



# Choosing and using your plan

Your guide to open enrollment and making the most of your benefits

**City of Salem and Schools**  
**Anthem Medical Plans Guidebook**  
**Effective January 1, 2024**



# Time to choose your plan

## Your trusted health partner

Anthem is committed to being your trusted healthcare partner. We're developing technology, solutions, programs, and services that give you greater access to care. We are also working with healthcare professionals to make sure you get affordable quality healthcare.



# Time to choose your plan

A great way to start is to focus on what's important to you

Open enrollment is the time to explore your benefits, programs, and resources that can support your health and well-being all year long.

This guide was created to help you understand our plans. It also has tips, tools, and resources that can help you reach your health and wellness goals when you become a member.

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# Explore your plan options

Review the health plans below to find the right fit for your needs.

## PPO

With a preferred provider organization (PPO) plan, you can go to almost any doctor or hospital — giving you more choices and flexibility.

- You can choose a primary care doctor from the plan's network for preventive care, such as checkups and screenings.
- You do not need to have a primary care doctor to see a specialist.
- When you want to see a specialist, such as an orthopedic doctor or a cardiologist, you do not need to visit your primary care doctor first for a referral. This can save you time and a copay.
- You'll pay less if you choose doctors and facilities in your plan

## Health savings account (HSA)

An HSA allows you to set aside pretax dollars to pay for care when you need it. You can use money in the account to pay for qualified medical expenses, such as hospital visits, prescription drugs, or copays for a doctor visit.<sup>1</sup>

- The money you put into your HSA, any interest you earn, and the money you take out to pay for healthcare is tax-free.
- You can contribute up to \$4,150 for an individual and \$8,300 for a family.
- If you are 55 or older, you can contribute an extra \$1,000 a year.

<sup>1</sup> For a full list of qualified expenses for an individual, visit [qme.anthem.com](https://www.qme.anthem.com).

<sup>2</sup> Veterans who have received medical benefits from Veterans Affairs due to a service-connected disability are eligible to receive or make HSA contributions. Visit the IRS website at [irs.gov/irb/2004-33\\_IRB](https://www.irs.gov/irb/2004-33_IRB) for details.

# Pharmacy Benefits

## What your plan will cover

### Your medication coverage

Your plan covers:

- Brand-name and generic drugs on your drug list.
- Certain preventive drugs at a more affordable or no extra cost to you.
- Most specialty drugs if you have an ongoing health matter or serious illness, such as cancer or hepatitis C.

### Your drug list

Your plan includes various drug lists. You can check the lists for your medicines and the brand-name and generic drugs that are included. Typically, drugs on lower tiers cost less.

If your medication isn't on the list, you will see other options. Drug lists can change, so you may want to check it again when you have a new prescription.

To find the latest drug lists:

- Visit <https://www.anthem.com/pharmacy-information/drug-list-formulary> for the **VA 4 Tier** Drug List.

### Your pharmacy options

You have choices for filling your prescriptions, including local pharmacies in your plan's network and convenient home delivery.

- **Retail pharmacies:** Your costs may be lower if you use one of the pharmacies in your plan's network.
- **Home delivery:** If there are medications you take regularly, you can save time and money with our home-delivery service.
- **Specialty pharmacy:** If you have a health condition that requires specialty medicine, such as those you take by injection or infusion, or that needs special handling, you will need to order through CarelonRx Specialty Pharmacy.

# Using your plan



## How to use your plan

Once you become a member, explore how to make the most of your benefits . This guide shows you ways to make using your plan easier. You will also discover tools and resources that can help you reach your health and wellness goals.



# How to use your plan

## Register for online tools and resources

Your plan comes with great tools and programs to help you reach your health goals that may come at no extra cost, and save money on health products and services. For detailed information, use the **Engage Wellbeing** mobile app or register at **anthem.com**.

### Engage Wellbeing mobile app

Discover a powerful and more personalized health app. Access your benefits and wellness tools to improve your overall health with the **Engage Wellbeing** app. The app works with you by guiding you to better overall health — and brings your benefits and health information together in one convenient place. **Engage Wellbeing** has everything you need to know to make the most of your benefits while taking care of your health.

### Engage helps you:

- Know what's covered, including out-of-pocket expenses, giving you more control of your healthcare costs while still having complete access to the quality care you deserve.
- Find doctors using quality ratings and firsthand patient reviews to make finding the care you need simpler and more convenient.
- Sync your fitness trackers, log activities, and track progress to enable positive and meaningful changes in your health.

## Use your ID card from your phone

Quickly access your ID card on your phone by using the **Engage Wellbeing** mobile app or logging in at **anthem.com**. Your digital ID card works the same as a paper one. You can share it with your doctor or pharmacy by printing a copy anytime you need one, or emailing or faxing it from your computer or mobile device. You also can download your ID card for quicker access.

## Find a doctor in your plan

The right doctor can make all the difference. Choosing a doctor who is in your plan's network can save you money. Your plan includes a broad selection of high-quality doctors. If you decide to receive care from doctors outside the plan's network, it will cost you more and your care might not be covered.

To find a healthcare professional or facility in your plan's network, use the **Find Care** tool on the **Engage Wellbeing** mobile app or at **anthem.com**. You can search for doctors, hospitals, pharmacies, and high-quality labs such as Quest Diagnostics and Labcorp.

# How to use your plan

## Schedule a checkup

Preventive care, such as regular checkups and screenings, can help you avoid health issues in the future. Your plan covers these services at little or no extra cost when you see a doctor in your plan's network:

- Yearly physical
- Well-child visits
- Flu shot
- Routine shots
- Screenings and tests

## Where to go for care when you need it now

When it is an emergency, call 911 or go to the nearest emergency room. If you need nonemergency care right away:

- Check to see if your primary care doctor can see you.
- Search for nearby urgent care to avoid costly emergency room visits and long wait times.
- Have a virtual chat with your doctor from your mobile device or computer.
- Call 24/7 NurseLine and receive helpful advice from a registered nurse.

1 If you have a high-deductible health plan and have not met your deductible, the price of a visit will be \$39, starting on the date in 2023 your plan renews.

Other virtual care services offered through an arrangement with LiveHealth Online.

LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of your health plan.

In addition to using a telehealth service, you can receive in-person or virtual care from your own doctor or another healthcare provider in your plan's network. If you receive care from a doctor or healthcare provider not in your plan's network, your share of the costs may be higher. You may also receive a bill for any charges not covered by your health plan.



# Make the most of your pharmacy benefits

## Understanding medicine coverage and costs

- **Search the drug list.** Find out if your medicines are covered and which tier they are in. Lower-cost, brand-name drugs and generics are usually in Tiers 1 and 2. You will save the most money if you use Tier 1 drugs.
- **Price a medication.** See how much a medicine costs before you get it. You can compare retail drug costs at local pharmacies and see the price of generic options. Results will include the cost of up to a 90-day supply and home delivery.
- **Check if there are generic options.** If you take a brand-name drug, you can find a list of generic options that are just as effective and cost less. Be sure to talk with your doctor to see if a generic option is right for you.
- **Save money on certain noncovered medicines.** If your prescription isn't covered by your plan, you may be able to receive a discount. Share your member ID card at the pharmacy, and the available discount will automatically be applied.

## Coverage requirements

Certain medications require you to take other steps before your plan covers them. Here are examples:

- **Preapproval, also known as prior authorization.** This means Anthem needs to approve a drug before the pharmacy fills it. If you already have preapproval, you or your doctor will need to fill out a new form at [anthem.com](https://www.anthem.com).
- **Step therapy.** You may need to try other medicine before we can cover the one your doctor prescribed.
- **Quantity limits.** To help protect your health, your plan may limit how much medication you can receive each month.

- **Dose optimization.** If a higher strength is available, you may be able to switch from taking multiple doses to a single dose each day.
- **90-day supply.** If you take maintenance medication for ongoing conditions like asthma, diabetes, or high cholesterol, your plan may require that you set up 90-day supplies at a pharmacy, including CVS, or through home delivery.

## You have pharmacy options

**Choose a pharmacy that's in your plan.** You have many retail pharmacies from which to choose. Use a pharmacy that is in your plan to avoid paying full price. To find a pharmacy in your plan, visit [anthem.com/pharmacyinformation/rxnetworks.html](https://www.anthem.com/pharmacyinformation/rxnetworks.html), and choose your network list.

Your plan uses the **Base Network** list of pharmacies.

The **Base Network** is our national pharmacy network and includes nearly 70,000 retail pharmacies across the country. To find a pharmacy, visit [anthem.com/pharmacyinformation/rxnetworks.html](https://www.anthem.com/pharmacyinformation/rxnetworks.html) and choose the **Base Network** list.

**Receive a 90-day refill at a retail pharmacy.** Ninety-day supplies of covered medications are available at participating retail pharmacies. You can save time with fewer trips to the pharmacy by switching to a 90-day supply for medications you take on a regular basis. Depending on your plan, you may also save on copays. That's because a 90-day supply of certain drugs usually costs less than three 30-day refills.

- **Home delivery.** Save time and money with home delivery. If you take medicines regularly or need them on a longterm basis, you can also save time with home delivery. With CarelonRx Home Delivery, you can receive up to a 90-day supply of medications delivered quickly and safely to you. Plus, with home delivery, you receive free standard shipping on automatic refills, so you won't need to go to the pharmacy. Depending on your plan, you may also save on copays. Once you're a member, visit [anthem.com](https://www.anthem.com) to sign up or call the Pharmacy Member Services number on your ID card.

# Make the most of your pharmacy benefits

For more information, go to [anthem.com/FAQs](https://www.anthem.com/FAQs), select your state, and then **Pharmacy**.

Drug type		Cost
<b>Tier 1</b>	Preferred generic drugs	\$
<b>Tier 2</b>	Preferred brand-name and newer, higher-cost generic drugs	\$\$
<b>Tier 3</b>	Nonpreferred brand-name and generic drugs	\$\$\$
<b>Tier 4</b>	Preferred specialty drugs (brand name and generic)	\$\$\$\$

# Plan extras that support your health

## Medical guidance

**24/7 NurseLine** — You can connect with a registered nurse who will answer your health questions wherever you are — anytime, day or night. They can help you decide where to go for care and find doctors and other healthcare professionals in your area.

Call **800-337-4770**.

**Building Healthy Families** — This program offers support to help your family from preconception through the stages of pregnancy, childbirth, and early childhood (to age 5 and beyond). It is available 24/7 through our **Engage Wellbeing** app and features an extensive content library covering topics to support diverse families, including single parents, same-sex, or multicultural couples. In addition, the app features many tools, including fertility, diaper change, and feeding trackers, due date calculators, and blood pressure monitoring. Visit the **Engage Wellbeing** app to enroll today.

**ConditionCare** — Receive support from a dedicated nurse team to manage ongoing conditions, such as asthma, chronic obstructive pulmonary disease (COPD), diabetes, heart disease, or heart failure. Work with dietitians, health educators, and pharmacists who can help you learn about your condition and manage your health. Call **866-962-1071** to begin.

# Your summary of benefits



Anthem® Blue Cross and Blue Shield

City of Salem and Schools

Your Contract Code: 3ZEPCustom

01/01/2024-12/31/2024

Your Plan: Anthem KeyCare 30 2000/20%/5000 Rx \$15/\$40/\$75/20%

Your Network: KeyCare

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge medical deductible does not apply
Mental Health & Substance Use Disorder Services	No charge medical deductible does not apply
Specialist care	\$50 copay per visit medical deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	\$2,000 person / \$4,000 family	\$3,000 person / \$6,000 family
Overall Out-of-Pocket Limit	\$5,000 person / \$10,000 family	\$7,250 person / \$14,500 family

The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit.

All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit.

In-Network and Non-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.

**Doctor Visits (virtual and office)** *You are encouraged to select a Primary Care Physician (PCP).*

**Primary Care (PCP)** *virtual and office*

\$30 copay per visit  
medical deductible  
does not apply

40% coinsurance after  
medical deductible is  
met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b>Mental Health and Substance Use Disorder Services</b> <i>virtual and office</i></p> <p><b>Specialist Care</b> <i>virtual and office</i></p>	<p>\$30 copay per visit medical deductible does not apply</p> <p>\$50 copay per visit medical deductible does not apply</p>	<p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p>
<p><b><u>Other Practitioner Visits</u></b></p> <p><b>Routine Maternity Care</b> (Prenatal and Postnatal)</p> <p><b>Retail Health Clinic</b> <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i></p> <p><b>Manipulation Therapy</b> <i>Coverage is limited to 30 visits per benefit period.</i></p>	<p>20% coinsurance after medical deductible is met</p> <p>\$30 copay per visit medical deductible does not apply</p> <p>\$25 copay per visit medical deductible does not apply</p>	<p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p>
<p><b><u>Other Services in an Office</u></b></p> <p><b>Allergy Testing</b></p> <p><b>Prescription Drugs</b> <i>Dispensed in the office</i></p> <p><b>Surgery</b></p>	<p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p> <p>\$30 copay (PCP)/\$50 copay (Specialist) no medical deductible applies.</p>	<p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p>
<p><b>Preventive care / screenings / immunizations</b></p>	<p>No charge</p>	<p>40% coinsurance after medical deductible is met</p>
<p><b>Preventive Care for Chronic Conditions</b> <i>per IRS guidelines</i></p>	<p>No charge</p>	<p>40% coinsurance after medical deductible is met</p>
<p><b><u>Diagnostic Services</u></b></p> <p><b>Lab</b></p> <p>Office</p>	<p>No charge</p>	<p>40% coinsurance after medical deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Preferred Reference Lab	No charge	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<b>X-Ray</b>		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<b>Advanced Diagnostic Imaging</b> <i>for example: MRI, PET and CAT scans</i>		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<p><b><u>Emergency and Urgent Care</u></b></p> <p><b>Urgent Care</b> <i>includes doctor services. Additional charges may apply depending on the care provided.</i></p> <p><b>Emergency Room Facility Services</b></p> <p><b>Emergency Room Doctor and Other Services</b></p> <p><b>Ambulance</b></p>	<p>\$30 PCP/\$50 (Specialist) copay per visit medical deductible does not apply</p> <p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>

<p><b>Outpatient Mental Health and Substance Use Disorder Services at a Facility</b> Facility Fees</p>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<p><b>Covered Medical Benefits</b></p>	<p><b>Cost if you use an In-Network Provider</b></p>	<p><b>Cost if you use a Non-Network Provider</b></p>
<p>Doctor Services</p>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<p><b><u>Outpatient Surgery</u></b> <b>Facility Fees</b> Hospital</p> <p><b>Physician and other services <i>including surgeon fees</i></b> Hospital</p>	<p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p>
<p><b><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u></b>  <b>Facility Fees</b></p> <p><b>Physician and other services <i>including surgeon fees</i></b></p>	<p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p>
<p><b>Home Health Care</b> <i>Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.</i></p>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<p><b>Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies.</i></b> <i>Coverage for physical and occupational therapies is limited to 30 visits combined per benefit period. Coverage for speech therapy is limited to 30 visits per benefit period.</i></p> <p>Office</p>	\$30 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met

Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<b>Covered Medical Benefits</b>	<b>Cost if you use an In-Network Provider</b>	<b>Cost if you use a Non-Network Provider</b>
<b>Pulmonary rehabilitation</b> <i>office and outpatient hospital</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<b>Cardiac rehabilitation</b> <i>office and outpatient hospital</i> <i>Coverage is unlimited.</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<b>Dialysis/Hemodialysis</b> <i>office and outpatient hospital</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<b>Chemo/Radiation Therapy</b> <i>office and outpatient hospital</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<b>Skilled Nursing Care (facility)</b> <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 100 days combined per benefit period.</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<b>Inpatient Hospice</b>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<b>Durable Medical Equipment</b>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<b>Prosthetic Devices</b> <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<b>Covered Prescription Drug Benefits</b>	<b>Cost if you use an In-Network Pharmacy</b>	<b>Cost if you use a Non-Network Pharmacy</b>
<b>Pharmacy Deductible</b>	Not applicable	Not applicable
<b>Pharmacy Out-of-Pocket Limit</b>	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit



**Prescription Drug Coverage Network: Base (National) Network**

**Drug List: National Direct Plus** Drugs not included on the National Direct Plus drug list will not be covered.

**Day Supply Limits:**

**Retail Pharmacy** 30 day supply (cost shares noted below)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
<p><b>Retail 90 Pharmacy</b> 90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies). You may receive up to a 90 day supply of medication at any retail location at 3 times the 30 day supply cost share charged at in-network pharmacies.</p> <p><b>Home Delivery Pharmacy</b> 90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail. You will need to call us on the number on your ID card to sign up when you first use the service. Home Delivery is an optional service on this plan.</p> <p><b>Specialty Pharmacy</b> 30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.</p>		
<p><b>Tier 1 - Typically Generic</b></p>	<p>\$15 copay per prescription, deductible does not apply (retail) and \$38 copay per prescription, deductible does not apply (home delivery)</p>	<p>\$15 copay per prescription, deductible does not apply (retail) and Not Covered (Home delivery)</p>
<p><b>Tier 2 – Typically Preferred Brand</b></p>	<p>\$40 copay per prescription, deductible does not apply (retail) and \$100 copay per prescription, deductible does not apply (home delivery)</p>	<p>\$40 copay per prescription, deductible does not apply (retail) and Not Covered (home delivery)</p>
<p><b>Tier 3 - Typically Non-Preferred Brand</b></p>	<p>\$75 copay per prescription, deductible does not apply (retail) and \$188 copay per prescription, deductible does not apply (home delivery)</p>	<p>\$75 copay per prescription, deductible does not apply (retail) and Not Covered (home delivery)</p>
<p><b>Tier 4 - Typically Specialty (brand and generic)</b></p>	<p>20% coinsurance up to \$200 per prescription, deductible does not apply (retail) and 20% coinsurance up to</p>	<p>Not Covered</p>

	\$400, deductible does not apply(home delivery)	
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Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<i>This is a brief outline of your vision coverage. To receive the In-Network benefit, you must use a Blue View Vision Provider. Only children's vision services count towards your out-of-pocket limit.</i>		
<b>Children's Vision exam (up to age 19)</b> <i>Limited to 1 exam per benefit period.</i>	No charge	Reimbursed Up to \$30
<b>Adult Vision exam (age 19 and older)</b> <i>Limited to 1 exam per benefit period.</i>	\$15 copay	Reimbursed Up to \$30

**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.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.
- The representations of benefits in this document are subject to Virginia Bureau of Insurance (BOI) approval and are subject to change.

*This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This policy has exclusions and limitations to benefits and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact your insurance agent or contact us. If there is a difference between this summary and the contract of coverage, the contract of coverage will prevail.*

*This benefit summary is not to be distributed without also providing access on limitations and exclusions that apply to our medical plans. Visit <https://www.anthemplancomparison.com/va> to access this information.*

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Questions: (833) 592-9956 or visit us at [www.anthem.com](http://www.anthem.com)

# Your summary of benefits



Anthem® Blue Cross and Blue Shield

City of Salem and Schools

Your Contract Code: 3ZEN Custom

01/01/2024-12/31/2024

Your Plan: Anthem HSA 3500/0%/4000 Rx \$10/\$30/\$50/20%

Your Network: KeyCare

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
<b>Primary Care, and medical services for urgent/acute care</b>	No charge after deductible is met
<b>Mental Health &amp; Substance Use Disorder Services</b>	No charge after deductible is met
<b>Specialist care</b>	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
<b>Overall Deductible</b> <i>In-network and out-of-network deductibles are combined</i>	\$3,500 person / \$7,000 family	\$3,500 person / \$7,000 family
<b>Overall Out-of-Pocket Limit</b>	\$4,000 person / \$8,000 family	\$6,000 person / \$12,000 family

The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit.

All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit.

In-Network and Non-Network out-of-pocket limit amounts are separate and do not accumulate toward each other.

**Doctor Visits (virtual and office)** *You are encouraged to select a Primary Care Physician (PCP).*

<b>Primary Care (PCP) and Mental Health and Substance Use Disorder Services</b> <i>virtual and office</i>	0% coinsurance after deductible is met	20% coinsurance after deductible is met
<b>Specialist Care</b> <i>virtual and office</i>	0% coinsurance after deductible is met	20% coinsurance after deductible is met
<b>Other Practitioner Visits</b>		
<b>Routine Maternity Care</b> (Prenatal and Postnatal)	0% coinsurance after deductible is met	20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Retail Health Clinic</b> for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.	0% coinsurance after deductible is met	20% coinsurance after deductible is met
<b>Manipulation Therapy</b> Coverage is limited to 30 visits per benefit period.	0% coinsurance after deductible is met	20% coinsurance after deductible is met
<u><b>Other Services in an Office</b></u> <b>Allergy Testing</b>  <b>Prescription Drugs</b> Dispensed in the office  <b>Surgery</b>	0% coinsurance after deductible is met  0% coinsurance after deductible is met  0% coinsurance after deductible is met	20% coinsurance after deductible is met  20% coinsurance after deductible is met  20% coinsurance after deductible is met
<b>Preventive care / screenings / immunizations</b>	No charge	20% coinsurance after deductible is met
<b>Preventive Care for Chronic Conditions</b> per IRS guidelines	No charge	20% coinsurance after deductible is met
<u><b>Diagnostic Services</b></u> <b>Lab</b> Office  Preferred Reference Lab  Outpatient Hospital	0% coinsurance after deductible is met  0% coinsurance after deductible is met  0% coinsurance after deductible is met	20% coinsurance after deductible is met  20% coinsurance after deductible is met  20% coinsurance after deductible is met
<b>X-Ray</b> Office  Outpatient Hospital	0% coinsurance after deductible is met  0% coinsurance after deductible is met	20% coinsurance after deductible is met  20% coinsurance after deductible is met
<b>Advanced Diagnostic Imaging</b> for example: MRI, PET and CAT scans  Office  Outpatient Hospital	0% coinsurance after deductible is met  0% coinsurance after deductible is met	20% coinsurance after deductible is met  20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b><u>Emergency and Urgent Care</u></b></p> <p><b>Urgent Care</b></p> <p><b>Emergency Room Facility Services</b></p> <p><b>Emergency Room Doctor and Other Services</b></p> <p><b>Ambulance</b></p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p><b>Outpatient Mental Health and Substance Use Disorder Services at a Facility</b></p> <p>Facility Fees</p> <p>Doctor Services</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>
<p><b><u>Outpatient Surgery</u></b></p> <p><b>Facility Fees</b></p> <p>Hospital</p> <p>Ambulatory Surgical Center</p> <p><b>Physician and other services <i>including surgeon fees</i></b></p> <p>Hospital</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>
<p><b><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u></b></p> <p>Facility Fees</p> <p>Physician and other services <i>including surgeon fees</i></p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>
<p><b>Home Health Care</b>  <i>Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.</i></p>	<p>0% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b>Rehabilitation and Habilitation services</b> <i>including physical, occupational and speech therapies.</i>  <i>Coverage for physical and occupational therapies is limited to 90 visits combined per benefit period. Coverage for speech therapy is limited to 90 visits per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>
<p><b>Pulmonary rehabilitation</b> <i>office and outpatient hospital</i></p>	<p>0% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p><b>Cardiac rehabilitation</b> <i>office and outpatient hospital</i>  <i>Coverage is unlimited.</i></p>	<p>0% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p><b>Dialysis/Hemodialysis</b> <i>office and outpatient hospital</i></p>	<p>0% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p><b>Chemo/Radiation Therapy</b> <i>office and outpatient hospital</i></p>	<p>0% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p><b>Skilled Nursing Care (facility)</b>  <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 100 days combined per admission.</i></p>	<p>0% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p><b>Inpatient Hospice</b></p>	<p>0% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p><b>Durable Medical Equipment</b></p>	<p>0% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p><b>Prosthetic Devices</b>  <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i></p>	<p>0% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
<p><b>Pharmacy Deductible</b>  <i>In-network and out-of-network deductibles are combined</i></p>	<p>Combined with In-Network medical deductible</p>	<p>Combined with Non-Network medical deductible</p>
<p><b>Pharmacy Out-of-Pocket Limit</b></p>	<p>Combined with In-Network medical out-of-pocket limit</p>	<p>Combined with Non-Network medical out-of-pocket limit</p>

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
<p><b>Prescription Drug Coverage Network: <i>Base (National) Network</i></b>  <b>Drug List: <i>National Direct Plus</i></b> <i>Drugs not included on the National Direct Plus drug list will not be covered.</i></p>		
<p><b>Day Supply Limits:</b>  <b>Retail Pharmacy</b> <i>30 day supply (cost shares noted below) You may receive up to a 90 day supply of medication at retail at 3 times the 30 day supply cost share at any retail location.</i>  <b>Home Delivery Pharmacy</b> <i>90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail. You will need to call us on the number on your ID card to sign up when you first use the service.</i>  <b>Specialty Pharmacy</b> <i>30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.</i></p>		
<p><b>Tier 1 - Typically Generic</b></p>	<p>\$10 copay per prescription after deductible is met (retail) and \$25 copay per prescription after deductible is met (home delivery)</p>	<p>\$10 copay per prescription after deductible is met (retail) and Not covered (home delivery)</p>
<p><b>Tier 2 – Typically Preferred Brand</b></p>	<p>\$30 copay per prescription after deductible is met (retail) and \$75 copay per prescription after deductible is met (home delivery)</p>	<p>\$30 copay per prescription after deductible is met (retail) and Not covered (home delivery)</p>
<p><b>Tier 3 - Typically Non-Preferred Brand</b></p>	<p>\$50 copay per prescription after deductible is met (retail) and \$125 copay per prescription after deductible is met (home delivery)</p>	<p>\$50 copay per prescription after deductible is met (retail) and Not covered (home delivery)</p>
<p><b>Tier 4 - Typically Specialty (brand and generic)</b></p>	<p>20% coinsurance (minimum \$10 and maximum \$200) after deductible is met (retail and home delivery)</p>	<p>Not Covered (retail) and Not covered (home delivery)</p>



Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<i>This is a brief outline of your vision coverage. To receive the In-Network benefit, you must use a Blue View Vision Provider. Only children's vision services count towards your out-of-pocket limit.</i>		
<b>Children's Vision exam (up to age 19)</b> <i>Limited to 1 exam per benefit period.</i>	No charge	Reimbursed up to \$30
<b>Adult Vision exam (age 19 and older)</b> <i>Limited to 1 exam per benefit period.</i>	\$15 copay	Reimbursed Up to \$30

**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.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.
- The representations of benefits in this document are subject to Virginia Bureau of Insurance (BOI) approval and are subject to change.

*This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This policy has exclusions and limitations to benefits and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact your insurance agent or contact us. If there is a difference between this summary and the contract of coverage, the contract of coverage will prevail.*

*This benefit summary is not to be distributed without also providing access on limitations and exclusions that apply to our medical plans. Visit <https://www.anthemplancomparison.com/va> to access this information.*

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Questions: (833) 592-9956 or visit us at [www.anthem.com](http://www.anthem.com)

 <p>The Summary of Benefits and Coverage (SBC) document will help you choose a health <a href="#">plan</a>. The SBC shows you how you and the <a href="#">plan</a> would share the cost for covered health care services. <b>NOTE: Information about the cost of this <a href="#">plan</a> (called the <a href="#">premium</a>) will be provided separately. This is only a summary.</b> For more information about your coverage, or to get a copy of the complete terms of coverage, <a href="https://eoc.anthem.com/eocdps/">https://eoc.anthem.com/eocdps/</a>. For general definitions of common terms, such as <a href="#">allowed amount</a>, <a href="#">balance billing</a>, <a href="#">coinsurance</a>, <a href="#">copayment</a>, <a href="#">deductible</a>, <a href="#">provider</a>, or other <u>underlined</u> terms, see the Glossary. You can view the Glossary at <a href="http://www.healthcare.gov/sbc-glossary/">www.healthcare.gov/sbc-glossary/</a> or call (833) 592-9956 to request a copy.</p>		
Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$2,000/person or \$4,000/family for In- <a href="#">Network Providers</a> . \$3,000/person or \$6,000/family for Non- <a href="#">Network Providers</a> .	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Primary Care Specialist Visit Preventive Care for In- <a href="#">Network Providers</a> . Tier 1 Tier 2 Tier 3 Tier 4 Prescription Drugs for In- <a href="#">Network</a> and Non- <a href="#">Network Providers</a> . Vision for In- <a href="#">Network</a> and <a href="#">Network Providers</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$5,000/person or \$10,000/family for In- <a href="#">Network Providers</a> . \$7,250/person or \$14,500/family for Non- <a href="#">Network Providers</a> .	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .

**Will you pay less if you use a [network provider](#)?**

Yes. See [www.anthem.com/find-care/?alphaprefix=VQX](http://www.anthem.com/find-care/?alphaprefix=VQX) or call (833) 592-9956 for a list of [network providers](#). Costs may vary by site of service and how the [provider bills](#).

This [plan](#) uses a [provider network](#). You will pay less if you use a [provider](#) in the [plan's network](#). You will pay the most if you use an [out-of-network provider](#), and you might receive a bill from a [provider](#) for the difference between the [provider's](#) charge and what your [plan](#) pays ([balance billing](#)). Be aware, your [network provider](#) might use an [out-of-network provider](#) for some services (such as lab work). Check with your [provider](#) before you get services.

VA/LG/Anthem KeyCare 30 2000/20%/5000 R\* \$15/\$40/\$75/20%/AEZ0/01-24

**Do you need a referral to see a specialist?** No. You can see the [specialist](#) you choose without a [referral](#).

**!** All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's office</a> or clinic	Primary care visit to treat an injury or illness	\$30/visit deductible does not apply	40% <a href="#">coinsurance</a>	Virtual visits (Telehealth) benefits available.
	<a href="#">Specialist</a> visit	\$50/visit <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	Virtual visits (Telehealth) benefits available.
	<a href="#">Preventive care/screening/immunization</a>	No charge	40% <a href="#">coinsurance</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a>	Typically Generic (Tier 1)	\$15/prescription, <a href="#">deductible</a> does not apply (retail) and \$38/prescription, <a href="#">deductible</a> does not apply (home delivery)	\$15/ prescription (retail) (no home delivery)	For more information, refer to "National Direct Plus List" at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a>
	Typically Preferred Brand & Non-Preferred Generic Drugs (Tier 2)	\$40/prescription, <a href="#">deductible</a> does not apply (retail) and \$100/prescription, <a href="#">deductible</a> does not apply (home delivery)	\$40/ prescription (retail) (no home delivery)	*See Prescription Drug section Pharmacy member cost shares count towards the combined Medical/Drug out-of-pocket maximum. Most Retail pharmacy drugs are limited to a 30-day supply. Mail order drugs are limited to a 90-day day supply.
	Typically Non-Preferred Brand and Generic drugs (Tier 3)	\$75/prescription, <a href="#">deductible</a> does not apply (retail) and \$188/prescription, <a href="#">deductible</a> does not apply (home delivery)	\$75/ prescription (retail) (no home delivery)	In-network you can get a 90 day supply of retail maintenance drugs for 3x the Retail 30 day supply copay. (Continued on next page)

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://eoc.anthem.com/eocdps/>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Typically Preferred <a href="#">Specialty</a> (brand and generic) (Tier 4)	20% <a href="#">coinsurance</a> up to \$200/prescription, per 30 day supply and \$400 for 90 day supply (retail and home delivery) and \$400 for 90 day supply (retail and home delivery)	n/a	Your plan uses a preferred drug list (formulary). <b>Self-administered Specialty drugs must be dispensed by IngenioRx (name change to CarelonRX in 2023).</b> Some drugs may require preauthorization, while other drugs are subject to step therapy and quantity limit requirements. -----none-----
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	Covered as In-Network	-----none-----
If you need immediate medical attention	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	Covered as In-Network	-----none-----
	<a href="#">Urgent care</a>	\$30 PCP/\$50 Specialist copay/visit	40% <a href="#">coinsurance</a>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	100 days/benefit period for Inpatient rehabilitation and skilled nursing services combined.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
	Outpatient services	Office Visit \$30/visit <a href="#">deductible</a> does not apply Other Outpatient 20% <a href="#">coinsurance</a>	Office Visit 40% <a href="#">coinsurance</a> Other Outpatient 40% <a href="#">coinsurance</a>	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient -----none-----
If you need mental health, behavioral health, or substance abuse services	Inpatient services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
	Office visits	\$30 PCP/\$50 Spec. (non global)	40% <a href="#">coinsurance</a>	-----none-----
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
If you are pregnant	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://eoc.anthem.com/eocdpps/>.

If you need help recovering or have other special health needs	<a href="#">Home health care</a>	<a href="#">20% coinsurance</a>	<a href="#">40% coinsurance</a>	100 visits/benefit period for Home Health and Private Duty Nursing combined.
	<a href="#">Rehabilitation services</a>	20% coinsurance	<a href="#">40% coinsurance</a>	*See Therapy Services section.
Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	<a href="#">Habituation services</a>	20% coinsurance	<a href="#">40% coinsurance</a>	
	<a href="#">Skilled nursing care</a>	<a href="#">20% coinsurance</a>	<a href="#">40% coinsurance</a>	100 days/benefit period for Inpatient rehabilitation and skilled nursing services combined.
	<a href="#">Durable medical equipment</a>	<a href="#">20% coinsurance</a>	<a href="#">40% coinsurance</a>	*See <a href="#">Durable Medical Equipment</a> Section
If your child needs dental or eye care	<a href="#">Hospice services</a>	<a href="#">20% coinsurance</a>	<a href="#">40% coinsurance</a>	-----none-----
	Children's eye exam	No charge	Reimbursed Up to \$30	*See Vision Services section
	Children's glasses	Not covered	Not covered	-----none-----
	Children's dental check-up	Not covered	Not covered	

**Excluded Services & Other Covered Services:**

**Services Your Plan Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)**

- Acupuncture
- Cosmetic surgery
- Infertility treatment
- Weight loss programs
- Bariatric surgery
- Dental care (Adult)
- Long-term care
- Children's dental check-up
- Glasses for a child
- Routine foot care unless [medically necessary](#)

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

- Chiropractic care 30 visits/benefit period
- Private-duty nursing 100 visits/benefit period combined with Home Health
- Hearing aids 1 item every 24 months for children 18 years of age or under. \$1,500 maximum/hearing aid.
- Routine eye care (Adult) 1 exam/benefit period
- Most coverage provided outside the United States. See [www.bcbsglobalcare.com](http://www.bcbsglobalcare.com)

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://eoc.anthem.com/eocdps/>.

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Virginia Bureau of Insurance, 1300 East Main Street, P. O. Box 1157, Richmond, VA 23218, (800) 552-7945, Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or contact Anthem at the number on the back of your ID card. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://eoc.anthem.com/eocdps/>.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact:

ATTN: Grievances and Appeals, P.O. Box 27401, Richmond, VA 23279

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

Virginia Bureau of Insurance, 1300 East Main Street, P. O. Box 1157, Richmond, VA 23218, (800) 552-7945

**Does this plan provide Minimum Essential Coverage? Yes.**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet the Minimum Value Standards? Yes.**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://eoc.anthem.com/eocdps/>.



## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's overall deductible](#) \$2,000
- [Specialist copayment](#) \$50
- [Hospital \(facility\) coinsurance](#) 20%
- [Other coinsurance](#) 0%

This EXAMPLE event includes services

like:

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

**Total Example Cost** \$12,700

In this example, Peg would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$2,000
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$1,900
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,970</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's overall deductible](#) \$2,000
- [Specialist copayment](#) \$50
- [Hospital \(facility\) coinsurance](#) 20%
- [Other coinsurance](#) 0%

This EXAMPLE event includes services

like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription](#) drugs  
[Durable medical equipment](#) (*glucose meter*)

**Total Example Cost** \$5,600

In this example, Joe would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,700
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,720</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's overall deductible](#) \$2,000
- [Specialist copayment](#) \$50
- [Hospital \(facility\) coinsurance](#) 20%
- [Other coinsurance](#) 0%

This EXAMPLE event includes services

like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

**Total Example Cost** \$2,800

In this example, Mia would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$2,000
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$20
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,320</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

 <p>The Summary of Benefits and Coverage (SBC) document will help you choose a health <a href="#">plan</a>. The SBC shows you how you and the <a href="#">plan</a> would share the cost for covered health care services. <b>NOTE: Information about the cost of this <a href="#">plan</a> (called the <a href="#">premium</a>) will be provided separately. This is only a summary.</b> For more information about your coverage, or to get a copy of the complete terms of coverage, <a href="https://eoc.anthem.com/eocdps/">https://eoc.anthem.com/eocdps/</a>. For general definitions of common terms, such as <a href="#">allowed amount</a>, <a href="#">balance billing</a>, <a href="#">coinsurance</a>, <a href="#">copayment</a>, <a href="#">deductible</a>, <a href="#">provider</a>, or other <u>underlined</u> terms, see the Glossary. You can view the Glossary at <a href="http://www.healthcare.gov/sbc-glossary/">www.healthcare.gov/sbc-glossary/</a> or call (833) 592-9956 to request a copy.</p>		
Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	\$3,500/person or \$7,000/family for In- <a href="#">Network Providers</a> and Non- <a href="#">Network Providers</a> combined.	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your deductible?</b>	Yes. Preventive Care for In- <a href="#">Network Providers</a> . Vision for In- <a href="#">Network</a> and Non- <a href="#">Network Providers</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	\$4,000/person or \$8,000/family for In- <a href="#">Network Providers</a> . \$6,000/person or \$12,000/family for Non- <a href="#">Network Providers</a> .	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the out-of-pocket limit?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.anthem.com/find-care/?alphabetix=VQX">www.anthem.com/find-care/?alphabetix=VQX</a> for a list of <a href="#">network providers</a> . Costs may vary by site of service and how the <a href="#">provider</a> bills.	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.

**Do you need a referral to see a specialist?** No. You can see the [specialist](#) you choose without a [referral](#).

**!** All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's office</a> or clinic	Primary care visit to treat an injury or illness	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Virtual visits (Telehealth) benefits available.
	<a href="#">Specialist</a> visit	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Virtual visits (Telehealth) benefits available.
	<a href="#">Preventive care/screening/immunization</a>	No charge	20% <a href="#">coinsurance</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	-----none-----
	Imaging (CT/PET scans, MRIs)	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	-----none-----
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a>	Typically Generic (Tier 1)	\$10/prescription (retail) and \$25/prescription (home delivery)	\$10/prescription (retail) (no home delivery)	For more information, refer to "National Direct Plus Drug List" at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a>
	Typically Preferred Brand & Non-Preferred Generic Drugs (Tier 2)	\$30/prescription (retail) and \$75/prescription (home delivery)	\$30/prescription (retail) (no home delivery)	*See Prescription Drug section <b>Copays &amp; Coinsurance apply after Deductible.</b>
	Typically Non-Preferred Brand and Generic drugs (Tier 3)	\$50/prescription (retail) and \$125/prescription (home delivery)	\$50/prescription (retail) (no home delivery)	In-network you can get a 90 day supply of retail maintenance drugs for 3x the Retail 30 day supply copay.
	Typically Preferred <a href="#">Specialty</a> (brand and generic) (Tier 4)	20% <a href="#">coinsurance</a> up to \$200/prescription (retail and home delivery)	n/a	Some drugs may require prior authorization, while other drugs are subject to step therapy and quantity limit requirements. Must use IngenioRx (name change to CarelonRx in 2023) pharmacy. Out of network you'll be responsible for amounts over the allowable.
If you have outpatient surgery	Facility fee (e.g, ambulatory surgery center)	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	-----none-----
	Physician/surgeon fees	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	-----none-----
If you need immediate medical attention	<a href="#">Emergency room care</a>	0% <a href="#">coinsurance</a>	Covered as In-Network	-----none-----
	<a href="#">Emergency medical transportation</a>	0% <a href="#">coinsurance</a>	Covered as In-Network	-----none-----
	<a href="#">Urgent care</a>	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	-----none-----

<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	100 days/benefit period for Inpatient rehabilitation and skilled nursing services combined.
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\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://eoc.anthem.com/eocdps/>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Physician/surgeon fees	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	-----none-----
	Outpatient services	Office Visit 0% <a href="#">coinsurance</a> Other Outpatient 0% <a href="#">coinsurance</a>	Office Visit 20% <a href="#">coinsurance</a> Other Outpatient 20% <a href="#">coinsurance</a>	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient -----none-----
	Inpatient services	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	-----none-----
	Office visits	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
If you are pregnant	Childbirth/delivery professional services	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery facility services	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	100 visits/benefit period for Home Health and Private Duty Nursing combined.
	<a href="#">Rehabilitation services</a>	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	*See Therapy Services section.
	<a href="#">Habilitation services</a>	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	100 days/benefit period for Inpatient rehabilitation and skilled nursing services combined.
	<a href="#">Durable medical equipment</a>	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	*See <a href="#">Durable Medical Equipment Section</a>
If your child needs dental or eye care	<a href="#">Hospice services</a>	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	-----none-----
	Children's eye exam	No charge	Reimbursed up to \$30	
	Children's glasses	Not covered	Not covered	*See Vision Services section
	Children's dental check-up	Not covered	Not covered	-----none-----

**Excluded Services & Other Covered Services:**

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Acupuncture
- Bariatric surgery
- Children's dental check-up

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://eoc.anthem.com/eocdps/>.

- Cosmetic surgery
- Infertility treatment
- Weight loss programs

- Dental care (Adult)
- Long-term care
- Glasses for a child
- Routine foot care unless [medically necessary](#)

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan document](#).)**

- Chiropractic care 30 visits/benefit period
- Hearing aids 1 item every 24 months for children 18 years of age or under. \$1,500 maximum/hearing aid.
- Private-duty nursing 100 visits/benefit period combined with Home Health
- Routine eye care (Adult) 1 exam/benefit period

- Most coverage provided outside the United States. See [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Virginia Bureau of Insurance, 1300 East Main Street, P. O. Box 1157, Richmond, VA 23218, (800) 552-7945, Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or contact Anthem at the number on the back of your ID card. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact:

ATTN: Grievances and Appeals, P.O. Box 27401, Richmond, VA 23279

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

Virginia Bureau of Insurance, 1300 East Main Street, P. O. Box 1157, Richmond, VA 23218, (800) 552-7945

**Does this plan provide Minimum Essential Coverage? Yes.**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet the Minimum Value Standards? Yes.**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://eoc.anthem.com/eocdps/>.

About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's overall deductible](#) **\$3,500**
- [Specialist coinsurance](#) **0%**
- [Hospital \(facility\) coinsurance](#) **0%**
- [Other coinsurance](#) **0%**

This **EXAMPLE** event includes services like:

- [Specialist](#) office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- [Diagnostic tests](#) (*ultrasounds and blood work*)
- [Specialist](#) visit (*anesthesia*)

**Total Example Cost** **\$12,700**

In this example, Peg would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$3,500
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$1,900
<i>What isn't covered</i>	
Limits or exclusions	\$60

**The total Peg would pay is** **\$5,470**

**Managing Joe's Type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The [plan's overall deductible](#) **\$3,500**
- [Specialist coinsurance](#) **0%**
- [Hospital \(facility\) coinsurance](#) **0%**
- [Other coinsurance](#) **0%**

This **EXAMPLE** event includes services like:

- [Primary care physician](#) office visits (*including disease education*)
- [Diagnostic tests](#) (*blood work*)
- [Prescription](#) drugs
- [Durable medical equipment](#) (*glucose meter*)

**Total Example Cost** **\$5,600**

In this example, Joe would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$3,500
<a href="#">Copayments</a>	\$600
<a href="#">Coinsurance</a>	\$60
<i>What isn't covered</i>	
Limits or exclusions	\$20

**The total Joe would pay is** **\$4,180**

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- The [plan's overall deductible](#) **\$3,500**
- [Specialist coinsurance](#) **0%**
- [Hospital \(facility\) coinsurance](#) **0%**
- [Other coinsurance](#) **0%**

This **EXAMPLE** event includes services like:

- [Emergency room care](#) (*including medical supplies*)
- [Diagnostic test](#) (*x-ray*)
- [Durable medical equipment](#) (*crutches*)
- [Rehabilitation services](#) (*physical therapy*)

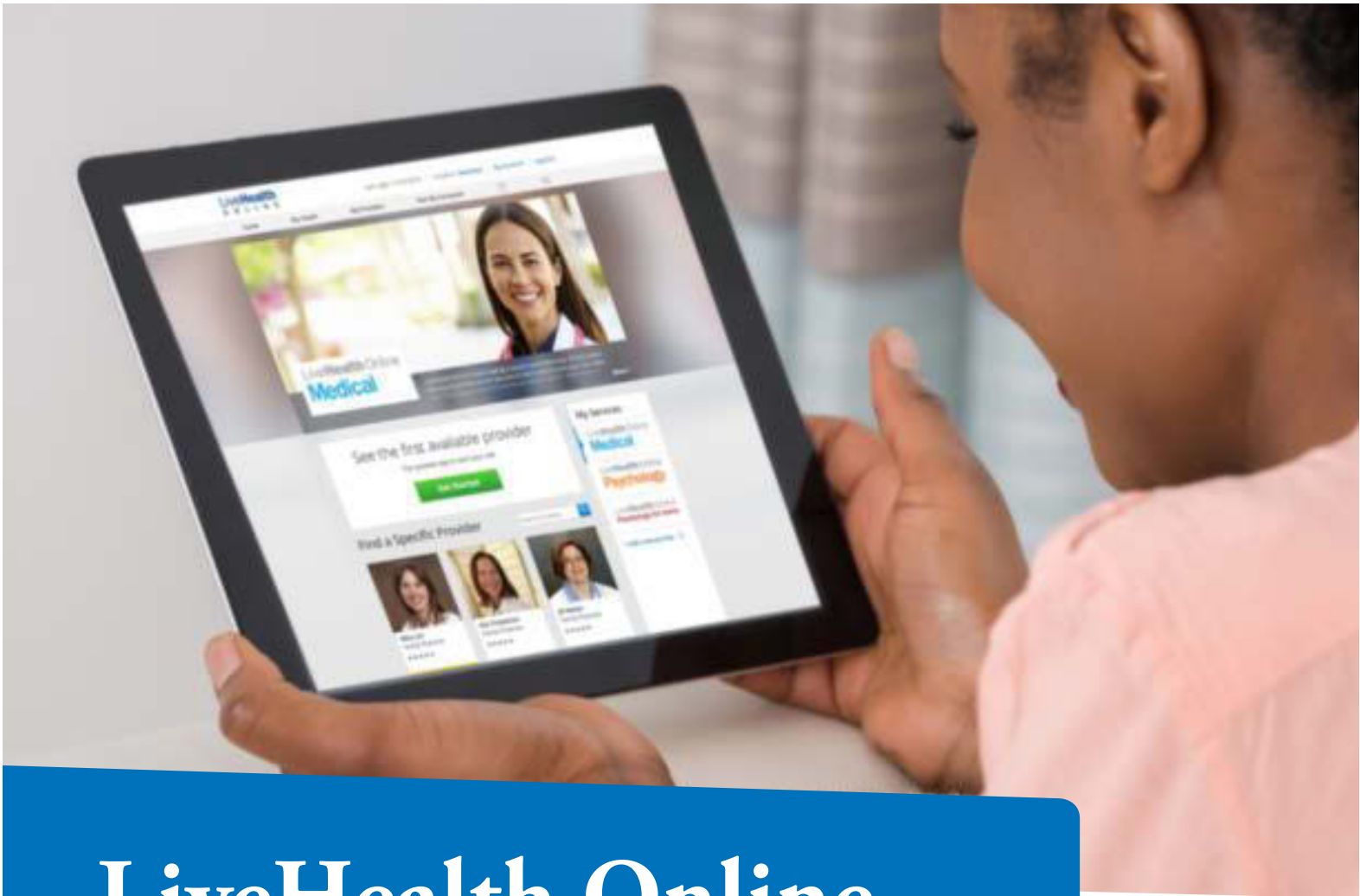
**Total Example Cost** **\$3,500**

In this example, Mia would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$3,500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0

**The total Mia would pay is** **\$3,500**

The [plan](#) would be responsible for the other costs of these **EXAMPLE** covered services.



# LiveHealth Online

How to register in minutes  
before you feel sick

Using LiveHealth Online, you can have a private and secure video visit with a board-certified doctor 24/7 on your smartphone, tablet or computer with a webcam. It's a quick and easy way to get the care you need with no appointments or long wait times.

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 other common health condition. A doctor can assess your condition, provide a treatment plan and even send a prescription to your pharmacy, if it's needed.<sup>1</sup>





## How to get started

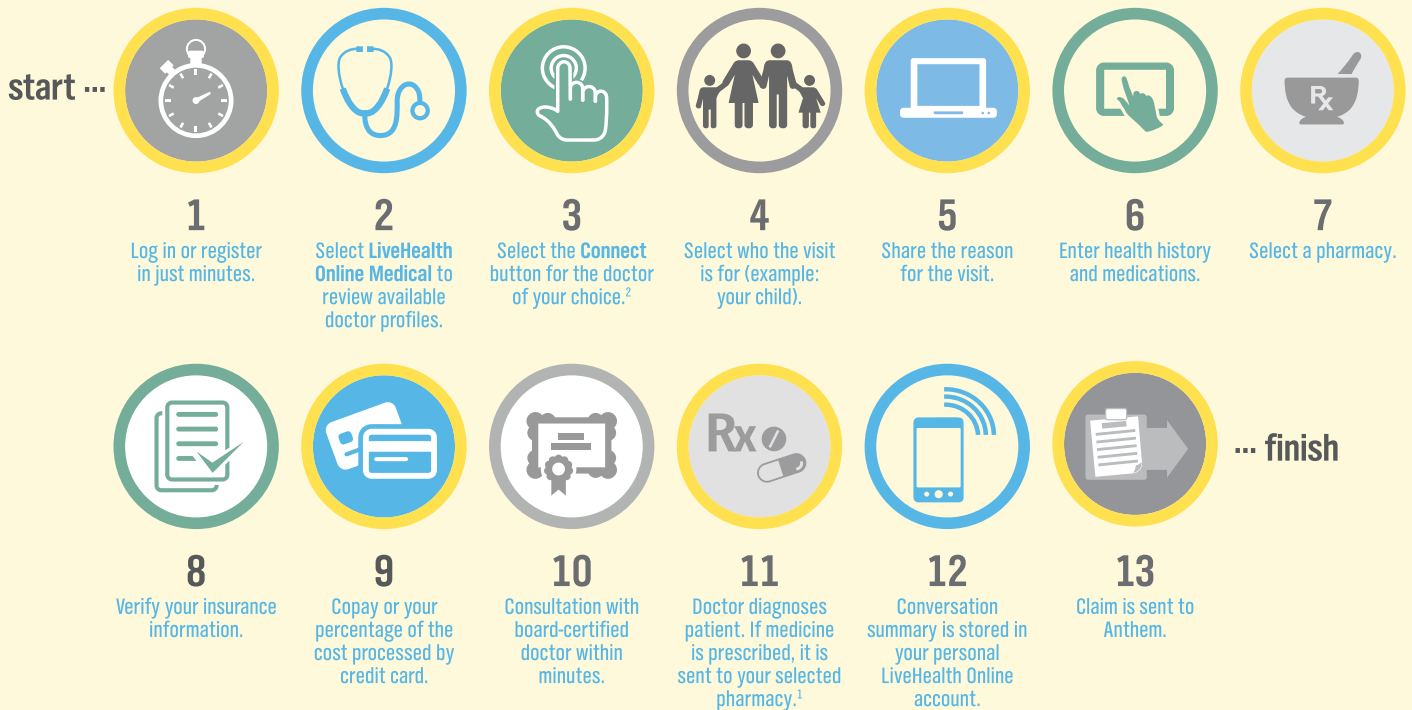
Rather than waiting to sign up when you're not feeling well, register today so you're ready for a visit when you need one. To sign up, visit [livehealthonline.com](https://livehealthonline.com) or download the free LiveHealth Online app to your mobile device. Next, you:

1. Choose **Sign Up** to create your LiveHealth Online account. Then enter information like your name, email address, date of birth and create a secure password.
2. Read the *Terms of Use* and check the box to agree.
3. Choose your location in the drop-down box of states.
4. Enter your birth date and choose your gender.
5. For the question "Do you have insurance?", select **Yes**. Be sure to have your Anthem member ID card handy to complete your insurance information. If you choose **No**, you can still enter your insurance information later.
6. For **Health Plan**, select **Anthem Virginia**
7. For **Subscriber ID**, enter your identification number, which is found on your Anthem member ID card. Select **Yes** if you are the primary subscriber or **No** if you are not the primary subscriber.
8. Insert a service key if you have one. If you don't have a service key that's OK, this is optional and not required to register.
9. Select the green **Finish** button.

## Your account securely stores your personal and health information

You can be confident knowing you can easily connect with doctors when you need to consult about certain conditions, share your health history, and schedule online visits at times that fit your schedule.

## How to use LiveHealth Online for a video visit with a doctor



## Questions about how to use LiveHealth Online?

Call toll free at **1-888-LiveHealth (548-3432)** or email [help@livehealthonline.com](mailto:help@livehealthonline.com). If you send us an email, please include your name, email address and a phone number where we can reach you.

<sup>1</sup> Prescription availability is defined by physician judgment and state regulations. Visit the home page of [livehealthonline.com](https://livehealthonline.com) to view the service map by state.

<sup>2</sup> Select a doctor licensed to practice in the state where you're physically located. If that doctor is seeing another patient, you can choose to go to an online waiting room or you can select another doctor who is available at that moment.

LiveHealth Online is the trade name of Health Management Corporation, a separate company providing telehealth services on behalf of Anthem.

If you're a retiree or have coverage that complements your Medicare benefits, your employer sponsored health plan may not include coverage for online visits using LiveHealth Online. Check your plan documents for details. You can still use LiveHealth Online, but you may have to pay the full cost of a visit. Online visits using LiveHealth Online may not be a covered benefit for HRA and HIA+ members.

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. Copies of Colorado network access plans are available on request from member services or can be obtained by going to [anthem.com/co/networkaccess](https://anthem.com/co/networkaccess). In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE<sup>SM</sup> Managed Care, Inc. (RIT), Healthy Alliance<sup>SM</sup> Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by CompCare Health Services Insurance Corporation (CompCare) or Wisconsin Collaborative Insurance Corporation (WCIC). CompCare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc.



# Building Healthy Families



A new program to support growing families

## Benefits to help you thrive

Family Care Coaches

Interactive health trackers

24/7 access

Personalized content

Every family grows in its own way. That's part of what makes each one unique. Anthem's new, all-in-one program can help your family grow strong whether you're trying to conceive, expecting a child, or in the thick of raising young children.

Building Healthy Families offers personalized, digital support through the Sydney<sup>SM</sup> Health mobile app or on **anthem.com** at no extra cost to you. This convenient hub offers an extensive collection of tools and information to help you navigate your family's unique journey.

# Designed with you in mind

When you enroll in Building Healthy Families, you can count on personalized support at every stage, from family planning and pregnancy through the toddler years. Plus, if you have a family story that includes adoption, surrogacy, or single parenthood, the resources, tools, and information on your profile will be tailored to what you need. Depending on your situation, you'll have unlimited access to:

## Tools to help you stay organized

- Log newborn feedings, diaper changes, growth, vaccinations, and your child's developmental milestones.
- Monitor prenatal health risks, such as blood pressure and weight.

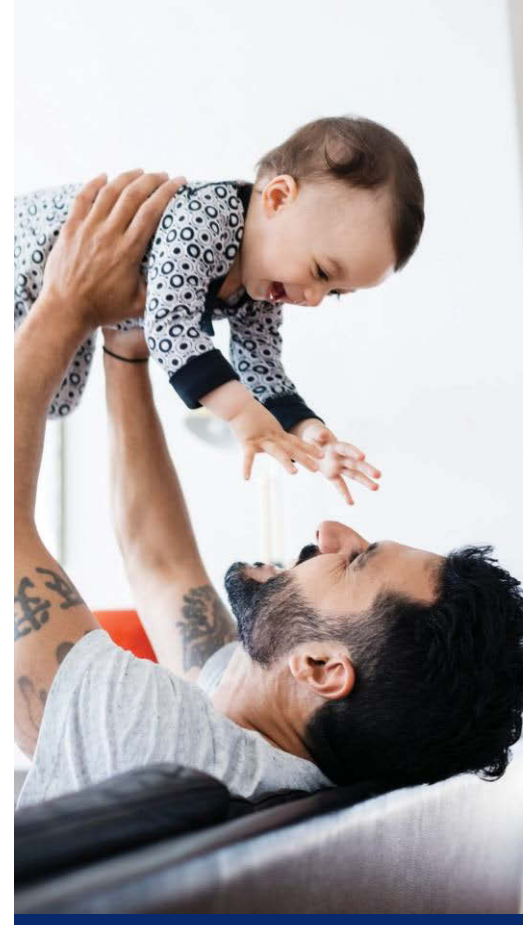
## Health and wellness expertise for you and your family

- Explore a library with thousands of educational articles and videos on everything from family planning to parenting tips.
- Connect with a maternity nurse and access virtual lactation support, if needed.

## Personalized pregnancy support

- Chat with a Family Care Coach during pregnancy for help navigating your Building Healthy Families experience.
- Receive updates on your pregnancy progress, like development of your baby and body changes.

It's exciting to watch your family grow, but that doesn't mean there aren't challenges along the way. Building Healthy Families can help you nurture your family's health and tackle every stage of growth with confidence.



## Enroll today

1. Visit **anthem.com** or log in to Sydney Health.
2. Find *Featured Programs* at the bottom of the homepage.
3. Select **View All** then choose the **Building Healthy Families** tile.

You can also scan this QR code with your phone's camera to get started.



Sydney Health is offered through an arrangement with Carelon Digital Platforms, a separate company offering mobile application services on behalf of your health plan. ©2023

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# Stay on top of your health

## Use your preventive care benefits

Regular preventive care can help you stay healthy and catch problems early, when they are easier to treat. Our health plans offer all the preventive care services and immunizations below at no cost to you.<sup>1</sup> As long as you use a doctor, pharmacy, or lab in your plan's network, you won't have to pay anything. If you go to doctors or facilities that are not in your plan, you may have to pay out of pocket.

If you are not sure which exams, tests, or shots make sense for you, talk to your doctor.

### Preventive care vs. diagnostic care

What's the difference? Preventive care helps protect you from getting sick. If your doctor recommends you receive 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

#### General preventive physical exams, screenings, and tests (all adults):

- Alcohol misuse: related screening and behavioral counseling
- Aortic aneurysm screening (for men who have smoked)
- Behavioral counseling to promote a healthy diet
- Blood pressure
- Bone density test to screen for osteoporosis
- Cholesterol and lipid (fat) levels screening
- Colorectal cancer screenings, including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and related prep kit, and computed tomography (CT) colonography (as appropriate)<sup>2</sup>
- Depression screening
- Diabetes screening (type 2)<sup>3</sup>
- Eye chart test for vision<sup>4</sup>
- Hepatitis B virus (HBV) screening for people at increased risk of infection
- Hepatitis C virus (HCV) screening
- Hearing screening
- Height, weight, and body mass index (BMI) measurements
- Human immunodeficiency virus (HIV): screening and counseling
- Interpersonal and domestic violence: screening and counseling
- Lung cancer screening for those ages 55 to 80 who have a history of smoking 30 packs or more per year and still smoke, or who have quit within the past 15 years<sup>2</sup>
- Obesity: related screening and counseling<sup>3</sup>
- Prostate cancer screenings, 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

#### Women's preventive care:

- Breast cancer screenings, including exam, mammogram, and genetic testing for BRCA1 and BRCA2 when certain criteria are met<sup>5</sup>
- Breastfeeding: primary care intervention to promote breastfeeding support, supplies, and counseling<sup>6,7,8</sup>
- Contraceptive (birth control) counseling
- Counseling related to chemoprevention for those at high risk for breast cancer
- Counseling related to genetic testing for those with a family history of ovarian or breast cancer
- Food and Drug Administration (FDA)-approved contraceptive medical services, including sterilization, provided by a doctor
- Human papillomavirus (HPV) screening<sup>7</sup>
- Interpersonal and domestic violence: screening and counseling
- Pelvic exam and Pap test, including screening for cervical cancer
- Pregnancy screenings, including gestational diabetes, hepatitis B, asymptomatic bacteriuria, Rh incompatibility, syphilis, HIV, and depression<sup>7</sup>
- Well-woman visits

#### Immunizations:

- Coronavirus disease (COVID-19)
- 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)

The preventive care services listed above are recommendations of the Affordable Care Act (ACA) and therefore are subject to change. They may not be right for every person. 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 group policy provisions will rule. Please see your combined *Evidence of Coverage and Disclosure Form* or *Certificate* for exclusions and limitations.

## Child preventive care

### Preventive physical exams, screenings, and tests:

- Behavioral counseling to promote a healthy diet
- Blood pressure screening
- Cervical dysplasia screening
- Cholesterol and lipid (fat) levels screening
- Depression screening
- Development and behavior screening
- Diabetes screening (type 2)
- Hearing screening
- Height, weight, and BMI measurements
- Hemoglobin or hematocrit (blood count) screening
- Lead testing
- Newborn screening
- Obesity: related screening and counseling
- Oral (dental health) assessment, when done as part of a preventive care visit
- Sexually transmitted infections: related screening and counseling
- Skin cancer counseling for those ages 6 months to 24 years with fair skin
- Tobacco use: related screening and behavioral counseling
- Vision screening, when done as part of a preventive care visit<sup>4</sup>

### Immunizations:

- Chickenpox
- Flu
- Haemophilus influenzae type B (HIB)
- Hepatitis A and hepatitis B
- Human papillomavirus (HPV)
- Meningitis
- Measles, mumps, and rubella (MMR)
- Pneumonia
- Polio
- Rotavirus
- Whooping cough

## Coverage for 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.
- Receive and fill prescriptions from doctors, pharmacies, or other healthcare professionals in your plan's network.
- 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 (CVD), preeclampsia, and colorectal cancer in adults younger than age 70
- Colonoscopy prep kit (generic or OTC only) when prescribed for preventive colon screening
- Generic low-to-moderate dose statins for members ages 40 to 75 who have one or more CVD risk factors (dyslipidemia, diabetes, hypertension, or smoking)
- Pre-exposure prophylaxis (PrEP) for the prevention of HIV
- Tobacco cessation products, including all FDA-approved brand-name 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 tooth decay in children ages 5 and younger
- Fluoride supplements for children ages 6 and younger

### Women's preventive drugs and other pharmacy items (age appropriate):

- Breast cancer risk-reducing medications, such as tamoxifen, raloxifene, and aromatase inhibitors, that follow the U.S. Preventive Services Task Force criteria<sup>2</sup>
- Contraceptives, including generic prescription drugs and OTC items like female condoms and spermicides<sup>7</sup>
- Folic acid for women ages 55 or younger who are planning to become pregnant
- Low-dose aspirin (81 mg) for pregnant women who have an increased risk of preeclampsia

If you'd like more help understanding your preventive care benefits, call the number on the back of your member ID card. For a complete list of covered preventive drugs under the Affordable Care Act, view the *Preventive ACA Drug List* flyer, available at [anthem.com/pharmacyinformation](http://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 You may be required to receive preapproval for these services.

3 The Centers for Disease Control and Prevention (CDC)-recognized diabetes prevention programs are available for overweight or obese adults with abnormal blood glucose or who have abnormal CVD risk factors.

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

5 Check your medical policy for details.

6 Breast pumps and supplies must be purchased from suppliers or retailers in your plan's network for 100% coverage. We recommend using plan durable medical equipment (DME) suppliers.

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

8 Counseling services for breastfeeding (lactation) can be provided or supported by a doctor or facility in your plan's network, such as a pediatrician, OB-GYN, or family medicine doctor, and hospitals with no member cost share (deductible, copay, or coinsurance). Contact the provider to see if such services are available.



# Connect with us 24/7

Text, chat, or ask Alexa to find answers and support whenever is best for you

When you have questions about your Anthem health plan, you can find answers in real time, in the way that suits you best. Anthem's digital tools ensure that help is available whenever you need it. Whether you prefer interactive chat, hands-free voice commands, or live chat, you now have solutions that make it easier for you to focus on your unique needs and priorities.



## Sydney Health

The Sydney<sup>SM</sup> Health mobile app provides quick access to your health plan information — all in one place. The app's interactive chat feature helps you navigate your benefits with greater ease. Simply type your questions in the app to find answers quickly. Sydney Health can also suggest resources to help you understand your benefits, improve your health, and save money.

### How to use Sydney Health's interactive chat

#### Download the app

- Download the Sydney Health app from the App Store® or Google Play™.
- Register or log in to your account using your Anthem username and password.
- Look for the interactive chat feature icon, then type in your questions.

#### Use the Sydney Health interactive chat feature to:

- Search for doctors, hospitals, labs, and other health care providers in your plan.
- Check costs for care before you see a doctor.
- Pull up your digital member ID card.
- See what your plan covers.
- Find your deductible, copay, and share of costs.
- Access your spending account balance.



**Discover how Sydney Health simplifies health care**

Download and start using the app today.



Use your smartphone camera to scan this QR code.



## Live Chat

Available on Sydney Health or **anthem.com**, our Live Chat tool enables you to chat in real-time with a representative who can answer your benefit questions or connect you with others who can help.

### How to use Live Chat

#### Log in using Sydney Health or **anthem.com**:

1. For Sydney Health, go to the **Menu** tab and under *Get Support*, select **Start a live chat**.
2. For **anthem.com**, choose **Live Chat** under the *Support* tab.

#### Choose your chat topic:

Once you start a chat, select a topic or program to connect with a representative who can best help you. Topics include:



24/7 NurseLine



Behavioral health



Benefits, coverage, and claims



Maternity and baby benefits



Pharmacy

With more ways to reach us, we're making it easier for you to find the answers and support you need, right when you need it.



## Anthem Skill for Alexa

Quick, hands-free help is here. The Anthem Skill works through Alexa-ready devices, such as an Amazon Echo, or on your mobile device using the Amazon Alexa app. Say the words, "Alexa, ask Anthem ..." to start using the skill.

### How to use Anthem Skill

#### Enable the Skill:

- Download the Amazon Alexa app from the App Store® or Google Play™.
- Go to **Skills and Games** and search for the **Anthem Skill**. Then tap **Enable to Use**.
- Enter your Anthem username and password to link the Skill with your Anthem account.
- Set up your Alexa voice profile and passcode if you haven't already.
- Ask Alexa for help by saying, "Alexa, ask Anthem ..."

#### Use the Skill to:

- Ask for your digital member ID card.
- Check your deductible and out-of-pocket maximum.
- Refill, renew, cancel, and check the order status of home delivery prescriptions.
- Access your spending account balance.
- Schedule a call with our Member Services team.
- Search for a doctor, specialist, or facility.
- Access claim information.
- Learn what a health care term means.

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# Expanding your virtual care options

Find complete care support, on your time, through the **Sydney Health app**

## Visit with a doctor at your convenience

Accessing the care you need, when you need it, matters. That's why our Sydney<sup>SM</sup> Health mobile app connects you to a team of doctors ready to help you on your time. There are two secure ways to find low or no-additional cost care through our app:

- ① **Chat with a doctor 24/7 without an appointment**
  - Urgent care support for health issues, such as allergies, a cold, or the flu.
  - New prescriptions<sup>1</sup> for concerns such as a cough or a sinus infection.
- ② **Schedule a virtual primary care appointment**
  - Routine care, including virtual annual preventive care (wellness) visit and prescription refills.<sup>1,2,3,4</sup>
  - Personalized care plans for chronic conditions, such as asthma or diabetes.

## Assess your symptoms with the Symptom Checker

When you're sick, you can use the Symptom Checker on Sydney Health to answer a few questions about how you're feeling. That information is run against millions of medical data points to provide care advice tailored to you.

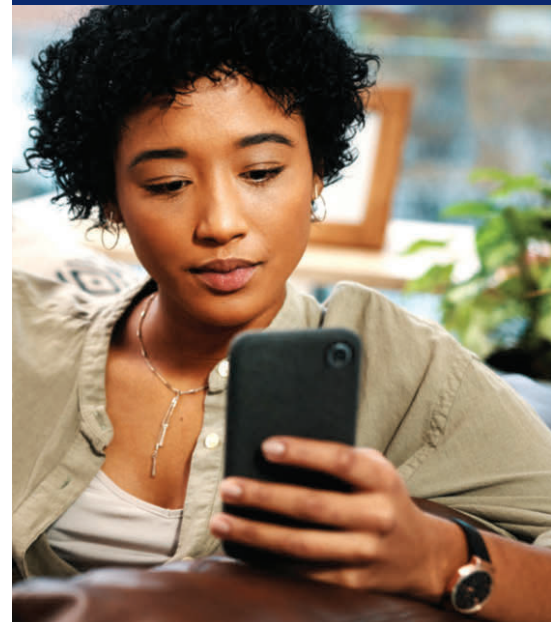
## Save money and time with virtual care

Sydney Health brings care to you anywhere, anytime. The Symptom Checker is always free to use, while virtual primary care visits and on-demand urgent care through the app are available at low or no-additional cost.

▶ Download our Sydney Health mobile app today.



Set up your account right away and it will be ready to use when you need it.



**85%** of virtual visits resolve the person's need.<sup>5</sup>

1 Virtual annual preventive care (wellness) visits through the Sydney Health app are available starting September 2022. The virtual annual preventive care (wellness) visit is covered in full unless the employer has a limit or cap under their benefit plan.  
 2 Virtual primary care medical services provided by Preventive Medical Associates P.C. through an arrangement with Hydrogen Health, which provides the virtual care platform.  
 3 Eligible employees are those who have not yet had an annual preventive care (wellness) visit during the plan year (either virtual or in-person) whose group benefit plan covers a virtual primary care exam. If an employer group has a cap on the number of preventive care (wellness) visits that are covered in full and the employee has exceeded the cap but would like to have another preventive care (wellness) visit, they may be responsible for copays and other out-of-pocket costs for the visit. Employees should consult their benefit plan and/or contact Member Services if they have any questions.  
 4 Your doctor will determine if a prescription is needed at time of visit.  
 5 K Health analysis of Q4 2020 visit depositions.  
 Sydney Health is offered through an arrangement with Carelon Digital Platforms, a separate company offering mobile application services on behalf of your health plan. ©2020-2022 The Virtual Primary Care experience is offered through an arrangement with Hydrogen Health.  
 In addition to using a telehealth service, you can receive in-person or virtual care from your own doctor or another healthcare professional in your plan's network. If you receive care from a doctor or healthcare professional not in your plan's network, your share of the costs may be higher. You may also receive a bill for any charges not covered by your health plan.  
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# The ins and outs of coverage

Knowing that you have health care coverage that meets your and your family's needs is reassuring.

But part of your decision in choosing a plan also means you need to understand:

- Who can enroll
- How you and your employer handle coverage changes
- What's not covered by your plan
- How your coverage works with other health plans you might have

## Who can be enrolled

You can choose coverage for just you. Or, you can have coverage for your family, including you and any of the following family members:

- Your spouse
- Your children age 26 or younger, including:
  - A newborn, natural child or a child placed with you for adoption
  - A stepchild
  - Any other child for whom you have legal guardianship

Coverage will end on the last day of the month in which they turn 26.

Some children have mental or physical challenges that prevent them from living independently. The dependent age limit does not apply to these enrolled children as long as these challenges were present before they turned 26.

**1. At the employer level, which affects you and other employees covered by an employer’s plan, your plan can be:**

Renewed	Canceled	Changed	When
●			<p>Your employer:</p> <ul style="list-style-type: none"> <li>Keeps its status as an employer.</li> <li>Stays in our service area.</li> <li>Meets our guidelines for employee participation and premium contribution.</li> <li>Pays the required health care premiums.</li> <li>Doesn't commit fraud or misrepresent itself.</li> </ul>
	●		<p>Your employer:</p> <ul style="list-style-type: none"> <li>Makes a bad payment.</li> <li>Voluntarily cancels coverage (30-days advance written notice required).</li> <li>Is unable (after being given at least a 30-day notice) to meet eligibility requirements to maintain a group plan.</li> <li>Still does not pay the required health care premium (after being given a 31-day grace period and at least a 15-day notice).</li> </ul>
	●		<ul style="list-style-type: none"> <li>We decide to no longer offer the specific plan chosen by your employer (you'll get a 90-day advance notice).</li> <li>We decide to no longer offer any coverage in Virginia (you'll get a 180-day advance notice).</li> </ul>
		●	<p>You and your employer received a 30-day advance written notice that the coverage was being changed (services were added to your plan or the copays were lowered). Copays can be increased or services can be decreased only when it is time for your group to renew its coverage.</p>

**2. At the individual level, which affects you and covered family members, your plan can be:**

Renewed	Canceled	When you
●		<ul style="list-style-type: none"> <li>Stay eligible for your employer’s coverage.</li> <li>Pay your share of the monthly payment (premium) for coverage.</li> <li>Don't commit fraud or misrepresent yourself.</li> </ul>
	●	<p>Give wrong information on purpose about yourself or your dependents when you enroll. Cancellation is effective immediately.</p>
	●	<ul style="list-style-type: none"> <li>Lose your eligibility for coverage.</li> <li>Don't make required payments or make bad payments.</li> <li>Commit fraud.</li> <li>Are guilty of gross misbehavior.</li> <li>Don't cooperate if we ask you to pay us back for benefits that were overpaid (coordination of benefits recoveries).</li> <li>Let others use your ID card.</li> <li>Use another member's ID card.</li> <li>File false claims with us.</li> </ul> <p>Your coverage will be canceled after you receive a written notice from us.</p>

## Special enrollment periods

In most cases, you're only allowed to enroll in your employer's health plan during certain eligibility periods, such as when it's first offered to you as a "new hire" or during your employer's open enrollment period, when employees can make changes to their benefits for an upcoming year.

But there can be other times when you may be eligible to enroll. For example, let's say the first time you were offered coverage, you stated in writing that you didn't want to enroll yourself, your spouse or your covered dependents because you had coverage through another carrier or group health plan. If you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage) you may be able to enroll your family later. But you must ask to be enrolled within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Also, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Finally, a special enrollment period of 60 days will be allowed if:

- Your or your dependents' coverage under Medicaid or the State Children's Health Insurance Program (SCHIP) is terminated as a result of a loss of eligibility.
- You or your dependents become eligible for premium assistance under a state Medicaid or SCHIP plan.

To request special enrollment or get more information, contact your employer.

## When you're covered by more than one plan

If you're covered by two different group health plans, one is considered primary and the other is considered secondary. The primary plan is the first to pay a claim and reimburse according to plan allowances. The secondary plan then reimburses, usually covering the remaining allowable costs.

## Determining the primary and secondary plans

See the chart below to learn which health plan is considered the primary plan. The term “participant” means the person who signed up for coverage:

When a person is covered by two group plans, and	Then	Primary	Secondary
One plan does not have a COB provision	The plan without COB is	●	
	The plan with COB is		●
The person is the participant under one plan and a dependent under the other	The plan covering the person as the participant is	●	
	The plan covering the person as a dependent is		●
The person is the participant in two active group plans	The plan that has been in effect longer is	●	
	The plan that has been in effect the shorter amount of time is		●
The person is an active employee on one plan and enrolled as a COBRA participant for another plan	The plan in which the participant is an active employee is	●	
	The COBRA plan is		●
The person is covered as a dependent child under both plans	The plan of the parent whose birthday occurs earlier in the calendar year (known as the birthday rule) is	●	
	The plan of the parent whose birthday is later in the calendar year is		●
	Note: When the parents have the same birthday, the plan that has been in effect longer is	●	
The person is covered as a dependent child and coverage is required by a court decree	The plan of the parent primarily responsible for health coverage under the court decree is	●	
	The plan of the other parent is		●
The person is covered as a dependent child and coverage is <i>not</i> stipulated in a court decree	The custodial parent's plan is	●	
	The noncustodial parent's plan is		●
The person is covered as a dependent child and the parents share joint custody	The plan of the parent whose birthday occurs earlier in the calendar year is	●	
	The plan of the parent whose birthday is later in the calendar year is		●
	Note: When the parents have the same birthday, the plan that has been in effect longer is	●	

## How benefits apply if you're eligible for Medicare

Some people under age 65 are eligible for Medicare in addition to any other coverage they may have. The following chart shows how payment is coordinated under various scenarios:

When a person is covered by Medicare and a group plan, and	Then	Your plan is primary	Medicare is primary
Is qualified for Medicare coverage due solely to end-stage renal disease (ESRD-kidney failure)	During the 30-month Medicare entitlement period	●	
	Upon completion of the 30-month Medicare entitlement period		●
Is a disabled member who is allowed to maintain group enrollment as an active employee	If the group plan has more than 100 participants	●	
	If the group plan has fewer than 100 participants		●
Is the disabled spouse or dependent child of an active full-time employee	If the group plan has more than 100 participants	●	
	If the group plan has fewer than 100 participants		●
Is a person who becomes qualified for Medicare coverage due to ESRD after already being enrolled in Medicare due to a disability	If Medicare had been secondary to the group plan before ESRD entitlement	●	
	If Medicare had been primary to the group plan before ESRD entitlement		●

## Recovering overpayments

If health care benefits are overpaid by mistake, we will ask for reimbursement for the overpayment. This is referred to as “coordination of benefits recoveries.” We appreciate your help in the recovery process. We reserve the right to recover any overpayment from:

- Any person to or for whom the overpayments were made
- Any health care company
- Any other organization

## What's Not Covered

In this section you will find a review of items that are not covered by your Plan. Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary. This section is only meant to be an aid to point out certain items that may be misunderstood as Covered Services. This section is not meant to be a complete list of all the items that are excluded by your Plan.

We will have the right to make the final decision about whether services or supplies are Medically Necessary and if they will be covered by your Plan.

- 1) **Acts of War, Disasters, or Nuclear Accidents** In the event of a major disaster, epidemic, war, or other event beyond our control, we will make a good faith effort to give you Covered Services. We will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.

Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, a riot, or civil disobedience.

- 2) **Administrative Charges**

- a) Charges to complete claim forms,
- b) Charges to get medical records or reports,
- c) Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.

- 3) **Aids for Non-verbal Communication** Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices approved by us.

- 4) **Alternative / Complementary Medicine** Services or supplies for alternative or complementary medicine. This includes, but is not limited to:

- a) Acupuncture, (Removed when Acupuncture Rider is included)
- b) Acupressure, or massage to help alleviate pain, treat illness or promote health by putting pressure to one or more areas of the body,
- c) Holistic medicine,
- d) Homeopathic medicine,
- e) Hypnosis,
- f) Aroma therapy,
- g) Massage and massage therapy,
- h) Reiki therapy,
- i) Herbal, vitamin or dietary products or therapies,
- j) Naturopathy,
- k) Thermography,
- l) Orthomolecular therapy,
- m) Contact reflex analysis,
- n) Bioenergetic synchronization technique (BEST),
- o) Iridology-study of the iris,
- p) Auditory integration therapy (AIT),
- q) Colonic irrigation,
- r) Magnetic innervation therapy,
- s) Electromagnetic therapy,

t) Neurofeedback / Biofeedback.

- 5) **Applied Behavioral Treatment** (including, but not limited to, Applied Behavior Analysis) unless Medically Necessary.
- 6) **Autopsies** Autopsies and post-mortem testing unless requested by us as stated in “Physical Examinations and Autopsy” in the “General Provisions” section.
- 7) **Before Effective Date or After Termination Date** Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.
- 8) **Certain Providers** Services you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet. Examples include, but are not limited to, masseurs or masseuses (massage therapists), and physical therapist technicians.
- 9) **Charges Not Supported by Medical Records** Charges for services not described in your medical records.
- 10) **Charges Over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services. The exception to this exclusion is outlined in “Balance Billing by Out-of-Network Providers” in the “How Your Plan Works” section.
- 11) **Clinical Trial Non-Covered Services** Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.
- 12) **Clinically-Equivalent Alternatives** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. “Clinically equivalent” means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at [www.anthem.com](http://www.anthem.com).

If you or your Doctor believes you need to use a different Prescription Drug, please have your Doctor or pharmacist get in touch with us. We will cover the other Prescription Drug only if we agree that it is Medically Necessary and appropriate over the clinically equivalent Drug. We will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary.

- 13) **Complications of/or Services Related to Non-Covered Services** Services, supplies, or treatment related to or, for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.
- 14) **Compound Drugs** Compound Drugs unless all of the ingredients are FDA approved, require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
- 15) **Contraceptives** Contraceptive devices including diaphragms, intrauterine devices (IUDs), and implants. (Added when contraceptives are excluded via a qualified religious exemption)
- 16) **Contraceptive Devices** Contraceptive devices including intrauterine devices (IUDs) and implants. (Added when contraceptive devices are excluded via partial religious exemption)
- 17) **Cosmetic Services** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how you look or are given for social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).

This Exclusion does not apply to:

- a) Surgery or procedures to correct deformity caused by disease, trauma, or previous therapeutic process.

- b) Surgery or procedures to correct congenital abnormalities that cause Functional Impairment.
- c) Surgery or procedures on newborn children to correct congenital abnormalities.

- 18) **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.
- 19) **Cryopreservation** Charges associated with the cryopreservation of eggs, embryos, or sperm, including collection, storage, and thawing.
- 20) **Custodial Care** Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.
- 21) **Delivery Charges** Charges for delivery of Prescription Drugs.
- 22) **Dental Devices for Snoring** Oral appliances for snoring.
- 23) **Dental Treatment** Dental treatment, except as listed below.

Excluded treatment includes but is not limited to preventive care and fluoride treatments; dental X rays, supplies, appliances and all associated costs; and diagnosis and treatment for the teeth, jaw or gums such as:

- Removing, restoring, or replacing teeth;
- Medical care or surgery for dental problems (unless listed as a Covered Service in this Booklet);
- Services to help dental clinical outcomes.

Dental treatment for injuries that are a result of biting or chewing is also excluded.

This Exclusion does not apply to services that we must cover by law.

- 24) **Drugs Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- 25) **Drugs Over Quantity or Age Limits** Drugs which are over any quantity or age limits set by the Plan or us.
- 26) **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
- 27) **Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations, and/or certifications, as determined by Anthem.
- 28) **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin or other Drugs provided in the Preventive Care paragraph of the "What's Covered" section.
- 29) **Educational Services** Services, supplies or room and board for teaching, vocational, or self-training purposes. This includes, but is not limited to boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based.
- 30) **Emergency Room Services for non-Emergency Care** Services provided in an emergency room that do not meet the definition of Emergency. This includes, but is not limited to, suture removal in an emergency room. For non-emergency care please use the closest network Urgent Care Center or your Primary Care Physician.
- 31) **Experimental or Investigational Services** Services or supplies that we find are Experimental / Investigational. This also applies to services related to Experimental / Investigational services, whether you get them before, during, or after you get the Experimental / Investigational service or supply.

The fact that a service or supply is the only available treatment will not make it Covered Service if we conclude it is Experimental / Investigational.



Please see the “Clinical Trials” section of “What’s Covered” for details about coverage for services given to you as a participant in an approved clinical trial if the services are Covered Services under this Plan. Please also read the “Experimental or Investigational” definition in the “Definitions” section at the end of this Booklet for the criteria used in deciding whether a service is Experimental or Investigational.

- 32) **Eyeglasses and Contact Lenses** Eyeglasses and contact lenses to correct your eyesight unless listed as covered in this Booklet. This Exclusion does not apply to lenses needed after a covered eye surgery or accidental injury.
- 33) **Eye Exercises** Orthoptics and vision therapy.
- 34) **Eye Surgery** Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.
- 35) **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your Spouse, child, brother, sister, parent, in-law, or self.
- 36) **Foot Care** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:
  - a) Cleaning and soaking the feet.
  - b) Applying skin creams to care for skin tone.
  - c) Other services that are given when there is not an illness, injury or symptom involving the foot.This Exclusion does not apply to the treatment of corns, calluses, and care of toenails when the services are medically necessary.
- 37) **Foot Orthotics** Foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting the lower limbs, such as severe diabetes.
- 38) **Foot Surgery** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
- 39) **Fraud, Waste, Abuse, and Other Inappropriate Billing** Services from an Out-of-Network Provider that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing activities. This includes an Out-of-Network Provider's failure to submit medical records required to determine the appropriateness of a claim.
- 40) **Free Care** Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, services during a jail or prison sentence, services you get from Workers Compensation, and services from free clinics.

If your Group is not required to have Workers' Compensation coverage, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.
- 41) **Growth Hormone Treatment** Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.
- 42) **Health Club Memberships and Fitness Services** Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Doctor. This Exclusion also applies to health spas.
- 43) **Hearing Aids** Hearing aids or exams to prescribe or fit hearing aids, including bone-anchored hearing aids, unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.

- 44) **Home Health Care**
- a) Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.
  - b) Food, housing, homemaker services and home delivered meals. The exception to this Exclusion is homemaker services as described under “Hospice Care” in the “What’s Covered” section.
- 45) **Hospital Services Billed Separately** Services rendered by Hospital resident Doctors or interns that are billed separately. This includes separately billed charges for services rendered by employees of Hospitals, labs or other institutions, and charges included in other duplicate billings.
- 46) **Hyperhidrosis Treatment** Medical and surgical treatment of excessive sweating (hyperhidrosis).
- 47) **Infertility Treatment** Testing or treatment related to infertility. (Replaced with “**Infertility Treatment** Infertility procedures not specified in this Booklet” when Infertility Rider is included)
- 48) **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
- 49) **Maintenance Therapy** Treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better.
- 50) **Medical Chats Not Provided through Our Mobile App** Texting or chat services provided through a service other than our mobile app.
- 51) **Medical Equipment, Devices, and Supplies**
- a) Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
  - b) Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
  - c) Non-Medically Necessary enhancements to standard equipment and devices.
  - d) Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowed Amount for the standard item which is a Covered Service is your responsibility.
  - e) Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as covered in the “What’s Covered” section.
  - f) Continuous glucose monitoring systems. These are covered under the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy.
- 52) **Medicare** For which benefits are payable under Medicare Parts A and/or B or would have been payable if you had applied for Parts A and/or B, except as listed in this Booklet or as required by federal law, as described in the section titled “Medicare” in “General Provisions.” If you do not enroll in Medicare Part B when you are eligible, you may have large out-of-pocket costs. Please refer to [www.medicare.gov](http://www.medicare.gov) for more details on when you should enroll and when you are allowed to delay enrollment without penalties.
- 53) **Missed or Cancelled Appointments** Charges for missed or cancelled appointments.
- 54) **Non-approved Drugs** Drugs not approved by the FDA.
- 55) **Non-Approved Facility** Services from a Provider that does not meet the definition of Facility.
- 56) **Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
- 57) **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional

formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.

- 58) **Off label use** Off label use, unless we must cover it by law or if we approve it.
- 59) **Oral Surgery** Extraction of teeth, surgery for impacted teeth and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth, except as listed in this Booklet.
- 60) **Out-of-Network Care** Services from a Provider that is not in our network. This does not apply to Emergency Care, Urgent Care, or Authorized Services. (Applicable to EPO products only)
- 61) **Personal Care, Convenience and Mobile/Wearable Devices**
- a) Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs,
  - b) First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads),
  - c) Home workout or therapy equipment, including treadmills and home gyms,
  - d) Pools, whirlpools, spas, or hydrotherapy equipment,
  - e) Hypoallergenic pillows, mattresses, or waterbeds,
  - f) Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).
  - g) Consumer wearable / personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.
- 62) **Private Duty Nursing** Private duty nursing services given in a Hospital or Skilled Nursing Facility. Private duty nursing services are a Covered Service only when given as part of the “Home Health Care Services” benefit.
- 63) **Prosthetics** Prosthetics for sports or cosmetic purposes.
- 64) **Residential accommodations** Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Center. This Exclusion includes procedures, equipment, services, supplies or charges for the following:
- a) Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member’s own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
  - b) Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
  - c) Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward-bound programs, even if psychotherapy is included. Licensed professional counseling, as described in the “What’s Covered” section of this Booklet, and provided as part of these programs, is considered a Covered Service.
- 65) **Routine Physicals and Immunizations** Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law under the “Preventive Care” benefit.
- 66) **Services Not Appropriate for Virtual Telemedicine / Telehealth Visits** Services that Anthem determines require in-person contact and/or equipment that cannot be provided remotely.
- 67) **Services Received Outside of Virginia** Services received from a Provider outside of Virginia. This does not apply to:

- a) Emergency or Urgent Care; or
  - b) Covered Services approved in advance by Anthem. (Applicable to EPO products only)
- 68) **Services Received Outside of the United States** Services rendered by Providers located outside the United States, unless the services are for Emergency Care, Urgent Care and Emergency Ambulance. (Applicable to EPO products only)
- 69) **Sexual Dysfunction** Services or supplies for male or female sexual problems.
- 70) **Stand-By Charges** Stand-by charges of a Doctor or other Provider.
- 71) **Sterilization** Services to reverse elective sterilization. (Replaced with “**Sterilization** For female sterilization or reversal of sterilization.” When there is a qualified religious exemption)
- 72) **Surrogate Mother Services** Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
- 73) **Temporomandibular Joint Treatment** Fixed or removable appliances that move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).
- 74) **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.
- 75) **Vein Treatment** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.
- 76) **Vision Services**
- a) Eyeglass lenses, frames, or contact lenses, unless listed as covered in this Booklet.
  - b) Safety glasses and accompanying frames.
  - c) For two pairs of glasses in lieu of bifocals.
  - d) Plano lenses (lenses that have no refractive power).
  - e) Lost or broken lenses or frames, unless the Member has reached their normal interval for service when seeking replacements.
  - f) Vision services not listed as covered in this Booklet.
  - g) Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, unless specifically listed in this Booklet.
  - h) Blended lenses.
  - i) Oversize lenses.
  - j) Sunglasses and accompanying frames.
  - k) For services or supplies combined with any other offer, coupon or in-store advertisement, or for certain brands of frames where the manufacturer does not allow discounts.
  - l) For vision services for pediatric members, no benefits are available for frames or contact lenses not on the Anthem formulary.
  - m) Services and materials not meeting accepted standards of optometric practice or services that are not performed by a licensed provider.
- 77) **Waived Cost-Shares Out-of-Network** For any service for which you are responsible under the terms of this Plan to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by an Out-of-Network Provider.
- 78) **Weight Loss Programs** Programs, whether or not under medical supervision, unless listed as covered in this Booklet.

This Exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

- 79) **Weight Loss Surgery** Bariatric surgery. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgeries to lower stomach capacity and divert partly digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgeries that reduce stomach size), or gastric banding procedures. (Replaced with “**Weight Loss Services and Surgery** Except for Covered Services for the treatment of morbid obesity described in the Bariatric Surgery Rider, your coverage does not include benefits for services and supplies related to obesity or services related to weight loss or dietary control, including complications that directly result from such surgeries and/or procedures. This includes weight reduction therapies/activities, even if there is a related medical problem.” when Bariatric Surgery Rider is included)
- 80) **Wilderness or other outdoor camps and/or programs.** Licensed professional counseling, as described in the “What’s Covered” section of this Booklet, and provided as part of these programs, is considered a Covered Service.

### **What’s Not Covered Under Your Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy Benefit**

In addition to the above Exclusions, certain items are not covered under the Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy benefit:

1. **Administration Charges** Charges for the administration of any Drug except for covered immunizations as approved by us or the PBM.
2. **Charges Not Supported by Medical Records** Charges for pharmacy services not related to conditions, diagnoses, and/or recommended medications described in your medical records.
3. **Clinical Trial Non-Covered Services** Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.
4. **Clinically-Equivalent Alternatives** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. “Clinically equivalent” means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at [www.anthem.com](http://www.anthem.com).

If you or your Doctor believes you need to use a different Prescription Drug, please have your Doctor or pharmacist get in touch with us. We will cover the other Prescription Drug only if we agree that it is Medically Necessary and appropriate over the clinically equivalent Drug. We will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary.

5. **Compound Drugs** Compound Drugs unless all of the ingredients are FDA approved, require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
6. **Contraceptives** Contraceptive Drugs, injectable contraceptive Drugs and patches unless we must cover them by law. (Added when contraceptives are excluded via a qualified religious exemption)
7. **Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
8. **Delivery Charges** Charges for delivery of Prescription Drugs.
9. **Drugs Given at the Provider’s Office / Facility** Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy

in the office as described in the “Prescription Drugs Administered by a Medical Provider” section, or Drugs covered under the “Medical and Surgical Supplies” benefit – they are Covered Services.

10. **Drugs Not on the Anthem Prescription Drug List (a formulary)** You can get a copy of the list by calling us or visiting our website at [www.anthem.com](http://www.anthem.com). If you or your Doctor believes you need a certain Prescription Drug not on the list, please refer to “Prescription Drug List” in the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” for details on requesting an exception.
11. **Drugs Over Quantity or Age Limits** Drugs which are over any quantity or age limits set by the Plan or us.
12. **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
13. **Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations and/or certifications, as determined by Anthem.
14. **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin or other Drugs provided in the Preventive Care paragraph of the “What’s Covered” section.  

This Exclusion does not apply to over-the-counter drugs that we must cover under federal law when recommended by the U.S. Preventive Services Task Force and prescribed by a physician.
15. **Emergency Contraceptives** Emergency contraceptives (also referred to as “the morning-after pill”), such as Plan B and Ella. (Added when contraceptive devices are excluded via partial religious exemption)
16. **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your Spouse, child, brother, sister, parent, in-law, or self.
17. **Fraud, Waste, Abuse, and Other Inappropriate Billing** Services from an Out-of-Network Provider that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing activities. This includes an Out-of-Network Provider’s failure to submit medical records required to determine the appropriateness of a claim.
18. **Gene Therapy** Gene therapy that introduces or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material. While not covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” benefit, benefits may be available under the “Gene Therapy Services” benefit. Please see that section for details.
19. **Growth Hormone Treatment** Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.
20. **Hyperhidrosis Treatment** Prescription Drugs related to the medical and surgical treatment of excessive sweating (hyperhidrosis).
21. **Infertility Drugs** Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT). (Removed when Infertility Rider is included)
22. **Items Covered as Durable Medical Equipment (DME)** Therapeutic DME, devices and supplies except peak flow meters, spacers, and glucose monitors. Items not covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” benefit may be covered under the “Durable Medical Equipment (DME), Medical Devices and Supplies” benefit. Please see that section for details.
23. **Items Covered Under the “Allergy Services” Benefit** Allergy desensitization products or allergy serum. While not covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” benefit, these items may be covered under the “Allergy Services” benefit. Please see that section for details.

24. **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
25. **Mail Order Providers other than the PBM's Home Delivery Mail Order Provider** Prescription Drugs dispensed by any Mail Order Provider other than the PBM's Home Delivery Mail Order Provider, unless we must cover them by law.
26. **Non-approved Drugs** Drugs not approved by the FDA.
27. **Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
28. **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.
29. **Off label use** Off label use, unless we must cover the use by law or if we, or the PBM, approve it.  
The exception to this Exclusion is described in "Covered Prescription Drugs" in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section.
30. **Onychomycosis Drugs** Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.
31. **Over-the-Counter Items** Drugs, devices and products permitted to be dispensed without a prescription and available over the counter.  
This Exclusion does not apply to over-the-counter products that we must cover as a "Preventive Care" benefit under federal law with a Prescription.
32. **Sexual Dysfunction Drugs** Drugs to treat sexual or erectile problems.
33. **Syringes** Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
34. **Weight Loss Drugs** Any Drug mainly used for weight loss.

# 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 무료 지원을 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

## 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 ਅਧਿਕਾਰ 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>





# Protecting your privacy

## How we keep your information safe and secure

As a member, you have the right to expect us to protect your personal health information. We take this responsibility very seriously, following all state and federal laws, as well as our own policies.

You also have certain rights and responsibilities when receiving your healthcare. To understand how we protect your privacy, your rights and responsibilities when receiving healthcare, and your rights under the Women's Health and Cancer Rights Act, go to [anthem.com/privacy](https://www.anthem.com/privacy). For a printed copy, please contact your Benefits Administrator or Human Resources representative.

### How we help manage your care

To see if your health benefits will cover a treatment, procedure, hospital stay, or medicine, we use a process called utilization management (UM). Our UM team is made up of doctors and pharmacists who want to be sure you receive the best treatments for certain health conditions. They review the information your doctor sends us before, during, or after your treatment. We also use case managers. They're licensed healthcare professionals who work with you and your doctor to help you manage your health conditions. They also help you better understand your health benefits.

For additional information about how we help manage your care, go to [anthem.com/memberrights](https://www.anthem.com/memberrights). To request a printed copy, please contact your Benefits Administrator or Human Resources representative.

### Special enrollment rights

Open enrollment usually happens once a year. That's the time you can choose a plan, enroll in it, or make changes to it. If you choose not to enroll, there are special cases when you're allowed to enroll during other times of the year.

- **If you had another health plan that was canceled.** If you, your dependents, or your spouse are no longer eligible for benefits with another health plan (or if the employer stops contributing to that health plan), you may be able to enroll with us. You must enroll within 31 days after the other health plan ends (or after the employer stops paying for the plan). For example: You and your family are enrolled through your spouse's health plan at work. Your spouse's employer stops paying for health coverage. In this case, you and your spouse, as well as other dependents, may be able to enroll in one of our plans.

- **If you have a new dependent.** You gain new dependents from a life event, such as marriage, birth, adoption, or if you have custody of a minor and an adoption is pending. You must enroll within 31 days after the event. For example: If you marry, your new spouse and any new children may be able to enroll in a plan.
- **If your eligibility for Medicaid or SCHIP changes.** You have a special period of 60 days to enroll after:
  - You (or your eligible dependents) lose Medicaid or the State Children's Health Insurance Program (SCHIP) benefits because you're no longer eligible.
  - You (or eligible dependents) become eligible to receive help from Medicaid or SCHIP for paying part of the cost of a health plan with us.

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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>.

For full details, read your plan document, which has all the details about your plan. You can find on [anthem.com](https://www.anthem.com).



## Your plan is here for you to use

### If you would like extra help

If you have questions, we are here to help. Contact us through our online Message Center or call the Member Services number on your ID card.



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