



# 2021 Comparison Of Statewide Plans

Effective July 1, 2021 or October 1, 2021

# The Local Choice 2021 Comparison of Statewide Plans

	Key Advantage Expanded	Key Advantage 250
<b>Plan Year Deductible</b> (Key Advantage: Applies to Certain Medical Services as Indicated on Chart)  (HDHP: Applies to Medical, Behavioral Health, and Prescription Drug Services)	<b>In-Network:</b> One Person    Two People    Family \$100            See Family       \$200  <b>Out-of-Network:</b> \$200            See Family       \$400	<b>In-Network:</b> One Person    Two People    Family \$250            See Family       \$500  <b>Out-of-Network:</b> \$500            See Family       \$1,000
<b>Plan Year Out-of-pocket Expense Limit</b>	<b>In-Network:</b> One Person    Two People    Family \$2,000          See Family       \$4,000  <b>Out-of-Network:</b> \$3,000          See Family       \$6,000	<b>In-Network:</b> One Person    Two People    Family \$3,000          See Family       \$6,000  <b>Out-of-Network:</b> \$5,000          See Family       \$10,000
<b>Out-of-Network Benefits</b>	Yes. Once you meet the out-of-network deductible, you pay 30% coinsurance for medical and behavioral health services. Copayments do not apply to medical and behavioral health services. Copayments and coinsurance for routine vision, outpatient prescription drugs and dental services will still apply.	Yes. Once you meet the out-of-network deductible, you pay 30% coinsurance for medical and behavioral health services. Copayments do not apply to medical and behavioral health services. Copayments and coinsurance for routine vision, outpatient prescription drugs and dental services will still apply.
<b>Medical Care When Traveling (BlueCard)</b>	Included	Included
<b>Lifetime Maximum</b>	Unlimited	Unlimited
<b>Covered Services</b>	<b>In-Network You Pay</b>	<b>In-Network You Pay</b>
<b>Ambulance Travel</b>	20% coinsurance after deductible	20% coinsurance after deductible
<b>Autism Spectrum Disorder</b>	Copayment/coinsurance determined by service received	Copayment/coinsurance determined by service received
<b>Behavioral Health and EAP</b> <i>Inpatient treatment</i> • Facility Services • Professional Provider Services  <i>Outpatient Professional Provider Visits</i>	\$300 copayment per stay \$0  \$15 copayment	\$400 copayment per stay \$0  \$20 copayment
<b>Employee Assistance Program (EAP)</b> 4 visits per issue (per plan year)	\$0	\$0
<b>Dental Care</b> <b>Preventive Dental Option</b> ( <i>diagnostic and preventive services only for lower premium</i> )	\$0	\$0
<b>Comprehensive Dental Option</b> (for higher premium)	<i>One Person    Two People    Family</i> \$25            \$50            \$75	<i>One Person    Two People    Family</i> \$25            \$50            \$75
Dental Plan Year Deductible Plan Year Maximum (Except Orthodontics)	\$1,500	\$1,500
• Preventive Dental Care • Primary Dental Care • Major Dental Care • Orthodontic Services (Includes Adult Ortho)	\$0 20% coinsurance after dental deductible 50% coinsurance after dental deductible 50% coinsurance, no dental deductible, with \$1,500 lifetime maximum	\$0 20% coinsurance after dental deductible 50% coinsurance after dental deductible 50% coinsurance, no dental deductible, with \$1,500 lifetime maximum

## Key Advantage 500

## Key Advantage 1000

## High Deductible Health Plan

### In-Network:

One Person	Two People	Family
\$500	See Family	\$1,000

### Out-of-Network:

One Person	Two People	Family
\$1,000	See Family	\$2,000

### In-Network:

One Person	Two People	Family
\$1,000	See Family	\$2,000

### Out-of-Network:

One Person	Two People	Family
\$2,000	See Family	\$4,000

One Person	Two People	Family
\$2,800	See Family	\$5,600

Deductible is combined for In-Network and Out-of-Network services.

### In-Network:

One Person	Two People	Family
\$4,000	See Family	\$8,000

### Out-of-Network:

One Person	Two People	Family
\$7,000	See Family	\$14,000

### In-Network:

One Person	Two People	Family
\$5,000	See Family	\$10,000

### Out-of-Network:

One Person	Two People	Family
\$9,000	See Family	\$18,000

### In-Network:

One Person	Two People	Family
\$5,000	See Family	\$10,000

### Out-of-Network:

One Person	Two People	Family
\$10,000	See Family	\$20,000

Yes. Once you meet the out-of-network deductible, you pay 30% coinsurance for medical and behavioral health services. Copayments do not apply to medical and behavioral health services. Copayments and coinsurance for routine vision, outpatient prescription drugs and dental services will still apply.

Yes. Once you meet the out-of-network deductible, you pay 30% coinsurance for medical and behavioral health services. Copayments do not apply to medical and behavioral health services. Copayments and coinsurance for routine vision, outpatient prescription drugs and dental services will still apply.

Yes. Once you meet the combined deductible you pay 40% coinsurance for medical, behavioral health and prescription drug services from Out-of-Network providers.

Included

Included

Included

Unlimited

Unlimited

Unlimited

## In-Network You Pay

## In-Network You Pay

## In-Network You Pay

20% coinsurance after deductible

20% coinsurance after deductible

20% coinsurance after deductible

Copayment/coinsurance determined by service received

Copayment/coinsurance determined by service received

20% coinsurance after deductible

20% coinsurance after deductible

20% coinsurance after deductible

20% coinsurance after deductible

\$0

\$0

20% coinsurance after deductible

\$25 copayment

\$25 copayment

20% coinsurance after deductible

\$0

\$0

\$0

\$0

\$0

\$0

One Person

Two People

Family

\$25

\$50

\$75

One Person

Two People

Family

\$25

\$50

\$75

One Person

Two People

Family

\$25

\$50

\$75

\$1,500

\$1,500

\$1,500

\$0

\$0

\$0

20% coinsurance after dental deductible

20% coinsurance after dental deductible

20% coinsurance after dental deductible

50% coinsurance after dental deductible

50% coinsurance after dental deductible

50% coinsurance after dental deductible

50% coinsurance, no dental deductible, with \$1,500 lifetime maximum

50% coinsurance, no dental deductible, with \$1,500 lifetime maximum

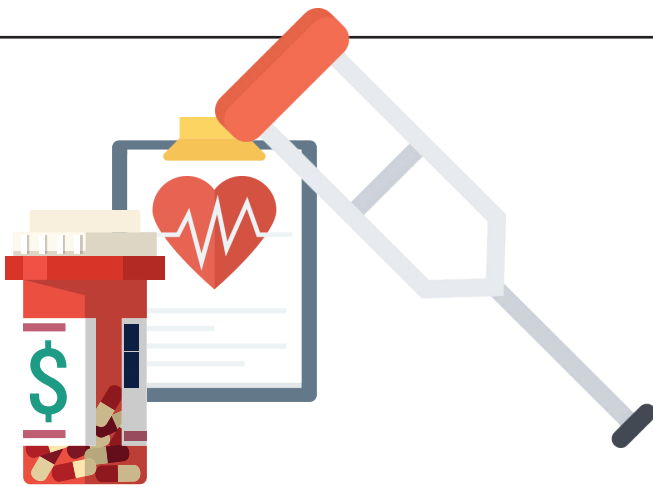
50% coinsurance, no dental deductible, with \$1,500 lifetime maximum

# The Local Choice 2021 Comparison of Statewide Plans (continued)

Covered Services	Key Advantage Expanded In-Network You Pay	Key Advantage 250 In-Network You Pay
<b>Diabetic Education</b>	\$0	\$0
<b>Diabetic Equipment</b>	20% coinsurance after deductible	20% coinsurance after deductible
<b>Diabetic Supplies - See Outpatient Prescription Drugs</b>		
<b>Diagnostic Tests and X-rays</b> (for specific conditions or diseases at a doctor's office, emergency room or outpatient hospital department)	20% coinsurance, no deductible	20% coinsurance after deductible
<b>Doctor Visits – on an Outpatient Basis</b> <i>Primary Care Physicians</i> <i>Specialty Care Providers</i>	\$15 copayment \$25 copayment	\$20 copayment \$35 copayment
<b>Early Intervention Services</b>	Copayment/coinsurance determined by service received	Copayment/coinsurance determined by service received
<b>Emergency Room Visits</b> <i>Facility Services</i>  <i>Professional Provider Services</i> – Primary Care Physicians – Specialty Care Providers <i>Diagnostic Tests and X-rays</i>	\$250 copayment per visit (waived if admitted to hospital)  \$15 copayment \$25 copayment 20% coinsurance, no deductible	\$350 copayment per visit (waived if admitted to hospital)  \$20 copayment \$35 copayment 20% coinsurance after deductible
<b>Home Health Services</b> (90 visit plan year limit per member)	\$0	\$0
<b>Home Private Duty Nurse's Services</b>	20% coinsurance after deductible	20% coinsurance after deductible
<b>Hospice Care Services</b>	\$0	\$0
<b>Hospital Services</b> <i>Inpatient Treatment</i> • Facility Services • Professional Provider Services – Primary Care Physicians – Specialty Care Providers  <i>Outpatient Treatment</i> • Facility Services • Professional Provider Services – Primary Care Physicians – Specialty Care Providers <i>Diagnostic Tests and X-Rays</i>	\$300 copayment per stay  \$0 \$0  \$100 copayment  \$15 copayment \$25 copayment 20% coinsurance, no deductible	\$400 copayment per stay  \$0 \$0  \$150 copayment  \$20 copayment \$35 copayment 20% coinsurance after deductible
<b>LiveHealth Online</b> (Online doctor's visits)	\$0	\$0



Key Advantage 500 In-Network You Pay	Key Advantage 1000 In-Network You Pay	High Deductible Health Plan In-Network You Pay
\$0	\$0	20% coinsurance after deductible
20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
\$25 copayment \$40 copayment	\$25 copayment \$40 copayment	20% coinsurance after deductible 20% coinsurance after deductible
Copayment/coinsurance determined by service received	Copayment/coinsurance determined by service received	20% coinsurance after deductible
20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
\$25 copayment \$40 copayment 20% coinsurance after deductible	\$25 copayment \$40 copayment 20% coinsurance after deductible	20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible
\$0	\$0	20% coinsurance after deductible
20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
\$0	\$0	20% coinsurance after deductible
20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
\$0 \$0	\$0 \$0	20% coinsurance after deductible 20% coinsurance after deductible
20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
\$25 copayment \$40 copayment 20% coinsurance after deductible	\$25 copayment \$40 copayment 20% coinsurance after deductible	20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible
\$0	\$0	Determined by services received



# The Local Choice 2021 Comparison of Statewide Plans (continued)

Covered Services	Key Advantage Expanded In-Network You Pay	Key Advantage 250 In-Network You Pay
<b>Maternity</b> <i>Professional Provider Services (Prenatal &amp; Postnatal Care)</i> – Primary Care Physicians – Specialty Care Providers  <i>Delivery</i> – Primary Care Physicians – Specialty Care Providers  <i>Hospital Services for Delivery (Delivery Room, Anesthesia, Routine Nursing Care for Newborn)</i>  <i>Outpatient Diagnostic Tests</i>	\$15 copayment \$25 copayment If your doctor submits one bill for delivery, prenatal and postnatal care services, there is no copayment required for physician care. If your doctor bills for these services separately, your payment responsibility will be determined by the services received.  \$0 \$0 \$300 copayment per stay*  20% coinsurance, no deductible	\$20 copayment \$35 copayment   \$0 \$0 \$400 copayment per stay*  20% coinsurance after deductible
<b>Medical Equipment, Appliances, Formulas, Prosthetics and Supplies</b>	20% coinsurance after deductible	20% coinsurance after deductible
<b>Outpatient Prescription Drugs - Mandatory Generic</b> <i>Retail up to 34-day supply*</i> *You may purchase up to a 90-day supply at a retail pharmacy by paying multiple copayments, or the coinsurance after the deductible  <i>Home Delivery Services (Mail Order)</i> Covered Drugs for up to a 90-Day Supply	Tier 1 - \$10 copayment Tier 2 - \$30 copayment Tier 3 - \$45 copayment Tier 4 - \$55 copayment  Tier 1 - \$20 copayment Tier 2 - \$60 copayment Tier 3 - \$90 copayment Tier 4 - \$110 copayment	Tier 1 - \$10 copayment Tier 2 - \$30 copayment Tier 3 - \$45 copayment Tier 4 - \$55 copayment  Tier 1 - \$20 copayment Tier 2 - \$60 copayment Tier 3 - \$90 copayment Tier 4 - \$110 copayment
<b>Diabetic Supplies</b>	20% coinsurance, no deductible	20% coinsurance, no deductible
<b>Routine vision - Blue View Vision Network</b> (Once Every Plan Year) <i>Routine Eye Exam</i> <i>Eyeglass Lenses</i> <i>Eyeglass Frames</i> <i>Contact Lenses (In Lieu of Eyeglass Lenses)</i> <ul style="list-style-type: none"> <li>• Elective</li> <li>• Non-Elective</li> </ul> <i>Upgrade Eyeglass Lenses (Available for Additional Cost)</i> <ul style="list-style-type: none"> <li>• UV Coating, Tints, Standard Scratch-Resistant</li> <li>• Standard Polycarbonate</li> <li>• Standard Progressive</li> <li>• Standard Anti-Reflective</li> <li>• Other Add-Ons</li> </ul>	\$25 copayment \$20 copayment Up to \$100 retail allowance**  Up to \$100 retail allowance Up to \$250 retail allowance  \$15 \$40 \$65 \$45 20% off retail	\$35 copayment \$20 copayment Up to \$100 retail allowance**  Up to \$100 retail allowance Up to \$250 retail allowance  \$15 \$40 \$65 \$45 20% off retail
<b>Shots - Allergy &amp; Therapeutic Injections</b> (At Doctor's Office, Emergency Room or Outpatient Hospital Department)	20% coinsurance, no deductible	20% coinsurance after deductible

\*This plan will waive the hospital copayment if the member enrolls in the maternity management pre-natal program within the first 16 weeks of pregnancy, has a dental cleaning during pregnancy and satisfactorily completes the program.

\*\*You may select a frame greater than the covered allowance and receive a 20% discount for any additional cost over the allowance.



**Key Advantage 500  
In-Network You Pay**

**Key Advantage 1000  
In-Network You Pay**

**High Deductible Health Plan  
In-Network You Pay**

\$25 copayment  
\$40 copayment

If your doctor submits one bill for delivery, prenatal and postnatal care services, there is no copayment required for physician care. If your doctor bills for these services separately, your payment responsibility will be determined by the services received.

\$0  
\$0

20% coinsurance after deductible

20% coinsurance after deductible

20% coinsurance after deductible

\$25 copayment  
\$40 copayment

\$0  
\$0

20% coinsurance after deductible

20% coinsurance after deductible

20% coinsurance after deductible

20% coinsurance after deductible  
20% coinsurance after deductible

20% coinsurance after deductible  
20% coinsurance after deductible

20% coinsurance after deductible

20% coinsurance after deductible

20% coinsurance after deductible

Tier 1 - \$10 copayment  
Tier 2 - \$30 copayment  
Tier 3 - \$45 copayment  
Tier 4 - \$55 copayment

Tier 1 - \$20 copayment  
Tier 2 - \$60 copayment  
Tier 3 - \$90 copayment  
Tier 4 - \$110 copayment

20% coinsurance, no deductible

Tier 1 - \$10 copayment  
Tier 2 - \$30 copayment  
Tier 3 - \$45 copayment  
Tier 4 - \$55 copayment

Tier 1 - \$20 copayment  
Tier 2 - \$60 copayment  
Tier 3 - \$90 copayment  
Tier 4 - \$110 copayment

20% coinsurance, no deductible

20% coinsurance after deductible

20% coinsurance after deductible

20% coinsurance after deductible

\$40 copayment  
\$20 copayment  
Up to \$100 retail allowance\*\*

Up to \$100 retail allowance  
Up to \$250 retail allowance

\$15  
\$40  
\$65  
\$45  
20% off retail

20% coinsurance after deductible

\$40 copayment  
\$20 copayment  
Up to \$100 retail allowance\*\*

Up to \$100 retail allowance  
Up to \$250 retail allowance

\$15  
\$40  
\$65  
\$45  
20% off retail

20% coinsurance after deductible

\$15 copayment  
\$20 copayment  
Up to \$100 retail allowance\*\*

Up to \$100 retail allowance  
Up to \$250 retail allowance

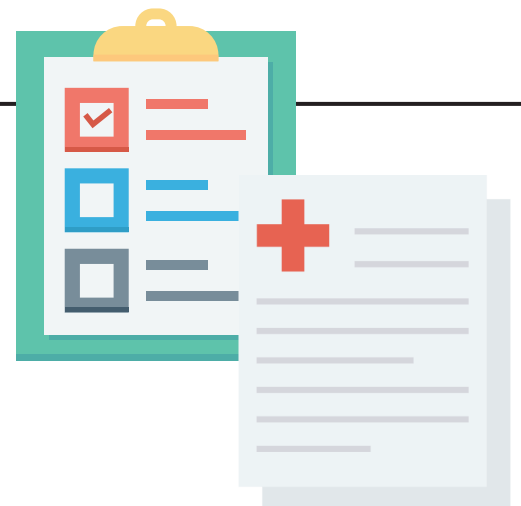
\$15  
\$40  
\$65  
\$45  
20% off retail

20% coinsurance after deductible



# The Local Choice 2021 Comparison of Statewide Plans (continued)

Covered Services	Key Advantage Expanded In-Network You Pay	Key Advantage 250 In-Network You Pay
<b>Skilled Nursing Facility Stays</b> (180-Day Per Stay Limit Per Member) <i>Facility Services</i> <i>Professional Provider Services</i>	\$0 \$0	\$0 \$0
<b>Spinal Manipulations and Other Manual Medical Interventions</b> (30 Visits Per Plan Year Limit Per Member) <i>Primary Care Physicians</i> <i>Specialty Care Providers</i>	\$15 copayment \$25 copayment	\$20 copayment \$35 copayment
<b>Surgery – See Hospital Services</b>		
<b>Therapy Services</b> <i>Infusion Services, Cardiac Rehabilitation Therapy, Chemotherapy, Radiation Therapy, Respiratory Therapy, Occupational Therapy, Physical Therapy, and Speech Therapy</i> <i>Facility Services</i> Professional Provider Services – Primary Care Physicians – Specialty Care Providers	20% coinsurance after deductible  20% coinsurance after deductible 20% coinsurance after deductible	20% coinsurance after deductible  20% coinsurance after deductible 20% coinsurance after deductible
<b>Wellness services</b> <i>Well Child (Office Visits at Specified Intervals Through Age 6)</i> – Primary Care Physicians; – Specialty Care Providers; – Immunizations and Screening Tests  <i>Routine Wellness – Age 7 &amp; Older</i> • Annual Check-Up Visit (One Per Plan Year) – Primary Care Physicians – Specialty Care Providers – Immunizations, Lab and X-Ray Services • Routine Screenings, Immunizations, Lab and X-Ray Services (Outside of Annual Check-Up Visit)  <i>Preventive Care (One of Each Per Plan Year)</i> • Gynecological Exam • Pap Test • Mammography Screening • Prostate Exam (Digital Rectal Exam) • Prostate Specific Antigen Test • Colorectal Cancer Screenings	No copayment, coinsurance, or deductible  No copayment, coinsurance, or deductible  No copayment, coinsurance, or deductible  No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible  No copayment, coinsurance, or deductible  No copayment, coinsurance, or deductible  No copayment, coinsurance, or deductible





**Key Advantage 500  
In-Network You Pay**

**Key Advantage 1000  
In-Network You Pay**

**High Deductible Health Plan  
In-Network You Pay**

\$0

\$0

20% coinsurance after deductible

\$0

\$0

20% coinsurance after deductible

\$25 copayment  
\$40 copayment

\$25 copayment  
\$40 copayment

20% coinsurance after deductible  
20% coinsurance after deductible

20% coinsurance after deductible

20% coinsurance after deductible

20% coinsurance after deductible

20% coinsurance after deductible  
20% coinsurance after deductible

20% coinsurance after deductible  
20% coinsurance after deductible

20% coinsurance after deductible  
20% coinsurance after deductible

No copayment, coinsurance, or deductible

No copayment, coinsurance, or deductible

No copayment, coinsurance, or deductible

No copayment, coinsurance, or deductible

No copayment, coinsurance, or deductible

No copayment, coinsurance, or deductible

No copayment, coinsurance, or deductible

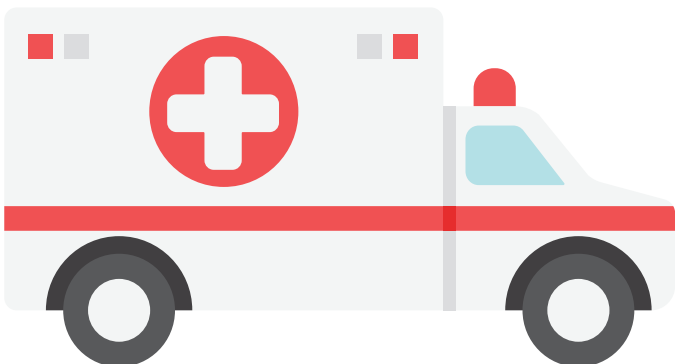
No copayment, coinsurance, or deductible

No copayment, coinsurance, or deductible

No copayment, coinsurance, or deductible

No copayment, coinsurance, or deductible

No copayment, coinsurance, or deductible





# Health & Wellness Programs

Be your healthy best! The TLC plans include access to a host of health and wellness programs to help you manage your health issues.

o **Sydney:** The **Sydney mobile app** 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. Download from the App Store (iOS) or Google Play (Android).

- Find care and check costs
- View and use digital ID cards
- Check all benefits and view claims

o **ConditionCare:** Take advantage of free and confidential support to manage these conditions:

- Asthma
- Heart failure
- Diabetes
- Hypertension
- Chronic obstructive pulmonary disease (COPD)
- High cholesterol
- Coronary artery disease (CAD)
- Metabolic syndrome
- Obesity

You may receive a call from ConditionCare if your claims indicate you or an enrolled family member may be dealing with one or more of these conditions. While you're encouraged to enroll and take advantage of help from registered nurses and other healthcare professionals, you may also opt out of the program when they call.

o **Future Moms:** Enroll and receive pre- and post-natal support. Access a nurse coach and other maternity support specially designed to help women have healthy pregnancies and healthy babies.

o **MyHealth Advantage:** Receive personalized health-related suggestions, tips, and reminders via mail or email to alert you of potential health risks, care gaps or cost-saving opportunities.

o **Staying Healthy Reminders:** Receive yearly reminders of important checkups, tests, screenings, immunizations, and other preventive care needs for you and your family.

o **24/7 NurseLine & Audio Health Tape Library:** Sometimes you need health questions answered right away - even in the middle of the night. Call 24/7 NurseLine (800-337-4770) to speak with a nurse. Or use the Audio Health Library if you want to learn about a health topic on your own. Your call is always free and completely confidential.

o **CommonHealth** is the employee wellness program for The Local Choice. The main objective of CommonHealth is to promote wellness in the workplace. Yearly programs cover a variety of health and wellness subjects and are presented in a variety of formats - including onsite programs and video presentations that make it easy to participate. Not only are the programs educational and fun, they help you stay fit and healthy. For more information, visit [www.commonhealth.virginia.gov/tlc](http://www.commonhealth.virginia.gov/tlc).



See more information on Health & Wellness programs at [www.anthem.com/tlc](http://www.anthem.com/tlc).

## LiveHealthOnline.com

LiveHealth Online lets you have a face-to-face doctor visit from your mobile device or computer with a webcam at **no cost**. Go to [livehealthonline.com](http://livehealthonline.com) or download the app so you'll be ready whenever you need these LiveHealth Online services.

- o **LiveHealth Online Medical** - Use your smartphone, tablet or computer to see a board-certified doctor in minutes, any time, day or night. It's a fast, easy way to get care for common medical conditions like the flu, colds, allergies, pink eye, sinus infections, and more.
- o **LiveHealth Online Psychology** - Use your device to make an appointment to see a therapist or psychologist online.
- o **LiveHealth Online Psychiatry** - Unlike therapists who provide counseling support, psychiatrists can also provide medication management. Use your device to set up a visit online.
- o **LiveHealth Online EAP** - You can access your free EAP counseling sessions from your device. Contact your EAP to learn more.

## Employee Assistance Program (EAP)

Your EAP gives you, your covered dependents and members of your household **up to four free confidential counseling sessions per issue** each plan year.

Turn to your EAP for information and resources about:

- o Emotional well-being
- o Addiction and recovery
- o Work and career
- o Childcare and parenting
- o Helping aging parents
- o Financial issues (including free credit monitoring and identity theft recovery)
- o Legal concerns
- o Smoking cessation

# We're here for you – in many languages

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

## Spanish

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

## Chinese

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

## Vietnamese

Quý vị có quyền nhận miễn phí trợ giúp bằng ngôn ngữ của mình. Chỉ cần gọi số Dịch vụ dành cho thành viên trên thẻ ID của quý vị. Bị khiếm thị? Quý vị cũng có thể hỏi xin định dạng khác của tài liệu này."

## Korean

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

## Tagalog

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

## Russian

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

## Armenian

Դուք իրավունք ունեք ստանալ անվճար օգնություններ լեզվով: Պարզապես զանգահարեք Անդամների սպասարկման կենտրոն, որի հեռախոսահամարը նշված է ձեր ID քարտի վրա:

## Farsi

"شما این حق را دارید تا به صورت رایگان به زبان مادری تان کمک دریافت کنید. کافی است با شماره خدمات اعضا (Member Services) درج شده روی کارت شناسایی خود تماس بگیرید." دچار اختلال بینایی هستید؟ می توانید این سند را به فرمت های دیگری نیز درخواست دهید.

## French

Vous pouvez obtenir gratuitement de l'aide dans votre langue. Il vous suffit d'appeler le numéro réservé aux membres qui figure sur votre carte d'identification. Si vous êtes malvoyant, vous pouvez également demander à obtenir ce document sous d'autres formats.

## Arabic

لك الحق في الحصول على مساعدة بلغتك مجاناً. ما عليك سوى الاتصال برقم خدمة الأعضاء الموجود على بطاقة الهوية. هل أنت ضعيف البصر؟ يمكنك طلب أشكال أخرى من هذا المستند.

## Japanese

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

## Haitian

Se dwa ou pou w jwenn èd nan lang ou gratis. Annik rele nimewo Sèvis Manm ki sou kat ID ou a. Èske ou gen pwoblèm pou wè? Ou ka mande dokiman sa a nan lòt fòm tou.

## Italian

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

## Polish

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

## Punjabi

ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮੁਫਤ ਸੇਵਾਵਾਂ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਆਪਣਾ ਹੱਕ ਹੈ। ਬਸ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਸਿਰਵਸ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। ਨਜ਼ਰ ਕਮਜ਼ੋਰ ਹੈ? ਤੁਸ ਇਸ ਦਸਤਾਵੇਜ਼ ਦੇ ਹੋਰ ਰੂਪਾਂਤਰ ਮੰਗ ਸਕਦੇ ਹੋ।

## TTY/TTD:711





## It's important we treat you fairly

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

# Quick Access to Your Plan






## [Anthem.com/tlc](https://www.anthem.com/tlc)

Your dedicated website for health benefits documents, no log in needed

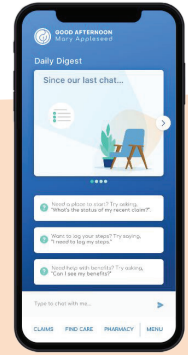
-  Download your health benefits summary and member handbook
-  Find a doctor and urgent care
-  Register for LiveHealth Online video doctor visits
-  Learn about your Employee Assistance Program (EAP)

## [Anthem.com](https://www.anthem.com)




Log in to your confidential and secure account

-  View your claims
-  Download your ID card
-  Find a doctor and urgent care
-  Refill prescriptions online
-  Compare costs for hundreds of medical procedures

## Sydney mobile app

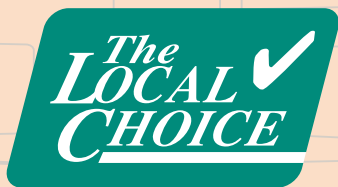


Log in using your anthem.com username and password to:

-  View your ID card
-  See all your medical and pharmacy benefits in one place
-  Use the chatbot to get answers and resources quickly

## [thelocalchoice.virginia.gov](https://www.thelocalchoice.virginia.gov)

This is your resource for forms, BES information and member notifications.



Language Access Services - (TTY/TDD: 711)

(Spanish) - Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda.

(Korean) - 귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오.

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