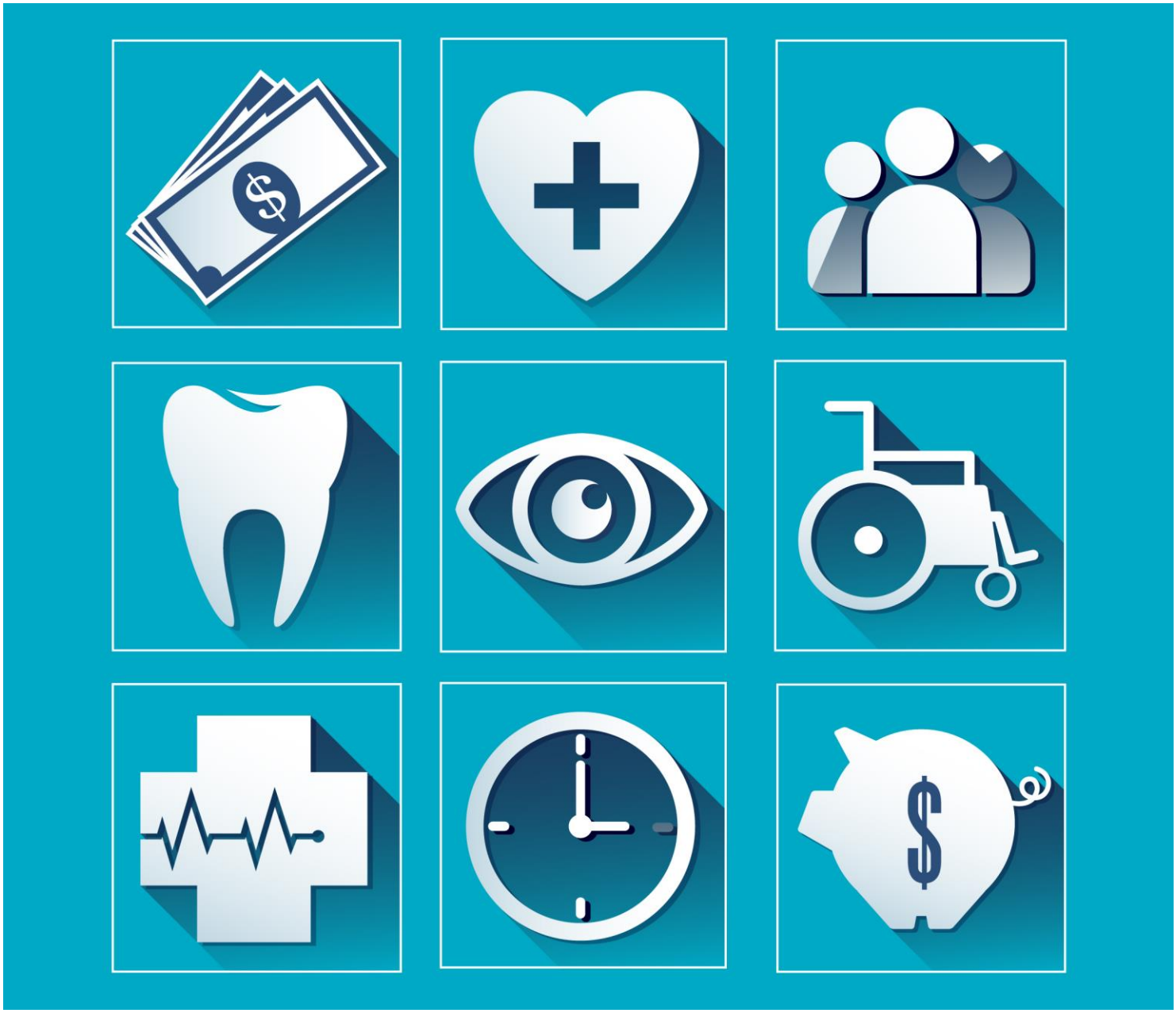
"Providing the best wireless experience to every customer, every time."

OLLIS/AKERS/ARNEY
INSURANCE & BUSINESS ADVISORS

RussellCellular

Employee Benefits Enrollment Guide

Plan Year: 2019 - 2020



Welcome to your 2019 – 2020 Benefits!

Russell Cellular Inc. offers you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

Who is Eligible?

If you are a Russell Cellular Inc. regular full-time employee (working 30 or more hours per week) you are eligible to enroll in the benefits described in this guide. You are eligible first day of the month following a 30 days provisional period plus a 60-day benefits waiting period.

The following family members are eligible for medical, dental, vision and optional life coverage:

Spouse or Domestic Partner*
Child(ren)

**A Domestic Partner Affidavit must be completed, contact your Benefits Department for the form.*

How to Enroll

Log into your Ascentis Employee Self-Service and access your My Self page. Under "Benefits" you will see a selection in red called "Continue 2019-2020 Open Enrollment". Verify your personal information and current benefit elections, you can make any changes if necessary. Once you have made your elections, you will not be able to change them until the next open enrollment period unless you have a qualified change in status.

When to Enroll

The open enrollment period runs from **June 14, 2019** through **June 26, 2019**. The benefits you elect during open enrollment will be effective from July 1, 2019 through June 30, 2020.

How to Make Changes

Unless you have a qualified change in status, you cannot make changes to the benefits you elect until the next open enrollment period. Qualified changes in status include, for example: marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, change in residence, commencement or termination of adoption proceedings, change in employment status or change in coverage under another employer-sponsored plan.

Benefits for **2019-2020**

- ✓ Medical
- ✓ Dental
- ✓ Vision
- ✓ Optional Life

Medical and Prescription Drugs

Russell Cellular Inc. will remain with **Anthem** for plan year July 1, 2019 – June 30, 2020 for medical benefits. The benefits listed below are for employees **excluding Southwest Missouri employees.** As a reminder, our plan allows for preventive care services listed under the Patient Protection and Affordable Care Act to be covered at **no cost** when using an In-Network provider.

Contact the Human Resources Department for details on your monthly rates!

	Option 1	Option 2	Option 3
In-Network Services	**Blue Access Option 1**	**Blue Access Option 2**	**Blue Access Option 3**
Deductible **-Individual** **-Family**	$1,000 $3,000	$2,500 $7,500	$5,000 $10,000
Out-of-Pocket Max **- Individual** **- Family** ***Includes Deductible**	$4,000 $8,000	$5,500 $11,000	$7,000 $14,000
Physician Visit	$30	$30	$30
Specialist Visit	$50	$50	$50
Preventive Care	No Cost ($0) for services mandated by PHSA Section 2713	No Cost ($0) for services mandated by PHSA Section 2713	No Cost ($0) for services mandated by PHSA Section 2713
Hospitalization	Deductible + 20%	Deductible + 20%	Deductible + 20%
Emergency Room	$250 + 20%	$250 + 20%	$250 + 20%
Urgent Care	$50	$50	$50
Retail Prescription Drugs **- Tier 1** **- Tier 2** **- Tier 3** **- Tier 4**	$15 $45 $75 25% to max of $400	$15 $45 $75 25% to max of $400	$15 $45 $75 25% to max of $400
Mail Order Prescription Drugs **- Tier 1** **- Tier 2** **- Tier 3** **- Tier 4**	$15 $112 $225 25% to max of $400	$15 $112 $225 25% to max of $400	$15 $112 $225 25% to max of $400

To locate a provider, visit www.anthem.com and select "Find a Doctor".

Your Summary of Benefits

Anthem BlueCross BlueShield

Russell Cellular
Blue Access® PPO /Blue Preferred Select
Effective July 1, 2019

Option 1

Covered Benefits	Network	Non-Network
Deductible (Single/Family)	$1,000/$3,000	$3,000/$9,000
Out-of-Pocket Limit (Single/Family)	$4,000/$8,000	$6,500/$13,000
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, non-maternity related Ultrasounds, and pharmaceutical products	$30/$50 $5 20% 20%	50% 50% 50% 50%
Preventive Care Services Services included but not limited to: • Routine medical exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations[1], Annual diabetic eye exam, Hearing screenings and Vision screenings which are limited to Screening tests (i.e. Snellen eye chart) and Ocular Photo screening • Immunizations through age 5	 No cost share No cost share	 50% No cost share
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, non-maternity related Ultrasounds, and pharmaceutical products • Allergy injections • Allergy testing	 $250/20% $50 20% $5 20%	 $250/20% 50% 50% 50% 50%
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%	50%
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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%	50%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	20%	50%
Other Outpatient Services (including but not limited to): • Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds, and other diagnostic outpatient services. • Home Care Services 100 visits (excludes IV Therapy) (Network/Non-Network combined) • Durable Medical Equipment • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	20% See note below for cost share details. 20% 20%	50% See note below for cost share details. 50% 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: • Physical/Manipulation therapy excluding Chiropractic Services: 20 visits • Occupational therapy: 20 visits • Chiropractic Services: 26 visits(Network only) • Speech therapy: Unlimited visits • Cardiac Rehabilitation: 36 visits • Pulmonary Rehabilitation: 20 visits	 $30/$50 20% See note below for cost share details	 50% 50% Not covered
Accidental Dental Services $3,000 per accident (Network and Non-network combined)	Copayments/Coinsurance based on setting where covered services are received	50%

Your Summary of Benefits

Covered Benefits	Network	Non-Network
Behavioral Health Services[2]: Mental Health and Substance Abuse (Network and Non-Network) • Inpatient Facility Services • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services, Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional	Benefits provided in accordance with Federal Mental Health Parity	50%
Human Organ and Tissue Transplants[3] • Acquisition and transplant procedures, harvest and storage.	20%	50%
Prescription Drugs Anthem Essential Drug List Network Tier structure equals 1/2/3 (and 4, if applicable) • Network Retail Pharmacies: (30-day supply) Includes diabetic test strip • Anthem Rx Home Delivery Service: (90-day supply) Includes diabetic test strip Member may be responsible for additional cost when not selecting the available generic drug. Members have additional cost with retail supply greater than 30 days. Medicare Rx - Wrap Specialty Medications must be obtained via our Specialty Pharmacy network in order to receive network level benefits. Specialty medications are limited to 30 day supply regardless of whether they are retail or mail order.	$15/$45/$75/25% w $400 Max $15/$112/$225/25% w $400 Max	50% (min $75)[5] Not covered

Notes:

- 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)
- Deductible(s) apply to covered medical services listed with a percentage (%) coinsurance, including 0%. However, the deductible does not apply to Emergency Room Services where a copayment and a 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.
- No cost share (NCS) 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.
- Physical Therapy and Occupational Therapy will take the PCP cost share when performed in the office visit setting.
- SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice. Specialist (SCP) copayment is applicable to all Specialists (excludes: General Physicians, Internists, Pediatricians, OB/Gyns, Geriatrics, Physical Therapy, Occupational Therapy or any other Network provider as allowed by the plan).
- Live Health Online (LHO) is covered at the PCP costshare.

Your Summary of Benefits

- Certain diabetic and asthmatic supplies, except diabetic test strips, have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies.
- Benefit period = calendar year
- Elective abortions are not covered.
- Mammograms (Diagnostic) 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.
- Chiropractic services at 50% Network coinsurance up to the maximum allowable amount and the Deductible applies when Office Visit is Deductible and Coinsurance. Non-network settings not covered.
- DME at 50% coinsurance for both network and non-network services, excludes Prosthetics, Wigs, Diabetic Supplies, Asthma Supplies and Hearing Aids will apply the plan's cost shares (common deductible/coinsurance).
- Private Duty Nursing – limited to 82 visits/Calendar Year and 164 visits/lifetime

[1] These covered services for age 6 and above 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 review the Schedule of Benefits for limitations. .

[3] Kidney and cornea are treated the same as any other illness and subject to the medical benefits.

[4] If applicable, all prescription drug expenses except tier 1, (Network Retail/Mail-service combined) apply to the per individual RX deductible. Once the RX deductible is met, the appropriate copayment applies. Once the RX deductible is met, the appropriate copayment applies.

[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 the member know if the services are considered not medically necessary.

Pre-existing Exclusion Period: NONE

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.

Your Summary of Benefits

Anthem BlueCross BlueShield

Russell Cellular
Blue Access® PPO /Blue Preferred Select Option 2
Effective July 1, 2019

Covered Benefits	Network	Non-Network
Deductible (Single/Family)	$2,500/$7,500	$5,000/$15,000
Out-of-Pocket Limit (Single/Family)	$5,500/$11,000	$9,500/$19,000
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, non-maternity related Ultrasounds, and pharmaceutical products	$30/$50 $5 20% 20%	50% 50% 50% 50%
Preventive Care Services Services included but not limited to: • Routine medical exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations[1], Annual diabetic eye exam, Hearing screenings and Vision screenings which are limited to Screening tests (i.e. Snellen eye chart) and Ocular Photo screening • Immunizations through age 5	 No cost share No cost share	 50% No cost share
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, non-maternity related Ultrasounds, and pharmaceutical products • Allergy injections • Allergy testing	 $250/20% $50 20% $5 20%	 $250/20% 50% 50% 50% 50%
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%	50%
Blue 9		

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%	50%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	20%	50%
Other Outpatient Services (including but not limited to): • Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds, and other diagnostic outpatient services. • Home Care Services 100 visits (excludes IV Therapy) (Network/Non-Network combined) • Durable Medical Equipment • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	20% See note below for cost share details. 20% 20%	50% See note below for cost share details. 50% 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: • Physical/Manipulation therapy excluding Chiropractic Services: 20 visits • Occupational therapy: 20 visits • Chiropractic Services: 26 visits(Network only) • Speech therapy: Unlimited visits • Cardiac Rehabilitation: 36 visits • Pulmonary Rehabilitation: 20 visits	 $30/$50 20% See note below for cost share details	 50% 50% Not covered
Accidental Dental Services $3,000 per accident (Network and Non-network combined)	Copayments/Coinsurance based on setting where covered services are received	50%

Your Summary of Benefits

Covered Benefits	Network	Non-Network
Behavioral Health Services[2]: Mental Health and Substance Abuse (Network and Non-Network) • Inpatient Facility Services • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services, Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional	Benefits provided in accordance with Federal Mental Health Parity	50%
Human Organ and Tissue Transplants[3] • Acquisition and transplant procedures, harvest and storage.	20%	50%
Prescription Drugs Anthem Essential Drug List Network Tier structure equals 1/2/3 (and 4, if applicable) • Network Retail Pharmacies: (30-day supply) Includes diabetic test strip • Anthem Rx Home Delivery Service: (90-day supply) Includes diabetic test strip Member may be responsible for additional cost when not selecting the available generic drug. Members have additional cost with retail supply greater than 30 days. Medicare Rx - Wrap Specialty Medications must be obtained via our Specialty Pharmacy network in order to receive network level benefits. Specialty medications are limited to 30 day supply regardless of whether they are retail or mail order.	$15/$45/$75/25% w $400 Max $15/$112/$225/25% w $400 Max	50% (min $75)[5] Not covered

Notes:

- 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)
- Deductible(s) apply to covered medical services listed with a percentage (%) coinsurance, including 0%. However, the deductible does not apply to Emergency Room Services where a copayment and a 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.
- No cost share (NCS) 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.
- Physical Therapy and Occupational Therapy will take the PCP cost share when performed in the office visit setting.
- SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice. Specialist (SCP) copayment is applicable to all Specialists (excludes: General Physicians, Internists, Pediatricians, OB/Gyns, Geriatrics, Physical Therapy, Occupational Therapy or any other Network provider as allowed by the plan).
- Live Health Online (LHO) is covered at the PCP costshare.

Your Summary of Benefits

- Certain diabetic and asthmatic supplies, except diabetic test strips, have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies.
- Benefit period = calendar year
- Elective abortions are not covered.
- Mammograms (Diagnostic) 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.
- Chiropractic services at 50% Network coinsurance up to the maximum allowable amount and the Deductible applies when Office Visit is Deductible and Coinsurance. Non-network settings not covered.
- DME at 50% coinsurance for both network and non-network services, excludes Prosthetics, Wigs, Diabetic Supplies, Asthma Supplies and Hearing Aids will apply the plan's cost shares (common deductible/coinsurance).
- Private Duty Nursing – limited to 82 visits/Calendar Year and 164 visits/lifetime

[1] These covered services for age 6 and above 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 review the Schedule of Benefits for limitations. .

[3] Kidney and cornea are treated the same as any other illness and subject to the medical benefits.

[4] If applicable, all prescription drug expenses except tier 1, (Network Retail/Mail-service combined) apply to the per individual RX deductible. Once the RX deductible is met, the appropriate copayment applies. Once the RX deductible is met, the appropriate copayment applies.

[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 the member know if the services are considered not medically necessary.

Pre-existing Exclusion Period: NONE

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.

Your Summary of Benefits

Anthem BlueCross BlueShield

Russell Cellular
Blue Access® PPO
Effective July 1, 2019

Option 3

Covered Benefits	Network	Non-Network
Deductible (Single/Family)	$5,000/$10,000	$15,000/$30,000
Out-of-Pocket Limit (Single/Family)	$7,000/$14,000	$20,000/$40,000
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, non-maternity related Ultrasounds, and pharmaceutical products	$30/$50 $5 20% 20%	50% 50% 50% 50%
Preventive Care Services Services included but not limited to: • Routine medical exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations[1], Annual diabetic eye exam, Hearing screenings and Vision screenings which are limited to Screening tests (i.e. Snellen eye chart) and Ocular Photo screening • Immunizations through age 5	 No cost share No cost share	 50% No cost share
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, non-maternity related Ultrasounds, and pharmaceutical products • Allergy injections • Allergy testing	 $250/20% $50 20% $5 20%	 $250/20% 50% 50% 50% 50%
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%	50%
Blue 9		

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%	50%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	20%	50%
Other Outpatient Services (including but not limited to): • Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds, and other diagnostic outpatient services. • Home Care Services 100 visits (excludes IV Therapy) (Network/Non-Network combined) • Durable Medical Equipment • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	20% See note below for cost share details. 20% 20%	50% See note below for cost share details. 50% 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: • Physical/Manipulation therapy excluding Chiropractic Services: 20 visits • Occupational therapy: 20 visits • Chiropractic Services: 26 visits(Network only) • Speech therapy: Unlimited visits • Cardiac Rehabilitation: 36 visits • Pulmonary Rehabilitation: 20 visits	 $30/$50 20% See note below for cost share details	 50% 50% Not covered
Accidental Dental Services $3,000 per accident (Network and Non-network combined)	Copayments/Coinsurance based on setting where covered services are received	50%

Your Summary of Benefits

Covered Benefits	Network	Non-Network
Behavioral Health Services[2]: Mental Health and Substance Abuse (Network and Non-Network) • Inpatient Facility Services • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services, Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional	Benefits provided in accordance with Federal Mental Health Parity	50%
Human Organ and Tissue Transplants[3] • Acquisition and transplant procedures, harvest and storage.	20%	50%
Prescription Drugs Anthem Essential Drug List Network Tier structure equals 1/2/3 (and 4, if applicable) • Network Retail Pharmacies: (30-day supply) Includes diabetic test strip • Anthem Rx Home Delivery Service: (90-day supply) Includes diabetic test strip Member may be responsible for additional cost when not selecting the available generic drug. Members have additional cost with retail supply greater than 30 days. Medicare Rx - Wrap Specialty Medications must be obtained via our Specialty Pharmacy network in order to receive network level benefits. Specialty medications are limited to 30 day supply regardless of whether they are retail or mail order.	$15/$45/$75/25% w $400 Max $15/$112/$225/25% w $400 Max	50% (min $75)[5] Not covered

Notes:

- 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)
- Deductible(s) apply to covered medical services listed with a percentage (%) coinsurance, including 0%. However, the deductible does not apply to Emergency Room Services where a copayment and a 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.
- No cost share (NCS) 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.
- Physical Therapy and Occupational Therapy will take the PCP cost share when performed in the office visit setting.
- SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice. Specialist (SCP) copayment is applicable to all Specialists (excludes: General Physicians, Internists, Pediatricians, OB/Gyns, Geriatrics, Physical Therapy, Occupational Therapy or any other Network provider as allowed by the plan).
- Live Health Online (LHO) is covered at the PCP costshare.

Your Summary of Benefits

- Certain diabetic and asthmatic supplies, except diabetic test strips, have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies.
- Benefit period = calendar year
- Elective abortions are not covered.
- Mammograms (Diagnostic) 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.
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- DME at 50% coinsurance for both network and non-network services, excludes Prosthetics, Wigs, Diabetic Supplies, Asthma Supplies and Hearing Aids will apply the plan's cost shares (common deductible/coinsurance).
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[1] These covered services for age 6 and above are not subject to the deductible/copayment if you have a flat dollar copayment and if rendered without an office visit

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[3] Kidney and cornea are treated the same as any other illness and subject to the medical benefits.

[4] If applicable, all prescription drug expenses except tier 1, (Network Retail/Mail-service combined) apply to the per individual RX deductible. Once the RX deductible is met, the appropriate copayment applies. Once the RX deductible is met, the appropriate copayment applies.

[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 the member know if the services are considered not medically necessary.

Pre-existing Exclusion Period: NONE

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.

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Dental

Russell Cellular Inc. will remain with **Anthem** for plan year July 1, 2019 – June 30, 2020 for dental benefits. The plan continues to allow you to seek treatment from any dentist. As always, greater discounts are given from dentists within the Anthem Network.

Amount You Pay	Base Plan		Buy-Up Plan	
Services	**In-Network/Out-of-Network**		**In-Network/Out-of-Network**	
Preventive Services	Exams, cleanings, x-rays		Exams, cleanings, x-rays	
	100%	100%	100%	100%
Deductible **(Applies to Basic & Major Services)**	$50 Individual $150 Family		$50 Individual $150 Family	
Basic Services	Fillings, endodontics, periodontics		Fillings, endodontics, periodontics	
	80%	80%	80%	80%
Major Services	Crowns, dentures, oral surgery		Crowns, dentures, oral surgery	
	Not Covered		60%	50%
Annual Maximum	$500		$1,000	

*To locate a provider, visit **www.anthem.com/mydentalvision***

Anthem BlueCross BlueShield

Your Summary of Benefits
Russell Cellular and Satellite - Base Plan
Effective Date: 07/01/2019
Anthem Dental Complete

WELCOME TO YOUR DENTAL PLAN!
This 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 certificate of coverage.

Dental coverage you can count on
Your Anthem dental plan lets you visit any licensed dentist or specialist you want – with costs that are normally lower when you choose one within our large network.

Savings beyond your dental plan benefits – you get more for your money.
You pay our negotiated rate for covered services from in-network dentists even if you exceed your annual benefit maximum.

YOUR DENTAL PLAN AT A GLANCE	In-Network	Out-of-Network
Annual Benefit Maximum – (Calendar Year) • Per insured person Annual Maximum Carryover	 $500 No	 $500 No
Orthodontic Lifetime Benefit Maximum • Per eligible insured [Select one]	Not applicable	Not applicable
Annual Deductible – (Calendar Year) • Per insured person • Family maximum	 $50 3x single member deductible	 $50 3x single member deductible
Deductible Waived for Diagnostic/Preventive Services	Yes	Yes
Out-of-Network Reimbursement	90th percentile	

Dental Services	In-Network Anthem Pays:	Out-of-Network Anthem Pays:	Waiting Period
Diagnostic and Preventive Services • Periodic oral exam • Teeth cleaning (prophylaxis) • Bitewing X-rays (once in 12 mos. for all ages) • Intraoral X-rays	100% coinsurance	100% coinsurance	No waiting period
Basic Services • Amalgam (silver-colored) Filling • Front composite (tooth-colored) Filling • Back Composite Filling, alternated to amalgam allowance • Simple Extractions	80% coinsurance	80% coinsurance	No waiting period
Endodontics • Root canal	80% coinsurance	80% coinsurance	No waiting period
Periodontics • Scaling and root planing	80% coinsurance	80% coinsurance	No waiting period
Oral Surgery • Surgical Extractions	Not covered	Not covered	No waiting period
Major Services • Crowns	Not covered	Not covered	No waiting period
Prosthodontics • Dentures • Bridges • Dental Implants (not covered)	Not covered	Not covered	No waiting period
Prosthetic Repairs/Adjustments	Not covered	Not covered	No waiting period
Orthodontic Services • Not covered	Not covered	Not covered	Not applicable

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.

Remove if no child ortho: *Child orthodontic coverage begins at age eight and runs through age 18. This means that the child must have been banded between the ages of eight and 19 in order to receive coverage. If children are dependents until age 19, they can continue to receive coverage, but they must have been banded before age 19.

ABCBC_IN_KY_MO_OH_WI_PCLG_FI-Custom

Emergency dental treatment for the international traveler

As an Anthem dental member, you and your eligible, covered dependents automatically have access to the International Emergency Dental Program.** With this program, you may receive emergency dental care from our listing of credentialed dentists while traveling or working nearly anywhere in the world.

** The International Emergency Dental Program is managed by DeCare Dental, which is an independent company offering dental-management services to Anthem. To learn more about the program, please visit the International Emergency Dental Web site at www.decaredental.com/internationalDentalProgram.do.

Incl/Remv: Promoting healthy mouths for members who are pregnant or living with diabetes

Incl/Remv: If you are pregnant or living with diabetes, you can sign up to receive one additional dental cleaning or periodontal maintenance procedure per year.

Finding a dentist is easy.

To select a dentist by name or location, do one of the following:

- Go to anthem.com/mydentalvision
- Call Anthem dental customer service at the toll-free number listed on the back of your ID card.

TO CONTACT US:

Call	Write
Refer to the toll-free number indicated on the back of your plan ID card to speak with a U.S.-based customer service representative during normal business hours. Calling after hours? We may still be able to assist you with our interactive voice-response system.	Refer to the back of your plan ID card for the address.

Limitations & Exclusions

Limitations – Below is a partial listing of dental plan limitations when these services are covered under your plan. Please see your certificate of coverage for a full list.

Diagnostic and Preventive Services

Oral evaluations (exam) Limited to two per Calendar Year

Teeth cleaning (prophylaxis) Limited to two per Calendar Year

Intraoral X-rays, single film Limited to four films per 12-month period

Complete series X-rays (panoramic or full-mouth) Limited to once every five years

Topical fluoride application Limited to once every 12 months for members through age 18

Sealants Limited to first and second molars once every 24 months per tooth for members through age 15; sealants may be covered under Diagnostic and Preventive or Basic Services.

Basic and/or Major Services***

Fillings Limited to once per surface per tooth in any 24 months

Space Maintainers Limited to extracted primary posterior teeth once per lifetime per tooth for members through age 16; space maintainers may be covered under Diagnostic and Preventive or Basic Services.

Crowns Limited to once per tooth in a seven-year period

Fixed or removable prosthodontics – dentures, partials, bridges

Covered once in any seven-year period; benefits are provided for the replacement of an existing bridge, denture or partial for members age 16 or older if the appliance is seven years old or older and cannot be made serviceable.

Root canal therapy Limited to once per lifetime per tooth; coverage is for permanent teeth only.

Periodontal surgery Limited to one complex service per single tooth or quadrant in any 36 months, and only if the pocket depth of the tooth is five millimeters or greater

Periodontal scaling and root planing Limited to once per quadrant in 36 months, when the tooth pocket has a depth of four millimeters or greater

Brush biopsy (Not covered)

***Waiting periods for endodontic, periodontic and oral surgery services may differ from other Basic Services or Major Services under the same dental plan. There may be a waiting period of up to 24 months for replacement of congenitally missing teeth or teeth extracted prior to coverage under this plan.

ADDITIONAL LIMITATION FOR ORTHODONTIC SERVICES – *if Orthodontia is included as a benefit of your dental plan*

Orthodontia Limited to one course of treatment per member per lifetime

Exclusions – Below is a partial listing of noncovered services under your dental plan. Please see your certificate of coverage 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) Orthodontic braces, appliances and all related services

Cosmetic dentistry Services 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 Intravenous conscious sedation, IV sedation and general anesthesia when performed with nonsurgical dental care

Analgesia, analgesic agents, 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.

Extractions Surgical removal of third molars (wisdom teeth) that do not exhibit symptoms or impact the oral health of the member

The in-network dental providers mentioned in this communication are independently contracted providers who exercise independent professional judgment. They are not agents or employees of Anthem Blue Cross Life and Health Insurance Company.

Choice of dentists

While your dental plan lets you choose any dentist, you may end up paying more for a service if you visit an out-of-network dentist.

Here's why:

In-network dentists have agreed to payment rates for various services and cannot charge you more. On the other hand, out-of-network dentists don't have a contract with us and are able to bill you for the difference between the total amount we allow to be paid for a service – called the "maximum allowed cost" – and the amount they usually charge for a service. When they bill you for this difference, it's called "balance billing."

How Anthem dental decides on maximum allowed costs

For services from an out-of-network dentist, the maximum allowed cost is determined in one of the following ways:

- Out-of-network dental fee schedule/rate developed by Anthem, which may be updated based on such things as reimbursement amounts accepted by dentists contracted with our dental plans, or other industry cost and usage data
- Information provided by a third-party vendor that shows comparable costs for dental services
- In-network dentist fee schedule

Here's an example of higher costs for out-of-network dental services

This is an example only. Your experience may be different, depending on your insurance plan, the services you receive and the dentist who provides the services.

Say Ted's dental plan allows him 50% coinsurance for either in- or out-of-network services... Ted chooses to get a crown from an out-of-network dentist who charges $1,200 for the service and bills Anthem for that amount. If Anthem's maximum allowed cost for this dental service is $800, this means there will be a $400 difference. The out-of-network dentist can "balance bill" Ted for that amount.

Ted will also need to pay $400 coinsurance. Therefore, the total he will pay the out-of-network dentist is $800. Here's the math:

- Dentist's charge: $1,200
- Anthem's maximum allowed cost: $800
- Anthem pays 50%: $400
- Ted pays 50% (coinsurance): $400
- Balance Ted owes the provider: $1,200 - $800 = $400
- Ted's total cost: $400 coinsurance + $400 provider balance = $800

In the example, if Ted had gone to an in-network dentist, his cost would be only $400 for the coinsurance because he would not have been "balance billed" the $400 difference.

Anthem BlueCross BlueShield

Your Summary of Benefits
Russell Cellular and Satellite - Buy-Up Plan
Effective Date: 07/01/2019
Anthem Dental Complete

WELCOME TO YOUR DENTAL PLAN!
This 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 certificate of coverage.

Dental coverage you can count on
Your Anthem dental plan lets you visit any licensed dentist or specialist you want – with costs that are normally lower when you choose one within our large network.

Savings beyond your dental plan benefits – you get more for your money.
You pay our negotiated rate for covered services from in-network dentists even if you exceed your annual benefit maximum.

YOUR DENTAL PLAN AT A GLANCE	In-Network	Out-of-Network
Annual Benefit Maximum – (Calendar Year) • Per insured person Annual Maximum Carryover	 $1,000 Yes	 $1,000 Yes
Orthodontic Lifetime Benefit Maximum • Per eligible insured [Select one]	Not applicable	Not applicable
Annual Deductible – (Calendar Year) • Per insured person • Family maximum	 $50 3x single member deductible	 $50 3x single member deductible
Deductible Waived for Diagnostic/Preventive Services	Yes	Yes
Out-of-Network Reimbursement	90th percentile	

Dental Services	In-Network Anthem Pays:	Out-of-Network Anthem Pays:	Waiting Period
Diagnostic and Preventive Services • Periodic oral exam • Teeth cleaning (prophylaxis) • Bitewing X-rays (once in 12 mos. for all ages) • Intraoral X-rays	100% coinsurance	100% coinsurance	No waiting period
Basic Services • Amalgam (silver-colored) Filling • Front composite (tooth-colored) Filling • Back Composite Filling, alternated to amalgam allowance • Simple Extractions	80% coinsurance	80% coinsurance	No waiting period
Endodontics • Root canal	80% coinsurance	80% coinsurance	No waiting period
Periodontics • Scaling and root planing	80% coinsurance	80% coinsurance	No waiting period
Oral Surgery • Surgical Extractions	60% coinsurance	50% coinsurance	No waiting period
Major Services • Crowns	60% coinsurance	50% coinsurance	No waiting period
Prosthodontics • Dentures • Bridges • Dental Implants (not covered)	60% coinsurance	50% coinsurance	No waiting period
Prosthetic Repairs/Adjustments	60% coinsurance	50% coinsurance	No waiting period
Orthodontic Services • Not covered	Not covered	Not covered	Not applicable

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.

Remove if no child ortho: *Child orthodontic coverage begins at age eight and runs through age 18. This means that the child must have been banded between the ages of eight and 19 in order to receive coverage. If children are dependents until age 19, they can continue to receive coverage, but they must have been banded before age 19.

ABCBC_IN_KY_MO_OH_WI_PCLG_FI-Custom

Emergency dental treatment for the international traveler

As an Anthem dental member, you and your eligible, covered dependents automatically have access to the International Emergency Dental Program.** With this program, you may receive emergency dental care from our listing of credentialed dentists while traveling or working nearly anywhere in the world.

** The International Emergency Dental Program is managed by DeCare Dental, which is an independent company offering dental-management services to Anthem. To learn more about the program, please visit the International Emergency Dental Web site at www.decaredental.com/internationalDentalProgram.do.

Incl/Remv: Promoting healthy mouths for members who are pregnant or living with diabetes

Incl/Remv: If you are pregnant or living with diabetes, you can sign up to receive one additional dental cleaning or periodontal maintenance procedure per year.

Finding a dentist is easy.

To select a dentist by name or location, do one of the following:

- Go to anthem.com/mydentalvision
- Call Anthem dental customer service at the toll-free number listed on the back of your ID card.

TO CONTACT US:

Call	Write
Refer to the toll-free number indicated on the back of your plan ID card to speak with a U.S.-based customer service representative during normal business hours. Calling after hours? We may still be able to assist you with our interactive voice-response system.	Refer to the back of your plan ID card for the address.

Limitations & Exclusions

Limitations – Below is a partial listing of dental plan limitations when these services are covered under your plan. Please see your certificate of coverage for a full list.

Diagnostic and Preventive Services

Oral evaluations (exam) Limited to two per Calendar Year

Teeth cleaning (prophylaxis) Limited to two per Calendar Year

Intraoral X-rays, single film Limited to four films per 12-month period

Complete series X-rays (panoramic or full-mouth) Limited to once every five years

Topical fluoride application Limited to once every 12 months for members through age 18

Sealants Limited to first and second molars once every 24 months per tooth for members through age 15; sealants may be covered under Diagnostic and Preventive or Basic Services.

Basic and/or Major Services***

Fillings Limited to once per surface per tooth in any 24 months

Space Maintainers Limited to extracted primary posterior teeth once per lifetime per tooth for members through age 16; space maintainers may be covered under Diagnostic and Preventive or Basic Services.

Crowns Limited to once per tooth in a seven-year period

Fixed or removable prosthodontics – dentures, partials, bridges

Covered once in any seven-year period; benefits are provided for the replacement of an existing bridge, denture or partial for members age 16 or older if the appliance is seven years old or older and cannot be made serviceable.

Root canal therapy Limited to once per lifetime per tooth; coverage is for permanent teeth only.

Periodontal surgery Limited to one complex service per single tooth or quadrant in any 36 months, and only if the pocket depth of the tooth is five millimeters or greater

Periodontal scaling and root planing Limited to once per quadrant in 36 months, when the tooth pocket has a depth of four millimeters or greater

Brush biopsy (Not covered)

***Waiting periods for endodontic, periodontic and oral surgery services may differ from other Basic Services or Major Services under the same dental plan. There may be a waiting period of up to 24 months for replacement of congenitally missing teeth or teeth extracted prior to coverage under this plan.

ADDITIONAL LIMITATION FOR ORTHODONTIC SERVICES – *if Orthodontia is included as a benefit of your dental plan*

Orthodontia Limited to one course of treatment per member per lifetime

Exclusions – Below is a partial listing of noncovered services under your dental plan. Please see your certificate of coverage 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) Orthodontic braces, appliances and all related services

Cosmetic dentistry Services 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 Intravenous conscious sedation, IV sedation and general anesthesia when performed with nonsurgical dental care

Analgesia, analgesic agents, 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.

Extractions Surgical removal of third molars (wisdom teeth) that do not exhibit symptoms or impact the oral health of the member

The in-network dental providers mentioned in this communication are independently contracted providers who exercise independent professional judgment. They are not agents or employees of Anthem Blue Cross Life and Health Insurance Company.

Choice of dentists

While your dental plan lets you choose any dentist, you may end up paying more for a service if you visit an out-of-network dentist.

Here's why:

In-network dentists have agreed to payment rates for various services and cannot charge you more. On the other hand, out-of-network dentists don't have a contract with us and are able to bill you for the difference between the total amount we allow to be paid for a service – called the "maximum allowed cost" – and the amount they usually charge for a service. When they bill you for this difference, it's called "balance billing."

How Anthem dental decides on maximum allowed costs

For services from an out-of-network dentist, the maximum allowed cost is determined in one of the following ways:

- Out-of-network dental fee schedule/rate developed by Anthem, which may be updated based on such things as reimbursement amounts accepted by dentists contracted with our dental plans, or other industry cost and usage data
- Information provided by a third-party vendor that shows comparable costs for dental services
- In-network dentist fee schedule

Here's an example of higher costs for out-of-network dental services

This is an example only. Your experience may be different, depending on your insurance plan, the services you receive and the dentist who provides the services.

Say Ted's dental plan allows him 50% coinsurance for either in- or out-of-network services... Ted chooses to get a crown from an out-of-network dentist who charges $1,200 for the service and bills Anthem for that amount. If Anthem's maximum allowed cost for this dental service is $800, this means there will be a $400 difference. The out-of-network dentist can "balance bill" Ted for that amount.

Ted will also need to pay $400 coinsurance. Therefore, the total he will pay the out-of-network dentist is $800. Here's the math:

- Dentist's charge: $1,200
- Anthem's maximum allowed cost: $800
- Anthem pays 50%: $400
- Ted pays 50% (coinsurance): $400
- Balance Ted owes the provider: $1,200 - $800 = $400
- Ted's total cost: $400 coinsurance + $400 provider balance = $800

In the example, if Ted had gone to an in-network dentist, his cost would be only $400 for the coinsurance because he would not have been "balance billed" the $400 difference.

Vision

Russell Cellular Inc. will remain with **Anthem** for plan year July 1, 2019 – June 30, 2020 for vision benefits. The plan continues to allow you to seek treatment from any provider. As always, greater discounts are given from providers within the Anthem Network.

In-Network Services	July 1, 2019	
Frequency **- Exams** **- Lenses** **- Frames** **- Contact Lenses**	 1 every 12 months 1 every 12 months 1 every 12 months 1 every 12 months	
*Contact lenses in lieu of lenses allowance		
Copay **- Exams** **- Materials**	 $10 $25	
Maximum Allowance	**In-Network**	**Out-of-Network**
- WellVision Exam **- Single Vision** **- Lined Bifocal** **- Lined Trifocal**	$10 $25 $25 $25	Up to $42 Up to $40 Up to $60 Up to $80
Maximum Allowance	**In-Network**	**Out-of-Network**
- Frames **- Elective Contacts** **- Necessary Contacts**	$120/20% off remaining balance $120/15% off remaining balance Covered in full	Up to $45 Up to $105 Up to $210

*To locate a provider, visit **www.anthem.com/mydentalvision***

Blue View Vision℠
Russell Cellular
July 1, 2019

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
Routine Eye Exam			
A comprehensive eye examination	$10 copay	Up to $42 allowance	Once every 12 months
Eyeglass Frames			
One pair of eyeglass frames	$120 allowance, then 20% off any remaining balance	Up to $45 allowance	Once every 12 months
Eyeglass Lenses *(instead of contact lenses)*			
One pair of standard plastic prescription lenses: • Single vision lenses • Bifocal lenses • Trifocal lenses	 $25 copay $25 copay $25 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)	$120 allowance, then 15% off any remaining balance $120 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 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.
	○ 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
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.	○ Standard contact lens fitting[3] ○ Premium contact lens fitting[4]	Up to $55 10% 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.

[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:

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 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

Optional Life Insurance

Eligible Employees **previously declining coverage but wishing to enroll themselves and their eligible dependent(s), may do so during open enrollment. However, an evidence of insurability form will be required for the entire amount of coverage.*

Eligible Employees **currently enrolled in coverage but wishing to enroll their eligible dependent(s), may do so during open enrollment. However, an evidence of insurability form will be required for the entire amount of coverage.*

Employees enrolled in the medical and life benefits who want to supplement their group life insurance benefits may purchase additional coverage through **Anthem**. When you enroll yourself and/or your dependents in this benefit, you pay the full cost through payroll deductions. You can purchase coverage for:

- Yourself up to 5 times salary in increments of $10,000. Maximum coverage is $300,000 with a ***guaranteed issue limit of $100,000***.
- Spouse up to 50% of employee amount in increments of $5,000. Maximum coverage is $50,000 with a ***guaranteed issue limit of $25,000.***
- Child(ren) up to 50% of employee coverage amount in increments of $5,000. Maximum coverage is $10,000 with a ***guaranteed issue limit of $10,000***.

Monthly Cost for Each $1,000 of Employee & Spouse Life Insurance Coverage										
Age	**<25**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**	**65-69**
Life	$0.09	$0.08	$0.09	$0.11	$0.19	$0.28	$0.44	$0.72	$1.04	$1.81
Dependent Children	**Life** $0.21 per $1,000									

Welcome to Anthem Life! Good news—life insurance coverage is easy to understand. This benefit summary gives a basic outline of life insurance coverage including benefits that can be used now, and much more!

Anthem Life

Your Optional Life Insurance Benefits

Russell Cellular and Satellite

Benefits effective July 1, 2019

Feel confident in knowing that your family is protected with Anthem Life's Optional Group Term Life Insurance. Please review your benefit certificate for specific plan details, eligibility definitions, limitations and exclusions.

Optional group term life insurance benefit amount

You may purchase coverage in an amount from $10,000 to $300,000 or 5 times annual earnings, whichever is less in increments of $10,000. Your family or beneficiary will get this additional benefit amount if you pass away.

If you choose an optional life benefit amount of more than $100,000, you will need to have a personal health statement approved by Anthem Life. Your optional life benefit amount will be limited to $100,000 if it's not approved by Anthem Life.

Optional life coverage for your family

You may also choose additional life coverage for your spouse and your children:

You may purchase coverage for your spouse in increments of $5,000 to a maximum of $50,000
You may purchase coverage for your children in increments of $5,000 to a maximum of $10,000

If you choose optional life coverage for your Spouse of more than $25,000 your Spouse will need to have a personal health statement approved by Anthem Life. Your Spouse's optional life benefit amount will be limited to $25,000 if it's not approved by Anthem Life.

Dependents' coverage may not exceed 50% of the employee's benefit amount.

Benefits after age 65

You will still have benefits after age 65, though they will reduce as follows:

35% reduction at age 65; 50% reduction at age 70

All benefits end at retirement.

Living Benefit (accelerated death benefit)

You can ask for up to 75% of your optional life benefits to be paid while you are living, if you are terminally ill with less than 12 months to live. If you take a Living Benefit payment, the amount your beneficiary gets after your death will be reduced by the amount you were paid.

Waiver of premium

We may continue your life insurance coverage until you turn 65 if you become totally disabled and not able to work prior to age 60. You will not pay premiums after the first six months after we approve your waiver of premium claim.

Portability of optional life insurance

If you leave employment for reasons other than retirement or disability, this feature allows you to take your optional life insurance coverage with you by paying the required premiums. Plus, the rates are typically lower than an individual policy.

Conversion

If you leave your job – for any reason – you may be able to change your group life coverage to an individual policy. You must apply for coverage and pay the first month's premium for the individual policy within 31 days of the last day you were employed.

Resource Advisor

This support program comes with your life coverage to give you and your family private access to work/life resources, at no additional cost to you, including: counseling sessions for qualifying events; identity theft victim recovery services; legal and financial consultations; toll-free, 24/7 phone consultations and referrals from anywhere in the United States; and unlimited access to Resource Advisor online resources at www.resourceadvisor.anthem.com, program name "anthemresourceadvisor". You can also access Resource Advisor benefits by calling (888) 209-7840.

Travel assistance

This program comes with your life coverage to give you access to emergency medical help, travel services and useful tips for your trip if you travel more than 100 miles from home – all at no additional cost to you. To access benefits, visit www.europassistance-usa.com. The username is AnthemLife, the password is 75293. You can also access Travel assistance benefits by calling: US and Canada (866) 295-4890, other locations (call collect) (202) 296-7482.

SpecialOffers@Anthem[sm]

This program gives you and your family money saving discounts on products and services that promote better health and well-being. To find out more about SpecialOffers@Anthem[sm] discounts and benefits, go to anthem.com/specialoffers.

Beneficiary support programs

If you should pass away, we're here to help your beneficiary (the person who gets your life insurance benefit):

- Beneficiaries continue to have access to Resource Advisor services, including all the features described above, plus they get three face-to-face visits with a counselor in the first six months after their loss.
- Beneficiary Companion services help them close accounts and settle important estate matters with one phone call. That way, they can focus on healing.
- Beneficiaries can order copies of *The Healing Book – Facing the Death – and Celebrating the Life – of Someone You Love* for children affected by the loss. This book can really help children at a time when they need it most – and there's no charge for it.
- Your beneficiary can choose to have your life insurance benefits paid through our Access Advantage account. That way the funds can be used right away or when they are needed. Access Advantage accounts earn interest, so important investment decisions can be made later, at a less stressful time.

Questions & Answers

Changes that can be made effective July 1, 2019:

- Change medical plans (Low plan to high plan, middle plan to low plan, etc.)
- Enroll or terminate individual and/or dependent coverage in the medical, dental, vision and/or optional life plans

Steps to complete during Open Enrollement to verify your enrollment or to make changes:

- Log into your Ascentis Employee Self-Service and go to your My Self Page. Under "*Benefits"* you will see a selection in red called "Continue 2019-2020 Open Enrollment".

- Click "Next" and verify your information as well as your current enrollments. If you want to make changes, you can click the selections for the other plans you are currently eligible for.
  - As you make changes, your benefit cost will total at the bottom of the screen.

- Before you confirm any changes, a final page that lists your benefits summary will show to allow you to review all your changes. You will be able to go back if you need to adjust your enrollments if needed. To finalize changes, click **"Confirm Enrollment".**

- Once complete, HR will review your changes and apply them to your profile.

When are my changes due?

- All changes must be submitted by **06/26/2019. ONLY CHANGES MADE IN ASCENTIS WILL BE APPLIED**!

I already submitted my enrollment but I need to make changes, what do I do?

- Reach out to your HR Team to reset your changes, you will then be able to re-enter your enrollment options.

Who do I contact with questions?

- Contact Human Resources with any questions you may have.

Other Information:

- ***If you do not make changes to your current medical election, you and your covered dependents will remain in the respective plan (Low $5000 deductible, Middle $2500 deductible or High $1000 deductible) for the plan year July 1, 2019 to June 30, 2020.***

- ***If you do not make changes to your current optional life elections, those elections will remain the same for the plan year July 1, 2019 to June 30, 2020.***

- ***If you do not make changes to your current vision and dental elections, those elections will remain the same for the plan year July 1, 2019 to June 30, 2020.***

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents the actual plan, documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Benefits Department.

Take care of yourself
Use your preventive care benefits

Anthem BlueCross BlueShield

Getting regular checkups and exams can help you stay healthy and catch problems early — when they're easier to treat.

That's why our health plans offer all the preventive care services and immunizations below — at no cost to you.[1] As long as you see a doctor or use a pharmacy in the plan, you won't have to pay anything for these services and immunizations. If you want to visit a doctor or pharmacy outside the plan, you may have to pay out of pocket.

Not sure which services make sense for you? Talk to your doctor. He or she can help you figure out what you need.

Preventive vs. diagnostic care

What's the difference? Preventive care helps protect you from getting sick. If your doctor recommends you have services even though you have no symptoms, that's preventive care. Diagnostic care is when you have symptoms and your doctor recommends services to determine what's causing those symptoms.

Adult preventive care

Preventive physical exams

Screening tests:

- Alcohol misuse: related screening and behavioral counseling
- Aortic aneurysm screening (men who have smoked)
- Behavioral counseling to promote a healthy diet
- Blood pressure
- Bone density test to screen for osteoporosis
- Cholesterol and lipid (fat) level
- Colorectal cancer, including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and related prep kit, and computed tomography (CT) colonography (as appropriate)
- Depression screening
- Hepatitis C virus (HCV) for people at high risk for infection and a one-time screening for adults born between 1945 and 1965
- Type 2 diabetes screening
- Eye chart test for vision[2]
- Hearing screening
- Height, weight and body mass index (BMI)
- HIV screening and counseling
- Lung cancer screening for those ages 55-80 who have a history of smoking 30 packs per year and still smoke, or quit within the past 15 years[3]
- Obesity: related screening and counseling
- Prostate cancer, including digital rectal exam and prostate-specific antigen (PSA) test
- Sexually transmitted infections: related screening and counseling
- Tobacco use: related screening and behavioral counseling
- Violence, interpersonal and domestic: related screening and counseling

Immunizations:

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

Women's preventive care:

- Well-woman visits
- Breast cancer, including exam, mammogram, and genetic testing for BRCA 1 and BRCA 2 when certain criteria are met[4]
- Breastfeeding: primary care intervention to promote breastfeeding support, supplies and counseling[5,6,7]
- Contraceptive (birth control) counseling
- Food and Drug Administration (FDA)-approved contraceptive medical services, including sterilization, provided by a doctor
- Counseling related to chemoprevention for those with a high risk of breast cancer
- Counseling related to genetic testing for those with a family history of ovarian or breast cancer
- HPV screening[6]
- Screening and counseling for interpersonal and domestic violence
- Pregnancy screenings, including gestational diabetes, hepatitis B, asymptomatic bacteriuria, Rh incompatibility, syphilis, HIV and depression[6]
- Pelvic exam and Pap test, including screening for cervical cancer

These preventive care services are recommendations of the Affordable Care Act (ACA or health care reform law). They may not be right for every person, so ask your doctor what's right for you.

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

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Child preventive care

Preventive physical exams

Screening tests:

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

Immunizations:

- Chickenpox
- Flu
- Haemophilus influenza type b (Hib)
- Hepatitis A and hepatitis B
- HPV
- Meningitis
- MMR
- Pneumonia
- Polio
- Rotavirus
- Whooping cough

1 The range of preventive care services covered at no cost share when provided by plan doctors is designed to meet state and federal requirements. The Department of Health and Human Services decided which services to include for full coverage based on U.S. Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and certain guidelines for infants, children, adolescents and women supported by Health Resources and Services Administration (HRSA) Guidelines. You may have additional coverage under your insurance policy. To learn more about what your plan covers, see your Certificate of Coverage or call the Member Services number on your ID card.

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

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

4 Check your medical policy for details.

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

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

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

Anthem BlueCross BlueShield

LiveHealth® ONLINE

Here's why you'll love LiveHealth Online:

- Reduced health care costs. When employees choose to see doctors online instead of going to urgent care centers or retail health clinics, everyone saves money.
- Higher productivity. Employees may be absent less and not come to work sick because they can't find time to get to the doctor.
- Less stressed employees. Employees will enjoy how fast and easy it is to see a doctor online and get the care they need.
- High satisfaction rates. Users of online care report high satisfaction results: 92% report a "good," "very good" or "excellent" experience.[1]

See how easy it is to get started with LiveHealth Online!

Contact your Sales representative for more information and visit **livehealthonline.com**. LiveHealth Online is not available in all states.

Your employees can use LiveHealth Online for nonurgent matters like:

- Cold and flu symptoms including a cough and fever
- Allergies
- Sinus infections
- Bronchitis
- Urinary tract infections
- Diarrhea

1 2011 study by American Well, Inc.

RussellCellular

Your Human Resources Department

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HR ABBO Team

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