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

OLLIS/AKERS/ARNEY
INSURANCE & BUSINESS ADVISORS

RussellCellular

Employee Benefits Enrollment Guide

All other employees excluding Missouri Employees

Plan Year: 2020 - 2021

Welcome to your 2020 – 2021 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 2020-2021 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 10, 2020** through **June 24, 2020.** The benefits you elect during open enrollment will be effective from **July 1, 2020** through **June 30, 2021**.

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 **2020-2021**

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

Medical and Prescription Drugs

Russell Cellular Inc. will remain with **Anthem** for plan year July 1, 2020 – June 30, 2021 for medical benefits. The benefits listed below are for employees **excluding 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 Employee Services 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 and BlueShield

Your Plan: Russell Cellular Inc Anthem Blue Access PPO

Your Network: Blue Access

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

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.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.*	$1,000 person / $3,000 family	$3,000 person / $9,000 family
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.*	$4,000 person / $8,000 family	$6,500 person / $13,000 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	50% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit to treat an injury or illness *When Allergy injections are billed separately by network providers, the member is responsible for a $5 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.*	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Specialist Care Visit *When Allergy injections are billed separately by network providers, the member is responsible for a $5 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.*	$50 copay per visit deductible does not apply	50% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prenatal and Post-natal Care *In-Network preventive prenatal services are covered at 100%.*	$30 copay per pregnancy for the first 1 visit deductible does not apply and then 20% coinsurance after deductible is met	50% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Preferred On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	$10 copay per visit deductible does not apply	50% coinsurance after deductible is met
Other Participating Provider On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 26 visits per benefit period. Limit is combined In-Network and Non-Network . Limit is combined across professional visits and outpatient facilities.*	50% coinsurance deductible does not apply	50% coinsurance deductible does not apply
Other Services in an Office:		
Allergy Testing	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Chemo/Radiation Therapy Performed by a Primary Care Physician	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Chemo/Radiation Therapy Performed by a Specialist	$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Dialysis/Hemodialysis	No charge	50% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prescription Drugs *For the drugs itself dispensed in the office through infusion/injection.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Diagnostic Services		
Lab:		
Office	No charge	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
X-Ray:		
Office	No charge	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency and Urgent Care		
Urgent Care *The urgent care office visit cost share applies to both office and facility based urgent care providers. When Allergy injections are billed separately by network providers, the member is responsible for a $5 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.*	$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$250 copay per visit and 20% coinsurance deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance deductible does not apply	Covered as In-Network
Ambulance (Air, Ground, and Water) *Non-emergency non-network Ambulance Services are Unlimited per occurrence.*	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Facility visit:		
Facility Fees	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Surgery		
Facility Fees:		
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospital Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse)		
Facility fees (for example, room & board) *Coverage for Inpatient physical medicine and rehabilitation including day rehabilitation programs is limited to 60 days combined per benefit period. Limit is combined In-Network and Non-Network.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Human Organ and Tissue Transplants *Acquisition and transplant procedures, collection and storage. Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and other services	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 100 visits per benefit period. Coverage for private duty nursing is limited to 82 visits per benefit period and 164 visits per lifetime. Limit is combined In-Network and Non-Network.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for Occupational Rehabilitation services is limited to 20 visits per benefit period. Coverage for Physical Rehabilitation and Manipulation Therapy services is limited to 20 visits per benefit period. Limit does not apply to manipulation performed by a Chiropractor. Limit is combined In-network and Non-Network across professional and outpatient visits. Speech Therapy has no visit limit. Benefit limit does not apply to Applied Behavioral Analysis. Benefit limit does not apply when performed as part of Early Intervention.*	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital *Coverage for Occupational Rehabilitation services is limited to 20 visits per benefit period. Coverage for Physical Rehabilitation and Manipulation Therapy services is limited to 20 visits per benefit period. Limit does not apply to manipulation performed by a Chiropractor. Limit is combined In-network and Non-Network across professional and outpatient visits. Speech Therapy has no visit limit. Benefit limit does not apply to Applied Behavioral Analysis. Benefit limit does not apply when performed as part of Early Intervention.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Cardiac rehabilitation		
Office *Coverage is limited to 36 visits per benefit period. Limit is combined In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital *Coverage is limited to 36 visits per benefit period. Limit is combined In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pulmonary rehabilitation		
Office *Coverage is limited to 20 visits per benefit period. Limit is combined In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital *Coverage is limited to 20 visits per benefit period. Limit is combined In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (in a facility) *Coverage is limited to 90 days per benefit period. Limit is combined In-Network and Non-Network. Benefit includes coverage for Outpatient Rehabilitation program.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospice	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Durable Medical Equipment	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs needed after cancer treatment is limited to 1 item per benefit period. Limit is combined In-Network and Non-Network. Applies to In-Network.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out of Pocket	Combined with medical out of pocket maximum	Combined with medical out of pocket maximum
Prescription Drug Coverage *Essential Drug List* *This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.*		
Tier 1 - Typically Generic *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	$15 copay per prescription, deductible does not apply (retail and home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	$45 copay per prescription, deductible does not apply (retail) and $112 copay per prescription, deductible does not apply (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	$75 copay per prescription, deductible does not apply (retail) and $225 copay per prescription, deductible does not apply (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Tier 4 - Typically Specialty (brand and generic) *Covers up to a 30 day supply (retail pharmacy). Covers up to a 30 day supply (home delivery program). No coverage for non-formulary drugs.*	25% coinsurance up to $350 per prescription, deductible does not apply (retail and home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

Your summary of benefits

Notes:

- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.
- 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 in which the child attains age 26.
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- Certain diabetic and asthmatic supplies are available at Network pharmacies, diabetic test strips paid same as any other drug.
- 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.
- Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.
- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
- All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services).
- No Copayment or Coinsurance applies to certain diabetic and asthmatic supplies when you get them from an In-Network Pharmacy. These supplies are covered as Medical Supplies and Durable Medical Equipment if you get them from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment / Coinsurance. Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.
- DME - 50% coinsurance for Network/Non-Network Durable Medical Equipment, Medical Supplies, Orthotics, Asthma Supplies, and Phenylketonuria (PKU). Excludes Prosthetics, Wigs, Diabetic Supplies and Mastectomy prostheses which will apply the plan's cost shares.
- Hospital stay for Maternity Coverage will not be limited to less than 48 hours for a vaginal delivery or 96 hours for a caesarean section.
- The Rx option includes the Essential formulary which is a closed drug list with a focus on therapeutic efficacy and cost effectiveness.
- 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. 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).

- Bariatric Surgery is covered subject to cost share based on setting.
- Immunization through age 5 – No Cost Share up to the maximum allowable amount (Network/Non-Network).
- Benefits are limited to abortions performed to preserve the life of the female upon whom the abortion is performed. Elective abortions are not a Covered Service.
- Urgent Care Facility Copay exclude certain diagnostic test such as MRAs, MRIs, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, Allergy Testing, and Pharmaceutical injection and drugs.
- If you get Covered Services from a Physical Therapist or Occupational Therapist, you will not have to pay an office visit or outpatient Facility Copayment or Coinsurance that is higher than what you would pay for a Primary Care Physician office visit.

Your summary of benefits

Anthem® BlueCross and BlueShield

Your Plan: Russell Cellular Inc Anthem Blue Access PPO

Your Network: Blue Access

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

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.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.*	$2,500 person / $7,500 family	$5,000 person / $15,000 family
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.*	$5,500 person / $11,000 family	$9,500 person / $19,000 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	50% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit to treat an injury or illness *When Allergy injections are billed separately by network providers, the member is responsible for a $5 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.*	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Specialist Care Visit *When Allergy injections are billed separately by network providers, the member is responsible for a $5 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.*	$50 copay per visit deductible does not apply	50% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prenatal and Post-natal Care *In-Network preventive prenatal services are covered at 100%. All office visit copayments count towards the same visit limit.*	$30 copay per pregnancy for the first visit deductible does not apply and then 20% coinsurance after deductible is met	50% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Preferred On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	$10 copay per visit deductible does not apply	50% coinsurance after deductible is met
Other Participating Provider On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 26 visits per benefit period. Applies to In-Network. Limit is combined across professional visits and outpatient facilities.*	50% coinsurance deductible does not apply	Not covered
Other Services in an Office:		
Allergy Testing	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Chemo/Radiation Therapy Performed by a Primary Care Physician	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Chemo/Radiation Therapy Performed by a Specialist	$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Dialysis/Hemodialysis	No charge	50% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prescription Drugs *For the drugs itself dispensed in the office through infusion/injection.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Diagnostic Services		
Lab:		
Office	No charge	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
X-Ray:		
Office	No charge	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency and Urgent Care		
Urgent Care *When Allergy injections are billed separately by network providers, the member is responsible for a $5 copay. When billed as part of an office visit, there is no additional cost to the member for the injection. The urgent care office visit cost share applies to both office and facility based urgent care providers.*	$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$250 copay per visit and 20% coinsurance deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance deductible does not apply	Covered as In-Network
Ambulance (Air, Ground, and Water)	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Facility visit:		
Facility Fees	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Surgery		
Facility Fees:		
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospital Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse)		
Facility fees (for example, room & board) *Coverage is limited to 60 days per benefit period. Limit is combined In-Network and Non-Network. Benefit includes coverage for Outpatient Rehabilitation program.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Human Organ and Tissue Transplants *Acquisition and transplant procedures, collection and storage. Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and other services	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 100 visits per benefit period. Limit is combined In-Network and Non-Network.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for Occupational Rehabilitation services is limited to 20 visits per benefit period. Coverage for Physical Rehabilitation and Manipulation Therapy services is limited to 20 visits per benefit period. Limit does not apply to manipulation performed by a Chiropractor. Limit is combined In-network and Non-Network across professional and outpatient visits. Speech Therapy has no visit limit. Benefit limit does not apply to Applied Behavioral Analysis. Benefit limit does not apply when performed as part of Early Intervention.*	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital *Coverage for Occupational Rehabilitation services is limited to 20 visits per benefit period. Coverage for Physical Rehabilitation and Manipulation Therapy services is limited to 20 visits per benefit period. Limit does not apply to manipulation performed by a Chiropractor. Limit is combined In-network and Non-Network across professional and outpatient visits. Speech Therapy has no visit limit. Benefit limit does not apply to Applied Behavioral Analysis. Benefit limit does not apply when performed as part of Early Intervention.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Cardiac rehabilitation		
Office *Coverage is limited to 36 visits per benefit period. Limit is combined In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital *Coverage is limited to 36 visits per benefit period. Limit is combined In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pulmonary rehabilitation		
Office *Coverage is limited to 20 visits per benefit period. Limit is combined In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital *Coverage is limited to 20 visits per benefit period. Limit is combined In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (in a facility) *Coverage is limited to 90 days per benefit period. Limit is combined In-Network and Non-Network. Benefit includes coverage for Outpatient Rehabilitation program.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospice	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Durable Medical Equipment	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs needed after cancer treatment is limited to 1 item per benefit period. Limit is combined In-Network and Non-Network.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out of Pocket	Combined with medical out of pocket maximum	Combined with medical out of pocket maximum
Prescription Drug Coverage *Essential Drug List* *This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.*		
Tier 1 - Typically Generic *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	$15 copay per prescription, deductible does not apply (retail and home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	$45 copay per prescription, deductible does not apply (retail) and $112 copay per prescription, deductible does not apply (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	$75 copay per prescription, deductible does not apply (retail) and $225 copay per prescription, deductible does not apply (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Tier 4 - Typically Specialty (brand and generic) *Covers up to a 30 day supply (retail pharmacy). Covers up to a 30 day supply (home delivery program). No coverage for non-formulary drugs.*	25% coinsurance up to $350 per prescription, deductible does not apply (retail and home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

Your summary of benefits

Notes:

- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.
- 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 in which the child attains age 26.
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- Certain diabetic and asthmatic supplies are available at Network pharmacies, diabetic test strips paid same as any other drug.
- 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.
- Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.
- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
- All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services).
- No Copayment or Coinsurance applies to certain diabetic and asthmatic supplies when you get them from an In-Network Pharmacy. These supplies are covered as Medical Supplies and Durable Medical Equipment if you get them from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment / Coinsurance. Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.
- DME - 50% coinsurance for Network/Non-Network Durable Medical Equipment, Medical Supplies, Orthotics, Asthma Supplies, and Phenylketonuria (PKU). Excludes Prosthetics, Wigs, Diabetic Supplies and Mastectomy prostheses which will apply the plan's cost shares.
- Hospital stay for Maternity Coverage will not be limited to less than 48 hours for a vaginal delivery or 96 hours for a caesarean section.
- The Rx option includes the Essential formulary which is a closed drug list with a focus on therapeutic efficacy and cost effectiveness.
- 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. 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).

- Bariatric Surgery is covered subject to cost share based on setting.
- Immunization through age 5 – No Cost Share up to the maximum allowable amount (Network/Non-Network).
- Benefits are limited to abortions performed to preserve the life of the female upon whom the abortion is performed. Elective abortions are not a Covered Service.
- Urgent Care Facility Copay exclude certain diagnostic test such as MRAs, MRIs, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, Allergy Testing, and Pharmaceutical injection and drugs.
- If you get Covered Services from a Physical Therapist or Occupational Therapist, you will not have to pay an office visit or outpatient Facility Copayment or Coinsurance that is higher than what you would pay for a Primary Care Physician office visit.

Your summary of benefits

Anthem® BlueCross and BlueShield

Your Plan: Russell Cellular Inc Anthem Blue Access PPO

Your Network: Blue Access

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

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.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.*	$5,000 person / $10,000 family	$15,000 person / $30,000 family
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.*	$7,000 person / $14,000 family	$20,000 person / $40,000 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	50% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit to treat an injury or illness *When Allergy injections are billed separately by network providers, the member is responsible for a $5 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.*	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Specialist Care Visit *When Allergy injections are billed separately by network providers, the member is responsible for a $5 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.*	$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Prenatal and Post-natal Care *In-Network preventive prenatal services are covered at 100%. All office visit copayments count towards the same visit limit.*	$30 copay per pregnancy for the first 1 visit deductible does not apply then 20% coinsurance after deductible is met	50% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Preferred On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	$10 copay per visit deductible does not apply	50% coinsurance after deductible is met
Other Participating Provider On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 26 visits per benefit period. Applies to In-Network. Limit is combined across professional visits and outpatient facilities.*	50% coinsurance deductible does not apply	Not covered
Other Services in an Office:		
Allergy Testing	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Chemo/Radiation Therapy Performed by a Primary Care Physician	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Chemo/Radiation Therapy Performed by a Specialist	$50 copay per visit deductible does not apply	50% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Dialysis/Hemodialysis	No charge	50% coinsurance after deductible is met
Prescription Drugs *For the drugs itself dispensed in the office through infusion/injection.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Diagnostic Services		
Lab:		
Office	No charge	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
X-Ray:		
Office	No charge	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency and Urgent Care		
Urgent Care *When Allergy injections are billed separately by network providers, the member is responsible for a $5 copay. When billed as part of an office visit, there is no additional cost to the member for the injection. The urgent care office visit cost share applies to both office and facility based urgent care providers.*	$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$250 copay per visit and 20% coinsurance deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance deductible does not apply	Covered as In-Network
Ambulance (Air, Ground, and Water) *Non-emergency non-network Ambulance Services are unlimited.*	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Facility visit:		
Facility Fees	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Surgery		
Facility Fees:		
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospital Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse)		
Facility fees (for example, room & board) *Coverage for inpatient physical medicine and rehabiliation including day rehabiliation programs is limited to 60 days per benefit period. Limit is combined In-Network and Non-Network. Benefit includes coverage for Outpatient Rehabilitation program.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Human Organ and Tissue Transplants *Acquisition and transplant procedures, collection and storage. Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and other services	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 100 visits per benefit period. Coverage for private duty nursing is limited to 82 visits per benefit period and 164 visits per lifetime. Limit is combined In-Network and Non-Network.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for Occupational Rehabilitation services is limited to 20 visits per benefit period. Coverage for Physical Rehabilitation and Manipulation Therapy services is limited to 20 visits per benefit period. Limit does not apply to manipulation performed by a Chiropractor. Limit is combined In-network and Non-Network across professional and outpatient visits. Speech Therapy has no visit limit. Benefit limit does not apply to Applied Behavioral Analysis. Benefit limit does not apply when performed as part of Early Intervention.*	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital *Coverage for Occupational Rehabilitation services is limited to 20 visits per benefit period. Coverage for Physical Rehabilitation and Manipulation Therapy services is limited to 20 visits per benefit period. Limit does not apply to manipulation performed by a Chiropractor. Limit is combined In-network and Non-Network across professional and outpatient visits. Speech Therapy has no visit limit. Benefit limit does not apply to Applied Behavioral Analysis. Benefit limit does not apply when performed as part of Early Intervention.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Cardiac rehabilitation		
Office *Coverage is limited to 36 visits per benefit period. Limit is combined In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital *Coverage is limited to 36 visits per benefit period. Limit is combined In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pulmonary rehabilitation		
Office *Coverage is limited to 20 visits per benefit period. Limit is combined In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital *Coverage is limited to 20 visits per benefit period. Limit is combined In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (in a facility) *Coverage is limited to 90 days per benefit period. Limit is combined In-Network and Non-Network. Benefit includes coverage for Outpatient Rehabilitation program.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospice	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Durable Medical Equipment	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs needed after cancer treatment is limited to 1 item per benefit period. Limit is combined In-Network and Non-Network.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out of Pocket	Combined with medical out of pocket maximum	Combined with medical out of pocket maximum
Prescription Drug Coverage *Essential Drug List* *This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.*		
Tier 1 - Typically Generic *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	$15 copay per prescription, deductible does not apply (retail and home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	$45 copay per prescription, deductible does not apply (retail) and $112 copay per prescription, deductible does not apply (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	$75 copay per prescription, deductible does not apply (retail) and $225 copay per prescription, deductible does not apply (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Tier 4 - Typically Specialty (brand and generic) *Covers up to a 30 day supply (retail pharmacy). Covers up to a 30 day supply (home delivery program). No coverage for non-formulary drugs.*	25% coinsurance up to $350 per prescription, deductible does not apply (retail and home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

Your summary of benefits

Notes:

- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.
- 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 in which the child attains age 26.
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- Certain diabetic and asthmatic supplies are available at Network pharmacies, diabetic test strips paid same as any other drug.
- 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.
- Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.
- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
- All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services).
- No Copayment or Coinsurance applies to certain diabetic and asthmatic supplies when you get them from an In-Network Pharmacy. These supplies are covered as Medical Supplies and Durable Medical Equipment if you get them from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment / Coinsurance. Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.
- DME - 50% coinsurance for Network/Non-Network Durable Medical Equipment, Medical Supplies, Orthotics, Asthma Supplies, and Phenylketonuria (PKU). Excludes Prosthetics, Wigs, Diabetic Supplies and Mastectomy prostheses which will apply the plan's cost shares.
- Hospital stay for Maternity Coverage will not be limited to less than 48 hours for a vaginal delivery or 96 hours for a caesarean section.
- The Rx option includes the Essential formulary which is a closed drug list with a focus on therapeutic efficacy and cost effectiveness.
- 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. 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).

- Bariatric Surgery is covered subject to cost share based on setting.
- Immunization through age 5 – No Cost Share up to the maximum allowable amount (Network/Non-Network).
- Benefits are limited to abortions performed to preserve the life of the female upon whom the abortion is performed. Elective abortions are not a Covered Service.
- Urgent Care Facility Copay exclude certain diagnostic test such as MRAs, MRIs, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, Allergy Testing, and Pharmaceutical injection and drugs.
- If you get Covered Services from a Physical Therapist or Occupational Therapist, you will not have to pay an office visit or outpatient Facility Copayment or Coinsurance that is higher than what you would pay for a Primary Care Physician office visit.

Dental

Russell Cellular Inc. will remain with **Anthem** for plan year July 1, 2020 – June 30, 2021 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***

Your Summary of Benefits
Russell Cellular - Base Plan Effective Date: 07/01/2020
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.**

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.

6/2014

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.

6/2014

Your Summary of Benefits
Russell Cellular - Buy-Up Plan Effective Date: 07/01/2020
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.**

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.

6/2014

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.

6/2014

Vision

Russell Cellular Inc. will remain with **Anthem** for plan year July 1, 2020 – June 30, 2021 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, 2020	
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, 2020

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

Benefits effective July 1, 2020

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, 2020:

- 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 Enrollment 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 2020-2021 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?

- Ascentis Self-Service page under the Open Enrollment widget

When are the forms due and where do I return them?

- All changes must be submitted by **06/24/2020. 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 your ES Team to reset your changes, you will then be able to re-enter your enrollment options.

Who do I contact with questions?

- Contact Employee Services 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, 2020 to June 30, 2021.***

- ***If you do not make changes to your current optional life elections, those elections will remain the same for the plan year July 1, 2020 to June 30, 2021.***

- ***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, 2020 to June 30, 2021.***

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 Employee Services.

Take care of yourself
Use your preventive care benefits

Anthem

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 or lab 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)[3]
- 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
- Tuberculosis screening
- 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
- Screening and counseling for interpersonal and domestic violence
- Pregnancy screenings, including gestational diabetes, hepatitis B, asymptomatic bacteriuria, Rh incompatibility, syphilis, HIV and depression[6]
- Pelvic exam and Pap test, including screening for cervical cancer

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

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

* CDC-recognized Diabetes Prevention programs are available for overweight or obese adults with abnormal blood glucose or who have abnormal CVD risk factors.

43199MUMENABS VPOD Rev. 9/18

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)
- Lead testing
- Newborn screening
- Screening and counseling for obesity
- Counseling for those ages 10–24 with fair skin about lowering their risk for skin cancer
- Oral (dental health) assessment when done as part of a preventive care visit
- Screening and counseling for sexually transmitted infections
- Tobacco use: related screening and behavioral counseling
- Vision screening when done as part of a preventive care visit[2]

Immunizations:

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

A word about pharmacy items

For 100% coverage of your over-the-counter (OTC) drugs and other pharmacy items listed here, you must:

- Meet certain age requirements and other rules.
- Get prescriptions from plan providers and fill them at plan pharmacies.
- Have prescriptions, even for OTC items.

Adult preventive drugs and other pharmacy items — age appropriate:

- Aspirin use (81 mg and 325 mg) for the prevention of cardiovascular disease, preeclampsia and colorectal cancer by adults less than 70 years old.
- Colonoscopy prep kit (generic or OTC only) when prescribed for preventive colon screening
- Generic low to moderate dose statins for members that are 40-75 years and have 1 or more CVD risk factors (dyslipidemia, diabetes, hypertension, or smoking)
- Tobacco-cessation products, including all FDA-approved brand and generic OTC and prescription products, for those ages 18 and older

Child preventive drugs and other pharmacy items — age appropriate:

- Dental fluoride varnish to prevent the tooth decay of primary teeth for children ages 0-5
- Fluoride supplements for children ages 6 months to 16 years old

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

- Contraceptives, including generic prescription drugs, brand-name drugs with no generic equivalent and OTC items like female condoms and spermicides[6,8,9]
- Low-dose aspirin (81 mg) for pregnant women who are at increased risk of preeclampsia
- Folic acid for women ages 55 or younger who are planning and able to get pregnant

Breast cancer risk-reducing medications, such as tamoxifen and raloxifene, that follow the U.S. Preventive Services Task Force criteria[3]

For a complete list of covered preventive drugs under the Affordable Care Act, view the Preventive ACA Drug List flier available at anthem.com/pharmacyinformation.

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

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

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

4 Check your medical policy for details.

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

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

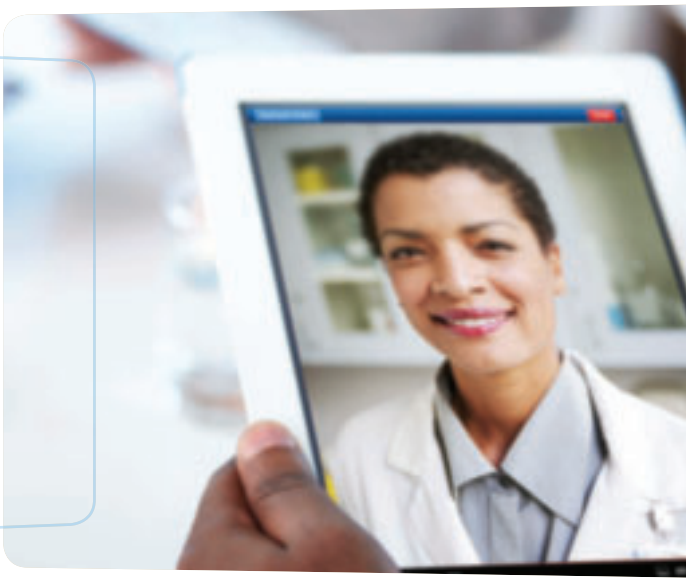
7 Counseling services for breastfeeding (lactation) can be provided or supported by a plan doctor or hospital provider, such as a pediatrician, obstetrician/gynecologist or family medicine doctor, and hospitals with no member cost share (deductible, copay, coinsurance). Contact the provider to see if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

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

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

See a doctor or therapist when it works for you

Using LiveHealth Online, any time works for a video visit with a doctor or therapist.



If you need care for a health issue, or support if you're feeling anxious or having trouble coping on your own, LiveHealth Online is ready to help. You can stay home and have a video visit with a board-certified doctor or licensed therapist on your smartphone, tablet or computer.

By using LiveHealth Online, you can

- **See a board-certified doctor in a few minutes with no appointment.** Doctors are available 24/7 to assess your condition and, if it's needed, they can send a prescription to your local pharmacy.[1] When your own doctor isn't available, use LiveHealth Online if you have pinkeye, a cold, the flu, a fever, allergies, a sinus infection or another common health condition.
- **Make an appointment with a licensed therapist in four days or less.**[2] You can have a video visit with a therapist from home, at work or on the go — evenings and weekend appointments are available too. Appointments can be scheduled online or over the phone at **1-888-548-3432** from 7 a.m. to 7 p.m., seven days a week. You can get help for anxiety, depression, grief, panic attacks and more.

What will a visit cost?

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

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

Go to **livehealthonline.com** or download the app and register on your phone or tablet.

Download on the App Store

ANDROID APP ON Google play

Anthem

LiveHealth ONLINE

60019ANMENABS_MP VPOD 06/17

Anthem

Say hi to Sydney

Anthem's new app is simple, smart — and all about you

With Sydney, you can find everything you need to know about your Anthem benefits – personalized and all in one place. Sydney makes it easier to get things done, so you can spend more time focused on your health.

Get started with Sydney
Download the app today!

GET IT ON Google Play

Download on the App Store

Simple

Ready for you to use quickly, easily, seamlessly — with one-click access to benefits info, Member Services, wellness resources and more.

Smart

Sydney acts like a personal health guide, answering your questions and connecting you to the right resources at the right time. And you can use the chatbot to get answers quickly.

Personal

Get alerts, reminders and tips directly from Sydney. Get doctor suggestions based on your needs. The more you use it, the more Sydney can help you stay healthy and save money.

With just one click, you can:

- Find care and check costs
- Check all benefits
- See claims
- Get answers even faster with our chatbot
- View and use digital ID cards

Already using one of our apps?

It's easy to make the switch. Simply download the Sydney app and log in with your Anthem username and password.

115993MUMENABS 06/19

Need a doctor – and no surprises?

Use Care & Cost Finder

Life happens. When it does, we've got your back.

There's a lot to think about when you need care. Things like the best place to go and what's covered by your benefits. Care & Cost Finder helps you put an end to the guesswork. Included in this powerful tool is the Personalized Match* sort option. This provides customized search results based on your location, unique profile, and history to help you find the right doctor for you.

Find a doctor, check quality and compare costs all in one place — on the go or online!

You can search for doctors, dentists, pharmacies, hospitals and other health care providers in your plan with the Anthem Anywhere app or on **anthem.com**. You'll get important facts like office location, services provided, gender, languages spoken, patient ratings and if providers have received awards for high-quality care.

Care & Cost Finder includes costs for different kinds of care. You can compare doctors and costs side by side and get an estimate of what you'll pay based on your benefits.

It's easy to find, easy to use — and all in one place.

Ready to start using Care & Cost Finder?

Just register or log in with the **Anthem Anywhere** mobile app today. You can also use **anthem.com** to get the same great information.

Download on the App Store

ANDROID APP ON Google play

It's easy. Everything you need to know about your plan is in one place – your medical, pharmacy, dental, vision, life insurance – all in one. Making your health care journey simple, personal – all about you.

63020MUMENABS VPOD Rev. 06/19

Anthem

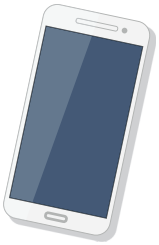
Looking for a doctor?

Finding one online is fast and easy

The right doctor can make all the difference — and choosing one in your plan can save you money, too. Our **Find a Doctor** tool helps you find doctors, dentists, hospitals, labs and other health care providers in your plan. If you decide to get care from doctors outside the plan, it'll cost you more and your care might not be covered at all.

Here's all you need to do to find a doctor near you:

1. Go to **anthem.com/find-doctor**
2. You can look for a doctor by using either:
   - **Search as a member:** Log in with a username and password or with the member number on your ID card.
   - **Search as guest:** Select a plan or network,* or search by all plans and networks, to get started.
3. Once you log in, select the **Find Care** option on the welcome menu.
4. Next, choose who you'd like to see. You can search for a doctor nearby or use the doctor's name.
5. Select a provider to get details, like:
   - Specialties
   - Gender
   - Languages spoken
   - Training
   - A map of their office location
   - Phone number



Going mobile

Search for doctors, hospitals and more on your smartphone or mobile device.
And don't forget that going mobile keeps everything you need to know about your plan — including medical, pharmacy, dental, vision, life insurance — in one place. It's simple, personal and all about you. Simply download the **Sydney** app to get started.

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

00734ANMENABS VPOD Rev. 06/19

Anthem

It Pays to Go the Extra Mile for Your Health

Earn up to $200 through Anthem Health Rewards

Get rewarded for healthy living activities you may already be doing, such as getting preventive care and being tobacco-free. There are a variety of health and wellness programs that you and your covered spouse or partner can participate in to earn rewards.

Tobacco–free Certification - $50[1]
For not using tobacco products during the previous six months.

Health Assessment - $50
For completing a free health assessment.

Well-Being Coach: Lifestyle Management
One-on-one support for employees and their covered family members.

Flu Shot + Wellness Visit - $100[2]
For receiving both a preventive wellness exam and flu shot.

Ready to Get Started?

It's easy, here's how:

1. Register online at **anthem.com**
2. Once you are logged in, go to the **Health & Wellness** section
3. Select **Get My Rewards**

You'll be taken to the Anthem Health Rewards site, where you can view activities and start earning rewards.

1. To earn the tobacco-free certification reward, an associate must log in to anthem.com and certify they are tobacco-free.
2. Rewards will show in account when the provider submits claims to Anthem after the associate receives their annual preventive wellness exam and flu shot.

RussellCellular

Your Employee Services Department

ES ABBA Team:

- Phone: 417-886-7542 x1630
- Email: HRAABA@RussellCellular.com

ES ABBO Team

- Phone: 417-886-7542 x1631
- Email: HRABBO@RussellCellular.com

ES ACLU Team

- Phone: 417-886-7542 x1632
- Email: HRACLU@RussellCellular.com

Amanda Mika – Employee Services Assistant Manager

- Phone: 417-886-7542 x1603
- Email: Amanda.Mika@RussellCellular.com

John Bogue -- Employee Services Coordinator

- Phone: 417-886-7542 x1655
- Email: John.Bogue@RussellCellular.com

Diane Manning – Employee Services Manager

- Phone: 417-886-7542 x1012
- Email: Diane.Manning@RussellCellular.com