Anthem BlueCross BlueShield

Ready to choose *your benefits?*

We can point you in the right direction.

Diocese of Covington
Effective July 1, 2017

This guide is information only. You must enroll to be covered.

You're ready to enroll. Let's take a look at your options.

In this guide, you'll find:

- How most health plans work
- Pharmacy benefit info
- Specialty offerings
- Frequently Asked Questions (FAQ)
- Plan details
- Your privacy and rights

How your health plan works

Visit **anthem.com/basics** to learn more.

PPO

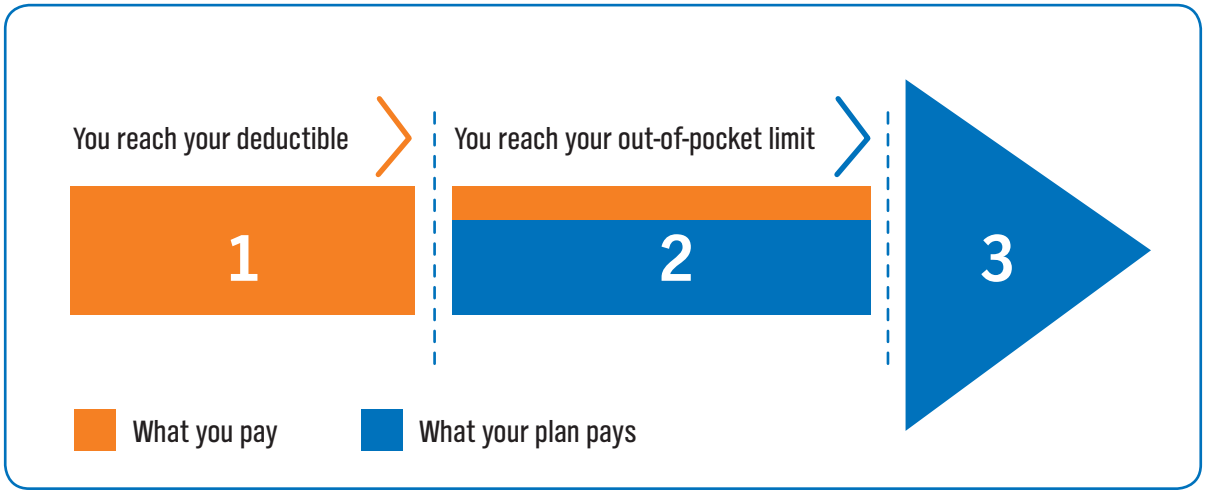
This plan covers services from almost any doctor or hospital, but you get a discount if you use a doctor from the **Preferred Provider Organization** (PPO) plan. You pay more if you go to a doctor who's not in the PPO plan. You don't usually need a referral from your main doctor, also called a primary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

Some PPO plans may have different rules. So be sure to check your plan details.

The doctors, hospitals, pharmacies and other health care providers in your plan have agreed to charge lower rates for our members.

Getting started with health insurance

When you visit your doctor, it's important to understand how your health plan works.



1. **You pay your deductible.** This is a set amount that you pay before we share the cost for covered health care.
2. **After you meet your deductible, you'll only pay part of the cost.** You pay a percentage of the cost, also called coinsurance, each time you get care. Your plan covers the rest.
3. **You're protected by your plan's out-of pocket limit.** That's the most you pay for covered health services each year.
   - What about the money for your health plan that gets deducted from your paycheck? That's the payment for your plan. Think of it like a membership fee. It's separate from what you pay when you get care.
   - Remember, this chart is only an example. Your actual costs will depend on the type of plan you choose, the service you get and the doctor you choose. To see your actual costs, please refer to your plan information.

Your pharmacy benefits

Here's an overview to help you enroll.

Getting the medicine you need is important for good health. Your plan will cover:

- Brand name and generic drugs covered by your benefits.
  - You can find out if the drug you take is covered on the **National 3-tier** Drug List by visiting **anthem.com/nationaltier3**.

Understand how your pharmacy benefits work

It's important to understand how your health plan works when you visit the pharmacy.

Your annual deductible

Before a plan starts to help pay for medicine, you may first pay a set amount out of your pocket. This is your deductible. You'll want to check the plan details to see if it has a:

- **Pharmacy deductible:** You first pay a set amount of drug costs out of your pocket and it's separate from a medical deductible.
- **Combined deductible:** You first pay a set amount for both covered medical care and drug costs out of your pocket.
- **No pharmacy deductible:** Your plan helps pay for medicine before you reach your deductible.

What you pay after meeting your deductible

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

- **Copays:** You pay a set amount, or copay, for medicine. Your copay will be based on which tier the drug is on. See *Save money with Tier 1 drugs* to learn more.
- **Coinsurance:** You pay a certain percentage of the drug's cost, which can be different based on the pharmacy you use.

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

Save money with Tier 1 drugs

Drugs are listed in groups called "tiers." Your cost is based on which tier the drug is in. Lower-cost drugs and generics are usually in Tier 1 and 2. You can see from the chart that you'll save the most money when you use Tier 1 drugs. You'll pay more out of pocket for drugs in higher tiers.

	Drug type	Cost
Tier 1	Preferred generic	$
Tier 2	Preferred brand name and newer, more expensive generic drugs	$$
Tier 3	Non-preferred brand and generic drugs	$$$

Take advantage of your pharmacy benefits

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

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

Use generics for health — and wealth. Talk to your doctor about using a generic versus a brand-name drug. Because generics cost less than brand-name drugs, they'll save you money.

Use over-the-counter drugs when possible. For some health issues, you may not need to see a doctor for relief. Over-the-counter drugs can treat common health problems like allergies or an upset stomach. They aren't covered by your health plan, but you could save time and money without having to see a doctor for a prescription and they usually cost less. Keep a list of your over-the-counter drugs to show your doctor at the next visit, so he or she can make sure there are no drug interactions that could harm you.

When you enroll, you'll probably need to opt-in for the coverage options in this section.

More benefits for you

Vision

With Blue View Vision℠, you have access to over 33,000 doctors and more than 26,000 locations across the country, including convenient retail stores like LensCrafters®, Sears Optical℠, Target Optical®, JCPenney® Optical and most Pearle Vision® stores.

You also can order glasses and contacts online through Glasses.com (glasses.com), ContactsDirect (ContactsDirect.com) or 1-800 CONTACTS (1800contacts.com).

Your new vision coverage includes a routine eye exam, frames and either eyeglass lenses or contact lenses.

Covered children under 19 can get Transitions® lenses to protect their eyes from harmful UV rays and polycarbonate lenses at no additional cost.

You've got access

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

You can register at anthem.com or on the Anthem Anywhere mobile app — your simple and convenient solution to managing your health.

Frequently asked questions (FAQ)

Can I keep my current doctor?

Yes, you can. But keep in mind that you get the most out of your benefits if you choose a doctor in your plan. Some plans cover only services from doctors in your plan, which means you pay for the full cost if you see a doctor outside of the plan. Other plans cover services from doctors outside the plan — but your plan pays more of the cost when you see a doctor in your plan. Be sure to check the details of your plan.

To find out if your doctor is in the plan, or to find a new doctor in the plan, go to our *Find a Doctor* tool on **anthem.com**. You can search by specialty and check a doctor's training, certifications and member reviews. Be ready to enter your plan name to view the doctors that serve your plan. You can also use *Find a Doctor* on your smartphone.

How do I enroll?

Your employer has chosen an alternative enrollment process rather than using our standard enrollment form. Your Benefits Administrator or Human Resources Representative will be able to provide you with plan enrollment instructions.

How do I use my health plan when I need care?

After you enroll, your member ID card will come in the mail. Be sure to bring it with you to the doctor or pharmacy. You can also show a copy of your ID card from the Anthem mobile app.

Is preventive care covered?

Yes, preventive care from a doctor in the plan is covered at 100%. It's very important to take care of your health with regular checkups even when you feel fine. So talk to your doctor about screenings and immunizations that you may need to protect your health.

Can I manage my plan and health care on anthem.com?

Yes. As soon as you become a member, you'll be able to register at **anthem.com** or on the Anthem mobile app. It's designed to help you manage your health care and your benefits simply and conveniently. Many of our members find these self-service tools helpful:

- Check on your claims.
- Find a doctor.
- Check the price of a drug and refill a presciption.
- Track your health care spending.
- Compare quality and costs at hospitals and other facilities.

Visit **anthem.com/guidedtour** to watch a video explaining how our website can help you.

Can I use my plan when I am traveling?

When you travel, you have access to care anywhere in the country. Plus, if you are going out of the country, you have access to care abroad through the BlueCard Worldwide® program.

Do I have health and wellness benefits with my plan?

Yes. In fact, we have a set of tools and resources that can help you reach your health goals. They can also save you money on products and services for your health.

Check out these health and wellness programs your employer is providing in addition to your health benefits:

Case Management — If you are hospitalized or have a serious health condition that needs extra care, a nurse care manager will help answer your questions, work to coordinate your care, and help you effectively use your health benefits.

Behavioral Health Resource — Work with licensed mental health professionals who are available 24/7 to help you deal with behavioral health issues.

How can Anthem help me save money?

You'll save money every time you go to a doctor in your plan – they've agreed to charge lower rates for Anthem members. But we'll also help save you money before you go to the doctor.

At **anthem.com**, you can compare how much a medical procedure will cost at different locations. Plus, all members get discounts on health-related products. You can even print your

Frequently asked questions (FAQ)

own coupons for healthier groceries. Check out these cost saving programs your employer is also offering.

Home Delivery Pharmacy — You can save money and time by having your prescriptions delivered to your home.

LiveHealth Online — Using LiveHealth Online, you can have a video visit with a board-certified doctor or therapist on your smartphone, tablet or computer with a webcam. It's easy to use and there when you need it. All you have to do is sign up to use it at **livehealthonline.com** or download the app.

Your plan details

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

Your Summary of Benefits

Diocese of Covington
Blue Access® (PPO)
Effective 07/01/2017

Covered Benefits	Network	Non-network
Deductible (Single/Family)	$400/$800	$800/$1,600
Out-of-Pocket Maximum (Single/Family)	$3,000/$6,000	$6,000/$12,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician (PCP)/ Specialty Care Physician (SCP) Including Office Surgeries and allergy serum: • allergy injections (PCP and SCP) • allergy testing • MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, **and non-maternity related Ultrasounds**	$25/$25 No copayment/coinsurance 20% 20%	40% 40% 40% 40%
Preventive Care Services Services include but are not limited to: Routine Exams, Pelvic Exams, Pap testing, PSA tests, Immunizations[1], Annual diabetic eye exam, Vision and Hearing screenings • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility	 No copayment/coinsurance No copayment/coinsurance	 40% 40%
Emergency and Urgent Care **Emergency Room Services** • **facility/other covered services** (copayment waived if admitted) **Urgent Care Center Services** • MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, • Allergy injections • Allergy testing	 $100 $35	 $100 $35
Inpatient and Outpatient Professional Services Include but are not limited to: • Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams	20%	40%
Blue 3.0		

Your Summary of Benefits

Covered Benefits	Network	Non-network
Inpatient Facility Services Unlimited days except for: • 60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) • 90 days Network/Non-Network combined for skilled nursing facility	20%	40%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	20%	40%
Other Outpatient Services (Combined Network & Non-Network limits) including but not limited to: • Non Surgical Outpatient Services for example: MRIs, C-Scans, Chemotherapy, Ultrasounds, and other diagnostic outpatient services. • Home Care Services 90 visits (excludes IV Therapy) • Durable Medical Equipment and Orthotics (excluding Prosthetic Devices, Limbs and Medical Supplies) • Prosthetic Devices • Prosthetic Limbs • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	20% No copayment/coinsurance 20%	40% No copayment/coinsurance 20%
Outpatient Therapy Services **(Combined Network & Non-Network limits apply)** • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: • Cardiac Rehabilitation • Pulmonary Rehabilitation • Physical Therapy: 20 visits • Occupational Therapy: 20 visits • Manipulation Therapy: 12 visits • Speech therapy: 20 visits	 $25/$25 20%	 40% 40%
Accidental Dental:	Copayments/Coinsurance based on setting where covered services are received	40%

Your Summary of Benefits

Covered Benefits	Network	Non-network
Behavioral Health: **Mental Illness and Substance Abuse[2]** • Inpatient Facility Services • Inpatient Professional Services • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services. Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional	 0% 0% No copayment/coinsurance No copayment/coinsurance	 40%
Human Organ and Tissue Transplants[3] • Acquisition and transplant procedures, harvest and storage	No copayment/coinsurance	50%
Prescription Drug Options: **Network Tier structure equals 1/2/3** • **Network Retail Pharmacies:** (30-day supply) Includes diabetic test strip • **Anthem Rx Direct Mail Service:** (90-day supply) Includes diabetic test strip **Medicare Rx - Wrap** **Specialty Medications** must be obtained via our Specialty Pharmacy network in order to receive network level benefits.	 $10/$30/50% $20/$70/$125	 50%, min $60[5] Not covered
Lifetime Maximum	Unlimited	Unlimited

Notes:

- Flat dollar copayments are excluded from the out-of-pocket limits. Also Prescription Drug deductibles/copayments/coinsurance and Non-network Human Organ and Tissue Transplants are excluded from the out-of-pocket limits.
- Deductible(s) apply only to covered medical services listed with a percentage (%) coinsurance. However, the deductible does not apply to Emergency Room Services where a copayment and percentage (%) coinsurance applies and may not apply to some Behavioral Health services where coinsurance applies.
- Network and Non-network deductibles, copayments, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- Dependent Age: to end of the month which the child attains age 26
- Specialist copayment is applicable to all Specialists excluding General Physicians, Internist, Pediatricians, OB/GYNs and Geriatrics or any other Network Provider as allowed by the plan.
- When allergy injections are rendered with a Physicians Home and Office Visit, only the Office Visit cost share applies. When the Office Visit cost share is a % coinsurance, deductible and coinsurance apply to allergy injections.
- No copayment/coinsurance 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.
- PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network provider as allowed by the plan.
- SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.
- Certain diabetic and asthmatic supplies have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies except diabetic test strips.
- Autism Spectrum Disorder is covered based on the state law for members age 1 through 21
- Benefit period = calendar year

Your Summary of Benefits

- Mammograms (Routine), Diabetic Education and Medical Nutritional Therapy are no copayment/coinsurance in Network office and outpatient facility settings.
- Behavioral Health Services: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.
- Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits are covered.
- Physical and Occupational Therapy in the office setting are subject to the PCP cost share.

1 These covered services are not subject to the deductible/copayment if you have a flat dollar copayment and if rendered without an office visit.
2 We encourage you to refer to the Schedule of Benefits for limitations.
3 Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.

5 Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.

Precertification:
Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.

Pre-existing Exclusion Period:
We will not provide benefits for services, supplies or charges for any pre-existing condition for the time period specified below (subject to HIPAA portability requirements and excludes Members under age 19):

12 months after the member's enrollment date

A pre-existing condition is a condition (mental or physical) which was present and for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on the member's enrollment date. Pregnancy and domestic violence are not considered a pre-existing condition. Genetic information may not be used as a condition in the absence of a diagnosis.

Grandfathered Health Plan
Anthem Blue Cross and Blue Shield believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections of the Affordable Care Act apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Anthem Blue Cross and Blue Shield at the telephone number printed on the back of your member identification card, or contact your group benefits adminstrator if you do not have an identifiication card. For ERISA plans, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or *www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. For nonfederal governmental plans, you may also contact the U.S. Department of Health and Human Services at www.healthcare.gov*.

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

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

Blue View Vision℠

Diocese of Covington

Anthem BlueCross BlueShield

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
Eyeglass Frames			
One pair of eyeglass frames	$130 allowance, then 20% off any remaining balance	Up to $45 allowance	Once every 24 months
Eyeglass Lenses *(instead of contact lenses)*			
One pair of standard plastic prescription lenses: • Single vision lenses • Bifocal lenses • Trifocal lenses	 $20 copay $20 copay $20 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.			
• Transitions® 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 *(instead of eyeglass 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.			
• Elective conventional (non-disposable) OR • Elective disposable OR • Non-elective (medically necessary)	$130 allowance, then 15% off any remaining balance $130 allowance *(no additional discount)* Covered in full	Up to $105 allowance Up to $105 allowance Up to $210 allowance	Once every 12 months

This is a primary vision plan with benefits intended to cover only corrective eyewear. 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)

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.
	• Transitions lenses (Adults)
	• Standard Polycarbonate (Adults)
	• Tint (Solid and Gradient)
	• UV Coating
	• Progressive Lenses[1]
	  • Standard
	  • Premium Tier 1
	  • Premium Tier 2
	  • Premium Tier 3
	• Anti-Reflective Coating[2]
	  • Standard
	  • Premium Tier 1
	  • Premium Tier 2
	• Other Add-ons
		$75
		$40
		$15
		$15
		
		$65
		$85
		$95
		$110
		
		$45
		$57
		$68
		20% off retail price

Additional Pairs of Eyeglasses Anytime from any Blue View Vision network provider.	• Complete Pair • Eyeglass materials purchased separately	40% off retail price 20% off retail price
Eyewear Accessories	• Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc.	20% off retail price
Conventional Contact Lenses	• Discount applies to materials only	15% off retail price

[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.

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:

GLASSES.COM · contactsdirect · LensCrafters · Pearle Vision · Target Optical · Sears Optical · JCPenney optical

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 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

Take care of yourself. Use your preventive care benefits.

Anthem BlueCross BlueShield

Getting regular checkups and exams can help you stay well and catch problems early. It may even save your life.

Our health plans offer the services listed in this preventive care flier at no cost to you.[1] When you get these services from doctors in your plan's network, you don't have to pay anything out of your own pocket. You may have to pay part of the costs if you use a doctor outside the network.

Preventive versus diagnostic care

What's the difference? Preventive care helps protect you from getting sick. Diagnostic care is used to find the cause of existing illnesses. For example, say your doctor suggests you have a colonoscopy because of your age when you have no symptoms. That's preventive care. On the other hand, say you have symptoms and your doctor suggests a colonoscopy to see what's causing them. That's diagnostic care.

Child preventive care

Preventive physical exams

Screening tests:

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

Immunizations:

- Diphtheria, tetanus and pertussis (whooping cough)
- Haemophilus influenza type b (Hib)
- Hepatitis A and Hepatitis B
- Human papillomavirus (HPV)
- Influenza (flu)
- Measles, mumps and rubella (MMR)
- Meningococcal (meningitis)
- Pneumococcal (pneumonia)
- Polio
- Rotavirus
- Varicella (chickenpox)

Women's preventive care:

- Well-woman visits
- Breast cancer, including exam, mammogram, and genetic testing for BRCA 1 and BRCA 2 when certain criteria are met[3]
- Breast-feeding: primary care intervention to promote breast-feeding support, supplies and counseling (female)[4,5,6]
- Contraceptive (birth control) counseling
- FDA-approved contraceptive medical services provided by a doctor, including sterilization
- Counseling related to chemoprevention for women with a high risk of breast cancer
- Counseling related to genetic testing for women with a family history of ovarian or breast cancer
- HPV screening[5]
- Screening and counseling for interpersonal and domestic violence
- Pregnancy screenings: includes, but is not limited to, gestational diabetes, hepatitis, asymptomatic bacteriuria, Rh incompatibility, syphilis, iron deficiency anemia, gonorrhea, chlamydia and HIV[5]
- Pelvic exam and Pap test, including screening for cervical cancer

The preventive care services listed are recommendations as a result of the Affordable Care Act (ACA, or health care reform law). The services listed may not be right for every person. Ask your doctor what's right for you, based on your age and health condition(s).

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

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Adult preventive care

Preventive physical exams

Screening tests:

- Alcohol misuse: related screening and behavioral counseling
- Aortic aneurysm screening (men who have smoked)
- Behavioral counseling to promote a healthy diet
- Blood pressure
- Bone density test to screen for osteoporosis
- Cholesterol and lipid (fat) level
- Colorectal cancer, including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and related prep kit and CT colonography (as appropriate)
- Depression screening
- Hepatitis C virus (HCV) for people at high risk for infection and a one-time screening for adults born between 1945 and 1965
- Type 2 diabetes screening
- Eye chart test for vision[2]
- Hearing screening
- Height, weight and BMI
- HIV screening and counseling
- Lung cancer screening for those ages 55-80 who have a history of smoking 30 packs per year and still smoke, or quit within the past 15 years[7]
- Obesity: related screening and counseling
- Prostate cancer, including digital rectal exam and PSA test
- Sexually transmitted infections: related screening and counseling
- Tobacco use: related screening and behavioral counseling
- Violence, interpersonal and domestic: related screening and counseling

Immunizations:

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

A word about pharmacy items

For 100% coverage of over-the-counter (OTC) drugs and other pharmacy items listed below, the person receiving the item(s) must meet the age and other specified criteria. You need to work with your in-network doctor or other health care provider to get a prescription for the item(s) and take the prescription to an in-network pharmacy. Even if the item(s) do not "need" a prescription to purchase them, if you want the item(s) covered at 100%, you have to have the prescription.

Child preventive drugs and other pharmacy items — age appropriate:

- Dental fluoride varnish to prevent tooth decay of primary teeth for children from birth to 5 years old
- Fluoride supplements for children from birth through 6 years old

Adult preventive drugs and other pharmacy items — age appropriate:

- Aspirin use for the prevention of cardiovascular disease including aspirin for men ages 45-79 and women ages 55-79
- Colonoscopy prep kit (generic or OTC only) when prescribed for preventive colon screening
- Tobacco cessation products including select generic prescription drugs, select brand-name drugs with no generic alternative, and FDA-approved over-the-counter products, for those 18 and older
- Vitamin D for men and women over 65

Women's preventive drugs and other pharmacy items — age appropriate:

- Contraceptives including generic prescription drugs, brand-name drugs with no generic alternative, and over-the-counter items like female condoms or spermicides[5,8,9]
- Low dose aspirin (81 mg) for pregnant women who are at increased risk of preeclampsia
- Folic acid for women 55 years old or younger
- Breast cancer risk-reducing medications following the U.S. Preventive Services Task Force criteria (such as tamoxifen and raloxifene)[7]

1 The range of preventive care services covered at no cost share when provided in-network are designed to meet the requirements of federal and state law. The Department of Health and Human Services has defined the preventive services to be covered under federal law with no cost share as those services described in the U.S. Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and certain guidelines for infants, children, adolescents and women supported by the Health Resources and Services Administration (HRSA) Guidelines. You may have additional coverage under your insurance policy. To learn more about what your plan covers, see your ***Certificate of Coverage*** or call the Customer Service number on your ID card.

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

3 Check your medical policy for details.

4 Breast pumps and supplies must be purchased from an in-network medical provider for 100% coverage; we recommend using an in-network durable medical equipment (DME) supplier.

5 This benefit also applies to those younger than 19.

6 Counseling services for breast feeding (lactation) can be provided or supported by an in-network (participating) provider such as a pediatrician, ob-gyn, family medicine doctor, and hospitals with no member cost-share expense (deductible, copay, coinsurance). Contact the provider to determine if lactation counseling services are available.

7 You may be required to get prior authorization for these services.

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

9 The cost share will be waived if the use of the multi-source brand is deemed medically necessary by your doctor.

Anthem BlueCross BlueShield

A Guide to Your Explanation of Benefits (EOB)

What's an EOB?

The EOB explains how your benefits pay for your care — it's not a bill. We send you an EOB when a doctor or hospital files a claim for your care. For every doctor visit or service, your EOB explains the services, the cost of those services and the benefits from your plan that may be applied to the care you received. It's as simple as that.

You may not always get an EOB in the mail. For example, if you only need to pay a copay for a doctor visit or other service, we won't send you an EOB. But you can still view your medical EOBs online at **anthem.com**. You can even choose to go completely paperless for all medical EOBs by logging in at **anthem.com** and choosing **Email Preferences** in your account profile.

Going paperless not only helps the environment, but saves you from unnecessary clutter. Plus, you'll find searching through your EOB a lot easier online. So consider making the switch today — it's free and only takes a few minutes!

How much do I owe?

When you get an EOB, this is probably the first thing you look for. Our new EOBs make it easier to find all the information you need to help you better manage your health care services and what you spend for care.

On the upper right-hand side is a sample of an EOB you might get. We've put boxes around key sections of the EOB, and included explanations.* To find out more about your EOB, see the other side of this flier.

Medical services payment detail
as of 2/01/2015

Services provided for:	Claim number	Provider	Network status	Patient account	1
Jane Q. Member (Self)	1234567891234	Deaconess Hospital	Out-of-network	98765432198765	

						Your health benefits paid			You pay				
Day you got care	Services received 2	Reason code	Amount charged by your provider	Your discounts –	Amount due to your provider = 3	Another insurance paid –	Anthem paid –	Your health account paid – 4	Copay +	Deductible +	Coinsurance +	Services not covered +	Total you pay (or may have paid) =
1/6/15	Office visit	135	175.00	-77.00	98.00	0.00	-73.00	0.00	25.00	0.00	0.00	0.00	25.00
1/6/15	Lab service	038	68.00	-50.50	17.50	0.00	0.00	0.00	0.00	17.50	0.00	0.00	17.50
1/6/15	Lab service	038 067	55.00	-39.50	15.50	0.00	-6.40	0.00	0.00	7.50	1.60	0.00	9.10
Subtotal			298.00	-167.00	131.00	0.00	-79.40	0.00	25.00	25.00	1.60	0.00	51.60

038: This amount has been applied to the member's medical deductible.
067: This balance is the member's coinsurance responsibility.
135: This amount is the member's copayment amount.

Total for Jane	298.00	-167.00	131.00	0.00	-79.40	0.00	25.00	25.00	1.60	0.00	51.60

Claim summary

Section 1 — Claim tracking details.

Shows who received the service and the relationship to the cardholder. Contains information that you can use to track the specific service and what the payment is for.

Section 2 — Service details

Includes the day you got care, the service received and any explanation of payment reason codes.

Section 3 — Charges

What you'll find in the *Charges* section:

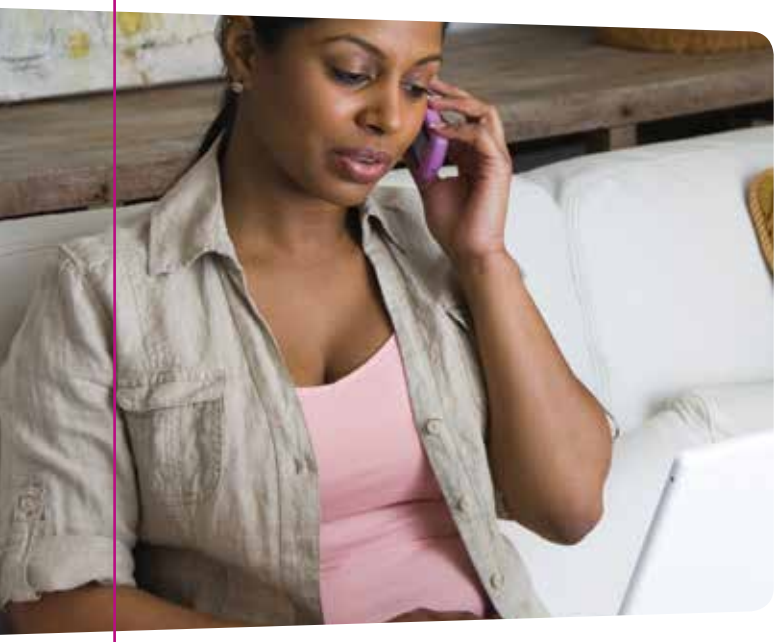
- The amount billed by the provider and your network discounts.
- How much is owed to the provider, plus any coinsurance or copays you owe for this claim.

Section 4 — Payments

What you'll find in the *Payments* section:

- How much another insurance plan pays. This section only appears if we are the secondary insurance carrier.
- How much your health plan owes the provider.
- How much your health account paid. This only appears if your claim has money coming from a Health Reimbursement Account (HRA) or other health accounts.
- Your copay. This is the flat-dollar amount you may pay for certain services, such as doctor visits.
- How much you need to pay as part of your deductible (the flat-dollar amount you may pay for certain services before your health plan begins to pay). Some plans may have more than one deductible.
- Your coinsurance. This is the fixed percentage you may pay for certain services. Some plans may require you to pay a deductible first.
- The cost for services that aren't covered under your plan. The provider may bill you for these charges.

*Please note that some of these sections may not appear on your EOB. Also, your EOB may include a check.



Year-to-date summary

Section 1 — Deductible details

Shows how much you've paid so far and how much you still need to pay for your deductible.

Section 2 — Out-of-pocket details

Gives you the in- and out-of-network totals of the dollars applied to the individual and family out-of-pocket maximum.

2015 Year-to-date Information — *To learn more about what's covered, see your benefits booklet.*

It's important to know how close you are to meeting your plan's deductible and out-of-pocket maximum.

Plan deductible

Individual (1)	In-network maximum	Applied to date	Remaining deductible	Out-of-network maximum	Applied to date	Remaining deductible
Jane Q. Member	$500.00	-$500.00	$0.00	$750.00	-$750.00	$0.00
An individual deductible may be different than your deductible for all covered family members combined.						
Family	$2,000.00	-$1,000.00	$1,000.00	$2,500.00	-$850.00	$1,650.00

Out-of-pocket (OOP) maximum

Individual (2)	In-network maximum	Applied to date	Remaining OOP	Out-of-network maximum	Applied to date	Remaining OOP
Jane Q. Member	$1,000.00	-$510.00	$490.00	$2,000.00	-$1,060.00	$940.00
An individual out-of-pocket maximum may be different than your out-of-pocket maximum for all covered family members combined.						
Family	$3,000.00	-$555.00	$2,445.00	$5,000.00	-$1,060.00	$3,940.00

Register at anthem.com and sign up to receive your EOBs online.

HOME DELIVERY ORDER FORM

EXPRESS SCRIPTS®

1 Member information: Please verify or provide member information below.

Member ID: _____
Group: _____
Name: _____
Street Address: _____
Street Address: _____
Street Address: _____
City, ST, ZIP: _____

☐ Please send me e-mail notices about the status of the enclosed prescription(s) and online ordering at:
_____@_____.____

☐ New shipping address:

_____

_____

_____

(Express Scripts will keep this address on file for all orders from this membership until another shipping address is provided by any person in this membership.)

Daytime phone: ☐☐☐ ☐☐☐ ☐☐☐☐

Evening phone: ☐☐☐ ☐☐☐ ☐☐☐☐

FOLD HERE

2 Patient/doctor information: Complete **one section** for each person with a prescription. If a person has prescriptions from more than one doctor, complete a new section for each doctor (additional sections are on back). Send all prescriptions in one envelope.

First name ☐☐☐☐☐☐☐☐☐☐☐☐☐

Last name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Birth date (MM/DD/YYYY) ☐☐ ☐☐ ☐☐☐☐

Sex ☐ M ☐ F

Patient's relationship to member ☐ Self ☐ Spouse ☐ Dependent

Doctor's last name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

1st initial ☐

Doctor's phone number ☐☐☐ ☐☐☐ ☐☐☐☐

First name ☐☐☐☐☐☐☐☐☐☐☐☐☐

Last name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Birth date (MM/DD/YYYY) ☐☐ ☐☐ ☐☐☐☐

Sex ☐ M ☐ F

Patient's relationship to member ☐ Self ☐ Spouse ☐ Dependent

Doctor's last name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

1st initial ☐

Doctor's phone number ☐☐☐ ☐☐☐ ☐☐☐☐

FOLD HERE

3 Complete your order: You can pay by e-check, check, money order, or credit card. Make checks and money orders **payable to Express Scripts,** and write your member ID number on the front. You can enroll for e-check payments and price medications at Express-Scripts.com, or call the Member Services phone number found on your ID card.

Number of prescriptions sent with this order: ☐

Payment options: ☐ e-check ☐ Payment enclosed ☐ Credit card ☐ Send bill

For credit card payments:
☐ Visa ☐ MC ☐ Discover ☐ Amex ☐ Diners

Credit card number ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiration date ☐☐ ☐☐
M M Y Y

X _____
Cardholder signature

☐ I authorize Express Scripts to charge this card for all orders from any person in this membership.

☐ Rush the mailing of this shipment ($21, cost subject to change). NOTE: This will only rush the shipping, not the processing of your order. Street address is required; P.O. box is not allowed.

WLPMSNWB

Mailing instructions are provided on the back of this form.

Patient/doctor information continued

First name | Last name

Birth date (MM/DD/YYYY) | Sex ☐ M ☐ F | Patient's relationship to member ☐ Self ☐ Spouse ☐ Dependent

Doctor's last name | 1st initial | Doctor's phone number

First name | Last name

Birth date (MM/DD/YYYY) | Sex ☐ M ☐ F | Patient's relationship to member ☐ Self ☐ Spouse ☐ Dependent

Doctor's last name | 1st initial | Doctor's phone number

FOLD HERE

Important reminders and other information

Check that your doctor has prescribed the maximum days' supply allowed by your plan (not a 30-day supply), plus refills for up to 1 year, if appropriate. Also, ask your doctor or pharmacist about safe, effective, and less expensive generic drugs.

Complete the Health, Allergy & Medication Questionnaire.

There may be a limit to the balance that you can carry on your account. If this order takes you over the limit, you must include payment. Avoid delays in processing by using e-checks or a credit card. (See Section 3 for details.)

If you are a Medicare Part B beneficiary AND have private health insurance, check your prescription drug benefit materials to determine the best way to get Medicare Part B drugs and supplies. Or, call Member Services at the phone number found on your ID card. To verify Medicare Part B prescription coverage, call Medicare at 1.800.633.4227.

Express Scripts will make all possible efforts, as appropriate by law, to substitute generic formulations of medication, unless you or your doctor specifically directs otherwise.

☐ Pennsylvania and Texas laws permit pharmacists to substitute a less expensive generic equivalent for a brand-name drug unless you or your doctor directs otherwise.

Check the box if you do not wish a less expensive brand or generic drug.

Please note that this applies only to new prescriptions and to any refills of that prescription.

For additional information or help, visit us at Express-Scripts.com or call Member Services at the phone number found on your ID card. TTY/TDD users should call 1.800.759.1089.

Federal law prohibits the return of dispensed controlled substances.

FOLD HERE

Program: <<XXXXXXXXX>>

Place your prescription(s), this form, and your payment in an envelope. Do not use staples or paper clips.

EXPRESS SCRIPTS
PO BOX 66558
ST. LOUIS, MO 63166-6558

WLPMSNWB

Anthem BlueCross BlueShield

Be a smart shopper – it pays to compare

Hospital 1	Procedures	Hospital 2
$3,000	Bronchoscopy	$5,000
$300	Chest CT scan	$1,000
$25,000	Hip replacement	$36,000
$25,000	Knee replacement	$37,000

Sample cost comparison*

Different doctors and hospitals may charge different amounts for the same service. So shop around using the **Estimate Your Cost** tool to see costs based on your own benefits. You can also compare the quality of different procedures.

Know your costs before you get care

Go to **anthem.com** and log in to use the **Estimate Your Cost** tool. Search for the procedure you need and the tool will help guide you.

For even quicker cost comparison, use the **Anthem Blue Cross and Blue Shield** mobile app.

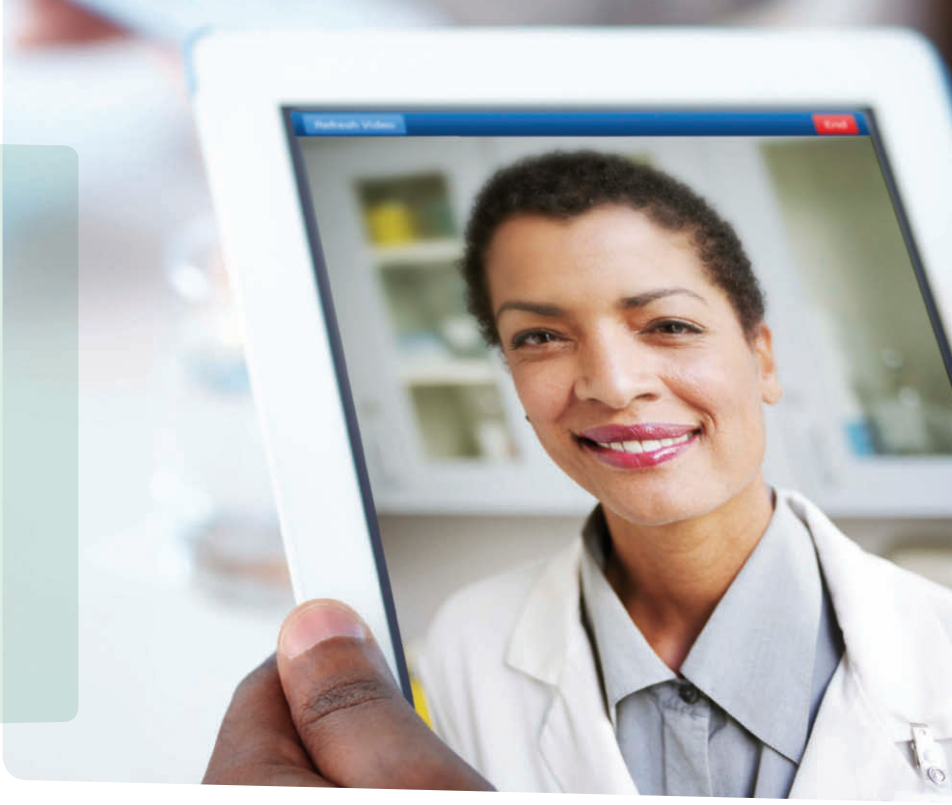
Download on the App Store | ANDROID APP ON Google play

* These rates are national averages for the services listed. Your experience may be different depending on your specific plan, the services you receive and the health care provider. Rates as of 2014.

11916ANMENABS VPOD Rev. 3/16

LiveHealth Online

Quick and easy access to a doctor 24/7



Have you ever been at work and didn't feel well? Maybe you had a fever or a sore throat but you didn't have time to leave and see your doctor or go to urgent care. Now, with LiveHealth Online, you can see a board-certified doctor in minutes.

Just use your smartphone, tablet or computer with a webcam. It's so convenient, almost 90% of people who've used it feel they saved two hours or more and would use it again in the future.[1] Plus, online visits using LiveHealth Online are already part of your Anthem Blue Cross and Blue Shield benefits. To start using LiveHealth Online, all you need to do is sign up at **livehealthonline.com** or download the app.

Sign up for free today and get:

1. **24/7 access to doctors.** They can assess your condition, provide treatment options and even send a prescription to the pharmacy of your choice, if needed.[2] It's a great way to get care when your doctor isn't available.
2. **Medical care when you need it.** For things like the flu, a cold, sinus infection, pink eye, rashes, fever and more.
3. **Convenience.** Since there are no appointments or long waits. In fact, most people are connected to a doctor in about 10 minutes or less.

Doctors using LiveHealth Online typically charge $49 or less per visit, depending on your health plan.

LiveHealth Online Psychology

An easy, convenient way to see a therapist or psychologist in just a few days

If you're feeling stressed, worried, or having a tough time, you can talk to a licensed psychologist or therapist through video using LiveHealth Online Psychology. It's easy to use, private and, in most cases, you can see a therapist within four days or less.[3] All you have to do is sign up at **livehealthonline.com** or download the app to get started. The cost is similar to what you'd pay for an office therapy visit.

Make your first appointment — when it's easy for you

- Use the app or go to **livehealthonline.com** and log in. Select **LiveHealth Online Psychology** and choose the therapist you'd like to see.
- Or, call LiveHealth Online at **1-844-784-8409** from 7 a.m. to 11 p.m.
- You'll get an email confirming your appointment.

Anthem BlueCross BlueShield

LiveHealth® ONLINE

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LiveHealth Online: what you need to know

What kind of doctors can you see on LiveHealth Online?

Doctors on LiveHealth Online are:

- Board certified with an average of 15 years of practicing medicine
- Mainly primary care physicians
- Specially trained for online visits

When can you use LiveHealth Online?

LiveHealth Online is a great option for care when your own doctor isn't available and more convenient than a trip to the urgent care. With LiveHealth Online, you can receive medical care for things like:

- Cold and flu symptoms, such as a cough, fever and headaches
- Allergies
- Sinus infections and more

How do I pay for an online visit using LiveHealth Online?

LiveHealth Online accepts Visa, MasterCard and Discover cards as payment for an online doctor visit. Keep in mind that charges for prescriptions aren't included in the cost of your doctor visit.

LiveHealth Online Psychology

What conditions can be treated when you have a visit with a psychologist or therapist?

You can get help for these types of conditions:

- Stress
- Anxiety
- Depression
- Family or relationship issues
- Grief
- Panic attacks
- Stress from coping with a sickness

How much does a therapist visit cost?

The cost should be similar to what you'd pay for an office therapy visit, depending on your benefits, copay or coinsurance. You'll see what you owe before you start a visit and any cost is charged to your credit card. The cost is the same no matter when you have the visit — whether it's a weekday, the weekend, evening or a holiday.

How do I decide which therapist to see?

After you log in at **livehealthonline.com** or with the app, select **LiveHealth Online Psychology**. Next, you can read profiles of therapists and psychologists. Once you select the one you would like to see, schedule a visit online or by phone. At the end of the first visit, you can set up future visits with the same therapist if both of you feel it's needed. You always have the choice of the therapist you want to see.

What else do I need to know about LiveHealth Online Psychology?

- You must be at least 18 years old to see a therapist online and have your own LiveHealth Online account.
- Psychologists and therapists using LiveHealth Online do not prescribe medications.
- Visits usually last about 45 minutes.

Get started today

It's quick and easy to sign up for LiveHealth Online. Just go to **livehealthonline.com** or download the mobile app at Google Play™ or the App Store℠.

Download on the App Store

ANDROID APP ON Google play

Take your benefits with you

With the BlueCard® PPO and Blue Cross Blue Shield Global Core programs

What happens if you're away from home and you need care right away? As an Anthem Blue Cross and Blue Shield (Anthem) member, you have access to care across the country through the **BlueCard® PPO Program**. This includes **92% of doctors and 96% of hospitals in the U.S.**[1]

If you're outside the U.S., you can use the **Blue Cross Blue Shield Global Core Program**. It gives you access to doctors and hospitals in over 190 countries and territories around the world.[2]

How to access care across the U.S.

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

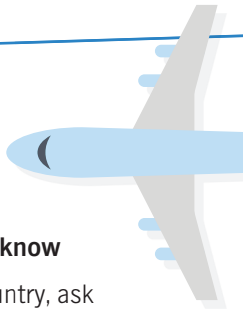
Go to **anthem.com**, log in and use the **Find a Doctor** tool to search for a BlueCard PPO Program doctor or hospital.

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

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

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

Traveling?



Here's what you need to know

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

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

Anthem BlueCross BlueShield

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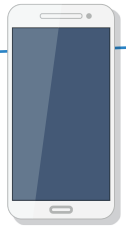
How to access care around the world

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

If you're outside the U.S. and need care, you can:

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



Download the Blue Cross Blue Shield Global Core app today

With the app, you can:

- Search for a doctor or hospital.[3]
- Get medical terms and phrases for many symptoms translated — and even use an audio feature to play the translation.[3]
- Find a drug's generic name, local brand name and if it's available.
- Get information about how to find and contact a U.S. embassy.

Download on the App Store | ANDROID APP ON Google play

What if you get care from a doctor or hospital who is not part of the Blue Cross Blue Shield Global Core Program?

1. You will need to pay up front in full for your care.
2. Download an international claim form at **www.bcbsglobalcore.com** or get a form by calling Member Services at the number on your ID card.
3. Fill out the claim form and send it with the original bills to the Blue Cross Blue Shield Global Core Service Center.

1 Blue Cross Blue Shield Association website, *About Blue Cross Blue Shield Association* (accessed January 2016): bcbs.com/about-the-association/.

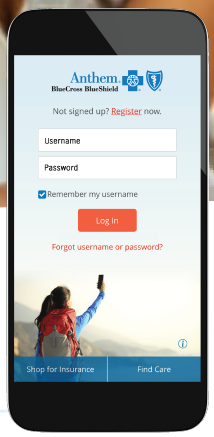
2 Blue Cross Blue Shield Association website, Blue Facts: *Healthcare Coverage Designed For Your Community, Accessible Across The Country* (accessed January 2016): bcbs.com/healthcare-news/press-center/blue-facts.html.

3 Using the BlueCard Worldwide app itself does not require an internet connection. However, using GPS for mapping or downloading an audio translation does require an internet connection.

The Blue Cross Blue Shield Global Core program was formerly known as BlueCard Worldwide®.

You've got quick access to your health care!

Register on anthem.com or the Anthem Anywhere mobile app.*



From your computer

- Go to anthem.com and select the icon above **Already a member? Sign in here.**
- Provide the personal information requested
- Create a username and password
- Set your email preferences
- Follow the prompts to complete your registration

From your mobile device

- Download the free Anthem Anywhere mobile app and select **Register**
- Confirm your identity
- Create a username and password
- Set your email preferences
- Follow the prompts to complete your registration

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

Anthem BlueCross BlueShield

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

13206ANMENABS VPOD 9/16

Anthem BlueCross BlueShield

Looking for a doctor?

Finding one online is fast and easy

Use our online **Find a Doctor** tool to look for doctors, hospitals, labs and other health care providers in your Anthem Blue Cross and Blue Shield plan. Check if your favorite doctor is part of your plan, or look for one near you. Avoid getting care from doctors outside of your plan if you can — it will cost you more or your plan may not cover it all.

Here's all you need to do:

If you're a member

1

Go to anthem.com, select the member icon and log in.

Under *Useful Tools* on the right, select **Find a Doctor**.

If you're not a member yet

Go to anthem.com.

Select **Menu** and then choose **Find a Doctor**.

Next, select a type of doctor, place or name.

Select **Search**.

2

First answer a few questions, so we can help find you the right plan and doctor in your plan. Then enter or select the plan/network*.

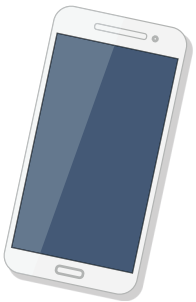
Next, select a type of doctor, place or name.

Select **Search**.

3

Select a doctor to see more information, such as:

- Training
- Specialties
- Languages spoken
- Address (including a map)
- Phone number



Going mobile

Use your mobile device to search for doctors, hospitals and more with our free app from the App Store® or Google Play™. Just search for Anthem Anywhere and download the app.

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

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Anthem BlueCross BlueShield

A Guide to Your Explanation of Benefits (EOB)

What's an EOB?

The EOB explains how your benefits pay for your care — it's not a bill. We send you an EOB when a doctor or hospital files a claim for your care. For every doctor visit or service, your EOB explains the services, the cost of those services and the benefits from your plan that may be applied to the care you received. It's as simple as that.

You may not always get an EOB in the mail. For example, if you only need to pay a copay for a doctor visit or other service, we won't send you an EOB. But you can still view your medical EOBs online at **anthem.com**. You can even choose to go completely paperless for all medical EOBs by logging in at **anthem.com** and choosing **Email Preferences** in your account profile.

Going paperless not only helps the environment, but saves you from unnecessary clutter. Plus, you'll find searching through your EOB a lot easier online. So consider making the switch today — it's free and only takes a few minutes!

How much do I owe?

When you get an EOB, this is probably the first thing you look for. Our new EOBs make it easier to find all the information you need to help you better manage your health care services and what you spend for care.

On the upper right-hand side is a sample of an EOB you might get. We've put boxes around key sections of the EOB, and included explanations.* To find out more about your EOB, see the other side of this flier.

Medical services payment detail
as of 2/01/2015

Services provided for:	Claim number	Provider	Network status	Patient account	1
Jane Q. Member (Self)	1234567891234	Deaconess Hospital	Out-of-network	98765432198765	

						Your health benefits paid			You pay				
Day you got care	Services received 2	Reason code	Amount charged by your provider	Your discounts —	Amount due to your provider = 3	Another insurance paid —	Anthem paid —	Your health account paid — 4	Copay +	Deductible +	Coinsurance +	Services not covered +	Total you pay (or may have paid) =
1/6/15	Office visit	135	175.00	-77.00	98.00	0.00	-73.00	0.00	25.00	0.00	0.00	0.00	25.00
1/6/15	Lab service	038	68.00	-50.50	17.50	0.00	0.00	0.00	0.00	17.50	0.00	0.00	17.50
1/6/15	Lab service	038 067	55.00	-39.50	15.50	0.00	-6.40	0.00	0.00	7.50	1.60	0.00	9.10
Subtotal			298.00	-167.00	131.00	0.00	-79.40	0.00	25.00	25.00	1.60	0.00	51.60

038: This amount has been applied to the member's medical deductible.
067: This balance is the member's coinsurance responsibility.
135: This amount is the member's copayment amount.

Total for Jane	298.00	-167.00	131.00	0.00	-79.40	0.00	25.00	25.00	1.60	0.00	51.60

Claim summary

Section 1 — Claim tracking details.

Shows who received the service and the relationship to the cardholder. Contains information that you can use to track the specific service and what the payment is for.

Section 2 — Service details

Includes the day you got care, the service received and any explanation of payment reason codes.

Section 3 — Charges

What you'll find in the *Charges* section:

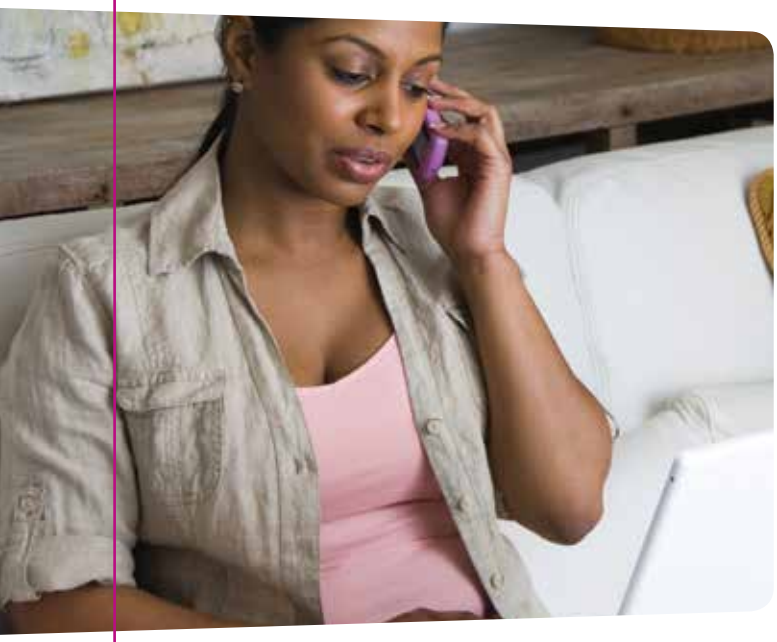
- The amount billed by the provider and your network discounts.
- How much is owed to the provider, plus any coinsurance or copays you owe for this claim.

Section 4 — Payments

What you'll find in the *Payments* section:

- How much another insurance plan pays. This section only appears if we are the secondary insurance carrier.
- How much your health plan owes the provider.
- How much your health account paid. This only appears if your claim has money coming from a Health Reimbursement Account (HRA) or other health accounts.
- Your copay. This is the flat-dollar amount you may pay for certain services, such as doctor visits.
- How much you need to pay as part of your deductible (the flat-dollar amount you may pay for certain services before your health plan begins to pay). Some plans may have more than one deductible.
- Your coinsurance. This is the fixed percentage you may pay for certain services. Some plans may require you to pay a deductible first.
- The cost for services that aren't covered under your plan. The provider may bill you for these charges.

*Please note that some of these sections may not appear on your EOB. Also, your EOB may include a check.



Year-to-date summary

Section 1 — Deductible details

Shows how much you've paid so far and how much you still need to pay for your deductible.

Section 2 — Out-of-pocket details

Gives you the in- and out-of-network totals of the dollars applied to the individual and family out-of-pocket maximum.

2015 Year-to-date Information — *To learn more about what's covered, see your benefits booklet.*

It's important to know how close you are to meeting your plan's deductible and out-of-pocket maximum.

Plan deductible

Individual (1)	In-network maximum	Applied to date	Remaining deductible	Out-of-network maximum	Applied to date	Remaining deductible
Jane Q. Member	$500.00	-$500.00	$0.00	$750.00	-$750.00	$0.00
An individual deductible may be different than your deductible for all covered family members combined.						
Family	$2,000.00	-$1,000.00	$1,000.00	$2,500.00	-$850.00	$1,650.00

Out-of-pocket (OOP) maximum

Individual (2)	In-network maximum	Applied to date	Remaining OOP	Out-of-network maximum	Applied to date	Remaining OOP
Jane Q. Member	$1,000.00	-$510.00	$490.00	$2,000.00	-$1,060.00	$940.00
An individual out-of-pocket maximum may be different than your out-of-pocket maximum for all covered family members combined.						
Family	$3,000.00	-$555.00	$2,445.00	$5,000.00	-$1,060.00	$3,940.00

Register at anthem.com and sign up to receive your EOBs online.

Anthem BlueCross BlueShield

Where to get care

when you need it now

What should you do when you need care right away, but it's not an emergency?

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

First call your primary care doctor

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

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

Choose an option that could save time and money

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

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

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

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

Pick a care facility and call before you go

Ask:

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

What you pay for a visit

Care facility	Cost*
ER	$1200
Retail health clinic	$85
Walk-in doctor's office	$125
Urgent care center	$190
LiveHealth Online	$49

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

When to use the ER

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

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

See the other side for examples of when to go to the ER and when to consider other options. ▶

Deciding where to go

	Who usually provides care	Sprains, strains	Animal bites	X-rays	Stitches	Mild asthma	Minor headaches	Back pain	Nausea, vomiting, diarrhea	Minor allergic reactions	Coughs, sore throat	Bumps, cuts, scrapes	Rashes, minor burns	Minor fevers, colds	Ear or sinus pain	Burning with urination	Eye swelling, irritation, redness or pain	Vaccinations	Cost
Retail health clinic	Physician assistant or nurse practitioner									•	•	•	•	•	•	•	•	•	$85
Walk-in doctor's office	Family practice doctor					•	•	•	•	•	•	•	•	•	•	•	•	•	$125
Urgent care center	Internal medicine, family practice, pediatric and ER doctors	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	$190
LiveHealth Online	Board-certified doctor						•		•	•	•			•	•	•	•		$49

When to go to the ER

Some examples of ER medical emergencies are:

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

Options have different services and costs. Call and ask before you go. Remember you have choices. If it's not an emergency, call your doctor first or the 24/7 NurseLine. The phone number is on your ID card. The nurse on the phone can help you decide what to do next.

If you are an HMO member, you should call your primary care doctor's office or medical group to find out your choices for urgent care.

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

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

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

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

* Internal claims analysis.

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

Let's talk about your privacy and rights

As a member, you have the right to expect the privacy of your personal health information to be protected, consistent with state and federal laws and our policies. And you also have certain rights and responsibilities when receiving your health care.

To learn more about how we protect your privacy, your rights and responsibilities when receiving health care and your rights under the Women's Health and Cancer Rights Act, go to **www.anthem.com/memberrights**. To request a printed copy, please contact your Benefits Administrator or Human Resources representative.

How we help manage your care

To decide if we'll cover a treatment, procedure or hospital stay, we use a process called Utilization Management (UM). UM is a program that lets us make sure you're getting the right care at the right time. Licensed health care professionals review information your doctor has sent us to see if the requested care is medically needed. These reviews can be done before, during or after a member's treatment. UM also helps us decide if the services will be covered by your health plan.

We also use case managers. They're licensed health care professionals who work with you and your doctor to help you learn about and manage your health conditions. They also help you better understand your health benefits.

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

Special Enrollment Rights

There are certain situations when you can enroll in a plan outside the open enrollment period. Open enrollment usually happens only once a year. That's the time you can enroll in a plan or make changes to it. If you choose not to enroll during open enrollment, there are special cases when you're allowed to enroll yourself and your dependents. Special enrollment is allowed:

- ***If you had another health plan that was canceled.*** If you, your dependents or your spouse are no longer eligible for other coverage (or if the employer stops contributing to your health plan), you may be able to enroll with us. You must enroll within 31 days after the other coverage ends (or after the employer stops paying for it).
- For example: You and your family are enrolled through your spouse's coverage at work. Your spouse's employer stops paying for health coverage. In this case, you and your spouse, as well as other dependents, may be able to enroll in a plan.
- ***If you have a new dependent.*** This could mean 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 CHIP coverage because you're no longer eligible.
  - You (or eligible dependents) become eligible to get help from Medicaid or SCHIP for paying part of the cost.

You've got health goals. We've got your back.

Anthem BlueCross BlueShield

An employer may elect to insure or self-fund its group health plan. For self-funded accounts, Anthem Blue Cross and Blue Shield provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. In Ohio, if your employer selects Blue Preferred Primary and elects to insure its group health plan, Blue Preferred Primary is a health insuring corporation product ("HIC"); if your employer selects Blue Preferred Primary and elects to self-fund its group health plan, Anthem provides access to the Blue Preferred Primary network, provides administrative claims payment services only and assumes no financial risk for claims. Please consult your employer for plan funding details.

The benefit descriptions in this plan overview are intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract and are subject to your employer's plan funding arrangement. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.