



2024 Comparison Of Statewide Plans

Effective July 1, 2024 or October 1, 2024

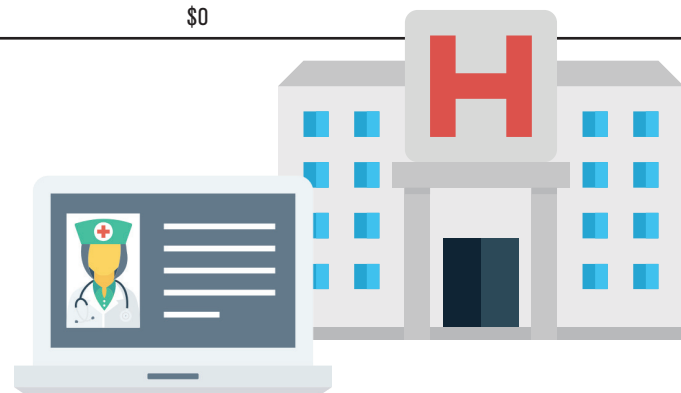
The Local Choice 2024 Comparison of Statewide Plans

	Key Advantage Expanded			Key Advantage 250		
Plan Year Deductible (Key Advantage: Applies to Certain Medical Services as Indicated on Chart) (HDHP: Applies to Medical, Behavioral Health, and Prescription Drug Services)	In-Network: One Person Two People Family \$100 See Family \$200 Out-of-Network: \$200 See Family \$400			In-Network: One Person Two People Family \$250 See Family \$500 Out-of-Network: \$500 See Family \$1,000		
Plan Year Out-of-pocket Expense Limit	In-Network: One Person Two People Family \$2,000 See Family \$4,000 Out-of-Network: \$3,000 See Family \$6,000			In-Network: One Person Two People Family \$3,000 See Family \$6,000 Out-of-Network: \$5,000 See Family \$10,000		
Out-of-Network Benefits	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.		
Medical Care When Traveling (BlueCard)	Included			Included		
Lifetime Maximum	Unlimited			Unlimited		
Covered Services	In-Network You Pay			In-Network You Pay		
Ambulance Travel	20% coinsurance after deductible			20% coinsurance after deductible		
Autism Spectrum Disorder	Copayment/coinsurance determined by service received			Copayment/coinsurance determined by service received		
Behavioral Health and EAP <i>Inpatient treatment</i> <ul style="list-style-type: none"> • 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		
Employee Assistance Program (EAP) 4 visits per issue (per plan year)	\$0			\$0		
Dental Care Preventive Dental Option (<i>diagnostic and preventive services only for lower premium</i>) Comprehensive Dental Option (<i>for higher premium</i>) Dental Plan Year Deductible Plan Year Maximum (Except Orthodontics) <ul style="list-style-type: none"> • Preventive Dental Care • Primary Dental Care • Major Dental Care • Orthodontic Services (Includes Adult Ortho) 	\$0 <i>One Person Two People Family</i> \$25 \$50 \$75 \$1,500 \$0 20% coinsurance after dental deductible 50% coinsurance after dental deductible 50% coinsurance, no dental deductible, with \$1,500 lifetime maximum			\$0 <i>One Person Two People Family</i> \$25 \$50 \$75 \$1,500 \$0 20% coinsurance after dental deductible 50% coinsurance after dental deductible 50% coinsurance, no dental deductible, with \$1,500 lifetime maximum		

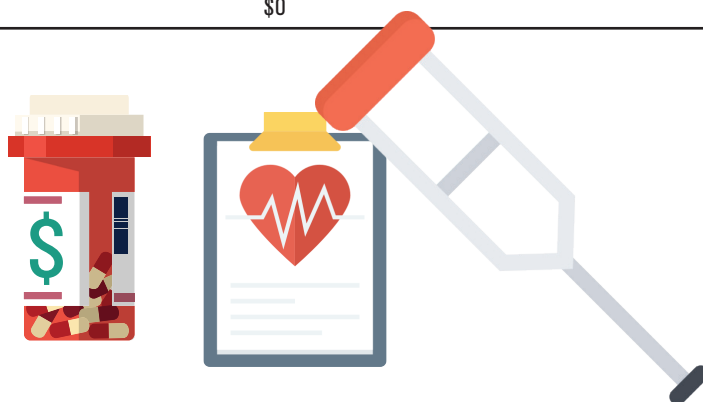
Key Advantage 500			Key Advantage 1000			High Deductible Health Plan		
In-Network:			In-Network:					
One Person	Two People	Family	One Person	Two People	Family	One Person	Two People	Family
\$500	See Family	\$1,000	\$1,000	See Family	\$2,000	\$3,200	See Family	\$6,400
Out-of-Network:			Out-of-Network:			Deductible is combined for In-Network and Out-of-Network services.		
\$1,000	See Family	\$2,000	\$2,000	See Family	\$4,000			
In-Network:			In-Network:			In-Network:		
One Person	Two People	Family	One Person	Two People	Family	One Person	Two People	Family
\$4,000	See Family	\$8,000	\$5,000	See Family	\$10,000	\$5,000	See Family	\$10,000
Out-of-Network:			Out-of-Network:			Out-of-Network:		
\$7,000	See Family	\$14,000	\$9,000	See Family	\$18,000	\$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		
<i>One Person</i>	<i>Two People</i>	<i>Family</i>	<i>One Person</i>	<i>Two People</i>	<i>Family</i>	<i>One Person</i>	<i>Two People</i>	<i>Family</i>
\$25	\$50	\$75	\$25	\$50	\$75	\$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 2024 Comparison of Statewide Plans (continued)

Covered Services	Key Advantage Expanded In-Network You Pay	Key Advantage 250 In-Network You Pay
Diabetic Education	\$0	\$0
Diabetic Equipment	20% coinsurance after deductible	20% coinsurance after deductible
Diabetic Supplies - See Outpatient Prescription Drugs		
Diagnostic Tests and X-rays (for specific conditions or diseases at a doctor's office, emergency room or outpatient hospital department)	20% coinsurance, no deductible	20% coinsurance after deductible
Doctor Visits – on an Outpatient Basis Primary Care Physicians Specialty Care Providers	\$15 copayment \$25 copayment	\$20 copayment \$35 copayment
Early Intervention Services	Copayment/coinsurance determined by service received	Copayment/coinsurance determined by service received
Emergency Room Visits Facility Services Professional Provider Services – Primary Care Physicians – Specialty Care Providers Diagnostic Tests and X-rays	\$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
Home Health Services (90 visit plan year limit per member)	\$0	\$0
Home Private Duty Nurse's Services	20% coinsurance after deductible	20% coinsurance after deductible
Hospice Care Services	\$0	\$0
Hospital Services Inpatient Treatment • Facility Services • Professional Provider Services – Primary Care Physicians – Specialty Care Providers Outpatient Treatment • Facility Services • Professional Provider Services – Primary Care Physicians – Specialty Care Providers Diagnostic Tests and X-Rays	\$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
Virtual Care through Sydney Health app • LiveHealth Online • Symptom Checker • Text Chat or Video Visit with Medical Provider • Virtual Wellness/ Preventive Visit	\$0 no cost \$0 \$0	\$0 no cost \$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 no cost \$0 \$0	\$0 no cost \$0 \$0	Determined by services received no cost \$39 or 20% coinsurance after deductible \$99 or 20% coinsurance after deductible



The Local Choice 2024 Comparison of Statewide Plans (continued)

Covered Services	Key Advantage Expanded In-Network You Pay	Key Advantage 250 In-Network You Pay
Maternity <i>Professional Provider Services (Prenatal & 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
Medical Equipment, Appliances, Formulas, Prosthetics and Supplies	20% coinsurance after deductible	20% coinsurance after deductible
Outpatient Prescription Drugs - Mandatory Generic <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
Diabetic Supplies	20% coinsurance, no deductible	20% coinsurance, no deductible
Prescription Insulin Drugs to Treat Diabetes	34-day supply not to exceed \$50 90-day supply not to exceed \$150	34-day supply not to exceed \$50 90-day supply not to exceed \$150
Routine vision - Blue View Vision Network (Once Every Plan Year) <i>Routine Eye Exam</i> <i>Standard Eyeglass Lenses (in Lieu of Contact Lenses)</i> <i>Eyeglass Frames</i> <i>Contact Lenses (In Lieu of Eyeglass Lenses)</i> <ul style="list-style-type: none"> • Elective • Non-Elective <i>Upgrade Eyeglass Lenses (Available for Additional Cost)</i> <ul style="list-style-type: none"> • UV Coating, Tints, Standard Scratch-Resistant • Standard Polycarbonate (Adult) • Standard Progressive • Standard Anti-Reflective • Other Add-Ons 	\$25 copayment \$20 copayment** Up to \$100 retail allowance*** Up to \$100 retail allowance Covered in full \$15 \$40 \$65 \$45 20% off retail	\$35 copayment \$20 copayment** Up to \$100 retail allowance*** Up to \$100 retail allowance Covered in full \$15 \$40 \$65 \$45 20% off retail
Shots – Allergy & Therapeutic Injections (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.

**Polycarbonate lenses included at no additional cost for children under 19 years old.

***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.

\$25 copayment
\$40 copayment

20% coinsurance after deductible
20% coinsurance after deductible

\$0
\$0
20% coinsurance after deductible

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

20% coinsurance after deductible

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

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

20% coinsurance after deductible

20% coinsurance, no deductible

20% coinsurance, no deductible

20% coinsurance after deductible

34-day supply not to exceed \$50
90-day supply not to exceed \$150

34-day supply not to exceed \$50
90-day supply not to exceed \$150

34-day supply not to exceed \$50
90-day supply not to exceed \$150

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

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

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

Up to \$100 retail allowance
Covered in full

Up to \$100 retail allowance
Covered in full

Up to \$100 retail allowance
Covered in full

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

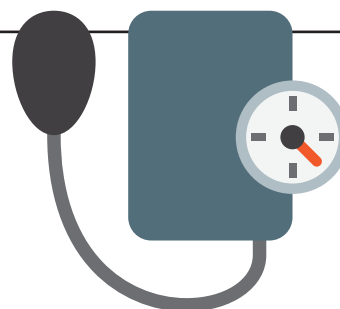
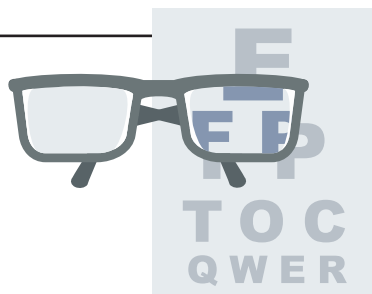
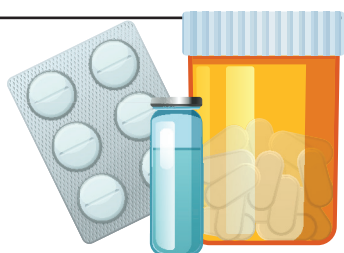
\$15
\$40
\$65
\$45
20% off retail

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

20% coinsurance after deductible

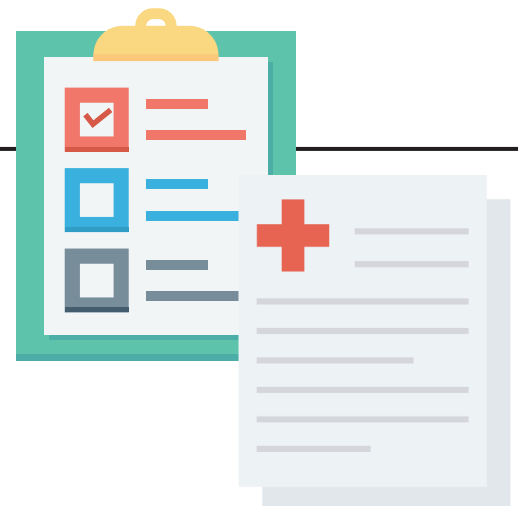
20% coinsurance after deductible

20% coinsurance after deductible



The Local Choice 2024 Comparison of Statewide Plans (continued)

Covered Services	Key Advantage Expanded In-Network You Pay	Key Advantage 250 In-Network You Pay
Skilled Nursing Facility Stays (180-Day Per Stay Limit Per Member) <i>Facility Services</i> <i>Professional Provider Services</i>	\$0 \$0	\$0 \$0
Spinal Manipulations and Other Manual Medical Interventions (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
Surgery – See Hospital Services		
Therapy Services <i>Infusion Services, Cardiac Rehabilitation Therapy, Chemotherapy, Radiation Therapy, Respiratory Therapy, Occupational Therapy, Physical Therapy, and Speech Therapy</i> <i>Facility Services</i> <i>Professional Provider Services</i> – 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
Wellness services <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 & 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

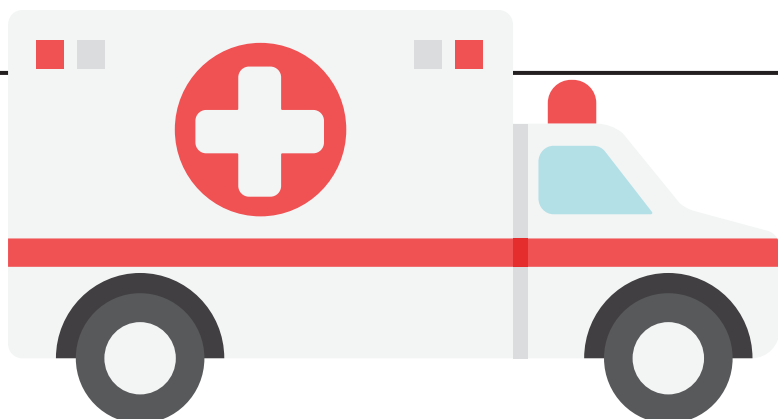
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No copayment, coinsurance, or deductible

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.

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

- Asthma
- Heart failure
- Diabetes
- Hypertension
- Coronary artery disease (CAD)
- Chronic obstructive pulmonary disease (COPD)

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.

- **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.
- **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.

- **24/7 NurseLine & Audio Health 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.

- **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.



See more information on Health & Wellness programs at www.anthem.com/tlc.

Virtual Care Options through Sydney Health

Life is busy. When you need care and are short on time, you have many options for quick and convenient virtual care through the Sydney Health app. Whether you prefer to use medical text chat or have a video visit, Sydney Health is the gateway that connects you to the virtual care options included in your benefits. Use your smartphone to access virtual care solutions for all your physical and behavioral health needs, any hour of any day.

Services include:

- Comprehensive primary care, coordinated by a care team
- Wellness visits
- Preventive care and lab screenings
- 24/7 Urgent or sick care for common medical conditions like the flu, colds, allergies, pink eye, sinus infections, and more
- New prescriptions and refills
- Behavioral Health providers including therapists or psychologists, psychiatrists or EAP counselors
- Care for on-going conditions like diabetes, hypertension, and asthma
- Access to specialty care such as lactation consultants, dermatologists, sleep specialists, and allergists

Log in to the Sydney Health app, and access the **Care Center** to view all the options available to you.

Note: Some options require a secondary app. You will be prompted to download the app during the account setup process.

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:

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

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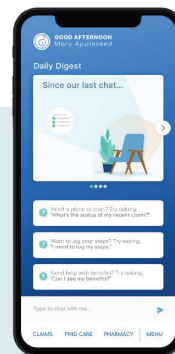
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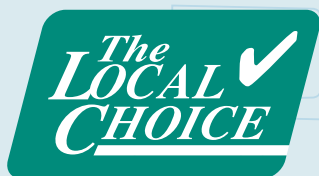
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- Register at employer.anthem.com/eea.
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SBCs are available on the web (www.thelocalchoice.virginia.gov) and the website is now included on the back of the benefit summary booklets. Subsequently, members will no longer receive postcards with the web address to SBCs. Please remember to order Open Enrollment Packets (which include Benefit Summaries and other member materials) for Open Enrollment. Order lead time is typically 10 business days.

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