and how it's given to you, it can be covered one of two ways: through your plan’s prescription drug benefit or through the medical benefit. If you give the drug to yourself, it's often covered under the pharmacy benefit. If you get a drug as a shot or infusion at a doctor’s office or hospital outpatient clinic, it may be covered under your medical benefit.

Getting started with your specialty pharmacy
Here’s a quick guide to the specialty pharmacy you’ll need to use and how to get started.

<table>
<thead>
<tr>
<th>If your drug is covered by your ...</th>
<th>Your specialty pharmacy is ...</th>
<th>Here's how to get started</th>
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<tr>
<td>Ingenio</td>
<td>Ingenio Specialty Pharmacy</td>
<td>Call Ingenio Care Team at 1-833-255-0645.</td>
</tr>
</tbody>
</table>

After you or your doctor contact Ingenio, a care coordinator will call you to set up delivery of your medicine. If you have questions about how to take the drug or ways to manage side effects, you can call them 24/7 at 1-833-255-0645.

Want to know more?
We’re here to help. To see your personalized pharmacy benefits information, log in at anthem.com. If you have questions, you can always call us at the Member Services number on your ID card.
Take your benefits with you
With the BlueCard® PPO and Blue Cross Blue Shield
Global Core programs

What happens if you’re away from home and you need care right away? As an Anthem Blue Cross and Blue Shield (Anthem) member, you have access to care across the country through the BlueCard® PPO Program. This includes 93% of doctors and 96% of hospitals in the U.S.¹

How to access care across the U.S.:

Call 911 or go to the nearest hospital in an emergency.*

Go to anthem.com, log in and use the Find a Doctor tool to search for a BlueCard PPO Program doctor or hospital.

Use the Sydney app to search for a BlueCard PPO Program doctor or hospital. Get turn-by-turn directions to the nearest doctor, urgent care center or hospital.

Call Member Services at the number on your ID card. They can help you find a doctor or hospital.

*You or a family member needs to call the Member Services number on your ID card within 24 hours (48 hours for members in Indiana) after going to the hospital or as soon as you can.

Traveling?

Here’s what you need to know:

- Before leaving the country, ask Member Services if your international benefits are different.
- Ask for approval before getting care. This is “precertification” and helps you find care covered by your plan. To see if you need precertification, call Member Services at the number on your ID card.
- Save money by seeing a BlueCard program doctor or hospital. You only pay your usual out-of-pocket amounts (such as deductible, your percentage of costs or copay). If you go to a doctor or hospital outside the program, you’ll need to pay the entire bill up front.
- Show your Anthem ID card so the doctor or hospital can check your benefits and send us a claim for processing.

Remember to carry your ID card
The “PPO-in-a-suitcase” symbol shows you can get care from BlueCard PPO Program doctors and hospitals.

Anthem

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. (RMCMS), In Montana: Rocky Mountain Hospital and Medical Service, Inc. (RMHMS), In New Mexico: Rocky Mountain Hospital and Medical Service, Inc. (NMHMS), In Nevada: Rocky Mountain Hospital and Medical Service, Inc. (NMHMS), In Washington: Rocky Mountain Hospital and Medical Service, Inc. (RMHMS), In Oregon: Rocky Mountain Hospital and Medical Service, Inc. (RMHMS), In Utah: Rocky Mountain Hospital and Medical Service, Inc. (RMHMS).

Anthem Blue Cross and Blue Shield is the trade name of: In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross Blue Shield HealthCare Plan of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In New York: Blue Cross Blue Shield of New York, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Richmond, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by Compcare Insurance Corporation (Compcare) or Wisconsin Collaborative Insurance Corporation (WCI). Compcare underwrites or administers indemnity policies and underwrites or administers POS policies. Independent licensees of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

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How to access care around the world

The Blue Cross Blue Shield Global Core Program gives you benefits when you travel outside the U.S.

If you’re outside the U.S., you can use the **Blue Cross Blue Shield Global Core Program**. It gives you access to preferred doctors and hospitals in nearly 190 countries and territories around the world.

**Need care outside the U.S.? You can:**

- **Go straight to the nearest hospital in an emergency.**
- **Go to** [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com) **to search for a doctor or hospital.**
- **Use the Blue Cross Blue Shield Global Core app** to find a doctor or hospital.
- **Call the Blue Cross Blue Shield Global Core Service Center** 24/7 at 1-800-810-2583 (BLUE) or call collect at 1-804-673-1177. They can help you set up a doctor visit or hospital stay.

Unless it’s an emergency, call the Global Core Service Center before getting care outside the U.S. Global Core will work with the doctor and Anthem to approve and accept a Guarantee of Payment (GOP). What if you get care from a doctor or hospital that has not accepted a GOP?

1. You will need to pay up front in full for your care.
2. Download an international claim form at [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com) or get a form by calling Member Services at the number on your ID card.
3. Fill out the claim form and send it with the original bills to the Blue Cross Blue Shield Global Core Service Center. You can submit them through the mobile app, email or postal mail.

**Download the Blue Cross Blue Shield Global Core app today**

With the app, you can:

- Search for a doctor or hospital.
- Submit claims.
- Get medical terms and phrases for many symptoms translated — and even use an audio feature to play the translation.
- Find a drug’s generic name, local brand name and check whether it’s available.
- Get information about how to find and contact a U.S. embassy.

[App Store](https://apps.apple.com)  
[Google play](https://play.google.com)

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2 GeoBlue website, More than 20 years as a leader in international healthcare (accessed March 2017): about.geo-blue.com.
3 Using the Blue Cross Blue Shield Global Core app itself does not require an internet connection. However, using GPS for mapping or downloading an audio translation does require an internet connection (accessed March 2017): bcbsglobalcore.com/Home/MobileApp/#features.

The Blue Cross Blue Shield Global Core program was formerly known as BlueCard Worldwide®. Blue Cross, Blue Shield, the Blue Cross and Blue Shield symbols, BlueCard, BlueCard Worldwide, and Blue Cross Blue Shield Global are trademarks of the Blue Cross Blue Shield Association, an association of independent Blue Cross and Blue Shield companies.
Peace of mind is something your employees can travel with anywhere they go

BlueCard® PPO and Blue Cross Blue Shield Global Core programs feature health care benefits that travel with your employees

Through the BlueCard PPO and Blue Cross Blue Shield Global Core programs, your employees can access doctors and hospitals in their plan throughout the U.S., as well as around the world.

Coverage in the U.S.

BlueCard PPO gives them access to their PPO benefits when they use doctors and hospitals that contract with Blue Cross and/or Blue Shield in other states. We’re talking about 96% of hospitals and 93% of doctors across the country.1 The BlueCard program links them all together as one big network.

Just like when they seek care at home, your employees may pay less out of pocket — and we may cover more services — when they get care from doctors and hospitals that are in a Blue Plan.

Coverage around the globe

For travel abroad, the Blue Cross Blue Shield Global Core program gives your employees access to doctors and hospitals in nearly 190 countries and territories around the world.2

2 GeoBlue website, More than 20 years as a leader in international healthcare (accessed December 2016): about.geo-blue.com.
Coast-to-coast coverage with BlueCard PPO

The “PPO-in-a-suitcase” symbol on your employees’ member ID card is recognized by doctors and hospitals across the country. It identifies your employees as BlueCard PPO members so they can access their PPO benefits where they live and when they travel.

Access made easy

Finding a PPO doctor or hospital is easy. Your employees go to anthem.com to find a doctor or hospital in the BlueCard PPO program. They can also call the number on the back of their ID card to get names and addresses of the nearest doctor.

Network doctors make life easier

While your employees can choose in-network or out-of-network doctors each time they need medical care, having a long-term relationship with one network doctor has its advantages like:

- One doctor who knows them and can direct all of their health care
- A chance to save money
- Less paperwork

If your employees have an emergency while traveling

There’s a difference between an emergency and a need for urgent care. Your employees should understand this difference and know how to access care in each case.

Emergency care

Emergencies are medical conditions that pose a serious risk to someone’s health. Here are a few questions your employees should ask themselves:

- Are my symptoms severe and/or life-threatening?
- Did they happen all of the sudden and without warning?
- Is there a lot of bleeding, extreme pain, shortness of breath or broken bones?
- Using my best judgment, do I believe there may be serious impairment to bodily functions or serious dysfunction of a bodily organ/part without immediate medical attention?

If the answer is “yes” to any of these questions, employees should call 911 or go to the nearest emergency room.

Urgent care

Urgent care is for medical symptoms, pain or conditions that need medical care right away but aren’t severe or life-threatening. This includes an earache, sore throat, rash, sprained ankle, flu and fever of 104° and lower.

When your employees need to call us before they seek medical care

Sometimes, we ask that your employees call us before they get certain care or services so that we can be sure they get the right care in the right setting. This is called “precertification.”

Emergency care doesn’t require precertification, but we still need to know about it

Precertification is not required for emergency care or admissions, but we do need to know about them. The employee or a relative must tell us within 24 hours or as soon as they can. Employees who don’t let us know may have to pay more if we determine that certain services weren’t medically necessary.
Services and equipment that need precertification

Precertification is usually required for the following services. Your employees should see their benefits booklet for their plan’s complete list and rules.

- Human organ and tissue transplants
- Hospital stays and stays at other facilities, except for childbirth
- Diagnostic services and advanced imaging
- Private-duty nursing services at home
- One-day surgery for: uvulopalatopharyngoplasty (UPPP) and certain plastic/reconstructive procedures
- Certain durable medical equipment/prosthetics including special wheelchairs and hospital beds, powered prosthetics and custom-made orthotics/braces

Your employees are responsible for getting precertification. Even if their doctor offers to do it for them, it’s a good idea for your employees to call us and confirm.

How BlueCard works when employees need care while traveling in the U.S.

- Your employees should always carry an up-to-date ID card.
- When they need health care, your employees can search for the nearest BlueCard PPO doctors and hospitals by looking them up online. They can also call the number on the back of their ID card to find a BlueCard PPO doctor or hospital.
- Your employees are responsible for calling us for precertification. They should use the phone number on their ID card.
- When they get to the doctor’s office or hospital, your employees should show their ID card, and the doctor or hospital will verify their membership and coverage information.

- After your employees get care, the claim is electronically sent to us for processing.
- BlueCard PPO doctors and hospitals are paid directly, and your employees normally only need to pay for out-of-pocket costs (noncovered services, deductible, copay or their percentage of the costs). They’ll get a detailed explanation of benefits summary showing how the claim was processed.

We’re here to help

If your employees have questions, they can call the Member Services number on the back of their ID card. We’ll be happy to help them understand their BlueCard and Blue Cross Blue Shield Global Core benefits and how to use them.

To learn more about how BlueCard PPO and Blue Cross Blue Shield Global Core can cover your employees when they’re away from home, call your Sales representative.

Employees can learn more about Blue Cross Blue Shield Global Core by:

- Calling the Member Services number on their ID card.
- Visiting bcbsglobalcore.com.
- Calling the Blue Cross Blue Shield Global Core service center toll free at 1-800-810-2583 or collect at 1-804-673-1177.
Coverage abroad with Blue Cross Blue Shield Global Core

Whether traveling or living outside of the U.S., your employees can use the Blue Cross Blue Shield Global Core program when they need medical care.

Here’s what happens when employees need care while traveling or living abroad

- Before leaving the U.S., employees should call the Member Services number on the back of their ID card to find out how they’re covered abroad.
- Your employees should always carry an up-to-date member ID card.
- In an emergency, employees should go to the nearest hospital.

- If your employees need help finding a doctor or hospital, or have any questions about getting care abroad, they should call the Blue Cross Blue Shield Global Core service center toll free at 1-800-810-2583 or collect at 1-804-673-1177, 24 hours a day, seven days a week.
  - An assistance coordinator, together with a medical professional, will arrange a doctor’s appointment or hospital stay, if needed.
- If employees need to be admitted to the hospital, they should call the Blue Cross Blue Shield Global Core service center toll free at 1-800-810-2583 or collect at 1-804-673-1177.
  - Besides contacting the Blue Cross Blue Shield Global Core service center, employees should call the Member Services number on their ID card for precertification. **Note:** This number is not the phone number listed above.
- Employees will need to pay up front for care received from an out-of-network doctor and/or out-of-network hospital. Then, they’ll have to fill out a Blue Cross Blue Shield Global Core claim form and send it with the bill(s) to the Blue Cross Blue Shield Global Core service center (the address is on the form).
  - Employees can download a claim form by visiting [bcbsglobalcore.com](http://bcbsglobalcore.com) and entering their three-digit alpha prefix. They can also get a form by calling the Blue Cross Blue Shield Global Core service center.
Save money with discounts at anthem.com

Saving money is good. Saving money on things that are good for you — that’s even better. With SpecialOffers, you can get discounts on products and services that help promote better health and well-being.* It’s just one of the perks of being an Anthem member. Check out how much you can save:

**Vision, hearing and dental**

**Glasses.com™ and 1-800-CONTACTS®** — Get the latest brand-name frames for just a fraction of the cost at typical retailers — every day. Plus, you get an additional $20 off orders of $100 or more, free shipping and free returns.

**EyeMed** — Get 30% off a new pair of glasses, 20% off non-prescription sunglasses and 20% off all eyewear accessories.

**Premier LASIK** — Save $800 on LASIK when you choose any ‘featured’ Premier LASIK Network provider. Save 15% with all other in-network providers.

**TruVision** — Save up to 40% on LASIK eye surgery at more than 1,000 locations (over 6.5 million procedures performed in the network).

**Nations Hearing** — Get hearing screenings and in-home service at no additional cost. All hearing aids start at $599 each, powered by the Beltone network.

**Hearing Care Solutions** — Digital instruments start at $500. Plus, get a free hearing exam. Hearing Care Solutions has 3,100 locations and eight manufacturers, and offers a three-year warranty, two years of batteries and unlimited visits for one year.

**Amplifon** — Get 25% off, plus an extra $50 off one hearing aid; $125 off two.

**ProClear™ Aligners** — Get $1,200 off a set of custom aligners. Improving your smile shouldn’t cost a fortune. Now you can get a beautiful, professional smile in the comfort of your own home — all at a 50% savings. No metal braces; no time-consuming dentist visits; no hidden fees. Order now and get a free whitening kit, along with your great-looking smile.

*Restrictions apply. Check out more SpecialOffers on the other side.
**Special Offers on anthem.com**

**Fitness and health**

**Active&Fit Direct™** — Active&Fit Direct allows you to choose from more than 9,000 participating fitness centers nationwide for $25 a month (plus a $25 enrollment fee and applicable taxes). Offered through American Specialty Health Fitness, Inc.

**FitBit** — Get fit your way with Fitbit trackers and smartwatches that fit with your lifestyle, budget and goals. Save up to 22% on select Fitbit devices.

**Garmin** — Get 25% off select Garmin wellness devices.

**Jenny Craig** — Take advantage of a free, three-month program (food not included) plus $120 in food savings (purchase required), or save 50% off premium programs (food cost separate).

**ChooseHealthy** — Get discounts on acupuncture, chiropractic, massage and fitness clubs.

**Global Fit** — Get discounts on gym memberships, fitness equipment, coaching and more.

**Family and home**

**23andMe** — Get $40 off each Health + Ancestry kit. Your DNA says a lot about you. Save 20% on a 23andMe kit and learn about your wellness, ancestry and more.

**Safe Beginnings®** — Babyproof your home while saving 15% on everything from safety gates to outlet covers.

**Nationwide Pet Insurance** — Receive an automatic 5% discount when you enroll through your company or organization. Save up to 15% when you enroll multiple pets.

**ASPCA Pet Insurance** — Get 5% off pet insurance. You can choose from three levels of care, including flexible deductibles and custom reimbursements.

**WINFertility®** — Save up to 40% on infertility treatment. WINFertility helps make quality treatment affordable.

**LifeMart®** — Get great deals on beauty and skin care, diet plans, fitness club memberships and plans, personal care, spa services and yoga classes, sports gear and vision care.

**Medicine and treatment**

**SelfHelpWorks** — Choose one of the online Living programs and save 15% on coaching to help you lose weight, stop smoking, manage stress or diabetes, restore sound sleep or face an alcohol problem.

**Brevena** — Enjoy a 41% discount on BREVENA® skin care creams and balms for smooth, rejuvenated skin from face to foot.

**Puritan’s Pride** — Choose from a large selection of discounted vitamins, minerals and supplements from Puritan’s Pride.

**Allergy Control Products** — Save 20% on select doctor-recommended products such as allergy friendly bedding, air purifiers and filters, asthma products and more. Plus enjoy free shipping on all orders over $79 when shipping ground within the contiguous U.S.

**National Allergy® supply** — Save 20% on select National Allergy® Doctor Recommended Products.

- Allergy bedding
- Air purifiers and filters
- Home allergy products
- Personal care
- Humidifiers and dehumidifiers
- Vacuums and steam cleaners

* All discounts are subject to change without notice.
Geting regular checkups and exams can help you stay healthy and catch problems early — when they’re easier to treat.

That’s why our health plans offer all the preventive care services and immunizations below — at no cost to you. As long as you see a doctor or lab in the plan, you won’t have to pay anything for these services and immunizations. If you want to visit a doctor outside the plan, you may have to pay out of pocket.

Not sure which services make sense for you? Talk to your doctor. He or she can help you figure out what you need.

Preventive vs. diagnostic care

What’s the difference? Preventive care helps protect you from getting sick. If your doctor recommends you have services even though you have no symptoms, that’s preventive care. Diagnostic care is when you have symptoms and your doctor recommends services to determine what’s causing those symptoms.

Adult preventive care

Preventive physical exams

Screening tests:

- Alcohol misuse: related screening and behavioral counseling
- Aortic aneurysm screening (men who have smoked)
- Behavioral counseling to promote a healthy diet
- Blood pressure
- Bone density test to screen for osteoporosis
- Cholesterol and lipid (fat) level
- Colorectal cancer, including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and related prep kit, and computed tomography (CT) colonography (as appropriate)
- Depression screening
- Hepatitis C virus (HCV) for people at high risk for infection and a one-time screening for adults born between 1945 and 1965
- Type 2 diabetes screening
- Eye chart test for vision

Immunizations:

- Diphtheria, tetanus and pertussis (whooping cough)
- Hepatitis A and hepatitis B
- Human papillomavirus (HPV)
- Influenza (flu)
- Measles, mumps and rubella (MMR)
- Meningococcal (meningitis)
- Pneumococcal (pneumonia)
- Varicella (chickenpox)
- Zoster (shingles)

Women’s preventive care:

- Well-woman visits
- Breast cancer, including exam, mammogram, and genetic testing for BRCA 1 and BRCA 2 when certain criteria are met
- Breastfeeding: primary care intervention to promote breastfeeding support, supplies and counseling
- Contraceptive (birth control) counseling
- Food and Drug Administration (FDA)-approved contraceptive medical services, including sterilization, provided by a doctor
- Counseling related to chemoprevention for those with a high risk of breast cancer
- Counseling related to genetic testing for those with a family history of ovarian or breast cancer
- HPV screening
- Screening and counseling for interpersonal and domestic violence
- Pregnancy screenings, including gestational diabetes, hepatitis B, asymptomatic bacteriuria, Rh incompatibility, syphilis, HIV and depression
- Pelvic exam and Pap test, including screening for cervical cancer

These preventive care services are recommendations of the Affordable Care Act (ACA or health care reform law). They may not be right for every person, so ask your doctor what’s right for you.

This sheet is not a contract or policy with Anthem Blue Cross and Blue Shield. If there is any difference between this sheet and the group policy, the provisions of the group policy will rule. Please see your combined Evidence of Coverage and Disclosure Form or Certificate for exclusions and limitations.

* CDC-recognized Diabetes Prevention programs are available for overweight or obese adults with abnormal blood glucose or who have abnormal CVD risk factors.
Child preventive care

Preventive physical exams

Screening tests:
- Behavioral counseling to promote a healthy diet
- Blood pressure
- Cervical dysplasia screening
- Cholesterol and lipid level
- Depression screening
- Development and behavior screening
- Type 2 diabetes screening
- Hearing screening
- Height, weight and BMI
- Hemoglobin or hematocrit (blood count)
- Lead testing
- Screening and counseling for obesity
- Counseling for those ages 10-24 with fair skin about lowering their risk for skin cancer
- Oral (dental health) assessment when done as part of a preventive care visit
- Screening and counseling for sexually transmitted infections
- Tobacco use: related screening and behavioral counseling
- Vision screening when done as part of a preventive care visit

Immunizations:
- Chickenpox
- Flu
- Haemophilus influenza type b (Hib)
- Hepatitis A and hepatitis B
- HPV
- Meningitis
- MMR
- Pneumonia
- Polio
- Rotavirus
- Whooping cough
We’re here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here’s the English version: “You have the right to get help in your language for free. Just call the Member Services number on your ID card.” Visually impaired? You can also ask for other formats of this document.

Spanish
Usted tiene derecho a recibir ayuda en su idioma en forma gratuita. Simplemente llame al número de Servicios para Miembros que figura en su tarjeta de identificación.

Chinese
您有權免費獲得透過您使用的語言提供的幫助。請撥打您的ID卡片上的會員服務電話號碼。若您是視障人士，還可索取本文的其他格式版本。

Vietnamese
Quý vị có quyền nhận sistem trợ giúp bằng ngôn ngữ của mình. Chỉ cần gọi số Dịch vụ danh cho thành viên trên thẻ ID của quý vị. Mặt khác thì? Quý vị cũng có thể hỏi xin dịch đang khác của tài liệu này.“

Korean
귀하는 자극어로 무료지원을 받을 권리가 있습니다. ID 카드에 있는 멤버 서비스번호로 연락하십시오.

Tagalog
May karapatan ka na makakuha ng tulong sa iyong wika nang libre. Tawagan lamang ang numero ng Member Services sa iyong ID card. May kapansanan ka ba sa panining? Maaari ka ring humiling ng iba pang format ng dokumentong ito.

Russian
Вы имеете право на получение бесплатной помощи на вашем языке. Просто позвоните по номеру обслуживания клиентов, указанному на вашей идентификационной карте. Пациенты с нарушением зрения могут заказать документ в другом формате.

Arabic
أنت有权使用您首选的语言向我们求助。只需拨打会员服务所列出的电话号码。

Japanese
お客様の言語で無償サポートを受けることができます。IDカードに記載されているメンバーサービス番号までご連絡ください。

Italian
Ricevere assistenza nella tua lingua è un tuo diritto. Chiama il numero dei Servizi per i membri riportato sul tuo tesserino. Sei ipovedente? È possibile richiedere questo documento anche in formati diversi

Polish
Masz prawo do uzyskania darmowej pomocy udzielonej w Twoim języku. Wystarczy zadzwonić na numer działu pomocy znajdujący się na Twojej karcie identyfikacyjnej.

Punjabi
ਆਪਣੀਆਂ ਤਕਤਾ ਵਿੱਚ ਮੂਲ ਲੋਕਿਅਰ ਸਰੂਪ ਵਿੱਚ ਰਹਿਣ ਦਾ ਵਿਚਕਾਰ ਹੈ। ਆਪਣੀ ਆਪਣੀ ਵਿਆਹ ਦੀ ਤਰੀਕਾ ਵੇਖਣ ਦੇ ਵਾਲ ਵਾਲੇ ਸਰੂਪ ਨੂੰ ਮਿਲਾਣ ਹੈ? ਆਪਣੀ ਆਪਣੀ ਵਿਆਹ ਦੀ ਤਰੀਕਾ ਵੇਖਣ ਦੇ ਵਾਲ ਵਾਲੇ ਸਰੂਪ ਨੂੰ ਮਿਲਾਣ ਹੈ?

TTY/TDD:711
It’s important we treat you fairly

We follow federal civil rights laws in our health programs and activities. By calling Member Services, our members can get free in-language support, and free aids and services if you have a disability. We don’t discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn’t English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed in any of these areas, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
As a member, you have the right to expect us to protect your personal health information. We take this responsibility very seriously, following all state and federal laws, as well as our own policies.

You also have certain rights and responsibilities when receiving your health care. To learn more about how we protect your privacy, your rights and responsibilities when receiving health care, and your rights under the Women’s Health and Cancer Rights Act, go to anthem.com/privacy. For a printed copy, please contact your Benefits Administrator or Human Resources representative.

How we help manage your care

To see if your health benefits will cover a treatment, procedure, hospital stay or medicine, we use a process called utilization management (UM). Our UM team is made up of doctors and pharmacists who want to be sure you get the best treatments for certain health conditions. They review the information your doctor sends us before, during or after your treatment. We also use case managers. They’re licensed health care professionals who work with you and your doctor to help you manage your health conditions. They also help you better understand your health benefits.

To learn more about how we help manage your care, go to anthem.com/memberrights. To request a printed copy, please contact your Benefits Administrator or Human Resources representative.

Special enrollment rights

Open enrollment usually happens once a year. That’s the time you can choose a plan, enroll in it or make changes to it. If you choose not to enroll, there are special cases when you’re allowed to enroll during other times of the year.

- If you had another health plan that was canceled. If you, your dependents or your spouse are no longer eligible for benefits with another health plan (or if the employer stops contributing to that health plan), you may be able to enroll with us. You must enroll within 31 days after the other health plan ends (or after the employer stops paying for the plan). For example: You and your family are enrolled through your spouse’s health plan at work. Your spouse’s employer stops paying for health coverage. In this case, you and your spouse, as well as other dependents, may be able to enroll in one of our plans.

- If you have a new dependent. You gain new dependents from a life event like marriage, birth, adoption or if you have custody of a minor and an adoption is pending. You must enroll within 31 days after the event. For example: If you got married, your new spouse and any new children may be able to enroll in a plan.

- If your eligibility for Medicaid or SCHIP changes. You have a special period of 60 days to enroll after:
  - You (or your eligible dependents) lose Medicaid or the State Children’s Health Insurance Program (SCHIP) benefits because you’re no longer eligible.
  - You (or eligible dependents) become eligible to get help from Medicaid or SCHIP for paying part of the cost of a health plan with us.

Get the full details

Read your Certificate of Coverage, which spells out all the details about your plan. You can find it on anthem.com.
Questions?

Please call us with your questions!

833-578-4441

Ready to use your plan?

Get some extra help

If you have questions, it's easy to get answers. Contact us through our online Message Center or call the Member Services number on your ID card.