Your summary of benefits

Anthem®

Anthem® Blue Cross Life and Health Insurance Company

Your Plan: PRISM (CSURMA): Custom Premier PPO 150/15/30 - Medicare

Your Network: Prudent Buyer PPO

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	**$150 per person**	**$150 per person**
Out-of-Pocket Limit	**$5,000 per person**	**$5,000 per person**
The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per person deductible and per person 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 per person deductible or per person out-of-pocket maximum. **Your copays, coinsurance and deductible count toward your out of pocket amount(s).** **In-network and out-of-network out-of-pocket maximum amounts are combined and accumulate toward each other.**		
Preventive Care / Screening / Immunization	**No charge**	**No charge**
Preventive Care for Chronic Conditions *per IRS guidelines*	**No charge**	**No charge**
Virtual Care (Telemedicine / Telehealth Visits) **Virtual Visits - Online visits with Doctors who also provide services in person**		
Primary Care (PCP) including Mental Health and Substance and Substance Abuse care by a PCP	**$15 copay per visit after deductible is met**	**$15 copay per visit after deductible is met**
Mental Health and Substance Use Disorder care by Providers other than a PCP	**0% coinsurance after deductible is met**	**0% coinsurance after deductible is met**
Specialist	**$30 copay per visit after deductible is met**	**$30 copay per visit after deductible is met**

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Virtual Visits from Online Provider LiveHealth Online *via www.livehealthonline.com; our mobile app, website or Anthem-enabled device*		
Primary Care (PCP) and Mental Health and Substance Use Disorder	$15 copay per visit deductible does not apply	
Specialist Care	$30 copay per visit deductible does not apply	
Visits in an Office		
Primary Care (PCP)	$15 copay per visit after deductible is met	$15 copay per visit after deductible is met
Specialist Care	$30 copay per visit after deductible is met	$30 copay per visit after deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	$15 copay per visit after deductible is met	$15 copay per visit after deductible is met
Retail Health Clinic	$15 copay per visit l after deductible is met	$15 copay per visit after deductible is met
Manipulation Therapy *Coverage is limited to 30 visits per benefit period.*	$20 copay per visit after deductible is met	$20 copay per visit after deductible is met
Acupuncture	Not covered	Not covered
Other Services in an Office		
Allergy Testing	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Chemo/Radiation Therapy	0% coinsurance after l deductible is met	0% coinsurance after deductible is met
Dialysis/Hemodialysis	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office*	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Surgery	0% coinsurance after deductible is met	0% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Diagnostic Services **Lab**		
Office	$30 copay per visit after deductible is met	$30 copay per visit after deductible is met
Freestanding Lab	$30 copay per visit after deductible is met	$30 copay per visit after deductible is met
Outpatient Hospital	$30 copay per visit after deductible is met	$30 copay per visit after deductible is met
X-Ray		
Office	$30 copay per visit after deductible is met	$30 copay per visit after deductible is met
Freestanding Radiology Center	$30 copay per visit after deductible is met	$30 copay per visit after deductible is met
Outpatient Hospital	$30 copay per visit after deductible is met	$30 copay per visit after deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	$75 copay per test after deductible is met	$75 copay per test after deductible is met
Freestanding Radiology Center	$75 copay per test after deductible is met	$75 copay per test after deductible is met
Outpatient Hospital	$75 copay per test after deductible is met	$75 copay per test after deductible is met
Emergency and Urgent Care		
Urgent Care	$30 copay per visit deductible does not apply	$30 copay per visit deductible does not apply
Emergency Room Facility Services *Copay waived if admitted.*	$75 copay per admission after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	0% coinsurance after deductible is met	Covered as In-Network
Ambulance	$75 copay per trip after deductible is met	Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Mental Health and Substance Use Disorder		
Doctor Office Visit	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Facility Visit		
Facility Fees	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Doctor Services	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	$150 copay per admission after deductible is met	$150 copay per admission after deductible is met
Freestanding Surgical Center	$150 copay per admission after deductible is met	$150 copay per admission after deductible is met
Doctor and Other Services		
Hospital	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Use Disorder)		
Facility Fees	$500 copay per admission after deductible is met	$500 copay per admission after deductible is met
Doctor and other services	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 100 visits per benefit period.*	No charge	No charge
Rehabilitation services		
Office	$30 copay per visit after deductible is met	$30 copay per visit after deductible is met
Outpatient Hospital	$30 copay per visit after deductible is met	$30 copay per visit after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Cardiac rehabilitation		
Office	**$30 copay per visit after deductible is met**	**$30 copay per visit after deductible is met**
Outpatient Hospital	**$30 copay per visit after deductible is met**	**$30 copay per visit after deductible is met**
Skilled Nursing Care (facility) ***Coverage is limited to 100 days per benefit period.***	**0% coinsurance after deductible is met**	**0% coinsurance after deductible is met**
Inpatient Hospice	**No charge**	**No charge**
Durable Medical Equipment	**0% coinsurance after deductible is met**	**0% coinsurance after deductible is met**
Prosthetic Devices	**10% coinsurance after deductible is met**	**10% coinsurance after deductible is met**

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Not covered	Not covered
Pharmacy Out-of-Pocket Limit	Not covered	Not covered
Prescription Drug Coverage		
Home Delivery Pharmacy		
Tier 1 - Typically Generic	Not covered (retail and home delivery)	Not covered (retail and home delivery)
Tier 2 – Typically Preferred Brand	Not covered (retail and home delivery)	Not covered (retail and home delivery)
Tier 3 - Typically Non-Preferred Brand	Not covered (retail and home delivery)	Not covered (retail and home delivery)
Tier 4 - Typically Specialty (brand and generic)	Not covered (retail and home delivery)	Not covered (retail and home delivery)

Notes:

- **If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".**
- **Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.**
- **Outpatient Facility visit for Mental/Behavioral Health and Substance Abuse is limited to $350 per visit for Non-Network Providers.**
- **Coverage includes standard fertility preservation services as a basic healthcare service including but are not limited to, injections, cryopreservation and storage for both male and female members when a medically necessary treatment may cause iatrogenic infertility. Member cost share for fertility preservation services is based on provider type and service rendered.**

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.

Your Plan: PRISM (CSURMA): Custom Premier PPO-Medicare

Your Network: Prudent Buyer PPO

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

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

Authorized group signature (if applicable)	**Date**
Underwriting signature (if applicable)	**Date**

Get help in your language

Language Assistance Services

Curious to know what all this says? We would be too. Here's the English version:
IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish
IMPORTANTE: ¿Puede leer esta carta? De lo contrario, podemos hacer que alguien lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721. (TTY/TDD: 711)

Arabic
مهم: هل يمكنك قراءة هذه الرسالة؟ إذا لم تستطع، فيمكننا الاستعانة بشخص ما ليساعدك على قراءتها. كما يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. للحصول على المساعدة المجانية، يُرجى الاتصال فورًا بالرقم1-888-254-2721 (TTY/TDD:711).

Armenian
ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք ընթերցել այս նամակը: Եթե ոչ, մենք կարող ենք տրամադրել ինչ-որ մեկին, ով կօգնի Ձեզ՝ կարդալ այն: Կարող ենք նաև այս նամակը Ձեզ գրավոր տարբերակով տրամադրել: Անվճար օգնություն ստանալու համար կարող եք անհապաղ զանգահարել 1-888-254-2721 հեռախոսահամարով: (TTY/TDD: 711)

Chinese
重要事項：您能看懂這封信函嗎？如果您看不懂，我們能夠找人協助您。您有可能可以獲得以您的語言而寫的本信函。如需免費協助，請立即撥打1-888-254-2721。(TTY/TDD: 711)

Farsi
مهم: آیا می‌توانید این نامه را بخوانید؟ اگر نمی‌توانید، می‌توانیم شخصی را به شما معرفی کنیم تا در خواندن این نامه شما را کمک کند. همچنین می‌توانید این نامه را به صورت مکتوب به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، همین حالا با شماره 1-888-254-2721 تماس بگیرید.(TTY/TDD:711)

Hindi
महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? अगर नहीं, तो हम आपको इसे पढ़ने में मदद करने के लिए किसी को उपलब्ध करा सकते हैं। आप यह पत्र अपनी भाषा में लिखवाने में भी सक्षम हो सकते हैं। निःशुल्क मदद के लिए, कृपया 1-888-254-2721 पर तुरंत कॉल करें। (TTY/TDD: 711)

Hmong
TSEEM CEEB: Koj puas muaj peev xwm nyeem tau daim ntawv no? Yog hais tias koj nyeem tsis tau, peb muaj peev xwm cia lwm tus pab nyeem rau koj mloog. Tsis tas li ntawd tej zaum koj kuj tseem yuav tau txais daim ntawv no sau ua koj hom lus thiab. Txog rau kev pab dawb, thov hu tam sim no rau tus xov tooj 1-888-254-2721. (TTY/TDD: 711)

Japanese

重要：この書簡を読めますか？もし読めない場合には、内容を理解するための支援を受けることができます。また、この書簡を希望する言語で書いたものを入手することもできます。次の番号にいますぐ電話して、無料支援を受けてください。
1-888-254-2721 (TTY/TDD: 711)

Khmer
សំខាន់៖ តើអ្នកអាចអានលិខិតនេះបាន? បើមិនអាចទេ យើងអាចឲ្យនរណាម្នាក់អានវាជូនអ្នក។ អ្នកក៏អាចទទួលលិខិតនេះជាភាសាសម្រាប់អ្នកផងដែរ។ សម្រាប់ជំនួយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទមកលេខ 1-888-254-2721, (TTY/TDD: 711)

Korean
중요: 이 서신을 읽으실 수 있으십니까? 읽으실 수 없을 경우 도움을 드릴 사람이 있습니다. 귀하가 사용하는 언어로 쓰여진 서신을 받으실 수도 있습니다. 무료 도움을 받으시려면 즉시 1-888-254-2721**로 전화하십시오.** (TTY/TDD: 711)

Punjabi
ਮਹੱਤਵਪਰਨ: ਕੀ ਤੁਸ ਇਹ ਹਾਪਤਰ ਪੜਹ ਸਕਦੇ ਹ? ਜ ਨਹ ਤ ਅਸ ਇਹ ਸ ਨ ਪੜਹ ਿ ਵਚ ਤਹ ਡੀ ਮਦਦ ਲਈ ਿ ਕਸ ਨ ਬਲ ਸਕਦ ਹ। ਤੁਸ ਇਹ ਪਤਰ ਨ ਆਪਣੀ ਭ ਸ਼ ਿ ਵਚ ਿ ਿਲਖਆ ਹਇਆ ਵ ਬੀ ਪਰ ਪ ਾ ਕਰ ਸਕਦ ਹ। ਮਫ਼ਤ ਮਦਦ ਲਈ, ਿ ਕਰਪ ਕਰਕ ਫਰਨ 1-888-254-2721 ਤ ਕਾ ਲ ਕਰ।
(TTY/TDD: 711)

Russian
ВАЖНО. Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по номеру 1-888-254-2721. (TTY/TDD: 711)

Tagalog
MAHALAGA: Nababasa ba ninyo ang liham na ito? Kung hindi, may taong maaaring tumulong sa inyo sa pagbasa nito. Maaari ninyo ring makuha ang liham na ito nang nakasulat sa ginagamit ninyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

Thai
หมายเหตุสำคัญ: ท่านสามารถอ่านจดหมายฉบับนี้ รือไม่ หากท่านไม่สามารถอ่านจดหมายฉบับนี้ เราสามารถจัดหาเจ้าหน้าทมี่ าอ่านให้ท่านฟังได้ ท่านยังอาจให้เจ้าหน้าทซี่ ่ วยเขยีนจดหมายในภาษาของท่านอีกด้วย หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดโทรตดิต่อทหี่ มายเลข 1-888-254-2721 (TTY/TDD: 711)

Vietnamese
QUAN TRỌNG: Quý vị có thể đọc thư này hay không? Nếu không, chúng tôi có thể bố trí người giúp quý vị đọc thư này. Quý vị cũng có thể nhận thư này bằng ngôn ngữ của quý vị. Để được giúp đỡ miễn phí, vui lòng gọi ngay số 1-888-254-2721. (TTY/TDD: 711)

It’s important we treat you fairly

That’s why we follow federal civil rights laws in our health programs and activities. We don’t discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. 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 to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with 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 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or

online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Benefit Overview

Express Scripts Medicare® (PDP) for PRISM

YOUR 2023 PRESCRIPTION DRUG PLAN BENEFIT

Here is a summary of what you will pay for covered prescription drugs across the different stages of your Medicare Part D benefit. You can fill your covered prescriptions at a network retail pharmacy or through our home delivery service.

Plan Premium	Your group benefits administrator will tell you the amount that you pay for your plan. If you have any questions, please contact your group benefits administrator.
Initial Coverage stage	You will pay the following until your total yearly drug costs (what you and the plan pay) reach $4,660:

Tier	**Retail One-Month (31-day) Supply**	**Retail Two-Month (60-day) Supply**	**Retail Three-Month (90-day) Supply**	**Express Scripts® Pharmacy Home Delivery* Three-Month (90-day) Supply**
Tier 1: **Generic Drugs**	$5 copayment	$10 copayment	$15 copayment	$10 copayment
Tier 2: **Preferred Brand Drugs**	$20 copayment	$40 copayment	$60 copayment	$40 copayment
Tier 3: **Non-Preferred Drugs**	$50 copayment	$100 copayment	$150 copayment	$100 copayment

If your doctor prescribes less than a full month's supply of certain drugs, you will pay a daily cost-sharing rate based on the actual number of days of the drug that you receive.

*Your cost-sharing amount may differ from the information shown in this chart if you use a home delivery pharmacy other than Express Scripts® Pharmacy. Other pharmacies are available in our network.

	You may receive up to a 90-day supply of certain maintenance drugs (medications taken on a long-term basis) by mail through Express Scripts® Pharmacy. There is no charge for standard shipping. Not all drugs are available at a 90-day supply, and not all retail pharmacies offer a 90-day supply. Please contact Express Scripts Medicare Customer Service at the numbers on the back of this document for more information.
Coverage Gap stage	After your total yearly drug costs reach $4,660, you will continue to pay the same cost-sharing amount as in the Initial Coverage stage until your yearly out-of-pocket drug costs reach $7,400.
Catastrophic Coverage stage	After your yearly out-of-pocket drug costs (what you and others pay on your behalf, including manufacturer discounts but excluding payments made by your Medicare prescription drug plan) reach $7,400, you will pay **the greater of 5% coinsurance or:** • a $4.15 copayment for covered generic drugs (including drugs treated as generics), with a maximum not to exceed the standard copayment during the Initial Coverage stage • a $10.35 copayment for all other covered drugs, with a maximum not to exceed the standard copayment during the Initial Coverage stage.

Long-Term Care (LTC) Pharmacy
If you reside in an LTC facility, you pay the same as at a network retail pharmacy. LTC pharmacies must dispense brand-name drugs in amounts of 14 days or less at a time. They may also dispense less than a one month's supply of generic drugs at a time. Contact your plan if you have questions about cost sharing or billing when less than a one-month supply is dispensed.

Out-of-Network Coverage
You must use Express Scripts Medicare network pharmacies to fill your prescriptions. Covered Medicare Part D drugs are available at out-of-network pharmacies only in special circumstances, such as illness while traveling outside of the plan's service area where there is no network pharmacy. You generally have to pay the full cost for drugs received at an out-of-network pharmacy at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. Please contact Express Scripts Medicare Customer Service at the numbers on the back of this document for more details.

IMPORTANT PLAN INFORMATION

- The service area for this plan is all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands and American Samoa. You must live in one of these areas to participate in this plan.
- You are eligible for this plan if you are entitled to Medicare Part A and/or are enrolled in Medicare Part B, are a U.S. citizen or are lawfully present in the United States, and are eligible for benefits from PRISM.

- The amount you pay may differ depending on what type of pharmacy you use; for example, retail, home infusion, LTC or home delivery.
- To find a network pharmacy near you, visit our website at **express-scripts.com/pharmacies**.
- Your plan uses a formulary – a list of covered drugs. The amount you pay depends on the drug's tier and on the coverage stage that you've reached. From time to time, a drug may move to a different tier. If a drug you are taking is going to move to a higher (or more expensive) tier, or if the change limits your ability to fill a prescription, Express Scripts will notify you before the change is made.
- A PDF of our printed drug list for 2023 will be available by logging into **express-scripts.com/documents** beginning on October 15, 2022.
- The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.
- Your healthcare provider must get prior authorization from Express Scripts Medicare for certain drugs.
- If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.
- If you request an exception for a drug and Express Scripts Medicare approves the exception, you will pay the cost-sharing amount set by your plan for that drug.
- You must continue to pay your Medicare Part B premium, if not otherwise paid for under Medicaid or by another third party.
- When you use your Part D prescription drug benefits, Express Scripts Medicare sends you an Explanation of Benefits (Part D EOB), or summary, to help you understand and keep track of your benefits. You may also be able to receive a copy electronically by visiting our website, **express-scripts.com**, or by contacting Express Scripts Medicare Customer Service at the phone numbers on the back of this document.

For an explanation of your plan's rules, contact Express Scripts Medicare Customer Service at the numbers on the back of this document or review the *Evidence of Coverage* (EOC) by visiting our website, **express-scripts.com/documents**. You can request a copy of the EOC by calling Express Scripts Medicare Customer Service.

Does my plan cover Medicare Part B or non–Part D drugs?
In addition to providing coverage of Medicare Part D drugs, this plan provides coverage for Medicare Part B medications, as well as for some other non–Part D medications that are not normally covered by a Medicare prescription drug plan. The amount paid for these medications will not count toward your total drug costs or total out-of-pocket expenses. Please call Customer Service for additional information about specific drug coverage and your cost-sharing amount.

Will my income affect my cost for Medicare Part D coverage?
Some people may pay an extra amount called the Part D Income-Related Monthly Adjustment Amount (Part D-IRMAA) because of their yearly income. If you have to pay an extra amount, Social Security – *not your Medicare plan* – will send a letter telling you what the extra amount will be and how to pay it. If you have any questions about this extra amount, contact Social Security at 1.800.772.1213 between 8 a.m. and 7 p.m., Monday through Friday to speak with a representative. Automated messages are available 24 hours a day. TTY users should call 1.800.325.0778.

Read the *Medicare & You* 2023 handbook.
The *Medicare & You* handbook has a summary of Original Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. You can get a copy at the Medicare website (https://www.medicare.gov) or by calling 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.

Express Scripts Medicare Customer Service

1.844.468.0428

24 hours a day, 7 days a week

We have free language interpreter services available for non-English speakers.

TTY: **1.800.716.3231**

You can also visit us on the Web at **express-scripts.com**.

This information is not a complete description of benefits Call Express Scripts Medicare at the phone numbers above for more information.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1.800.268.5707** (TTY: **1.800.716.3231**).

This document may be available in braille. Please call Customer Service at the phone numbers listed above for assistance.

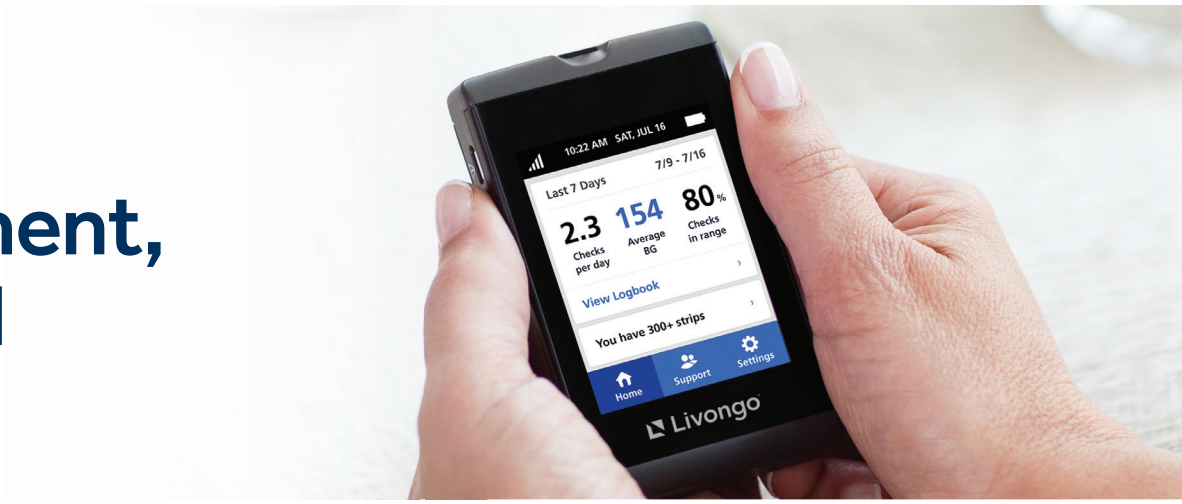
For questions about premiums, enrollment and eligibility, please contact the Benefits Office at the Organization from which you retired.

Express Scripts Medicare (PDP) is a prescription drug plan with a Medicare contract.
Enrollment in Express Scripts Medicare depends on contract renewal.

EXPRESS SCRIPTS®

Livongo® by Teladoc Health

Diabetes management, simplified



An advanced blood glucose meter and as many strips and lancets as you need, paid for by your employer.

It's all in the meter and on the house.

- Personalized tips with each blood sugar check
- Real-time support when you're out of range
- Strip reordering right from your meter
- Optional alerts to keep contacts in the loop
- Send a Health Summary Report directly from your meter
- Automatic uploads mean no more paper logbooks

Get started

Text **"GO PRISM-EXPRESSSCRIPTS"** to 85240 to learn more and join

You can also join by visiting **Join.Livongo.com/PRISM-EXPRESSSCRIPTS/register** or call **800-945-4355** and use registration code: **PRISM-EXPRESSSCRIPTS**

Las comunicaciones del programa Livongo están disponibles en español. Al inscribirse, podrá configurar el idioma que prefiera para las comunicaciones provenientes del medidor y del programa. Para inscribirse en español, llame al (800) 945-4355 o visite bienvenido.livongo.com/PRISM-EXPRESSSCRIPTS

This program is offered by your employer in conjunction with Express Scripts.

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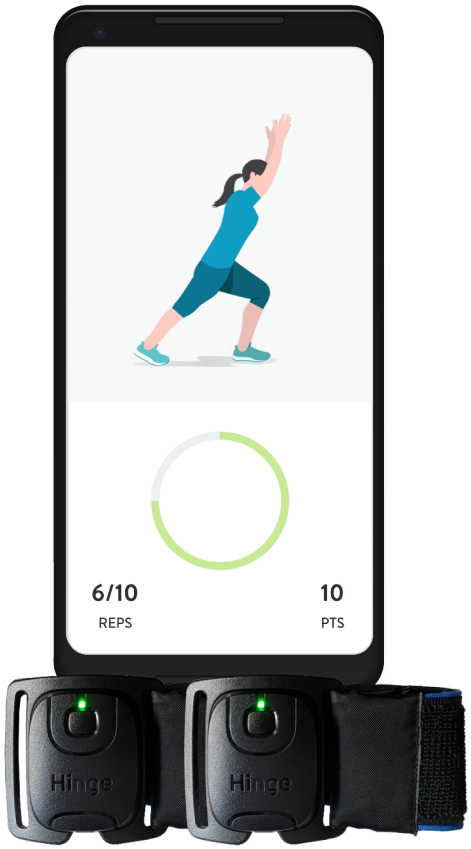
Better Surgeons, Better Results

Conquer back and joint pain without drugs or surgery

You and your eligible family members get **free access** to Hinge Health's programs for **back, knee, hip, shoulder, neck, and other pain**, which may include:

- Wearable sensors for live feedback in the app
- Unlimited 1-on-1 health coaching
- Personalized exercise therapy

Over 180,000 members have joined our programs so far, and cut their pain by nearly 70%!



Eligibility: Members, pre-65 retirees, and dependents 18+ enrolled in a PRISM medical plan through Anthem or Blue Cross Blue Shield of California are eligible (includes EPO, PPO, and HDHPs).

To learn more call (855) 902-2777, or apply at:

HINGEHEALTH.COM/PRISM