Ready to choose your benefits?

We can point you in the right direction.

Capital Area Health Consortium
Effective July 1, 2018

This guide is for information purposes only. You must enroll in a plan for your benefits to start.
Let's take a look

We know picking a health plan is a big deal, so this guide makes it easier for you to understand your benefit options. We'll explain how the plan works and give you other important details. That way you can enroll with confidence!

In this guide, you'll find:
- The plan at a glance
- Your health care basics
- How to use your health plan
- Dental and vision benefits
- Your privacy and rights

Pay a visit to anthem.com to get an idea of what you can do once you're a member. Find a doctor, estimate care costs, sign up to get emails instead of mail and much more!
The plan at a glance

Here’s a quick overview of the plan your employer is offering. To learn more plan basics visit anthem.com/basics.

Century Preferred PPO

- This plan covers services from almost any doctor or hospital.
- You pay less if you use a doctor from the Preferred Provider Organization (PPO) plan.
- You pay more if you go to a doctor who’s not part of the PPO plan.
- You don’t usually need a referral from your main doctor, also called a primary care doctor, to see a specialist.

It’s easy to get care in your plan

You can find doctors, hospitals and other health care professionals in our plans on anthem.com — and they charge our members lower rates.

1 Each of our plans may have different rules, so always check your plan details for more specific information.
Know your health care basics
Learn about the kinds of costs you’ll share with your plan

You pay your deductible.
This is a set amount that you pay before we start sharing in the cost of the covered health care you receive. If your plan has copays (flat fees like $30 for each visit) along with a deductible, you only need to pay the copay for most doctor visits.

What happens after I pay my deductible?
You pay a copay or a percentage of the cost, also called coinsurance, each time you receive care for covered services, and then your plan covers the rest.

What’s an out-of-pocket limit?
Each year, there’s a maximum amount you can pay out of your own pocket for covered services — that’s your out-of-pocket limit. Once you’ve reached that limit — it varies by plan — we cover the rest for covered services. If you visit doctors or hospitals that aren’t in your plan, you’ll still have out-of-pocket costs. With some plans, you still have copays even after you reach your out-of-pocket limit.

What about the money for the plan that gets taken out of my paycheck?
That’s what you pay for the plan. Think of it like a membership fee. It’s separate from what you pay when you get care.
Using your health plan

It's easy to get started with your plan and make the best of your benefits.

Choose a doctor in your plan
Avoid getting care from doctors outside of your plan; it will cost you more or your plan may not cover it at all. We've made it easy for you to find doctors in your plan. Visit anthem.com to look for a primary care doctor, hospitals, labs and other health care professionals in your plan.

Use your ID card
You'll be a member after you complete enrollment and your benefits begin. Then, you’ll be able to use your ID card. Don’t forget, it’s always available and easy to use on the Anthem Anywhere mobile app. It’s like your passport to care since you’ll need to show it whenever you go to the doctor.

Anthem.com
Once your benefits begin and you access your ID card, register on anthem.com or on the Anthem Anywhere mobile app to get personalized information about your health plan.
- Find a doctor.
- Estimate your costs, before you step into the doctor’s office.
- Set up your communication preferences to receive important information electronically, instead of by mail.

Learn more at anthem.com/guidedtour.

Preventive care is covered at no extra cost
Preventive care from a doctor in your plan is covered at 100%. Getting these regular checkups, screenings and shots can help you stay healthy and catch problems early – when they’re easier to treat. So, talk to your doctor about what preventive care you may need to protect your health.

Save emergency room visits for emergencies only
Knowing where to go for care saves you time and money. So if you have a real emergency, head straight to the ER or call 911. Otherwise, visit your regular doctor or an urgent care center for minor medical issues.

We’re here for you
When you become a member, we make it easy for you to get your questions answered in the way that works best for you.
- By phone: Call the Member Services number on your mobile ID card.
- Online: Register at anthem.com or download the Anthem Anywhere mobile app to chat with a team member.
Dental and Vision benefits

When you enroll, you'll probably need to sign up separately for the benefits in this section.

Dental

Dental benefits not only protect your teeth, but can support overall health, too. Some conditions like heart disease, for example, can have warning signs in the mouth and gums. Our dental plan gives you all the benefits you need for a healthy mouth and more.

*Our dental plan offers:*

- Access to a large number of dentists in the plan.
- No out-of-pocket costs for cleanings, X-rays and other preventive care services when you see a dentist in the plan.
- Easy to use online tools including a Dental Health Assessment, Dental Cost Estimator and Ask a Dental Hygienist.

Vision

With Blue View Vision™, you have access to over 36,000 doctors at over 27,000 locations across the country, including convenient retail stores like LensCrafters® Sears Optical™, Target Optical®, JCPenney® Optical and most Pearle Vision® stores. You also can order glasses and contacts online through Glasses.com (glasses.com), ContactsDirect (ContactsDirect.com) or 1-800-CONTACTS (1800contacts.com).

*Enrolling in a vision plan helps you pay for:*

- Routine eye exams. Even if you can see well, regular eye exams are important to help keep your eyes healthy - and you can catch other health problems early.
- Frames and either eyeglass lenses or contact lenses.
Your plan details

In this next section, you’ll find more information about your plan.
Century Preferred is a preferred provider organization (PPO) plan.

### COST SHARE PROVISIONS

<table>
<thead>
<tr>
<th>In-Network Member pays:</th>
<th>Out-of-Network Member pays:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital (HSP) Copayment</td>
<td>No Charge</td>
</tr>
<tr>
<td>Urgent Care (UR) Copayment</td>
<td>$25</td>
</tr>
<tr>
<td>Emergency Room (ER) Copayment – waived if admitted</td>
<td>$50</td>
</tr>
<tr>
<td>Outpatient Surgery (OS) Copayment</td>
<td>No Charge</td>
</tr>
<tr>
<td>Annual Deductible (individual/2-member family/3+ member family)</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>20% after deductible up to $1,000</td>
</tr>
<tr>
<td>Cost Share Maximum (individual/2-member family/3+ member family)</td>
<td>$6,600/$13,200/ $13,200</td>
</tr>
</tbody>
</table>

### PREVENTIVE CARE

<table>
<thead>
<tr>
<th>Preventive Care</th>
<th>In-Network Member pays:</th>
<th>Out-of-Network Member pays:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well child care</td>
<td>No Charge</td>
<td>Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td>Periodic, routine health examinations</td>
<td>No Charge</td>
<td></td>
</tr>
<tr>
<td>Routine eye screening</td>
<td>No Charge</td>
<td></td>
</tr>
<tr>
<td>Routine OB/GYN visits</td>
<td>No Charge</td>
<td></td>
</tr>
<tr>
<td>Mammography</td>
<td>No Charge</td>
<td></td>
</tr>
<tr>
<td>Hearing screening (as part of preventive exam)</td>
<td>No Charge</td>
<td></td>
</tr>
</tbody>
</table>

### MEDICAL CARE

<table>
<thead>
<tr>
<th>Medical Care</th>
<th>In-Network Member pays:</th>
<th>Out-of-Network Member pays:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visits</td>
<td>$15</td>
<td>Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td>Specialist visits</td>
<td>$20</td>
<td></td>
</tr>
<tr>
<td>Outpatient mental health &amp; substance abuse - prior authorization required</td>
<td>No Charge</td>
<td></td>
</tr>
<tr>
<td>OB/GYN care</td>
<td>$20</td>
<td></td>
</tr>
<tr>
<td>Maternity care – initial visit subject to copayment, no charge thereafter</td>
<td>$20</td>
<td></td>
</tr>
<tr>
<td>Diagnostic lab and x-ray</td>
<td>No Charge</td>
<td></td>
</tr>
<tr>
<td>High-cost outpatient diagnostic – prior authorization required</td>
<td>No Charge</td>
<td></td>
</tr>
<tr>
<td>Allergy services</td>
<td>$20</td>
<td></td>
</tr>
<tr>
<td>Office visits/testing</td>
<td>No Charge</td>
<td></td>
</tr>
<tr>
<td>Injections—80 visits in 3 years</td>
<td>No Charge</td>
<td></td>
</tr>
</tbody>
</table>

### HOSPITAL CARE – Prior authorization required

<table>
<thead>
<tr>
<th>Hospital Care</th>
<th>In-Network Member pays:</th>
<th>Out-of-Network Member pays:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Semi-private room (General/Medical/Surgical/Maternity)</td>
<td>No Charge</td>
<td>Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td>Inpatient mental health &amp; substance abuse</td>
<td>No Charge</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing facility – up to 120 days per calendar year</td>
<td>No Charge</td>
<td></td>
</tr>
<tr>
<td>Rehabilitative services – up to 60 days per person per calendar year</td>
<td>No Charge</td>
<td></td>
</tr>
<tr>
<td>Outpatient surgery – in a hospital or surgi-center</td>
<td>No Charge</td>
<td></td>
</tr>
</tbody>
</table>

### EMERGENCY CARE

<table>
<thead>
<tr>
<th>Emergency Care</th>
<th>In-Network Member pays:</th>
<th>Out-of-Network Member pays:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walk-in centers</td>
<td>$15</td>
<td>Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td>Urgent care – at participating centers only</td>
<td>UR Copayment</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Emergency care – copayment waived if admitted</td>
<td>ER Copayment</td>
<td>ER Copayment</td>
</tr>
<tr>
<td>Ambulance</td>
<td>No Charge</td>
<td>No Charge</td>
</tr>
</tbody>
</table>
OTHER HEALTH CARE

<table>
<thead>
<tr>
<th>In-Network Member pays:</th>
<th>Out-of-Network Member pays:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient rehabilitative services</td>
<td>No Charge</td>
</tr>
<tr>
<td>Durable medical equipment / Prosthetic devices</td>
<td>No Charge</td>
</tr>
<tr>
<td>Hospice 60 day maximum</td>
<td>$200 copay</td>
</tr>
<tr>
<td>Infertility services (diagnosis and treatment)</td>
<td>$20</td>
</tr>
<tr>
<td>Home health care</td>
<td>No Charge</td>
</tr>
<tr>
<td>Prescription drugs – filled at a pharmacy</td>
<td>See drug plan</td>
</tr>
</tbody>
</table>

PREVENTIVE CARE SCHEDULES

**Mammography**
- 1 baseline screening, ages 35-39
- 1 screening per year, ages 40+
- Additional exams when medically necessary

**Vision Exams**: 1 exam every calendar year

**Hearing Exams**: 1 exam every 2 calendar years
- copay applies

**Notes To Benefit Descriptions**
- In situations where the member is responsible for obtaining the necessary prior authorization and fails to do so, benefits may be reduced or denied.
- Inpatient Hospital Per Admission Copay is waived if readmitted within 30 days for same diagnosis. Maximum of 3 copays per person per year.
- Skilled Nursing Facility Copay is waived if admitted within 3 days of hospital discharge.
- Home Health Care services are covered when in lieu of hospitalization. Includes infusion (IV) therapy.
- Members must utilize participating Blue Quality Centers for Transplant hospitals to receive benefits for Human Organ & Tissue Transplant services. This network of the finest medical transplant programs in the nation is available to members who are candidates for an organ or bone marrow transplant. A nurse consultant trained in case management is dedicated to managing members who require organ and/or tissue transplants.
- Members are responsible for the balance of charges billed by out-of-network providers after payment for covered services has been made by Anthem Blue Cross and Blue Shield according to the Comprehensive Schedule of Professional Services.

Please refer to the SpecialOffers@Anthem brochure in your enrollment kit for information on the discounts we offer on health-related products and services.

This does not constitute your health plan or insurance policy. It is only a general description of the plan. The following are examples of services NOT covered by your Century Preferred Plan. Please refer to your Subscriber Agreement/Certificate of Coverage/Summary Booklet for more details:
- Cosmetic surgeries and services; custodial care; genetic testing; hearing aids; refractive eye surgery; services and supplies related to, as well as the performance of, sex change operations; surgical and non-surgical services related to TMJ syndrome; travel expenses; vision therapy; services rendered prior to your contract effective date or rendered after your contract termination date; and workers’ compensation.

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.

A product of Anthem Blue Cross and Blue Shield serving residents and businesses in the State of Connecticut.

Effective 7/1/15 NGF
Capital Area Health Consortium
Prescription Drug Program
$10 Copayment Generic Drugs
$20 Copayment Brand-Name Drugs
Unlimited Annual Maximum

### Description of Benefits

<table>
<thead>
<tr>
<th>Tier 1: Generic Drugs</th>
<th>You Pay:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The term “generic” refers to a prescription drug that is considered non proprietary and is not protected by a trademark. It is required to meet the same bioequivalency test as the original brand-name drug. Tier 1 copayment applies.</td>
<td>$10</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tier 2: Brand-Name Drugs</th>
<th>Plan Pays:</th>
</tr>
</thead>
<tbody>
<tr>
<td>This category refers to covered prescription drugs that are sold using a commercial name rather than a generic name. For example, Prozac, the antidepressant, is a brand-name for Fluoxetine, the generic equivalent. Tier 2 copayment applies.</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

### How To Use The 2-Tier Managed Prescription Drug Program

The 2-Tier Managed Prescription Drug Program incorporates two different levels of copayments: one for generic, and one for brandname prescription drugs, as defined in the chart above. You minimize your copayments when you use generic prescriptions. You’ll still have coverage for brand-name drugs, but at a higher cost share. **Talk to your provider** about using generic drugs. You’ll have lower copayments when you use these drugs.

- You will be responsible for one copayment when purchasing prescription drugs from a participating retail pharmacy.
- You’ll be responsible for No copayment when purchasing maintenance drugs through the mailorder program.

### Generic Substitution: Prescriptions may be filled with the generic equivalent when available.

- When you purchase a generic drug at a participating pharmacy, you’ll only be responsible for a Tier 1 copayment.
- When a generic equivalent is available and you obtain a brand-name drug, you will be responsible for the brand-name copayment plus the difference in cost between the generic and brand-name drug. This provision applies unless your provider obtains Prior Authorization. When Prior Authorization is obtained (at the discretion of Anthem Blue Cross and Blue Shield), you will be responsible only for the brand-name copayment.

### Connection (Concurrent Drug Utilization Review)

Connection works with the retail pharmacy’s standard guidelines to provide a second level of quality and safety checks. The process, which is provided on-line as part of the electronic claims filing process, helps promote access to safe, appropriate, cost-effective medications for members. Connection involves a series of rules or guidelines, which identify potential medication therapy issues and deliver a message to the pharmacy by computer before the medication is dispensed. The process alerts the pharmacist of potential issues such as drug-to-drug interactions, refills requested too close together, incorrect dosing or drug duplications.
Pharmacy Programs

Home Delivery Pharmacy
Home delivery is for people who take medications on an ongoing basis. Our preferred home delivery pharmacy, operated by Express Scripts, delivers the medications you need, right to your door. You can easily refill home delivery prescriptions by phone, fax, mail or online and view benefit information 24/7 at anthem.com

When ordering a 35-day to 100-day supply, 0 copayments will apply.

Retail Pharmacies
Our retail pharmacy network includes more than 62,000 pharmacies throughout the United States. That means you have convenient access to your prescriptions wherever you are – at home, work or even on vacation. To find out if your pharmacy participates in our network, contact Customer Care at the phone number listed on your member ID card or visit anthem.com for a list of participating pharmacies.

Non-participating Pharmacies
Members who fill prescriptions at a non-participating pharmacy are responsible for payment at the time the prescription is filled. Members must submit claims to Anthem Blue Cross and Blue Shield for reimbursement, and payment will be sent to the member. Members who use non-participating pharmacies will pay 20% of the in-network allowance, plus the difference between Anthem Blue Cross and Blue Shield’s payment and the pharmacist’s actual charge.

Points to Remember
• Anthem Blue Cross and Blue Shield will provide coverage for prescription drugs dispensed by a participating pharmacy when prescription drugs are deemed medically necessary based on specific criteria and dispensed pursuant to a prescription issued by a participating physician or by a non-participating physician, subject to copayment.
• Anthem Blue Cross and Blue Shield will not be liable for any injury, claim or judgment resulting from the dispensing of any drug covered by this plan. Anthem Blue Cross and Blue Shield will not provide benefits for any drug prescribed or dispensed in a manner contrary to normal medical practice.
• Anthem Blue Cross and Blue Shield reserves the right to apply quantity limits to specified drugs as listed on the formulary. If a member requires a greater supply, the member’s provider can follow the prior authorization process.

Prescription Drug Eligibility
Eligible prescription drug benefits are limited to injectable insulin and those drugs, biologicals, and compounded prescriptions that are required to be dispensed only according to a written prescription, and included in the United States Pharmacopoeia, National Formulary, or Accepted Dental Remedies and New Drugs, and which, by law, are required to bear the legend: “Caution—Federal Law prohibits dispensing without a prescription” or which are specifically approved by the Plan.

Limits and Exclusions
Benefits are limited to no more than a 34-day supply for covered drugs purchased at a retail pharmacy, and no more than a 100-day supply for covered drugs purchased by mail order. All prescriptions are subject to the quantity limitations imposed by state and federal statutes.

This drug rider does not provide drugs dispensed by other than a licensed, retail pharmacy or our mail-order service; any drug not required for the treatment or prevention of illness or injury; vaccines or allergenic extracts; devices and appliances; needles and syringes that are not prescribed by a provider for the administration of a covered drug; prescriptions dispensed in a hospital or skilled nursing facility; over-the-counter or non-legend drugs; antibacterial soaps/detergents, shampoos, toothpastes/gels and mouthwashes/rinse.

Benefits for prescription birth control are covered for most groups. However, such coverage is optional if your group is self-insured or a bona fide religious organization. Check with your benefits administrator.
This is not a legal contract. It is only a general description of the $10 generic/$20 brand-name 2-Tier Managed Prescription Drug Program with an Unlimited annual maximum. Please consult the Evidence of Coverage or prescription drug rider for a complete description of benefits and exclusions applicable to your coverage.
**Summary of Benefits and Coverage**

What this [Plan](#) Covers & What You Pay For Covered Services

**Anthem Blue Cross and Blue Shield:**

**Century Preferred PPO**

---

The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, [https://eoc.anthem.com/eocdps/find](https://eoc.anthem.com/eocdps/find). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other [underlined](#) terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call (800) 922-6621 to request a copy.

| Important Questions | Answers | Why This Matters:
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall <a href="#">deductible</a>?</td>
<td>$0/individual or $0/2-member family or $0/3+ member family for In- <a href="#">Network Providers</a> $200/individual or $400/2-member family or $600/3+ member family for Out-of-<a href="#">Network Providers</a>.</td>
<td>Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</td>
</tr>
<tr>
<td>Are there services covered before you meet your <a href="#">deductible</a>?</td>
<td>Yes.</td>
<td>You will not have to meet the <a href="#">deductible</a> before the <a href="#">plan</a> pays for any services.</td>
</tr>
<tr>
<td>Are there other <a href="#">deductibles</a> for specific services?</td>
<td>Yes. $50 for Out-of-<a href="#">Network Providers</a> for Home Health Care. There are no other specific <a href="#">deductibles</a>.</td>
<td>You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.</td>
</tr>
<tr>
<td>What is the <a href="#">out-of-pocket</a> limit for this <a href="#">plan</a>?</td>
<td>$6,600/individual or $13,200/2-member family or $13,200/3+ member family for In-<a href="#">Network Providers</a>, $1,200/individual or $1,400/2-member family or $1,600/3+ member family for Out-of-<a href="#">Network Providers</a>.</td>
<td>The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a>, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.</td>
</tr>
<tr>
<td>What is not included in the <a href="#">out-of-pocket</a> limit?</td>
<td><a href="#">Premiums</a>, balance-billing charges, and health care this <a href="#">plan</a> doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the <a href="#">out-of-pocket limit</a>.</td>
</tr>
<tr>
<td>Will you pay less if you use a <a href="#">network provider</a>?</td>
<td>Yes, PPO. See <a href="http://www.anthem.com">www.anthem.com</a> or call (800) 922-6621 for a list of <a href="#">network</a></td>
<td>This <a href="#">plan</a> uses a <a href="#">provider network</a>. You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan’s network</a>. You will pay the most if you use an out-of-<a href="#">network provider</a>, and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider’s</a> charge and what your <a href="#">plan</a> covers.</td>
</tr>
</tbody>
</table>
providers. pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Do you need a referral to see a specialist?

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>In-Network Provider (You will pay the least) $15 copay/visit</td>
<td>Out-of-Network Provider (You will pay the most) 20% coinsurance after deductible</td>
</tr>
<tr>
<td></td>
<td><a href="predicted.id">Specialist</a> visit</td>
<td>$20 copay/visit</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/ immunization</td>
<td>No charge</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1 - Typically Generic</td>
<td>$10 Copay/prescription (retail) and $0 Copay (home delivery)</td>
<td>20% of the in-network allowance, plus the difference between Anthems payment and the pharmacist's actual charge</td>
</tr>
<tr>
<td></td>
<td>Tier 2 - Typically Preferred/Non-Preferred Brand</td>
<td>$20 Copay/prescription (retail) and $0 Copay (home delivery)</td>
<td>20% of the in-network allowance, plus the difference between Anthems payment and the pharmacist's actual charge</td>
</tr>
<tr>
<td></td>
<td>Tier 3 - Typically Non-Preferred/Specialty Drugs</td>
<td>$20 Copay/prescription (retail) and $0 Copay (home delivery)</td>
<td>20% of the in-network allowance, plus the difference between Anthems payment and the pharmacist's actual charge</td>
</tr>
<tr>
<td></td>
<td>Essential Tier 4 - Typically Specialty (brand and generic)</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

* All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

* For more information about limitations and exceptions, see plan or policy document at [https://eoc.anthem.com/eocdps/fi](https://eoc.anthem.com/eocdps/fi).
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>No charge</td>
<td>20% coinsurance after deductible</td>
<td>---none-------</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>20% coinsurance after deductible</td>
<td>---none-------</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td><strong>Emergency room care</strong></td>
<td>$50 copay/visit</td>
<td>$50 copay/visit</td>
<td>Copay waived if admitted.</td>
</tr>
<tr>
<td></td>
<td><strong>Emergency medical transportation</strong></td>
<td>No charge</td>
<td>Covered as In-Network</td>
<td>---none-------</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$25/visit</td>
<td>Not covered</td>
<td>Out of network urgent care paid as emergency room</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>No charge</td>
<td>20% coinsurance after deductible</td>
<td>Failure to obtain pre authorization may result in non coverage or reduced benefits</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>20% coinsurance after deductible</td>
<td>---none-------</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office Visit No charge</td>
<td>Office Visit 20% coinsurance after deductible</td>
<td>---none-------</td>
</tr>
<tr>
<td></td>
<td>Other Outpatient</td>
<td>No charge</td>
<td>Other Outpatient 20% coinsurance after deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>No charge</td>
<td>20% coinsurance after deductible</td>
<td>Failure to obtain pre authorization may result in non coverage or reduced benefits</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>$20/visit first visit</td>
<td>20% coinsurance after deductible</td>
<td>Failure to obtain pre authorization may result in non coverage or reduced benefits. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
<td>20% coinsurance after deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>No charge</td>
<td>20% coinsurance after deductible</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No charge</td>
<td>20% coinsurance after deductible, Home Health Care deductible applies</td>
<td>Coverage is limited to 200 visits. Prior authorization is required.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>No charge</td>
<td>20% coinsurance after deductible</td>
<td>Coverage is limited to 50 visits per member per calendar year for</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>--------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No charge</td>
<td>20% coinsurance after deductible</td>
<td>Chiropractor, Speech, Physical and Occupational therapy.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No charge</td>
<td>20% coinsurance after deductible</td>
<td>120 days limit/benefit period.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>No charge</td>
<td>20% coinsurance after deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>$200 Copay</td>
<td>20% coinsurance after deductible</td>
<td>Prior authorization is required</td>
</tr>
</tbody>
</table>

**If your child needs dental or eye care**

|                      | Eye exam(routine or medical) | No charge if preventative Medical $20 Copay | 20% coinsurance after deductible | Coverage for Eye exams is limited to one exam every 1 calendar years. Separate Vision plan (glasses) |
|                      | Children’s glasses | Not covered | Not covered | |
|                      | Children’s dental check-up | Not covered | Not covered | |

**Excluded Services & Other Covered Services:**

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acupuncture</td>
</tr>
<tr>
<td>• Cosmetic surgery</td>
</tr>
<tr>
<td>• Long term care</td>
</tr>
<tr>
<td>• Weight loss programs</td>
</tr>
<tr>
<td>• Routine foot care</td>
</tr>
</tbody>
</table>

**Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)**

| • Chiropractic care |
| • Hearing aids(restrictions apply) |
| • Infertility treatment |
| • Bariatric surgery |
| • Routine eye care (adult) |
| • Most coverage provided outside the United States. See www.bcbsglobalcore.com |

* For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/fi.
Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Connecticut Department of Insurance, 153 Market Street, 7th Floor, Hartford, CT 06103, (860) 297-3000, (800) 203-3447. Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

ATTN: Grievances and Appeals, P.O. Box 1038, North Haven, CT 06473-4201

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform

Connecticut Department of Insurance, 153 Market Street, 7th Floor, Hartford, CT 06103, (860) 297-3000, (800) 203-3447

Does this plan provide Minimum Essential Coverage? Yes

If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/fi.
About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan’s overall deductible $0
- Specialist copayment $50
- Hospital (facility) copayment $500
- Other coinsurance 0%

This EXAMPLE event includes services like:
- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (ultrasounds and blood work)
- Specialist visit (anesthesia)

Total Example Cost $12,840

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$640</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

What isn’t covered

Limits or exclusions $60
The total Peg would pay is $700

Managing Joe’s type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan’s overall deductible $0
- Specialist copayment $50
- Hospital (facility) copayment $500
- Other coinsurance 0%

This EXAMPLE event includes services like:
- Primary care physician office visits (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs
- Durable medical equipment (glucose meter)

Total Example Cost $7,460

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,985</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

What isn’t covered

Limits or exclusions $55
The total Joe would pay is $2,040

Mia’s Simple Fracture
(in-network emergency room visit and follow up care)

- The plan’s overall deductible $0
- Specialist copayment $50
- Hospital (facility) copayment $500
- Other coinsurance 0%

This EXAMPLE event includes services like:
- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

Total Example Cost $2,010

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,585</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$37</td>
</tr>
</tbody>
</table>

What isn’t covered

Limits or exclusions $0
The total Mia would pay is $1,622

The plan would be responsible for the other costs of these EXAMPLE covered services.
Language Access Services:

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përthyes, telefononi (800) 922-6621

Amharic (አማርኛ): የአማርኛውም ከስለዚሁ ያስቀርባቸውን ከክርስት እንወር ከም በአማርኛውም ከስለዚሁ ያስቀርባቸውን ከክርስት እንወር ከም ከተማ ከስለዚሁ ያስቀርባቸውን ከክርስት እንወር ከም ሲብት ሕግ ያስቀርባቸውን ከክርስት እንወር ከም (800) 922-6621.

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (800) 922-6621.

Armenian (հայերեն): Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով։ Թարգմանչի հետ խասեք հեռախոսահամար (800) 922-6621: 


Bengali (বাংলা): যদি এই নথিগুলির বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিস্তারিত সাহায্য পাওয়ার ও ভাষা পাওয়ার অধিকার আপনার আছে। একজন পরামর্শক সাথে কথা বলার জন্য (800) 922-6621 —তে কল করুন।

Burmese (ဗီနာ): သင်တို့အနေဖြင့် စိတ်ကူးစိတ်ကူးပါစေဆိုင်ရာ စာမျက်နှာချက်များကို အကြောင်းပြုလုပ်သော အခြေခံအကြောင်းပြုလုပ်သုံးစွဲနိုင်သည်။ သင်တို့အနေဖြင့် စိတ်ကူးစိတ်ကူးပါစေဆိုင်ရာ စာမျက်နှာချက်များကို အကြောင်းပြုလုပ်သော အခြေခံအကြောင်းပြုလုပ်သုံးစွဲနိုင်သည်။ (800) 922-6621

Chinese (中文)：如果您對本文件有任何疑問, 您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 (800) 922-6621。

Dinka (Dinka): Na noŋ thiëée nê ke de yâ thorë, ke yin noŋ log bë yi kuony ku wek ałëu bë geer yic yin ne thon du ke cin wëw täsë ke pinya. Te kòr yin ba jëm wëné ran ye thok geryic, ke yin co (800) 922-6621.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (800) 922-6621.

Farsi (فارسی): در صورتی که سوالی بپردازید این سنند داده، این حق را داده که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادریتای دریافت کنید. برای گفتگو با یک مترجم فارسی، با شماره 1-800-922-6621 (800) تماس بگیرید.

French (Français): Si vous avez des questions sur ce document, vous avez la possibilité d’accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (800) 922-6621.
Language Access Services:

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (800) 922-6621.

Greek (Ελληνικά): Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (800) 922-6621.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અને આપને ગુજરાતી પ્રમાણે લાગું હોય તો, ગુજરાતી વિષય વગર આપની ભાષામાં મદદ અને માહિતી મળવાનો તમને અધિકાર છે. તમામ પણ વાત કરવા માટે, કોલ કરો (800) 922-6621.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (800) 922-6621.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज के बारे में कोई प्रश्न हैं, तो आपको लिए: शुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है।

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (800) 922-6621.

Igbo (Igbo): Ọ bụrụ na i nwere ajụju o bua gbasara akwụkwọ a, i nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ o bua. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (800) 922-6621.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguale nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (800) 922-6621.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (800) 922-6621.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (800) 922-6621.

Japanese (日本語): この文書について何か不明な点があれば、あなたはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(800) 922-6621 にお電話ください。
Language Access Services:

Khmer (ភាសាខ្មែរ): ប្រើប្រាស់សំណួរលក់នៅក្នុងការសម្រួល: អត្ថបទនិយម្ត៍ចង់បង្ហាញ់ព័ត៌មានជាក់លាក់មកលើភាសាខ្មែរនេះ អំពីវិធីសាស្ត្រចង់បង្ហាញជាក់លាក់ឬជាក់ស្តែង។ សូមទំនើបទូរស័ព្ទ (800) 922-6621។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (800) 922-6621.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (800) 922-6621 로 문의하십시오.

Lao (ລາວ): ວັກນ້ອຍມິວິບໍລະດັບໄທທັງນັກອຸປະກອນ, ໃຫ້ມີສຳຄັນງານອື່ນໜ້າອິດສະຫົາງທ່ານນັ້ນ ເຊິ່ງ ຕັ້ງຂົບຂື້ນສາມາດດັ່ງກ່າວ. ວັກນ້ອຍມິວິບໍລະດັບໄທທັງນັກອຸປະກອນ, ເຊິ່ງທ້ອງ (800) 922-6621.

Navajo (Diné): Díí naltsoos biká’iigii lahgó bina’idilkidgo ná bohóóedzág dóó bee ahóot’i’ t’áá ni nízaad k’ehjí bee nií hodoodníi táadoo bááh ilinígóó. Ata’ halne’iigii la’ bich’jí’ hadeesdzih nínizingo kojí hodiilnih (800) 922-6621.

Nepali (नेपाली): यदि आप कामजातबाटे तपाईंले केही प्रश्नहरू छन् भने, आफ्नो भाषामा निश्चितता सहयोग तथा जानकारी प्राप्त गर्न पाउने हुनु तपाईंले छ।

Oromo (Oromifaa): Sanadi kanaa wajjii walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (800) 922-6621 bilbilla.


Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer (800) 922-6621.

Portuguese (Português): Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para (800) 922-6621.

Punjabi (ਪੰਜਾਬੀ): ਜੋ ਤੁਸੀ ਦੀ ਚਿਨਾ ਸੰਭਾਲ ਦਰਜ ਕੇ ਤੁਸੀ ਉਸਾਰੇ ਲਗ ਚੁੱਕੇ ਹਨ ਤੁਸੀ ਵੇਲ ਲਗੂਂ ਲਿਖ ਤਿਆਂ ਲਿਖ ਨਾਹੀ ਪੰਜਾਬੀ ਭਾਸ਼ਾ ਵਾਲੇ ਦੇ ਅਧਿਕਾਰੀ ਦੁਆਰਾ ਹੈ। ਹਿਰਨ ਤੁਰਕਸ਼ਟੀ ਫਸਲ ਵਲੋਂ ਵਾਲੀ ਹੈ, (800) 922-6621 ਤੋਂ ਕਲਸ ਵਲੇ।
Language Access Services:

Romanian (Română): Dacă aveți întrebări referitoare la acest document, aveți dreptul să primiți ajutor și informații în limba dumneavoastră în mod gratuit. Pentru a vă adresa unui interprét, contactați telefonic (800) 922-6621.

Russian (Русский): Если у вас есть какие-либо вопросы в отношении данного документа, вы имеет право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (800) 922-6621.

Samoan (Samoa): Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou ‘aia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totogi. Ina ia talanoa i se tagata faaliliu, vili (800) 922-6621.

Serbian (Srpski): Ukoliko imate bilo kakvih pitanja u vezi sa ovim dokumentom, imate pravo da dobijete pomoć i informacije na vašem jeziku bez ikakvih troškova. Za razgovor sa prevodiocem, pozovite (800) 922-6621.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (800) 922-6621.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulungan at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (800) 922-6621.

Thai (ไทย): หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร (800) 922-6621 เพื่อพูดคุยกับล่าม

Ukrainian (Українська): Якщо у вас виникають запитання з приводу цього документа, ви маєте право безкоштовно отримати допомогу й інформацію вашою рідною мовою. Щоб отримати послуги перекладача, зв’яжіться з нами по номеру (800) 922-6621.

Urdu (اردو): اگر اس نسبت، کی کی بارے میں آب کا کوئی سوال ہے，“آپ کو مدد اور اپنی زبان میں مفت معلومات حاصل کرنے کا حق حاصل ہے، کسی مترجم سے بات کرنے کے لئے ایک رقم ہے ہاتھ کے لئے ایک نمبر اور 11, (800) 922-6621، پر کال کریں۔

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thống dịch viên, hãy gọi (800) 922-6621.

Yiddish (אידיש): זיא אויר באיטן שולאַן צווען טאַבךָו, אַקַּי צווען רַעַכְן ציזען טאַבךָו די טקסטן. Büro די רַעַכְן ציזען די טקסטן אַסער שפראַךְן אַן ליילן די אַר sweetheart שפראַךְן אַן ליילן די אַר sweetheart שפראַךְן אַן ליילן די אַר sweetheart שפראַךְן אַן ליילן די אַר sweetheart שפראַךְן אַן ליילון די אַר sweetheart שפראַךְן אַן ליילון די אַר sweetheart שפראַךְן אַן ליילון די אַר sweetheart שפראַךְן אַן ליילון די אַר sweetheart שפראַךְן אַן ליילון די אַר sweetheart שפראַךְן אַן ליילון די אַר sweetheart שפראַךְן אַן ליילון די אַר sweetheart שפראַךְן אַן ליילון די אַר sweetheart שפראַךְן אַןLEY 21, (800) 922-6621، ראות ה. (800) 922-6621.

Yoruba (Yoruba): Ti o bá ni évíkéyí bí èrè nipa àkọsílọ̀ yìí, o ní ètò láti gba ìránwọ̀ àti ìwínún ni èdè rẹ̀ lofè. Bà wá ọgbúfù kan sọrọ, pe (800) 922-6621.
Language Access Services:

It's important we treat you fairly

That’s why we follow federal civil rights laws in our health programs and activities. We don’t discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. 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 to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA  23279. Or you can file a complaint with 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 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
CAPITAL AREA HEALTH CONSORTIUM  
FLEX DENTAL PLAN  

CATEGORY I - DIAGNOSTIC & PREVENTIVE SERVICES  
Payable at 100% of usual, customary and reasonable charges at participating dentists:

- Initial Oral Exams - 1/36 months
- Periodic Oral Exams - 2/Yr
- Prophylaxis – 2/Yr
- Topical application of fluoride – 2/Yr. to age 19
- Periapical and Bitewing X-rays
- Repair and relining of dentures-1/year
- Palliative Emergency Treatment
- Routine Fillings
- Simple Extractions
- Endodontics

CATEGORY II - BASIC SERVICES  
Payable at 80% of usual, customary and reasonable charges at participating dentists:

- Inlays 1 per tooth every 5 years
- Onlays 1 per tooth every 5 years
- Crowns 1 per tooth every 5 years
- Post & Core 1 per tooth every 5 years
- Prostodontics 1 per tooth every 5 years
- Night Guards 1 guard every 2 years (for teeth grinders)
- Oral Surgery
- Space Maintainers
- Apicoectomy
- Bridges
- Anesthesia
- Implants & Build-ups
- Periodontics

PRINCIPAL LIMITATIONS AND EXCLUSIONS  
Services received from a dental or medical department maintained by an employer, a mutual benefit association, labor union, trustee or other similar person or group; Services for which the member incurs no Dentists’ Charge or which are services of a type ordinarily performed by a physician, or charges which would not have been made if insurance was not available; Services with respect to congenital malformations; Services, treatment or supplies furnished by or at the direction of any government, state or political subdivision; Any items not specifically listed in this Policy; Lost or stolen dentures or denture duplication; Gold foil restorations; Temporary services and appliances; such as crown or tooth preparations and temporary fillings, crowns, bridges and dentures; Application of sealants, regardless of reason; Services as determined by the company, that are rendered in a manner contrary to normal dental practice. A complete list of exclusions appears in the Master Group Policy on file with your employer or your Certificate of Membership.

This is not a legal policy or contract. It is only a general description of your Blue Cross & Blue Shield benefits. If there are discrepancies between the dental rider and this summary, the dental rider shall control.
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!

Your Blue View Vision network
Anthem Blue Cross and Blue Shield vision members have access to one of the nation’s largest vision networks. Blue View Vision is the only vision plan that gives members the ability to use their in-network benefits at 1-800 CONTACTS, or choose a private practice eye doctor, or go in store to LensCrafters®, Sears OpticalSM, Target Optical®, JCPenney® Optical and most Pearle Vision locations.

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

#### Eyeglass frames
Once every two calendar years you may select an eyeglass frame and receive an allowance toward the purchase price

<table>
<thead>
<tr>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>$130 allowance, then 20% off any remaining balance</td>
<td>$64 allowance</td>
</tr>
</tbody>
</table>

#### Eyeglass lenses (Standard)
Once every two calendar years you may receive any one of the following lens options:

<table>
<thead>
<tr>
<th>Lens Type</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard plastic single vision lenses (1 pair)</td>
<td>$25 copay</td>
<td>$36 allowance</td>
</tr>
<tr>
<td>Standard plastic bifocal lenses (1 pair)</td>
<td>$25 copay</td>
<td>$54 allowance</td>
</tr>
<tr>
<td>Standard plastic trifocal lenses (1 pair)</td>
<td>$25 copay</td>
<td>$69 allowance</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Lens Type</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transitions Lenses (for a child under age 19)</td>
<td>$0 copay</td>
<td>No allowance on lens enhancements when obtained out-of-network</td>
</tr>
<tr>
<td>Standard Polycarbonate (for a child under age 19)</td>
<td>$0 copay</td>
<td></td>
</tr>
<tr>
<td>Factory Scratch Coating</td>
<td>$0 copay</td>
<td></td>
</tr>
</tbody>
</table>

#### Contact lenses
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.

<table>
<thead>
<tr>
<th>Lens Type</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective Conventional Lenses; or Elective Disposable Lenses; or Non-Elective Contact Lenses</td>
<td>$130 allowance, then 15% off any remaining balance</td>
<td>$105 allowance</td>
</tr>
<tr>
<td>($no additional discount)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

BLUE VIEW VISION MEMBER EXCLUSIVE!

You may use your in-network benefit to order your contact lenses from 1-800 CONTACTS offers a huge in-stock inventory, unbeatable prices, outstanding customer service and free shipping. Just call 1-800 CONTACTS or go to 1800contacts.com for fast and easy ordering of your contact lenses.

EXCLUSIONS & LIMITATIONS (not a comprehensive list)

- **Combined Offers.** Not to be combined with any offer, coupon, or in-store advertisement.
- **Excess Amounts.** Amounts in excess of covered vision expense.
- **Sunglasses.** 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.

Transitions and the swirl are registered trademarks of Transitions Optical, Inc.
### OPTIONAL SAVINGS AVAILABLE FROM IN-NETWORK PROVIDERS ONLY

<table>
<thead>
<tr>
<th>Eyeglass lens upgrades</th>
<th>In-network Member Cost (after any applicable copay)</th>
</tr>
</thead>
<tbody>
<tr>
<td>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>- Transitions® Lenses (Adults)</td>
<td>$75</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</td>
<td></td>
</tr>
<tr>
<td>- 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</td>
<td></td>
</tr>
<tr>
<td>- 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></td>
</tr>
<tr>
<td>- Transitions® Lenses (Adults)</td>
<td>$75</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</td>
<td></td>
</tr>
<tr>
<td>- 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</td>
<td></td>
</tr>
<tr>
<td>- 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></td>
</tr>
</tbody>
</table>

#### Additional Pairs of Eyeglasses
- Anytime from any Blue View Vision network provider
  - Complete Pair
  - Eyeglass materials purchased separately
  - 40% off retail price
  - 20% off retail price

#### Eyewear Accessories
- Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc.
  - 20% off retail price

#### Conventional Contact Lenses
- Discount applies to materials only
  - 15% off retail price

### SOME OF THE ADDITIONAL SAVINGS AVAILABLE THROUGH OUR SPECIAL OFFERS PROGRAM

#### 1-800 CONTACTS
After your benefits for the coverage period have been used, you can save on contact lenses with this offer.³
- For this and other great offers, login to member services, select discounts, then Vision, Hearing & Dental
- Save $20 on orders of $100 or more and get free shipping

#### Laser vision correction surgery
LASIK refractive surgery.
- For this offer and more like it, login to member services, select discounts, then Vision, Hearing & Dental
- Discount per eye

---

1. Please ask your provider for his/her recommendation as well as the progressive brands by tier.
2. Please ask your provider for his/her recommendation as well as the coating brands by tier.
3. Discount cannot be used in conjunction with your covered benefits.

**Employee Rates:** $4.00 Employee Only / $7.00 Employee + 1 / $11.20 Family

### 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
**To Email:** onclaims@eyewearspecialoffers.com
**To Mail:** Blue View Vision
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

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 plan with benefits intended to cover only 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. Laws in some states may prohibit network providers from discounting products and services that are not covered benefits under the plan. 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.

Anthem Blue Cross and Blue Shield is the trade name of: In Connecticut: Anthem Health Plans, Inc. In Maine: Anthem Health Plans of Maine, Inc. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. 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.
Getting 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 use a pharmacy in the plan, you won’t have to pay anything for these services and immunizations. If you want to visit a doctor or pharmacy 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*

**Immunizations:**

- Diphtheria, tetanus and pertussis (whooping cough)
- Hepatitis A and hepatitis B
- Human papillomavirus (HPV)
- Influenza (flu)
- Measles, mumps and rubella (MMR)
- Eye chart test for vision²
- Hearing screening
- Height, weight and body mass index (BMI)
- HIV screening and counseling
- Lung cancer screening for those ages 55-80 who have a history of smoking 30 packs per year and still smoke, or quit within the past 15 years³
- Obesity: related screening and counseling*
- Prostate cancer, including digital rectal exam and prostate-specific antigen (PSA) test
- Sexually transmitted infections: related screening and counseling
- Tobacco use: related screening and behavioral counseling
- Violence, interpersonal and domestic: related screening and counseling
- 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 met⁴
- Breastfeeding: primary care intervention to promote breastfeeding support, supplies and counseling⁵,⁶,⁷
- 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 screening⁶
- Screening and counseling for interpersonal and domestic violence
- Pregnancy screenings, including gestational diabetes, hepatitis B, asymptomatic bacteriuria, Rh incompatibility, syphilis, HIV and depression⁶
- 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 physical 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)
- HPV screening (female)
- Lead testing
- Newborn screening
- 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

A word about pharmacy items

For 100% coverage of your over-the-counter (OTC) drugs and other pharmacy items listed here, you must:
- Meet certain age requirements and other rules.
- Get prescriptions from plan providers and fill them at plan pharmacies.
- Have prescriptions, even for OTC items.

Child preventive drugs and other pharmacy items — age appropriate:
- Dental fluoride varnish to prevent the tooth decay of primary teeth for children ages 0-5
- Fluoride supplements for children ages 0-6

Adult preventive drugs and other pharmacy items — age appropriate:
- Aspirin use (81 mg and 325 mg) for the prevention of cardiovascular disease, preeclampsia and colorectal cancer by adults less than 60 years old
- Colonoscopy prep kit (generic or OTC only) when prescribed for preventive colon screening
- Tobacco-cessation products, including select generic prescription drugs, select brand-name drugs with no generic alternative and FDA-approved OTC products, for those ages 18 and older
- Vitamin D for adults over age 65

Women’s preventive drugs and other pharmacy items — age appropriate:
- Contraceptives, including generic prescription drugs, brand-name drugs with no generic alternative and OTC items like female condoms and spermicides
- Low-dose aspirin (81 mg) for pregnant women who are at increased risk of preeclampsia
- Folic acid for women ages 55 or younger who are planning and able to get pregnant
- Breast cancer risk-reducing medications, such as tamoxifen and raloxifene, that follow the U.S. Preventive Services Task Force criteria

Screening and counseling for those ages 10-24 with fair skin about lowering their risk for skin cancer

Guidelines. You may have additional coverage under your insurance policy. To learn more about what your plan covers, see your Certificate of Coverage or call the Member Services number on your ID card.
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. On average, members save up to 25% on their copay when they use home delivery.² Standard shipping is free, and you can even set up automatic refills.

Getting started with home delivery is easy:

1. Go online to get a prescription order form.

Visit anthem.com, choose Manage Your Prescriptions from the home page and log in with your username and password. If you haven’t signed up on the site yet, you’ll need to do that first.

On your personal pharmacy page, select Start a New Prescription.

That’ll take you to the site of the company that helps manage our prescription benefits.³ There, you can download and print the physician fax form or, if you already have a new prescription for a 90-day supply of medicine from your doctor, download the home delivery mail form. You’ll use one of these forms to send in your prescription.

2. Get a new prescription from your doctor for home delivery.

You’ll need an up-to-90-day supply prescription. Your doctor can send in your prescription through eprescribe or fax it using the physician fax form from step 1.

Also ask your doctor for a 30-day prescription. Get this filled at your regular pharmacy to make sure you have enough medicine to last until you get your first home delivery prescription.
3. Send in your prescription

Fill out the home delivery order form and mail it to the address on the form. Be sure to include prescription and payment information along with it.

or

Your doctor can fill out the physician fax form and fax or efax it to the number on the form.

4. Pay for your prescription.

You can pay by check, echeck, money order, credit or debit card, flexible spending account or health savings account.

You can sign up for e-payments or have your credit card on file online. To set up your payments, go to anthem.com, choose Manage Your Prescriptions from the home page and log in. Then, select Start a New Prescription. Once you’re on our prescription benefit manager’s site, select My Account to choose how you’d like to pay.

If you want to use our Home Delivery Pharmacy and are enrolled in a program that helps you with your copay or if you use manufacturer coupons to help pay for prescriptions, you’ll need to give the program or manufacturer detailed claim information and a receipt to get paid back. The company that manages our prescription benefits can’t bill us or these third parties for prescriptions you fill through home delivery.

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 the home delivery pharmacy gets it. 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. It will still take 3 to 5 days to process the order, plus the shipping time. 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.

1 Supplies are based on your pharmacy plan design.
2 Express Scripts internal data, 2017.
3 Express Scripts is a separate company that manages pharmacy services for our health plan members.
4 Drugs that are defined as controlled substances are highly regulated, which requires the home delivery pharmacy to follow special rules for filling these prescriptions.
Get help in your language

Curious to know what all this says? We would be too. Here’s the English version:
You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish
Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Chinese
您有權使用您的語言免費獲得該資訊和協助。請撥打您的ID卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Vietnamese
Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

Korean
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Tagalog
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Russian
Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Arabic
يمكنكم الحصول على هذه المعلومات والمساعدة للغة مجانية. يرجى الاتصال بالرقم الذي يظهر على بطاقتك الشخصية. (TTY/TDD: 711)

Armenian
Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով. (TTY/TDD: 711)

Farsi
شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید. (TTY/TDD: 711)

French
Vous avez le droit d’accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d’identification. (TTY/TDD: 711)
It's important we treat you fairly
That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. 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 to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with 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 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Let's talk about your privacy and rights
Safeguarding your information

As a member, you have the right to expect us to protect the privacy of your personal health information. We do this according to state and federal laws, and our 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 www.anthem.com/memberrights. To ask for a printed copy, please contact your Benefits Administrator or Human Resources representative.

How we help manage your care

To decide if we’ll cover a treatment, procedure or hospital stay, we use a process called Utilization Management (UM). Doctors and pharmacists who want to be sure you get the best treatments for certain health conditions make up Anthem’s UM team. They review the information your doctor sends us. These reviews can be done 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 learn about and manage your health conditions. They also help you better understand your health benefits.

To learn more detailed information about how we help manage your care, visit www.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 enroll in a plan or make changes to it. If you choose not to enroll yourself or dependents during open enrollment, there are special cases when you're allowed to enroll yourself and dependents in a plan during other times of the year. Special enrollment is allowed:

- If you had another health plan that was canceled. If you, your dependents or your spouse are no longer eligible for other coverage (or if the employer stops contributing to your health plan), you may be able to enroll with us. You must enroll within 31 days after the other coverage ends (or after the employer stops paying for it). For example: You and your family are enrolled through your spouse’s coverage 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 SCHIP coverage 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.
We’ve got your back!