



# 2025 open enrollment

Your guide to your health plan and benefits

**Anthem Medical Plans Guidebook  
City of Salem and Schools**

January 1, 2025

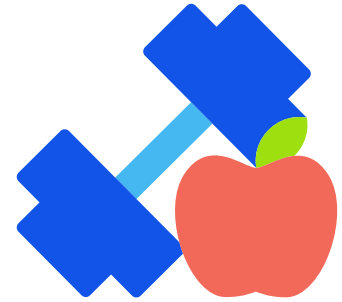


# Welcome to Anthem

## We're here to help you choose your health plan with confidence

Choosing a health plan is one of the most important decisions you'll make this year. We're here to help you make the best choice so you and your family feel confident and cared for every step of the way. Open enrollment is your time to explore benefits, programs, and resources that can support your whole health and well-being all year long.

This guide will help you understand everything that's available to you, from benefits to wellness programs. You'll also find tips and tools that can help you reach your health and wellness goals once you've enrolled in an Anthem health plan.



### Why Anthem

At Anthem, we're dedicated to improving your health and providing quality coverage to the 47 million people who have an Anthem health plan.<sup>1</sup> To make sure you're receiving safe, quality care and service, we review the benefits and programs you use to know what's working — and learn where we can take action — to help you be your healthiest self. With an Anthem plan, you'll have access to a variety of benefits, including:

<sup>1</sup> Elevance Health website: *Advancing Health Together* (May 2023): [advancinghealth.elevancehealth.com](https://advancinghealth.elevancehealth.com).



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# Medical plans

## Review your options to find the right fit for your needs

You deserve peace of mind when it comes to your healthcare. An Anthem health plan gives you that and more, supporting you every step of the way with coverage that fits your needs and your budget.

Review the health plans before making your selection. You'll want to check to see if your doctors are in the plan's network, which will help you make the most of your benefits and save money.

### PPO

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

- Choose a primary care doctor in the plan's network for preventive care, such as checkups and screenings.
- No referral is needed from your primary care doctor to see a specialist, such as an orthopedic doctor or a cardiologist — saving you time and money.
- You'll pay less if you choose doctors and facilities in your plan's network.

- You can contribute up to \$4,300 for an individual and \$8,550 for a family. If you're 55 or older, you can contribute an extra \$1,000 a year.

### Health Savings Account (HSA)

A high-deductible Health Savings Account (HSA) plan allows you to set aside pretax dollars to pay for care tax free. Use the money in the account to pay for qualified medical expenses, such as doctor or hospital visits, prescription drugs, or copays.<sup>1</sup>

- The money in your HSA rolls over from year to year and is yours to keep, even if you change health plans or jobs, or retire.

### Healthcare terms

**Deductible:** A set amount of money you must pay for covered healthcare services before your health plan shares the costs. An example deductible is \$1,250.

**Coinsurance:** Your share of the costs for covered healthcare services after you've met your deductible. For example, if you have 30% coinsurance, your plan covers 70% of the cost.

**Copay:** A set fee that you pay at a doctor's visit or when picking up a prescription.<sup>2</sup>

**Primary care doctor:** A doctor you see regularly for checkups and minor illnesses and injuries. Learn more healthcare terms online at [anthem.com/glossary](https://www.anthem.com/glossary).

### Find care



Use our **Find Care** tool to see if your doctors are in the plan's network by visiting [anthem.com/find-care](https://www.anthem.com/find-care)

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

<sup>2</sup> There are plans that require you to pay a copay at the time of service.





# Pharmacy benefits

## Reliable prescription drug coverage

Having the right medicine at the right time can make a big difference in your health and well-being. We're here to help you access the medications you need, when you need them, while also saving money.

### 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 required to treat an ongoing health matter or serious illness.

### Coverage requirements

Certain medications require you to take other steps before your plan covers them.

- **Preapproval, also known as prior authorization:** This means Anthem needs to approve a drug before the pharmacy fills it.

- **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.

### To understand pharmacy benefits:

- Review your medication list to see if your prescriptions are covered.

### Tips: How to get your prescriptions and save money

- **Retail pharmacies:** Your costs may be lower with pharmacies in your plan's network.
- Price a medication tool on **anthem.com** or the **Sydney<sup>SM</sup> Health** app.
- **Noncovered medicine:** If your prescription isn't covered by your plan, you may be able to receive a discount. Share your ID card at the pharmacy, and the available discount will automatically be applied.
- Check for generic instead of brand name medicines, which are just as effective and can save you money.

- Price a medication to find the best price in your plan’s network, which can save you more when buying certain medicines.
- Check to make sure your local retail pharmacy is in your plan’s network.
- Get more information on our specialty pharmacy once you have a health plan. Most specialty drugs are covered if you need them.
- Review the drug tier chart to see where your medicines fall and how to save money.

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

### Your pharmacy options

You have choices for filling your prescriptions, including local retail pharmacies in your plan’s network . If you use a specialty medicine, it will need to be filled through our specialty pharmacy.

The **Base Network** is our national pharmacy network with 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.

### How your benefits and deductible work

#### Combined medical and pharmacy deductible

Your plan comes with a combined medical and pharmacy deductible, which is the amount you pay out of pocket for covered prescriptions and medical care before the plan starts to share the cost.

# Plan extras

## Extra benefits that support your whole health

Once you enroll in your Anthem health plan, you'll have access to a variety programs and resources — at no added cost. These programs will help you to improve your overall health, save on the cost of care, and better manage a health condition if you have one.

### Condition support

Managing a health condition can be hard, which is why we have programs to help you coordinate care and manage your care more easily. Whether you're managing diabetes, heart disease, or asthma, help is just a call, tap, or click away.

#### 24/7 NurseLine

A registered nurse is available to answer your health questions anytime, day or night. They can help you decide where to go for care and find doctors and other healthcare professionals in your area.

#### Autism Spectrum Disorder Program

This program focuses on building a strong support system for the entire family. A specialized team of clinicians will work with you to create a customized care plan, help coordinate care, and connect you with resources in your community.

### Maternity

Our maternity programs help support you no matter where you're at in your parenting journey. From planning a family to raising small children, there's resources available to help you thrive.



## **Building Healthy Families**

Offering 24/7 digital support, Building Healthy Families is here to help your family with everything from preconception and pregnancy to childbirth and early childhood. The program features an extensive content library to support diverse families, including single parents and same-sex and multicultural couples. You'll have access to a library and other tools, such as fertility, diaper change and feeding trackers, due date calculators, and blood pressure monitoring.

# Your summary of benefits



Anthem® Blue Cross and Blue Shield

City of Salem and Schools

Your Contract Code: 3ZEP Custom

01/01/2025-12/31/2025

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
<b>Primary Care, and medical services for urgent/acute care</b>	No charge medical deductible does not apply
<b>Mental Health &amp; Substance Use Disorder Services</b>	No charge medical deductible does not apply
<b>Specialist care</b>	\$50 copay per visit medical deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<b>Overall Deductible</b>	\$2,000 person / \$4,000 family	\$3,000 person / \$6,000 family
<b>Overall Out-of-Pocket Limit</b>	\$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 (excluding Out-of-Network Human Organ and Tissue Transplant (HOTT), Cellular and Gene Therapy services).

In-Network and Out-of-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

**Mental Health and Substance Use Disorder Services** *virtual and office*

\$30 copay per visit  
medical deductible  
does not apply

40% coinsurance after  
medical deductible is  
met

VA/LG/Anthem KeyCare 30 2000/20%/5000 Rx \$15/\$40/\$75/20%/8DD2/01-01-2025

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



Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<b>X-Ray</b>  Office  Outpatient Hospital	20% coinsurance after medical deductible is met  20% coinsurance after medical deductible is met	40% 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  Outpatient Hospital	20% coinsurance after medical deductible is met  20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met  40% coinsurance after medical deductible is met
<u><b>Emergency and Urgent Care</b></u>  <b>Urgent Care</b> <i>includes doctor services. Additional charges may apply depending on the care provided.</i>  <b>Emergency Room Facility Services</b>  <b>Emergency Room Doctor and Other Services</b>  <b>Ambulance</b> <i>Non-emergency Out-of-Network ambulance services are limited to an Anthem maximum payment of \$50,000 per trip. The \$50,000 limit does not apply to air ambulance services.</i>	\$30 PCP/\$50 (Specialist) copay per visit medical deductible does not apply  20% coinsurance after medical deductible is met  20% coinsurance after medical deductible is met  20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met  Covered as In-Network  Covered as In-Network  Covered as In-Network
<b>Outpatient Mental Health and Substance Use Disorder Services at a Facility</b>  Facility Fees	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Doctor Services	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<p><b><u>Outpatient Surgery</u></b></p> <p><b>Facility Fees</b></p> <p>Hospital</p> <p><b>Physician and other services <i>including surgeon fees</i></b></p> <p>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></p> <p><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></p> <p><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></p> <p><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> <p>Outpatient Hospital</p>	<p>\$30 copay per visit medical deductible does not apply</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>
Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider

<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 admission.</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<b>Inpatient Hospice</b>	No charge	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 an Out-of-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 Out-of-Network medical out-of-pocket limit
<b>Prescription Drug Coverage</b> <b>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>		
<b>Day Supply Limits:</b> <b>Retail Pharmacy</b> <i>30 day supply (cost shares noted below)</i>		

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-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 our home delivery pharmacy. 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>		
<b>Tier 1 - Typically Generic</b>	\$15 copay per prescription, deductible does not apply (retail) and \$38 copay per prescription, deductible does not apply (home delivery)	\$15 copay per prescription, deductible does not apply (retail) and Not Covered (Home delivery)
<b>Tier 2 - Typically Preferred Brand</b>	\$40 copay per prescription, deductible does not apply (retail) and \$100 copay per prescription, deductible does not apply (home delivery)	\$40 copay per prescription, deductible does not apply (retail) and Not Covered (home delivery)
<b>Tier 3 - Typically Non-Preferred Brand</b>	\$75 copay per prescription, deductible does not apply (retail) and \$188 copay per prescription, deductible does not apply (home delivery)	\$75 copay per prescription, deductible does not apply (retail) and Not Covered (home delivery)
<b>Tier 4 - Typically Specialty (brand and generic)</b>	20% coinsurance up to \$200 per prescription, deductible does not apply (retail) and 20% coinsurance up to \$400, deductible does not apply (home delivery)	Not Covered

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<p><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></p>		
<p><b>Children's Vision exam (up to age 19)</b> <i>Limited to 1 exam per benefit period.</i></p>	No charge	Reimbursed Up to \$30
<p><b>Adult Vision exam (age 19 and older)</b> <i>Limited to 1 exam per benefit period.</i></p>	\$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)



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## Language Access Services:

### Get help in your language

Curious to know what all this says? We would be too. Here's the English version:

If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (833) 592-9956

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

(TTY/TDD: 711)

**Arabic (العربية):** إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (833) 592-9956

**Armenian (հայերեն).** Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (833) 592-9956:

**Chinese(中文):** 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(833) 592-9956。

**Farsi (فارسي):** در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (833) 592-9956 تماس بگیرید.

**French (Français):** Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (833) 592-9956.

**Haitian Creole (Kreyòl Ayisyen):** Si ou gen nempòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (833) 592-9956.

**Italian (Italiano):** In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (833) 592-9956.

**Japanese (日本語):** この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(833) 592-9956 にお電話ください。

**Korean (한국어):** 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(833) 592-9956로 문의하십시오.

**Navajo (Diné):** Dii naaltsoos biká'ígíí lahgo bina'ídiikidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehj'í bee nił hodoonih t'áadoo báąh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih nínizingo koj' hodiilnih (833) 592-9956.

## Language Access Services:

**Polish (polski):** W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer: (833) 592-9956.

**Punjabi (ਪੰਜਾਬੀ):** ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (833) 592-9956 ਤੇ ਕਾਲ ਕਰੋ।

**Russian (Русский):** если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (833) 592-9956.

**Spanish (Español):** Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (833) 592-9956.

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### It's important we treat you fairly

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

# Your summary of benefits



Anthem® Blue Cross and Blue Shield

City of Salem and Schools

Your Contract Code: 3ZEN Custom

01/01/2025-12/31/2025

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 an Out-of-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 (excluding Out-of-Network Human Organ and Tissue Transplant (HOTT), Cellular and Gene Therapy services).

In-Network and Out-of-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>	20% 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><u>Other Practitioner Visits</u></b>		
<b>Maternity Doctor services</b> (prenatal/postnatal care and delivery)	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 an Out-of-Network Provider
<b>Retail Health Clinic</b> <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i>	0% coinsurance after deductible is met	20% coinsurance after deductible is met
<b>Manipulation Therapy</b> <i>Coverage is limited to 30 visits per benefit period.</i>	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> <i>Dispensed in the office</i>  <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> <i>per IRS guidelines</i>	No charge	20% coinsurance after deductible is met
<u><b>Diagnostic Services</b></u> <b>Lab</b> Office 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> <i>for example: MRI, PET and CAT scans</i> 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 an Out-of-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>  <i>Non-emergency Out-of-Network ambulance services are limited to an Anthem maximum payment of \$50,000 per trip. The \$50,000 limit does not apply to air ambulance services.</i></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><u>Outpatient Mental Health and Substance Use Disorder Services at a Facility</u></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 including surgeon fees</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>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>20% coinsurance after deductible is met</p>
<p><b><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u></b></p> <p><b>Facility Fees</b></p> <p><b>Physician and other services including surgeon fees</b></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 an Out-of-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 an Out-of-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 Out-of-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 Out-of-Network medical out-of-pocket limit</p>

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
<p><b>Prescription Drug Coverage</b>  <b>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 our home delivery pharmacy. 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 an Out-of-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)

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## Language Access Services:

### Get help in your language

Curious to know what all this says? We would be too. Here's the English version:

If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (833) 592-9956

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

(TTY/TDD: 711)

**Arabic (العربية):** إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (833) 592-9956

**Armenian (հայերեն).** Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (833) 592-9956:

**Chinese(中文):** 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(833) 592-9956。

**Farsi (فارسي):** در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (833) 592-9956 تماس بگیرید.

**French (Français):** Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (833) 592-9956.

**Haitian Creole (Kreyòl Ayisyen):** Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (833) 592-9956.

**Italian (Italiano):** In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (833) 592-9956.

**Japanese (日本語):** この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(833) 592-9956 にお電話ください。

**Korean (한국어):** 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(833) 592-9956로 문의하십시오.

**Navajo (Diné):** Dii naaltsoos biká'ígíí lahgo bina'ídiikidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehj'í bee nił hodoonih t'áadoo báąh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih nínizingo koj' hodiilnih (833) 592-9956.

## Language Access Services:

**Polish (polski):** W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer: (833) 592-9956.

**Punjabi (ਪੰਜਾਬੀ):** ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (833) 592-9956 ਤੇ ਕਾਲ ਕਰੋ।

**Russian (Русский):** если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (833) 592-9956.

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**Vietnamese (Tiếng Việt):** Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (833) 592-9956.

### It's important we treat you fairly

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



 <p>The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. <b>NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, 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>	\$2,000/person or \$4,000/family for In-Network Providers. \$3,000/person or \$6,000/family for Out-of-Network Providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your deductible?</b>	Yes. Primary Care. Specialist Visit. Preventive Care. Certain Prescription Drugs. Vision Exam. For more information see below.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive</u> services without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> 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 <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	\$5,000/person or \$10,000/family for In-Network Providers. \$7,250 /person or \$14,500 /family for Out-of-Network Providers.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the out-of-pocket limit?</b>	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.anthem.com/find-care/?alphanumeric=VQX">www.anthem.com/find-care/?alphanumeric=VQX</a> or call (833) 592-9956 for a list of <u>network providers</u> . Costs may vary by site of service and how the <u>provider</u> bills.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>Out-of-Network Provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>Out-of-Network Provider</u> for some services (such as lab work). Check with your <u>provider</u> 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)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30/visit, deductible does not apply	40% coinsurance	Virtual visits (Telehealth) benefits available.
	Specialist visit	\$50/visit, deductible does not apply	40% coinsurance	Virtual visits (Telehealth) benefits available.
	Preventive care/screening/immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	-----none-----
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	-----none-----
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a>	Typically Generic (Tier 1)	\$15/prescription, deductible does not apply (retail) and \$38/prescription, deductible 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, deductible does not apply (retail) and \$100/prescription, deductible 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, deductible does not apply (retail) and \$188/prescription, deductible 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/eocdpls/>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Typically Preferred Specialty (brand and generic) (Tier 4)	20% coinsurance 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.
If you have outpatient surgery	Facility fee (e.g, ambulatory surgery center)	20% coinsurance	40% coinsurance	-----none-----
	Physician/surgeon fees	20% coinsurance	40% coinsurance	-----none-----
	Emergency room care	20% coinsurance	Covered as In-Network	-----none-----
If you need immediate medical attention	Emergency medical transportation	20% coinsurance	Covered as In-Network	Non-emergency <u>Out-of-Network</u> Ambulance Services are limited to \$50,000 per trip, does not apply to air ambulance.
	Urgent care	\$30 PCP/\$50 Specialist copay/visit	40% coinsurance	-----none-----
If you have a hospital stay	Facility fee (e.g, hospital room)	20% coinsurance	40% coinsurance	100 days/benefit period for Inpatient rehabilitation and skilled nursing services combined.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit \$30/visit, deductible does not apply Other Outpatient 20% coinsurance	Office Visit 40% coinsurance Other Outpatient 40% coinsurance	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient -----none-----
	Inpatient services	20% coinsurance	40% coinsurance	-----none-----
	Office visits	\$30 PCP/\$50 Spec. (non global)	40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
If you are pregnant	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	

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

If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	100 visits/benefit period for Home Health and Private Duty Nursing combined.
	Rehabilitation services	20% coinsurance	40% coinsurance	*See Therapy Services section.
	Habilitation services	20% coinsurance	40% coinsurance	
Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	20% coinsurance	40% coinsurance	100 days/benefit period for Inpatient rehabilitation and skilled nursing services combined.
	Durable medical equipment	20% coinsurance	40% coinsurance	*See Durable Medical Equipment section.
	Hospice services	No charge	40% coinsurance	-----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:**

<p><b>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</b></p> <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> <li>• Infertility treatment</li> <li>• Weight loss programs</li> </ul>	
<ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Dental care (Adult)</li> <li>• Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>• Children's dental check-up</li> <li>• Glasses for a child</li> <li>• Routine foot care unless <u>medically necessary</u></li> </ul>

<p><b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)</b></p> <ul style="list-style-type: none"> <li>• Chiropractic care 30 visits/benefit period</li> <li>• Private-duty nursing 100 visits/benefit period combined with Home Health</li> </ul>		<ul style="list-style-type: none"> <li>• Hearing aids 1 item/ear every 24 months for children 18 years of age or under. \$1,500 maximum/hearing aid.</li> <li>• Routine eye care (Adult) 1 exam/benefit period</li> </ul>	<ul style="list-style-type: none"> <li>• Most coverage provided outside the United States. See <a href="http://www.bcbsglobalcare.com">www.bcbsglobalcare.com</a></li> </ul>
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\* 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.

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



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.*

## 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:

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$10
Coinsurance	\$1,900
<i>What isn't covered</i>	
Limits or exclusions	\$60

**The total Peg would pay is** \$3,970

### 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:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,700
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20

**The total Joe would pay is** \$1,720

### 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:

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$300
Coinsurance	\$20
<i>What isn't covered</i>	
Limits or exclusions	\$0

**The total Mia would pay is** \$2,320

The plan would be responsible for the other costs of these EXAMPLE covered services.



## Language Access Services:

(TTY/TDD: 711)

**Albanian (Shqip):** Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (833) 592-9956

**Amharic (አማርኛ):** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቀንቁ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (833) 592-9956 ይደውሉ።

. (833) 592-9956 على مترجم، اتصل على للتحدث إلى مقابل. للمعلومات بلغتك دون مقابل. (العربية) Arabic

**Armenian (հայերեն).** Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (833) 592-9956:

**Bassa (Bässò Wùdù):** M̐ d̐yí d̐yí-d̐iè-d̐è b̐é b̐éq̐é b̐á céé-d̐è nià ke d̐yí ní, ɔ mò ni d̐yí-b̐éd̐èin-d̐è b̐é m̐ ké gbo-kpá-kpá kè b̐ǎ kpǎ d̐é m̐ bíq̐í-wùd̐ùùn b̐ó pídyi. B̐é m̐ ké wudu-ziiin-nyò d̐ò gbo wùd̐ù ke, d̐á (833) 592-9956.

**Bengali (বাংলা):** যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্য সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (833) 592-9956 - (ত কল করুন।

**Burmese (ပြန်စာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ၃ (833) 592-9956 သို့ ခေါ်ဆိုပါ။

**Chinese (中文):** 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 (833) 592-9956。

**Dinka (Dinka):** Na naŋ thiëc né ke de ya thoŋe, ke yin naŋ loŋ bē yi kuony ku wer aléu bē gēer yic yin ne thoŋ du ke cin wēu tāáuē ke piny. Te kor yin ba jam wēnē ran ye thok geryic, ke yin col (833) 592-9956.

**Dutch (Nederlands):** Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (833) 592-9956.

**Farsi (فارسی):** در صورتی که سوالی بپرسید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادرتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (833) 592-9956 تماس بگیرید.

## Language Access Services:

**French (Français) :** Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (833) 592-9956.

**German (Deutsch):** Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (833) 592-9956.

**Greek (Ελληνικά)** Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (833) 592-9956.

**Gujarati (ગુજરાતી):** જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (833) 592-9956.

**Haitian Creole (Kreyòl Ayisyen):** Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (833) 592-9956.

**Hindi (हिंदी):** अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (833) 592-9956 ।

**Hmong (White Hmong):** Yog tias koj muaj lus nug dab tsi ntsig txog daim ntaav no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (833) 592-9956.

**Igbo (Igbo):** O bur u na i nwere ajuju o bula gbasara akwukwo a, i nwere ikike inweta enyemaka na ozi n'asusu gi na akwughị ugwo o bula. Ka gi na okowa okwu kwuo okwu, kpoo (833) 592-9956.

**Ilokano (Ilokano):** Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahe nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (833) 592-9956.

**Indonesian (Bahasa Indonesia):** Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (833) 592-9956.

**Italian (Italiano):** In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (833) 592-9956

**Japanese (日本語):** この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには (833) 592-9956 にお電話ください。

## Language Access Services:

**Khmer (ខ្មែរ):** បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។  
ដើម្បីជ្រកយកយើងអ្នកប្រកបស្របសូមហៅ(833) 592-9956 ។

**Kirundi (Kirundi):** Ugize ikibazo icyo arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (833) 592-9956.

**Korean (한국어):** 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(833) 592-9956 로 문의하십시오.

**Lao (ພາສາລາວ):** ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໄດ້ເປັນເສຍຄ່າ.  
ເພື່ອໄດ້ຮັບກ່ຽວກັບລ່າມແປພາສາ, ໃຫ້ໂທຫາ (833) 592-9956.

**Navajo (Diné):** Dii naatsoos bika'igii lahgo bina'idilkidgo ná bohónéedzǫ́ dóó bee ahóót'i' t'áá ni nizaad k'ehj' bee nií hodoonih t'áadoo báháh ílínigóó. Ata' halné'ígíí la' bich'i' hadeesdzih nínízingo koj' hodíilnih (833) 592-9956.

**Nepali (नेपाली):** यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ।  
दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (833) 592-9956

**Oromo (Oromifaa):** Sanadi kanaa wajjin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (833) 592-9956 bilbilla.

**Pennsylvania Dutch (Deutsch):** Wann du Frooge iwver selle Document hoscht, du hoscht die Recht um Hilfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff (833) 592-9956 aa.

**Polish (polski):** W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer (833) 592-9956.

**Portuguese (Português):** Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para (833) 592-9956.

**Punjabi (ਪੰਜਾਬੀ):** ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਬਾਰੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ (833) 592-9956 ਤੇ ਕਾਲ ਕਰੋ।



## Language Access Services:

**Romanian (Română):** Dacă aveți întrebări referitoare la acest document, aveți dreptul să primiți ajutor și informații în limba dumneavoastră în mod gratuit. Pentru a vă adresa unui interpret, contactați telefonic (833) 592-9956.

**Russian (Русский):** если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (833) 592-9956.

**Samoan (Samoa):** Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou 'aia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totagi. Ina ia talanoa i se tagata faaliliu, vili (833) 592-9956.

**Serbian (Srpski):** Ukoliko imate bilo kakvih pitanja u vezi sa ovim dokumentom, imate pravo da dobijete pomoć i informacije na vašem jeziku bez ikakvih troškova. Za razgovor sa prevodiocem, pozovite (833) 592-9956.

**Spanish (Español):** Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (833) 592-9956.

**Tagalog (Tagalog):** Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (833) 592-9956.

**Thai (ไทย):** หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร (833) 592-9956 เพื่อพูดคุยกับล่าม

**Ukrainian (Українська):** якщо у вас виникають запитання з приводу цього документа, ви маєте право безкоштовно отримати допомогу й інформацію вашою рідною мовою. Щоб отримати послуги перекладача, зателефонуйте за номером: (833) 592-9956.

**Urdu (اردو):** اگر اس دستاویز کے بارے میں آپ کا کوئی سوال ہے، تو آپ کو مند اور اپنی زبان میں مفت معلومات حاصل کرنے کا حق حاصل ہے۔ کسی مترجم سے بات کرنے کے لیے، (833) 592-9956 پر کال کریں۔

**Vietnamese (Tiếng Việt):** Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (833) 592-9956.


**Yiddish (אידיש):** אויב איר האט שאלות וועגן דעם דאקומענט, האט איר דער ריכטיגער באקומען דעם באקומען אין אינגליש און יידיש. (833) 592-9956 פאר אירע שאלות.

**Yoruba (Yorùbá):** Tí o bá ní èyíkẹyí ibèrè nípa akọsílẹ̀ yí, o ní ètọ́ láti gba àrànwọ́ àti iwífún ní èdè rẹ̀ lófẹ́ẹ̀. Bá wa ògbùfọ̀ kan sọ̀rọ̀, pe (833) 592-9956.

## Language Access Services:

### It's important we treat you fairly

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

 <p>The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. <b>NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, 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-Network Providers.and Out-of-Network Providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your deductible?</b>	Yes. <u>Preventive Care</u> . <u>Vision Exam</u> . For more information see below.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> 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 <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	\$4,000/person or \$8,000/family for In-Network Providers. \$6,000/person or \$12,000/family for Out-of-Network Providers.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the out-of-pocket limit?</b>	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.anthem.com/find-care/">www.anthem.com/find-care/</a> <a href="http://palphaprefix=VQX">palphaprefix=VQX</a> or call (833) 592-9956 for a list of <u>network providers</u> . Costs may vary by site of service and how the <u>provider</u> bills.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>Out-of-Network Provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>Out-of-Network Provider</u> for some services (such as lab work). Check with your <u>provider</u> 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)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% <u>coinsurance</u>	20% <u>coinsurance</u>	Virtual visits (Telehealth) benefits available.
	Specialist visit	0% <u>coinsurance</u>	20% <u>coinsurance</u>	Virtual visits (Telehealth) benefits available.
	Preventive care/screening/immunization	No charge	20% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% <u>coinsurance</u>	20% <u>coinsurance</u>	-----none-----
	Imaging (CT/PET scans, MRIs)	0% <u>coinsurance</u>	20% <u>coinsurance</u>	-----none-----
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> 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 Specialty (brand and generic) (Tier 4)	20% <u>coinsurance</u> 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.
If you have outpatient surgery	Facility fee (e.g, ambulatory surgery center)	0% <u>coinsurance</u>	20% <u>coinsurance</u>	Must use IngenioRx (name change to CarelonRX in 2023) pharmacy.
	Physician/surgeon fees	0% <u>coinsurance</u>	20% <u>coinsurance</u>	Out of network you'll be responsible for amounts over the allowable.
	Emergency room care	0% <u>coinsurance</u>	Covered as In-Network	-----none-----

\* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdpls/>.



If you need immediate medical attention	Emergency medical transportation <u>Urgent care</u>	0% coinsurance	Covered as In-Network	Non-emergency Out-of-Network Ambulance Services are limited to \$50,000 per trip. -----none-----
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	20% coinsurance	100 days/benefit period for Inpatient rehabilitation and skilled nursing services combined.
	Physician/surgeon fees	0% coinsurance	20% coinsurance	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit 0% coinsurance Other Outpatient 0% coinsurance	Office Visit 20% coinsurance Other Outpatient 20% coinsurance	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient -----none-----
	Inpatient services	0% coinsurance	20% coinsurance	-----none-----
If you are pregnant	Office visits	0% coinsurance	20% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	0% coinsurance	20% coinsurance	
If you need help recovering or have other special health needs	Childbirth/delivery facility services	0% coinsurance	20% coinsurance	100 visits/benefit period for Home Health and Private Duty Nursing combined. *See Therapy Services section.
	Home health care	0% coinsurance	20% coinsurance	
	Rehabilitation services	0% coinsurance	20% coinsurance	100 days/benefit period for Inpatient rehabilitation and skilled nursing services combined. *See Durable Medical Equipment section.
	Habilitation services	0% coinsurance	20% coinsurance	
If your child needs dental or eye care	Skilled nursing care	0% coinsurance	20% coinsurance	-----none----- *See Vision Services section.
	Durable medical equipment	0% coinsurance	20% coinsurance	
	Hospice services	0% coinsurance	20% coinsurance	Reimbursed up to \$30 Not covered Not covered
	Children's eye exam	No charge		
	Children's glasses	Not covered		
	Children's dental check-up	Not covered		

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

## 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
- Cosmetic surgery
- Dental care (Adult)
- Glasses for a child
- Infertility treatment
- Long-term care
- Routine foot care unless medically necessary
- Weight loss programs

### 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/ear every 24 months for
- Private-duty nursing 100 visits/benefit period combined with Home Health maximum/hearing aid. \$1,500
- Routine eye care (Adult) 1 exam/benefit period

**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.

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)

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

**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%

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- **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*)

**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*)

**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** \$12,700

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

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

**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$3,500
Copayments	\$10
Coinsurance	\$1,900
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5,470</b>

**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$3,500
Copayments	\$600
Coinsurance	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$4,180</b>

**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$3,500
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$3,500</b>

The plan would be responsible for the other costs of these EXAMPLE covered services.

## Language Access Services:

(TTY/TDD: 711)

**Albanian (Shqip):** Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (833) 592-9956

**Amharic (አማርኛ):** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቀንቁ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (833) 592-9956 ይደውሉ።

. (833) 592-9956 على مترجم، اتصل على للتحدث إلى مقابل. للمعلومات بلغتك دون مقابل. (العربية) Arabic

**Armenian (հայերեն).** Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և սեղեկապատություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (833) 592-9956:

**Bassa (Bässò Wùdù):** M̄ dyi dyi-diè-dè b̄é b̄éqé b̄á céé-dè nià ke d̄yí ní, ɔ mò ni d̄yí-b̄éq̄d̄èin-d̄é b̄é m̄ ké gbo-kpá-kpá kè b̄ǒ kp̄ǒ d̄é m̄ b̄íq̄f-wùd̄ùùn b̄ó pídyi. B̄é m̄ ké wudu-ziiin-nyò d̄ò gbo wùd̄ù ke, d̄á (833) 592-9956.

**Bengali (বাংলা):** যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্য সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (833) 592-9956 - (ত কল করুন।

**Burmese (ပြန်စာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ၃ (833) 592-9956 သို့ ခေါ်ဆိုပါ။

**Chinese (中文):** 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 (833) 592-9956。

**Dinka (Dinka):** Na noŋ thiëc né ke de ya thoŋe, ke yin noŋ loŋ bē yi kuony ku wer alēu bē gēer yic yin ne thoŋ du ke cin wēu tāauē ke piny. Te kor yin ba jam wēnē ran ye thok geryic, ke yin col (833) 592-9956.

**Dutch (Nederlands):** Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (833) 592-9956.

**Farsi (فارسی):** در صورتی که سوالی بپرسید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادرتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (833) 592-9956 تماس بگیرید.



## Language Access Services:

**French (Français) :** Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (833) 592-9956.

**German (Deutsch) :** Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (833) 592-9956.

**Greek (Ελληνικά) :** Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (833) 592-9956.

**Gujarati (ગુજરાતી) :** જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (833) 592-9956.

**Haitian Creole (Kreyòl Ayisyen) :** Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (833) 592-9956.

**Hindi (हिंदी) :** अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (833) 592-9956 ।

**Hmong (White Hmong) :** Yog tias koj muaj lus nug dab tsi ntsig txog daim ntaav no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (833) 592-9956.

**Igbo (Igbo) :** O bur u na i nwere ajuju o bula gbasara akwukwo a, i nwere ikike inweta enyemaka na ozi n'asusu gi na akwughị ugwo o bula. Ka gi na okowa okwu kwuo okwu, kpoo (833) 592-9956.

**Ilokano (Ilokano) :** Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lengua hem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (833) 592-9956.

**Indonesian (Bahasa Indonesia) :** Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (833) 592-9956.

**Italian (Italiano) :** In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (833) 592-9956

**Japanese (日本語) :** この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには (833) 592-9956 にお電話ください。

## Language Access Services:

**Khmer (ខ្មែរ):** បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។  
ដើម្បីជ្រកយកស្រុកស្រែ សូមហៅ(833) 592-9956 ។

**Kirundi (Kirundi):** Ugize ikibazo icyo arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (833) 592-9956.

**Korean (한국어):** 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(833) 592-9956 로 문의하십시오.

**Lao (ພາສາລາວ):** ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໄດ້ເປັນເສຍຄ່າ.  
ເພື່ອໄດ້ຮັບກັບລ່າມເປັນພາສາ, ໃຫ້ໂທຫາ (833) 592-9956.

**Navajo (Diné):** Dii naatsoos bika'igii lahgo bina'idilkidgo ná bohónéedzǫ́ dóó bee ahóót'i' t'áá ni nizaad k'ehj' bee nií hodoonih t'áadoo báháh ílínigóó. Ata' halné'ígíí la' bich'i' hadeesdzih nínízingo koj' hodóilnih (833) 592-9956.

**Nepali (नेपाली):** यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ।  
दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (833) 592-9956

**Oromo (Oromifaa):** Sanadi kanaa wajjin walqabaate gaffi kamiyyu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (833) 592-9956 bilbilla.

**Pennsylvania Dutch (Deutsch):** Wann du Frooge iwver selle Document hoscht, du hoscht die Recht um Hilfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff (833) 592-9956 aa.

**Polish (polski):** W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer (833) 592-9956.

**Portuguese (Português):** Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para (833) 592-9956.

**Punjabi (ਪੰਜਾਬੀ):** ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਬਾਰੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ (833) 592-9956 ਤੇ ਕਾਲ ਕਰੋ।



## Language Access Services:

**Romanian (Română):** Dacă aveți întrebări referitoare la acest document, aveți dreptul să primiți ajutor și informații în limba dumneavoastră în mod gratuit. Pentru a vă adresa unui interpret, contactați telefonic (833) 592-9956.

**Russian (Русский):** Если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (833) 592-9956.

**Samoan (Samoa):** Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou 'aia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totagi. Ina ia talanoa i se tagata faaliliu, vili (833) 592-9956.

**Serbian (Srpski):** Ukoliko imate bilo kakvih pitanja u vezi sa ovim dokumentom, imate pravo da dobijete pomoć i informacije na vašem jeziku bez ikakvih troškova. Za razgovor sa prevodiocem, pozovite (833) 592-9956.

**Spanish (Español):** Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (833) 592-9956.

**Tagalog (Tagalog):** Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (833) 592-9956.

**Thai (ไทย):** หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร (833) 592-9956 เพื่อพูดคุยกับล่าม

**Ukrainian (Українська):** Якщо у вас виникають запитання з приводу цього документа, ви маєте право безкоштовно отримати допомогу й інформацію вашою рідною мовою. Щоб отримати послуги перекладача, зателефонуйте за номером: (833) 592-9956.

**Urdu (اردو):** اگر اس دستاویز کے بارے میں آپ کا کوئی سوال ہے، تو آپ کو مند اور اپنی زبان میں مفت معلومات حاصل کرنے کا حق حاصل ہے۔ کسی مترجم سے بات کرنے کے لئے، (833) 592-9956 پر کال کریں۔

**Vietnamese (Tiếng Việt):** Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (833) 592-9956.

**Yiddish (Yiddish):** אויב איר האט שאלות וועגן דעם דאקומענט, האט איר דאס רעכט צו באקומען דעם אינאקאמאניע אין א"ע שפראך אהרין פרייז. צו רעדן צו אן איבערזעצער, רופט 592-9956 (833).

**Yoruba (Yorùbá):** Tí o bá ní èyíkẹyí ibèrè nípa akọsílẹ̀ yí, o ní ètọ́ láti gba àrànwọ́ àti iwífún ní èdè rẹ́ lófẹ́ẹ́. Bá wa ògbùfọ́ kan sọ̀rọ̀, pe (833) 592-9956.

## Language Access Services:

### It's important we treat you fairly

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

# Receive virtual care and support

through our **Sydney Health** mobile app



When you aren't feeling your best—physically, mentally, or emotionally—or you need guidance managing a health condition, help is available. You can connect to the care you need using our **Sydney<sup>SM</sup> Health** mobile app. You can have a video visit with a doctor 24/7 for common health issues and annual wellness visits. Care for mental and emotional health is available by appointment.<sup>1</sup> Plus, the Sydney Health app is your avenue to specialized programs designed to help you improve your habits and your health.



## Visit with a doctor for common medical concerns

Doctors are available anytime, with no long wait times and no appointments needed. They can help you with health issues, such as a cold or the flu, allergies, sore throat, migraines, or skin rashes. During your private and secure video visit, the doctor will assess your condition, provide a treatment plan, and send prescriptions to the pharmacy of your choice, if needed.<sup>3</sup>



## Receive care for your behavioral health

If you're feeling anxious or depressed, or having trouble coping, you can set up a video visit with a therapist, psychologist, or psychiatrist.<sup>4</sup> Appointments can be scheduled within one to two weeks.<sup>1</sup> Psychiatrists help manage medications; they do not provide counseling or talk therapy.<sup>5</sup>

## What people say about virtual care visits<sup>2</sup>

92%

were able to book a virtual visit sooner than an in-person visit

89%

said the doctor they saw was professional and helpful

92%

thought the doctor understood their concerns

## How to download our Sydney Health app:

Scan the QR code with your phone's camera.





## Use Sydney Health app to:



### Help you manage your blood pressure

Our Healthy Blood Pressure program connects you with a health coach, doctor, and therapist to help you reach your blood pressure goals through virtual visits. The program also includes a free, smart blood-pressure cuff mailed directly to your home. Of those in the program, 71% indicated that the health coach had an impact on how they manage their blood pressure.<sup>6</sup>



### Connect with a dermatologist

When you have a skin issue and need care quickly, use [anthem.com](https://www.anthem.com) to receive virtual care from a dermatologist 24 hours a day, seven days a week. No appointment needed. Visit with a dermatologist for common skin conditions, such as acne, psoriasis, rosacea, athlete's foot, hair loss, or suspicious moles.



### Help you avoid diabetes

Our Prevent Diabetes program combines the latest in telehealth technology, biometric data, and artificial intelligence to provide you with a personalized behavior-change experience. If you qualify, you will work with a health coach to achieve your health goals and help you prevent diabetes.

## Here's how to access the program through virtual care:

### Download our Sydney Health app.

1. Register (if you haven't yet) and log in.
2. Once you register, your username and password are the same for our app and [anthem.com](https://www.anthem.com).
3. Select **Care** and then select **Video Visit**.

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

1. Register (if you haven't yet) and log in.
2. Once you register, your username and password are the same for [anthem.com](https://www.anthem.com) and our Sydney Health app.
3. Select **Care** and then select **Virtual Video Visit with a provider**.

<sup>1</sup> Appointments subject to availability.

<sup>2</sup> Based on Sydney Health utilization trends from top national clients.

<sup>3</sup> The doctor will determine what medications should be prescribed or refilled.

<sup>4</sup> Online counseling is not appropriate for all kinds of problems. If you are in crisis or having suicidal thoughts, it's important that you seek help immediately. Please text, chat, or call 988 (Suicide and Crisis Lifeline), or 911 for help. If your issue is an emergency, call 911 or go to your nearest emergency room. Emergency services are not provided through virtual care on the Sydney Health app or [anthem.com](https://www.anthem.com).

<sup>5</sup> Prescriptions determined to be a "controlled substance" (as defined by the Controlled Substances Act under federal law) cannot be prescribed through virtual care on the Sydney Health app or [anthem.com](https://www.anthem.com).

<sup>6</sup> Anthem internal data, 2020.

LiveHealth Online is offered through an arrangement with Amwell, a separate company, providing telehealth services on behalf of your health plan.

Sydney Health is offered through an arrangement with Caredot Digital Platforms, a separate company offering mobile application 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.

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# 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.



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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:

- 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.



# The Sydney Health mobile app makes healthcare easier

Access personalized health and wellness information wherever you are

Use Sydney<sup>SM</sup> Health to keep track of your health and benefits — all in one place. With a few taps, you can quickly access your plan details, Member Services, virtual care, and wellness resources. Sydney Health stays one step ahead — moving your health forward by building a world of wellness around you.

## Find Care

Search for doctors, hospitals, and other healthcare professionals in your plan's network and compare costs. You can filter providers by what is most important to you, such as gender, languages spoken, or location. You'll be matched with the best results based on your personal needs.

## My Health Dashboard

Use My Health Dashboard to find news on health topics that interest you, health and wellness tips, and personalized action plans that can help you reach your goals. It also offers a customized experience just for you, such as syncing your fitness tracker and scanning and tracking your meals.

## Chat

If you have questions about your benefits or need information, Sydney Health can help you quickly find what you're looking for and connect you to an Anthem representative.

## Virtual Care

Connect directly to care from the convenience of home. Assess your symptoms quickly using the Symptom Checker or talk to a doctor via chat or video session.

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.

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## Community Resources

This resource center helps you connect with organizations offering no-cost and reduced-cost programs to help with challenges such as food, transportation, and child care.

## My Health Records

See a full picture of your family's health in one secure place. Use a single profile to view, download, and share information such as health histories and electronic medical records directly from your smartphone or computer.

## ¿Prefieres obtener información en español?

Tienes opciones. Si tu teléfono móvil ya está configurado en español, la aplicación Sydney Health también estará en español. Si no es así, selecciona el **menú** dentro de la aplicación Sydney Health y elige el **idioma de la aplicación**. También puedes visitar [anthem.com/es](http://anthem.com/es).



## Download the Sydney Health app today

Use the app anytime to:

- Find care and compare costs.
- See what's covered and check claims.
- View and use digital ID cards.
- Check your plan progress.
- Fill prescriptions.



Scan the QR code to download the Sydney Health app.

You can also set up an account at [anthem.com/register](http://anthem.com/register) to access most of the same features from your computer.

# 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
- Your domestic partner, if deemed eligible by your employer
- Your domestic partner and children, if deemed eligible by your group

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.

# The ins and outs of coverage

## 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
			Your employer: <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>
			Your employer: <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>
			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.

## 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>
		Give wrong information on purpose about yourself or your dependents when you enroll. Cancellation is effective immediately.
		<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> Your coverage will be canceled after you receive a written notice from us.

# The ins and outs of coverage

## 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.



# The ins and outs of coverage

## 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	.	

# The ins and outs of coverage

## 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.

- **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.

- **Administrative Charges**

- Charges to complete claim forms,
- Charges to get medical records or reports,
- 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.

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

- Holistic medicine,
- Homeopathic medicine,
- Massage and massage therapy,
- Reiki therapy,
- Herbal, vitamin or dietary products or therapies,
- Thermography,
- Orthomolecular therapy,
- Contact reflex analysis,
- Bioenergetic synchronization technique (BEST),
- Iridology-study of the iris,
- Auditory integration therapy (AIT),
- Colonic irrigation,
- Magnetic innervation therapy,
- Electromagnetic therapy,

- **Autopsies** Autopsies and post-mortem testing.
- **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.
- **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.
- **Charges Not Supported by Medical Records** Charges for services not described in your medical records.

# What's Not Covered

- **Charges Over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services.
- **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.
- **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 [anthem.com](https://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.

- **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.
- **Compound Ingredients** Compound ingredients that are not FDA approved or do not 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.
- **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:

- Surgery or procedures to correct deformity caused by disease, trauma, or previous therapeutic process.
- Surgery or procedures to correct congenital abnormalities that cause Functional Impairment.
- Surgery or procedures on newborn children to correct congenital abnormalities.

- **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.
- **Custodial Care** Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.
- **Delivery Charges** Charges for delivery of Prescription Drugs.
- **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.

# What's Not Covered

- **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.
- **Drugs Over Quantity or Age Limits** Drugs which are over any quantity or age limits set by the Plan or us.
- **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.
- **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 HealthKeepers.
- **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.
- **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.
- **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.
- **Experimental or Investigational Services** Services or supplies that are found to be 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.

- **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.
- **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.
- **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.
- **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:
  - Cleaning and soaking the feet.
  - Applying skin creams to care for skin tone.
  - 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.



# What's Not Covered

- **Foot Surgery** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratosis.
- **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.
- **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.

- **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.
- **Hearing Aids** For Members age 19 or older, 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.
- **Home Health Care**
  - 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.
  - 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.
- **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.
- **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
- **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.
- **Medical Chats Not Provided through Our Mobile App** Texting or chat services provided through a service other than our mobile app.
- **Medical Equipment, Devices, and Supplies**
  - Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
  - Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
  - Non-Medically Necessary enhancements to standard equipment and devices.
  - 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.

# What's Not Covered

- 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.
- **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.
- **Missed or Cancelled Appointments** Charges for missed or cancelled appointments.
- **Non-approved Drugs** Drugs not approved by the FDA.
- **Non-Approved Facility** Services from a Provider that does not meet the definition of Facility.
- **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.
- **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Booklet or that must be covered 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.
- **Off label use** Off label use, unless we approve it.
- **Personal Care, Convenience and Mobile/Wearable Devices**
  - Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs,
  - 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),
  - Home workout or therapy equipment, including treadmills and home gyms,
  - Pools, whirlpools, spas, or hydrotherapy equipment,
  - Hypoallergenic pillows, mattresses, or waterbeds,
  - Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).
  - Consumer wearable / personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.
- **Prescription Drugs** Prescription Drugs received from a Retail or Home Delivery (Mail Order) Pharmacy.
- **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:
  - 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.
  - 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.

# What's Not Covered

— 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.

- **Services Not Appropriate for Virtual Telemedicine / Telehealth Visits** Services that HealthKeepers determines require in-person contact and/or equipment that cannot be provided remotely.
- **Sexual Dysfunction** Services or supplies for male or female sexual problems.
- **Specialty Drugs** Specialty Drugs for which another source of payment is available, including but not limited to, manufacturer and copay assistance programs. This Exclusion applies to the full amount charged for any such Drug, not just the amount of alternate assistance potentially available, and applies regardless of whether such alternate assistance is received or pursued\*
- **Stand-By Charges** Stand-by charges of a Doctor or other Provider.
- **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).
- **Temporomandibular Joint Treatment** Fixed or removable appliances that move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).
- **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.
- **Vein Treatment** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.
- **Vision Services** Vision services not described as Covered Services in this Booklet.
- **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.
- **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.
- **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:

- **Administration Charges** Charges for the administration of any Drug except for covered immunizations as approved by the Plan or the PBM.
- **Charges Not Supported by Medical Records** Charges for pharmacy services not related to conditions, diagnoses, and/or recommended medications described in your medical records.
- **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.

# What's Not Covered

- **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 [anthem.com](http://anthem.com).
- **Compound Ingredients** Compound ingredients that are not FDA approved or do not 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.
- **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.
- **Delivery Charges** Charges for delivery of Prescription Drugs.
- **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.
- **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).
- **Drugs Over Quantity or Age Limits** Drugs which are over any quantity or age limits set by the Plan or us.
- **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.
- **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 HealthKeepers.
- **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 must be covered under federal law when recommended by the U.S. Preventive Services Task Force and prescribed by a physician.

- **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.
- **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.
- **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.
- **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.

# What's Not Covered

- **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
- **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.
- **Non-approved Drugs** Drugs not approved by the FDA.
- **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.
- **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.
- **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.

- **Syringes** Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.



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# 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, 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 your eligible dependents) become eligible to receive help from Medicaid or SCHIP for paying part of the cost of a health plan with us.

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

# 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 ունեւ ստանալ անվար օգնություն ձեր լեզվով: Պարզապէս զանգահարե՛ք 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 ਵਿੱਚ ਮਦਦ ਹਾਸਲ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਬਸ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਸੇਵਿਸ 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>



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

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