

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Access PPO Option 5 with Rx Option T1

Your Network: Blue Access

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	\$500 person / \$1,500 family	\$1,500 person / \$3,000 family
Out-of-Pocket Limit	\$4,000 person / \$8,000 family	\$12,000 person / \$24,000 family
<p>The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both 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.</p>		
Preventive Care / Screening / Immunization	No charge	50% coinsurance after deductible is met
<p><u>Doctor Home and Office Services</u></p> <p>Primary Care Visit <i>When Allergy injections are billed separately by network providers, the member is responsible for a \$10 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.</i></p> <p>Enhanced Personal Healthcare Provider Office Visit</p>	<p>\$25 copay per visit deductible does not apply</p> <p>\$10 copay per visit deductible does not apply</p>	<p>50% coinsurance after deductible is met</p> <p>Not Applicable</p>
<p>Specialist Care Visit <i>When Allergy injections are billed separately by network providers, the member is responsible for a \$10 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.</i></p>	\$50 copay per visit deductible does not apply	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prenatal and Post-natal Care	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<p><u>Other Practitioner Visits:</u></p> <p>Retail Health Clinic</p> <p>On-line Visit <i>Includes Mental/Behavioral Health and Substance Abuse</i></p> <p>Manipulation Therapy <i>Coverage is limited to 12 visits per benefit period.</i></p>	<p>\$25 copay per visit deductible does not apply</p> <p>\$25 copay per visit deductible does not apply</p> <p>\$25 copay per visit deductible does not apply</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><u>Other Services in an Office:</u></p> <p>Allergy Testing</p> <p>Chemo/Radiation Therapy - PCP</p> <p>Chemo/Radiation Therapy - Specialist</p> <p>Dialysis/Hemodialysis</p> <p>Prescription Drugs - <i>Dispensed in the office</i></p>	<p>20% coinsurance after deductible is met</p> <p>\$25 copay per visit deductible does not apply</p> <p>\$50 copay per visit deductible does not apply</p> <p>\$50 copay per visit deductible does not apply</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><u>Diagnostic Services</u></p> <p>Lab:</p> <p>Office</p> <p>Freestanding Lab/Reference Lab</p> <p>Outpatient Hospital</p>	<p>No charge</p> <p>No charge</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
X-Ray: Office Outpatient Hospital	No charge 20% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met
Advanced Diagnostic Imaging: Office Freestanding Radiology Center Outpatient Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met
<u>Emergency and Urgent Care</u> Urgent Care <i>When Allergy injections are billed separately by network providers, the member is responsible for a \$10 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.</i>	\$75 copay per visit deductible does not apply	50% coinsurance after deductible is met
Emergency Room Facility Services <i>Copay waived if admitted.</i> Emergency Room Doctor and Other Services	\$250 copay per visit and 20% coinsurance deductible does not apply 20% coinsurance deductible does not apply	Covered as In-Network Covered as In-Network
<u>Ambulance</u>	20% coinsurance after deductible is met	Covered as In-Network
<u>Outpatient Mental/Behavioral Health and Substance Abuse</u> Doctor Office Visit Facility visit: Facility Fees	\$25 copay per visit deductible does not apply 20% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Doctor Services	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<p><u>Outpatient Surgery</u></p> <p>Facility Fees:</p> <p>Hospital</p> <p>Freestanding Surgical Center</p> <p>Doctor and Other Services:</p> <p>Hospital</p> <p>Freestanding Surgical Center</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><u>Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):</u></p> <p>Facility fees</p> <p>Human Organ and Tissue Transplants <i>Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.</i></p> <p>Doctor and other services</p>	<p>20% coinsurance after deductible is met</p> <p>No charge</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><u>Recovery & Rehabilitation</u></p> <p>Home Health Care <i>Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.</i></p>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<p>Rehabilitation services:</p> <p>Office <i>Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 20 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 20 visits per benefit period.</i></p> <p>Outpatient Hospital <i>Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 20 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 20 visits per benefit period.</i></p>	<p>\$25 copay per visit deductible does not apply</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p>Cardiac rehabilitation</p> <p>Office <i>Coverage is limited to 36 visits per benefit period.</i></p> <p>Outpatient Hospital <i>Coverage is limited to 36 visits per benefit period.</i></p>	<p>\$50 copay per visit deductible does not apply</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p>Skilled Nursing Care (facility) <i>Coverage for Skilled Nursing, Outpatient Rehabilitation and Inpatient Rehabilitation facility settings is limited to 150 days combined per benefit period.</i></p>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<p>Hospice</p>	No charge	No charge
<p>Durable Medical Equipment</p>	50% coinsurance after deductible is met	50% coinsurance after deductible is met
<p>Prosthetic Devices</p>	50% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Not applicable	Not applicable	Not applicable
Pharmacy Out of Pocket	Combined with In-Network medical	Combined with In-Network medical	Combined with Non-Network medical
Prescription Drug Coverage <i>Rx Choice Tiered Network w/R90</i> <i>Essential Drug List</i> <i>This product has a 90-day Retail Pharmacy Network available. No coverage for non-formulary drugs.</i>			
Tier 1 - Typically Generic <i>30 day supply (retail pharmacy). 90 day supply (home delivery).</i>	\$10 copay per prescription, deductible does not apply (retail) and \$25 copay per prescription, deductible does not apply (home delivery)	\$20 copay per prescription, deductible does not apply (retail) and Not covered (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand <i>30 day supply (retail pharmacy). 90 day supply (home delivery).</i>	\$35 copay per prescription, deductible does not apply (retail) and \$105 copay per prescription, deductible does not apply (home delivery)	\$45 copay per prescription, deductible does not apply (retail) and Not covered (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand <i>30 day supply (retail pharmacy). 90 day supply (home delivery).</i>	\$75 copay per prescription, deductible does not apply (retail) and \$225 copay per prescription, deductible does not apply (home delivery)	\$85 copay per prescription, deductible does not apply (retail) and Not covered (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic) <i>30 day supply (retail pharmacy). 30 day supply (home delivery).</i>	25% coinsurance up to \$350 per prescription, deductible does not apply (retail and home delivery)	25% coinsurance up to \$450 per prescription, deductible does not apply (retail) and Not covered (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

Notes:

- Dependent age: to end of the month in which the child attains age 26.
- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
- All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services).
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- If your plan includes out-of-network benefits, In-network and out-of-network deductibles, copayments, coinsurance and out-of-pocket maximum amounts are separate and do not accumulate toward each other.
- If you have an office visit with your Primary Care Physician, Specialist or Urgent Care at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services" which is generally coinsurance or coinsurance after your deductible is met.
- If you get Covered Services from a Physical Therapist or Occupational Therapist, you will not have to pay an office visit or outpatient Facility Copayment or Coinsurance that is higher than what you would pay for a Primary Care Physician office visit.

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.

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 (833) 578-4443

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، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (833) 578-4443.

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՝ (833) 578-4443:

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(833) 578-4443。

Farsi (فارسی): 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 (833) 578-4443 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 (833) 578-4443.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nempòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (833) 578-4443.

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 (833) 578-4443.

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、(833) 578-4443 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 이야기하려면(833) 578-4443로 문의하십시오.

Language Access Services:

Navajo (Diné): Dii naaltsoos biká'ígíí lahgo bina'idiikidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehj̄ bee nił hodoonih t'áadoo bą́ąh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih ninizingo koj̄' hodiilnih (833) 578-4443.

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: (833) 578-4443.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (833) 578-4443 ਤੇ ਕਾਲ ਕਰੋ।

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. (833) 578-4443.

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 (833) 578-4443.

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 (833) 578-4443.

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 (833) 578-4443.

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>.

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Access PPO HSA Option E4 with Rx Option T5

Your Network: Blue Access

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	\$3,000 person / \$6,000 family	\$9,000 person / \$18,000 family
Out-of-Pocket Limit	\$4,000 person / \$8,000 family	\$12,000 person / \$24,000 family
<p>The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both 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.</p>		
Preventive Care / Screening / Immunization	No charge	30% coinsurance after deductible is met
<u>Doctor Home and Office Services</u>		
Primary Care Visit	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Specialist Care Visit	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Prenatal and Post-natal Care	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<u>Other Practitioner Visits:</u>		
Retail Health Clinic	0% coinsurance after deductible is met	30% coinsurance after deductible is met
On-line Visit <i>Includes Mental/Behavioral Health and Substance Abuse</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Manipulation Therapy <i>Coverage is limited to 12 visits per benefit period.</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<u>Other Services in an Office:</u>		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Allergy Testing	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Chemo/Radiation Therapy	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Dialysis/Hemodialysis	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Prescription Drugs - <i>Dispensed in the office</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<u>Diagnostic Services</u> Lab: Office Freestanding Lab/Reference Lab Outpatient Hospital	0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met
X-Ray: Office Outpatient Hospital	0% coinsurance after deductible is met 0% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met
Advanced Diagnostic Imaging: Office Freestanding Radiology Center Outpatient Hospital	0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<u>Emergency and Urgent Care</u> Urgent Care	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Emergency Room Facility Services Emergency Room Doctor and Other Services	0% coinsurance after deductible is met	Covered as In-Network
<u>Ambulance</u>	0% coinsurance after deductible is met	Covered as In-Network
<u>Outpatient Mental/Behavioral Health and Substance Abuse</u> Doctor Office Visit Facility visit: Facility Fees Doctor Services	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<u>Outpatient Surgery</u> Facility Fees: Hospital Freestanding Surgical Center Doctor and Other Services: Hospital Freestanding Surgical Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><u>Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):</u></p> <p>Facility fees</p> <p>Human Organ and Tissue Transplants <i>Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.</i></p> <p>Doctor and other services</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><u>Recovery & Rehabilitation</u></p> <p>Home Health Care <i>Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.</i></p>	<p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p>
<p>Rehabilitation services:</p> <p>Office <i>Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 20 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 20 visits per benefit period.</i></p> <p>Outpatient Hospital <i>Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 20 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 20 visits per benefit period.</i></p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p>Cardiac rehabilitation</p> <p>Office <i>Coverage is limited to 36 visits per benefit period.</i></p> <p>Outpatient Hospital <i>Coverage is limited to 36 visits per benefit period.</i></p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p>Skilled Nursing Care (facility) <i>Coverage for Skilled Nursing, Outpatient Rehabilitation and Inpatient Rehabilitation facility settings is limited to 150 days combined per benefit period.</i></p>	<p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p>
<p>Hospice</p>	<p>0% coinsurance after deductible is met</p>	<p>0% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Durable Medical Equipment	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices	50% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with In-Network medical deductible	Combined with Non-Network medical deductible
Pharmacy Out of Pocket	Combined with In-Network medical	Combined with In-Network medical	Combined with Non-Network medical

Prescription Drug Coverage

Rx Choice Tiered Network w/R90

Essential Drug List

This product has a 90-day Retail Pharmacy Network available. No coverage for non-formulary drugs.

Tier 1 - Typically Generic <i>30 day supply (retail pharmacy). 90 day supply (home delivery).</i>	\$10 copay per prescription after deductible is met (retail) and \$25 copay per prescription after deductible is met (home delivery)	\$20 copay per prescription after deductible is met (retail) and Not covered (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand <i>30 day supply (retail pharmacy). 90 day supply (home delivery).</i>	\$35 copay per prescription after deductible is met (retail) and \$105 copay per prescription after deductible is met (home delivery)	\$45 copay per prescription after deductible is met (retail) and Not covered (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand <i>30 day supply (retail pharmacy). 90 day supply (home delivery).</i>	\$75 copay per prescription after deductible is met (retail) and \$225 copay per prescription after	\$85 copay per prescription after deductible is met (retail) and Not covered (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
	deductible is met (home delivery)		
Tier 4 - Typically Specialty (brand and generic) 30 day supply (retail pharmacy). 30 day supply (home delivery).	25% coinsurance up to \$350 per prescription after deductible is met (retail and home delivery)	25% coinsurance up to \$450 per prescription after deductible is met (retail) and Not covered (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)

Notes:

- Dependent age: to end of the month in which the child attains age 26.
- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
- All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services).
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- If your plan includes out-of-network benefits, In-network and out-of-network deductibles, copayments, coinsurance and out-of-pocket maximum amounts are separate and do not accumulate toward each other.
- If you have an office visit with your Primary Care Physician, Specialist or Urgent Care at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under “Outpatient Facility Services” which is generally coinsurance or coinsurance after your deductible is met.
- If you get Covered Services from a Physical Therapist or Occupational Therapist, you will not have to pay an office visit or outpatient Facility Copayment or Coinsurance that is higher than what you would pay for a Primary Care Physician office visit.

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.

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 (833) 578-4443

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، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (833) 578-4443.

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՝ (833) 578-4443:

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(833) 578-4443。

Farsi (فارسی): 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 (833) 578-4443 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 (833) 578-4443.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nempòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (833) 578-4443.

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 (833) 578-4443.

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、(833) 578-4443 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 이야기하려면(833) 578-4443로 문의하십시오.

Language Access Services:

Navajo (Diné): Dii naaltsoos biká'ígíí lahgo bina'idiikidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehj̄ bee nił hodoonih t'áadoo bą́ąh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih ninizingo koj̄' hodiilnih (833) 578-4443.

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: (833) 578-4443.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (833) 578-4443 ਤੇ ਕਾਲ ਕਰੋ।

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. (833) 578-4443.

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 (833) 578-4443.

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 (833) 578-4443.

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 (833) 578-4443.

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
Anthem Dental Essential Choice
Ale 8 One
Anthem Dental Complete Network



WELCOME TO YOUR DENTAL PLAN!

Regular dental checkups can help find early warning signs of certain health problems, which means you can get the care you need to get healthy. So, don't skimp on your dental care, good oral care can mean better overall health!

Powerful and easily accessible member tools.

- **Ask a Hygienist:** Dental members can simply email their dental questions to a team of licensed dental professionals who in turn will respond in about 24 hours.
- **Dental Health Risk Assessment:** We want our dental members to better understand their oral health and their risk factors for tooth decay, gum disease and oral cancer. This easy to use online tool can help them do this.
- **Dental Care Cost Estimator:** In order to help our dental member better understand the cost of their dental care, we offer access to a user-friendly, web-based tool that provides estimates on common dental procedures and treatments when using a network dentist.
- **More Capabilities:** With our latest mobile application, Anthem Anywhere, members can find a network dentist as well as view their claims. It's available both for Android and Apple phones.

Dentists in your plan network.

- You'll save money when you visit a dentist in your plan network because Anthem and the dentist have agreed on pricing for covered services. Dentists who are not in your plan network have not agreed to pricing, and may bill you for the difference between what Anthem pays them and what the dentist usually charges.
- To find a dentist by name or location, go to anthem.com or call dental customer service at the number listed on the back of your ID card.

Ready to use your dental benefits?

- Choose a dentist from the network
- Make an appointment
- Show the office staff your member ID card
- Pay any deductible or copay that is part of your plan

Need to contact us?

See the back of your ID card for who to call, write or email.

Your dental benefits at a glance

The following benefit summary outlines how your dental plan works and provides you with a quick reference of your dental plan benefits. For complete coverage details, please refer to your policy.

	In-Network	Out-of-Network
Annual Benefit Maximum · Per insured person Calendar Year	\$1,000	\$1,000
D&P applies to Annual Maximum	Yes	Yes
Annual Maximum Carryover / Carry in	Yes/No	Yes/No
Orthodontic Lifetime Benefit Maximum · Per eligible insured person	N/A	N/A
Annual Deductible · Per insured person/Family maximum Calendar Year	\$50/3X Individual	\$100/3X Individual
Deductible Waived for Diagnostic/Preventive Services	Yes	Yes
Out-of-Network Reimbursement:	Prime (MAC)	

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Kentucky, Inc. Independent licensee of the Blue Cross and Blue Shield Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Dental Services	In-Network Anthem Pays:	Out-of-Network Anthem Pays:	Waiting Period
Diagnostic and Preventive Services · Periodic oral exam 2 per 12 months · Teeth cleaning (prophylaxis) 2 per 12 months; w/periodontal maintenance · Bitewing X-rays: 1 set per 12 months · Full-mouth or Panoramic X-rays: 1 per 60 months · Fluoride application: 1 per 12 months through age 18 · Sealants 1 per 60 months; through age 18	100% Coinsurance	90% Coinsurance	No Waiting Period
Basic Services · Consultation (second opinion) 1 per 12 months · Amalgam (silver-colored) Filling 1 per tooth per 24 months · Composite (tooth-colored) Filling 1 per tooth per 24 months posterior (back) fillings covered as composites · Brush Biopsy (cancer test) Covered, 1 per 12 months; all ages · Space Maintainers 1 per lifetime through age 18; posterior teeth	100% Coinsurance	75% Coinsurance	No Waiting Period
Endodontics (Non-Surgical) · Root Canal and retreatments 1 per tooth per lifetime	60% Coinsurance	40% Coinsurance	12 Month
Endodontics (Surgical) · Apicoectomy and apexification 1 per tooth per lifetime	60% Coinsurance	40% Coinsurance	12 Month
Periodontics (Non-Surgical) · Periodontal Maintenance 4 per 12 months; w/teeth cleaning · Scaling and root planing 1 per quadrant per 24 months	60% Coinsurance	40% Coinsurance	12 Month
Periodontics (Surgical) 1 per quadrant per 36 months · Periodontal Surgery (osseous, gingivectomy, graft procedures)	60% Coinsurance	40% Coinsurance	12 Month
Oral Surgery (Simple) · Simple Extractions 1 per tooth per lifetime	100% Coinsurance	75% Coinsurance	No Waiting Period
Oral Surgery (Complex) · Surgical Extractions 1 per tooth per lifetime	100% Coinsurance	75% Coinsurance	No Waiting Period
Major (Restorative) Services · Crowns, onlays, veneers 1 per tooth per 60 months · Cosmetic teeth whitening Not Covered	60% Coinsurance	40% Coinsurance	12 Month
Prosthodontics · Dentures and bridges 1 per tooth per 60 months · Dental Implants Covered, 1 per tooth per 60 months	60% Coinsurance	40% Coinsurance	12 Month
Prosthodontic Repairs/Adjustments · Crown, denture, bridge repairs 1 per 12 months; 6 months after placement · Denture and bridge adjustments: 2 per 12 months; 6 months after placement	60% Coinsurance	40% Coinsurance	12 Month
Orthodontic Services · None	Not Covered	Not Covered	N/A

Additional Services and Programs

Anthem Whole Health Connection -Dental

- For members with certain health conditions, additional dental benefits are available without a deductible or waiting periods. Eligible services are paid at 100% and won't reduce your coverage year annual maximum (if applicable)

Accidental Dental Injury Benefit

- Provides members 100% coverage for accidental injuries to teeth up to the coverage year annual maximum (if applicable). No deductibles, member coinsurance, or waiting periods apply

Extension of Benefits

- Following termination of coverage, members are provided up to 60 days to complete treatment started prior to their termination of coverage under the plan and eligible services will be covered

International Emergency Dental Program

- Provides emergency dental benefits while working or traveling abroad from licensed, English-speaking dentists. Eligible covered services will be paid 100% with no deductibles, member coinsurance, or waiting periods and won't reduce the member coverage year annual maximum (if applicable)

Additional Limitations & Exclusions

Below is a partial listing of non-covered services under your dental plan. Please see your policy for a full list.

Services provided before or after the term of this coverage - Services received before your effective date or after your coverage ends, unless otherwise specified in the dental plan certificate

Orthodontics (unless included as part of your dental plan benefits) including orthodontic braces, appliances and all related services

Cosmetic dentistry (unless included as part of your dental plan benefits) provided by dentists solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (cavities) exist

Drugs and medications including intravenous conscious sedation, IV sedation and general anesthesia when performed with nonsurgical dental care

Analgesia, analgesic agents, and anxiolysis nitrous oxide, therapeutic drug injections, medicines or drugs for nonsurgical or surgical dental care except that intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.

Waiting periods for endodontic, periodontic and oral surgery services may differ from other Basic Services or Major Services under the same dental plan.

There is a waiting period of up to 24 months for replacement of congenitally missing teeth or teeth extracted prior to coverage under this plan.

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

Welcome to your Blue View Vision plan!

You have many choices when it comes to using your benefits. As a Blue View Vision plan member, you have access to one of the nation's largest vision networks. You may choose from many private practice doctors, local optical stores, and national retail stores including LensCrafters®, Target Optical®, Sears Optical®, JCPenney® Optical and most Pearle Vision® locations. You may also use your in-network benefits to order eyewear online at Glasses.com and ContactsDirect.com. To locate a participating network eye care doctor or location, log in at anthem.com, or from the home page menu under Care, select **Find a Doctor**. You may also call member services for assistance at **1-866-723-0515**.

Out-of-Network – If you choose to, you may instead 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 up to your maximum out-of-network allowance.

YOUR BLUE VIEW VISION PLAN BENEFITS	IN-NETWORK	OUT-OF-NETWORK	FREQUENCY
Routine Eye Exam			
A comprehensive eye examination	\$10 copay	Up to \$42 allowance	Once every 12 months
Eyeglass Frames			
One pair of eyeglass frames	\$130 allowance, then 20% off any remaining balance	Up to \$45 allowance	Once every 12 months
Eyeglass Lenses (<i>instead of contact lenses</i>)			
One pair of standard plastic prescription lenses:			
<ul style="list-style-type: none"> ○ Single vision lenses ○ Bifocal lenses ○ Trifocal lenses 	\$10 copay \$10 copay \$10 copay	Up to \$40 allowance Up to \$60 allowance Up to \$80 allowance	Once every 12 months
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.			
<ul style="list-style-type: none"> ○ Transiti^{ons} Lenses (for a child under age 19) ○ Standard polycarbonate (for a child under age 19) ○ Factory scratch coating 	\$0 copay \$0 copay \$0 copay	No allowance when obtained out-of-network	Same as covered eyeglass lenses
Contact Lenses (<i>instead of eyeglass lenses</i>)			
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.			
<ul style="list-style-type: none"> ○ Elective conventional (non-disposable) OR	\$130 allowance, then 15% off any remaining balance	Up to \$105 allowance	Once every 12 months
<ul style="list-style-type: none"> ○ Elective disposable OR	\$130 allowance (<i>no additional discount</i>)	Up to \$105 allowance	
<ul style="list-style-type: none"> ○ Non-elective (medically necessary) 	Covered in full	Up to \$210 allowance	

This is a primary vision care benefit intended to cover only routine eye examinations and corrective eyewear. Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care doctor from your medical network. 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. This benefit overview is only one piece of your entire enrollment package.

EXCLUSIONS & LIMITATIONS (not a comprehensive list – please refer to the member Certificate of Coverage for a complete 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. Plano 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.

OPTIONAL SAVINGS AVAILABLE FROM BLUE VIEW VISION IN-NETWORK PROVIDERS ONLY	In-network Member Cost (after any applicable copay)
Retinal Imaging - at member's option can be performed at time of eye exam	Not more than \$39
Eyeglass lens upgrades When obtaining eyewear from a Blue View Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass lens copayment applies.	<ul style="list-style-type: none"> o! Transitions lenses (Adults) \$75 o! Standard Polycarbonate (Adults) \$40 o! Tint (Solid and Gradient) \$15 o! UV Coating \$15 o! Progressive Lenses¹ <ul style="list-style-type: none"> o! Standard \$65 o! Premium Tier 1 \$85 o! Premium Tier 2 \$95 o! Premium Tier 3 \$110 o! Anti-Reflective Coating² <ul style="list-style-type: none"> o! Standard \$45 o! Premium Tier 1 \$57 o! Premium Tier 2 \$68 o! Other Add-ons 20% off retail price
Additional Pairs of Eyeglasses Anytime from any Blue View Vision network provider.	<ul style="list-style-type: none"> o! Complete Pair 40% off retail price o! Eyeglass materials purchased separately 20% off retail price
Eyewear Accessories	<ul style="list-style-type: none"> o! Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc. 20% off retail price
Contact lens fit and follow-up A contact lens fitting and up to two follow-up visits are available to you once a comprehensive eye exam has been completed.	<ul style="list-style-type: none"> o! Standard contact lens fitting³ Up to \$55 o! Premium contact lens fitting⁴ 10% off retail price
Conventional Contact Lenses	<ul style="list-style-type: none"> o! Discount applies to materials only 15% off retail price

¹ Please ask your provider for his/her recommendation as well as the available progressive brands by tier.

² Please ask your provider for his/her recommendation as well as the available coating brands by tier.

³ Standard fitting includes spherical clear lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.

⁴ Premium fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

Discounts are subject to change without notice. Discounts are not 'covered benefits' under your vision plan and will not be listed in your certificate of coverage. Discounts will be offered from in-network providers except where state law prevents discounting of products and services that are not covered benefits under the plan. Discounts on frames will not apply if the manufacturer has imposed a no discount policy on sales at retail and independent provider locations. Some of our in-network providers include:



ADDITIONAL SAVINGS AVAILABLE THROUGH ANTHEM'S SPECIAL OFFERS PROGRAM *

Savings on items like additional eyewear after your benefits have been used, non-prescription sunglasses, hearing aids and even LASIK laser vision correction surgery are available through a variety of vendors. Just **log in at anthem.com**, select discounts, then Vision, Hearing & Dental.

* Discounts cannot be used in conjunction with your covered benefits.

OUT-OF-NETWORK

If you choose to receive covered services or purchase covered eyewear from an out-of-network provider, network discounts will not apply and you will be responsible for payment of services and/or eyewear materials at the time of service. 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. To download a claim form, log in at **anthem.com**, or from the home page menu under Support select Forms, click Change State to choose your state, and then scroll down to Claims and select the Blue View Vision Out-of-Network Claim Form. You may instead call member services at **1-866-723-0515** to request a claim form.




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

Transitions and the swirl are registered trademarks of Transitions Optical, Inc. !
 Anthem Blue Cross and Blue Shield is the trade name of: In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Ohio: Community Insurance Company. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or 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. The Blue Cross and Blue Shield names and symbols are the registered marks of the Blue Cross and Blue Shield Association. CR FS LG (2017)



The resources you need to meet life's challenges

*EmployeeConnect*SM offers professional, confidential services to help you and your loved ones improve your quality of life.

 In-person guidance	 Unlimited 24/7 assistance	 Online resources
<p>Some matters are best resolved by meeting with a professional in person. With <i>EmployeeConnect</i>SM, you and your family get:</p> <ul style="list-style-type: none"> ▪ In-person help for short-term issues (up to five sessions with a counselor per person, per issue, per year) ▪ In-person consultations with network lawyers, including one free 30-minute in-person consultation per legal issue, and 25% off subsequent meetings 	<p>You and your family can access the following services anytime – online, on the mobile app or with a toll-free call:</p> <ul style="list-style-type: none"> ▪ Information and referrals on family matters, such as child and elder care, pet care, vacation planning, moving, car buying, college planning and more ▪ Legal information and referrals for family law, estate planning, consumer and civil law ▪ Financial guidance on household budgeting and short- and long-term planning 	<p><i>EmployeeConnect</i>SM offers a wide range of information and resources you can research and access on your own. Expert advice and support tools are just a click away when you visit GuidanceResources.com or download the <i>GuidanceNow</i>SM mobile app. You'll find:</p> <ul style="list-style-type: none"> ▪ Articles and tutorials ▪ Videos ▪ Interactive tools, including financial calculators, budgeting worksheets and more

*EmployeeConnect*SM

EMPLOYEE ASSISTANCE PROGRAM SERVICES

Confidential help 24 hours a day, seven days a week for employees and their family members. Get help with:

- Family
- Parenting
- Addictions
- Emotional
- Legal
- Financial
- Relationships
- Stress

Insurance products issued by:
 The Lincoln National Life Insurance Company
 Lincoln Life & Annuity Company of New York
 Lincoln Life Assurance Company of Boston



We partner with your employer to offer this service at no additional cost to you!



*EmployeeConnect*SM counselors are experienced and credentialed.

When you call the toll-free line, you'll talk to an experienced professional who will provide counseling, work-life advice and referrals. All counselors hold master's degrees, with broad-based clinical skills and at least three years of experience in counseling on a variety of issues. For face-to-face sessions, you'll meet with a credentialed, state-licensed counselor.

You'll receive customized information for each work-life service you use.



Take advantage of *EmployeeConnect*SM

For more information about the program, visit GuidanceResources.com, download the *GuidanceNow*SM mobile app or call 888-628-4824.

GuidanceResources.com login credentials:

Username: LFGSupport Password: LFGSupport1

©2020 Lincoln National Corporation

LincolnFinancial.com

LCN-2836182-112019

MAP 2/20 Z02

Order code: LTD-EAPEE-FLI001



*EmployeeConnect*SM services are provided by ComPsych[®] Corporation, Chicago, IL. ComPsych[®] and GuidanceResources[®] are registered trademarks of ComPsych[®] Corporation. ComPsych[®] is not a Lincoln Financial Group[®] company. Coverage is subject to actual contract language. Each independent company is solely responsible for its own obligations.

Insurance products are issued by The Lincoln National Life Insurance Company, Fort Wayne, IN, Lincoln Life & Annuity Company of New York, Syracuse, NY, and Lincoln Life Assurance Company of Boston, Dover, NH. The Lincoln National Life Insurance Company does not solicit business in New York, nor is it licensed to do so. Product availability and/or features may vary by state. Limitations and exclusions apply.

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates. Affiliates are separately responsible for their own financial and contractual obligations.

*EmployeeConnect*SM

EMPLOYEE ASSISTANCE PROGRAM SERVICES

To find out more:

- Visit GuidanceResources.com
username: LFGSupport password: LFGSupport1
- Download the *GuidanceNow*SM mobile app
- Call 888-628-4824



COMPSYCH[®]
GuidanceResources[®] Worldwide





A Winning Partnership!

Starting November 28, 2020, Fifth Third Bank will partner with Empower Retirement. The recordkeeping and administrative services for your retirement plan will transition to Empower Retirement.

You'll still be using the same site, just with a different address. Lots of the same features will remain, plus some enhanced ones will be available to you.

To Access your Account:

Website: empowermyretirement.com

App: **Empower Retirement**

Log in with the same username and password you used with Fifth Third.

Phone: **1-800-338-4015**

Retirement representatives are available to assist you weekdays from 8:00 a.m. to 10:00 p.m. ET and Saturdays from 9:00 a.m. to 5:30 p.m. ET (exclusions may apply).

The Fifth Third transaction is expected to close during the fourth quarter, subject to required regulatory approvals and other customary closing conditions. References in this document constitute forward-looking statements, representing management's current view of future events based on reasonable assumptions. These statements are not guarantees of future performance, as actual results may differ depending on the development and completion of these business combinations. Consider these and other factors, uncertainties and potential events carefully and do not place undue reliance on forward-looking information. Other than as specifically required by applicable law, forward-looking information as a result of new information, future events or otherwise will not be updated.

Investments and investment services are offered through or are made available by one or more of Fifth Third Bancorp's indirect subsidiaries. Investments and Investment Services are not FDIC insured, offer no bank guarantee, may lose value, are not insured by any federal government agency, and are not a deposit. © 2020 Fifth Third Bank, National Association

Securities offered and/or distributed by GWFS Equities, Inc., Member FINRA/SIPC. GWFS is an affiliate of Empower Retirement, LLC; Great-West Funds, Inc.; and registered investment advisers, Advised Assets Group, LLC and Personal Capital. This material is for informational purposes only and is not intended to provide investment, legal or tax recommendations or advice.

©2020 Empower Retirement, LLC. All rights reserved. RO1419818-1120

ALE-8-ONE BOTTLING COMPANY EMPLOYEE BENEFIT PLAN
PRIVACY NOTICE – JANUARY 1, 2021

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.** This Notice applies to major medical and medical flexible spending account benefits.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information, which we will never do without your written permission

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and if we do agree to your request, we may still use or disclose the information if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are not present, or are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company maintains the health plan, and the health plan provides your company (employer) with certain statistics to determine costs and the portion of the premiums (costs) participants pay, as well as plan design changes.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Other Instructions for Notice

- Human Resources, 25 Carol Road, Winchester, KY 40392, 859-744-3484

Important Notice from Ale-8-One Bottling Company About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Ale-8-One Bottling Company and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

PPO and HDHP Plans

2. **Anthem has determined that the prescription drug coverage offered by the Ale-8-One Bottling Company PPO and HDHP plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Ale-8-One Bottling Company coverage may be affected.

You can retain your existing coverage and choose not to enroll in a Part D plan or you can also enroll in a Part D plan as a supplement to the coverage you have with Ale-8-One Bottling Company. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your dependents will still be eligible to receive all of your current health and prescription drug benefits.

If you do decide to join a Medicare drug plan and drop your current coverage, you or your dependent may enroll back into the benefit plan during an open enrollment period under the Ale-8-One Bottling Company benefit plan as long as you are eligible for coverage.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Ale-8-One Bottling Company and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have

CMS Form 10182-CC

Updated April 1, 2011

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Ale-8-One Bottling Company changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: December 1, 2020
Name of Entity/Sender: Ale-8-One Bottling Company
Contact--Position/Office: Human Resources
Address: 25 Carol Road, Winchester, KY 40391
Phone Number: 859-744-3484