Anthem BlueCross BlueShield

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.

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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.[1] 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.

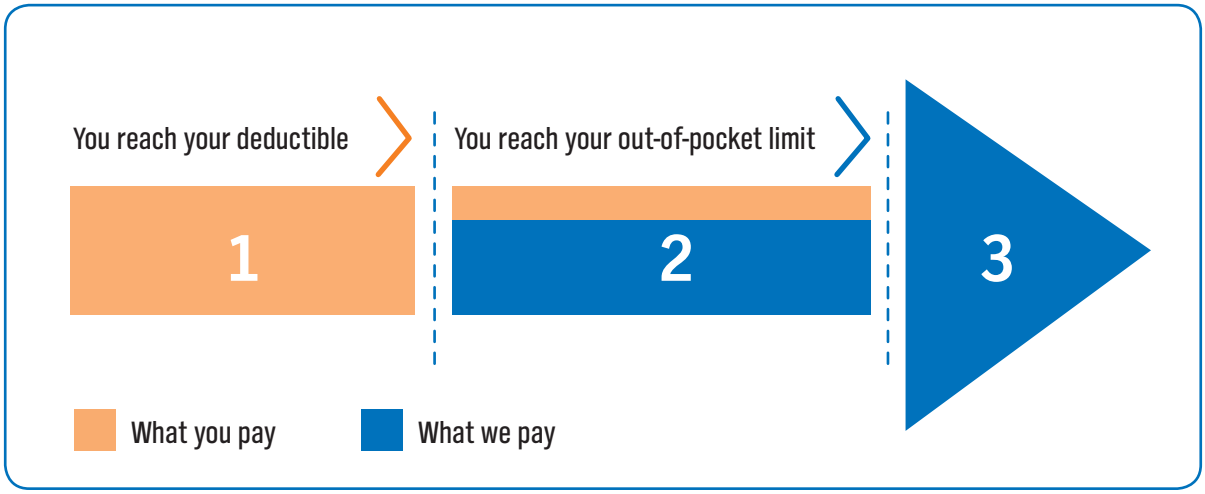
It's easy to get care in your plan

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



This chart is only an example. Your actual cost share will depend on your plan, the service you get and the doctor you choose. For your actual cost share, see your plan details.

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**).

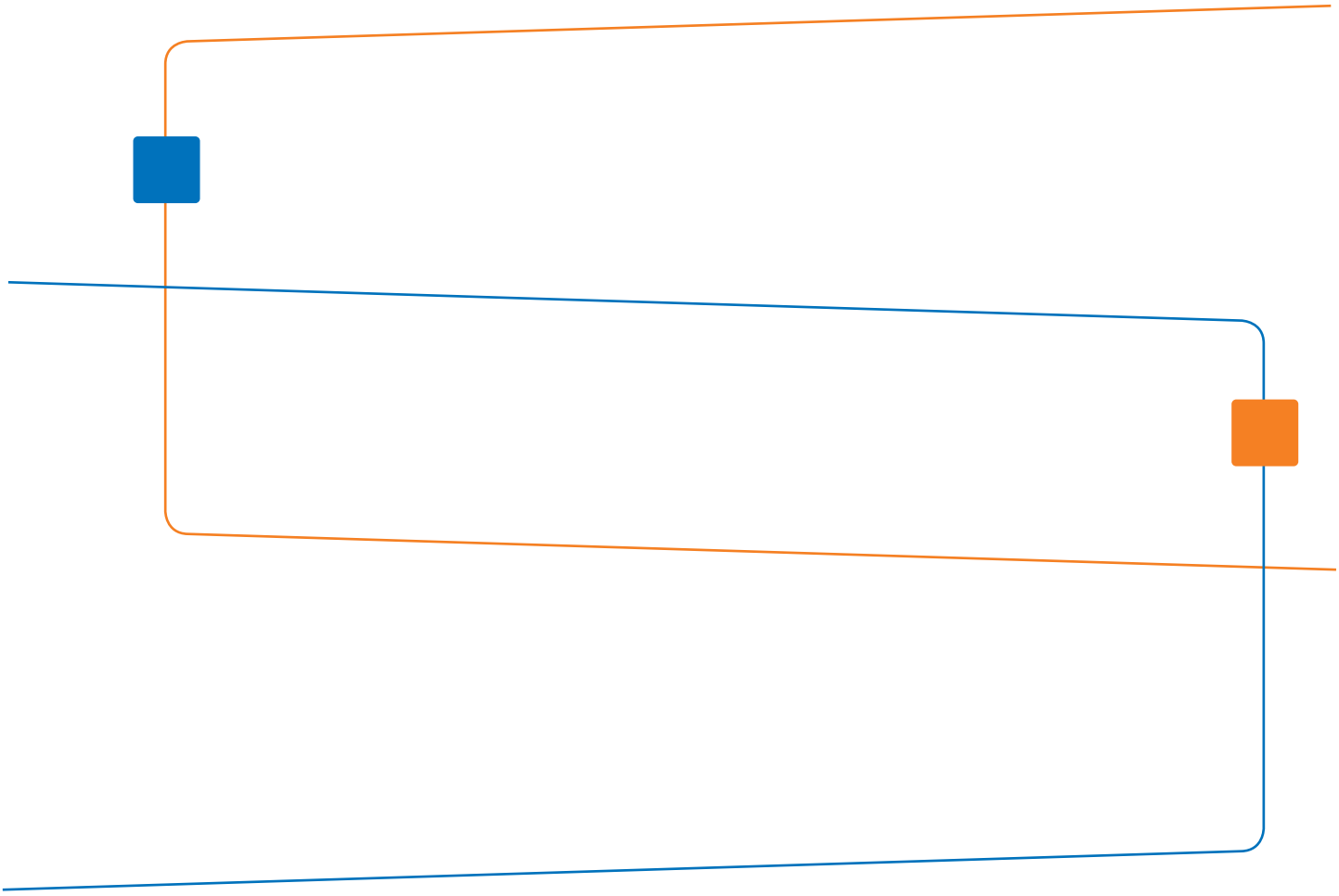
Enrolling in a vision plan helps you pay for:

- 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 Anthem ID card gives you easy access to quality care from quality doctors.

Your plan details

In this next section, you'll find more information about your plan.



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Capital Area Health Consortium
Century Preferred
Description of Benefits

Century Preferred is a preferred provider organization (PPO) plan.

COST SHARE PROVISIONS	**In-Network** *Member pays:*	**Out-of-Network** *Member pays:*
Hospital (**HSP**) Copayment	No Charge	Deductible & Coinsurance
Urgent Care (**UR**) Copayment	$25	Not Covered
Emergency Room (**ER**) Copayment – *waived if admitted*	$50	$50
Outpatient Surgery (**OS**) Copayment	No Charge	Deductible & Coinsurance
Annual Deductible (*individual/2-member family/3+ member family*)	Not Applicable	$200/$400/$600
Coinsurance		20% after deductible up to
Coinsurance Maximum (*individual/2-member family/3+ member family*)		$1,000
Cost Share Maximum *(individual/2-member family/3+member family)*	$6,600/$13,200/ $13,200	$1,200/$1,400/$1,600
Lifetime Maximum	Unlimited	Unlimited
PREVENTIVE CARE		
Well child care	No Charge	Deductible & Coinsurance
Periodic, routine health examinations	No Charge	
Routine eye screening	No Charge	
Routine OB/GYN visits	No Charge	
Mammography	No Charge	
Hearing screening (*as part of preventive exam)*	No Charge	
MEDICAL CARE		
Office visits	$15	Deductible & Coinsurance
Specialist visits	$20	
Outpatient mental health & substance abuse - *prior authorization required*	No charge	
OB/GYN care	$20	
Maternity care – *initial visit subject to copayment, no charge thereafter*	$20	
Diagnostic lab and x-ray	No Charge	
High-cost outpatient diagnostic – *prior authorization required*	No Charge	
Allergy services *Office visits/testing* *Injections—80 visits in 3 years*	 $20 No Charge	
HOSPITAL CARE – *Prior authorization required*		
Semi-private room *(General/Medical/Surgical/Maternity)*	No Charge	Deductible & Coinsurance
Inpatient mental health & substance abuse	No Charge	
Skilled nursing facility – *up to 120 days per calendar year*	No Charge	
Rehabilitative services – *up to 60 days per person per calendar year*	No Charge	
Outpatient surgery – *in a hospital or surgi-center*	No Charge	
EMERGENCY CARE		
Walk-in centers	$15	Deductible & Coinsurance
Urgent care – *at participating centers only*	UR Copayment	Not Covered
Emergency care – *copayment waived if admitted*	ER Copayment	ER Copayment
Ambulance	No Charge	No Charge

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OTHER HEALTH CARE	In-Network *Member pays:*	Out-of-Network *Member pays:*
Outpatient rehabilitative services *50 visit maximum for PT, OT, ST and Chiro. per year*	No Charge	Deductible & Coinsurance
Durable medical equipment / Prosthetic devices	No Charge	
Hospice *60 day maximum*	$200 copay	
Infertility services *(diagnosis and treatment)*	$20	Deductible & Coinsurance
Home health care	No Charge	$50 Deductible & Coinsurance
Prescription drugs – *filled at a pharmacy*	See drug plan	See drug plan

PREVENTIVE CARE SCHEDULES

Mammography
- 1 baseline screening, ages 35-39
- 1screening 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

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Capital Area Health Consortium
Prescription Drug Program
$10 Copayment Generic Drugs
$20 Copayment Brand-Name Drugs
Unlimited Annual Maximum

Description of Benefits		***You Pay:***
Tier 1: Generic Drugs	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.	$10
Tier 2: Brand-Name Drugs	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.	$20

		Plan Pays:
Annual Maximum	Per member per calendar year	Unlimited

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.

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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.

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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/fi. 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/ or call (800) 922-6621 to request a copy.

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

	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?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay/visit	20% coinsurance after deductible	--------none--------
	Specialist visit	$20 copay/visit	20% coinsurance after deductible	--------none--------
	Preventive care/screening/ immunization	No charge	20% coinsurance after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance after deductible	--------none--------
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance after deductible	Prior authorization is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.anthem.com/pharmacyinformation/ Essential	Tier 1 - Typically Generic	$10 Copay/prescription (retail) and $0 Copay (home delivery)	20% of the in-network allowance, plus the difference between Anthems payment and the pharmacist's actual charge	34-day supply for Retail 35-100-day supply for Mail Order.
	Tier 2 - Typically Preferred / Non- Preferred Brand	$20 Copay/prescription (retail) and $0 Copay (home delivery)		
	Tier 3 - Typically Non-Preferred / Specialty Drugs	$20 Copay/prescription (retail) and $0 Copay (home delivery)	20% of the in-network allowance, plus the difference between Anthems payment and the pharmacist's actual charge	
	Tier 4 - Typically Specialty (brand and generic)	Not applicable	Not applicable	

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance after deductible	--------none--------
	Physician/surgeon fees	No charge	20% coinsurance after deductible	--------none--------
If you need immediate medical attention	Emergency room care	$50 copay/visit	$50 copay/visit	Copay waived if admitted.
	Emergency medical transportation	No charge	Covered as In-Network	--------none--------
	Urgent care	$25/visit	Not covered	Out of network urgent care paid as emergency room
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance after deductible	Failure to obtain pre authorization may result in non coverage or reduced benefits
	Physician/surgeon fees	No charge	20% coinsurance after deductible	--------none--------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit No charge Other Outpatient No charge	Office Visit 20% coinsurance after deductible Other Outpatient 20% coinsurance after deductible	--------none--------
	Inpatient services	No charge	20% coinsurance after deductible	Failure to obtain pre authorization may result in non coverage or reduced benefits
If you are pregnant	Office visits	$20/visit first visit	20% coinsurance after deductible	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).
	Childbirth/delivery professional services	No charge	20% coinsurance after deductible	
	Childbirth/delivery facility services	No charge	20% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance after deductible, Home Health Care deductible applies	Coverage is limited to 200 visits. Prior authorization is required.
	Rehabilitation services	No charge	20% coinsurance after deductible	Coverage is limited to 50 visits per member per calendar year for

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	No charge	20% coinsurance after deductible	Chiropractor, Speech, Physical and Occupational therapy.
	Skilled nursing care	No charge	20% coinsurance after deductible	120 days limit/benefit period.
	Durable medical equipment	No charge	20% coinsurance after deductible	--------none--------
	Hospice services	$200 Copay	20% coinsurance after deductible	Prior authorization is required
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	

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Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Long term care
- Weight loss programs
- Routine foot care

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:

Cost Sharing	
Deductibles	$0
Copayments	$640
Coinsurance	$0
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:

Cost Sharing	
Deductibles	$0
Copayments	$1,985
Coinsurance	$0
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:

Cost Sharing	
Deductibles	$0
Copayments	$1,585
Coinsurance	$37
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 përkthyes, telefononi (800) 922-6621

Amharic (አማርኛ):- ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (800) 922-6621 ይደውሉ።

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 խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (800) 922-6621:

Bassa (Bǎsɔ́ɔ̀ Wùdù): Mˋ dyi dyi-diè-dɛ̀ bě bédé bá céè-dɛ̀ nià kɛ dyí ní, ɔ mɔ̀ nì dyí-bɛ̀dɛ̀ìn-dɛ̀ bɛ́ m̀ ké gbo-kpá-kpá kè bɔ̌ kpɔ̃ dé m̀ bídí-wùdùǔn bó pídyi. Bé m̀ ké wudu-zììn-nyɔ̀ dò gbo wùdù kɛ, dá (800) 922-6621.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (800) 922-6621 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အခမဲ့အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန် (800) 922-6621 သို့ ခေါ်ဆိုပါ။

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 nɔŋ thiëëc në ke de yä thorë, ke yin nɔŋ loŋ bë yi kuony ku wɛr alëu bë gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kɔr yin ba jam wënë ran ye thok geryic, ke yin cɔl (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 (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (800) 922-6621 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 અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે 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 दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (800) 922-6621 ।

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 bụr ụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. 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 lenguahem 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): この文書についてなにかご不明な点があれば、あなたに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 (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ (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 (ພາສາລາວ): ຖ້າທ່ານມີຄຳຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອໂອ້ລົມກັບລ່າມແປພາສາ, ໃຫ້ໂທຫາ (800) 922-6621.

Navajo (Diné): Díí naaltsoos bikáʼígíí łahgo bínaʼídiłkidgo ná bohónéedzą́ dóó bee ahóótʼiʼ tʼáá ni nizaad kʼehjí bee nił hodoonih tʼáadoo bą́ą́h íłínígóó. Ataʼ halneʼígíí łaʼ bichʼį́ʼ hadeesdzih nínízingo kojį́ʼ hodíilnih (800) 922-6621.

Nepali (नेपाली): यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ। दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (800) 922-6621

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

Pennsylvania Dutch (Deitsch): Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Helfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff (800) 922-6621 aa.

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): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (800) 922-6621 ਤੇ ਕਾਲ ਕਰੋ।

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 interpret, contactați telefonic (800) 922-6621.

Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете 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 tulong 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, зателефонуйте за номером: (800) 922-6621.

Urdu (اردو): اگر اس دستاویز کے بارے میں آپ کا کوئی سوال ہے، تو آپ کو مدد اور اپنی زبان میں مفت معلومات حاصل کرنے کا حق حاصل ہے۔ کسی مترجم سے بات کرنے کے لئے، (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 thông dịch viên, hãy gọi (800) 922-6621.

Yiddish (אידיש): אויב איר האט שאלות וועגן דעם דאקומענט, האט איר די רעכט צו באקומען דעם אינפארמאציע אין אייער שפראך אהן קיין פרייז. צו רעדן צו אן איבערזעצער, רופט (800) 922-6621.

Yoruba (Yorùbá): Tí o bá ní èyíkéyìí ìbèrè nípa àkọsílẹ̀ yìí, o ní ẹ̀tọ́ láti gba ìrànwọ́ àti ìwífún ní èdè rẹ lọ́fẹ̀ẹ́. Bá wa ògbùfọ̀ kan sọ̀rọ̀, 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

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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!

Anthem BlueCross BlueShield

Capital Area Health Consortium
Blue View Vision℠ BVMO C25.130.130

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 Optical℠, 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	IN-NETWORK	OUT-OF-NETWORK
Eyeglass frames Once every two calendar years you may select an eyeglass frame and receive an allowance toward the purchase price	$130 allowance, then 20% off any remaining balance	$64 allowance
Eyeglass lenses *(Standard)* Once every two calendar years you may receive any one of the following lens options:		
• Standard plastic single vision lenses *(1 pair)*	$25 copay	$36 allowance
• Standard plastic bifocal lenses *(1 pair)*	$25 copay	$54 allowance
• Standard plastic trifocal lenses *(1 pair)*	$25 copay	$69 allowance
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.		
• Transitions Lenses (for a child under age 19)	$0 copay	No allowance on lens enhancements when obtained out-of-network
• Standard Polycarbonate (for a child under age 19)	$0 copay	
• Factory Scratch Coating	$0 copay	
Contact lenses – once every two calendar years		
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	$130 allowance, then 15% off any remaining balance	$105 allowance
• Elective Disposable Lenses; or	$130 allowance *(no additional discount)*	$105 allowance
• Non-Elective Contact Lenses	Covered in full	$210 allowance

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.
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		In-network Member Cost (after any applicable copay)

Eyeglass lens upgrades
When obtaining eyewear from a Blue View Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass lens copayment applies.
	o Transitions® Lenses (Adults)
	o Standard Polycarbonate (Adults)
	o Tint (Solid and Gradient)
	o UV Coating
	o Progressive Lenses[1]
	  o Standard
	  o Premium Tier 1
	  o Premium Tier 2
	  o Premium Tier 3
	o Anti-Reflective Coating[2]
	  o Standard
	  o Premium Tier 1
	  o Premium Tier 2
	o Other Add-ons and Services
		$75
		$40
		$15
		$15
		
		$65
		$85
		$95
		$110
		
		$45
		$57
		$68
		20% off retail price

Additional Pairs of Eyeglasses Anytime from any Blue View Vision network provider	o Complete Pair o Eyeglass materials purchased separately	40% off retail price 20% off retail price
Eyewear Accessories	o Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc.	20% off retail price
Conventional Contact Lenses	o Discount applies to materials only	15% off retail price
SOME OF THE ADDITIONAL SAVINGS AVAILBLE THROUGH OUR SPECIAL OFFERS PROGRAM		
1800CONTACTS After your benefits for the coverage period have been used, you can save on contact lenses with this offer.[3]	o 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.	o 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: oonclaims@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.

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Take care of yourself
Use your preventive care benefits

Anthem BlueCross BlueShield

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.[1] 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*
- Eye chart test for vision[2]
- 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 years[3]
- 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

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[4]
- Breastfeeding: primary care intervention to promote breastfeeding support, supplies and counseling[5,6,7]
- 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 screening[6]
- Screening and counseling for interpersonal and domestic violence
- Pregnancy screenings, including gestational diabetes, hepatitis B, asymptomatic bacteriuria, Rh incompatibility, syphilis, HIV and depression[6]
- 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)
- 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[2]

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[6,8,9]
- 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[3]

1 The range of preventive care services covered at no cost share when provided by plan doctors is designed to meet state and federal requirements. The Department of Health and Human Services decided which services to include for full coverage based on U.S. Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and certain guidelines for infants, children, adolescents and women supported by Health Resources and Services Administration (HRSA) 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.

2 Some plans cover additional vision services. Please see your contract or Certificate of Coverage for details.

3 You may be required to get preapproval for these services.

4 Check your medical policy for details.

5 Breast pumps and supplies must be purchased from plan providers for 100% coverage. We recommend using plan durable medical equipment (DME) suppliers.

6 This benefit also applies to those younger than age 19.

7 Counseling services for breastfeeding (lactation) can be provided or supported by a plan doctor or hospital provider, such as a pediatrician, obstetrician/gynecologist or family medicine doctor, and hospitals with no member cost share (deductible, copay, coinsurance). Contact the provider to see if such services are available.

8 A cost share may apply for other prescription contraceptives, based on your drug benefits.

9 Your cost share may be waived if your doctor decides that using the multisource brand is medically necessary

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Anthem BlueCross BlueShield

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.

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Need help?

Call the home delivery pharmacy at 1-866-281-2966 and we'll get you started.

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.[4]

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.

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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
يمكنك الحصول على هذه المعلومات والمساعدة بلغتك دون مقابل. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة الهوية الخاصة بك للحصول على المساعدة.
(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)

Japanese
この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Haitian
Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Italian
Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Polish
Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Punjabi
ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Navajo
Bee ná ahoot'i' t'áá ni nizaad k'ehjí níká a'doowoł t'áá jíík'e. Naaltsoos bee atah nílínígíí bee néého'dólzingo nanitínígíí béésh bee hane'í bikáá' áaji' hodíílnih. (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!

Anthem BlueCross BlueShield

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