Choosing and using your plan

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

Capital Area Health Consortium

This guide is for information purposes only. You must enroll in a plan for your benefits to start.
Your trusted health partner

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

Save this guide

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

Let's get started

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

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

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Choosing your plan

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

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

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

What you pay and what your plan pays

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

Words that are helpful to know

Deductible:
A set amount you pay each year for covered services before your plan starts to pay for covered health care costs.

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

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

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

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

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

We can help you crack the code of health insurance lingo. Here are the meanings of some common terms:

Deductible:
A set amount you pay each year for covered services before your plan starts to pay for covered health care costs.

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

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

**PPO**

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

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

When you choose Blue View VisionSM, you'll be covered for checkups and eye exams and you'll get allowances for the glasses or contacts you rely on.

Blue View Vision gives you access to more than 38,000 eye doctors at more than 27,000 locations across the country so you can find eye care and eyewear close to home and work. Locations include retail stores like LensCrafters®, Target Optical® and most Pearle Vision® stores. You can order glasses and contacts online through Glasses.com, ContactsDirect or 1-800-CONTACTS.

Blue View Vision’s International Travel Solution helps you when traveling outside of the U.S.:

- Find a trusted eye doctor in 20 countries and territories.1
- Get 24/7 phone support with translation services in 160 languages.
- If you lose or break your glasses, you can get temporary emergency glasses with adjustable lenses delivered within 24 hours in most locations at no additional cost.

Keep an eye on your health

Routine eye checkups go beyond making sure you can see clearly. They also can catch other health problems early, like diabetes, high blood pressure, high cholesterol and rheumatoid arthritis.2

1 Available in Australia, Austria, Brazil, Canada, Chile, China, Colombia, Ecuador, England, France, Germany, Hong Kong SAR, Italy, Japan, Mexico, New Zealand, Peru, Puerto Rico, U.S., Spain and Switzerland.
How to use your plan

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

Use your ID card right from your phone

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

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

Register for online tools and resources

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

- Quickly access your digital ID card.
- Find a doctor and estimate your costs before you go.
- View your claims, see what’s covered and what you may owe for care.
- Get support managing your health conditions and tracking your goals.
- Update your email and communication preferences.
How to use your plan

Find a doctor in your plan

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

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

Schedule a checkup

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

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

Check your plan details on the Sydney Health mobile app or anthem.com to confirm what preventive care is covered.
Anthem® BlueCross and BlueShield

Your Plan: Anthem Century Preferred PPO $15/$0/$0/$50 Rx $10/$20

Your Network: Century Preferred

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

<table>
<thead>
<tr>
<th>Covered Medical Benefits</th>
<th>Cost if you use an In-Network Provider</th>
<th>Cost if you use a Non-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall Deductible</strong></td>
<td>$0 person / $0 family</td>
<td>$200 person / $600 family</td>
</tr>
<tr>
<td><em>See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Out-of-Pocket Limit</strong></td>
<td>$6,600 person / $13,200 family</td>
<td>$1,200 person / $1,600 family</td>
</tr>
<tr>
<td><em>When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Preventive care/screening/immunization</strong></td>
<td>No charge</td>
<td>20% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td><em>In-network preventive care is not subject to deductible, if your plan has a deductible. Included are the preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Doctor Home and Office Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Primary Care Visit to treat an injury or illness</strong></td>
<td>$15 copay per visit</td>
<td>20% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td><em>All services performed in the office are included in the office copay.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Specialist Care Visit</strong></td>
<td>$20 copay per visit</td>
<td>20% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td><em>All services performed in the office are included in the office copay.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Routine Prenatal Care</strong></td>
<td>No charge</td>
<td>20% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td><em>Initial visit subject to $20 copay</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered Medical Benefits</td>
<td>Cost if you use an In-Network Provider</td>
<td>Cost if you use a Non-Network Provider</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>----------------------------------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>Routine Postnatal Care</td>
<td>No charge</td>
<td>20% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td>Other Practitioner Visits:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retail Health Clinic</td>
<td>$15 copay per visit</td>
<td>20% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td>On-line Visit</td>
<td>$15 copay per visit</td>
<td>20% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td>Live Health Online is the preferred telehealth solutions (<a href="http://www.livehealthonline.com">www.livehealthonline.com</a>)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic</td>
<td>No charge</td>
<td>20% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td>Coverage is limited to 50 combined visits with pt,ot,st per benefit period. Limit is combined In-Network and Non-Network.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acupuncture</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Other Services in an Office:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy Testing</td>
<td>$20 copay per visit</td>
<td>20% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td>Chemo/Radiation Therapy</td>
<td>No charge</td>
<td>20% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td>Dialysis/Hemodialysis</td>
<td>No charge</td>
<td>20% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>No charge</td>
<td>20% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td>For the drugs itself dispensed in the office through infusion/injection.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lab:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Covered Medical Benefits

<table>
<thead>
<tr>
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<th>Cost if you use an In-Network Provider</th>
<th>Cost if you use a Non-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office</td>
<td>No charge</td>
<td>20% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td><em>All services performed in the office are included in the office copay.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Freestanding/Site-of-Service Lab</td>
<td>No charge</td>
<td>20% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>No charge</td>
<td>20% coinsurance after medical deductible is met</td>
</tr>
</tbody>
</table>

### X-Ray:

<table>
<thead>
<tr>
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<th>Cost if you use a Non-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office</td>
<td>No charge</td>
<td>20% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td><em>All services performed in the office are included in the office copay.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Breast ultrasound cannot exceed $20 copay.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Freestanding/Site-of-Service Radiology Center</td>
<td>No charge</td>
<td>20% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td><em>Breast ultrasound cannot exceed $20 copay.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>No charge</td>
<td>20% coinsurance after medical deductible is met</td>
</tr>
</tbody>
</table>

### Advanced Diagnostic Imaging:

*Imaging services include MRI, MRA, CAT, CTA, PET, and SPECT scans.*

<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Office</td>
<td>No charge</td>
<td>20% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td><em>All services performed in the office are included in the office copay.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Freestanding/Site-of-Service Radiology Center</td>
<td>No charge</td>
<td>20% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>No charge</td>
<td>20% coinsurance after medical deductible is met</td>
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<th>Cost if you use an In-Network Provider</th>
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<tbody>
<tr>
<td><strong>Emergency and Urgent Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td>$25 copay per visit</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Emergency Room Facility Services</strong></td>
<td>$50 copay per visit</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td><strong>Emergency Room Doctor and Other Services</strong></td>
<td>No charge</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td><strong>Ambulance Transportation</strong></td>
<td>No charge</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td><strong>Outpatient Mental/Behavioral Health and Substance Abuse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Doctor Office Visit and Online Visit</strong></td>
<td>No charge</td>
<td>20% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td><strong>Facility visit:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Facility Fees</strong></td>
<td>No charge</td>
<td>20% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td><strong>Doctor Services</strong></td>
<td>No charge</td>
<td>20% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td><strong>Outpatient Surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Facility Fees:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospital</strong></td>
<td>No charge</td>
<td>20% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td><strong>Freestanding Surgical Center</strong></td>
<td>No charge</td>
<td>20% coinsurance after medical deductible is met</td>
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</tr>
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<tbody>
<tr>
<td><strong>Doctor and Other Services:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>No charge</td>
<td>20% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td>Freestanding Surgical Center</td>
<td>No charge</td>
<td>20% coinsurance after medical deductible is met</td>
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</tbody>
</table>

| Hospital Stay (all Inpatient stays including Maternity, Mental/Behavioral Health, Substance Abuse, Infertility, Human Organ and Tissue Transplant services): |                                        |                                       |
| Facility fees (for example, room & board)                      | No charge                              | 20% coinsurance after medical deductible is met |
| Doctor and other services                                     | No charge                              | 20% coinsurance after medical deductible is met |

| Recovery & Rehabilitation                                     |                                        |                                       |
| **Home Health Care**                                           |                                        |                                       |
| *Coverage is limited to 200 visits per benefit period. Limit is combined In-Network and Non-Network.* | No charge                              | $50 deductible then 20% coinsurance   |

<p>| Rehabilitation services (for example, physical/speech/occupational therapy): |                                        |                                       |
| Office <em>Coverage for rehabilitative and habilitative physical therapy, occupational therapy, speech therapy and chiropractic care combined is limited to 50 visits per benefit period. Limit is combined across professional visits and outpatient facilities. Limit is combined In-Network and Non-Network.</em> | No charge                              | 20% coinsurance after medical deductible is met |
| Outpatient Hospital <em>Coverage for rehabilitative and habilitative physical therapy, occupational therapy, speech therapy, and chiropractic care combined is limited to 50 visits per benefit period. Limit is combined across professional visits and outpatient facilities. Limit is combined In-Network and Non-Network.</em> | No charge                              | 20% coinsurance after medical deductible is met |</p>
<table>
<thead>
<tr>
<th>Covered Medical Benefits</th>
<th>Cost if you use an In-Network Provider</th>
<th>Cost if you use a Non-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cardiac rehabilitation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office</td>
<td>No charge</td>
<td>20% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td>Coverage is limited to 36 visit(s) per episode. Limit is combined In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>No charge</td>
<td>20% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td>Coverage is limited to 36 visit(s) per episode. Limit is combined In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Skilled Nursing Care (in a facility)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coverage is limited to 120 days per benefit period. Limit is combined In-Network and Non-Network.</td>
<td>No charge</td>
<td>20% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td><strong>Hospice</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60 day maximum</td>
<td>$200 copay</td>
<td>20% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coverage for hearing aids is limited to 1 per ear every 2 years.</td>
<td>No charge</td>
<td>20% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td><strong>Prosthetic Devices</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mandatory coverage of a wig if prescribed by a licensed oncologist for a patient who suffers hair loss as a result of chemotherapy.</td>
<td>No charge</td>
<td>20% coinsurance after medical deductible is met</td>
</tr>
</tbody>
</table>
## Covered Prescription Drug Benefits

<table>
<thead>
<tr>
<th>Covered Prescription Drug Benefits</th>
<th>Cost if you use an In-Network Provider</th>
<th>Cost if you use a Non-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy Deductible</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Pharmacy Out of Pocket</td>
<td>Combined with medical out of pocket maximum</td>
<td>Combined with medical out of pocket maximum</td>
</tr>
</tbody>
</table>

### Prescription Drug Coverage

**National Drug List**

<table>
<thead>
<tr>
<th>Tier 1 - Typically Generic</th>
<th>Cost if you use an In-Network Provider</th>
<th>Cost if you use a Non-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Covers up to a 34 day supply (retail pharmacy)</em>. Covers up to a 100 day supply (home delivery program). Covers up to 100 day supply (retail maintenance pharmacy).</td>
<td>$10 copay per prescription (retail only). $0 copay per prescription (home delivery only).</td>
<td>20% coinsurance (retail and home delivery)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tier 2 – Typically Preferred Brand</th>
<th>Cost if you use an In-Network Provider</th>
<th>Cost if you use a Non-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Covers up to a 34 day supply (retail pharmacy)</em>. Covers up to a 100 day supply (home delivery program). Covers up to 100 day supply (retail maintenance pharmacy).</td>
<td>$20 copay per prescription (retail only). $0 copay per prescription (home delivery only).</td>
<td>20% coinsurance (retail and home delivery)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tier 3 - Typically Non-Preferred Brand</th>
<th>Cost if you use an In-Network Provider</th>
<th>Cost if you use a Non-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Covers up to a 34 day supply (retail pharmacy)</em>. Covers up to a 100 day supply (home delivery program). Covers up to 100 day supply (retail maintenance pharmacy).</td>
<td>$20 copay per prescription (retail only). $0 copay per prescription (home delivery only).</td>
<td>20% coinsurance (retail and home delivery)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tier 4 - Typically Specialty (brand and generic)</th>
<th>Cost if you use an In-Network Provider</th>
<th>Cost if you use a Non-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Covers up to a 30 day supply (retail pharmacy)</em>. Covers up to a 30 day supply (home delivery program).</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>
Notes:

- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum; in addition, amounts for all family members apply to the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.

- For additional information on this plan, please visit sbc.anthem.com to obtain a "Summary of Benefit Coverage".

- If your plan includes out of network benefits, all services with calendar/year limits are combined both in and out of network.

- If your plan includes out of network benefits and you use a non-participating provider, you are responsible for any difference between the covered expense and the actual non-participating providers charge. When receiving care from providers out of network, members may be subject to balance billing in addition to any applicable copayments, coinsurance and/or deductible. This amount does not apply to the out of network out of pocket limit.
Get help in your language

Curious to know what all this says? We would be too. Here’s the English version:
If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call

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.

(TTY/TDD: 711)

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فبدون مقابل. للتحدث إلى مترجم، اتصل على .

Armenian (հայերեն): Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվո վ.

Chinese (中文): 如果您对本文文件有任何疑问，您有权在不支付任何额外费用的情况下使用您的语言获得帮助和信息。

Chinese (简体中文): 如果您对本文文件有任何疑问，您有权在不支付任何额外费用的情况下使用您的语言获得帮助和信息。

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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 .

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

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 parlarle con un interprete, chiama il numero .

Japanese (日本語): この文書についても何か不明な点があれば、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、にお電話ください。

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면로 문의하십시오.
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.
## Summary of Benefits and Coverage:

What this **Plan** Covers & What You Pay For Covered Services

### Anthem Blue Cross and Blue Shield:

**Century Preferred PPO**

### Coverage Period:

07/01/2020–06/30/2021

**Coverage for:** Individual + Family | **Plan Type:** PPO

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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/file](https://eoc.anthem.com/eocdps/file). 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.

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

<table>
<thead>
<tr>
<th>Do you need a referral to see a specialist?</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>You can see the specialist you choose without a referral.</td>
<td></td>
</tr>
</tbody>
</table>

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

<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 visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$15 copay/visit</td>
<td>20% coinsurance after deductible</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$20 copay/visit</td>
<td>20% coinsurance after deductible</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>20% coinsurance after deductible</td>
<td>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.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
<td>20% coinsurance after deductible</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge</td>
<td>20% coinsurance after deductible</td>
<td>Prior authorization is required.</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>
<td>34-day supply for Retail 35-100-day supply for Mail Order.</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></td>
<td></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></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 4 - Typically Specialty (brand and generic)</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td></td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/fi.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>What You Will Pay</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Facility fee (e.g. ambulatory surgery center)</strong></td>
<td>No charge</td>
<td>No charge</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td><strong>Physician/surgeon fees</strong></td>
<td>No charge</td>
<td>$50 copay/visit</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td><strong>Emergency room care</strong></td>
<td>Covered as In-Network</td>
<td>Not covered</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td><strong>Urgent care</strong></td>
<td>Not covered</td>
<td>$25/visit</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td><strong>Outpatient services</strong></td>
<td>No charge</td>
<td>$20/visit first visit</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td><strong>Inpatient services</strong></td>
<td>No charge</td>
<td>No charge</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td><strong>Childbirth/delivery services</strong></td>
<td>No charge</td>
<td>No charge</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td><strong>Rehabilitation services</strong></td>
<td>No charge</td>
<td>No charge</td>
<td>20% coinsurance after deductible</td>
</tr>
</tbody>
</table>

*For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/#.*
<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></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>Habilitation services</td>
<td></td>
<td>No charge</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td></td>
<td>No charge</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td></td>
<td>No charge</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Hospice services</td>
<td></td>
<td>$200 Copay</td>
<td>20% coinsurance after deductible</td>
</tr>
</tbody>
</table>

If your child needs dental or eye care

<table>
<thead>
<tr>
<th>If your child needs dental or eye care</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye exam(routine or medical)</td>
<td>No charge if preventative Medical $20 Copay</td>
<td>20% coinsurance after deductible</td>
<td>Coverage for Eye exams is limited to one exam every 1 calendar years. Separate Vision plan (glasses)</td>
</tr>
<tr>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td></td>
</tr>
</tbody>
</table>

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 (For members enrolled effective 7/1/19 or thereafter, covered services related to infertility must be rendered at the Center for Advanced Reproductive Services. Infertility services performed by any provider other than the Center for Advanced Reproductive Services are considered non-covered services.)
- 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](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](http://www.HealthCare.gov). For more information about the [Marketplace](http://www.HealthCare.gov), visit [www.HealthCare.gov](http://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](http://www.HealthCare.gov) and [Appeals](http://www.HealthCare.gov), 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](http://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](http://www.HealthCare.gov).

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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](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>Amount</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>

Of this, $700 is what isn’t covered.

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>Amount</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>

Of this, $2,040 is what isn’t covered.

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>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$55</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$37</td>
</tr>
</tbody>
</table>

Of this, $1,622 is what isn’t covered.

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 (አአአአአአአአአአአአአአአአአአአአአአአአአአ апрар успешно контактовать с переводчиком, звоните (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 (800) 922-6621.

Bassan (Bãddi Wùɗu): M di dyi di-die dèbé bédé há cèé-ðë nià ke dyi ni, o mò ni dyi-bèdèìn-dè bé m ké gbo-kpá-kpá ké bò kpö dé m bii-woo dön bó pìdyi. Bé m ké wuɗu-zìni-nyò dó gbo wùɗu ke, dá (800) 922-6621.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষার বিন্যাসের সাথে কথা বলা জন্য (800) 922-6621 থেকে কল করুন।

Burmese (မြန်မာ): မြန်မာဖြင့်အပြုသော စာသီးတော်များကို ဖျင်မှု အကြောင်းပြောင်းလဲလိုအပ်ပါသည်။ (800) 922-6621

Chinese (中文): 如果您对本文件有任何疑问，您有权使用您的语言免费获得协助和资讯。如需与口译员通话，请致电 (800) 922-6621。

Dinka (Dinka): Na nang thiere cee ke de ya thorë, ke yin nang log bë yi kwon ku wer ake bë geë yin ne thon du ke cin wëu tăstu ke piny. Te kër yin ha jam wëné ran ye thok getyic, ke yin col (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 سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادریتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره 1-800-922-6621 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 απόριες 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):** ત્યારે એક દસ્તાવજ અંગે આપને કોઈપણ પ્રશ્નો દોષ નથી, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહતી મળવા માટે તમને અધિકાર છે. દુભાષયા 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):** जब आपके पास इस दस्तावेज के बारे में कोई प्रश्न है, तो आपको लिंग्वाइट अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दूभाषिये 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 tsōm xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (800) 922-6621.

**Igbo (Igbo):** O búrụ na i nwere ajụма ụ bula gbasara akwu kwọ a, i nwere ikike ịnweta enyemaka na ozi n'asụsụ gi na akwughị ụgwọ ọ bula. Ka gi na ọkwọa 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。通訳話すには、(800) 922-6621 にお電話ください。
Language Access Services:

Romanian (Română): Dacă aveți întrebări referitoare la acest document, aveți dreptul să primiti 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 kahumingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (800) 922-6621.

Thai (ไทย): หากท่านมีคำถามใดๆ เพื่อเกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร (800) 922-6621 เพื่อพูดคุยกับสำนักงาน

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 номером (800) 922-6621.

Urdu (اُردُو): اگر اس نسٹریز کے بارے میں آپ کا کوئی سوال ہے، تو آپ کو متعلقہ اینٹی زبان میں مفت معلومات حاصل کریں کہ احکام حاصل ہیں یکی متوجہ سے بات کریں گے

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): איברער אין אנערען אין דאַנקומסוטן. אַן אַירד דאַ רעטן דאַ בקעװן דאַ יונאָפּאַרעהַן אַיייר פּאָסַר אַלט קָלאָ פּאָר. צא רעטן!

Yoruba (Yorùbá): Ti o bá ní èyíkéyì ìbèrè nipa àkọsílẹ̀ yìí, o ní ètò láti gba èrinwọ̀ àti è yií ìwú láti ní èdè re lọ̀fèé. Bá wá ógbù̀fù kan sòrò, 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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**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

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**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

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**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 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

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

Eyeglass lens enhancements
When obtaining covered eyewear from a Blue View Vision provider, you may choose to add any of the following lens enhancements at no extra cost.
- Transitions Lenses (for a child under age 19)
- Standard Polycarbonate (for a child under age 19)
- Factory Scratch Coating

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

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><strong>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.</strong></td>
<td></td>
</tr>
<tr>
<td>o Transitions® Lenses (Adults)</td>
<td>$75</td>
</tr>
<tr>
<td>o Standard Polycarbonate (Adults)</td>
<td>$40</td>
</tr>
<tr>
<td>o Tint (Solid and Gradient)</td>
<td>$15</td>
</tr>
<tr>
<td>o UV Coating</td>
<td>$15</td>
</tr>
<tr>
<td>o Progressive Lenses^1</td>
<td></td>
</tr>
<tr>
<td>o Standard</td>
<td>$65</td>
</tr>
<tr>
<td>o Premium Tier 1</td>
<td>$85</td>
</tr>
<tr>
<td>o Premium Tier 2</td>
<td>$95</td>
</tr>
<tr>
<td>o Premium Tier 3</td>
<td>$110</td>
</tr>
<tr>
<td>o Anti-Reflective Coating^2</td>
<td></td>
</tr>
<tr>
<td>o Standard</td>
<td>$45</td>
</tr>
<tr>
<td>o Premium Tier 1</td>
<td>$57</td>
</tr>
<tr>
<td>o Premium Tier 2</td>
<td>$68</td>
</tr>
<tr>
<td>o Other Add-ons and Services</td>
<td>20% off retail price</td>
</tr>
</tbody>
</table>

### Additional Pairs of Eyeglasses

<table>
<thead>
<tr>
<th>Anytime from any Blue View Vision network provider</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>o Complete Pair</td>
<td>40% off retail price</td>
</tr>
<tr>
<td>o Eyeglass materials purchased separately</td>
<td>20% off retail price</td>
</tr>
</tbody>
</table>

### 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

<table>
<thead>
<tr>
<th><strong>1-800 CONTACTS</strong></th>
<th><strong>Laser vision correction surgery</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>After your benefits for the coverage period have been used, you can save on contact lenses with this offer.^3</td>
<td>LASIK refractive surgery.</td>
</tr>
<tr>
<td>o For this and other great offers, login to member services, select discounts, then Vision, Hearing &amp; Dental</td>
<td>o For this offer and more like it, login to member services, select discounts, then Vision, Hearing &amp; Dental</td>
</tr>
</tbody>
</table>

Discount per eye

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

On LiveHealth Online, you can:

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

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

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

You’ve got access to affordable and convenient care

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

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

Go to livehealthonline.com or download the app and register on your phone or tablet.
Prescription availability is defined by physician judgment and state regulations. Visit the home page of livehealthonline.com to view the service map by state.

Appointments subject to availability of a therapist.

Prescriptions determined to be a “controlled substance” (as defined by the Controlled Substances Act under federal law) cannot be prescribed using LiveHealth Online. Psychiatrists on LiveHealth Online will not offer counseling or talk therapy. Appointments subject to availability.

Online counseling is not appropriate for all kinds of problems. If you are in crisis or have suicidal thoughts, it’s important that you seek help immediately. Please call 1-800-273-TALK (National Suicide Prevention Lifeline) or 911 and ask for help. If your issue is an emergency, call 911 or go to your nearest emergency room. LiveHealth Online does not offer emergency services.

If you’re a retiree or have coverage that complements your Medicare benefits, your employer-sponsored health plan may not include coverage for online visits using LiveHealth Online. Check your plan documents for details. You can still use LiveHealth Online, but you may have to pay the full cost of a visit. Online visits using LiveHealth Online may not be a covered benefit for HRA and HIA+ members.

LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of Anthem Blue Cross and Blue Shield.

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. Copies of Colorado network access plans are available on request from member services or can be obtained by going to anthem.com/co/networkaccess. In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (including 35 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliances® Life Insurance Company (HALIC), and HMO Missouri, Inc. HMO and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not administer benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by Compcare Health Services Insurance Corporation (Compcare) or Wisconsin Collaborative Insurance Company (WCIC). Compcare underwrites or administers HMO or POS policies. WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.
Choose an easier way to better health

Health and wellness programs designed for your unique needs

Whether you’re suffering from asthma, expecting a baby or just fighting a cold, our health and wellness programs can help.

**ConditionCare**

If you have asthma, diabetes, chronic obstructive pulmonary disease (COPD), heart disease or heart failure, ConditionCare can give you the tools and resources you need to take charge of your health. You’ll get:

- 24/7, toll-free phone access to nurses who can answer health questions.
- Support from nurse care managers, dietitians and other health care professionals to help you reach your health goals.
- Educational guides, electronic newsletters and tools to help you learn more about your condition(s).

**Future Moms**

Having a baby is an exciting time! Future Moms can help you have a healthy pregnancy and a healthy baby. Sign up as soon as you know you’re pregnant. You’ll get:

- A nurse specializing in obstetrics who can answer your questions, 24/7, and will call to check on your progress.
- The *Mayo Clinic Guide to a Healthy Pregnancy*, which explains the changes your body and baby are going through.
- A screening to check your health risks.
- Resources to help you make healthier decisions during pregnancy.
- Free phone access to pharmacists, nutritionists and other specialists, if needed.
- Other helpful information on labor and delivery, including options and how to prepare.

**24/7 NurseLine**

Whether it’s 3 a.m. or a lazy Sunday afternoon, you can talk to a registered nurse any time of the day or night.

These nurses can:

- Answer questions about health concerns.
- Help you decide where to go for care when your doctor, dentist, or eye doctor isn’t available.
- Help you find providers and specialists in your area.
- Enroll you and your dependents in health management programs.
- Remind you about scheduling important screenings and exams, including dental and vision check ups.

Get the support you need

Call us to sign up and use these programs at no extra cost:

- ConditionCare: 866-962-0959
- Future Moms: 800-828-5891
- 24/7 NurseLine: 800-337-4770
You’ve got quick access to your health care!

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

From your computer

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

From your mobile device

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

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

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

* You must be 18 years or older to register your own account.

Anthem Blue Cross and Blue Shield is the trade name of:

- In Colorado: Rocky Mountain Hospital and Medical Service, Inc. (RMHCS), dba HMO Colorado, Inc. (HMO Colorado). A copy of Colorado network access plans are available on request from member services or can be obtained by going to anthem.com/colorado. In Colorado, Rocky Mountain Hospital and Medical Service, Inc. (RMHCS), dba HMO Colorado, Inc. (HMO Colorado) is not the issuer of self-funded plans and do not underwrite benefits.
- In Connecticut: Anthem Health Plans, Inc.
- In Georgia: Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.
- In Indiana: Anthem Insurance Companies, Inc.
- In Kentucky: Kentucky Blue Insurance Company, Inc. (Kentucky Blue)
- In Maine: Anthem Blue Cross Health Plan of Maine, Inc.
- In Missouri: Missouri Blue Cross Blue Shield, a division of Blue Cross and Blue Shield of Missouri, Inc.
- In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada.
- In New Hampshire: Anthem Health Plans of New Hampshire, Inc.
- In Ohio: Community Insurance Company
- In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Triana, and the area east of State Route 222. In Virginia, Blue Cross Blue Shield of Virginia (VHCS), underwrites or administers PPO and indemnity policies and underwrites the out-of-network benefits in POS policies offered by Compcare Health Services Insurance Corporation (Compcare) or Wisconsin Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers Well Priority HMO or POS policies.
- In Wisconsin: Blue Cross Blue Shield of Wisconsin

Anthem is a registered trademark of Anthem Insurance Companies, Inc. 13206ANMENABS VPOD  Rev 06/19 5567 4486-122033677
We’re here for you – in many languages

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

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

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

Vietnamese
Quy vị có quyền nhận miễn phí trợ giúp bằng ngôn ngữ của mình. Chỉ cần gọi số Dịch vụ dành cho thành viên tren thẻ ID của quy vị. Bị khai thải? Quy vị cùng có thể hỏi xin định dạng khác của tài liệu này." 

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

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

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

Arabic
لقد الحق في الحصول على مساعدة بلغتك مجانًا. ما عليك سوى الإتصال برقم خدمة الأعضاء الموجود على بطاقتك الهوية. هل أنت ضعيف البصر؟ يمكنك طلب تشكيل آخر من هذا المستند.

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

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

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

Punjabi
ਅਪਾਟੀ ਦਾ ਨਾਂ ਬਿੱਤੇ ਮੱਡ ਅਗਤ ਕਰ੍ਚ ਹੁਣ ਸ਼ਾਮਹ ਜਸਨਾ ਹੁਣ ਲੇਨ ਦਾ ਬਿਅਰਜ ਹੈ। ਵਾਨ ਅਪਾਟੀ ਅਗਤੀ ਵਧਾਣ ਦੇ ਵੇਚ ਦੇ ਬਹੁਤ ਬਹੁਤ। ਤਰੰਤ ਹੋਣ ਵਾਲੀ ਦੀ ਤਰਜਮਾਤ ਕਰਨ ਦਾ ਬਿਅਰਜ ਹੈ ਜਿਸ ਦੀ ਤਰਜਮਾਤ ਦੇ ਵੇਚ ਕੁਹਕੁਹ ਮੰਗ ਮਿਲਦੀ ਹੈ।

TTY/TTD: 711

It’s important we treat you fairly

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

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

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

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

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

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

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

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

Prior Authorization Pass Program
All in-network doctors in Connecticut who meet certain criteria are able to participate in Anthem’s Prior Auth Pass Program. Under this program, eligible doctors will no longer need to submit a request and wait for pre-approval for Anthem members* on more than 400 common outpatient medical procedures done in Connecticut.

*Exceptions: BlueCard Host members, Federal Employee Program members, New York State and New York City employees.

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

It's time to choose your plan

Using your plan

Notes
Ready to use your plan?

Get some extra help

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